Southern Health and Social Care Trust
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TRUST BOARD ANNUAL CYCLE OF REPORTING

1st SEPTEMBER 2023 – 31ST AUGUST 2024

STANDARD AGENDA ITEMS	Date
Declaration of Interests	Each meeting
Minutes of previous meeting	"
Matters arising	"
Chief Executive's Current Issues	
Chair and Chief Executive's Business and Visits including Non-Executive Directors' Business and Visits	"
Application of Trust seal	"
Presentation: Service Improvement/Learning from Service User Experience	As appropriate
STRATEGY	
Capital and Revenue Business Cases >£300,000	Sept 2023/Jan 2024/ March 2024
Corporate Plan 2023/24 six-monthly Update Corporate Plan 2024/25 – 'One Year Plan'	Jan 2024/May 2024 June 2024
Surgical Services update	As appropriate
ACCOUNTABILITY	
Update on Trust Service Delivery Plan	Oct 2023/Jan 2024/ March 2024
Year-end report of Capital and Revenue Investment 2023/24	June 2024
Finance Report	Each meeting
Financial Resource Budget/Financial Plan	June 2024
Trust Annual Report and Accounts Trust Charitable Funds Annual Report and Accounts	June 2024
Statement of Losses and Special Payments	June 2024
Mid-Year Assurance Statement	October 2023
Report to Those Charged with Governance	June 2023 (draft) October 2023 (final)
Board Governance Self-Assessment Tool	September 2023
Corporate Parenting Progress Report	October 2023
Delegation of Statutory Functions Report	May 2024

For Trust Board approval on 22.6.2023

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Trust Board 28th September 2023		
Title of paper	Changes to Trust Board Committee composition		
Accountable Director	Name	Eileen Mullan	
	Position	Chair	
Report Author	Name	Eileen Mullan	
	Email	Personal Information redacted by the USI	
This paper sits within the Trust Board role of:		Accountability	
This paper is presented for:		Approval	

Links to Trust Corporate Objectives	☒	Promoting Safe, High Quality Care
	☒	Supporting people to live long, healthy active lives
	☒	Improving our services
	☒	Making best use of our resources
	☒	Being a great place to work – supporting, developing and valuing our staff
	☒	Working in partnership

The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report).

Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee

1. Detailed summary of paper contents:

Under Standing Orders, "*the Board shall determine the membership and Terms of Reference of Committees and shall approve the appointments to each of the Committees it has formally constituted."*

As part of the review of the Trust's Governance arrangements, a review of Trust Board Committees has been undertaken. As a result, the Committees have been reconstituted as follows:-

- Governance Committee
- Audit and Risk Assurance Committee
- Remuneration and Terms of Service Committee
- Charitable Trust Funds Committee
- Finance and Performance Committee
- Patient and Client Experience Committee
- Strategy and Transformation Committee

This report details the Committees' composition, including changes to Committee Chairs, given that the tenure of 2 Non-Executive Directors will end on 15.2.2024 and the tenure of 3 Non-Executive Directors will end on 31.12.2024.

2. Areas of improvement/achievement:

- Membership strengthened to include Executive Directors

- The establishment of a new Strategic and Transformation Committee. A first draft of its Terms of Reference will be considered at the first meeting of this Committee in November 2023. A final draft will be presented at a future Trust Board meeting for approval.

- The Finance and performance committee will provide the opportunity for deeper analysis of financial performance and challenges.

- Each Committee will review their Terms of Reference and a final draft will presented at a future Trust Board meeting for approval.

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Committee Chair Role Description

Working together Excellence Openness & Honesty Compassion

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COMMITTEE CHAIR ROLE DESCRIPTION

Position Summary:
The Committee Chair acts as the leader for one of the Southern Health and Social Care Trust's Trust Board sub-committees and is key in providing effective leadership to the committee membership. They are responsible for chairing committee meetings, facilitating discussion, and ensuring the committee fulfils its duties and responsibilities as set out in the committee terms of reference and in alignment with Trust objectives and priorities. The Committee Chair will set clear expectations concerning the Trust's culture, values and behaviours, including Committee member attendance and commitment and setting the style and tone of discussions at Committee meetings.

The Committee Chair will have a clear understanding of the Committee's duties and responsibilities, be able to commit the necessary time and have the requisite business, financial, communication and leadership skills.

As Chair, you will cultivate a culture of accountability, transparency, and mission-driven decision making to aid the organisation in upholding its standards and achieving its performance objectives.

Main Responsibilities:

- Chair committee meetings according to an established schedule, facilitating productive discussion and decision-making
- Provide assurance to Trust Board on the work and remit of the Committee including areas of risk, non-compliance and success via submission of a Committee Chair's report to Trust Board after each Committee meeting
- Ensure items are escalated to Trust Board by the Committee through detailing within the Committee Chair report.
- Provide inspiring leadership and strategic oversight to keep the committee focused on the Trust's priority governance issues, objectives and required standards in the committee's designated area of responsibility
- To ensure an annual cycle of Committee meetings is put in place and to ensure Committee meetings are conducted in an appropriate manner and that all members are free to contribute
- Ensure that the Terms of Reference are reviewed on an annual basis and approved by Trust Board
- Ensure that an annual Committee work programme is in place and approved by Trust Board

Trust Board Committee Composition

From 28th September 2023

GOVERNANCE COMMITTEE

- Chair of Governance Committee (Non-Executive Director)
  - Mr Martin McDonald (to 31st December 2023)
  - Mrs Pauline Leeson (from 1st January 2024)
- 2 Non-Executive Directors
- Chief Executive
- Executive Director of Nursing, Midwifery and AHPs & Functional Support Services / Deputy Chief Executive
- Executive Director of Finance, Procurement and Estates/Deputy Chief Executive
- Medical Director
- Executive Director of Social Work

Attendance for the full meeting:

- Director of Mental Health and Learning Disability

Attendance for specific agenda items:
Requirement that any Director / Assistant Director will be requested to attend when a report pertinent to their area of responsibility is being discussed.

FINANCE AND PERFORMANCE COMMITTEE

- Chair of Finance and Performance Committee (Non-Executive Director)
  - Mrs Pauline Leeson (up to 21st September 2023)
  - Ms Geraldine Donaghy (from 22nd September 2023)
- 2 Non-Executive Directors
- Chief Executive/Accounting Officer
- Executive Director of Finance, Procurement and Estates / Deputy Chief Executive
- Executive Director of Nursing, Midwifery & AHPs and Functional Support Services / Deputy Chief Executive
- Medical Director

In attendance for the full meeting:

- Director of Surgery & Clinical Services
- Director of Medicine and Unscheduled Care
- Director of Performance, Planning and Informatics
- Director of Human Resources and Organisational Development
- Assistant Director of Performance Improvement
- Assistant Director of Financial Management

Attendance for specific agenda items:
Requirement that a Director / Assistant Director will be requested to attend when a report pertinent to their area of responsibility is being discussed.

PATIENT AND CLIENT EXPERIENCE COMMITTEE

- Chair of Patient & Client Experience Committee (Non-Executive Director)
  - Mr John Wilkinson (up to 15th February 2024)
  - New Non-Executive Director (from appointment - Chair from 16th February 2023)
- 2 Non-Executive Directors
- Executive Director of Nursing, Midwifery and Allied Health Professions/Deputy Chief Executive
- Interim Director of Children and Young People/Executive Director of Social Work
- Not less than 3 representatives of the Public and Personal Involvement (PPI) Panel.

In attendance for the full meeting:

- Director of Mental Health and Learning Disability
- Director of Adult and Community Services
- Assistant Director, Nursing, Midwifery and AHPs
- Assistant Director, Promoting Wellbeing
- Assistant Director Quality Improvement

Attendance for specific agenda items:
Requirement that a Director / Assistant Director will be requested to attend when a report pertinent to their area of responsibility is being discussed.

REMUNERATION AND TERMS OF SERVICE COMMITTEE

- Chair of Remuneration and Terms of Service Committee (Non-Executive Director)
  - Ms Eileen Mullan
- 2 Non-Executive Directors

In attendance:

- Chief Executive
- Director of Human Resources and Organisational Development

STRATEGY AND TRANSFORMATION COMMITTEE

- Chair of Strategy and Transformation Committee (Non-Executive Director)
  - Ms Eileen Mullan
- 2 Non-Executive Directors
- Chief Executive
- Executive Director Finance, Procurement and Estates / Deputy Chief Executive
- Executive Director of Nursing, Midwifery and AHPs & Functional Support Services / Deputy Chief Executive
- Medical Director

Attendance for the full meeting:

- Director of Planning, Performance and Informatics
- Director of Human Resources and Organisational Development
- Head of Communications

Attendance for specific agenda items:
Requirement that a Director / Assistant Director will be requested to attend when a report pertinent to their area of responsibility is being discussed.

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Medical Leadership Review

Revised March 2020

Senior Management Team Meeting - Date 10th March 2020

6. Over time there has been an erosion of the number and impact of these leadership roles which in turn has affected morale, recruitment and retention of staff, particularly doctors. (See section 14, p 22)

7. Given the length of time since the 2011 review and the significant changes in the health and social care landscape it is now time to -re-visit, the Trust medical leadership form and function, based on an assessment of how fit for purpose it remains in a highly dynamic environment.

8. Any structure that emerges must drive a culture of effective, continually improving high quality, safe, patient / service user focussed services underpinned by quality improvement, education and research.

9. It must be open and transparent in its decision making. It must encourage all clinicians to contribute to Trust's strategic priorities and take responsibility for contributing their delivery.

2. Strategic Drivers

10. The Southern Trust must nurture a culture that ensures the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are fostered is fundamental[5].

11. The task of leaders is to ensure direction, alignment of purpose and commitment within teams and organisations. Direction ensures agreement and pride among people in relation to what the organisation is trying to achieve, consistent with vision, values and strategy. Alignment refers to effective coordination and integration of the work.

[5] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*

8. Consultation with Trust Medical Leadership

30. As part of the scoping exercise to review the current medical leadership structure, an independent survey of medical leaders was carried out to identify barriers and enablers to achieving a robust medical leadership structure and engagement model (2018/19). A supplementary paper titled *Consultation with Trust Medical Leadership* can be found in appendix 4. A summary of key findings that relate to the current medical leadership model is found in the table below.

	Key Themes
Motivation to Become Involved in Medical Leadership	• There is a high level of motivation among Trust Medical Leaders • Medical Leaders feel acknowledged by their colleagues and the Trust • While there is acknowledgement that medical leadership is challenging, current leaders feel a sense of purpose and achievement in their roles
Challenges to Developing Medical Leadership	• There is a lack of engagement in leadership roles throughout the Trust • There is not adequate PA allocation and backfilling • Clear links between medical leadership and tangible improvements to the quality of services should be sought
Barriers to Implementing Medical Leadership	• Associate Medical Directors perceive that they are often left out of decision making • Medical Leaders often undertake their leadership roles in unpaid time
The Medical Leadership Setting	• Medical leaders regard themselves as having autonomy and freedom to get on with the job • While medical leaders feel recognised in their roles, the provision of protected time to deliver the job is only available to a small proportion

31. The survey brings to attention several key findings including a high level of motivation to become and remain a medical leader that is contrasted with restrictions imposed by limited time and balancing clinical commitments.

32. Associate Medical Directors feel they would like a bigger role in decision making regarding services provided, however acknowledge that this will require allocated resource to ensure existing service levels are maintained.

9. Consultation with Trust Directors

33. Trust Directors were asked to give their views and opinions on the current medical leadership structure (2018). A short questionnaire was provided to participants asking for views on the current medical leadership functions and roles including contribution to leading and developing services, integration with operational management teams and what opportunities exist to strengthen the medical leader role. A summary of key findings that relate to the current medical leadership model is found in the table below (appendix 4 contains full reponses).

	Key Themes
Strengthening the Role of Medical Leaders	• Clarification of roles and responsibilities of Medical Leaders and how they relate to operational management roles • Requirement to identify clear areas of responsibility and accountability for medical leaders • Need for protected time to conduct medical leadership role • Provide support for service innovation and quality improvement • Stronger links between directorate senior managers and senior medical leaders • Increased opportunities to gain understanding of wider directorate service demands / pressures • Trust senior managers and Medical Leaders to agree a set of corporate annual objectives for service improvements
Integration of Medical Leadership with Operational Management	• Can be dependent on the nature of the directorate services • The role of Clinical Directors is less clear than that of Associate Medical Director • Clarification of medical leadership roles with more structured engagement

Section 2 – Proposed Medical Leadership Structure

11. Medical Leadership Development and Competence

36. A supplementary paper titled Medical Management and Leadership Development will follow.

12. Medical Leadership Appointments

37. It is proposed that if approved, all Medical Leadership management posts will be vacated and reappointed collectively.

38. This paper proposes that all senior medical leadership positions commencing from August 2019 are fixed-term appointments (details found in subdivision 14 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

13. Proposed Medical Leadership Roles and Responsibilities

The below sections provide outlines of both existing and new medical leadership posts.

13.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director position, responsible for providing assurance to Trust Board those effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services,

21.9 In 2022, as a second phase Trust Clinical Director roles have been revised and strengthened to include more allocated time along with a stronger clinical governance role.

21.10 The table below lists the elements that now feature in both Divisional Medical Director and Clinical Director job descriptions.

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DivMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

21.11 In support of these changes three new Deputy Medical Director positions were created to both strengthen the medical governance function and improve coordination of information flows regarding same.

COMMENCED DATE	END DATE	POSTHOLDER NAME	POST
22/11/2021	CURRENT	Dr Damian Scullion	Deputy Medical Director - Appraisal and Revalidation
06/04/2020	CURRENT	Dr Aisling Diamond	Deputy Medical Director - Workforce and Education
01/04/2021	CURRENT	Dr Damian Gormley	Deputy Medical Director - Quality, Safety and Governance

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JOB DESCRIPTION

POST: Divisional Medical Director – Urology Improvement (Temporary post – 2 years initially)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Urology Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- Provide medical leadership and direction regarding strategic development of Urology Services within the Southern Trust.

- In conjunction with the AD Surgery and Elective Care lead on the Urology review lookback and coordinate clinical resources as appropriate.

- In conjunction with the AD Surgery and Elective Care provide clinical leadership on the development of business cases to involve independent sector support for lookback reviews as required.

- Be the Trust key clinical contact for liaising with external bodies such as the Royal College of Surgeons and BAUS to gain independent expert advice on urology lookback and quality improvement proposals.

- Review and provide input into the modification of the department to improve and expand Urology services and have an active involvement in the implementation of quality improvement initiatives. This includes specifically:

  - Chairing the urology quality improvement group designated with responsibility for ensuring effective, high quality care is provided.

  - Co-Chairing the Urology SAI task and finish group responsible for ensuring compliance with SAI recommendations made in the 2016 and 2021 urology SAI reviews regarding urology and cancer services.

- Ensure all clinical staff are aware of Trust policies and procedures in relation to good medical practice, and compliant with relevant standards and guidelines.

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Burns, Deborah
Sent: 10 June 2014 19:11
To: McVey, Anne; Trouton, Heather; Corrigan, Martina; Stinson, Emma M
Cc: Cardwell, David; Kerr, Vivienne
Subject: FW: URGENT: Personal Information redacted by the USI

Please see for urgent review and logging by governance – probably a urology issue / gynae let me know
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Wright, Elaine
Sent: 10 June 2014 15:22
To: Burns, Deborah
Cc: Stinson, Emma M; Complaints
Subject: URGENT: Personal Information redacted by the USI

Please find as below for urgent action/response.
Many thanks – Elaine

From: Wright, Elaine
Sent: 10 June 2014 15:21
To: South Tyrone
Subject: Personal Information redacted by the USI

Dear Alastair
Thank you for your email.
I will ask that contact is made with you regarding the issue you have raised.
Many thanks.
Kind regards, Elaine

From: South Tyrone [mailto: Personal Information redacted by the USI]
Sent: 10 June 2014 11:34
To: Wright, Elaine
Cc: Personal Information redacted by the USI; Alan Dourish- UUP FST; t.elliot Personal Information redacted by the USI Tom (Assembly) Elliott; Tom Elliott
Subject: Personal Information redacted by the USI

Mairead

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Job Planning Steering Group

Terms of Reference

Aim

The aim of the Job Planning Steering Group is to ensure that:

- Processes are in place so that all directly employed and medium to long term locum medical staff working for the Trust have a job plan in place.
- Processes are in place so that all directly employed and medium to long term locum medical staff have job plans agreed and signed off prospectively on an annual basis
- There is consistency of approach in job planning between specialties, divisions and directorates and that this is reflected in the resultant job plans.
- Developments in job planning and consider issues of concern relating to job planning are discussed taking account of Trust priorities and objectives.
- All job plans include, as far as is reasonably practical, quantifiable levels of activity and outcomes, either at team and/or individual level.
- The Trust's Job Planning Policy is kept up to date.

Guiding Principles and Values

The overarching principles of this Job Planning Steering Group are:

- To ensure effective decision making around solutions to meet identified priorities, which offer the best value for money from investment of public funding.

- To consider progress on achieving completed job plans which align to the Trust's strategic priorities

The approach to achieving these aims will be underpinned by a set of values that demonstrate that job planning is:-

- undertaken in a spirit of collaboration and cooperation
- mutually agreed and not imposed
- completed in good time with at least annual review
- reflective of the professionalism of being a doctor
- agreed taking account of the career development and aspirations of the doctor
- focused on maintaining high-quality care
- transparent, fair and honest
- agreed taking into account the individual doctor's area(s) of expertise
- agreed with adequate provision for any activities mandated by regulating agencies
- responsive to appraisal discussion

55.9

When and in what context did you first become aware of issues of concern regarding Mr. O'Brien?
11th March 2019, I received Mr O'Brien's appraisals for 2014-2016.
What were those issues of concern and when and by whom were they first raised with you?
I ascertained that, in the course of these, he had not raised reflections about the concerns raised about him leading to MHPS and the recent SAIs involving his patients.
Do you now know how long these issues were in existence before coming to your or anyone else's attention?
There was no clear evidence in the Appraisals that his appraiser had been made aware of any concerns. In addition to this, his 2017 Appraisal had not been completed nor had his 2018 Appraisal (for which 360 degree feedback was required) and his Revalidation date was due for renewal on the 4th April 2019. I requested any complaints, SAIs, and medicolegal and coroners' court involvement in relation to Mr O'Brien since his last revalidation. These did not appear to indicate any specific clinical concerns that could be differentiated from long waits at that time.
Please provide any relevant documents
Attach medicolegal excel spreadsheet emailed 8.7.22. Document located at *S21 No 29 of 2022, 211. 20211005 Open Urology Claims* ATTACH COMPLAINTS EXCEL SHEET. Document located at S21 No 29 of 2022, 176. *UROLOGY COMPLAINTS SINCE 2009*

55.10

Date of discussions	Detail of the content and nature of all discussions including meetings in which I was involved which considered concerns about Mr O'Brien	Name those present
11th March 2019	Discussion with Dr Scullion appraiser by phone to confirm that what was contained in the Appraisals was what was known to him and to ascertain whether he had patient safety or other concerns on the basis of the appraisals. He stated that he did not. Received and reviewed all complaints in relation to Mr O'Brien- theme in relation to waiting list Appraisals 2014,15,16 received - Failure to mention and reflect on complaints concerns re probity, insight.	Dr Damian Scullion

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TRUST BOARD COVER SHEET

Meeting Date	January 2024		
Agenda item	Medical Director's Report Medical Appraisal and Revalidation		
Accountable Director	Dr Stephen Austin – Medical Director		
Report Author	Name	Maggie Davison	
	Email Address	Personal Information redacted by the USI	
This paper sits within the Trust Board role of: **Accountability**			
This paper is presented for: **Assurance**			
Links to Trust Corporate Objectives	☐	Promoting Safe, High Quality Care	
	☐	Supporting people to live long, healthy active lives	
	√	Improving our services	
	☐	Making best use of our resources	
	☐	Being a great place to work – supporting, developing and valuing our staff	
	☐	Working in partnership	

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

Southern Health and Social Care Trust

Divisional Medical Director Review Meeting

Divisional Medical Director	
Division	
Meeting Date	

Southern Health and Social Care Trust

Professional Governance

1. Job Planning	
Current Status	
Discussion	*e.g. Issues delaying job planning activities, staff absences, discussion of additional supports required*
Agreed Actions	•

2. Medical Appraisal	
Current Status	**Example below:** **Appraisal Year 2020**
Discussion	*e.g. Issues delaying appraisals, staff absences, discussion of additional supports required*
Agreed Actions	•

3. Revalidation	
Current Status	**Total Number of Divisional Doctors Requiring Revalidation in Year:** **Total Number of Divisional Doctors Revalidated In Year:** **Total Number of Divisional Doctors with Deferred Revalidation Date:**
Discussion	*e.g. Issues delaying revalidation, staff absences, reasons for deferrals, any concerns with staff meeting required deadlines*
Agreed Actions	•

4. Professional Performance Management	
Current Status	**Total Number of Divisional Doctors Performance Management Reviews in Year:** **Total Number of Divisional Doctors Undertaken Performance Management Reviews In Year:**
Discussion	*e.g. Issues delaying revalidation, staff absences, reasons for deferrals, issues identified via professional performance management*
Agreed Actions	

5. Medical Workforce

Current Status

Specialty 1

	Substantive Posts	Locum Posts
Number of funded Consultant Posts		
Number of funded SAS Posts		
Number of Training Grade Posts		

Details of Posts Actively Being Recruited:

Specialty 2

	Substantive Posts	Locum Posts
Number of funded Consultant Posts		
Number of funded SAS Posts		
Number of Training Grade Posts		

Details of Posts Actively Being Recruited:

Discussion

e.g. Issues delaying recruitment, efforts to make posts substantive , areas of short staffing, mitigation steps taken, escalation of issuesetc

Agreed Actions

-

6. Doctors and Dentists Oversight	
Current Status	
Discussion	*e.g. Issues identified from DDOG meeting, other issues arising that may need addressed, doctors in difficulty*
Agreed Actions	•

Southern Health and Social Care Trust

Clinical and Social Care Governance

1. Adverse Incidents (Datix)

Current Status

Reported Incidents

	Signed off	Not Signed Off	Total
Number of Catastrophic Incidents this Quarter (Oct – Dec)			
Number of Major Incidents this Quarter (Oct – Dec)			
Number of Moderate Incidents this Quarter (Oct – Dec)			
Number of Minor Incidents this Quarter (Oct – Dec)			

Medication Incidents

Discussion

e.g. trends in incidents, learning from incidents, quality improvemen intiatives, where further support is required etc

Agreed Actions

-

2. Serious Adverse Incidents

Current Status

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3	Total

New SAIs This Quarter (Oct – Dec)	Governance Team Update

Ongoing SAIs	Update

Discussion

e.g. trends in SAIs, learning from SAIs, quality improvemen intiatives, where further support is required

Agreed Actions

- .

3. Litigation and Claims Management	
Current Status	
Discussion	*e.g. trends in litigation, learning from litigaion, quality improvemen intiatives, where further support is required etc* .
Agreed Actions	•

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Medical and Dental Oversight Group

Terms of Reference
2020

Summary & Purpose

The Purpose of the Medical and Dental Oversight Group is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is;

- a process for review of all cases where a practitioners practice, conduct, health gives cause for concern,
- regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS),
- regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or any national professional regulatory body of another sovereign state,
- no undue delays in addressing practitioner performance issues.
- Adequate support, guidance for clinical managers and individual practitioners
- Consistency in approach and decision making where appropriate across the organisation

Terms of Reference

The panel will review the case files of all medical and dental practitioners employed in the Trust, or engaged via Agency for whom there concerns have been raised about their professional practice. This applies to any medical or dental practitioner registered with the GMC and/or GDC who is currently employed or was employed at the time concerns arose. Termination of employment, for whatever reason, does not necessarily end Trust responsibility in terms of MHPS or regulatory Fitness to Practice procedures.

Concerns about professional practice shall include;

- all Fitness to Practice procedures with regulatory agencies,
- all practitioners subject to procedures under MHPS (or equivalent procedures for doctors in training),
- restrictions, undertakings, suspensions or other sanctions imposed by a regulatory agency,
- all cases where NCAS have provided advice or assessment,
- all practitioners subject to a remediation process,
- practitioners whose performance has been called into question through appraisal and/or governance systems (as determined by the Responsible Officer),
- and all doctors for whom a recommendation to revalidate could not be provided at the time requested by GMC.

The Oversight Panel shall regularly review each case file with the Medical/Dental manager for the practitioner.

Managing Low Level Concerns Training Record

Mandatory for all Clinical Directors, Clinical Leads and Operational Assistant Directors. Training required every 3 years
Last updated 17/01/2024

Name	Role	Date trained	Renewal Date	Certificate issued	Notes
Dr Andrew Knox	Clinical Director Obstetrics & Gynaecology CAH	02/05/2023	02/05/2026	Y	
Dr Aiden Cullen	Clinical Director Anaesthetics (DHH)	18/04/2023	18/04/2026	Y	
Dr Chris Clarke	Clinical Director ICU	02/05/2023	02/05/2026	Y	
Mr Adrian Neill	Clinical Director General Surgery	02/05/2023	02/05/2026	Y	
Dr James Hughes	Clinical Director Community Paediatrics	02/05/2023	02/05/2026	Y	
Dr Philip Quinn	Clincial Director Acute Paediatrics (CAH)	18/04/2023	18/04/2026	Y	
Dr Aisling Diamond	Deputy Medical Director Workforce and Education	18/04/2023	18/04/2026	Y	
Dr David Mawhinney	Clinical Director Emergency Medicine DHH	02/05/2023	02/05/2026	Y	
Dr Una Bradley	Clinical Director Medicine CAH (Acute Med /Gastro / Gmed / Respiratory / Diab & Endo	02/05/2023	02/05/2026	Y	
Dr Gareth Hampton	DMD Emergency Medicine & Unscheduled Care	02/05/2023	02/05/2026	Y	
Dr Rose McCullagh (AMD)	AMD Primary Care	02/05/2023	02/05/2026	Y	
Dr Damian Scullion	Deputy Medical Director Appraisal and Revalidation	18/04/2023	18/04/2026	Y	
Caroline Keown	AD of Integrated Maternity and Women's Health	02/05/2023	02/05/2026	Y	
Mary Burke	AD of Unscheduled Care	18/04/2023	18/04/2026	Y	
Julie McConville	AD of Specialist Child Health & Disability	02/05/2023	02/05/2026	Y	
Amie Nelson	HOS General & Oral Surgery, Breast and Endoscopy	02/05/2023	02/05/2026	Y	
Denise Newell	Head of Diagnostics	18/04/2023	18/04/2026	Y	
Wendy Clarke	Head of Midwifery & Gynaecology	02/05/2023	02/05/2026	Y	
Bernie McGibbon	Head of Acute Paediatric Services	02/05/2023	02/05/2026	Y	
Joan McMahon	Head of Community Paediatrics	02/05/2023	02/05/2026	Y	
Denise Carroll	Head of CAMHS/Autism	02/05/2023	02/05/2026	Y	
Ashley Craig	Consultant DHH	02/05/2023	02/05/2026	Y	
Bronagh McGleenon		02/05/2023	02/05/2026	Y	
Edgar Boggs	O&G Consultant	02/05/2023	02/05/2026	Y	
Janine Redmond	Medical Manager - Paeds	02/05/2023	02/05/2026	Y	
Kieran O'Connor	Anaesthetic Consultant	02/05/2023	02/05/2026	Y	
Rosemary Sloan	Clinical Lead Urgent Care Service Southern Trust	02/05/2023	02/05/2026	Y	
Karen Walker	Head of Urgent Care Service Southern Trust (GP)	02/05/2023	02/05/2026	Y	
Kerrie Smyth	Respiratory Physiologist DHH	02/05/2023	02/05/2026	Y	
David Grier	Paeds Consultant	18/04/2023	18/04/2026	Y	
Donna Muckian	CD DHH MED	18/04/2023	18/04/2026	Y	

Edel O'Neill	Consultant	18/04/2023	18/04/2026	Y	
Jayne McAuley	Palliative Care Consultant	18/04/2023	18/04/2026	Y	
Robin Brown	Consultant DHH	18/04/2023	18/04/2026	Y	
Shane Moan	Respiratory Consultant DHH	18/04/2023	18/04/2026	Y	
Shiva Arava	Specialist Reg Anaesthetics	18/04/2023	18/04/2026	Y	
Elaine Mulligan	Head of Specialist Primary Care Services	18/04/2023	18/04/2026	Y	
Nicola O'Reilly	Medical HR Case Manager	18/04/2023	18/04/2026	Y	
Rachelle Moore	Research & Development Manager	18/04/2023	18/04/2026	Y	
Simon Gibson	AD Medical Education & Workforce	18/04/2023	18/04/2026	Y	
Tracey Woods	Medical HR Manager	18/04/2023	18/04/2026	Y	
Dr Tanmoy Chakrabarty	Clinical Director Acute Paediatrics (DHH)	28/11/2023	28/11/2026	Y	
Dr Jonathan Boyd	Clinical Director Community Paediatrics	28/11/2023	28/11/2026	Y	
Dr Erskine Holmes	Clinical Director Emergency Medicine CAH	28/11/2023	28/11/2026	Y	
Dr Pat McCaffrey	DMD Older People Services	28/11/2023	28/11/2026	Y	
Sharon Holmes	HOS AMU, Ambulatory, DAU & Patient Flow	28/11/2023	28/11/2026	Y	
Paul Smyth	Acting HOS Emergency Department, Minor Injuries	28/11/2023	28/11/2026	Y	
Brigid Collins	EM Consultant	28/11/2023	28/11/2026	Y	
Ruth Spedding	Consultant DHH	28/11/2023	28/11/2026	Y	
Cheryl Gaston	ED Consultant	28/11/2023	28/11/2026	Y	
Declan Keenan	AMU Consultant	28/11/2023	28/11/2026	Y	
Aaron Ervine	Consultant Histopathologist	28/11/2023	28/11/2026	Y	
Lynda Magowan	ED Consultant	28/11/2023	28/11/2026	Y	
Elaine Campbell	Quality Nurse Lead	28/11/2023	28/11/2026	Y	
John Simpson	Independent SAI Chair	28/11/2023	28/11/2026	Y	
Grace Hamilton	AD Nursing, Safety, Quality and Patient Experience	28/11/2023	28/11/2026	Y	
Maggie Davison	Senior Revalidation & Appraisal Manager (Medical & Nursing)	28/11/2023	28/11/2026	Y	
Alice O'Neill	Consultant Anaesthetist	28/11/2023	28/11/2026	Y	
Siobhan Hynds	Deputy Director of HR Services	28/11/2023	28/11/2026	Y	

Not 'Low Level Concerns' Trained

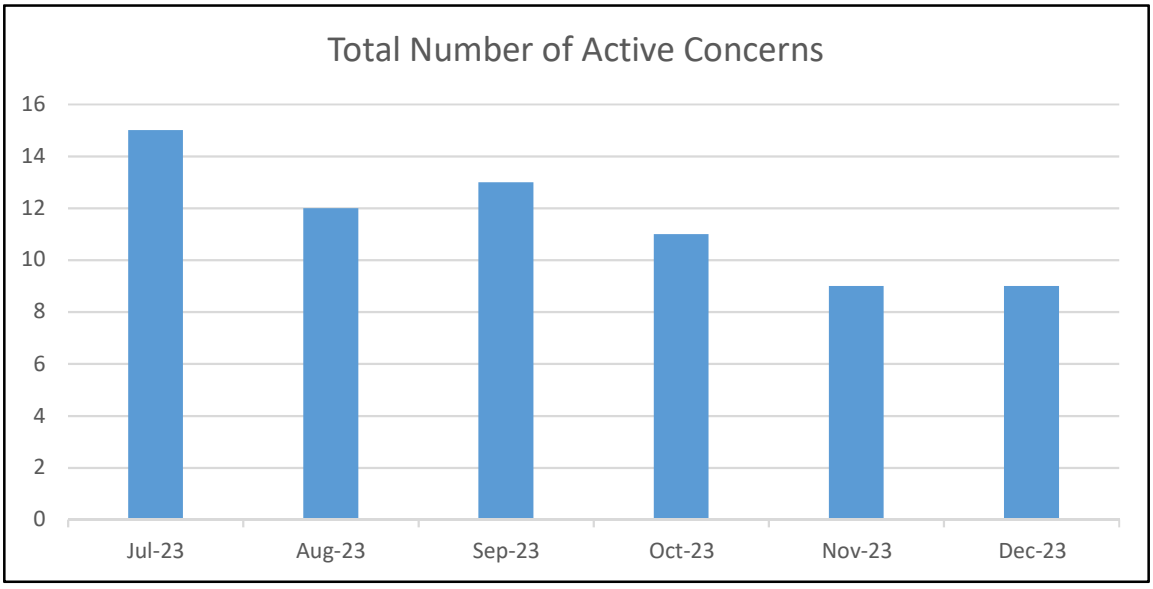
Name	Role	Email	Notes
Dr Janet Acheson	Clinical Director O&G DHH	Personal Information redacted by the USI	
Dr Katharine Loane	Clinical Director O&G DHH		
Dr Chris Southwell	Clinical Director Psychiatry Old Age		
Dr Matt Armstrong	Clinical Director Intellectual Disability		
Dr Orlagh McCambridge	Clinical Director MHDS Community & Specialist Mental Health		
Dr Paul Coulter	Clinical Director MHDS Acute & Unscheduled MH		
Dr Brian Donnelly	Clinical Director Anaesthetics CAH		
Dr Imran Yousuf	Clinical Director Radiology		
Dr Clare McGalie	Clinical Director Laboratory Services		
Dr Sarinda Millar	Clinical Director Acute Paeds DHH		
Ms Veronica Roberts	Clinical Director T&O		
Dr David McEneaney	Clinical Director Cardiology		
Dr Adam Uprichard	Clinical Director Cancer Services		
Dr Caroline Sheehan	Clinical Director CAMHS		
Dr Arun Subramanian	Clinical Director Learning Disability		
Dr Shahid Tariq	DMD Cancer & Clinical Services		
Dr Mark Haynes	DMD Surgery & Elective Care		
Mr Ted McNaboe (Interim)	DMD Surgery & Elective Care		
Dr Philip Murphy	Medicine		
Dr Beverly Adams	DMD Integrated Maternity & Women's Health		
Dr Raymond McKee	DMD Anaesthetics, Theatre & ICU		
Dr Jo Minay	DMD MH & Disanbility		
Dr Anna McGovern	DMD Children and Young People		
Dr Peter Sharpe	Research & Development		
Dr Darrell Lowry	Director of Medical Education		
Dr Damian Gormley	Deputy Medical Director Quality Safety and Governance		
Lynn Lappin (interim)	AD Surgery and Out-Patients		
Declan McClements (Interim)	AD Surgery, Anaesthetics, Theatres and ICU		
Barry Conway	AD Cancer & Clinical Services		
Chris Wamsley	AD Medicine		
John McEntee	AD Mental Health Services		
Roisin O'Hare	AD Disability Services		
Joe Walker	AD MH & ID Inpatients		
Lisa Houlihan	Assistant Director Medicine		
Catherine Sheeran	(Interim) Assistant Director Enhanced Services		
Monica McAlister	AD Older People's Services		
Helena Murray	HOS Anaesthetics/Theatres & ICU		
Brigeen Kelly	HOS T&O		
Wendy Clayton	HOS ENT & Urology, Ophthalmology & Out-Patients		
Fiona Reddick	Head of Cancer Services		
Geoff Kennedy	Laboratory Services		
Neal Tohani	HOS Cardiology, Respiratory, Renal and DHH Medical Wards		
Patricia Loughan	HOS Elderly, Geriatric, Stroke Rehab, Haematology & Dermatology		

MHPS

1.0 Cases – Themes and Trends (July 2023 to January 2024) over the last 6 months

1.1 The data below sets out the key statistics in respect of formal MHPS cases and informal low level concerns raised and logged from July 2023 to January 2024. The below shows the number of active cases both formal and informal during that specific month.

Month	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023
Total Number of Active Concerns	15	12	13	11	9	9



1.2 *As at today 1 March 2024 – we are managing and monitoring 2 formal cases and 15 at low-level management and/or screening stage. The majority listed at low-level stage are simply being reported to the Medical Director at an oversight meeting but are successfully being managed successfully and safely at local level by the Clinical Directors.*

1.3 The two formal cases open are cases involving Doctors who no longer work in the Trust. One case is in its final stages through internal investigation regarding

Southern Health and Social Care Trust

Surgery and Clinical Services

Update on the Action Plan

In response to the Dermot Hughes SAI Recommendations Action PLAN

Private and Confidential

Evidence of Improvement against Root Cause Analysis Report on the review of a Serious Adverse Incident including Service User / Family Carer Engagement Checklist D Hughes 26 February 2021 (produced 28 February 2024)			
<u>Recommendation 1.</u> Southern Health and Social Care Trust must provide high quality Urological Cancer Care for all patients. ***This will be achieved by Urology Cancer Care delivered through a co-operative mutli-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through diagnosis, treatment, planning and completion and survivorship. Assurance from comprehensive pathway audit of all patients care and experience. This should be externally benchmarked within a year by Cancer Peer Review/ External Service Review by Royal College.***			
To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document references (Appendix 1)

I. Baseline assessment of all Trust Cancer Multidisciplinary Team meetings (7 local Cancer MDM meetings including Urology)	**Update as at 28 February 2024:**
	• All local MDTs completed a baseline assessment using NICAN guidance and the National Cancer Audit Tool (NCAT) June –August 2021.
	• Individual action plans agreed for all MDTs including Urology highlighting improvements which would be made
	• Cancer Service improvement lead supported implementation of this work with each cancer MDT lead
	• Principles document developed based on best practice outlining how each MDT, including Urology would function. This was implemented from January 2023.
	• System assurance audits established from April 2022 (starting with Urology) to evidence that each MDT was working in line with the MDT Principles document
	• System assurance audits include monthly reports:
	  ○ Quoracy
	  ○ Confirmation that new cancer cases are brought to MDT for discussion
	  ○ Allocation of key worker to each newly diagnosed patient
	  ○ Confirmation that plan agreed at MDT has been implemented
	
	If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:
	
	System assurance audits are completed monthly and reviewed within the governance structures within the Cancer Services Division. To date no significant system / process concerns have flagged, however there continues to be regional pressures around Oncology Services which impact on quoracy. These pressures are logged as a risk on the Trust
			NCAT baseline improvement plan (November 2021)
			
			MDT principles document (January 2023)
			
			Sample MDT system assurance audits (include selection from 2023)

HSC Business Services Organisation
Internal Audit

Southern Health & Social Care Trust

Management of Multi-Disciplinary Team (MDT) Cancer Pathways 2023/24

nqa. ISO 9001 Registered Quality Management

Scope of Assignment

The scope of this audit was to review the Management of MDT Cancer Pathways in the Trust. Internal Audit reviewed four of the seven MDT areas (Urology, Lung, Skin and Breast) attended a MDT meeting and met with key staff in the Cancer multi-disciplinary teams. We reviewed the process for ensuring all patients were added for review at MDT meetings in the four areas under review. The audit also included review of corporate oversight arrangements, policies and procedures, allocation of Cancer Nurse Specialists (CNSs), monthly assurance audits and progress against the Urology Task & Finish Group action plan in relation to MDT meeting processes.

The audit was based on the following risks:-

- Risk to safe, high quality care due to delay in accessing elective services for assessment, diagnostics, and treatment in accordance with clinical need due to a demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the COVID 19 Pandemic. Reputational risk exists in the process of the Public Inquiry – the public release of information and the Public Hearings which are likely to attract media attention. (*Corporate Risk*)
- Risk to safe, high quality care where the cancer MDT approach is not utilised for the management of patients with a cancer diagnosis

The objectives of this audit were:

- To ensure that there is appropriate corporate oversight of cancer MDTs within the Trust.
- To ensure that there are policies and procedures in place for the management of cancer MDTs within the Trust.
- To ensure that appropriate processes are operational to ensure that all patients who have a cancer diagnosis are brought to the relevant Cancer MDT for discussion.
- To ensure that the Trust have processes in place to ensure that all patients with a cancer diagnosis are allocated a Key Worker/Cancer Nurse Specialist.
- To ensure that new processes put in place in relation to cancer MDTs are operational across all teams reviewed.
- To ensure that the Action Plan Developed by the Urology Task and Finish Group in July 2021 has been progressed.

Limitation of Scope:
This audit focused on cancer MDT processes within the Trust only and did not review regional MDTs or access to Radiotherapy etc which is provided by Belfast Trust.

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide Satisfactory assurance in relation to the Management of MDT Cancer Pathways within the Trust. Satisfactory assurance has been provided on the basis that MDTs had met weekly in the period under review (April to October 2023) across the four areas reviewed: Lung, Skin, Breast, Urology. Weekly pathology reports of all patients with a cancer diagnosis are received and checked to ensure that all newly diagnosed patients are discussed at a MDT meeting. Whilst Consultants add patients for discussion to the relevant MDT following review of results, this pathology report is a secondary check by the Cancer Admin Team to CaPPS to ensure that the patient has been discussed at an MDT meeting or are listed for discussion. Review of a sample of 60 newly diagnosed cancer patients identified that they

had been all listed and discussed at the next Cancer MDT meeting following diagnosis and were appropriately assigned a Cancer Nurse Specialist.

Monthly audits for MDT meeting attendance and quoracy have been developed, and sample audits of actions from MDT meetings have been put in place for 4 of the 7 areas (Urology, Lower GI, Upper GI & Gynae). There is a weekly report tracking the top 10 longest waiters for each tumour site which are then followed up. Updates on the ongoing work of MDT meetings are reported through fortnightly Cancer Team Meetings attended by the AD for Cancer Services, Head of Service of Cancer Services, Operational Support Lead and Cancer MDT admin team. There is also a monthly Cancer Performance meeting chaired by the Director of Surgery & Clinical Services and senior cancer team. This meeting focuses on working towards achieving the performance targets, areas for improvement, breaches of cancer targets, an update on MDT meeting attendances and quoracy etc. Cancer performance targets are presented at the Trust Performance and Governance Committees. A presentation was made to Trust Board in June 2023 in relation to the MDT Cancer pathway processes and what actions had been taken to address the identified weaknesses in the system.

The SAI in Urology in relation to the MDT process for cancer patients identified weaknesses in processes including that not all patients with a Urology Cancer diagnosis were brought forward for MDT discussion; not all of these patients were allocated a Keyworker/Cancer Nurse Specialist (CNS); and a lack of management awareness of weaknesses in the MDT meetings. To address these weaknesses, the Trust have developed: -

- Monthly Assurance Audits for MDT Attendance & Quoracy which is in place for all seven MDTs in the Trust.
- Weekly pathology reports to ensure all newly diagnosed patients are discussed at a MDT meeting. This report details all samples/specimens which have had a cancer diagnosis in the previous week. Whilst Consultants add patients for discussion to the relevant MDT meeting this pathology report provides a secondary check that all patients are reviewed at a MDT meeting. The report is cross checked by the Cancer Admin Team to CaPPS to ensure that the patient has been discussed at a MDT meeting or are listed for discussion. Any patient not discussed at MDT will be added to the next meeting.
- Audits of agreed MDT actions in place for 4 of the 7 MDTs. Roll out to the remaining 3 were due to commence in November 2023 with reporting by December 2023.
- Report on Longest waiting patients and escalation process to Assistant Directors and Heads of Service.
- Additional audit and support staff to support the MDT Meetings.

There were a total of 11 recommendations in the Urology SAI resulting in 26 actions. At November 2023 17 (65%) of the 26 actions were deemed to be fully implemented by the Trust. The remaining 9 actions are deemed to be partially implemented with work ongoing across teams to ensure compliance.

Whilst satisfactory assurance has been provided, some areas still require further development and embedding. In particular, attendance at some MDT meetings needs improved; MDT Outcome Audit roll out needs completed; and the Trust need to develop a means to obtain assurance that all cancer patients are allocated a Clinical Nurse Specialist.

There are no significant findings in this report that impact on the assurance provided.

The key findings of the audit are:

1. All MDTs have a policy document which details which staff should attend each meeting to make the meeting quorate. Internal Audit reviewed the minutes of MDT meetings in the areas of Breast, Lung, Skin & Urology during the period April to October 2023 to ensure the meetings occurred and that each meeting was quorate and noted the following:
    - None of the Lung MDMs and only 67% of the Urology MDM were quorate.
    - In relation to the Lung MDM Internal Audit noted that a member of the palliative care team did not attend any of the meetings, two meetings where a Consultant Thoracic Surgeon did not attend and 5 meetings where a Clinical Oncologist did not attend.
    - In relation to Urology MDMs, there were 3 where a Radiologist did not attend, 1 where a Medical Oncologist did not attend and 7 where a Clinical Oncologist did not attend.

    Whilst these MDTs were not quorate decisions around the clinical management of the patient can still take place to enable patients to progress along the cancer pathway.

		If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier: This work has been completed and is subject to ongoing audit by way of assurance. **IF not GREEN, what is the mitigation:** Not applicable		
ii.	MDM Chairs and essential representation e.g. CHS will have job plan sessions for the MDM role. This should also be reflected in the Job description.	**Update as at 28 February 2024:** • Cancer MDM chairs have additional time set aside in their job plan to enable them to fulfil this role • The role of Cancer MDM chair has been reviewed and an updated Job Description produced **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The immediate work to address this recommendation is complete. It is however recognised that with the high level of Red Flag referrals and the volume of cases requiring discussion at Cancer MDMs, the time allocated for Cancer MDMs and for its members will need to be kept under review. The Clinical Director for Cancer will be working closely with Cancer MDM chairs to consider other ways to manage this demand differently including protocolisation of cases for registration at MDM rather than for discussion as the management plan for these cases may be pre-determined in line with recognised treatments. **IF not GREEN, what is the mitigation:** Not applicable		**Update Cancer MDM Chair job Description**
RAG rating for Recommendation 4		**GREEN**		

<u>Recommendation 5.</u> The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations/ actions are completed.

This will be achieved by appropriate resourcing of the MDM tracking team to ENCOMPASSs a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by a safety mechanism from laboratory services and Clinical Nurse Specialists as Key Workers. A report should be generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit/assurance. It is essential that current limited clinical resource is focused on patient care. Assurance from comprehensive cancer care pathway audit, exception reporting and escalation.			
To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG staus	Evidence document reference (Appendix 5)
i. Compliance with regional tracking requirements. Currently 31 &62 day tracking is the only requirement in accordance with CaPPS	**Update as at 28 February 2024:** • The Trust track patients from referral to first definitive treatment in line with what happens across all HSC Trusts in NI. The Trust is resourced to enable tracking to this scope and the CAPPS system can only support tracking from referral to first definitive treatment. • Cancer Services monitor tracking monthly to ensure this is kept up to date to support escalation of any delays patients may experience on their cancer journey • The Trust has been commended by SPPG for keeping cancer tracking up to date, especially given the high and increasing trend in Red Flag Cancer referrals • All patients with a new cancer diagnosis discussed are discussed at a Cancer MDM • All patients will be allocated a Cancer Nurse Specialist as their Key Worker. A monthly report is produced by Cancer Services to evidence that patients are being allocated a Key Worker in line with the Cancer MDM Principles document (January 2023) • Monthly snapshot reports are completed for all local Cancer MDMs to check that the plan agreed at MDM is implemented. These audits are completed by Cancer Services and issues flagged to Cancer Senior Management Team in line with an agreed escalation process **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Immediate work has been completed to address this recommendation. **IF not GREEN, what is the mitigation:** Not applicable		**Cancer Tracking guidelines** **Key Worker monthly report** **Escalation flowchart /Supporting Safer and effective Care**

		Directorate risk register and are escalated to Belfast Trust Cancer Service throughout the year, at regional cancer meetings and on the MDT annual reports. If concerns are noted there is an agreed escalation framework through which these issues will be escalated within the Directorate and corporately if required. Cancer Service Improvement lead continues to work closely with MDT leads to implement further improvement work as required. **IF not GREEN, what is the mitigation:** Not applicable		

II.	Feedback from Urology patients from a variety of sources	**Update as at 28 February 2024:**
		
		• Review of patient feedback from a range of sources including:
		  o Complaints
		  o Datix
		  o Care opinion
		  o 10,000 Voices
		  o Patient Surveys
		  o Engagement with patients / relatives involved in the Urology SAIs
		• Care Opinion kiosk established in Urology Outpatients to actively seek feedback from patients accessing urology Services commenced in February 2022
		• Training in Care Opinion provided for Urology Cancer Nurse Specialists and Urology medical staff- February 2022 and feedback via care opinion is ongoing
		• Macmillan Peer Support facilitators undertook engagement work in September 2022 with Urology Service users to secure feedback on their experience which was presented to the Urology Service. An example of a change made through this exercise was that patients should be aware that the title for roles may be used interchangeably such as Cancer Nurse Specialist / Key worker / Macmillan nurse, and if in doubt, to ask the staff member if you have any queries about any terminology
		• Patients feedback shared with the Urology team in February 2023 and service user feedback is a standing item on the Urology monthly Departmental meeting
		
		If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:
				Urology Patient Experience report (September 2022)
				
				Patient Engagement Report for Urology SAIs (September 2022)

		Patient feedback continues to be reviewed monthly by the Urology specialty and is a standing item on the Department meeting **IF not GREEN, what is the mitigation:** Not applicable		
III.	Data mapping the patient pathway for the Urology Service	**Update as at 8 March 2024:** • A process mapping exercise was completed for the Urology patient pathway on January 2022 supported by the Trusts Quality Improvement Team. The exercise highlighted opportunities to streamline the patient pathway. • The Trust are now adopting this focus across other cancer patient pathways including GI and Renal and the Cancer Service Improvement Lead is supporting this work with cancer specialties and Cancer MDT leads. • Work to identify and deliver on opportunities for improving cancer pathways is also being progressed through the Cancer Optimisation Plans which are being implemented across all HSC Trusts in NI focussing on Urology, lower GI, Skin and Gynaecology • In addition to the work outlined above, regional work is ongoing through the NICAN Cancer Clinical Groups **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The immediate work which needed to be delivered in relation to Urology has been completed. The Trust is adopting an ongoing improvement focus across all cancer Pathways supported by the Cancer Service Improvement Lead working in partnership with the relevant specialties and MDT leads. The RAG status for this sub action is therefore YELLOW, however the overall status for the recommendation is GREEN **IF not GREEN, what is the mitigation:** Not applicable.		**Urology Pathway Process Map (January 2022)** **Renal Pathway (May 2023)** **Urology Cancer Optimisation Plan** **Urology Cancer Optimisation Plan (February 2024)**
RAG rating for Recommendation 1		GREEN		

Cancer MDM System & Process Audit Update 06/06/23

1) Cancer MDM Attendance & Quoracy

	Jan-23			Feb-23			Mar-23			Apr-23			May-23		
	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate
Breast	4	3	**75%**	3	2	**67%**	5	4	**80%**	4	4	**100%**	5	5	**100%**
Colorectal	4	4	**100%**	4	2	**50%**	5	4	**80%**	4	3	**75%**	4	3	**75%**
Gynae	5	5	**100%**	4	4	**100%**	4	4	**100%**	3	3	**100%**	5	5	**100%**
Lung	4	0	**0%**	4	0	**0%**	5	0	**0%**	4	0	**0%**	5	0	**0%**
Skin	4	4	**100%**	4	3	**75%**	5	4	**80%**	4	4	**100%**	4	4	**100%**
Upper GI	4	0	**0%**	4	2	**50%**	5	1	**20%**	4	1	**25%**	4	1	**25%**
Urology	4	4	**100%**	4	3	**75%**	5	4	**80%**	4	3	**75%**	2	2	**100%**

Breast

January – No Clinical Oncologist

February – No Clinical Oncologist

March – No Clinical Oncologist

Colorectal

February – May -No Clinical Oncologist

Lung

January - No Thoracic Surgeon, Clinical Oncologist, Palliative Care Rep & Pathologist

February – No Palliative Care Rep & Clinical Oncologist

March - No Thoracic Surgeon & Palliative Care Rep

April - No Thoracic Surgeon, Clinical Oncologist, Palliative Care Rep & Pathologist

May – No Palliative Care Rep

Cancer MDM System & Process Audit Update 06/06/23

Skin

February & March – No CNS

Thyroid

January – May – No Oncologist & Nuclear Medicine Specialist

Upper GI

January – No CNS & Palliative Care Rep

February – No CNS, Palliative Care Rep & Clinical Oncologist

March - No CNS, Palliative Care Rep & Clinical Oncologist

April - No Palliative Care Rep & Clinical Oncologist

May - No Palliative Care Rep

Urology

February – No Clinical Oncologist

March - No Clinical Oncologist

April - No Clinical Oncologist & Consultant Radiologist

Main risk areas:

- **Palliative Medicine Representation at Lung & Upper GI MDM**
- **Clinical Oncology Representation**
- **Thoracic Surgery Representation at Lung MDM**

2) ***MDM Outcome Snapshot Audit***

- Urology ongoing from January 2022 & Lower GI, Upper GI & Gynae commenced April 2023. See breakdown of numbers audited per month from January 2023. There have been no major discrepancies identified in the patients audited to date.

Urology

2023	Total Discussions	No. of Discussions Audited
Jan	105	20
Feb	131	20
Mar	148	25
Apr	126	20

Lower GI, Upper GI & Gynae

April 2023	Total Discussions	No. of Discussions Audited
Gynae	48	15
Lower GI	83	20
Upper GI	30	19

3) ***Pathology Cross Check***

- 1369 specimens on the lab report provided from BHSCT in Jan – May 2023. 178 patients emailed to the tracking team to add for MDM discussion or to query if further action required.
- 24 lab specimens dispatched elsewhere (not reported SHSCT) April 2023 – 2 patients picked up and added to CaPPs.

4) ***Keyworker Audit***

- Report has been set up but not working properly so has been escalated to BSO by the information team. I have emailed for an update today (06/06/23) our information. Once the report is fixed it will need validated by myself & Mark

Southern Health and Social Care Trust

Quality Care - for you, with you

Protocol to support safe and effective care for Cancer patients managed through local Cancer Multidisciplinary Teams *(version 2.0:September 2023)*

Context:

By way of assurance and to address early learning from the Urology Service Inquiry, Cancer Services Division are establishing systems and process audits to ensure patients are managed safely through the local cancer MDTs.

The purpose of the protocol is to clarify the following:

1 ***Process for MDT members to raise concerns about:***
- the functioning of the MDT
- the management of patients discussed at the MDT

See pathways 1-3

2 ***Process for escalation of issues flagged by Cancer Services Division through systems and process audits which monitor the functioning of local Cancer MDTs.***

In the first instance, these audits will be in relation to:

- MDT Attendance / quoracy
- Pathology crosscheck for cases discussed at MDT
- Allocation and recording of key worker
- Implementation of MDT outcomes

**See pathway 4*

Cancer Services Systems and Process Audits:

The objective of the pathways is to ensure that the MDT processes are patient centred and delivering safe and effective care for our cancer patients.

Cancer Services Division have recruited new posts to support the function of our local Cancer MDTs. These posts are as follows:

- Cancer MDT Administrator / Project Officer: Angela Muldrew
- Cancer Services Information and Audit Officer: Mark Quinn
- Cancer Services Data Officer: Heather Jackson

These post-holders sit within Cancer Services Division and support the work of the Cancer MDTs including completion of weekly / monthly audits as detailed above.

Received from SHSCT on 04/03/2024. Annotated by the Urology Services Inquiry.

	• The Trust are awaiting enhancement to the CAPPS system which will enable reports to be built to check the allocation of key worker, however this has been delayed due to ENCOMPASSS rollout • In the interim, a BOXI report is ran monthly from CAPPS to check that patients are being allocated a key worker as described above. **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The Trust are awaiting enhancement to the CAPPS system which will enable reports to be built to check the allocation of key worker, however this has been delayed due to ENCOMPASS rollout **IF not GREEN, what is the mitigation:** Enhanced functionality will enable automated reports which require less manual work**.**		

iv. Key Performance Indicator Audit Framework for CNS	**Update as at 28 February 2024:**
	
	• Key Performance Indicators (KPIs) for Cancer Nurse Specialists are agreed regionally
	• There are 5 KPIs as follows:
	  ○ Service delivery
	  ○ Service improvement
	  ○ Holistic approach
	  ○ Patient information and support
	  ○ Supporting professional activities
	• In future monitoring of CNS KPIs will be supported through enhanced CAPPS functionality, and this will be a standing agenda item in the CNS forum and developed within the work plan
	• In the interim, it is the responsibility of each service to monitor adherence to these KPIs through the annual appraisal process
	
	If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:
	
	A Cancer Nurse Specialist workshop was held in March 2022 and as an action from this workshop it was agreed to establish a CNS Forum, and the first meeting of this forum was
			Summary from CNS Workshop / First meeting of CNS Forum (June 2022)

<u>Recommendation 2.</u> All patients receiving care from the Southern Health and Social Care Trust Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectations of Cancer Peer Review.

This will be achieved by ensuring all patient receive Multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent. Assurance from comprehensive Cancer Pathway Audit and Patient Experience.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document reference (Appendix 2)
i. Information Pathway Review	**Update as at 28 February 2024:** • In line with NICAN Guidelines, it was agreed that core information should be provided to patients at the point of diagnosis and throughout their cancer journey consistently across all cancer specialties in the Trust • Each Cancer Nurse Specialist provides patient with core information as well as specific information which applies to the patient's condition • Requirement for informing patients throughout their cancer journey has been included in the Cancer MDT Principles document (January 2023) • Within the Trust it has been agreed that the Cancer Nurse Specialist is the key worker for the patient • As the key worker, the Cancer Nurse Specialist takes a lead role in sharing information with the patient throughout their cancer journey. The responsibility is also a Key Performance Indicator for Cancer Nurse Specialists • Snapshots audits have been undertaken in Urology (June 2022 and September / October 2022) to evidence that information is being shared. This continue to be monitored through the monthly pathology reports in order to provide assurance. • Further work is being planned regionally to enhance the Cancer Patient Pathway System (CAPPS) which will enable this to be checked automatically in the future. This enhanced functionality has been delayed due to the rollout of ENCOMPASSS **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Sharing information with Cancer patients is a key requirement for all Cancer Nurse Specialists. This is also a Key Performance Indicator for a Cancer Nurse Specialist.		**Cancer Nurse Specialist KPI document**

	IF not GREEN, what is the mitigation: As the new CAPPS functionality is not yet available which will allow monitoring of this and other KPIs, and given that sample audits have been undertaken for Urology, we have a level of assurance on this however we cannot yet fully sign this recommendation off as being GREEN.		
ii. Advanced Communication Skills	**Update as at 28 February 2024:** • A number of advanced communication skills course have been delivered from January - March 2024 aimed at core members of Cancer MDTs including Urology • This is a two day course which staff need to attend once • Certificate of attendances are logged in Cancer Services and summarised in the Annual Report for each cancer MDT • Core MDT members that require training are prioritised **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** The Trust secured non recurrent funding for the courses that ran January-March 2024, however currently there is no recurrent resources available for these courses year on year. This has been escalated through the regional Cancer Programme Board however due to the ongoing financial position, there is not yet regional funding for these courses. **IF not GREEN, what is the mitigation:** Whist we await recurrent funding, the Trust will continue to seek non recurrent funding opportunities and may consider the use of Trust Charitable Funds for these courses.		
iii. Allocation of Key Worker at Diagnosis	**Update as at 28 February 2024:** • It has been agreed that the key worker is the Cancer Nurse Specialist and this is outlined in the Cancer MDT Principles document (January 2023) and each of the cancer tumour site Operational Policies (including Urology) • The name of the Cancer Nurse Specialist / key worker is recorded on CAPPS either during or soon after the Cancer MDT meeting		**Sample Boxi Key Worker report**

	held in June 2022. This forum is led by Nicola Shannon as Lead Nurse for Cancer Services. The Forum meets quarterly. **IF not GREEN, what is the mitigation:** Although progress has been made against this sub action, and whilst the new CAPPS functionality is outstanding, further work is needed through the CNS Forum to provide further assurance and the completion of an assurance report on the Cancer Nurse Specialist KPIs		
v. Staffing complement within CNS and Support Workers across all Tumour sites	**Update as at 28 February 2024:** • Regional Cancer Nurse Specialist Workforce Expansion plan completed in September 2023 • This expansion plan highlighted areas where the Trust would require additional CNS support across tumour sites. This work was led regionally by Lorna Nevin / PHA • As yet there has not been any update on recurrent funding to address the workforce requirements outlined through the September 2023 expansion plan • Tumour sites most challenged in terms of CNS capacity in the expansion plan were – Colorectal, Gynae and Skin • Whilst awaiting allocation of funding, the Trust has allocated 0.5 wte Band 7 non recurrently for Gynae and 1.0 wte Band 6 temporary for 3 years in partnership for Macmillan **If work not completed and RAG status GREEN, what is outstanding and is this an internal or external barrier:** Awaiting allocation of funding to address the requirements outlined in the regional CNS Expansion Plan (September 2023). **IF not GREEN, what is the mitigation:** Awaiting allocation of funding to address the requirements outlined in the regional CNS Expansion Plan (September 2023). In the interim, other opportunities for funding are sought by specialty teams however this is challenging due to the financial climate regionally.		**CNS Workforce Expansion Plan (September 2023)**

	Targeted non recurrent investment has been made in Urology (0.5 WTE funded out of the Trust's Public Inquiry spend, and 1.5 WTE where the Trust have went at risk), and upper GI and Gynae as noted above. More recently, SPPG have indicated they will support additional funding for 2.0 wte for Skin although this is not yet finalised.		
RAG rating for Recommendation 2	AMBER		

<u>Recommendation 3.</u> The Southern Health and Social Care Trust must promote and encourage a culture that allows all staff to raise concerns openly and safely.

This will be achieved by ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collaborative and equal culture. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight monthly agenda. There must be action on issues escalated. Assurance form the number of issues raised through Cancer Services, Datix incidents identified, numbers of issues resolved and number of issues outstanding.

To address this recommendation the Trust agreed to focus on the following:	Service Lead / Update as at 28 February 2024	Sub point RAG status	Evidence document reference (Appendix 3)

i. Review of Trust and Regional Guidelines and Policies
• Whistle Blowing Policy
• DOH Your Right to Raise a Concern Guide
• Nursing & Midwifery Accountability & Assurance Framework
• Working Well Together Policy
	Update as of May 2022
	
	• Work commenced January 2022 to Review of all current Trust & Regional Policies including:
	  ○ Whistle Blowing Policy
	  ○ DOH Your Right to Raise a Concern
	  ○ Nursing and Midwifery Accountability and Assurance Framework
	  ○ Working Well Together Policy
	• Focus on Induction Pathway
	• Support and encourage raising of concerns / potential concerns.
	• Review of historical reporting of concerns completed.
	• Recognised that theme of concerns raised was based on working conditions associated with staffing levels.
	• Leadership "walkabouts" from Operational and Corporate Senior Staff across all directorates established.
	• Allows staff to become familiar with management and be comfortable in potentially raising concerns.
	• Identifying learning from other Inquiries for example Muckamore.
			Raising Concerns Policy
			
			DOH Your Right to Raise a Concern
			
			Working Well Together Policy
			
			Nursing and Midwifery Accountabilty Framework
			
			Terms of Reference – Cancer Nurse

Champion Review Recommendations

No	Action Required	Person Responsible	Date for Completion	Actions Undertaken	Actions Required	Status
1	The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting agenda by April 2020.	Chair and Chief Executive	Complete	Completed – Annual Cycle of Board reporting in place.	Complete	**Complete**
2	The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director.	Chair and Chief Executive	Complete	Completed – Director of Finance, Procurement and Estates has been attending meetings since December 2018.	Complete	**Complete**
3	The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020	Chair	Complete	Completed – Chair and Board Assurance Manager meet prior to each meeting to develop and agree agenda.	Complete	**Complete**
4	The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	CSCG safety and quality indicators have been agreed for weekly governance debrief meetings. These are shared and reviewed weekly by SLT. Information includes Governance, Nursing, Litigation and Safeguarding staff in the form of Weekly Governance Activity Reports. These include information, by Operational Directorate, on numbers of New SAIs, SAIs submitted, On-going SAIs, NIPSO cases accepted for investigation, NIPSO Reports received, Early Alerts, New Moderate/High Risk Complaints, Numbers and timescale of outstanding complaints, Catastrophic Incidents, Never Events, RQIA reports, Directors Oversight groups, Medication Incidents, Adult Safeguarding activity, Subject Access requests, Litigation, Coroner's Inquiries and Inquests, Data Breaches, Freedom of Information requests, New Standards & Guidelines received and Assurances due or submitted, Clinical Audits and Regional PIVFAIT Audits, National Audit/Confidential Enquiry participation, IPC statistics, numbers and grading of Falls and Pressure Ulcer Incidents and Approval status of Datix incidents. This report is continually under review as new key performance indictors become available as per new evidence.	Complete	**Complete**
5	The SLT Terms of Reference should be reviewed including the provision for tabling urgent papers	Dr Maria O'Kane, Chief Executive	Sep-23	Terms of Reference for SLT meetings have been approved by SLT, several changes have been made to the format and structure of the meeting including the following: • Move to use Decision Time for eletronic recording • Timings and ratings introduced to smooth agenda workflow • Agenda format reflecting item types • SLT now meets twice weekly (Formal Tuesday, Informal Thursday) • Process in place for tabling urgent papers	Complete	**Complete**

Champion Review Recommendations

13	Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area.	Deborah Hanlon, Head of Adult Safeguarding	Complete	Complete - The audit of practice in Adult Safeguarding was extended to evidence areas for improvement. Actions identified were completed and continue to be restated through training, refresher and CPD support forum. There is now a much clearer governance structure in the Trust as per the presentation in the EDSW report to Trust Board in January 2023. While there remain some areas of risk, mainly associated with the capacity issues of relevant staff across Directorates to deliver timely, quality outcomes, the linkages with Directorate Social Work Leads and developments in practice, training and support have strengthened the overall position.	Complete	**Complete**
14	The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.	Dr Stephen Austin, Medical Director - Vivienne Toal, Director HROD	Jun-24	Work commenced on Being Open along with Dr Peter McBride, DoH and will consider DoH direction on potential Duty of Candour consultation outcomes. Trust Being Open Workstream to be jointly chaired by Medical Director and Director of Human Resources and Organisational Development. SHSCT Being Open work has temporarily paused pending the outcome of the regional work being done by Dr Peter McBride. The Trust Being Open Policy paused pending the conclusion of the above.	• Trust Being Open Policy has been paused pending conclusion of Dr Peter McBride's work • Trust workstream on Being Open set up	**In Progress**
15	The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation.	Catherine Teggart, Director of Finance,Procurement & Estates	Nov-23	Audit carried out by internal audit Nov 2022 and many of the recommendations have been implemented with others still in progress. Some of these recommendations however require additional resource within teams.	• Additional resources required to meet recommendation requirements - posts are currently being filled. Update 03.03.2024 A business case has been submitted to the DoF requesting additional resource to adequately manage the backlog servicing of medical equipment. Until this resource issue is resolved the risks to patients due backlog servicing of medical equipment will remain. Purchasing additional equipment to support existing and new service development will also compound the risks and issues	**In Progress**
16	The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards.	Catherine Teggart, Director of Finance,Procurement & Estates	Complete	A review of the Controls Assurance process was carried out in 2022-23 alongside the establishment of the 3 new Governance Groups. It resulted in the decision to close the controls assurance group with oversight of the governance and controls reporting to the 3 Governance groups. A mapping exercise of the controls assurance areas were linked to the Governance Groups and these areas of governance are now being addressed and reviewed at Governance groups and reported to the TB Governance Committee	Complete	**Complete**
17	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.	Caroline Doyle, Interim Assistant Director Clinical & Social Care Governance	Complete	Complete - Risk Management Strategy for 2019 - 2022 was approved. SMT has agreed its extension to September 2023 by which stage it is to be reviewed and approved by SMT	Complete	**Complete**
18	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.	Chair and Chief Executive	Complete	Trust Board formally agreed the Trust Risk Appetite statement in January 2024. The Trust Risk Appetite will be applied to the development of the renewed Strategic Objectives and Corporate Risk Register from 2024.	Complete	**Complete**

Southern Health and Social Care Trust

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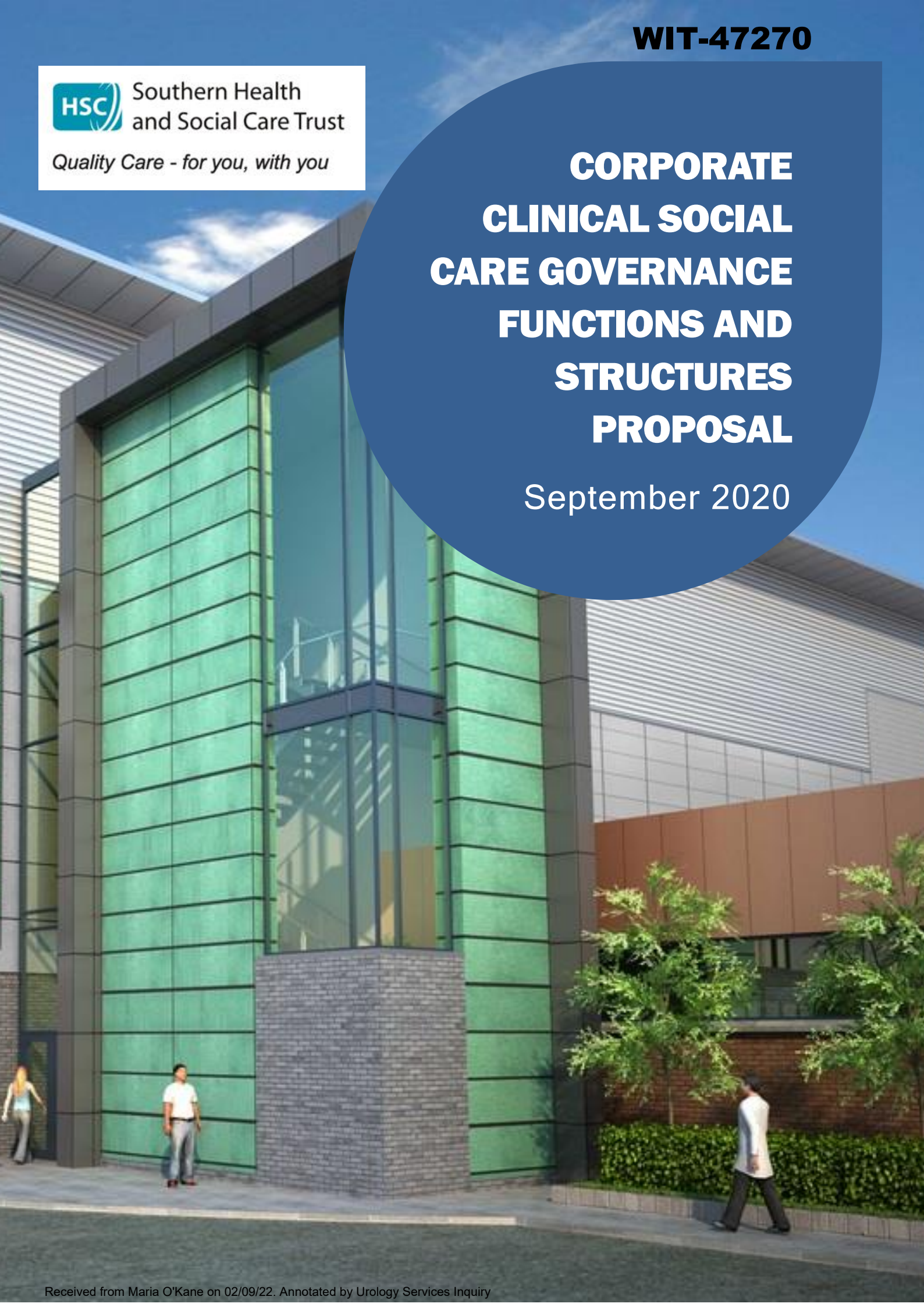
CORPORATE CLINICAL SOCIAL CARE GOVERNANCE FUNCTIONS AND STRUCTURES PROPOSAL

September 2020



Southern Health and Social Care Trust
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CORPORATE CLINICAL SOCIAL CARE GOVERNANCE FUNCTIONS AND STRUCTURES PROPOSAL

1st September 2020

PURPOSE OF PAPER

- **To outline the Trust vision to become a top performing organisation in the UK as a consequence of Learning from Experience, Improvement and providing Safe Patient and Service User Care**
- **To detail the elements of continuous improvement in Clinical and Social Care Governance including upholding of standards, embedding learning from experience and improving overall patient and staff experience**
- **To provide an overview of Trust-wide Clinical and Social Care Functions, Structure and Resourcing required to deliver the vision**
- **To set out two proposals in response to the Trust governance review 2019 and CSCG work scoping exercise 2020**
    - **Proposal to Realign Clinical and Social Care Governance Structures**
    - **Proposal to Increase Resourcing in the Trust Clinical and Social Care Governance Function**
- **To provide outline details of the functions and benefits of the proposed additional resourcing and revised structures**
- **To provide details on costing of the proposal**
- **To provide details on a phased approach to implementation of the proposals**

INTRODUCTION

1. Clinical governance is “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson 1998). Within public healthcare services in Northern Ireland we can expand this definition to include social care governance.

2. Clinical and Social Care governance is an umbrella term. It describes activities that not only sustain and continuously improve high standards of patient care, but also provide quality assurance.

PROPOSAL 1 – REALIGNMENT CLINICAL AND SOCIAL CARE GOVERNANCE STRUCTURES

18. The Trust has traditionally operated a model of distributed clinical and social care governance. The Medical Director serves as the overall Director with responsibility for the function. The model has the following key characteristics:

- Each Operational Directorate has a senior Governance Coordinator post which reports directly to the service director
- Each Operational Directorate retains responsibility for the approval and final sign off of all clinical and social care governance activity relating to their service areas
- Each Operational Directorate decides at a local level the funding and resourcing requirements for their clinical and social care governance service areas.
- Each Operational Directorate is responsible for designing systems and processes for delivering on their clinical and social care governance function (for example staff designing and delivering, training, adverse incident and serious adverse incident screening and completion, complaint management processes, management and oversight and standard and guideline implementation etc)

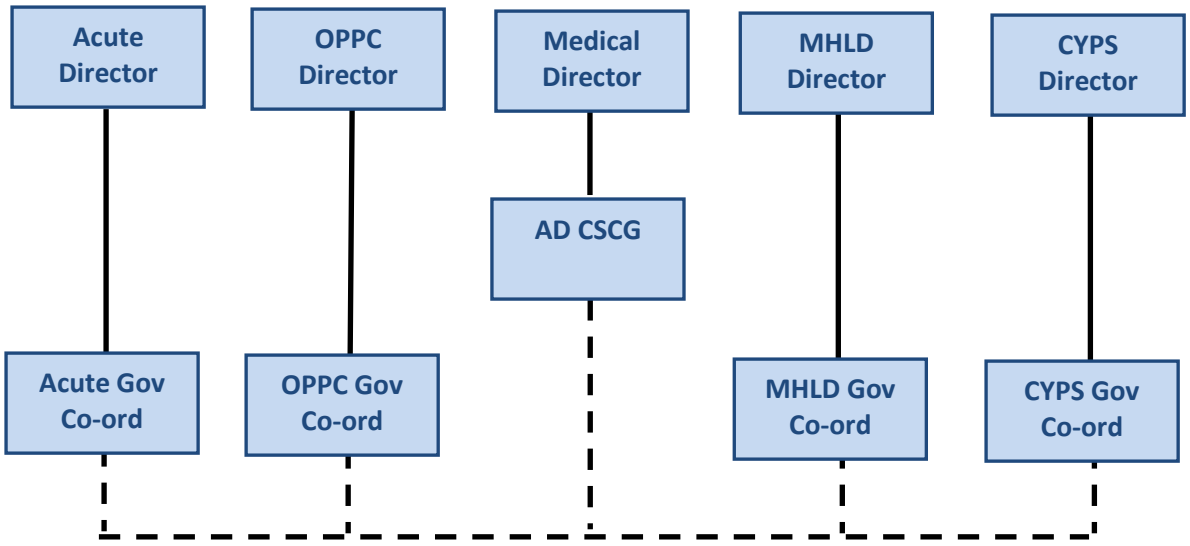

Figure 1 – Current Clinical and Social Care Governance Structure within the Trust

Challenges with a distributed Clinical and Social Care Governance Structure

19. The following weaknesses have been identified in the current distributed structure:

- Corporate quality assurance of Clinical and Social Care Governance processes and outputs

iii. Monitoring of Learning and assurance of implementation
iv. Triangulation of Data to inform Improvement Plans and Learning
v. Recording and development of action plans in response to RQIA, National Audits, Morbidity and Mortality, Adverse and Serious Adverse Incidents
vi. Processes governing the identification and implementation of Standard and Guideline processes
vii. Provision of Trust-wide standardised staff training
viii. Processes for managing and responding to complaints

22. The structure detailed below illustrates how the accountabilities would move.

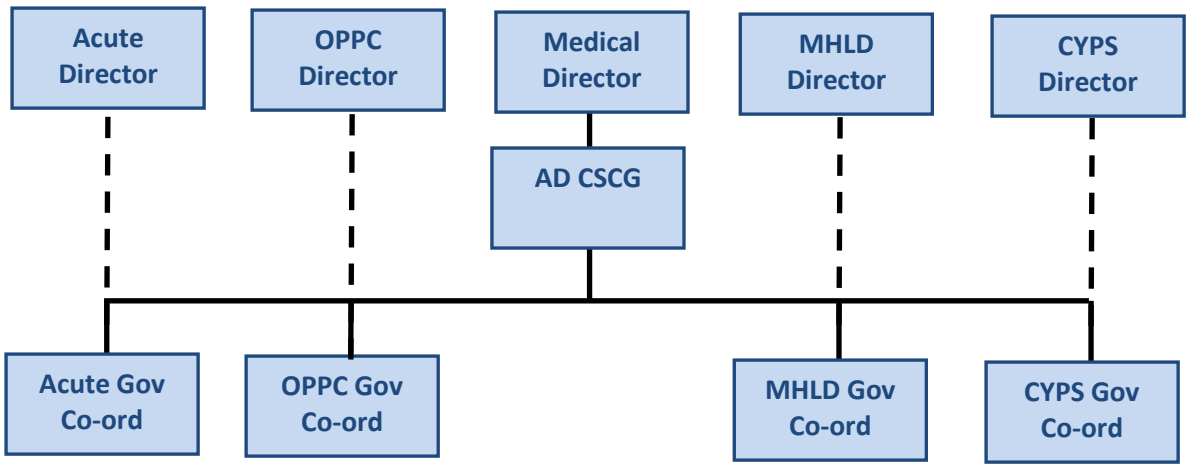

Figure 2 – Proposed Clinical and Social Care Governance Structure

23. This proposal advocates the development of a Corporate lead clinical and social care governance structure with operational management transferring to the Medical Directorate.

24. Operational directors will retain responsibly for the commissioning and oversight of clinical and social care governance activity in the same model as is delivered by other corporate services such as Finance and Procurement, Human Resources and Organisational Development and Performance and Reform.

Options Appraisal

Option 1 – Do Nothing – Existing Directorate Led Model Remains in Place

The current system continues without the ability for robust corporate clinical and social care governance oversight. Risks continue to exist regarding resourcing for directorate level clinical and social care governance team resourcing. Standardisation of processes will

REPORT FROM CLINICAL AND SOCIAL CARE GOVERNANCE IN RELATION TO:

IMPROVEMENTS MADE

IMPROVEMENTS IN PROGRESS

IMPROVEMENTS STILL REQUIRED TO BE IMPLEMENTED

March 2024

Introduction

Over the last two years, a significant investment in Clinical and Social Care Governance has been made by SHSCT. This is aimed at improving patient safety, enhancing learning from incidents which did not go as well as planned, improving quality of services and increasing patient and service user involvement.

The level of investment is evident in the attached Organisational Structure. The significant majority of these posts have commenced in the last 2 years. Also, the adoption of the Business Partner model for clinical and social care governance has been effected during this time.

Set out below are the improvements which have already been made, those which are underway and those which still need to be achieved in relation to:

Reporting to Governance Committee

SAIs and Incident Management

Service User Feedback

Datix Incident Management System

Liaison Service

Patient Safety

IMPROVEMENTS TO DATE - REPORTING
Enhanced quarterly reporting to Governance Committee
Introduction of a standalone Service User Feedback Report to Governance Committee
Weekly reporting / escalation of issues to SLT
Quarterly Reporting to Safety & Quality Steering Group
Quarterly Reporting to Standards, Compliance and Regulation Steering Group
Introduction of Patient Safety Data & Improvement Team (M&M) Report to Safety & Quality Steering Group
Extended scope of Weekly Governance meeting agenda
Reporting of outstanding Enquiry responses at Weekly Governance meeting
IMPROVEMENTS TO DATE – INCIDENT MANAGEMENT
Development of Datix system for recording, monitoring and reporting of SAI Recommendations
Monthly updates requested on progression of SAIs from Operational Directorate Governance teams, with maintenance of central database
Escalation of SAI progression to AD CSCG as required
Escalation of Overdue SAIs to SLT
IMPROVEMENTS TO DATE – DATIX INCIDENT MANAGEMENT SYSTEM
Datix Upgrade
Development of Datix System for recording, monitoring and reporting of RQIA recommendations
IMPROVEMENTS TO DATE – SERVICE USER FEEDBACK
Quarterly meetings with NIPSO and PCC to assist with progression, oversight and assurance
IMPROVEMENTS TO DATE – LIAISON SERVICE
Extended scope of Liaison Service to support the Urology Lookback Review and Cervical Cytology Review
Extended scope of Liaison Service to support Complex Complaints

Meeting: Date:	Senior Leadership Team (SLT) – 9th January 2024
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Stephen Austin, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information

Overview: Provide SLT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance

Please note the information included in this paper relates to Governance activity between 18.12.2023 - 31.12.2023. Exceptionally, there may be Governance activity reported outside of this timescale for information to SLT e.g. in this case, Governance activity between 01.01.24 and 03.01.24 (the latter being the cut-off date for submission of the report for SLT papers) which requires notification rather than waiting to the next weekly report.

Ongoing SAIs

- Ongoing SAIs – 81 – MUSC – 10, SCS – 23, MHD – 40, CYP – 3, ACS – 5

SAI Notifications (1)

- **MHD**- Personal Information - Suspected suicide in the community of a male known to Mental Health Services

SAI Reports (3)

- **MUSC**- Personal Information - Patient had a past medical history of melanoma to right medial shin, excised with no residual tumour. Patient was admitted with back pain. MRI completed. MSCC pathway was not followed in this case. Delayed referral to Oncology and the patient Personal Information redacted by the USI. Patient deceased. Recommendations include the sharing of the report with all staff involved in the patients care as well as the development of a learning letter in relation to MSSC Pathway
- **MUSC**- Personal Information Patient attended DHH ED with vomiting. X-Rays completed but not reviewed before discharge. Patient returned days late with bowel obstruction. T/F to CAH and sadly died. Recommendations includes the Trust review of its current induction training pack to ensure NVPS will be included in the trainee doctors training programme
- **SCS**- Personal Information - During surgery to remove adenoids the left tonsil was mistakenly removed. Recommendations include the operating surgeon to read out the procedure from the consent form to a quiet theatre

MUSC and SCS Governance Coordinator escalated staff shortages within the department including 2 off on longterm sick leave. This is likely to impact on deadlines.

Early Alerts (2+1 Update)

- **EA DEC** Personal Information **SCS/MUSC**- Notification of preliminary hearing. Personal Information redacted by the USI admitted to CAH via Ambulance with imaging consistent with as left hemispheric stroke. Following further examination the deceased was blue lighted to RVH where is sadly passed away. The Coroner's Office has advised that a Preliminary Hearing will take place on Tuesday 23rd January at 9.30pm
- **EA DEC** Personal Information **MHD**- Personal Information redacted by the USI service user requiring to transition from Disability Children's Residential Unit as he turned Personal Information redacted by the USI. The Trust continues to work with an independent sector provider for a placement however there have been a number of significant challenges to achieve this
- **EA DEC** Personal Information **MHD Update 1**- Service user admitted to Dorsy Learning Disability Inpatient Ward, Bluestone Unit on evening of Personal Information redacted by the USI as a place of safety as Woodlawn House was unable to provide safe and effective care. Service User returning to Woodlawn House on Personal Information redacted by the USI

Catastrophic Incidents (5)

- **MUSC**- Personal Information - Presented to ED on Personal Information redacted by the USI in Cardiac Arrest CPR ongoing with NIAS. Patient had been discharged from Neonatal Unit on Personal Information redacted by the USI. Passed away in department. SAI Notification raised by CYPS, will appear in next week's paper
- **SCS**- Personal Information - Patient transferred from PACU to emergency theatre 1 in peri arrest, massive blood loss called. Patient passed away
- **MHD**- Personal Information - SAI Notification reported above
- **MHD**- Personal Information - Death of male. Cause of death was due to natural causes. Not being investigated as an SAI
- **MHD**- Personal Information - Suspected suicide of a male patient in the community. SAI Notification will appear in next week's paper.

IMPROVEMENTS TO DATE – PATIENT SAFETY DATA & IMPROVEMENT
New de-brief form is produced following M&M meetings, highlighting additional information on SAIs and outcomes of discussion and sent to relevant M&M attendees and operational/governance colleagues
Application of the Shared Learning Policy and completion of template has begun following M&M meetings. A quarterly report is produced based on information obtained from regional Splunk reports showing areas and themes for learning
IMPROVEMENTS UNDERWAY – INCIDENT MANAGEMENT
Development of Executive Director Oversight Group – meetings have taken place, ToR being finalised
Development of Trust SAI Policy and Procedure to assist in standardising processes – to be presented at SHSCT Policy Scrutiny meeting 28/03/2024, aim for implementation by April 2024
Development of Incident Management Awareness training package – Corporate Mandatory Training for all staff across the organisation, aiming to go live by 1st April 2024
IMPROVEMENTS UNDERWAY – DATIX INCIDENT MANAGEMENT SYSTEM
Ongoing work by embedded Corporate Governance Datix team on 'Contacts' to facilitate the ability to triangulate Incidents, Complaints and Claims information
Development of standardised Revalidation reports on Datix
Use of Business Intelligence software to triangulate and theme information within Datix across various modules such as Incidents, Complaints and Claims (including Coronial Affairs)
Development of Automated Reporter Feedback in Datix
Review of the Incident Reporting Form on Datix
Inclusion of timeframes for review in Datix and Incident Management Procedure, with escalation pathway
Transition of Complaints module from Datix 'Rich Client' (an older version of Datix) to Datix Web - Work has commenced on this transition, help is being sought from RL Datix to support this work.
Development of standardised datasets for reporting of Complaints from Datix
Transition of Claims module (Litigation services) from Datix 'Rich Client' (an older version of Datix) to Datix Web
As pioneers in developing Datix in the recording, monitoring and reporting of SAI and RQIA recommendations within the Region, continue to promote and share knowledge of this system development

Southern Health and Social Care Trust

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Policy and Procedures for the Reporting and Management of Adverse Incidents

Version 2.0 2023

Lead Policy Author & Job Title:	Caroline Doyle, Interim Assistant Director of Clinical & Social Care Governance
Directorate responsible for document:	Medical Directorate
Issue Date:	19 December 2023
Review Date:	19 December 2025

Working together Excellence Openness & Honesty Compassion

defined by the HSCB within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAIs), Oct 2016[4].

Service User[5]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

2.2 The organisation's approach to Adverse Incident Reporting and Management: A just and learning culture[6]

As part of its proactive approach to risk management, the organisation promotes a just and learning culture in which errors or service failures can be admitted, reported and discussed without fear of reprisal. This will enable lessons to be identified and allow active learning to take place and the necessary changes made or reflected in policies, procedures and practices.

All staff must report and manage adverse incidents according to this policy (and any related operational procedures) for adverse incident reporting. Crucial to the effectiveness of adverse incident reporting and management is the organisation's commitment to the promotion of a just and learning culture where all staff can participate in reporting adverse incidents. Staff are encouraged to report incidents and to look critically at their own actions and those of their teams, to ensure the organisation can provide quality services for our service users, staff and visitors.

Ultimately, the organisation wants to encourage staff to report areas of concern and to foster a positive ethos around reporting. Trust staff work within complex systems in which many factors influence events and outcomes. The principles of a just and learning culture will be applied to determine the most appropriate response when things do not go as planned. It is important that learning takes place to prevent a reoccurrence of an adverse incident rather than adopting a punitive approach. Staff who make a prompt and honest report in relation to an adverse incident should not expect to be subject to disciplinary action except under the following circumstances: -

- A breach of law;
- Wilful or gross carelessness or professional misconduct;
- Repeated breaches of Trust policy and procedure;
- Where, in the view of the Trust, and/or any professional registration body, the action causing the incident is far removed from acceptable practice; or
- Where there is failure to report a serious incident in which a member of staff was involved or about which they were aware.

Completion of an adverse incident report does not discharge staff of their duty of care and their risk management responsibility. There should be timely and appropriate follow-up of adverse incidents. Where preventative measures and/or procedural changes are identified these should be put in place to minimise the risk of the adverse incident recurring.

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[4] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[5] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

[6] *a just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. ''…generally in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts'. (NHS England, A Just Culture Guide; Professor Sir Norman Williams's Review into Gross Negligence Manslaughter in Healthcare report, June 2018).*

IMPROVEMENTS UNDERWAY – SERVICE USER FEEDBACK
Development of Service User Feedback Awareness training package – Corporate Mandatory Training for all staff across the organisation, aiming to go live by 1st April 2024
Service User Feedback Pilot in relation to early resolution – to commence April 2024
Implementation of a procedure for the management of Independent Clinical Record Review of Complaint. Information on how complaints relating to professional members of staff are managed across the Trust along with the opinions, thoughts and views on the process of an Independent Review have been obtained. Staffing resources within the Corporate Service User Feedback team has prevented progression of this work. It is planned this will be revisited in April 2024
IMPROVEMENTS UNDERWAY – PATIENT SAFETY DATA & IMPROVEMENT
SHSCT Safety Framework – Drafted and presented to SLT on 20.02.24
IMPROVEMENTS STILL TO BE ACHIEVED – INCIDENT MANAGEMENT
Increased use of 'Hot Debrief' for Level 1 SAI reviews across the Trust to ensure Learning is rapidly identified and shared
Audit evidence provided to support SAI recommendations which have been fully implemented
SAI Theming
Audit compliance with Corporate SAI Policy and Procedure
Inclusion of SAI recommendations in the triangulation of Governance activity information
Development of a Professional Governance Information System (PGIS) to further improve oversight and assurance of governance activity in relation to staff
IMPROVEMENTS STILL TO BE ACHIEVED – DATIX INCIDENT MANAGEMENT SYSTEM
Focus on Unapproved Datix incidents and reporting of these in the Weekly Governance Meeting, Governance Committee and at Governance Coordinators meeting
Development of Datix Training package for reviewers
Development of Datix Workshops for staff to access to learn or refresh on Datix functionality

199. There are significant issues with the operation of the SAI process which the PCC hope the current review by the Department of the process will address. The PCC view is that there is a need to implement the recommendations of the Hyponatraemia Inquiry set out at paragraph 100 101 above.

200. To set in context the examples of SAI practice experience it is essential to understand the starting point for the PCC. The majority of the public who seek support from the PCC have experienced harm resulting from the service received from statutory providers. They have described a negative and distressing engagement experience when trying to find a resolution with the statutory body. Whilst this may not be true for all service users, it is for the those who have availed of the PCC advocacy service.

201. The PCC reached out to families in advance of completing this Corporate Witness Statement requesting permission to highlight their experiences. Paragraph 97 details one family's experience over a 5-year period with the PCC assisting them to engage across the system, including the SHSCT. The second family experienced a Level 2 SAI review which was conducted following the death of daughter / sibling by suicide, while under the care of the Southern Trust. The following sets out their experience on being advised that an SAI was to take place;

- No information was provided as to how Trust/GP records could be obtained, this would have made the initial meeting with the Chair of the review panel more productive.
- SAI was deemed Level 2 without any discussion with the family.
- Terms of reference of the SAI were presented to the family but at the early stage of the process it was not made clear that these could be challenged,
- The family had no independent advice.
- Initial contact person within the governance office was absent for a prolonged period of time, and the family were not provided with a suitably senior alternative in his absence.

- The family had requested a meeting with the lead professional, prior to issue of the draft SAI report, this request was never passed to him by the governance office.
- There was a lack of regular updates thus had to constantly seek information.
- Family input was not considered to be an integral part of the review process,
- Support from PCC at this time was intermittent as the officer worked part time and then left on maternity leave.
- Lack of confirmation that draft report would be available on the date promised.
- The Trust insisted on meeting with us to explain the report content despite the family telling them on multiple occasions that we would take the report, read it, respond and then ask for a meeting.
- A series of meetings with the Southern Trust, facilitated by the PCC eventually took place, virtually, including a meeting with a new Chair of the SAI panel.
- Following the finalisation of the SAI, the family were offered an opportunity to escalate our concerns with the office of the Public Service Ombudsman.
- The Ombudsman accepted our case for investigation.
- The SAI process certainly caused further harm to my family, not the investigation itself but the lack of engagement and communication, lack of openness and willingness to answer all questions asked. We were not treated as equals.
- On reading the RQIA review of the systems and processes for learning from SAIs (June 2022) it is obvious that what we were asking for from the Trust should have been delivered, we were not asking for anything that was unreasonable.
- Many straightforward questions remain unanswered in the final SAI report.
- The family requested that their response to the draft report be included as an Appendix to the final report, this did not occur.

202. The timeframes of SAI's usually relate to the actual time required to complete an SAI Review. This does not take into consideration the timeframe to

7.9 In delivering on these responsibilities, I had oversight of the following Governance processes, each addressed in turn below:

	ELEMENT	DESCRIPTION	REPORTING ARRANGEMENTS / FREQUENCY	IMPROVEMENTS INTRODUCED DURING MY TENURE
CORPORATE CLINICAL AND SOCIAL CARE GOVERNANCE	**Adverse Incidents**	I had responsibility for the oversight and management of the Trust incident reporting system (DATIX). This includes coordination and production of trend and activity reports for Trust Governance Committee. I provide challenge and scrutiny to directorate teams on incidents reported via the weekly governance debrief meeting, DivMD 1-1s and Trust Senior Management Teams	• Weekly Governance Debrief meeting • Quarterly Corporate Clinical and Social Care Governance Trust Board Report	• Upgrade of DATIX system • Weekly Challenge function introduced via the Governance Debrief meeting • Appointment of a DATIX systems manager
	Serious Adverse Incidents (SAIs)	I provided coordination of the Trust SAI processes. This includes monitoring of regional timescales and managing corporate supports to assist with SAI completion including the Family Liaison Team and use of the SAI Corporate Chair resource. All completed SAIs are currently approved by the operational Director who commissioned the review. I provide challenge and scrutiny to directorate teams on Serious Adverse Incidents reported via the weekly governance debrief meeting, Divisional Medical Director 1-1s and Trust Senior Management Teams	• Weekly Governance Debrief meeting • Quarterly Corporate Clinical and Social Care Governance Trust Board Report	• Introduction of Family Liaison Officer Role • Introduction of Corporate SAI Chair role • Introduction of Corporate Clinical and Social Care Governance Officer role • Pending introduction of Executive Director SAI Oversight Group • Weekly Challenge function introduced via the Governance Debrief meeting
	Clinical Audit	I was the lead director for Clinical Audit within the Trust. To date the Trust Clinical Audit function has been significantly understaffed. This has been referenced in the Trust Clinical Audit Strategy 2018.	• Annual National Audit Report to Trust Governance Committee • Weekly Governance Debrief	• Renewed Clinical Audit Strategy due for launch Summer 2022 • Additional funded secured to rebuild

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SMT COVER SHEET

Meeting/Date	SMT Meeting – 18th January 2022	
Accountable Director	Dr Maria O'Kane Medical Director	
Title	Patient Safety and Clinical Audit Resourcing Proposal Strengthening Structure and Function	
Report Author	Name	Fiona Davidson & Joanne McConville
	Contact details	Personal Information redacted by the USI Personal Information redacted by the USI
This paper is presented for: ***Approval***		

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	√	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide SMT with a clear summary of the paper being presented, with the key matters for attention and the ask of SMT.* *It details how it impacts on the people we serve.*

1. Detailed summary of paper contents:

- The proposal paper sits within the context of the Clinical & Social Care (CSCG) Governance Review 2019, the September 20200 CSCG Resourcing proposal. It recommends the establishment of a dedicated clinical audit function and a strengthened Patient Safety Data and Improvement function.
- The proposal seeks the overall investment of £600,533 over a two year phased implementation. (£303,582 of this investment was previously set out in phases 2 & 3 of the CSCG Sept 2020 Resource paper to SMT).
- Currently the Patient Safety Data and Improvement Team have a mixed role and function across mortality and morbidity, patient safety indicator monitoring, clinical audit and SHSCT clinical guidelines. Lack of capacity, has over time prevented a robust focus on clinical audit. The Clinical Audit Strategy (2018) identified insufficient resources were available to support the organisational function.
- Currently facilitation of the Patient Safety Peer Review (M&M) process is limited, particularly at sub-specialty and in assuring the sharing and implementation of learning.
- The pandemic requirements of 7/7 daily mortality reporting has placed additional requirements on a small departmental team requiring additional cover arrangements that could be sustained with the investment proposed in this paper.

2. Areas of improvement/achievement:

- The successful implementation of the regional policy and mortality reporting system since 2018 despite the on-going challenges of the RMMRS reporting functionality.
- The establishment of daily pandemic mortality reporting processes since April 2020.
- Patient safety indicator monitoring continues to report on key improvement areas known to reduce avoidable harm to patients and service users.
- The annual National Audit Assurance report submitted to Governance Committee in November 2021 details the continued levels of clinical commitment and engagement in National Audit programmes. National Audit Assurance Summary Report_PostSMT_GC_161121.pdf

3. Areas of concern/risk/challenge:

- The identification and sharing of key learning from mortality and morbidity processes is comprehensive, timely and effective.
- Areas of concern or risk identified in national audit reports and local audit action plans have effective organisational oversight and escalation processes.
- The provision of a comprehensive clinical audit function is reflective of an organisation that is culturally curious, learning and improvement focused at service level.
- Measurement of safety and audit outcomes are key elements for triangulation, integral to good governance. Their role in improvement and assurance underpins quality service provision, part of the over-riding Trust objective of promoting safe, high quality care.

4. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	Clinical audit processes are part of a directorate's assurance gathering processes on evidencing safe and effective care. Identifying areas of risk at directorate, and as required corporate levels.
Board Assurance Framework	The role of clinical audit as a tool for governance sits in context of the SHSCT Board Assurance Framework (BAF) where clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care, a core Trust objective.

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Clinical Audit Department

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Clinical Audit Assurance Report

Clinical Audit Reference Group (CARG) Meeting

13/12/2023

Working together Excellence Openness & Honesty Compassion

1.0 Executive Summary

The SHSCT Clinical Audit Policy sets out the monitoring requirements for CARG assurance reporting. This report details the position of the Trust to **30th November 2023.**

- In the period 01/04/2023 – 30/11/2023, 117 clinical audits have been centrally registered. This includes audits registered prior to 01/04/2023, which would be 'on-going' or continuous at the 01/04/2023 as an agreed action at the September CARG meeting (27/09/2023).

- The observed drop in newly registered audits, also noted in the September report, has improved. Registration activity will continue to be monitored and divisions are asked to continue to promote clinical audit at all relevant operational / governance or patient safety forums. In particular relating to number of Level 2 HQIP priority audits currently registered (see section 6.0 of this report).

- Audit follow-up processes are embedded and have continued to see a level of feedback and engagement on the completion status of registered audits. However for the Trust to establish a repository of audit actions or recommendations, further improvement is required to requests from the clinical audit department for evidence of audit follow-up, recommendations, action plans or learning.

- The clinical audit department will be working with directorates from early January 2024 to provide an updated position/progress report in the delivery of Clinical Audit plans for 2023/2024. This will be in advance of directorates planning for their 2024/2025 programme, to start in April 2024.

- The post of Senior Facilitator Audit and Training (B6) has been appointed (Nov 23) and is expected to take up post in early 2024. This completes Phase 1 of the critical clinical audit posts recruited since approved in July 2021.

- 'An introduction to clinical audit training' session has been designed and piloted with Radiology and Integrated Maternity & Woman's Health (IMWH). Further pilots across introductory and more advanced training levels are planned for 2024 with a view to a training curriculum being in place (new post dependent).

Clinical Audit Section Departmental Meeting

Urology Improvement Division

18/10/2023

Southern Health and Social Care Trust

Urology Division Annual Clinical Audit Programme 2023/2024 - Update January 2024_v0.4

Priority Level	Descriptor		Host Organisation or Standard	Audit Title	Clinical Lead	Audit Supervisor	January 2024 Update
1	NEW External 'Must Do'	National HQIP	British Association Of Urological Surgeons (BAUS)	**Nephrostomy Audit**	Dr Omar Ababneh	Mr Mark Haynes, Consultant Urologist	Case Identification Oct & Nov 2023. Jot form data entry / BAUS Feb 2024
1	ON-GOING External 'Must Do'	~~National HQIP~~	~~British Urology Researchers in Surgical Training (BURST)~~	~~**Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.**~~	~~Mr Conor McCann- Specialty Doctor~~	~~Mr A Glackin, Consultant Urologist~~	Not completed - data not submitted by closing date
1	On-Going External 'Must Do'	National HQIP	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	**Testicular Torsion - Child Health Clinical Outcome Review Programme - Clinician Questionnaire**	Participation in National Enquiry Director approval 14/10/2022 Multiple Clinicians	Participation in National Enquiry Director approval 14/10/2022 Not Assigned	CQs submitted to NCEPOD - CfC letter Mr Haynes aware - scheduled for 16/01/2024
1	On-Going External 'Must Do'	National HQIP	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	**Testicular Torsion - Child Health Clinical Outcome Review Programme - Organisational Questionnaire - CAH**	Participation in National Enquiry Director approval 14/10/2022 Mr A Glackin	Not Applicable	OQ submitted to NCEPOD. NCEPOD Report due winter 2024
2	ON-GOING Internal 'Must Do'	Public Inquiry	NICE NG2 Bladder cancer: diagnosis and management (2015)	**Retrospective audit all cases from all consultants in the two financial year periods of 2012/2013 and FY 2013/2014 (working title)**	CNS - Leanne McCourt & Patricia Thompson	Mr M Haynes & Mr J O'Donoghue	Completed and proposed by Mr Haynes on 18/10/2023 to be presented alongside a current review of NG2 cases (3 month time frame)
2	Internal 'Must Do'	Regional	Urology Regional Audit Meeting for Northern Ireland Topics	**To be advised by Clinical Team**	No current regional audit programme	No current regional audit programme	Mr Haynes advised Dr Cull presented initial cases of biopsy audit at row 20
			On-going Internal Divisional Priority Audits from 2022/2023 to be rolled forward for completion by July / August 2023				**Local Audits - Update / Comments**
3	Divisional Priorities	Local SHSCT based on Morecambe Bay Report	STAR Methodology / BAUS Leaflet compliance on consenting practice	**Consenting in TURBTs (transurethral resection of bladder tumour) + URS (Ureteroscopy) for Stone, How good we are?**	Dr Zuhdi Al-Nabulsi, ST3 Urology	Mr J O'Donoghue, Consultant Urologist	Presentation 18/10/2023 PSM. Discussion / action that 'process' of consent now to be reviewed
3	Divisional Priorities	Local SHSCT based on Morecambe Bay Report	Getting It Right First Time Programme (GIRFT)	**Comparing GIRFT recommendation that definitive treatment following ureteric stent insertion for ureteric stone should be provided no longer than 4weeks from the acute septic episode to our secondary URS waiting list times for these cases.**	Ms Laura McAuley, Urology Specialty Doctor	Mr Matt Tyson, Consultant Urologist	Presented 15/11/2023 PSM - on-going review as a result of GIRFT standards and SAIs linked to outcomes. Monthly data from Grace McCrory
3	Divisional Priorities	Local SHSCT based on Morecambe Bay Report	Compliance with NICE Guidance / EAU guidelines	**Review of Serum Calcium Assessment in New Stone Patients**	Dr Sadaf Imitaz	Mr Matt Tyson, Consultant Urologist	Presented 20/04/2023 PSM
3	Divisional Priorities	Local SHSCT based on Morecambe Bay Report	International Continence Society (ICS) Guidelines	**Comparative Audit of Urodynamics Practice in the Southern Trust ~~2018 &~~ 2023**	Ms Abigail Nelson / Jenny McMahon	Mr J O'Donoghue, Consultant Urologist	Presentation 18/10/2023 PSM. Post form introduction cases audited / agreed that 'pre' new form stage to be assigned for audit - see row 22 below
			On-going Internal Divisional Priority Audits from 2023/2024 for completion by March 2024				
3	Divisional Priorities	Local SHSCT based on Morecambe Bay Report	NICE Guidelines – 2015 update, EAU Guidelines – 2022 update, ICS Guidelines	**Male LUTS Service Re-Audit**	Dr Andrew McAdam (Urology Registrar)	Mr A Glackin, Consultant Urologist	Presented 15/11/2023 PSM
		Local SHSCT based on Morecambe Bay Report	NICE Guidelines – 2015 update, EAU Guidelines – 2022 update, ICS Guidelines	**Male LUTS Service Re-Audit - 'new' patients**	Dr Jay Atkinson (Urology Registrar)		To examine new patients from the previous audit and re-audit cycles
3	Divisional Priorities	Local SHSCT topic important to division	UK & European LUTS Guidelines for selection of patients for Rezum Procedure	**Patient outcomes following REZUM surgery within Southern Trust**	Jason Young, Urology Specialist Nurse	Mr A Glackin, Consultant Urologist	To be Scheduled for presentation Jan 24 PSM
3	Divisional Priorities	Local SHSCT rolling audits	NG 131 https://www.nice.org.uk/guidance/ng131/chapter/Recommendations#information-and-decision-support-for-people-with-prostate-cancer-their-partners-and-carers https://uroweb.org/guidelines/prostate-cancer	**Combined Service Evaluation and Audit of prostate biopsies in the SHSCT**	Dr Susan Cull, Clinical Felow	Mr M Haynes (Div Medical Director)	Presented 15/11/2023 PSM - on going review of SHSCT cases and not those to 352 HC
~~3~~	~~Divisional Priorities~~	~~Local SHSCT~~	~~None Advised~~	~~**Female Lower Urinary Tract Service Audit (registered but on hold)**~~	~~Ms Laura McAuley and Clare Crothers~~	~~Mr J O'Donoghue, Consultant Urologist~~	~~Confirmed 18/10/2023 now a QI project - to be removed from CA Plan~~
3	Divisional Priorities	Local SHSCT rolling audits	NICE NG2 Bladder cancer: diagnosis and management (2015)	**Audit of recent cases from quarter period - (Feb, Mar, April 2023)**	Dr Samara Fleville	Mr M Haynes (Div Medical Director)	Agreed at PSM 18/10/2023
3	Divisional Priorities	Local SHSCT rolling audits	International Continence Society (ICS) Guidelines	**Retrospective Audit of Urodynamics Practice in the Southern Trust 2018 ~~& 2023~~**	Dr Samara Fleville	Mr J O'Donoghue, Consultant Urologist	Agreed at PSM 18/10/2023
3	Divisional Priorities	Local SHSCT	https://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/ESWL.pdf	**Audit of Complication rates for ESWL against national averages- mainly haematoma formation, infection and steinstrasse**	Ms Laura McAuley, Urology Specialty Doctor	Mr Matt Tyson, Consultant Urologist	Agreed at PSM 18/10/2023
4	Individual Priority	Clinician / Educational Interest	Comparison with National Complication Rates - Clavien Dindo	**Local Anaesthetic urology procedures (Complex Procedures Audit)**	Ms L McAuley / C Crothers	Mr M Haynes (Div Medical Director)	Agreed at PSM 18/10/2023

Noted at departmental meeting on 07/09/2023 - awaiting confirmation of NiCAN CRG Regional Audit Topics, ? Access to emergenct theatre / ureteric stones and ? 1 - 2 Guideline adherence audits / CNS audits - for consideration / discussion and then to update the CA plan at Oct PSM - 18/10/2023
Agreed on 18/10/2023 that further audits to be proposed by using a 'one slide' proposal at Nov PSM
Discussion in Nov 23 meeting of an evaluation of 'handover' plan compared with 'discharge' plan to be allocated following Dec 2023 rotation

Please Note: **Cancer MDT / MDM pathway audit sit within Cancer and Clinical Services Division**
National Cancer Audits - NI HSCTS do not participate and are part of NiCAN / Cancer Registry

Not Applicable to NI HSCTs	National HQIP	e.g National Prostate Cancer Audit (NPCA) - All men newly diagnosed with C61 prostate cancer. Such patients are identified for inclusion from the country-specific cancer registries (NCRAS in England and Canisc in Wales)

Hyponatraemia Inquiry - Recommendation 29 that all Medical Notes be subject to rigourous and routine audit
Independent Neurology Inquiry - Recommendation 51 - Healthcare organisations should ensure that newly introduced therapies are the subject of early clinical audit processes.
Jan 2024 - HoS / PSM Chair tabling audits required as an outcome of the RCS Review Action Plan - Recommendation 3 & 13

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4.0 Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

This section of the NAAR highlights areas where, despite service or staff efforts, it has not yet been possible to achieve the desired level of compliance with audit standards, or to fully implement action or improvement plan recommendations.

In this context clinical audit leads have been asked to highlight any key areas to be raised for the committees' attention and these are highlighted, under each audit in the following section.

1. Intensive Care National Audit & Research Centre ICNARC Case Mix Programme (CMP)

- Ongoing building work is essential to allow ICU to function effectively, allowing timely admission and minimising pressure and out of hours discharges. These have been identified nationally as issues. Overspill of critical care patients to post-operative recovery currently impacts on the smooth functioning of that area, while also making provision more challenging from a critical care perspective.
- Development of outreach and follow up service will help CAH with identification of unwell patients, while also allowing appropriate ward follow up. This should help reduce early re-admission rates (another ICNARC Quality indicator).
- Ongoing development of ICU capacity will limit the number of non-clinical transfers from CAH.

2. National Comparative Audit of Blood Transfusion (NCABT)

- The Southern Trust was unable to participate during 2022/2023 due to haemovigilance staffing pressures. Participation in future NCABT audits remains desirable if staffing resource permits.

3. Patient Blood Management in Adults Undergoing Elective, Scheduled Surgery

- The new Surgical Ambulatory Unit has resulted in the decant of the Preoperative Assessment Department into two different areas in CAH. This has led to a disconnect between clinical and admin areas. The Trust should consider investing in a Preoperative Assessment Department that allows us to prepare patients for surgery in the best way possible.
- The dream is to have a department that is visible, has a high profile within the Trust, is recognised by patients and above all, can deliver all the facets of preoperative preparation.
- Positive outcomes are driven by good preparation. This includes, IV iron, dedicated physiotherapy input for exercise prehabilitation, cardiopulmonary exercise testing in a suitable lab with adequate space, dedicated dietetics input for patients with malnutrition and a waiting area that lends itself to healthcare interventions with bespoke audio-visual messaging.
- Careful consideration must be given to the consolidation of CAH and DHH Preoperative Assessment Departments onto one non-acute site, preferably Armagh.

Summary Update on the Strengthening and Improvement of SHSCT Clinical Audit Function - February 2024

Section 1: Strategic Level Improvement:

Strategic Drivers for Improvement:

- Previous Internal Audit of Clinical Audit (16/17) and Clinical Audit Strategy (2018)
- Review of Clinical and Social Care Governance Report (CSCG) (Nov 2019)
- Improvements as a result of events leading to / early learning from the Urology Services Inquiry

Best Practice followed:

- Health Care Improvement Partnership (HQIP) guidance April 2020 FINAL-Clinical-Audit-Strategy-2020.pdf (hqip.org.uk)

The following improvements have therefore been taken forward since August 2021 and are summarised across five key strategic and eight operational improvement areas.

Table 1.Five Key Strategic Improvements in SHSCT Clinical Audit

No.	Improvement Area	Timeline	Evidence	Difference made	Challenges (C) / Work (W) going forward
1.	**Clinical Audit Resourcing Plan**	January 2022	Patient Safety_Clinical Audit	- Established a clear plan to strengthen clinical audit over a 5 year period identifying the resources required. - Completed a recommendation of the CSCG review (2019)	Phase 1 posts 'at risk' post USI **(C)** Phase 2 bid of the paper to be funded **(C)**
2.	Updated **Clinical Audit Strategy** (2022/23 – 23/24)	June 2022	Clinical audit strategy_SMT_appro Clinical audit strategy_June 2022	- Completed a best practice recommendation of HQIP Guidance - Updated the previous 2018 CA Strategy.	Strategy update in 24/25 will need to align to enable the new SHSCT Vision and Strategy (2030) **(W)**

6.	**National Audit Assurance Reporting** - Corporate Oversight	Annually – Governance Committee Report – Feb 2024	20240229_National Audit Assurance Sur	- Provides corporate oversight of relevant HSCNI / SHSCT national audit participation. - Key areas for improvement and areas of challenge or risk are identified by audit leads and supported by CA Dept.	Participation in national programmes is reported as being maintained and where SHSCT is eligible to submit datasets.**(W)** Challenge is around improvement work between cycles to make changes that will improve outcomes.**(C)**

Section 4: Strengthening and Improvement Work in Progress / Remaining Areas

No.	Improvement Area	Timeline	Evidence	Difference made	Challenges (C) / Work (W) going forward
1.	Development of **Quality Manual System (QMS)**	August 2023 – February 2024	In development	- Strengthened processes to guide CA resulting in the development of Standard Operating Procedures and Work Instructions - in final drafting stage.	QMS to standardise operations via a bespoke system such as QPulse will be explored to replace manual processes and Microsoft office based SoPs and WIs **(C)**
2.	**Clinical Audit Training**	Nov / Dec 2023 – pilot work	In development for 2024/2025	- An **'Introduction to Clinical Audit':** initial pilots within Radiology, Pharmacy and	Key to improving and strengthening the quality of clinical audits is training. In a similar manner to the support provided for Quality Improvement (QI) training, clinical

				Midwifery delivered in Nov / Dec 2023	audit as a methodology in SHSCT requires access to training resources**.(W)** Immediate challenge is to design and deliver SHSCT wide CA training on 4 stage CA cycle. Post holder now in post from 29/01/2024. **(W)**
3.	Improving **Learning and Assurance** through strengthening the quality of Clinical audit activity and it's integration in wider governance processes for triangulation.	2024/2025 – 2025/2026	In development / longer time frame	- The combining effect of all of the strategic and operational improvements will over the next 3 years increasingly deliver incremental benefits in learning and assurance.	A continued focus on: Increasing the clinical / multi-disciplinary engagement in CA processes, oversight of audit completion rates, identifying key recommendations, defining smart objectives, action planning and implementing improvement processes, ensuring a 'home' for the regular discussion and sharing of learning from audits and triangulation with wider governance areas in developing audit schedules in directorate plans that ensure participation in national programmes and compliance with national guidance priorities on safe and effective care. **(W) & (C)**