Regarding Children's Allied Health Professionals (AHPs), Mr McCafferty pointed to the table of referrals for Occupational Therapy, Physiotherapy, Speech and Language (SLT) and Dietetics which demonstrated referral increases in all four areas since 2019. Mr McCafferty explained that the pandemic has had an impact on children and this is particularly evident in SLT, with the largest volume of children waiting for an assessment. He reported that there has been an increase in the number of newly diagnosed children with type 1 diabetes which requires significant input from Dietetics. Mr McCafferty informed members that the recent industrial action is having an impact on the number of staff undertaking overtime shifts.

Elective Paediatric Surgery was discussed. Mr McCafferty stated that this service has been significantly impacted by the pandemic with significantly reduced level of theatre sessions available. He commented that this service has been difficult to rebuild. He reported on the number of waits for surgical intervention and explained that the majority of children are waiting for ENT or dental surgery. Mr McCafferty added that a cross directorate group is focusing on the recovery of paediatric elective surgery. A recruitment drive with a focus on DHH for theatre staff took place. He advised that 24 applications were received and it is hoped that the paediatric theatres will open in April 2023. Mr McCafferty reported that there are 745 children identified as urgent and 550 relate to dental. He noted that other avenues have been explored and referrals have been sent to the independent sector in Mullingar and overtime initiatives in the Trust. However, this is not a viable to substitute to upscaling and recovering the service to pre Covid levels which remains the objective. Mrs McCartan asked if the Royal Victoria Hospital dental service has been approached, to which Mr McCafferty explained that they are in the same position and unable to offer their service.

In response to a question asked by Mrs Tally, Mr McCafferty indicated that the impact of the increase in birth rate within the SHSCT can be seen in the number of referrals and increase across the waiting lists.

The Chair requested item 13 be taken at this point

13. EXTERNAL ASSURANCE – CARDIOLOGY SERVICES

The Chair welcomed Dr David McEneaney, Consultant Cardiologist and Mrs Kay Carroll, Head of Service for Cardiology to present information on the Cardiology Service within the Trust. The National Cardiac Audit Programme - Myocardial Ischaemia National Project (MINAP) summary report which focused on 2020/21 data was included in members' papers. Members noted that MINAP (Myocardial Ischaemia National Audit Project) is a domain within NICOR (National Institute for Cardiovascular Outcomes Research) that collects data and produces analysis to enable hospitals and health care improvement bodies to monitor and improve the quality of care and outcomes of cardiovascular patients. All hospitals in Northern Ireland contribute to the MINAP national Audit and the Southern Trust participates and utilises information from MINAP to inform the Trusts Cardiology Governance team and the Regional Cardiology Network.

Mrs Carroll began by explaining that the Trust has 32 dedicated Cardiology beds on the CAH site and 6 Cardiology beds on the DHH site. There is a dedicated Cardiac Catherisation laboratory which is operational Monday to Friday 7.30am to 9pm. The Cardiology Service also has a dedicated Cardiac Investigation Department across both acute sites which operates Monday to Friday 8.30am – 5pm service plus Saturday and Sunday ECHO service only on CAH site. Mrs Carroll spoke on the role of the Rapid Access Chest Pain Nurse in the Emergency Department. She advised that the nurse has the skills and knowledge to make decisions to discharge patient's home with no further investigation or discharge with investigations as an outpatient. Mrs Carroll was pleased to report that the Chest Pain Nurse won the Northern Health Care Award for this work in 2021.

Mrs Carroll explained to members the pathways for patients with different diagnosis. Those patients with NSTEMI, their care will be based on NICE guidelines and added to the Regional Cardiology Whiteboard and if accepted for an inpatient procedure the MINAP nurse will monitor the care provided.

Mrs Carroll noted her concern that the Trust does not have protected beds for cardiology patients. She stated that this can lead to patients

being admitted to the AMU (Acute Medical Ward) and wait for a Cardiologist which delays their treatment. She advised that the Trust has one dedicated session per week in the Cardiac Cath Lab which has an impact on patient safety and access times. Mrs Carroll drew members' attention to the current waiting list data for Cardiac Cath Lab procedures as at 1st November 2022. She reminded members that the 2nd Cardiac Cath Lab was removed and highlighted the information on the longest waits: March 2019 longest wait was 55 weeks, following removal of 2nd Cardiac Cath lab this has increased to 150 weeks in March 2022.

In relation to standards, Mrs Carroll reported that the NSTEMI patients should have their cardiac cath lab procedure within 72 hours. Currently the Southern Trust is achieving 33% and following a discussion with the nurse in Belfast and Western Trusts they are achieving 80% and 79%. She also noted her concern that box changes (battery change) the standard should be 6 weeks and the Trust is achieving 13 weeks. She added that these patients are carefully monitored by the cardiac team.

Dr McEneaney informed the Committee that the current Cardiology division is unique in that the service spans both the CAH and DHH site. Consultant staff move between both sites and the same care is provided to patients. He noted that the Trust Cardiology service is the busiest in Northern Ireland and explained that the treatment provided on both sites covers a wide range of procedures and treatment in comparison to Belfast who are a specialised unit. Dr McEneaney stated that during the pandemic, activity decreased and now those patients who did not seek medical care are filtering into the system which is having an impact on the ability to provide treatment and address waiting lists. He spoke of the bed turnover and felt if the service had protected beds, this turnover would improve. Dr McEneaney also raised the importance of securing protected cardiac beds in the Trust.

Dr McEneaney advised that the Cardiac service has seen an increase in the number of acute inpatients on both sites. He explained that these patients are prioritised, therefore this increases the wait time for outpatient elective lists. Dr McEneaney added that he has received complaints from patients and MLAs on this issue and

these have been logged. He noted that the waiting list is growing by 15 patients per week and without appropriate intervention this issue will not be resolved. He said that patients have been sent to other Trusts to treatment however to have a positive impact on patient safety and waiting lists he felt that the only solution was to reinstate the modular Cardiac Cath Lab onto the CAH site and to protect cardiology beds on both sites. Mrs Carroll informed members on a number of incidents that have occurred due to the breakdown of the C-Arm equipment and noted her concern that this impact the integrity of the Trust to provide safe care for patients. In concluding Dr McEneaney reminded members of the high political commentary that has been received in previous months due to the downtime of the Cardiac Cath lab which also has an impact on the reputation of the Trust.

The Chair thanked Dr McEneaney and Mrs Carroll and commented that she was deeply concerned with the information presented. She welcomed that there was a dedicated team to deliver high quality care.

Mrs McCartan questioned why the Cardiology service does not have protected beds and was conscious on the number of times the Cardiac Cath lab was out of order. Due to this, Mrs McCartan provided her support for the immediate protection of cardiology beds and to reinstate the modular cardiac cath lab.

Dr Gormley advised that when a patient is under the care of a cardiologist in the right environment from the beginning of their admission to hospital, the length of stay is reduced, therefore he agreed with the need to protect beds. He was mindful however that this may have an impact on other areas and this should be taken into consideration.

In response to a question asked by Ms Donaghy on the 17 deficits that were not met, Dr McEneaney explained that this can be attributed to only having one Cardiac Cath Lab in situ. He commented that having an additional modular Cardiac Cath Lab will reduce the waiting lists and targets can be met. He spoke of the Day Procedure Unit and how this unit would be able to accommodate the elective work if an additional lab was made available. Ms Donaghy suggested

that a business case paper is required to highlight these issues to the operational team who can take this forward.

Mrs Leeman commented that patient flow and ring fencing beds is important. She advised that she has liaised with Mrs Teggart to bring forward a paper to support a modular Cardiac Cath lab on the CAH site. This proposal will include a number of options and will be submitted to SMT for discussion. Mrs Leeman added that previous work has focused on reducing the elective waiting lists, however in the last 6 months this has moved to focus on the unscheduled care demand and the need to have a backup facility on the Acute Hospital site. She provided assurance that the commissioner is aware of the situation and the proposal. The commissioner has appointed a clinical lead to review cardiac services across the region, however the work has not concluded yet.

Dr McEneaney spoke of CAWT and advised that discussions have taken place to introduce a cross border cardiovascular service. He stated that costings will be reviewed to provide a service to patients in Monaghan and Cavan and the Trust is seeking £3.4m to provide hardware and staff. Mrs Tally added that she has been working with the Cardiology team on this and advised that there is £97m available, however it is oversubscribed and working groups has been asked to revisit their bids. She stated the cardiac service is one theme to be developed and the Trust bid will be submitted.

The Chair thanked Dr McEneaney and Mrs Carroll for their presentation and pledged her full support for the protection of cardiology beds and to reinstate the modular cardiac cath lab. She advised that Mr McDonald, Non-Executive Director, has expressed the view that he would like to see an improvement plan put in place to address the issues and presented to the Governance Committee

Action: Mrs T Reid

The Chair advised that she will formally write to the Chair and Chief Executive highlighting the Committee's concerns and how the Trust plans to address these issues going forward.

Action: Mrs Leeson

The Chair left the meeting at this point.

Ms Donaghy took over as Chair

10. INFECTION, PREVENTION AND CONTROL

Dr Gormley presented the Infection Prevention & Control (IPC) report for October 2022. The IPC report includes information on SHSCT PFA targets, Monthly Target Monitoring Report, Hand hygiene audit, Commode audit, Independent Hand hygiene audit, Independent Commode audit and COVID 19 data.

Dr Gormley reported on those areas of improvement and informed members that the IPC team have been using ribotyping to exclude Clostridium Difficile Infection transmission however it does have limitations and is not as discriminatory as the most advanced whole genome sequencing (WGS).

Dr Gormley reported that HCAI cases have increased across the region and felt that this was due to overcrowding and the flow of patients through the wards.

In relation to MRSA, Dr Gormley reported 7 cases to date with 3 cases being preventable and 36 MSSA cases to date with 14 of these preventable.

Dr Gormley presented data on Clostridium difficile (C. Difficile) and advised that there are 55 C. Difficile cases to date for 2022/23. He noted that cases are increasing and attributed this to a delay in isolation due to limited isolation facilities, lack of side rooms, en-suite, toilets and space is an ongoing challenge. Dr Gormley advised that a task force group has been set up and additional training is underway for medical, nursing and domestic staff. He added that with the pressures to turn beds around quickly this must not be to the detriment of cleaning standards.

Gram negative bacteraemia was discussed. Dr Gormley noted that a number of men with urinary catheters in place who are waiting on elective prostate procedures and delays in surgery are contributing to an increase of gram negative bacteraemia cases.

IPC mandatory training was discussed. Dr Gormley advised that overall 67% of staff have undertook their IPC mandatory training to date. He stated that he would like to see this increase over the next few months.

In response to a question asked by Ms Donaghy, Dr Gormley advised that the pandemic has heighten alertness for IPC and the learning identified has shown the importance of basic IPC measures regarding hand hygiene and space. He added that due to patient's not seeking care during the pandemic, patients are presenting to hospital in a poorer condition and this adds pressures to bed flow, length of stay and overall outcome for the patient.

Mrs McCartan noted the challenges with workforce, ward environment, infrastructure issues within the Emergency Department, high agency and locum use which contributes to an increase in HCAI.

12. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty presented the above named report and noted that as at 31st October 2022, there were in total 247 unallocated cases, which is a decrease from 289 in the previous quarter. There are no unallocated Child Protection or Looked After Children (LAC) cases.

Mr McCafferty noted that there is a high level of Child Protection and Looked After Children activity associated with complexity of cases. He assured members that all cases have a social worker assigned and an appropriate care plan in place.

Mr McCafferty informed members on the recruitment of staff skills mix and creating capacity within the Safeguarding Division. He reported that the Trust recruited additional Social Work Assistants into both Family Support Service and Corporate Parenting divisions initially on a temporary basis. Mr McCafferty was pleased to report that a number of social work assistants have been offered permanent band 4 posts and those staff currently working within the Trust as agency who were successful at interview have been offered posts in their current team, thus creating continuity of service provision. He

believes that available resources were being used efficiently and effectively whilst also seeking to support highly pressurised staff.

Mr McCafferty noted the recruitment of new social workers will not be available until summer 2023 and there is uncertainty on the number of social workers from this co-hort that will be recruited into the Trust and in particular into “hard to Fill Posts” such as Gateway and Family Intervention Teams. He provided assurance that child protection and Looked after cases continue to be managed as per policy and procedures.

Ms Donaghy referred to the governance group who are tasked with agreeing the application of the “Delegated Framework” (delegation of roles to non-qualified social care staff) and asked if there is a timescale for this. Mr McCafferty explained that this is being progressed on a regional basis, requires regional consistency and effective governance arrangements and he anticipates this will be incrementally introduced to the service during the forthcoming year.

Mrs McCartan welcomed the report, the actions to address those areas of concern and the inclusion on the Corporate Risk Register. She asked if additional support or advice has been sought from the Department of Health. Mr McCafferty advised that the Chief Social Worker Aine Morrison is aware of the workforce supply issue and the need to address the number of training places for social workers.

14. COMMITTEE WORK PLAN 2023

Members discussed the content of the work programme for 2023. The committee work programme was approved for submission to Trust Board in January 2023.

15. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.50 p.m.

Signed _____ ***Dated*** _____

Stinson, Emma M

From: Leeson, Pauline
Sent: 05 December 2022 11:39
To: Mullan, Eileen; OKane, Maria
Cc: McDonald, Martin; McCartan, Hilary; Donaghy, Geraldine; Wilkinson, John; Leeman, Lesley; Judt, Sandra
Attachments: Cardiology discussion at Performance Committee meeting on 1st December 2022.docx

Eileen/Maria. Please find attached a record of discussion at Performance Committee on Thursday 1st December. I agreed to escalate the main issue of the need for protected beds and a second Cardiac Cath lab to you for more urgent consideration with the full support of the committee. We did commend the high standard of care that is presently provided and note that Lesley and Catherine are working closely with Dr David McEneaney and Kay Carroll on a business case. Martin has suggested that this issue also goes to Governance with an Improvement Plan. Pauline

Performance Committee 1st December 2022

Item 13. External Assurance - Cardiology Services

The Chair welcomed Dr David McEneaney, Consultant Cardiologist and Mrs Kay Carroll, Head of Service for Cardiology to present information on the Cardiology Service within the Trust. The National Cardiac Audit Programme - Myocardial Ischaemia National Project (MINAP) summary report which focused on 2020/21 data was included in members' papers. She explained that MINAP (Myocardial Ischaemia National Audit Project) is a domain within NICOR (National Institute for Cardiovascular Outcomes Research) that collects data and produces analysis to enable hospitals and health care improvement bodies to monitor and improve the quality of care and outcomes of cardiovascular patients. All hospitals in Northern Ireland contribute to the MINAP national Audit and the Southern Trust participates and utilises information from MINAP to inform the Trusts Cardiology Governance team and the Regional Cardiology Network.

Mrs Carroll began by explaining that the Trust has 32 dedicated Cardiology beds on the CAH site and 6 Cardiology beds on the DHH site. There is a dedicated Cardiac Catherisation laboratory which is operational Monday to Friday 7.30am to 9pm. The Cardiology Service also has a dedicated Cardiac Investigation Department across both acute sites which operates Monday to Friday 8.30am – 5pm service plus Saturday and Sunday ECHO service only on CAH site. Mrs Carroll spoke on the role of the Rapid Access Chest Pain Nurse in the Emergency Department. She advised that the nurse has the skills and knowledge to make decisions to discharge patients home with no further investigation or discharge with investigations as an outpatient. Mrs Carroll was pleased to report that the Chest Pain Nurse won the Northern Health Care Award for this work in 2021.

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Dr McEneaney informed the committee that the current Cardiology division is unique in that the service spans both the CAH and DHH site. Consultant staff move between both sites and the same care is provided to patients. He noted that the Trust Cardiology service is the busiest in Northern Ireland and explained that the treatment provided on both sites covers a wide range of procedures and treatment in comparison to Belfast who are a specialised unit. Dr McEneaney stated that during the pandemic activity decreased and now those patients who did not seek medical care are filtering into the system which is having an impact on the ability to provide treatment and waiting lists. He spoke of the bed turnover and felt if the service had protected beds the turnover would improve. Dr McEneaney noted that the Southern Trust is the only Trust in Northern Ireland who do not have protected cardiac beds and queried why this was. He advised that he has spoken to his physician colleagues and they were all of the same view that if there was protected cardiac beds, this would improve patient safety and reduce their length of stay and improve their outcome. Dr McEneaney stated that he has raised this with the Medical Director prior to the pandemic on the importance of securing protected cardiac beds.

Dr McEneaney advised that the Cardiac service has seen an increase in the number of acute inpatients on both sites. He explained that these patients are prioritised, therefore this increases the wait time for outpatient elective lists. Dr McEneaney added that he has received complaints from patients and MLAs on this issue and these have been logged. He noted that the waiting list is growing by 15 patients per week and without appropriate intervention this issue will not be resolved. He said that patients have been sent to other Trusts to treatment however to have a positive impact on patient safety and waiting lists he felt that the only solution was to reinstate the modular Cardiac Cath Lab onto the CAH site and to protect cardiology beds on both sites. Mrs Carroll informed members on a number of incidents that have occurred due to the breakdown of the C-Arm equipment and noted her concern that this impact the integrity of the Trust to provide safe care for patients. In concluding Dr McEneaney reminded members of the high political commentary that has been received in previous months due to the downtime of the Cardiac Cath lab which also has an impact on the reputation of the Trust.

The Chair thanked Dr McEneaney and Mrs Carroll and commented that she was deeply concerned with the information presented. She welcomed that there was a dedicated team to deliver high quality care.

Mrs McCartan questioned why the Cardiology service does not have protected beds and was conscious on the number of times the Cardiac Cath lab was out of order. Due to this, Mrs McCartan provided her support for the immediate protection of cardiology beds and to reinstate the modular cardiac cath lab.

Dr Gormley advised that when a patient is under the care of a cardiologist in the right environment from the beginning of their admission to hospital, the length of stay is reduced, therefore he agreed with the protection of beds. He was mindful that this may have an impact on other areas and this should be taken into consideration.

In response to a question asked by Ms Donaghy on the 17 deficits that were not met, Dr McEneaney explained that this can be attributed only having one Cardiac Cath Lab in situ. He commented that having an additional modular Cardiac Cath Lab will reduce the waiting lists and targets can be met. He spoke of the Day Procedure Unit and how this unit

would be able to accommodate the elective work if an additional lab was made available. Ms Donaghy suggested that a business case paper is required to highlight these issues to the operational team who can take this forward.

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The Chair thanked Dr McEneaney and Mrs Carroll for their presentation and pledged her full support for the protection of cardiology beds and to reinstate the modular cardiac cath lab. She advised that Mr McDonald, Non Executive Director, has expressed the view that he would like to see an improvement plan put in place to address the issues. The Chair advised that she will formally write to the Chair and Chief Executive highlighting the Committee's concerns and how the Trust plans to address these issues going forward.

Action: Mrs Leeson

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 10th March 2022 at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Dr D Gormley, Deputy Medical Director *(for Dr O'Kane)*
Mr C McCafferty, Interim Director of Children and Young People's Services / Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs L Leeman, Assistant Director Performance Improvement
Mrs G Hamilton, Assistant Director Patient Safety, Quality and Experience *(for Mrs Trouton)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Mrs H McCartan, Non-Executive Director
Dr M O'Kane, Temporary Accounting Officer / Medical Director
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and noted the apologies above. She particularly welcomed Dr Damian Gormley and Mrs Grace Hamilton deputising for their respective Directors.

At this point, the Chair advised members on some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

The Chair informed members that Mrs Leeman has been appointed as the Interim Director of Performance and Reform. Members congratulated and wished her well in her new role.

4. MINUTES OF PREVIOUS MEETING HELD ON 2nd DECEMBER 2021

The Minutes of the meeting held on 2nd December 2021 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

Mr McDonald asked for an update on item 7 Performance Report on the matters arising on the audit of appropriateness of GP referrals to the Emergency Department. Mrs Leeman stated that following discussions with the Acute Directorate a date has not been agreed to carry out this audit in DHH. She agreed to seek a further update and report back at the next meeting.

Action: Mrs Leeman

Ms Donaghy asked for an update on the Internal Audit report on Performance Management. Mrs Leeman explained that the draft report is currently with the Trust for factual accuracy checking. The final report will then be presented to the Audit Committee and subsequently to this committee in May 2022.

6. SICKNESS ABSENTEEISM

The Chair welcomed Deputy Directors, Mrs Maxine Williamson and Mrs Siobhan Hynds to the meeting to present an overview on Sickness Absenteeism within the Trust. Mrs Toal introduced the item and advised that the presentation will focus on key data and trends, impact on service delivery, management issues and support for staff.

Mrs Hynds began by explaining that the sickness absence figures are up to December 2021 so do not represent the full 2021-22 year figure. It includes COVID sickness absence but excludes COVID self-isolation/shielding absences. . Sickness absence figures also exclude Domiciliary Care Workers (system / contracted hours issue). Mrs Hynds presented statistics on sickness absence and Covid self-isolation/shielding (non-sickness) and provide the sickness absence level over a 3 year period. She noted that, as at December 2021, the cumulative 2021/22 sickness figure was 7.01% an increase from 6.78% on the previous year. Mrs Hynds added that although the Trust sickness absence levels have increased, the Trust continues to have lower levels of non-COVID sickness absence in comparison to other HSC Trusts.

Regarding Covid sickness, Mrs Hynds reported that for 2020/21 the Trust had the highest level of COVID sickness absence and in 2021/22 (as at December 21) the third highest level. She attributed this to the link that the Southern Trust Council areas having the largest COVID 19 community transmission rates at certain times during the pandemic.

Mrs Hynds stated that 51% of staff have not had any episodes of sickness. Mr McDonald felt it would be valuable to review the factors such as demographics and age profile for this cohort of staff which might highlight trends. Mrs Toal agreed to undertake this and feedback at the next meeting.

Action: Mrs Toal

Mrs Hynds noted that corporate directorates who have the ability of homeworking throughout the pandemic have a lower level of sickness than those staff who cannot work from home.

Mrs Williamson reported that there were no flu or viral sickness absences in 2020/21. She reminded members that pregnant women were shielding from 28 weeks during the pandemic. Mrs Williamson stated that Mental Health related absences were increasing and noted that in 2020/21 this was the number one reason for absences with stress the top reason. She continued to guide members through the presentation and spoke of the impact on service delivery across all directorates and provided examples of specific service areas affected. Mrs Williamson reported that the Functional Support Service division is above the baseline level of absences and advised that this is an area of focus. She informed members that the Trust has to be mindful that the longer hospital waiting lists is affecting many of Trust staff and how this has an impact on sickness levels.

Mrs Williamson spoke of the support available to staff through Occupational Health, Staff Health Protection and the Psychology Service. She presented a number of statistics on the activity within the Occupational Health department.

In concluding, Mrs Toal stated that the Trust is working to 'get back on track' in terms of normal sickness absence management within HROD and throughout the Directorates.

Mr McCafferty welcomed the presentation and asked that the presentation be shared with managers. Mrs Toal welcomed this suggestion and agreed to action this.

Action: Mrs Toal

Ms Donaghy commented that critical services and waiting lists are negatively impacted with sickness absenteeism and asked how this is being addressed. Mrs Toal explained that redeployment of staff is undertaken in areas where delivery of service is affected and the use of bank and agency staff is used. She added that the AHP flexible pool is used to cover long-term vacancies and maternity leave.

Ms Teggart noted that the Belfast and South Eastern Trusts sickness figures are lower than the Southern Trust and asked why this may be and if there is learning that can be implemented across the Trust. Mrs

Toal clarified for Ms Teggart that this was not the case overall, and that it was the Covid absence levels that were higher due to higher Covid rates across the Southern council areas. Mrs Toal went on to confirm that the Trust's non-Covid sickness rate is lower than all other Trusts, and has been consistently this way for a number of years.

Ms Teggart spoke of 'Inspire Workplaces' which offers free confidential and immediate support for all staff and felt that this could be promoted more across the Trust. Mr Wilkinson agreed that that the Inspire service is an excellent tool and would welcome further promotion of the service across the Trust. Mrs Toal agreed to take this forward.

Action: Mrs Toal

7. PERFORMANCE MANAGEMENT FRAMEWORK

Mrs Leeman presented the Performance Management Framework (PMF) for approval. The document provides information to the committee in exercising its function of overseeing the Trust's Performance Management arrangements. Mrs Leeman reminded that the Performance Committee determined in December 2021 that the PMF should be updated to reflect the interim arrangements established during the Covid-19 pandemic. Mrs Leeman drew members' attention to the section of the report which highlights the change. She advised that the PMF will remain subject to change and will require to be updated to reflect the output of the new integrated care system model and aligned planning arrangements.

Members approved the Performance Management Framework

8. PERFORMANCE REPORT

Mrs Leeman presented the Performance Report for approval. She advised that this report focuses on a broad range of issues and spoke of the areas of improvement / achievement. Mrs Leeman advised that the regional work on new planning and performance arrangements, led by the Department of Health (DoH) and the Health and Social Care Board (HSCB), including Trust Directors of Planning/Performance, is ongoing. The DoH stakeholder

consultation in respect of the 'Future Planning Model – Integrated Care System NI' has closed. Engagement with citizen hubs is ongoing facilitated by the Integrated Care Partnership. The Trust is a member of a number of work streams focused on development of an outcomes framework. Mrs Leeman noted that the Trust's Service Delivery Plan for January 2022 – March 2022, which includes the Winter and Covid surge plan arrangements, has been published on the Department of Health's website.

Mrs Leeman highlighted the key risk areas; access to elective and cancer services, wait times at Emergency Department, inpatient bed demand for adult unscheduled care, access to social work workforce, mental health and disability support services, unallocated domiciliary care cases and ongoing covid transmissibility and impact of workforce. Mrs Leeman guided members through the detailed report which set out the broad performance of each directorate and the actions taken.

Mrs Leeman referred to section 1.1 of the report and noted her concern that waits over 12 hours in the Emergency Department continue to reflect an increasing trend. She advised that the graph highlights those patients who waited over 36 hours and members agreed that this is unacceptable.

In relation to Carers Assessment, Mrs Leeman advised that the older people's services have the largest volume of carer's assessments across the Trust. She explained that the volume of offers has decreased however, in actual terms noted the number of carers assessment actually undertaken reflected an improving trend indicating a more appropriate targeting of assessments. Mrs Leeman noted that there was evidence a level of need was being addressed with the provision of cash grants for short breaks and additional levels of self-directed support payments and domiciliary care hours Mrs Leeman added that work continues to ensure that carer assessments are completed.

In response to a question asked by Ms Donaghy, Mrs Leeman explained that patients are attending the Emergency Department with undiagnosed cancer and attributed this to patients not presenting to their GP and hospitals during the pandemic. Ms Donaghy asked if

referrals have returned to pre-covid levels, to which Mrs Leeman stated that numbers are increasing and there is an unmet demand and an increase in patients added to waiting lists. Dr Gormley explained that the length of stay is impacted by the acuity of the patient. Ms Donaghy asked if it can be established as to whether those surgical patients on a waiting list have had their length of stay increased above the normal range for that condition. Mrs Leeman agreed to undertake this review and feedback at the next meeting.

Action: Mrs Leeman

Mr McDonald referred to section 4.4 - GP Out of Hours and noted that a review of this service has been initiated with the first meeting in February 2022. He asked what Directors are members of the review team to which Mrs Leeman confirmed that Mr Beattie and Ms Teggart are the leads for the Trust. She added that this work links in with the 'No More Silos' – urgent and emergency care work stream for which there was an ongoing consultation.

Members approved the Performance Report

9. CORPORATE PERFORMANCE SCORECARD

Mrs Leeman presented the Corporate Performance Scorecard (January 2022 performance) for approval. The report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework. She reported that historic CPD objectives have been maintained for 2019/2020, 2020/2021 and 2021/2022. Mrs Leeman advised that improvements have not been achieved and performance further impacted in year as result of the current pressures/pandemic response. High level Service Delivery Plan monitoring (previously Corporate Rebuild) is now included in the CPD Performance Scorecard.

Mrs Leeman drew members' attention to the cover sheet, highlighting those areas of concern, risk and challenge and those areas of improvement. She advised that access to services is highlighted throughout the report and in particular elective areas that are concerning. She noted that the statistics in the report are a reflection on the current position of the Trust.

In response to a question asked by Mr McDonald, Mrs Leeman explained that the current targets are outdated, having been rolled over year on year from 2019/2020 and were in the main not available in the current environment. Mrs Leeman indicated that work on a new outcome framework was ongoing.

Mrs Leeman reminded members that the Minister for Health has set out his 'Elective Care Framework' and 'Cancer Recovery Plan', however the success of the plans will depend on a budget and workforce available.

Mr Wilkinson asked on the success of the validation of waiting lists and if this is having a significant impact. Mrs Leeman commented that validation of waiting lists is important to cleanse the lists and ensure that patients still require treatment. However, she advised that the number of patients waiting treatment that no longer require are small in comparison to the volume of waits and this has not made a significant inroad in reducing waiting lists.

Members approved the Corporate Performance Scorecard

The Chair requested that item 13 be taken at this point

13. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty presented the above named report and noted that as at 31st January 2022 there were in total 296 unallocated cases which is an increase from 86 in the previous quarter. There are no unallocated Child Protection or Looked After Children (LAC) cases. He did note that whilst high, the Trust has the lowest number of unallocated cases across the region.

Mr McCafferty informed members that during the reporting period and as of the end of January 2022 there were two families, which consisted of four children on the Child Protection register who did not have a named social worker over a six-week period due to social work sick leave and vacancies.

Mr McCafferty advised that the cases were risk assessed and that there was close inter-professional monitoring including home visits pending allocation to a named social worker. He advised that this was reported to the HSCB and provided assurance that both families were assigned a social worker from the 1st week in February. Mr McCafferty stated presently there are no unallocated Child Protection or Looked After Children (LAC) cases. He advised that an update on pressures within CYP will be presented to confidential Trust Board on 31st March 2022.

Mr McCafferty referred members to the unallocated cases over a 6 week period. He provided assurance that all unallocated cases within Gateway have been reviewed by a Senior Manager and prioritisation of actions identified. An action plan has been developed in respect of higher priority referral.

Workforce capacity issues across the social work service was discussed. Mr McCafferty advised that there is currently a regional shortage of qualified social workers available and who are willing to take up employment in front line children's services, and this will not improve until early Summer when newly qualified staff become available. Even then, there will not be sufficient numbers of new staff available to fill all vacancies.

Mr McCafferty drew members' attention to increase of referrals month on month since October 2021. Me McCafferty advised that at present there is a cross Divisional approach to managing the challenges and seeking to ensure that the most vulnerable and complex cases receive a social work service. He was optimistic that an improved positon would be achieved by early summer, however challenges are likely to remain for the medium term in relation to unallocated cases.

Ms Teggart noted that in some cases there may be families on the poverty line and asked if the Trust and the voluntary sector offer assistance. Mr McCafferty agreed that poverty is a key feature for many families and spoke of a number of charities who can help families in need however, this does not address the systemic issue associated with poverty. Mr McCafferty added that the Trust does offer family support through the FIT team and in addition via the Family Support teams.

In relation to recruitment and retention, Mrs Toal stated that there will be 230 newly qualified social workers across the region however this will not address the capacity and vacancy issues as all five Trusts are in the same position. Responding to a question asked by Mrs Toal, Mr McCafferty advised that unlike nursing and medical there very limited international social workers available for recruitment. The Chair highlighted alternative routes into social work: social work assistants at the local training centres and the Open University.

10. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Enhanced / Specialist Community Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Brian Beattie Interim Director of Older People and Primary Care and Mr Gerard Rocks, Assistant Director of Promoting Wellbeing to the meeting to present the above named item. Members received the presentation in advance of the meeting.

Mr Beattie guided members through the presentation, which consisted of the commissioning plan direction, continuum of care, access and information service, community and voluntary sector service and potential new developments. He began by presenting data and information on OGIs for carers assessments, short breaks, direct payments and self-directed support.

In relation to Access to Services, Mr Beattie spoke of the importance of the right service at the right time. He reported that the Trust has 140 contracts in place with independent, charitable and social enterprise providers. Mr Beattie presented an overview of the Access and Information service within OPPC and advised that between 2018 and 2021 there has been a 15% increase in the number of referrals into the ICT service and within social work there has been an increase of 29% for the same reporting period. Approximately 53% of all referrals for Social Work are redirected from ICT Social Work by the Access and Information service.

Mr Rocks presented information on Promoting Wellbeing and reported that this service manages 22 contracts with CV sector organisations with a total value of £550k per annum. He spoke of the overarching priority areas to provide early intervention and prevention, addressing social isolation and loneliness by building connections and capacity in communities, and tackling poverty and disadvantage. Mr Rocks explained that the target groups are: carers, BME groups including Travellers, older people and those communities experiencing inequalities in health.

In concluding Mr Beattie informed members of the potential future developments, namely: review access and information staff capacity to deal with increasing level of demands, increasing Social Worker capacity to support downturn of referrals to ICTs, dedicated PARIS support to enhance A&I systems and to support a data driven approach to management and commissioning of CVSE sector and commissioning of community and voluntary social enterprise contracts.

Mr McDonald commented on the need for the Trust to allocate further investment and resources to Health and Wellbeing. He felt that the pathways for referrals provided a richness of data to demonstrate the benefits of the using these pathways for a better outcome. Mr Rocks advised that this is an area of focus to better evidence the value of these pathways.

Ms Donaghy commented that the pandemic has had an economic effect on families and the increase need for people to turn towards food banks. Mr Beattie stated that there is an increasing trend of families highlighting to their social workers that they use food banks and this is concerning.

Mr Wilkinson welcomed the linkage with the community and voluntary sector and spoke on the importance of including in the education sector. He asked if an annual report from voluntary and community sectors is sought to demonstrate their achievements and outcomes. Mr Rocks advised that an annual report is not required however, through their contract management and end of year reviews, assurances are sought through these processes. Mr Beattie advised

that he intends to bring a proposal to SMT during 2022/23 to scope the existing community and voluntary contracts against the corporate objectives and he envisaged that this may provide clarity in respect of whether any of the existing contracts should be amended/ended and if any new contracts should be commenced.

Ms Donaghy noted that EU funding is available until 2022 in relation to the mPower project and asked if funding is available beyond that. Mr Rocks advised that a number of options and discussions would be taken forward; however in the interim the learning from the mPower project will be reviewed on how best to implement it across the service.

Mr Beattie and Mr Rocks *left the meeting at this point*

Mr Wilkinson left the meeting at this point

11. SENTINEL STROKE NATIONAL AUDIT PROGRAMME

The Chair welcomed Dr Michael McCormick, Consultant Stroke Physician, Mrs Anne McVey, Assistant Director of Acute Services Medicine and Mr James Gilpin Stroke Service Improvement Lead to the meeting. Mrs McClements introduced this item and explained that the service has 19 dedicated acute stroke beds on the CAH site, DHH has a 30 bedded unit encompassing acute stroke and stroke rehabilitation patients alongside older peoples beds. She reminded members that following a local consultation on 2014 the outcome was a centralised model to support improvement of stroke services with acute beds centralised in CAH and rehabilitation beds at DHH. The infrastructure and investment required to deliver on the preferred model has not been actualised. In 2019, a subsequent regional public consultation was undertaken with CAH identified as a hyper-acute site. The outcome of the report was delayed and is as yet not concluded.

Dr McCormick presented data on the Sentinel Stroke National Audit Programme (SSNAP). He explained that the audit consists of two elements: clinical and organisational audit and explained the difference in both. Dr McCormick presented clinical audit comparable peer information on the status of stroke units across the region. He reported that the SSNAP quarterly audit performance in CAH has

been banded as a level 'D' and DHH banded as a level 'C' in the quarter July – September 2021, comparative Trust analysis was included in table 1 of the report.

Dr McCormick reported on the areas of achievement. The Trust has a Stroke Improvement Group which meets regularly and reviews SSNAP data; the stroke service improvement lead has now returned to his post with an aim of focussing on key areas for improved performance following redeployment during covid; a Quality Improvement Project (QIP) has commenced on stroke identification in the Emergency Department and targeting ward of first admission;, a new consultant has been appointed to the Craigavon Area Hospital and has stroke dedicated sessions; a need for an increase in stroke Allied Health Professional capacity has been identified and an investment proposal has been developed, exploring the option to reconfigure and improve stroke services within the existing infrastructure to create a centre of frailty and stroke services and the collaborative working with non-acute colleagues in the management of early and support discharged for stroke patients.

Dr McCormick spoke of the areas of concern. He reported that the bed pressures on the CAH site affect the access to dedicated stroke beds. Overcrowding in the emergency department impacts on the ability to triage patients and ensure their treatment is administered in a timely manner. Dr McCormick explained that stroke services are provided across four different hospital sites, which dilutes staff within an already under-resourced service, which affects performance. The four-site model does not facilitate focused 7-day therapy and early supported discharge. Dr McCormick stated that the AHP staff co-hort is inadequate and falls below the recommended guidelines. He spoke of the need for AHPs cover over 7 days in particular Speech and Language therapists to undertake swallow reviews and the need to increase nursing staff to ensure the safe delivery of thrombolysis 24/7.

In concluding, Dr McCormick advised that solutions are required for the short term outlook, namely; workforce investment, prioritisation of stroke service, stroke assessments at weekends and dedicated ward. In relation to a long-term model, he spoke of the centre for stroke and frailty to facilitate consolidation.

Mrs McClements agreed with Dr McCormick on the concern that stroke beds are not protected, that patients are being displaced and the infrastructure is not in place to provide the required level of care. She informed members that work is ongoing to establish a dedicated ward and there are a number of options being discussed, however the need for investment and infrastructure is required. Mrs McClements advised that discussions have taken place with OPPC if there is capacity to increase the workforce; however this is proving difficult due to their own capacity gaps.

Dr Gormley commented that the main outcome for these patients was to return home and the importance of receiving the correct treatment at the right time in a dedicated ward is crucial. He suggested that the team liaise with the Belfast Trust who can offer the learning identified through their introduction of therapy at the weekends. Dr McCormick welcomed this, however he stated that the Trust is unable to offer the same level of intensity of therapy available at the weekends, therefore this impacts the performance and length of stay for patients.

In response to a question asked by Ms Donaghy, Dr McCormick explained that target for administering lysis has decreased on both site particularly during covid. He attributed this to patients not presenting in a timely manner, rural setting for a co-hort of the population and challenges within the NIAS response times. He advised that DHH has the highest rate for carrying out Thrombectomy on patients which can be done within 24 hours of the patient presenting.

Ms Teggart asked that following the concerning figures presented what can Trust Board / Committees do to lend its support for further investment into the service? Mrs McClements explained that this issue has been raised with the stroke strategic group on a regular basis and the inequity across the region for funding. She added that the Trust has went at risk to create therapy roles and geriatricians in OPPC and Acute and work in ongoing with the planning department to keep the commissioners informed and up to date of the situation. Mrs McClements noted that additional resources are required within practice education facilitators, nurse specialists, succession planning, ambulatory service and an improve infrastructure. Ms Teggart

welcomed this and commented that the data presented supports the need for this.

Mrs McVey commented that the stroke service staff have shown compassion and professionalism during a challenging time and would welcome the support from Trust Board.

The Chair thanked Dr McCormick for his presentation and asked that an update be presented at the December 2022 meeting. She advised that she would write to the Trust Chair and Chief Executive to alert them to the significant findings from SNNAP and the need to for this service to be an area of prioritisation.

Action: Mrs Leeson

12. CHKS EXTERNAL BENCHMARKING PERFORMANCE REPORT

The Chair welcomed Mrs Lynn Lappin, Head of Performance to the meeting. She reminded members that at the last meeting time did not permit for a full discussion.

Mrs Lappin presented the CHKS Annual Performance Report, which provides an overview of the Trusts performance across a range of efficiency and patient safety indicators for the 12-month period of April 2020 to March 2021. She explained that the analysis undertaken in this report relies on the accuracy and completeness of clinically coded data. 100 is the maximum score achievable and is the most favourable position. The Trust scores comparatively positively to the NI Peer – Southern Trust 95.76 versus NI Peer 93.33.

Mrs Lappin presented data on length of stay (LOS). She stated that Craigavon Area Hospital (CAH) LOS analysis demonstrates a higher LOS in comparison to the NI Peer. However, when risk adjusted the LOS demonstrates better performance than the Peer – CAH 84.48 versus NI Peer 92.50. Daisy Hill Hospital (DHH) demonstrates better performance to Peer in relation to LOS indicators, including risk adjusted – DHH RALI 83.14 versus NI Peer RALI 92.50. Mrs Lappin added that a group has been established to review the current length of stay and looking for options to reduce this appropriate; this group is being led by Dr Gormley.

Readmissions were discussed. Mrs Lappin reported that the Trust's rate for readmissions within 30 days demonstrates better performance than the UK Peer and in line with NI Peers – Trust 8.3% versus UK Peer 9.8% versus NI Peer 8.3%.

Mrs Lappin noted the areas of concern. She advised that delayed discharge at the weekend for non – elective inpatients demonstrates a lower level of performance to that of the NI peer. Mrs Lappin stated that weekend discharges remains a longstanding challenge for the Trust with recent investment to extend services to in-patients across 7-days. To enable the Trust to improve performance further investment is required to enable full 7-day service provision.

In relation to Out-Patients, Mrs Lappin reported that the Trust's new to review out-patient ratio compares less favourably to both the UK Peer and the NI Peer – Trust 1:2.37 versus UK Peer 1:2.19 versus NI Peer 1:1.86. She attributed this decrease in performance with the Trust's New to Review ratio that is likely to have been impacted by the downturn in face to face out-patients with a focus on virtual appointments, which favoured review appointments over new appointments.

In response to a question asked by the Chair, Mrs Lappin explained that virtual appointments have worked well for a number of clinicians and services.

Dr Gormley advised that the data available from CHKS is very broad and if there were any data points that members would like included in future reports to inform him.

Mrs Leeman spoke of the resources within the Quality Improvement Team, which can be utilised to support data drive improvements and use their expertise to drive Quality Improvement across the Trust.

Mr McDonald referred to the readmission section and noted that the readmissions performance does not take into account any patients managed in Acute Care at Home (AC@H) and then subsequently admitted to a hospital bed. He asked if AC@H and virtual visiting has impacted admission rates and length of stay and if this can be

compared to peers. Mrs Leeman agreed to undertake further analysis of this and feedback at the next meeting.

Action: Mrs Leeman

Mrs Lappin left the meeting at this point

14. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

The Chair welcomed Mrs Trudy Reid, Interim Assistant Director Infection Prevention & Control to present the above named report. The paper provides data from 1st April 2019 to 15th November 2021 on infection data and antimicrobial stewardship data for PFA targets. A number of appendices were included with the reporting which contained information on: SHSCT PFA targets, Monthly Target Monitoring Report, Hand hygiene audit, Commode audit, Independent Hand hygiene audit, Independent Commode audit, COVID 19 data and Trust data on Antimicrobial Stewardship report.

Mrs Reid presented information on the current situation of Covid-19 pandemic. She highlighted the figures locally, regionally and hospital occupancy on those patients diagnosed with Covid. She reminded members that with there is a delay with covid community cases presenting to hospital for admission. Mrs Reid reminded members that patients/visitors attending the Emergency Departments continue to be tested and outbreak meetings are continuing on a daily basis. Reflection from covid cases in Care Homes is continuing to be worked through for learning.

Mrs Reid reported that work has commenced on one side of 4 South ward in CAH to improve the toilet facilities, ventilation and felt that this was a good model to use going forward for improving additional wards.

Data on Clostridium difficile (C. Difficile) was presented. Mrs Reid reported that C. Difficile rates are rising. For 2021/22 to date there is a total of 61 cases an increase of 20 from the previous report. She advised that there has been one outbreak of Clostridium difficile involving two patients; incident management meetings have taken

place. Learning has been shared at various forums and a serious adverse incident review is in progress. She further advised of a potential outbreak that is under investigation and is at an early stage.

Mrs Reid reported that there has been three preventable MRSA bacteraemia to date and post infection reviews have been carried out to identify learning. Learning has been shared with relevant teams involved. She provided background to the third cases and advised that it is being reviewed by the SHSCT and WHSCT.

Mrs Toal left the meeting at this point

15. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Hamilton presented the Executive Director of Nursing, Midwifery and AHPs report which largely covers the period from October 2021 to December 2021 and provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Frameworks and include areas regarding workforce, education training, and quality of practice.

Mrs Hamilton guided members through the report and highlighted specific areas for noting. She advised that for International recruitment, a regional plan is currently being developed to maximise overseas nurse recruitment to support Trust requirements. A requirement of 12 nurses per month was re-established and agencies are working to increase the pipeline of nurses. Seven nurses were recruited to the Trust in January 2022 and a further eight nurses are expected in February 2022. It is hoped that by March the target of 12 nurses per month will be reached. Mrs Hamilton stated that the vacancy levels across Acute and MHLD has reduced from October 2021 to January 2022.

Mrs Hamilton informed members that transformation work within the Dysphagia Service continues to progress and was pleased to report that RQIA has agreed to adopt the Trusts Dysphagia model regionally.

Mrs Hamilton reported on Nursing, Midwifery and AHP vacancy rates. She noted that from November 2021 to January 2022, CYP vacancy rate has increased by 18.06 wte and the OPPC vacancy rate has increased by 12.08 wte. Mrs Hamilton advised that open recruitment drives continues and the Practice Development team continue to support students and encouraging them to remain in the Trust following graduation.

Supervision was discussed. Mrs Hamilton drew members' attention to page 21 of the report, which outlines the directorate and divisional position as at 31st December 2021 for the first and second supervision sessions. The graphs show the compliance over the first 3 quarters of 21/22. Ms Donaghy noted her concern that within the Acute Directorate the percentage of staff having received their first supervision session is 39% (a 2 % increase on last reporting quarter) and 21% having had their second supervision session. Mrs Hamilton stated that a change in culture around supervision is needed and this is an ongoing process to ensure supervision is completed and documented to reflect accurate numbers. She reinforced the need for protected time for managers to carry out supervision, however due to workforce gaps and daily pressures this is challenging to achieve. Mrs Hamilton advised that discussions have taken place in Acute to ensure that supervision is prioritised.

In relation of agency staff and cost of agency pay rate, Ms Teggart asked what the Trust is doing to reduce this. Mrs Hamilton explained that this is a regional issue and until action is taken collectively by all 5 Trusts, the Southern Trust continues to face challenges on rising agency costs and usage. Mrs Hamilton agreed to seek an update from the regional group of the status of agency pay rate.

Action: Mrs Hamilton

16. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.50 p.m.

Signed _____ ***Dated*** _____

Comac, Jennifer

From: OKane, Maria [redacted]
Sent: 23 May 2022 13:59
To: Mullan, Eileen; Leeson, Pauline
Cc: chiefexecutiveoffice; Comac, Jennifer; McClements, Melanie
Subject: RE: Stroke Services - Sentinel Stroke National Audit (SSNAP)
Attachments: RE: Stroke Services - Sentinel Stroke National Audit (SSNAP) (9.27 KB)

Thanks Eileen - SMT met to discuss this last week and have agreed to implement the plan Melanie brought forward on behalf of stroke services to address these areas that we share your concerns about.

We will provide an update on progress at the next TB beyond this week.

Maria

Comac, Jennifer

From: Mullan, Eileen [redacted]
Sent: 23 May 2022 11:04
To: Leeson, Pauline
Cc: OKane, Maria; chiefexecutiveoffice; Comac, Jennifer
Subject: RE: Stroke Services - Sentinel Stroke National Audit (SSNAP)

Pauline

By way of update on the below. Maria is taking a lead in reviewing and agreeing a way forward with SMT.

I will add this to the CEO/NED meeting scheduled for June for Maria to update.

Eileen

Eileen Mullan
Southern Trust Board Chair

From: Leeson, Pauline [redacted]
Sent: 11 March 2022 16:15
To: Mullan, Eileen [redacted] McDonald, Martin [redacted] >; Donaghy, Geraldine [redacted] McCartan, Hilary [redacted] Wilkinson, John [redacted]
Cc: OKane, Maria [redacted]; McClements, Melanie [redacted]
Subject: Stroke Services - Sentinel Stroke National Audit (SSNAP)

Eileen. We had a presentation from Dr McCormick at Performance Committee yesterday on SSNAP and I wanted to raise my deepest concern at what we heard. Dr McCormick came to Governance Committee in 2019 when there were plans for a regional strategy, restructuring and investment. I would encourage everyone to read his presentation. Despite the deep professional and personal commitment of him and his team, there is now a marked deterioration in the service. It will be detailed in Committee report and my Chair's report. It appears that he has done everything that was expected of him in terms of reconfiguring services at CAH and DHH but the SSNAP quarterly audit performance in CAH in particular is far below what I would deem as acceptable. Nursing, therapy and rehab goals are also all below recommended guidelines. I understand that his staff were redeployed to ICT during the pandemic and there have also been pressures on AHPs but the deterioration in this service is unacceptable. My overwhelming feeling was of a dedicated clinician and his team who had been quietly working away trying to do their best with little support from us as a Trust. Melanie McClements has picked this up and drawn up an action plan which is very helpful. She has even put in posts at risk to help. I feel strongly that we should be keeping a close eye on this service and on Dr McCormick and his team, giving Stroke Services more priority as part of Rebuild, actively looking for investment and providing support to staff who are at risk , in my opinion, of burnout. We have a duty of care to our staff and an obligation to maintain and improve services for our population. This concern is not a reflection on any of our staff but I would want an assurance going forward that this service and its action plan is prioritised and I have requested that it comes back to Performance Committee in 9 months for an update. Happy to discuss further. I don't think that it would be helpful to bounce this issue around other committees or Trust Board. It seems clear enough that we need to implement Melanie's action plan and reassure Dr McCormick that we care as part of our Trust values. Pauline

Southern Health and Social Care Trust
Quality Care - for you, with you

GOVERNANCE COMMITTEE MEETING

DATE: Thursday 11th May 2023
TIME: 9.40 a.m. – 1.30 p.m.
VENUE: New Boardroom, Trust HQ

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.40 – 9.50 a.m.	1.	Welcome and apologies: • Mrs C. Reid, Director of Surgery & Clinical Services *(Mr B Conway, Assistant Director attending)*	Mr M. McDonald	
	2.	Declaration of Interests	Mr M. McDonald	
	3.	Chair's Remarks	Mr M. McDonald	Information
	4.	Minutes of meeting held on 12th January 2023 and 9th February 2023	Mr M. McDonald	Approval
	5.	Matters Arising from previous meeting	Mr M. McDonald	Information
9.50 – 10.00 a.m. 10.00 – 10.10 a.m.	6.	**Information Governance** i. Information and IT Governance Report: 1st January 2023 – 31st March 2023 ii. Information Governance Annual Report	Mrs L. Leeman " "	Information Assurance
10.10 – 10.20 a.m. 10.20 – 10.30 a.m.	7.	**Medicines Governance** i. Medication Safety Report ii. Royal Pharmaceutical Society – Summary Report on Implementation of Standards	Ms A. McCorry " "	Assurance Assurance
10.30 – 10.40 a.m.	8.	**Hyponatraemia** i. Hyponatraemia Progress Update Report	Dr S. Austin / Mrs H. Trouton	Assurance
10.40 – 10.50 a.m.	9.	**Litigation** i. Claims Management	Mrs V. Toal	Assurance
10.50 – 11.00 a.m.	10.	**Raising Concerns** i. Raising Concerns Report *(Please refer to item 7 in Confidential papers)*	Mrs V. Toal	Assurance
COFFEE BREAK				
11.10 – 11.20 a.m. 11.20 – 11.30 a.m.	11.	**Clinical and Social Care Governance** i. Clinical and Social Care Governance Report ii. Management of Trust Standards and Guidelines	Dr S. Austin " "	Assurance Assurance

TIME		ITEM	DIRECTOR	Purpose
11.30 – 11.40 a.m.		iii. Mortality Report	Dr S. Austin	Assurance
11.40 – 11.50 a.m.		iv. RQIA Review of the implementation of NICE CG 174 – IV Fluid Therapy in adults in hospitals in NI	" "	Assurance
11.50 – 12 noon	12.	**Risk Management** *i.* Corporate Risk Register	Dr M O'Kane	Approval
12.00 – 12.10 p.m.	13.	**Health and Safety** i. Health and Safety Update	Ms C. Teggart	Assurance
12.10 – 12.20 p.m.	14.	**Estates Governance** i. Estates Governance Group - Summary Report	Ms C. Teggart	Assurance
12.20 – 12.30 p.m.	15.	**Learning from Experience Forum** i. Update Report	Dr S. Austin	Information
12.30 – 12.35 p.m.	16.	**Governance Statement** i. Draft Governance Statement	Dr M. O'Kane	Assurance
12.35 – 12.45 p.m.	17.	**Annual Reports** i. Research and Development Annual Report 2022/23	Dr S. Austin	Assurance
12.45 – 12.55 p.m.		ii. Emergency Planning Annual Report 2022/23	" "	Assurance
12.55 – 1.15 p.m.	18.	**Feedback from Audit Committee - Internal Audit Reports** i. Safeguarding/statutory responsibilities for Looked After Children *(Satisfactory)* ii. Risk Management *(Satisfactory)* iii. Point of Care Testing *(Limited)* iv. Corporate Mandatory & Profession Specific Training (Nursing) 2022/23 *(Limited)*	Mrs H. McCartan Mr C. McCafferty Dr S. Austin Mrs T. Reid / Mr B. Conway Mrs V. Toal	Information
1.15 – 1.20 p.m.	19.	Director Visits *(January 2023 - March 2023)*	Mr M. McDonald	Information
1.20 – 1.25 p.m.	20.	Non-Executive Director's Visits to Children's Home Report *(January 2023 - March 2023)*	Mr C. McCafferty	Information
1.25 – 1.30 p.m.	21.	Any other Business	Mr M. McDonald	
The next meeting of the Governance Committee will take place on 7th September 2023				

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of Meeting	Governance Committee 11th May 2023		
Title of paper	Clinical and Social Care Governance Report		
Accountable Director	Name	Dr Stephen Austin	
	Position	Medical Director	
Report Author	Name	Caroline Doyle	
	Email	Personal Information redacted by the USI	
This paper sits within the Trust Board role of:		Accountability	
This paper is presented for:		Information	
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:

This paper provides a report to Governance Committee (May 2023) on key Trust Clinical and Social Care Governance Performance Indicators on Incident Reporting, SAIs, Catastrophic Incidents, Patient Safety and Quality Measures, Service User Feedback and Ombudsman cases.

2. Areas of improvement/achievement:

- There has been a significant improvement in the number of unapproved incidents on Datix, particularly in Adult Community Services (ACS) as shown in Figure 9.4
- A temporary Liaison Officer dedicated to support Service Users and families in cohort 2 of the Urology Lookback Review has been appointed
- The number of complaints this quarter have decreased by 18%, returning to normal variation
- Work is progressing on documentation required to implement the Independent Clinical Record Review process
- Improvements have been made to the DATIX test system to enable the tracking of RQIA recommendations. It is anticipated that this will be introduced to the live system and reporting commenced in 2023/24
- Use of the Shared Learning template continues to be encouraged and 4 learning summaries from CYPS SAIs were completed this quarter
- 25% of SAIs are within timescales, a slight improvement from the previous quarter when 22% were within timescales
- Details of completed SAI recommendations are included in the paper for the first time

3. Areas of concern/risk/challenge:

- Increased number of SAIs relating to a theme of abnormal radiology findings not being followed up
- 75% of SAIs outside of timescales

- Increase in the number of SAI notifications this year
- Increase in the number of Catastrophic incidents reported this year
- Never Event reported as SAI
- Number of Incidents reported for the year continues to rise: 23,305 (2022-23) (22,045 in 2021/22), with increases in Insignificant, Minor (biggest increase), Major and Catastrophic
- Increase in number of Incidents reported March 2023 for ACS and MHD, however due to the number of uncoded incidents it is not possible to theme these
- Non-compliance with ED waiting times:
  - The target that 95% of patients attending Type 1, 2 or 3 Emergency Departments (defined in Appendix E) are either treated and discharged home, or admitted, within four hours of their arrival in the department has again not been met this quarter
  - The target of 5% of patients waiting between 4-12 hours continues not to be met this quarter
  - The target of 0% of patients waiting longer than 12 hours continues not to be met. There has been a persistent deterioration over the past 9 months.
- The usefulness of the Healthcare Complaint Analysis Tool (HCAT) continues to be considered. As referenced on pages 64 and 65, the development of a HCAT App/Dashboard (see Appendix G) could make greater use of the HCAT information than currently

4. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	
Corporate Risk Register	This links to the risk of harm to the SHSCT population through inability to access safe, timely and appropriate care.
Board Assurance Framework	Yes
Equality and Human Rights	No

Southern Health and Social Care Trust

Quality Care - for you, with you

Clinical and Social Care Governance Report May 2023

Contents

Appendices

1.0 Purpose of Report

This report is to provide information to Trust Governance Committee regarding the Clinical and Social Care Governance performance indicators agreed by the Trust Senior Management Team:

- **Incident monitoring to include Serious Adverse Incident and reporting timeframes**
- **Patient safety & quality measures**
- **Complaint monitoring**
- **Compliment monitoring**

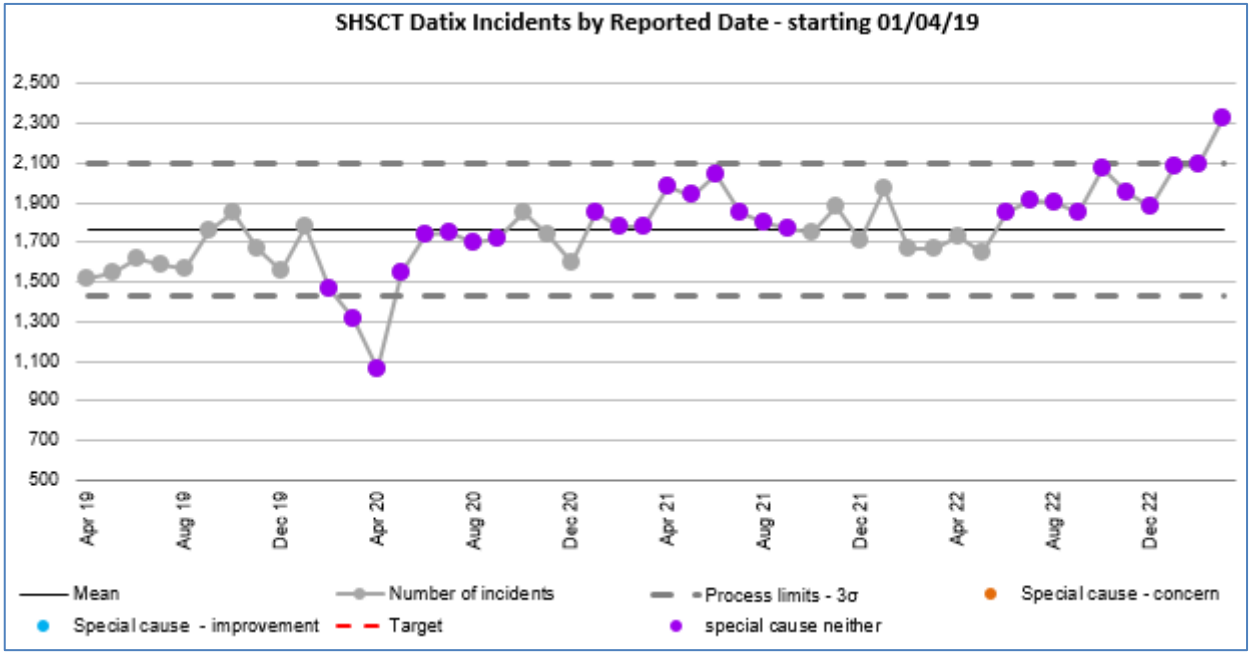
The report analyses activity for the period **1st January 2023 – 31st March 2023 (Quarter 4),** with the exception of Patient Safety & Quality measures which are for the previous quarter **1st October 2022 – 31st December 2022 (Quarter 3),** please see Appendix A. Incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognizing and reporting an incident (or near-miss), no matter the level of harm, is the first step in learning to reduce the risk of recurrence.

To set the wider context, this quarterly reporting period – **01/01/2023 to 31/03/2023 -** reports on Clinical and Social Care Governance performance indicators during the ongoing Coronavirus pandemic period, winter pressures, trade union staff strike action/action short of strike and other issues facing the Trust and the wider NHS system such as overcrowding and staff shortages.

The Directorate formally known as Older People and Primary Care (OPPC) is now Adult Community Services (ACS) and the Acute Directorate has now been split into 2 Directorates - Medicine and Unscheduled Care (MUSC) and Surgery and Clinical Services (SCS).

2.0. Incident Reporting (via Datix)[1]

2.1 Total No. Incidents Logged via Datix

	Figure 1.0 – Total SHSCT Incidents by Month 01 April 2019 – 31st December 2022, SPC charts now reporting from April 2019, due to the number of data points
Overall Trust Position In Q4 2022/23 - SHSCT directorates reported: ▪ 6501 IR1 incidents ▪ 2022/2023 – 23,305 IR1 incidents ▪ 2021/2022 – 22,045 IR1 incidents ▪ 2020/2021 – 20,156 IR1 incidents ▪ 2019/2020 - 19,207 IR1 incidents ▪ 2018/2019 - 15,043 IR1 incidents The reporting of incidents in this quarter continues the shift in data that was reported last quarter, which means there are more than 7 sequential points which fall above the mean, indicating a significant change in process. An additional special variation this quarter is identified in the UCL breach in March 2023. A breakdown by Directorate is provided in the SPC charts below.	

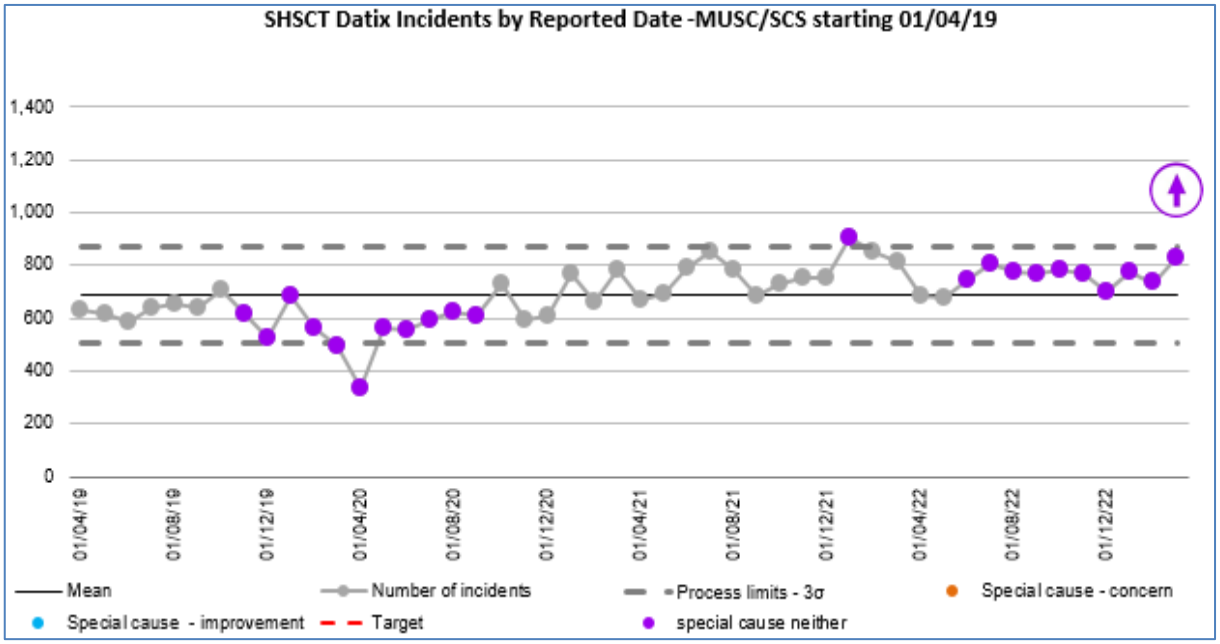
[1] Monthly incidents are reported on the basis of the date on which the incident was reported via Datix and not the date that the incident occurred.

Figure 2.0 Operational Directorate Monthly Datix Incidents 01 April 2019 – 30th March 2023.

Operational Directorate Position

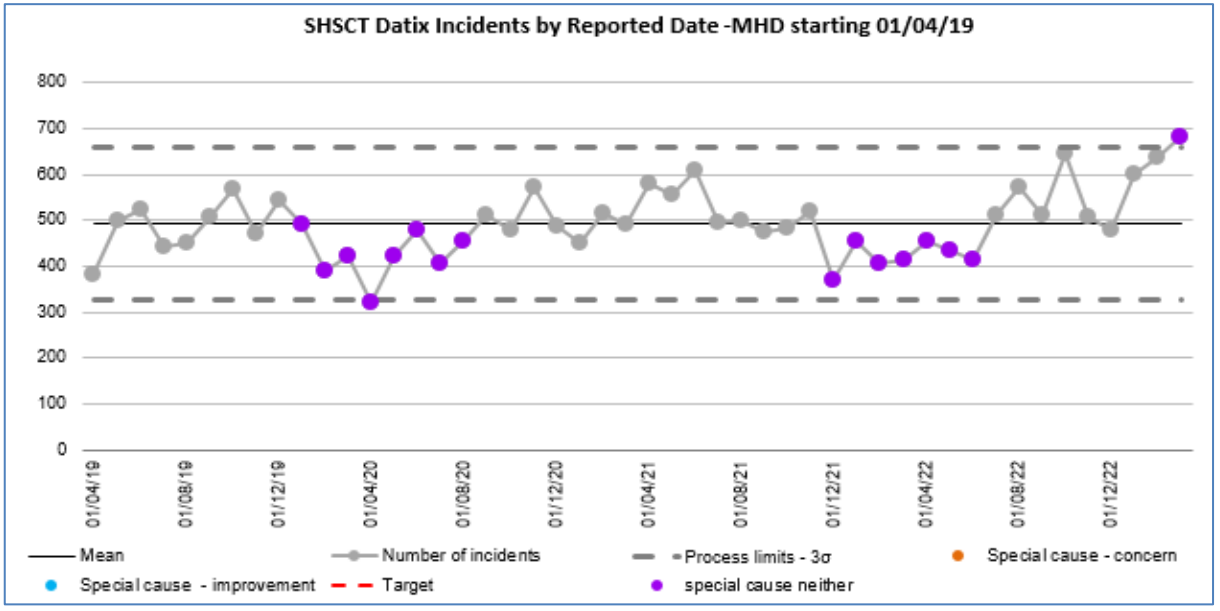
MUSC/SCS share 36% of the 6501 incidents reported this quarter (n=2340).
The shift reported in last quarters data has continued this quarter with 9 data points above the MEAN.
When reporting for 2023/24 commence, MUSC and SCS will be reported separately.

MUSC/SCS – no comments received from the Directorate Governance teams.



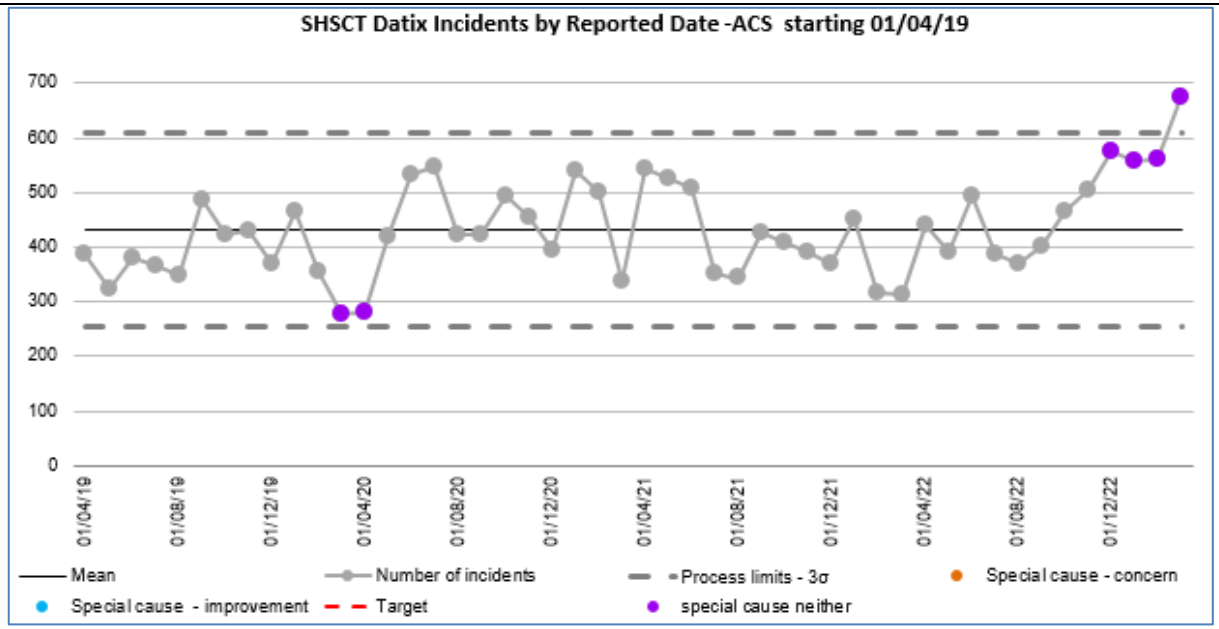
MHD share 30% of the 6501 incidents reported this quarter (n=1919).
This quarter there has been a statistical significant change in data for the month of March 2023. The number of reported incidents was above the UCL which is unusual for this Directorate.

The reported increase is reflective of increased levels acuity within the Bluestone & Dorsy Units. There was also a notable increase in two LD Supported Living facilities due to some tenant's behavioural presentations.

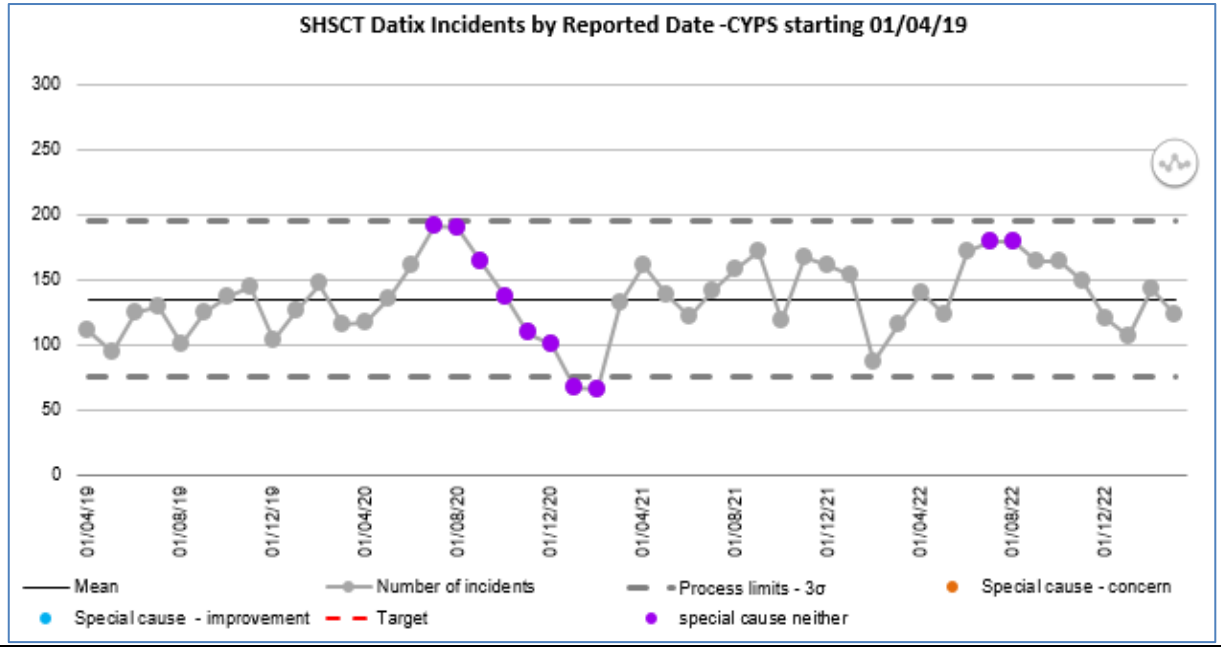


Adult Community Services (ACS) share 28% of the 6501 incidents reported this quarter (n=1794).
This quarter there has been a statistical significant change in data. The number of reported incidents, this quarter is at its highest level including a breach of the UCL in March 2023 which is unusual for this Directorate.

The increase in reported incidents reflects a focussed piece of work to address an administration back log in the processing of incident reports received from the Independent sector which then need logged onto Datix. 783 of the 1794 incidents occurred in 2022.

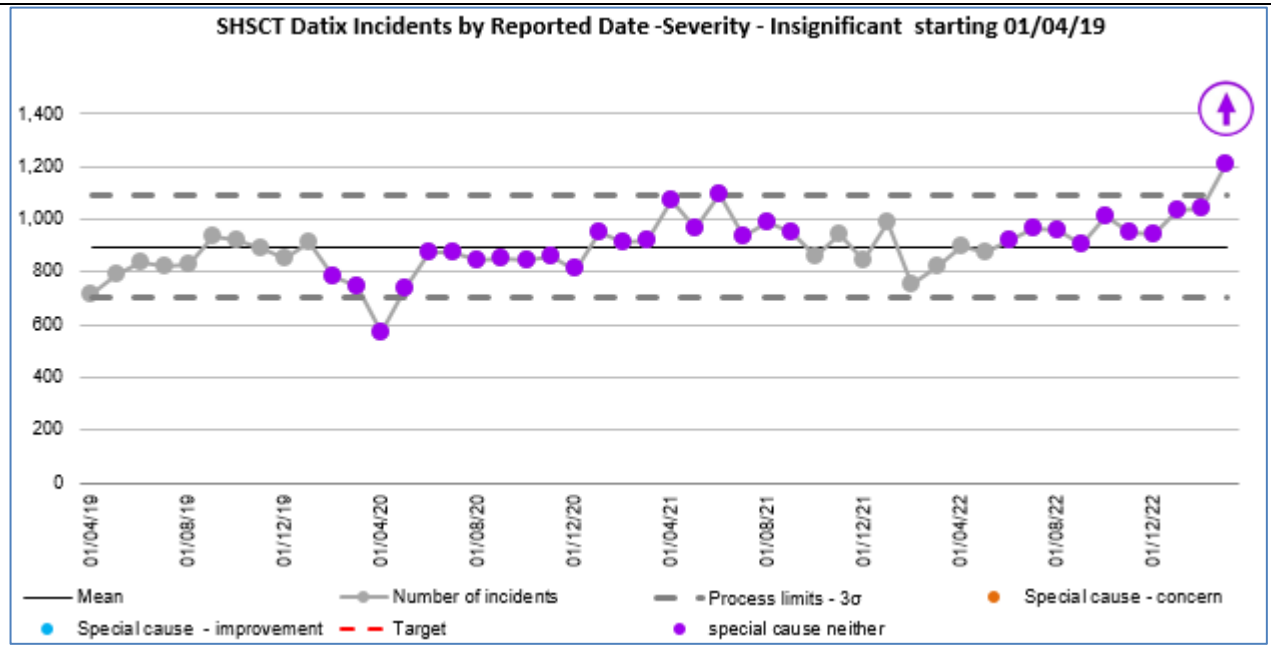


CYPS share 6% of the 6501 incidents reported this quarter (n=372).
The reporting of incidents in this quarter shows normal variation with no significant change.



2.2 Incident Severity[23]

Figure 3.0 - Total SHSCT Monthly Incidents by Severity 01 April 2019 – 31st March 2023



Q4 2022/2023 (January – March 2023)

50.6% of SHSCT IR1 Incidents categorised as severity 'Insignificant'.

The shift in data reported last quarter, continues this quarter with 10 data points above the MEAN. An additional special variation this quarter is identified in the UCL breach in March 2023.

613 (19%) out of these 3290 incidents remain uncoded, (this is the same percentage share as Quarter 3 of uncoded Insignificant incidents) which affects the ability to theme the incidents:

- Patient Accidents/Falls – 803
- Patient Behaviour – 767
- Medication – 353
- Behaviour (Including violence and aggression against staff) - 331
- Service Disruptions - 107

The number of uncoded incidents in March 2023 (n342) makes it difficult to identify the theme attributed to the increase in March 2023.

The only noticeable change in the Top 5 themes this quarter, compared to last quarter, is the number of Service Disruption coded incidents. However the number of these incidents has not increased significantly.

[2] Includes incident Severity for 'unapproved incidents' which could be subject to change on final approval of the incident

[3] A full breakdown of all CCS2 codes by Severity is detailed in Appendix B, the potential impact of uncoded incidents could change any of the themes when coded as illustrated in this Appendix.

42.5% of SHSCT IR1 Incidents categorised as severity 'Minor'.

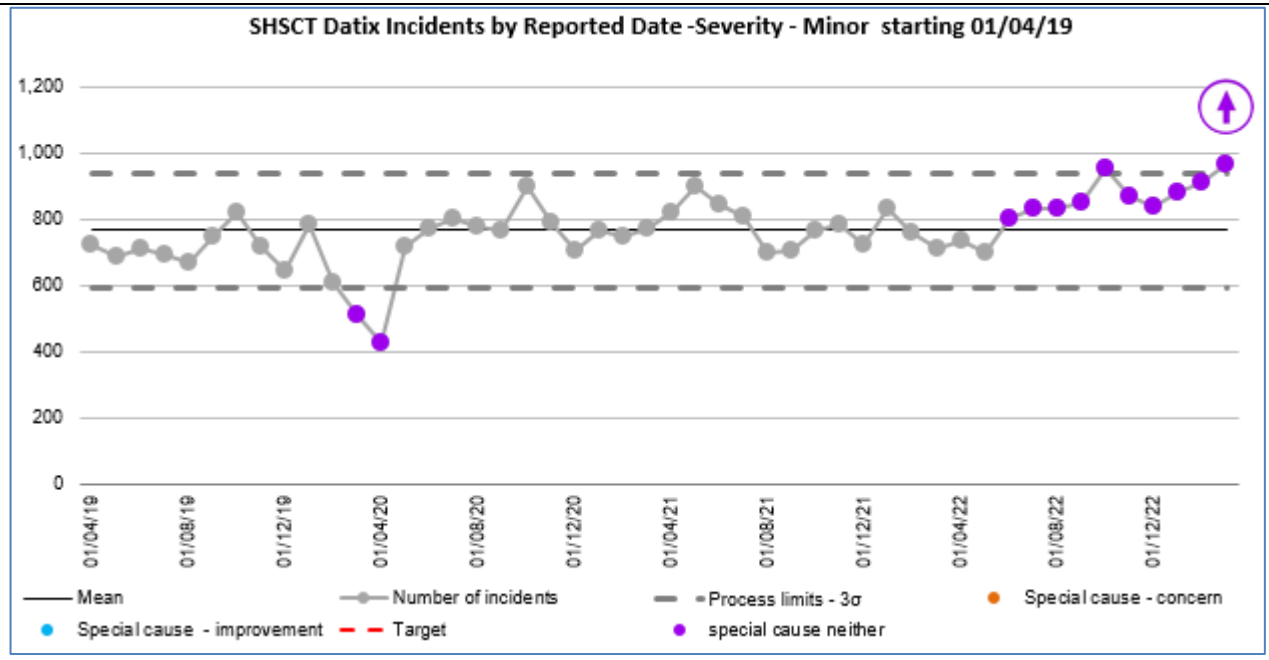
The shift in data reported last quarter, continues this quarter with 10 data points above the MEAN. An additional special variation this quarter is identified in the UCL breach in March 2023.

597 (22%) out of these 2761 incidents remain uncoded, (compared with 21% in Quarter 3) which affects the ability to theme the incidents.

- Patient Accidents/Falls – 530
- Patient Behaviour - 364
- Behaviour (Including violence and aggression against staff) – 220
- Medication – 193
- Pressure Ulcers - 147

The number of uncoded incidents in March 2023 (n310) makes it difficult to identify the theme attributed to the increase in March 2023.

The only noticeable change in the Top 5 themes this quarter, compared to last quarter, is the number of Pressure Ulcer coded incidents. However the number of these incidents has not increased significantly.



5.5% of SHSCT IR1 Incidents categorised as severity 'Moderate'.

In this quarter there were 2 special cause variations in January and March 2023 where the number of reported incidents graded as Moderate was above the UCL.

121 (34%) out of these 358 incidents remain uncoded (compared with 35% in Quarter 3) which affects the ability to theme the incidents:

- Medication – 51
- Maternity Care - 35
- Patient Accident/Falls – 19
- Incidents Coded as Other – 21
- Patient Behaviour - 18

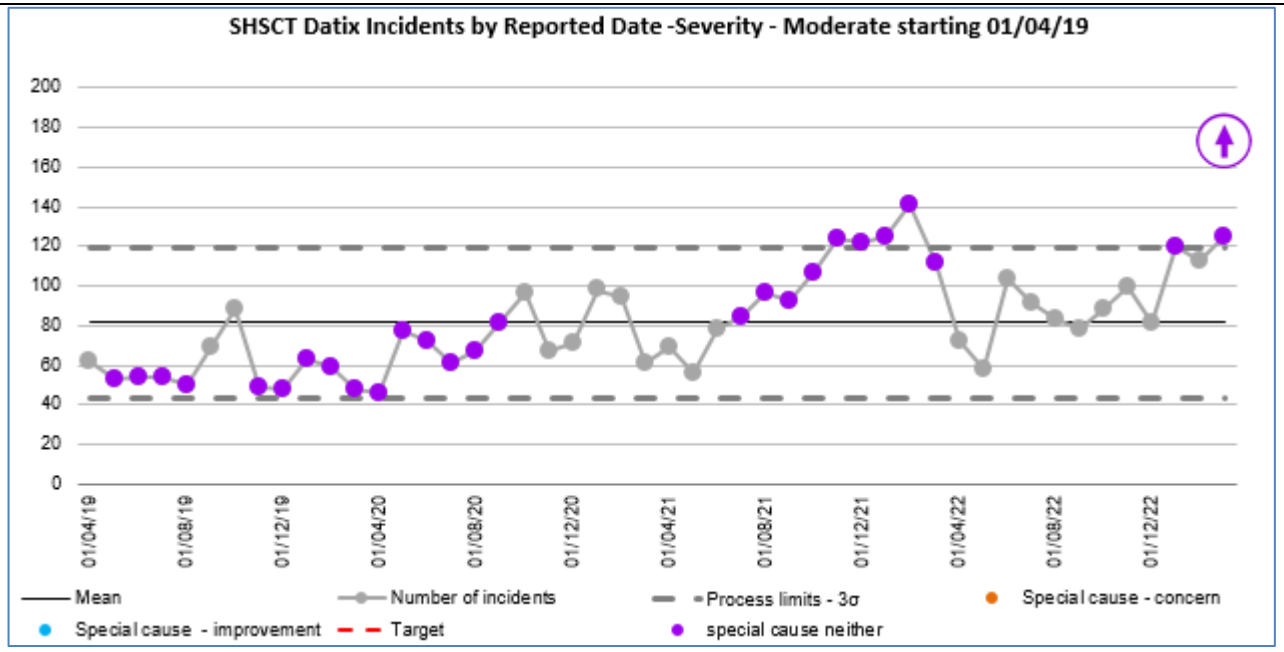
The number of uncoded incidents makes comparison of themes against previous quarters difficult.

The 21 incidents graded as 'Other' includes Patient Behaviour, Overcrowding, Clinical incidents, Pressure Ulcer and Falls. On review of the 'Other' coded incidents, it is apparent the incorrect CCS2 code has been selected and more appropriate codes are available. Future developments in the management of Datix incidents will assist in ensuring the most appropriate code is selected.

When plotted on a SPC Chart the number of Moderate graded Medication incidents breached the UCL in January 2023. The majority of these incidents are related to the Urology Look Back exercise.

The number of Moderate graded Maternity incidents continues to be unstable, with a breach of the UCL in February 2023.

Based on the coded incidents the top themes have not changed since the last quarter.



1% of SHSCT IR1 Incidents categorised as severity 'Major'

The shift in data reported last quarter, continues this quarter with 15 data points above the MEAN. Two additional special variations this quarter have been identified in the UCL breach in January and February 2023.

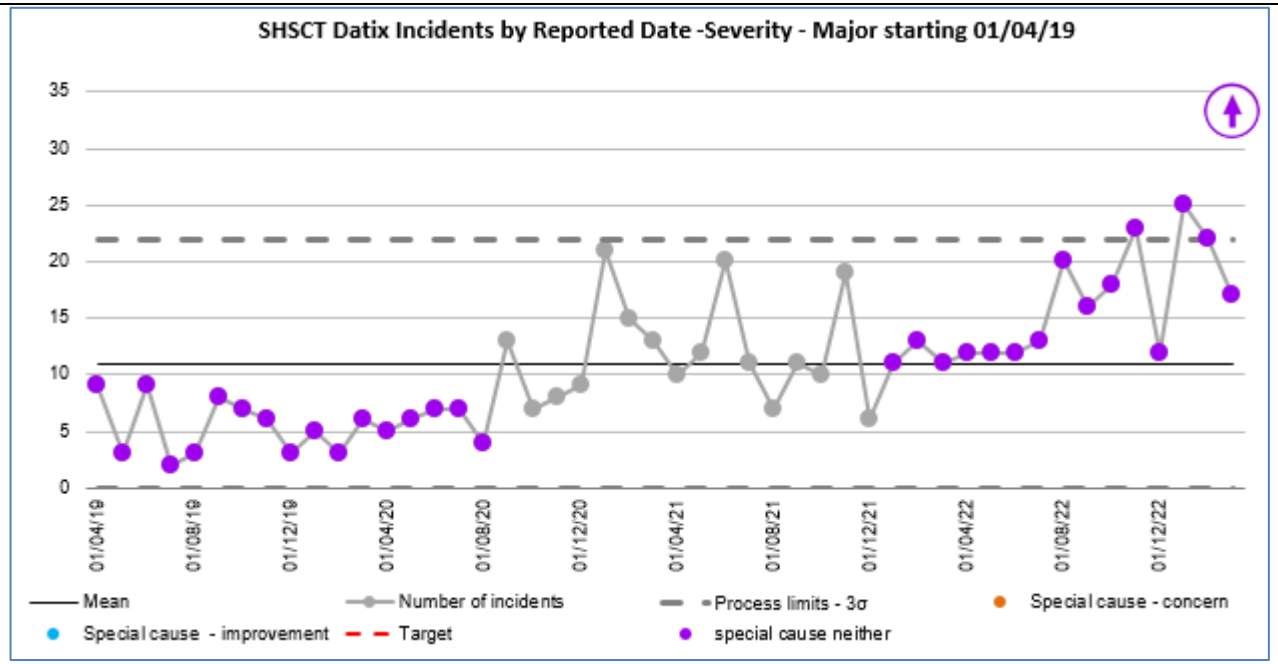
21 (33%) out of 61 of these incidents remain uncoded (compared to 37% in Quarter 3) which has impacted on the top themes:

Themes for Major graded incidents:

- Service Disruptions - 12
- Patient Accident/Falls – 9
- Other – 5
- Communication – 4
- Diagnostic Processes – 3
- Administrative Processes (Excluding Documentation) - 3
- Medication/Biologics/Fluids – 2
- Maternity Care - 2
- Medical Devices, Equipment, Supplies - 1
- Behaviour (including violence and aggression) – 1
- Exposure to Environmental Hazards - 1

Unfortunately the majority of these incidents are not coded and are also aligned to MUSC.

The Service Disruption incidents (except 1) relate to InterTrust incidents from NIAS re Ambulance waits at ED. In January 2023 the number of Major Service Disruption incidents breached the UCL.



0.4% of SHSCT IR1 Incidents categorised as severity 'Catastrophic'

In this quarter the number of Catastrophic (n28) incidents remained within a normal variation, with 1 incident uncoded (relates to an unexplained death within the Community).

Top themes for Catastrophic graded incidents:

- Patient Behaviour – 14
- Unexpected Death/Severe Harm – 4
- ***Patient Accidents/Falls – 4***
- Diagnostic Processes/Procedures – 2
- Therapeutic Processes/Procedures – 1
- Administrative Processes (Excluding Documentation) – 1
- Medical Devices, Equipment, Supplies - 1

An increase in Catastrophic Incidents within MHD is recognised, this is not unique to SHSCT and has been an identified trend across the region during this reporting period. A breakdown of the Catastrophic incidents across the Operational Directorates, along with SAI notifications submitted to the SPPG, is provided in Table 2 below, this includes the 1 uncoded incident.

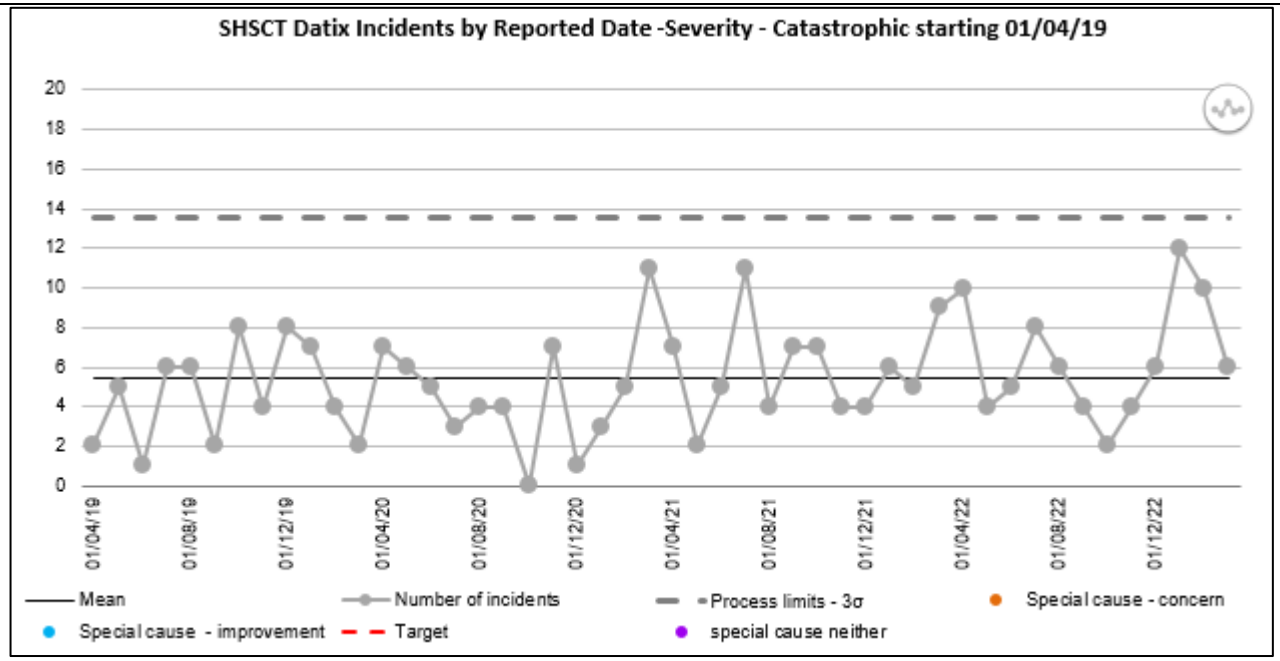


Table 1.0 provides the breakdown of all SHSCT catastrophic incidents by Operational Directorate since July 2020.

Table 1.0 SHSCT Catastrophic incidents by Directorate (July 2020 – March 2023)

Catastrophic Incidents	July - Sept 20	Oct - Dec 20	Jan - Mar 21	Apr - Jun 21	July - Sept 21	Oct - Dec 2021	Jan - Mar 2022	Apr - Jun 22	July - Sept 22	Oct - Dec 22	Jan - March 2023
MUSC/SCS	3	3	9	6	14	10	9	7	8	2	6
CYPS	1	0	2	0	1	0	0	1	2	3	0
MHD	8	6	6	4	5	6	8	10	7	6	19
ACS	1	0	4	1	0	1	4	1	2	1	3
Grand Total	13	9	21	11	20	17	21	19	19	12	28

Table 1.1 details overall proportion of incidents in each severity category from 2017/18 to 2022/23

Table 1.1 Percentage Incidents per Severity (2017/18 – 2022/23)

Year % Severity	Insignificant	Minor	Moderate	Major	Catastrophic
% 2017/18	35.34%	57.75%	6.13%	0.57%	0.20%
% 2018/19	40.85%	52.96%	5.32%	0.61%	0.13%
% 2019/20	52.48%	42.93%	3.87%	0.35%	0.30%
% 2020/21	49.93%	43.30%	5.69%	0.74%	0.34%
% 2021/22	50.80%	40.44%	7.46%	0.98%	0.31%
% 2022/23	50.30%	43.72%	4.78%	0.87%	0.33%

Table 1.2 Details Total Trust Incidents by year.

Table 1.2 Total Incidents per Year by Severity (2017/18 – 2022/23)

FY	Insignificant	Minor	Moderate	Major	Catastrophic	Unallocated	Grand Total
2017/18	4671	7634	810	75	27	2	13219
2018/19	6145	7967	801	92	20	18	15043
2019/20	10080	8245	743	68	58	13	19207
2020/21	10063	8728	1146	149	69	1	20156
2021/22	11199	8915	1645	216	69	1	22045
2022/23	11723	10190	1113	202	77	0	23305

2.3 Incident Severity Cont'd - Catastrophic Incidents and SAI Notifications

Between 1st January – 31st March 2023 – 28[4] catastrophic incidents (0.4%) were recorded MUSC/SCS – 6, MHD – 19 and ACS – 3). A total of 35 SAI Notifications have been submitted to SPPG (1 was deescalated).

Summary: Total Number 44

- Catastrophic Incidents during this reporting timeframe, not SAI – 9
- Catastrophic Incidents during this reporting timeframe and reported as an SAI – 19
- Catastrophic Incidents outside this reporting timeframe and reported as an SAI, not listed below as documented in Quarter 3 paper as a Catastrophic Incident – 1 (175274)
- Other, non-catastrophic Incidents reported during this timeframe as SAI's – 15 (2[5] insignificant, 2 minor, 3 moderate and 8 major)

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within SPPG timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director and Clinical Lead along with the Directorate Governance Coordinator. This process enables any areas of immediate learning resulting from incidents to be identified and to ensure they are acted upon.

Table 2.0 – Catastrophic Incidents and / or SAIs notified to the SPPG by Directorate

[4] 2 of these incidents are duplicates

[5] 1 SAI was a Never Event

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Irrelevant information redacted by the USI		n/a	n/a	Patient had CT scan completed during OOH/BH period which reported ovarian cancer and multiple PE's. Report was not escalated during OOH period for urgent follow up. GP reviewed report on return to work. Patient later passed away.	SCS	Catastrophic	No	Radiology to develop protocol for communicating urgent results during the OOH period. Radiology are in process of developing a protocol.
Irrelevant information redacted by the USI		n/a	n/a	Patient (DNAR) was brought to theatre for OGD. Patient arrested in theatre, decision made to withdraw care.	SCS	Catastrophic	No	No early learning identified. DNAR in place. Patient had appropriate care and surgeon and anaesthetist were both present - patient deteriorated and died.
Irrelevant information redacted by the USI		n/a	n/a	Death following fall.	ACS	Catastrophic	No	Post falls pathway was followed with immediate medical attention sought and delivered.
Irrelevant information redacted by the USI		n/a	n/a	Patient left ward for a smoke. Collapsed off ward, cardiac arrest. CPR commenced and continued for 40 minutes. Pt deceased.	SCS	Catastrophic	No	Unexpected death - treatment and care appropriate. No early learning identified.
Irrelevant information redacted by the USI		n/a	n/a	Unexpected death of patient known to mental health services. Patient died of natural causes.	MHD	Catastrophic	No	None

Irrelevant information redacted by the USI	n/a	n/a	Patient transferred to Cath lab for complex PCI, developed VF, CPR commenced, no ROSC. Deceased.	MUSC	Catastrophic	No	For Cardiology M&M peer review and discussion.
Irrelevant information redacted by the USI	n/a	n/a	Unexpected death of patient with pacemaker. Pacemaker was under a field safety notice. Device check completed on 23/01/2023 and reported all satisfactory, no alerts on remote monitoring. Patient deceased on Personal information redacted by USI	MUSC	Catastrophic	No	No early learning identified. As per field safety notice a device check was completed 3 weeks previous and no concerns were identified. Cardiac physiologist attempted to contact patient when device became disconnected.
Irrelevant information redacted by the USI	16/01/2023	01/08/2023 listed for screening 15/08/2023 Enhanced Clinical review completed. 02/12/2022 upgraded to level 1 SAI. 16/01/2023 notification sent to Corporate for submission to SPPG.	4 month delay in follow up of CT scan result. Patient diagnosed with lung cancer.	MUSC	Major	Yes	Radiology reports should be emailed to referring clinician and referring clinician's secretary for follow urgent follow up.
Irrelevant information redacted by the USI			De-escalated	ACS		No	

Irrelevant information redacted by the USI	16/02/2023	28/07/2022 listed for screening. 15/08/2022 decision made for SAI review. 16/02/2023 Notification sent to Corporate CSCG for submission to SPPG. Delay due to administration error, overlooked by Operational Governance.	A number of Red Flag endoscopy and cystoscopy procedures booked under the incorrect clinical priority; leading to delay in their cancer pathway.	SCS	Major	Yes	Balance check process implemented to ensure Red Flag Patients were correctly coded – now implemented.
Irrelevant information redacted by the USI	21/02/2023	Date of incident 16 November 2022 24/11/2022 Listed on Surgical screening meeting. Referred to M&M for discussion and held pending outcome. 26/1/2023 Surgical screening confirmed notification for level 1 to be completed 4/2/2023 draft notification approved 21/2/2023 delay sending approved notification due to miscommunication in clinical governance team	Pre-operative assessment failed to recognise that surgery required postponing pending further work up and investigations. Surgery proceeded andfollowing surgery patient required prolonged hospital stay.	SCS	Major	Yes	Tachyarrhythmia in an elective patient presenting for surgery mandated further investigation and intervention prior to elective orthopaedic surgery

Irrelevant information redacted by the USI	04/01/2023	22.12.2022 listed for screening. Never event - decision for level 1 review. 22/12/202 notification shared with screening team for approval. 04/01/2023 notification shared with Corporate CSCG for submission to SPPG	Never event- wrong site of surgery - wrong site for pain block.	SCS	Insignificant	Yes	When administering block follow safety guidance 'prepare, stop before block'.
Irrelevant information redacted by the USI	16/01/2023	Listed for Screening on 22/12/22. Decision made for SAI on 06/01/23. Notification drafted and sent to AD DMD. Approval gained for processing on 12/01/23.	Delay in cancer diagnosis	SCS	Major	Yes	Patient for discussion at MDT and outpatient follow up.
Irrelevant information redacted by the USI	16/01/2023	Not reported by clinical team until 05/01/23. Screened. Notification approved for processing on 09/01/23.	Patient's surgery cancelled after insertion of arterial line putting him at unnecessary risk.	SCS	Moderate	Yes	Patient discharged to await rescheduling.

Irrelevant information redacted by the USI	18/01/2023	Listed for screening on 05/01/23. Notification drafted and sent to AD DMD for approval on 06/01/23. Approved for processing on 13/01/23. Received into Corporate CSCG 17/01/23.	Transmission of Clostridium Difficile from patient to patient.	SCS	Major	Yes	Ward put on Clostridium Difficile trigger and a number of outbreak meetings were held.
Irrelevant information redacted by the USI	05/01/2023	No delay as informed on 03.01.2022 by SD1 PSNI.	Death of male patient in community of suspected hanging.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	13/01/2023	Presented at ED M&M 29/11/2023 listed for screening. 20/12/2023 Notification shared with screening team for approval. 04/01/2023 notification approved. 10/01/2023 notification forwarded to Corporate.	Patient attended ED with chest pain, left department before review and treatment. Troponin result required action, there was no follow up. Patient returned to ED via ambulance due to cardiac arrest, and was transferred to RVH for PCI.	MUSC	Moderate	Yes	There was no follow up of the patient's investigations. The patient's troponin result was abnormal requiring treatment

Irrelevant information redacted by the USI		13/01/2023	Case discussed at ED M&M. Notification drafted on 4 January 2023 and out to AD and DMD for approval. Received into Corporate CSCG 13/01/23.	An Personal Information redacted by the USI patient waited outside the ED in the ambulance for approximately six hours. Patient arrived into department had a cardiac arrest. Patient passed away	MUSC	Catastrophic	Yes	Bed waits led to overcrowding in the ED, consequently ambulance could not off load. Delayed treatment.
Irrelevant information redacted by the USI		13/01/2023	07/12/2022 listed for screening. 14/12/2022 decision for level 1 review 21/12/2022 notification shared with screening team for approval 10/01/2023 notification sent to Corporate. Received into Corporate CSCG 13/01/23.	Due to hospital pressures, the ED was overcrowded which caused a delay in time critical treatment of a hemorrhagic stroke.	MUSC	Major	Yes	Due to hospital pressures and overcrowding in the ED there was a delay in time critical treatment

Irrelevant information redacted by the USI	13/03/2023	Incident screened initially as an Enhanced Clinical Incident Review on 18.01.23. Patient had Lung scan completed and this was discussed at ED screening on 22.02.23. Given findings of lung scan decision made on 01.03.23 that case be escalated to Level 1 SAI. Draft notification sent to AD and DMD for approval on 07.03.23. Received into Corporate CSCG 13/01/23.	No follow up of small lung nodule identified on CT. Patient has now received a cancer diagnosis.	SCS	Major	Yes	None
Irrelevant information redacted by the USI	12/01/2023	DOD 25.12.2022 informed by Team 03.01.2023 Confirmation of death by Coroner 10.01.23 – cause undetermined at this time	Death of female patient in community of cause undetermined	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	13/01/2023	DOD 09.01.2023 SD1 received 11.01.2023 informed by Team 10.1.23 Confirmation by Coroner 11.01.23	Death of male patient in community	MHD	Catastrophic	Yes	None

Irrelevant information redacted by the USI	11/01/2023	Information gathering re incident. Early alert sent up on 13/01/2023	A Learning Disability client who resides in an independent supported living facility has passed away after sustaining an injury from a fall out of a vehicle.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	20/01/2023	Ascertaining preliminary cause of death from coroner.	Preliminary Cause of death undetermined at this time. Female patient in the community	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	20/01/2023	Delay in receiving SD1 form from PSNI, received 18/01/2023	Suspected Suicide in the community of a service user who was known to Mental Health Services.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	19/01/2023	DOD 14.01.2023 informed by Team 16.1.23 Confirmation by Coroner 18.01.23	Preliminary Cause of death undetermined at this time. Male patient in the community.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	24/01/2023	SD1 from police received by Governance 23.1.23.	Death of a male patient in community. Suspected cause hanging.	MHD	Catastrophic	Yes	None

Irrelevant information redacted by the USI	13/02/2023	Delay in reporting of incident by clinical teams. Listed for screening on 26/01/23. Notification drafted and sent to AD DMD on 09/02/23. Approved for processing.	Results of CT scan not followed up by clinical team.	SCS	Minor	Yes	Patient awaiting partial nephrectomy.
Irrelevant information redacted by the USI	14/02/2023	Clarity sought re cause of death Internal screening process to reach decision that SAI should proceed	Following an unobserved fall, patient became unresponsive, continued to deteriorate and died.	ACS	Catastrophic	Yes	Learning from good practice – procedures followed regarding monitoring patient and urgent transfer.
Irrelevant information redacted by the USI	07/02/2023	No delay SD1 from police received by Governance 06.02.2023	Death of a male patient in community.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	06/02/2023	No delay SD1 from police received by Governance 06.02.2023	Death of a male patient in community.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	08/02/2023	No delay	Death of a male patient in community.	MHD	Catastrophic	Yes	None

Irrelevant information redacted by the USI	10/03/2023	Establishing circumstances of incident/ staff availability	Difficulty in finding placement for Personal information with pneumothorax and chest drain who presented in DHH ED, not accepted by RBHSC as over Personal information not accepted by adult respiratory SHSCT as under Personal information Transferred to CAH paeds under joint surgical care. Difficulties in terms of skill set to manage patient. Patient deteriorated and was transferred to Thoracics BHSCT.	CYPS	Major	Yes	Need for pathway for specialist care 14-16yrs
Irrelevant information redacted by the USI	13/02/2023	No delay	Death of a male patient in community.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	16/02/2023	No delay SD1 from police received by Governance 14.02.2023.	Death of a male patient in community.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	22/02/2023	Delay in receiving SD1 form and director approval.	Death of a male patient in community.	MHD	Catastrophic	Yes	None

Irrelevant information redacted by the USI	13/03/2023	Incident : 15/02/2023 Early Alert : 16/02/2023 Screened : 23/02/23 agreed for SAI. Notification drafted 06/03/2023	Non-compliance with the Termination of pregnancy policy.	SCS	Minor	Yes	Only a Consultant to complete prescription for Mifepristone. Any one dispensing Mifepristone must check correct "Termination of Pregnancy" documentation has been completed. Mifepristone to be stored in one location- Delivery Suite. Ensure all band 7s are up to date with Termination of Pregnancy framework.
Irrelevant information redacted by the USI	09/03/2023	No delay PSNI sent SD1 form 07.03.2023	Death of a male patient in community.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	10/03/2023	Delay in response from coroner re prelim cause of death	Death of a female patient in community.	MHD	Catastrophic	Yes	None
Irrelevant information redacted by the USI	16/03/2023	No delay	Child inadvertently received tube feed via jejunsotomy instead of gastrostomy. Patient had high risk of aspiration.	CYPS	Moderate	Yes	Training needs
[redacted]	20/03/2023	No delay SD1 from police received by Governance 16.03.2023	Death of a male patient in community.	MHD	Catastrophic	Yes	None

2.4 Incidents Classification[6]

Datix reporting introduced a new classification system which was adopted regionally by all HSC Trusts on 15/04/2019. This has introduced changes to categorisation and also requires an allocation of "who" the incident involved.

Tables 3.0 and 4.0 below summarised:

- Total incidents (across all directorates) for the period January – March 2023, by who was involved.
- Trust Top 10 categories

20.8% (1353) incidents – uncategorised at the time of running this report, this number has increased since the last quarter from 1230 to 1353 This increase is attributed to the short period of time between, end of the reporting period and the development of this report.

Table 3.0 below provides a breakdown of Incidents broken down by 'Who was involved'

Incident Involved	Q4 22/23	% Total	Q3 22/23	% Total	Q2 22/23	% Total	Q1 22/23	% Total	Q4 21/22	% Total
Patient & Service User	4161	64.01	3725	63.05	3579	63.12	3187	60.89	2952	55.6
Staff	718	11.04	712	12.05	797	14.06	640	12.23	977	18.4
Public / Visitors	48	0.74	41	0.69	28	0.49	20	0.38	20	0.4
Organisational	221	3.40	200	3.39	237	4.18	163	3.11	131	2.5
Uncategorised (Involved)	1353	20.81	1230	20.82	1029	18.15	1224	23.39	1226	23.1
Total	6501		5908		5670		5234		5306	

Table 4.0 below provides a breakdown of the Top 10 Incident areas by Category.
Categorised/Themed incidents account for 75% of Incidents as detailed below.

Qu 4 SHSCT 'Top 10' By Incident Category	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Behaviour (Including Violence and Aggression)	1098	584	24	1	14	1721
Accidents/Falls	827	613	30	9	4	1483
Uncategorised at time of Reporting	613	597	121	21	1	1353
Medication/Biologics/Fluids	353	193	51	2	0	599
Other	93	129	21	5	0	248
Pressure Ulcers	27	147	16	0	0	190
Service Disruptions (environment, infrastructure, human resources)	107	39	9	12	0	167
Maternity Care	1	96	35	2	0	134
Diagnostic Processes/Procedures	18	70	11	3	2	104
Communication	22	58	13	4	0	97
Other Categories outside Top 10	131	235	27	5	7	405
Grand Total	3290	2761	358	64	28	6501

In this quarter the categories remain consistent with previous quarters. A breakdown of these CCS codes by 'Who the Incident involved' is provided in Table 5 onwards.

[6] Incident classification is now reported at the aggregated category level, accumulating all relevant smaller sub-categories.

Tables 5.0 – 8.0 provide a further drill down listing the top 10, by involvement, category and severity[7].

Table 5.0. Incidents involving Service Users – 64%. This is consistent with the previous quarter. Falls and pressure ulcers are key patient safety areas further reported in Appendix A. Whilst table 5.0 provides details on all pressure ulcer and patient falls, Appendix A reports on hospital acquired pressure ulcers and injurious fall sub-categories.

Table 5.0. Incidents involving Service Users

Q4 Jan - March 2023 Patient/Service User Incidents by Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Patient Accidents/Falls	803	530	29	9	4	1375
Behaviour	750	348	17		13	1128
Medication/Biologics/Fluids	349	188	50	2		589
Other	93	129	21	5		248
Pressure Ulcers	27	147	16			190
Maternity Care	1	96	35	2		134
Diagnostic Processes/Procedures	18	70	11	3	2	104
Communication	22	58	13	4		97
Administrative Processes (Excluding Documentation)	13	31	4	3	1	52
Documentation	17	32	1			50
Other Categories outside Top 10	40	126	33	4	5	208
Grand Total	1822	1548	173	21	15	3579

There were no significant changes to the themes or the number of incidents against each category.

Table 6.0. Incidents involving Staff – 11%

Q4 January - March Staff Incidents by Category	Insignificant	Minor	Moderate	Major	Total
Behaviour (Including Violence and Aggression)	331	220	6	1	558
Accidents/Falls	19	79	0	0	98
Property	13	17	1	0	31
Exposure to Environmental Hazards	14	15	1	1	31
Grand Total	377	331	8	2	718

There were no significant changes to the themes or the number of incidents against each category.

[7] Datix data quality impacts the categorisation, e.g. if IR1 incorrectly associates the incident to a staff member when a patient is the 'involved' person. Datix training investment is required for improvement alongside data quality processes.

Table 7.0. Incidents at an Organisational Level – 3.4%

Q4 Jan - March 2023 Organisational Incidents by Category	Insignificant	Minor	Moderate	Major	Total
Service Disruptions (environment, infrastructure, human resources)	107	39	9	12	167
Fires, Fire Alarms and Fire Procedures	17	6		0	23
Security of Organisation's Property, Data and Buildings	8	3	0	0	11
IT Systems	1	9	0	0	10
Medication/Biologics/Fluids	4	5	1	0	10
Grand Total	137	62	10	12	221

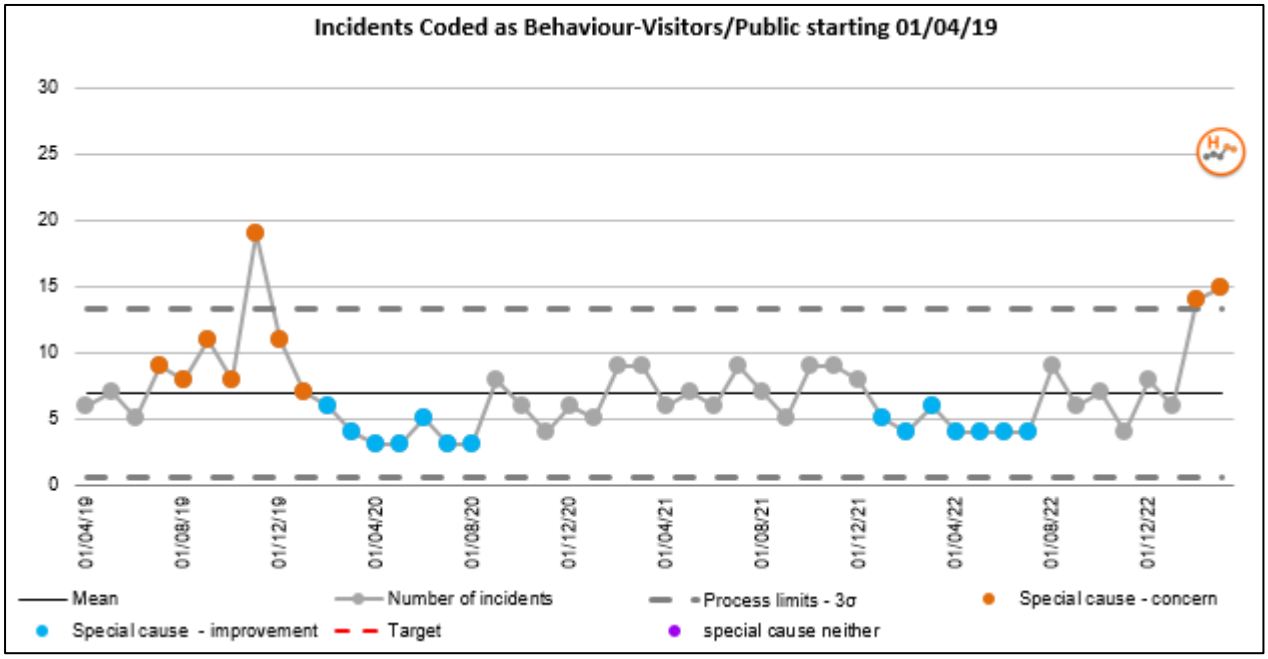
There were no significant changes to the themes or the number of incidents against each category.

Table 8.0. Incidents involving the visitor/public – 0.7%

Q4 Jan - March 2023 Public Incidents by Category	Insignificant	Minor	Moderate	Total
Behaviour	17	16	1	34
Accidents/Falls	5	4	1	10
Property	4	0	0	4
Grand Total	26	20	2	48

The number of Behaviour coded incidents has increased significantly this quarter. When plotted on an SPC chart, the number exceeds the UCL. When further analysed a large number of these incidents relate to Violence and Aggression incidents from family members of patients/service users.

Figure 4 – SPC Chart – Behaviour coded incidents involving Visitor/Public



2.5 Incidents of Behaviour / Abuse including Self Harm

The following two tables (Tables 9.0 – 10.0) provide a further breakdown, by the person affected groups (Patient and Staff), of the 1666 recorded incidents of Behaviour / Abuse by Severity.

Incidents of Behaviour / Abuse including Self Harm – Patient/Service User

There were 9 incidents incorrectly coded in the **"**Inappropriate/Aggressive Behaviour towards a Patient by Staff".

The 9 incidents correctly coded as "Inappropriate/Aggressive Behaviour towards a Patient by Staff" included safeguarding incidents and other alleged incidents including verbal and physical abuse.

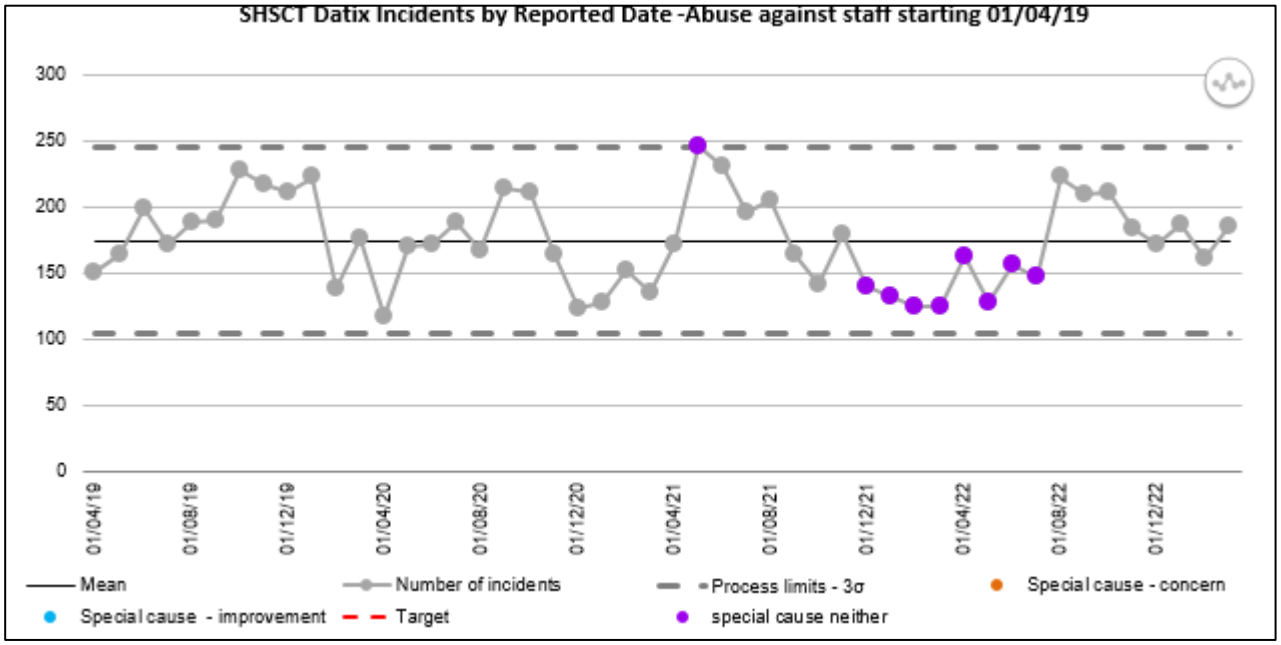
Table 9: Incidents of Behaviour / Abuse including Self Harm – Patient/Service User

Person Affected - Patient/Service User	Severity				
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Catastrophic	Grand Total
Missing Patient (absconded/abducted patient)	153	120	1		274
Patient Behaviour that challenges	203	56	3		262
Self-harming Behaviour	114	75	6	13	208
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	105	44	2		151
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	124	19	2		145
Patient refusal of diagnostic/therapeutic recommendations/interventions	17	7			24
Use/Possession of Prohibited/Stolen Goods	15	6			21
Inappropriate/Aggressive Behaviour towards a Patient by Staff	13	4	1		18
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	4	9	2		15
Persons Performing Unauthorised Acts	2	8			10
Grand Total	750	348	17	13	1128

Table10: Incidents of Behaviour / Abuse including Self Harm – Staff Member

Person Affected - Staff Member	Severity				
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Grand Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	305	184	4	1	494
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	11	8			19
Inappropriate/Aggressive Behaviour towards Staff by Staff	6	8	2		16
Other	3	4			7
Persons Performing Unauthorised Acts	1				1
Grand Total	327	204	6	1	538

Figure 5: SHSCT Datix Incidents – Abuse against staff from 01/04/2019



2.6 Incidents coded as 'Missing Patient'

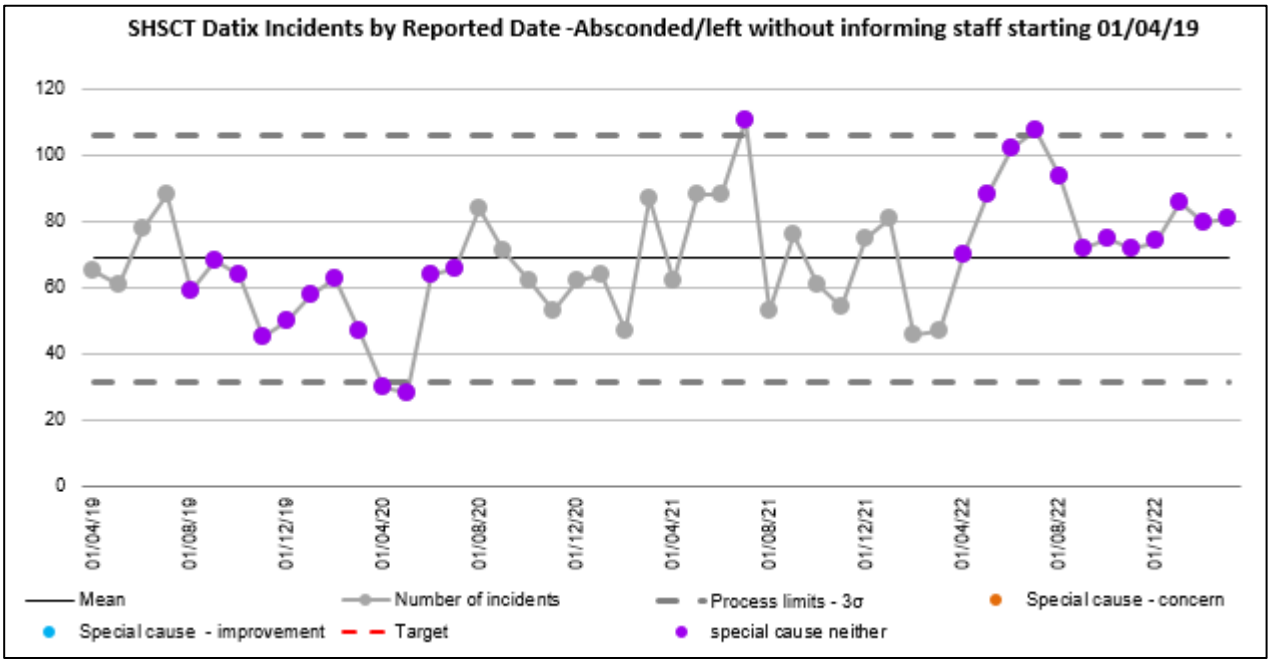
Table 11.0 below provides a further breakdown, by category and severity of the 274 recorded incidents of missing, absconded or AWOL patients or service users.

Table 11: 'Missing Patient' incidents by Severity

Person Affected - Patient	Severity			
Type of Missing Patient	Insignificant	Minor	Moderate	Grand
Absconded/left without informing staff	131	115	1	247
Attempted to abscond/leave without informing staff	19	4	0	23
AWOL / Absconded (detained patients only)	2	1	0	3
Left with notice contrary to advice	1	0	0	1
Grand Total	153	120	1	274

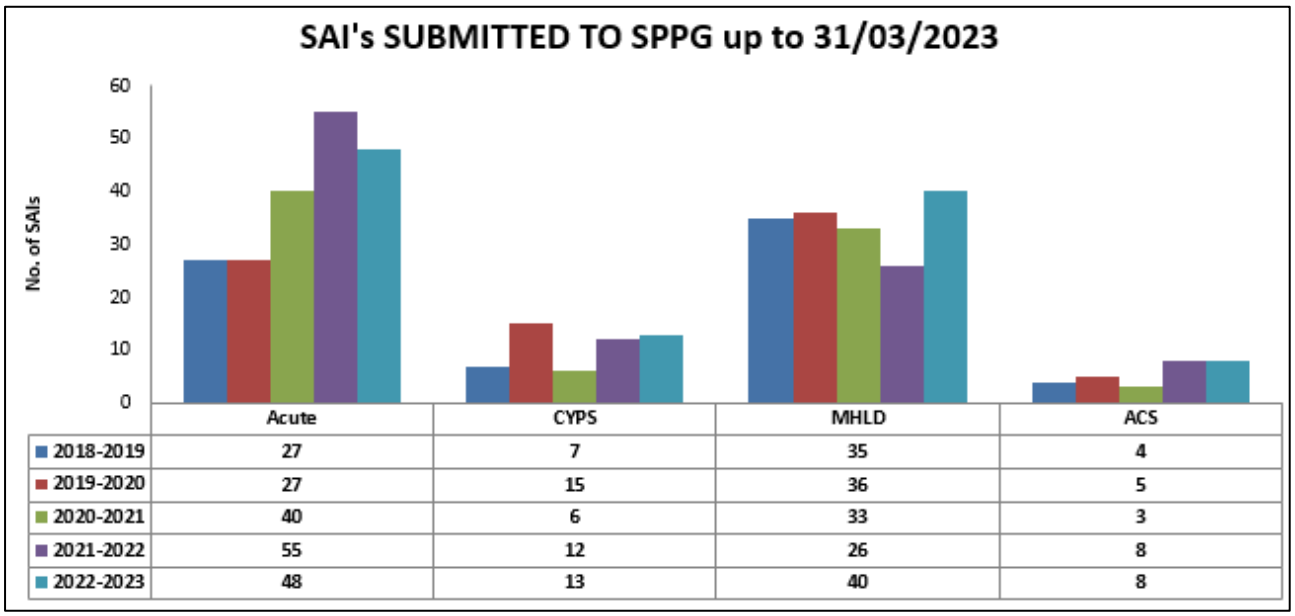
Figure 6 below shows the number of incidents coded as "Absconded/left without informing staff" since April 2019. The data for this reporting period continues with the shift in data with 12 sequential points above the MEAN which is unusual.

Figure 6: SHSCT Incident – Absconded/left without informing Staff from 01/04/2019



2.7 Serious Adverse Incident Investigations submitted to SPPG as at 31st March 2023 (Table 12.0).

Table 12: SAIs submitted to SPPG up until 31/03/2023



	Acute	CYPS	MHLD	ACS
2018-2019	27	7	35	4
2019-2020	27	15	36	5
2020-2021	40	6	33	3
2021-2022	55	12	26	8
2022-2023	48	13	40	8

Table 13: Themes of SAI Notifications submitted between 1st January 2023 and 31st March 2023.

Theme of SAI	Number of SAIs
Behaviour	15
Administrative Processes (Excluding Documentation)	6
Diagnostic Processes/Procedures	5
Patient Accidents/Falls	2
Unexpected Deaths or Severe Harm	2
Service Disruptions	1
Therapeutic Processes/Procedures	1
Infection Control Incident	1
Documentation	1
Nutrition Pharmacy Products	1
Grand Total	35

2.8 Trust Performance against Regionally Agreed Timescales

Timescales for the completion of Serious Adverse Incidents are set out by SPPG:

- Level 1 - 8 weeks
- Level 2 - 12 weeks
- Level 3– timescales are agreed between the reporting organisation and the SPPG/PHA DRO

	In Timescale	Outside Timescale	Total
Acute	6	36	42
CYP	3	3	6
MHD	14	24	38
OPPC	2	12	14
On Hold	n/a	n/a	0
Total	25	75	100
%	26	77	

Table 14.0 – SHSCT SAI status as at 31st March 2023: **100** SAI investigations in total[8]. **25** SAI investigations (26%)[9] remain within the SPPG timescales for submission. **75** are outside of timescales. This is broken down by Operational Directorate in table 15 below.

There are a number of contributory factors which influence the compliance of completion of SAI reports within the timescales identified in the SPPG Serious Adverse Incident Procedures.

- The most common theme across Operational Directorates is the availability of panel members due to operational pressures.
- Appropriate team configuration to ensure relevant level of clinical independence and expertise.
- Difficulties in obtaining external chairs / review team members.
- The prioritisation of SAI investigations within existing workloads.
- Necessary engagement with service users and their families, particularly where a death has occurred.

[8] SAIs notified in a period will vary from the number actively in progress or paused at any particular point in time.
[9] Compared to 22% the previous quarter

- Where the SAI investigation spans across 2 or more Trusts.
- Capacity constraints on Clinical and Social Care Governance Teams, compared with current demand and complexity.

To assist with some of these issues the Trust has recruited dedicated SAI Chairs and has secured ongoing external SAI Chair training to increase the pool of available staff to participate with the progression of SAIs.

SPPG has recently sourced an external resource to assist all Trusts with the backlog of Level 1 SAIs. The Corporate and Operational CSCG teams meet with Clinical Leadership Solutions (CLS) (the commissioned supplier), on a regular basis to discuss progress and allocate SAIs. CLS are currently supporting the Trust on 20 SAIs.

It was agreed that the primary focus for CLS support would be MUSC/SCS Services outstanding Level 1 reports due to the number overdue. Of the 20 SAIs which CLS are involved in, 14 of these are from within the MUSC/SCS Directorates.

As detailed above in Table 14, there are 100 open SAIs as at 31st March 2023, this is compared to 99 in the previous quarter. A breakdown of SAI activity has been provided below.

Ongoing SAIs last quarter	99
Add New SAI notifications:	35
Less SAI reports submitted:	-32
Less SAIs deescalated	-2
Ongoing SAIs as at 31/12/2022	100

Table 15.0 sets out the detailed position on the progress of the 100 SAI investigations currently on-going as at 31/03/2023.

	MUSC/SCS			CYPS			MHD			ACS		
SAI Level	Within SPPG Timescales	Outside SPPG Timescales week 26 >	Outside SPPG Timescales weeks 26 <	Within SPPG Timescale	Outside SPPG Timescales weeks 26 >	Outside SPPG Timescales weeks 26 <	Within SPPG Timescales	Outside SPPG Timescales weeks 26 >	Outside SPPG < Timescales weeks 26<	Within SPPG Timescales	Outside SPPG > Timescales weeks 26>	Outside SPPG < Timescales weeks 26<
Level 1	6	12	19	2	0	3	6	1	7	1	10	1
Level 2	0	4	1	1	0	0	6	8	8	1	1	0
Level 3	0	0	0	0	0	0	2	0	0	0	0	0
Totals	Within SPPG Timescales	Outside SPPG Timescales		Within SPPG Timescale	Outside SPPG Timescales		Within SPPG Timescales	Outside SPPG Timescales		Within SPPG Timescales	Outside SPPG Timescales	
	6	16	20	3	0	3	14	9	15	2	11	1

SPC Charts have been provided in Appendix C to show the length of time from Date of Notification to submission of SAI report per Directorate. This does not include any SAIs which are ongoing.

The SPC Charts in Appendix C has highlighted significant improvements in the length of time taken to complete SAI reports in the MUSC/SCS, CYPS and MHD Directorates.

2.9 SAI Reports and Recommendations

In Quarter 4, 32 SAI reports were submitted to the SPPG, 21 from MUSC/SCS, 6 from MHD, 4 from CYPS and 1 from ACS.

All SAI recommendations for reports submitted from reporting period 2021/22, to date have been uploaded to Datix and are being progressed by the Operational Directorate Governance teams and relevant Service Areas for quality assurance and implementation updates.

A summary position of all recommendations for submitted SAI reports , from reporting year April 2022 – March 2023 is provided below in Figure 7.

Directorate Governance Teams were asked that all SAI recommendations uploaded to Datix were Quality Assured and implementation progress updated by 13th January 2023, however due to service pressures it has not been possible to fully complete this across all Directorates. For the next Governance Committee meeting, a year end accurate position will be provided, as well as a status report for 21/22.

Figure 7 – Status of Recommendations from SAI Reports submitted 22/23.

	Fully Implemented	Partially Implemented - Internal Barriers	Partially Implemented - External Barriers	Not Implemented - Internal and External Barriers	Entered by Governance team, no status known at this stage	Total
Apr 2022	0	0	0	0	16	16
May 2022	0	0	0	0	7	7
Jun 2022	4	0	0	1	8	13
Jul 2022	1	0	0	0	12	13
Aug 2022	0	1	0	0	28	29
Sep 2022	1	0	0	0	3	4
Oct 2022	0	1	0	0	20	21
Nov 2022	1	2	0	0	11	14
Dec 2022	0	0	0	0	16	16
Jan 2023	7	1	1	0	11	20
Feb 2023	2	0	0	0	23	25
Mar 2023	0	0	0	0	15	15
Apr 2023	2	0	0	0	22	24
May 2023	0	0	0	0	15	15
Jun 2023	0	0	0	0	37	37
Jul 2023	0	0	0	0	4	4
Aug 2023	0	0	0	0	2	2
Sep 2023	0	0	0	0	7	7
Oct 2023	0	0	0	0	0	0
Nov 2023	0	0	0	0	0	0
Dec 2023	0	0	0	0	10	10
Jan 2024	0	0	0	0	0	0
Feb 2024	0	0	0	0	0	0
Mar 2024	0	0	0	0	4	4
Total	18	5	1	1	271	296

Of the 296 Recommendations uploaded to Datix from April 2022, 271 remain within the "Entered by Governance Team, no status known at this stage", having not been assigned to anyone for responsibility to action/implement.

18 have progressed to "Fully Implemented" a breakdown of these completed recommendations is provided below:

MHD – 12

- Expedite the roll out of the Pisani Assessment and management of suicide risk training to all relevant teams in Mental Health Services

- A reminder should be circulated to staff about the importance of transferring the relevant key risks from a Mental Health Assessment to the Risk Assessment
- The Review team recommends that notes should be written as soon as possible after an event has occurred preferably within 24 hours and when retrospective notes are being added this should be clearly labelled at the start of an entry. The review team is however aware that all entries made on the PARIS system are date/time/staff name stamped.
- A reminder should be circulated to the Team Leads throughout the service to ensure all staff have completed relevant mandatory training including information Governance.
- Community Mental Health teams to be reminded when a date has been agreed with the patient for follow up contact, an entry should be included in the PARIS system to confirm whether or not that contact took place.
- A reminder is to be sent to staff to note that Opioids are identified as drugs of particular concern in relation to unexpected deaths.
- Mental Health Encompass Lead should be made aware that the Lithium side effect assessment tool should be considered for inclusion in the new Encompass system.
- Regional Lithium Care Pathway to be reviewed by the Regional Mental Health Pharmacy Group to take into account the collaborative decision with patients around pathway and choice as there is a lack of information relating to specific side effects in current care pathway and how this is recorded and acted on.
- Where Lithium is prescribed, there should be assessments in relation to side-effects undertaken at each clinical contact and the outcomes recorded in the patient's careplan.
- The review panel consider the patient could benefit from a referral to the Belfast Trust for psychotherapeutic interventions services that the SHSCT have not yet been able to offer her.
- The panel recommends that learning from this review should be highlighted at the next triage supervision session and at the next CAT team meeting.
- A shared letter should be circulated to remind all staff that planned discharge due to non-response in a given period should be completed by the responsible practitioner within 10 working days. The responsible Practitioner should inform the GP at the point of sending the 10 day response letter to the patient.

MUSC – 1

- The NIAS Inter-Facility Transfer documentation should be recirculated to all clinical staff and awareness of its existence raised.

CYPS – 2

- The audit team recommend that regular SIM training is undertaken by the Community Dental Service and Theatre staff to fully imbed the process of the WHO checklist and LocSIPP in the theatre setting.
- An addition to the Neonatal Handbook has been progressed to include consideration of Enterovirus within the possible list of viral causes for Neonatal Thrombocytopenia.

ACS – 3

- This incident will be shared with the education providers in the Clinical Education Centre for inclusion in the Safe Administrations of Medicines Programme training.
- The Learning from this incident will be shared within the Trust as a reminder of best practice in the second checking of medicines administration.
- Team members should be aware to review discharge documentation on NIECR in relation to referrals received.

2.10 Learning from SAIs

In Quarter 4, 4 Shared Learning Templates were completed in relation to SAIs within the CYPS Directorate.

LT 2022/23 04

Learning Theme – Service Disruptions (human resources)

Incident - XX was a Looked After Child who resides within a SHSCT residential facility and was placed in Secure Care due to high risk behaviours.
XX was on a day visit back to the Trust residential facility as part of XX's transitioning from Secure Care. XX absconded from the residential facility and was escorted back by the PSNI at 23:30hrs. As it was night time, XX should have been transferred back to Secure Care at this point, and residential staff requested assistance from the PSNI to do so, however they were not able to assist and returned XX back to the residential facility.
During night shift (sleep in), there are only two staff on duty within residential facilities which does not allow sufficient staffing to respond to incidents of this nature.
XX remained settled throughout the night with no issues arising.
XX absconded again from the residential facility the following morning and once located reported a serious assault.

Learning - There is a need to ensure staffing levels are sufficiently flexible to reflect the changing needs of the young people within residential facilities. The CYPS Directorate will give consideration as to how best to maintain flexible staffing at night during difficult periods in the home, to allow for increased responsiveness to situations such as, when a young person absconds from the facility.

Shared Learning disseminated to – Residential Facility and Corporate Parenting Residential Facilities

LT 2022/23 05

Learning Theme – Administrative Processes

Incident - XX is a Personal information Looked After young person, who currently resides in a Trust residential facility. XX was permitted to leave the facility at 14:00hrs in accordance with their safety plan, under the agreement of checking in every 20 minutes. XX did not return to placement at planned time and staff conducted a search of the local area. A few hours later XX returned to the residential facility and alleged to residential staff that they had been

sexually assaulted in the community. The PSNI were contacted and a forensic examination was subsequently undertaken at the regional Sexual Assault Referral Centre (The Rowans Service). The PSNI investigation remains ongoing.

Learning - The audit team acknowledge that staff regularly reviewed CSE concerns in respect of XX during Professional Network Meetings, however the audit team consider it appropriate to have made a formal referral to the Trust's CSE Lead at an earlier stage.

Shared Learning disseminated to – Residential Facility and Corporate Parenting Division.

LT 2022/23 06 - Diagnostic Processes/Procedures

Incident - Sudden unexpected death of a 4 week old infant who had been admitted to the Paediatric Ward following a high temperature at home. Covered and screened for sepsis on admission. Infant suddenly deteriorated on day 4 of admission having suffered from a large infarct affecting both of the frontal lobes of the brain, and sadly passed away.

XX had a previous admission to the Neonatal Unit shortly after birth for treatment of high bilirubin levels and low platelets and was treated for ABO compatibility. XX was discharged home with a follow up outpatient's appointment and a further planned appointment at the outpatients department in 6 weeks' time.

Following SAI review, congenital Enterovirus was suspected by the review team as the cause for the infant's deterioration and further sampling was requested which later returned positive for Enterovirus.

Learning –

- Whilst severe neonatal Enterovirus infection is extremely rare, it has a high mortality and should always be considered in a case of thrombocytopenia and jaundice, alongside cytomegalovirus infection. The highest likelihood of confirming Enterovirus infection is via PCR testing on stool sample or throat swab/respiratory secretions.
- Where sepsis is suspected, administration of antibiotics should be within one hour.
- A seizure in the context of sepsis must always be considered a symptomatic seizure and requires urgent treatment and investigation including neuroimaging. It is essential that a child who is showing clinical deterioration is reassessed and discussed with the Paediatric Consultant. Neonatal seizures are subtle and should be afforded a higher index of suspicion.
- Clinical observations:
  - Consideration should be given to repeating clinical observations more frequently despite low scoring PEWS where there is clinical concerns (watcher) or parental concern.
  - Blood pressure outside of normal range should be repeated.
  - GCS observations should be undertaken when seizure activity is suspected.

Shared Learning disseminated to – Acute Paediatric Services, SHSCT

LT 2022/23 07 - Diagnostic Processes/Procedures

Incident - XX was a Personal information redacted by USI with a background of Idiopathic Pulmonary Hypertension. XX attended Royal Belfast Hospital for Sick Children (RBHSC) in Personal Information redacted by USI for restorative dental work. 17 days after his dental treatment, XX presented to his local District General Hospital (DGH) with lethargy and reduced oxygen saturations. A diagnosis of Paediatric Inflammatory Multisystem Syndrome (PIMS) was suspected due to a recent Covid 19 infection. The working diagnosis changed to sepsis of unknown origin, and following clinical improvement, XX was discharged home.
Subsequently developed Endocarditis leading to cerebral abscesses (in addition to abscess formation in the left kidney). Taken to theatre and underwent burr-hole aspiration of probable cerebral abscesses and was taken back to theatre for a left sided decompressive craniotomy. XX remained in PICU for 3 days however sadly deteriorated and passed away following a severe pulmonary hypertensive crisis.

Learning –

- There was no written confirmation in XX's notes with regard to the sharing of the dental information leaflet following their treatment on Personal information redacted by USI, or if this information was discussed with XX and his family. This information should have been provided and a record kept to ensure patients are aware of symptoms that require further attention and would warrant contact with a healthcare professional.

- Where patients present with symptoms suggestive of infection and have an underlying cardiac condition (particularly with artificial stents), a robust history should be taken to include questioning regarding any recent dental treatment/ surgical procedures.

- Where there is a differential diagnosis of Endocarditis with high risk patients, the appropriate investigations should be undertaken to aid the diagnosis and inform the most appropriate management.

- Where patients present with significant neurological symptoms such as headache, vomiting, incontinence, fluctuating GCS and seizures, A CT brain should be progressed even if neurological exam is unremarkable or difficult to undertake.

- When an urgent radiological examination for an inpatient child is requested, one to one communication is recommended between the requesting Consultant and the Consultant Radiologist.

- Transfer of unwell complex paediatric patients between institutions is challenging and carries many competing risks. In order to ensure the process is completed as efficiently and safely as possible, clear complete communication between key team members is vital. This ensures all team members have a similar mental model regarding the current needs of the patient.

- Referrals to the paediatric Critical Care and Nurse Led NISTAR teams should be directed through a single point of care phone number. This line should be available 24/7, recorded and staffed by an appropriately skilled call handler.

- This would be in line with national Paediatric Critical Care Society (PCCS)

standards which require specialist paediatric retrieval teams to have:

- A dedicated phone line for referrals from referring hospitals with the facility to record calls
- Conference call facility.
- Facilities to contact specialist teams throughout the emergency transfer, including during transport.

- This system could have an inbuilt risk assessment to allow appropriate call escalation and also where appropriate, facilitate the establishment of a conference call between key stakeholders to ensure shared mental modelling of all practitioners involved in the transfer.

Shared Learning disseminated to – Locally where incident occurred in SHSCT and BHSCT.

2.11 Trust Liaison Service

The SHSCT Liaison Service supports service users and their families/carers to facilitate their engagement with and understanding of the SAI process. Currently there are 85 service users/families/carers actively engaging with the Liaison Service (this figure covers SAIs across all Operational Directorates and those involved with the Level 3 Covid-19 SAI). The Liaison Officers provide a central point of contact for service users and their families/carers ensuring they have access to the SAI panel, an opportunity to share their personal experience, receive regular updates and are signposted to additional support services if required.

On 01 April 2023 a new referral process came into operation. An automatic referral is now made to the Liaison Service upon the receipt of each new SAI notification. Service users/families/carers will receive an initial direct contact from a Liaison Officer who is best placed to fully discuss the support on offer. The Liaison Officer will outline to the service users/families/carers the support available to facilitate their full involvement in the SAI review process this will enable them to make an informed choice regarding how they wish to proceed. Service users/families/carers involvement is key to support a culture of learning from incidents within the SHSCT.

The Liaison Service will also be utilised in the coming months as an additional resource to support colleagues and service users/families/carers involved in the upcoming cytology look back exercise (in relation to cervical screening) and Urology Look Back Review.

2.12 Approval Status of Incidents

Fig 8.0 highlights the number of incidents in each Directorate which are not Finally Approved. Incidents in the review process are not categorised by subject and the final severity rating has not been approved**.** There are 3 incidents pre-April 2019 which relate to the Urology review.

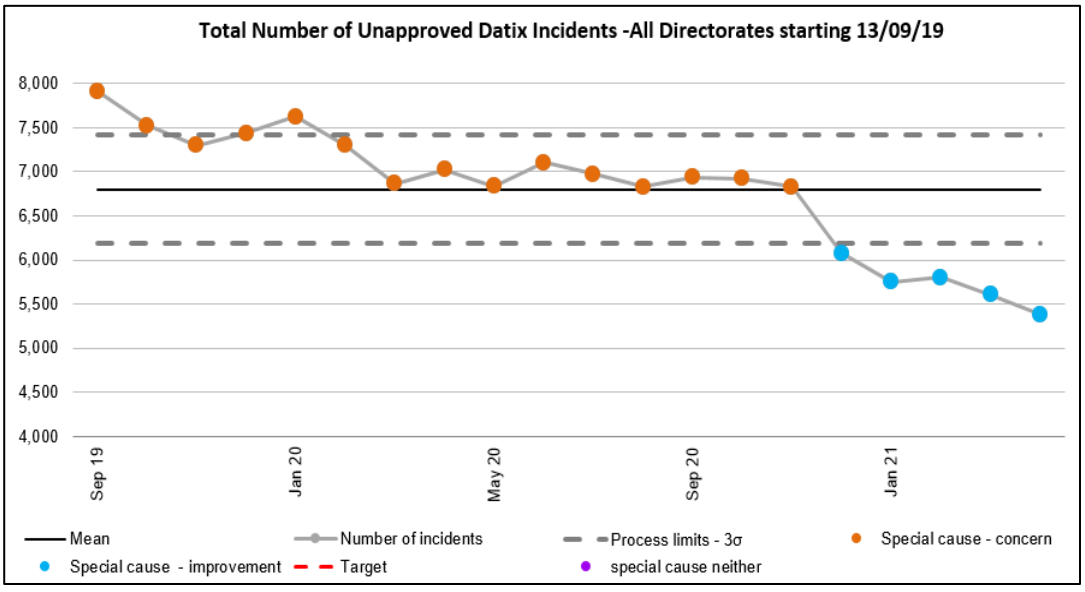
	2019	2020	2021	2022	2023	Total
Acute Services	15	28	111	760	725	1639
Children and Young Peoples Services	0	0	0	4	150	154
Finance Procurement & Estates	0	0	2	22	15	39
Human Resources and Organisational Development	0	0	0	2	3	5
Medicine & Unscheduled Care	0	0	1	5	189	195
Mental Health and Disability	0	0	41	176	469	686
Nursing, Midwifery and AHP	0	0	0	4	23	27
Office of the Chair and Chief Executive	0	0	0	1	0	1
Office of the Medical Director	0	0	0	0	1	1
Older People and Primary Care	0	8	187	1196	824	2215
Performance and Reform	0	0	0	2	4	6
Surgery & Clinical Services	0	0	0	2	122	124
Governance Use Only	4	6	87	70	37	207
Total	19	42	429	2244	2562	5299

Fig. 9.1 – 9.5 SPC Charts for unapproved incidents.[10]

This reporting period, January – March 2023, saw a significant improvement in the reduction of unapproved incidents, particularly within Adult Community Services.

The number of Unapproved Incidents across the Trust and for each of the Directorates has been plotted on SPC Charts:

Figure 9.1 - Total Number of Unapproved Datix Incidents – All Directorates



[10] Any open SAIs will remain on this report until the SAI report is submitted

Figure 9.2 - Total Number of Unapproved Datix Incidents – MHD

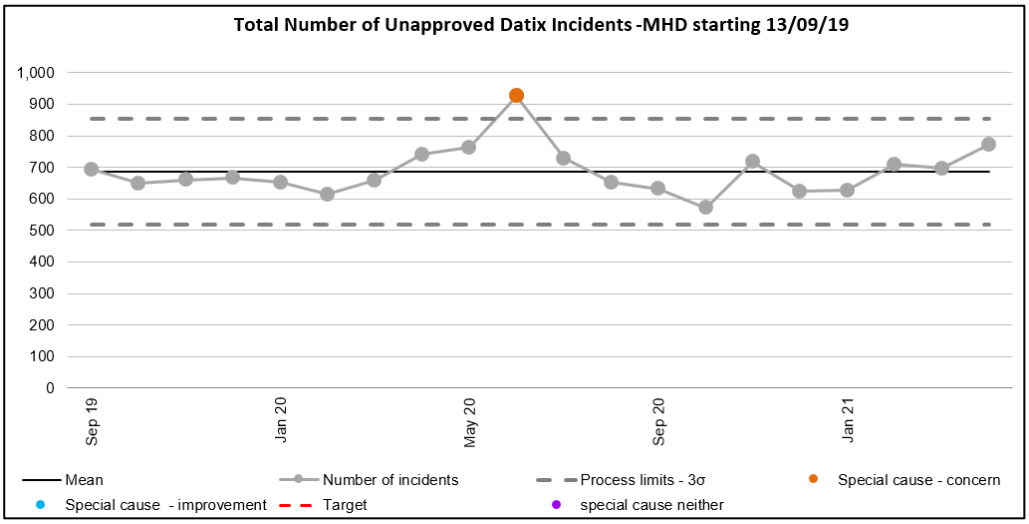


Figure 9.2 - Total Number of Unapproved Datix Incidents – CYPS

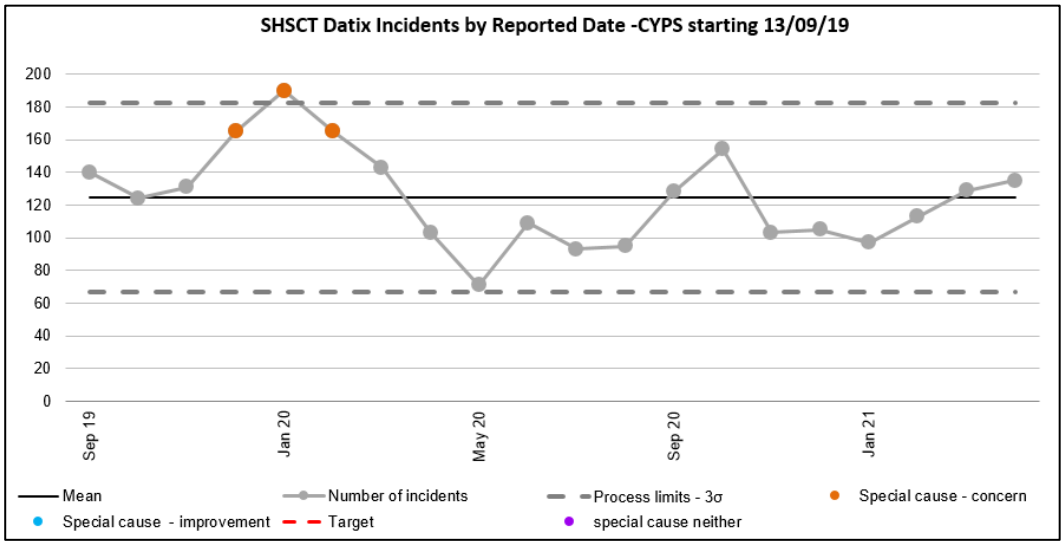


Figure 9.3 - Total Number of Unapproved Datix Incidents – MUSC/SCS

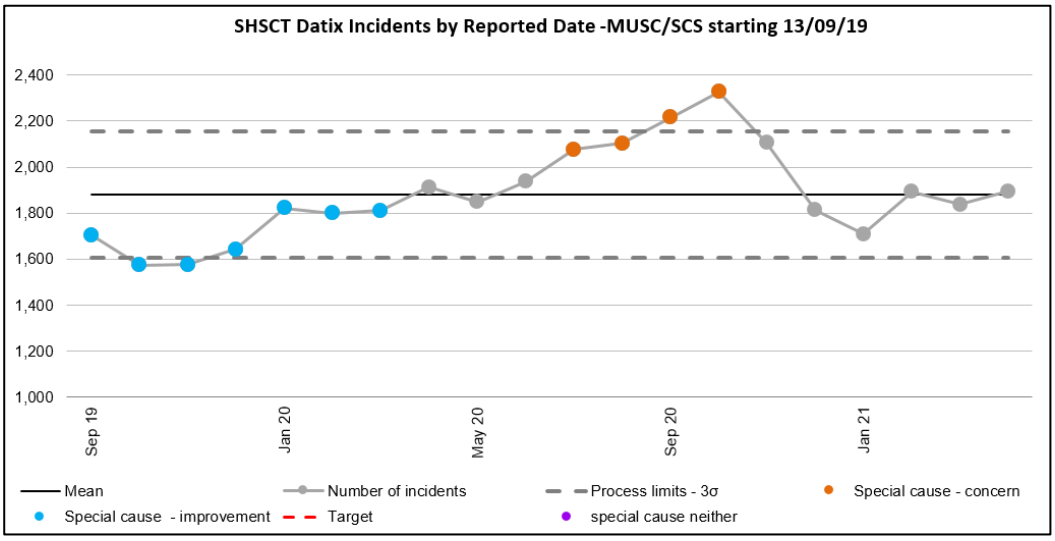
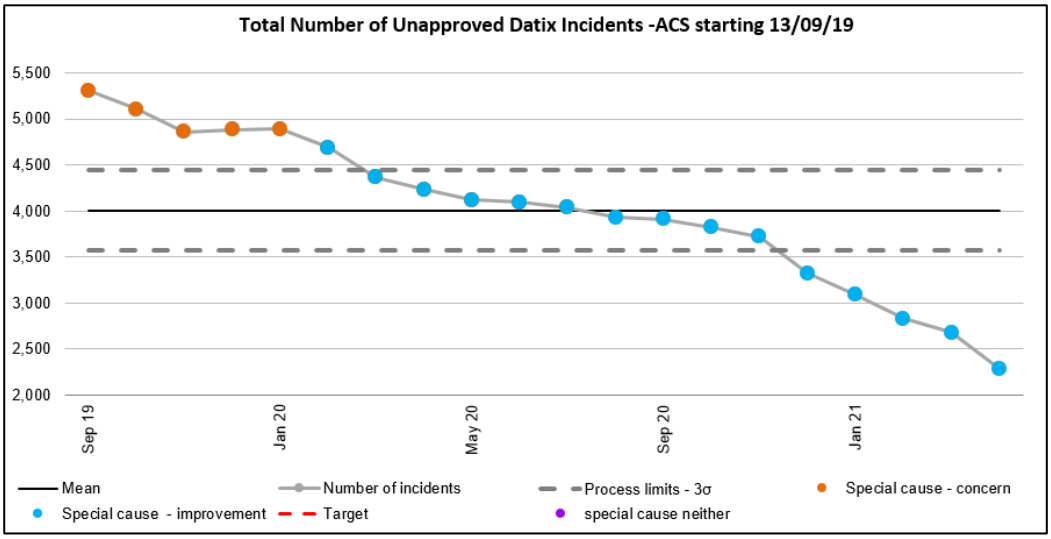


Figure 9.4 - Total Number of Unapproved Datix Incidents – ACS



2.13 Early Alerts Submitted by the Southern Health and Social Care Trust

Between 1st January 2023 and 31st March 2023, there were 33 (8 of which are in relation to GP OOH) Early Alerts submitted to the DoH. Of these Early Alerts, 19 were new alerts; 14 were updates on previously submitted Early Alerts. A breakdown of the new Early Alerts is provided below in Table 16.

Table 16: Early Alerts Submitted by the Southern Health and Social Care Trust

Type of Early Alert	Number of New Early Alerts
GP OOH	8
Staffing/Operational Pressures	4
Issues with Cytology screening	1
Litigation Activity	1
Maternity related incident	1
MHD Incident in the Community	1
Safeguarding Incident	1
Staff altercation	1
Incorrect advice re orthopaedic product	1

3.0. Service User Formal Complaints

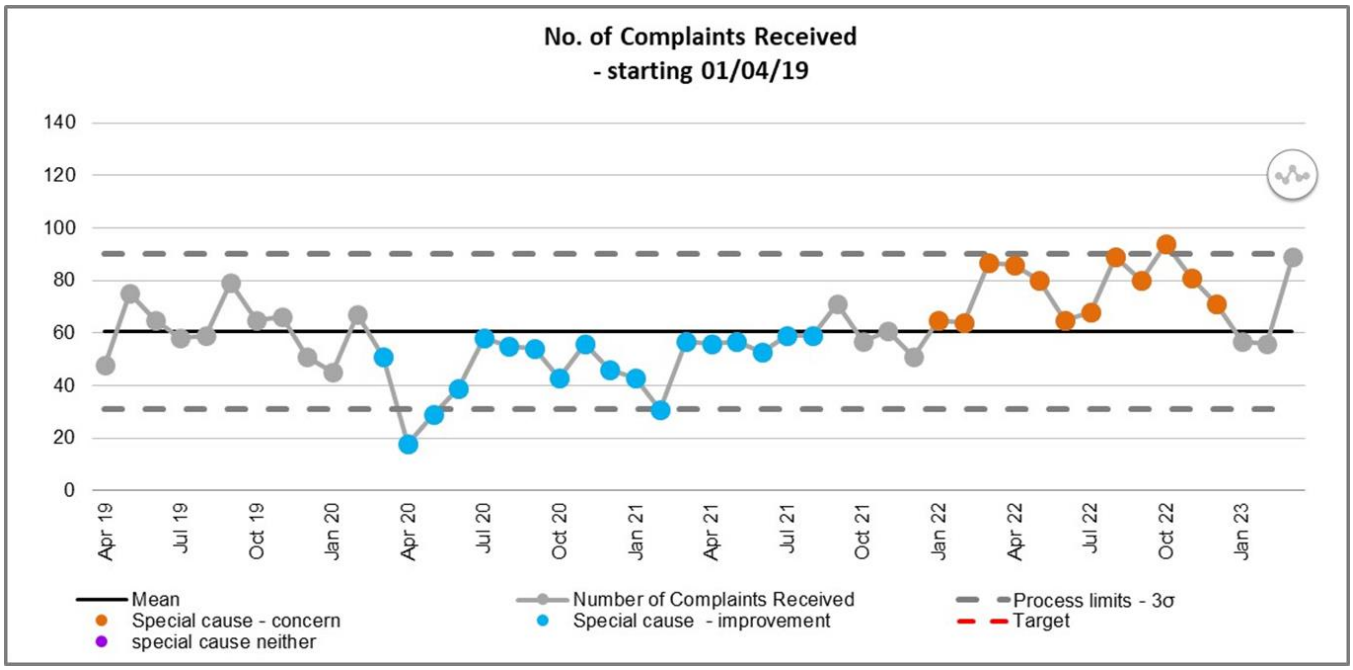
3.1 Complaints received

Regionally complaints are categorised and reported by the subject within the complaint. One complaint letter may have multiple complaints subjects.

In this reporting period **204 complaints** were received, **18% decrease** on the Oct - Dec 22 reporting period and a **15% decrease** (37 less complaints) on the same reporting quarter for 2022.

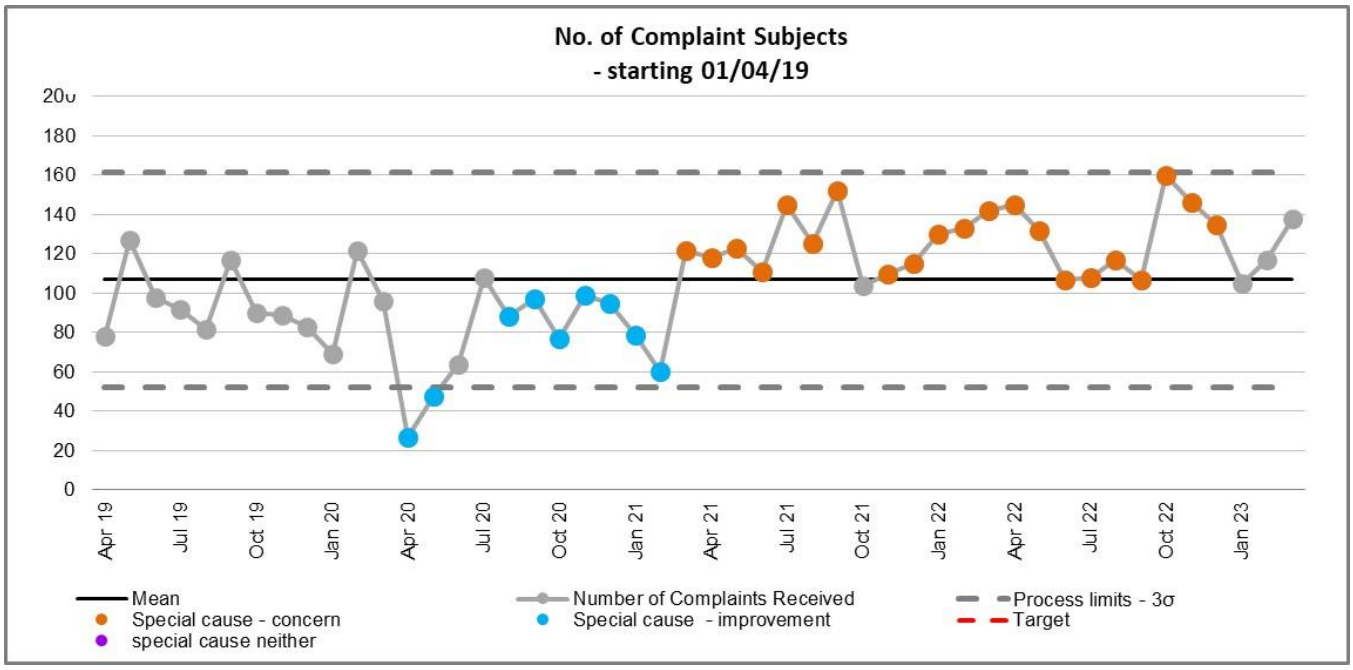
The data illustrated in Figure 10 below for this period shows a continual decrease from the previous reporting quarter, in the number of complaints received in January and February 23. This reduction in the number of complaints fell below the mean in January and February 23. Although there has been an increase in the number of complaints received in March 23, the figure remains within normal variation. Within this reporting quarter, the majority of the complaints were shared between MUSC, SCS, CYP and MHD.

Figure 10.0 Number of Complaints



Of the 204 complaints received, **360 complaint subjects** were identified, **a decrease of 18%** compared to the previous reporting quarter. The number of complaint subjects has continued to fall from October 22 where there was a significant increase, the figures for this reporting period have returned to within normal variation. Up to this point, the average number of subjects within complaints had remained at a higher level from November 21 as noted in the previous report.

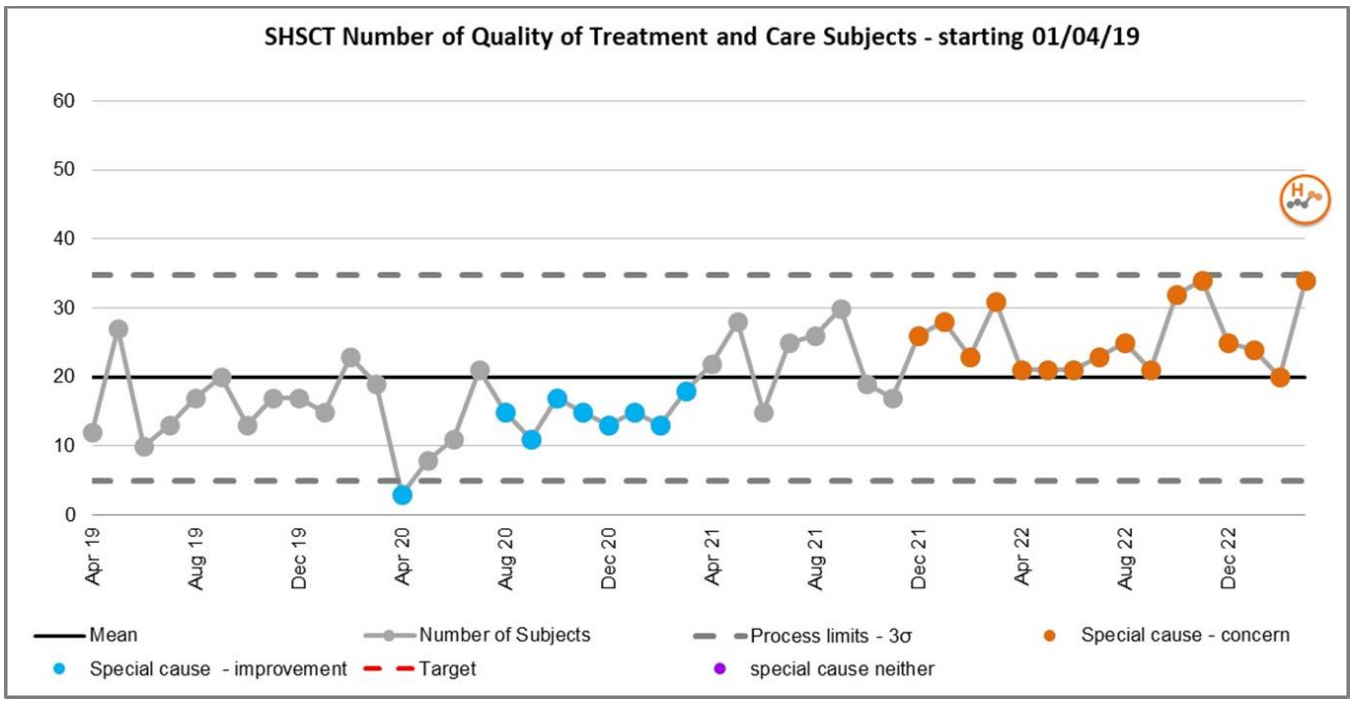
Figure 11.0 Number of Complaint subject levels



3.2 Complaint Subjects

SPC Charts have been produced to display the data since April 2019 for the Top 10 Complaints.

Figure 12.1 – Quality of Treatment and Care



From December 2021 there has been 16 sequential points above the MEAN indicating a statistical change. Within this reporting quarter, there has been an increase in complaints subjected to Quality of Treatment and Care within the CYP and ACS Directorates attributed to packages of care following new discharge arrangements and increase in complaints within Domiciliary Care following recent strike action.

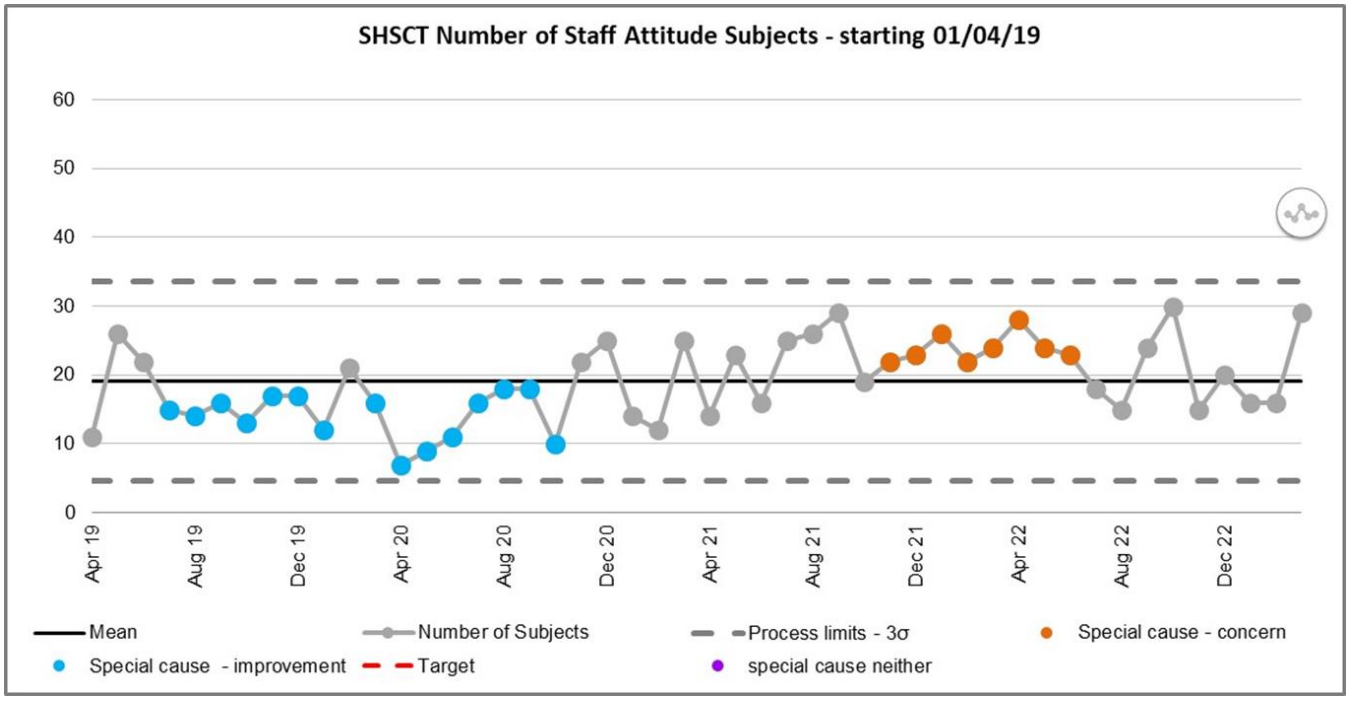
MUSC/SCS Directorates

Complaints subjected to Quality of Treatment and Care decreased within MUSC/SCS, however the volume received did account for 13% of the overall complaint subjects, the majority of all the Directorates.

CYPS Directorate

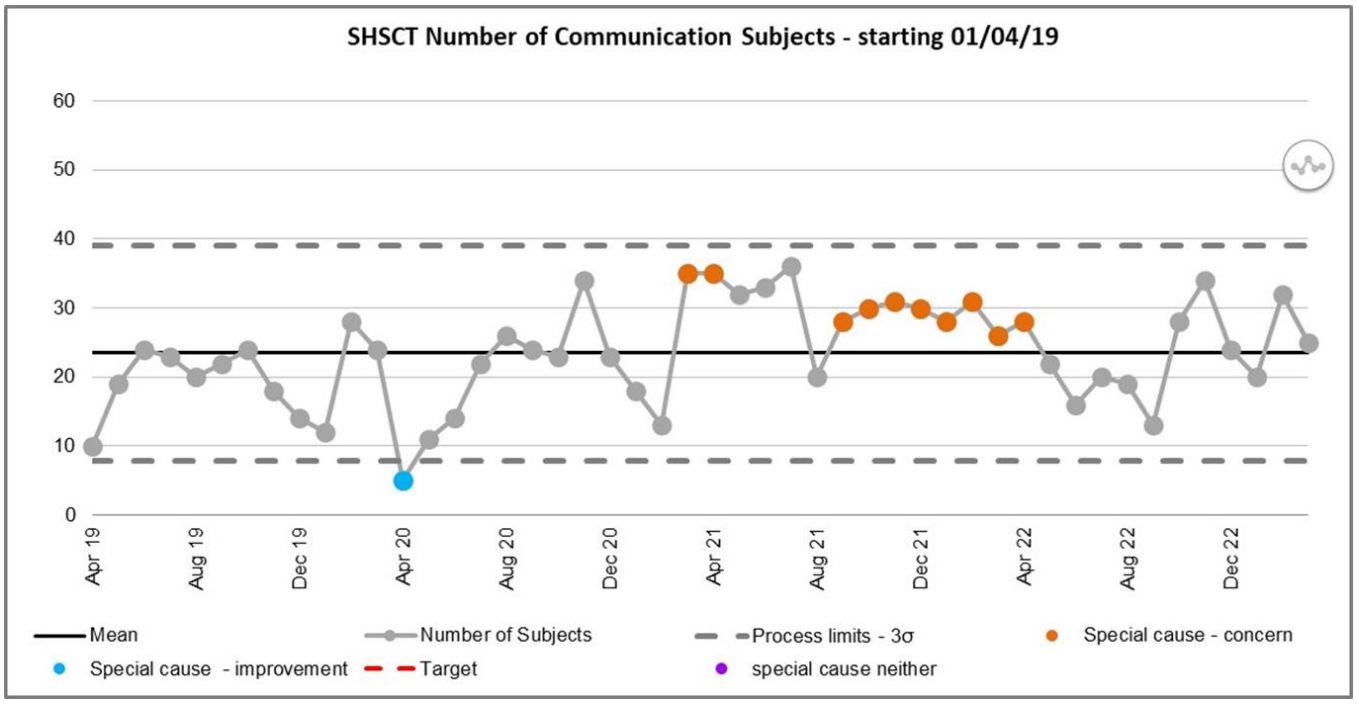
Quality of Treatment and Care continues to be the most frequent cause for the complaint within the CYP Directorate, this reporting quarter being within Specialist Child Health and Disability.

Figure 12.2 – Staff Attitude



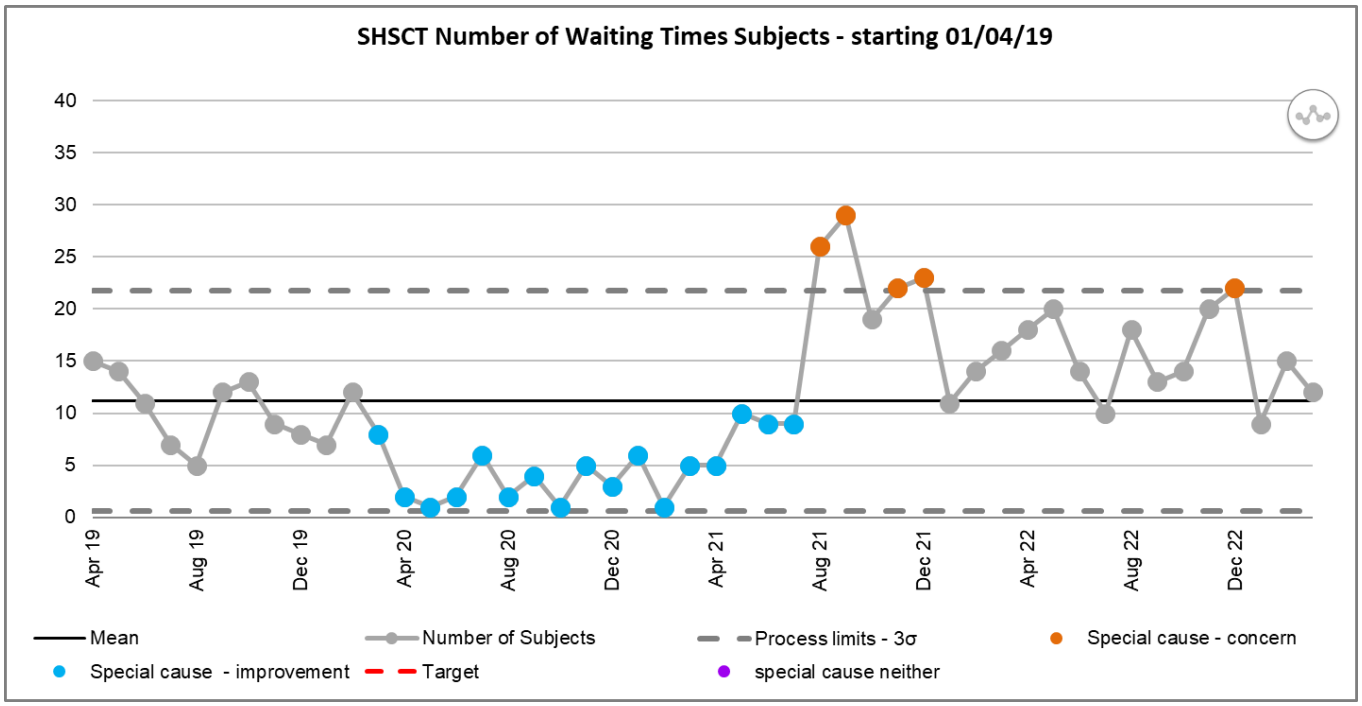
Complaints subjected as Staff Attitude remains within a normal variation this quarter.

Figure 12.3 – Communication



Complaints subjected as Communication has remained within a normal variation this quarter. The majority of complaints subjected to Communication referred to lack of information provided by Nursing and Medical staff in relation to care and diagnosis within Medicine and Unscheduled Care.

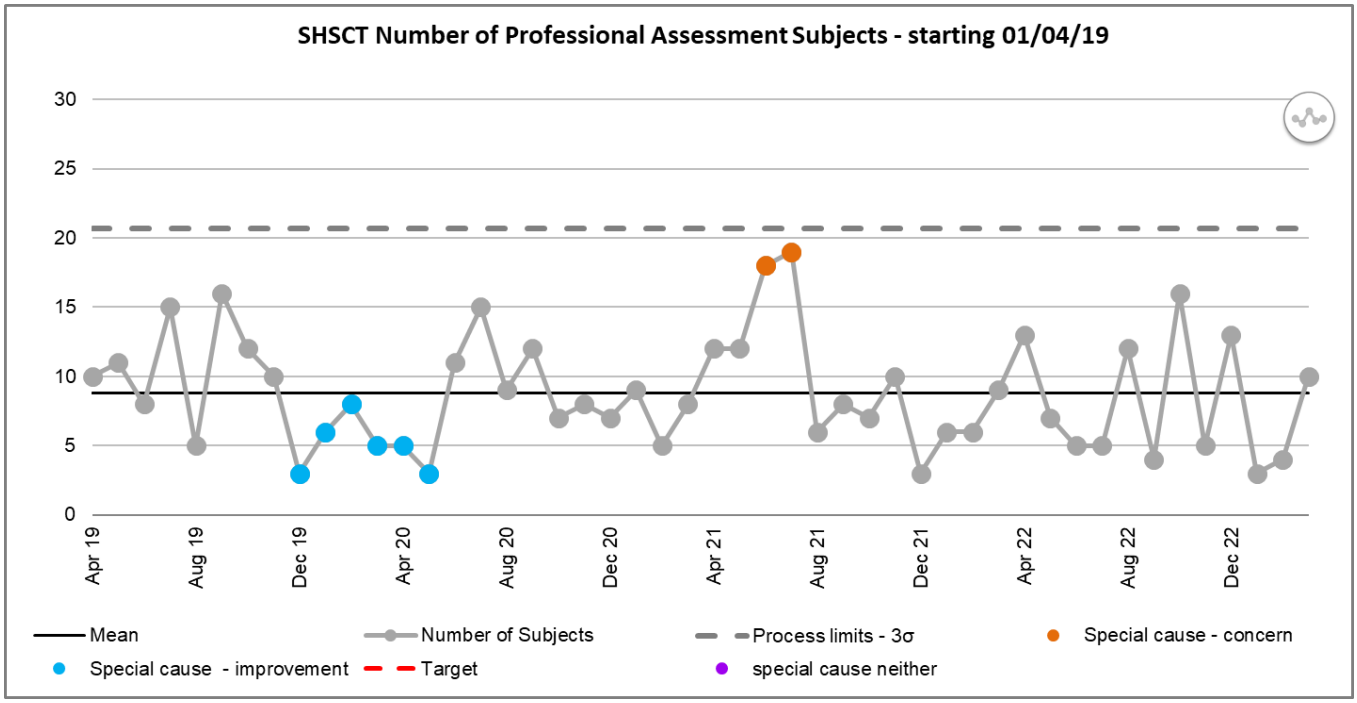
Figure 12.4 Waiting Times/Lists[11]



Complaints subjected as Waiting Times/Lists decreased from the previous reporting quarter and remained within normal variation.

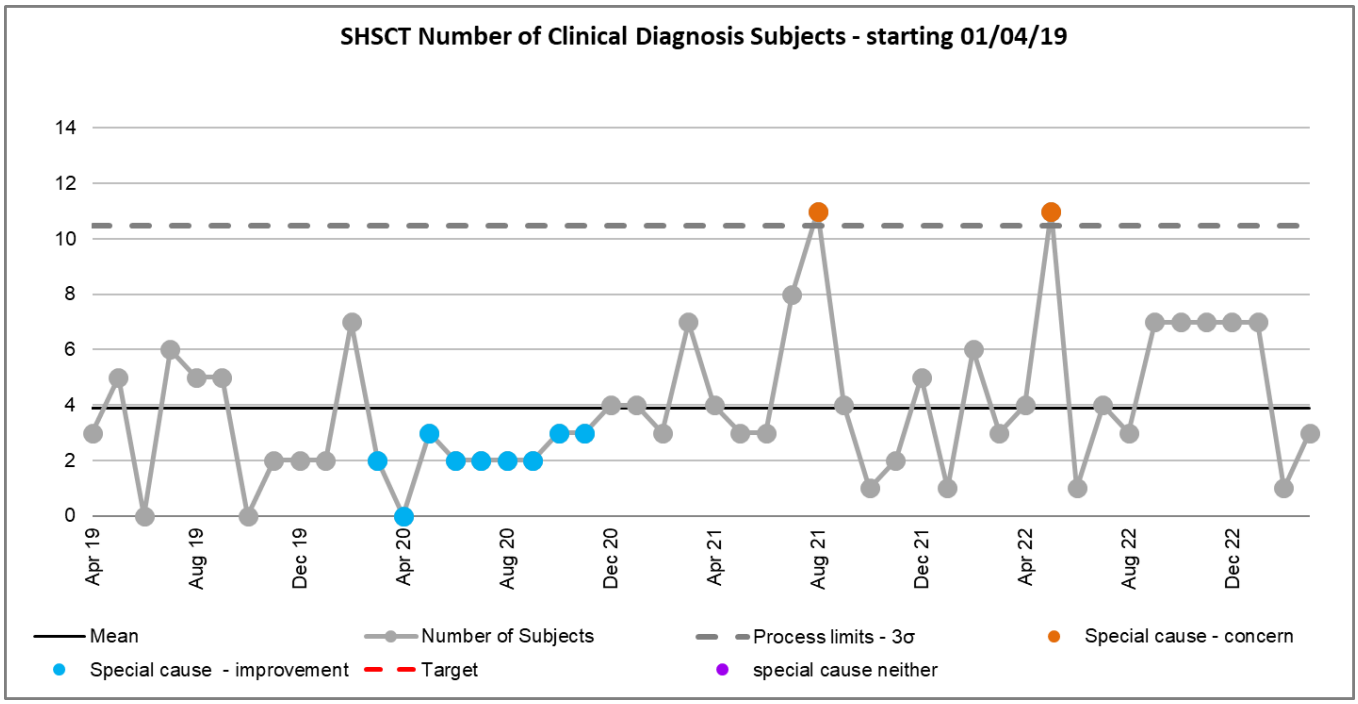
[11] Waiting Times in ED and in relation to Cancer Access Standards are collated by the Informatics team. This data was obtained by the Corporate CSCG team and developed to display in SPC charts which can be viewed in Appendix D and E.

Figure 12.5 Professional Assessment of Need



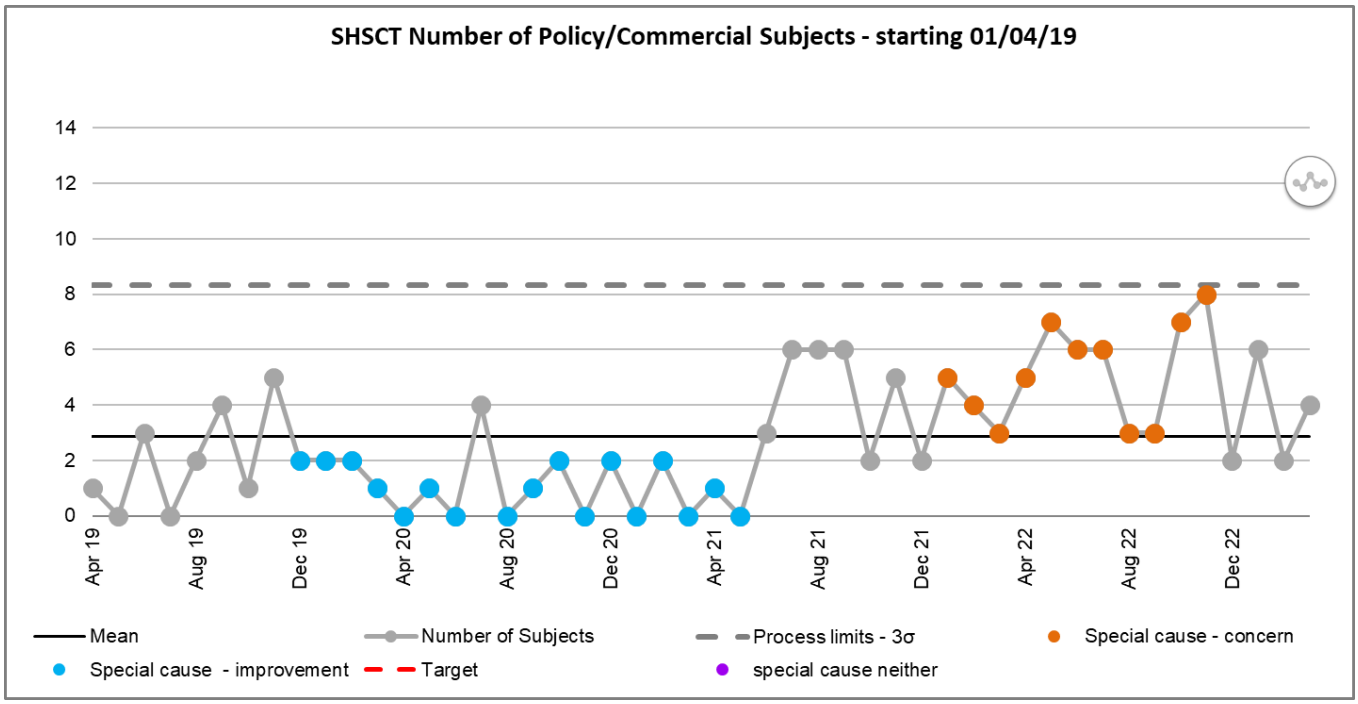
Complaints subjected as Professional Assessment of Need decreased this reporting quarter, remaining within a normal variation.

Figure 12.6 Clinical Diagnosis



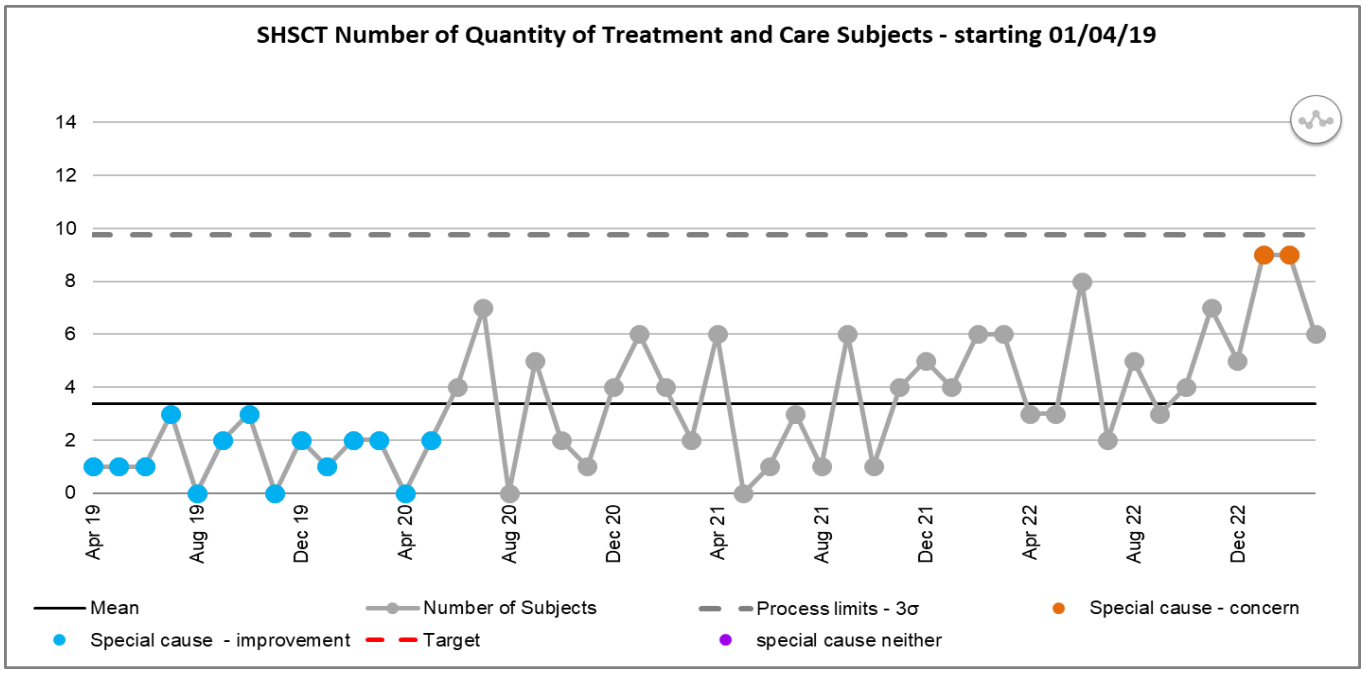
Complaints subjected Clinical Diagnosis reduced this quarter, remain within a normal variation.

Figure 12.7 Policy Commercial Decisions



Complaints for Policy Commercial Decisions returned to within normal variation.

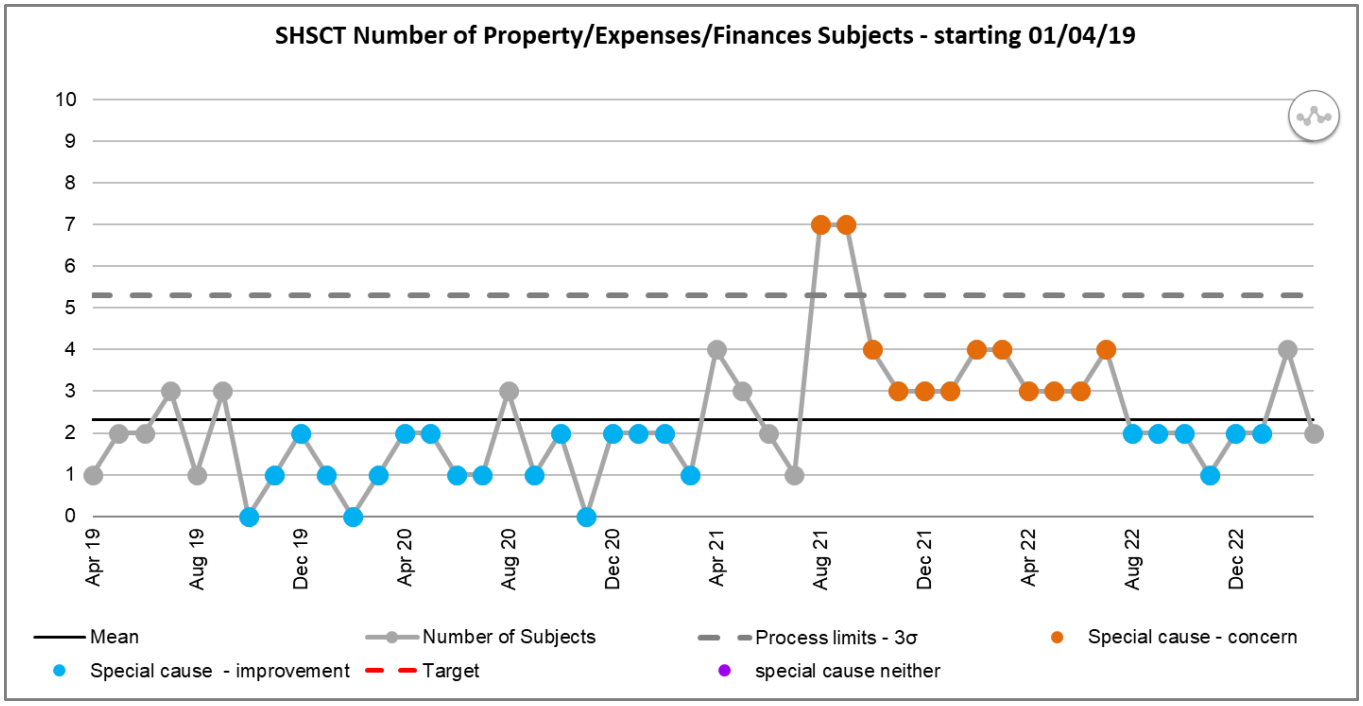
Figure 12.8 Quantity of Treatment and Care



In this reporting period, complaints subjected as Quantity of Treatment and Care identified two points which although have remained below the upper limit, have special

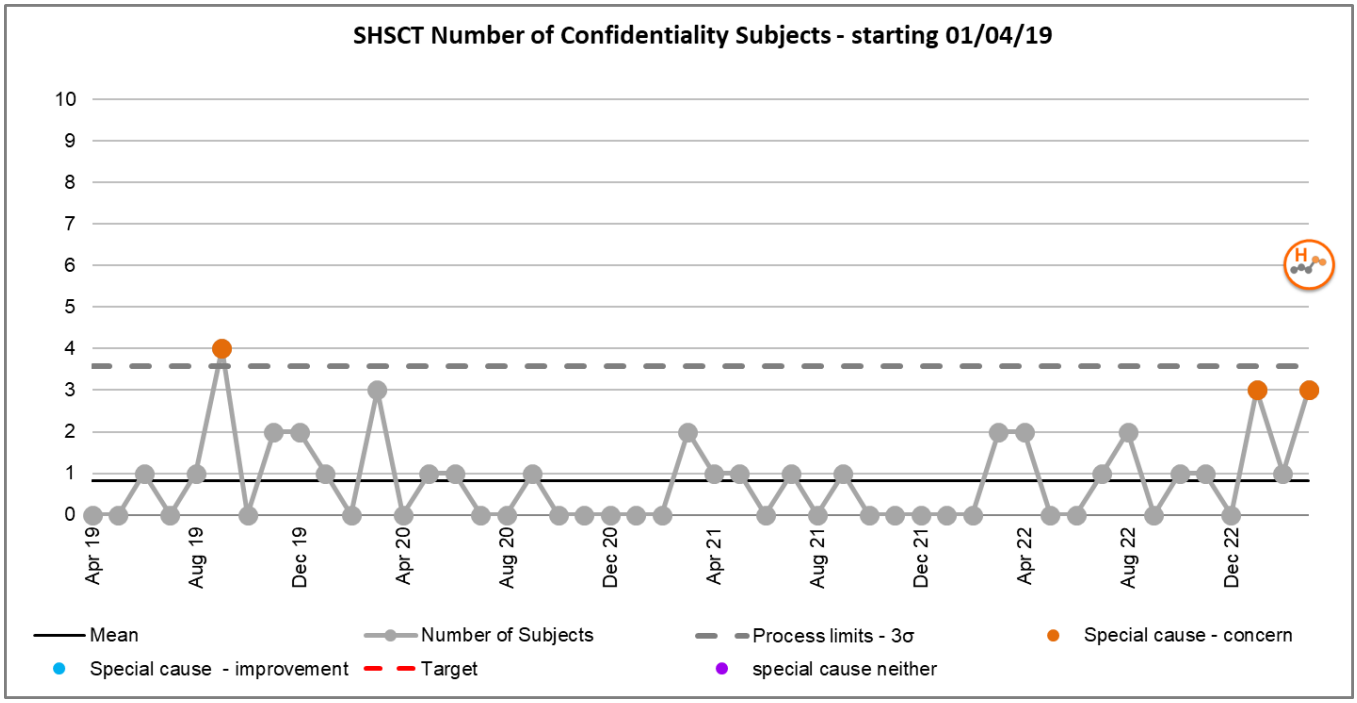
cause concern. Complaints subjected to Quantity of Treatment and Care reached its highest levels since 2019 for January (n=9) and February (n=9), this figure fell again within normal range in March 23 (n=6).

Figure 12.9 Property/Expenses/Finances



Complaints subjected to Property/Expenses/Finances have remained within normal variation, an increase in February 23 ended the special cause improvement which had been identified for the previous 6 points.

Figure 12.10 confidentiality



Complaints subjected as Confidentiality have remained relatively low, however, in this reporting period figures peaked for the first time since March 2020 with 3 complaints subjected to Confidentially recorded in both January and March. All complaints subjected to Confidentiality fell within the MUSC/SCS Directorates.

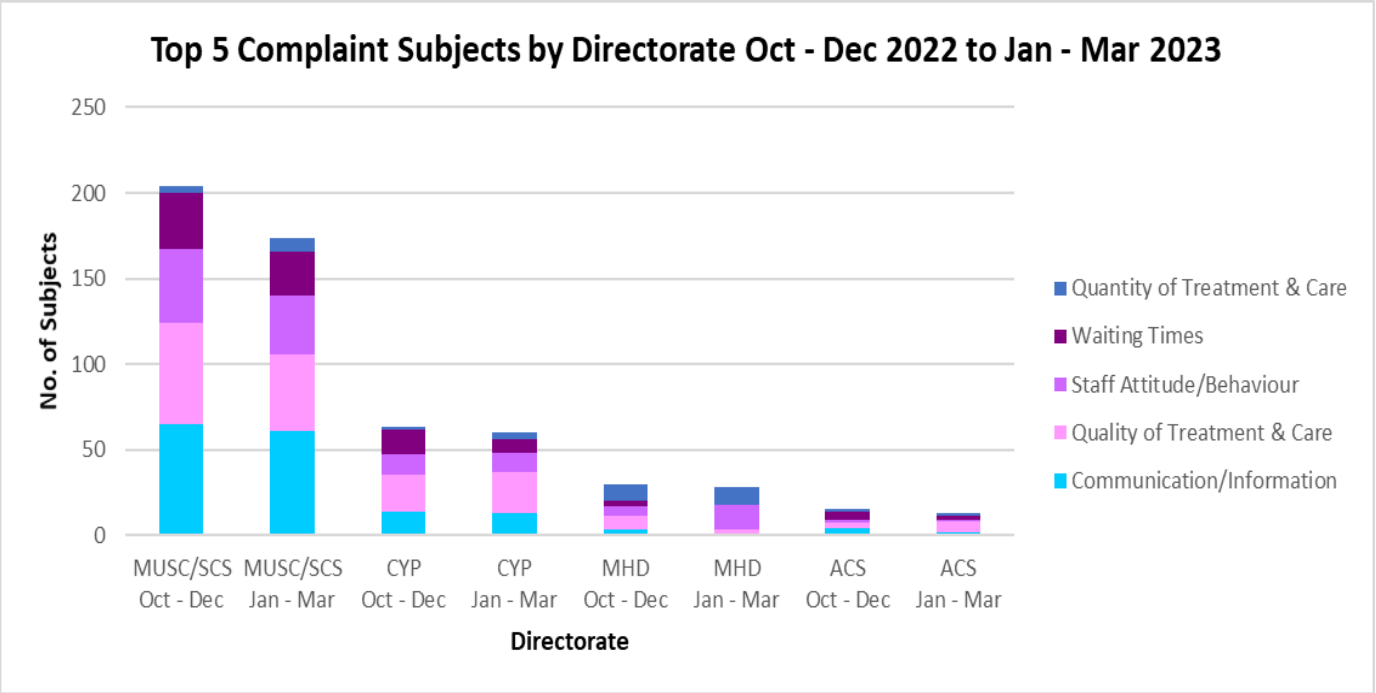
The following table details the percentage share for the top 10 complaint subjects, for the period Jan – Mar 2023, and how this compares with previous quarters (Table 18.0).

This quarter, Quality of Treatment and Care (n=78) was the highest complaint subject (21.67% of the 360 subjects), 35% of which came from within the MUSC/SCS Directorate, followed by 19% within CYPS.

	Percentage Share of Total Complaints							
Complaint Subject	Apr-Jun 21	Jul - Sep 2021	Oct - Dec 2021	Jan - Mar 2022	Apr - Jun 2022	Jul - Sep 2022	Oct - Dec 2022	Jan - Mar 2023
Quality of Treatment & Care	18.47%	19.19%	18.84%	20.25%	16.15%	20.78%	20.63%	21.67%
Communication/Information	28.41%	19.91%	28.57%	20.99%	17.19%	15.66%	19.50%	21.39%
Staff Attitude/Behaviour	15.06%	18.96%	19.45%	17.78%	19.53%	17.17%	14.74%	16.94%
Waiting Lists/Times	6.82%	9.00%	7.29%	10.12%	13.54%	12.35%	12.70%	10.00%
Quantity of Treatment & Care	2.84%	1.90%	3.04%	3.95%	3.65%	3.01%	3.63%	6.67%
Professional Assessment of Need	11.93%	7.82%	6.08%	5.19%	6.51%	6.33%	7.71%	4.72%
Policy/Commercial Decisions	1.14%	4.27%	2.74%	2.96%	4.69%	3.61%	3.85%	3.33%
Clinical Diagnosis	2.84%	5.45%	2.43%	2.47%	4.17%	4.22%	4.76%	3.06%
Property & Expenses	3.00%	3.00%	3.00%	2.00%	2.00%	2.00%	2.00%	2.22%
Confidentiality	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	2.00%	1.94%

The top 5 subject areas, with a comparison to the previous quarter, broken down within each Operational Directorate can be viewed in Figure 13 below.

Figure 13: Top 5 Complaint Subjects by Operational Directorate.

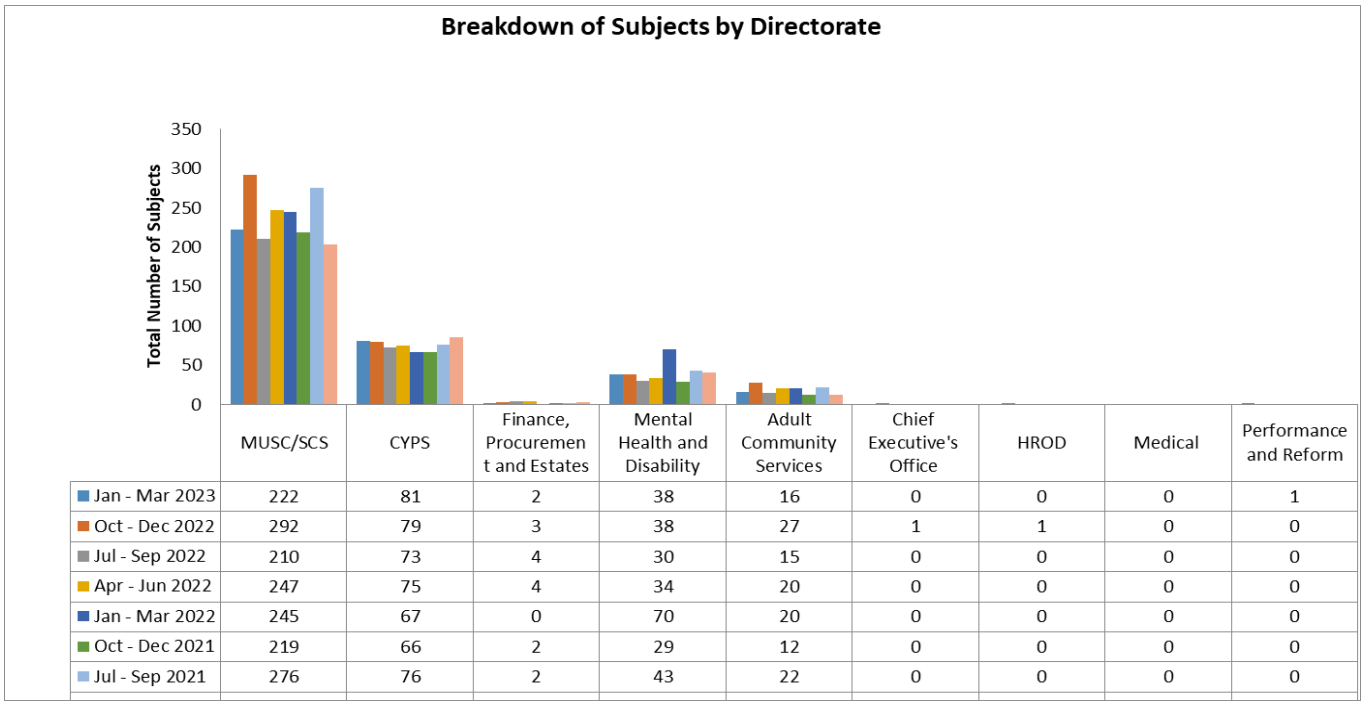


3.3 Complaints % by Directorate[12]

The total number of Complaint Subjects received by Directorate from quarter ended June 2021 to quarter ended March 2023 can be viewed in Figure 14.

[12] A breakdown by Division is available through the relevant Directorate Governance Team

Figure 14: Breakdown of Subjects by Directorate*



	MUSC/SCS	CYPS	Finance, Procurement and Estates	Mental Health and Disability	Adult Community Services	Chief Executive's Office	HROD	Medical	Performance and Reform
Jan - Mar 2023	222	81	2	38	16	0	0	0	1
Oct - Dec 2022	292	79	3	38	27	1	1	0	0
Jul - Sep 2022	210	73	4	30	15	0	0	0	0
Apr - Jun 2022	247	75	4	34	20	0	0	0	0
Jan - Mar 2022	245	67	0	70	20	0	0	0	0
Oct - Dec 2021	219	66	2	29	12	0	0	0	0
Jul - Sep 2021	276	76	2	43	22	0	0	0	0

*No complaints were received for this Quarter via the Chief Executive Office, HROD or the Medical Directorate

Word cloud illustrating words used and most common themes found within complaints for this quarter (Jan – Mar 23):

3.4 Complaint Response

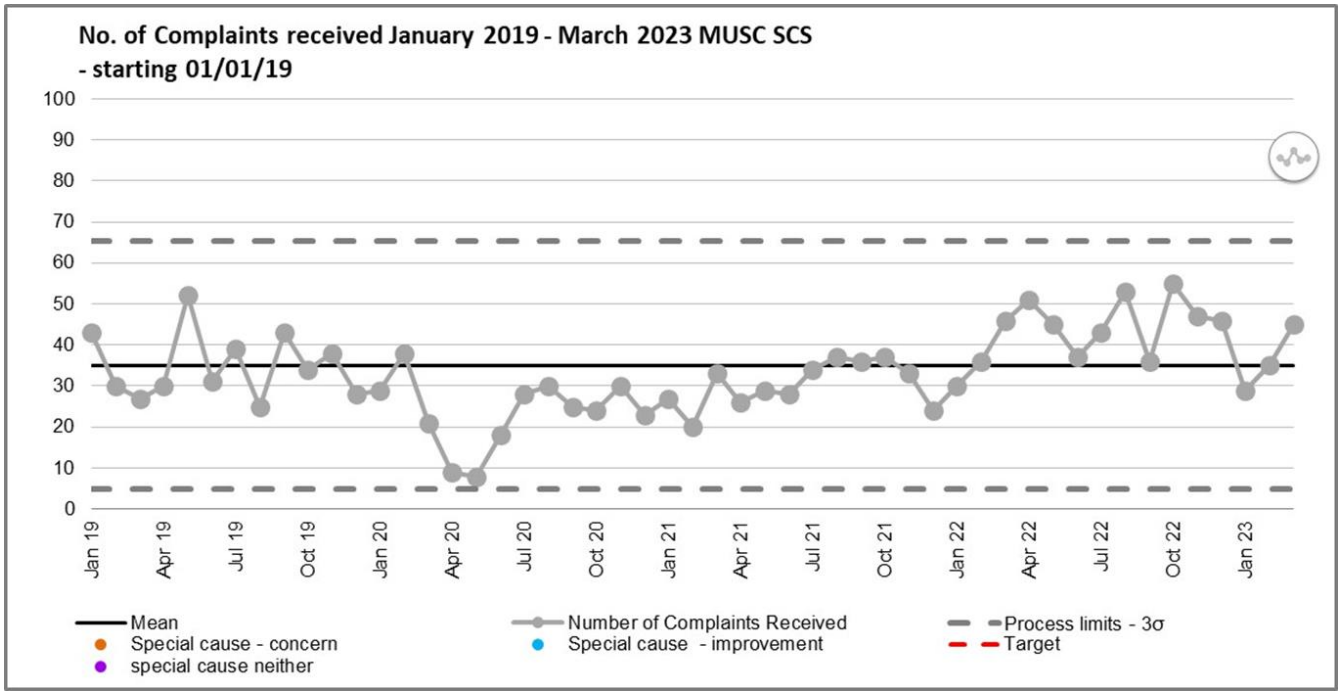
The regional complaints procedure sets out standards in respect to acknowledgement and response times to formal complaints. Each complaint should be acknowledged within 2

working days and each complaint should be responded to within 20 working days.

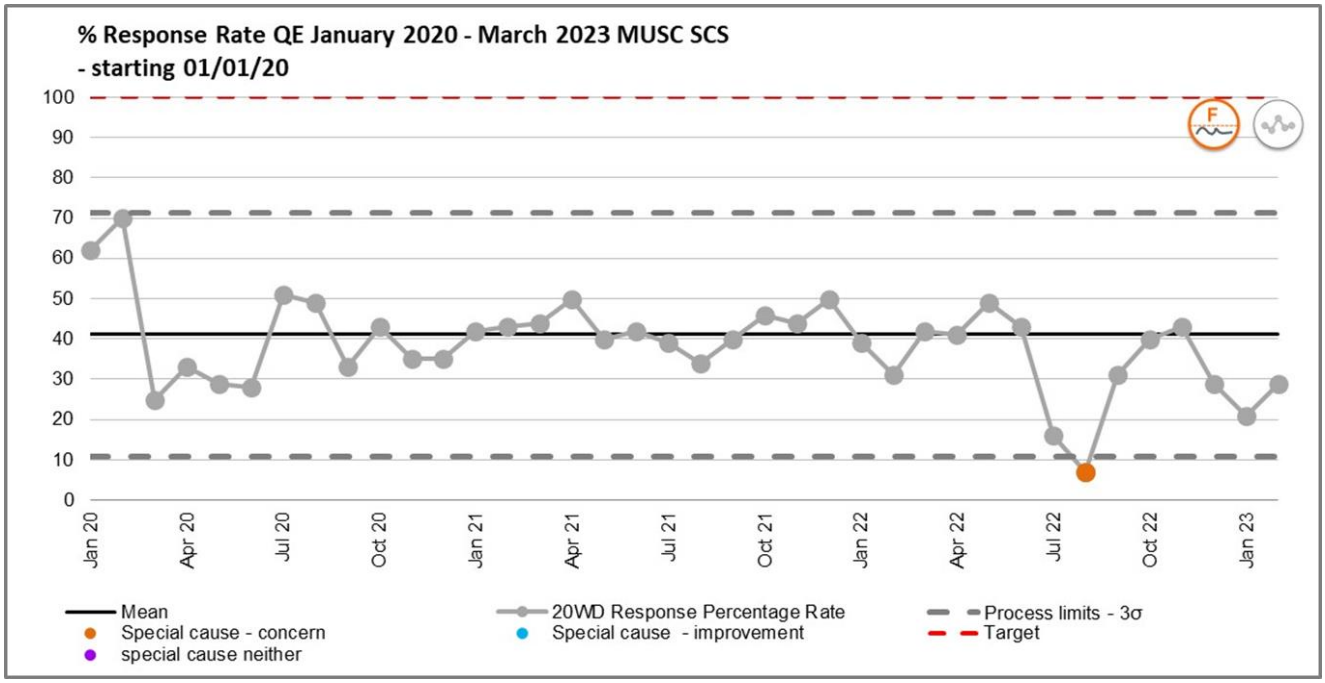
The information in the following charts (collectively **figure 15**) details the number of complaints by Operational Directorate, and 20 working day response rates. Please note in previous quarters this data was presented by quarter, to allow for more data points this data has been re-run and broken down by months[13].

Within this quarter, there was a timely response to the majority of complaints, however, no Operational Directorate was able to respond to all complaints within 20 working days. In some cases this was due to the complexity of the complaint, where issues fall across more than one Directorate, or staff availability due to annual leave and/or service pressures.

MUSC/SCS Directorate Complaints and Response Times



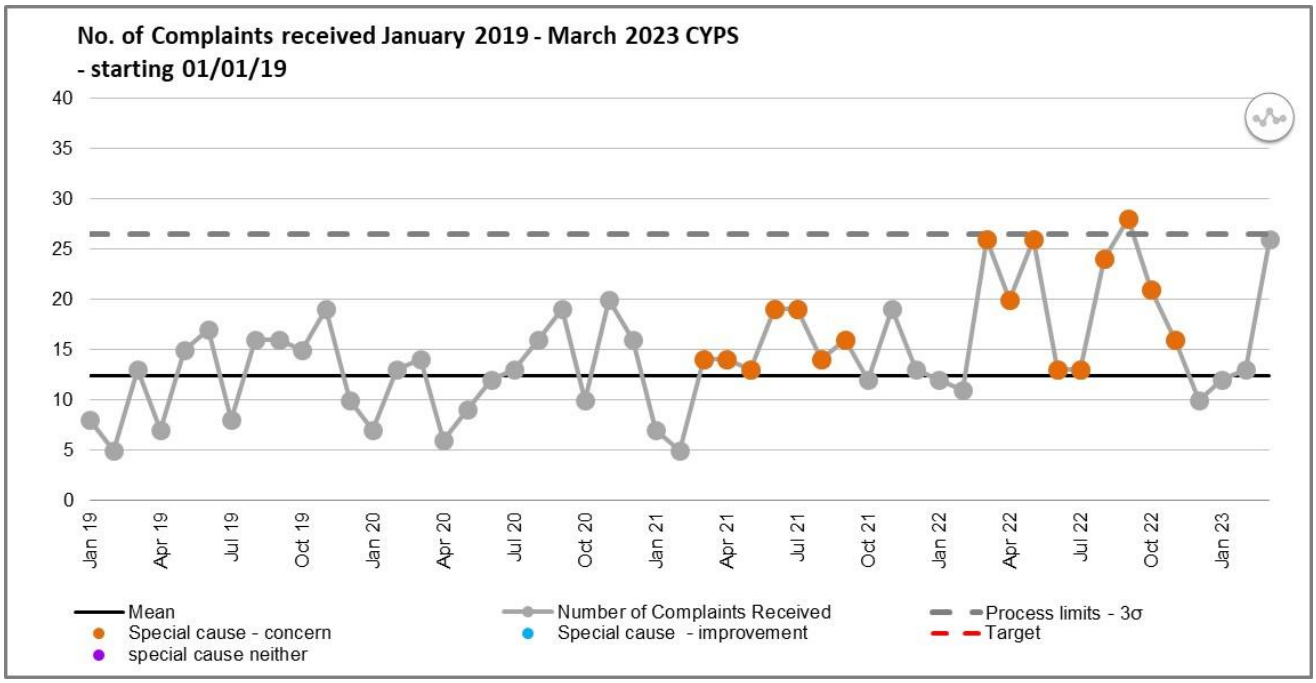
[13] The 20 Working Day response times and number of complaints received are created using P charts. The P chart displays an Upper control Limit (UCL/target) which correlates to the number of complaints received e.g. low number of complaints received, higher likelihood of achieving compliance, which would reach the upper control limit (100%).

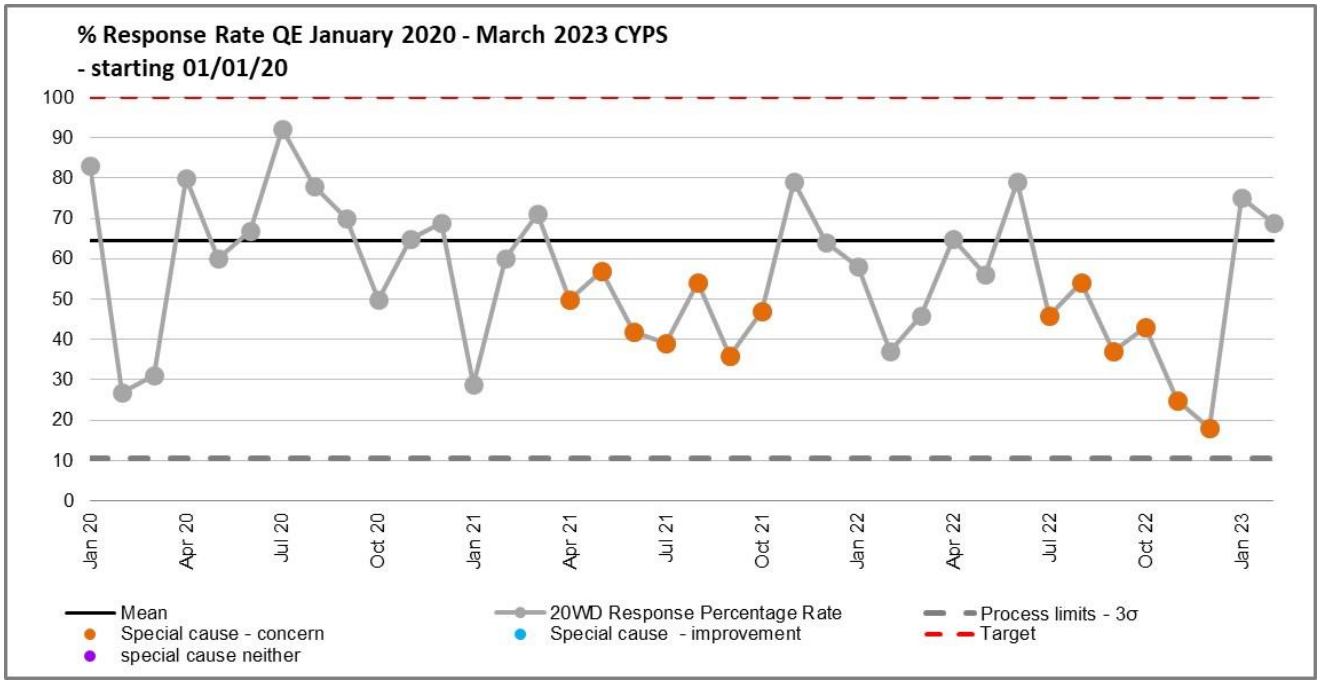


MUSC/SCS Directorate

The number of complaints and response times remain within a normal variation for this reporting period.

CYPS Directorate Complaints and Response Times

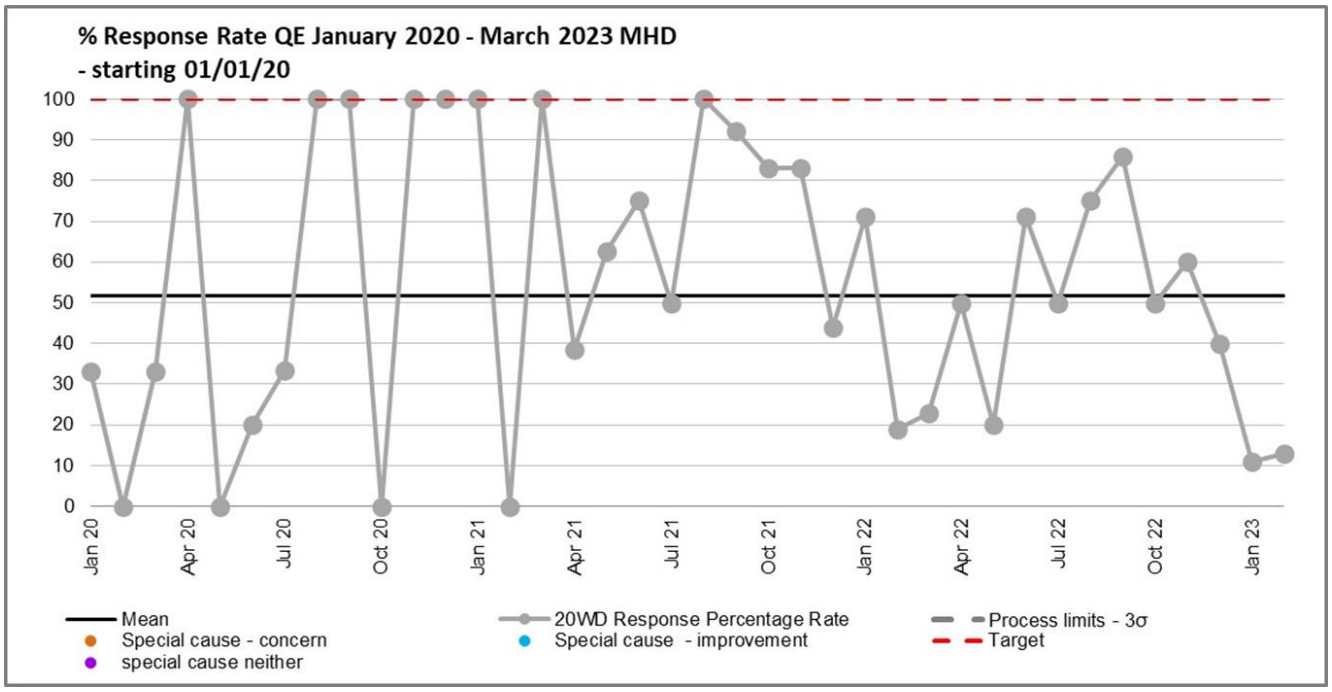


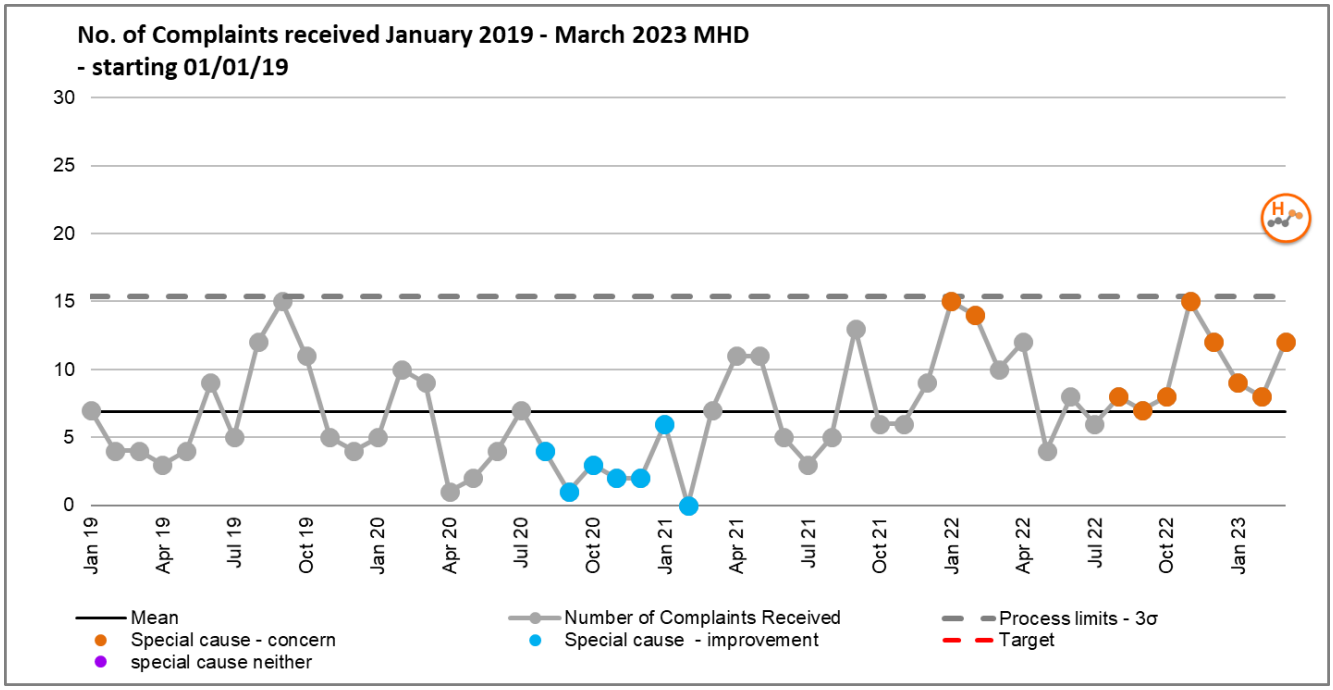


CYP Directorate

The number of complaints received for this reporting period remain within normal variation.

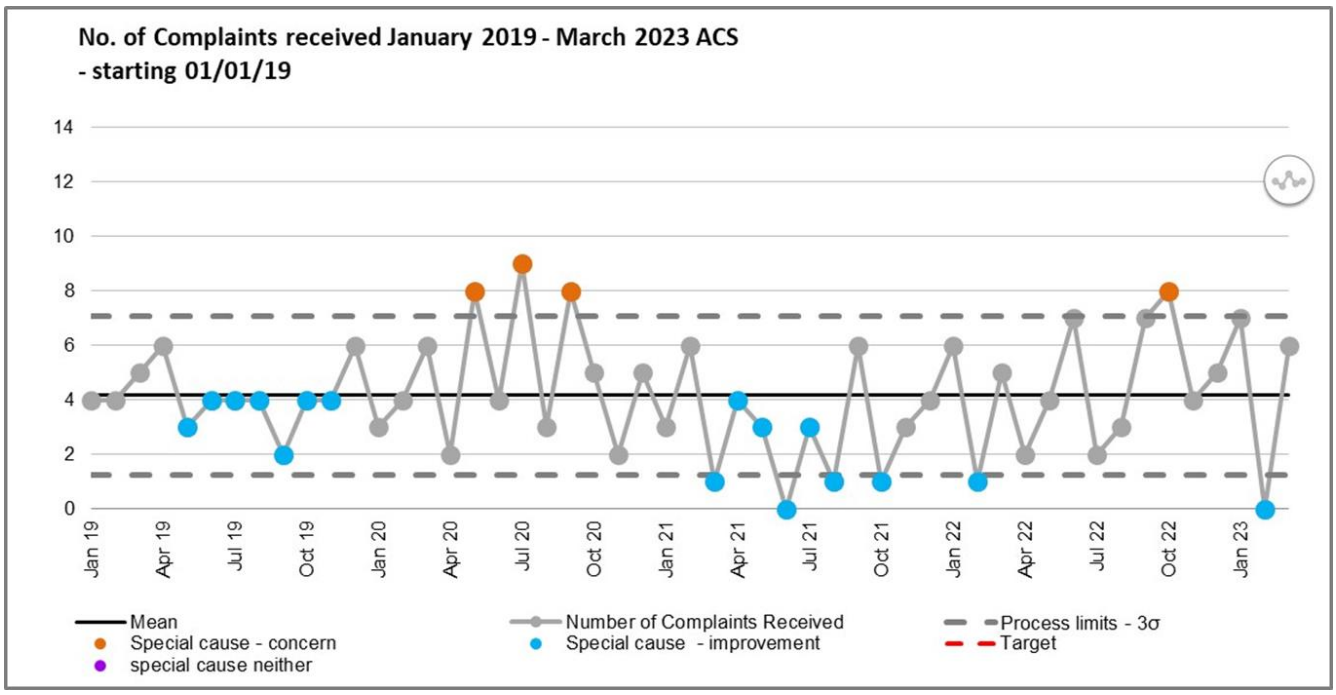
MHD Directorate Complaints and Response Times[14]

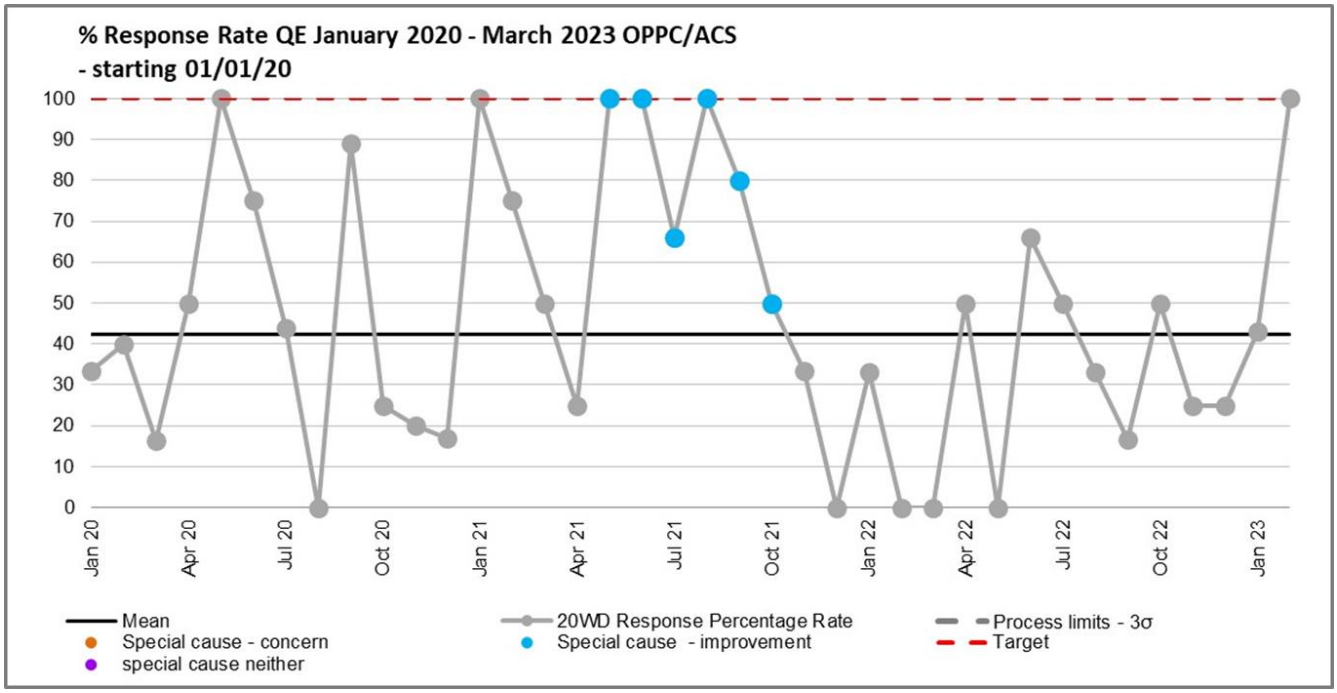




There have been 8 sequential points above the mean from August 2023, highlighting special cause concerns and suggesting a change in process. The majority of complaints received within MHD within this reporting period are subjected to Staff Attitude & Behavior and Quantity of Treatment and Care.

ACS Directorate Complaints and Response Times





Within this reporting quarter, there were (n=0) complaints received in to ACS for the month of February 23. January and March 23 are within normal variation.

3.5 Nursing/Residential Homes and Supported Living Providers

The HSC Complaints Procedure stipulates that these providers must:

1. Manage complaints in line with best practice guidance and keep a full list of complaints and action taken, including learning from the outcome. A complaints register must be available for inspection by the Trust and those working on the Trust's behalf.

2. Submit a record of complaints to the Trust no later than 10 working days after the end of each Quarter for complaints closed in that period. This includes a Nil return if appropriate. The quarterly report should be sent electronically to the Trust.

3. Notify immediately the nominated Trust Corporate Governance Office any complaints of a serious nature, including those associated with alleged abuse, contraventions of employment legislation, accidents resulting in personal injury to staff or residents, or theft. Notification in writing must also be completed within one Working Day of the complaint being received.

In this quarter, 26 homes within the SHSCT area provided a response regarding complaints closed between January and March 2023. Of these 26, 12 homes had not closed any complaints and 14 submitted a record of the complaints closed.

During this same timeframe (Jan 23 – March 23), 5 responses were received from homes that sit outside of the SHSCT catchment area but care for SHSCT service users, 3 of which submitted a nil response and 2 submitted a record of the complaints closed.

3.6 Informal/Enquiries and Local Resolution

The Trust received a number of informal complaints and/or enquiries as detailed in Table 18.0 below.

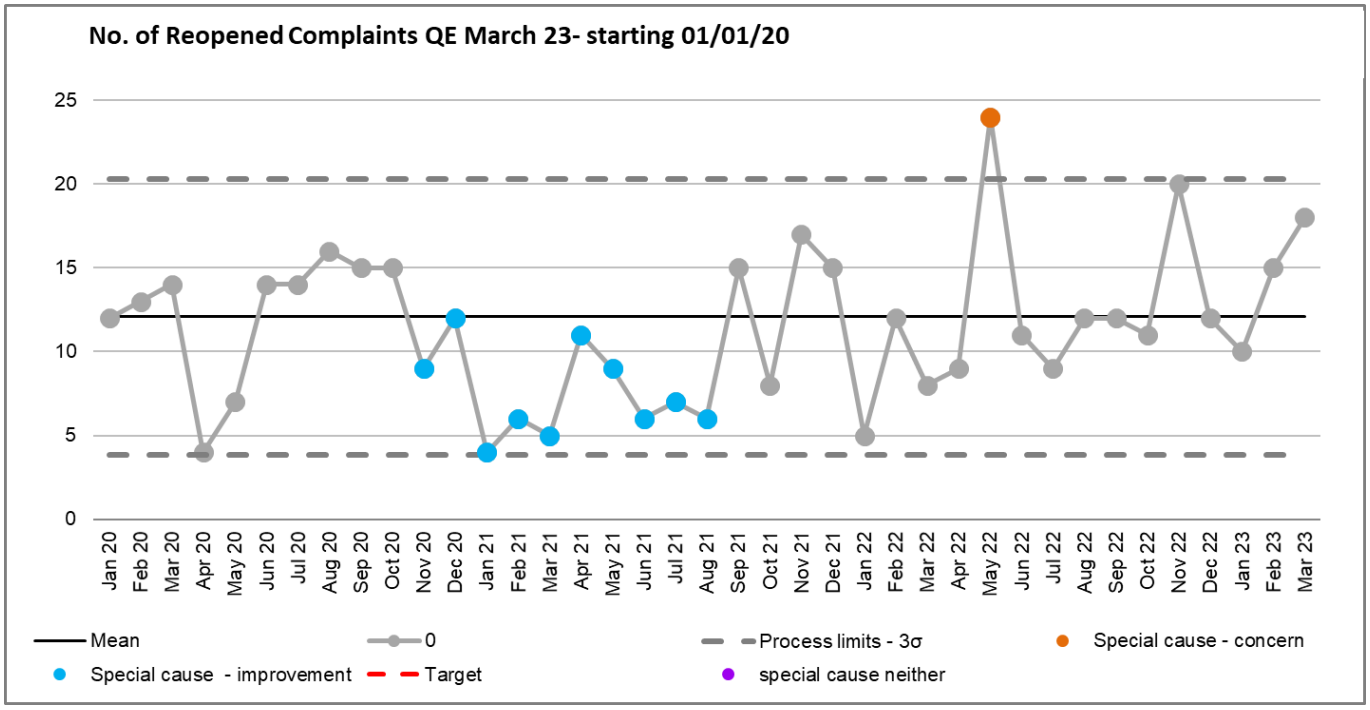
Table 18: Informal complaints/Enquiries received into the Trust since January 2021

Resolution Stage / Method	Jan - Mar 2021	Apr - Jun 2021	Jul - Sept 2021	Oct - Dec 2021	Jan - Mar 2022	Jul - Sept 2022	Apr - Jun 2022	Oct - Dec 2022	Jan - Mar 2023
Enquiry	104	119	129	127	117	134	134	134	128
Informal HSC Complaint	46	61	50	66	66	89	81	100	103
Resolved at Point of Service Delivery	4	15	15	2	3	3	1	2	12
Redirected	4	2	3	3	11	12	16	7	6
COVID 19 Enquiry	28	5	17	3	11	1	1	0	0
Totals	186	220	214	201	208	239	233	243	249

3.7 Complaints – Re-opened

In this quarter, January – March 2023, 43 complaints were re-opened as the complainant remained dissatisfied with the initial investigation and outcome. The number of re-opened complaints this quarter remain within a normal variation. No common themes were identified as the reopened complaints contained varied subjects across a number of Divisions. Figure 15 below, shows the number of re-opened complaints since January 2020.

Figure 15.0



The number of re-opened complaints this quarter stayed within a normal variation.

3.8 Complaints - Response Audit

In previous quarters, the Service User Feedback team undertook an audit of 25% of all complaint responses using the 'Checklist for Preparing Draft Responses to Complaints'. To strengthen the Trusts oversight of Complaint Responses a revised audit programme is being developed to incorporate aspects of the revised Service User Feedback Policy and Procedures.

For this reporting period the Service User feedback Tem undertook an audit of 50% of responses issued. There were 92 formal complaint responses issued and of the responses audited, 3 had experienced bereavement, the Trust included condolences in the 3 response letters. All responses provided a short summary of the issues raised and a meeting to discuss the outcome of the complaint investigation was offered to all of the complainants where applicable. Of the 46 complaint responses audited, 10 were responded to outside of the 20 working days, holding letters were not issued for 2.

The Service User Feedback (SUF) team undertook an audit of all complaints/enquiries received via the SUF office. Findings for this reporting quarter have been broken down by month, initially for formal complaints received and then enquiry/informal complaints received.

Month	Number of records audited	Number uploaded onto Datix	Considered for Formal Review	Formal Review undertaken	Awaiting Consent	Re-graded-informal Review undertaken	Re-graded-Enquiry	Redirected to another Trust	Re-graded as Urology Enquiry	Resolved at Point of Service
January 2023	125	109	82	52(21 not risk graded)	6	14	3	1	1	0
February 2023	115	101	75	51(16 not risk graded)	7	11	0	0	0	0
March 2023	159	137	94	62(17 not risk graded)	11	15	1	0	0	0

Month	Considered as Enquiry/Informal Review	Enquiry/Informal Review Undertaken	Upgraded to Formal Review	Awaiting Consent	Resolved at Point of Service	Re-graded as Urology Enquiry
January 2023	43	30	12	0	1	0
February 2023	40	34	6	0	0	0
March 2023	65	41	10	14	0	0

Internal Audit

Work on the recommendations from the BSO Internal Audit of the Trust's Management of Complaints process is progressing within associated timescales for completion, most of which have been revised and accepted.

Internal Audit have accepted there was sufficient evidence to classify 13 of the audit recommendations as now being fully implemented. The implementation date for 3 partially implemented recommendations have been amended to 30/06/2023 and work will continue to progress these. Of the remaining 4, 2 relate to Training, 1 relates to Datix with work progressing now that the upgrade is complete and 1 recommendation which is not implemented is a regional recommendation.

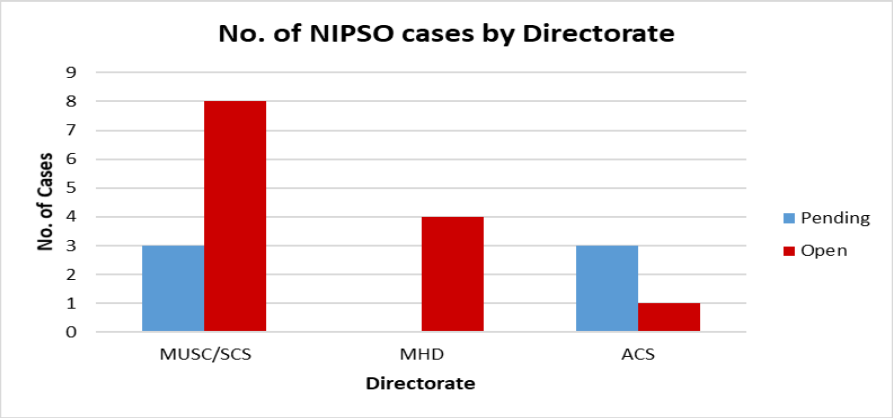
Training recommendations relate to the provision of Complaints Awareness training and the ability to collate figures for staff trained. A Service User Feedback training package has been developed and was presented to SLT for consideration to incorporate as Corporate Mandatory Training for all staff. It was agreed to pilot the training in identified service areas, obtain feedback and re-present to SLT on 9th May 2023. A further update will be provided in the next Governance Committee report.

3.9 Ombudsman Cases

In the period January – March 2023, the SHSCT received 7 requests for information from the Ombudsman's Office, 4 of these cases are currently pending, 2 case were accepted for investigation and the remaining 1 was closed at initial assessment.

At present, there are 13 open Ombudsman cases and 6 pending cases.

Figure 17.0 Breakdown of NIPSO cases across Directorates.



Of the 13 open cases, 0 draft reports have been received.

A summary of 3 completed reports for the MUSC/SCS Directorates have been included within this report, 2 reports requested an apology letter to be issued for which 1 has been completed. One report did not contain any recommendations as the case was not upheld by NIPSO. The remaining recommendations have been shared with the relevant teams involved to action and evidence implementation of the recommendations. Monthly updates on progress will be requested by the Service User Feedback team.

Recommendations received Jan – Mar 2023

SCS

Ombudsman accepted the following issue of complaint for investigation:

The complainant raised concerns about the Care and Treatment the Trust provided to their infant son on 22 and 25 September 2020 at the hospital.

Recommendations

- Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified within one month

- The findings of this report are shared with Paediatrician B in a supportive manner that encourages learning. This should be evidenced with records of information sharing and the Trust should provide this Office with an update within three months

Update on Recommendations

Recommendation 2 regarding Paediatrician B has been actioned and completed by CYP. The report has been shared with Paediatrician B in a supportive manner. The learning from the report has also be tabled at M&M Meeting in October 2022 and the Clinical Governance

Oversight meeting.

The apology letter is currently awaiting approval.

MUSC

Ombudsman accepted the following issue of complaint for investigation:

The complainant raised concerns about the care and treatment the Trust provided to the complainant's mother (the patient) following her diagnosis in September 2018.

The Ombudsman partially upheld this complaint

Recommendations

- The Trust provides to the complainant a written apology for the injustice caused as a result of the failures and maladministration identified.

- The Trust discusses the findings of the report with the staff involved in the patient's care at their next staff appraisal, and reminds them of the importance of putting in place a suitable treatment plan following diagnosis of SIADH.

- The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to address all elements of the complaint in its written response, in accordance with the DoH Complaints Procedure.

- Furthermore, the Chief Executive should remind relevant staff of the importance of making sufficient efforts to resolve complaints in a timely manner at a local level before signposting the complainant to my office.

- The Trust undertake an audit of record keeping to include a review of a random sample of records relating to the treatment of patients diagnosed with SIADH in the past three years. The Trust should ensure staff have put in place an appropriate treatment and monitoring plan for the patients within 3 months.

Update on Recommendations

Apology issued within timeframe. All other recommendations are ongoing to be completed by 15th May 2023.

3.10 Health Care Complaint Analysis Tool

The report for complaints received January - March 2023 can be found at Appendix F.

SHSCT continues to consider the usefulness of HCAT. The development of an App/HCAT Dashboard was previously demonstrated to the Patient and Client Experience Committee in December 2021 by Dr Gormley who highlighted that, as it utilises patient experiences, it has the potential to enhance the quality and safety of healthcare. The demo showed how, when complaints are coded and loaded onto the App, users can select from a huge variety

of variables, by simply clicking on them, and display visually the content of the complaints. This allows the complaints to be collated and reviewed using multiple variables including directorate, staff group, complaint subject and severity of complaint. Seeing the data in this format is much more useful and meaningful than the narrative report. The more detailed level of coding may allow better understanding of service user feedback to help drive improvement and monitor progress over time.

An example of what the App looks like, depending on the variables selected for display, is included in Appendix G.

4.0 Service User Compliments

Business Services Organisation (BSO) is the HSC organisation that hosts the compliments websites and servers, on which SHSCT compliment data is stored. BSO is now providing compliment information to HSCTs.

Compliments received into the Trust in this reporting period can be found in Table 19.0 below. Only written compliments are reported to the DOH (verbal compliments, confectionary etc. are not included) and only compliments from service users are included (compliments from staff are not included) in the figures.

There has been a **21% decrease** in recorded compliments received since the previous quarter. The Care Opinion team have confirmed there were inconsistencies in figures due to errors in collation of Care Opinion stories, in this case Care Opinion has been omitted for this report. The issue with collation of data has now been remedied. The number of Compliments recorded by staff has shown a decreasing trend. This is thought to be reflective of the increasing pressures on the operational staff, compounded by managers trying to facilitate accrued annual leave, strike action, and action short of strike. A Memo was communicated in November 2022 to encourage recording of compliments by staff in an effort to reflect the positive stories. The process for recording compliments at service level has also been included in a Service User Feedback Awareness training package which is being piloted in a few service areas.

Table 20.0 – Compliments Received January – March 2023

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Total
Quality of Treatment and Care	74	19	11	7	0	0	111
Staff Attitude & Behaviour	65	21	15	8	0	0	109
Information & Communication	55	14	7	2	0	0	78
Environment	24	0	1	1	0	0	26
Other	0	0	0	0	0	0	0
Total Compliments	**218**	**54**	34	**18**	**0**	0	**324**

Table 21.0 – Previous Quarter

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Total
Quality of Treatment and Care	123	18	22	12	1	1	**177**
Staff Attitude & Behaviour	104	23	16	11	1	1	**156**
Information & Communication	20	18	7	8	0	1	**54**
Environment	4	6	1	4	0	1	**16**
Other	4	0	1	0	0	0	**5**
Total Compliments	**255**	**65**	**47**	**35**	**2**	**4**	**408**

5.0. Quality Improvement Work for Incidents and Service User Feedback

5.1 Serious Adverse Incident (SAI)/Complex Complaints Executive Director Review Group (EDRG)

This group is meeting on 23rd May 2023, to commence the review of SAI reports and Complex Complaints. A further update will be provided in the next Governance Committee paper.

5.2 Datix Development

During this quarter, the Datix team merged 16,450 contacts (A 'contact' is a record on the Datix Risk Management system, which may be a staff member, patient/service user, relative etc.), most of which were duplicate persons affected from separate incidents. As more contacts are merged this will allow multiple incidents, complaints or litigation relating to individuals whether service user or staff to be associated with a single contact and reported effectively which has not been previously possible. The team have recently focused on merging duplicate staff records with a view to quality assure and insert professional registration identifiers. This work has given rise to discussions with Medical Revalidation to link with incident reporting in Datix.

From the start of 2023/24 the option to code incidents to the historical Acute directorate ceased. Incidents reported following this date can now only be coded to MUSC, SCS or Nursing, Midwifery, AHPs and Functional Support Services (FSS). Discussions to further reorganise MUSC/SCS specialties and locations at service level are ongoing.

Following examination of the system audit trail the Datix team discovered 862 incidents which had been deleted on Datix since 2012. Access permissions were amended to prevent further deletion of incidents and a memo was distributed to advise that under no circumstances should incidents be deleted. The Datix team was able to recover detailed information from the database server tables and email archive for approximately 50% of the incidents with a further 20% of the incidents were partially recovered from the email archive only.

The Datix team has successfully tested an email merge facility to send feedback to the reporter of Incident investigation outcomes, action taken & lessons learned upon final approval of incidents. Content of the reporter feedback message is to be agreed by SLT with a view to commencing a pilot.

5.3 SAI Recommendations on Datix

As reported in the last Governance Committee paper, all SAI recommendations from April 2021 to date have now been uploaded to Datix, to facilitate monitoring of, and enable assurance to be provided to Governance Committee on, the implementation of SAI

recommendations.

A large number of recommendations uploaded to Datix have not yet been updated to identify implementation progress, particularly in ACS and MUSC/SCS.

5.4 Independent Clinical Record Review of Complaints

The Corporate CSCG is working towards establishing a pathway to trigger and facilitate peer review of clinical records in complaint cases relating to quality of treatment and care from medical staff. The process aims to formalise independent clinical review of complaint issues as standard practice. A template has been drafted and is under consultation. It is intended that this template will be piloted and feedback collected prior to wider dissemination.

5.5 Liaison Support to Urology Lookback/Independent Inquiry

A dedicated Liaison Officer has been appointed temporarily to support Service Users and their families in Cohort 2 of the Urology Lookback Review. This member of staff will offer support to all those impacted by this review, assisting to provide information, signposting whilst also offering advice, guidance and support.

5.6 RQIA Recommendations from Inspection Reports

The Corporate CSCG team has developed functionality within Datix to create a system for reporting and monitoring progress and completion of RQIA Recommendations from Inspection reports.

A meeting has been arranged with the AD of CSCG and the Chief Executive's Office to discuss the current process, with the aim of reporting against all RQIA Recommendations from 01/04/2023. This will be reported in the next Governance Committee paper.

Southern Health and Social Care Trust
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Minutes of a virtual confidential meeting of the Governance Committee held on Tuesday, 16th November 2021 at 2.00 p.m.

PRESENT:

Ms E Mullan, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mr B Beattie, Interim Director of Older People and Primary Care
Mrs A Magwood, Director of Performance and Reform
Mr C McCafferty, Interim Director of Children and Young People's Services/ Executive Director of Social Work
Mrs M McClements, Director of Acute Services
Dr M O'Kane, Medical Director and Interim Director of Mental Health and Disability Services
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwives and Allied Health Professions
Mrs S Judt, Board Assurance Manager (Minutes)

1. **DECLARATION OF INTERESTS**

Ms Mullan asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

2. REVIEW OF MR A's COMPLIANCE WITH RELEVANT AUTHORITIES/GUIDANCE IN TERMS OF HIS PRIVATE WORK

The Chair advised that the above-named Internal Audit report had been remitted to the Governance Committee from the Audit Committee meeting held on 14th October 2021 given the clinical governance issues identified.

The Chief Executive stated that the Internal Audit review focused primarily on Mr A's change of status private patients work during the period 1 January 2019 to 30 June 2020. All the management actions have been agreed and will be taken forward within the timelines identified. He advised that this report is a review of one aspect of Mr A's practice and reviews of other aspects of his work are underway. The learning from these various strands will be taken forward through the structures put in place within the Trust and updates provided to Trust Board on emerging issues.

Discussed ensued on the Internal Audit recommendations.

Recommendation 2.1

This recommends that the Trust should consider charging for the identified private activity. Ms Donaghy raised the following points:-

i) The report does not state who should be charged and she asked why did the Trust determine that this recommendation applies to the patients/recipients of the private care? Did the Trust consider at any time that this recommendation may relate to Mr A being charged for the health care that he obtained free of charge for his private patients? If so, what was the outcome of that consideration and if not considered, why not?
ii) Has the Trust quantified the cost of the healthcare provided to Mr A's private patients?
iii) Does the Trust consider that recompense should be sought from Mr A in line with policy and procedures (and precedent) within the Trust?

Dr O'Kane advised that this recommendation has been considered by the Trust and it was felt it would not be appropriate to charge these patients. As there was no evidence of private activity declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices raised for private treatment, both these indicated that Mr A did not perform private work on HSC premises. Dr O'Kane advised that advice had been sought from the Department of Health with regard to seeking recompense from Mr A, but their advice is that there is no mechanism to do so.

Recommendation 2.3

Ms Donaghy welcomed the fact that a number of recommendations in the report address strengthening the policies and procedures regarding the management of Consultants undertaking private practice. She raised the point that this recommendation states that *'Where concerns are raised about a Consultant's compliance, the Department of Health's framework 'Maintaining High Professional Standards in the Modern HPSS should be followed'* and asked if the Trust management accept that this is an adequate process? Ms Donaghy also asked if there was any other process, disciplinary or otherwise, in place to aid the Trust in the future management of private practice by Trust Consultants should a similar case to the current one arise?

Mrs Toal advised that for cases such as the one involving this Consultant, the MHPS, as the overarching framework, would be followed. Conduct concerns are one of the strands of the framework. Mr Wilkinson and Mrs Toal both emphasised the importance of robust Trust policy and procedures being in place to ensure appropriate behaviours.

Recommendation 1.4

The findings in the report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The report recommends that the Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. Ms Donaghy asked the following questions:-

i) Is this an administrative process or will it be a robust process engaging with all Consultants to provide assurance that procedures are being followed?
ii) If the latter, can Trust Board be provided with a plan on how this will be undertaken and will those Consultant specialisms most likely to attract private work be reviewed as a priority?

Mrs McClements stated that as part of the revised process to govern the declaration of private practice, medical staff engaging in private practice will be required to provide signed confirmation that they are aware and will abide by the Trust Guidance on Private Practice and the regional Management of Private Practice in Health Service Hospitals in Northern Ireland (2007). Dr O'Kane provided assurance that systems were being strengthened as regards private patients and advised that the Trust has developed a private practice appraisal template to be signed off by the respective Clinical Director before appraisal.

Mr McDonald referred to the defined time period of this Internal Audit review i.e. 1 January 2019 – 30 June 2020 and queried the need to go back further in terms of Mr A's practice. He also raised the fact that the analysis conducted was largely based on the data provided by the Trust and Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete. Dr O'Kane stated that clinical concerns relating to Mr A's practice is a function of the look back exercise. She reminded members that previous concerns were raised in relation to Mr A in March 2016 and managed within the MHPS framework. Dr O'Kane stated that the transfer of private patients to the NHS goes back over 28 years of Mr A's practice and she was not sure what would be gained by going back over this without any robust hospital system in place to check. Mrs McClements advised that the current look back covers the 18-month period prior to Dr A's retirement. The focus of this is to provide assurance in respect of the safety of the patients involved and any probity issues identified will also be addressed. As issues come to light, there may be a need to go back over a longer timeframe.

Mrs McCartan, Audit Committee Chair, stated that Mrs McClements had attended the Audit Committee meeting on 14th October 2021 for discussion on this item. Issues raised included wider learning generally and strengthening of systems of internal controls in relation to Job plans and appraisals/validations for all Consultants.

Mrs Leeson sought assurance that both private and NHS patients are seen based on clinical need. Dr O'Kane provided assurance that this was the case.

Mrs Leeson raised the Neurology Public Inquiry and the decision of voluntary erasure of Dr Watt's name from the medical register. She asked about the likelihood of this happening with the Urology Public Inquiry and if so, raised her concern that patients would not get answers to what had happened. Dr O'Kane acknowledged that this could happen and advised that there has been a significant level of medico-legal requests from patients associated with the Neurology Inquiry.

In terms of next steps, it was agreed that Audit Committee will monitor the implementation of the Internal Audit recommendations and a progress update on the recommendations will be brought to the Governance Committee in February 2022.

The meeting concluded at 2.30 p.m.

SIGNED: _____ ***DATED:*** _____

SHSCT MID-YEAR ACCOUNTABILITY MEETING

Wednesday 25 January 2023, Castle Buildings

Note of Meeting

SHSCT Attendees:

Eileen Mullan **- EM**	Chair of the Board
Dr Maria O'Kane - **MOK**	Chief Executive

DOH Attendees:

Peter May – **PM**	Permanent Secretary
Jim Wilkinson - **JW**	EBM Sponsor
Carol Blee – **CB**	HSC Sponsor Branch

1. Welcome and Introduction

1.1 Following introductions, PM welcomed the return of the accountability meeting and explained the meetings' importance in context of the overall Assurance Framework. He highlighted that the upcoming move to Partnership Agreements would help to change the relationship between the Department and the Trust. MOK welcomed the move to Partnership Agreements particularly the opportunity for ongoing evaluation.

1.2 PM stated that the while the Department retained the need for accountability, it wanted to be fair in terms of its requirements. He said the Department would be happy to discuss any onerous Departmental requirements particularly those which did not add value to either party.

1.3 There was a general discussion on challenges facing the HSC system from the need to reconfigure services hospital services regionally and locally, to pressures in the primary care model. MOK said she felt there was a lot of duplication across the region, but that both senior managers and service users understood the need for change. Specifically in relation to primary care MOK highlighted challenges around

the roll out of the current MDT model. JW stated that the MDT model could be revisited and reviewed while PM agreed that this could include the grading of staff. EM suggested it was time to look at alternative ways to deliver primary care.

2 Financial Position

2.1 PM provided an overview on the current Departmental financial position, including the 3% - 5% efficiency plans, and he encouraged the Trust to focus on efficiency across the system.

2.2 PM thanked MOK for agreeing to be the Efficiency Champion on the PTEB Group looking at how waste can be reduced, and efficiency improved. There was a general discussion about off contract agency spend, including the opportunity presented by the new contracts, the need for Trusts to act collectively, and the importance of effective rostering.

2.3 PM asked EM how the Trust Board oversees Finance and Performance. EM explained that a Performance Committee was set up two years ago to ensure that performance gets close attention. She said that the committee reports to the Trust Board with any urgent issues escalated to the Chief Executive and Chair. She went on to explain that the committee delves deeply on particular issues and the Chair highlights issues via reports and action plans.

2.4 EM advised that the Trust does not have a Finance Committee, but a review of Corporate Clinical and Social Care Governance recommended that finance be built into a Board committee. The Trust plan to create a joint Finance and Performance committee with the Terms of Reference being created to focus on both. The aim is to have the Committee in place between April and June 2023. EM said the intention is this new Committee would provide the necessary scrutiny that would support performance management and efficiency.

2.5 PM asked for an update on the SHSCT financial position. MOK acknowledged that the Trust is projecting a break-even however she highlighted

that uncommissioned beds and use of agency staff particularly in relation to theatre staffing were causing pressures.

3 Performance

3.1 PM acknowledged there were areas where the Trust was performing well such as outpatient services and Echo and other areas where improvements could be made. MOK highlighted that the unlike other Trusts SHSCT had just one Cath Lab which had broken down three times in the last two years. She suggested the Trust needs an addition Cath Lab to build resilience. MOK went on to raise the need for regional waiting lists and suggested that a regional approach would help reduce lists PM also raised the issue of waiting lists and outliers and had asked the Trust to look at all patients on lists for over 5 years to make progress.

4 Ambulance Turn Around Times

4.1 PM welcomed the progress that was being made on ambulance turn around times and acknowledged the challenges in Craigavon Area Hospital.

5 Industrial Action

5.1 PM acknowledged the challenges Industrial Action would cause the Trust this week.

6 Workforce

6.1 Discussion took place on Community and District Nursing. MOK suggested that alternative thinking on the nursing model was needed. PM agreed and the need to look both at skills mix and additional pathways.

6.2 Discussion followed on Domiciliary Care and the SEHSCT Pilot. MOK acknowledge the need to monitor community provision and look at how time is being utilised PM advised Peter Toogood, Social Services Policy Group would be working on a plan to grow social care especially domiciliary care subject to funding.

EM highlighted that Southern Regional College offer Healthcare Assistant training and suggested that the FE sector could be utilised to help build the workforce. JW agreed and suggested that accredited training needed to be linked to career pathways for Domiciliary Care.

7 Estate Buildings

7.1 PM welcomed the announcement of the Daisy Hill Hospital electrical upgrade. He acknowledged the need for new build in SHSCT but highlighted that the capital budget for the next 3/4 years was very challenging, and no guarantees could be made at this time which he understood was disappointing. EM asked if capital budget could be found from other sources such as Levelling up, Peace II or private investment. She gave an example of UK new build that had been funded differently with a range of sources. PM acknowledged it would be worth exploring and he was happy to engage further on the issue.

8 Urology Inquiry

8.1 PM recognised the impact of the Inquiry on the SHSCT, and discussion took place on impact on staff. MOK said she felt staff and been open and honest to the Inquiry EM highlighted the pressure the team had been under while also doing their day jobs and welcomed the leadership shown.

8.2 MOK advised that SPPG had been asked to help and options were being worked through. JW acknowledged the challenge of having capacity in place to service the Inquiry and identifying patients who have been negatively impacted and manage normal workloads, this was a key challenge, and it was critical that the Trust develop a plan, with SPPG to manage this.

9. AOB

No further business was raised, and the meeting was brought to a close.

Southern Health and Social Care Trust

Quality Care - for you, with you

SOUTHERN HEALTH AND SOCIAL CARE TRUST

GOVERNANCE COMMITTEE

TERMS OF REFERENCE

CONTENTS

1. CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Governance Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. MEMBERSHIP OF THE COMMITTEE

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust following recommendation from the Trust Chair and shall consist of not less than three members. A quorum shall be two members. One of the members will be appointed the Chair of the Committee by the Board.

3. ATTENDANCE

The following senior staff shall be invited to attend meetings:

- Chief Executive
- Medical Director
- Director of Finance, Procurement and Estates
- Director of Children and Young People's Services/Executive Director of Social Work
- Director of Mental Health and Disability Services
- Executive Director of Nursing, Midwifery and AHPs
- Director of Acute Services
- Director of Older People and Primary Care Services
- Director of Human Resources and Organisational Development
- Director of Performance and Reform
- Assistant Director, Clinical and Social Care Governance
- Head of Pharmacy and Medicines Management

Other members of Trust staff may be required to attend meetings as the Committee considers necessary.

The Board Assurance Manager, supported by the Committee Secretary, shall be secretary to the Committee and shall attend the meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

Meetings shall be held on a quarterly basis.

5. AUTHORITY

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, through the relevant Director, and will be given the resources necessary to carry out its role. The Committee will be given full access to any information within the Southern Health and Social Care Trust that it requires to fulfil its function. The Committee is authorised by the Board to obtain external professional advice and to invite external personnel with relevant experience and expertise if it considers this necessary.

6. REMIT

The remit of the Committee is to ensure that:

- There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.
- Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
- Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board
- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
- Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

In carrying out its work, the committee will utilise information from:

- Clinical and Social Care Governance systems
- Risk assessment and risk management systems
- Health and Safety
- Medicines management systems
- Information Governance systems
- Litigation systems
- National Audit outcomes
- Whistleblowing process

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to any reviews by Department of Health commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, other accreditation bodies, etc.).

The Committee will review the adequacy of all governance and risk management and control related disclosure statements (in particular the Governance Statement).

The Committee will work closely with the Audit Committee to provide comprehensive assurance to the Audit Committee's own scope of work.

The Committee will receive the minutes of the Trust's Mid-Year and End-Year Ground Clearing meetings for information.

7. REPORTING

The minutes of the Governance Committee shall be formally recorded by the Committee Secretary and submitted to the Trust Board following approval of the Governance Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require executive action.

Any business conducted in a confidential session by the Governance Committee will be reported to a confidential session of the Trust Board.

Following each Committee meeting, the Chair of the Governance Committee will provide a written summary report on the meeting to the next Trust Board meeting.

The Committee will report to the Board annually on its work in support of the Governance Statement.

OTHER MATTERS

The Committee shall be supported administratively by the Board Assurance Manager and the Committee Secretary, whose duties in this respect will include:

- Agreement of agenda with the Chair.
- Collation and distribution of papers no less than 5 working days in advance of the meeting.
- Producing the minutes of the meeting and taking forward matters arising and issues to be carried forward.
- Advising the committee on pertinent issues.

Matters arising from Governance Committee Meeting on 11th February 2021

Item	Issue / Action	Lead Director	Progress update
Item 6) **Matters Arising**	Judicial Reviews to be reported on at future Governance Committee meetings.	Chair and Chief Executive	Chair and Chief Executive have discussed and Judicial Reviews will be reported through the Litigation Report to Governance Committee going forward. A verbal update will be provided at 13th May 2021 meeting.
	O&G Whistleblowing investigation – final report to be presented at a future meeting.	Dr M. O'Kane / Mrs V. Toal	Final report commissioned by the Trust has now been received by the Trust – 12th April 2021. Summary report detailing outcome of investigation, recommendations and action plan is now being prepared for approval by Director's oversight for issue to relevant parties during w/c 17th May 2021 and will be shared / presented at next Governance Committee.

Item	Issue / Action	Lead Director	Progress update
Item 7i) Clinical and Social Care Governance Report	Request that 'immediate learning' terminology be reviewed.	Chief Executive/ Dr O'Kane	Terminology amended – included in report - item 10i.
Item 7ii) Management of Standards and Guidelines	Request that more detail on the external barriers to achieving full compliance be included in future reports.	Dr O'Kane	Included in report – item 10ii.
Item 8) Corporate Risk Register	Internal Audit Report on Risk Management 2020/21 to be shared with members.	Chief Executive	Completed. Circulated 11.02.2021

Matters arising from Governance Committee Meeting on 13th May 2021

Item	Issue / Action	Lead Director	Progress update
Item 5) Matters Arising	Report on Obstetrics and Gynaecology Whistleblowing Investigation	Mrs McClements Dr O'Kane Mrs Toal Mrs Trouton	Confidential briefing held with Non-Executive Directors on 17th May 2021. Copy of updated Action Plan shared with Non-Executive Directors - attached item 5b.
Item 7i) **Freedom of Information, Environmental Information and Subject Access Requests**	Query to re-look at request FOI/00000318 on Covid-19.	Mrs A. Magwood	FOI 318 was rejected due to all of the data on Covid 19 deaths being published by NISRA via PHA. It was decided that whilst we hold the data, it was best to refer the requestor to the PHA. It was thought that this was best for Regional consistency. It has been agreed (since 28th July 2021) that all COVID related requests will be exempted by the Trust under 'future publication and validation by PHA'.
Item 7ii) **Third Party Cyber incidents**	Update to be provided on the Cyber Attacks on those organisations in which the Trust shares data with.	Mrs A. Magwood	**Update on 3rd Party Cyber Incidents:** **QUB -** Email communications and connection to Systems are back up and running. A decision regarding resuming 3rd party by SIROS **North West Independent Hospital -** Access has been re-

Item	Issue / Action	Lead Director	Progress update
			established as agreed by SIROS. Access to NIECR and & NIPACs has also been enabled. **HSE-** BSO have not yet re-established connections – too high risk. **MACS NI (Children's Charity) -** Access has been re-established. Protocol has been established as agreed with BSO and SIROS **South West Regional College -** Access still blocked – awaiting response from BSO in relation to further action to be taken before reinstatement of access.
Item 19) **Feedback from Audit Committee**	*Adult Safeguarding Internal Audit Report:* Action plan to address recommendations to be developed and presented at a future Governance Committee meeting.	Mr P. Morgan	Action Plan developed. Directorate Oversight Group established and due to meet again 16.09.21

Performance Committee

Agenda Focus:

Children and Young Peoples Directorate

December 2022

Contents

- Children with Disabilities Short Breaks
- Health Visiting
- CAMHS/Autism
- AHP
- Elective Paediatric surgery
- Community Paeds

Children with Disabilities Short Breaks- Jul – Sep (Q2)

Overnights Provided

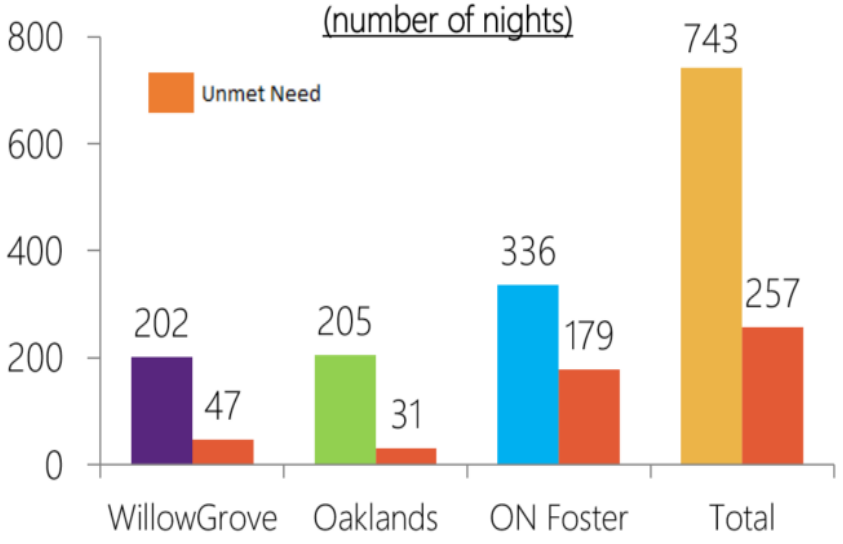
486 (no change) — Total Nights Provided

155 (-4.32%) — Willowgrove

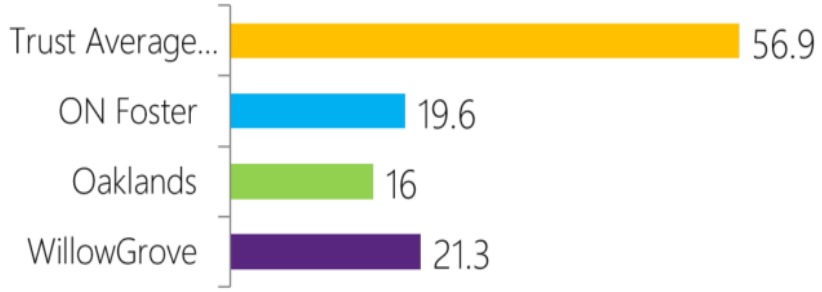
174 (-4.4%) — Oaklands

157 (+9.7%) — ON Foster Care

Demand and Unmet Need (number of nights)



Average Service Users per Month in Q2



Q2 Trust wide Performance in Comparison to Q1

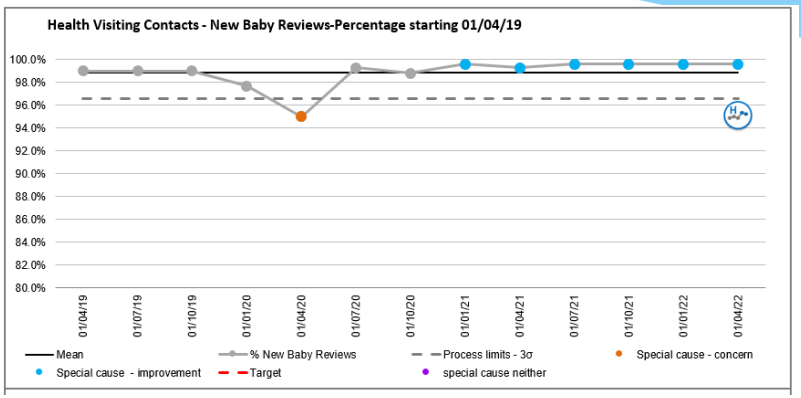
- 486 **Overnights** provided. **No Change** in comparison with Q1 (486)
- Decrease in **Demand** for **Overnights** from 762 in Q1 to 743 in Q2. -19 **(-2.5%)**
- 257 nights of **Unmet need** which is an **decrease of -22 (-7.8%)** in comparison to Q1 (279).
- Average of 56.9 **Service users per month** in Q2. **Increase from 53.3 in Q1 (+3.6)**

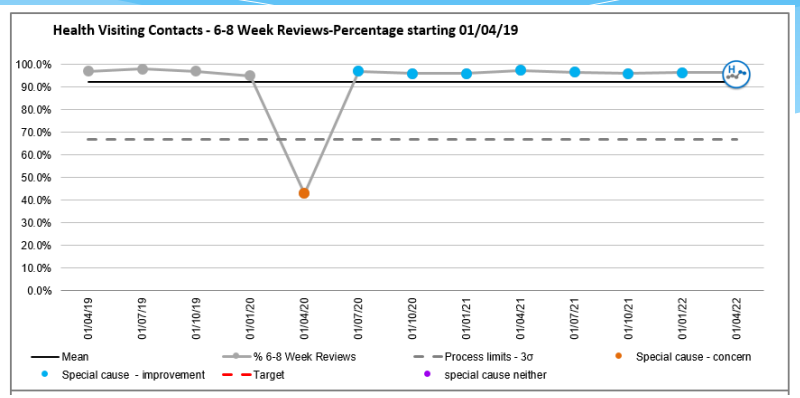
Note:
ON Foster Care Service is provided to all children aged under 18 years therefore demand for this service is higher than for Willowgrove and Oaklands residential facilities who care for children from age 12 years.

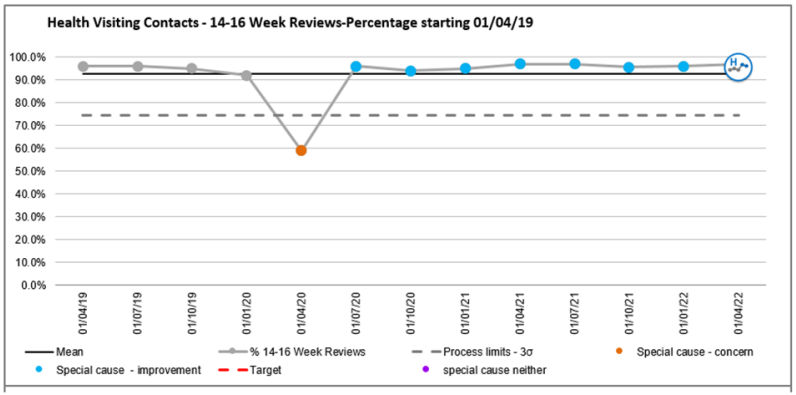
Actions and Issues

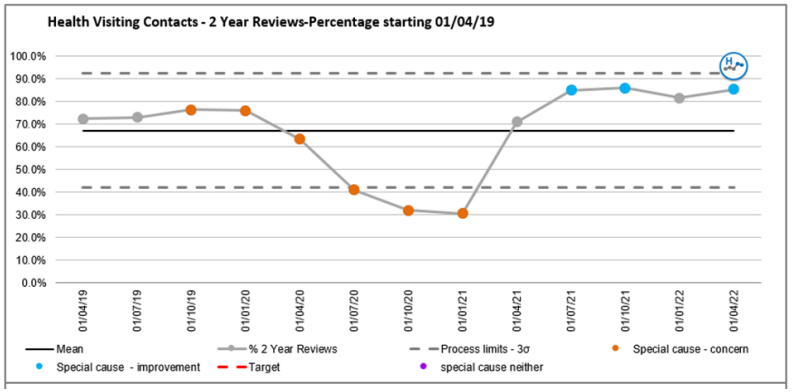
* Steady progress achieved in relation to rebuild of Short Breaks residential
* Positive upscaling of Short Breaks fostering
* Recurrent funding secured from SPPG to maintain increased opening In Willowgrove
* Service limitations to support increasing numbers of Short Breaks foster carers
* Quality preventative supports including Over-night short breaks required to avoid full time admissions to LAC
* CAWT proposal

Percentage completed of Health Visiting Early Infant and 2 Year Developmental Reviews









Issues and Actions

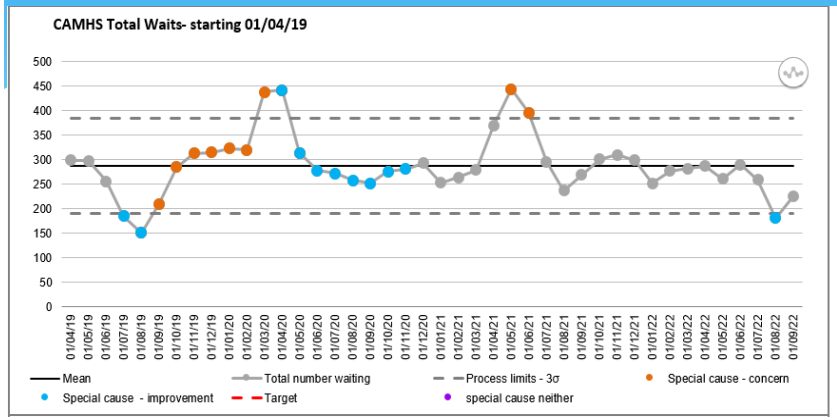
Issues

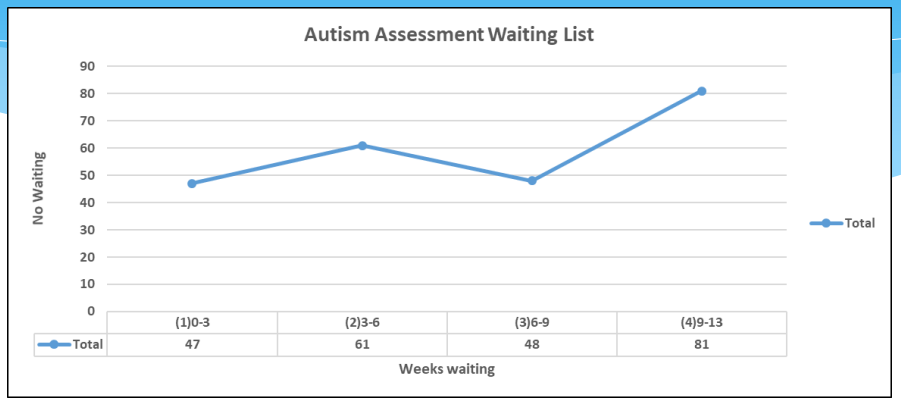
* There is currently a 37% deficit of health visitors across the service
* Out of 118 caseloads 44 do not have a health visitor
* This is due to 15 vacancies, 17 maternity leave and 12 long term S/L
* Recruitment of health visitors is becoming increasingly difficult due to the insufficient number trained each year
* The health visiting service have not been able to deliver fully on the Universal Child Health Promotion programme for many years
* The biggest impact is of the reduced capacity on the ability to deliver preventative and early intervention for children and families which if carried out would reduce the need for later intervention which would improve outcomes and be much more cost effective

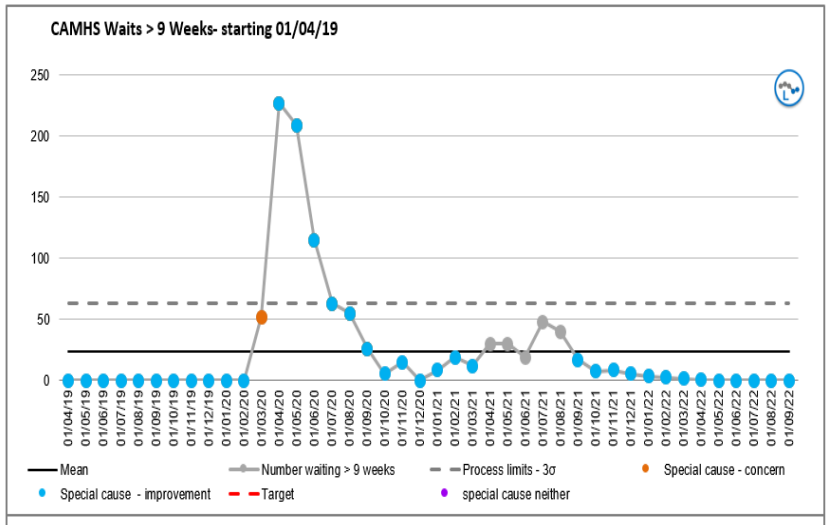
Actions

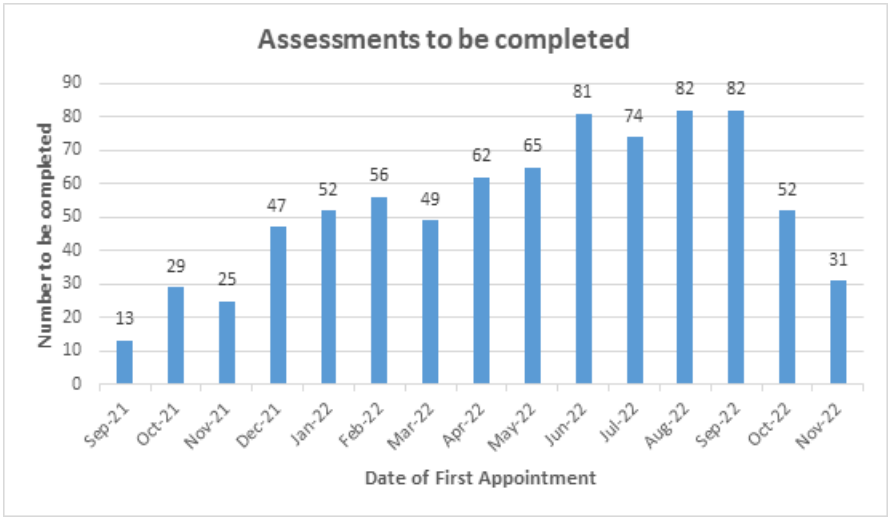
* Risk assessment completed with all infants and families with increased need prioritised
* Recruitment of skill mix to support the HV teams to respond to children and families
* Additional weekend \ clinics for children staffed through additional hours
* National recruitment campaign being arranged
* Communication strategy which includes providing information on child development and children's minor ailment management easily accessible to families
* Children who have missed review at 2 years will be identified and offered a developmental review to ensure children who require it are referred to and have access to services prior to them starting school
* Preschool settings have been communicated with and teachers & parents encouraged to contact their HV if they have concerns about their child in the absence of routine reviews

Child and Adolescent Mental Health (CAMHS) and Autism Services

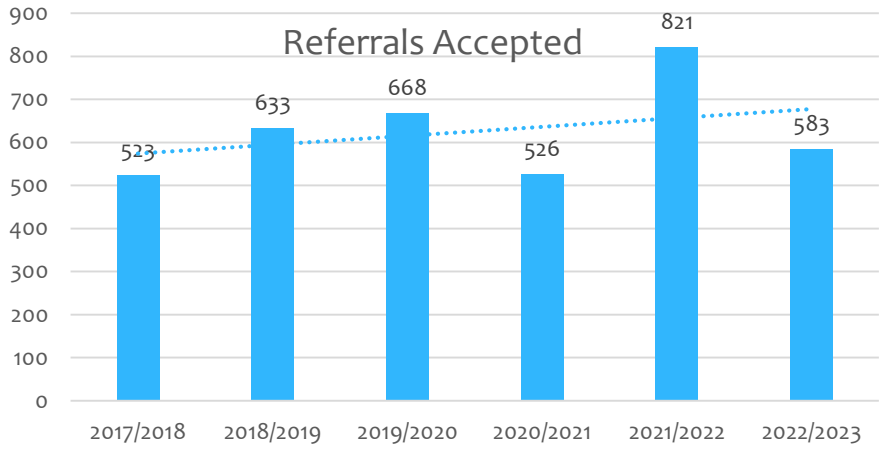


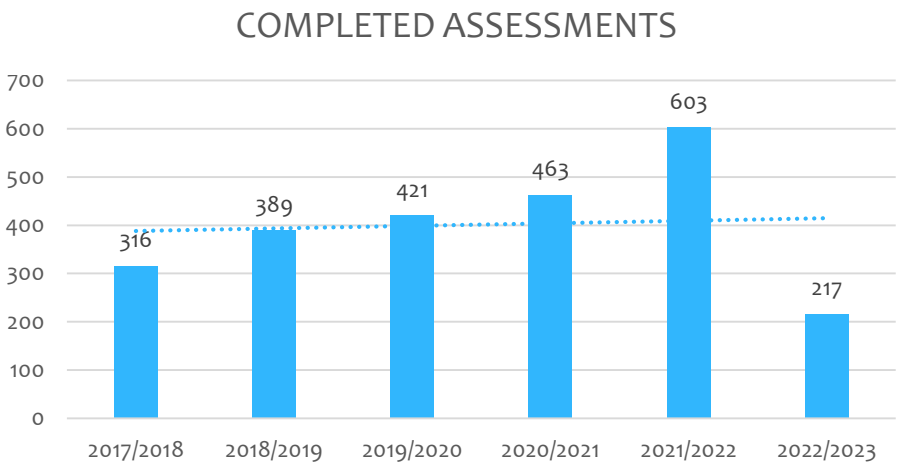






As at September 2022 there were no patients waiting over 9 weeks. CAMHS continue to use telephone and video platforms for both new and review patients.





Issues and Actions

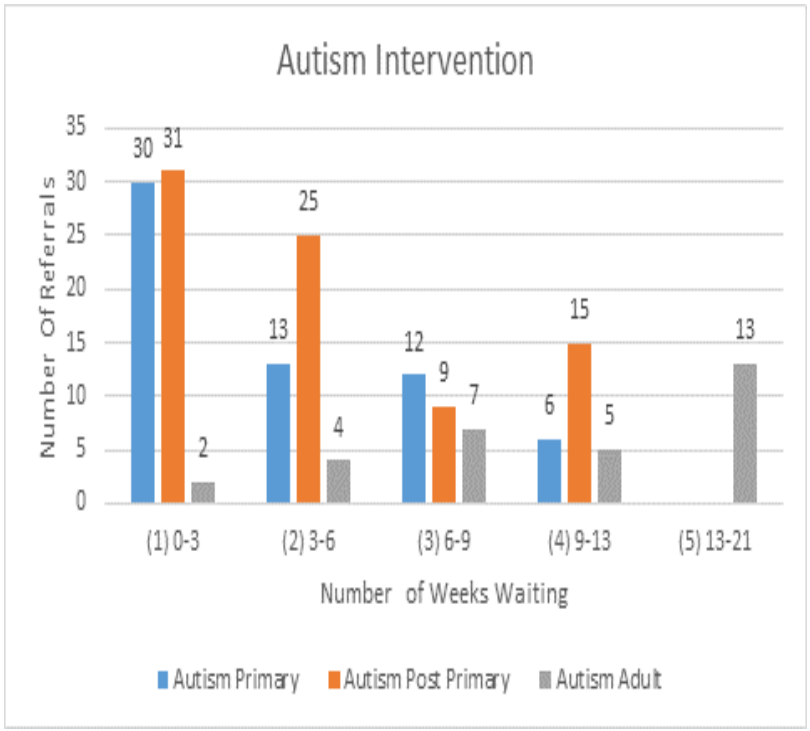
Issues

* Within the ASD service demand is being met for primary wait for referrals accepted
* Demand is not being met for completed assessments with wait in excess of 13 months

Actions

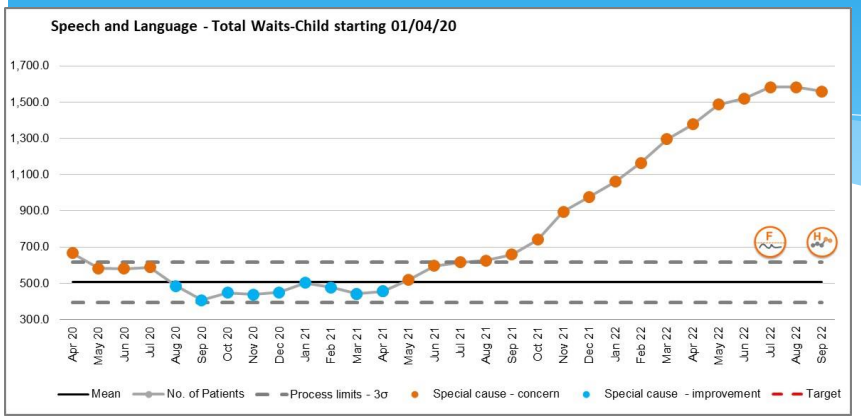
* Capacity to complete x34 observations per week which is the demand wait. To commence 1st December 2022.
* Each observation requires two trained staff to complete the observation, panel discussion and write up.
* Given each observation requires two staff to complete and as we don't have even numbers we can also complete 10 initial appointments per week (This does not include any annual leave or training).
* **817 children awaiting an observation. 817/34 = 24 weeks to clear those in the Assessment process.**
* **This will mean a breach position for 24 weeks**
* Once demand waiting list is cleared we will complete a one stop shop assessment approach.

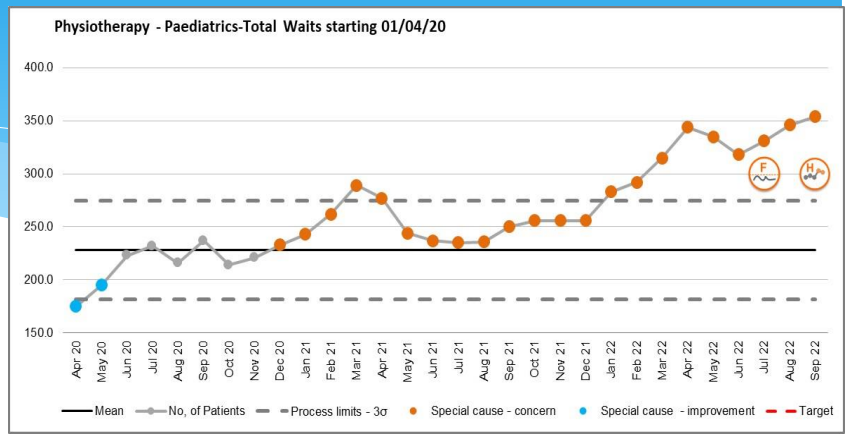
Autism Intervention

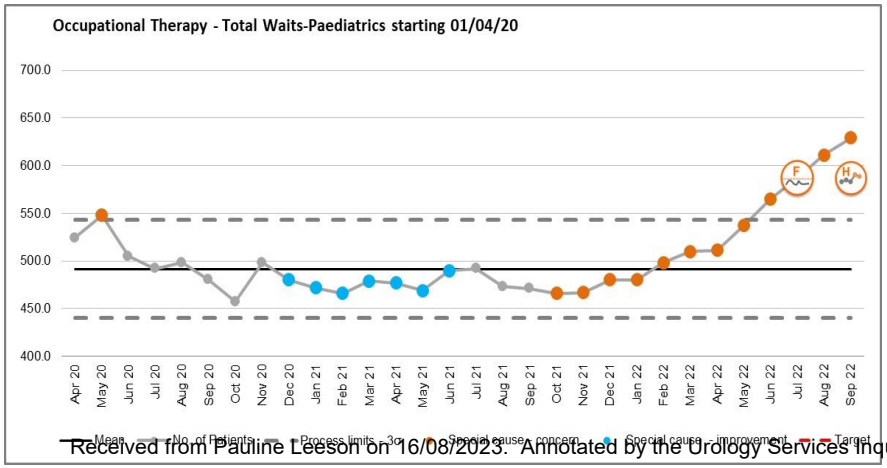


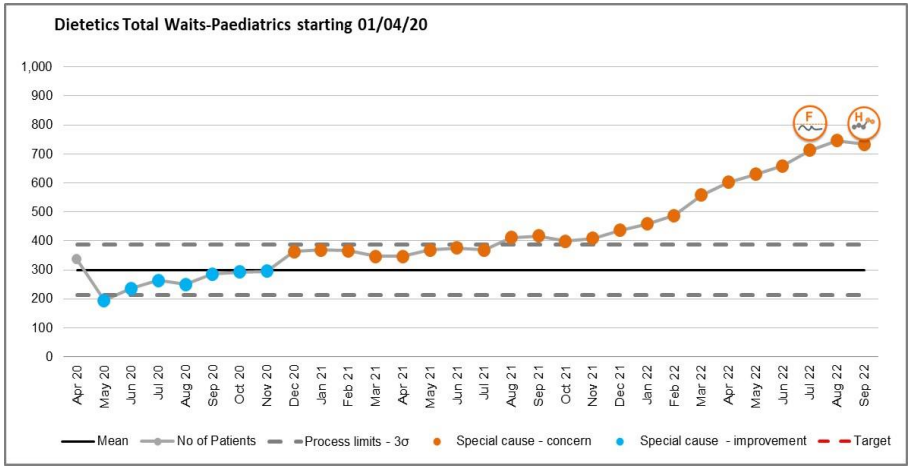
* Non breach position for primary and post primary team
* Adult intervention in breach position due to recruitment. Interview scheduled for 1st December 2022

Children's Allied Health Professionals









Children's Allied Health Professionals Waiting List as at 30th September 22

AHP		Total Volume of Waits	13+ Weeks	52+ Weeks	Longest Wait (Weeks)	Average Wait (Weeks)	75th Percentile (Weeks)
Dietetics	Paed	766	407	0	43	15	23
Occupational Therapy	Paed	653	500	109	133	34	43
Orthoptics	Paed	1439	777	1	68	14	20
Physiotherapy	Paed	673	398	12	58	19	30
Podiatry	Paed	435	287	0	48	21	30
Speech & Language	Paed	1559	1205	31	58	25	34
Total AHP	Paed	5525	3574	153	133	21	30

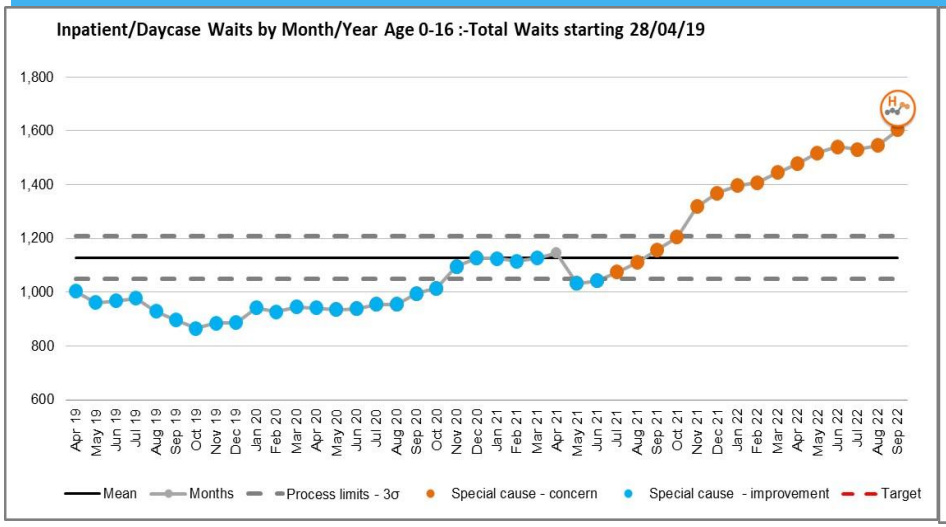
- Children's Allied Health Professional Waits represent 25% (5525/22093) of total AHP waits
- Speech & Language have the largest volume of children waiting at 28%
- Occupational Therapy have the highest volume of children waiting more than 52 weeks at 71%
- The longest wait in CYPS is in Paediatric Occupational Therapy at 70 weeks

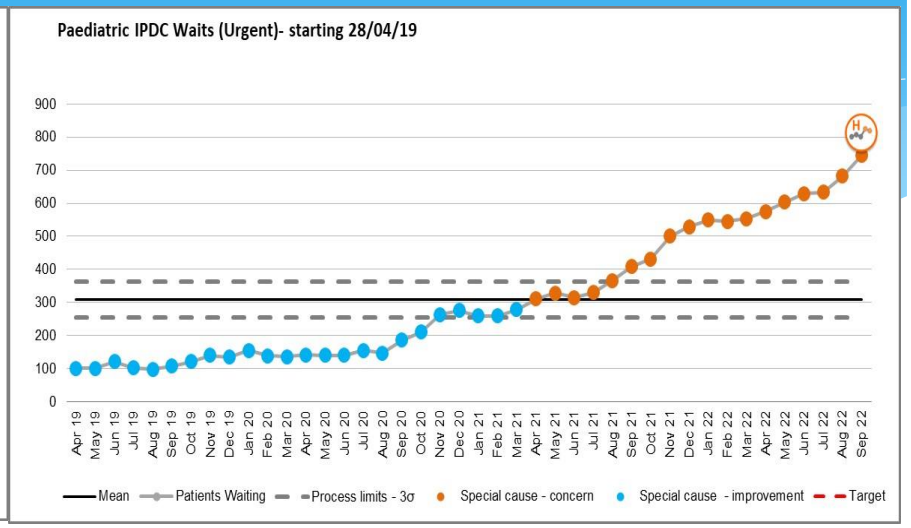
Actions and Issues

- Validation of new and review waiting lists
- Physiotherapy – additional Saturday clinics in QTR 3
- Change of rotational posts to static posts in physiotherapy to stabilise the workforce
- SLT – change to Band 5 clinic templates and increase in face to face appointments with availability of clear masks
- WLI funding for additional SLT clinics in QTR 1/2/3
- Practice Educator completing QI project to attract more SHSCT school leavers to SLT
- Setting up an advice line to reduce inappropriate referrals

- Referrals and complexity increasing
- Service Delivery remains variable compared to pre-pandemic levels. SDP Cumulative assessment up until October 22 shows that
  - Dietetics and OT are exceeding SPPG expected outturn.
  - SLT (-28%), Physio (-15.2%) are below the expected outturn.
- Staffing - general shortage of paediatric physiotherapists and occupational therapists
- Actual wte reduction – Physio (2.1 wte), SLT (3wte) , OT (2.6 wte), Dietetics (1 wte)
- Increasing demand for SEN advice reports for Education within 6 week timeframe - SLT increase 28%
- Significant increase in the number of newly diagnosed children with Type 1 Diabetes which requires significant input from the Dietetic service
- Increase in children with avoidant restrictive intake disorder which is potentially related to the disruption in children's lives during the pandemic
- Drift of AHP graduates to developing private sector, international work and ROI

Elective Paediatric Surgery





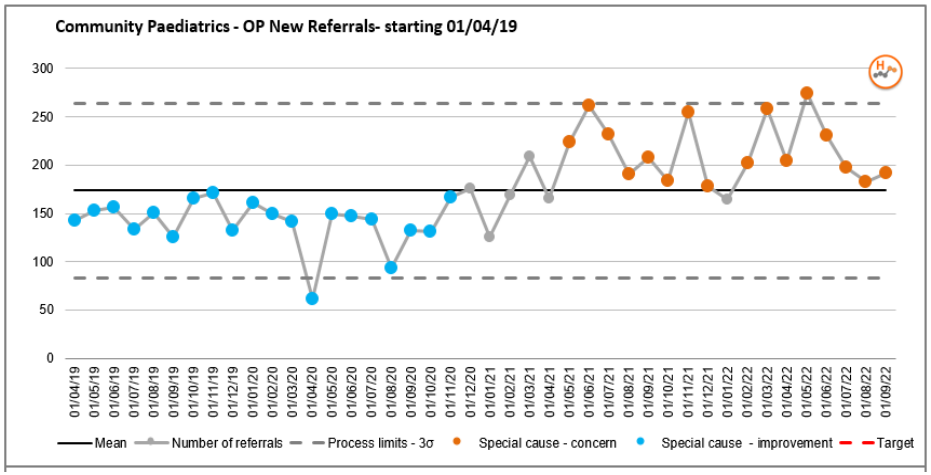
- Paediatric Elective Surgery has been significantly impacted by the pandemic and general impact in reduced levels of theatre sessions as can be shown from the charts above.
- At the 30th September there are 1604 children waiting for surgical intervention which has increased by 49% (+529) June 2021 (1075). There are currently 653 children that have been waiting for more than 52 weeks. The majority of children are waiting for ENT or dental surgery.
- There are currently 745 children identified as clinically urgent.

Actions and Issues

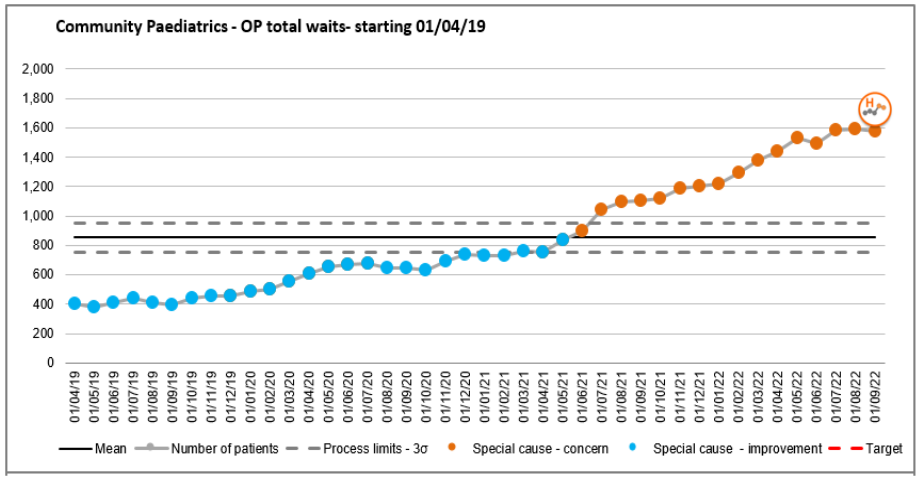
- Cross Directorate Group focusing on recovery of paediatric elective surgery
- Ongoing validation of waiting lists – all children continue to require treatment, prioritisation according to current guidance
- Recruitment drive with a focus on DHH for theatre staff (Recruitment closed 17th November)
- Waiting list initiative Dental lists, in house and IS in the Republic of Ireland
- Utilisation of emergency GA capacity at DHH
- Attempt to identify regional capacity
- Flexibility to utilise theatre time at short notice
- CDS using alternative treatment modalities – sedation in use and available at all clinics for children who be managed without GA

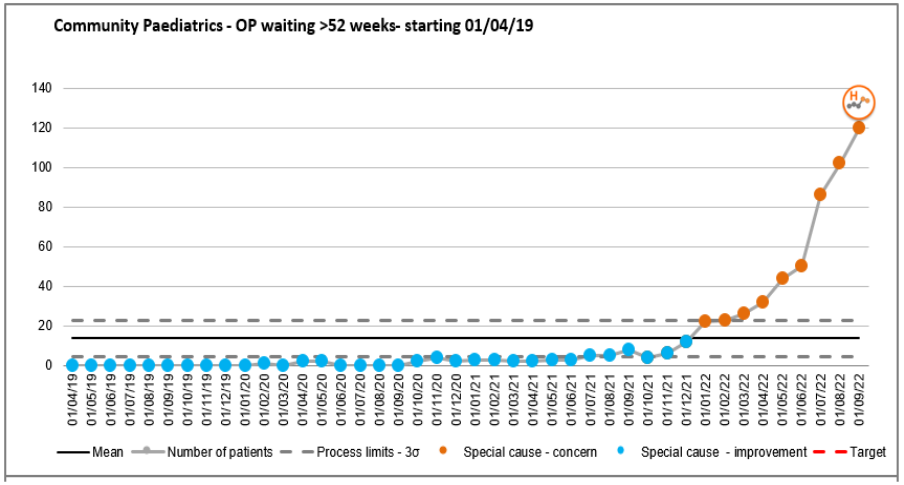
- Waiting lists remain static – only most urgent cases being treated within current capacity
- Regional/UK wide issues in recruitment to theatre nurses and paediatric nursing staff
- Regional demand on theatre capacity
- Impact on outpatient activity in prioritisation/utilisation of theatre capacity at short notice

Community Paediatrics



- Community Paediatric Referrals have increased by 34% (+49) (143 in April 19 to 192 in September 22).
- Total waits have trebled from 401 in April 19 to 1574 in September 22.
- Most significantly Paediatric waiting list over 52 weeks has increased from 0 to 120 with cause for concern showing from December 21. This is largely contributed to Consultant Vacancies within Paediatrics.





Actions and Issues

* Recently recruited 1.5 WTE Speciality Doctors
* Ongoing recruitment of Consultant Community paediatrician
* Waiting list Initiative
* Employment 1.0 WTE Locum Speciality Doctor
* EHWB-Single point of Entry
* Pre-covid position
* Increase in referrals and complexity
* Recruitment and retention of Community Paediatric medical staff
* Several Community Paediatrician retirements
* 1x vacant Consultant Community Paediatrician post
* Regional Community Paediatrician workforce shortfall
* Covid impact-staff redeployment to acute. Reconfiguration of work over 2 years

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Performance Committee 1st December 2022	
Title of paper	Unallocated Childcare Cases Report	
Accountable Director	Name	Colm McCafferty
	Position	Interim Director of Children & Young People's Services
Report Author	Name	Donna Murphy
	Email	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

	The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that 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:

The attached report aims to provide an overview of risk in relation to CYPS unallocated cases resulting in children and families experiencing increased waiting times for assessment and intervention at family support level.

The report provides an overview regarding referrals to the Trust regarding statutory casework, the subsequent impact of social work vacancies in allocation of family support assessment and intervention to children and families.

2. Areas of improvement/achievement:

- A Cross Divisional collective leadership approach has been implemented to review resources and allocation of work, this includes ongoing engagement with staff and staff side organisations.
- All children and families in need of a targeted service are assessed and support identified.
- All children on the CPR and Looked After Children (LAC) have an allocated social worker.
- Development of a skills mix approach to increase direct contact with children and families, supported by experienced Senior Staff.
- Improvements are progressed in relation to Gateway Processes.
- Child's Pathway Procedure reviewed and implemented to include an earlier transition for LAC to the Corporate Parenting division.
- Unallocated case initiative has resulted in reducing unallocated cases in GW.

3. Areas of concern/risk/challenge:

- Unallocated referrals time waiting to be allocated
- High level of Child Protection and LAC activity associated with complexity of cases.
- Maintaining a full complement of staff in the context of social work vacancies, maternity/sick leave across the Service and COVID-19 contingency arrangements
- Retention of staff in highly pressurised teams
- Maintaining a responsive and accessible service
- Managing the risk of unallocated cases. Weekly monitoring completed by team managers and monthly monitoring completed by HOS and Assistant Director which is very resource intensive.

4. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	
Corporate Risk Register	Assessed as high risk given the limited potential for recruitment with FSS Division
Board Assurance Framework	Yes
Equality and Human Rights	N/A

UNALLOCATED CHILDCARE CASES

PERFORMANCE MANAGEMENT BRIEFING REPORT
For Trust Board – November 2022

1.0 Gateway Single Point of Entry:

Referrals	June	July	August	September	October
TOTAL	**999**	**950**	**1108**	**989**	**1014**

2.0 Southern Trust weekly unallocated cases:

July 2022

	01.07.22	08.07.22	15.07.22	22.07.22	29.07.22	29.07.22 Priority 5
Gateway	78	82	80	91	117	117
Family Support	157	131	130	133	135	135
Disability	28	21	26	26	28	28
TOTAL	**260**	**234**	**236**	**250**	**280**	**280**

August 2022

	05.08.22	12.08.22	19.08.22	26.08.22	31.08.22	31.08.22 Priority 5
Gateway	117	131	140	155	162	162
Family Support	127	130	112	114	116	116
Disability	27	21	17	16	11	11
TOTAL	**271**	**282**	**269**	**285**	**289**	**289**

September 2022

	02.09.22	09.09.22	16.09.22	23.0922	30.09.22	30.09.22 Priority 5
Gateway	156	174	157	153	138	138

Family Support	113	128	127	128	127	127
Disability	12	9	10	8	10	10
TOTAL	**281**	**311**	**294**	**289**	**275**	**275**

October 2022

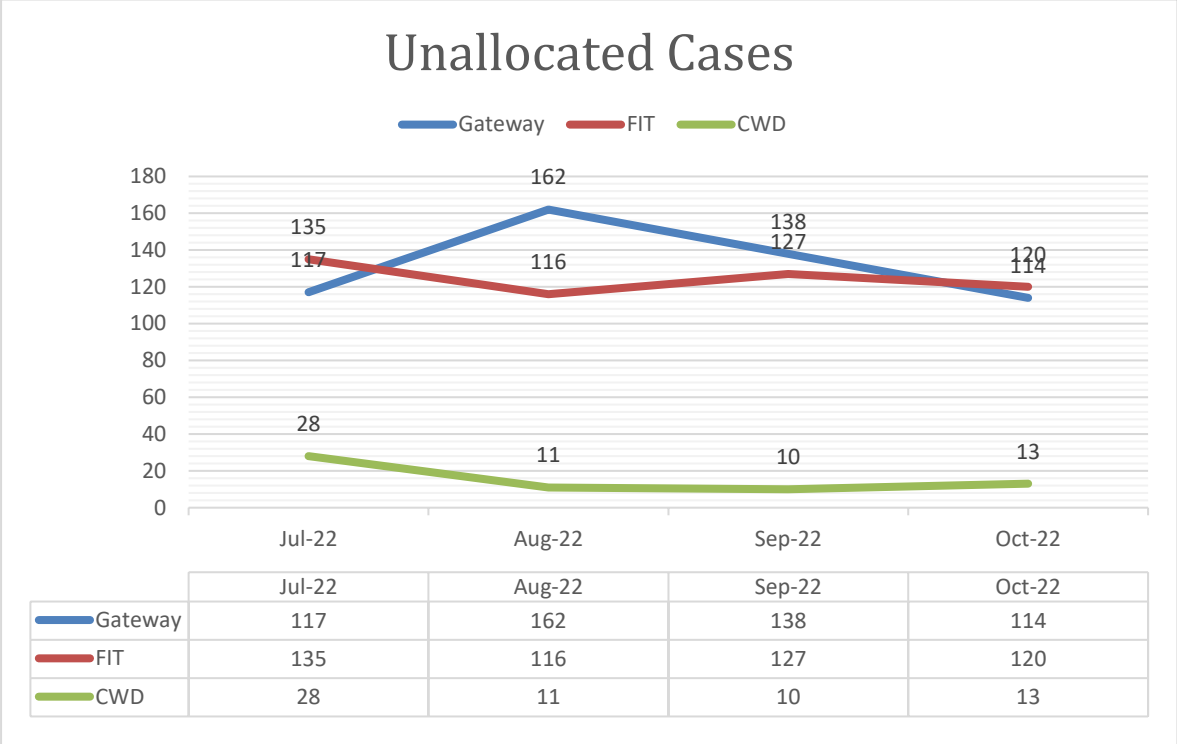
	07.10.22	14.10.22	21.10.22	28.10.22	31.10.22	31.10.22 Priority 5
Gateway	122	122	136	107	114	114
Family Support	122	122	121	118	120	120
Disability	9	13	16	13	13	13
TOTAL	**253**	**257**	**273**	**238**	**247**	**247**

- **Total Unallocated Cases as at 31.10.22 - 247**

- There continues to be a high number of unallocated child care referrals within the Trust's Gateway Service, due to the workforce vacancies including summer leave, priority having to be afforded to child protection investigations, safeguarding risks and looked after child referrals made to the service.
- As a result, this is resulting in an ongoing reduction in the service's ability to allocate Article 18 Children in Need assessments resulting in a significant increase in unallocated cases.
- Sick leave is not covered as a consequence of the Trust's inability to recruit social workers into the service and remaining staff have to cover work load.
- Regional workforce supply is inadequate in terms of meeting vacancy demands in social work services, particularly in relation to Family Intervention teams.
- Vacancies across the Gateway, Family Intervention and CWD Service continue to impact on the level of unallocated cases.

Unallocated cases over 6 weeks –

- All unallocated cases within GW are reviewed by a Senior Manager and prioritisation of actions identified. An Action Plan has been developed in respect of higher priority referrals, including; home visits where required; updated multi-disciplinary checks; contact with family to review circumstances; update provided to referrer; and confirmation of point of contact for referrer and family provided.



	Jul-22	Aug-22	Sep-22	Oct-22
Gateway	117	162	138	114
FIT	135	116	127	120
CWD	28	11	10	13

Gateway Teams and FIT	**Month in which the referral was made**				
Referrals	**June**	**July**	**August**	**September**	**October**
No. of Child Protection Referrals received during month	88	56	79	55	63
Percentage of total referrals which are Child Protection	8.81%	5.89%	7.12%	5.56%	6.21%
No. of Children becoming Looked After	18	16	18	12	9
Percentage	1.8%	1.68%	1.62%	1.21%	0.88%
No. of Child Protection Case Conferences	13	11	24	21	26
Percentage of child protection referrals progressing to case conference	14.77%	19.64%	30.37%	38.18%	41.26%

3.0 Unallocated Cases (as at 31.10.22) Time Waiting to be allocated (in days)

Type of Referral	Greater than 20 working days but less than 30 days	Greater than 30 working days but less than 40 days	40+ working days **(* See Footnote)**
Family Support	29	47	171
Level for Allocation	0 - High 0 - Medium 29 - Low	0 - High 0 - Medium 47 - Low	0 - High 0 - Medium 171 - Low
Example of low level referral	NIAS responded to a concern for safety for self-harm. Parent had a verbal domestic argument resulting in father self-harming. Two children in the family aged 5 and 11 years not in the home at the time of the incident.		
Example of Medium level referral	• No medium level unallocated cases at present.		
Example of High level referral	• No high level unallocated cases at present.		

* Footnote

Longest Waiter: **307 days** – Referral from the police who attended family home following domestic incident between parents in relation to contact dispute. Further Intervention required due to ongoing parental acrimony in relation to contact. Following further support and review the case has since been allocated for Family Group Conferencing to address the parental acrimony and put a network of supports in place to ensure the child is not exposed to similar incidents.

4.0 Action taken to mitigate risks and strengthen our system:

CYPS senior management have engaged with frontline staff in relation to action plans to support and address the presenting demands Actions have been progressed as follows;

4.1. There are no unallocated Child Protection or LAC Cases.

4.2. All unallocated cases within Gateway are reviewed by a Team Manager or a Senior Manager and prioritisation of actions identified. An action plan has been developed in respect of higher

priority referrals, including; home visits where required; updated multi-disciplinary checks; contact with family to review circumstances; update provided to referrer; and confirmation of point of contact for referrer and family provided.

4.3. Business Continuity Plans are implemented in Gateway and Family Intervention Team.

4.4. An overtime initiative commenced in Feb/Mar 2022 with identified staff from across the service taking on extra work to begin to address unallocated cases and progress initial assessments. This consisted of a cohort of eight staff. This initiative saw a reduction in unallocated cases within Gateway from 192 in Feb 2022 to 76 in June 2022. During the summer period reduced staff availability to deal with referral backlogs added to staff vacancies over the summer period resulted in an increase in unallocated cases in July and August 2022. In June 2022 the above cohort of staff had advised they would be available to re-engage in overtime work from Sept 2022, however only one staff member returned in Sept 22. Despite this, there has been a reduction in Gateway unallocated cases from 162 in Aug to 120 in Oct. This remains a priority for CYPS as these children and families do not have an initial assessment.

4.5. Recruitment of staff skills mix and creating capacity in Safeguarding Division – The Trust recruited additional Social Work Assistants into both FSS and Corporate Parenting divisions initially on a temporary basis via employment agency, until a permanent recruitment drive could be achieved. There are presently 17 additional SWA (12 additional to 9 FIT Teams and 2 additional to YPP) and LAC Teams (3 x SWA) have been offered permanent Band 4 SWA posts, within FSS, 12 are currently in post. Staff currently working within the Trust as Agency workers who were successful at interview have been offered posts in their current team, thus creating continuity of service provision.

4.6. A Governance group has been established within the SHSCT to agree the application of the “Delegated Framework” (DOH document re delegation of roles to non-qualified social care staff). Further work regarding this is being progressed via the regional social work Leadership workstreams.

4.7. The Trust recruited a SSWP for Domestic Violence in January 2022 and funding has been secured to recruit (skills mix) Domestic Abuse Workers within GW Service. Recruitment of 2 x Domestic Abuse Support and Engagement workers is currently active, it is anticipated that these staff will be in post by end of 2022. The focus of work will be within Gateway; cases not requiring statutory intervention will be linked into Family Support Hubs, cases (post initial assessment) requiring short term direct work with children or families will be progressed and case managed by the Domestic Abuse Worker, supervised by the SSWP and closed or stepped down to FSH as applicable. This will ensure timely intervention to children and families in need of support due to domestic abuse and reduce cases pending allocation with FIT teams.

4.8. The Trust has a dedicated Adolescent Service (Young Persons Partnership) consisting of social workers, Homeless workers, Outreach workers and mental health input. However, within the current period of business continuity social workers within this service have been allocated child protection work. When front line child protections services are stabilised, plans are being developed to introduce more skills mix to YPP with a more prevention focus. In line with the Business Continuity Plan the YPP service child protection plans are progressed and young people have timely intervention and assessment.

A quality improvement initiative has been progressed to support unallocated adolescents, this model will enable a SSWP update the assessment with the support of a skills mix of staff who will provide direct support and interventions to young people. Early projections highlight a 20% (n=9) reduction in unallocated young people through this model of practice. It is projected that over the next 3 months a plan will be in place to provide support to this cohort of young people which will be overseen and reviewed by a SSWP and Service Manager (Band 8a).

4.9. A Cross Divisional approach was progressed regarding expediting Looked after child case transfers where possible. A Task & Finish group was established including FSS, Corporate Parenting and the Trust's Performance and Planning service to review and update the Child's Pathway and Transfer Procedure.

This revised pathway was completed in June 2022. The revision to the procedure includes an earlier transfer point for Looked After Children from FIT teams to LAC and 14+ teams.

It is agreed, that in cases where rehabilitation is not an agreed care plan, the family episode will transfer to the LAC service at the 3-month review meeting. (Previous transfer point when rehabilitation formally ruled out). Following the revision to the pathway, 42 children already meeting the revised pathway were identified to transfer to the LAC/14+ Service and during the period July – Oct 22 plans have been progressed to transfer the above children to Corporate Parenting Division.

This has created some capacity within Family Interventions teams to concentrate on core child protection and complex Family Support casework and has resulted in a reduction in unallocated cases within FIT, (157 unallocated FS cases in July to 120 unallocated FS cases at end of Oct.

4.10. The FSS Division has increased capacity in both Family Centres to complete additional Parenting assessments to support the Family Intervention Teams. The Assistant Director is also in final discussion stages with the Family Centres re a pilot programme whereupon SW within the Family Centre will review and update children and families currently unallocated within FIT Teams. Plans are in place to allocate FS cases to the above staff over the next 4 weeks with the support of a Trust Band 8a Service Manager. It is anticipated that this pilot will inform the role of C&V sector in future family support cases and for consideration of the Children's Services Review.

4.11. Staff engagement seminars and face to face team meetings continue to be progressed by the Director and Assistance Directors to keep the workforce fully updated with the current challenge and existing efforts to manage. Induction, support plans and engagement sessions were held with level 3 Students commencing post over the summer period and a comprehensive support plan is in place for newly recruited AYE/ social workers is in place.

4.12. SPPG have been kept appraised of the current situation, including submission of a detailed reports.

4.13 The Regional Directors of Children services have established the following workstreams in response to the current challenges faced by the service. It is intended that this work will assist in informing the current review being undertaken by Professor Ray Jones.

- Workforce Recruitment and Retention

- Skills Mix and Delegation Framework

- Review of Administrative Support in Children's Services

- Unallocated cases

-Reducing Bureaucracy

- Early Help

5.0 Challenges for the Service

- There continues to be a major challenge in the regional recruitment of social workers across CYPS. Within SHSCT Gateway Service there are presently 8 vacant posts and two staff working their notice period, therefore by December 2022 GW will be operating at 60%, with limited potential for recruitment, given the regional recruitment brought about new entrants to GW from Sept 2022. This remains a significant challenge for the Trust as children and young people referred to the GW Service pending an initial assessment, cases are prioritized based on referral information only.

- Within the FIT there are ongoing challenges in recruitment and retention and of social work staff, the service is currently at 65% workforce at social work practitioner level. It is anticipated that there will be no new entrants to social work until minimum period summer 2023 with new qualifying social workers available in June / July 2023. However based on recruitment in June 2021 there was no new entrants to FIT teams and this remains a long term risk for the service.

- To minimise unallocated cases and maintain a low number of same.

- To minimize risk associated with unallocated cases

- Protect the reputation of the service

- To maintain staff morale

- Maintain a collaborative and constructive inter-face with staff side organisations.

- To maintain an effective and safe child protection service

- To maintain targets for the allocation and completion of family support assessments

- To sustain a full complement of staff and cover vacancies as a result of sick/maternity leave.

- To create adequate capacity in Safeguarding /Gateway services to make it a more appealing service for new staff to come to and to remain within.

- Provide remaining staff (including team managers) with required support in what is a highly stressful and challenging situation

- Impact of impending Industrial Action

Stinson, Emma M

From: Corporate.Governance [redacted]
Sent: 10 January 2022 11:11
To: earlyalert@[redacted]
Cc: Beattie, Brian; Black, Tony; Comac, Jennifer; Connolly, Connie; Devlin, Shane; Donaghy, Geraldine; Doyle, Caroline; Gormley, Damian; Hainey, Lynne; Hetherington, Stacey; Leeson, Pauline; Liggett, Lindsey; Magennis, Marita; Magwood, Aldrina; McCafferty, Colm; McCartan, Hilary; McClements, Melanie; McDonald, Martin; McKimm, Jane; McNally, ClaireA; McNeany, Barney; Mullan, Eileen; OKane, Maria; ONeill, Nicole; Reid, Trudy; Rogers, Ruth; Stinson, Emma M; Teggart, Catherine; Toal, Vivienne; Trouton, Heather; Wallace, Stephen; Wamsley, Chris; Wilkinson, John; Wright, Elaine
Subject: Emailing: EA JAN 202209 OPPC
Attachments: EA JAN 202209 OPPC.pdf

Please find attached Early Alert from SHSCT.

Thanks
Nicole

ANNEX A

Initial call made to:

Spoke with Gearoid Cassidy at 9:53

(DHSSPS) on 10/01/2022 **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Cathrine Reid	Organisation	Southern Health & Social Care Trust
Position	Interim Assistant Director of Primary Care	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated

DESCRIPTION OF INCIDENT:

There are 16 service users awaiting clinical triage this am. All calls were routine, and the service user was made aware that if they did not receive a call back, to contact their own GP. They were also told, if their condition deteriorated, to contact OOHs again.
Email will be circulated to all GP practices this am.

There is a risk to providing a safe and timely OOHs service, due to reduced GP cover.

Also on 8 January 2022, at 11pm the Adastra system crashed, and the service contingency plan was implemented. This had an impact on the service, as those clinicans working remotely and who coudlnt come into base, meant that clinical capacity was further reduced for the service.
The system was reinstated by 9:50am on Sunday 9 January and all the manual recorded information had to be uploaded to Adastra.

There is no GP on the Red Eye 11th January, with 2 nurses providing clinical cover thoughout

IMMEDIATE ACTION TAKEN:
Email to be circulated to GP practices about the patients who had not received triage

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: **Claire McNally**
Telephone (work or home) Personal Information redacted by the USI
Email address (work or home) Personal Information redacted by the USI

Forward proforma to the Department at: Irrelevant information redacted by the USI *and the HSC Board at:* Irrelevant information redacted by the USI

FOR COMPLETION BY DHSSPS:
Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …….. Date: ...
Detail of follow-up action (if applicable…….

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 10th March 2022 at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Dr D Gormley, Deputy Medical Director *(for Dr O'Kane)*
Mr C McCafferty, Interim Director of Children and Young People's Services / Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs L Leeman, Assistant Director Performance Improvement
Mrs G Hamilton, Assistant Director Patient Safety, Quality and Experience *(for Mrs Trouton)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Mrs H McCartan, Non-Executive Director
Dr M O'Kane, Temporary Accounting Officer / Medical Director
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and noted the apologies above. She particularly welcomed Dr Damian Gormley and Mrs Grace Hamilton deputising for their respective Directors.

At this point, the Chair advised members on some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

The Chair informed members that Mrs Leeman has been appointed as the Interim Director of Performance and Reform. Members congratulated and wished her well in her new role.

4. MINUTES OF PREVIOUS MEETING HELD ON 2nd DECEMBER 2021

The Minutes of the meeting held on 2nd December 2021 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

Mr McDonald asked for an update on item 7 Performance Report on the matters arising on the audit of appropriateness of GP referrals to the Emergency Department. Mrs Leeman stated that following discussions with the Acute Directorate a date has not been agreed to carry out this audit in DHH. She agreed to seek a further update and report back at the next meeting.

Action: Mrs Leeman

Ms Donaghy asked for an update on the Internal Audit report on Performance Management. Mrs Leeman explained that the draft report is currently with the Trust for factual accuracy checking. The final report will then be presented to the Audit Committee and subsequently to this committee in May 2022.

6. SICKNESS ABSENTEEISM

The Chair welcomed Deputy Directors, Mrs Maxine Williamson and Mrs Siobhan Hynds to the meeting to present an overview on Sickness Absenteeism within the Trust. Mrs Toal introduced the item and advised that the presentation will focus on key data and trends, impact on service delivery, management issues and support for staff.

Mrs Hynds began by explaining that the sickness absence figures are up to December 2021 so do not represent the full 2021-22 year figure. It includes COVID sickness absence but excludes COVID self-isolation/shielding absences. . Sickness absence figures also exclude Domiciliary Care Workers (system / contracted hours issue). Mrs Hynds presented statistics on sickness absence and Covid self-isolation/shielding (non-sickness) and provide the sickness absence level over a 3 year period. She noted that, as at December 2021, the cumulative 2021/22 sickness figure was 7.01% an increase from 6.78% on the previous year. Mrs Hynds added that although the Trust sickness absence levels have increased, the Trust continues to have lower levels of non-COVID sickness absence in comparison to other HSC Trusts.

Regarding Covid sickness, Mrs Hynds reported that for 2020/21 the Trust had the highest level of COVID sickness absence and in 2021/22 (as at December 21) the third highest level. She attributed this to the link that the Southern Trust Council areas having the largest COVID 19 community transmission rates at certain times during the pandemic.

Mrs Hynds stated that 51% of staff have not had any episodes of sickness. Mr McDonald felt it would be valuable to review the factors such as demographics and age profile for this cohort of staff which might highlight trends. Mrs Toal agreed to undertake this and feedback at the next meeting.

Action: Mrs Toal

Mrs Hynds noted that corporate directorates who have the ability of homeworking throughout the pandemic have a lower level of sickness than those staff who cannot work from home.

Mrs Williamson reported that there were no flu or viral sickness absences in 2020/21. She reminded members that pregnant women were shielding from 28 weeks during the pandemic. Mrs Williamson stated that Mental Health related absences were increasing and noted that in 2020/21 this was the number one reason for absences with stress the top reason. She continued to guide members through the presentation and spoke of the impact on service delivery across all directorates and provided examples of specific service areas affected. Mrs Williamson reported that the Functional Support Service division is above the baseline level of absences and advised that this is an area of focus. She informed members that the Trust has to be mindful that the longer hospital waiting lists is affecting many of Trust staff and how this has an impact on sickness levels.

Mrs Williamson spoke of the support available to staff through Occupational Health, Staff Health Protection and the Psychology Service. She presented a number of statistics on the activity within the Occupational Health department.

In concluding, Mrs Toal stated that the Trust is working to 'get back on track' in terms of normal sickness absence management within HROD and throughout the Directorates.

Mr McCafferty welcomed the presentation and asked that the presentation be shared with managers. Mrs Toal welcomed this suggestion and agreed to action this.

Action: Mrs Toal

Ms Donaghy commented that critical services and waiting lists are negatively impacted with sickness absenteeism and asked how this is being addressed. Mrs Toal explained that redeployment of staff is undertaken in areas where delivery of service is affected and the use of bank and agency staff is used. She added that the AHP flexible pool is used to cover long-term vacancies and maternity leave.

Ms Teggart noted that the Belfast and South Eastern Trusts sickness figures are lower than the Southern Trust and asked why this may be and if there is learning that can be implemented across the Trust. Mrs

Toal clarified for Ms Teggart that this was not the case overall, and that it was the Covid absence levels that were higher due to higher Covid rates across the Southern council areas. Mrs Toal went on to confirm that the Trust's non-Covid sickness rate is lower than all other Trusts, and has been consistently this way for a number of years.

Ms Teggart spoke of 'Inspire Workplaces' which offers free confidential and immediate support for all staff and felt that this could be promoted more across the Trust. Mr Wilkinson agreed that that the Inspire service is an excellent tool and would welcome further promotion of the service across the Trust. Mrs Toal agreed to take this forward.

Action: Mrs Toal

7. PERFORMANCE MANAGEMENT FRAMEWORK

Mrs Leeman presented the Performance Management Framework (PMF) for approval. The document provides information to the committee in exercising its function of overseeing the Trust's Performance Management arrangements. Mrs Leeman reminded that the Performance Committee determined in December 2021 that the PMF should be updated to reflect the interim arrangements established during the Covid-19 pandemic. Mrs Leeman drew members' attention to the section of the report which highlights the change. She advised that the PMF will remain subject to change and will require to be updated to reflect the output of the new integrated care system model and aligned planning arrangements.

Members approved the Performance Management Framework

8. PERFORMANCE REPORT

Mrs Leeman presented the Performance Report for approval. She advised that this report focuses on a broad range of issues and spoke of the areas of improvement / achievement. Mrs Leeman advised that the regional work on new planning and performance arrangements, led by the Department of Health (DoH) and the Health and Social Care Board (HSCB), including Trust Directors of Planning/Performance, is ongoing. The DoH stakeholder

consultation in respect of the 'Future Planning Model – Integrated Care System NI' has closed. Engagement with citizen hubs is ongoing facilitated by the Integrated Care Partnership. The Trust is a member of a number of work streams focused on development of an outcomes framework. Mrs Leeman noted that the Trust's Service Delivery Plan for January 2022 – March 2022, which includes the Winter and Covid surge plan arrangements, has been published on the Department of Health's website.

Mrs Leeman highlighted the key risk areas; access to elective and cancer services, wait times at Emergency Department, inpatient bed demand for adult unscheduled care, access to social work workforce, mental health and disability support services, unallocated domiciliary care cases and ongoing covid transmissibility and impact of workforce. Mrs Leeman guided members through the detailed report which set out the broad performance of each directorate and the actions taken.

Mrs Leeman referred to section 1.1 of the report and noted her concern that waits over 12 hours in the Emergency Department continue to reflect an increasing trend. She advised that the graph highlights those patients who waited over 36 hours and members agreed that this is unacceptable.

In relation to Carers Assessment, Mrs Leeman advised that the older people's services have the largest volume of carer's assessments across the Trust. She explained that the volume of offers has decreased however, in actual terms noted the number of carers assessment actually undertaken reflected an improving trend indicating a more appropriate targeting of assessments. Mrs Leeman noted that there was evidence a level of need was being addressed with the provision of cash grants for short breaks and additional levels of self-directed support payments and domiciliary care hours Mrs Leeman added that work continues to ensure that carer assessments are completed.

In response to a question asked by Ms Donaghy, Mrs Leeman explained that patients are attending the Emergency Department with undiagnosed cancer and attributed this to patients not presenting to their GP and hospitals during the pandemic. Ms Donaghy asked if

referrals have returned to pre-covid levels, to which Mrs Leeman stated that numbers are increasing and there is an unmet demand and an increase in patients added to waiting lists. Dr Gormley explained that the length of stay is impacted by the acuity of the patient. Ms Donaghy asked if it can be established as to whether those surgical patients on a waiting list have had their length of stay increased above the normal range for that condition. Mrs Leeman agreed to undertake this review and feedback at the next meeting.

Action: Mrs Leeman

Mr McDonald referred to section 4.4 - GP Out of Hours and noted that a review of this service has been initiated with the first meeting in February 2022. He asked what Directors are members of the review team to which Mrs Leeman confirmed that Mr Beattie and Ms Teggart are the leads for the Trust. She added that this work links in with the 'No More Silos' – urgent and emergency care work stream for which there was an ongoing consultation.

Members approved the Performance Report

9. CORPORATE PERFORMANCE SCORECARD

Mrs Leeman presented the Corporate Performance Scorecard (January 2022 performance) for approval. The report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework. She reported that historic CPD objectives have been maintained for 2019/2020, 2020/2021 and 2021/2022. Mrs Leeman advised that improvements have not been achieved and performance further impacted in year as result of the current pressures/pandemic response. High level Service Delivery Plan monitoring (previously Corporate Rebuild) is now included in the CPD Performance Scorecard.

Mrs Leeman drew members' attention to the cover sheet, highlighting those areas of concern, risk and challenge and those areas of improvement. She advised that access to services is highlighted throughout the report and in particular elective areas that are concerning. She noted that the statistics in the report are a reflection on the current position of the Trust.

In response to a question asked by Mr McDonald, Mrs Leeman explained that the current targets are outdated, having been rolled over year on year from 2019/2020 and were in the main not available in the current environment. Mrs Leeman indicated that work on a new outcome framework was ongoing.

Mrs Leeman reminded members that the Minister for Health has set out his 'Elective Care Framework' and 'Cancer Recovery Plan', however the success of the plans will depend on a budget and workforce available.

Mr Wilkinson asked on the success of the validation of waiting lists and if this is having a significant impact. Mrs Leeman commented that validation of waiting lists is important to cleanse the lists and ensure that patients still require treatment. However, she advised that the number of patients waiting treatment that no longer require are small in comparison to the volume of waits and this has not made a significant inroad in reducing waiting lists.

Members approved the Corporate Performance Scorecard

The Chair requested that item 13 be taken at this point

13. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty presented the above named report and noted that as at 31st January 2022 there were in total 296 unallocated cases which is an increase from 86 in the previous quarter. There are no unallocated Child Protection or Looked After Children (LAC) cases. He did note that whilst high, the Trust has the lowest number of unallocated cases across the region.

Mr McCafferty informed members that during the reporting period and as of the end of January 2022 there were two families, which consisted of four children on the Child Protection register who did not have a named social worker over a six-week period due to social work sick leave and vacancies.

Mr McCafferty advised that the cases were risk assessed and that there was close inter-professional monitoring including home visits pending allocation to a named social worker. He advised that this was reported to the HSCB and provided assurance that both families were assigned a social worker from the 1st week in February. Mr McCafferty stated presently there are no unallocated Child Protection or Looked After Children (LAC) cases. He advised that an update on pressures within CYP will be presented to confidential Trust Board on 31st March 2022.

Mr McCafferty referred members to the unallocated cases over a 6 week period. He provided assurance that all unallocated cases within Gateway have been reviewed by a Senior Manager and prioritisation of actions identified. An action plan has been developed in respect of higher priority referral.

Workforce capacity issues across the social work service was discussed. Mr McCafferty advised that there is currently a regional shortage of qualified social workers available and who are willing to take up employment in front line children's services, and this will not improve until early Summer when newly qualified staff become available. Even then, there will not be sufficient numbers of new staff available to fill all vacancies.

Mr McCafferty drew members' attention to increase of referrals month on month since October 2021. Me McCafferty advised that at present there is a cross Divisional approach to managing the challenges and seeking to ensure that the most vulnerable and complex cases receive a social work service. He was optimistic that an improved positon would be achieved by early summer, however challenges are likely to remain for the medium term in relation to unallocated cases.

Ms Teggart noted that in some cases there may be families on the poverty line and asked if the Trust and the voluntary sector offer assistance. Mr McCafferty agreed that poverty is a key feature for many families and spoke of a number of charities who can help families in need however, this does not address the systemic issue associated with poverty. Mr McCafferty added that the Trust does offer family support through the FIT team and in addition via the Family Support teams.

In relation to recruitment and retention, Mrs Toal stated that there will be 230 newly qualified social workers across the region however this will not address the capacity and vacancy issues as all five Trusts are in the same position. Responding to a question asked by Mrs Toal, Mr McCafferty advised that unlike nursing and medical there very limited international social workers available for recruitment. The Chair highlighted alternative routes into social work: social work assistants at the local training centres and the Open University.

10. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Enhanced / Specialist Community Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Brian Beattie Interim Director of Older People and Primary Care and Mr Gerard Rocks, Assistant Director of Promoting Wellbeing to the meeting to present the above named item. Members received the presentation in advance of the meeting.

Mr Beattie guided members through the presentation, which consisted of the commissioning plan direction, continuum of care, access and information service, community and voluntary sector service and potential new developments. He began by presenting data and information on OGIs for carers assessments, short breaks, direct payments and self-directed support.

In relation to Access to Services, Mr Beattie spoke of the importance of the right service at the right time. He reported that the Trust has 140 contracts in place with independent, charitable and social enterprise providers. Mr Beattie presented an overview of the Access and Information service within OPPC and advised that between 2018 and 2021 there has been a 15% increase in the number of referrals into the ICT service and within social work there has been an increase of 29% for the same reporting period. Approximately 53% of all referrals for Social Work are redirected from ICT Social Work by the Access and Information service.

Mr Rocks presented information on Promoting Wellbeing and reported that this service manages 22 contracts with CV sector organisations with a total value of £550k per annum. He spoke of the overarching priority areas to provide early intervention and prevention, addressing social isolation and loneliness by building connections and capacity in communities, and tackling poverty and disadvantage. Mr Rocks explained that the target groups are: carers, BME groups including Travellers, older people and those communities experiencing inequalities in health.

In concluding Mr Beattie informed members of the potential future developments, namely: review access and information staff capacity to deal with increasing level of demands, increasing Social Worker capacity to support downturn of referrals to ICTs, dedicated PARIS support to enhance A&I systems and to support a data driven approach to management and commissioning of CVSE sector and commissioning of community and voluntary social enterprise contracts.

Mr McDonald commented on the need for the Trust to allocate further investment and resources to Health and Wellbeing. He felt that the pathways for referrals provided a richness of data to demonstrate the benefits of the using these pathways for a better outcome. Mr Rocks advised that this is an area of focus to better evidence the value of these pathways.

Ms Donaghy commented that the pandemic has had an economic effect on families and the increase need for people to turn towards food banks. Mr Beattie stated that there is an increasing trend of families highlighting to their social workers that they use food banks and this is concerning.

Mr Wilkinson welcomed the linkage with the community and voluntary sector and spoke on the importance of including in the education sector. He asked if an annual report from voluntary and community sectors is sought to demonstrate their achievements and outcomes. Mr Rocks advised that an annual report is not required however, through their contract management and end of year reviews, assurances are sought through these processes. Mr Beattie advised

that he intends to bring a proposal to SMT during 2022/23 to scope the existing community and voluntary contracts against the corporate objectives and he envisaged that this may provide clarity in respect of whether any of the existing contracts should be amended/ended and if any new contracts should be commenced.

Ms Donaghy noted that EU funding is available until 2022 in relation to the mPower project and asked if funding is available beyond that. Mr Rocks advised that a number of options and discussions would be taken forward; however in the interim the learning from the mPower project will be reviewed on how best to implement it across the service.

Mr Beattie and Mr Rocks *left the meeting at this point*

Mr Wilkinson left the meeting at this point

11. SENTINEL STROKE NATIONAL AUDIT PROGRAMME

The Chair welcomed Dr Michael McCormick, Consultant Stroke Physician, Mrs Anne McVey, Assistant Director of Acute Services Medicine and Mr James Gilpin Stroke Service Improvement Lead to the meeting. Mrs McClements introduced this item and explained that the service has 19 dedicated acute stroke beds on the CAH site, DHH has a 30 bedded unit encompassing acute stroke and stroke rehabilitation patients alongside older peoples beds. She reminded members that following a local consultation on 2014 the outcome was a centralised model to support improvement of stroke services with acute beds centralised in CAH and rehabilitation beds at DHH. The infrastructure and investment required to deliver on the preferred model has not been actualised. In 2019, a subsequent regional public consultation was undertaken with CAH identified as a hyper-acute site. The outcome of the report was delayed and is as yet not concluded.

Dr McCormick presented data on the Sentinel Stroke National Audit Programme (SSNAP). He explained that the audit consists of two elements: clinical and organisational audit and explained the difference in both. Dr McCormick presented clinical audit comparable peer information on the status of stroke units across the region. He reported that the SSNAP quarterly audit performance in CAH has

been banded as a level 'D' and DHH banded as a level 'C' in the quarter July – September 2021, comparative Trust analysis was included in table 1 of the report.

Dr McCormick reported on the areas of achievement. The Trust has a Stroke Improvement Group which meets regularly and reviews SSNAP data; the stroke service improvement lead has now returned to his post with an aim of focussing on key areas for improved performance following redeployment during covid; a Quality Improvement Project (QIP) has commenced on stroke identification in the Emergency Department and targeting ward of first admission;, a new consultant has been appointed to the Craigavon Area Hospital and has stroke dedicated sessions; a need for an increase in stroke Allied Health Professional capacity has been identified and an investment proposal has been developed, exploring the option to reconfigure and improve stroke services within the existing infrastructure to create a centre of frailty and stroke services and the collaborative working with non-acute colleagues in the management of early and support discharged for stroke patients.

Dr McCormick spoke of the areas of concern. He reported that the bed pressures on the CAH site affect the access to dedicated stroke beds. Overcrowding in the emergency department impacts on the ability to triage patients and ensure their treatment is administered in a timely manner. Dr McCormick explained that stroke services are provided across four different hospital sites, which dilutes staff within an already under-resourced service, which affects performance. The four-site model does not facilitate focused 7-day therapy and early supported discharge. Dr McCormick stated that the AHP staff co-hort is inadequate and falls below the recommended guidelines. He spoke of the need for AHPs cover over 7 days in particular Speech and Language therapists to undertake swallow reviews and the need to increase nursing staff to ensure the safe delivery of thrombolysis 24/7.

In concluding, Dr McCormick advised that solutions are required for the short term outlook, namely; workforce investment, prioritisation of stroke service, stroke assessments at weekends and dedicated ward. In relation to a long-term model, he spoke of the centre for stroke and frailty to facilitate consolidation.

Mrs McClements agreed with Dr McCormick on the concern that stroke beds are not protected, that patients are being displaced and the infrastructure is not in place to provide the required level of care. She informed members that work is ongoing to establish a dedicated ward and there are a number of options being discussed, however the need for investment and infrastructure is required. Mrs McClements advised that discussions have taken place with OPPC if there is capacity to increase the workforce; however this is proving difficult due to their own capacity gaps.

Dr Gormley commented that the main outcome for these patients was to return home and the importance of receiving the correct treatment at the right time in a dedicated ward is crucial. He suggested that the team liaise with the Belfast Trust who can offer the learning identified through their introduction of therapy at the weekends. Dr McCormick welcomed this, however he stated that the Trust is unable to offer the same level of intensity of therapy available at the weekends, therefore this impacts the performance and length of stay for patients.

In response to a question asked by Ms Donaghy, Dr McCormick explained that target for administering lysis has decreased on both site particularly during covid. He attributed this to patients not presenting in a timely manner, rural setting for a co-hort of the population and challenges within the NIAS response times. He advised that DHH has the highest rate for carrying out Thrombectomy on patients which can be done within 24 hours of the patient presenting.

Ms Teggart asked that following the concerning figures presented what can Trust Board / Committees do to lend its support for further investment into the service? Mrs McClements explained that this issue has been raised with the stroke strategic group on a regular basis and the inequity across the region for funding. She added that the Trust has went at risk to create therapy roles and geriatricians in OPPC and Acute and work in ongoing with the planning department to keep the commissioners informed and up to date of the situation. Mrs McClements noted that additional resources are required within practice education facilitators, nurse specialists, succession planning, ambulatory service and an improve infrastructure. Ms Teggart

welcomed this and commented that the data presented supports the need for this.

Mrs McVey commented that the stroke service staff have shown compassion and professionalism during a challenging time and would welcome the support from Trust Board.

The Chair thanked Dr McCormick for his presentation and asked that an update be presented at the December 2022 meeting. She advised that she would write to the Trust Chair and Chief Executive to alert them to the significant findings from SNNAP and the need to for this service to be an area of prioritisation.

Action: Mrs Leeson

12. CHKS EXTERNAL BENCHMARKING PERFORMANCE REPORT

The Chair welcomed Mrs Lynn Lappin, Head of Performance to the meeting. She reminded members that at the last meeting time did not permit for a full discussion.

Mrs Lappin presented the CHKS Annual Performance Report, which provides an overview of the Trusts performance across a range of efficiency and patient safety indicators for the 12-month period of April 2020 to March 2021. She explained that the analysis undertaken in this report relies on the accuracy and completeness of clinically coded data. 100 is the maximum score achievable and is the most favourable position. The Trust scores comparatively positively to the NI Peer – Southern Trust 95.76 versus NI Peer 93.33.

Mrs Lappin presented data on length of stay (LOS). She stated that Craigavon Area Hospital (CAH) LOS analysis demonstrates a higher LOS in comparison to the NI Peer. However, when risk adjusted the LOS demonstrates better performance than the Peer – CAH 84.48 versus NI Peer 92.50. Daisy Hill Hospital (DHH) demonstrates better performance to Peer in relation to LOS indicators, including risk adjusted – DHH RALI 83.14 versus NI Peer RALI 92.50. Mrs Lappin added that a group has been established to review the current length of stay and looking for options to reduce this appropriate; this group is being led by Dr Gormley.

Readmissions were discussed. Mrs Lappin reported that the Trust's rate for readmissions within 30 days demonstrates better performance than the UK Peer and in line with NI Peers – Trust 8.3% versus UK Peer 9.8% versus NI Peer 8.3%.

Mrs Lappin noted the areas of concern. She advised that delayed discharge at the weekend for non – elective inpatients demonstrates a lower level of performance to that of the NI peer. Mrs Lappin stated that weekend discharges remains a longstanding challenge for the Trust with recent investment to extend services to in-patients across 7-days. To enable the Trust to improve performance further investment is required to enable full 7-day service provision.

In relation to Out-Patients, Mrs Lappin reported that the Trust's new to review out-patient ratio compares less favourably to both the UK Peer and the NI Peer – Trust 1:2.37 versus UK Peer 1:2.19 versus NI Peer 1:1.86. She attributed this decrease in performance with the Trust's New to Review ratio that is likely to have been impacted by the downturn in face to face out-patients with a focus on virtual appointments, which favoured review appointments over new appointments.

In response to a question asked by the Chair, Mrs Lappin explained that virtual appointments have worked well for a number of clinicians and services.

Dr Gormley advised that the data available from CHKS is very broad and if there were any data points that members would like included in future reports to inform him.

Mrs Leeman spoke of the resources within the Quality Improvement Team, which can be utilised to support data drive improvements and use their expertise to drive Quality Improvement across the Trust.

Mr McDonald referred to the readmission section and noted that the readmissions performance does not take into account any patients managed in Acute Care at Home (AC@H) and then subsequently admitted to a hospital bed. He asked if AC@H and virtual visiting has impacted admission rates and length of stay and if this can be

compared to peers. Mrs Leeman agreed to undertake further analysis of this and feedback at the next meeting.

Action: Mrs Leeman

Mrs Lappin left the meeting at this point

14. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

The Chair welcomed Mrs Trudy Reid, Interim Assistant Director Infection Prevention & Control to present the above named report. The paper provides data from 1st April 2019 to 15th November 2021 on infection data and antimicrobial stewardship data for PFA targets. A number of appendices were included with the reporting which contained information on: SHSCT PFA targets, Monthly Target Monitoring Report, Hand hygiene audit, Commode audit, Independent Hand hygiene audit, Independent Commode audit, COVID 19 data and Trust data on Antimicrobial Stewardship report.

Mrs Reid presented information on the current situation of Covid-19 pandemic. She highlighted the figures locally, regionally and hospital occupancy on those patients diagnosed with Covid. She reminded members that with there is a delay with covid community cases presenting to hospital for admission. Mrs Reid reminded members that patients/visitors attending the Emergency Departments continue to be tested and outbreak meetings are continuing on a daily basis. Reflection from covid cases in Care Homes is continuing to be worked through for learning.

Mrs Reid reported that work has commenced on one side of 4 South ward in CAH to improve the toilet facilities, ventilation and felt that this was a good model to use going forward for improving additional wards.

Data on Clostridium difficile (C. Difficile) was presented. Mrs Reid reported that C. Difficile rates are rising. For 2021/22 to date there is a total of 61 cases an increase of 20 from the previous report. She advised that there has been one outbreak of Clostridium difficile involving two patients; incident management meetings have taken

place. Learning has been shared at various forums and a serious adverse incident review is in progress. She further advised of a potential outbreak that is under investigation and is at an early stage.

Mrs Reid reported that there has been three preventable MRSA bacteraemia to date and post infection reviews have been carried out to identify learning. Learning has been shared with relevant teams involved. She provided background to the third cases and advised that it is being reviewed by the SHSCT and WHSCT.

Mrs Toal left the meeting at this point

15. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Hamilton presented the Executive Director of Nursing, Midwifery and AHPs report which largely covers the period from October 2021 to December 2021 and provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Frameworks and include areas regarding workforce, education training, and quality of practice.

Mrs Hamilton guided members through the report and highlighted specific areas for noting. She advised that for International recruitment, a regional plan is currently being developed to maximise overseas nurse recruitment to support Trust requirements. A requirement of 12 nurses per month was re-established and agencies are working to increase the pipeline of nurses. Seven nurses were recruited to the Trust in January 2022 and a further eight nurses are expected in February 2022. It is hoped that by March the target of 12 nurses per month will be reached. Mrs Hamilton stated that the vacancy levels across Acute and MHLD has reduced from October 2021 to January 2022.

Mrs Hamilton informed members that transformation work within the Dysphagia Service continues to progress and was pleased to report that RQIA has agreed to adopt the Trusts Dysphagia model regionally.

Mrs Hamilton reported on Nursing, Midwifery and AHP vacancy rates. She noted that from November 2021 to January 2022, CYP vacancy rate has increased by 18.06 wte and the OPPC vacancy rate has increased by 12.08 wte. Mrs Hamilton advised that open recruitment drives continues and the Practice Development team continue to support students and encouraging them to remain in the Trust following graduation.

Supervision was discussed. Mrs Hamilton drew members' attention to page 21 of the report, which outlines the directorate and divisional position as at 31st December 2021 for the first and second supervision sessions. The graphs show the compliance over the first 3 quarters of 21/22. Ms Donaghy noted her concern that within the Acute Directorate the percentage of staff having received their first supervision session is 39% (a 2 % increase on last reporting quarter) and 21% having had their second supervision session. Mrs Hamilton stated that a change in culture around supervision is needed and this is an ongoing process to ensure supervision is completed and documented to reflect accurate numbers. She reinforced the need for protected time for managers to carry out supervision, however due to workforce gaps and daily pressures this is challenging to achieve. Mrs Hamilton advised that discussions have taken place in Acute to ensure that supervision is prioritised.

In relation of agency staff and cost of agency pay rate, Ms Teggart asked what the Trust is doing to reduce this. Mrs Hamilton explained that this is a regional issue and until action is taken collectively by all 5 Trusts, the Southern Trust continues to face challenges on rising agency costs and usage. Mrs Hamilton agreed to seek an update from the regional group of the status of agency pay rate.

Action: Mrs Hamilton

16. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.50 p.m.

Signed _____ ***Dated*** _____

Southern Health and Social Care Trust

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COVER SHEET

Meeting and Date of meeting	Performance Committee Thursday 1st December 2022	
Agenda item	External Assurance Cardiology Service	
Accountable Director	Name	Cathrine Reid
	Position	Interim Director of Acute Services
Report Author	Name	Mrs Kay Carroll Head Of Service Cardiology Dr David Mc Eneaney, Consultant Cardiologist Charlotte Anne Wells Interim Assistant Director of Medicine and Unscheduled Care
	Email	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

The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that 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:

Background and Context

- The Trust has 32 dedicated Cardiology Beds on the CAH site and 6 Cardiology beds on DHH.
- The Trust has dedicated Cardiac Catherisation laboratory which is operational Monday to Friday 7.30am -9pm Monday to Friday exclusive of Bank Holidays
- The Cardiology Service has dedicated Cardiac Investigation Department across both acute site which operates Monday to Friday 8.30am – 5pm service plus Saturday and Sunday ECHO service only on CAH site.

Purpose

- Patients presenting to our Emergency Department are assessed based on following pathways
  - NCG 95 Acute Chest pain Pathway.
  - Acute Coronary Syndrome Sept 2014.

- Following assessment by a member of the Cardiology Medical Team Monday to Friday 9am -5pm the patient will be either admitted, discharged home or discharged for outpatient investigations.

- If patient admitted with NSTEMI the patient's care will be based on NICE guidelines. Patient will be added to Regional Cardiology Whiteboard and if accepted for inpatient procedure the MINAP nurse will monitor care provided.

- MINAP (Myocardial Ischaemia National Audit Project) is a domain within NICOR (National Institute for Cardiovascular Outcomes Research) that collects data and produces analysis to enable hospitals and health care improvement bodies to monitor and improve the quality of care and outcomes of cardiovascular patients.

  All NICOR Clinical audits and registries are now based in NHS Arden & Gem commissioning support unit.

  All hospitals in Northern Ireland contribute to the MINAP national Audit.

- The Southern Trust participates and utilises information from MINAP to inform the Trusts Cardiology Governance team and the Regional Cardiology Network.

This report is to provide information to the Performance Committee to provide assurance that a range of mechanisms are in place and new improvement opportunities identified in respect of arrangements to manage and improve Cardiology Services throughout the Trust.

Minap report see attached

Performance

Current Activity

The table below shows the split between elective and non-elective activity over the last y3 year period:

	Elective	Non-Elective	Total	Elective / Non-Elective
2019/2020	636	812	1448	44% : 56%
2020/2021	527	755	1282	41% : 59%
2021/2022	649	761	1410	46% : 54%

The table below highlights the current waiting list data for cath lab procedures (1/11/22)

Procedure	Total Number on Waiting List	Access Time in Weeks
Diagnostic Cath	784	Urgent 180 Routine 182
PCI	50	Urgent 125 No routine
Pacemaker / ICD	10	All urgent 13 weeks
Box Change	23	All urgent 20 weeks

Since removal of 2nd Cardiac Cath lab

Time Period (Month End)	Total Waits	Waits >13-Weeks	Longest Wait	Notes
March 2019	556	150	55-weeks	End of 2nd WLI in MCCL
March 2020	961	673	56-weeks	Start of Pandemic
March 2021	1109	896	108-weeks	-
March 2022	1054	801	150-weeks	-

Standard for Pacing Devices

- **British Heart Rhythm Society 2018**
  Standards for implementation and follow up on Cardiac Rhythm management devices in adults.

We have only one dedicated session per week in our Cardiac Catherisation Lab. Which impacts on patient safety and access times. SABA volume was 100 per year which we have exceeded due to patient safety.

PROCEDURE NAME	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
ILR implant	48	110	64	114	122
ILR Explant	13	29	10	33	13
ICD implant	0	1	8	14	12
CRT-D implant	0	0	1	0	0
Pacemaker implant	81	84	71	89	85
Pacemaker box change (including PPM/ICD/ CRT)	22	42	41	33	46

Lead revision/ extraction	0	1	2	3	3
Pocket evacuation	1	1	0	1	2
system explant	0	0	1	1	4
Implant totals	117	158	134	174	127
Device reviews (Pacemakers/ ICD/ CRT ILR)	2413	2653	4113	4156	

Links to Regional / Local Strategies:

Quarter Ending	HSC Trust	Specialty	Management	Programme Of Care	0 - 6 weeks	> 6 - 13 weeks	> 13 - 21 weeks	> 21 - 26 weeks	> 26 weeks	>26-52 weeks	>52 weeks	Total
30-Sep-19	Belfast	Cardiology	Day Case	Acute Services	137	83	43	21		51	17	**352**
30-Sep-19	Northern	Cardiology	Day Case	Acute Services	70	48	20	2		3	0	**143**
30-Sep-19	South Eastern	Cardiology	Day Case	Acute Services	93	50	37	17		68	3	**268**
30-Sep-19	Southern	Cardiology	Day Case	Acute Services	228	215	242	39		83	3	**810**
30-Sep-19	Western	Cardiology	Day Case	Acute Services	56	74	61	32		12	0	**235**
30-Sep-22	Belfast	Cardiology	Day Case	Acute Services	188	111	102	43		134	130	**708**
30-Sep-22	Northern	Cardiology	Day Case	Acute Services	58	47	33	7		27	4	**176**
30-Sep-22	South Eastern	Cardiology	Day Case	Acute Services	141	102	78	14		75	71	**481**
30-Sep-22	Southern	Cardiology	Day Case	Acute Services	110	112	99	43		213	362	**939**
30-Sep-22	Western	Cardiology	Day Case	Acute Services	99	100	49	9		36	26	**319**

Standards:

- NStemi Patients should have their cardiac cath lab procedure carried out within 72 hours. Currently SHSCT is only achieving 33%. See attached Minap report
- Belfast and Western Trust Did not Submit Data but MINAP nurse advised that following discussion with their Nurse **Belfast achieved 80%** and **Western Trust 79%**
- Staged PCI Presentation within 45 days -
- Primary Pacemaker within 48 hrs – SHSCT patients wait 5 – 7 days as an inpatient
- Box change within 6 weeks – currently SHSCT patients waiting 13 weeks

2. Areas of improvement / achievement:

- The Trust has a Cardiology Governance team which meets Bi Monthly and reviews MINAP data.
- The Trust is currently working with our Planning and Performance team exploring options regarding a second Cardiac Catherisation Laboratory – this will require investment from the Trusts general capital and commissioner commitment to revenue support.
- There is close collaborative working with various disciplines across the Trust and Belfast Trust to provide timely access to Investigations i.e. Pulmonary

Function Test, Cardiac MRI, for patients who have attended our Cardiac Catherisation laboratory for stenting and who require Cardiac Surgery.
- Weekly Heart Team meeting with our Cardiology Team and Cardiac surgeons. Some patients the Cardiac Surgeon may request further steinting by our Interventionalist Team and that's when we require two operators.
- MINAP nurse provides updates on twice weekly reports and escalation process regarding delays to Cardiology Network Lead.
- The development of Rapid access Chest Pain Nurse in our Emergency Department has facilitated discharge home with no further investigation or discharge with investigations as outpatient which the Nurse can order. The Chest Pain Nurse has won Northern Health Care Award for this work in 2021.

3. Areas of concern/risk/challenge:

Key areas of concern relate to
- Bed pressures on both site present challenges in ensuring that Cardiology patient's assessed and accepted by the Cardiology Team are admitted to Cardiology Bed in 1 North CAH and to a bed in Coronary Care DHH.
- The Cardiology Beds within the Trust are not protected and this is not in keeping with other 4 Trusts in NI.
- There is a need to have protected bed in cardiology for Primary Percutaneous patients returning 6 hours post PCI stenting from Belfast Trust.
- Overcrowding in Emergency Department, impacts on triage and the patients journey time which is critical in this time-sensitive condition.
- In order to care appropriately for Cardiology patients the Trust needs to protect bed capacity to provide the necessary acute care and rehabilitation requirement. There is no Inpatient Cardiac rehab Nurse for DHH site. We are waiting on the results of the Regional review of Cardiac Rehabilitation across NI.
- All patients who are referred to Regional Cardiology Whiteboard and accepted for Intervention must have ECHO carried out within 24 hours of admission. There is inadequate ECHO provision across both acute sites. DHH have no 7 day Service.
- Provision of Cardiac MRI session/s on the CAH site would reduce 10 day delay for this being provided on Mater Hospital and all the Transfer Issues.
- Increase Staff in Respiratory Physiology would assist with more timely access to Pulmonary Function test for our Cardiology Patient waiting Surgery.
- Patients admitted with Heart Block should have Pacemaker inserted so we need increased access to Cardiac cath lab there is no agreed OOH Regional Pathway as we have only 3 Cardiology pacemaker consultants which can insert temporary Pacemaker when on call.
- BHRS guidelines 2018 on Pacemaker indicate 6-8 weeks for insertion
- The workforce for Medical, Nursing and Clinical Physiology is inadequate and falls well below recommended guidelines. The Health Social care Board had recognised the workforce gaps Band 6 and Band 7 in Cardiac clinical Physiologist approximately 2 years ago but despite are concerns raised this Funding has not been secured Trust needs to commit to improving this so that improved standards of care can be achieved for our patients.
- We only have 1 wte Chest Pain nurse across both Acute Sites. We require 2.2 wte Band 7 per site.
- We only have dedicated Junior Medical Team 5 days per week Monday to Friday 9am -5pm. Other Trusts have SHOs which provide cover 7 days per

week and whilst they are rostered for Cardiology on Nights they also assist with General Medical Rota.

- We would require two further Cardiologist to assist with Service needs in imaging and Cardiac Cath Provision and also enhance Cross Site Working on DHH site.
- MINAP data, access volumes and access times should drive to improve performance and improve access for our patients for Cardiac Catherisation procedures. Despite this being raised change has not progressed at pace.
- Our daily waits for Cardiology beds should drive to have protected Cardiology Units on both sites.
- The challenging current financial climate and impact on the ability to secure capital and revenue investment to effect the reconfiguration in services required to achieve improvement.

4. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	
Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

Southern Health and Social Care Trust

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GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	9th September 2021		
Agenda item	Clinical and Social Care Governance Report		
Accountable Director	Dr Maria O'Kane		
Report Author	Name	Caroline Doyle	
	Contact details	Personal Information redacted by the USI	
This paper is presented for: **Information**			
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 Committee with a clear summary of the paper being presented, with the key matters for attention and the ask of the Committee.* *It details how it impacts on the people we serve.*

1. Detailed summary of paper contents:
The purpose of this paper to provide a report to Governance Committee (September 2021) on a number of Trust Clinical and Social Care Governance Indicators. This report provides information on Incident Reporting, SAIs, Catastrophic Incidents, Patient Safety and Quality Measures, Service User Feedback and Ombudsman cases.
2. Areas of improvement/achievement:
• 24 SAI Reports submitted this quarter • Number of Incidents relating to staff shortages caused by COVID-19 has reduced • Reduction in the number of reopened complaints
3. **Areas of concern/risk/challenge:**
• Number of Outstanding Incidents has increased • Number of SAI notifications submitted to HSCB has increased

4. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	This links to the risk of harm to the SHSCT population through inability to access safe, timely and appropriate care.
Board Assurance Framework	Yes
Equality and Human Rights	No

Southern Health and Social Care Trust

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Clinical and Social Care Governance Report September 2021

Contents

1.0 Purpose of Report

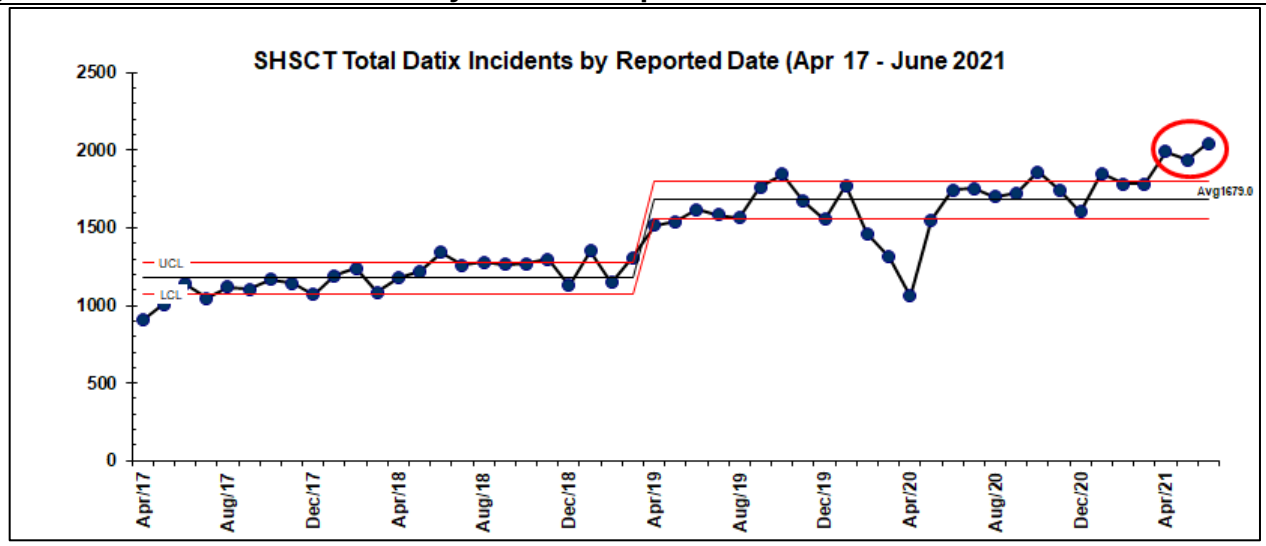
This report is to provide information to Trust Governance Committee regarding the Clinical and Social Care Governance indicators agreed by the Trust Senior Management Team:

- **Incident monitoring to include Serious Adverse Incident and reporting timeframes**
- **Patient safety & quality measures**
- **Complaint monitoring**
- **Compliment monitoring**

The report analyses activity for the period **1st April – 30th June 2021 (Quarter 1),** with the exception of Patient Safety & Quality measures which are for the previous quarter **(January - March 2021, Quarter 4).** Incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognising and reporting an incident (or near-miss), no matter the level of harm, is the first step in learning to reduce the risk of future occurrence.

To set the wider context, this quarterly reporting period – **01/04/2021 to 30/06/2021 -** reports on Clinical and Social Care Governance indicators during the CoronaVirus pandemic period.

2.0. Incident Reporting (via Datix)[1]

2.1 Total No. Incidents Logged via Datix	Fig 1.0 – Total SHSCT Incidents by Month 01 April 2017 – 30 June 2021.
Overall Trust Position In Q1 2021/22 - SHSCT directorates reported: ▪ 5971 IR1 incidents ▪ Forecast for the year based on this quarter 23,884 ▪ 2020/21 – **20,153 ↑4.9%** ▪ 2019/2020, **19,207** IR1 incidents **↑28%** ▪ 2018/2019, **15,043** IR1 incidents **↑14%** ▪ 2017/2018, **13,219** IR1 incidents This quarter has seen a significant rise in overall reported incidents in each month, demonstrated by special cause variation with 3 upper confidence level breaches.	

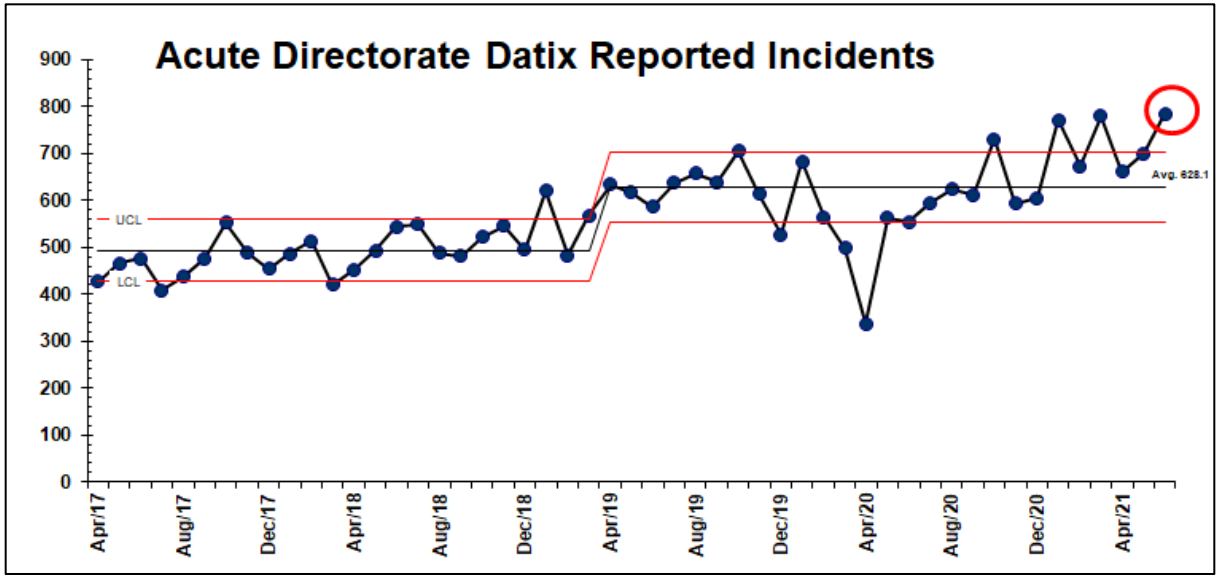
[1] Monthly incidents are now reported on the basis of the date on which the incident was reported via Datix and not the date that the incident occurred.

Fig 2.0 Operational Directorate Monthly Datix Incidents 01 April 2017 – 30th June 2021.

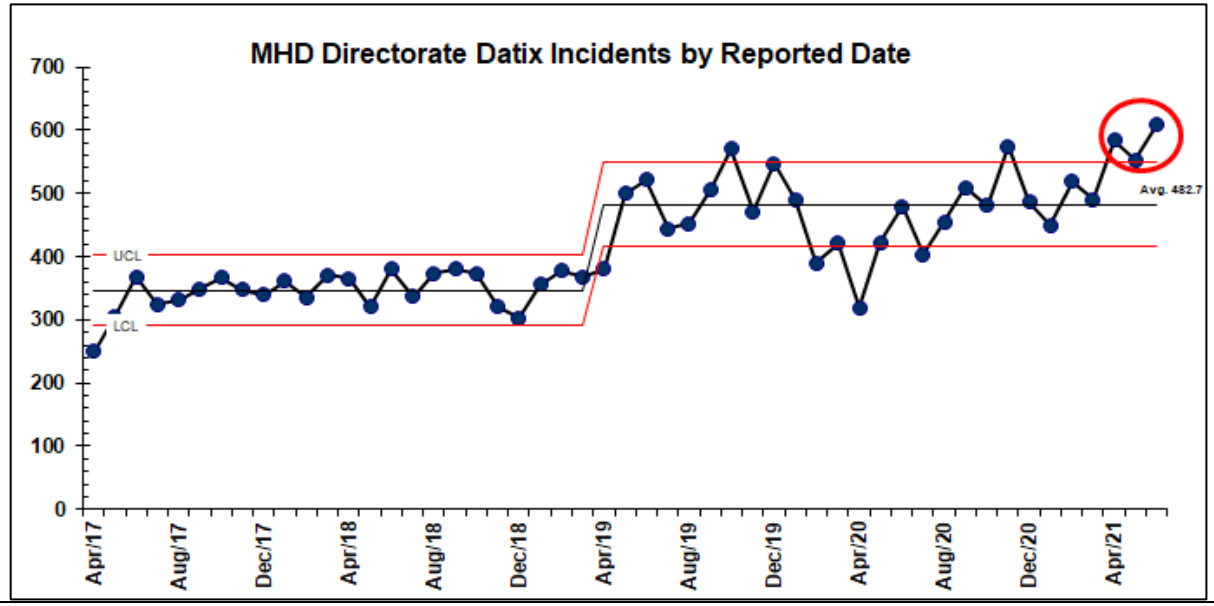
Directorate Position

In this quarter the Acute Directorate has seen a significant increase in incident reporting for the month of June, demonstrated by special cause variation with a single upper confidence interval breach. This follows 3 other significant breaches in the past year previously reported.

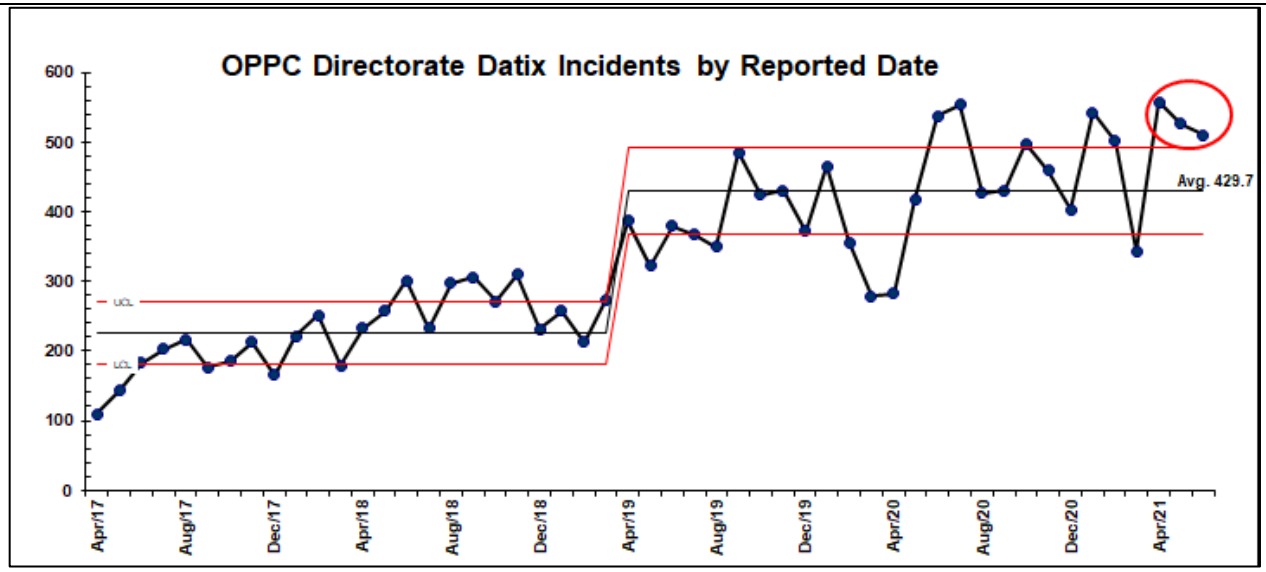
Since January 2021 the Acute Directorate identified an increase in reporting due to the COVID-19 pandemic. There has also been an increase of Violence and Aggression incidents (further broken down in the V&A section), with all incidents involving security being reported.



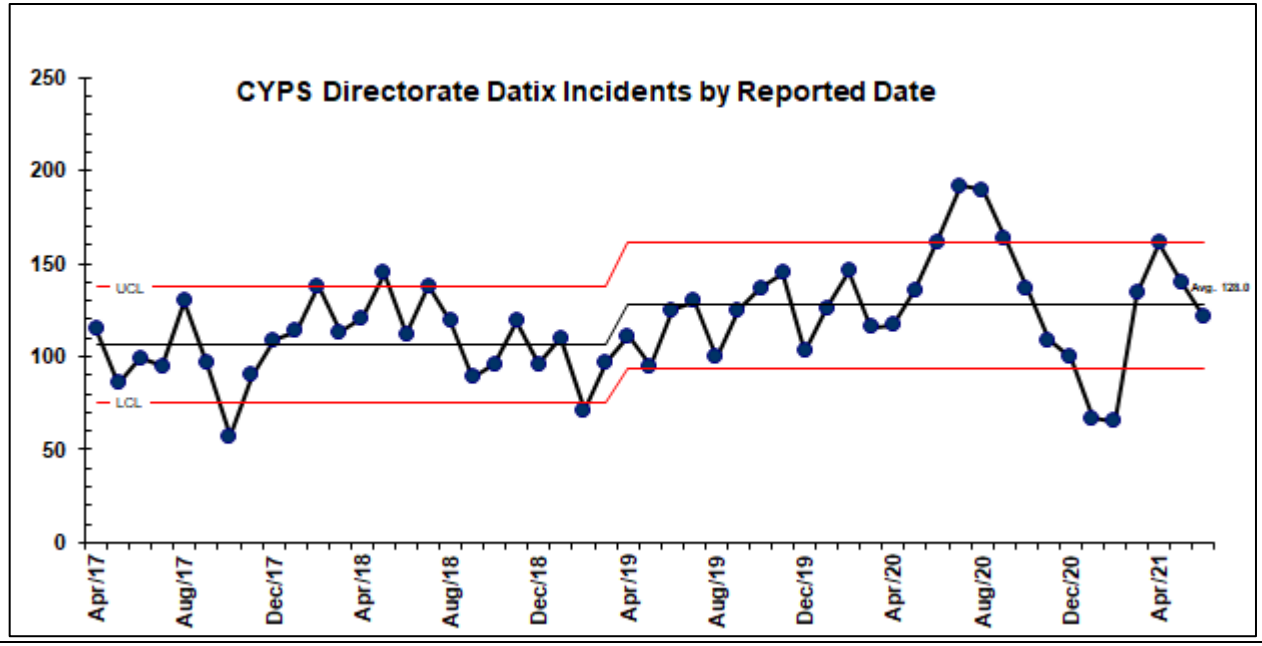
In this quarter the Mental Health Directorate (MHD) has seen a significant increase in incident reporting in all 3 months, demonstrated by special cause variation with 3 upper confidence breaches. This follows 1 other significant breach within the past year (previously reported).

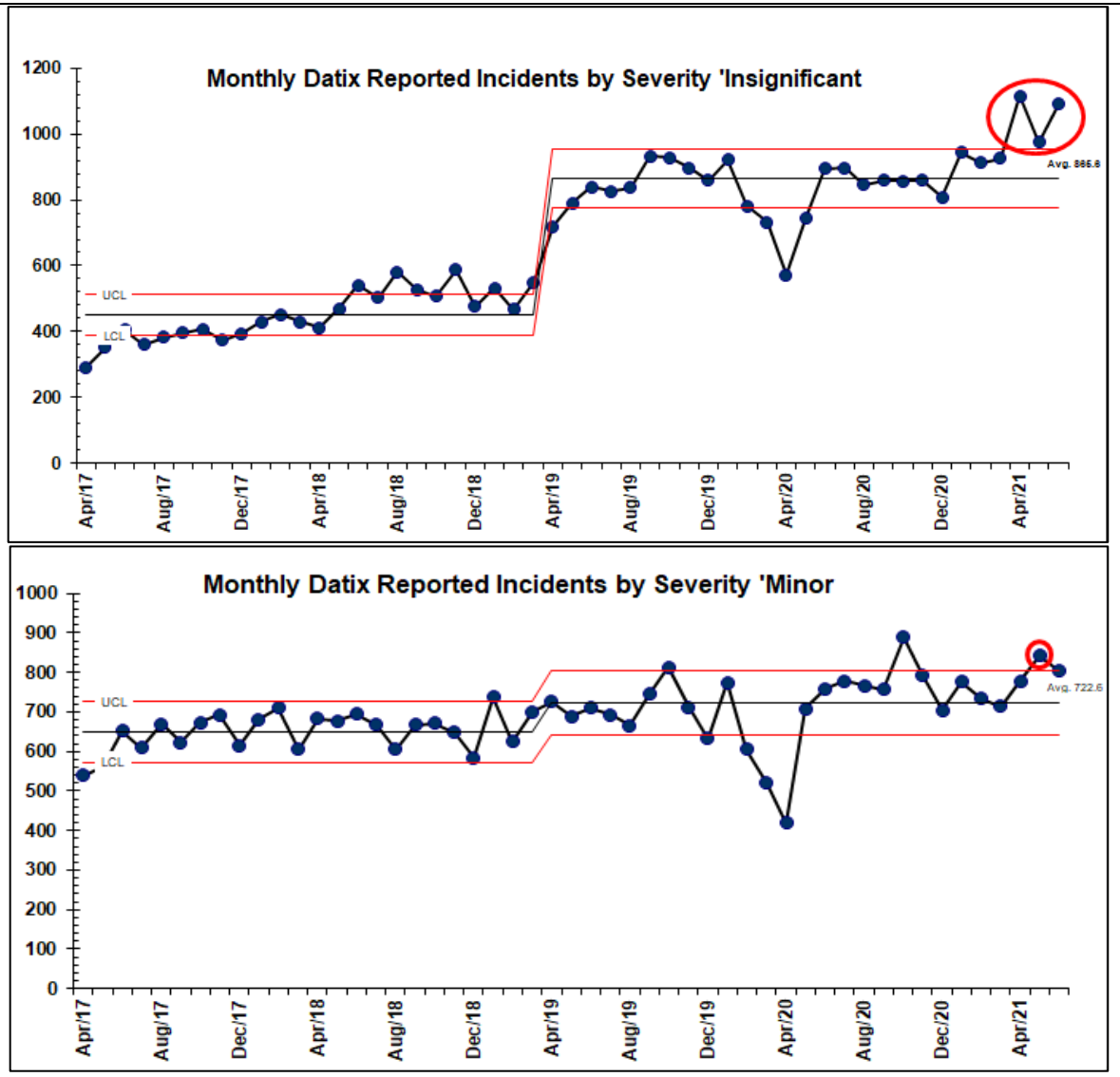


This quarter OPPC has seen a significant increase in incident reporting in all 3 months, demonstrated by special cause variation with 3 upper confidence breaches. This follows 4 other significant breach within the past year (previously reported).
This is thought to represent a healthy reporting culture which is now including the increased awareness of dysphagia type incidents reporting of which commenced in March 2021 across the Trust and Independent sectors.



In this quarter CYPS has seen no significant increase in reported incidents. The 3 other significant increases within the past year have been previously reported. The decrease in reporting this quarter is thought to be in relation to a more settled period within the residential units.



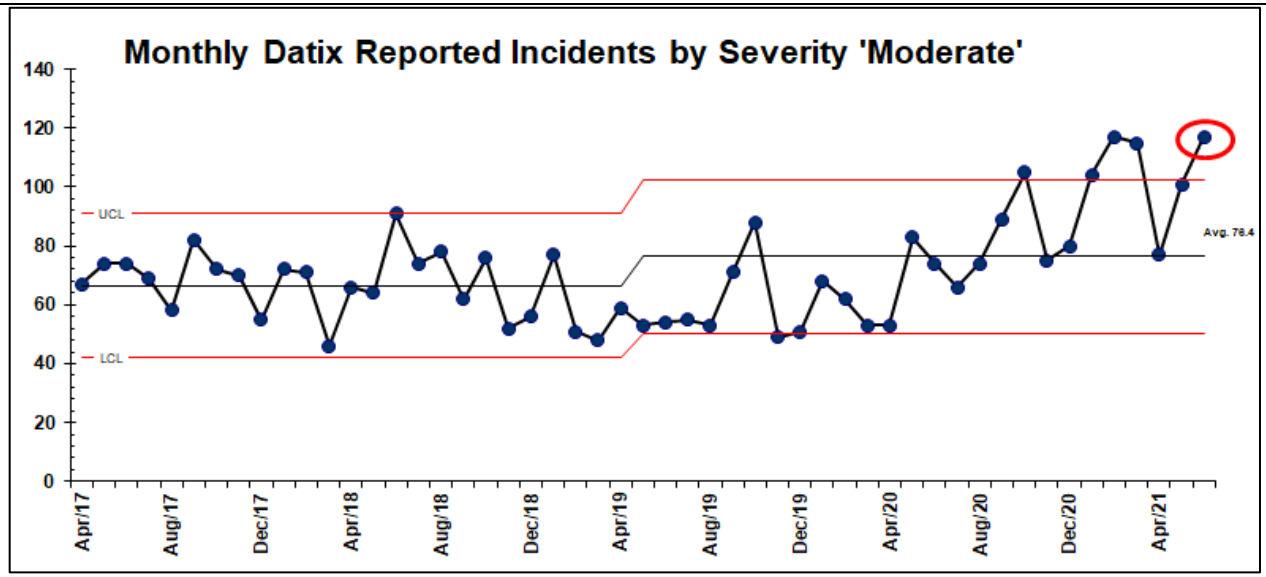
2.2 Incident Severity[2]	Fig 3.0 - Total SHSCT Monthly Incidents by Severity 01 April 2017 – 30 June 2021
Q1 2021/2022 (Apr – June 2021) **53%** of SHSCT IR1 Incidents categorised as severity 'Insignificant' In 20/21 the reporting of insignificant incidents dropped to 49.93**%** of all incidents. In this quarter there has been a significant increase in the reporting of incidents categorized as insignificant in each month. This is demonstrated by special cause variation with 3 upper confidence limit breaches, which reflects a positive culture of reporting. Such a culture contributes to learning, helps to prevent re-occurrence, reducing avoidable harm and increasing safety and quality. 26.2% of these incidents have not been categorised. 36% are Behaviour related incidents and 17% are in relation to Falls. **40%** of SHSCT IR1 Incidents categorised as severity 'Minor' In this quarter there was 1 month where there was a significant increase in incidents categorized as Minor. This is demonstrated by special cause variation with a single upper confidence limit breach. 16% of these incidents have not been categorised. 20% are in relation to	

[2] Includes incident Severity for 'unapproved incidents' (2021) which could be subject to change on final approval of the incident

Behaviour related incidents and 17% are in relation to Falls.

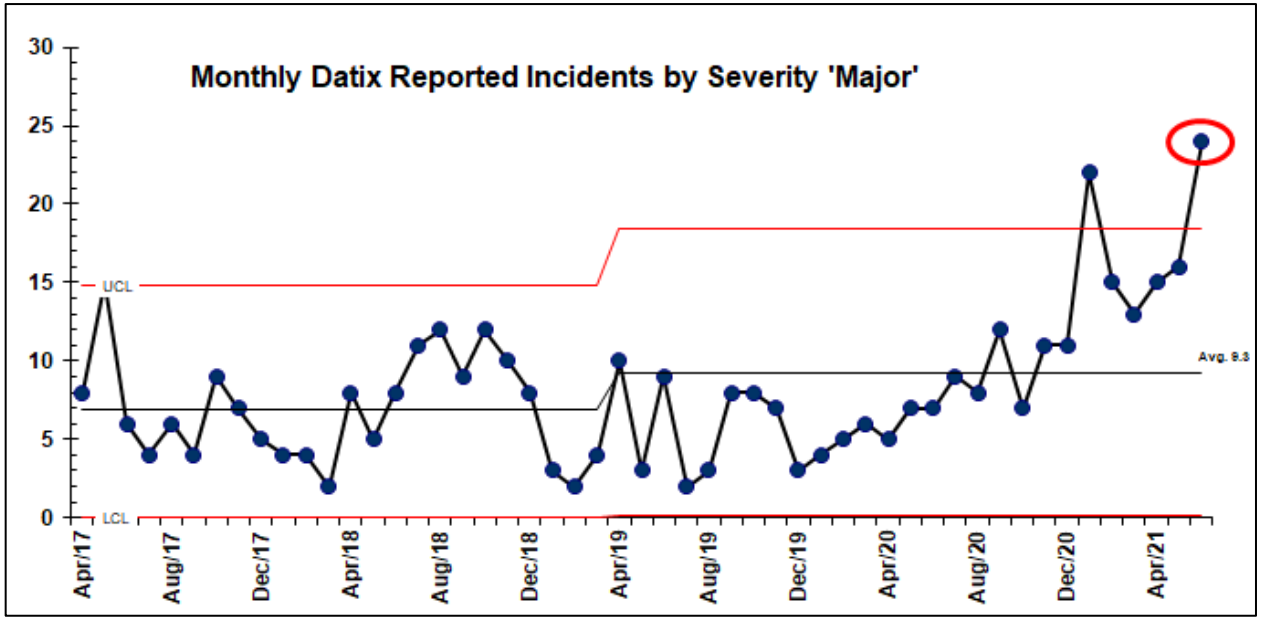
4.95% of SHSCT IR1 Incidents categorised as severity 'Moderate'

Over the last 3 months the incidents sit above the mean with a single upper confidence limit breach in June 2021. 36% of these incidents have not been coded. 13% are related to Medication and 9% are Behaviour related incidents.



0.92% of SHSCT IR1 Incidents categorised as severity 'Major'

This quarter the number of Major report incidents has increased. 36% of these incidents remain uncoded and 23% relate to Covid-19. There was an upper confidence limit breach in June and there has been 8 consecutive data points above the mean.
36% incidents remain uncategorised and 23% in relation to Infection Prevention Control.



0.18% of SHSCT IR1 Incidents categorised as severity 'catastrophic'

Numbers of catastrophic incidents remain low. In this quarter there has been no significant change in incidents reported as Catastrophic. The previous single upper limit breach was reported in the last quarter.
27% of these incidents remain uncategorised the categorised incidents include incidents involving suicides and HCAI Deaths.

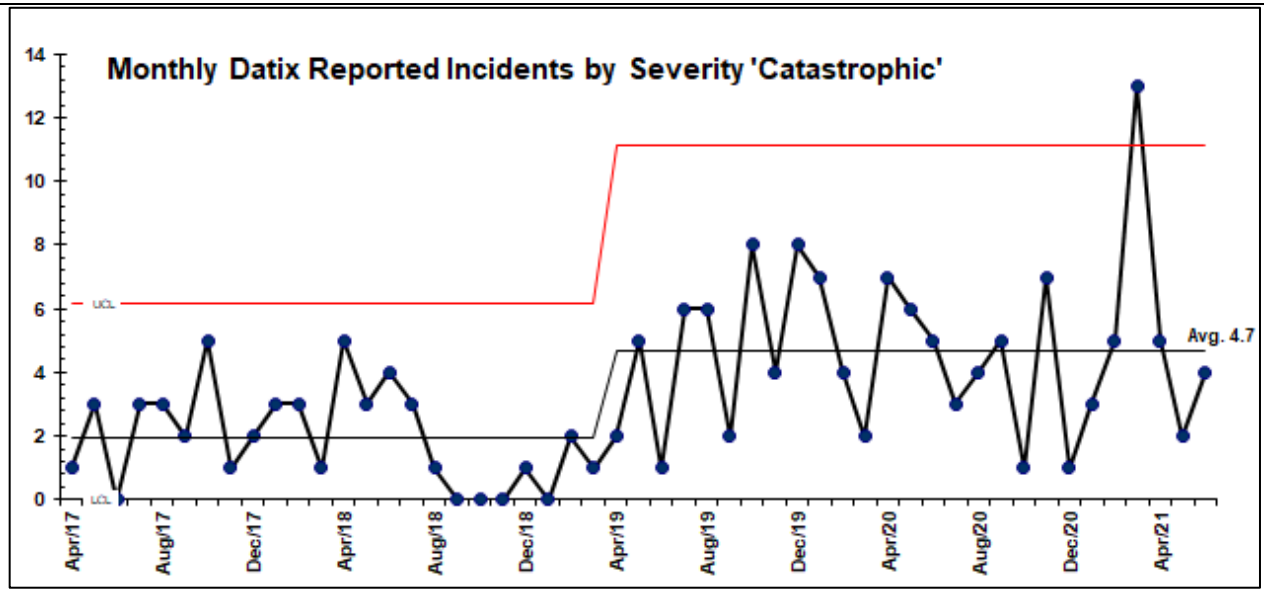


Table 1.0 provides the breakdown of all SHSCT catastrophic incidents by Directorate since January 2020.

Directorate/Catastrophic Incidents	Jan - Mar 20	Apr - Jun 20	July - Sept 20	Oct - Dec 20	Jan - Mar 21	Apr - Jun 21
Acute Services	3	4	3	3	9	6
CYPS	2	0	1	0	2	0
MHD	5	11	8	6	6	4
OPPC	0	2	1	0	4	1
Grand Total	10	17	13	9	21	11

Table 1.1 details overall proportion of incidents in each severity category year on year.

Year % Severity	Insignificant	Minor	Moderate	Major	Catastrophic
% 2017/18	35.34%	57.75%	6.13%	0.57%	0.20%
% 2018/19	40.85%	52.96%	5.32%	0.61%	0.13%
% 2019/20	52.48%	42.93%	3.87%	0.35%	0.30%
% 2020/21	49.93%	43.31%	5.69%	0.74%	0.30%
% 2021/22	53.34%	40.61%	4.94%	0.92%	0.18%

Table 1.2 Details Total Trust Incidents by year, by severity. 2021/22 forecasted for the full year.

FY	Insignificant	Minor	Moderate	Major	Catastrophic	Unallocated	Grand Total
2017/18	4671	7634	810	75	27	2	13219
2018/19	6145	7967	801	92	20	18	15043
2019/20	10080	8245	743	68	58	13	19207
2020/21	10063	8728	1146	149	60	7	20153
2021/22	12740	9700	1180	220	44	0	23884

2.2 Incident Severity Cont'd - Catastrophic Incidents and SAI Notifications

Between 1st April to 30th June 2021 – 11 catastrophic incidents (0.18%) were recorded. 8 of these incidents have also been notified to the HSCB as SAI's. In addition a further 19 SAI's were also reported to the HSCB and are set out in Table 4.0 below.

Summary: Total Number 32

Catastrophic Incident reported during period, not SAI – 5

Catastrophic Incident reported during period and reported as an SAI between 01/04/2021 – 30/06/2021 – 6

Catastrophic Incident reported before 01/04/2021 reported as an SAI between 01/04/2021 – 30/06/2021 - 2

Other Incidents reported as SAI's – 19 (1 insignificant, 2 minor, 10 moderate and 6 major – 2 of the moderate incidents was also a Never Event).

Table 2.0 – Catastrophic Incidents and / or SAI's notified to the HSCB by Directorate

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Irrelevant information redacted by the USI		n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await outcome from M&M/SJR.
Irrelevant information redacted by the USI		n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								outcome from M&M/SJR.
Irrelevant information redacted by the USI		n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await outcome from M&M/SJR.
Irrelevant information redacted by the USI		n/a	n/a	Child died in ED following injuries sustained in a road accident.	Acute	Catastrophic	No	No immediate learning.
Irrelevant information redacted by the USI		n/a	n/a	Hospital acquired Covid.	Acute	Catastrophic	No	Incident reviewed, no early learning for dissemination, await outcome from M&M/SJR.
Irrelevant information redacted by the USI		15/06/2021	Screening processes	Patient physically attacked two members of nursing staff with a knife.	Acute	Minor	Yes	Debrief with staff. Detox policy was not initiated.
Irrelevant information redacted by the USI		04/06/2021	Screening processes	Baby transferred to SCBU following low APGAR scores. Subsequently transferred to RVH for management.	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		04/06/2021	Screening processes	Following an emergency caesarean section patient experience 6500ml blood loss and required	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
				hysterectomy. Ventilated and transferred to ICU.				report recommendations. Maternity asked to comment
Irrelevant information redacted by the USI		03/06/2021	Screening processes	Patient attended for planned removal of ureteric stent. Pre-op bloods were not consulted prior to procedure which indicated there was new renal impairment. Patient readmitted with renal failure and sepsis. Subsequently transferred to RVH for bilateral nephrostomies.	Acute	Major	Yes	Available imaging and blood results at the time of planned procedure on 17/05/2021 suggested that the clinical situation had changed, this did result in a change of plan. However this change in plan was not communicated with the RVH.
Irrelevant information redacted by the USI		12/04/2021	Screening processes	Retained swab post caesarean section.	Acute	Moderate	Yes	All swabs must be counted thoroughly and swab counts done according to protocol. This must also be documented in the hand held notes. Patient must be kept informed about this.

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Irrelevant information redacted by the USI		25/06/2021	Screening processes	Retained swab post caesarean section.	Acute	Moderate	Yes	All swabs must be counted thoroughly and swab counts done according to protocol. This must also be documented in the hand held notes. Patient must be kept informed about this.
Irrelevant information redacted by the USI		24/05/2021	Screening processes	Delay with RVH accepting this patient, who had an unstable spine fracture, for management.	Acute	Moderate	Yes	The RVH was contacted by the SHSCT for transfer as per unstable spinal protocol. The RVH should have accepted patient as per protocol.
Irrelevant information redacted by the USI		07/06/2021	Screening processes	Still born baby.	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		24/05/2021	Complaints process first.	Patient experience reduced vision in both eyes two days following total hip replacement.	Acute	Major	Yes	Patient referred to Belfast Trust for management. Ischemic optic neuropathy

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								secondary to hypotension. Patient was on medication for hypertension, Consideration for review of hypertension medication.
Irrelevant information redacted by the USI	04/06/2021	Screening processes	Following a planned caesarean section patient experience 5000ml blood loss.	Acute	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations. Maternity asked to comment	
Irrelevant information redacted by the USI	08/04/2021	Internal SEA and then escalated to a Level 1.	FAST positive patient. Delays in getting patient to hospital. On arrival difficulty in establishing contact with on-call radiologist. After RVH accepted patient for management further delays experienced in obtaining ambulance transport.	Acute	Major	Yes	CT brain should be completed within 45 minutes of admission.	
Irrelevant information redacted by the USI	29/04/2021	Screening processes	Patient underwent recon nailing of his right femur and was discharged home. At review clinic 8 weeks later it was noted that the patient's	Acute	Major	Yes	True lateral x-ray should be undertaken in theatre for all	

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
				right leg was 2cm shorter than the left with some external rotation of the right foot.				patients who are undergoing recon nailing of the femur. Patient referred to Belfast Trust for management.
Irrelevant information redacted by the USI		29/04/2021	Screening processes	Delay in review due to Covid-19. Patient diagnosed with advance uterine sarcoma.	Acute	Major	Yes	Patient referred to Cancer MDM.
Irrelevant information redacted by the USI		15/04/2021	Screening processes	Patient experienced ruptured aortic dissection out of hospital. Had been in ED 3 days previously and treated for an upper respiratory tract infection.	Acute	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		07/06/2021	Early Alert notified on 19/04/2021. On 10/05/2021 Early Alert was discussed at the HSCB Incident Review Meeting and the Group confirmed that NO SAI is to be submitted. On 28/05/2021 the HSB advised that the Early Alert record had been reopened and requested that an SAI notification be made in respect of this incident given the potential risk posed by	On Personal information redacted by USI a Personal Information redacted by the USI left her foster home and was reported as a missing person to the PSNI. It transpired that the young person was abducted by her father and taken to Personal Information	CYPS	Moderate	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
			father to daughter.					
Irrelevant information redacted by the USI		01/04/2021	Delay in receipt of SD1 / Information gathering	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		01/04/2021	Information gathering & approval	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		30/06/2021	n/a	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		26/04/2021	Information gathering & approval	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		08/04/2021	Delay in receipt of SD1 from PSNI	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								recommendations.
Irrelevant information redacted by the USI		10/06/2021	Information gathering & approval	Suspected suicide in the community of a service user known to Mental Health Services.	MHD	Catastrophic	Yes	Incident reviewed, no early learning for dissemination, await report recommendations.
Irrelevant information redacted by the USI		01/06/2021	Adult Safeguarding and Public Prosecution Service processes. Competing resourcing priorities associated with the pandemic, restarting of services and the completion of Deprivation of Liberty applications as part of the Mental Capacity Act.	Allegation of physical abuse of service user by one care assistant against another.	OPPC	Insignificant	Yes	Staff member suspended from all duties by the Home Management with immediate effect
Irrelevant information redacted by the USI		17/05/2021	Delay in Acute notifying NAH of the death and therefore delay in the notification.	Choking incident while hospital inpatient. CPR commenced. Client subsequently died.	OPPC	Major	Yes	All wards and departments advised and instructed to review their defibrillation machine

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								pad stock and remove any incorrect stock and replace immediately with the correct pad stock. Ward Sisters instructed to check medical devices for correct compatible products. Resuscitation trolley checklist updated to include a prompt for staff to check the compatibility of the defibrillator pads as well as a picture of the correct pads to be completed on the regular weekly crash trolley and daily defibrillator checks. The Cardiac arrest protocol was reissued to all staff and the staff asked to sign and

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
								date they have read same. Protocol discussed at daily handovers safety brief. Ward Sisters to monitor compliance with reading of protocol and Nurse Manager will monitor compliance at Ward Sister 1 to 1. A review of the nursing staff Immediate Life Support (ILS) training was conducted by the Nurse
Irrelevant information redacted by the USI	01/06/2021		Delay in Keyworker being notified by Home.	Resident was observed with the call bell lead wrapped loosely around his neck.	OPPC	Moderate	Yes	Call bell changed to one with no lead. Client observed closely overnight. GP, relevant services and Next of Kin notified the next morning.
Irrelevant information redacted by the USI	01/06/2021		A joint protocol Police Service for Northern Ireland (PSNI) / Southern Health and Social care Trust (SHSCT) Adult Safeguarding Investigation. PSNI advised strong case to	Allegation of monies missing from Service User's bank account.	OPPC	Moderate	Yes	Referral was made to Safeguarding and the PSNI. Care staff ceased from carrying out shopping for resident. Resident's

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
			secure a prosecution in relation to this incident and that the PSNI are forwarding a report to the Public Prosecution Service (PPS).					family informed.
Irrelevant information redacted by the USI		06/05/2021	Care Home did not follow process for reporting incident to Trust. Trust advised of incident by family.	Residents family were contacted in error and informed their mother was passing away and that they needed to attend the home. Incorrect family notified.	OPPC	Minor	Yes	Staff member who contacted wrong family has reflected on incident. All other staff advised of the incident in order to raise awareness and try and reduce the likelihood of a similar incident occurring in the future. Electronic recording system assessed to determine if any adjustments could be made to try and reduce the likelihood of a similar incident occurring in the future. Care Home Management provided an apology to each family.

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Irrelevant information redacted by the USI		14/06/2021	Took time to ascertain the detail across the independent sector provider, and Trust services	Death of Service User following choking incident.	OPPC	Catastrophic	Yes	Emergency resuscitation commenced. Ambulance requested.

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director and Clinical Lead along with the Governance Coordinator. This process identifies any areas of immediate learning resulting from incidents to ensure they are acted upon

[3] This incident has been since upgraded to Catastrophic.

[3] Screening process as at Jan 2020.

2.3 Incidents Classification[4]

Datix reporting introduced a new classification system which was adopted regionally by all HSCTs on 15/04/2019. This has introduced changes to categorisation and also requires an allocation of 'who' the incident involved.

Tables 3.0 and 4.0 below summarise:

- Total incidents (across all directorates) for the period April – June 2021, by who was involved.
- Trust Top 10 categories
- **24.7 (up from 20.9% last quarter) % incidents – uncategorised at the time of reporting**.

Table 3.0 below provides a breakdown of Incidents broken down by 'Who was involved'

Incident Involved	Q1 21/22 No. of Incidents	% Total	Q4 20/21 No. of Incidents	% Total	Q3 20/21 No. of Incidents	% Total	Q2 20/21	% Total	Q1 20/21	% Total
Patient & Service User	3545	59.37029	3178	58.69966753	2855	55	3116	60	2699	62
Staff	711	11.90755	891	16.45733284	936	18	723	14	754	17
Public / Visitors	52	0.870876	30	0.554118951	26	0	25	0	23	1
Organisational	183	3.064813	181	3.343184337	182	3	143	3	142	3
Uncategorised	1480	24.78647	1134	20.94569634	1208	23	1172	23	737	17
Total	5971		**5414**		5207		**5179**		**4355**	

Table 4.0 below provides a breakdown of the Top 10 Incidents by Category.

Categorised incidents cover 36% of the 5971 incidents, excluding 'uncategorised' and 'other'.

Qu 1 SHSCT 'Top 10' By Incident Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Uncategorised at time of Reporting	835	516	108	20	3	1482
Behaviour (Including Violence and Aggression)	1149	613	27	4	3	1796
Accidents/Falls	551	362	26	6	1	946
Medication/Biologics/Fluids	269	209	41	1	0	520
Pressure Ulcers	38	183	10	0	0	231
Other	92	65	11	1	1	170
Diagnostic Processes/Procedures	32	76	10	3	0	121
Communication	40	55	9	0	0	104
Maternity Care	5	68	14	2	0	89
Service Disruptions (environment, infrastructure, human resources)	29	41	9	0	0	79
Other Categories outside Top 10	145	237	30	18	3	433
Grand Total	3185	2425	295	55	11	5971

In this quarter the categories remains consistent to previous quarters pre the Covid-19 pandemic, this quarter there were no Infection Control Incidents in the Top 10, other than incidents in relation to the vaccine. Maternity Care and Service Disruptions appeared in the Top 10 this quarter.

Tables 5.0 – 8.0 provide a further drill down listing the top 10, by involvement, category and severity[5].

Table 5.0. Incidents involving Service Users - 59%. Falls and pressure ulcers are key patient safety areas further reported in section 3.0. Whilst table 5.0 provides details on all pressure ulcer and patient falls, section 3.0 reports on hospital acquired pressure ulcers and injurious fall sub-categories.

[4] Incident classification is now reported at the aggregated category level, accumulating all relevant smaller sub-categories. This themes incident classification at the highest level with further sub-category drill down available.

[5] Datix data quality impacts the categorisation, e.g. if IR1 incorrectly associates the incident to a staff member when a patient is the 'involved' person. Datix training investment is required for improvement alongside data quality processes.

Q1 Apr - June 2021 Patient/Service User Incidents by Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Behaviour	814	406	19	3	3	1245
Patient Accidents/Falls	504	300	20	5	1	830
Medication/Biologics/Fluids	256	191	29	1		477
Pressure Ulcers	38	183	10			231
Other	92	65	11	1	1	170
Diagnostic Processes/Procedures	32	76	10	3		121
Communication	40	55	9			104
Maternity Care	5	68	14	2		89
Documentation	18	33	3	1		55
Infection Control Incident (Healthcare Associated Infection)	9	16	2	13	1	41
Other Categories outside Top 10	45	112	19	4	2	182
Grand Total	1853	1505	146	33	8	3545

Table 6.0. Incidents involving Staff – 11%

Q1 April - June 2021 Staff Incidents by Category	Insignificant	Minor	Moderate	Major	Grand Total
Behaviour (Including Violence and Aggression)	327	203	4	1	535
Accidents/Falls	39	51	5	1	96
Exposure to Environmental Hazards	14	28	0	0	42
Property	14	21	3	0	38
Grand Total	394	303	12	2	711

Table 7.0. Incidents at an Organisational Level – 3.06%.

Q1 Apr - Jun 2021 Organisational Incidents by Category	Insignificant	Minor	Moderate	Grand Total
Service Disruptions (environment, infrastructure, human resources)	29	41	9	79
Medication/Biologics/Fluids	13	18	12	43
Fires, Fire Alarms and Fire Procedures	22	5	1	28
Security of Organisation's Property, Data and Buildings	10	6	1	17
IT Systems	0	11	1	12
Public Order/Crowd Control	2	2	0	4
Grand Total	76	83	24	183

Table 8.0. Incidents involving the public – 0.87%

Q1 Apr - June 2021 Organisational Incidents by Category	Insignificant	Minor	Moderate	Grand Total
Accidents/Falls	8	11	1	20
Behaviour	8	4	4	16
Property	10	3	0	13
Exposure to Environmental Hazards	2	1	0	3
Grand Total	28	19	5	52

2.4 Incidents of Behaviour / Abuse including Self Harm

The following three tables (**Tables 9.0 – 11.0**) provide a further breakdown, by the person affected groups of the 1796 recorded incidents of Behaviour / Abuse by Severity.

Table 9.0

Of the 23 incidents recorded as Inappropriate/Aggressive Behaviour towards a Patient by Staff

have all been reviewed, 11 of these have been incorrectly coded and the 12 remaining have been referred to Safeguarding and PSNI (where appropriate).

Person Affected - Patient/Service User	Severity					
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Missing Patient (absconded/abducted patient)	162	124	7	1	0	294
Self-harming Behaviour	153	122	4	0	3	282
Patient Behaviour that challenges	211	58	3	0	0	272
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	135	32	2	0	0	169
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	111	40	1	1	0	153
Inappropriate/Aggressive Behaviour towards a Patient by Staff	10	11	2	0	0	23
Use/Possession of Prohibited/Stolen Goods	18	4	0	0	0	22
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	0	12	0	1	0	13
Patient Restraint Processes	9	1	0	0	0	10
Patient refusal of diagnostic/therapeutic recommendations/interventions	5	2	0	0	0	7
Grand Total	814	406	19	3	3	1245

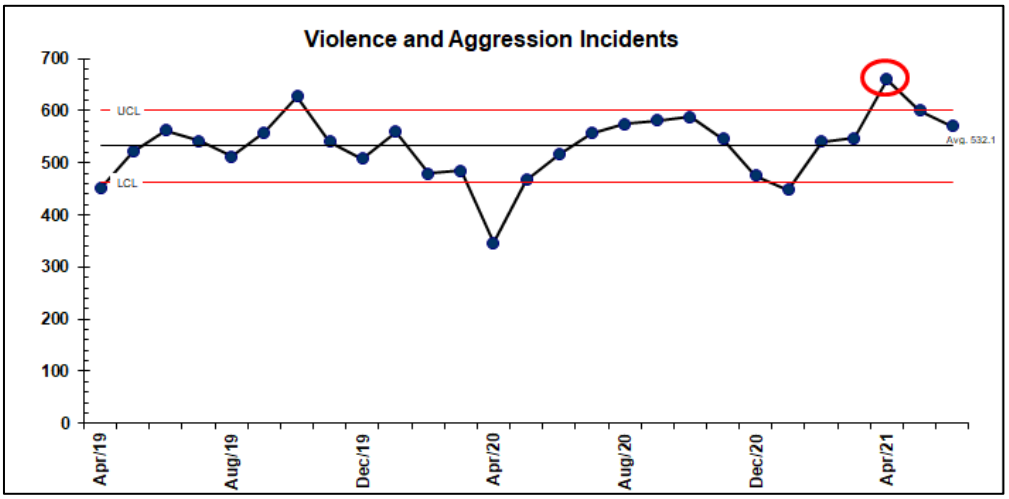
Table 10.0

Person Affected - Staff Member	Severity				
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Grand Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	311	193	3	1	508
Other	10	6	1	0	17
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	1	4	0	0	5
Inappropriate/Aggressive Behaviour towards Staff by Staff	4	0	0	0	4
Persons Performing Unauthorised Acts	1	0	0	0	1
Grand Total	327	203	4	1	535

Table 11.0

Person Affected - Visitor	Severity			
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Grand Total
Other	4	3	4	11
Inappropriate/Aggressive Behaviour towards a Visitor by a Visitor	2			2
Persons Performing Unauthorised Acts		1		1
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	1			1
Inappropriate/Aggressive Behaviour towards Visitor by Staff	1			1

Figure 4 below shows the number of Violence and Aggression incidents reported since April 2019. This is not broken down by Person Affected. These incidents will include V&A against staff and Self Harming behaviour. As mentioned in previous sections there has been an increase in V&A incidents being reported within the Trust, one of the reasons is all incidents involving security staff are now being reported via Datix.

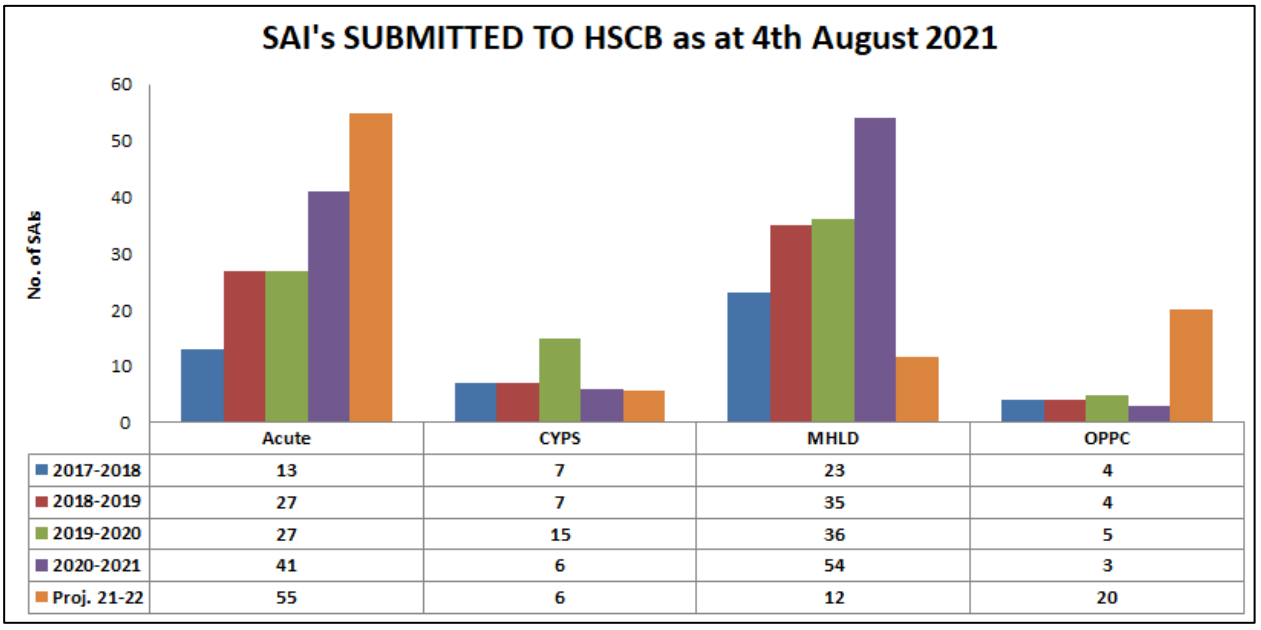


2.5 Incidents of / or attempted absconding and Absent Without Leave (AWOL)

Table 12.0 below provides a further breakdown, by category, directorate and severity of the 294 recorded incidents of missing or absconded or AWOL patients or service users.

Person Affected - Patient	Severity				
Type of Missing Patient	Insignificant	Minor	Moderate	Major	Grand Total
Absconded/left without informing staff	108	108	6	1	223
Attempted to abscond/leave without informing staff	29	12	0	0	41
Failed to return from authorized leave	10	1	0	0	11
Left with notice contrary to advice	8	2	0	0	10
AWOL / Absconded (detained patients only)	7	1	0	0	8
Abduction	0	0	1	0	1
Grand Total	162	124	7	1	294

2.6 Serious Adverse Incident Investigations submitted to HSCB as at 04th August 2021



	Acute	CYPS	MHLD	OPPC
2017-2018	13	7	23	4
2018-2019	27	7	35	4
2019-2020	27	15	36	5
2020-2021	41	6	54	3
Proj. 21-22	55	6	12	20

2.7 Trust Performance against Regionally Agreed Timescales

Timescales for the completion of Serious Adverse Incidents are set out by HSCB:

- Level 1 - 8 weeks
- Level 2 - 12 weeks
- Level 3– timescales are agreed between the reporting organisation and the HSCB/PHA DRO

	In Timesc	Outside Tir	Total
Acute	14	20	34
CYP	1	3	4
MHD	16	21	37
OPPC	2	9	11
On Hold	n/a	n/a	2
Total	33	53	88
%	39	62	

Table 14.0

SHSCT currently have:
88 SAI investigations in progress[6]. 2 of which have been paused due to ongoing investigations by external bodies such as Safeguarding Board Northern Ireland.
33 SAI investigations (37.5%)[7] remain within the HSCB timescales for submission. 53 are outside of timescales and this is broken down by Directorate in table 15 below.

There are a number of contributory factors which influence the compliance of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

[6] SAIs notified in a period will vary from the number actively in progress or paused at any particular point in time.
[7] Compared with 21% in the previous quarter.

- Appropriate team configuration to ensure appropriate level of clinical independence and expertise.
- Difficulties in obtaining external chairs / review team members.
- The prioritisation of SAI investigations within existing workloads.
- Necessary engagement with service users and their families, particularly where a death has occurred.
- Where the SAI investigation spans across 2 or more Trusts
- Capacity constraints on Clinical and Social Care Governance Teams, compared with current demand and complexity

As above there are 88 open SAI's as at 4th August 2021, this is compared to 83 in the previous quarter. A breakdown of the SAI activity has been provided below.

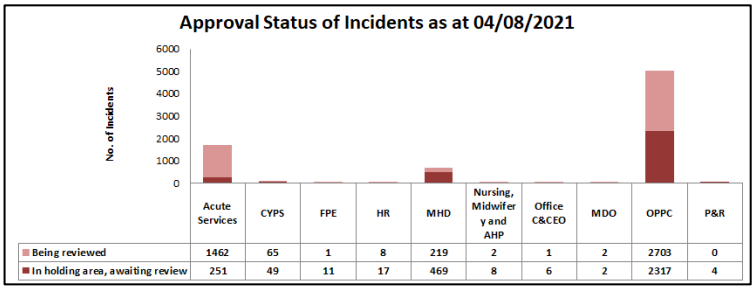
Ongoing SAIs last quarter		83
Add New SAI notifications:	Acute – 19, CYPS – 2, MHD – 4 and OPPC - 7	32
Less SAI reports submitted:	Acute – 11, CYPS – 4, MHD - 9	-24
Less De escalation of SAIs:	MHD	-3
Ongoing SAIs as at 04/08/2021		88

Table 15.0 sets out the detailed position on the progress of the 88 SAI investigations currently on-going as at 04/08/2021 (2 SAI investigation currently paused).

SAI Level	ACUTE			CYPS			MHD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales week 26 >	Outside HSCB Timescales weeks 26 <	Within HSCB Timescales	Outside HSCB Timescales weeks 26 >	Outside HSCB Timescales weeks 26 <	Within HSCB Timescales	Outside HSCB Timescales weeks 26 >	Outside HSCB < Timescales weeks 26<	Within HSCB Timescales	Outside HSCB > Timescales weeks 26>	Outside HSCB < Timescales weeks 26<
Level 1	7	0	12	1	0	2	0	4	4	2	3	5
Level 2	5	4	2	0	1	0	14	9	3	0	1	0
Level 3	2	0	2	0	0	0	2	0	1	0	0	0
Totals	Within HSCB Timescales	Outside HSCB Timescales		Within HSCB Timescales	Outside HSCB Timescales		Within HSCB Timescales	Outside HSCB Timescales		Within HSCB Timescales	Outside HSCB Timescales	
	14	4	16	1	1	2	16	13	8	2	4	5

2.8 Approval Status of Incidents[8]

Figs 5.0 & 6.0 highlights the number of incidents in each Directorate 'awaiting review' or 'being reviewed'. Incidents in the review process are not categorised by subject and the final severity rating has not been approved. In this quarter the number of unapproved incidents has increased within Acute and OPPC. MHD and CYPS numbers remain similar as last quarter.



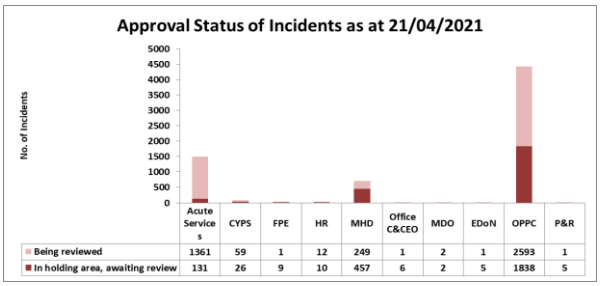


Fig. 7.0 Details the retrospective time frame for unapproved incidents.

Since the last quarter, there has been an 18% decrease in the number of 2020 incidents, 20% decrease in the number of 2019 incidents and 18% in 2018. There are 71 incidents from before December 2017 which remain unapproved. Directorates have been asked by the Medical Director for action plans to address the number of unapproved incidents.

	2010	2011	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Acute Services	1	1	0	0	1	3	5	10	86	314	1401	1822
Children and Young Peoples Services	0	0	0	0	0	0	0	0	0	4	127	131
Finance Procurement & Estates	0	0	0	0	0	0	0	0	0	1	11	12
Human Resources and Organisational Development	0	0	0	0	0	0	0	0	0	1	26	27
Mental Health and Disability	0	0	0	0	0	4	11	20	45	105	532	717
Nursing, Midwifery and AHP	0	0	0	0	0	0	0	0	0	0	13	13
Office of the Chair and Chief Executive	0	0	0	1	0	0	0	0	0	6	0	7
Office of the Medical Director	0	0	0	0	0	0	0	0	3	1	0	4
Older People and Primary Care	0	0	0	0	0	8	35	129	531	2473	1943	5119
Performance and Reform	0	0	1	0	0	0	0	1	0	2	0	4
Total	1	1	1	1	1	15	51	160	665	2907	4053	7856

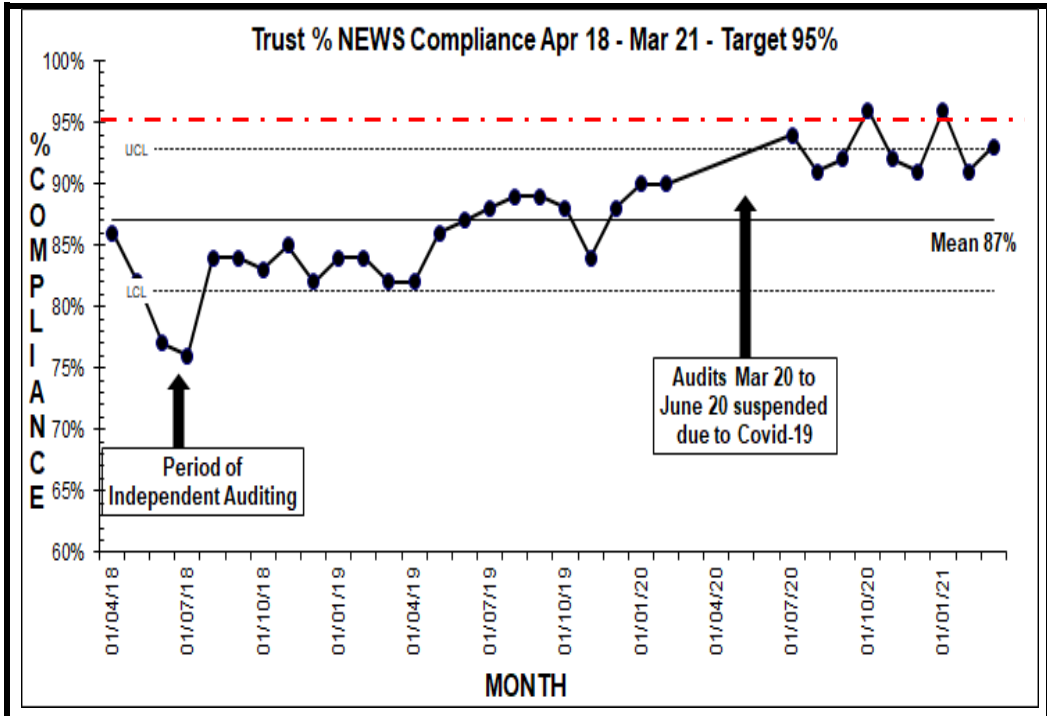
2.9 Early Alerts Submitted by the Southern Health and Social Care Trust

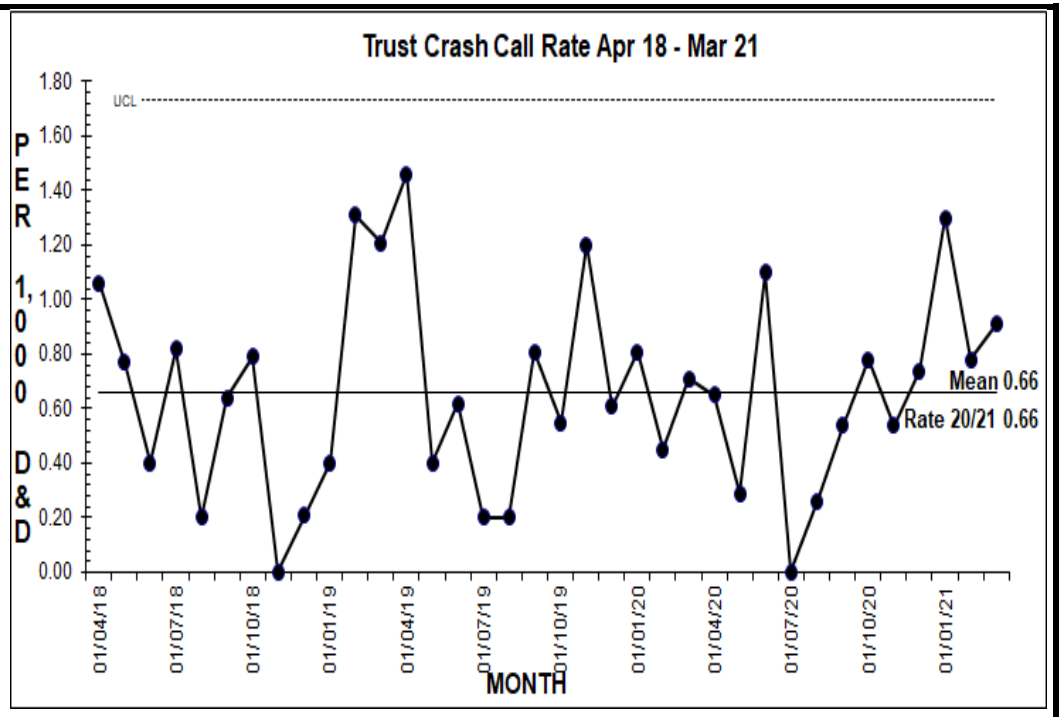
Between 1st April 2021 – 30th June 2021 there has been 42 (22 in relation to GP OOH) Early Alerts submitted to the DoH and the HSCB. 38 of these were new alerts; 4 were updates on previously submitted Early Alerts.

[8] Approval status reporting is for all unapproved incidents (6770@April 2021, 6825@January 2021, 6089 @ 07/11/2020 5107 @ 14/08/2020, 4486@ 27/04/202, 4532 @21/01/20, 4348 @ 15/11/19, 5107 @ 14/09/2020) on Datix Web pre governance committee report.

3.0 Patient Safety Measures Data – Quarter 4 Jan 2021 → March 2021

3.1. NEWS & Crash Calls[9]

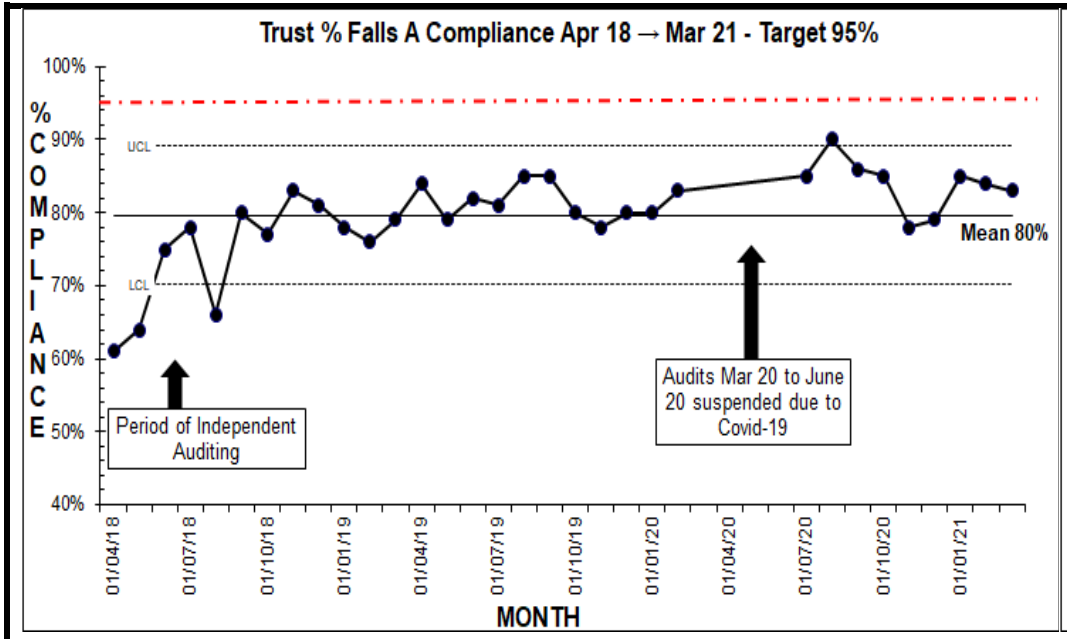


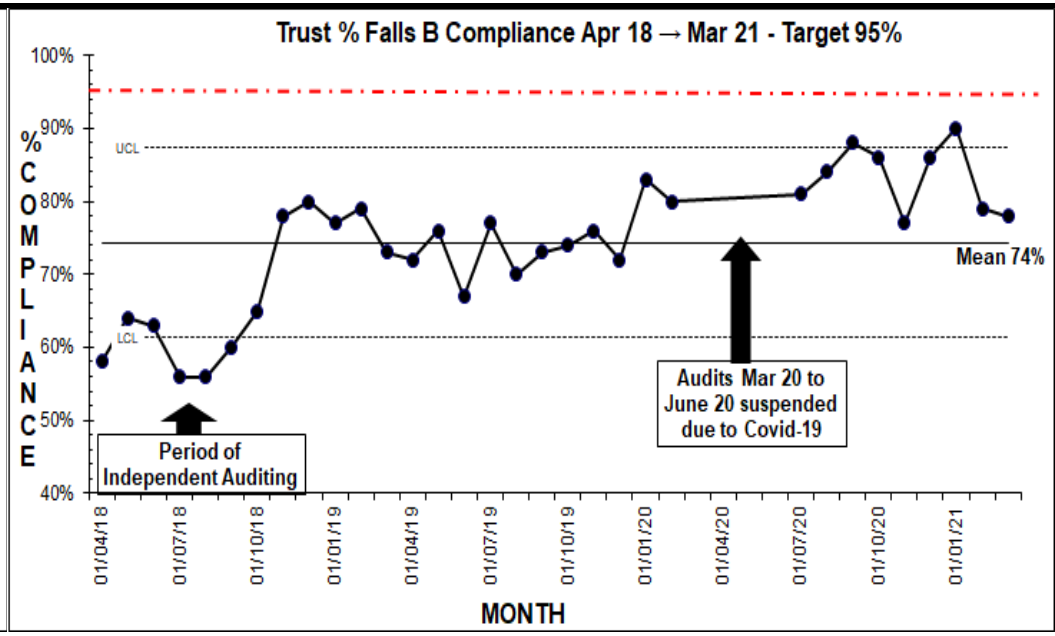


- NEWS – Q1 20/21 (Apr 20 → June 20) Audit was suspended by PHA due to Covid 19
- NEWS Compliance Q4 20/21 (Jan 21 → Mar 21) was **93%,** same as Q3
- Trust Crash Call Rate for 20/21 was **0.66** per 1,000 Deaths & Discharges (**30** Crash Calls) compared to **0.67** per 1,000 Deaths & Discharges (**39** Crash Calls) in 19/20
- Based on the data there has been no significant change in Crash Call Rates. NEWS compliance breached the target & also breached the upper confidence limit in Jan 21

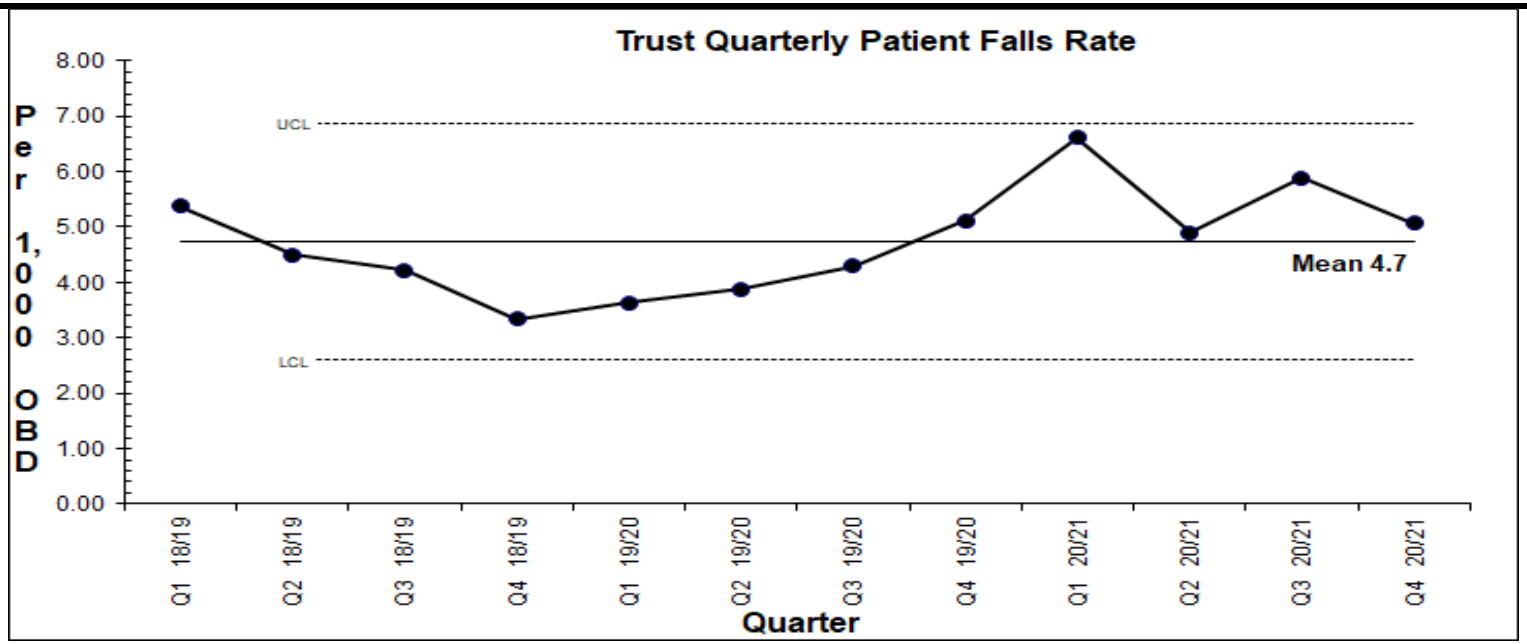
[9] The NEWS Audit is a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. March 20 Audit suspended due to Covid-19. Regional Improvement Work on Crash Calls began in 2008, since June 2008 the Trust's Crash Call Rate has fallen significantly from a Baseline of 1.89

3.2. Patient Falls[10]





[10] The Falls Audits are a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. Regional Improvement Work on Patient Falls began in 2011. In line with the Region since Apr 18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.

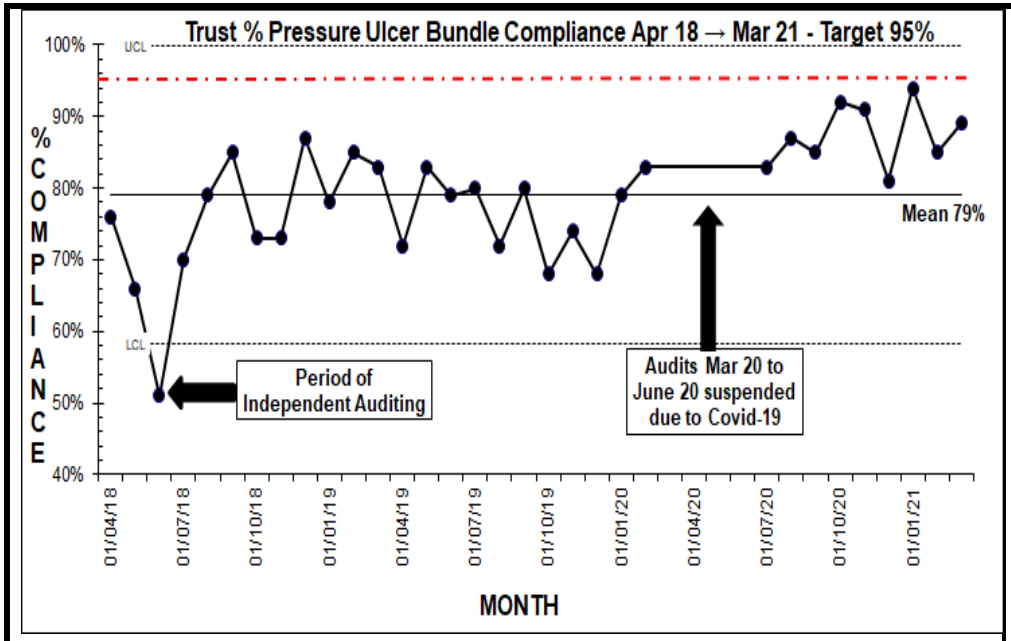


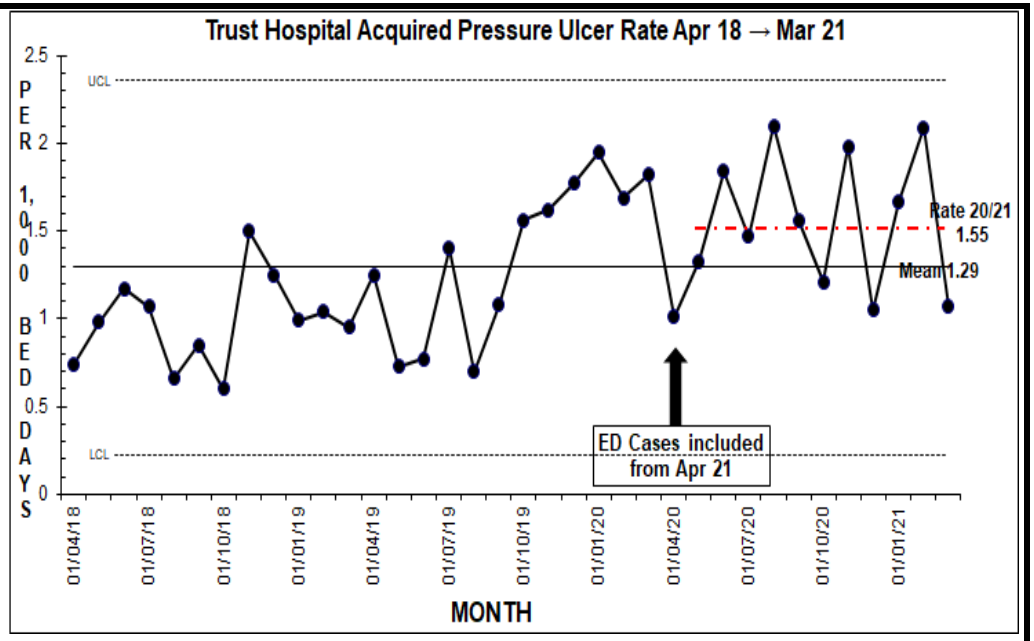
- FallSafe – Q1 20/21 (Apr 20 → June 20) Audits A & B were suspended by PHA due to Covid-19
- FallSafe Bundle A Compliance Audit Q4 (Jan → Mar 21) was **84%**, compared to **81%** in Q3 20/21
- FallSafe Bundle B Compliance Audit Q4 (Jan → Mar 21) was **82%**, compared to **83%** in Q3 20/21

- Patient Falls Rate Q4 20/21 was **5.06** per 1,000 Occupied Bed Days, compared to **5.89** in Q3 20/21
- Patient Moderate & Above Falls Rate Q4 20/21 was **0.19** per 1,000 Occupied Bed Days compared **0.11** in Q3 20/21
- Trust Patient Falls Rate 20/21 was **1,313** (**5.56** per 1,000 Occupied Bed Days) compared to **1,171** (**5.35** per 1,000 Occupied Bed Days) in 19/20
- Of the 27 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick **21** wards (**78%**) saw an increase in Patient Falls Rates in 20/21 compared to the same period 19/20.

- There has been no significant change in the falls rate, however there has been significant improvement in compliance with Falls Bundle B with 1 upper confidence limit breaches in Q4

3.3. Hospital Acquired Pressure Ulcers[11]

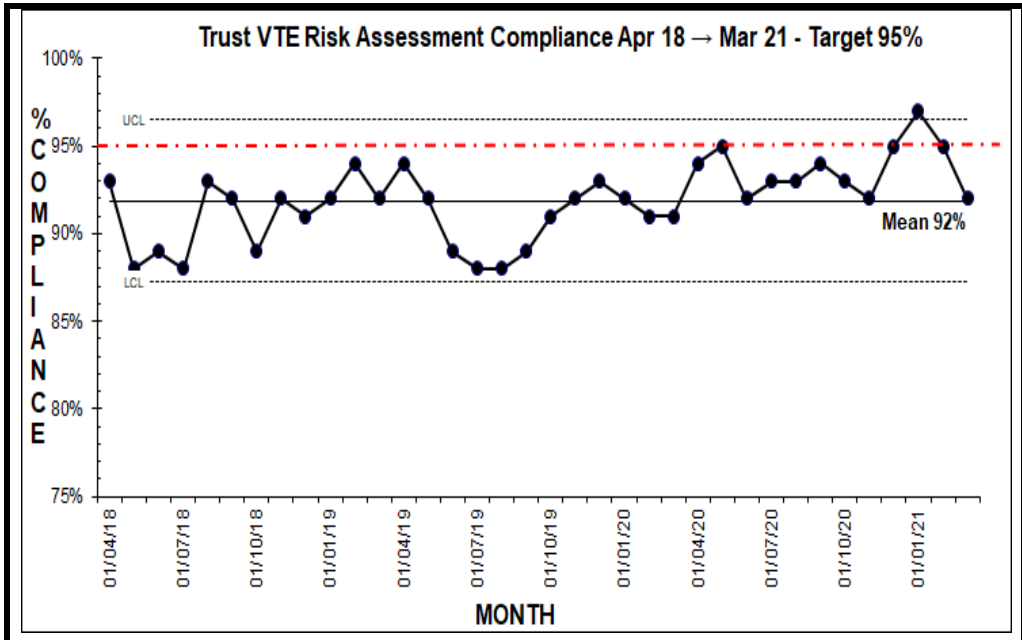


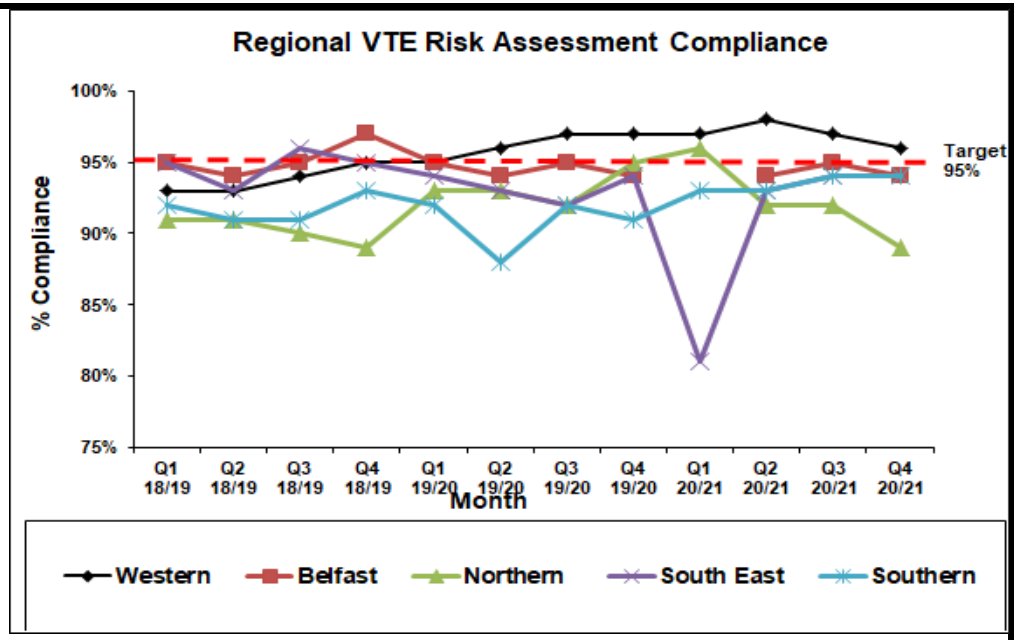


- Pressure Ulcer Audit – Q1 20/21 (Apr 20 → June 20) was suspended by PHA due to Covid-19
- Pressure Ulcer Bundle Compliance Audit Q4 (Jan → Mar 21) was **89%**, same as Q3
- From Apr 20 acquired cases in ED's are included as per Regional Direction
- In 20/21 **33** (**11%**) Stage 3 & above avoidable Pressure Ulcers were noted, compared to **35** (**12%**) in 19/20
- Themes/shared learning arising out of avoidable Post Incident Reviews are fed back to Ward Managers, via Lead Nurses
- There has been no significant change in Bundle compliance in Q4 20/21, however the incident rate has increased compared to 19/20, which is partly due to including cases in the ED's of CAH & DHH

[11] The Pressure Ulcer Audit is a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. Regional Improvement Work on Pressure Ulcers began 2011. A number of pro-active initiatives have subsequently taken place i.e. the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan. The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on ward acquired pressure ulcers to determine those which were avoidable.

3.4. Venous Thromboembolism (VTE) Risk Assessment Compliance[12]





- Trust compliance in Q4 20/21 was **94%**, same as Q3 20/21
- Trust compliance 20/21 **94%**
- Risk Assessment Compliance breached the target in Jan 21 & Feb 21 & also breached the upper confidence limit in Jan 21
- Performance is reported to Acute Governance on a monthly basis, where Wards with a decline in compliance is highlighted
- Audits not undertaken in Q1 20/21 in the Belfast Trust & Q4 20/21 in the South East Trust due to Covid-19

[12] Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009. All Trust's now use a Regional Risk Assessment Tool. For the past number of years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%. All Trusts have seen an increase in compliance since measurement began in April 2013.

4.0. Service User Formal Complaints

4.1 Complaints received

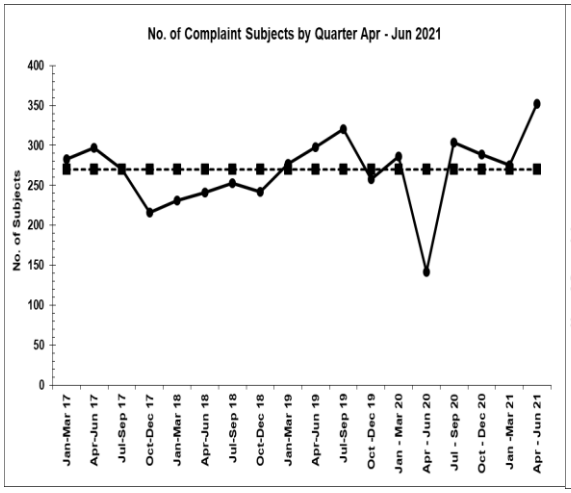
Regionally complaints are categorised and reported by the subject within the complaint. One complaint letter may have multiple complaints subjects.

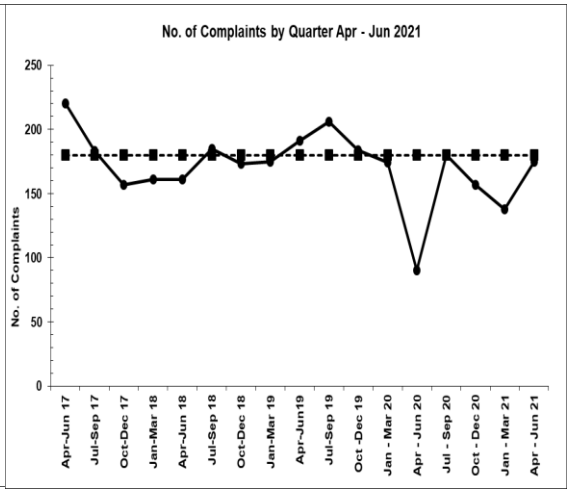
- April – June 2021 175 complaints received
- January – March 2021: 138 complaints received
- October – December 2020: 157 complaints received
- July – September 2020: 180 complaints received
- April – June 2020: 90 complaints received
- January – March 2020 174 complaints received

Although it appears there has been an increase in the number of complaints received this quarter, numbers are returning to similar prior to the COVID-19 pandemic.

This period **175 complaints** were received (**27% increase** on Jan - Mar 21). The 175 complaints contained **352 complaint subjects** (**an increase of 28%**).

Figures 8.0 & 9.0 below show complaint and complaint subject levels





4.2 Complaint Subjects

These have been ranked for the period Apr - Jun 2021, with previous quarter comparisons.

Table 16.0 below details the top 10 complaint subjects by % share of the 352 subject total. It also compares the level of those complaint subjects against previous quarters.

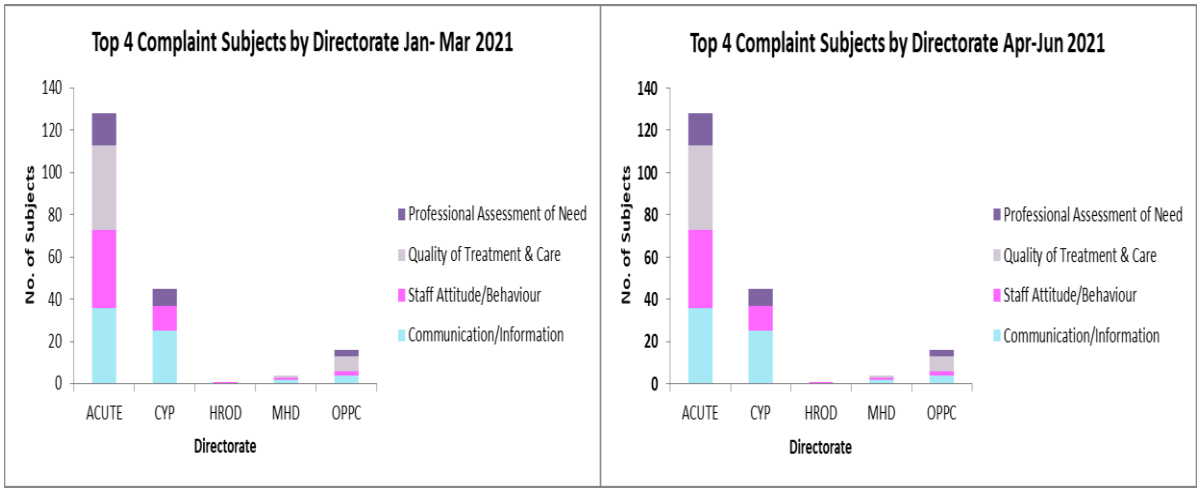
Apr - Jun 2021					
Complaint Subject	Jul Sep 20	Oct Dec 20	Jan Mar 21	Apr Jun 21	Subject %
Communication / Information	79	84	67	98	28%
Quality of Treatment & Care	47	54	48	65	18%
Staff Attitude/Behaviour	54	54	53	59	17%
Professional Assessment of Need	35	22	26	43	12%
Clinical Diagnosis	7	10	14	11	3%
Property/Expenses /Finances	4	6	5	9	3%
*Waiting Times, Outpatient Departments	2	3	2	8	2%
Waiting Times, A&E Departments	2	1	1	7	2%
**x3 Subjects = 6	23	22	19	18	5%
***Confidentiality	2	2	4	5	1%

*First time since Dec 2019 that Waiting times in Outpatients has occurred in the top 10. The majority of these complaints were received into IMWH, Surgery and Elective Care and 1 for Childrens Health.

**Three subjects appeared on 6 occasions within the time period April – June 2021 sharing 9th place. These subjects were Waiting List, Delay/Cancellation Outpatient Appointments, Quantity of Treatment & Care and Policy/Commercial Decisions.

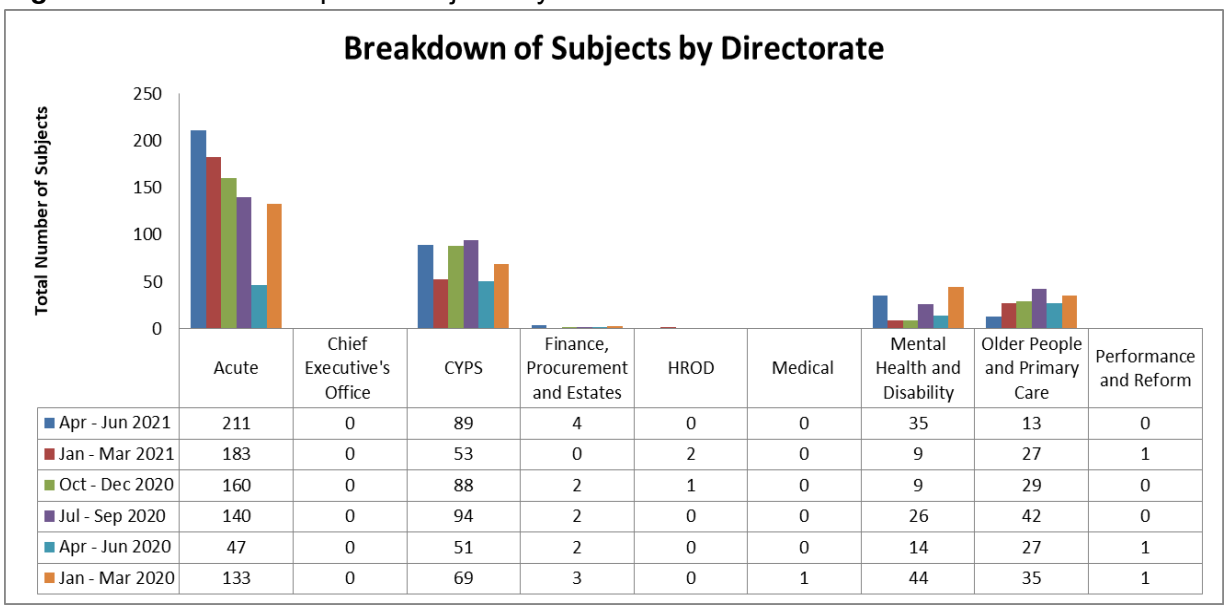
***Confidentiality last appeared in the top 10 in April – June 2020. These 5 complaint subjects were received into the Acute and MHD Directorates, covering 4 complaints.

A further drill down of the **'top 4'** areas shows they covered 75% of the quarter's 352 complaint subjects. These 4 subject areas are split across the 5 operational service directorates as shown in **Figs 10.0 & 11.0**, compared to previous Qtr.



4.3 Complaints % by Directorate[13]

Figure 12.0 - Total Complaint Subjects by Directorate since March 2020.



	Acute	Chief Executive's Office	CYPS	Finance, Procurement and Estates	HROD	Medical	Mental Health and Disability	Older People and Primary Care	Performance and Reform
Apr - Jun 2021	211	0	89	4	0	0	35	13	0
Jan - Mar 2021	183	0	53	0	2	0	9	27	1
Oct - Dec 2020	160	0	88	2	1	0	9	29	0
Jul - Sep 2020	140	0	94	2	0	0	26	42	0
Apr - Jun 2020	47	0	51	2	0	0	14	27	1
Jan - Mar 2020	133	0	69	3	0	1	44	35	1

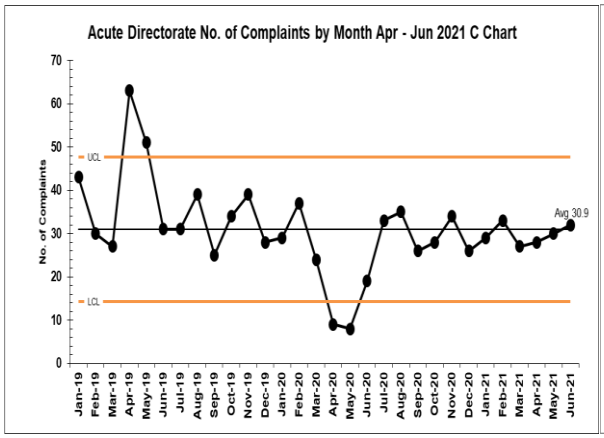
4.4 Complaint Response

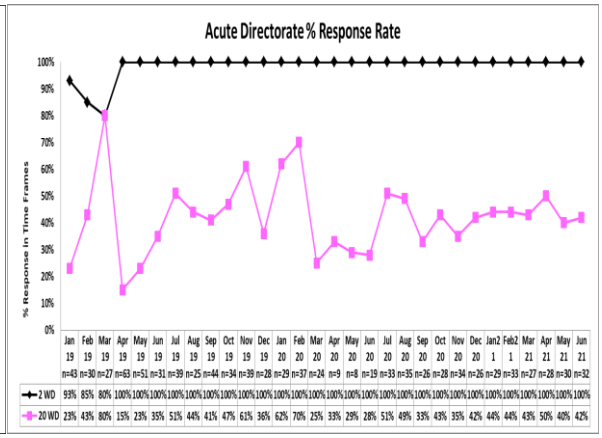
The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days.

The information in the following charts (collectively **figure 13**) details the number of complaints by directorate, the 2 working day acknowledgement and 20 working day response rates

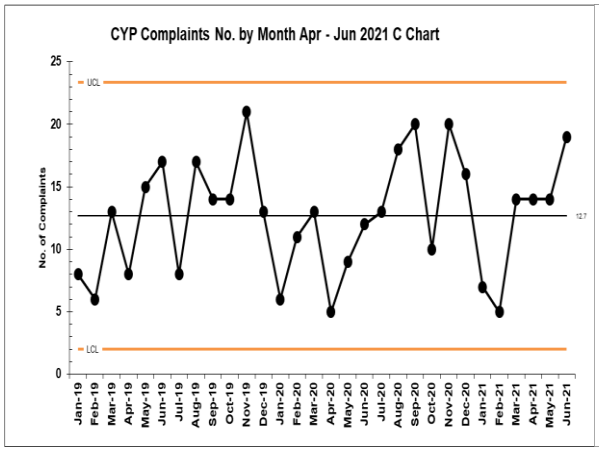
[13] A breakdown by Division is available through the relevant Directorate Governance Team

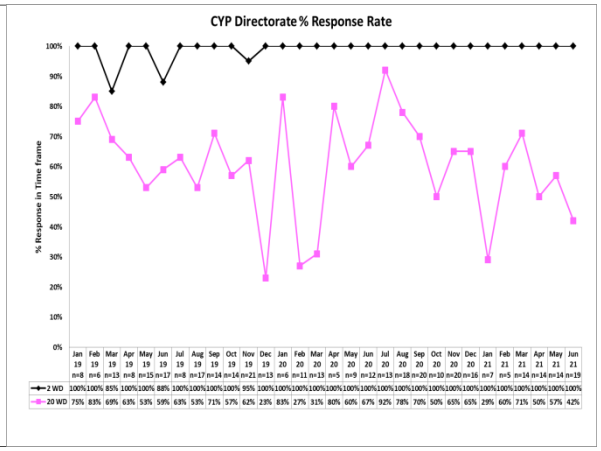
Acute Complaints and Response Times



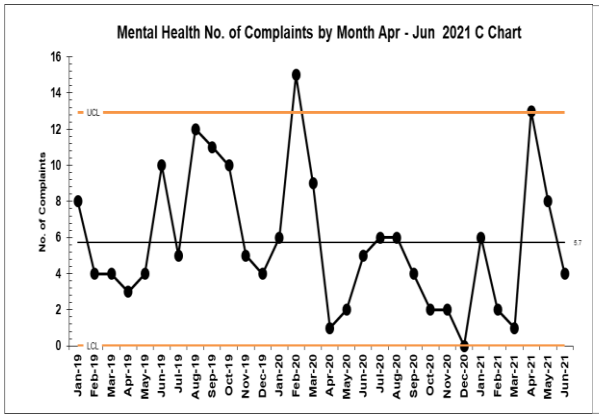


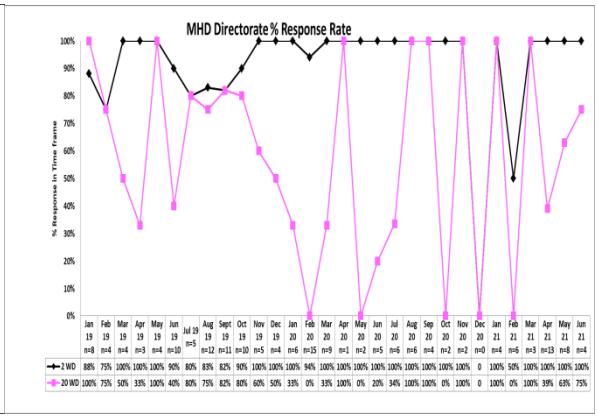
CYPS Complaints and Response Times



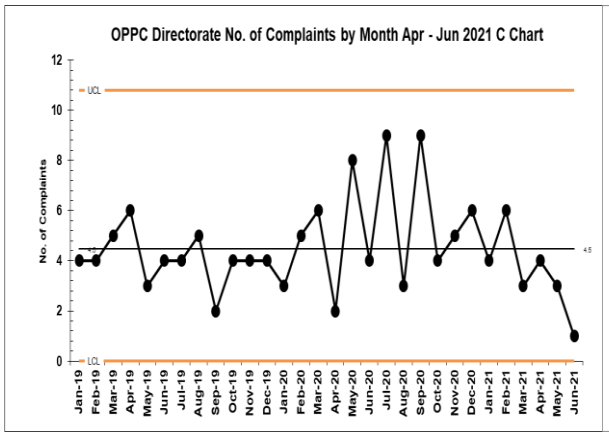


MHD Complaints and Response Times[14]





OPPC Complaints and Response Times



4.5 Independent Sector Providers

The new guidance (2019) in relation to the HSC Complaints Procedure stipulates that complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated. In order to become compliant with this section of the guidance, the governance departments would require additional resources. A meeting is being arranged to discuss all Governance arrangements for the Independent Sector.

4.6 Informal/Enquiries and Local Resolution

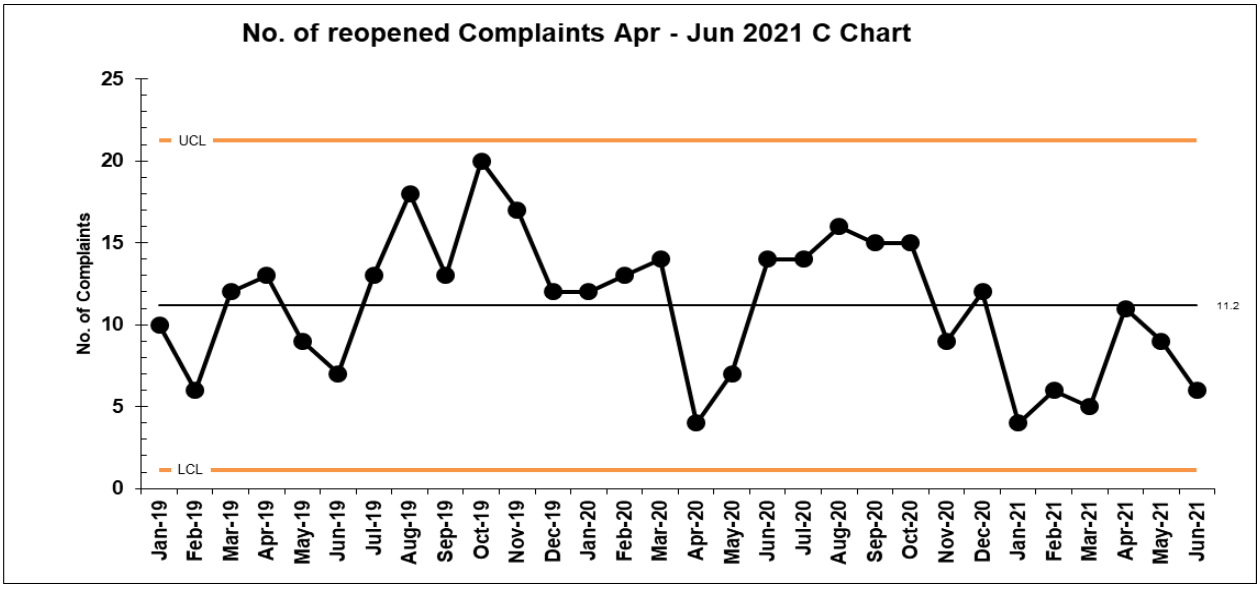
Table 17.0 below sets out the informal methods of complaints received for all directorates since July 2019.

	Total - All Directorates							
Resolution Stage / Method	July-Sep 19	Oct - Dec 19	Jan - Mar 20	Apr - Jun 20	Jul-Sep 20	Oct - Dec 20	Jan - Mar 21	Apr - Jun 21
Awaiting consent	12	33	12	10	15	4	7	18
Enquiry	148	66	98	63	143	132	104	119
Informal HSC Complaint	110	50	58	35	30	47	46	61
Resolved at Point of Service Delivery	16	2	7	3	7	3	4	15
Redirected	12	8	6	10	4	7	4	2
COVID 19 Enquiry			16	61	12	26	28	5
Totals	298	159	197	182	211	219	193	220

4.7 Complaints – Re-opened

Apr – Jun 2021 saw 26 complaints re-opened. The line graph below shows the number of Reopened complaints since January 2019.

Figure 14



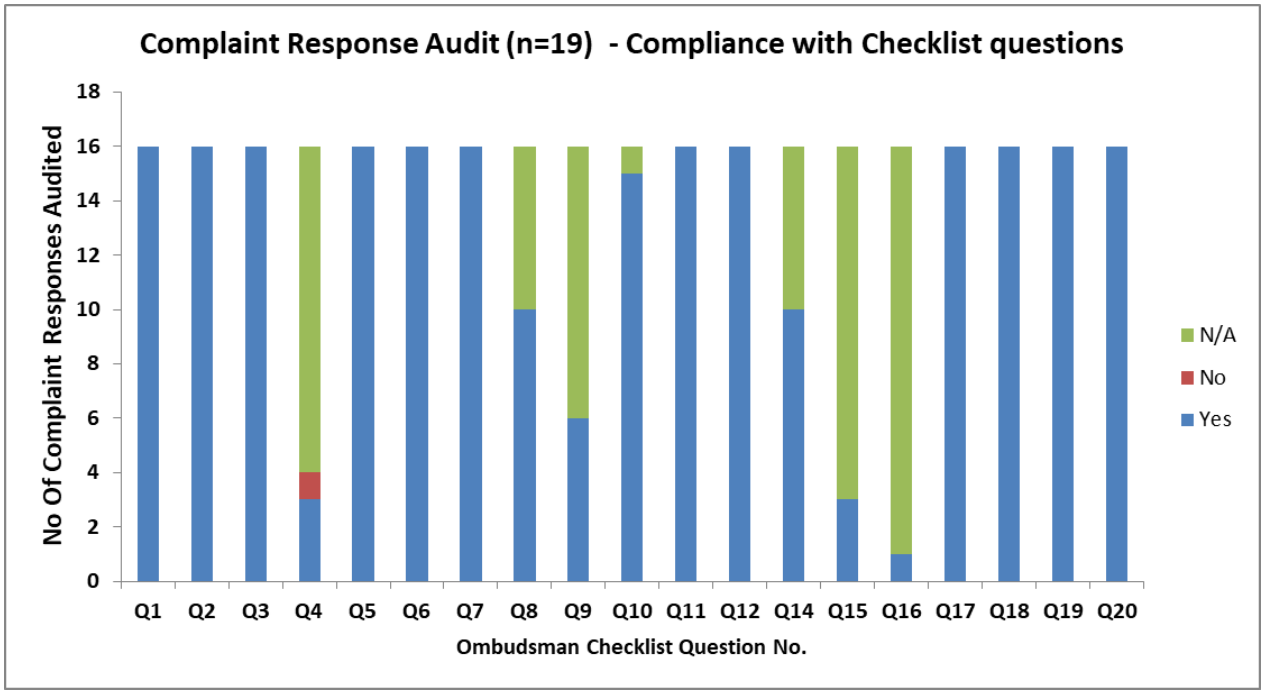
4.8 Complaints - Response Audit

A total of 175 complaints were received from April to June 2021, a response audit was carried out on 16 of these complaints using the regionally agreed 'Checklist for Preparing Draft Responses to Complaints'. The checklist takes into consideration the Ombudsman's Principles of Good Complaint Handling[15].

Fig 15.0 – Response Audit Results and Commentary

All complaints audited were fully understood and contained a polite opening to the letter and provided a short summary of the complaint issues. All of the responses reflected the Trust values and were very understandable and expressed regret were applicable. One complaint that experienced a bereavement did not include condolences in the response. The Trust had offered a remedy to a complainant in one response and a meeting to discuss the outcome of a complaint investigation was offered to one of the complainants. All of the responses advised the complainant of any changes/improvements that had taken place as a result of their complaint were applicable.

[15] Question 13 has been excluded from the chart above as there is no way of detecting from reviewing the response whether the accuracy of the facts was double checked.

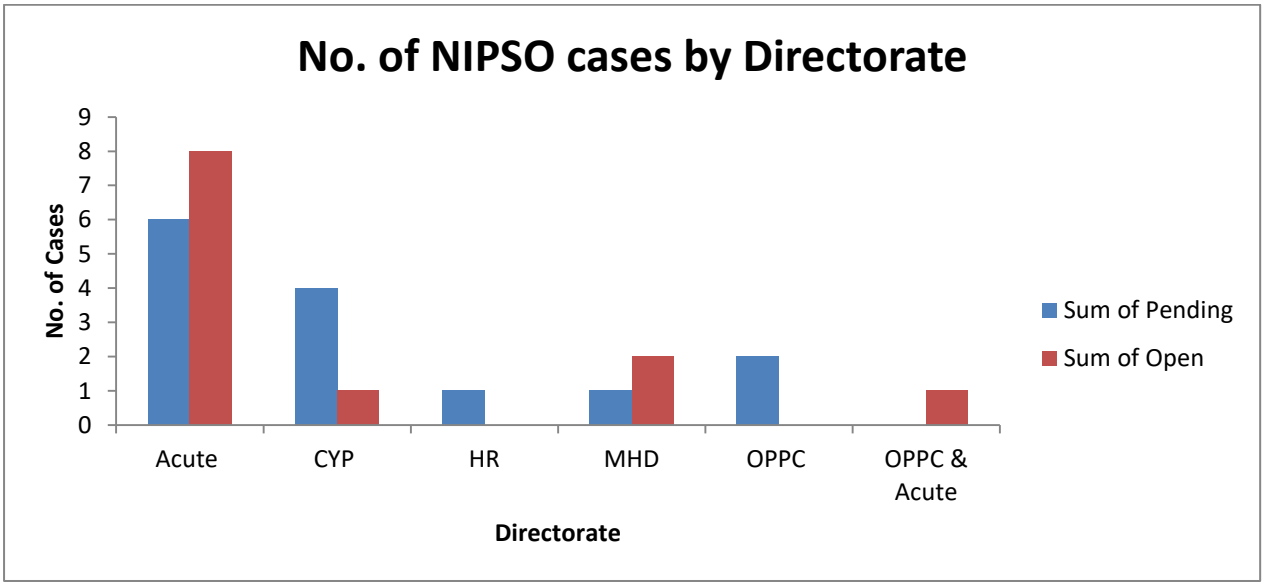


4.9 Ombudsman Cases

Apr - Jun 2021, SHSCT received 7 requests for information from the Ombudsman's Office. 6 of these cases are currently pending and 1 has been opened.

At present there are 12 open Ombudsman cases and 14 pending cases.

Figure 16 below shows a breakdown across the Directorates.



Three reports were received and the Recommendations from these have been circulated within the relevant Directorate for action. The three recommendations provided involved communication - GPs communicating plans to their patients, Record keeping - importance of ensuring that Diagnostic Assessment Reports reflect the information that is considered when reaching a diagnostic decisions, and the third related to record keeping also but in reference

to patient identity.

4.10 Health Care Complaint Analysis Tool

As an action from a previous Governance Committee meeting it was agreed that the HCAT tool would be used to analyse all formal complaints received into the Service User Feedback Team from the 1st June 2020. The report for complaints received April – June can be found at Appendix 1.

As previously noted in the last Governance paper, as the data collection continues to grow, greater in-depth analysis will facilitate learning for directorates to be able to focus upon and evidence any improvements to services they may make.

5.0 Service User Compliments

Business Services Organisation (BSO) is the HSC organisation that hosts the compliments websites and servers, on which SHSCT compliment data is stored. BSO is now providing compliment information to HSCTs.

Table 18.0 below shows the compliments received into the Trust in the period. Only written compliments are reported to the DOH (verbal compliments, confectionary etc. are not included) and only compliments from service users are included (compliments from staff are not included).

Table 18.0 – Compliments Received by Subject and Method Apr - Jun 2021 – There has been a slight decrease since previous quarter.

Apr - Jun

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	176	14	1	21	3	0	104	**319**
Staff Attitude & Behaviour	173	22	4	21	5	0	122	**347**
Information & Communication	92	12	2	15	0	0	98	**219**
Environment	75	4	2	13	0	0	11	**105**
Other	0	0	0	1	0	0	0	**1**
Total Compliments	**516**	**52**	**9**	**71**	**8**	**0**	**335**	**991**

Previous Quarter

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	187	40	7	6	2	0	94	**336**
Staff Attitude & Behaviour	170	55	10	8	3	0	173	**419**
Information & Communication	107	15	5	3	1	0	82	**213**

Environment	92	7	2	1	0	0	34	**136**
Other	0	1	0	0	0	0	0	**1**
Total Compliments	**556**	**118**	**24**	**18**	**6**	**0**	**383**	**1105**

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REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee September 2018
Title:	Clinical & Social Care Governance Report to Governance Committee
Lead Director:	Dr Ahmed Khan – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	To provide assurance to Trust Governance Committee regarding directorate management of: • Adverse Incidents • Complaints & Ombudsman's Complaints

Summary of Key Issues for Governance Committee

High level context:

- Revised report structure for Clinical and Social Care Governance Information
- Overview of trends in adverse incident reporting
- Data on Patient safety initiatives that support governance data to Quarter 1 2018/19

Key issues/risks for discussion:

- Breakdown of Serious Adverse Incidents by type of incident
- Breakdown of Ombudsman Case Outcomes

Summary of SMT challenge/discussion:

Internal/External Engagement:

- Senior Management Team
- Directorate Governance Coordinators

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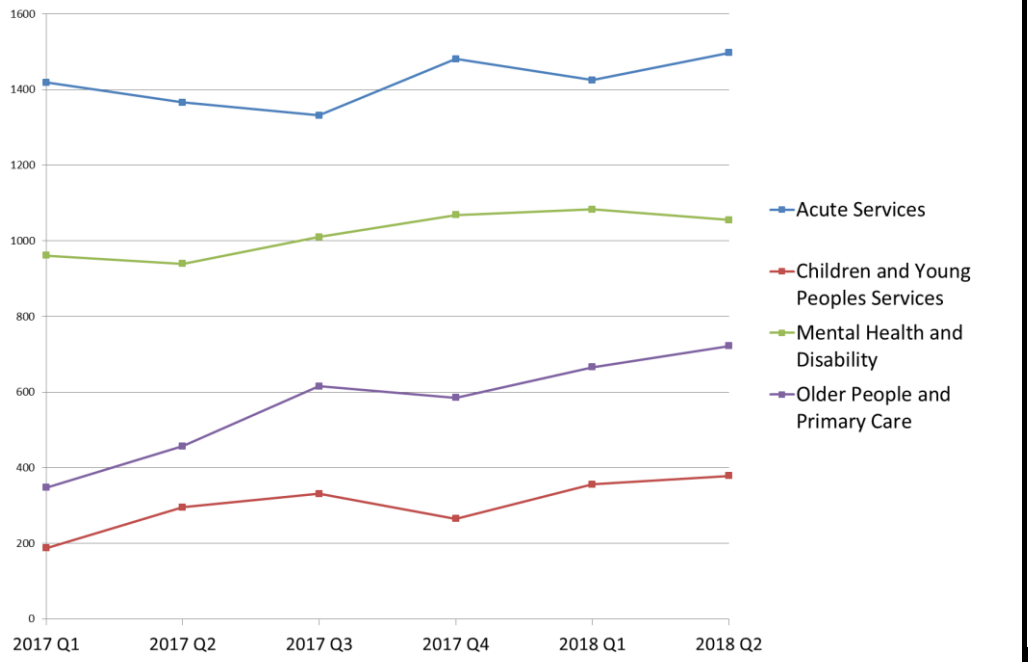
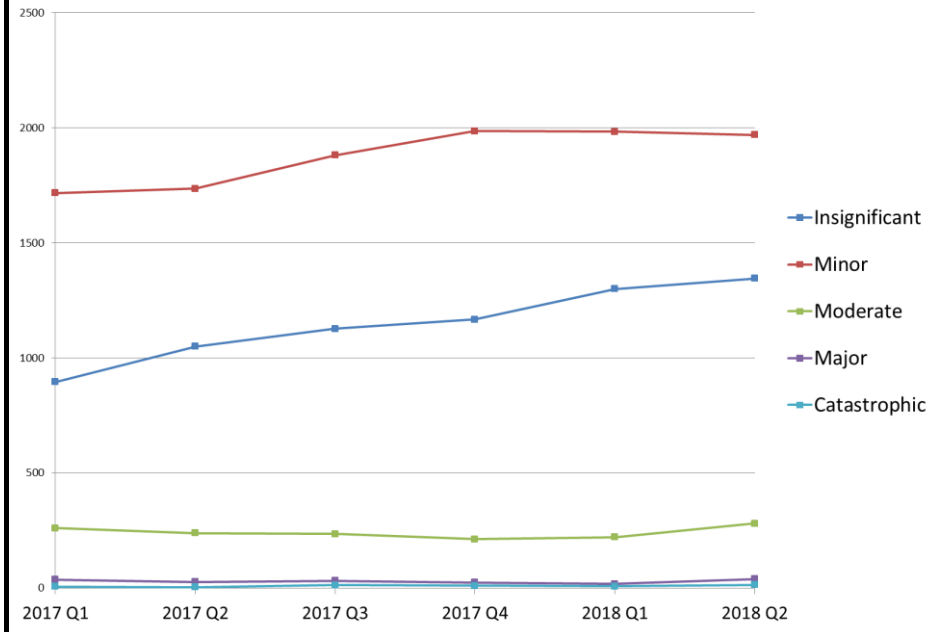
1. Adverse Incidents

Total No of Incidents Reported Over Time by Care Directorates 01 April 2017 – 30 June 2018



- Total incidents recorded
  - Quarter 1 2018 - 3530 incidents
  - Quarter 2 2018 – 3652 incidents
- Total number of incidents recorded for Quarter 2 2018 shows a slight increase from Quarter 1 2018, looking at the same period from last year there is also an increase in the number of incidents reported.

Total No. of Incidents by Severity Grading (Actual Harm) 01 April 2017 – 30 June 2018



- Quarter 2 2018 saw an increase in Catastrophic incidents from 7 to 14.
- Additional information on incidents that met Serious Adverse Incident thresholds can be found in section 2 of this report.

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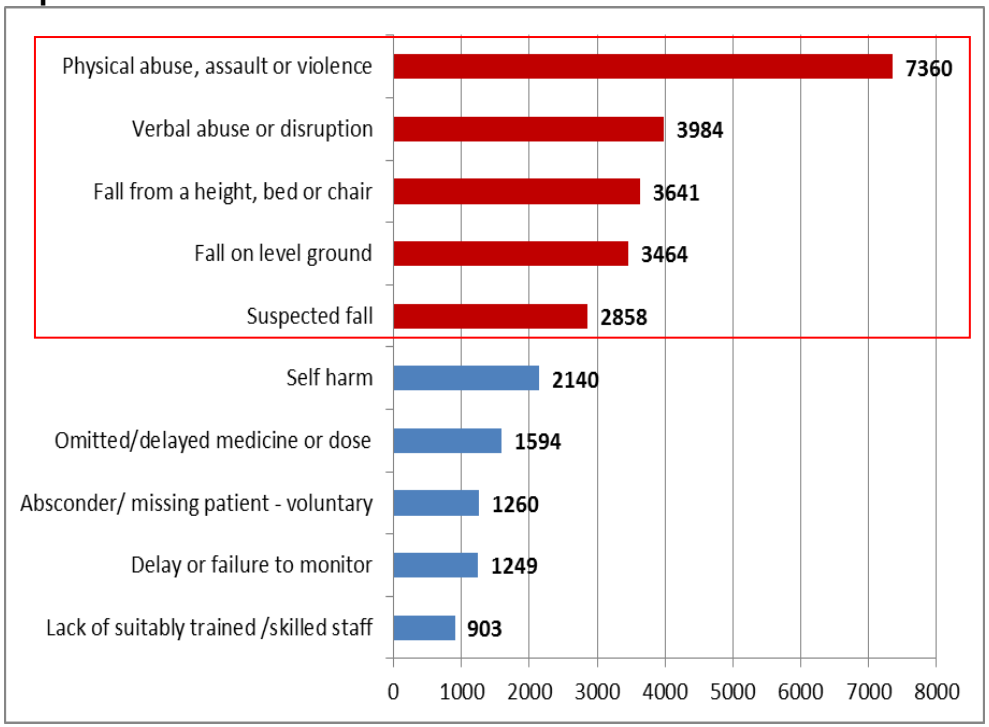
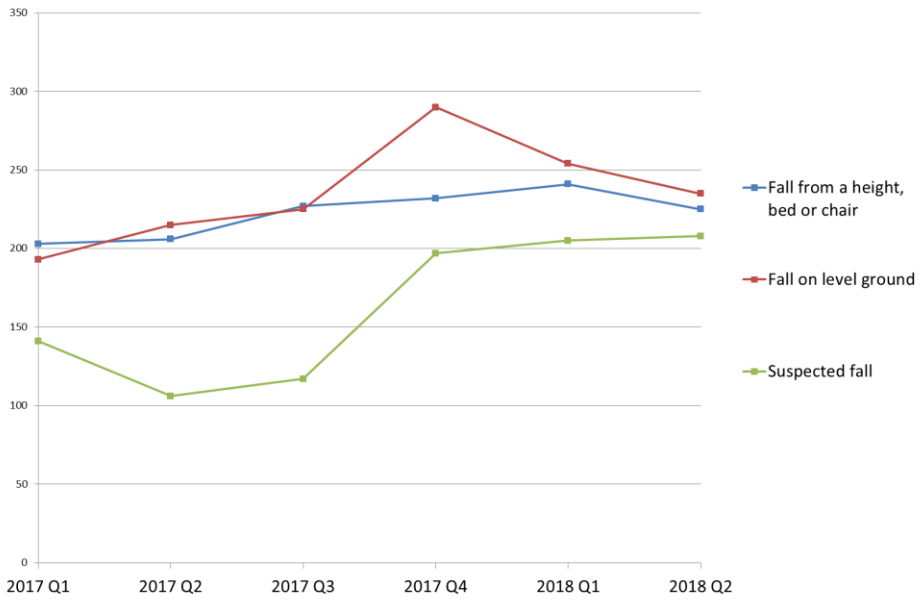
Breakdown of Top Incidents by Detail 1 April 2014 – 30 June 2018



Falls Incidents by Type 01 April 2017 – 30 June 2018



The 10 top most common reported incidents have remained the same since the last quarter.

The Southern Health and Social Care Trust's most common reported incidents are abuse and falls. The following graphs further detail the trends for these incidents.

- Fall from a height, bed or chair have continued to reduce from 241 reported incidents in Quarter 1 of 2018 to 225 in Quarter 2 in 2018. Suspected falls have slightly increased from 205 in Quarter 1 to 208 Quarter 2.
- Fall from level ground have decreased from 254 in Quarter 1, to 235 in Quarter 2.

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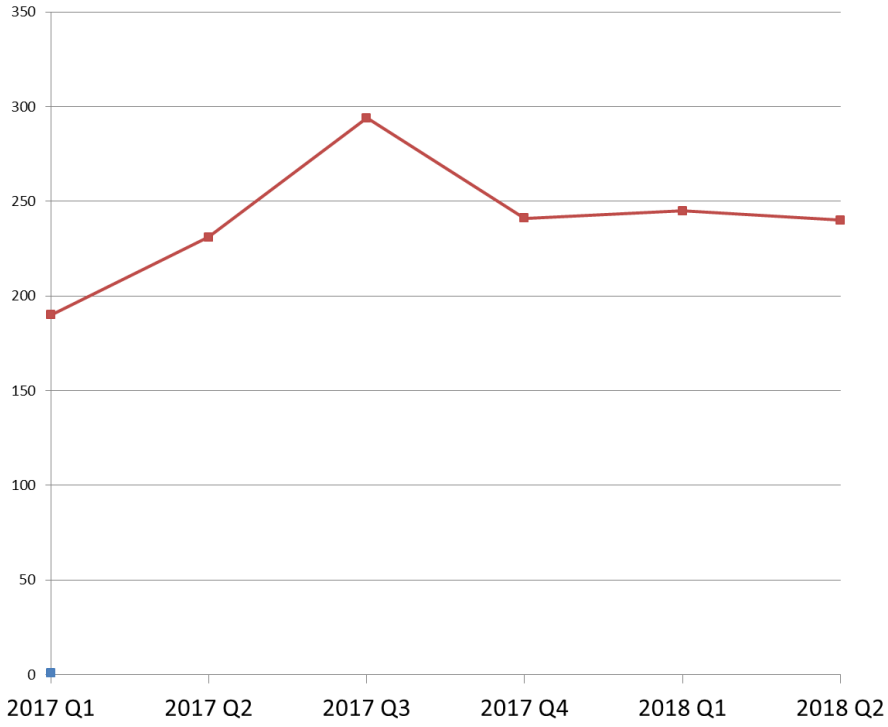
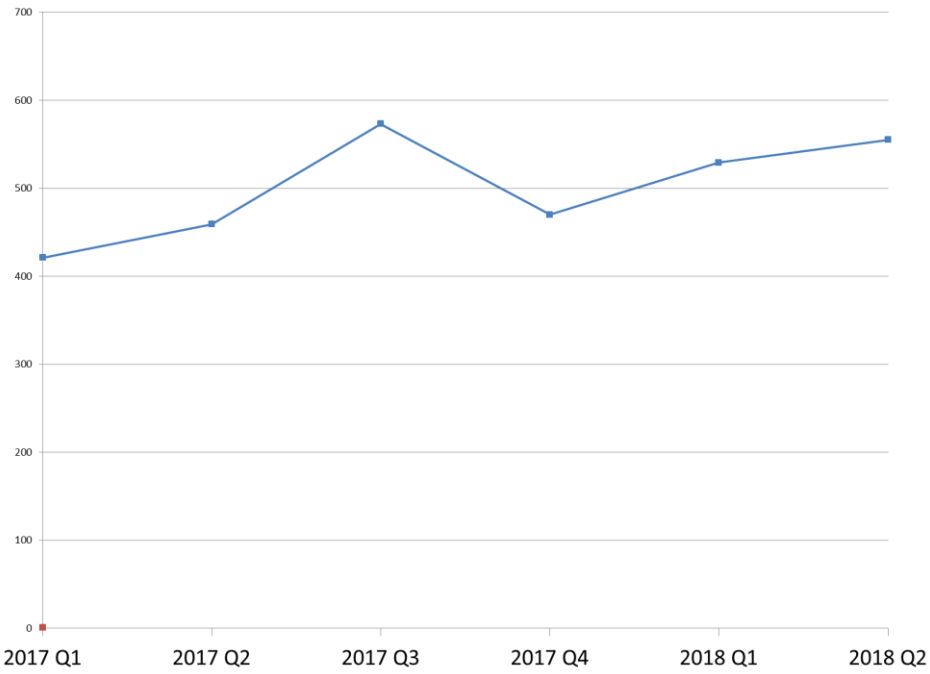
Verbal Abuse Incidents 01 April 2017 – 30 June 2018



- Although Verbal Abuse incidents remain one of the highest reported incidents there has been a small decrease in the number of verbal incidents this quarter.

Physical Abuse Incidents 01 April 2017 – 30 June 2018



- Physical Abuse remains one of the highest reported incident type, this quarter these types of incidents have increased since Quarter 1 2018, from 529 to 555.

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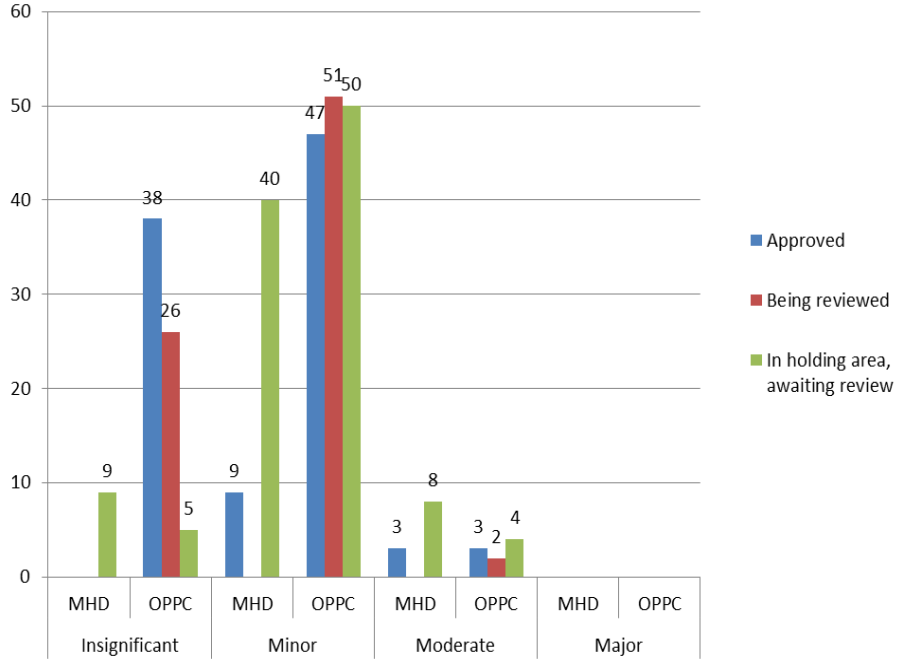
Independent Service Providers Incidents by Directorate, by Sub-category January – March 2018

	MHD	OPPC	Total
Slips, trips, falls and collisions	1	132	133
Administration or supply of a medicine from a clinical area	4	9	13
Self-harm during 24-hour care	8		8
Abuse by the staff to the patient		4	4
Accident caused by some other means		4	4
Abuse etc of Staff by patients	1		1
Self-harm in primary care, or not during 24-hour care	1		1
Abdominal organs other than digestive		1	1
Abuse etc of patient by patient		1	1
Connected with the management of operations / treatment		1	1
Infection Control		1	1

Independent Service Providers Total No. of Incidents recorded By Severity Grading (Actual Harm) January – March 2018



NB: the above grading may change as incidents are reviewed.

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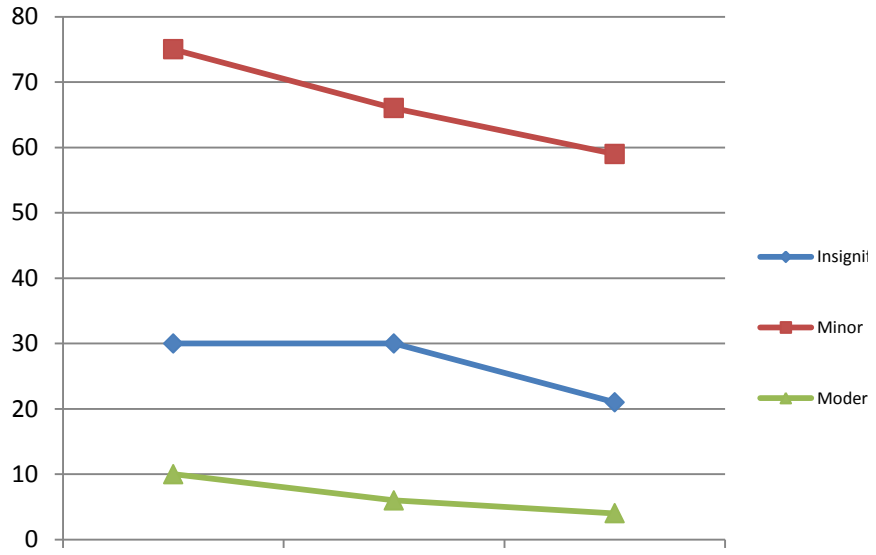
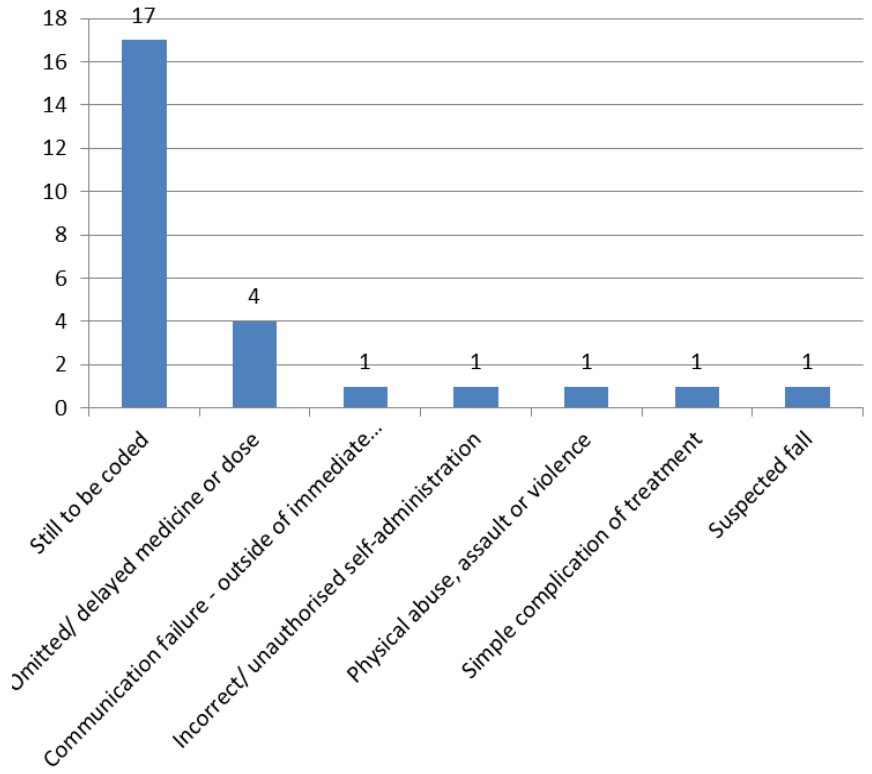
Independent Service Providers Trend Line: Incidents Involving PNH Providers by Severity Grading by Month January – March 2018



Independent Service Providers Incidents by Type January – March 2018



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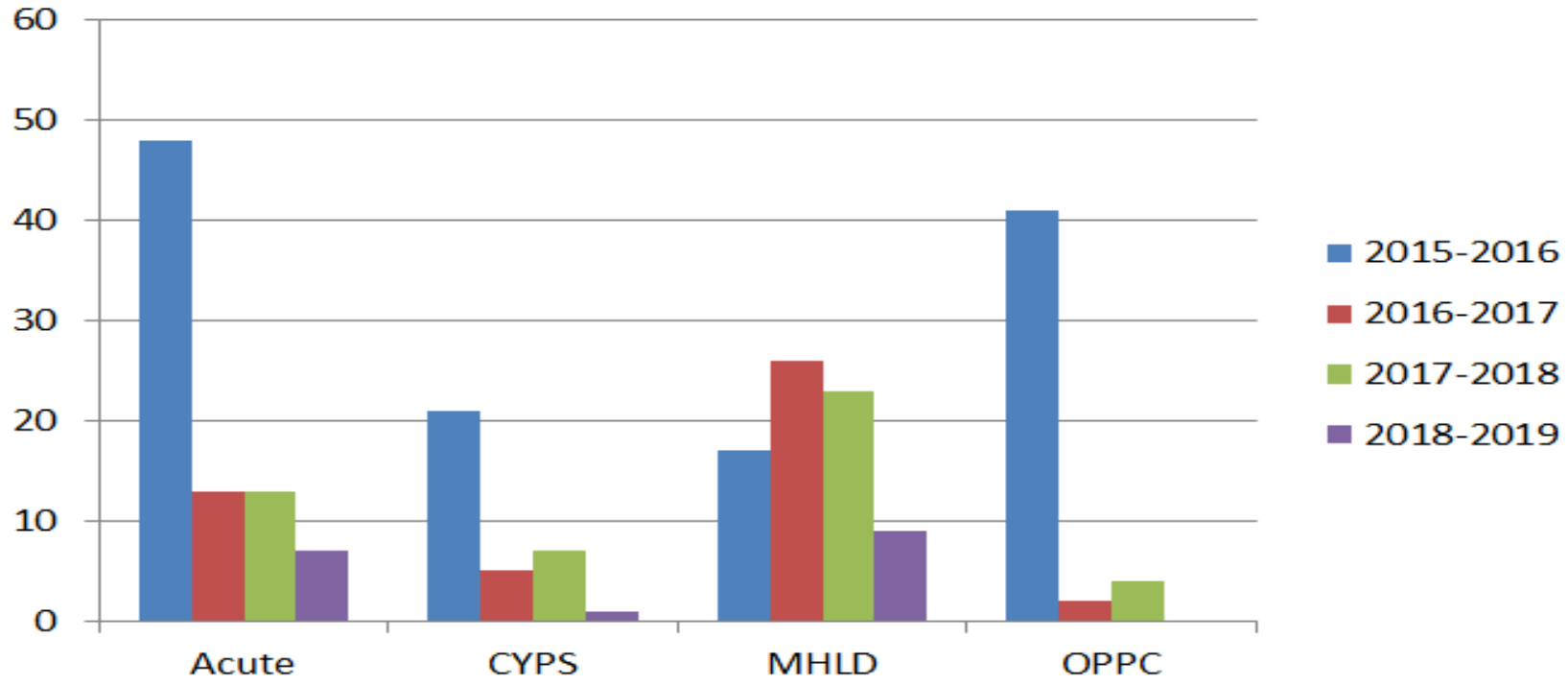
2. Serious Adverse Incidents (YTD)

Breakdown of SAI's Reported by Financial Year by Care Directorates 01 April 2015 – 1st August 2018



- Table above shows the number of adverse incidents have met the Serious Adverse Incident (SAI) criteria as the set by the HSCB.
- This number equates to (0.6%) of all adverse incidents reported via the Trust Incident Management system.

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Categorisation of SAIs 01 April 2015 – 1st August 2018 (YTD)

Area of Service	Incident Type	2015-16	2016-17	2017-18	2018-19	Total
Checking and oversight	Medication	0	1	0	0	1
	Test results	6	1	0	0	7
Equipment Related	Necessary Equipment Misused or misread by practitioner	0	0	1	0	1
	Necessary equipment not available	0	0	0	0	0
Prevention	Inpatient falls	7	0	1	0	8
Management of deterioration	Acting on or recognising deterioration	16	5	3	0	24
	Giving ordered treatment/support in a timely way	3	2	0	0	5
	Observe / review	6	1	0	0	7
No Area of Service Failure	No Area of service failure (a large number of these investigations were of expected child deaths and suicides)	50	35	21	1	107
Other	Other	4	1	2	0	7
SAI investigation in progress	SAI investigation in progress	0	0	19	16	35
N Home Falls	Not yet included in categorisation	35	0	0	0	35
Grand Total		127	46	47	17	237

The above table sets areas of learning which have been identified through Serious Adverse Incident Investigations.

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Position on the Progress of SAI Investigations

Timescales for the completion of Serious Adverse Incidents are set out by the Health and Social Care Board as follows:

Level 1 SAI investigations - 6 weeks

Levels 2 & 3 investigations – 12 weeks

Presently there are **35** SAI investigations currently being progressed within SHSCT, of which 7 are within the HSCB timescales for submission. There are a number of contributory factors set out below which influence the timescales of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads
- Necessary engagement with service users and their families, particularly where a death has occurred
- Where the SAI investigation spans across 2 or more Trusts

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

The table below sets out the position on the progress of SAI investigations ongoing

	Acute			CYPS			MHLD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks
Level 1	1	5	7	0	0	0	1	1	1	0	0	0
Level 2	0	1	1	1	0	1	3	8	1	0	1	0
Level 3	0	1	0	0	0	0	1	0	0	0	0	0

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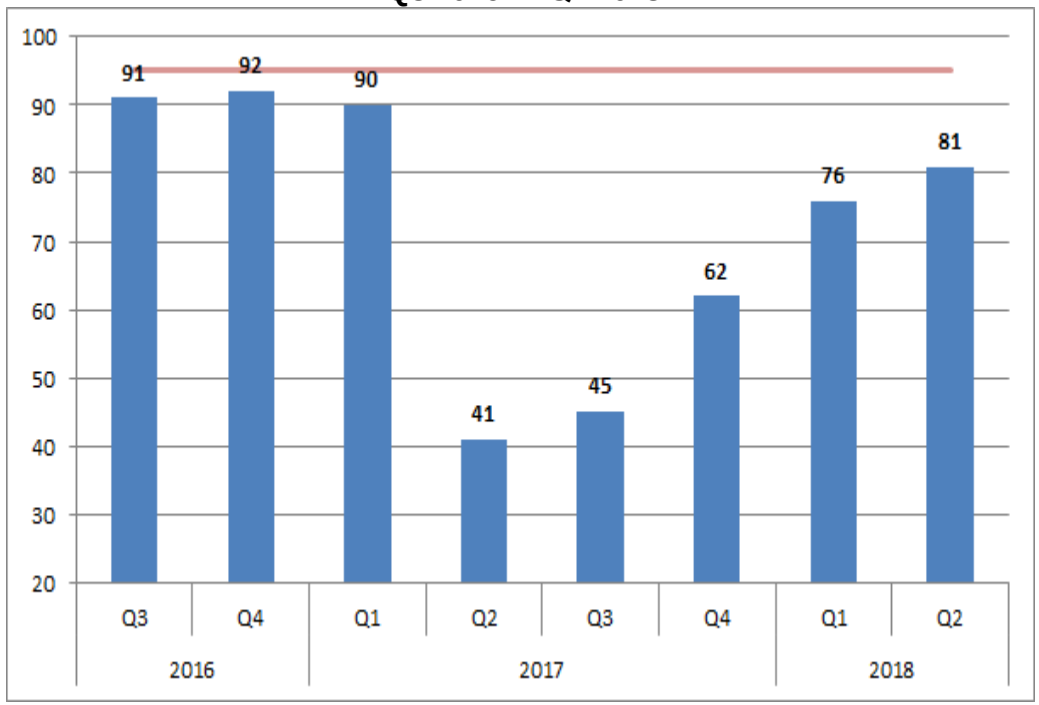
3. Patient Safety – NEWS

SHSCT NEWS Overall Bundle Compliance
Q3 2016 → Q2 2018



Introduction of Nursing Quality Indicators

In 2011 the Trust developed a range of Nursing Quality Indicators (NQI) aimed at measuring compliance with nursing care processes. The NEWS overall bundle compliance is captured through the Nursing Quality Indicator Audit Programme.

As part of this work the bundle compliance audit regarding NEWS documentation has been revised and updated following consultation with staff and review of best practice evidence.

Notable updates to the NEWS audit process:

- NEWS charts now subject to independent rather than self-audit
- Criteria adjusted to 'raise the bar' in terms of audit detail
- Production of detailed improvement plans at both ward and Trust level

As a result of the rebasing of audits Quarters 2-4 2017 has indicated a reduction in bundle compliance. The Ward Manager's Audit was reinstated in February 18 & will run alongside the Independent Audit, with a view to driving improvement between the Independent Audit 3 monthly cycle.

The Trust has discussed the care bundle in respect of compliance with the Public Health Agency who are now leading a regional Quality Improvement project to review the auditing process to provide additional assurance across the region.

In December 2017, the Royal College of Physicians published NEWS2. A Trust wide NEWS implementation and oversight group has been put in place to oversee the implementation of NEWS 2. The Group is jointly chaired by the Director of Medicine and the Executive Director of Nursing .

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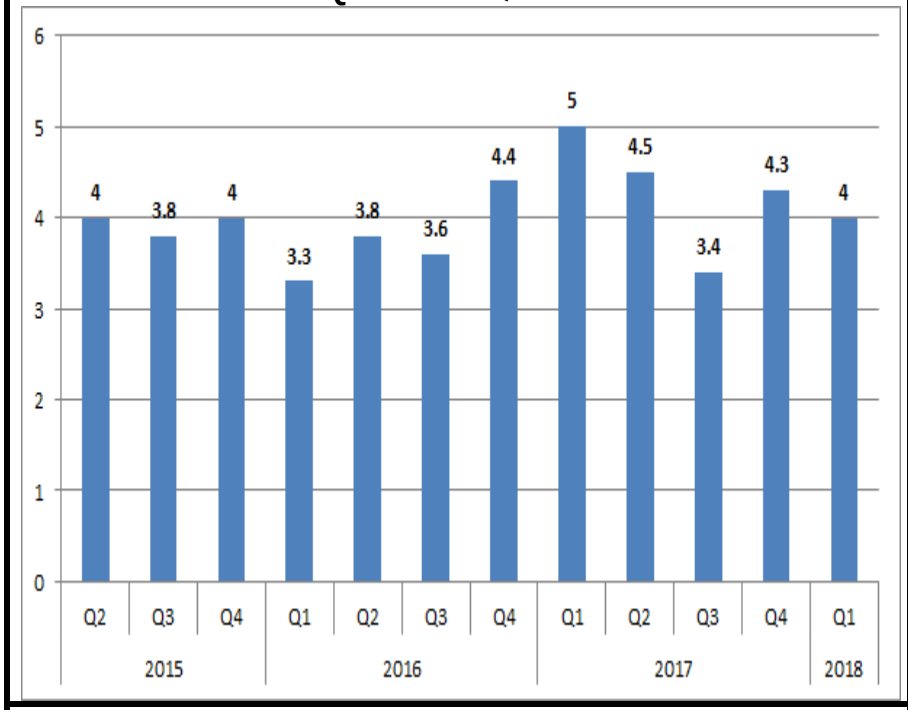
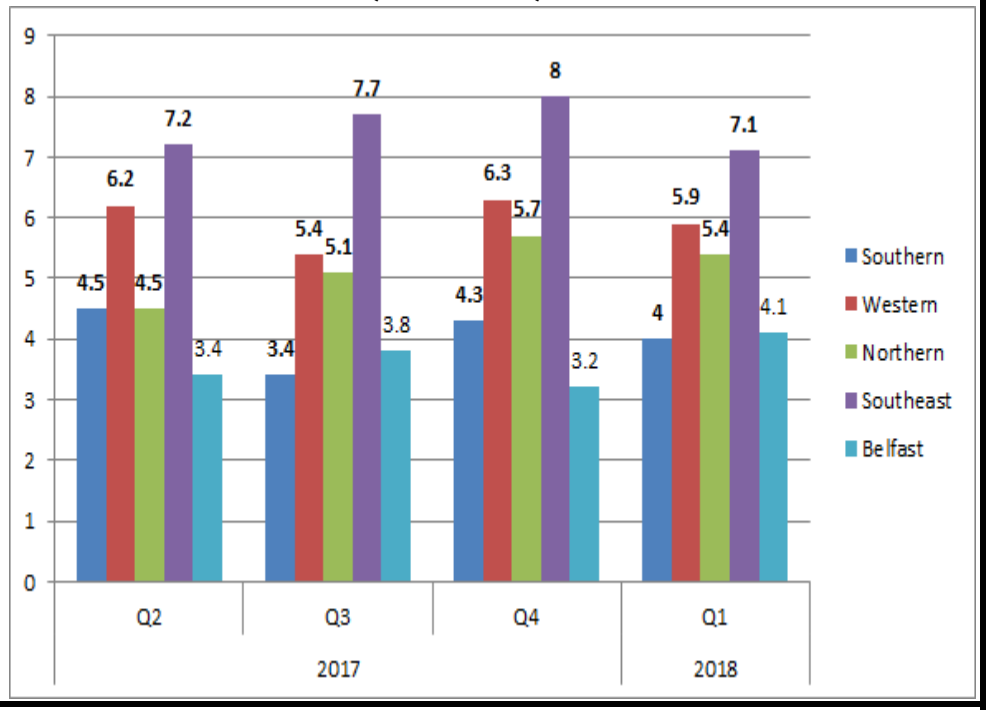
Patient Safety – Patient Falls

SHSCT Patient Fall Rate per 1,000 Occupied Bed Days Q2 2015 → Q1 2018



- Regional Improvement Work on Patient Falls began in 2011.
- A number of pro-active initiatives has resulted in the Trust's Falls Rate being consistently one of the best in NI, namely the implementation of elements of FallSafe Bundles A & B, the use of the Falls Walking Stick by Wards to capture details of their Patient Falls "Real Time", moving "at risk" patients to a more suitable location on the Ward, where possible.
- In line with the Region in 2017/18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.
- There is no regional target associated with patient falls.

NI Trust's Patient Fall Rate per 1,000 Occupied Bed Days Q2 2017 → Q1 2018



- In Q1 2018 the Trust's Patient Falls Rate was 4.0 per 1,000 Occupied Bed Days
- In Q1 2018 the Trust's Rate was the lowest in NI
- Of the 26 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick 14 wards (46%) saw a decrease in falls in 17/18, compared to 16/17

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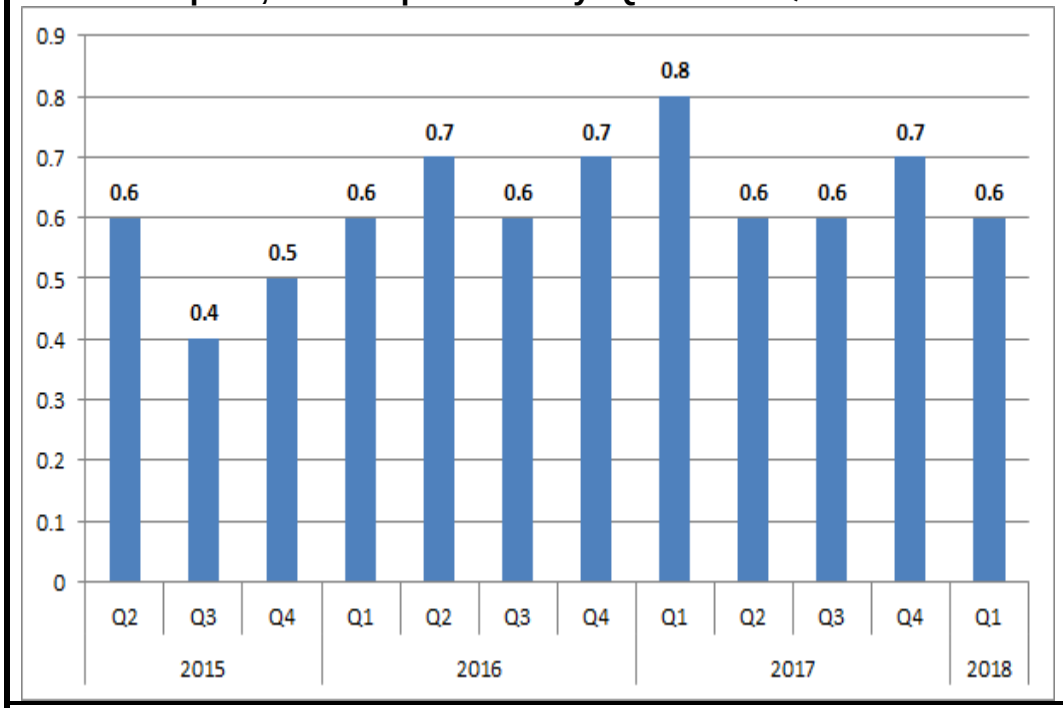
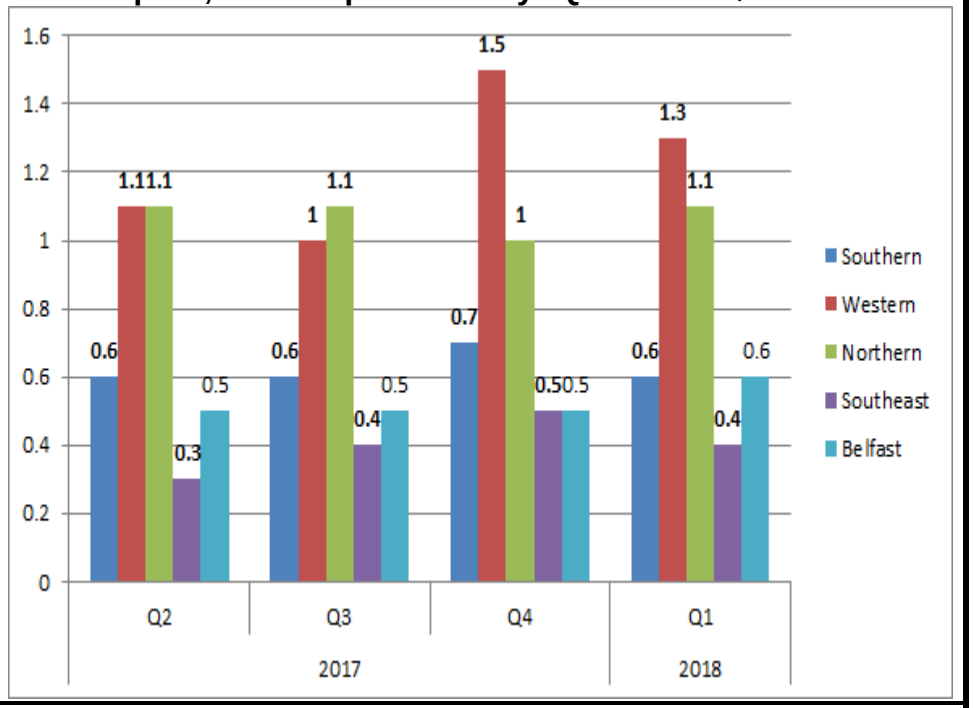
Patient Safety – Pressure Ulcers

SHSCT Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q2 2015 → Q1 2018



- Regional Improvement Work on Pressure Ulcers began 2011.
- A number of pro-active initiatives have been introduced namely the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan.
- The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on these cases within the Trust to determine those which were avoidable, with lessons learnt fed back by the Lead Nurses via Ward Manager's Meetings

NI Trust's Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q2 2017 → Q1 2018



- All Trusts saw an increase in "Ward Acquired" Pressure Ulcers in 16/17 compared to 15/16.
- Of the 27 Wards monitoring their Hospital Acquired Pressure Ulcers/Rate using the Pressure Ulcer Safety Cross 16 wards (59%) saw their rate remain the same or decrease in 17/18 compared to 16/17
- Of the 173 Ward Acquired Pressure Ulcers reported in 17/18, 26 (15%) were Grade 3 or 4 Pressure Ulcers. RCA's conducted on these cases concluded that only 6 were avoidable
- A series of Pressure Ulcer Awareness Coffee Mornings, funded by the PHA were held across the Trust in March 2018 to drive further improvement

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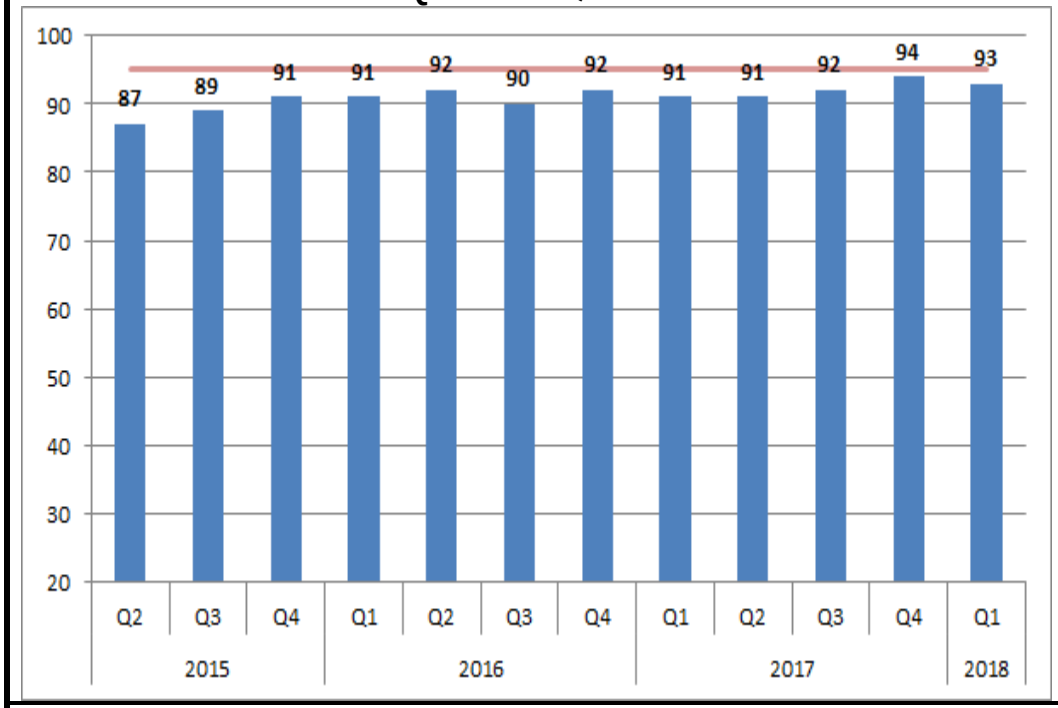
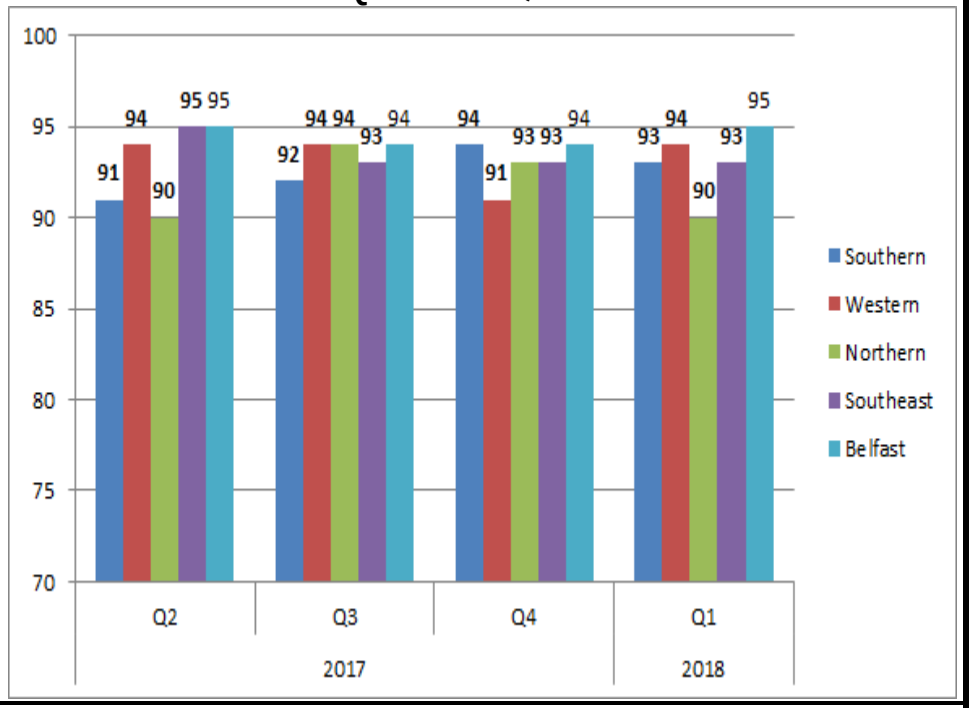
Patient Safety – Venous Thromboembolism (VTE) Risk Assessment

SHSCT VTE Risk Assessment Compliance
Q2 2015→ Q1 2018



- Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009.
- All Trusts now use a Regional Risk Assessment Tool.
- For the past 4 years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%.

NI Trust's VTE Risk Assessment Compliance
Q1 2017 → Q4 2017



- All Trusts have seen an increase in compliance since measurement began in April 2013.
- Southern Trusts overall compliance for Q1 2018 was 93%
- Southern Trust's Non-Acute Wards (Lurgan & South Tyrone) Compliance Rate was 98.3% in Q1 2018

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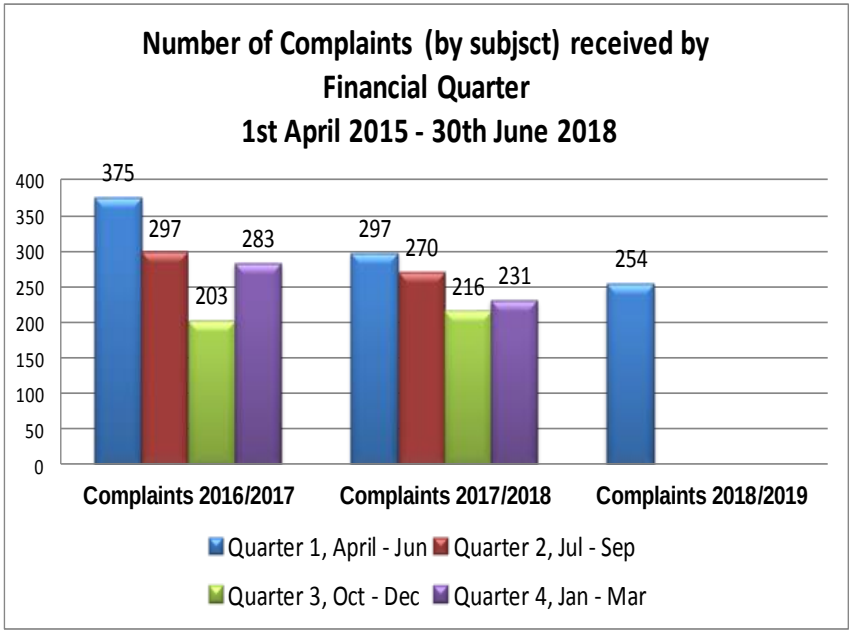
3. Complaints and Ombudsman's Complaints

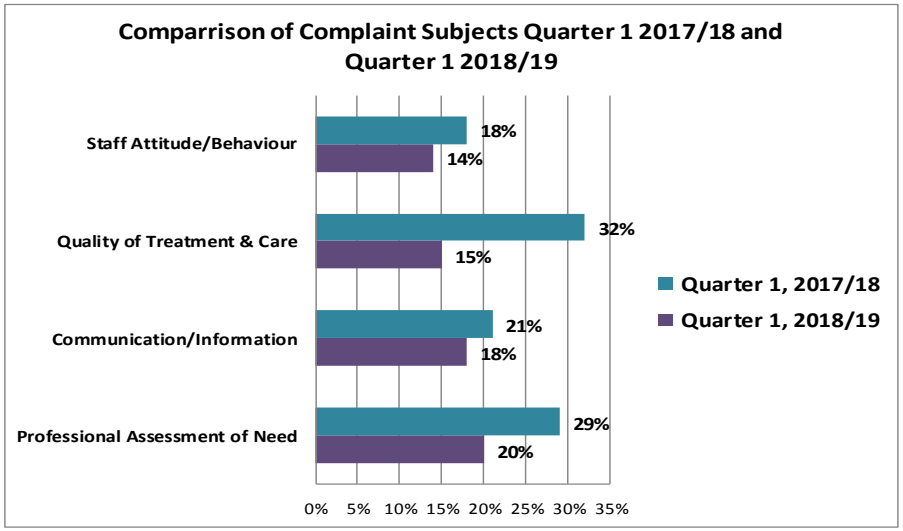
Number of Complaints Received



Regionally Complaints are categorised and reported by the subject within the complaint. One complaint letter may have multiple complaints subjects.

In Quarter 1 2018/19 the Trust received **161** formal complaints of which there were **254 complaints subjects**. There is a notable decrease in the number of complaint subjects in comparison to Quarter 1 in previous financial reporting years, as highlighted above.

What Our Service Users Complained About



Top 10 Complaint Subjects Q1, 2018/19

Professional Assessment of Need	20%
Communication/Information	18%
Quality of Treatment & Care	15%
Staff Attitude/Behaviour	14%
Policy/Commercial Decisions	4%
Waiting List, Delay/Cancellation Outpatient Appointments	3%
Waiting Times, Outpatient Departments	3%
Aids/Adaptions/Appliances	3%
Waiting List, Delay/Cancellation Planned Admission to Hospital	3%
Discharge/Transfer Arrangements	2%

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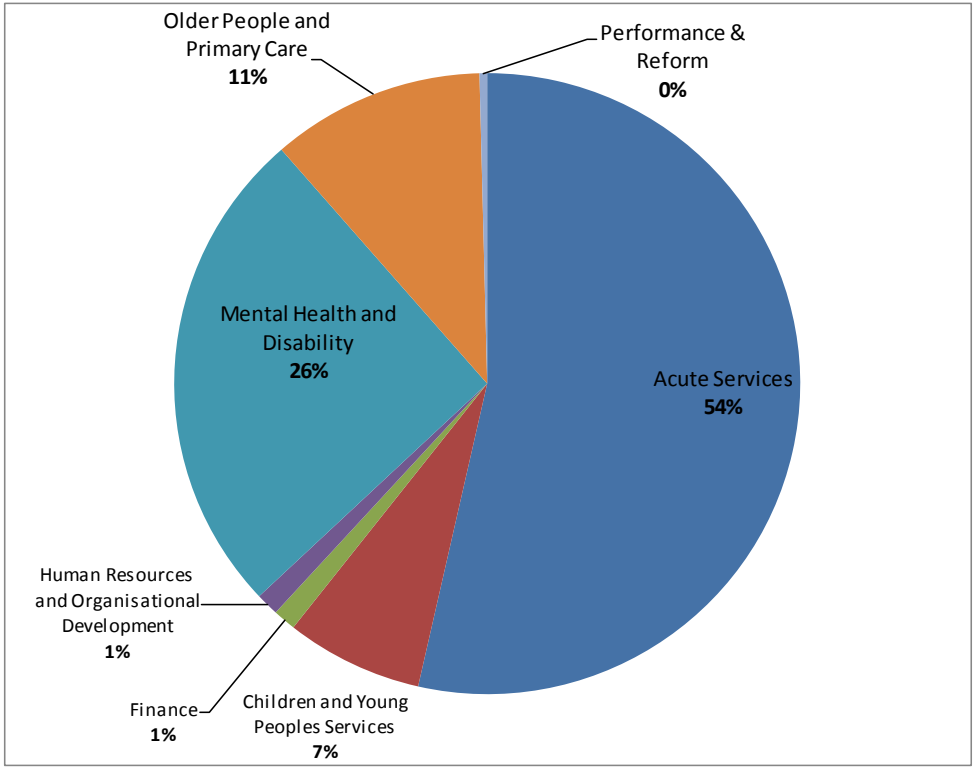
Breakdown of % of Complaints (subjects) by Directorate for Quarter 1 (1st April 2018 – 30th June 2018)



Breakdown of Number of Complaints (subjects) by Directorate and Division for Quarter 1 (1st April 2018 – 30th June 2018)

Directorate / Division	No Complaints Subjects
Acute Services	**136**
Functional Support Services	4
IMWH - Cancer and Clinical Services	30
Medicine and Unscheduled Care	47
Pharmacy	2
Surgery and Elective Care	53
Children and Young Peoples Services	**18**
Corporate Parenting	1
Family Support and Safeguarding	9
Specialist Child Health and Disability	8
Finance	**3**
Financial Accounting	3
Human Resources and Organisational Development	**3**
Employee Relations and Engagement	1
Estates	2
Mental Health and Disability	**65**
Learning Disability Services	6
Memory Services	11
Mental Health Service	42
Physical and Sensory Disability Service	6
Older People and Primary Care	**28**
Enhanced Services	10
Older Peoples Services	2
Primary Care	14
Promoting Wellbeing	2
Performance & Reform	**1**
Informatics	1
Grand Total	**254**

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Acknowledgement and Response Times for Complaint Letters per Directorate 1st April 2017– 30th June 2018

	Acute				CYP				MHD				OPPC			
	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE
Apr 2017	62	92%	37%	71%	**8**	100%	100%	100%	**5**	100%	100%	N/A	**2**	100%	100%	100%
May 2017	63	94%	35%	59%	**22**	94%	77%	82%	**8**	100%	63%	88%	**3**	100%	100%	100%
Jun 2017	55	87%	47%	67%	**15**	100%	73%	93%	**12**	100%	83%	100%	**1**	100%	100%	100%
Jul 2017	**72**	67%	44%	51%	**10**	100%	70%	70%	**7**	100%	86%	100%	**3**	100%	67%	100%
Aug 2017	**47**	94%	40%	74%	**12**	100%	92%	100%	**6**	100%	100%	100%	**6**	100%	83%	100%
Sept 2017	**65**	92%	32%	44%	**18**	100%	83%	83%	**6**	100%	100%	100%	**3**	100%	100%	100%
Oct 2017	**44**	98%	39%	75%	**12**	100%	83%	92%	**11**	91%	91%	100%	**2**	100%	100%	100%
Nov 2017	**55**	88%	47%	51%	**9**	100%	89%	89%	**8**	100%	87.5%	100%	**6**	100%	83%	100%
Dec 2017	**17**	100%	24%	53%	**8**	100%	88%	88%	**2**	100%	100%	100%	**4**	100%	100%	100%
Jan 2018	**69**	91%	28%	54%	**9**	100%	65%	75%	**4**	100%	100%	100%	**8**	100%	100%	100%
Feb 2018	**34**	94%	50%	74%	**11**	100%	55%	91%	**3**	100%	33.3%	33.3%	**5**	100%	100%	100%
Mar 2018	**40**	100%	33%	58%	**11**	100%	73%	73%	**10**	90%	90%	90%	**3**	100%	100%	100%
Apr 2018	**48**	98%	42%	77%	**6**	100%	67%	83%	**4**	100%	75%	75%	**3**	100%	100%	100%
May 2018	**59**	100%	46%	59%	**6**	100%	50%	50%	**9**	89%	78%	89%	**6**	100%	83%	100%
Jun 2018	**48**	100%	44%	50%	**4**	100%	100%	100%	**9**	100%	67%	89%	**3**	100%	100%	100%

The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days

The table above sets out the Trust performance by directorate against these standards. 30 Days is not a formal target however is monitored by the Trust for performance purposes.

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Ombudsman Cases

Breakdown of Ombudsman cases per Financial Year, 1st March 2014 –10th August 2018

	Local Resolution	Not Upheld	Open	Awaiting Screening	Upheld	Withdrawn	Not Accepted	Total
2014/2015	1	1	1	-	5	-	-	**8**
2015/2016	-	1		-	9	2	2	**14**
2016/2017	2	2	4	1	2	3	2	**16**
2017/2018	2	-	7	4	1	1	4	**19**
2018/2019	-	-	-	2	-	-	1	**3**
	5	**4**	**12**	**7**	**17**	**6**	**9**	**60**

The Trust's response to feedback about our services is based on principles of good complaint handling:

1) *Getting it right* **2)** *Being customer-focused* **3)** *Being open and accountable* **4)** *Acting fairly and proportionately* **5)** *Putting things right*

6) *Seeking continuous improvement*

When patients are not fully satisfied with the outcome from the Trust's complaint process they can choose to subsequently raise their concerns with the Northern Ireland Public Services Ombudsman. All complainants are provided with information about referring their issues to the Ombudsman at the point at which the Trust completes their investigations and closes the case with the complainant.

During the previous financial year 2017/2018, **19 cases** had been raised by the Ombudsman regarding complaints previously raised with the Trust; of which **2 cases** reached local resolution, **4 cases** were not accepted and **1 case** withdrawn. **1 case** was upheld by the Ombudsman following investigation while **7 cases** remain open within the investigation stage.

During this current financial year to date **2** cases awaits screening for acceptance by the Ombudsman's office and **1** case has not been accepted

We continued to work with the Ombudsman on cases raised during previous years.

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Governance Committee

Committee Chair Report for Trust Board Meeting on 22nd June 2023

The Governance Committee ('the Committee') met on 11th May 2023. The following is a summary of the areas considered at the meeting to update the Trust Board. The formal record of the meeting remains the approved minutes.

Chair's Remarks: none noted.

Minutes of meeting held on 12th January 2023 and 9th February 2023

- Minutes were approved

Matters arising

The Committee received updates on all matters arising from the Minutes.

Key points to note:

- Progress report on OG Whistleblowing case deferred to September meeting.
- Report on earning from Employer liability case/litigation to be provided at September meeting.
- Existing controls assurance tools to be replaced by new C&SCG structures currently in early stages of establishment
- Deep dive into estates cases as part of Raising concerns report to be provided in November report.
- Report on C&SCG Negligence Cases tabled for information.

6i: Information and IT Governance Report 01.01.23 – 31.03.23

Report received for **Information**

- New broader report tabled to give wider view of IT Governance.
- Volume of requests under FOI and SAR in this quarter is the highest since 2018. Compliance levels reduced from 70% to 56% against a target of at least 85%.
- Risk from noncompliance of potential action by ICO.
- 1 data breach explained concerning a third party IT host vendor.
- Cyber risk remains on Risk Register
- Limited assurance rating from informal audit and management response awaited.
- NIECR requiring update and investment to make the system more robust.

6ii: Information Governance Annual Report

Report deferred to September meeting

7i: Medication Safety Report

Report received for **Assurance**

- Assurance provided to the committee on medicines management –no significant new trends of concern
- EU exit update on supply of medicines provided and some risk remains in this area

7ii. Royal Pharmaceutical Society – Summary Report on Implementation of Standards

Report received for **Assurance**

- This is the first report submitted to the Governance Committee that assesses hospital Pharmacy performance against RPS standards
- Overall score 86% but some actions needed to improve performance.

8i. Hyponatraemia Report

Received for **Assurance**

- Overview of the IHRD 96 recommendations of which 63 have been fully actioned and 57 due to move to phase 2
- Completed stocktake of recommendations and progress on regional recommendations.
- Regional work streams will not be resumed.
- Training compliance among medical and nursing staff is still an area of concern

9i. Claims Management Report

Received for **Assurance**

- Litigation Activity summary, Enquires from Coroner's Office and medico legal requests to 03/23 tabled
- New Head of Litigation appointed 02/23
- Decrease of just under £2m in legal costs reported
- Overall increase in medico legal cases by 60 approx.
- Concerns around staffing issues discussed. New appointment of 1PA clinical input in this area. HOS now in place with a focus upon Urology cases.

10i. Raising Concerns

Report provided for assurance under confidential section

Moved to Confidential.

11i. Clinical and Social Care Governance Report

Received for **Assurance**

- Significant improvement in unapproved incidents on Datix
- Temporary service user and family liaison officer appointed
- Complaints down by 18%
- New Shared Learning template introduced
- SAI recommendations included in report for the first time –however 75% of SAI's outside of timescales and increase in notifications this year
- ED waiting times remain well of target
- Breakdown of CCS2 codes tabled along severity lines
- In last 23 months 98% of patients not receiving their first treatment within 31 days of DTT. Targets for receipt of treatment within 62 days has never been met in last 23 months

11ii: Management of Standards and Guidelines

Report received for **Assurance**

- Action on BSO Internal Audit Review recommendations prioritised
- New Sharepoint for Standards and Guidelines
- Service recruitment across Governance Teams but lack of adequate budget
- Need to ensure learning captured
- Fit for purpose IT system/solution emphasised

11iii: Mortality Report

Report received for **Assurance**

- Trust id performing on par with other NHS peers
- SHIMI score for SHSCT lower than expected
- No significant areas of concern

11iv: RQIA Review of the Implementation of NICE CG 174 – IV Fluid Therapy in adults in hospitals in NI

Report received for **Assurance**

- Regional workshop held in January 23 and attended by Trust representatives
- Demo of newly proposed Encompass IV Fluid e-prescribing programme provided
- Further round of student simulation completed

12: Corporate Risk Register

Report received for **Assurance**

- Updated CRR presented
- A deep dive into Urology Services planned for September meeting
- Two new high level risks identified In relation to cervical cancer

13: Health and Safety Update

Report received for **Assurance**

- Annual Report on H&S tabled
- Updated H&S policy agreed by H&S committee
- 4-Year Audit Plan to commence this quarter
- Operational structures ie insufficient staff highlighted as a risk
- Over reliance on temporary staff

14. Estates Governance Group – Summary Report

Report received for **Assurance**

- Quarterly Governance Paper tabled
- Two main concerns raised in terms of staffing levels of Corporate H&S Team and Clinical Engineering.

15. Learning from Experience Forum

Report received for **Information**

- Establishment of new Committees/Steering groups as part of enhanced Board Assurance Framework
- Structured Early Learning Tool developed
- Improvements to DATIX
- Time needed to fully implement the new BAF

16. Draft Governance Statement

Report received for **Assurance**

- Draft Governance Statement tabled for assurance.
- Statement has already been considered by The Audit Committee

17i. Research and Development Annual Report

Report received for **Assurance**

- While COVID-19 had an impact upon research it is clear this impact was minimal as evidenced by a steady increase in research across a wide range of specialities
- Research into Motor Neurone Disease commenced in last year
- Struggle to retain staff willing to act as principal investigators.

17ii. Emergency Planning Annual Report

Report received for **Assurance**

- Annual Report on Emergency preparedness tabled
- Trust is stretched to its absolute limit due to staffing pressures and this impacts upon the ability to respond to a major emergency or mass causality incident
- Similar risks across all Trusts

18: Feedback from Audit Committee – Internal Audit Reports

- Safeguarding/statutory responsibilities for Looked After Children *(Satisfactory)*
- Risk Management *(Satisfactory)*
- Point of Care Testing *(Limited)*
- Corporate Mandatory & Profession Specific Training (Nursing) 2022/23 *(Limited)*

Any other Business

Next meeting to take place on 7th September 2023

Action(s) requested/required of Trust Board

1. Note the areas considered
2. Note the Governance Committee Minutes of 12th January 2023 and 9th February 2023

Mr Martin McDonald
Committee Chair
On behalf of the Governance Committee
June 2023

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REPORT SUMMARY SHEET

Meeting: Date:	Trust Board- Confidential Thursday 7th June 2018
Title:	Action Card for Non Executive Directors in the event staff raise Whistleblowing Concerns
Lead Director:	Mrs Vivienne Toal Director of HROD
Corporate Objective:	Be a great place to work Provide safe, high quality care
Purpose:	For discussion / information

Summary of Key Issues for Trust Board

High level context:

To provide guidance to Non Executive Directors on the correct approach to take with any member of staff who approaches them about raising a concern (whistleblowing)

Key issues/risks for discussion:

- Do NEDs consider that this action card addresses the steps that they consider to be important? Is it helpful?
- The importance of ensuring that a 'confidentiality' discussion takes place with the member of staff on whether they wish their name to be shared with anyone following discussion, and if so, with whom?
- The importance of ensuring a member of staff knows what steps a NED will be taking following any discussion.

Summary of SMT challenge/discussion: General comments from SMT were that the action card was easy to follow. Wider discussion needed regarding action to be taken on the different types of information brought to the attention of the Chair's office to ensure appropriate response is made.
Internal/External engagement: Not applicable
Human Rights/Equality: Not applicable

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RAISING CONCERNS (WHISTLEBLOWING)

ACTION CARD FOR ALL NON-EXECUTIVE DIRECTORS

It is recognised that a member of staff may approach a Non-Executive Director in person to raise a concern which could be classed as 'whistleblowing'.

The following are the key actions that the Non-Executive Director should take if this situation arises:

1. Thank the worker for raising the concern (even if you think they may be mistaken)
2. Acknowledge how they may be feeling, that it may be a difficult or stressful situation, and offer reassurance that the Trust Board and Senior Management Team take very seriously any concerns that are raised, and that a zero tolerance approach is taken regarding any detrimental treatment of anyone who raises a concern.
3. Understand on a general level what the basis of their concern is e.g. fraud, patient safety, etc.
4. Establish if s/he has previously raised their concern and what the outcome was.
5. Advise that as a Non-Executive Director you cannot investigate their concern.
6. Advise that the Trust has a Whistleblowing Policy called – "Your right to raise a concern", and that it is available on the Trust's intranet or by contacting HR Department in Armagh – St Luke's site.
7. Offer, **with their agreement**, to refer the matter and their name & contact details to the Lead Director for raising concerns - Mrs Vivienne Toal – Director of HR / Lead Director for Whistleblowing, who will arrange to make contact with him / her, confidentially, to discuss their concern and agree how it will be addressed.
8. Assure him / her that the Director of HR will be the **only** individual you will pass their details on to, and that the Director of HR will have a conversation with him/her regarding how their confidentiality will be maintained if that is their wish.
9. If s/he is **not** willing to share their identity, advise that they can raise their concern anonymously by writing to the Director of HR, without giving their name, although they should be aware that this can limit the Trust's ability to robustly investigate the concern and provide feedback to him/her.
10. Make a note of your conversation and forward to the Director of HR.

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Policy for Reporting of Early Alerts to the Department of Health (DoH)

Lead Policy Author & Job Title:	Stacey Hetherington, Corporate Clinical and Social; Care Governance Co-Ordinator Nicole O'Neill, Corporate Clinical and Social Care Governance Manager
Directorate responsible for document:	Medical
Issue Date:	28 July 2022
Review Date:	Click here to enter a date.

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Policy Checklist

Policy name:	Policy for the Reporting of Early Alerts to the Department of Health (DoH)
Lead Policy Author & Job Title:	**Stacey Hetherington, Corporate CSCG Co-Ordinator** **Nicole O'Neil, Corporate CSCG Manager**
Director responsible for Policy:	Dr Damian Gormley, Interim Medical Director
Directorate responsible for Policy:	Medical
Equality Screened by:	Click here to enter text.
Trade Union consultation?	Yes ☐ No ☒
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	09 June 2022
Date approved by SMT:	Click here to enter a date.
Policy circulated to:	Operational Directorate Governance Co-Ordinators
Policy uploaded to:	SharePoint

Version Control

Version:	**1_0**		
Supersedes:	**N/A**		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
Eg Version 1_0	Click here to enter text	Click here to enter a date.	Click here to enter text
Eg Version 2_0	Click here to enter text	Click here to enter a date.	Click here to enter text

Contents

Introduction

The Early Alert System was introduced on 01 June 2010 to coincide with the transfer of responsibility for the Serious Adverse Incident (SAI) system from the Department of Health (DoH) (formerly known as the Department of Health, Social Services & Public Safety) to the Department of Health Strategic Planning and Performance Group (SPPG) (formerly known as the Health & Social Care Board (HSCB))/ Public Health Agency (PHA).

The Early Alert system outlines the requirements for Chief Executives and their senior staff in Health & Social Care (HSC) to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, which may require urgent attention by the Minister, Chief Professionals or policy leads, and/or require urgent regional action by the Department.

Purpose and Aims

The purpose of this policy is to ensure the Southern Health and Social Care Trust (SHSCT) adheres to the Early Alert guidance which have been in effect from 1 June 2010 (and subsequent updates) to ensure that the DoH/SPPG (and thus the Health Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the DoH/SPPG including those of media interest.

Objectives of this Policy

To support staff involved in the procedure for reporting Early Alerts to the DoH.

Policy Statement

Department of Health (DOH): Department of Health (previously known as the Department of Health, Social Services and Public Safety [DHSSPS]). Also referred to as the 'Department'.

Early Alert: an incident or an event which has occurred in the services provided or commissioned by the organisation and which may require immediate attention by the Health Minister, Chief Professional Officers or policy leads and/or requires urgent regional action by the Department.

Strategic Planning and Performance Group (SPPG) (formerly known as the Health & Social Care Board (HSCB)): department within the Department of Health responsible for the receiving, review and escalation of Early Alerts from the Trust. SPPG will advise the Trust if any further action is required on receipt of an Early Alert.

The Early Alert system (see Appendix 1) provides a channel which enables the Chief Executive and senior staff (Director level) to notify the DoH/SPPG, in a prompt and timely manner, of events or incidents which have occurred in any service provided by the Trust and which may require immediate attention by the Health Minister, Chief Professional Officers or policy leads and/or require urgent regional action by the Department.

It is important to note that this reporting system is intended to complement, not replace, existing channels of communication, both formal and informal.

Whilst it is likely that some of the notifications reported as Early Alerts will also require to be managed as Serious Adverse Incidents (see Policy and Procedure for the Reporting of Serious

Adverse Incidents to the Health & Social Care Board, November 2016) many Serious Adverse Incidents will NOT require to be reported through the Early Alert channel.

Where an Early Alert is identified out of hours, Directors should make contact with the relevant senior member of staff at Department level by telephone (Appendix 2). The completed proforma to the DoH/SPPG by the Corporate Governance office will follow as soon as possible thereafter.

Scope of Policy
This policy is applicable to incidents within all service areas across the SHSCT.

Responsibilities
Chief Executive: is responsible for ensuring that a system is in place to notify the DoH/SPPG in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, which may require urgent attention by the Health Minister, Chief Professionals or policy leads, and/or require urgent regional action by the DoH/SPPG.

Corporate Clinical and Social Care Governance: have responsibility for centrally managing the Trust's Early Alert's (through the mailbox: [redacted]), ensuring queries are raised with Directorate Clinical and Social Care Governance teams in a timely manner and that Early Alert Proformas are submitted to the DoH/SPPG as per the timeframes stipulated in the reporting process (Appendix 1).

Irrelevant information redacted by the USI

Directors: are responsible for making a decision as to whether an incident meets the criteria for an Early Alert and if so to make contact with the relevant senior member of staff at Department level by telephone, including out of hours (using the phone numbers at Appendix 2). They are responsible for agreeing with SPPG any follow-up action as required.

Directors are responsible for ensuring the initial telephone contact is followed up in writing (using the Early Alert proforma, Appendix 3) within the timescales set out by DoH.

Assistant Directors: are responsible for ensuring that incidents which may fall within the criteria for Early Alerts within their areas of responsibility are reported to the relevant Director as a matter of urgency to allow for a decision by their respective Director as to the merits of reporting to the DoH/SPPG. In addition, they may also have to make the telephone call to the DoHin the event the Director is not available.

Directorate Governance Co-Ordinators: are responsible for the coordination of the Early Alert process within their Directorates, ensuring Assistant Directors/Directors have reviewed and approved prior to submitting the proforma to Corporate Governance for onward submission. Directorate Co-Ordinators will ensure relevant updates to Early Alerts submitted are escalated for approval and submission.

Senior Managers: are responsible for making staff aware of this policy and ensuring discussion with the Assistant Director of any incident which may fall within the criteria for reporting as an Early Alert.

Staff (including permanent, temporary, locum, agency, bank, contractors and voluntary): are responsible for making themselves aware of, and adhering to, the content of this policy when involved with raising an Early Alert at service level.

Dissemination
Following approval, this policy will be disseminated widely to all Governance staff within the Trust but particularly Directorate Governance Co-Ordinators, Senior Managers, Assistant Directors and Directors within the organisation. Staff at service level involved in Early Alerts will be made aware of this Policy as required.

Resources
Within the Medical Directorate, the Corporate Clinical and Social Care Governance (CSCG) Department is responsible for ensuring all relevant staff detailed in 5.1 have an awareness of this policy, delivering bespoke training sessions as and when required.

Exceptions
This policy indirectly applies to all staff across all service areas within the Trust and there are no exceptions to its application.

Monitoring
Audit of the policy will be undertaken, to ensure adherence to the principles and procedures outlined within the document.

Legislative Compliance, Relevant Policies, Procedures and Guidance
Policy Circular HSC (SQSD) 64/16 – Early Alert System dated 28 November 2016 (Superseded)
Policy Circular HSC (SQSD) 10/10 – Establishing an Early Alert System dated 28 May 2010
Policy Circular HSC (SQSD) 5/19 – Early Alert System dated 27 February 2019
Regional Working Group consult
HSC (SQSD) circulars

Equality & Human Rights Considerations
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

Sources of Advice & Further Information
Appendix 1: Process for the Reporting of Early Alerts to the Department of Health
Appendix 2: Early Alert System Department Officer Contact List – March 2022

Appendix 3: Early Alert Proforma
Appendix 4: SHSCT Process Flowchart for the Reporting of Early Alerts

Appendix 1

Process for the Reporting of Early Alerts to the Department of Health Strategic Planning and Performance Group (SPPG) (formerly known as the Health & Social Care Board (HSCB))

1.0 Introduction

The purpose of this guidance is to make staff aware of the arrangements which should be followed to ensure that the DoH/SPPG (and thus the Health Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the DoH/SPPGincluding those of media interest.

1.0 Criteria for Reporting an Incident as an Early Alert

1.1 The established communications protocol between the DoH/SPPG and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, the Trust is required to notify the DoH/SPPG promptly **(within 48 hours of the event)** of any event which has occurred within Trust services which meets one or more of the following criteria:

a) Urgent regional action may be required by the DoH/SPPG, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;

b) The Trust is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

c) The Trust is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;

d) The media have inquired about the event;

e) The PSNI is involved in the investigation of a death or serious harm that has occurred in the Trust's Services, where there are concerns that a Trust service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:

(i) There has been an event which has caused harm to a patient or client and which has given rise to a coroner's investigation; or

(ii) Evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or
(iii) The Coroner's inquest is likely to attract media interest.

f) The following should always be notified:

(i) The death of, or significant harm to, a child and abuse or neglect are known or suspected to be a factor;
(ii) The death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;
(iii) Allegations that a child accommodated in a children's home has committed a serious offence; and
(iv) Any serious complaint about children's home or person(s) working there.

g) There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

2.0 Operational Arrangements

2.1 The **Assistant Director** should advise the relevant Director as soon as they are made aware of the incident having occurred within their area of responsibility.

2.2 The Director should consider the incident description against the criteria set out for reporting under the Early Alert system and make an assessment as to whether it is reportable.

2.3 The Director (or nominee) should communicate by telephone with the senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer or Assistant Secretary) and the Public Health Agency, as appropriate and any other relevant bodies regarding the event.

2.4 Appendix 2 provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list. The list of names is up to date as at March 2022 but contact details should not change even if individual staff members do.

2.5 The next steps should be agreed during the call and appropriate follow-up action taken by the relevant parties.

2.6 The Director (or nominee) will arrange for the follow-up proforma to be fully completed as soon as possible after the event but no later than **24 hours** from the original telephone report (Appendix 3) and forwarded to the Corporate CSCG department at [redacted] and email marked 'important' for processing.

Irrelevant information redacted by the USI

2.7 The Corporate CSCG office will insert the appropriate reference number, anonymise the content and issue to the DoH/SPPG early alerts mailbox within 24 hours of the initial telephone notification at 3.3. At no time should the completed proforma be forwarded to the DoH/SPPG by anyone other than Corporate CSCG Department staff.

2.8 The report will be issued simultaneously by the Corporate CSCG office to the Chief Executive, the Chair, Directors, Non-Executive Directors, the relevant Assistant Director, the Communications Manager, CSCG staff including the Assistant Director for CSCG and any other relevant officers as deemed appropriate by the Corporate CSCG department.

2.9 The SPPG will provide an update and decision on whether the file can be closed or further follow up is required to the Corporate CSCG department Irrelevant information redacted by the USI within 4 weeks of receipt of Early Alert. Details of this update will be shared with CSCG staff within the relevant Directorate. ** Early Alerts in relation to reduced cover within GP Out of Hours will not be followed and an automatic update of "the issue in relation to reduced cover within GP Out of Hours continues, Early Alerts will continue to be submitted when the Director feels appropriate.*

2.10 There may be occasions when Directors feel it is appropriate to provide updates to the DoH/SPPG on an Early Alert which has already been reported, and where there has been a considerable passage of time since the initial report, with possible Ministerial changes. It may be appropriate, therefore, for the Director (or nominee) to communicate with a senior member of staff in the Department of Health (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional officer or Assistant Secretary) regarding the update. This is not mandatory, however it is considered to be good practice. Any telephone update should be advised to the Corporate CSCG Department to allow for a written update to be provided also.

2.11 It is the responsibility of the Trust to comply with any other possible requirements to report or investigate the event being reported in line with any other relevant applicable guidance or protocols [e.g. Police Service for Northern Ireland (PSNI), Health & Safety Executive (HSE(NI)], Professional Regulatory Bodies, the Coroner etc. This should include compliance with GDPR requirements for information contained in the Early Alert proforma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the proforma should relate only to the key issue and it should not contain any personal data.

Appendix 2

Early Alert System
Departmental (DoH) Officer Contact List

The following information provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list. Voicemails must not be left.**

EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST MARCH 2022

HEALTHCARE POLICY GROUP

Deputy Secretary
Jim Wilkinson Personal Information redacted by the USI

General Dental, Ophthalmic Services & Criminal Justice Healthcare
Robbie Davis Personal Information redacted by the USI

Primary Care/Out of Hours Services
Gearoid Cassidy Personal Information redacted by the USI

Secondary Care
Ryan Wilson Personal Information redacted by the USI

Workforce Policy/Human Resources
Philip Rodgers Personal Information redacted by the USI

Transformation/EU Exit
Patricia Quinn Duffy Personal Information redacted by the USI

Hospital Services Reform
Tomas Adell Personal Information redacted by the USI

Regional Health Services Transformation
Peter Jakobsen Personal Information redacted by the USI

RESOURCE AND CORPORATE MANAGEMENT GROUP

Infrastructure Investment
Preeta Miller Personal Information redacted by the USI

Finance Director
Brigitte Worth Personal Information redacted by the USI

Director of Public Inquiries and Public Safety
La'Verne Montgomery Personal Information redacted by the USI

Director of Corporate Management
Paul Montgomery Personal Information redacted by the USI

CHIEF DIGITAL INFORMATION OFFICER

Chief Digital Information Officer
Dan West Personal Information redacted by the USI

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland Personal Information redacted by the USI

Child Protection/Looked After Children (LAC's)
Eilis McDaniel Personal Information redacted by the USI

Mental Health
Peter Toogood Personal Information redacted by the USI

Disability and Older People
Mark McGuicken Personal Information redacted by the USI

Social Services
Aine Morrison Personal Information redacted by the USI

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride Personal Information redacted by the USI

Deputy Chief Medical Officers
Dr Naresh Chada Personal Information redacted by the USI
Dr Lourda Geoghegan Personal Information redacted by the USI

Population Health Director
Liz Redmond Personal Information redacted by the USI

Director Quality, Safety and Improvement
Andrew Dawson Personal Information redacted by the USI

Chief Dental Officer
Caroline Lappin Personal Information redacted by the USI

Chief Pharmaceutical Officer
Cathy Harrison Personal Information redacted by the USI

Chief Environmental Health Officer
Nigel McMahon Personal Information redacted by the USI

Senior Medical Officers
Dr Carol Beattie Personal Information redacted by the USI
Dr Monica Hughes (Primary Care) Personal Information redacted by the USI
Dr Mark Roberts (Acute Care) Personal Information redacted by the USI

CHIEF NURSING OFFICER

Chief Nursing Officer
Maria McIlgorm Personal Information redacted by the USI

Deputy Chief Nursing Officer
Lynn Woolsey Personal Information redacted by the USI
Chief AHP Officer
Suzanne Martin Personal Information redacted by the USI

Midwifery
Dale Spence Personal Information redacted by the USI

Appendix 3

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Datix Reference (if applicable) _____

Follow-up Pro-forma for Early Alert Communication:
Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria under which event is being notified (mark as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children/young people in care or receiving after care support***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: * ***If this relates to a child please specify DOB, legal status, placement detail If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of the Safeguarding Board for Northern Ireland (SBNI).***

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the SPPG at: [redacted] and DoH at [redacted] hscni.net.

FOR COMPLETION BY DoH:

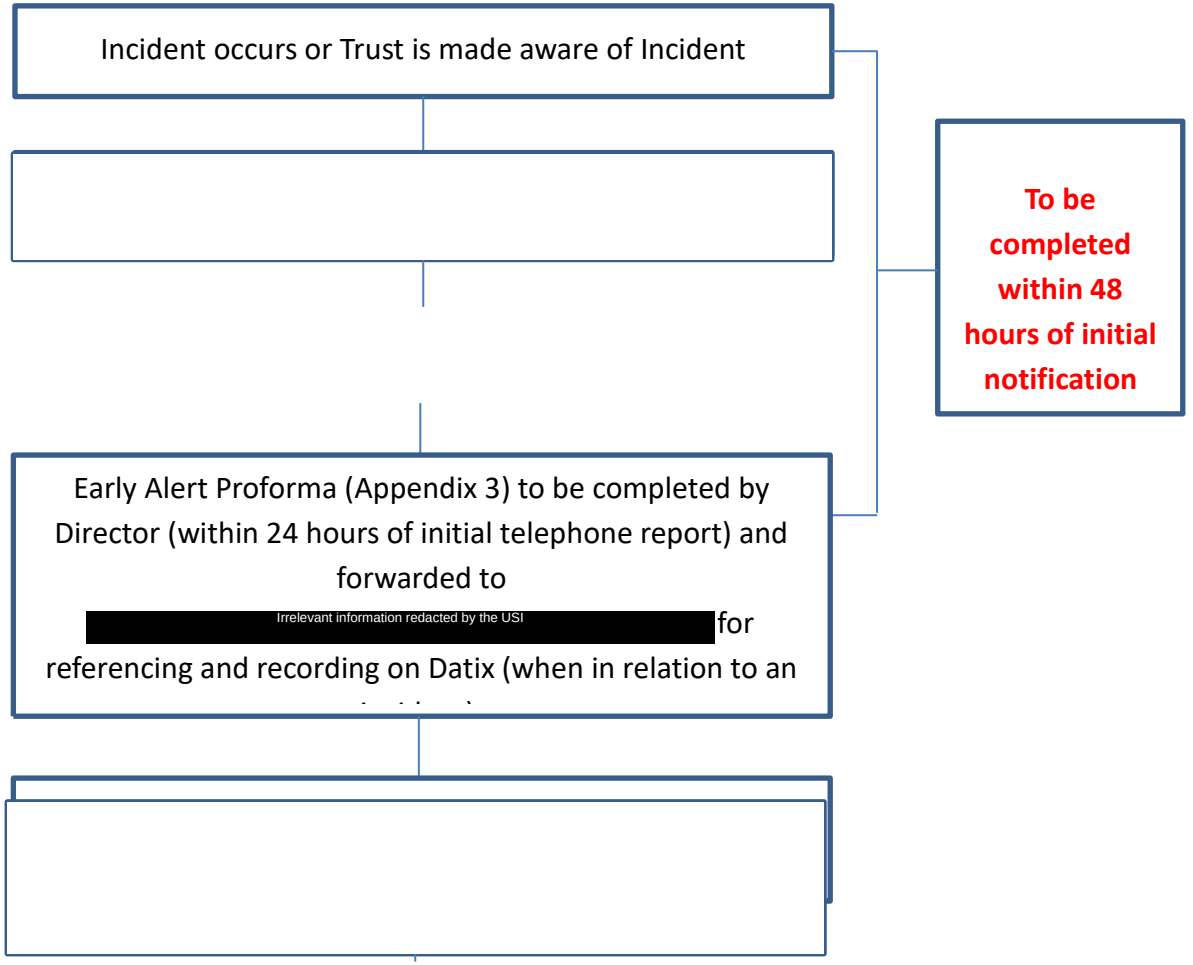
Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

Early Alerts Flowchart

Appendix 4



Southern Health and Social Care Trust

Quality care – for you, with you

BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 24th September 2020
Title:	Clinical concerns within Urology
Lead Director:	Dr Maria O'Kane Medical Director
Purpose:	Confidential – For Information

Key strategic aims:

Delivery of safe, high quality effective care

Key issues/risks for discussion:

This report outlines a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans to minimise risk or harm to patients.

There is likely to be significant media interest in this case.

Plans need to be put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns.

There is likely to be impact on other patients who are awaiting urological appointments/follow up.

Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post as at 30th June 2020. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016. Although Consultant A initially challenged this matter, following correspondence exchange between his solicitor (Tughan's) and DLS, he is no longer employed as of 17th July 2020. There has been no legal challenge in respect of this matter, to date.

Introduction

On 7th June 2020, Consultant A sent an email to the Scheduling administrative staff for Urology, which was copied to the Associate Medical Director (AMD) – Surgery, in which Consultant A explained that he had added 10 patients to the Trust's list for urgent admission. On the AMD's initial review of the list of patients in his capacity as AMD, he noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy".*

It appeared to the AMD that these patients had been assessed on the dates given by Consultant A (11th Sept 2019 and 11th Feb 2020), but the outcomes of these assessments did not appear to have been actioned by him as required i.e. to add the patients to the inpatient waiting list on the Trust's Patient Administration System at that time. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that.

As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there were wider service impacts. The internal reviews, which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), identified the following:

- The first internal review concentrated on whether the patients who had been admitted as an emergency had had a stent inserted during procedure and if this had been removed. There were 147 emergency patients under the care of Consultant A listed as being taken to theatre. Of these, information was not available on NIECR for 46 patients. Following further review of inpatient notes, it was identified that 3 patients had not had their stent management plans enacted. Management has been subsequently arranged for these 3 patients.

- The second internal review was for 334 elective-in patients admitted under Consultant A's name during the same period. Out of the 334 patients reviewed there were 120 of cases who were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system.

- To date five patient cases have been identified through screening for Serious Adverse Incident review - this screening has indicated potential deficiencies in the care provided by Consultant A. A further two cases, managed by Consultant A, have been identified and these are being screened as Serious Adverse Incidents. These seven patients' care is now being followed up by the Urology Team.

Immediate actions following discovery of concerns in June 2020

- Advice sought from NHS Resolutions (formerly NCAS) who recommended restrictions of clinical practice.
- Referral of these concerns in respect of Consultant A was made to the GMC.
- Up until the date of termination, restrictions were placed by the Trust that Consultant A was to no longer undertake clinical work and that he did not access or process patient information either in person or through others either in hard copy or electronically. A request was also made that he voluntarily undertake to refrain from seeing any private patients at his home or any other setting and same was confirmed in writing via Consultant A's solicitor.
- Given that Consultant A is no longer employed, the handling of this case is now through the GMC, relevant solicitors and Trust.
- The Trust has set up a panel for the Serious Adverse Incident Reviews and this is being chaired by an independent Chair, with a Urology Consultant recommended by the Royal College of Surgeons as a Urology Subject Expert (from England).
- An Early Alert has been sent to the Department of Health advising them of the issues.
- Two separate weekly meetings have been established:
    - Internal oversight meeting - chaired jointly by Director of Acute Services and Medical Director;
    - External – Chaired jointly by Medical Director and Director of HSCB with representatives from Trust, PHA, HSCB and Department of Health.

The following are the areas that have been identified that immediately need to be concentrated on and actions being taken on these patients to mitigate against potentially preventable harm:

1. A concern identified in the SAIs is that a Cancer MDM treatment recommendation for a patient was not enacted. As a result, all notes for post MDM follow-up patients for Consultant A are being reviewed to ensure MDM treatment recommendations have been actioned. (This data is currently being collected as this is a manual exercise)
2. A further concern identified is patients have had diagnostic tests and the results have not been actioned or communicated to the patients, including results with significant findings. The diagnostic tests identified are Pathology and Radiology results. A total of 1711 results are currently being looked at by two of the Trust's Clinical Nurse Specialists. Where they identify that follow-up may not have been actioned, this is escalated for a Consultant Urologist to review and provide input.

Where the reviewing consultant feels that there is a possible issue with care provided, a Datix will be completed by the Consultant Urologist.

3. A further review of inpatients who had stent procedures performed by Consultant A from January 2018 to December 2018 is being carried out to ascertain if any further patients require stent management plans.

In addition, a significant number of patients who are overdue follow up on Consultant A's Oncology Outpatient Review Waiting List (patients who are past their review date) are having their outpatient assessment provided by a recently retired Urologist who has been engaged by the Trust - 235 patients.

A preliminary discussion has been undertaken with the Royal College of Surgeons Invited Review Service regarding Consultant A's practice and potential scope and scale of any independent external review, if required.

Timescales

The above reviews and scoping exercises are either completed or under way so timescales still need to be clarified. The Department of Health is keen to manage the oversight of the review process. The Minister will be required to share details of this with the Assembly and this is likely to be mid- October, subject to the outcomes of the review exercises. A resource plan is in development to identify clinical capacity for communication, patient information and clinical assessment and management plans. This will present significant challenge given the current workforce issues within the Urology speciality.

Previous concerns relating to Consultant A

Previous concerns relating to Consultant A were being addressed since March 2016, and under Maintaining High Professional Standards from December 2016. The timeline for these previous concerns is detailed below:

March 2016

On 23 March 2016, Mr EM, the then Associate Medical Director (Consultant A's clinical manager) and Mrs HT, Assistant Director (Consultant A's operational manager) met with Consultant A to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Consultant A was provided with a letter dated 23 March 2016 detailing their concerns and asking him to respond with an immediate plan to address the concerns. Four broad concerns were identified:

- **Un-triaged outpatient referral letter**
  It was identified at that time that there were 253 un-triaged referrals dating back to December 2014.

- **Current Review Backlog up to 29 February 2016**
  It was identified at that time that there were 679 patient's on Consultant A's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- **Patient Centre letters and recorded outcomes from clinics**
  The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Consultant A on Patient Centre or on patient notes.

- **Patient's hospital charts at Consultant A's home**
  The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016
During the period April to October 2016, discussions were on-going between Acute Directorate and Medical Director about how best to manage the concerns raised with Consultant A in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Consultant A advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016
Consultant A was off work [redacted] from 16 November 2016 [redacted] and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient ([redacted]) who may have a poor clinical outcome because the GP referral was not triaged by Consultant A.

An SAI investigation was commenced in Autumn 2016. Through the SAI it was identified that the referral for patient [redacted] had not been triaged by Consultant A. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged by Consultant A. Further assessment of the

issue identified a significant number of patients who had not been triaged by Consultant A.

The issues of concern relating to patient Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr RW in late December 2016. As a result of the concerns raised with Consultant A on 23 March 2016 and the serious concern arising from the SAI investigation by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Consultant A's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- some of the patients seen by Consultant A may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service (NCAS) on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016
Consultant A was requested to attend a meeting on 30 December 2016 with Dr RW, Medical Director and Ms LH, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken.

A letter was issued to Consultant A in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Consultant A that Dr AK had been appointed as Case Manager for the case and Mr CW was identified as the Case Investigator.

03 January 2017
Consultant A met with Mrs MC, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr RW on 30 December 2017.

20 January 2017
During the period of the 4 week immediate exclusion period notified to Consultant A on 30 December 2016, Mr CW wrote to Consultant A to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Consultant A to state his case and propose alternatives to formal exclusion.

23 January 2017
On 23 January 2017, Mr CW wrote to Consultant A seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to him but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017
The meeting between Mr CW and Consultant A took place on 24 January 2017 with Mrs SH, Head of Employee Relations present.

26 January 2017
In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Consultant A's immediate exclusion and to determine if, from the initial preliminary enquiries, Consultant A had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting.

At the case conference meeting, it was determined by the Case Manager, Dr AK that Consultant A had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as formal exclusion was not deemed to be required. Instead, Consultant A's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Consultant A verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017
A letter was sent to Consultant A on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work.

9 February 2017
Consultant A attended a meeting with the Case Manager, Dr AK on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs SH and Consultant A's son were in attendance at the meeting. The action plan was accepted and agreed with Consultant A at the meeting.

20 February 2017
Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Consultant A was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

As part of the action plan agreed, monitoring mechanisms were put in place to continuously assess his administrative processes to safeguard against a recurrence of the concerns raised with regards to his outpatient work. This monitoring arrangement was in place up until Consultant A's date of leaving. There were 3 occasions when there were deviations from the agreed actions, and on two occasions Consultant A offered acceptable explanations. On the third occasion, Consultant A had no acceptable explanation for the delay in dictation, however all dictation was completed at the point of retirement.

January and February 2017
During January and February 2017, Consultant A made a number of representations to Dr RW, Medical Director and Mr JW, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr CW should step down as Case Investigator prior to the commencement of the formal investigation. Dr NC, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017
The terms of reference for the formal investigation were shared with Consultant A along with an initial witness list.

April, May and June 2017
During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

14 June 2017
Dr NC, Case Investigator wrote to Consultant A requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified.

19 June 2017
Consultant A requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Consultant A requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017
Consultant A advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017
A first investigation meeting was held with Consultant A in order to seek his response to the issues of concern.

At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Consultant A had been furnished to him. It was agreed that

a further meeting date would be arranged for this purpose once all information had been provided. Consultant A's responses to the remaining terms of reference were gathered.

16 October 2017
A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017
A second investigation meeting was held with Consultant A in order to seek his response to the issues of concern in respect of term of reference 4. At the meeting of 6 November 2017, Consultant A advised Dr NC that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018
By 15 February 2018, Consultant A had not provided the comments he had previously advised he wished to make and therefore this was queried with Consultant A and an update sought.

22 February 2018
No response was received and a further email reminder was sent to Consultant A on 22 February 2018. On the same day, Consultant A responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018.

Consultant A was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018
Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Consultant A requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

26 March 2018
No comments were received from Consultant A.

29 March 2018
A final opportunity was provided to Consultant A to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018
No comments were received from Consultant A.

2 April 2018
Comments on the statements from the meetings of 3 August and 6 November were received from Consultant A. Consultant A also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

21 June 2018
In the interests of concluding the investigation report without further delay, all comments from Consultant A were considered and a finalised report was provided to Consultant A on 21 June 2018 for comment.

14 August 2018
The Case Manager, Dr AK wrote to Consultant A acknowledging receipt of his comments and advising he would consider these along with the final report and reach his determination in terms of next steps.

1 October 2018
Dr AK, Case Manager met with Consultant A to outline outcome of his determination that the case should be forwarded to a Conduct Panel under MHPS.

The Findings from the investigation

There were 783 un-triaged referrals by Consultant A of which 24 were subsequently deemed to need upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

Consultant A stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing

but the review team is satisfied with Consultant A's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. Consultant A gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event.

Some of Consultant A's private patients were added to the HSC waiting list ahead of HSC patients without greater clinical need by these private patients.

27 November 2018

Consultant A submitted a lengthy and detailed grievance of 40 pages, with 49 Appendices. It was lodged along with a request for information. The grievance was held in abeyance pending completion of the information requests.

9 April 2019

Consultant A was advised by Dr AK, Case Manager that a GMC referral was to be submitted following a discussion regarding the case with the GMC Liaison Officer.

Timeline for grievance process – November 2018 to June 2020:

The requested information relating to the information request was provided to Consultant A in 2 returns – one on 21 December 2018 and one on 11 January 2019.

Consultant A wrote to the Trust again on 12 March 2019, and advised that he had sought the advice of the Medical Protection Society and also Legal Counsel, and that he was therefore submitting a request for further information. Consultant A advised that following its receipt, the Trust would be advised whether any further information was to be requested, and /or whether the Formal Grievance was to be amended.

HR Director wrote to Consultant A on 3 June 2019, seeking further clarity on information requested in his 12 March 2019 letter. The Trust advised him that the information request was extensive in nature and would require significant time and resources within the Trust to compile. The Trust advised him that all reasonable efforts were being made to gather the requested information, however within his request there were elements which were much too wide and not properly defined.

Consultant A was therefore asked to refine and clarify the specifics of his request in respect of a number of points.

Consultant A responded on 24th June 2019, clarifying the information plus seeking 2 additional items. The request for information was still significant in nature, and took significant time and resources for the Trust to compile. The requested information was delivered to Consultant A's Secretary for his attention on 30th October 2019.

Since Consultant A had indicated that, following receipt of the requested information, he would advise whether or not his formal grievance was to be amended, the Trust awaited hearing from him in this regard. However, no further correspondence was received from Consultant A in respect of his grievance, or any amendments to it.

At this stage, from November 2019 through to end of January 2020, the Trust suffered significant disruption to its services and its HR function by reason of widespread Industrial Action by health service trade unions.

Furthermore, work was ongoing to finalise the SAI (Serious Adverse Incident) processes in respect of the patients affected by the original concerns in respect of Consultant A's practise.

In recent months the Trust's services and normal HR processes has been very severely impacted by the Covid – 19 pandemic. This prevented any employee relations work, including the hearing of grievances, being taken forward for a 3 month period from March to start of June.

On 26th April 2020, Consultant A wrote to the Trust's HR Director again, highlighting that a number of pieces of information from original requests had not been provided, and he requested these by 15th May 2020. On 15th, 22nd May and also on 8th June the Director of HR wrote to Consultant A with responses to these requests. The Trust believes that all substantial and detailed information requests have now been responded to.

June 2020 – September 2020

Grievance process ongoing. The grievance panel is due to conclude by mid October 2020.

As Consultant A is no longer employed, the Conduct Hearing under MHPS cannot be concluded. The GMC processes will continue regarding Consultant A's fitness to practise in light of both the previous concerns and the most recent concerns.

Summary of previous Serious Adverse Incidents – from 2016 onwards

Following the SAI Index Case Patient 10 which triggered the first MHPS case, the Trust identified a number of GP Urology referrals who were not triaged by Consultant A. 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed. These five cases were subject to a further SAI review process.

Lessons Learned from the 5 SAI's

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant A (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The

Review Team consider that Consultant A's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Consultant A confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Consultant A's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Consultant A consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Consultant A is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

Southern Health and Social Care Trust
Quality Care - for you, with you

Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 31st March 2022 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Temporary Accounting Officer and Medical Director
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs L Leeman, Interim Director of Performance and Reform
Mrs M McClements, Director of Acute Services
Ms J McGall, Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Ms S McKinney, Boardroom Apprentice

APOLOGIES

Mr M McDonald, Non-Executive Director

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. She particularly welcomed Ms McGall and Mrs Leeman and congratulated them on their recent appointments. The Chair also congratulated Dr O'Kane, appointed as the Trust's Temporary Accounting Officer.

2. DECLARATION OF INTERESTS

The Chair noted declaration of interests from Ms McGall and Mrs Leeman in relation to agenda item no. 12 'Feedback from Remuneration Committee' and advised that they would leave the meeting for discussion on this item.

3. MINUTES OF PREVIOUS MEETINGS

The minutes of meetings held on 27th January 2022 and 12th February 2022 were approved as accurate records.

4. MATTERS ARISING FROM PREVIOUS MEETINGS

Members noted the progress updates from the relevant Directors.

5. NEWRY CTCC

The Chair welcomed Mrs A Turbitt, Head of Planning, to the meeting. Mrs Leeman referred members to a paper which provides an update on the current position in relation to financial affordability of the current project following further discussions with the preferred bidder and a subsequent meeting of HSC officials to agree next steps.

Members discussed the areas of concern, namely confirmation from the preferred bidder that despite their desire to see the Newry CTCC built, the current method of indexation, coupled with their assessment of construction costs in the current market, means the project is not financially viable and cannot proceed under the current 3PD model.

Members expressed their disappointment given the significant work undertaken on this project from the Trust's perspective to date. In response to a question from Mr Wilkinson on next steps, Ms Teggart advised of the offer from the preferred bidder for the Trust to buy the existing site (with planning permission) along with purchase of the design at a cost of £4.7m. Mrs Leeman stated that in recent discussions with HSC officials, all parties agreed that the offer to purchase the existing site along with the design may provide a viable solution to expedite a capital project for further exploration. To that

end, the Department has asked the Trust to complete a Strategic Outline Case (SOC) for the totality of the project including an option to purchase the existing site with design along with all other viable options based on revised and updated needs assessment being completed. Separate discussions will be required with the Capital Investment Directorate to secure the funding to deliver the scheme. Mrs Leeson asked about the Department's appetite for capital funding for this scheme. Mrs Leeman advised that the Trust would need to seek assurance from the Department that this would not impact on the Trust's other capital funding requirements.

Primary Care involvement in a new CTCC was discussed. Mrs McCartan raised the fact that Primary Care have indicated that they are not willing to move into Newry CTCC and asked if there would be a greater appetite from them for a primary care centre via capital funding. Mrs Donaghy asked if there was scope for a redesign given GP's unwillingness to move into Newry CTCC. Mrs Leeman stated that the design of the GMS space had been adjusted so it could be used as flexibly as possible going forward. Mrs Turbitt explained that the needs assessment and design will need to be revised and updated and confirmed there is scope for flexibility.

The Chair made reference to the fact that Trust Estates will urgently liaise with Land and Property Services to undertake an urgent site search in the Newry area to assess any other potentially suitable sites for development along with valuation of the site on offer for purchase. She raised the importance of Trust Board being assured that the purchase price of the site on offer has been commercially tested and asked that this assurance is included in the next update to Trust Board.

Action: Mrs Leeman

6. UPDATE ON DORSY UNIT

Ms McGall drew members' attention to the concerns restated in the paper. She stated that the focus is on actions that continue to be undertaken to improve the service and ensure the safety of patients and staff. She spoke in particular of the strengthening of Governance systems with improved community and inpatient working which has led to the successful discharge of 3 long stay individuals. In relation to

the dedicated management structure, an 8A Lead Nurse has now been appointed.

Ms McGall advised that the service would be undertaking a benchmarking exercise with the available RQIA inspection findings of the Lakeview Intellectual Disability Unit, Western HSC Trust.

Ms McGall concluded by advising of the ongoing challenges relating to workforce, cultural shift and environment, especially the seclusion room.

Members noted the actions in place to address. It was agreed that Ms McGall would provide one further closing update to Trust Board at the next meeting to include the outcome of the benchmarking exercise referenced above.

Action: Ms McGall

7. **UPDATE ON GRANVILLE MANOR LEARNING DISABILITY SUPPORTED LIVING FACILITY**

Ms McGall spoke to a paper which provides an update on the progress to date and the remaining challenges and risks. Ms Gall stated that a new dataset has been established and work continues on data analysis. Work also continues on the RQIA Quality Improvement Plan from the Care Inspection on 26th January 2022. Mrs McCartan asked Ms McGall if she was content with the overall progress being made in Granville including the work to address the RQIA Care Inspection report.
Ms McGall stated that she was assured that progress was being made as outlined in the paper.

In relation to challenges, Ms McGall advised of the ongoing work to deliver a service which is in accordance with the Ethos of Supported Living.

It was agreed that Ms McGall would provide one further closing update to Trust Board at the next meeting.

Action: Ms McGall

8. **PSYCHIATRY OF OLD AGE AND MEMORY SERVICES IN THE SHSCT**

The Chair welcomed Dr Chris Southwell, Consultant in Psychiatry of Old Age, to the meeting to present on 'Facing the Future – Dementia Service provision.' Members were advised that the Specialist Consultant Psychiatrist who had been working in Gillis has left the post and as of 31st March 2022, there is no Consultant Psychiatry cover for the Gillis unit. A contingency decision is therefore required to ensure safe and effective care.

Members discussed the options explored by the SMT and were supportive of the preferred option (option 3) to temporarily relocate from the Gillis Ward, St Luke's site, Armagh to Willows Ward, Bluestone site, Craigavon Area Hospital. This will allow the multi-disciplinary team to access on-site medical input and support until the Trust is able to provide dedicated Consultant in Psychiatry of Old Age to this vulnerable patient group. A formal project structure will be established to develop longer term proposals for public consultation on Psychiatry of Old Age and memory services across the Trust. In response to a member's question, Ms McGall advised that an Early Alert and conversations with the Department and the HSCB have taken place.

9. **CHILDREN AND YOUNG PEOPLE'S SERVICE PRESSURES**

Mr McCafferty presented a paper highlighting the current service challenges and associated risks in Children's Services. He stated that specific focus is afforded to the Safeguarding and Family Support Division (social work) and challenges presented linked to significant numbers of substantive vacancies and the continuing impact of the pandemic on both the workforce and families. Mr McCafferty highlighted the increasing number of unallocated children's social work cases and the lack of available social workers to recruit into the service. He advised that the paper also outlines the position in respect of the impact of the pandemic on service delivery in the other key areas of the Directorate including Specialist Child Health & Disability and Looked after Children services.

Members discussed the content of the paper in respect of the high level service pressures, staffing, risks and mitigations and asked a number of questions to which Mr McCafferty responded. He stated that the specific challenge experienced in children's social work services in the Southern Trust is reflected across the region to varying degrees. The five Executive Directors of Social work have written to the HSCB to outline the current challenge and associated risk. The HSCB responded by emphasising Delegated Statutory Functions must be adhered to at all time by the respective Trust social work services. At present, there is very limited scope to curtail non-statutory social work tasks to create additional capacity to enable the service to continue to respond to urgent child protection and Looked after child referrals and case episodes. Mr McCafferty concluded by advising that it is envisaged that the current crisis in The Gateway Service and the Family Intervention Service will endure for 4-6 months and a set of mitigations are in the process of being put in place and other alternative options are being considered.

Mr McCafferty undertook to provide an update at the Trust Board meeting on 23rd June 2022.

Action: Mr McCafferty

10. **UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY AND UROLOGY SERVICE INQUIRY (USI)**

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. Mrs McKimm outlined the key aspects of the update report. She advised that Margaret O'Hagan, currently Director of Surgery and Clinical Services in the Northern Health and Social Care Trust, will be working with the Public Inquiry Team providing reassurance to the USI about the integrity of the response, and guarding against any perception of Conflict of Interest.

Mrs McKimm also advised that the Trust is undertaking a review of all patient information that has been issued to date, following a number of concerns raised about the accuracy of information provided to patients and families.

The completion of Section 21 notices was discussed. Mrs McKimm explained that the scope of discovery has now extended back to 2009 in some cases and staff are required to stop their normal duties to

complete these very detailed responses, which is placing additional pressure on the health system, and the Trust continues to raise concerns about staff welfare through the Department of Legal Services (DLS). Members discussed the corporate risk that due to capacity issues, the Trust may be unable to respond in a timely and complete way to Section 21 requests. Mrs McKimm advised that the further risk will be issues identified through the discovery process which may impact on the reputation and function of the Trust.

Mrs McClements emphasized the lack of capacity in the system to respond to the USI over and above managing and delivering services during the ongoing pandemic.

It was agreed that the completed risk assessment would be attached to the update paper for the next meeting.

Action: Mrs McKimm

11. DRAFT BUDGET 2022/23

Ms Teggart presented a paper which sets out the Trust's draft Opening Financial position/Draft budget for the financial year 2022/23 for approval. She reminded members that under the Trust Standing Financial Instructions, an opening budget should be presented to the Trust Board for approval each year. Ms Teggart advised that given the Trust has not received confirmation of its budget allocation for 2022-23, this paper sets out the draft opening financial position for the financial year 2022/23 pending confirmation of opening budgets from the Department of Health. The Department of Health has confirmed in writing to the Trust that the current year budgets will continue into 2022-23, however no new proposals should be undertaken unless existing recurrent funding is made available within each Trust.

Ms Teggart spoke of the risk that funding will not be made available at the same level throughout the year with the expectation on Trusts to make savings to fund deficits. She advised that the 2021-22 roll forward budget does not take account of inflation, pay increases or increase in services. In addition, the Trust does not have an equity share of funding in comparison to other Trusts. This equity gap is in the region of £37m from figures provided by HSCB and they do agree that further

investment is required in the Southern Trust area and additional funding is required across many services e.g. normative nursing. In the absence of further funding, HSCB is unable to allocate further funding to SHSCT at this point, however, has agreed to look more favourably at SHSCT by reducing savings requirements and seeking to provide funding for investment in services when funding becomes available. This will be closely monitored during the 2022-23 financial year.

Ms Teggart took members through the details of the paper. She made reference to the fact that of the allocation received to date in 2021-22, approximately £145m is non-recurrent (which equates to around 17% of the total allocation). Of this £145m, the Trust has been advised by the commissioner that c£40m can be assumed recurrent, leaving a balance of £105m. Of this balance, c£60m non-recurrent funding relates to Covid response and rebuild and c£10m for Elective Care/Waiting List Initiatives, leaving a balance of c£35m (4% of total allocation). She stated that the non-recurrent funding needs to addressed in 2022-23 as the uncertainty around this funding is destabilising the Trust with temporary staff in post, staff recruited permanently at risk and the risk that vital services could be stopped if funding is not available recurrently.

Ms Teggart advised that the opening position for 2022-23 is the baseline including assumed recurrent funding and amounts to £808m. She referred members to Table 2 in the paper which summaries the non-recurrent elements of funding that are at risk of stopping or reducing in 2022-23. The non-recurrent impact is £34.8m and, in addition to this, the Trust will continue to have savings targets\gaps rolled over from 2021/22 into 2022/23 totalling £5m. As a result, the total 2022/23 estimated opening recurrent gap is £39.8m, before considering new\emerging pressures or potential funding streams\easements. Ms Teggart advised when new/emerging pressures/additional cost pressures associated with pressures identified in 2021/22 are added to the opening recurrent deficit, the potential deficit to be addressed increases from the opening position of £39.8m to £65m. She referred members to Table 5 which outlines a remaining estimated deficit of £48.3m after income/easement assumptions.

Mrs McCartan expressed her concern at an opening recurrent gap of £48m. Ms Teggart acknowledged that to implement a savings plan of a minimum £48.3m is a risk to the Trust and will have a detrimental

impact on services and is not achievable in 2022-23. A range of measures as outlined in the report will be undertaken to address this risk in 2022-23.

Ms Teggart advised of the recommendation that the Trust's Accounting Officer sets out in writing to the Department of Health Accounting Officer the risks associated with the deficit and the equity gaps.

In conclusion, Ms Teggart advised that the final estimated Resource Budget requirement for 2022-23, excluding COVID funding and pay/inflation increase, is £856.3m which is £11m higher than the 2021-22 final budget largely reflecting the impact of Full Year Effect of services.

Trust Board approved the draft opening budget for 2022/23.

Mrs Leeman and Ms McGall left the meeting at this point

12. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair advised that on 14th March 2022, Remuneration Committee considered a proposal in respect of the commencement salaries of Ms Jan McGall, Director of Mental Health & Disability and Mrs Lesley Leeman, Interim Director of Performance and Reform.

Personal information redacted by USI

Trust Board approved the recommendation of the Remuneration Committee.

13. **ANY OTHER BUSINESS**

None

Subject: FW: CONFIDENTIAL FROM THE CHAIR: URGENT COMMUNICATION
From: Judt, Sandra [redacted]
To: Brownlee, Roberta [redacted]
Sent: 6/11/2020, 2:15:44 PM

Letter to Mrs. Brownlee 10 June 2020.docx

ATT00001.htm

Letter to Mr Devlin 10 June 20.docx

ATT00002.htm

Letter to Mrs Toal 09 June 2020.docx

ATT00003.htm

fyi – forwarded to NEDs as below.

Regards

Sandra

Sandra Judt

Board Assurance Manager

SH&SCT

Trust Headquarters

68 Lurgan Road

Portadown

Craigavon

BT63 5QQ

Tel: [redacted]

Email: [redacted]

From: Judt, Sandra
Sent: 11 June 2020 14:06
To: Rooney, SiobhanNED; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; Mullan, Eileen; McDonald, Martin; Wilkinson, John
Subject: CONFIDENTIAL FROM THE CHAIR: URGENT COMMUNICATION

Please find attached confidential information from the Chair.

Regards

Sandra

Sandra Judt

Board Assurance Manager

SH&SCT

Trust Headquarters

68 Lurgan Road

Portadown

Craigavon

BT63 5QQ

Tel: Personal Information redacted by the USI

Email: Personal Information redacted by the USI

From: Brownlee, Roberta
Sent: 11 June 2020 14:01
To: Judt, Sandra
Subject: Fwd: URGENT COMMUNICATION

Sent from my iPad

Begin forwarded message:

From: "O'Brien, Aidan" [Personal Information redacted by the USI]
Date: 10 June 2020 at 23:26:08 BST
To: "Brownlee, Roberta" [Personal Information redacted by the USI]
Subject: URGENT COMMUNICATION

Dear Mrs. Brownlee,

I attach a letter addressed to you as Chair of the Southern Health & Social Care Trust Board.

I also attach letters sent to Mr. Devlin on 10 June 2020, and to Mrs. Toal on 09 June 2020.

I would be most grateful if you would bring the contents of these letters to the attention of the non-Executive members of the Board.

I would be grateful if you would acknowledge receipt of this communication.

Aidan O'Brien

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Mrs Roberta Brownlee,
Chair
Southern Health & Social Care Board
Trust Headquarters
Craigavon Area Hospital
Portadown
BT63 5QQ

10 June 2020

Dear Mrs. Brownlee,

I attach a letter which I sent to Mrs. Vivienne Toal, Director of Human Resources & Organisational Development, last evening, and a letter which I sent to Mr. Shane Devlin, Chief Executive, earlier today.

The point of both letters was to advise that I had submitted, on 06 March 2020, an application for pension benefits to become payable with effect from 30 June 2020, to coincide with an intent to withdraw from full time employment from that date, and with the intent to return to part time employment from 03 August 2020, having received the assurance of support from colleagues and line managers to do so, and without being informed by the Trust of any impediment to my doing so. I was then advised by telephone on Monday 08 June 2020 that I would not be permitted to return to part time employment in August 2020 due to the 'Trust's practice of not re-engaging people with ongoing HR processes'. If I had been informed of this practice by the Trust, I most certainly would not have submitted any notification of intent to withdraw from full time employment.

You will be aware that the ongoing HR processes to which reference has been made are the Formal Investigation (initiated on 30 December 2016 and completed on 01 October 2018) and a Formal Grievance (submitted on 27 November 2018 and not yet addressed). The Formal Grievance included an appeal of the Outcome of the Formal Investigation. That appeal has not been addressed, 20 months later.

I now feel all the more aggrieved by the Trust's claim to have a practice of not re-employing personnel if there are ongoing HR processes, when the Trust has been primarily responsible for the ongoing status of those HR processes, and not having been informed by the Trust, my employer, of that practice. It is important to note that it is the same Directorate which has failed to have my grievance and appeal addressed after 20 months in contravention of its own policy, the same Directorate which has accepted and processed my intent to withdraw from full time employment, and which would have been cognisant of my intent to return to part time employment as that intent is an integral part of the application proforma, and which would have been cognisant of a

Trust practice which would be an impediment to returning to part time employment, and about which I was not informed.

As a consequence, I have had no other option but to revoke my intention to withdraw from full time employment. I have already deferred payment of pension benefits earlier today.

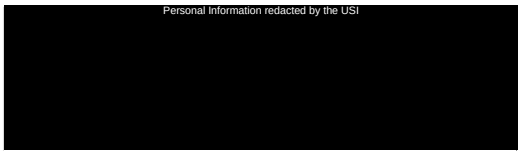
It will have been 28 years ago tomorrow, Thursday 11 June 1992, that I was appointed to the post of Consultant Urologist at Craigavon Area Hospital. From then until 1996, I single-handedly provided a 24 hour service. From 1996, with the assistance of increasing numbers of colleagues, I have endeavoured to contribute to the development of urological services by the Trust. Nevertheless, those services remain severely inadequate. Covid-19 has further exacerbated that inadequacy. By August 2020, there will be patients waiting up to six years for admission for surgery. By then, there will be patients waiting over three years for outpatient consultations following referral, and for review following investigation or management.

Today, Mr. Robin Swann, Health Minister, referring to a framework for rebuilding health and social care services in Northern Ireland, said that 'this strategic approach is about throwing absolutely everything we can at those waiting lists and those missed diagnoses and treatments that were put on pause during the Covid-19 pandemic'. The Minister advised that Northern Ireland has the longest waiting lists in the UK and Ireland. The Southern Trust's longest, surgical waiting lists are urological. Yet, the Trust finds it appropriate to prohibit me from part time employment in the face of such need due to ongoing HR processes for which the Trust has been responsible.

I do appreciate that you, and your non-Executive colleagues, have been appointed to the Trust Board by the Health Minister, and that the Trust is accountable to the Board, on behalf of the Minister, across a number of key areas, including the delivery of health and social care objectives, financial probity and governance. I write to ask you to bring to the attention of your non-Executive colleagues, the contents of this letter, and of those sent to Mr. Devlin and Mrs. Toal. In doing so, I have not made reference to any of the issues subject to the Investigation, or to any content of the Grievance or of the Appeal. I write to inform you and your colleagues of the severity of the lack of the Trust's compliance with its own Policies and Procedures, the severity of the impact of its lack of compliance upon a member of its staff, and the consequential impact upon the delivery of services expected by the Minister.

I hope that you and your non-Executive colleagues may be able to have some bearing in attempting to resolve this ongoing situation. For me, personally and professionally, it is very important that I can continue to work, but with a better work life balance. It is also most important for me that the Formal Grievance and its included Appeal are addressed. I am certainly prepared to work constructively with the Trust to achieve a just and satisfactory resolution, and particularly to the benefit of patients.

Yours sincerely,



Aidan O'Brien

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Mrs. Vivienne Toal
Director of Human Resources & Organisational Development
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

09 June 2020

Dear Mrs. Toal,

During January 2020, I had family reasons to consider significantly reducing my workload in order to create a better work to life balance going forward. I did so particularly in the context of the potential pension risks that prevailed at that time.

I had already consulted with Mr. Malcolm Clegg of the Directorate of Human Resources with regard to options available to reducing my workload while protecting my pension entitlement, including that of part time employment. During February 2020, I also discussed this option with Mr. Michael Young, Lead Clinician in Urology, who offered his full support to my returning to part time employment if I withdrew from full time employment. I discussed the option with Mrs. Martina Corrigan, Head of Service for Urology, who assured me of her full support to return to part time employment. I discussed the option with Mr. Mark Haynes, Assistant Medical Director, who was similarly supportive, discussing the nature and amount of clinical work which I would wish to undertake. In doing so, I assured him that I would continue to participate in the Urologist of the Week rota.

Owing to those conversations, on Friday 06 March 2020, I confidently submitted an application for scheme retirement benefits, with a proposed retirement date of Tuesday 30 June 2020, and confirmation of my availability and commitment to return to agreed part time employment from Monday 03 August 2020.

Since then, we have experienced the further disruption to urological services resulting from Covid 19. As you are aware, we had already been providing urological services with a reduced number of consultant urologists since July 2019. Covid 19 has further exacerbated the difficulties in providing an adequate service. I was therefore prepared to offer to return to work in July 2020 to support my colleagues in providing increasing services to those in most urgent clinical need.

Having made enquiries, during the last week of May 2020, as to whom I should meet to arrange an agreed return to part time employment, I was advised by Mrs. Corrigan on Monday 01 June 2020 that she would discuss the matter with Mr. Haynes. On further enquiry on Friday 05 June 2020, she advised that Mr. Haynes would be in contact with me. Yesterday afternoon, I received a telephone call from Mr. Haynes, with Mr. Ronan Carroll in attendance, to advise that, following discussions with the Medical Director and with Human Resources, he had been instructed to advise me that “it

was the 'practice' of the Trust not to re-engage people while there are ongoing HR processes". He confirmed that these issues were those of the Formal Investigation (initiated in December 2016 and concluded in October 2018) and my Formal Grievance (submitted in November 2018).

I had not received any written or other communication since I submitted the AW6 Form on 06 March 2020 regarding confirmation of its receipt or of processing the application, until one sent at 12.39 pm today, claiming that I had telephoned the Medical HR Department yesterday, Monday 08 June 2020, with regard to Medical HR acknowledging receipt of my 'retirement letter'. This claim is untrue. I telephoned to request a copy of the AW6 Form which I had submitted on 06 March 2020. I did not mention any letter. I did not send a letter to Medical HR. I sent a letter to Mrs. Martina Corrigan. I find it so distressing to be once again met with such misrepresentation.

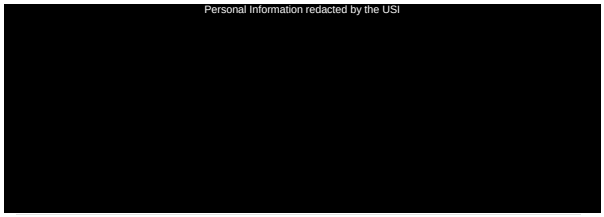
I wish to unequivocally emphasise that, until yesterday, I had not received any advice or indication that such 'ongoing HR processes' would be an impediment to my returning to part time employment, including from any of the personnel named in paragraph 2 above. It was the duty of my employer to inform me that ongoing HR processes prohibited my returning to part time employment. Had I been informed of such, I certainly would not have submitted the AW6 Form on 06 March 2020, with the self-evident pecuniary and reputational loss and damage that yesterday's development entails, in addition to disabling my ability to be appraised and revalidated. On the contrary, it was the absence of information regarding any factors prohibiting part time employment, and the support offered that underpinned my lodging the Form on 06 March 2020.

I therefore notify you that I now revoke my application for retirement benefits and indication of my withdrawal from full time employment, both with immediate effect. I will advise BSO of this notification. I therefore require, by 5.00 pm on Thursday 11 June 2020, the Trust's confirmation that my full time employment shall continue.

I also require full disclosure of all Trust policies relating to the Trust 'practice' referred to above. I require it by return by 5.00 pm on Thursday 11 June 2020.

Whilst I hope that this issue can be resolved by 05.00 pm on Thursday 11 June 2020, I must stress that otherwise all further correspondence in this matter shall immediately flow from the solicitor I have instructed to conduct proceedings.

Yours sincerely,



Aidan O'Brien

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Mr. Shane Devlin
Chief Executive
Southern Health & Social Services Board
Trust Headquarters
Craigavon Area hospital
68 Lurgan Road
Portadown
BT63 5QQ

10 June 2020

Dear Mr. Devlin,

On 27 November 2018, I lodged with you a Formal Written Grievance. I submitted it to you in person as I had already lost faith in the integrity of the Directorate of Human Resources. In lodging my grievance with you, I retained a confidence that you would ensure that the Grievance would be progressed in a timely manner, and in compliance with the Trust's Grievance Procedure. The Grievance included an appeal of the Case Manager's Outcome of the preceding Formal Investigation. Now almost 20 months later, neither the grievance nor the appeal has been addressed, even though I was assured by Mrs. Toal in writing in June 2019, and most recently on 22 May 2020, that arrangements were being made to convene the grievance hearing.

I attach a letter which I sent to Mrs. Toal last evening. It will inform you that I was advised on Monday 08 June 2020 that I would not be facilitated to return to part time employment from 3 August 2020 due to a 'practice of the Trust not to re-engage people with ongoing HR processes'. The letter to Mrs. Toal details the support which I had been given to return to part time employment and the absence of any advice from the Trust that ongoing HR processes would be an impediment to my returning to part time employment. I have notified Mrs. Toal that I revoke my application for retirement benefits and of the indication of my withdrawal from full time employment, both with immediate effect.

In making every effort to resolve this impasse, I write to ask you to ensure that the Grievance is addressed as soon as is possible, and so that it can be completed by Friday 26 June 2020. With confidence that the Grievance will be upheld, and that its included appeal will be equally so, there then would be no outstanding HR processes.

I would be grateful for an acknowledgement of receipt of this letter.

Yours sincerely,

Personal Information redacted by the USI

Aidan O'Brien

Stinson, Emma M

From: Brownlee, Roberta [redacted]
Sent: 22 September 2020 13:01
To: Devlin, Shane; Donaghy, Geraldine; Leeson, Pauline; McCartan, Hilary; McDonald, Martin; Mullan, Eileen; Wilkinson, John
Cc: Comac, Jennifer; Judt, Sandra; Wright, Elaine
Subject: Confidential Section Agenda 7

Shane/NEDS

Thank you for discussing the detail of Agenda 7 (Confidential) with me this am. The paper I have read and I understand you will forward paper to NEDS later today.
I will leave the meeting for Agenda 7 item and this part will be Chaired by Pauline Leeson in my absence.

NEDS. This is an urgent matter of high risk and I ask that you read this paper thoroughly and come prepared to question.

Roberta

Mrs Roberta Brownlee
Chair
Southern Health and Social Care Trust

Changed My Number

Tel: [redacted] **(External);** [redacted] **(Internal)**
Email: [redacted]

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