Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Francis Rice
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

28 April 2022

Dear Sir,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference.

The Inquiry is of the view that in your roles you will have an in-depth knowledge of matters that fall within our Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now, or at any stage throughout the duration of this Inquiry. Should you consider that is not the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full detail as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you may be aware the Trust has responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or your legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make an application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 13 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: **Francis Rice**
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon **on 10th June 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon **on 3rd June 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 28th April 2022

Signed: Personal Information redacted by the USI

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 13 of 2022]

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

   The Inquiry understands that you are no longer employed by the SHSCT. All questions asked in this Notice refer to the period of your tenure as Chief

Executive. The Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel which you are aware of as being relevant to the Inquiry's Terms of Reference.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you held during your period of employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, other roles, including the roles of the Directors and Assistant Directors, the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

Engagement with Staff and the Trust Board, Governance and Risk Issues

9. Describe how you usually engaged with your Senior Management Team on a day-to-day basis, including the Medical Director.

10. Describe how you usually engaged with your clinical staff on a day-to-day basis.

11. Please also set out the details of any weekly and monthly scheduled meetings with those staff members (referred to by you at 6, 7 and 8), and how long those meetings typically lasted. If a minute was taken of such meetings, please provide all minutes of any meeting which referenced urology services during your tenure from April 2016 until March 2018.

12. Please explain how you, as Chief Executive, assured both yourself and the Board that the clinical governance systems in place during your tenure were adequate. How did you ensure that the Board was appraised of both serious concerns and current performance given the applicable standards of clinical care and safety? What is your view of the efficacy of these systems in place, if any?

13. During your tenure, was the Board appraised of those departments within the Trust which were performing exceptionally well or unsatisfactorily and, if so, how was this done? Was there a committee which was responsible for overseeing performance? If so, where did it sit in the managerial structure and hierarchy and how did the Trust Board gain sight of these matters?

14. Please provide details of any specific training you received in respect of any aspects of clinical governance, patient care and safety or any other risk factors relevant to the Trust's operational functioning.

15. How, as the accountable officer, did you ensure that all Board members were kept up to date on clinical governance best practice?

16. How did you ensure that learning from clinical governance failures which may have been identified as a result of investigations were raised during Board discussions? Please illustrate your answer with examples, if applicable. Were any such issues concerning urology services raised with the Board?

17. Was it a requirement of your role that you undertook annual continuing professional development? If not, did you undertake such training anyway? In any event, please provide details of any training undertaken by you in your role as the CEO when you took up your post?

18. Were you aware of any avenues for sharing best/worst practice between Chief Executives of health care Trusts in NI, health care providers in the Republic of Ireland and NHS Trusts throughout the UK? If not, do you consider that the sharing of information in this way would assist in maintaining and enhancing clinical governance and overall patient care? Whether you agree or not, please explain your answer.

19. What is your view of the adequacy of the risk management arrangements in the Trust during your time in post?

20. Did you consider that the training and development for staff at all levels, including at senior management and Board level, encouraged a culture of reporting and learning from incidents? Please explain your answer. During your time, was the Board made aware of any problems in this area and, if so, what was done about it?

21. How was the Board assured, if at all, that there was a continued focus on reflective learning from the things that go wrong and celebration of the things that go well?

22. As former CEO, what is your view of the efficacy of the quality and safety monitoring systems that were in place in the Trust and executed through your operational teams during your tenure? Are there specific aspects of these systems that you found particularly helpful and are there parts of these systems

that required improvement? If yes, please explain. What changes did you either put in place, or attempt to put in place, to augment the assurance that was in place, and what direct observations and conversations did you have with clinical staff on the ground to see for yourself what the issues and problems were and what services were providing excellence?

23. How much time did you spend talking to your Senior Management Team and the Trust Board about clinical governance issues generally? This might helpfully be expressed as a percentage of daily/weekly hours.

24. How did staff generally inform you about or engage you in conversations regarding clinical governance issues? Was it your usual experience that they generally do so informally, or in writing, or both?

25. How would you describe the methods which you deployed to ensure that you got to know that what is expected of people in terms of compliance with clinical governance standards and arrangements was actually being carried out? Did you consider these methods successful? It would assist if you could illustrate your answer with examples.

26. Please provide examples of a number of issues that were escalated through to the Trust Board or Trust Board Committees where there were patient quality and safety concerns. The examples can come from any department, but we would be particularly interested to hear about any issues from urology. You should describe the route by which those concerns passed through the clinical governance structures and the route by which the Board then agreed a plan to improve matters and then sought assurance that the issues had been resolved. Did you as CEO have any concerns about these processes? If so, what changes, if any, did you make to improve assurance and ownership at all levels in the Trust?

27. In respect of your role, please detail your lines of engagement with the Trust Board, to include all formal and informal avenues.

28. Who on the Trust Board had responsibility for clinical governance and patient safety during your time in post? Please explain the Board oversight of clinical governance and patient safety generally, including the name(s) of and duties of any *Board Assurance Manager* during your tenure.

29. How did you let the Board know if problems regarding clinical governance arose? Did you utilise both formal and informal methods of contact and, if so, who was your point of contact and why? Did you think the mechanisms for doing this were good enough and, if not, what would have improved them?

30. Describe the most significant clinical governance/clinical risk challenges which you faced during your tenure as Chief Executive, and explain how you addressed them.

31. Did you engage in any program with a view to improving any aspect of clinical governance or clinical risk management during your tenure as Chief Executive? If so, fully explain the steps which you took as part of this program and outline any changes which resulted.

32. What percentage of the time at Trust Board was taken up with care quality and patient safety concerns and what emphasis was placed on receiving assurance that any such issues were resolved?

33. Was it your experience while in post that the Board had taken appropriate actions in relation to quality and safety concerns and sought to prioritise resources appropriately for these actions to be effective?

34. Do you have any knowledge of, or personal experience of, matters regarding clinical governance and patient safety not having been dealt with properly by the Trust and/ or the Trust Board during your tenure? If so, please provide full details, including setting out whether any failure to properly act has been admitted to and addressed, and any subsequent lessons identified and implemented – and if not, why do you think that did not happen?

35. Please set out what you considered to be the challenges in terms of learning the lessons from clinical governance and safety issues, and how staff were appraised of these and encouraged to reflect and learn? Are there any examples of this where minutes and presentations, if any, can be provided and where improvements have been put into place and embedded as demonstrated by audit?

36. Did you and the Trust Board identify and share lessons learned from adverse incidents, complaints, litigation and public inquiries, etc., concerning clinical governance and patient care and safety, both regionally and nationally? Whether your answer is yes or no, please explain. Do you consider it practicable that such lessons learned are shared and, if not, what needs to change to allow that to happen in a meaningful way?

37. How would you describe the "*risk appetite*" of the Trust and the Trust Board while you were Chief Executive? Was there, as part of the risk management strategy and process within the Trust, an annual Board appraisal of risk appetite in relation to quality and safety, operational performance and finance?

38. Were you, as CEO, able to assure the Board that high standards of professional practice were maintained? How did you seek to gain this assurance? Did this involve nurses, allied health professionals, doctors, technicians, and managers?

39. How were you assured as to how clinical appraisal was managed in the Trust? What assurance does the Board receive in this regard? Did you have any concerns about this during your tenure?

40. Did the Trust Board ever raise the issue of budget allocation and the prioritisation of risk, or seek to establish whether you, and they, were content that an acceptable risk prioritisation/budget allocation balance had been struck?

41. Please provide all notes and minutes of any meetings with the Trust Board, Trust Committees, any Trust or Departmental Staff or any third party or health body in which the problems with Urology Services were discussed during your time in post.

42. Do you consider that the Board operated efficiently and effectively during your tenure? If not, please describe your experiences.

43. Was it your view that the Board was, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?

44. Explain how your performance was appraised, to include how often and by whom, and how this was recorded. How were your performance targets evaluated?

45. Please explain how, if at all, the consideration of clinical risk within an area/specialty influenced how you allocated annual budgets for Departments? If you did prioritise clinical risk, what methodology did you use and what criteria did you apply? In other words, how, if at all, did you reflect clinical risk in budget allocation?

46. During your tenure, was it your experience that Departments or specialities sought an increased budget allocation to reflect their specific risk and, if so, what was your response? Please provide specific examples to explain your answer.

47. Did you have any personal knowledge whether such a system, which permitted budgetary requests specific to risk management, existed before your time in post?

48. Are you aware of other Trusts or health care providers who take or apply this risk/budget allocation approach or model?

49. How, if at all, did you satisfy yourself that the approach taken to risk in allocating budgets was acceptable?

Urology services/Urology unit: Staffing

50. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

51. What, if any, performance indicators were used within the urology unit at its inception?

52. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any previous or subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants and staff in the SHSCT? If yes, how and by whom was this done? If not, why not?

53. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any previous subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

54. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a

substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement, if any, with this plan?
II. How was it implemented, reviewed and its effectiveness assessed?
III. What was your role, if any, in that process?
IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

55. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents, minutes of meetings, and/or the Risk Register? Whose role was it to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

56. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

57. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

58. Were you aware of any staffing problems within the unit during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

59. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

60. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

61. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

62. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?

63. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.

64. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored

65. Were any concerns raised with you about the adequacy and/or availability of administrative staff for urology clinicians? Are you aware of such concerns having been raised with any other staff? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

66. Did administrative staff within urology services ever raise any concerns directly with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

67. Who was in overall charge of the day to day running of the urology unit during your tenure? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person/those persons answered.

68. What, if any role did you have in staff performance reviews?

69. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including

details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with unit staff

70. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

71. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

72. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

73. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Complaints

74. Please describe your role, and the role of members of the management team, should a complaint about clinical governance and/or patient safety be made by (i) member of staff, (ii) a patient, or (iii) anyone else, and provide an overview of how any such complaint was handled and your role in the process. It would be helpful if your answer referred to a specific example/s, preferably from urology, if any.

75. Please explain your understanding of how the management of clinical governance operated between clinical, nursing and other Directors and Departments, and detail your involvement in any of those processes.

76. During your tenure, did you think the relative responsibility for different aspects of clinical governance was clearly allocated between the relevant clinical and/or operational/managerial members of your senior team? Did you have cause to question or improve this? Was there a clear demarcation of particular responsibilities and, if so, how was this communicated within the senior team? Was it clearly set out or did it cause issues?

77. What is your view of how the complaints and whistle-blowing procedures, etc. operated and did you make any improvements in those areas? Have there been incidences where a member or members of staff, a patient or anyone else raised concerns about how effective those procedures were and what was your response to that?

Governance – generally

78. What was your role in relation to the Directors of Directors Human Resources and Organisational Development, the Assistant and Associate Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and other clinicians in the urology unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

79. Who oversaw the clinical governance arrangements of the urology department and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

80. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

81. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

82. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

83. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

84. Did those systems or processes change over time? If so, how, by whom and why?

85. How did you ensure that you were appraised of any concerns generally within the unit?

86. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary? If yes, please explain.

87. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

88. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

89. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

90. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

91. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

92. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns, having the potential to impact on patient care and safety, arose. Please provide an explanation of that process during your time in post, including the name(s) and roles of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

93. Did you feel supported in your role by the Trust Board and general management and medical line management? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

94. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:

    (i) The Trust Board
    (ii) The Chair of Trust Board – the Inquiry understands this to have been Roberta Brownlee
    (iii) The Medical Director - the Inquiry understand this to have been Richard Wright;
    (iv) The Director of Acute Services – the inquiry understands this to have been Esther Gishkori;

(v) The Director of Human Resources and relevant Human Resources personnel – the inquiry understands these to have been Vivienne Toal and Siobhan Hynds

(vi) The Assistant Directors - the inquiry understands these to have been Heather Trouton and Ronan Carroll;

(vii) The Associate Medical Director - the inquiry understands these to have been Mark Haynes (Surgery) and Damian Scullion (Anaesthetics)

(viii) The Clinical Director, the inquiry understands this to have been Colin Weir, however please name any other post holders during your tenure;

(ix) The Head of Service, namely Martina Corrigan,

(x) The consultant urologists in post.

(xi) The Nurse Managers –please name any post holders during your tenure.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to urology services concerns. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (xi) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

95. Can you explain from your perspective how you understood Urology Services was supposed to operate, from a clinical governance and patient care and safety perspective, during your time in post compared to how it did in fact operate?

96. Can you identify in what aspects you considered Urology Services to be operating adequately and in what respects it was failing to do so? If your understanding changed over time, please explain this within your answer.

97. During your tenure, please describe the main problems you encountered or that were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

(a) What were the concerns raised with you, when were they raised and who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not?

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

98. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) the potential risk to patients properly considered?

99. What, if any, support was provided to urology staff (other than Mr. O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q114 will ask about any support provided to Mr. O'Brien).

100. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

101. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

102. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

103. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant

documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

104. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

105. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

106. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

(i) what risk assessment did you undertake, and

(ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person and if known, any steps taken

107. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.

108. Did you ever speak to or contact Mr. O'Brien, either formally or informally, regarding the concerns raised, or any proposed actions or plans, or about any matter falling within the Inquiry's Terms of Reference? If so, please provide full details.

109. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

110. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

111. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

112. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

113. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised
(b) who did you raise it with and when?
(c) what action was taken by you and others, if any, after the issue was raised
(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

114. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

115. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

116. Did you communicate in any way, either formally or informally, with your predecessor Chief Executive, Paula Clark, or subsequent CEOs overlapping with or following on from your tenure, Stephen McNally and Shane Devlin, in relation to any issues of concern regarding urology services, such as patient safety, clinical risk or governance issues? If so, please provide all details and any relevant documentation.

Learning

117. What was the position regarding the concerns raised regarding urology by the end of your tenure? Had concerns of which you were made aware been addressed to your satisfaction? If so, please explain. If not, why not?

118. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why, and why you consider it did not come to your attention.

119. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

120. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and the concerns involving Mr. O'Brien in particular?

121. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to

engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

122. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

123. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

124. Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 13 of 2022

Date of Notice: 28th April 2022

Witness Statement of: Francis Rice

I, Francis Joseph Rice, will say as follows:-

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 I was Interim Chief Executive in the Southern Health and Social Care Trust (the Trust) from 13th April 2016 until 31st March 2018. My job role and responsibilities were:

a) Lead the development of the vision for the strategic direction of the Trust in line with the overall policies and priorities of the Department of Health Social Services and Public Safety (DHSSPS), Health and Social Care Board (HSCB)
b) As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, DHSSPS, RHSCB and ultimately the Minister for the performance and governance of the trust in the delivery of high quality care, responsive to the needs of the population in line with performance targets established.

c) The Chief Executive has overall responsibility for the management and performance of the Trust, including the Ministerial priorities as defined by the DHSSPS and HSCB, statutory requirements, achieving performance targets, securing continuous improvement and for providing high quality and effective services within a clear financial framework.

d) The Chief Executive will lead the reform within the Trust including the achievement of all organisational objectives, ensuring that appropriate robust systems are in place and necessary changes are achieved.

e) The Chief Executive is responsible for ensuring the Trust delivers high quality services and achieves the vision, values and priorities of the Trust business in line with the 5 year Strategic Plan.

1.2 I was the Director of Mental Health, Disability and Executive Director of Nursing and Allied Health Professions in the Southern Health and Social Care Trust from April 2007 until March 2016. My job purpose and responsibilities were:

a) Develop a suite of Nursing Quality Indicators which incorporate the patient experience, patient and carer involvement standards which resulted in much improved quality of care to patients, patient experience, a reduction in falls, much improved performance in pressure area care, nutrition, record keeping and medicines management

b) Establish structures and a performance action plan to ensure the efficient and effective management, development and delivery of mental health, disability, transport, nursing and allied health professions services throughout the Trust

c) Establish clinical and professional governance structures and processes for nursing, midwifery, health visiting and allied health professionals in the Trust across all directorates to include mechanisms to address lessons learnt from critical incidents and complaints, improve the patient experience and effectively manage risk

d) Develop and implemented a 5 year Nursing and Midwifery Strategy for the Trust in response to the Regional Nursing and Midwifery Strategy

e) Review and develop nursing, midwifery, health visiting and allied health professional policies, protocols and standards of practice across the Trust

f) Develop, on behalf of the region an action plan and systems and processes for implementation in response to four independent inquiries in mental health services in Northern Ireland which ensured the implementation of new standards of care and multi-disciplinary working, risk assessment and risk management documentation for mental health services

g) Develop and implement a Trust action plan in response to the 'Protect Life' Regional Suicide Strategy

1.3 I became Interim Chief Executive for the Southern Health and Social Care Trust on 13 April 2016. There had been one unsuccessful attempt to recruit to the post permanently and one interim arrangement which lasted approximately six weeks. I had not applied for either competition but was asked if I would be willing to become the Interim Chief Executive until a permanent CEO could be recruited.

1.4 Personal Information redacted by the USI [redacted]

1.5 Personal Information redacted by the USI [redacted] and part-time working Mr Stephen McNally was Interim Chief Executive.

1.6 I was first made aware by Dr Richard Wright, Medical Director, that there were potentially some issues in relation to governance and safety in the Urology department concerning Mr Aidan O'Brien in September 2016. Dr Wright came to my office to inform me that the Acute Services Directorate had some concerns that

patients of Mr O'Brien may not have been seen and reviewed in a timely manner. . Dr Wright and I discussed the matter and determined that the matter needed to be investigated in full to ascertain if there were issues and, if so, the nature and extent of the issues. This process was managed through the Trust Oversight Committee. I informed the Chair of the Trust, Mrs Roberta Brownlee, immediately and agreed to keep her appraised of progress.

1.7 As a result of the work being undertaken by the oversight Committee, a serious adverse incident involving a patient of Mr O Brien was uncovered and reported by Mr Mark Haynes, Associate Medical Director. The serious adverse incident reported the potential harm of a patient due to not being reviewed by Mr O'Brien in a timely fashion. An initial look back exercise was commenced.

1.8 The concerns arising from the SAI investigation were notified to Dr Richard Wright, Medical Director in late December 2016.He came to my office inform me of the concerns. Following a discussion with Dr Wright and Mrs Vivienne Toal, Director of Human Resources, we decided the situation required to be dealt with in a formal manner and sought advice from the National Clinical Assessment Service on 28th December 2016. Dr Wright met with Mr O'Brien, who had been on Personal Information leave from November 2016, on 30th December 2016 and explained the issue that had come to light and the action the Trust were taking, which was to commence a Maintaining High Professional Standards process and Mr O'Brien was excluded from work for a period of four weeks. Mr John Wilkinson, the designated Non Executive Director of Trust Board, was nominated by the Trust to be part this process.

1.9 A full case investigation was launched at this point as part of the MHPS process with Dr Ahmed Kahn as Case Manager with Dr Colin Weir he Clinical was appointed as Case Investigator.

1.10 Mr O'Brien's exclusion ended on 27th January 2017 and restrictions and monitoring arrangements were agreed and put in place on his practice by Dr Wright and Mrs Esther Gishkori, Director of Acute Services, to ensure patient safety when he in due course returned to work. These involved dictating patient notes in a timely

manner, triaging patients appropriately with timely access to services,reviewing patients in a timely manner, monitoring of the Patient Administration System on a weekly basis by Acute Services senior management to ensure targets were being met and Mr O Brien not seeing private patients.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry.

2.1 I do not have any documents relating to the Urology Services Inquiry and I presume the Inquiry team have the Senior Management Team, Senior Management Team Governance Trust Board, Governance Committee, Oversight minutes and the Directorate and Trust Risk Registers.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

The Inquiry understands that you are no longer employed by the SHSCT. All questions asked in this Notice refer to the period of your tenure as Chief Executive. The Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either

confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel which you are aware of as being relevant to the Inquiry's Terms of Reference.

3.1 I can confirm that the personnel named in this Notice holding the posts detailed were correct at the time of my tenure.

4. Please summarise your qualifications and your occupational history prior to commencing employment in the SHSCT

4.1 I became a Registered Nurse in 1988 and my NMC Pin Number is [redacted].

4.2 My education and qualifications are as follows:

a) Federal Executive Institute – Virginia USA – Leadership in a Democratic Society – 2010
b) Kings Fund / Burdett Trust – Development Programme for Executive Nurses and Trust Boards – 2007/2008
c) MSc (Primary Care and General Practice) University of Ulster 2001.
d) Kings Fund United Kingdom Senior Nurse Leadership Programme – London – 1998 – 2000
e) NEBSM – Diploma in Management Studies 1992
f) NEBSM– Certificate in Management Studies 1991
g) NHS – Certificate in Management Studies 1991
h) ENB – Teaching and Assessing in Clinical Practice 1990
i) 7 x GCE 'O' levels – 1981
j) 2 x GCE 'A' levels – 1984
k) 1 x GCE 'AO' level – 1984

4.3 My occupational history is as follows:

a) February 1985 – May 1988: Student Nurse Down Unit of Management in Northern Ireland. Training in all aspects of nursing encompassing psychiatry, general, learning disability and older people nursing.
b) May 1988 – May 1989: Staff Nurse – States of Jersey Channel Isles.
c) May 1989 – May 1991: Nurse Manager – Bloomsbury & Islington Health Authority, London.
d) May 1991 – October 1993: Deputy Manager – North Down & Ards Health & Social Services Trust, Northern Ireland.
e) October 1993 – October 1995: Community Care Manager – North Down & Ards Health & Social Services Trust, Northern Ireland. (Senior Manager)
f) October 1995 – April 1997: Mental Health Services Manager – Down Lisburn Health & Social Care Trust, Northern Ireland. (Senior Manager)
g) April 1997-August 2000 Assistant Director / Principal Nurse, Mental Health / Older People Services, Down Lisburn Health & Social Care Trust, Northern Ireland. (Senior Manager)
h) August 2000 – February 2005: Nursing officer, Department of Health, Social Services & Public Safety, Northern Ireland.
i) February 2005 – November 2005: Acting Chief Nursing Officer, Department of Health, Social Services & Public Safety – Northern Ireland
j) November 2005 – January 2007 (Secondment from DHSSPS) Executive Director of Nursing, Sperrin Lakeland Health and Social Care
k) April 2007-March 2016: Director of Mental Health and Disability Services /Executive Director of Nursing & AHPs, Southern Health and Social Care Trust
l) 13th April 2016- 31st March 2018: Interim Chief Executive Southern Health and Social Care Trust

5. Please set out all posts you held during your period of employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1 During my period of employment with the Trust my posts and responsibilities have been as set out at paragraphs 1.1 and 1.2 above.

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6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.

6.1 When employed as Interim Chief Executive, I was responsible to the Chair of the Trust, Mrs Roberta Brownlee, and Trust Board and accountable to the Permanent Secretary. I directly managed the Senior Management Team listed below:

a) Dr Richard Wright - Medical Director;
b) Mrs Angela McVeigh - Director of Older Peoples services, Executive Director of Nursing and AHPs;
c) Mr Paul Morgan - Director of Children's Services, Executive Director of Social work;
d) Mrs Esther Gishkori - Director of Acute Services;
e) Mr Bryce McMurray - Interim Director of Mental Health and Disability Services;
f) Mr Stephen McNally – Director of Finance;
g) Mrs Vivienne Toal - Director of Human Resources;
h) Mrs Aldrina Magwood - Director of Planning and performance;
i) Mrs Jane McKimm - Head of Communications;
j) Mrs Elaine Wright - Personal Secretary to CEO/Manager of the Office of the Chair and Chief Executive.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

7.1As Chief Executive, I managed the Director of Acute Services Mrs Esther Gishkori and the Medical Director Dr Richard Wright, who in turn managed the operational and governance aspects of the urology services.

Urology Services Inquiry

8. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, other roles, including the roles of the Directors and Assistant Directors, the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

8.1 My role and responsibilities did not overlap with any other of the roles detailed here, however, each of these roles would have had responsibility for individual and collective aspects of the operation and governance of the urology service and identifying any issues which required Chief Executive/ Senior Management Team consideration/intervention to provide Trust Board assurance and keep them abreast of the situation. It was my role to ensure that, if alerted to any issues which required action by the Senior Management Team, this was taken forward in the most expedient and appropriate manner.

<u>Engagement with Staff and the Trust Board, Governance and Risk Issues</u>

9. Describe how you usually engaged with your Senior Management Team on a day-to-day basis, including the Medical Director.

9.1 **I** engaged with the Senior Management Team (SMT) by telephone, email, 1-1 meetings and conversations if required, and zoom meetings.

10. Describe how you usually engaged with your clinical staff on a day-to-day basis.

10.1 I engaged with clinical staff primarily through both planned and informal visits to service areas arranged through the Public Relations Department. These would have taken place formally two to three times monthly and informally twice weekly. There is a full list of all my formal visits to Trust staff contained in the minutes of Trust Board.

Urology Services Inquiry

11. Please also set out the details of any weekly and monthly scheduled meetings with those staff members (referred to by you at 6, 7 and 8), and how long those meetings typically lasted. If a minute was taken of such meetings, please provide all minutes of any meeting which referenced urology services during your tenure from April 2016 until March 2018.

11.1 I met with the SMT Directors on a weekly basis for a half day each week plus one SMT Governance meeting for a half day every four weeks. The Trust Board met generally monthly, lasting six hours on average. There were also extraordinary meetings of Trust Board when required.

12. Please explain how you, as Chief Executive, assured both yourself and the Board that the clinical governance systems in place during your tenure were adequate. How did you ensure that the Board was appraised of both serious concerns and current performance given the applicable standards of clinical care and safety? What is your view of the efficacy of these systems in place, if any?

12.1 All clinical and social care issues identified through the monitoring of serious adverse incidents, adverse incidents, complaints, professional fora relating to each Trust Directorate were monitored by their respective risk and governance meetings and escalated to the Trust Clinical and Social Care Governance Committee accordingly, where they were actioned and were monitored by Trust Board.

12.2 I worked with all directors and the Director of Performance and Planning to ensure Trust Board were appraised of performance and serious concerns and the performance and actions against all key performance indicators including professional standards and practice were reported at Trust Board through the Performance Report and professional reports, e.g., Professional Nursing reports to Trust Board (24/11/2016) Ref(20161124) r*elevant document can be located at S21 No 13 of 2022 Attachments, 20161124 Nursing Report.*

12.2 The progress on action plans against incidents and complaints was also presented to Trust Board. I believed the Trust Systems were very effective during my tenure as they identified risk and areas for improvement in the system of care and treatment and reported on actions to address the respective issues.

13. During your tenure, was the Board appraised of those departments within the Trust which were performing exceptionally well or unsatisfactorily and, if so, how was this done? Was there a committee which was responsible for overseeing performance? If so, where did it sit in the managerial structure and hierarchy and how did the Trust Board gain sight of these matters?

13.1 The Trust Board was fully appraised of Trust performance through the Performance Department. The Director of Performance and Planning, Mrs Aldrina Magwood, provided SMT with a comprehensive report each week and Trust Board each month which detailed all performance against targets, satisfactory and unsatisfactory, and actions to improve and meet targets. There was not a committee to oversee this; this was done by SMT. Directorates were also provided with their respective performance reports.

14. Please provide details of any specific training you received in respect of any aspects of clinical governance, patient care and safety or any other risk factors relevant to the Trust's operational functioning.

14.1 I completed the ON BOARD training whilst employed as Director of Mental Health, Disability, Executive Director of Nursing and AHP's in the Southern Trust in approximately 2012. It lasted 1 day and detailed the responsibilities of Senior Officers in Public Service, Board effectiveness, conflicts of interest, the Nolan Principles and probity.

15. How, as the accountable officer, did you ensure that all Board members were kept up to date on clinical governance best practice?

15.1 Trust Board members were on the Governance Committee. They were appraised of all Nice guidelines, DOH professional letters coming into the Trust, and they received clinical governance reports at all Trust Board meetings. I also communicated any issues of immediate concern to Board members by email or an extraordinary meeting of Trust Board.

16. How did you ensure that learning from clinical governance failures which may have been identified as a result of investigations were raised during Board discussions? Please illustrate your answer with examples, if applicable. Were any such issues concerning urology services raised with the Board?

16.1 Any failures and associated actions to address failures were raised at Trust Board by me and the Head of Governance and the respective Executive Professional Director. No issues in relation to Urology were raised during my tenure due to the MHPS investigation (mentioned at Question 1 above) not having reported before I retired. There were issues pertaining to our inability to provide breast services in a timely manner due to medical staff shortages and issues relation to the inability to recruit Senior Medical staff in Daisy Hill Hospital, therefore potentially putting patients at risk, during my tenure along with the actions to address these issues which were discussed in detail with Trust Board.

17. Was it a requirement of your role that you undertook annual continuing professional development? If not, did you undertake such training anyway? In any event, please provide details of any training undertaken by you in your role as the CEO when you took up your post?

17.1 As a registered Nurse I had to complete continuing professional development, which I did. I was not required to undertake CPD in the role of CEO.

18. Were you aware of any avenues for sharing best/worst practice between Chief Executives of health care Trusts in NI, health care providers in the Republic of Ireland and NHS Trusts throughout the UK? If not, do you consider

that the sharing of information in this way would assist in maintaining and enhancing clinical governance and overall patient care? Whether you agree or not, please explain your answer.

18.1 There were avenues to share best/worst practice through the Regional Safety Forum and through professional director meetings in conjunction with DOH and the Chief Executive Forum. The Performance Department, in conjunction with senior professional staff, accessed best practice on a UK basis where appropriate.

19. What is your view of the adequacy of the risk management arrangements in the Trust during your time in post?

19.1 I believe that the risk management arrangements in the Trust during my tenure were comprehensive and effective as they succeeded in identifying a number of risks during my tenure, which were then subsequently successfully managed. The Trust always looked at ways to improve the risk management processes. During my tenure as CEO I initiated:

a) A review of the Adverse incident process (SMT minutes 26/10/2016)Ref (20161026) *relevant document can be located at S21 No 13 of 2022 Attachments, 20161026 SMT Notes 26 October 2016.*
b) A staff survey in relation to the attitude to reporting incident survey Monkey (SMT Governance Minutes 3/8/2016)Ref (20160803) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160830 SMT Notes 3 August 2016*
c) A new process for reviewing historical Deaths (SMT minutes 3/8/2016 commenced October 2016)Ref (20160803) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160830 SMT Notes 3 August 2016*
d) Trust participation in the UK National Complaints Pilot with the London School of Economics (LSE) to seek ways to further improve the process
e) A Safety Culture Questionnaire in the Trust (SMT minutes 26/10/2016)Ref(20161026) *relevant document can be located at S21 No 13 of 2022 Attachments, 20161026 SMT Notes 26 October 2016*

f) The development of a Safety and Quality Improvement Plan led by the Medical Director (SMT minutes 5/10/2016)Ref(20161005) *relevant document can be located at S21 No 13 of 2022 Attachments, 20161005 SMT Notes 5 October 2016*

g) Launch of the CHKS I compare initiative, UK wide (SMT minutes 14/9 2016)Ref(20160914) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160914 SMT Notes 14 September 2016*

h) The internal audit of Adverse Incident, risk management processes, and Culture in the Trust Ref(20161026) *relevant document can be located at S21 No 13 of 2022 Attachments, 20161026 SMT Notes 26 October 2016*

i) Issued the HSC code of conduct and asked all Directors to ensure this was cascaded down to team /staff level (SMT minutes 28/9/2016)(20160928) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160928 SMT Notes 28 September 2016*

j) Requested directors to keep all staff informed of developments and changes in the Trust (SMT minutes 23/11/2016). *relevant document can be located at S21 No 13 of 2022 Attachments, 20161123 SMT Notes 23 November 2016 – amended*

20. Did you consider that the training and development for staff at all levels, including at senior management and Board level, encouraged a culture of reporting and learning from incidents? Please explain your answer. During your time, was the Board made aware of any problems in this area and, if so, what was done about it?

20.1 Yes; the Trust encouraged the reporting of incidents, an open and honest 'no blame' culture and put in place Directorate, professional and Trust systems and processes to identify, action, and monitor issues of concern.

20.2 I do not recall the Board being made aware of any issues in relation to the reporting culture. During my tenure the "See Something Say Something" campaign

was widely promoted in the Trust to encourage staff to speak up if they identified poor practice or governance and to suggest improvements.

21. How was the Board assured, if at all, that there was a continued focus on reflective learning from the things that go wrong and celebration of the things that go well?

21.1 The Board was apprised of the actions being taken to address things that had gone wrong and action to implement good practice through the reports from each directorate's risk and governance meetings, the Professional Director reports, and the Morbidity and Mortality meetings in line with the Board Assurance Framework.

22. As former CEO, what is your view of the efficacy of the quality and safety monitoring systems that were in place in the Trust and executed through your operational teams during your tenure? Are there specific aspects of these systems that you found particularly helpful and are there parts of these systems that required improvement? If yes, please explain. What changes did you either put in place, or attempt to put in place, to augment the assurance that was in place, and what direct observations and conversations did you have with clinical staff on the ground to see for yourself what the issues and problems were and what services were providing excellence?

22.1 As Interim CEO I operated a formal programme of visits to service areas (details are included in all Trust Board minutes) where I met the entire teams and multi–professional staff. I sat in on Morbidity and Mortality meetings during some of these visits where staff discussed progress and identified issues to be addressed.

22.2 During my tenure, the Medical Director and I initiated a process whereby all professional staff were included in Morbidity and Mortality meetings, not just Doctors, which was a significant area of improvement. I believe the systems and processes were effective as evidenced through the risks that were identified and the improvements that teams made to continually improve their performance and practice. The Southern Trust was in the top 40 of the Comparative Health

Knowledge System (CHKS) which is a nationally accepted System which Benchmarks standards used to improve performance and improve the patient experience. The Trust was able to access the standards for the delivery of health services and benchmark ourselves against them.

23. How much time did you spend talking to your Senior Management Team and the Trust Board about clinical governance issues generally? This might helpfully be expressed as a percentage of daily/weekly hours.

23.1 With SMT, 2-3 hours weekly, within Trust Board, 4-5 hours monthly and more as issues arose outside of the formal meetings. (Approximately 25% of my time in my estimation).

24. How did staff generally inform you about or engage you in conversations regarding clinical governance issues? Was it your usual experience that they generally do so informally, or in writing, or both?

24.1 Staff generally informed me informally and on occasion in writing.

25. How would you describe the methods which you deployed to ensure that you got to know that what is expected of people in terms of compliance with clinical governance standards and arrangements was actually being carried out? Did you consider these methods successful? It would assist if you could illustrate your answer with examples.

25.1 The Trust emphasised and monitored the compliance with all clinical governance and professional standards at Professional supervision of staff, professional Fora, Directorate risk and Governance meetings, compliance with NICE Guidelines, Professional Standards and identified where there were issues.

25.2 Where compliance was a challenge and action was required to ensure compliance, a plan was developed and additional resource provided if required to

implement these in the Trust. We informed the DOH/RHSCB of any non-compliance issues.

25.3 One example is the application of an Early Warning System (EWS) which alerts clinicians to patients becoming ill and deteriorating. SAIs had identified this was not always being carried by the appropriately trained people and escalated in time. The Trust governance team carried out an audit, identified the issues, reviewed the EWS tool, determined who should carry out assessment, trained staff and the outcomes for patients significantly improved. The compliance with EWS was monitored and reported to Trust Board.

26. Please provide examples of a number of issues that were escalated through to the Trust Board or Trust Board Committees where there were patient quality and safety concerns. The examples can come from any department, but we would be particularly interested to hear about any issues from urology. You should describe the route by which those concerns passed through the clinical governance structures and the route by which the Board then agreed a plan to improve matters and then sought assurance that the issues had been resolved. Did you as CEO have any concerns about these processes? If so, what changes, if any, did you make to improve assurance and ownership at all levels in the Trust?

26.1 During my tenure there was an issue in relation to Medical staff shortages. In spite of huge efforts to recruit by the Trust in relation to the provision of breast services due to the sudden death of one medical colleague and another leaving the Trust, I was concerned about women not being seen within the target times. I was concerned about the time taken to be seen and the potential for increased harm.

26.2 These issues were identified through the operational and clinical teams, escalated to me as CEO, and in turn to SMT and Trust Board. Subsequently, I initiated joint working with the DOH/RHSCB/Trust to put a plan in place to address the issue, to which the Trust Board agreed and which it monitored. This got the Trust back on track through the assistance of two other Trusts breast services until we

were able to recruit into the vacated posts to provide the service in full in our Trust. This process worked extremely well.

27. In respect of your role, please detail your lines of engagement with the Trust Board, to include all formal and informal avenues.

27.1 My lines of engagement were almost daily with the Chair. Regarding individual Non Executive Directors, it depended on which Committees they sat or which Committees they chaired. I emailed, made phone calls and met with all Trust Board members when required; on occasion more than once daily. I engaged formally through Trust Board meetings.

28. Who on the Trust Board had responsibility for clinical governance and patient safety during your time in post? Please explain the Board oversight of clinical governance and patient safety generally, including the name(s) of and duties of any *Board Assurance Manager* during your tenure.

28.1 The Medical Director, Dr Richard Wright, Mrs Margaret Marshall, Trust Governance Manager, and the Executive Directors all had responsibility for clinical governance and patient safety. They provided reports through the performance professional and medical directors reports.Eg Executive Director of Nursing report to Trust Board.(Ref 20170330) *relevant document can be located at S21 No 13 of 2022 Attachments, 20170330 Nursing Report.*

29. How did you let the Board know if problems regarding clinical governance arose? Did you utilise both formal and informal methods of contact and, if so, who was your point of contact and why? Did you think the mechanisms for doing this were good enough and, if not, what would have improved them?

29.1 My first point of contact was the Chair and the respective operational/ Professional Directors and together we explored the issue, the potential solutions and how and who should we involve and communicate with. This was done to ensure no one was left out of the loop, that there was a quick response to address all

issues, and that everyone was content and approved the initial course of action. This would have been done on a mostly formal basis and reported to Trust Board.

30. Describe the most significant clinical governance/clinical risk challenges which you faced during your tenure as Chief Executive, and explain how you addressed them.

30.1 The most significant clinical governance/clinical risk challenge I faced was the provision of skilled and competent staff in Daisy Hill Hospital to provide safe and effective care. In 2016, a number of services were unable to provide safe and effective services, primarily the Emergency Department as there was an inability to attract senior medical staff in spite of the Trust embarking on a national recruitment drive and offer incentives which were agreed by the DOH.

30.2 I had to set up and chair an oversight group with membership from Trust Directors of Acute Services, Finance, Human Resources, Planning and Performance, the Medical Director, Associate and Clinical Medical Directors and Assistant Directors of Acute Services. The DOH policy and professional regional Health and Social Care, and Public Health Agency senior commissioning and professional staff, were also members of the group.

30.3 It was agreed that a senior Medical Consultant should be employed to Chair a Project Board ('Pathfinder') and lead a team supported by the Trust to scope the issues, assess risks, liaise with Royal Colleges and the local community and MLAs and bring forward a plan with options and associated actions to deliver a new model of service delivery that could be delivered safely in DHH. Phase I Pathfinder report (30/8/2017) *relevant document can be located at S21 No 13 of 2022 Attachments, 20170830 Phase 1 Report DHH Pathfinder Group APPROVED by SMT on 30 August 2017.* SHSCT press release 18/9/2017(Ref 20170918) *relevant document can be located at 20170918 DHH Pathfinder press release 1809 final.*

30.4 The Project Board reported on a regular basis to SMT and Trust Board where proposed actions were agreed and authorised for implementation. This project had

not completed when I went off on Personal information redacted by USI leave Personal Information redacted by the USI. The Chair passed to the Acting CEO Mr Stephen McNally.

31. Did you engage in any program with a view to improving any aspect of clinical governance or clinical risk management during your tenure as Chief Executive? If so, fully explain the steps which you took as part of this program and outline any changes which resulted.

31.1 Please see answer to question 30. I also adopted a similar approach to a problem we had where women were waiting in excess of 18 weeks for an appointment with Breast Services due to one Consultant leaving the Trust and another unfortunately dying. This issue was addressed satisfactorily and all women were seen with the assistance of two other Trusts.

31.2 I enlisted the help and collaboration of the other HSC Trusts, DOH, RHSCB and our senior Medical and operational staff and ensured all women were seen with the agreed timescales, some on other Trusts. This worked to a regional review of Breast Services as other Trusts also had Medical and Nursing workforce challenges.

32. What percentage of the time at Trust Board was taken up with care quality and patient safety concerns and what emphasis was placed on receiving assurance that any such issues were resolved?

32.1 There was a huge emphasis placed on care and quality and patient safety at Trust Board to include assurance on resolution. Approximately one half of Trust Board time was spent on this. The Trust also established a Patient and Client Experience Committee, representative of all service areas in the Trust to monitor experience, standards and improve on service delivery.

33. Was it your experience while in post that the Board had taken appropriate actions in relation to quality and safety concerns and sought to prioritise resources appropriately for these actions to be effective?

33.1 The Trust Board, without exception, always addressed issues of quality and safety and put patient and staff welfare at the heart of everything they did. The Trust took whatever action was necessary to prioritise actions, going at risk financially on occasions to do so, e.g., when Acute Hospital Services (in approximately 2013) were short of nursing staff across a number of specialties which had the potential to compromise patient safety. When this particular risk was identified to Trust Board they approved additional expenditure of £1.5 million.

34. Do you have any knowledge of, or personal experience of, matters regarding clinical governance and patient safety not having been dealt with properly by the Trust and/ or the Trust Board during your tenure? If so, please provide full details, including setting out whether any failure to properly act has been admitted to and addressed, and any subsequent lessons identified and implemented – and if not, why do you think that did not happen?

34.1 No; I have no knowledge or experience of clinical governance or patient safety matters not having been dealt with properly by the Trust and/or Trust Board during my tenure. If issues came to light, it was normal practice to identify what the issues were and what could be done to address them. They would bring them to my attention if their interventions had not worked, if harm had come to patients and required support and action from senior management to address (see, for example, the issue outlined in paragraph 30.3).

35. Please set out what you considered to be the challenges in terms of learning the lessons from clinical governance and safety issues, and how staff were appraised of these and encouraged to reflect and learn? Are there any examples of this where minutes and presentations, if any, can be provided and where improvements have been put into place and embedded as demonstrated by audit?

35.1 Trust Board reports detailed staff compliance with and awareness of learning lessons from clinical governance and safety issues including Serious Adverse Incidents **(see, for example, Executive Director of Nursing and AHP reports to**

Trust Board - Ref 20161124 *relevant document can be located at S21 No 13 of 2022 Attachments, 20161124 Nursing report*, **20160609** *relevant document can be located at S21 No 13 of 2022 Attachments, 20160609 Nursing report (a) and 20160619 Nursing report (b)*. This would also have been evidenced at Directorate risk and governance meetings, Morbidity and Mortality meetings and professional fora. The challenge was the effective dissemination of lessons learnt to all staff and the Trust used Staff meetings, handovers, intranet, emails and staff notifications to do this and used audit to monitor compliance. There was in my experience no resistance to implementing lessons learnt of any description.

36. Did you and the Trust Board identify and share lessons learned from adverse incidents, complaints, litigation and public inquiries, etc., concerning clinical governance and patient care and safety, both regionally and nationally? Whether your answer is yes or no, please explain. Do you consider it practicable that such lessons learned are shared and, if not, what needs to change to allow that to happen in a meaningful way?

36.1 The Trust did share lessons learnt from Incidents, complaints, litigation and public inquiries. A lot of this was done through emails, learning letters, professional letters from DOH, staff meetings, handovers and local and regional conferences. The Trust reinforced the accountablity/responsibility of all staff to read and digest the learning and apply it in practice. Lessons learnt and risks were shared regionally with the RHSCB through the SAI process. RHSCB ensured all Trusts were appraised of newly identified risks through written communication to respective CEOs and the RHSCB also shared nationally, if they deemed it appropriate.

37. How would you describe the "*risk appetite*" of the Trust and the Trust Board while you were Chief Executive? Was there, as part of the risk management strategy and process within the Trust, an annual Board appraisal of risk appetite in relation to quality and safety, operational performance and finance?

37.1 All risks were monitored at Directorate level and escalated to SMT and Trust Board where corporate action was required. The risks were reviewed at every Trust Board and action agreed escalated/de-escalated as appropriate. The risk appetite/tolerance was low where patient safety was concerned. The corporate Risk Register was reviewed at every Trust Board meeting.

38. Were you, as CEO, able to assure the Board that high standards of professional practice were maintained? How did you seek to gain this assurance? Did this involve nurses, allied health professionals, doctors, technicians, and managers?

38.1 Professional reports were provided to Trust Board by respective directors for all professions in the Trust in relation to performance against Key Performance Indicators and adherence to professional practice and standards. The Executive Director of Nursing and Allied Health Professions provided a report to Trust Board which involved nurses and allied health professionals for assurance. The Board confirmed their approval assessing against key performance indicators.

39. How were you assured as to how clinical appraisal was managed in the Trust? What assurance does the Board receive in this regard? Did you have any concerns about this during your tenure?

39.1 The Trust appointed a Medical Consultant to work with the Medical Director's office. The Medical Director reported compliance to Trust Board. I had no concerns during my tenure and progress was reported in the Medical Director's Report which was satisfactory.

40. Did the Trust Board ever raise the issue of budget allocation and the prioritisation of risk, or seek to establish whether you, and they, were content that an acceptable risk prioritisation/budget allocation balance had been struck?

40.1 Yes; simply to ensure any risk was prioritised, scoped and funded where required (please see paragraph 33.1 for an example of this),

41. Please provide all notes and minutes of any meetings with the Trust Board, Trust Committees, any Trust or Departmental Staff or any third party or health body in which the problems with Urology Services were discussed during your time in post.

41.The only meetings I attended in relation to problems with Urology Services was with Dr Wright and Mrs Esther Gishkori, Mrs Vivienne Toal and Mrs Roberta Brownlee in September 2016 and subsequently December 2016. These were not minuted.

42. Do you consider that the Board operated efficiently and effectively during your tenure? If not, please describe your experiences.

42.1 Yes; there was appropriate challenge, requests for information, and no assurance unless they were content with information provided. They were both constructively challenging and supportive.

43. Was it your view that the Board was, individually and collectively, motivated to address concerns regarding governance and clinical and patient safety as they arose within Urology Services or more generally? Did they always follow up on concerns raised? Were meetings conducted in an open and transparent manner? What was your experience of the Boards appetite for identifying concerns and implementing lessons learned?

43. I found the Board to be extremely motivated to identify and address concerns regarding governance and clinical and patient safety. We did follow up concerns raised and conducted open and transparent meetings (please see paragraphs 30.1-30.4). As soon as I became aware of the issues with Mr O'Brien I, along with the Medical Director, Director of Human Resources, and Director of Acute Services, initiated immediate action and informed the Chair, Mrs Roberta Brownlee, who was

in full accordance with the direction of travel suggested and requested to be kept fully informed.

44. Explain how your performance was appraised, to include how often and by whom, and how this was recorded. How were your performance targets evaluated?

44.1 I had a set of objectives agreed by the Chair of the Trust,in line with the Trust Corporate Objectives monitored monthly at 1-1 meetings with the Chair..

45. Please explain how, if at all, the consideration of clinical risk within an area/specialty influenced how you allocated annual budgets for Departments? If you did prioritise clinical risk, what methodology did you use and what criteria did you apply? In other words, how, if at all, did you reflect clinical risk in budget allocation?

45.1 The measures to assess clinical risk and management (professional standards and key performance indicators) were continuously assessed and prioritised in terms of impact on patients and service delivery by SMT and Trust Board. Budgets were reviewed and allocated accordingly in conjunction with the RHSCB and DOH, where appropriate, where the Trust required additional resource to address clinical risk within an area/specialty. This was not done annually but on a rolling basis.

45.2 There was no specific methodology to do this but, whenever there was clinical risk, the issue was comprehensively scoped and solutions costed. The SMT then identified the finance required and, if the Trust required additional resource beyond that which the Trust could afford, it sought the help that it required formally from the RHSCB/DOH by submitting a paper detailing the issue, the solution, the finance required, and the outcomes.

46. During your tenure, was it your experience that Departments or specialities sought an increased budget allocation to reflect their specific risk and, if so,

what was your response? Please provide specific examples to explain your answer.

46.1 Yes; it was my experience that additional funds were sought and obtained to reflect specific risks. An example of which I am aware includes the Pathfinder Project (re Daisy Hill Hospital), which required a significant increase in budget and incentives to maintain safe and effective care whilst the Project Board was carrying out the comprehensive review which was agreed and monitored by Trust Board. There was also a shortage of nursing staff across the Trust and additional finance was identified to ensure patient safety.

47. Did you have any personal knowledge whether such a system, which permitted budgetary requests specific to risk management, existed before your time in post?

47.1 The same approach as described in 45.1 was operational before my tenure.

48. Are you aware of other Trusts or health care providers who take or apply this risk/budget allocation approach or model?

48.1 To my knowledge we all operated the same approach.

49. How, if at all, did you satisfy yourself that the approach taken to risk in allocating budgets was acceptable?

49.1 I monitored the impact in relation to addressing the risk through SMT each week through a monitoring report from the appropriate SMT director to assess whether the budgetary allocation was having the desired effect and achieving targets and reported to Trust Board monthly.

50. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality

standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

50.1 I had no involvement in the establishment of the urology service in the Southern Trust.

51. What, if any, performance indicators were used within the urology unit at its inception?

51.1 I understand that they used the ”Integrated Elective Access Protocol” and associated targets set by the DOH and monitored by the RHSCB, which specify the target times for patients to be seen by trusts by specialty for assessment and treatment.

52. Was the *‘Integrated Elective Access Protocol’* published by DOH in April 2008, or any previous or subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants and staff in the SHSCT? If yes, how and by whom was this done? If not, why not?

52.1 I managed Mental Health and Disability Services from April 2007 until March 2016 and used the Protocol to ensure targets for access to mental health and disability services were being met. I disseminated the Protocol to all staff working in the Directorate who were responsible for assessing and treating patients including administrative staff.

53. How, if at all, did the *‘Integrated Elective Access Protocol’* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as

against the requirements of that protocol or any previous subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

53.1 This would have been monitored by the Planning Department and provided to the Acute Directorate. The Urology Head of Service, Director, clinicians and planning department would have collectively addressed any issues. The SMT Performance Report monitored compliance and assurance sought and received from Directors that the IEAP was being implemented. The report was then submitted to the RHSCB Board. The RHSCB also monitored Trust compliance and intervened when they had concerns and/or to help.

54. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement, if any, with this plan?
II. How was it implemented, reviewed and its effectiveness assessed?
III. What was your role, if any, in that process?
IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

54.1 I have no detailed knowledge of the plan but was aware of the issue through reports to and discussions at Trust Board, as all backlogs and actions to address them were reported in the Performance Report. I was aware the plan was developed to improve access to urology services due to a regional issue where demand was outstripping capacity.

55. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents, minutes of meetings, and/or the

Risk Register? Whose role was it to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

55.1 It was the role of the Director of Acute Services and the Medical Director to ensure that any such governance risks were incorporated into the Directorate/Corporate Risk Registers (Ref 20160908) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160908 CRR* where access and review backlogs and the recruitment and retention of medical staff were logged against a number of specialties.

56. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

56.1 I believe that most of the issues were resolved satisfactorily although I understand that recruitment and retention of medical staff remained an ongoing issue for the Trust as it was for some other Trusts.

57. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

57.1 There was a problem with middle grade medical staff complement as I recall which was addressed quickly and satisfactorily and assurance given by Dr Richard Wright.

58. Were you aware of any staffing problems within the unit during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

58.1 Please see paragraph 57.1.

58.2 Dr Richard Wright informed Trust Board that there was an issue in relation to Middle grade medical staff shortage in 2017 which was quickly resolved through a successful recruitment process.

59. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

59.1 See paragraphs 58.1 and 58.2.

60. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

60.1 None to my knowledge.

61. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why

61.1 There were changes of personnel at Associate Medical and Clinical Director levels in the Surgical Directorate due to retirements.

62. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?

62.1 No.

63. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff.

63.1 The booking centre staff arranged appointments and reviews and in-patient admissions. Administrative staff managed the medical staff diaries and typing. I was not made aware of any specific issues in this area.

64. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

64.1 Consultants had their own specific administrative support and any workload issues would have been raised within the Directorate management structure.

65. Were any concerns raised with you about the adequacy and/or availability of administrative staff for urology clinicians? Are you aware of such concerns having been raised with any other staff? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

65.1 Mr Ronan Carroll, Assistant Director would be aware if there were any issues or concerns in relation to this. To my recollection, no concerns were raised with me or brought to my attention.

66. Did administrative staff within urology services ever raise any concerns directly with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

66.1 No.

67. Who was in overall charge of the day to day running of the urology unit during your tenure? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person/those persons answered.

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67.1 Ms Martina Corrigan, Head of Service, (who reported to Mr Ronan Carroll, Assistant Director, initially and subsequently to Mrs Heather Trouton, Assistant Director) was in overall charge of the day to day running of the unit.

68. What, if any role did you have in staff performance reviews?

68.1 I reviewed the performance of the SMT members at 1-1 meetings against agreed objectives and at SMT meetings.

69. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

69.1 My performance was reviewed by the Chair, Mrs Roberta Brownlee, based on the Trust's corporate objectives and in line with the DOH framework. It was reviewed at each 1-1 meeting and formally (annually) at the Remuneration Committee. Mrs Vivienne Toal should have the relevant documentation.

Engagement with unit staff

70. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

70.1 I had no engagement with unit staff on a day-to-day basis except if I visited informally.

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71. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

71.1 There were none involving me formally. I visited the unit informally in the course of my walk-arounds approximately 3 times in total.

72. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

72.1 None.

73. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

73.1 I was not aware of any contention between professional managers and medical staff during my tenure. I therefore had no reason to doubt that they worked well together.

Complaints

74. Please describe your role, and the role of members of the management team, should a complaint about clinical governance and/or patient safety be made by (i) member of staff, (ii) a patient, or (iii) anyone else, and provide an overview of how any such complaint was handled and your role in the process. It would be helpful if your answer referred to a specific example/s, preferably from urology, if any.

74.1 Any complaints received by me as Interim Chief Executive were sent to the appropriate Director and copied to the Complaints Department. All complaints were

fully investigated by the Complaints Department with statements obtained from all clinicians, people, and services implicated, including the patient and family. A response would be generally completed within 20 days and actions agreed and sent to the Director for approval before being sent to the complainant. If an internal complaint was received from a member of staff this would be investigated using the Trust's Whistleblowing Policy.

75. Please explain your understanding of how the management of clinical governance operated between clinical, nursing and other Directors and Departments, and detail your involvement in any of those processes.

75.1 The senior professionals and managers in each department, through their risk and governance meeting, identified any governance or safety issues, determined whether the issue was an operational or professional matter and communicated that to the appropriate manager / senior manager or senior professional to be dealt with and escalated to operational or Professional directors for inclusion in their senior directorate operational meeting or the professional director fora for action as appropriate.

75.2 The directorates, in turn, escalated any issues they determined SMT needed to be made aware of or action to me for information, monitoring, or action by SMT as appropriate, and to inform Trust Board for assurance.

75.3 The action and progress would then be communicated back down to staff level to ensure governance and safety issues have been addressed and implemented at patient/service level and reported at Trust Board.

76. During your tenure, did you think the relative responsibility for different aspects of clinical governance was clearly allocated between the relevant clinical and/or operational/managerial members of your senior team? Did you have cause to question or improve this? Was there a clear demarcation of particular responsibilities and, if so, how was this communicated within the senior team? Was it clearly set out or did it cause issues?

76.1 I believe the Senior team clearly understood their respective roles and responsibilities in relation clinical governance and operational responsibilities. The role, accountability and responsibility of the professional executive and operational directors was very well understood with clear lines of demarcation with respective responsibilities contained within Job Descriptions (e.g., Director of Mental Health, Disability and Executive Director of Nursing 2006). The senior team understood their individual and collective responsibilities. Lines of responsibility/accountability were discussed at SMT and Trust Board workshops to ensure there was no ambiguity.

77. What is your view of how the complaints and whistle-blowing procedures, etc. operated and did you make any improvements in those areas? Have there been incidences where a member or members of staff, a patient or anyone else raised concerns about how effective those procedures were and what was your response to that?

77.1 I believe these procedures were effective and staff felt empowered to highlight areas for improvement. No one person specifically raised concerns about these procedures with me but we did review the Trust Whistleblowing Policy in 2017 to encourage staff to speak up if they saw poor practice or standards. The Medical Director and I went round all clinical areas in the Trust to promote the revised policy.

Governance – generally

78. What was your role in relation to the Directors of Directors Human Resources and Organisational Development, the Assistant and Associate Directors, the Head of Service for Urology, the Medical and Clinical Directors, consultants and other clinicians in the urology unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

78.1 I, as CEO, directly managed the Medical Director, Dr Richard Wright, and the Director of Human Resources and Organisational Development, Mrs Vivienne Toal, and the Director of Acute Services, Mrs Esther Gishkori, whose responsibility it would have been to raise with me, the SMT, and Trust Board all matters of clinical governance and/or patient safety risk raised by the Assistant Director/Clinical Director in Urology.

79. Who oversaw the clinical governance arrangements of the urology department and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

79.1 The Clinical Director, Dr Colin Weir, and the Assistant Director for Surgery and Elective Care, Mrs Heather Trouton/Mr Ronan Carroll, oversaw the clinical governance arrangements of the urology department. I relied on the Director of Acute Services, Mrs Esther Gishkori, and the Medical Director, Dr Richard Wright, to appraise me of any clinical governance issues. I assured myself by relying on them and the professional reports to Trust Board, e.g., Executive Director of Nursing and AHP reports to Trust Board (REF 20160128, 20170928), *relevant documents can be located at S21 No 13 of 2022 Attachments, 20160128 Nursing report, 20170928 Nursing report (a) and Nursing report (b)***.** Medical Director Reports to Trust Board (20160929, 20160324) *relevant documents can be located at S21 No 13 of 2022 Attachments, 20160929 MD Report TB, 20160324 MD Report TB*, and Morbidity and Mortality meetings, e.g., (20160819, 20171018) *relevant documents can be located at S21 No 13 of 2022 Attachments, 20160819_Combines Surgical MM Minutes and S21 No 13 of 2022 Attachments, 20171018_Urology MM Minutes*.

80. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

80.1 All complaints, compliments, SAIs, key performance indicators, revalidation and appraisal information, and professional Director reports were monitored by the Acute Directorate and, subsequently, by the SMT and Trust Board and its Governance Committee. The Morbidity and Mortality rates were monitored and compared nationally and reported to Trust Board.

81. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

81.1 Performance metrics were included in the performance, professional and clinical and social care governance, morbity and mortality benchmarking reports presented to SMT (which I chaired as CEO) and Trust Board, and all were monitored by the Director of Acute Services Mrs Esther Gishkori.

82. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

82.1 I refer to my answer at 81.1 above. Any non-compliance with metrics, as well as compliance, was reported and discussed fully at SMT and Trust Board and action plans to achieve improvement were reported on until compliance was reached and signed off by Trust Board. Complaints, compliments, and incidents were monitored alongside this in any area where concerns were identified.

83. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

83.1 We were alerted to any concerns from staff, patients, families, GPs, which were reported on the Trust Datix system and/or in professional reports to Trust Board. Concerns were raised through directorate risk and governance meetings,

complaints, staff whistleblowing, appraisals, and senior staff walkabouts. I felt these systems were effective but we always looked at how we could continually improve.

83.2 The Trust introduced the 10,000 initiative in 2016 where patients and families were encouraged to give feedback of their experience of services and care in the Trust in conjunction with the then Public Health Agency. This feedback from approximately 500 patients a year was reported and reviewed at Trust Board and initiatives in relation to simplifying admission and discharge procedures, as well as procedures for effective communication with relatives, were reviewed and implemented, taking on board the constructive feedback of patients and their families.

84. Did those systems or processes change over time? If so, how, by whom and why?

84.1 The mode of reporting complaints evolved to give specific information about the area it came from and what was done about it, to identify themes and cases where a staff member was involved in more than one complaint.The Datix system evolved over time with additional modules being added to capture additional patient information and enable information to be scrutinised,cross referenced and identify patterns ie falls,medication errors,near misses.This occurred in approximately 2010, initiated to improve services for patients,standards of practice but also to identify any staff who patients felt did not treat them well and therefore could be addressed by the Trust.

85. How did you ensure that you were appraised of any concerns generally within the unit?

85.1 I was appraised through members of the Senior Management Team (the Director of Acute Services and the Medical Director) if there were any concerns.

86. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that

governance issues were not being identified, addressed and escalated as necessary? If yes, please explain.

86.1 I ensured governance systems, including clinical governance within the unit, were adequate through monitoring complaints, incidents, SAIs, Key Performance Indicators, Quality Indicators, monitoring professional standards and practice, and encouraging patient and staff feedback. I had some concerns when these systems identified issues with Mr O'Brien's practice late in 2016.

87. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

87.1 In respect of concerns about Mr O'Brien, the SAI and Datix system identified these issues, the MHPS investigation had just commenced prior to my sick leave in January 2017. However, the issues in relation to Mr O'Brien, the commencement of the MHPS process, and early alert to DOH were reported and recorded at the confidential Trust Board meeting on 27/1/2017 (REF 20170127) *relevant document can be located at S21 No 13 of 2022 Attachments, 20170127 Confidential Minutes.*

87.2 More broadly, the issue of workforce shortage and backlogs in relation to access to services and timely review for a number of specialties (including Urology) were on the Corporate Risk Register (20160908) *relevant document can be located at S21 No 13 of 2022 Attachments,* 20160908 CRR.

88. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

88.1 Systems included the morbidity and mortality data on patients collected in the Urology Unit, tracking against KPIs on waiting list times, and reports from the Referral and Booking Centre relating to untriaged Referrals. The Datix system also had information on some patients. The morbidity and mortality data was compared to

national data standards and, where there were outliers in relation to morbidity or mortality, this would have been investigated. The Datix, Booking Centre, and SAI systems helped identify issues with Mr O'Brien's practice.

89. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

89.1 These systems enabled us to collate and compare data, identify potential areas of concern, and make improvements to how Trust services were delivered and to professional practice. The upgrading and addition of new modules to the Datix system enabled the Trust to be alerted when, e.g., KPIs and QIs were not being met, to take appropriate action, to identify patterns, and to share this information widely. Prior to 2012, hard copy IR1s were completed on paper and then entered into the Datix system. From April 2012, the SHSCT used Datixweb online incident reporting, resulting in enhanced system functionality, faster access to incident informatio and the creation of live Datix 'dashboards'. I believed the systems to be very efficient.

90. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

90.1 I was assured by the Medical Director and the Director of Acute Services that the performance objectives for medical staff were satisfactory except when the issues with Dr O'Brien arose in December 2016. I am aware now that the Acute Directorate, along with the Medical Director, had identified some concerns to Mr O'Brien relating to a backlog of patients waiting to be seen and notes not been dictated in a timely fashion in early 2016 and were working with him to resolve them. The situation improved for a time but was not sustained.

91. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

91.1 I felt appraisal worked well as assurances were provided to Trust Board that the Trust was on target. This issue was also discussed regularly at SMT. The Trust invested extra financial resource to ensure all doctors were medically appraised.

91.2 The cycle of job planning did not work so well. There had been a number of changes at Associate Medical and Clinical Director level in the Surgical Directorate which impacted on the progress of the job planning process. The Medical and Human Resources Directors subsequently reviewed the job planning process in the Trust in 2017.

92. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns, having the potential to impact on patient care and safety, arose. Please provide an explanation of that process during your time in post, including the name(s) and roles of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

92.1 Please see answer to question 75. The medical staffing issue at Daisy Hill Hospital is a perfect example and the actions taken are in the ”Pathfinder Report” (30/8/2017) and reports to Trust Board *relevant document can be located at S21 No 13 of 2022 Attachments, 20170830 Phase 1 Report DHH Pathfinder Group APPROVED by SMT on 30 August 2017*.

93. Did you feel supported in your role by the Trust Board and general management and medical line management? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

93.1 Yes; when I became aware of the SAI and further concerns in relation to Mr O'Brien in December 2016 I initiated a course of action, look back exercise and MHPS, that was fully supported by the Acute Services Director and the Medical line management and also by the Trust Board.

Concerns regarding the urology unit

94. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:

(i) The Trust Board
(ii) The Chair of Trust Board – the Inquiry understands this to have been Roberta Brownlee
(iii) The Medical Director - the Inquiry understand this to have been Richard Wright;
(iv) The Director of Acute Services – the inquiry understands this to have been Esther Gishkori;
(v) The Director of Human Resources and relevant Human Resources personnel – the inquiry understands these to have been Vivienne Toal and Siobhan Hynds
(vi) The Assistant Directors - the inquiry understands these to have been Heather Trouton and Ronan Carroll;
(vii) The Associate Medical Director - the inquiry understands these to have been Mark Haynes (Surgery) and Damian Scullion (Anaesthetics)
(viii) The Clinical Director, the inquiry understands this to have been Colin Weir, however please name any other post holders during your tenure;
(ix) The Head of Service, namely Martina Corrigan,
(x) The consultant urologists in post.
(xi) The Nurse Managers – please name any post holders during your tenure.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient

care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to urology services concerns. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (xi) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

(i) to (xi)

94.1 I liaised regarding governance issues with SMT on a weekly basis, with directors Dr Richard Wright, Mrs Esther Gishkori, and Mrs Vivienne Toal at 1-1 meetings monthly, and with the Chair Mrs Roberta Brownlee weekly.

94.2 I did not liaise with Mrs Siobhan Hynds, Mrs Heather Trouton, Mr Ronan Carroll, Mr Mark Haynes, Mr Damian Scullion, Dr Colin Weir or Mrs Martina Corrigan in relation to general governance issues.

94.3 I did not liaise with the consultant urologists or nurse managers on governance issues (whether general or to do with Mr O'Brien) at all.

94.4 I appraised the Chair, Mrs Roberta Brownlee, when I became aware of potential concerns in relation to Mr O'Brien's work in September 2016. I also met with Dr Richard Wright (Medical Director), Mrs Esther Gishkori (Director of Acute Services), Mr Ronan Carroll (Assistant Director of Acute Services), and Mrs Vivienne Toal (Human Resources Director) to discuss the issues and decide on a course of action.

94.5 Post December 2016, I met with Dr Richard Wright, Mrs Esther Gishkori and Mrs Vivienne Toal at least weekly to monitor the progress of the MHPS process and the investigation until I went on sick leave at the end of January 2017. I asked them to establish the Look Back exercise to determine to nature and extent of the problem and determine if any patients had come to harm. This process was managed through

the Trust Oversight Group. I maintained regular contact with these four individuals and the Chair, Mrs Roberta Brownlee, through phone-calls and meetings.

94.6 Approximately four weeks into 2017, I had to go on a period of long term [redacted] leave [redacted].

Oversight Group

95. Can you explain from your perspective how you understood Urology Services was supposed to operate, from a clinical governance and patient care and safety perspective, during your time in post compared to how it did in fact operate?

95.1 I understood that the Urology service was supposed to provide efficient, effective, and safe services and treatment within agreed access times with appropriate review of patients.

95.2 However, issues existed in a number of specialties (including Urology) where demand was exceeding capacity and this was reported in the performance reports to Trust Board and put on the Corporate Risk Register because of its effect on the ability of the specialty to meet target times.

95.3 Away from the broader issue, it became apparent (including through an SAI investigation process) that in the case of Mr O'Brien there was a concern that he may not have been providing efficient, effective and safe services in that patients appeared not to be being triaged and reviewed appropriately. The Trust attempted to address this through a process which was overseen by the Oversight Committee and the Consultant's practice improved. Unfortunately, this improvement was not sustained by the Consultant.

96. Can you identify in what aspects you considered Urology Services to be operating adequately and in what respects it was failing to do so? If your understanding changed over time, please explain this within your answer.

96.1 believed urology services were operating adequately (albeit subject to the broad capacity vs. demand issue mentioned above) until I was advised in September 2016 that this might not have been the case. Acute Services had been working with Mr O'Brien over the previous months as some concerns had come to light in relation to potential delays in patients being seen. At this point Mr O'Brien went off sick and a plan was put in place for the remaining medical staff to see Mr O'Brien's patients.

96.2 The directorate began a lookback exercise to determine the nature and extent of the potential problem. Dr Richard Wright advised me in December 2016 that a patient of Mr O'Brien had potentially come to harm as a result of not being reviewed in a timely manner which had been brought to the Trust's attention through a serious adverse incident report.

97. During your tenure, please describe the main problems you encountered or that were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

(a) What were the concerns raised with you, when were they raised and who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

97(a)(i) Please see my response to question 1 above at paragraphs 1.5 to 1.8 in particular.

97(a)(ii) Following the look back exercise that was initiated in September 2016 into Mr O'Brien's patients, I was advised in December 2016 by Dr Richard Wright that he had been notified of an SAI which suggested that a patient of Mr O'Brien's had potentially come to harm due to not being reviewed in a timely manner. I talked through the issue with Dr Wright, Mrs E Gishkori and Mrs Vivienne Toal and decided

on a course of action, i.e., the instigation of the MHPS process. I immediately informed the Chair of the Trust, Mrs Roberta Brownlee, who agreed to the proposed action.

97(a)(iii) A serious adverse incident had been reported in relation to a Patient of Mr O'Brien's and Mr Mark Haynes, the Associate Medical Director, informed Dr Wright as soon as he became aware of it. The serious adverse incident,reported potential harm of a patient due to not being reviewed by Mr O'Brien in a timely fashion. Dr Wright, Mrs E Gishkori and Mrs Vivienne Toal met with me and, after discussion, we agreed Mr O'Brien's case should be referred to the National Clinical Assessment Service for advice which occurred on 28th December 2016.

97(a)(iv) Mr O'Brien was excluded from work for four weeks although he had been on sick leave from November 2016. Dr Wright met with Mr O'Brien on 30th December 2016 and explained the issue that had come to light and the action the Trust were taking which was to commence a Maintaining High Professional Standards process. Mr John Wilkinson, the designated Non Executive Director of Trust Board, was involved in this process, as required by the MHPS process.

97(a)(v) A full case investigation was launched at this point with Dr Ahmed Khan as Case Manager and Dr Colin Weir, Clinical Director in Surgery, as Case Investigator (Dr Weir was subsequently replaced by Dr Neta Chada, Associate Medical Director for Mental Health and Disability Services).

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

97(b)(i) The MHPS process was commenced, part of which involved a comprehensive look back exercise in relation to Mr O'Brien's patients.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not?

97(c)(i) Yes; particularly in light of what I learned regarding the SAI. In the circumstances, in addition to the SAI and MHPS processes and Mr O'Brien's initial exclusion from work for a period of 1 month, on 27 January 2017 conditions were placed on his practice in relation to patient access, triage, timely dictation of patient notes, and no private practice and a Look Back exercise commenced.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.

97(d)(i) Please see my answer to Question 1 (in particular, paragraphs 1.6-1.10) as well as the previous paragraphs of my answer to this question.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

97(e)(i) I received weekly reports to assure me from Mrs Esther Gishkori, Acute Services Director, and Dr Richard Wright, Medical Director, and Mrs Vivienne Toal Human Resource Director, including feedback from the MHPS process which had commenced.

(f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?

97(f)(i) Dr Richard Wright provided the assurance through Mrs Esther Gishkori (as the compliance with action plan was monitored weekly by the Acute Services

Directorate) to ensure patients were being seen in a timely fashion and the findings from the look back exercise was also reported to Dr Wright.

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

97(g)(i) At that point, yes.

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

97(h)(i) Metrics used were correct triage, waiting lists, time to access the service, review times, private patient appointments, and incidents where Mr O'Brien's patients were involved.

98. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) the potential risk to patients properly considered?

98.1 I believe the concerns were properly identified their extent and impact and potential risks assessed and considered through the various processes adopted in response, namely, the SAI, MHPS, and lookback processes as well as the system of control and supervision of Mr O'Brien.

99. What, if any, support was provided to urology staff (other than Mr. O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human

Resources? If yes, please explain in full. If not, please explain why not. (Q114 will ask about any support provided to Mr O Brien

99.1 Dr Wright and Mrs Esther Gishkori and their staff provided support to urology staff. I agreed with Dr Wright and Mrs Vivienne Toal that any additional staffing required to support urology services was to be put in place and Mrs Toal ensured staff were offered support from Occupational Health if required.

100. Was the urology department offered any support for quality improvement initiatives during your tenure?

100.1 The Trust conducted the look back exercise to establish the nature and extent of the problem and agreed an improvement plan to ensure all patients accessed urology services and were reviewed in a timely fashion. They were offered any additional manpower in terms of governance, administrative and medical staff to undertake this.

Mr O'Brien

101. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

101.1 I had no direct day to day responsibility for Mr O'Brien. I only had passing contact with Mr O'Brien on Chief Executive walkabouts. I never met Mr O'Brien during my tenure primarily due to his and my extended periods of sick leave.

102. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

102.1 I had no role in his job planning. I understood this was carried out by the Clinical Director, Mr Colin Weir, reported through to the Medical Director.

103. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

103.1 Please see my answers to Questions 1 and 97 above.

104. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

104.1 Please see my answers to Questions 1 and 97 above.

105. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

105.1 Please see my answers to Questions 1 and 97 above.

106. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

(i) what risk assessment did you undertake, and

(ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person and if known, any steps taken

106.1 Please see my answers to Questions 1 and 97 above.

107. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr. O'Brien and others, given the concerns identified.

107.1 Please see my answers to Questions 1 and 97 above.

108. Did you ever speak to or contact Mr. O'Brien, either formally or informally, regarding the concerns raised, or any proposed actions or plans, or about any matter falling within the Inquiry's Terms of Reference? If so, please provide full details.

108.1 No.

109. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

109.1 Monitoring Mr O'Brien's caseload in relation to effective triage, access time to services, delays in review and waiting lists, and timely dictation on patient notes were the metrics used primarily to address concerns. Private patients and timely dictation of patients' notes had not previously monitored

110. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and

comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

110.1 I was assured by Dr Wright and Mrs Esther Gishkori who reported on progress in relation to the establishment of the MHPS process and patients being seen and reviewed in a timely manner.

111. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

111.1 I believe at that particular time they remedied our immediate concerns. Mr O'Brien had returned to work and was practising under conditions and supervision. We also ensured that patients were being seen and reviewed by other medical colleagues in urology , embarked on a comprehensive look back process to scope the full extent of the problem, and commenced the MHPS process.

112. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

112.1 Not to my knowledge.

113. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised
(b) who did you raise it with and when?
(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

113.1 Please see my answers to Questions 1 and 97 above.

114. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

114.1 Dr Wright and Mrs V Toal provided support arrangements. Dr Wright met with Mr O'Brien to explain what had come to light and the MHPS process. Mr O'Brien was also offered support from Occupational Health Service in the Trust. I was on Personal In [redacted] at this point so am not sure of the nature of the support offered after this.

115. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

115.1 The issues in relation to Mr OBrien, the fact that the MHPS process had commenced, and the related Early Alert to the Department were all reported at the confidential Trust Board meeting on 27/1/2017 (Ref20170127) *relevant document can be located at S21 No 13 of 2022 Attachments, 20170127 Confidential Minutes*. The specific issues in relation to Mr O Brien were also reflected in the minutes of the Trust Oversight Committee (e.g., on 13/9/2016, 21/10,2016, 22/12/2016, 10/01/2017, and 26/1/2017) *relevant documents can be located at Relevant to HR, reference no 1, Oversight documentation Mr O'Brien, 20160913 Oversight Group Notes Action Points, Relevant to HR, reference no 1, Oversight documentation Mr O'Brien,*

20161021 Oversight Group Notes, Relevant to HR, reference no 1, Oversight documentation Mr O'Brien 20161222 Oversight Group Notes, Relevant to HR, reference no 1, Oversight documentation Mr O'Brien 20170110 Oversight Group notes and Relevant to HR, reference no 1, Oversight documentation Mr O'Brien 20170126 Oversight Group notes.

115.2 The other issues in relation to backlogs, demand vs. capacity, and recruitment and retention of medical staff were reflected generally in the Corporate Risk Register (20160908) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160908 CRR*.

116. Did you communicate in any way, either formally or informally, with your predecessor Chief Executive, Paula Clark, or subsequent CEOs overlapping with or following on from your tenure, Stephen McNally and Shane Devlin, in relation to any issues of concern regarding urology services, such as patient safety, clinical risk or governance issues? If so, please provide all details and any relevant documentation.

116.1 Mr Stephen McNally would have been aware that the MHPS process had commenced as part of my handover in January 2017. It was also reported at Trust Board on 27/1/2017 before my period of [redacted] commenced. We did not, at this point, know any of the specifics as the process had just begun. I was informed by Mr McNally that the MHPS process for Mr O Brien was still ongoing on my return in July 2017 and I was aware it had not completed when I went on the final period of [redacted] from November 2017 (and then retired on 31 March 2018 when Mr Devlin took up post of CEO). I cannot recall what, if any, information I gave to Mr McNally about the matter when he took over from me for a second time during my second spell of [redacted].

<u>Learning</u>

117. What was the position regarding the concerns raised regarding urology by the end of your tenure? Had concerns of which you were made aware been addressed to your satisfaction? If so, please explain. If not, why not?

117.1 I believe that, at that particular time, the immediate concerns were remedied. Mr O'Brien had returned to work and was practising under conditions and supervision. I also ensured that patients were being seen and reviewed by other medical colleagues in urology. The Trust embarked on a comprehensive look back process to scope the full extent of the problem and had commenced the MHPS process. Although neither process had concluded, I was content that the concerns were under control.

118. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why, and why you consider it did not come to your attention.

118.1 I am now aware that there had been some governance concerns in relation to Mr O'Brien's practice earlier in 2016 that the Acute Services Directorate had tried to sort out and put systems and processes in place to ensure safe and effective practice by Mr O Brien. I was informed in September 2016 whenever the Acute Services Directorate realised that the support mechanisms that had been agreed with Mr O'Brien had not been sustained and required the intervention of the SMT to remedy. I now am of the view that I could have been made aware sooner.

119. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

119.1 It would appear that Mr O'Brien was not triaging or reviewing patients in an appropriate and timely manner. He was also not dictating patient notes on time and was potentially prioritising some private patients. The Acute Services Directorate worked with him to address some of these issues. There was some improvement but it was not sustained my Mr O'Brien in spite of a lot of effort by Acute Service staff. I have been shown the MHPS Case Manager and Case Investigator reports in

the context of this Inquiry. I have read them and have no reason to disagree with them.

120. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and the concerns involving Mr. O'Brien in particular?

120.1 I believe that when the Directorate were aware that, in spite of their efforts to assist him, Mr O'Brien's efforts to improve his practice were not being sustained, , they should have escalated the concerns to SMT at that point for discussion and agreement on the immediate actions required and the way forward.

121. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

121.1. No I do not believe so, however the MHPS process had just begun as I went on my period of extended Personal In [redacted] leave and had not reported before I retired. Please see paragraphs 1.6-1.10.I believe that the Acute Services Directorate tried their hardest to work with and help Mr O Brien. When he did not sustain what was put in place the Directorate should have escalated the concerns at that point to formalise a corporate response

122. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

122.1 No, as soon as I was made aware of this issue I believe I and Trust Board took the correct and robust course of action. I am of the view, on reflection, that in this case the matter could have been brought to the attention of the CEO and the SMT perhaps sooner whenever the Acute Services Directorate realised their efforts to help and support Mr O'Brien were not achieving the desired results.

123. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

123.1 I believe the governance arrangements were fit for purpose and I had no concerns but always tried to improve on them. During my tenure as CEO I initiated:

a) A review of the Adverse incident process (SMT minutes 26/10/2016)Ref (20161026) relevant document can be located at S21 No 13 of 2022 Attachments, *20161026 SMT Notes 26 October 2016.*
b) A staff survey in relation to the attitude to reporting incident survey Monkey (SMT Governance Minutes 3/8/2016)Ref (20160803) relevant document can be located at S21 No 13 of 2022 Attachments, 20160830 SMT Notes 3 August 2016
c) A new process for reviewing historical Deaths (SMT minutes 3/8/2016 commenced October 2016)Ref (20160803) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160830 SMT Notes 3 August 2016*
d) Trust participation in the UK National Complaints Pilot with the London School of Economics (LSE) to seek ways to further improve the process
e) A Safety Culture Questionnaire in the Trust (SMT minutes 26/10/2016)Ref(20161026) *relevant document can be located at S21 No 13 of 2022 Attachments, 20161026 SMT Notes 26 October 2016*
f) The development of a Safety and Quality Improvement Plan led by the Medical Director (SMT minutes 5/10/2016)Ref(20161005) relevant document can be located at S21 No 13 of 2022 Attachments, 20161005 SMT Notes 5 October 2016

g) Launch of the CHKS I compare initiative, UK wide (SMT minutes 14/9 2016)Ref(20160914) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160914 SMT Notes 14 September 2016*

h) The internal audit of Adverse Incident, risk management processes, and Culture in the Trust Ref(20161026) *relevant document can be located at S21 No 13 of 2022 Attachments, 20161026 SMT Notes 26 October 2016*

i) Issued the HSC code of conduct and asked all Directors to ensure this was cascaded down to team /staff level (SMT minutes 28/9/2016)(20160928) *relevant document can be located at S21 No 13 of 2022 Attachments, 20160928 SMT Notes 28 September 2016*

j) Requested directors to keep all staff informed of developments and changes in the Trust (SMT minutes 23/11/2016) *relevant document can be located at S21 No 13 of 2022 Attachments, 20161123 SMT Notes 23 November 2016 – amended*

124. Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

124.1 I do not have anything further to add save to clarify that I liaised with Ms Emma Stinson, SHSCT, and Dr Richard Wright to access some information to enable me to complete the following parts of this Section 21 Notice:

a. Dr Richard Wright –provided information in relation to Questions 1, 26, 30, 34, 36, 39, 90, 91, 97A, 97B, 99, 104, 107, 114, and 118.

I obtained all other information and documents from Mrs Emma Stinson.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: __Francis Rice_____

Urology Services Inquiry

Date: _ 17/06/2022_____

S21 13 of 2022

Witness statement of: Francis Joseph Rice

Table of Attachments

Attachment	Document Name
1	Professional Nursing reports to Trust Board ref (20161124)
2	A review of the Adverse incident process (SMT minutes 26/10/2016)
3	SMT Governance Minutes 3/8/2016 Ref (20160803)
6	20161005 SMT minutes
7	20160914 SMT minutes
9	20160928 SMT minutes
10	20161123 SMT minutes
11	Executive Director of Nursing report to Trust Board(Ref 20170330)
12	Pathfinder report 20170830
13	SHSCT press release 18/9/2017 Ref 20170918
14	Executive Director of Nursing and AHP reports to Trust Board - Ref 20161124
15	Executive Director of Nursing and AHP reports to Trust Board 20160609 – Nursing report (a)
16	Executive Director of Nursing and AHP reports to Trust Board 20160609 – Nursing report (b)
17	Directorate/Corporate Risk Registers (Ref 20160908)
18	Executive Director of Nursing and AHP reports to Trust Board (REF 20160128)
19	Executive Director of Nursing and AHP reports to Trust Board 20170928 Nursing

	report (a)
20	Executive Director of Nursing and AHP reports to Trust Board 20170928 Nursing report (b)
21	Medical Director Reports to Trust Board 20160929
22	Medical Director Reports to Trust Board 20160324
23	Morbidity and Mortality meetings 20160819
24	Morbidity and Mortality meetings 20171018
25	Trust Board meeting on 27/1/2017 ref (20170127)

Southern Health and Social Care Trust

REPORT SUMMARY SHEET

Meeting Date	Trust Board 24th November 2016
Title	Executive Director of Nursing's update report on key nursing and midwifery governance, education and workforce activity.
Lead Director	Angela McVeigh, Director Older people and Primary Care Executive Director of Nursing/AHPs (Acting)
Corporate Objective	• Providing safe high quality care • Making best use of resources • Support people and communities to live healthy lives and improve their health and wellbeing
Purpose	Assurance and Information

Summary of Key Issues for Trust Board

High level context

NQI Framework
Trust Board approved the Nursing Quality Indicator (NQI) Framework as the mechanism for providing assurances on the quality of nursing care to patients in the Southern Trust.

NMC Revalidation
The Nursing and Midwifery Council's (NMC) has revised its revalidation criteria for registered nurses and midwives and the Trust has in place assurance arrangement to report on the revalidation status of all nursing / midwifery registrants employed by the Trust.

The Patient / Client Experience (PCE)
The Patient / Client Experience (PCE) surveys evidence the experience of patients and clients on the care provided by all nurses, midwives and other health care workers in unscheduled care areas.

Nursing Workforce
Appointing to Registered Nursing (all branches) and Midwifery posts across all service areas, remains extremely challenging despite significant, proactive local recruitment and international recruitment.

Nursing and Midwifery Education
The Trust continues to support students from all local Universities in compliance with Nursing and Midwifery Council Standards, to ensure a workforce fit for the future. Engagement with students has been increased across all Universities and branches of Nursing, and Southern Trust remains the only Trust in Northern Ireland to offer posts to students in Year 2 of their training. The Trust also ensures support for new Registrants with Nursing Induction and Preceptorship, and access to accredited post-registration development to ensure staff who are knowledgeable

and competent to deliver person-centred care.

Key issues/risks for discussion

NQI Framework
The NQI assurance framework is to be supported by a FileMaker data base version 15 as it has the ability to analyze complex data from all 4 domains across all directorates. The current version 11 needs to be upgraded as the software company will no longer support this version (since Sept 2015). Until this is completed and version 15 is functional, assurance on the quality of nursing care will continue to be provided via the paper-based audit analysis which, as per the research undertaken in the Trust, is considered to be less robust. A small number of iPads / android tablets are also required to ensure timely data collection and analysis using the upgraded version 15 and hopefully the software issues around functionality will be resolved in the near future.

NMC Revalidation
Assurance on nursing and midwifery revalidation is provided through reports generated via a bespoke FileMaker database which, as above requires to be upgraded to a new version 15. Until this work is completed reports on assurance on revalidation will be provided from reports from version 11.

Nursing Workforce
A risk for the Trust is how to continue to deliver safe nursing care given the number of vacancies across services that are unable to be filled despite significant local and international recruitment activity. This is on the Corporate Risk Register and actions plan are in place to maintain safe nursing care.

Summary of SMT challenge/discussion

NQI Framework
Following Trust Board approval, the implementation of the NQI Assurance Framework has continued with the development and testing of audit tools and data analysis continues. Moving to version 15 the EDN will support the EDON to provide more robust assurances on the quality of nursing care provided within the Trust.

NMC Revalidation
SMT is satisfied that arrangements are in place to provide assurance on timely revalidation and that monitoring procedures will identify those registrants at risk of failing to revalidate. As such, SMT agreed to reduce the risk from high to medium on the corporate risk register in September 2016. The current assurance arrangements are supported by a FileMaker database which is currently being upgraded.

Nursing Workforce
As a corporate risk SMT are aware of the risk of nursing vacancies on the delivery of services. It is recognised that the international recruitment campaigns in 2016 will provide additionally in terms of supply across 2017.

Internal/External engagement

Trust Ward Sisters / Charge Nurses / Team Leaders and nurses in all directorates continue to participate in a rollout programme for implementing the NQI Framework and a NQI Framework Steering Group continues to meet bi-monthly to oversee and support progress. There is ongoing engagement of Personal and Public Involvement (PPI) Leads involving patients in service improvement initiatives. Research and nursing leads have also engaged with the PHA's Patient / Client Experience Standards and 10,000 Voices initiative to ensure cross-agency information sharing and learning.

The Trust Assistant Director of Nursing (Workforce and Education), continues to lead international recruitment and review local recruitment approaches for the five Health and Social Care Trust, with Karyn Patterson seconded to the role of HR Regional Nursing and Medical International Recruitment Lead.

Human Rights/Equality

There are no perceived specific Human Rights or equality issues within the context of the framework approach proposed. The focus of nursing quality indicators is to provide assurances on high quality compassionate care that supports Trust delivery of Human Rights and equality requirements.

International nursing recruitment will be progressed taking into account all UK requirements as well as any legislative requirements from other countries.

Southern Health and Social Care Trust

Quality Care - for you, with you

Executive Director of Nursing Report to Trust Board

24th November 2016

Executive Director of Nursing Update Report to Trust Board 24th November 2016

This report provides an update on the key nursing and midwifery governance and workforce development and training activity set out in the reports tabled in June 2016.

2.1 The ST's Nursing Quality Indicator (NQI) aims to proactively drive improvements in the quality of nursing and midwifery care and the patient experience. In 2014 the EDN funded research which examined the application of a nursing quality indicator (NQI) framework in evidencing the impact of nursing on patient safety outcomes and the patient experience in adult in-patient wards. Proposed Framework: -

2.2

					Domain 4
		Safe and effective process indicators	**Safe and effective outcome indicators**	**Patient experience indicators**	**Nurse's knowledge of patient's care needs**
		Review of patient records to assess compliance with evidence- based care bundles	Review of patient records to determine patient safety outcomes in relation to selected NQIs	Exploration of patient's perception of their experience of nursing care	Nurses asked to identify the patient's nursing care needs. Responses mapped against nursing care plan
	Ward level Data	Patient safety outcome measures; feedback from nurses and complaints and incidents			

The research found that the NQI Framework provided a more robust and comprehensive analysis on the quality of nursing care as opposed to when domain elements were analysed individually. The NQI Framework supports a review of the patient's experience of their care journey and the knowledge of the nurses caring for them.

2.3 *Implementing the NQI Framework*

ST NQI Framework Implementation Group, chaired by the EDN, has agreed that **only those Nursing Quality Indicators (NQIs) which the Trust is required to report / provide assurance on locally (SMT / Trust Board) and regionally should be audited**, however, Directorate-specific monthly nursing audits could continue with the agreement of the director and senior nurses if required.

Nursing Quality Indicators (NQIs)	Reporting Mode
1. SKIN	Audit
2. Falls (Part A)	Audit
3. Nutrition (MUST)	Audit
4. NEWS / OEWS / PEWS	Audit
5. Omitted and Delayed Meds (Failure to record)	Audit
6. Nurse Record Keeping	Audit
7. Pt/C Experience Standards / 10,000 Voices	Audit
8. Professionalism (NMC Revalidation, Nurse Supervision)	Quarterly progress report
9. Preceptorship	End of year progress report
10. Delivering Care (Normative Staffing)	
11. NMC Standards to Support Learning and Assessment in Practice 2008	End of year progress report

2.4 It was agreed that FileMaker software would be used to analyse the audit data as it has the ability to analyze complex data from all 4 domains across all directorates. The Trust requires to update the FileMaker software as current versions are no longer supported. Until this is completed assurance on the quality of nursing care will continue to be provided via the paper-based audit analysis. Collection of data will be via use of an iPad / android tablet which hopefully will be available soon.

2.5 *NQI Framework Implementation Activity June – November 2016*

Post-research / Implementation Activity	Progress
Review and agree the NQIs which the Trust is required to report on regionally in line with 2016-17 requirements	**Concluded**
Pilot / testing of the associated NQI audit tools to ensure that they reflect the 4 domains	**Concluded**
Writing of NQI Framework database	**Concluded** – until FileMaker version 15 available
Upload of FileMaker Version 15 and supply of mobile devices for data collection	**Delayed** (as at Nov 2016)
Agreement on divisional / ward / team rollout arrangements	**Concluded**
Facilitated audit consistency training/awareness with identified auditors – a core recommendation to support valid and reliable reporting on audit outcomes	**Concluded** Will be repeated as new auditors come on board
Development of *Guidance for Auditors on the Application of the NQI Audit Tools*	**Concluded** for Acute Directorate but will be tested after database upload

Development of *Guidance for Managers on Areas for Improvement of Nursing Care* at both at ward/team and organisational level post-audit	**Ongoing** - will be tested after database upload
Engagement with Personal and Public Involvement (PPI) Leads on post-audit service improvement initiatives	**Ongoing**
Development of an evaluation strategy to assess success of Framework in evidencing safe, quality nursing care and enhanced patient experience.	**Ongoing**
Submission of research paper for publication in the *International Journal of Health Care Quality Assurance*	**Concluded** – awaiting peer reviewer feedback
The Acute directorate NQI Steering Group members to develop criteria for nurses' involvement in non-nursing audits to ensure that nursing care and capacity is not compromised.	**Ongoing**

The NQI Framework Steering Group continues to meet bi-monthly to review progress on the implementation. Further progress on implementation is delayed until the database is live and the iPads are available and functioning in the collection of data.

2.6 *Reporting Arrangements*

Arrangements for reporting on NQIs will reflect other formats used across the Trust, e.g., Trust Delivery Plan reports. The use of the file maker database will facilitate the development of the outcomes dashboard.

3.0 Reporting on Agreed NQIs

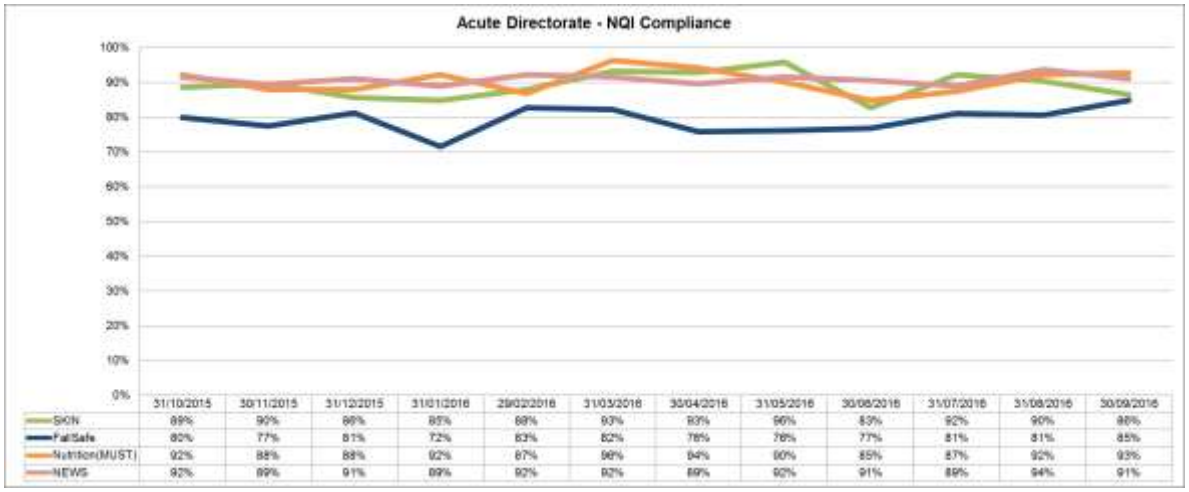
Monthly paper-based audits would continue to be undertaken by the Ward Sisters / Charge Nurses / Team Leaders (in those directorates where applicable) and collated on Excel with each indicators being reported on separately rather than across the 4 domains as recommended in the research.

3.1

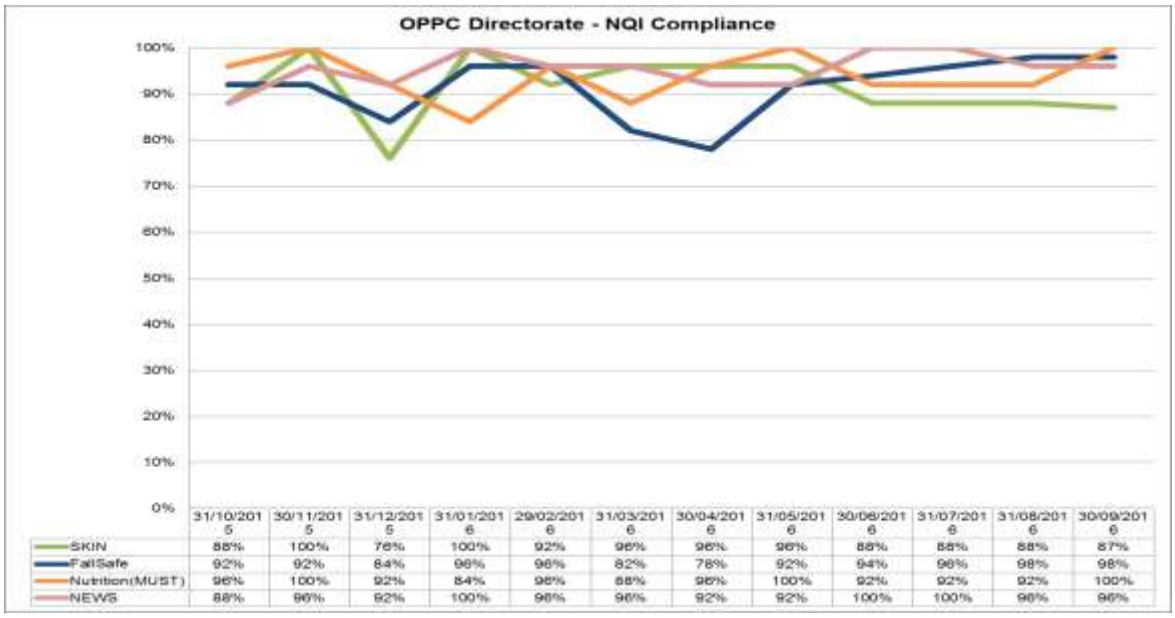
	NQI	Acute	OPPC	MHD	CYP	Report via
1.	SKIN	X	X			Audit
2.	Falls (Part A)	X	X	X		Audit
3.	Nutrition (MUST)	X	X	X		Audit
4.	NEWS / OEWS / PEWS	X	X	X	X	Audit
5.	Omitted and Delayed Meds (Failure to record)	X	X	X		Audit
6.	Nurse Record Keeping	X	X	X	X	Audit
7.	Pt/C Experience Standards / 10,000 Voices	X	X	X	X	Audit

8.	Professionalism (NMC Revalidation and Nurse Supervision	X	X	X	X	Monthly report
9.	Preceptorship	X	X	X	X	End of year reports
10.	Delivering Care (Normative Staffing)	X	X	X	X	
11.	. NMC Standards to Support Learning and Assessment in Practice 2008	X	X	X	X	

3.2 NQIs 1- 4 - Acute Adult Inpatient Wards



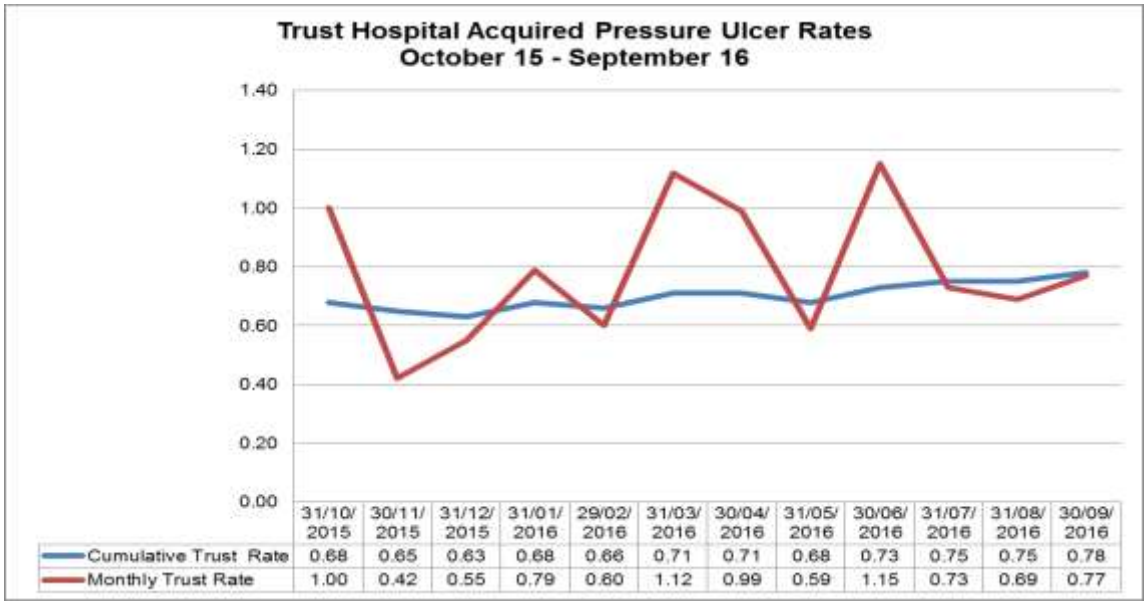
3.3 NQIs 1- 4 - OPPC (Non-Acute) Adult Inpatient Wards



In both Acute and Non-acute Directorates nurses are consistently achieving significant or full compliance with the SKIN (pressure ulcer), Falls, MUST (nutrition) and NEWS indicators. There is continued concentrated efforts by Ward Sisters through support,

education and enhanced monitoring to ensure full compliance on all indicators is achieved.

3.4 Southern Trust Hospital Acquired Pressure Ulcers (Oct 2015 – Sept 2016)



	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016
Cumulative Trust Rate	0.68	0.65	0.63	0.68	0.66	0.71	0.71	0.68	0.73	0.75	0.75	0.78
Monthly Trust Rate	1.00	0.42	0.55	0.79	0.60	1.12	0.99	0.59	1.15	0.73	0.69	0.77

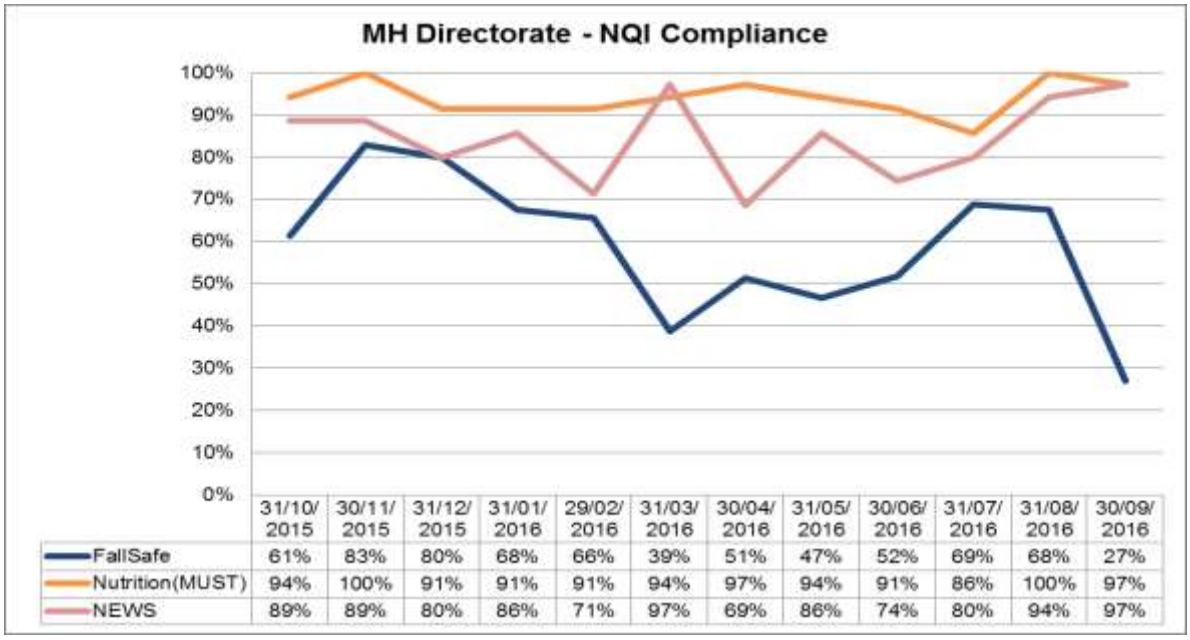
The data is taken from individual wards Safety Crosses across the Trust and cross referenced against Datix. The implementation of the SKIN Bundle and associated training over the last three years has increased staff awareness regarding the identification, grading, management and reporting of Hospital Acquired pressure ulcers.

The Public Health Agency Quality Improvement Plan Framework for 2016/7 requires Trusts to provide quarterly detail on the following: -

- Compliance with SKIN Bundle
- Total Number of Hospital Acquired Pressure Ulcers grade 2 and above
- Number of Hospital Acquired Pressure Ulcers grade 3 and 4
- Number of Hospital Acquired Pressure ulcers grade 3 and 4, which were unavoidable

To facilitate the above, the Trust's Tissue Viability Nurse Specialist and the relevant Ward Sisters have undertaken a Root Cause Analysis (RCA) on all Grade 3 and 4 Ward Acquired Pressure Ulcers identified since March 2015.

3.5 *NQIs 2 - 4 - Mental Health and Disability Directorate*

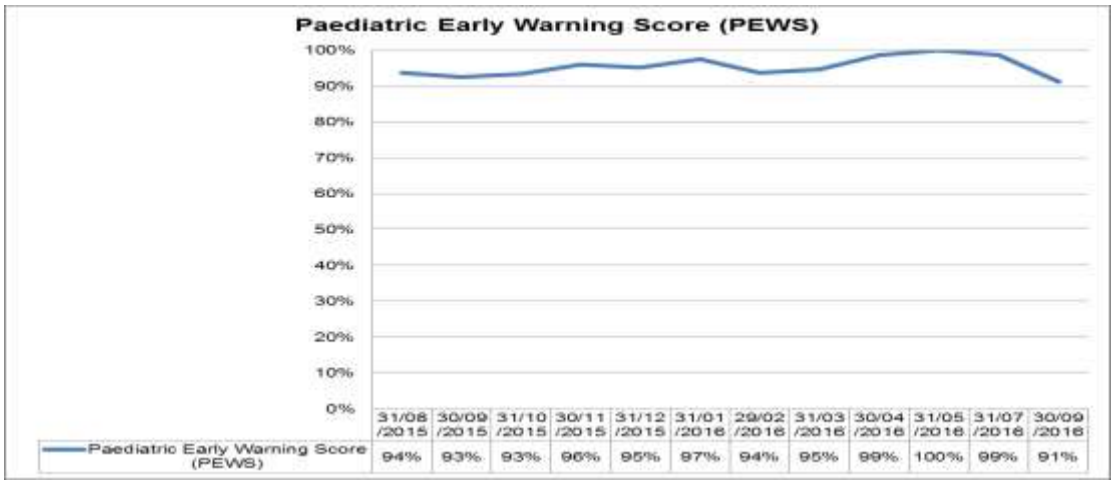


	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016
FallSafe	61%	83%	80%	68%	66%	39%	51%	47%	52%	69%	68%	27%
Nutrition(MUST)	94%	100%	91%	91%	91%	94%	97%	94%	91%	86%	100%	97%
NEWS	89%	89%	80%	86%	71%	97%	69%	86%	74%	80%	94%	97%

Compliance with the NEWS and Nutrition (MUST) bundles across the seven inpatient wards has improved from A RAG of amber in July to green in August and September 2016.

The record audit shows that Willows and Gillis Wards were full compliant with the FallSafe bundle, however, compliance in other wards ranged from 27% to 69% (n = 39). The elements contributing to non-compliance included:- not recording urinalysis (n=15), not recording if patients were asked about their fear of falling (n=2) and history of falling (n=2). Action plans are in place to address these gaps in recording.

3.6 *NQI 4 - Children and Young People's Directorate*



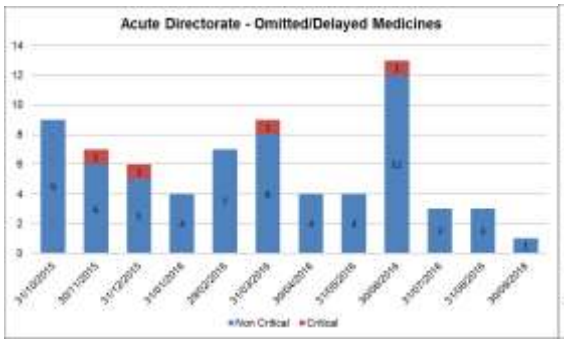
	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	31/07/2016	30/09/2016
Paediatric Early Warning Score (PEWS)	94%	93%	93%	96%	95%	97%	94%	95%	99%	100%	99%	91%

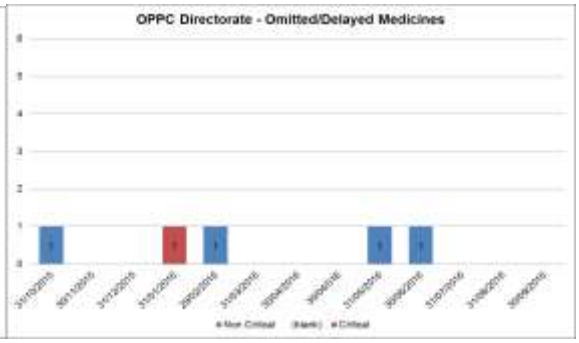
The Paediatric Early Warning Score (PEWS) audit is completed in both the DHH and CAH Children's Wards. The current PEWS template is a pilot of the new regional PEWS chart. The parameters and scoring in the new chart is more extensive than previously and feedback is currently being collated for regional review within the Quality Collaborative group. The parameters within the new chart no longer include temperature but now include

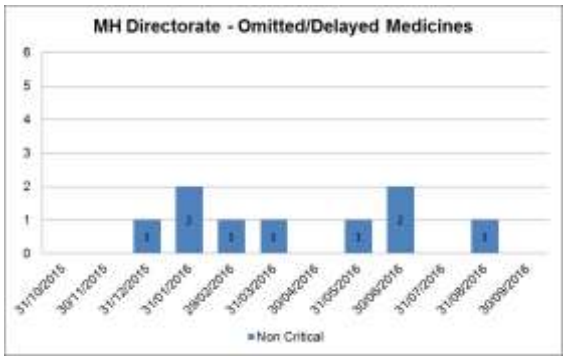
blood pressure monitoring. The numerical values have changed significantly therefore has affected the current existing template on the NQI data base which is also now under review.

3.7 *NQI 5 - Omitted / Delayed Critical Medicines* – all adult in-patient wards

Omitted / Delayed Critical Medicines have been monitored in all adult in-patient wards over the past year (since October 2015) with results for each directorate as outlined below.







October 2015 – September 2016

Directorate	Medicine Kardexes audited	Total no of medicine doses prescribed	No of 'Blank' doses	Total critical medicine doses prescribed	No of critical medicine doses that were 'Blank'
Acute	1,602	19,405	70 (0.36%)	5,478	4 (0.02%)
OPPC	296	5,096	5 (0.09%)	845	1 (0.01%)
MHD	420	5,600	9 (0.16%)	261	0
Total	**2,318**	**30,101**	**84(0.27%)**	**6,584**	**5 (0.01%)**

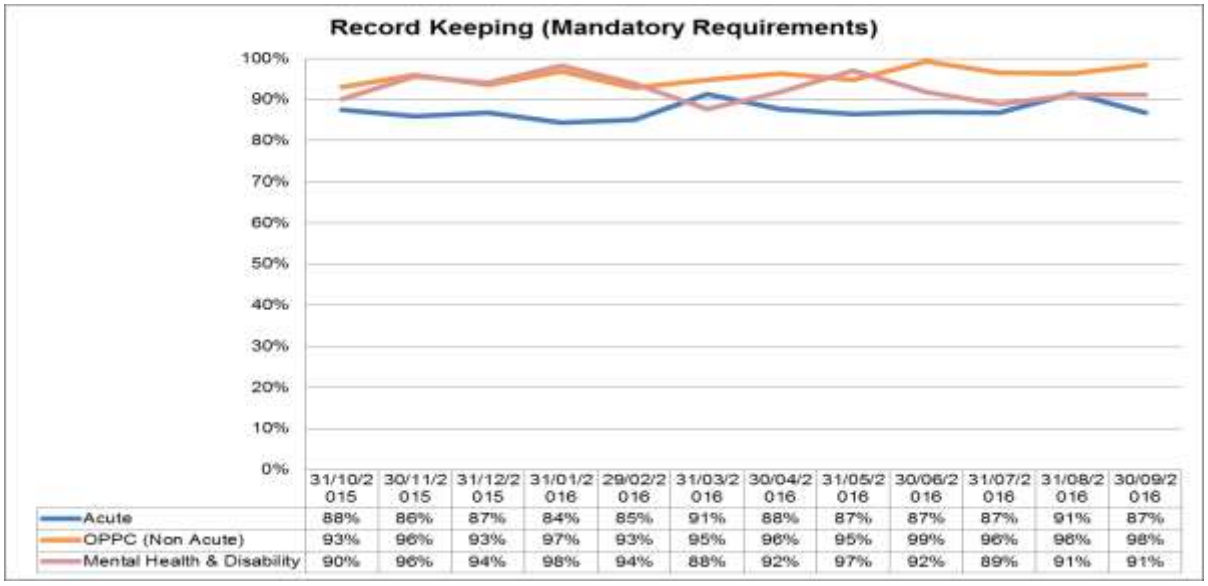
*Blank = no record in kardex that a medicine, including a critical medicine, had been administered at the prescribed time. This does not necessarily mean the medicine was not administered only that it was not recorded as being administered.

In the last 12 month period 5 out of a total of 6,584 [0.01%] prescribed *critical* medicines were recorded as 'Blank'; 4 were in the Acute Directorate, 1 in OPPC and 0 in MHD. There is a variety of reasons why a medicine may not have been administered, such as the patient was fasting, a new medicine was recently prescribed or the medicine was not

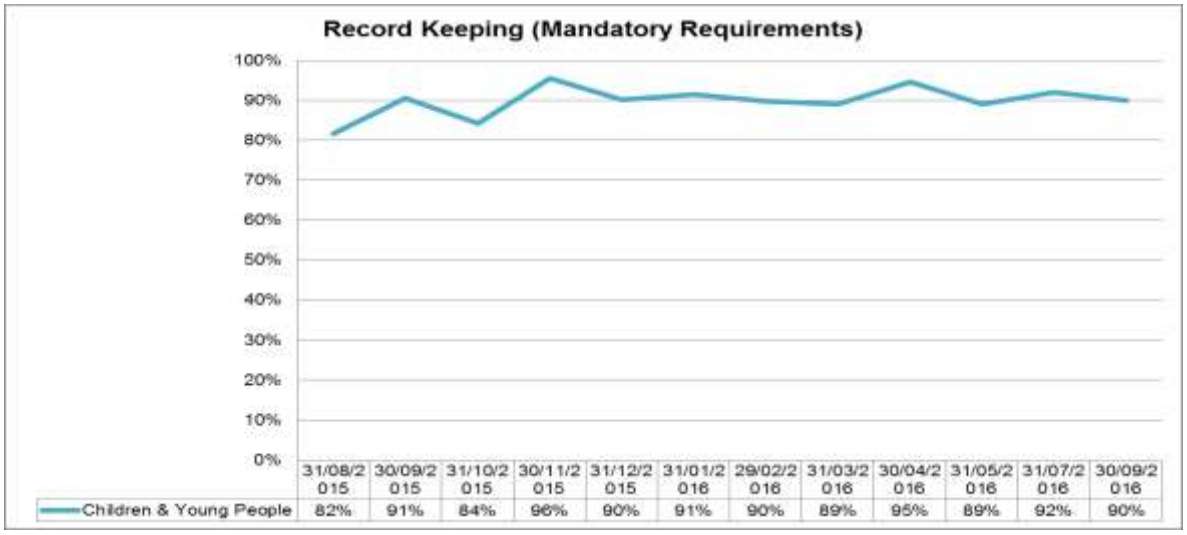
available on the wards.

3.8 *NQI 6 - Recording Care : Evidencing Safe and Effective Care*

Recording care is an important element in evidencing safe and effective nursing care and is a skill and activity which the profession is constantly promoting and improving on. Over the past year the average Trust compliance with mandatory record keeping standards in Acute, Non-acute and MHD adult in-patient areas was 91%.



	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016
Acute	88%	86%	87%	84%	85%	91%	88%	87%	87%	87%	91%	87%
OPPC (Non Acute)	93%	96%	93%	97%	93%	95%	96%	95%	99%	96%	96%	98%
Mental Health & Disability	90%	96%	94%	98%	94%	88%	92%	97%	92%	89%	91%	91%



	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	31/07/2016	30/09/2016
Children & Young People	82%	91%	84%	96%	90%	91%	90%	89%	95%	89%	92%	90%

The record keeping audit tools for adult and children's nursing differ and therefore cannot be compared against each other. CYP has scored an average of 90%.

The draft paediatric PEWS charts continue to be used within the Children's Wards. SHSCT CYPS comments in relation to the draft PEWS charts have been shared with the Regional Working Group. CYPS are awaiting the outcome of the collation of all regional comments and suggested amendments to the PEWS charts.

3.9 To support improvement in record keeping the EDN identified funding for the temporary

secondment of a Professional Development Facilitator. The Facilitator's role is to promoting a positive recording keeping culture amongst nurses that reflects the delivery of person-centred care and compliance with good recording keeping practices. Southern Trust Lead Nurses developed and tested a person-centred recording framework, known as the PACE (Patient-centre, Assessment, Nursing Care and Evaluation) Framework and the Facilitator is leading the rollout of the PACE Framework across the Acute Directorate. The Framework has been successful in supporting the recording of person-centred care and the other HSC Trusts are now testing the Framework with a view to rollout within their organisations.

3.10 A regional **r**ecord keeping competency framework and self-assessment tool has been developed to support Health Care Support Workers (HCSWs) in recording care and will now be tested across all Trusts prior to full implementation.

3.11 NQI 8 - Professionalism - NMC Revalidation and Nurse Supervision

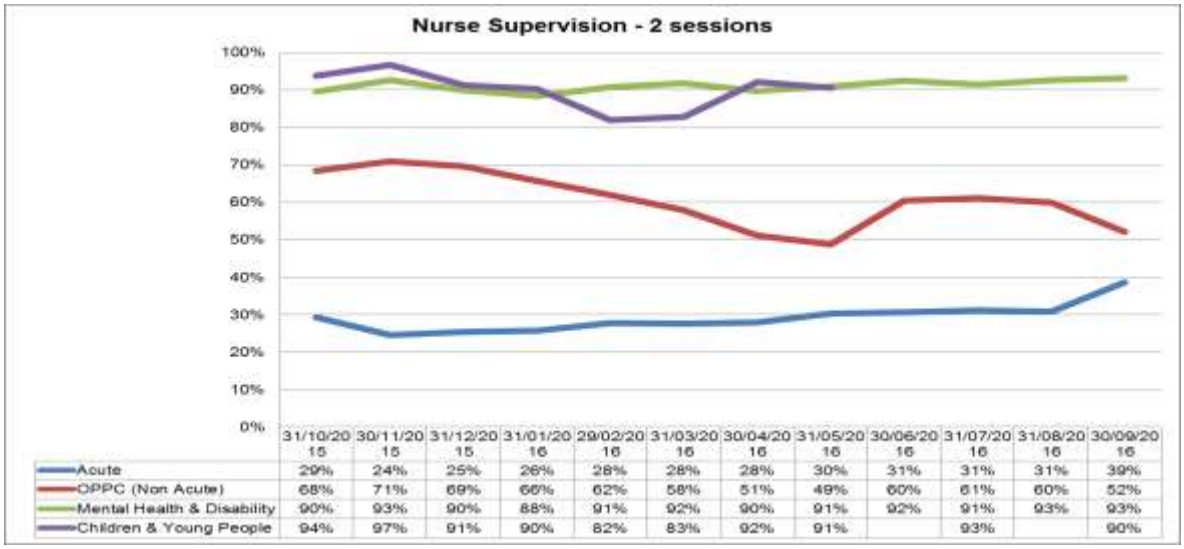
NMC Revalidation

The Nursing and Midwifery Council's (NMC) revised revalidation arrangements for registered nurses and midwives came in to effect in April 2016 and includes a number of additional elements designed to improve public protection and ensure that nurses and midwives remain fit to practise throughout their careers.

The Trust has put supportive arrangements in place to ensure organisational and registrant readiness for implementation of the additional criteria. This has included support provided by the Nursing Governance Co-ordinators and a Revalidation Support Team. The development of a database provides monthly reports to managers on those nurses and midwives who are due to revalidate and / or pay their annual fee. Since April 2016, excluding those who had been granted an extension, all but 3 of 727 (99.6%) registrants have revalidated / paid their annual fee on time. On the occasions where the 3 registrants did not revalidate / pay their annual fee on time their name was removed from the register until they satisfy the NMC's requirements.

3.12 ***Nurse Supervision***

The ST's Policy on Nurse Supervision requires that all registered nurses are able to avail of two sessions of professional supervision per year.



	31/10/20 15	30/11/20 15	31/12/20 15	31/01/20 16	29/02/20 16	31/03/20 16	30/04/20 16	31/05/20 16	30/06/20 16	31/07/20 16	31/08/20 16	30/09/20 16
Acute	29%	24%	25%	26%	28%	28%	28%	30%	31%	31%	31%	39%
OPPC (Non Acute)	68%	71%	69%	66%	62%	58%	51%	49%	60%	61%	60%	52%
Mental Health & Disability	90%	93%	90%	88%	91%	92%	90%	91%	92%	91%	93%	93%
Children & Young People	94%	97%	91%	90%	82%	83%	92%	91%		93%		90%

Ensuring nurses can access two supervision sessions has been a challenge in all directorates, particularly Acute. However, given the NMC's review of statutory supervision in midwifery, the CNO is also undertaking a review of the regional Nurse Supervision Policy. Recording and discussing reflections on practice is now a core component of revalidation and it is expected that this requirement will support and encourage better compliance with the nurse supervision policy.

3.13 *NQI 9 - Preceptorship*

Preceptorship is: 'a period of structured transition for the Preceptee during which he/she will be supported by a Preceptor, to develop confidence as an autonomous professional, refine skills, values, attitudes and behaviours and to continue on a journey of lifelong learning' (adapted from Department of Health (DoH), 2010). The programme is 26 weeks duration and is co-delivered by Clinical Education Centre and the Practice Education Team.

The table below provides an overview of activity April 2016 to September 2016:

Number of Programmes due to complete April 2016-September 2016	Number of Registrants due to complete a programme* April 2016-September 2016	Registrants indicated as having completed Programme	Reason for non-completion	Number of Preceptorship Programmes commenced April 2016-September 2016	On target to complete Programme within 26 week timescale
8	113	79	Left Trust (6) Long term sick/maternity leave (4) Withdrew as not a new registrant (1) Awaiting confirmation from line manager of completion of programme (23)	3	23 (x1 on sick leave)

*These programmes commenced prior to April 2016

3.14 *NQI 10 - Delivering Care (Normative Staffing)*

Progress regarding implementation of Delivering Care across all phases is set out as follows:

Phase 1 (Acute medical and surgical wards)

Bi-annual reporting regarding compliance for this phase of Delivering Care continues with the most recent report submitted for the reporting period April 2016 to September 2016. Additional funding was received to convert 15WTE Band 5 posts to Band 6 posts within acute medical wards, and staff are in post or due to commence imminently. The requirement for Ward Sisters/Charge Nurses to be 100% supervisory is being achieved across all acute surgical wards, however, the majority of acute medical wards are unable to achieve this standard.

Phase 2 (Emergency Departments)

Finalisation of the Emergency Department staffing model is in progress, with an expectation that this will be agreed pre-Christmas 2016.

Key elements of this model include senior staffing requirements (Band 6 or Band 7) across the 24 hour period, which will ensure that all key areas of the ED have an experienced nurse to provide expert clinical knowledge at all times, to ensure that patient pathways function seamlessly throughout the department to improve patient safety and enhance their experience in the department.

Phase 3 (District Nursing)

Development and agreement regarding a model for District Nursing remains challenging. Following a regional data collection exercise and analysis of the Hurst Model a draft summary paper based on 24 hour provision of care has been developed, recognising that this requires further analysis and refinement for registered skill mix, the supervisory role and palliative care key worker role. There are ongoing discussions to develop an IT tool to support caseloads and staff utilisation. The region is currently considering the Buurtzorg (Netherlands) model, and potential application to the Northern Ireland context.

Phase 4 (Health Visiting)

A summary paper was completed in September 2016, with a proposed caseload forming the model for Health Visiting, with the focus on 0-4 year olds to carry out the 3 core functions of the health visiting service.

Phase 5 (Mental Health)

This phase will commence December 2016.

4.0 *NMC Standards to Support Learning and Assessment in Practice*

Mentor Register (EiMs Electronic Register)

Current Mentorship Statistics

SHSCT for the reporting timeframe have 898 mentors who are currently available to mentor students.

Table 1 below provides further detail and Table 2 provides this information per Directorate/Divisions.

Table 1: SHSCT Mentor Statistics

	Available	Unavailable*	Total Number
Mentors	503	242	**745**
Sign-off mentors	380	181	**561**
Practice Teachers	15	8	**23**
TOTALS	**898**	**431**	**1329**

*Unavailable due to mentor criteria lapsed, leave reason, action plan in progress. The Practice Education Team continue to work with Ward Sisters/Charge Nurses/Team Leaders to maximise the availability of mentors, which is of paramount importance moving forwards due to the increased number of students from September 2016.

Table 2: Mentor Statistics per Directorate/Division*

Directorate / Division	Number of Mentors	Number of Sign-off Mentors	Number of Practice Teachers	Total
Acute: MUSC	130	105	0	**235**
Acute: ATICS & SEC	154	132	0	**286**
Acute: IMWH & CCS	20	123	0	**143**
CYPS	161	52	11	**224**
OPPC	151	76	7	**234**
MHLD	129	73	5	**207**
Totals	**745**	**561**	**23**	**1329**

Student Capacity

Number of practice areas approved for student placements	Number of educational audits carried out in past 6 months	Max. number of students that can be accommodated at any one time

141	66	358

Due to ongoing requirements to increase practice placements, the Practice Education Team continually work with service colleagues to scope placement capacity. A regional Task and Finish Group has been established to ensure consistency and continuity across Trusts regarding capacity of practice placements. The regional Practice Placement Agreement is being updated by DoH and Trusts to facilitate student placements for individuals on the Open University Pre-Registration Nursing Programme employed by the independent sector.

Mentors/Sign-off Mentors/Practice teachers CPD Activity

The Practice Education Team facilitates a number of programmes and updates for mentors, sign-off mentors and Practice Teachers throughout the year, which are Nursing and Midwifery Council requirements. CPD activity statistics can be viewed below:

Programme/Activity Title	Number of programmes/sessions facilitated April 2016 – Sept 2016	Number of mentors/SoM/PT who completed the programme/activity/added to mentor register
Mentorship Preparation Programme/APEL	1	125/2
Nursing and Midwifery annual update	45	592
Triennial reviews	N/A	92
Progression to sign-off mentor status programme	1	30
Model of support	1	22
Supervising mentor preparation programme	1	2
Practice Teacher Forum	1	12

Challenges in Practice Placements

The challenge of time for mentoring nursing and midwifery students continues, in particular the required 1 hour protected time per week for sign-off mentors with final placement students (NMC, 2008). A re-audit in August 2016 demonstrated that progress has been made since the previous audit in 2015, although the Trust remains not fully compliant. An action plan has been updated as a result.

5.0 *Advanced Nurse Practitioner Programme*

As previously reported DoH has confirmed financial support for the training fees for 20-25 nurses regionally to commence an Advanced Nursing Practice Programme. The initial

focus will be for Paediatric and Emergency Department settings.

SHSCT has contributed to the on-going debate regarding the development of this role over recent years and is currently represented on the Curriculum Planning Group with Ulster University. It is anticipated that the first programme will commence February 2017.

6.0 *Consultant Nurses and Midwives Framework*

A regional work-stream has reviewed the role of Nurse and Midwife Consultants in NI. Draft professional guidance for these Consultant roles has been developed and will be circulated on completion. The four core competencies will complement other generic competency frameworks which are relevant to the Consultant Nurse and Consultant Midwife roles, such as Knowledge and Skills Framework (DH, 2004); Healthcare Leadership Model (NHS Leadership Academy 2013); Attributes Framework (DoH, 2016).

7.0 *Post –registration Nursing and Midwifery Education Commissioning 2015-2016*

The Trust continues to conduct annual learning needs analysis for Registrants and works closely with the DoH to secure funding for those education programmes that are necessary for the nursing and midwifery workforce to continue to deliver a high standard of care. The financial constraints on this budget for the academic year September 2016 -2017 have continued, with only a limited number of courses inside and outside Northern Ireland being funded.

It has been communicated that the ongoing financial constraints in the nursing and midwifery workforce education budget will continue for 2017-2018. In order to make best use of resources the Trust have been asked to identify priorities for training for 2017-2018 and further scoping will commence shortly regarding identifying relevant education programmes.

8.0 *Clinical Education Centre (CEC)*

Southern Trust continues to fully utilise the Service Level Agreement (SLA) with the CEC. For the period March 2016 to September 2016, the utilisation was 76.46%. Further information will be submitted as part of the EDoN end of year report.

ADD SECTION re First Trust N&M Induction Programme

The first Trust-wide Nursing and Midwifery Induction Programme commenced October 2016, with 70 new staff attending. The introduction of the programme aims to have positive benefits for the Trust in terms of recruitment and retention. The programme will run over a period of 3-4 weeks (part-time attendance) and includes corporate and professional induction, mandatory training, a range of e-learning, and commencement on the Trust's Preceptorship programme for new registrants. Whilst the core induction programme will be delivered for all new staff, a variety of elements will be added for branch-specific nurses.

9.0 *Rotation Programme*

A rotational programme was introduced into the Acute Directorate in April 2015 as previously reported. The second cohort of 6 new registrants commenced the programme in October 2016. These staff will have the opportunity to work in three clinical areas over the next twelve months giving them an opportunity to consolidate their knowledge and skills as well as develop further skills in different care environments.

10.0 *Open University Nursing Programme (OU PRNP)*

This programme is available to Trust staff, and is a 4 year, part-time, work based programme for entry to the nursing profession (adult and mental health branches only). A total of 39 staff are currently undertaking the nursing programme, years 1 to 4.

Innovation in Delivery of the OU PRNP

Since September 2015 SHSCT, in partnership with the OU and DoH, have explored ways of increasing access to the programme for staff. A new model was implemented which facilitated 7 staff to complete the first two modules of the nursing programme as a stand-alone arrangement, and these staff have now commenced Year 2 of the programme in September 2016. This model has been replicated for September 2016, with a further 5 staff completing the first two modules of the nursing programme as a stand-alone arrangement. These 5 staff will commence stage 2 of the programme in September 2017.

In addition, SHSCT have commenced a further 15 staff onto Year 1 of the programme commencing September 2016, as a result of a realignment of backfill funding to additional places.

11.0 Cause for Celebration

Dawn Ferguson, Nursing Workforce and Education Coordinator, completed an MSc Developing Practice in Healthcare and has been awarded the University of Ulster's Mona Grey Award for Excellence in Post-Registration Research. Her dissertation was a qualitative study examining new registrants' views of a Preceptorship Programme during their transition year from student nurse/midwife to registrant.

12.0 Recruitment

The recognition of the insufficient supply of Registered Nurses across the province continues to be recognised, and nursing remains on the UK Shortage Occupation List.

12.1 International

Within the reporting timeframe of this report, six international recruitment campaigns have been conducted for the five H&SC Trusts in NI:

EU

1. May: Romania and Italy
2. June: Italy

3. October: Greece and Italy

Non-EU

4. Philippines: May, August and September.

All international recruits will be employed initially as Bank 3 Nursing Assistants pending registration with the NMC, in line with the arrangements for locally trained nurses.

On 16th September 2016 a group of 11 nurses from Italy arrived in the Trust, and are working across CAH and LH in acute medicine and non-acute. These staff are currently being supported to achieve NMC registration through a face to face English programme, in order to meet the Nursing and Midwifery requirements to achieve IELTS (International English Language Testing) at Level 7 across all domains. This programme is being delivered as part of a regional and local induction programme in partnership with the Clinical Education Centre.

Overview Update on All Offers (Regional)

To date there are currently 67 active offers from EU campaigns, and 724 offers from the Philippines. The current status of offers by Trust is detailed below:

Status of Offers	Northern	Belfast	Southern	Western	South Eastern	HSC [1]	Grand Total
Withdrawn / Offer Revoked	4	7	3	10	3	2	29
Pre-employment Checks in Progress	83	92	94	103	136	229	737
Started as Band 3	0	3	11	10	1		25
Total Offers	**87**	**102**	**108**	**123**	**140**	**231**	**791**
For those at Pre-employment checks							
Target Arrival Date In place	13	17	12	4	20		66

[1] *These are offers not yet allocated to any Trust. Allocations will be made once the appointees are nearing arrival. Any imbalances across Trusts will be rectified using this group of appointees.*

As previously reported, the arrivals date for EU campaigns can be identified almost immediately following interview, however the time from arrival to entry onto the NMC register is difficult to predict due to the individual requiring to obtain IELTS Level 7. The non EU timeframe for arrivals ranges between 7-14 months, with the majority anticipated around 10 months post-interview.

12.2 Local

Recommendations from the CNMAC Report (2015) relating to local recruitment approaches have been progressed through the regional Working Group and includes:

- More regular engagement with the student body across all local universities by Trust staff. The five Trusts are actioning this as a collaborative arrangement;
- All Trusts have initiated 'open' adverts on HSCRecruit;
- Job offers are now made to Year 3 students by all Trusts;
- Attending jobs fairs:
- The Working Group also has representation from the Recruitment Shared Service

Centre and is working to improve the recruitment experience for students and other applicants.

In addition, SHSCT has also progressed the following actions:

- Offers of posts to Year 2 students;
- Conducting 'one-stop-shops', with an interview conducted, decision given, pre-employment checks and Occupational Health checks commenced on the one day for all applicants. The October 2015 event resulted in 156 people interviewed, with 153 people successful. Of these 153, 107 have commenced in post. The next 'one-stop-shop' is planned for 25th November 2016;
- Streamlining of application and interview processes;
- Enhanced engagement with students throughout their placements in SHSCT, but particularly whilst on Placement 9 (management placement).

Following approval by SMT , a non-nursing support role, such as administration support or a housekeeping role, will be piloted to March 2017 and the impact on releasing nursing time will be evaluated.

13.0 *Conclusion*

This report provides a summary of a range of high quality, person-centred care being provided by nurses and midwives in the Southern Trust. Audits of the quality nursing care have shown incremental improvement in adherence to core nursing processes and action plans are being implemented to ensure quality improvements. Senior nurses are working to embed the NQI Framework and it is anticipated that outputs from these audits will be available for the next report. Community Nursing and Midwifery teams are also working to identify those indicators which would best evidence compliance with agreed quality standards in their area of care. The Trust has put in place arrangements to support the implementation of the new NMC revalidation arrangements which supports professional reflections and enhances practice. These arrangements are now well-embedded and success reflected in the 99.6% revalidation rate since the new arrangement came into effect in April 2016.

The report specifies the challenges the Trust is facing in securing and ensuring a sufficient nursing workforce both now and over the next number of years.

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 26 October 2016 @ 2pm in the Boardroom, Trust Headquarters

Present:	Francis Rice
	Dr Wright
	Stephen McNally
	Esther Gishkori
	Geraldine Maguire (for Paul Morgan)
	Bryce McMurray
	Vivienne Toal
	Angela McVeigh
	Geraldine Maguire (for Paul Morgan)
	Lesley Leeman (for Aldrina Magwood)
	Margaret Marshall
	Jane McKimm
	Elaine Wright (Notes)
Apologies:	Aldrina Magwood
	Paul Morgan

ITEM	NOTE	ACTION
Integrated Transport Policy		

Members welcomed Mr Michael Deery to the meeting to brief members on the Integrated Passenger Transport Project. Mr Crilly and Mr Collins were also in attendance.

Mr Crilly introduced the background to the new policy and asked Mr Deery to bring members up to date with developments. Mr Deery outlined the key drivers for change and advised that the Southern Trust was the first Trust to conduct a pilot of the new arrangements which was in the Dungannon area. As a result of the Pilot the SHSCT has been chosen to test public passenger transport integration and will work with the key stakeholders namely DFI, Education Authority, Community Transport, Translink and the Consumer Council, with a view to commencing the further Pilot in the autumn 2017.

This pilot will allow the Trust to shape and influence the project moving forward and this will present a different approach to transport use than that which the Trust is currently delivering. Members noted that the key next step is stakeholder/user engagement. Members acknowledged this was an ambitious plan and it was hoped the early benefits of changing will be seen late in 2017. Members agreed that local communication is vital to the process and Trade Union involvement crucial. Mr Crilly agreed to provide written updates to SMT. Members thanks Mr Crilly, Mr Collins and Mr Deery for their attendance.		
1	APOLOGIES Apologies were received from Aldrina Magwood and Paul Morgan.	
2	CORPORATE GOVERNANCE 2.1 Corporate Risk Register Members considered the Corporate Risk Register and discussed items for inclusion/removal. The Register will be further updated and shared with members again for final approval prior to the Governance Committee Meeting.	
3	CLINICAL AND SOCIAL CARE GOVERNANCE 3.1 Safety Culture Questionnaire – Key Findings (for information and more detailed discussion at next SMT Governance Meeting) Mrs Marshall referred members to the Safety Culture Questionnaire and highlighted the key findings. Members were informed that specific Directorate data can be themed accordingly. Mrs Marshall agreed to link with Mrs Toal in respect of linkages with the Raising Concerns discussions. It was agreed to bring back to SMT. 3.2 Progress report on Review of Adverse Incident Project – (for approval of workstreams) Mrs Marshall shared the progress report on the Review	*Mrs Marshall/ Mrs Toal*

	of Adverse Incidents and sought member's approval. She advised that the first meeting is planned for Friday 28 October 2016. Following consideration, SMT members approved the direction of travel outlined and noted that junior Medical Staff/Trainees had been involved in the project. 3.3 Mortality and Morbidity Outstanding Reviews – Update on Position Members referred to the Mortality & Morbidity report in relation to outstanding reviews. Members agreed to sign off those outstanding reviews which are not subject to or open to an SAI procedure. Mrs Marshall updated on progress of the M&M system. 3.4 Quality 2020 report (for final approval) Members reviewed the Quality 2020 Report and approval was given to forward to the Department. Mrs Marshall undertook to submit. 3.5 Circular from DHSSPS: Never Events (for information) Members referred to the Departmental Circular advising that statistics in relation to 'never events' are now going to be collected.	*Approved* *Mrs Marshall to submit to Department*
4	BEHAVIOURAL INSIGHT TEAM PRESENTATION Members welcomed the Behavioural Insight Team from the Cabinet Office to the meeting. The Team spoke to members about different behaviours of people and the importance of how people do behave rather than how they should behave and the process of thinking differently. The Team gave various examples to assist to highlight the process of how we think and the impact and influence this has on what we can deliver.	
5	PROFESSIONAL GOVERNANCE	

	Mrs McVeigh referred to the ongoing developments in Overseas Nurse Recruitment and it was agreed to invite Lynn Fee, Karyn Patterson & Iain Gough to the SMT Meeting on 2 November 2016 to give a presentation on developments to date.	*SMT 2 November 2017*
6	FINANCIAL GOVERNANCE 6.1 Feedback from Audit Committee Mr McNally encouraged members to ensure outstanding audits are cleared and up to date. Discussion took place how best to keep a handle on the process and it was agreed to discuss at all future Directorate Accountability Meetings and Mrs Magwood to place on forthcoming agenda's.	*Mrs Magwood Future Accountability Meetings*
7	APPROVAL OF PREVIOUS SMT NOTES The SMT notes for the meetings held on 14 September and 12 October 2016 were approved by members.	*Approved*
8	MENTAL CAPACITY ACT (NI) 2016 – Serious Interventions & Treatment with Serious Consequences Mr McMurray referred to the Mental Capacity Act (NI) 2016 and undertook to follow up as representation is required from all areas.	
9	PERFORMANCE DISCUSSION Members discussed in detail the Trust performance in advance of Trust Board on 27 October 2016. Each Director outlined their specific issues and action to progress. Mr McNally undertook to bring to SMT on 2 November a paper on Waiting List Initiatives.	*SMT 2 November 16*
10	ANY OTHER BUSINESS 10.1 Hello My Name Is Campaign	

	Mrs McVeigh highlighted to members a range of activities which are taking place to focus on the Hello My Name is Campaign. She advised members that as part of the ongoing work in the Patient Client Experience work plan 2016/2017 we continue to endorse the Hello my name *is* campaign which was commenced by the late Dr Kate Granger, as a way of way of reminding staff of the importance of introductions to each patient /client. Hello my name is campaign was launched in NI in September 2014. Kate passed away on 23 July 2016, following a five year illness with terminal cancer. It was agreed at the Patient/Client Steering group on 12 September 2016 that we would refresh the Hello my name is campaign, as a way of remembering Kate and celebrating her inspirational work. It was agreed it would be a fitting tribute to plan this for 31st October 2016 on what would have been Kate's 35th birthday. Members endorsed this good work. 10.2 Ministerial Engagement – Bengoa Members were informed that Minister O'Neil has indicated her intention to come to the Southern Trust on Thursday 27 October 2016 to meet with staff regarding the launch of the Bengoa Report. Communications will co-ordinate arrangements and members asked for nominations.	
11	DATE OF NEXT MEETING Wednesday 2 November 2016	

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Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 3 August 2016 @ 2.00 pm in the Boardroom, Trust Headquarters

Present: Francis Rice (Chair)
Aldrina Magwood
Angela McVeigh
Stephen McNally
Kieran Donaghy
Bryce McMurray
Dr Wright
Margaret Marshall (for SMT Governance)
Colm McCafferty (for Paul Morgan)
Helen O'Neill (for SMT Business item re Demography Funding)
Jane McKimm
Jennifer Comac (Notes)

Apologies: Paul Morgan
Esther Gishkori

ITEM	NOTE	ACTION
	SMT GOVERNANCE	
1	**APOLOGIES** Apologies were received from Mr Paul Morgan and Mrs Esther Gishkori.	
2	**CLINICAL AND SOCIAL CARE GOVERNANCE** ➢ **Review of Adverse Incident Processes – Paper for Discussion and Approval** Mrs Marshall spoke to the above paper and members discussed same. Mrs Marshall asked members if they would be in agreement to start with a baseline and if so then an evidence based	

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	staff survey on attitudes to incident reporting and subsequent learning has been developed and is ready to go out on survey monkey. Members agreed. Some members noted their concerns over the resources needed within individual Directorates to progress with this work. The Chief Executive asked Mrs Marshall to bring a proposal to SMT regarding resources needed once the project is up and running. ➢ **Mortality and Morbidity Outstanding Reviews** Dr Wright updated members and advised that the reporting process for Child Deaths has changed since February 2016 and this is working well. He added that 4 cases are still awaiting discussion and there are 18 cases in total. Dr Wright also advised members that in relation to adult deaths, there was a challenge in getting historical cases reviewed. He informed members that there is a new process in place and as at 1st August the number outstanding has been reduced by 55 to just under 400. Dr Wright concluded by advising that the Trust hopes by 1st November 2016 to only have cases within the last 12 weeks as outstanding. ➢ **Quality 2020 Report** Mrs Marshall briefed members and advised that Directorates were engaging well. She hopes to present a first draft to SMT at the beginning of September.	***Mrs Marshall*** ***Mrs Marshall***

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	➢ **Clinical Social Care Governance Internal Audits September-December: Adverse Incidents; Risk Management; Culture** Mrs Marshall spoke to the above and advised members that she will be communicating with Directorates in relation to the Adverse Incidents and Culture Audits. Mrs Marshall also advised members that the Risk Management audit has been postponed until further notice. ➢ **Formal Complaints – Categorisation Pilot** Mrs Marshall briefed members and advised that the Trust had made direct links with the London School of Economics. She added that the Trust has been picked as a test site and that a meeting has been scheduled for September with four other Trusts who are also taking part. ➢ **Ombudsman's Annual Report** Mrs Marshall advised members that the Chief Executive and herself will be meeting with the Ombudsman on 16 August 2016 to discuss the Annual Report. Mrs Marshall added that the report highlighted two areas in relation to the Trust – 1) Trust providing conflicting information; 2) General delays in getting information from the Trust within the Ombudsman's specified timescales. Mrs Marshall also advised members that the Ombudsman's legislation now includes Social Work complaints. Mrs Marshall asked members if they had any issues which they wanted raised at the meeting to forward these to her.	***Mrs Marshall*** ***All Members / Mrs Marshall***

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	➢ **MLA complaints flow chart** Mrs Marshall spoke to the above and members discussed in detail. The Chief Executive asked Mrs Marshall to ascertain what other Trust's do in relation to the response time i.e. 10 days or 20 days and in the meantime keep to 10 days on the flow chart.	***Mrs Marshall***
3	**PROFESSIONAL GOVERNANCE** ➢ **News Regional Audit Results** Dr Wright spoke to the above and advised members that the report was very impressive. The Chief Executive asked Mrs Marshall to bring to Governance Committee for information. ➢ **Minimum dataset for a Post Falls Review and the Falls Shared Learning Template** Mrs Marshall advised members that the PHA and HSCB decided that Trust's would no longer have to record all falls as SAI's. She added that the regional group set a minimum dataset and the PHA would hold the information and collate learning from any trends. Mrs Marshall said she would have concerns with the information going directly to the PHA as the Trust would have no corporate record and asked members if they would be in agreement for the information to come through the Trust as normal and then we would record prior to sending to the PHA. Members agreed.	***Mrs Marshall***
4	**INFORMATION GOVERNANCE** ➢ **Roles of Data Controller and Data Processor – BSO Hosted Systems**	

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	Mrs Magwood spoke to the above paper and members discussed. Mrs Magwood highlighted the recommendation that a written contract is put in place clarifying the Data Controller and Data Processor responsibility for shared regional patient record (NIECR) and BSO hosted systems.	
5	**FINANCIAL GOVERNANCE** There was no specific business to raise.	
	SMT BUSINESS	
1	**NOTES OF PREVIOUS MEETING** The notes of the previous meeting held on 20 July 2016 were approved by members.	***Approved***
2	**CHIEF EXECUTIVE BUSINESS** **2.1 Pam Plan 16/17** The Chief Executive advised members that the above had to be completed by 1st August 2016. Members raised the wording surrounding the use of Skeagh House and the Chief Executive advised that the Trust will have an opportunity to amend the plan once it is returned. **2.2 Letter re Cancer Peer Review Visit** Dr Wright advised members on the issue regarding upper gastrointestinal cancer surgery. He advised that the Trust's outpatients are doing very well but that the external review has suggested that one in patient centre would be better. Dr Wright added that he feels the Trust will have difficulty justifying keeping on this site. The Chief Executive asked Dr Wright to talk to Ms Gishkori and report back to SMT.	***Dr Wright***

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3	**MOBILE CT SCANNER** Dr Wright advised that the Mobile CT Scanner had now gone.	
4	**ALLOCATION OF DEMOGRAPHY FUNDING** Ms O'Neill tabled a paper re allocation of demography funding and members discussed in detail. Members re-prioritised the list provided by Ms O'Neill and the Chief Executive asked members to look at this list again within their Directorate, look at the impact on TDP and also the ability to spend. He asked that members come to SMT next week with their resolved positions.	***All Members***
5	**GUIDING PRINCIPLES TO ENABLE EFFECTIVE DISCHARGE PLANNING FOR ADULTS** Mrs McVeigh spoke to the above and members noted same.	
6	**CAPITAL BUSINESS CASE – OAKRIDGE POD** Mr McMurray spoke to the above. Mr Donaghy raised concerns over availability of Estates staff to complete this work. The Chief Executive advised that SMT would approve in principle but that further discussions were needed with Estates in relation to availability of staff to ensure the work is completed.	***Mr McMurray/ Mr Donaghy***
7	**SHO BANDING FOR AUGUST** Dr Wright briefed members on the above. The Chief Executive asked that this was included in discussions under Demography Funding.	

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8	**ANY OTHER BUSINESS** Organisational Charts – the Chief Executive advised that these needed updated and asked Mrs McKimm to co-ordinate same. Strictly Come Dancing – The Chief Executive advised that £52,000 has been raised to date for Strictly and that a photograph is planned for next Wednesday to publicise same. Slippage – Mr McNally briefed members and advised that he is meeting with Paul Cummings on 12th August re same.	***Mrs McKimm***
9	**DATE OF NEXT MEETING** **The next SMT Meeting will be held on Wednesday 10 August 2016 at 2pm in the Boardroom, Trust HQ.**	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 5 October 2016 @ 2pm in the Boardroom, Trust Headquarters

Present: Francis Rice
Dr Wright
Stephen McNally
Esther Gishkori
Paul Morgan
Aldrina Magwood
Bryce McMurray
Vivienne Toal
Brian Beattie (for Angela McVeigh)
Ruth Rogers
Elaine Wright (Notes)

Apologies: Angela McVeigh

ITEM	NOTE	ACTION
	Des O'Loan, Assistant Director of eHealth **Review of OBC – Options & Benefits** In attendance: Dr Mark Roberts & Mrs Siobhan Hanna. Members welcomed Mr Des O'Loan to the meeting. Mr O'Loan updated members on the development of the Business Case for eHealth, providing an overview of the work to date along with a vision and scope for the future development. Discussion took place regarding the recent workshop and the outcomes flowing from it. Mrs Magwood confirmed that the Trust had written to Sean Donaghy confirming our identified lead and advising of the Trusts internal arrangements. Members thanked Mr O'Loan for his attendance.	

1	**APOLOGIES** There were no apologies.	
2	**NOTES OF PREVIOUS MEETING** The notes of the meetings held on 21 & 28 September 2016 were approved.	***Approved***
3	**CHIEF EXECUTIVE BUSINESS** The Chief Executive informed members that the Bengoa Report was being tabled at Assembly on 25 October 2016. Members were reminded that within the HR Framework, Trust are to continue to seek Departmental approval for recruitment at Band 8C and above.	
4	**STRATEGIC PLANNING** **4.1SI Unscheduled Care – Winter Pressures** Members noted that the Resilience Plan had been submitted and this would be kept on future SMT agenda's for further discussion. **4.2 Radiology On-Call & Regional Network Reporting – *Dr David Gracey*** The Chief Executive thanked Dr Gracey for attending SMT today to further discuss the Radiology On-Call arrangements and the Regional Network reporting. Dr Gracey outlined the current demands on the on-call system in terms of staffing, governance and safety issues. He outlined the current available options with regards to outsourcing and discussion took place at length with regard to the feasibility, impact upon Trust staff in terms of working day and providing cover for shifts. Members agreed that this was the right approach to take and further work and discussion is needed with regard to the finer detail.	***Future SMT Agenda***

	The Chief Executive referred to the Radiology Regional Reporting Network and members noted that this was a Royal College Initiative. Members thanked Dr Gracey for his attendance at SMT.	
5	**FINANCIAL PLAN** **5.1 Proposals to Re-inforce the Delegated Financial Responsibilities of Staff** Mr McNally referred to the briefing prepared as a follow up to discussions at last week's SMT. Members noted the content and responsibilities.	
6	**FOR APPROVAL** **6.1 IPT Bereavement Midwife** Members noted the above IPT and discussed its content. Mrs Gishkori agreed to look take a closer look at the current arrangements. **6.2 Risk Assessment: Registration of Social Care Staff with NISCC** Mr Morgan highlighted to members the current low uptake in registration by Social Care Staff with NISCC. He advised that staff had been communicated with and asked members to remind staff and promote registration through operational lines. Mr Morgan advised that this would remain on his Directorate Risk Register. Completion of registration is to take place before the end of March 2017. To date only 20% of staff have registered.	***All***
7	**FOR NOTING/INFORMATION** **7.1 Workforce Monitoring Report** Mrs Toal drew member's attention to the Workforce Monitoring Report and discussion took place regarding the ability to get agency staff for block bookings. Members agreed the need to have a fuller discussion regarding the difficulties.	***Future SMT Meeting***

	7.2 Patient Safety Quality Improvement Plan Dr Wright referred members to the Patient Safety Quality Improvement Plan and members commended the work carried out. It was agreed that this should be integrated within the Trust processes and Dr Wright agreed to progress. **7.3 Mental Capacity Act** Mr McMurray advised members on the current position regarding the Mental Capacity Act and the intention to have a phased introduction. **7.4 Accelerated Access to IT** Mrs Magwood referred to the Accelerated Access to IT Process and advised that the Southern Trust is the only Trust taking the position of opting for option 7 which is to have a PC refresh only. Members agreed this as the Trust approach.	***Dr Wright***
8	**PERFORMANCE ISSUES** **8.1 Trust Board Performance Report** Members discussed in detail performance across the Trust and the need to take a deeper look now of all areas. It was agreed to conduct a cleanse/refresh process and come back with a recovery plan to SMT on 26 October 2016 for full discussion.	***SMT 26 October 2016***
9	**ANY OTHER BUSINESS** **9.1 Mid-Year Assurance Statement** The Chief Executive advised members that the revised version of the Mid-Year Assurance Statement had just been issued and shared with members. **9.2 Directorate SMT Meetings** The Chief Executive asked members if he could attend a forthcoming Directorate SMT Meeting and asked that dates are provided to Elaine.	***All – dates to Elaine***

	9.3 GP Boundary issue Mr Morgan raised an issue that had arisen within his Directorate with regards to GP Boundaries. Mr Morgan undertook to prepare a letter for staff and will share with members in advance for their approval and support. **9.4 Quality Improvement Event – 19 October 2016** Members noted the above all day event on Wednesday 19 October 2016. There will be no SMT on this date, unless by exception.	***Mr Morgan to draft letter for staff***
10	**DATE OF NEXT MEETING** **Wednesday 12 October 2016**	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 14 September 2016 @ 2pm in the Boardroom, Trust Headquarters

Present:

Francis Rice
Dr Wright
Stephen McNally
Angela McVeigh
Esther Gishkori
Paul Morgan
Aldrina Magwood
Bryce McMurray
Vivienne Toal
Elaine Wright (Notes)

ITEM	NOTE	ACTION
	Out of Hours Registrar cover in Radiology – Dr D Gracey Dr David Gracey attended the meeting to further discuss the Radiology Out of Hours Services, following discussions at a previous meeting. Dr Gracey outlined the current service and the issues which had led to the current position. The potential options for moving forward include a shift system, consultant first on call rota and outsourcing. Each option was considered and discussion took place regarding its potential. Members agreed that the current system is at risk and it was important to move forward. Dr Gracey undertook to further explore the potential to outsource the out of hours service and report back to members.	
1	**APOLOGIES** There were no apologies.	

2	**NOTES OF PREVIOUS MEETING** The notes of the meetings held on 7 September 2016 were approved with the amendment that Mr Gerard Rocks was in attendance.	***Approved***
3	**CHIEF EXECUTIVE BUSINESS** **3.1 Draft Trust Board Agenda's, 29 September 2016** Members considered the draft Trust Board Agendas and noted their content. **3.2 Medicines Optimisation Regional Efficiency Programme 2016/17, letter from Mr Pengelly dated 23 August 2016** The Chief Executive referred members to the above correspondence which was duly noted. **3.3 Controls Assurance Standards 2015-16/2016-17** The Controls Assurance Standards for 2015-16/2016-17 were noted and it was agreed that an action plan is tabled at SMT on 5 October 2016.	***SMT 5 October 2016***
4	**STRATEGIC PLANNING** **4.1 SI Unscheduled Care** Members agreed to discuss further at the next meeting the plan which is due for submission by 22 September 2016. **4.2 Waiting List Initiatives (SMT 7 September 2016)** Mr McNally referred to the above and members discussed the current position. **4.3 EHCR Event - Options and Benefits Workshop 23 Sept 16** Members noted the above correspondence and attendance at the workshop planned for 23 Sept 2016.	

5	**FINANCIAL PLAN** Mr McNally advised members that the budget report is due on Friday 16 September. He referred to the need for SMT members to be updated on the rules and regulations with regard to financial governance. It was agreed that Alison Rutherford and Fiona Jones attend the next SMT to present to members.	***SMT 21 September 2016***
6	**FOR APPROVAL** **6.1 Summary of Capital & Revenue Proposals greater than £300,000** Members noted the above summary report which will be tabled at the forthcoming Trust Board Meeting. Members approved the content and Mrs Magwood will streamline prior to submission to Trust Board. **6.2 Capital Update Paper** Mrs Magwood referred members to the Capital Update Paper and discussed its content. Members noted as outlined. **6.3 Capital Budget 2016/17 & forward planning** Members noted the Capital Budget paper for 2016/17 which updates on the current known position with regard to capital planning at regional level, and provides and initial stocktake of the changes to the internal process for approving 'general capital' allocations agreed by SMT from 1 April 2016. **6.4 October Monitoring: Capital, letter from Bill Pauley dated 6 September 2016** Members noted the above correspondence from Bill Pauley dated 6 September with regard to the October Monitoring Round. **6.5 Revised Capital Delegated Limits, letter from Bill Pauley dated 5 September 2016** The revised Capital Delegated Limits letter dated 5 September 2016 from Bill Pauley was noted by members.	***Trust Board/ Mrs Magwood***

	6.6 HSC Restructuring HR Framework Mrs Toal referred members to the HSC Restructuring HR Framework and sought comment by Friday, to allow a Trust response to be submitted. **6.7 Discussion/agreement on way forward re Commissioned Services by POC** Mr McMurray referred members to correspondence received from the Law Centre (NI) with regard to assessment processes for Children who are to transfer to Disability Adult Services. Mr McMurray advised that there will be potentially a number of similar cases. Members discussed the impact of the process and it was agreed that the Trust respond as requested and proceed to full assessment as noted in the letter. **6.8 IPTs** **– Paper** **- Summary of PHA IPTs** **- Additional Breast Screening Staff** Members noted the above IPT's and approval was granted. Mrs Magwood to clarify the available monies outlined on the Summary document. **6.9 Proposal: SIRO & Caldicott Training** Mrs Magwood shared with members the proposal for additional training in relation to SIRO and Caldicott. Members to advise of interest to Mrs Magwood. **6.10 Flu Vaccine Campaign** Members noted that the Trust target this year is 40%. A series of clinics have been arranged and an established network of flu champions in place to encourage and promote uptake. A letter will be issued to all front line staff within the next couple of weeks. This will be a standing item on future SMT Meetings.	***All/ Mrs Toal***

7	**FOR NOTING/INFORMATION** **7.1 Launch of CHKS i-Compare** Members noted the above information.	
8	**PERFORMANCE ISSUES** Members referred to the performance and potential list of discussion items.	
9	**ANY OTHER BUSINESS** **9.1 MLB Event: 30 September 2016** Members noted the forthcoming MLB Event planned for 30 September. It was confirmed that Mr Rocks would attend along with 2 Heads of Service. **9.2 PPI Annual Report** The PPI Annual Report will be presented to the next Patient & Client Experience Committee at the end of September 2016. **9.3 Mid-Year Performance Review** Mr McNally encouraged members to complete and finalise an outstanding internal audit recommendations.	***Mr Rocks plus 2 others to attend*** ***Next P&C Exp Committee*** ***All***
10	**DATE OF NEXT MEETING** **Wednesday 21 September 2016**	

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Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 28 September 2016 @ 2.00 pm in the Boardroom, Trust Headquarters

Present: Francis Rice (Chair)
Aldrina Magwood
Angela McVeigh
Stephen McNally
Vivienne Toal
Bryce McMurray
Dr Wright
Dr Tracey Boyce (for Esther Gishkori)
Barry Conway
Helen O'Neill
Alison Rutherford (for Financial Governance presentation)
Paul Morgan
Jane McKimm
Jennifer Comac (Notes)

Apologies: Esther Gishkori

ITEM	NOTE	ACTION
	Financial Governance Presentation – Alison Rutherford The Chief Executive welcomed Ms Rutherford to the meeting. Ms Rutherford presented the Trust Financial Governance Framework to members and briefed on the Trust's responsibilities and highlighted recent case examples of failures within the Trust. Members discussed in detail and the Chief Executive asked Ms Rutherford to document agreed actions to be tabled at next week's SMT meeting.	
1	**APOLOGIES** Apologies were received from Mrs Esther Gishkori.	
2	**NOTES OF PREVIOUS MEETING** The Chief Executive advised that the notes of the meeting held on 21 September 2016 would be tabled at	***Mrs J Comac***

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	SMT on 5 October 2016.	
3	**CHIEF EXECUTIVE BUSINESS** **3.1 Governance Committee Matters Arising** **Mr Rice spoke to the above and asked members to provide updates to Mrs S Judt.** **3.2 Q2020 Level 1 Attributes Framework** **The Chief Executive spoke to the above correspondence from Dr Eddie Rooney and asked Mrs Toal to co-ordinate response re nominations.**	***All Members*** ***Mrs Toal***
4	**STRATEGIC PLANNING** **4.1 Unscheduled Care – Winter Pressures** The Chief Executive advised that himself, Mrs Magwood, Mr Conway and Mrs McVey had attended the Unscheduled Care Operational Resilience and Capacity Planning Meeting with Southern LNG on Monday and that the Trust operational resilience plan has to go back to the HSCB by close of play tomorrow. Members discussed the list and highlighted the following: Rapid Access in DHH - Mr Conway advised that Clinicians feel this needs to be located in the main hospital and he undertook to ascertain where this could be situated. Ambulatory Paeds - Mr Conway and Mr Morgan advised that they need to have a discussion re staffing etc. Dispensing and Discharging Pharmacist - Dr Boyce advised that there are five Band 7's currently on the waiting list. Following discussion members agreed to proceed with the above. Discharge Lounge (Mr Trevor Burns and Mr Mark Bloomer from Estates joined the meeting for this part of the discussion) - Mr Burns and Mr Bloomer discussed the	

	options available to carry out this work. Mr Burns advised that if members agree to Option 1 then this would effectively mean creating a select list which is contrary to Estate's Procurement Process. SMT agreed to proceed with Option 1 as this would ensure the work is completed within the timeframe discussed. Members also discussed in detail acute priorities which total £2.8m against the allocated £1.4m. The Chief Executive asked Ms O'Neill to revisit the list of priorities again and bring back to SMT.	***Ms O'Neill***
5	**FINANCIAL PLAN 2015/16 & 2016/17** Mr McNally advised that the Month 5 position was reasonably good and that he had no concerns in the current year.	
6	**FOR APPROVAL** **6.1 Business Case: Appointment of a Design Team and Replacement of Existing Sewage Pipework with the Maternity Black at CAH** **Members discussed the above and approved same.** **6.2 Acute Hospitals Evacuation and Sheltering Guidance** Dr Wright spoke to the above and members discussed same. Mrs McVeigh suggested that the guidance should include non-acute hospitals. Dr Wright said that he would take this on board and follow-up with Ms T Cunningham and Mr S Gibson.	***Dr Wright***
7	**FOR NOTING /INFORMATION** **7.1 HSC Code of Conduct 2016** The Chief Executive referenced correspondence from the Permanent Secretary regarding the HSC Code of Conduct 2016 and said that this needs to be referenced at team	***All Members /***

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	meetings. Mrs Toal advised that this is part of staff contracts so will have to be circulated to all staff. **7.2 DoH Circulars: HSC(F) 53-2016 – Revision of Procurement Guidance Note (PGN) 01/13 Integrating Social Considerations into Contracts** The above DoH Circular was noted by members. **7.3 NMC Revalidation Status Update** Mrs McVeigh advised that a small number of registrants have been granted extensions but that this information hasn't been forwarded to the revalidation office so will not be included in the figures. Mrs McVeigh asked members to reiterate at team meetings the importance of forwarding information to the revalidation office and also the need to ensure all fees have been paid well in advance.	***Mrs Toal*** ***All Members***
8	**PERFORMANCE ISSUES** There were no specific issues to discuss.	
9	**ANY OTHER BUSINESS** **<u>Update on Psychology Position in the SH&SCT</u>** Mr McMurray advised that following initial discussions with SMT and subsequent consultations with each Directorate, the original position paper has been amended. Following discussion SMT approved same. **<u>Permanent Secretary Visit</u>** The Chief Executive advised that the Permanent Secretary's rescheduled visit has been scheduled for 20th October 2016. **<u>GMC National Review of Northern Ireland</u>** The Chief Executive advised that the GMC have invited Trust representatives to attend a preliminary meeting on	

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	25th October 2016 to introduce the QA (Quality Assurance) process for the GMC's visit to SHSCT in Spring 2017. Personal Information redacted by the USI **Residential Homes** Mrs McVeigh advised members that four Personal Information redacted by the USI Residential Homes have been placed in administration and that Mrs D Livingston, Head of Contracts, was following-up with Finance to ascertain if we had any clients placed in these homes. **Annual Service of Remembrance** Mrs Toal advised members that the Chaplains and Ms Edel Corr had asked if staff could be included in the Annual Service of Remembrance. Members approved same.	
10	**DATE OF NEXT MEETING** **The next SMT Meeting will be held on Wednesday 5 October 2016 at 2pm in the Boardroom, Trust HQ.**	

Southern Health and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on Wednesday 23 November 2016 @ 2pm in the Boardroom, Trust Headquarters

Present: Francis Rice
Angela McVeigh
Dr Wright
Aldrina Magwood
Paul Morgan
Stephen McNally
Maura Mallon (for Vivienne Toal)
Barry Conway (for Esther Gishkori)
Jane McKimm
Elaine Wright (Notes)

Apologies: Esther Gishkori
Vivienne Toal

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Esther Gishkori and Vivienne Toal.	
2	NOTES OF PREVIOUS MEETING The notes of the meeting held on 16 November will be approved at the next meeting.	*SMT 30 November 16*
3	CHIEF EXECUTIVE BUSINESS 3.1 PFG Delivery Plan: Workshop on Healthier Places, letter from V Watts Members noted the above letter from Valerie Watts regarding PfG Workshop on Healthier Places.	

	3.2 Draft Governance Committee Agenda, 8 December 2016 Members considered the draft Governance Committee Agenda for 8 December 2016 and the Chief Executive advised that the Heads of Governance will liaise with Directors on any particular issues. 3.3 Transformation Implementation Group Meeting, 21 November 2016 The Chief Executive referred to the Transformation Implementation Group Meeting which was held on 21 November 2016. Members considered the template for completion with regard to the various work streams and agreed content for submission. E Wright to submit by 24 November 2016. 3.4 Unscheduled Care Strategic Accountability Group Meeting, 22 Nov 2016 The Chief Executive reported on the Unscheduled Care Strategic Accountability Group Meeting held on 22 November 2016 and the Mid-Year Accountability Meeting held prior to SMT. The Chief Executive updated members on discussion areas and in particular the waiting list initiatives which will be announced by Minister in January 2017. Members discussed in particular outpatients and the need to cleanse the waiting lists and bring an updated position report to next week's meeting.	*For submission by 24 Nov 16*
4	STRATEGIC PLANNING 4.1 SI Unscheduled Care Mr Barry Conway updated members on the current progress/key milestones since the last meeting. Mr Conway advised that it had been an exceptionally busy week, but work continued to progress to manage the situation. Updates included: ➢ Work continues to manage any potential surge. Surge day of 22 November had been previously	

	identified and was managed ➢ Acute SMT meet every Tuesday to address key pieces of work in the plan ➢ Plans for a weekly 1-2pm meeting of Core Group to commence 7 December 2016 ➢ Some 'ambers' are now 'green' since the last meeting ➢ Appointments in specific areas are being progressed ➢ 2 week audit of non-elective admissions to ED is being completed ➢ Work progressing re pilot of 'frail elderly at front door' ➢ Fracture pathway work in ED progressing ➢ IMMAX work ongoing ➢ 12 beds opening ➢ Difficulties regarding nurse recruitment but work ongoing ➢ Pharmacy initiatives – recruitment situation ➢ Surgical meetings held The first meeting of the Core Group will commence on 7 December from 1-2pm. 4.2 Board Development – 10 years on – Repositioning for the Future The Chief Executive advised that the action plan from Board Development Day on 17 November was being written up and will be shared with members when complete. This will be brought back to Trust Board before Christmas and form part of our Corporate Plan.	*Core Group Meeting – 7 Dec 2016 (1-2pm)*
5	FINANCIAL PLAN 5.1 Capital Update Mrs Magwood advised that the Capital Update had been previously circulated for approval. Mr McNally referred to previous discussions in relation to potential bids which are to be submitted by next week. This will remain as a standing item on future agenda's.	

6	FOR APPROVAL 6.1 Business Cases - Day Opportunities Mr McMurray referred members to the business case for Day Opportunities which was tabled for retrospective approval. Members approved.	*Approved*
7	FOR NOTING/INFORMATION 7.1 HSC(F) 56-2016 - DAO 09/16 (DoF) – Good Practice Procedures in Fraud Investigations, 9 November 2016 Members noted the above departmental circular. Mr McNally advised that a new round of Fraud Awareness Training will be carried out commencing in the new year. Members noted. 7.2 Continuing Healthcare, letter from Chris Matthews, 25 October 2016 Mr Brian Beattie attended the meeting to discuss the above letter received into the Trust from Chris Matthews. Mr Beattie brought members up to date with the previous discussions and issues regarding this and highlighted the associated risks. Following discussion it was agreed to continue and await further outcome.	
8	PERFORMANCE ISSUES No additional issues as previously discussed earlier in the meeting.	
9	ANY OTHER BUSINESS 9.1 IS Treatment – Q3/Q4 – potential financial risks in 17/18 (for discussion) Members noted the letter received regarding the potential risks for 17/18. 9.2 Public Sector Transformation Fund Mrs Toal informed members that correspondence had	

	been received inviting ALB's to submit business cases for VES for the next financial year. Following discussion it was agreed that as the Trust cannot meet the criteria a business case would not be submitted. 9.3 Team Meetings The Chief Executive asked members to ensure Team Meetings are keep up to date with developments/changes in the Trust. 9.4 RQIA Child Protection Review Mr Morgan informed members that the RQIA Review of Child Protection for the Southern Trust has been identified for 11/12 January 2017. Mr Morgan to seek further information and informed relevant members accordingly. 9.5 International Medical Recruitment & Overseas Recruitment Dr Wright advised that the International Medical Recruitment was taking place in India. Mrs McVeigh ~~informed that~~updated on ~~the~~ Overseas Recruitment for GP's~~.~~.~~had taken place also~~. 9.6 Woodlawn Pod Building Mr McMurray raised with members the issue regarding costings for Woodlawn, which had been discussed at previous SMT meetings. Members noted the year one cost of £124k and £77k the following year and after discussion, approval was given to proceed as outlined. 9.7 AQ response times Mrs McKimm raised the issue of response times for AQ's and sought agreement for Directors to nominate a designated deputy for sign off when the Director is not about, in order to allow responses to be returned within the tight timeframe. Members agreed and will advise Mrs McKimm of names.	*All* *Mr Morgan to progress* *Approval to proceed as outlined* *All – Directors to nominate deputy for sign off as required*

	9.8 Nurse Revalidation Mrs McVeigh reported a 100% rate for Nurse Revalidation.	
10	DATE OF NEXT MEETING Wednesday 30 November 2016	

Southern Health and Social Care Trust

Quality Care - for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 30th March 2017
Title:	Executive Director of Nursing Report: Pre-registration Education
Lead Director:	Angela McVeigh Executive Director of Nursing
Corporate Objective:	- Promoting safe, high quality care - Being a great place to work, valuing people and clients - Making the best use of resources.
Purpose:	Assurance

Summary of Key Issues for Trust Board

<u>High level context</u>:
Southern Health and Social Care Trust continues to support pre-registration nursing and midwifery students across a wide range of clinical areas, as well as supporting new registrants in their first year of practice, and beyond, to ensure a future workforce fit for purpose, as well as a current workforce with the appropriate level of knowledge and skills to deliver person-centred care.

<u>Key issues/risks for discussion</u>:

1. Maintaining maximum numbers of mentors to ensure the Trust can support and accommodate the increase in pre-registration nursing places, through the reduction of mentors/sign-off mentors/practice teachers who are unavailable (pg.4 and 7).

2. The Nursing and Midwifery Council are proposing radical changes to pre-registration nursing programmes, and are planning to consult on these spring/summer 2017.

Summary of SMT challenge/discussion:

1. How to ensure Registered Nurses and Midwives can be supported to maintain compliance with NMC Standards in order to maintain Mentorship status to support and assess the increasing number of pre-registration students, during this time of Registrant shortage.

Internal/External engagement:

- Department of Health
- Queens University Belfast
- Ulster University
- Open University
- Central Nursing and Midwifery Advisory Group
- Executive Director of Nursing team
- Human Resources
- Senior Nursing and Midwifery Governance Forum
- Nursing Workforce Planning Group
- Directorates and Divisions.

Human Rights/Equality:
There are no issues or concerns identified.

1.0 Introduction

This report provides an update on a range of Nursing and Midwifery education governance, training and development activity within the Trust from April 2016 – March 2017, and focuses specifically on pre-registration nursing education and the first year as a Registered Nurse. The responsibility for pre-registration nursing education is managed across the Directorates and externally through partnerships with the Department of Health and the three local Accredited Education Institutions, Queens University Belfast, the University of Ulster and the Open University. The Trust's Practice Education Team[1] (PET) has operational responsibility for this, and are managed under the Assistant Director of Nursing (Education and Workforce). The PET have responsibility for the quality assurance, performance management and coordination of pre-registration education, and more recently, have been enabled to facilitate and coordinate Preceptorship provision for new registrants, a Trust Nursing Induction programme and Rotation programme(s). All of this activity is ultimately to ensure a current and future registered workforce who are knowledgeable and competent to deliver safe and effective person centred care.

2.0 Nursing and Midwifery Council (NMC) Standards to Support Learning and Assessment in Practice (SLAiP)

These standards were published by the NMC in 2006, reviewed in 2008, and detail the mandatory governance requirements for the Trust to ensure appropriate student supervision, support and assessment in practice, against which the Trust is externally inspected and measured periodically. Failure to meet these standards may result in the withdrawal of pre-registration students and loss of teaching status for the Trust.

The standards define the knowledge and skills Nurses and Midwives need to apply in practice when they support and assess students undertaking NMC approved programmes that lead to registration or a recordable qualification on the register, as well as defining the requirements for specific, required roles such as Mentor, sign-off Mentor and Practice Teacher.

SHSCT Mentor Register

A current mentor register is held electronically and managed locally by Ward Sisters/Charge Nurses/Team Leaders, with professional oversight and management responsibility residing with the Practice Education Team. This data provides the Nursing and Midwifery Council (NMC) and Southern Health and Social Care Trust with the assurance that appropriate governance arrangements are embedded to measure compliance to meet the NMC (2008) SLAiP standards. Directorates receive status reports regarding availability of Mentors/sign-off Mentors/Practice Teachers on a 6 monthly basis.

[1] The Practice Education Team consists of Registered Nurses and Midwives and is externally recurrently funded by the Department of Health.

Mentorship Statistics

SHSCT, for the reporting timeframe, have 908 mentors who are currently available to mentor students.

Table 1 below provides further detail and Table 2 provides this information per Directorate.

The Practice Education Team support Ward Sisters/Charge Nurses/Team Leaders to maximise the availability of mentors, as well as delivering training for staff to meet the requirements for entry onto and maintaining entry on the Mentor Register. This continues to be of paramount importance with the increased number of pre-registration students already introduced, and a further increase agreed from September 2017.

Table 1: SHSCT Mentor Statistics

	Available	Unavailable*	Total Number
Mentors	509	214	**723**
Sign-off mentors	376	159	**535**
Practice Teachers	23	8	**31**
TOTALS	**908**	**381**	**1289**

*Mentors/Sign-off Mentors/Practice Teachers are sometimes unavailable to mentor students due to the following reasons:

- Criteria lapsed: These are due to a Mentor/Sign-off Mentor/Practice Teacher failing to meet the NMC requirements, such as not having a triennial review, an annual update or their NMC Personal Identification Number updated on the system by managers. Clinical areas are finding it increasingly challenging to release staff to attend updates, or staff being off on long-term sick leave or maternity leave. An action plan is agreed with the PET and clinical staff to enable Mentors/Sign-off Mentors/Practice Teachers to achieve compliance as soon as possible;

- Leave reason: If a Mentor/Sign-off Mentor/Practice Teacher is off for over twenty-one days;

- Other reasons: A Mentor/Sign-off Mentor/Practice Teacher may themselves be undertaking study and cannot support a student, or any staff member who is going through capability or disciplinary procedures they cannot assess a student.

Table 2: Mentor Statistics per Directorate/Division

Directorate / Division	Number of Mentors	Number of Sign-off Mentors	Number of Practice Teachers	Total
ACUTE	297	344	1	**642**
CYPS	156	48	18	**222**
OPPC	149	76	7	**232**
MHLD	121	67	5	**193**
Totals	**723**	**535**	**31**	**1289**

This year, in response to service need, SHSCT in partnership with AEI's organised and facilitated an extra mentorship preparation programme to increase the number of mentors within the Trust. This enabled a total of 126 staff to obtain mentorship status, a 62% (n=48) increase to last year's total (Apr 15- Mar 16).

Mentors/Sign-off Mentors/Practice Teachers - Continuing Practice Development Activity (CPD)

The Practice Education Team has facilitated a number of programmes and updates for mentors, sign-off mentors and Practice Teachers throughout the year, which are Nursing and Midwifery Council requirements. CPD activity statistics can be viewed in Table 3 below:

Table 3: Mentors/Sign-off Mentors/Practice teachers CPD activity statistics

Programme/Activity Title	Number of programmes/sessions facilitated April 2016 – March 2017	Number of Mentors/SoM/PT added to mentor register
Mentorship Preparation Programme/APEL	5 (x3 nursing & x2 midwifery)	128
Nursing and Midwifery annual update	122	918
Triennial reviews	N/A	211
Progression to sign-off mentor status programme	2	37
Model of support	2	24
Supervising mentor preparation programme	17 (3 programmes + 14 individual sessions in wards)	60
Practice Teacher Forum	2	27

It should be noted that 2017 will be particularly challenging for Ward Sisters/Charge Nurses/Team Leaders in relation to triennial reviews. Triennial reviews are a regulatory three yearly process, to assure the NMC that every Mentor is meeting the standards to continue

practising safely as a Mentor. A total of 606 nursing and midwifery Mentors within SHSCT are required to undertake triennial review in 2017, of which 513 are due between March and October 2017[2].

The progression to Sign-off Mentor Programme has undergone review by the Practice Education Team in the past year, with changes to the programme having taken effect since September 2016. In accordance with the NMC (2008) SLAiP Standards, the programme has been designed to help Mentors achieve Sign-off Mentor status, gaining additional skills to support and sign-off an undergraduate final placement student or post-graduate specialist practice student. The face-to-face component of the programme, which was previously delivered in two half day sessions, is now completed in a half-day session. Verification and support by the Practice Education Facilitators (PEFs), previously provided at additional group workshops are now provided locally in the participant's area of work, thus minimising time staff will be absent from clinical practice. Without diluting the quality or value of the programme, the revised programme will ease some pressures experienced by managers to release staff for training.

Student Capacity

SHSCT currently have capacity to accommodate a maximum of 390 pre and post registration students at any one time across 143 approved practice areas (Table 4). Due to ongoing requirements to increase practice placements, the Practice Education Team continually work with service colleagues to scope placement capacity. A total increase of 2 practice areas approved for student placements in SHSCT has been achieved in the past 12 months, along with an increase of 34 in the maximum number of students that can be accommodated at any one time.

A number of regional initiatives have also taken place within this reporting period, including a regional Task and Finish Group project to ensure consistency and continuity across Trusts regarding capacity of practice placements, and the review and update of a regional Practice Placement Agreement by DoH and Trusts to facilitate student placements for individuals on the Open University Pre-Registration Nursing Programme employed by the independent sector. SHSCT are currently facilitating placements for one of these students.

Table 4: Student capacity statistics**

Number of practice areas approved for student placements	Number of educational audits carried out in past 12 months	Max. number of students that can be accommodated at any one time
143	80	390

**The Trust can reach capacity, mainly October-December each year, however, QUB are re-aligning student placements from September 2017 to alleviate this.

[2] The large numbers this year are due to the mapping of staff that occurred in 2008 when the Standards to Support Learning and Assessment in Practice were first introduced; therefore triennial reviews occur in 3 yearly cycles.

Challenges in Practice Placements

The challenge of time for mentoring nursing and midwifery students continues, in particular the required 1 hour protected time per week for Sign-off Mentors with final placement students (NMC, 2008). A re-audit in August 2016 demonstrated that progress has been made since the previous audit in 2015, although the Trust remains not fully compliant. An action plan has been updated as a result.

3.0 Open University (OU) Pre-registration Nursing Programme (PRNP)

This programme is available to Trust staff, and is a 4 year, part-time, work based programme for entry to the nursing profession (adult and mental health branches only). A total of 39 staff are currently undertaking the nursing programme, years 1 to 4.

Innovation in Delivery of the OU PRNP

Since September 2015 SHSCT, in partnership with the OU and DoH, have explored ways of increasing access to the programme for staff. A new model was implemented which facilitated 7 staff to complete the first two modules of the nursing programme as a stand-alone arrangement, and these staff have now commenced Year 2 of the programme in September 2016. This model has been replicated for September 2016, with a further 5 staff completing the first two modules of the nursing programme as a stand-alone arrangement. These 5 staff will commence stage 2 of the programme in September 2017.

In addition, SHSCT have commenced a further 15 staff onto Year 1 of the programme commencing September 2016, as a result of a realignment of backfill funding to additional places.

Recruitment and selection for the September 2017 programme is currently underway and it is hoped that the SHSCT will be able to facilitate a minimum of 20 staff to commence the programme across adult and MH fields.

4.0 Trust Nursing and Midwifery Band 5 Induction Programme

The first Trust-wide Nursing and Midwifery Induction Programme commenced in October 2016, with 85 new staff attending. This programme was initiated as part of the Trust's recruitment and retention strategies, to attract Registered Nurses to work in SHSCT. The programme consisted of two cohorts of Band 5 new nursing registrants, one adult and one children's field. The programme which was delivered in a blended approach by Clinical Education Centre, Practice Education Team and in-house SHSCT staff, ran over a period of 3-4 weeks (part-time attendance) and included corporate and professional induction, mandatory training, a range of e-learning, and commencement on the Trust's Preceptorship programme for new registrants. The programme was positively evaluated and will be available twice a year for all four fields of nursing.

5.0 *Preceptorship*

Preceptorship is: 'a period of structured transition for the Preceptee during which he/she will be supported by a Preceptor, to develop confidence as an autonomous professional, refine skills, values, attitudes and behaviours and to continue on a journey of lifelong learning' (adapted from Department of Health (DoH), 2010). The programme is 26 weeks duration. The Nursing and Midwifery Preceptorship Programme is co-delivered by Clinical Education Centre and the Practice Education Team, whilst the SCPHN preceptorship programme is co-delivered in-house by the Practice Education Team and the service colleagues.

Table 5 below provides an overview of activity April 2016 to March 2017.

Table 5: SHSCT preceptorship activities

Number of Programmes due to complete April 2016-March 2017	Number of Registrants due to complete a programme April 2016-March 2017	Number of registrants completed Programme	Number of registrants who did not complete incl. reason	Number of Programmes commenced but completion date due after March 2017	Number of registrants due to complete after March 2017
11	147	112	35***	7	136

NB: Figures compiled 9th March 2017

*** Leave reason x4, left Trust x11, awaiting confirmation of completion from line manager x19, commenced programme In error as not new registrant x1.

A review of the SHSCT Preceptorship Programme took place in October 2016 in response to feedback received from managers, preceptors and preceptees from previous programmes, particularly in relation to the portfolio and practice requirements. The changes implemented as a result of this feedback came into effect from January 2017. Information sessions were held for Ward Sisters/Charge Nurses/Team Leaders and existing preceptors to provide an update on the changes and also to provide further support in relation roles and responsibilities within preceptorship.

6.0 Rotation Programme

A rotational programme was introduced into the Acute Directorate in April 2015, as previously reported to Trust Board, as part of the Trust's recruitment and retention strategies. The second cohort of 6 new registrants commenced the programme in October 2016. These staff will have the opportunity to work in three clinical areas over a twelve month period giving them an opportunity to consolidate their knowledge and skills as well as develop further skills in different care environments. Evaluation data from the first Rotation Programme was reported to Trust Board in June 2016. The current programme is due to complete October 2017.

7.0 Celebration of Success

The past year has been an extremely successful year for some of our Trust staff in relation Nursing and Midwifery education.

Dawn Ferguson, Nursing Workforce and Education Coordinator, completed an MSc Developing Practice in Healthcare and has been awarded the University of Ulster's Mona Grey Award for Excellence in Post-Registration Research. Her dissertation was a qualitative study examining new registrants' views of a Preceptorship Programme during their transition year from student nurse/midwife to registrant.

Six mentors from the Trust were nominated by nursing students for the 'Queen's University Belfast Nurse Mentor of the Year Awards', with Muriel Stevenson as winner in the Adult category.

Staff nominated include:

- Nichola Tally, CAMHS, Dungannon;
- Tracy Lively, Craigavon Hospital;
- Michelle Calvin, Portadown Health Centre;
- Roisin Heavin, Trasna House Lurgan;
- Paul Agnew, Trasna House;
- Muriel Stevenson, Mandeville Unit, Craigavon Hospital – winner in the Adult category!

An awards ceremony was held on Thursday 12th May 2016 in QUB to coincide with International Nurses' Day 2016.

8.0 *Conclusion*

This report provides assurances on a range of Nursing and Midwifery education governance and training and development activity that has taken place within the Trust over the past 12 months to support pre- and post-registration education to ensure the NMC Standards to Support Learning and Assessment in Practice are maintained, and to ensure a workforce who are knowledgeable and competent to deliver safe and effective person-centred care. The report also specifies the ongoing challenges that managers and mentors face in relation to ensuring the NMC Standards are met and maintained both now and over the coming months.

Southern Health and Social Care Trust

Quality Care - for you, with you

DAISY HILL HOSPITAL
Pathfinder Group

Personal and Public Involvement (PPI) Involving you, improving care

DRAFT Phase 1 Report

Daisy Hill Hospital Pathfinder Project

Development of an Unscheduled Care Model through a Co-Production Approach

30th August 2017

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Appendices

Glossary

The Daisy Hill Hospital Pathfinder Group would like to thank the Project Team:

- Dr Anne-Marie Telford, Project Director
- Ms Charlene Stoops, Assistant Director of Corporate Planning, SHSCT - Project Manager for DHH Pathfinder Project
- Dr Richard Wright, Medical Director, SHSCT
- Mrs Angela McVeigh, Director of Older People & Primary Care, SHSCT
- Dr Brid Farrell, Assistant Director of Service Development, Safety and Quality, Public Health Agency - Chair of Needs Assessment Group
- Dr Diane Corrigan, Consultant in Public Health Medicine, Public Health Agency
- Mrs Ruth Rogers & Mrs Jane McKimm, Head of Communications, SHSCT
- Dr Rachel Doherty, Specialty Registrar in Public Health Medicine, Public Health Agency

1.0 EXECUTIVE SUMMARY

The Daisy Hill Hospital (DHH) Emergency Department (ED) Pathfinder Project was established "to develop an operational model for a long term ED service model for the Newry and Mourne area with identification of regional learning".

The Health & Social Care Project Initiation Document (PID) (16th June 2017) for the Project describes the scope of work required, the project objectives and the timescales for completion. This report addresses the tasks set out in Mr Pengelly's letter of 23rd June 2017 to "…report and make recommendations, on a population needs assessment for the Newry and Mourne area by 23rd August 2017". It also provides an overview of progress made in working towards the achievement of Objective 1 of the PID which is:

"To develop an exemplar Model to meet the acute unscheduled care needs for the Newry and Mourne population, fully aligned with the principles and recommendations within Systems not Structures and Delivering Together. The Model should take account of the evidence base for modern timely care, ehealth/Information Technology solutions, the science of efficient flow, the professional advice of clinicians in Daisy Hill and across the Southern Trust, General Practitioners and the people in the Daisy Hill catchment area, including other stakeholders, in keeping with the principles within Delivering Together and its commitment to co-production".

Development of a Co-Production Strategy

The need for a Co-Production Strategy was identified at the outset of the project to ensure active involvement of the local community, service users and carers as partners in planning for future emergency care services to meet the needs of the people of the Newry & Mourne area. A number of approaches were adopted, including stakeholder mapping; the development of a Communications and Engagement Strategy; meetings with the local community and Trust staff; and a range of methods to engage those working in the wider health and social care system.

The resources of the Regional and Local PPI Forums were used to explore options on how best to secure community representation on the Pathfinder Group. This led to a new and innovative process for engagement which included a number of meetings with members of the public, campaign groups, elected representatives (MP, MLA, local Councillors), health professionals, the Newry Chamber of Commerce and representatives of community and voluntary organisations. Following on from the community engagement meetings, the local Newry, Mourne and Down District Council agreed to convene a Pathfinder Community Forum. This will be facilitated by Roisin Mulgrew, the Chair of the Council and will be co-chaired by Maeve Hully, Chief Executive of the Patient and Client Council (PCC). Through this Forum, which is due to meet on 5th September 2017, it would be planned to undertake a process to identify 4 community representatives to sit on the DHH Pathfinder Group.

Population Health Needs Assessment Report

The Population Health Needs Assessment Report recognises that population growth in the Newry & Mourne area is projected to rise at a higher rate, particularly the older population, compared to the Northern Ireland population. DHH is the 6th busiest ED in Northern Ireland and demand for services has continued to grow, with an increase in ED attendances of 15% for adults and 28% for children in the 3 year period to 2016/17.

A literature review of models of urgent and emergency care has been undertaken and particular attention is being given to recent publications, both national and regional on patient flow.

The report identifies the challenge which would be presented in regards to access times for patients should a 24/7 type 1 ED service not be available in DHH. This would increase travel time to access services for some individuals in the population. The number of people living in Northern Ireland within a 1 hour drivetime to an ED, based on GP registered population, would reduce from 99.6% to 97.5%.

The population health needs assessment which has been undertaken would support the need to sustain a 24/7 ED at DHH. On this basis, the Southern Trust remains fully committed to delivering safe, sustainable 24/7 emergency services at DHH.

This will require the development of proposals to not only strengthen the ED but to strengthen community infrastructure and modernise acute inpatient assessment and diagnostic services.

Next steps

High level proposals for potential pathway changes and a new model for the delivery of unscheduled care will be considered. Account will be taken of the information generated through the Needs Assessment exercise, the experience of other Trusts, including the ImPACT approach in the Belfast Trust, and recommendations from Trust senior managers as well as staff, user involvement and community engagement events.

The DHHPG will provide a specific focus on clinical staffing issues in DHH ED as well as exploring other opportunities to implement new ways of working.

2.0 INTRODUCTION

2.1 Background

2.1.1 The Southern Health & Social Care Trust (Southern Trust) is fully committed to delivering safe, sustainable 24/7 emergency services at Daisy Hill Hospital (DHH).

2.1.2 A recent regional summit, convened by the Department of Health (DOH) on Tuesday 2nd May 2017, secured system-wide support to enable the Southern Trust to address immediate pressures and to stabilise the provision of Emergency Department (ED) services at DHH.

2.1.3 On the 16th June 2017 the DOH issued a Project Initiation Document (PID) providing guidance to the Southern Trust on establishing a clinically-led, managerially supported Pathfinder Project "to develop an operational model for a long term ED service model for the Newry and Mourne area with identification of regional learning".

The PID outlines the scope of work required, the project objectives and the timescales for completion.

2.1.4 The DHH ED Pathfinder Project provides a valuable opportunity to draw on the collective expertise of multidisciplinary health professionals from across Northern Ireland, alongside the experience and views of the local community, to develop proposals for the delivery of safe and sustainable emergency care services that will meet the needs of people in the Newry & Mourne area.

2.1.5 The key project milestones are identified in a letter from the Permanent Secretary issued 23rd June 2017 to the Trust's Acting Chief Executive and reflected in the PID. These are listed below and are based on a 20 week programme of work, which commenced following Trust Board approval on 27th June 2017.

- Report and recommendations on population health needs assessment (end of Week 8) – 23rd August 2017
- Interim report and recommendations on all other Objectives (end of Week 16) – 18th October 2017

- Final report (end of Week 20) – 15th November 2017

2.2 Project Reporting Structure and Governance Arrangements

2.2.1 The project structure and governance arrangements for the project are summarised below:

The Department of Health (DOH) **Transformation Implementation Group (TIG)** has overall oversight of the project. This group, chaired by Richard Pengelly, Permanent Secretary, provides the strategic leadership to oversee and make decisions on the design, development and implementation of the Minister of Health's *'Delivering Together'* Transformation Programme.

The **Emergency Care Regional Collaborative (ECRC)**, chaired by Dr Michael McBride, Chief Medical Officer for Northern Ireland as Senior Responsible Officer (SRO) is the main decision making body for overseeing the project and reporting progress to the Transformation Implementation Group. It will endorse recommendations and share learning with the HSC.

The Trust's Interim Chief Executive is the Senior Responsible Officer for the DHHPG and is working with the **Trust's Senior Management Team (SMT)** to ensure that the project group adheres to the Trust's established principles, policies and working practices in delivering the project outcomes and timescales and will provide progress reports over the duration of the project and identify any issues which may need Trust Board consideration and/or approval.

The **Trust Board** will be provided with timely, relevant and reliable information by the Trust's Interim Chief Executive and SMT. The End of Project Report, following approval of the ECRC, will be presented to Trust

Board for endorsement. Special Trust Board meetings will be convened if necessary by the Board Chair.

The **Daisy Hill Pathfinder Group (DHHPG),** led and Chaired by Dr Anne Marie Telford, Project Director, is responsible for the direction and planning of the project and for overseeing the day to day/operational running of the Project. The corporate values and the priorities of the Trust guide its work.

Members of the DHHPG were selected to reflect the range of knowledge, skills and experience considered necessary to support the successful delivery of the project and work streams. Membership of the group (see Appendix 1) includes representation from:

- Southern Health & Social Care Trust (Southern Trust)
- Public Health Agency (PHA)
- Health & Social Care Board (HSCB)
- Southern Local Commissioning Group (Southern LCG)
- General Practitioners (GPs)
- Northern Ireland Ambulance Service (NIAS)
- Trade Union Representation
- Local Community Nominees

The DHHPG's remit includes:

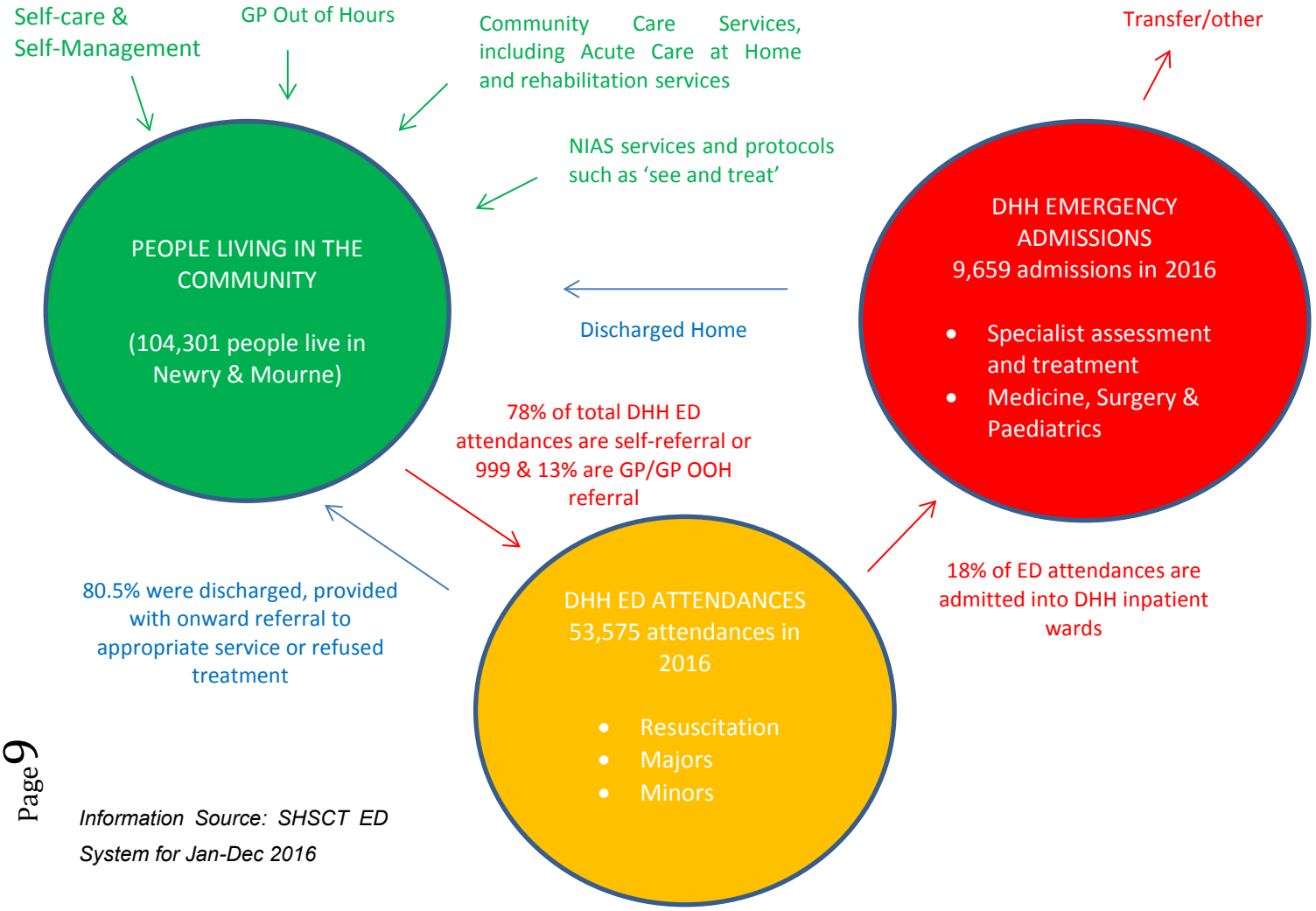
- Agreeing the workstreams, their membership and remits;
- Setting timescales to meet PID requirements;
- Developing recommendations.

The DHHPG reports to the Southern Trust Interim Chief Executive who is the SRO of the Project.

2.3 Project Scope

For the purpose of the DHH Pathfinder Project, 'unscheduled care' has been defined as any unplanned contact with Health and Social Care by a person requiring or seeking help, care or advice. It follows that such demand can occur at any time, and that services must be available to meet this demand 24 hours a day. It includes urgent care and emergency care.

The task of the DHHPG is to develop 'an exemplar Model to meet the acute unscheduled care needs of people for the Newry & Mourne area'. The scope of the project includes consideration of the Emergency Department, its staffing and interfaces with other services that feed into and support it. These include GP Out of Hours (GP OOH), diagnostic services and community based services, such as Acute Care at Home and other rehabilitation services.



Information Source: SHSCT ED System for Jan-Dec 2016

2.4 Report Structure

2.4.1 This report addresses the tasks set out in Mr Pengelly's letter of 23rd June 2017 to "… report and make recommendations, on a population needs assessment for the Newry and Mourne area by 23rd August 2017". It also provides an overview of progress made in working towards the achievement of Objective 1 of the PID which is:

"To develop an exemplar Model to meet the acute unscheduled care needs for the Newry and Mourne population, fully aligned with the principles and recommendations within Systems not Structures and Delivering Together. The Model should take account of the evidence base for modern timely care, ehealth/IT solutions, the science of efficient flow, the professional advice of clinicians in Daisy Hill and across the Southern Trust, General Practitioners and the people in the Daisy Hill catchment area, including other stakeholders, in keeping with the principles within Delivering Together and its commitment to co-production".

In delivering on this requirement, the Phase 1 report focuses on:

- The approach adopted to engage and involve the local community from the outset and the progress made towards developing a Co-Production Strategy for the Project.
- Measures undertaken to involve clinical and non-clinical staff and local General Practitioners to raise awareness of the Project and how they might contribute to its work.
- The outcome of an interim population health needs assessment for unscheduled care, taking into account access and travel times as appropriate.

The report also references work already commenced and which will now be progressed through the following phases of the project to deliver on the full requirements of Objective 1, specifically:

- Assessment of alternative care pathways across the continuum of community, primary and secondary care that might effectively meet some of the emergency care health needs in the Newry & Mourne area; and
- Development of outline proposals for a service model for emergency care, taking account of the principles set out in *Delivering Together*.

This report should be read in conjunction with the separate 'Interim Report of the Needs Assessment Group'.

2.4.2 High level proposals for potential pathway changes and a new model for the delivery of unscheduled care are being considered. Refining, prioritising and costing these will be the main task of the next phase of work for the DHH Pathfinder Project.

3.0 DEVELOPMENT OF A CO-PRODUCTION STRATEGY

3.1 Introduction

3.1.1 'Co-production' is defined as 'a relationship where HSC staff and service users, carers and the public share power to generate policy, plan and deliver services together, recognising that all partners have vital contributions to make in order to transform the HSC' *(New Economics Foundation).* This partnership approach has been further emphasised in a recent joint letter from Dr McBride, Chief Medical Officer and Professor McArdle, Chief Nursing Officer (27th June 2017) which advises that "co-production recognises that all partners have vital contributions to make to enable effective transformation in the HSC" and that "the expectation is that HSC staff, service users and carers, and the public should work in partnership generating policy or planning and delivering services together".

3.1.2 The Southern Trust is fully committed to the principles of co-production and Personal & Public Involvement. The Trust's Personal & Public Involvement (PPI) toolkit, which was developed in 2010/11 and is currently being updated in line with new standards, guidance and policy, has provided a valuable foundation for moving towards the delivery of co-production.

3.1.3 The Board of the Southern Trust agreed that comprehensive arrangements for community engagement and involvement with the DHH Pathfinder Project should be in place from the outset. It was agreed that a Co-Production Strategy should be developed for the Project to enable it to actively involve the local community, service users and carers as partners in planning for future emergency care services to meet the needs of the people of the Newry & Mourne area.

3.1.4 Recognising that co-production principles should be applied to all stages of the DHH Pathfinder Project the following approaches were taken:

- Stakeholder mapping
- Development of an internal and external Communication Strategy

- Development of a plan to engage the local community to jointly design their involvement as partners
- Engaging the wider Health & Social Care System

3.2 Stakeholder mapping

3.2.1 As part of the mobilisation and establishment of the project, a stakeholder mapping exercise was undertaken. The following key stakeholders have been identified as important partners in the process.

3.2.2 A Communications & Engagement Strategy was then developed targeted to the key stakeholder groups. A key objective is to raise awareness of the project, to encourage wide stakeholder involvement to support the project and deliver effective and sustainable outcomes. This is a "live" strategy which is being reviewed and updated regularly to meet the needs of the project.

3.2.3 As staff are key stakeholders, a range of channels have been utilised to ensure that they are briefed first at all times, and face to face when possible. A 'DHH Pathfinder Project E-Zine' has been developed. This is a new on-line monthly newsletter that aims to keep everyone up to date with all the developments from the Project. A dedicated section has also been set up on the home page of the Trust's website where all updates and materials are recorded. Other channels used include social media; fortnightly staff newsletter; global e mails and desktop messaging.

3.2.4 Externally, key stakeholders are regularly updated at project milestones via briefings, face to face meetings, news releases and interviews.

3.3 Engaging the Local Community

3.3.1 A key challenge facing the Project was how to secure community representatives to sit on the DHHPG and its subgroups and how to ensure that the wider community remained involved in its work. The resources of the Regional and Local PPI Forums were used to explore options. A meeting was convened with the Chair of the Southern Trust PPI Panel, the Trust staff with responsibility for PPI and Communications, and a member of the Regional Personal & Public Involvement (PPI) Panel to inform.

It was agreed that members of the community should be invited in small groups to meet with the Project Director of the DHHPG to share their views on how best to involve them in this work. It was felt that discussions should be face to face and held in locations across the Newry & Mourne area.

3.3.2 The Chair of the local PPI Panel informed the development of communications documentation and approach to support this process. On the 24th July 2017 the DHHPG launched its Communication & Engagement Plan using email, twitter, Facebook and the local press to reach out to the public of Newry & Mourne inviting members to meet with Dr Telford (Project Director) (see Video Link Dr Telford).

3.3.3 Arrangements were then made for meetings on 2nd, 3rd and 4th August 2017 in Kilkeel Health Centre, Daisy Hill Hospital and Crossmaglen Community Centre. Appointments were arranged in advance giving each a 30 minute slot. Those attending were asked to consider the following 3 questions:

- How do we best ensure community involvement in the Pathfinder group and its subgroups? E.g. should there be a nomination/other process?
- Can you recommend ways to promote partnership working for the duration of the project? (July – November 2017)
- How can we maintain this partnership working in the longer term as our plan is implemented in the Newry & Mourne area?

3.3.4 Both Peter Donnelly, Chair of the Local PPI Panel and Brian O'Hagan, a member of the Regional PPI Panel who lives in Newry, offered to hold places on the DHHPG and Needs Assessment Group until community nominations could be agreed.

3.3.5 Support to the Project Director was provided by the member of the Regional PPI forum, Mr Brian O'Hagan, who attended all meetings, Southern Trust Non-Executive Directors (one per day), a Public Health Speciality Registrar from the PHA and members of the Trust Communications Team. Each meeting was documented and those attending were invited to record a short video message afterwards. Recorded interviews were placed on the Trust's website and Facebook page (see Video Link - Community Interviews).

3.3.6 Offering interested members of the community the opportunity to book face to face thirty minute appointments with a panel from the DHHPG was a new

and innovative process for engagement. It allowed personal convenience for participants, offered a chance for those who may otherwise not have contributed to speak in confidence, and the geographic spread of the meeting venues ensured that each of the main areas from the district were included. The open format also provided a rich opportunity to hear a wealth of local feedback, as well as a unique chance to personally introduce the Chair of the working group, and provide an overview of the background to and authority of the project, in order to build local confidence.

3.3.7 The panel were very pleased by the positive response to the invitation, and in the relatively short period of three days during the thirty separate meetings that took place, were able to listen to the thoughts and opinions of people representing a wide range of community interests, including members of the public, campaign groups, elected representatives (MP, MLA, local Councillors), health professionals, the Newry Chamber of Commerce and representatives of community and voluntary organisations.

3.3.8 In advance of the meeting, participants received a letter from the Project Chair asking them to consider suggestions on how community representatives should be identified to sit on the DHHPG and sub groups and how to promote and maintain partnership working in the long term. The main idea emerging in relation to this process was that a forum representing all community perspectives, facilitated and overseen by a neutral body such as the local Council, should be created. It was felt that the DHHPG should have representation from each of the Mourne, Newry and South Armagh areas and that three to four representatives should be self-nominated by the forum. This platform would also offer a two way communication channel for raising community priorities and views and feeding back on the work and progress of the project.

3.3.9 It was clear from the meetings, that the people of Newry and Mourne have a deep pride in their local hospital and its services. They perceive that it plays a key role in the community with many staff coming from the area and it is also viewed as important for local business. Many participants expressed genuine gratitude for the opportunity to have their opinions heard.

3.3.10 It is also apparent that there is a real fear within the community about losing emergency services and the 'downgrading of the hospital', with a perception that there has been an erosion of confidence with a 'drip-drip' of services removed from the unit.

The other main themes emerging from the meetings included:

Public confidence

Many participants highlighted their concern that negative messages surrounding the hospital are both worrying and confusing for the public and counter-productive when trying to address some of the recruitment challenges faced. It was felt that a key message of this work should be not only to sustain local emergency services but how best to develop the hospital going forward. Promoting the positive aspects of living in the area was viewed as important. It was suggested that the project should deliver some initial 'early wins' … 'deeds not words' to boost public confidence.

Communication

The importance for the public to be receiving consistent messaging with clear lines of trusted communication in and out of the community sector, whilst also allowing other informal access for individuals to remain open, was highlighted. Participants felt this should be an open and transparent process, that jargon must be avoided, and instead plain English summaries should be used. These should be cascaded using a variety of methods to reach diverse audiences, including print media, social media, leaflets and E-zine which all participants agreed to share and forward on within their community networks.

Geographic isolation

The wide geographic spread of the communities of Newry, Mourne and South Armagh was highlighted. The needs of the communities in these areas may differ and in particular the Mourne and South Armagh communities are rural. Poor roads, a lack of transport services and rural deprivation, and their impact upon response and travel times, are some of the issues they have particular concerns about. It was also perceived that the impact of reduction

in emergency services would be most acute for vulnerable groups in the community. In several of the meetings there were representatives from the older people's forum, mental health and addiction voluntary services, the travelling community and the hospice.

Staff engagement

It was perceived that staff morale within the hospital is poor and it was seen as very important that staff, who know the services in which they work, should have their suggestions listened to. There were also some concerns that previously staff ideas had been heard but not actioned.

Cross border considerations

Several participants highlighted the proximity of the area to the border with the Republic of Ireland and the potential for cross border services. The renal and maternity units and cross border working in the north west of the province were quoted as examples of good practice in this. Being 'ideally situated between Belfast and Dublin' it was suggested that the unit could act as a hub for cross border working. It was also acknowledged that Brexit will be another direct challenge for the community in this area.

Regional issues

Many participants also felt there should be a regional approach to workforce planning and job sharing opportunities to improve recruitment and retention of staff.

3.3.11 DHH Pathfinder Community Forum

Following on from the community engagement meetings the local Newry, Mourne and Down District Council (the Council) agreed to convene a Pathfinder Community Forum. This will be facilitated by Roisin Mulgrew, the Chair of the Council and will be co-chaired by Maeve Hully, Chief Executive of the Patient & Client Council (PCC). Through this Forum, which is due to meet on 5th September 2017, it would be planned to undertake a process to identify 4 community representatives to sit on the DHH Pathfinder Group.

3.4 Engaging the wider Health & Social Care System

A range of methods are being used to meet and engage those working in the wider health and social care system in the Newry and Mourne area.

3.4.1 A Clinical & Non-Clinical Staff Engagement event entitled "Developing Unscheduled Care Services for the Future", which was supported by the HSC Leadership Centre, was held on Wednesday 9th August in the Canal Court Hotel, Newry. There were 85 people in attendance with multidisciplinary representatives including Trust Executive Directors, Public Health Consultants, Associate Medical Directors, Clinical Directors, Consultants, Specialty Doctors, Senior Nurses, Allied Health Professional Leads, Social Work Leads, Diagnostics, Community staff, GP Out of Hours, local GPs, Pharmacy, Labs, non-clinical staff representation and the Patient Client Council.

The objective of the event was to encourage staff to get involved in considering new ways of working to improve acute unscheduled care services. It was also to raise awareness of the Pathfinder Project and of opportunities to get involved. Discussion areas were designed to get a range of ideas from the groups represented.

The key themes arising from the discussion groups have been summarised under the following headings:

- Emergency Department
- Improving Patient Flow in the Hospital
- Alternative pathways
- Interface with Primary Care
- Supporting our Staff / Workforce issues
- Public Education & Communication
- Improving access through Technology

Participants also emphasised the need for good communication with staff throughout the Project, and that the process supported engagement and involvement of staff and evidence that ideas had been adopted.

3.4.2 Individual Meetings with Key Stakeholders

There have been a range of meetings with the Trust Chief Executive, Chair, Directors, senior managers and clinicians in DHH. This included a tour of DHH with a separate tour of the ED. Other meetings included:

Northern Ireland Medical & Dental Training Agency – 26th June 2017 & 15th August 2017.
Patient Client Council – 7th August 2017
Newry, Mourne & Down District Council – 8th August, 14th August & 21st August 2017
Northern Ireland Ambulance Service – 14th August 2017

3.4.3 The DHHPG has also drawn on the experience of other Trusts as well as work ongoing internally within the Trust to improve unscheduled care services including the views and ideas captured through a recent Ambulatory Care Workshop hosted by the Southern Trust and Southern Locality Care Network on 28th July 2017 which involved staff in considering new ambulatory care models for their services.

3.5 Conclusion

A "long list" of proposals for developing alternative care pathways across the continuum of community, primary and secondary care is being collated. Account is being taken of the information generated through the Needs Assessment exercise, the experience of other Trusts, including the ImPACT approach in the Belfast Trust, and recommendations from Trust senior managers as well as staff and community engagement events. These will be considered by the DHHPG in the next phase.

A literature review of models of urgent and emergency care has been undertaken.

The aim is to recommend proposals for maintaining the ED at DHH on a long-term basis. The DHHPG will consider ED workforce options and identify additional measures across community and hospital services to deliver a 'sustainable' model for the Newry & Mourne population in the future.

4.0 Needs Assessment for the Newry & Mourne Area

4.1 Role of the Needs Assessment Group

4.1.1 The DHHPG agreed to establish a Needs Assessment Group (see Appendix 2 for membership) which was tasked with exploring the medium and long term acute unscheduled care needs of the Newry and Mourne Population, including the role of the ED in Daisy Hill Hospital to take account of the recognised clinical need, population size and growth.

4.1.2 Needs Assessment is a systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way.[1] It describes health problems of a population, identifies inequalities in health and access to services and identifies priorities for the most effective use of resources.

4.1.3 The Group, Chaired by Dr Brid Farrell, PHA, undertook the following schedule of work:

- Agreement on the evidence required which would be necessary to inform a population health needs assessment for unscheduled care, taking account of access and travel times as appropriate;
- Review of available activity at Northern Ireland level, Southern Trust level and Newry & Mourne level to include population/demographics; DHH ED Activity Analysis; travel distances and times; activity for GP OOH; Acute Care at home and available audits on other services;
- Consideration of the evidence base for modern timely care, including learning from other models such as e-health/IT solutions and the potential development of other services including looking at acute care at home, patient flows in ED and the hospital, minor injuries, short stay observation, clinical assessment, speciality wards, acute medical units, NIAS 'see and treat' protocols, communication with GPs; and
- Development of a report to summarise the key findings and considerations of the needs assessment group.

[1] Wright J et al. Development and importance of health needs assessment *BMJ*. 1998; 316(7140): 1310–1313

4.2 Interim Report – Summary of Key Findings

4.2.1 The place, the people

Compared to Northern Ireland as a whole, the Newry and Mourne area:

- Has a younger population;
- Population growth is projected to rise at a higher rate, particularly the older population, compared to the N Ireland population
- Has a higher birth rate;
- Slightly higher average life expectancy:
  - 78 years for men compared to the Northern Ireland average of 77.7 years,
  - 82.3 years for women compared to the Northern Ireland average of 82.1 years;
- The most common cause of death in 2015 was malignant neoplasm (28% of deaths), followed by circulatory disease (24.3%);
- Using primary care data for the Newry & Mourne Integrated Care Partnership (ICP), consisting of a practice population of 118,801 people, the Newry & Mourne ICP had:
  - 47,173 patients in 2015/16 with one or more chronic conditions;
  - Many patients, particularly those in the older age group, with multiple comorbidities;
  - 4,832 patients with 3 or more comorbidities.

4.2.2 Service Utilisation

- DHH is ranked the 6th busiest ED in Northern Ireland with 51,268 attendances in 2015/16;
- Using 2014/15 data at Northern Ireland level factors associated with ED attendance were age (infants and young adults accounted for the largest numbers of attendances), living in a deprived area and living near to a hospital;
- ED attendances were more likely to result in hospital admission with advancing age. From the age of 74 years onwards, more than half of attendances result in admission.

The Southern LCG area population:

- Had the second highest ED attendance rate in Northern Ireland;
- Had the lowest emergency admission rate compared to other areas;
- Used the lowest number of emergency bed days per head of population;
- Had the lowest rate of emergency admissions to hospital for ambulatory-care sensitive chronic conditions and spends the smallest number of bed days in hospital with these conditions.

4.2.3 Daisy Hill Hospital

- There has been an increase in attendances of 15% for adults and 28% for children in the 3 year period to 2016/17;
- 85% of ED attendees come from Newry & Mourne and Banbridge Local Government Districts and 1.2% from the Republic of Ireland;
- Medical admissions have increased by 35% between the hours of 8pm and 8am, this is particularly noticeable for patients aged >75 years;
- GP Out of Hours (GP OOH) in DHH was closed on 60 occasions in 2016/17. SHSCT have put in a range of measures to encourage GPs to work in OOH services;
- The throughput per bed and average Length of Stay in DHH compares favourably with similar sized hospitals in Northern Ireland;
- In common with other acute hospitals in Northern Ireland, delayed discharge from inpatient wards after the acute phase of illness continues to be a challenge.

4.2.4 Right Care in the Right Place

The best clinical outcomes require skills and expertise in diagnostics and interventional treatments which cannot all be delivered in every hospital.

There are a number of key services and clinical interfaces that ensure that patients requiring unscheduled care receive the correct care in the appropriate place. These include:

- *Primary Percutaneous Intervention (PCI)* – patients who have had an ST Elevation Myocardial Infarction where appropriate are taken directly to the Royal Victoria Hospital for primary PCI;

- *Major Trauma* – National Institute of Clinical and Healthcare Excellence (NICE) guidance recommends that major trauma cases within a 60 minute drivetime of a major trauma centre (MTC), which in Northern Ireland is the Royal Victoria Hospital (RVH) should be taken there directly. Work is underway with a view to implementing this model during 2018. This will work alongside the Helicopter Emergency Medical Service (HEMS). It is anticipated that there are approximately 370 cases of major trauma annually in Northern Ireland.
- *Critical Care* – DHH does not have a critical care unit. Patients needing critical care are transferred to Craigavon Area Hospital (CAH) or the RVH. There is a surgical high dependency unit and in 2015/16 there were plans to strengthen this service with additional consultant intensivist sessions from the CAH team.
- *NIAS Treat and Leave Protocols* – following agreed protocols Ambulance personnel may either treat a patient and/or refer them on to another service such as the falls service;
- *Mental Health Services for Adults and Children* which provide in-reach to the acute hospitals as well as supporting people in the community. They include:
    - Alcohol and substance misuse liaison,
    - Over 65 year old liaison – Memory Liaison and Psychiatry of Old Age,
    - Under 65 year old liaison,
    - Child and Adolescent Mental Health Services;
- *Community Based Services* which can provide alternatives to hospital admissions and attendance at ED include:
    - GP Out of Hours Service,
    - Acute Care at Home,
    - Palliative Care Team,
    - Heart Failure Service,
    - Respiratory Team.
- *Hospital based paediatric ambulatory care services* – provide an alternative to hospital admissions for GPs.

- *Community services and nursing homes,* which although their main roles are not to deliver unscheduled care, need to work closely with the hospital to allow prompt discharge of patients, thus ensuring there will be capacity within DHH to accept new patients.

4.2.5 Accessibility

- The report identifies the challenge which would be presented in regards to access times for patients should a 24/7 type 1 ED service not be available in DHH. This would increase travel time to access services for some individuals in the population.
- The number of people in Northern Ireland living within a 1 hour drivetime to a Type 1 ED, based on GP registered population, would reduce from 99.6% to 97.5%.
- It should be noted that there is no definitive standard which indicates an appropriate drivetime to an ED.

4.2.6 An Overview of Models of Urgent and Emergency Care and their Effectiveness

A rapid review approach which examined existing published previews of models of urgent and emergency care was undertaken on behalf of the needs assessment group. In the face of continuously rising demands, urgent and emergency health care services around the globe are adopting alternative models of care in order to remain safe and sustainable.

The wide scope of this review and numerous models outlined reflects the reality of the complexity of urgent and emergency care systems.

Although the evidence base on the effectiveness of models of urgent care is improving it remains in development, with gaps in particular in relation to assessment of economic impacts and cost effectiveness. Whilst strong positive evidence has emerged for some models including 'ambulance/paramedic triage to the community, condition-specific rehabilitation, additional clinical support to people in nursing and care homes, improved end-of-life care in the community, remote monitoring of people with

certain long-term conditions and support for self-care'[2], it is also recognised that absence of evidence may not necessarily equate to negative outcomes in other interventions, particularly in small scale changes. However this reinforces the need for robust evaluations, of newer models of care going forward, and should not be underestimated.

4.3 Next Steps

The Interim Needs Assessment Report will be finalised when two further clinical audits are completed. These will provide more detailed clinical information which will assist the DHHPG in planning the future model of unscheduled care for the Newry & Mourne population.

The first audit is being undertaken by clinicians in DHH and will examine all admissions to DHH over a 7 day period to determine whether alternatives to hospital admission could have been considered. The data collection for this audit has been completed.

The second audit will be undertaken in September 2017 by senior nurse review team from HSCB, working with DHH clinicians, to review a sample of ward inpatient cases in DHH and assess;

- Their need for ongoing inpatient care
- Timely access to diagnostics
- Access to senior medical decision makers
- Access to multidisciplinary team where appropriate.

[2] Imison C et al. *Shifting the balance of care Great expectations*. Research Report. Nuffield Trust: 2017 Full report accessed at: https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf

5.0 RISK AND UNCERTAINTY

5.1 Introduction

The purpose of monitoring risk is to provide an approach to identify, assess and control uncertainty and to improve the ability of a project to succeed. The risks for this project will be monitored during the full life of the project via the following 3 steps:

- Identification of Risk
- Assessment of Risk and the likely impact on the objectives of the project
- Management of Risk and Mitigating Measures

5.2 Summary of Key Project Risks

A summary of the key project risks identified are as follows:

- Timeframe to deliver project objectives – 20 week timeframe
- Access to all stakeholders to inform proposals
- Meeting expectations of all stakeholders
- Securing buy-in from wider Newry & Mourne locality to satisfy requirements of co-production
- Maintaining existing service provision
- Insufficient physical space in DHH to support new models of working
- Insufficient manpower availability to implement new models of care
- Insufficient funding to implement proposals
- Timescales to deliver project proposals over the next 12-15 months

6.0 Recommendations & Next Steps

6.1 Recommendations

The DHHPG would propose the following next steps:

- To provide a specific focus on clinical staffing issues in DHH Emergency Department;
- To recommend proposals for maintaining the ED at DHH on a long-term basis.
- To identify additional measures across community and hospital services to deliver a 'sustainable' model for the Newry & Mourne population in the future.
- To set up 'task and finish' groups to consider proposals in more detail. These would be clinically led and managerially supported. The Groups would consider workforce issues, costing and estate issues with a view to producing a high level implementation and investment plan. Community representatives and staff will be involved in this work and input from the ECRC will be sought to support the work of specific "Task and Finish" groups as appropriate.

6.2 Project Programme - Summary of Key Milestones

Key Stage	
ECRC feedback on approach to date and approval of recommendations	To be confirmed
DHHPG members to agree approach to prioritisation of proposals	Mid-September 2017
Establishment of "task and finish" groups to develop short, medium and long-term implementation and investment plans	Mid-September 2017
DHHPG Meeting to monitor progress	21st September 2017
DHHPG Meeting to review Draft Interim Report	12th October 2017
Draft Interim Report to be submitted to ECRC	18th October 2017
DHHPG Meeting to review Draft Final Report	3rd November 2017
Draft Final Report to ECRC	15th November 2017

Appendix 1
DHH Pathfinder Group Membership

DHH PATHFINDER GROUP MEMBERSHIP

Meetings on 26th July 2017 and 21st August 2017

Member of Group
Dr Anne Marie Telford, Project Director
Dr Richard Wright, Medical Director, SHSCT
Mrs Angela McVeigh, Director of Older People & Primary Care, SHSCT
Mrs Aldrina Magwood, Director of Performance & Reform, SHSCT
Mrs Esther Gishkori, Director of Acute Services, SHSCT
Mrs Ruth Rogers & Mrs Jane McKimm Head of Communications, SHSCT
Ms Charlene Stoops, Assistant Director of Corporate Planning, SHSCT – Project Manager for DHH Pathfinder Project
Dr Brid Farrell, Assistant Director of Service Development, Safety & Quality, PHA – Chair of Needs Assessment Group
Dr Diane Corrigan, Consultant in Public Health Medicine, PHA
Mrs Mary Hinds, Director of Nursing, PHA
Ms Sophie Lusby, SLCG nominee
Ms Rosie Byrne, Assistant Director of Unscheduled Care, HSCB nominee
Mr Brian Smyth, NIPSA, Staff side Representative
Mr Brian O'Hagan, PPI
Mr Peter Donnelly, Chair of PPI Panel
Dr Arnie McDowell, Chair of LMC
Mrs Carmel Harney, Assistant Director of AHP, WFD and Training
Mr Shane Devlin, Chief Executive, NIAS
Dr Shane Moan (or Deputy)*
Mrs Kay Carroll, Head of Service, SHSCT*

* Joined as members of the group on 21st August 2017

Appendix 2
List of Attendees at Meetings, Workshops & Engagement Events

NEEDS ASSESSMENT GROUP MEMBERS

Meetings on 27th July 2017 and 10th August 2017

Member of Group
GPs
Dr Arnie McDowell, GP Federation and LMC
Dr Laurence Dorman GP Federation
SHSCT
Dr Richard Wright, Medical Director
Mr David Gilpin, Consultant Surgery DHH
Ms Charlene Stoops, Assistant Director of Corporate Planning – Project Manager for DHH Pathfinder Project
Dr Alan Evans, GP Out of Hours
Mrs Cathrine Reid, Head of Service, GP Out of Hours
Dr Bronagh McGleenon, Consultant Geriatrician
Mrs Anne McVey, Assistant Director of Medicine & Unscheduled Care
Dr Gareth Hampton, Clinical Director ED
Ms Catherine Farrell, Unison, Staffside Rep
Ms Rosin Toner, Assistant Director of Enhanced Division
Mrs Cathie McIlroy, Head of AHPs (CAH & DHH)
PHA
Dr Diane Corrigan, Consultant in Public Health Medicine
Dr Brid Farrell, Assistant Director of Service Development, Safety & Quality
Dr Rachel Doherty, Specialty Registrar in Public Health Medicine
Southern LCG
Mrs Alison Patterson
NIAS
Mr Brian McNeill
Community Nominees
Mr Brian O'Hagan, PPI
Mr Peter Donnelly, Chair of PPI Panel
PMSI, BSO
Mr Stephen McDowell, PMSI
HSCB
Mr Martin Doyle, Acute Information
Ms Fiona Dunbar, Community Information

CO-PRODUCTION GROUP MEMBERS

Meetings on 30th June 2017 and 10th August 2017

Member of Group
Dr Anne Marie Telford, Project Director
Mrs Angela McVeigh, Director of Older People & Primary Care, SHSCT
Mrs Jane McKimm, Head of Communications, SHSCT
Ms Charlene Stoops, Assistant Director of Corporate Planning, SHSCT - Project Manager for DHH Pathfinder Project
Mr Gerard Rocks, Assistant Director of Promoting Wellbeing (Acting), SHSCT
Mrs Carolyn Agnew, HOS User Involvement and Community Development, SHSCT
Mr Peter Donnelly, Service User, Chair SHSCT PPI Panel
Mr Brian O'Hagan, Service User, Chair Southern ICP
Mrs Alison Patterson, HSCB
Ms Sophie Lusby, HSCB
Ms Anna Donnelly, Communications Team, SHSCT

LIST OF STAKEHOLDERS ENGAGED THROUGH SMALL COMMUNITY ENGAGEMENT EVENTS

Meetings on 2nd, 3rd & 4th August 2017

Venues: Kilkeel Primary Care Centre, Daisy Hill Hospital & Crossmaglen Community Centre

Panel Members
Dr Anne Marie Telford, Project Director
Mr Brian O'Hagan, Service User, Chair Southern ICP
Ms Eileen Mullan, Non-Executive Director, SHSCT
Mr Martin McDonald, Non-Executive Director, SHSCT
Dr Rachel Doherty, Specialty Registrar in Public Health Medicine, Public Health Agency

List of Stakeholders

Name	Date	Venue
Glyn Hanna & Diane Forsythe, DUP MLAs	2nd August 2017	Kilkeel Primary Care Centre
Sean McManus, DHH Action Group, N&M Councillor	2nd August 2017	Kilkeel Primary Care Centre
3 x Members of Staff, Clinical, DHH	2nd August 2017	Kilkeel Primary Care Centre
Margaret Annett, Member of local community	2nd August 2017	Kilkeel Primary Care Centre
Sinead Ennis, Chris Hazzard, South Down MLA Sinn Fein & Cllr Oksana McMahon, Sinn Fein	2nd August 2017	Kilkeel Primary Care Centre
Brian Quinn, Newry, Mourne & Down Councillor	2nd August 2017	Kilkeel Primary Care Centre
Margaret Rogers & Mary McMahon, Members of local community	2nd August 2017	Kilkeel Primary Care Centre
Stevan Barry, Member of local community	3rd August 2017	Daisy Hill Hospital
Justin McNulty, MLA SDLP Newry & Armagh	3rd August 2017	Daisy Hill Hospital
Ralph Hewitt, Newry Democrat	3rd August 2017	Daisy Hill Hospital
Mary Doran, Health Matters (Health & Safety) Ltd.	3rd August 2017	Daisy Hill Hospital
Mickey Brady Sinn Fein Newry & Armagh with 3 representatives	3rd August 2017	Daisy Hill Hospital
Sinead Bradley, MLA SDLP South Down & Declan McAteer	3rd August 2017	Daisy Hill Hospital
John O'Dowd, Sinn Fein MLA Upper Bann & Councillor Kevin Savage, Banbridge	3rd August 2017	Daisy Hill Hospital
Cuan Mhuire Group	3rd August 2017	Daisy Hill Hospital
Barbara Fitzgerald, Traveller Group	3rd August 2017	Daisy Hill Hospital
Seamus McCabe, PIPS N&M Suicide and Self harm Support Group	3rd August 2017	Daisy Hill Hospital
Mary Meehan, Michael McKeown, Julie Gibbons & Conor Patterson, Newry Chamber of Commerce	3rd August 2017	Daisy Hill Hospital

Name	Date	Venue
Jim Wells, MLA DUP Kilkeel	3rd August 2017	Daisy Hill Hospital
Jackie Coade, Alliance Party Newry & Armagh	3rd August 2017	Daisy Hill Hospital
Francis Gallagher, Chair of the DHH Action Group Jerome Mullen, DHH Action Group and member of Polish Council NI	3rd August 2017	Daisy Hill Hospital
Geraldine Merindo and 2 representatives of Newry Neighbourhood Renewal Group	3rd August 2017	Daisy Hill Hospital
Seana Grant, Sarah Devlin & Robert Keenan, Save our Emergency Department Group	3rd August 2017	Daisy Hill Hospital
Dr Morris, Southern Area Hospice	3rd August 2017	Daisy Hill Hospital
Susan Carey, Local Networks Officer (NI – South) MS Society NI	4th August 2017	Crossmaglen Community Centre
Lorraine O'Reilly, Age Friendly Coordinator – Active and Health Communities, Newry, Mourne and Down Council	4th August 2017	Crossmaglen Community Centre
Lorna Mackey & Ann McGuinness, Busy Bees Group & Dorsey Youth Club	4th August 2017	Crossmaglen Community Centre
Megan Fearon, MLA Sinn Fein & Cllr Terry Hearty	4th August 2017	Crossmaglen Community Centre
Dr Patrick Loughran, Member of local community	4th August 2017	Crossmaglen Community Centre
Teresa McShane & Family Member, Members of local community	4th August 2017	Crossmaglen Community Centre

LIST OF STAKEHOLDERS ENGAGED THROUGH CLINICAL & NON-CLINICAL STAFF ENGAGEMENT EVENT IN 'DESIGNING UNSCHEDULED CARE SERVICES FOR THE FUTURE'
Workshop held on 9th August 2017

Venue: Canal Court Hotel, Newry

Professional Group SHSCT Medical/Management

Dr Bassam Aljarad,	AMD Children & Young People's Services	Mr Ronan McKeown	Consultant T&O Surgeon
Dr James Crockett	Specialty Doctor, Anaesthetics	Mrs Anne McVey	AD, Acute Services
Dr Donal Duffin	Consultant Physician	Dr David Mawhinney	Consultant in Emergency Medicine
Mrs Esther Gishkori	Director of Acute Services	Dr Shane Moan	Consultant Physician
Mr Simon Gibson	AD Medical Directorate	Dr Seamus Murphy	Consultant Physician
Dr David Gracey	Consultant Radiologist	Dr Neville Rutherford-Jones	Consultant Anaesthetist
Mr David Gilpin	Consultant Surgeon	Dr Damian Scullion	Acting AMD for Anaesthetics, Theatres & ICU
Dr Gareth Hampton	Clinical Director, Emergency Medicine	Mr David Sim	Consultant in Obstetrics & Gynaecology
Dr John Harty	Consultant Nephrologist	Dr Ruth Spedding	Consultant in Emergency Medicine
Dr Martina Hogan	Associate Medical Director, Maternity & Women's Health	Dr Shahid Tariq	Consultant Anaesthetist

Dr Paul Hughes	Associate Specialist General Surgery	Mrs Heather Trouton	AD, Acute Services
Dr Sanjeev Kamath	Consultant in Obstetrics & Gynaecology	Mr Colin Weir	Consultant Surgeon
Professional Group <u>SHSCT Nursing</u>			
Mrs Mary Burke	Head of Service – Acute Medicine & Unscheduled Care	Mrs Anne Harris	Sister – Stroke Ward (DHH)
Mrs Alison Campbell	Sister – Elective Admission Ward (DHH)	Ms Laura McAuliffe	Department Manager – Emergency Medicine & Minor Injuries
Mrs Wendy Clarke	Lead Midwife - CAH	Mrs Joanne McGlade	Lead Midwife - DHH
Ms Natasha Cummins	Clinical Sister – Endoscopy (DHH)	Ms Noelle McGarvey	Staff Nurse – General Outpatients (DHH)
Ms Margaret Donnelly	Clinical Sister – High Dependency Unit (DHH)	Mrs Fiona Reddick	Head of Cancer Services
Ms Lynn Fee	AD – Nursing (Workforce Development Training)	Mrs Siobhan Rooney	Sister Coronary Care (DHH)
Ms Dawn Ferguson	Nursing, Education & Workforce		

Professional Group <u>SHSCT Allied Health Professionals</u>			
Ms Lynn Allen	Speech & Language Therapy (CAH)	Mrs Teresa Ross	Head of Physiotherapy Services
Ms Emma Givan	Dietetics	Mrs Denise Russell	Head of Podiatry
Mrs Carmel Harney	Assistant Director of AHP, WFD and Training	Ms Joanne Tilley	Physiotherapy (DHH)
Ms Lis O'Connor	Dietetics		
Professional Group <u>SHSCT Other Services</u>			
Ms Carolyn Agnew	Head of Promoting Wellbeing	Ms Catherine Farrell	Trade Union Representative - UNISON
Mr Brian Beattie	AD – Primary Care	Dr Richard Hamilton	General Practitioner
Mrs Tracey Boyce	Director of Pharmacy	Ms Shirley Henning	Social Work Team Manager
Mrs Anita Carroll	AD – Acute Services	Dr Maeve Lambe	General Practitioner
Mr Adrian Corrigan	AD – Mental Health	Dr Arnie McDowell	General Practitioner
Mr Loughlinn Duffy	Trade Union Representative – NIPSA	Mr Brian Magee	Head of Pathology Services
Dr Sandra Elliott	GP Out-of-Hours	Ms Suzanne Martin	Patient & Client Council
Dr Alan Evans	Clinical Lead – GP Out-of-Hours	Ms Yvonne Murphy	Team Leader – Integrated Care Services & Stroke
Dr Derval O'Reilly	General Practitioner	Mrs Catherine Sheeran	Head of Non-Acute Hospital, Integrated Care Services & Stroke

Mrs Jeanette Robinson	Head of Diagnostic Services	Dr John Shannon	General Practitioner
Dr David Rogers	Associate Medical Director – Primary Care	Ms Fiona Waldron	Lead Social Worker
Dr Petrina Ryan	General Practitioner	Mrs Catherine Weaver	Head of ITS Programme Management

Facilitators/Support			
Dr Anne Marie Telford	Project Director		
Mr Barry Conway	Assistant Director – Acute Services	Ms Charlene Stoops	Assistant Director of Corporate Planning
Dr Diane Corrigan	Consultant in Public Health Medicine, Public Health Agency	Ms Michelle Tennyson	Assistant Director of Allied Health Professionals – Public Health Agency
Dr Brid Farrell	Assistant Director of Service Development, Safety & Quality, Public Health Agency	Mrs Vivienne Toal	Director of Human Resources & Organisational Development
Ms Claire Fordyce	Public Health Agency	Mrs Roisin Toner	Assistant Director of Enhanced Services

Mrs Mary Hinds	Director of Nursing and AHPs, Public Health Agency	Mrs Sandra Waddell	Head of Acute Planning
Ms Joanne McCloskey	HSC Leadership Centre	Dr Richard Wright	Medical Director
Ms Rose McHugh	Nursing, Public Health Agency	Ms Elaine Orr	Public Health Agency
Mrs Angela McVeigh	Director of Older People & Primary Care		
Mrs Heather Mallagh-Cassells	PA to Director of Human Resources & Organisational Development		

HSC Leadership Centre			
Christine McGowan	Principal Consultant, HSC Leadership Centre	Paula Taylor	ICT Programme System Training Support Officer, HSC Leadership Centre

LIST OF STAKEHOLDERS ENGAGED THROUGH SMALL GROUP MEETINGS

There have been a range of meetings with the Trust Chief Executive, Chair, Directors, senior managers and clinicians in DHH. This included a tour of DHH with a separate tour of the ED. Other meetings included:

- Northern Ireland Medical & Dental Training Agency – 26th June 2017 & 15th August 2017.
- Patient Client Council – 7th August 2017
- Newry, Mourne & Down District Council – 8th August, 14th August & 21st August 2017
- Northern Ireland Ambulance Service – 14th August 2017

VIEWS OF STAKEHOLDERS FROM OTHER EVENTS/WORK ALREADY IN PROGRESS

This project will take cognisance of:

- Any ideas and views on the development of ambulatory care services specific to DHH which were captured at the Southern Area Locality Network Ambulatory Workshop on 28th July 2017.

- Previous work undertaken in other Trusts to improve unscheduled care services, including the review undertaken by the Northern Trust in 2010 and improvements seen through the Belfast Trust ImPACT Project.

Glossary

CAH – Craigavon Area Hospital
DHH – Daisy Hill Hospital
DHHPG – Daisy Hill Hospital Pathfinder Group
DOH – Department of Health
ECRC – Emergency Care Regional Collaborative
ED – Emergency Department
GP – General Practitioner
GP OHH – GP Out of Hours
HEMS – Helicopter Emergency Medical Service
HSC – Health and Social Care
HSCB – Health & Social Care Board
LCG – Local Commissioning Group
MLA – Member of Legislative Assembly
MP – Member of Parliament
MRI – Magnetic Resonance Imaging
MTC – Major Trauma Centre
NIAS – Northern Ireland Ambulance Service
NICE – National Institute of Clinical and Healthcare Excellence
NIMDTA – Northern Ireland Medical & Dental Training Agency
PCC – Patient Client Council
PCI – Primary Percutaneous Intervention
PHA – Public Health Agency
PID – Project Initiation Document
PPI – Personal and Public Involvement
SMT – Senior Management Team
SRO – Senior Responsible Officer
TIG – Transformation Implementation Group

Southern Health and Social Care Trust

News Release

September 18, 2017

Daisy Hill Hospital Pathfinder Group – First Phase Report

The Daisy Hill Hospital Pathfinder Group will shortly complete its First Phase report on the delivery of sustainable acute and emergency care in the Newry and Mourne area.

The process has brought together community interest groups, staff representations, nursing, medical, allied health professionals, ambulance staff and public health experts.

The report not only considers the delivery of sustainable acute and emergency care but also looks at how these services are changing across Northern Ireland, with very specialist services provided in dedicated centres of excellence; and how a range of alternatives to hospital admissions could be developed in the Newry and Mourne area.

This First Phase report is on the agenda of the Pathfinder Group meeting on Thursday 21st September, will then be presented to the Trust's Board meeting on Thursday 28th September and subsequently to the Department of Health for consideration.

Speaking ahead of the Pathfinder Group meeting, Trust Chief Executive Francis Rice said:

"It has always been the Trust's position that we want to maintain the Emergency Department at Daisy Hill.

"The work of the Pathfinder Project going forward will be focused on how to attract and retain staff to enable the Trust to achieve the best outcomes for our patients. Although challenges remain we are more confident of recruiting high calibre medical and nursing staff. "

"The project will also look at new models of care which can provide more appropriate and timely care for patients, particularly older patients.

"The delivery of emergency care is of course an issue for the whole of Northern Ireland, and will ultimately require solutions at a regional level. I am confident that the work being carried out by the Pathfinder Group will help to identify examples of regional learning and look forward to working closely with colleagues across the HSC to design a model for emergency care that makes the best use of our resources and which is sustainable in the long term."

Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon BT63 5QQ
Tel: Personal Information redacted by the USI • Fax: Personal Information redacted by the USI • www.southerntrust.hscni.net

Southern Health and Social Care Trust

News Release

Chair of the Daisy Hill Pathfinder Group, Dr Anne-Marie Telford said:

"I would like to thank the team for their excellent and comprehensive work on this First Phase and for their continued commitment in developing the Second Phase of this important project."

ENDS

For further information contact Personal Information redacted by the USI

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Southern Health and Social Care Trust

REPORT SUMMARY SHEET

Meeting Date	Trust Board 24th November 2016
Title	Executive Director of Nursing's update report on key nursing and midwifery governance, education and workforce activity.
Lead Director	Angela McVeigh, Director Older people and Primary Care Executive Director of Nursing/AHPs (Acting)
Corporate Objective	• Providing safe high quality care • Making best use of resources • Support people and communities to live healthy lives and improve their health and wellbeing
Purpose	Assurance and Information

Summary of Key Issues for Trust Board

High level context

NQI Framework
Trust Board approved the Nursing Quality Indicator (NQI) Framework as the mechanism for providing assurances on the quality of nursing care to patients in the Southern Trust.

NMC Revalidation
The Nursing and Midwifery Council's (NMC) has revised its revalidation criteria for registered nurses and midwives and the Trust has in place assurance arrangement to report on the revalidation status of all nursing / midwifery registrants employed by the Trust.

The Patient / Client Experience (PCE)
The Patient / Client Experience (PCE) surveys evidence the experience of patients and clients on the care provided by all nurses, midwives and other health care workers in unscheduled care areas.

Nursing Workforce
Appointing to Registered Nursing (all branches) and Midwifery posts across all service areas, remains extremely challenging despite significant, proactive local recruitment and international recruitment.

Nursing and Midwifery Education
The Trust continues to support students from all local Universities in compliance with Nursing and Midwifery Council Standards, to ensure a workforce fit for the future. Engagement with students has been increased across all Universities and branches of Nursing, and Southern Trust remains the only Trust in Northern Ireland to offer posts to students in Year 2 of their training. The Trust also ensures support for new Registrants with Nursing Induction and Preceptorship, and access to accredited post-registration development to ensure staff who are knowledgeable

and competent to deliver person-centred care.

Key issues/risks for discussion

NQI Framework
The NQI assurance framework is to be supported by a FileMaker data base version 15 as it has the ability to analyze complex data from all 4 domains across all directorates. The current version 11 needs to be upgraded as the software company will no longer support this version (since Sept 2015). Until this is completed and version 15 is functional, assurance on the quality of nursing care will continue to be provided via the paper-based audit analysis which, as per the research undertaken in the Trust, is considered to be less robust. A small number of iPads / android tablets are also required to ensure timely data collection and analysis using the upgraded version 15 and hopefully the software issues around functionality will be resolved in the near future.

NMC Revalidation
Assurance on nursing and midwifery revalidation is provided through reports generated via a bespoke FileMaker database which, as above requires to be upgraded to a new version 15. Until this work is completed reports on assurance on revalidation will be provided from reports from version 11.

Nursing Workforce
A risk for the Trust is how to continue to deliver safe nursing care given the number of vacancies across services that are unable to be filled despite significant local and international recruitment activity. This is on the Corporate Risk Register and actions plan are in place to maintain safe nursing care.

Summary of SMT challenge/discussion

NQI Framework
Following Trust Board approval, the implementation of the NQI Assurance Framework has continued with the development and testing of audit tools and data analysis continues. Moving to version 15 the EDN will support the EDON to provide more robust assurances on the quality of nursing care provided within the Trust.

NMC Revalidation
SMT is satisfied that arrangements are in place to provide assurance on timely revalidation and that monitoring procedures will identify those registrants at risk of failing to revalidate. As such, SMT agreed to reduce the risk from high to medium on the corporate risk register in September 2016. The current assurance arrangements are supported by a FileMaker database which is currently being upgraded.

Nursing Workforce
As a corporate risk SMT are aware of the risk of nursing vacancies on the delivery of services. It is recognised that the international recruitment campaigns in 2016 will provide additionally in terms of supply across 2017.

Internal/External engagement

Trust Ward Sisters / Charge Nurses / Team Leaders and nurses in all directorates continue to participate in a rollout programme for implementing the NQI Framework and a NQI Framework Steering Group continues to meet bi-monthly to oversee and support progress. There is ongoing engagement of Personal and Public Involvement (PPI) Leads involving patients in service improvement initiatives. Research and nursing leads have also engaged with the PHA's Patient / Client Experience Standards and 10,000 Voices initiative to ensure cross-agency information sharing and learning.

The Trust Assistant Director of Nursing (Workforce and Education), continues to lead international recruitment and review local recruitment approaches for the five Health and Social Care Trust, with Karyn Patterson seconded to the role of HR Regional Nursing and Medical International Recruitment Lead.

Human Rights/Equality

There are no perceived specific Human Rights or equality issues within the context of the framework approach proposed. The focus of nursing quality indicators is to provide assurances on high quality compassionate care that supports Trust delivery of Human Rights and equality requirements.

International nursing recruitment will be progressed taking into account all UK requirements as well as any legislative requirements from other countries.

Southern Health and Social Care Trust

Quality Care - for you, with you

Executive Director of Nursing Report to Trust Board

24th November 2016

Executive Director of Nursing Update Report to Trust Board 24th November 2016

This report provides an update on the key nursing and midwifery governance and workforce development and training activity set out in the reports tabled in June 2016.

2.1 The ST's Nursing Quality Indicator (NQI) aims to proactively drive improvements in the quality of nursing and midwifery care and the patient experience. In 2014 the EDN funded research which examined the application of a nursing quality indicator (NQI) framework in evidencing the impact of nursing on patient safety outcomes and the patient experience in adult in-patient wards. Proposed Framework: -

2.2

					Domain 4
		Safe and effective process indicators	**Safe and effective outcome indicators**	**Patient experience indicators**	**Nurse's knowledge of patient's care needs**
		Review of patient records to assess compliance with evidence- based care bundles	Review of patient records to determine patient safety outcomes in relation to selected NQIs	Exploration of patient's perception of their experience of nursing care	Nurses asked to identify the patient's nursing care needs. Responses mapped against nursing care plan
	Ward level Data	Patient safety outcome measures; feedback from nurses and complaints and incidents			

The research found that the NQI Framework provided a more robust and comprehensive analysis on the quality of nursing care as opposed to when domain elements were analysed individually. The NQI Framework supports a review of the patient's experience of their care journey and the knowledge of the nurses caring for them.

2.3 *Implementing the NQI Framework*

ST NQI Framework Implementation Group, chaired by the EDN, has agreed that **only those Nursing Quality Indicators (NQIs) which the Trust is required to report / provide assurance on locally (SMT / Trust Board) and regionally should be audited**, however, Directorate-specific monthly nursing audits could continue with the agreement of the director and senior nurses if required.

Nursing Quality Indicators (NQIs)	Reporting Mode
1. SKIN	Audit
2. Falls (Part A)	Audit
3. Nutrition (MUST)	Audit
4. NEWS / OEWS / PEWS	Audit
5. Omitted and Delayed Meds (Failure to record)	Audit
6. Nurse Record Keeping	Audit
7. Pt/C Experience Standards / 10,000 Voices	Audit
8. Professionalism (NMC Revalidation, Nurse Supervision)	Quarterly progress report
9. Preceptorship	End of year progress report
10. Delivering Care (Normative Staffing)	
11. NMC Standards to Support Learning and Assessment in Practice 2008	End of year progress report

2.4 It was agreed that FileMaker software would be used to analyse the audit data as it has the ability to analyze complex data from all 4 domains across all directorates. The Trust requires to update the FileMaker software as current versions are no longer supported. Until this is completed assurance on the quality of nursing care will continue to be provided via the paper-based audit analysis. Collection of data will be via use of an iPad / android tablet which hopefully will be available soon.

2.5 *NQI Framework Implementation Activity June – November 2016*

Post-research / Implementation Activity	Progress
Review and agree the NQIs which the Trust is required to report on regionally in line with 2016-17 requirements	**Concluded**
Pilot / testing of the associated NQI audit tools to ensure that they reflect the 4 domains	**Concluded**
Writing of NQI Framework database	**Concluded** – until FileMaker version 15 available
Upload of FileMaker Version 15 and supply of mobile devices for data collection	**Delayed** (as at Nov 2016)
Agreement on divisional / ward / team rollout arrangements	**Concluded**
Facilitated audit consistency training/awareness with identified auditors – a core recommendation to support valid and reliable reporting on audit outcomes	**Concluded** Will be repeated as new auditors come on board
Development of *Guidance for Auditors on the Application of the NQI Audit Tools*	**Concluded** for Acute Directorate but will be tested after database upload

Development of *Guidance for Managers on Areas for Improvement of Nursing Care* at both at ward/team and organisational level post-audit	**Ongoing** - will be tested after database upload
Engagement with Personal and Public Involvement (PPI) Leads on post-audit service improvement initiatives	**Ongoing**
Development of an evaluation strategy to assess success of Framework in evidencing safe, quality nursing care and enhanced patient experience.	**Ongoing**
Submission of research paper for publication in the *International Journal of Health Care Quality Assurance*	**Concluded** – awaiting peer reviewer feedback
The Acute directorate NQI Steering Group members to develop criteria for nurses' involvement in non-nursing audits to ensure that nursing care and capacity is not compromised.	**Ongoing**

The NQI Framework Steering Group continues to meet bi-monthly to review progress on the implementation. Further progress on implementation is delayed until the database is live and the iPads are available and functioning in the collection of data.

2.6 *Reporting Arrangements*

Arrangements for reporting on NQIs will reflect other formats used across the Trust, e.g., Trust Delivery Plan reports. The use of the file maker database will facilitate the development of the outcomes dashboard.

3.0 Reporting on Agreed NQIs

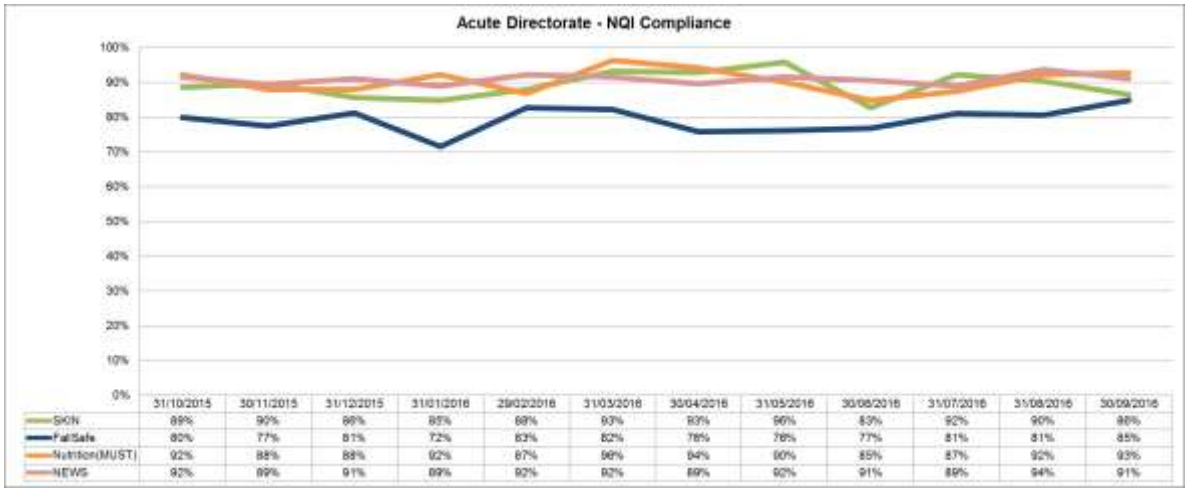
Monthly paper-based audits would continue to be undertaken by the Ward Sisters / Charge Nurses / Team Leaders (in those directorates where applicable) and collated on Excel with each indicators being reported on separately rather than across the 4 domains as recommended in the research.

3.1

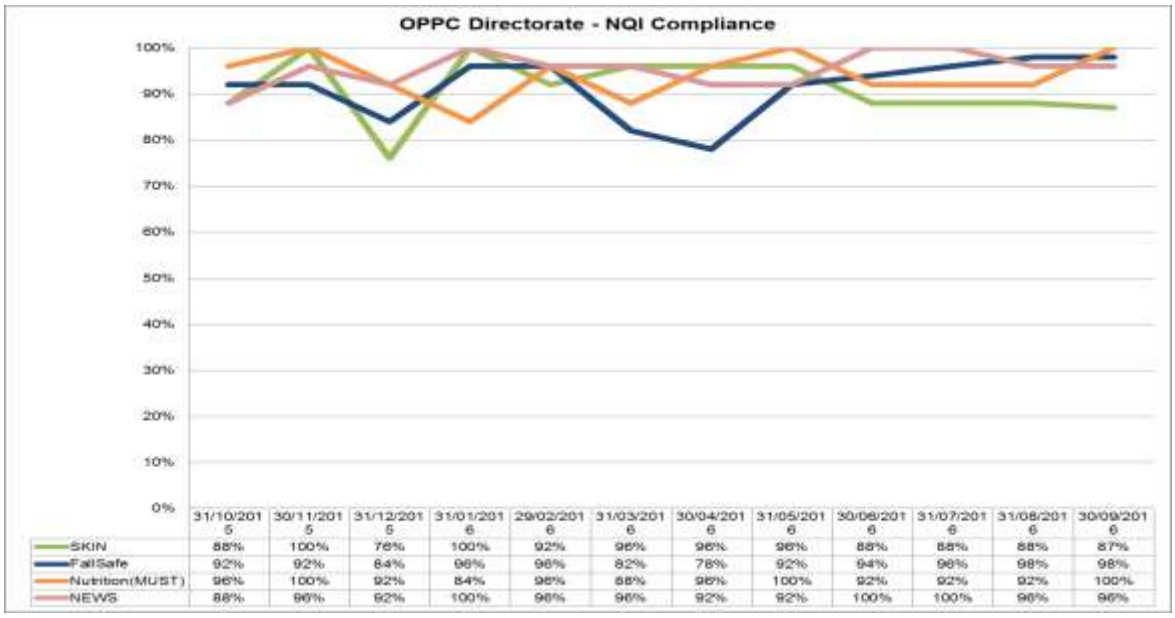
	NQI	Acute	OPPC	MHD	CYP	Report via
1.	SKIN	X	X			Audit
2.	Falls (Part A)	X	X	X		Audit
3.	Nutrition (MUST)	X	X	X		Audit
4.	NEWS / OEWS / PEWS	X	X	X	X	Audit
5.	Omitted and Delayed Meds (Failure to record)	X	X	X		Audit
6.	Nurse Record Keeping	X	X	X	X	Audit
7.	Pt/C Experience Standards / 10,000 Voices	X	X	X	X	Audit

8.	Professionalism (NMC Revalidation and Nurse Supervision	X	X	X	X	Monthly report
9.	Preceptorship	X	X	X	X	End of year reports
10.	Delivering Care (Normative Staffing)	X	X	X	X	
11.	. NMC Standards to Support Learning and Assessment in Practice 2008	X	X	X	X	

3.2 NQIs 1- 4 - Acute Adult Inpatient Wards



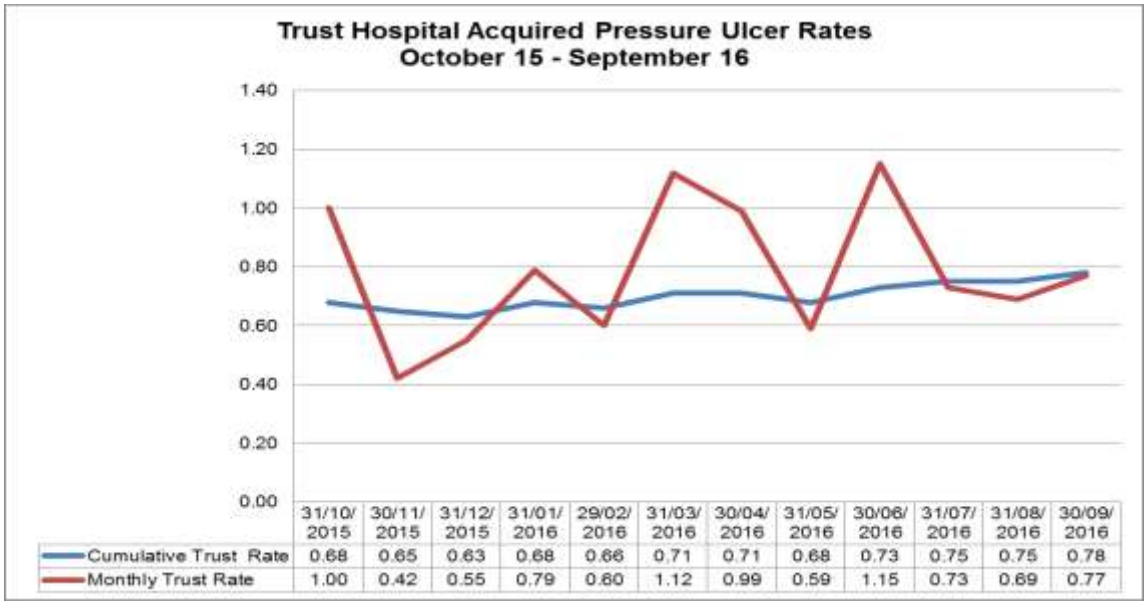
3.3 NQIs 1- 4 - OPPC (Non-Acute) Adult Inpatient Wards



In both Acute and Non-acute Directorates nurses are consistently achieving significant or full compliance with the SKIN (pressure ulcer), Falls, MUST (nutrition) and NEWS indicators. There is continued concentrated efforts by Ward Sisters through support,

education and enhanced monitoring to ensure full compliance on all indicators is achieved.

3.4 Southern Trust Hospital Acquired Pressure Ulcers (Oct 2015 – Sept 2016)



	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016
Cumulative Trust Rate	0.68	0.65	0.63	0.68	0.66	0.71	0.71	0.68	0.73	0.75	0.75	0.78
Monthly Trust Rate	1.00	0.42	0.55	0.79	0.60	1.12	0.99	0.59	1.15	0.73	0.69	0.77

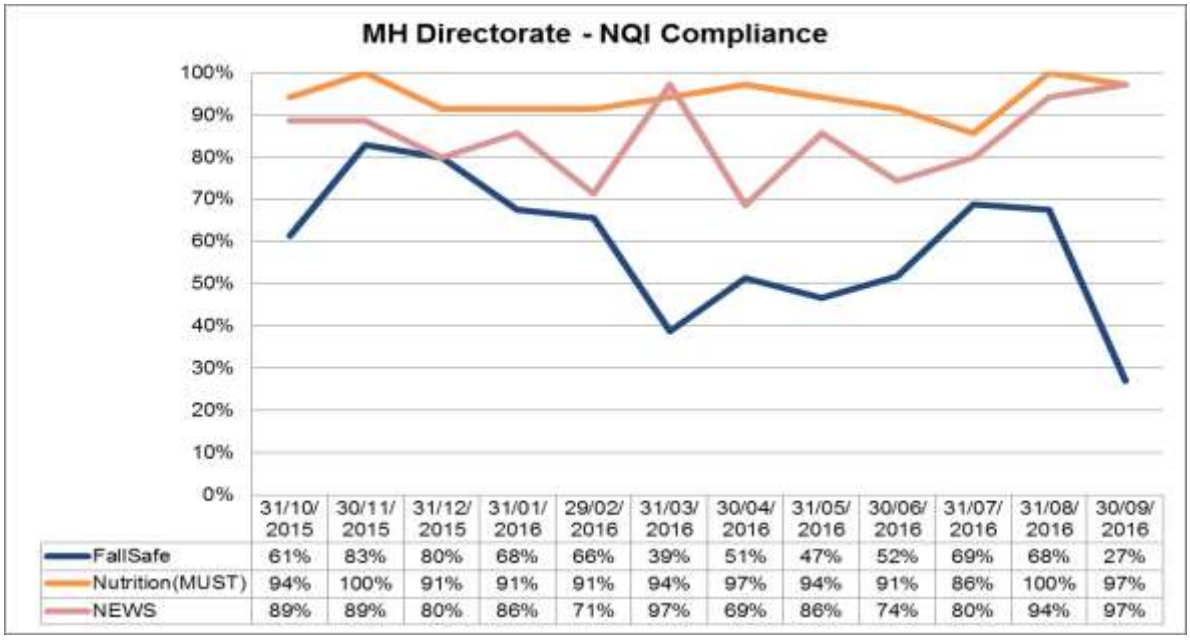
The data is taken from individual wards Safety Crosses across the Trust and cross referenced against Datix. The implementation of the SKIN Bundle and associated training over the last three years has increased staff awareness regarding the identification, grading, management and reporting of Hospital Acquired pressure ulcers.

The Public Health Agency Quality Improvement Plan Framework for 2016/7 requires Trusts to provide quarterly detail on the following: -

- Compliance with SKIN Bundle
- Total Number of Hospital Acquired Pressure Ulcers grade 2 and above
- Number of Hospital Acquired Pressure Ulcers grade 3 and 4
- Number of Hospital Acquired Pressure ulcers grade 3 and 4, which were unavoidable

To facilitate the above, the Trust's Tissue Viability Nurse Specialist and the relevant Ward Sisters have undertaken a Root Cause Analysis (RCA) on all Grade 3 and 4 Ward Acquired Pressure Ulcers identified since March 2015.

3.5 *NQIs 2 - 4 - Mental Health and Disability Directorate*

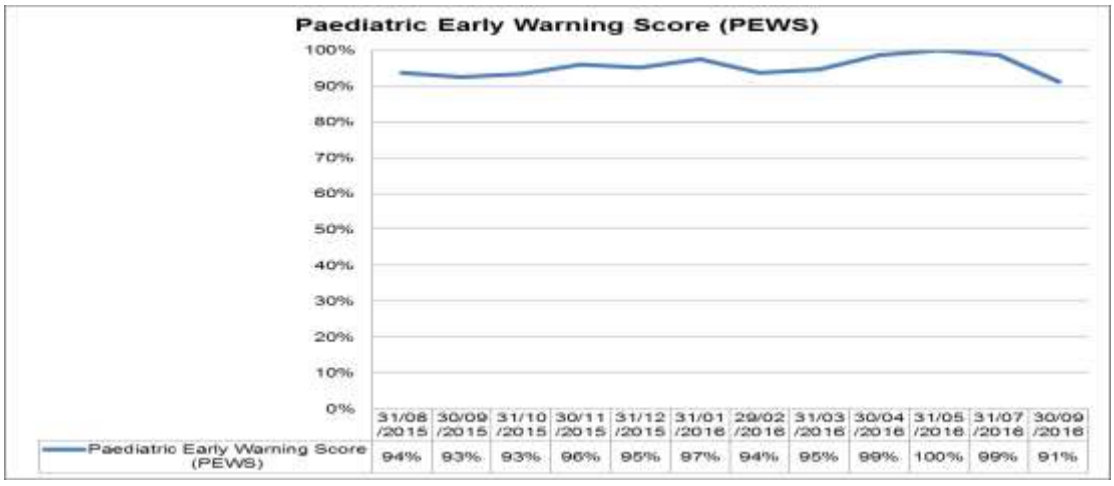


	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016
FallSafe	61%	83%	80%	68%	66%	39%	51%	47%	52%	69%	68%	27%
Nutrition(MUST)	94%	100%	91%	91%	91%	94%	97%	94%	91%	86%	100%	97%
NEWS	89%	89%	80%	86%	71%	97%	69%	86%	74%	80%	94%	97%

Compliance with the NEWS and Nutrition (MUST) bundles across the seven inpatient wards has improved from A RAG of amber in July to green in August and September 2016.

The record audit shows that Willows and Gillis Wards were full compliant with the FallSafe bundle, however, compliance in other wards ranged from 27% to 69% (n = 39). The elements contributing to non-compliance included:- not recording urinalysis (n=15), not recording if patients were asked about their fear of falling (n=2) and history of falling (n=2). Action plans are in place to address these gaps in recording.

3.6 *NQI 4 - Children and Young People's Directorate*



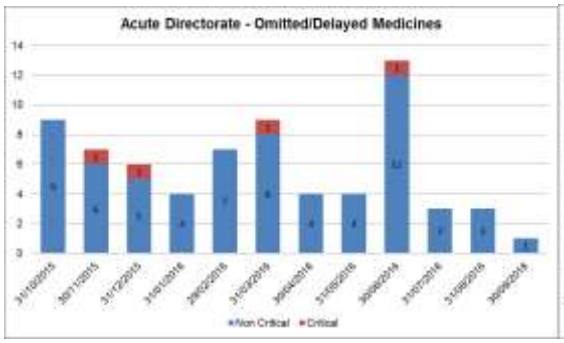
	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	31/07/2016	30/09/2016
Paediatric Early Warning Score (PEWS)	94%	93%	93%	96%	95%	97%	94%	95%	99%	100%	99%	91%

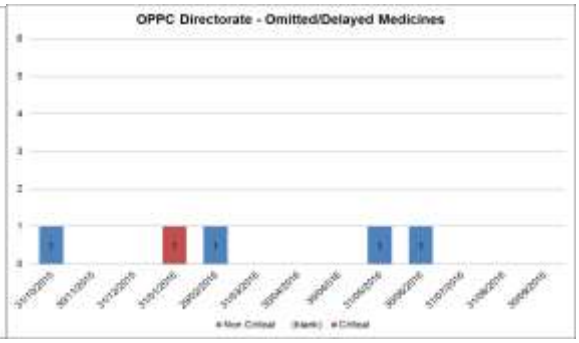
The Paediatric Early Warning Score (PEWS) audit is completed in both the DHH and CAH Children's Wards. The current PEWS template is a pilot of the new regional PEWS chart. The parameters and scoring in the new chart is more extensive than previously and feedback is currently being collated for regional review within the Quality Collaborative group. The parameters within the new chart no longer include temperature but now include

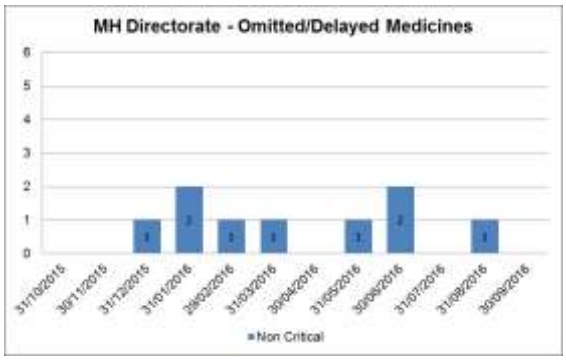
blood pressure monitoring. The numerical values have changed significantly therefore has affected the current existing template on the NQI data base which is also now under review.

3.7 *NQI 5 - Omitted / Delayed Critical Medicines* – all adult in-patient wards

Omitted / Delayed Critical Medicines have been monitored in all adult in-patient wards over the past year (since October 2015) with results for each directorate as outlined below.







October 2015 – September 2016

Directorate	Medicine Kardexes audited	Total no of medicine doses prescribed	No of 'Blank' doses	Total critical medicine doses prescribed	No of critical medicine doses that were 'Blank'
Acute	1,602	19,405	70 (0.36%)	5,478	4 (0.02%)
OPPC	296	5,096	5 (0.09%)	845	1 (0.01%)
MHD	420	5,600	9 (0.16%)	261	0
Total	**2,318**	**30,101**	**84(0.27%)**	**6,584**	**5 (0.01%)**

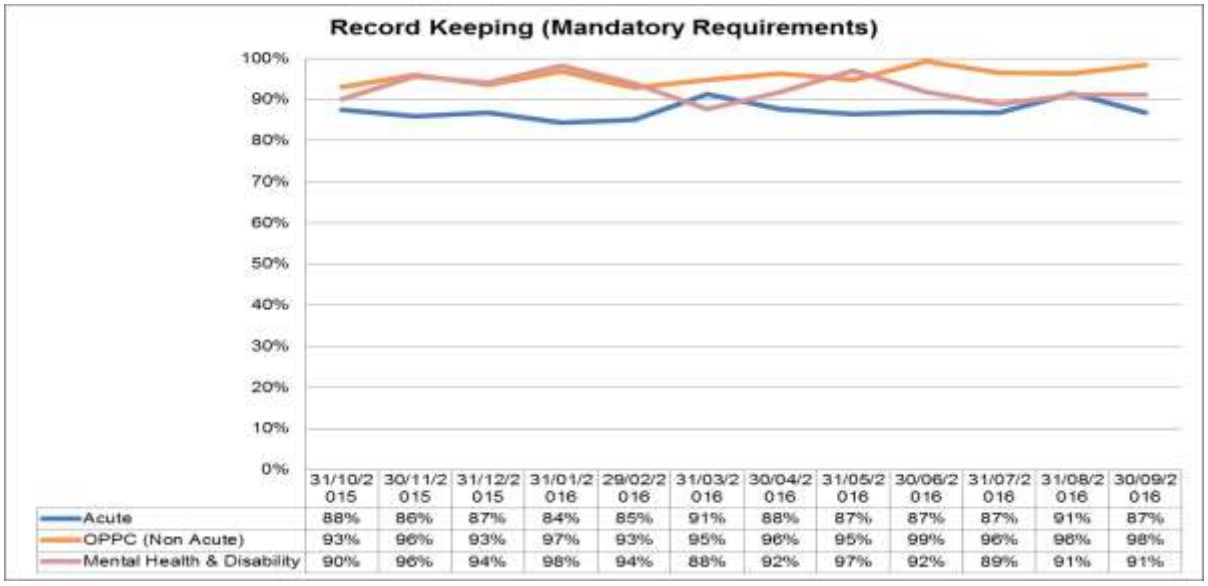
*Blank = no record in kardex that a medicine, including a critical medicine, had been administered at the prescribed time. This does not necessarily mean the medicine was not administered only that it was not recorded as being administered.

In the last 12 month period 5 out of a total of 6,584 [0.01%] prescribed *critical* medicines were recorded as 'Blank'; 4 were in the Acute Directorate, 1 in OPPC and 0 in MHD. There is a variety of reasons why a medicine may not have been administered, such as the patient was fasting, a new medicine was recently prescribed or the medicine was not

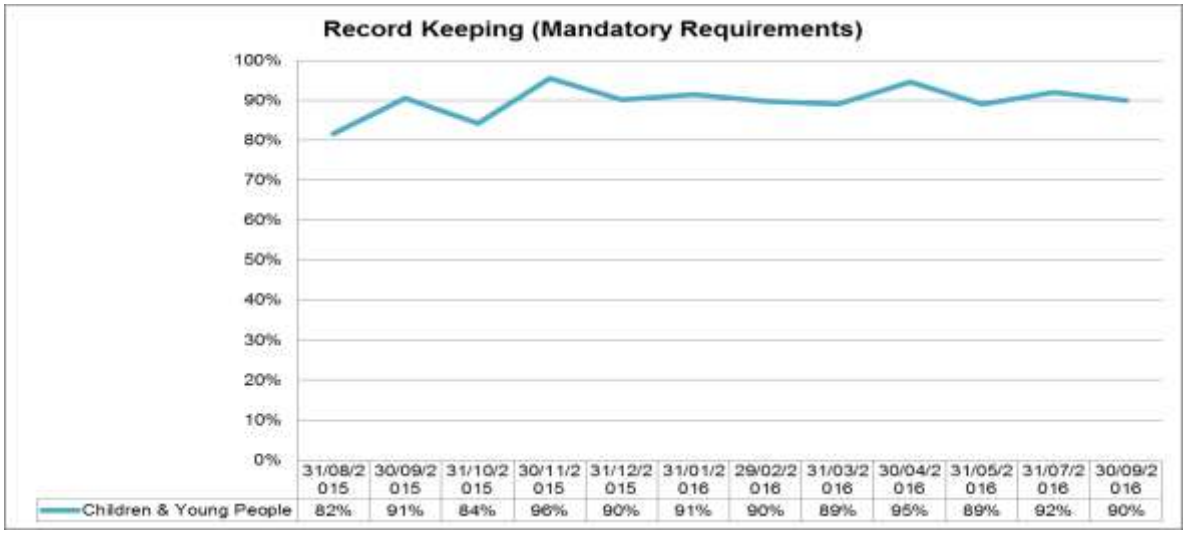
available on the wards.

3.8 *NQI 6 - Recording Care : Evidencing Safe and Effective Care*

Recording care is an important element in evidencing safe and effective nursing care and is a skill and activity which the profession is constantly promoting and improving on. Over the past year the average Trust compliance with mandatory record keeping standards in Acute, Non-acute and MHD adult in-patient areas was 91%.



	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016
Acute	88%	86%	87%	84%	85%	91%	88%	87%	87%	87%	91%	87%
OPPC (Non Acute)	93%	96%	93%	97%	93%	95%	96%	95%	99%	96%	96%	98%
Mental Health & Disability	90%	96%	94%	98%	94%	88%	92%	97%	92%	89%	91%	91%



	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016	30/04/2016	31/05/2016	31/07/2016	30/09/2016
Children & Young People	82%	91%	84%	96%	90%	91%	90%	89%	95%	89%	92%	90%

The record keeping audit tools for adult and children's nursing differ and therefore cannot be compared against each other. CYP has scored an average of 90%.

The draft paediatric PEWS charts continue to be used within the Children's Wards. SHSCT CYPS comments in relation to the draft PEWS charts have been shared with the Regional Working Group. CYPS are awaiting the outcome of the collation of all regional comments and suggested amendments to the PEWS charts.

3.9 To support improvement in record keeping the EDN identified funding for the temporary

secondment of a Professional Development Facilitator. The Facilitator's role is to promoting a positive recording keeping culture amongst nurses that reflects the delivery of person-centred care and compliance with good recording keeping practices. Southern Trust Lead Nurses developed and tested a person-centred recording framework, known as the PACE (Patient-centre, Assessment, Nursing Care and Evaluation) Framework and the Facilitator is leading the rollout of the PACE Framework across the Acute Directorate. The Framework has been successful in supporting the recording of person-centred care and the other HSC Trusts are now testing the Framework with a view to rollout within their organisations.

3.10 A regional **r**ecord keeping competency framework and self-assessment tool has been developed to support Health Care Support Workers (HCSWs) in recording care and will now be tested across all Trusts prior to full implementation.

3.11 NQI 8 - Professionalism - NMC Revalidation and Nurse Supervision

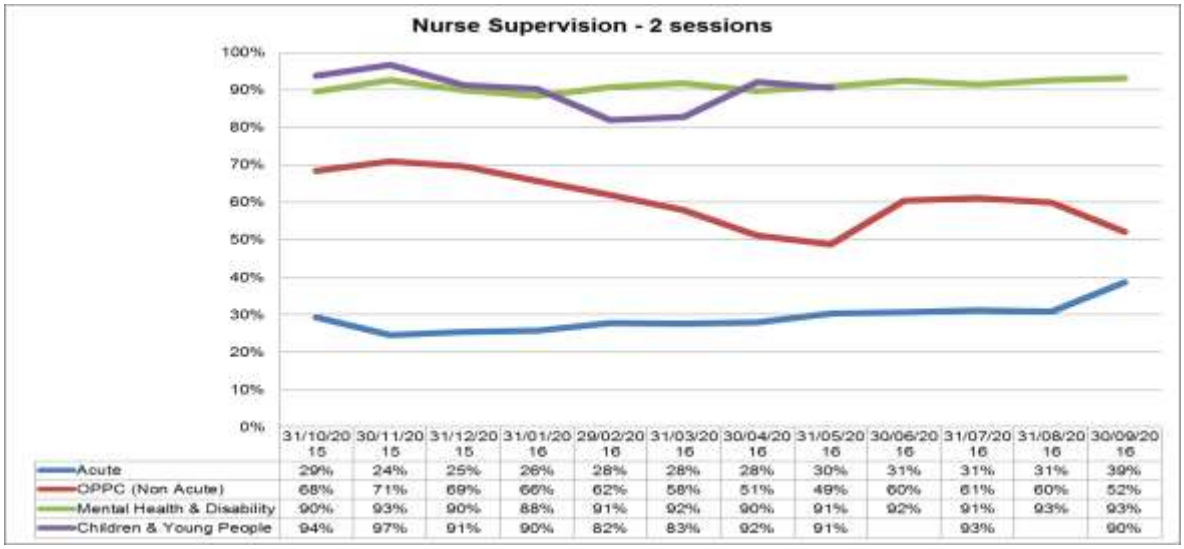
NMC Revalidation

The Nursing and Midwifery Council's (NMC) revised revalidation arrangements for registered nurses and midwives came in to effect in April 2016 and includes a number of additional elements designed to improve public protection and ensure that nurses and midwives remain fit to practise throughout their careers.

The Trust has put supportive arrangements in place to ensure organisational and registrant readiness for implementation of the additional criteria. This has included support provided by the Nursing Governance Co-ordinators and a Revalidation Support Team. The development of a database provides monthly reports to managers on those nurses and midwives who are due to revalidate and / or pay their annual fee. Since April 2016, excluding those who had been granted an extension, all but 3 of 727 (99.6%) registrants have revalidated / paid their annual fee on time. On the occasions where the 3 registrants did not revalidate / pay their annual fee on time their name was removed from the register until they satisfy the NMC's requirements.

3.12 ***Nurse Supervision***

The ST's Policy on Nurse Supervision requires that all registered nurses are able to avail of two sessions of professional supervision per year.



Ensuring nurses can access two supervision sessions has been a challenge in all directorates, particularly Acute. However, given the NMC's review of statutory supervision in midwifery, the CNO is also undertaking a review of the regional Nurse Supervision Policy. Recording and discussing reflections on practice is now a core component of revalidation and it is expected that this requirement will support and encourage better compliance with the nurse supervision policy.

3.13 *NQI 9 - Preceptorship*

Preceptorship is: 'a period of structured transition for the Preceptee during which he/she will be supported by a Preceptor, to develop confidence as an autonomous professional, refine skills, values, attitudes and behaviours and to continue on a journey of lifelong learning' (adapted from Department of Health (DoH), 2010). The programme is 26 weeks duration and is co-delivered by Clinical Education Centre and the Practice Education Team.

The table below provides an overview of activity April 2016 to September 2016:

Number of Programmes due to complete April 2016-September 2016	Number of Registrants due to complete a programme* April 2016-September 2016	Registrants indicated as having completed Programme	Reason for non-completion	Number of Preceptorship Programmes commenced April 2016-September 2016	On target to complete Programme within 26 week timescale
8	113	79	Left Trust (6) Long term sick/maternity leave (4) Withdrew as not a new registrant (1) Awaiting confirmation from line manager of completion of programme (23)	3	23 (x1 on sick leave)

*These programmes commenced prior to April 2016

3.14 *NQI 10 - Delivering Care (Normative Staffing)*

Progress regarding implementation of Delivering Care across all phases is set out as follows:

Phase 1 (Acute medical and surgical wards)

Bi-annual reporting regarding compliance for this phase of Delivering Care continues with the most recent report submitted for the reporting period April 2016 to September 2016. Additional funding was received to convert 15WTE Band 5 posts to Band 6 posts within acute medical wards, and staff are in post or due to commence imminently. The requirement for Ward Sisters/Charge Nurses to be 100% supervisory is being achieved across all acute surgical wards, however, the majority of acute medical wards are unable to achieve this standard.

Phase 2 (Emergency Departments)

Finalisation of the Emergency Department staffing model is in progress, with an expectation that this will be agreed pre-Christmas 2016.

Key elements of this model include senior staffing requirements (Band 6 or Band 7) across the 24 hour period, which will ensure that all key areas of the ED have an experienced nurse to provide expert clinical knowledge at all times, to ensure that patient pathways function seamlessly throughout the department to improve patient safety and enhance their experience in the department.

Phase 3 (District Nursing)

Development and agreement regarding a model for District Nursing remains challenging. Following a regional data collection exercise and analysis of the Hurst Model a draft summary paper based on 24 hour provision of care has been developed, recognising that this requires further analysis and refinement for registered skill mix, the supervisory role and palliative care key worker role. There are ongoing discussions to develop an IT tool to support caseloads and staff utilisation. The region is currently considering the Buurtzorg (Netherlands) model, and potential application to the Northern Ireland context.

Phase 4 (Health Visiting)

A summary paper was completed in September 2016, with a proposed caseload forming the model for Health Visiting, with the focus on 0-4 year olds to carry out the 3 core functions of the health visiting service.

Phase 5 (Mental Health)

This phase will commence December 2016.

4.0 *NMC Standards to Support Learning and Assessment in Practice*

Mentor Register (EiMs Electronic Register)

Current Mentorship Statistics

SHSCT for the reporting timeframe have 898 mentors who are currently available to mentor students.

Table 1 below provides further detail and Table 2 provides this information per Directorate/Divisions.

Table 1: SHSCT Mentor Statistics

	Available	Unavailable*	Total Number
Mentors	503	242	**745**
Sign-off mentors	380	181	**561**
Practice Teachers	15	8	**23**
TOTALS	**898**	**431**	**1329**

*Unavailable due to mentor criteria lapsed, leave reason, action plan in progress. The Practice Education Team continue to work with Ward Sisters/Charge Nurses/Team Leaders to maximise the availability of mentors, which is of paramount importance moving forwards due to the increased number of students from September 2016.

Table 2: Mentor Statistics per Directorate/Division*

Directorate / Division	Number of Mentors	Number of Sign-off Mentors	Number of Practice Teachers	Total
Acute: MUSC	130	105	0	**235**
Acute: ATICS & SEC	154	132	0	**286**
Acute: IMWH & CCS	20	123	0	**143**
CYPS	161	52	11	**224**
OPPC	151	76	7	**234**
MHLD	129	73	5	**207**
Totals	**745**	**561**	**23**	**1329**

Student Capacity

Number of practice areas approved for student placements	Number of educational audits carried out in past 6 months	Max. number of students that can be accommodated at any one time

141	66	358

Due to ongoing requirements to increase practice placements, the Practice Education Team continually work with service colleagues to scope placement capacity. A regional Task and Finish Group has been established to ensure consistency and continuity across Trusts regarding capacity of practice placements. The regional Practice Placement Agreement is being updated by DoH and Trusts to facilitate student placements for individuals on the Open University Pre-Registration Nursing Programme employed by the independent sector.

Mentors/Sign-off Mentors/Practice teachers CPD Activity

The Practice Education Team facilitates a number of programmes and updates for mentors, sign-off mentors and Practice Teachers throughout the year, which are Nursing and Midwifery Council requirements. CPD activity statistics can be viewed below:

Programme/Activity Title	Number of programmes/sessions facilitated April 2016 – Sept 2016	Number of mentors/SoM/PT who completed the programme/activity/added to mentor register
Mentorship Preparation Programme/APEL	1	125/2
Nursing and Midwifery annual update	45	592
Triennial reviews	N/A	92
Progression to sign-off mentor status programme	1	30
Model of support	1	22
Supervising mentor preparation programme	1	2
Practice Teacher Forum	1	12

Challenges in Practice Placements

The challenge of time for mentoring nursing and midwifery students continues, in particular the required 1 hour protected time per week for sign-off mentors with final placement students (NMC, 2008). A re-audit in August 2016 demonstrated that progress has been made since the previous audit in 2015, although the Trust remains not fully compliant. An action plan has been updated as a result.

5.0 *Advanced Nurse Practitioner Programme*

As previously reported DoH has confirmed financial support for the training fees for 20-25 nurses regionally to commence an Advanced Nursing Practice Programme. The initial

focus will be for Paediatric and Emergency Department settings.

SHSCT has contributed to the on-going debate regarding the development of this role over recent years and is currently represented on the Curriculum Planning Group with Ulster University. It is anticipated that the first programme will commence February 2017.

6.0 *Consultant Nurses and Midwives Framework*

A regional work-stream has reviewed the role of Nurse and Midwife Consultants in NI. Draft professional guidance for these Consultant roles has been developed and will be circulated on completion. The four core competencies will complement other generic competency frameworks which are relevant to the Consultant Nurse and Consultant Midwife roles, such as Knowledge and Skills Framework (DH, 2004); Healthcare Leadership Model (NHS Leadership Academy 2013); Attributes Framework (DoH, 2016).

7.0 *Post –registration Nursing and Midwifery Education Commissioning 2015-2016*

The Trust continues to conduct annual learning needs analysis for Registrants and works closely with the DoH to secure funding for those education programmes that are necessary for the nursing and midwifery workforce to continue to deliver a high standard of care. The financial constraints on this budget for the academic year September 2016 -2017 have continued, with only a limited number of courses inside and outside Northern Ireland being funded.

It has been communicated that the ongoing financial constraints in the nursing and midwifery workforce education budget will continue for 2017-2018. In order to make best use of resources the Trust have been asked to identify priorities for training for 2017-2018 and further scoping will commence shortly regarding identifying relevant education programmes.

8.0 *Clinical Education Centre (CEC)*

Southern Trust continues to fully utilise the Service Level Agreement (SLA) with the CEC. For the period March 2016 to September 2016, the utilisation was 76.46%. Further information will be submitted as part of the EDoN end of year report.

ADD SECTION re First Trust N&M Induction Programme

The first Trust-wide Nursing and Midwifery Induction Programme commenced October 2016, with 70 new staff attending. The introduction of the programme aims to have positive benefits for the Trust in terms of recruitment and retention. The programme will run over a period of 3-4 weeks (part-time attendance) and includes corporate and professional induction, mandatory training, a range of e-learning, and commencement on the Trust's Preceptorship programme for new registrants. Whilst the core induction programme will be delivered for all new staff, a variety of elements will be added for branch-specific nurses.

9.0 *Rotation Programme*

A rotational programme was introduced into the Acute Directorate in April 2015 as previously reported. The second cohort of 6 new registrants commenced the programme in October 2016. These staff will have the opportunity to work in three clinical areas over the next twelve months giving them an opportunity to consolidate their knowledge and skills as well as develop further skills in different care environments.

10.0 *Open University Nursing Programme (OU PRNP)*

This programme is available to Trust staff, and is a 4 year, part-time, work based programme for entry to the nursing profession (adult and mental health branches only). A total of 39 staff are currently undertaking the nursing programme, years 1 to 4.

Innovation in Delivery of the OU PRNP

Since September 2015 SHSCT, in partnership with the OU and DoH, have explored ways of increasing access to the programme for staff. A new model was implemented which facilitated 7 staff to complete the first two modules of the nursing programme as a stand-alone arrangement, and these staff have now commenced Year 2 of the programme in September 2016. This model has been replicated for September 2016, with a further 5 staff completing the first two modules of the nursing programme as a stand-alone arrangement. These 5 staff will commence stage 2 of the programme in September 2017.

In addition, SHSCT have commenced a further 15 staff onto Year 1 of the programme commencing September 2016, as a result of a realignment of backfill funding to additional places.

11.0 Cause for Celebration

Dawn Ferguson, Nursing Workforce and Education Coordinator, completed an MSc Developing Practice in Healthcare and has been awarded the University of Ulster's Mona Grey Award for Excellence in Post-Registration Research. Her dissertation was a qualitative study examining new registrants' views of a Preceptorship Programme during their transition year from student nurse/midwife to registrant.

12.0 Recruitment

The recognition of the insufficient supply of Registered Nurses across the province continues to be recognised, and nursing remains on the UK Shortage Occupation List.

12.1 International

Within the reporting timeframe of this report, six international recruitment campaigns have been conducted for the five H&SC Trusts in NI:

EU

1. May: Romania and Italy
2. June: Italy

3. October: Greece and Italy

Non-EU

4. Philippines: May, August and September.

All international recruits will be employed initially as Bank 3 Nursing Assistants pending registration with the NMC, in line with the arrangements for locally trained nurses.

On 16th September 2016 a group of 11 nurses from Italy arrived in the Trust, and are working across CAH and LH in acute medicine and non-acute. These staff are currently being supported to achieve NMC registration through a face to face English programme, in order to meet the Nursing and Midwifery requirements to achieve IELTS (International English Language Testing) at Level 7 across all domains. This programme is being delivered as part of a regional and local induction programme in partnership with the Clinical Education Centre.

Overview Update on All Offers (Regional)

To date there are currently 67 active offers from EU campaigns, and 724 offers from the Philippines. The current status of offers by Trust is detailed below:

Status of Offers	Northern	Belfast	Southern	Western	South Eastern	HSC [1]	Grand Total
Withdrawn / Offer Revoked	4	7	3	10	3	2	29
Pre-employment Checks in Progress	83	92	94	103	136	229	737
Started as Band 3	0	3	11	10	1		25
Total Offers	**87**	**102**	**108**	**123**	**140**	**231**	**791**
For those at Pre-employment checks							
Target Arrival Date In place	13	17	12	4	20		66

[1] *These are offers not yet allocated to any Trust. Allocations will be made once the appointees are nearing arrival. Any imbalances across Trusts will be rectified using this group of appointees.*

As previously reported, the arrivals date for EU campaigns can be identified almost immediately following interview, however the time from arrival to entry onto the NMC register is difficult to predict due to the individual requiring to obtain IELTS Level 7. The non EU timeframe for arrivals ranges between 7-14 months, with the majority anticipated around 10 months post-interview.

12.2 Local

Recommendations from the CNMAC Report (2015) relating to local recruitment approaches have been progressed through the regional Working Group and includes:

- More regular engagement with the student body across all local universities by Trust staff. The five Trusts are actioning this as a collaborative arrangement;
- All Trusts have initiated 'open' adverts on HSCRecruit;
- Job offers are now made to Year 3 students by all Trusts;
- Attending jobs fairs:
- The Working Group also has representation from the Recruitment Shared Service

Centre and is working to improve the recruitment experience for students and other applicants.

In addition, SHSCT has also progressed the following actions:

- Offers of posts to Year 2 students;
- Conducting 'one-stop-shops', with an interview conducted, decision given, pre-employment checks and Occupational Health checks commenced on the one day for all applicants. The October 2015 event resulted in 156 people interviewed, with 153 people successful. Of these 153, 107 have commenced in post. The next 'one-stop-shop' is planned for 25th November 2016;
- Streamlining of application and interview processes;
- Enhanced engagement with students throughout their placements in SHSCT, but particularly whilst on Placement 9 (management placement).

Following approval by SMT , a non-nursing support role, such as administration support or a housekeeping role, will be piloted to March 2017 and the impact on releasing nursing time will be evaluated.

13.0 *Conclusion*

This report provides a summary of a range of high quality, person-centred care being provided by nurses and midwives in the Southern Trust. Audits of the quality nursing care have shown incremental improvement in adherence to core nursing processes and action plans are being implemented to ensure quality improvements. Senior nurses are working to embed the NQI Framework and it is anticipated that outputs from these audits will be available for the next report. Community Nursing and Midwifery teams are also working to identify those indicators which would best evidence compliance with agreed quality standards in their area of care. The Trust has put in place arrangements to support the implementation of the new NMC revalidation arrangements which supports professional reflections and enhances practice. These arrangements are now well-embedded and success reflected in the 99.6% revalidation rate since the new arrangement came into effect in April 2016.

The report specifies the challenges the Trust is facing in securing and ensuring a sufficient nursing workforce both now and over the next number of years.

Southern Health and Social Care Trust

REPORT SUMMARY SHEET

Meeting Date	Trust Board 9th June 2016
Title	Executive Director of Nursing's update report on key nursing and midwifery governance, education and workforce activity.
Lead Director	Angela McVeigh, Executive Director of Nursing/AHPs
Corporate Objective	• Providing safe high quality care • Making best use of resources • Support people and communities to live healthy lives and improve their health and wellbeing
Purpose	Assurance

Summary of Key Issues for Trust Board

High level context

NQI Framework
Trust Board has approved the Nursing Quality Indicator (NQI) Framework as its mechanism for providing assurances on the quality of nursing care provided to patients in the Southern Trust.

NMC Revalidation
The Nursing and Midwifery Council's (NMC) has revised its revalidation criteria for registered nurses and midwives and the Trust has in place assurance arrangement to report on the revalidation status of all nursing / midwifery registrants employed by the Trust.

The Patient / Client Experience (PCE)
The Patient / Client Experience (PCE) surveys evidence the excellent care provided by all nurses and other health care workers in unscheduled care areas. The regional PCE Steering Group now has approved the rollout of PCE surveys in a number of new areas including Autism and Child and Adolescent Mental Health areas.

Nursing Workforce
Appointing to Registered Nursing posts remains extremely challenging despite proactive recruitment activity. International nursing recruitment is now being progressed on a five Trust basis.

Key issues/risks for discussion

NQI Framework
The NQI assurance framework is supported by a FileMaker data base version 11

as it has the ability to analyze complex data from all 4 domains across all directorates. Version 11 now requires to be uplifted to version 14 as support for version 11 was withdrawn in September 2015. The IT Department has advised that it cannot support the costs of this uplift (approx. £3740). The risk is therefore that assurance on the quality of nursing care cannot be provided without the uplift to version 14. Additionally, IT advises that the costs of a small number of ipads / android tablets necessary to data collection cannot be borne by its Department.

NMC Revalidation
The Nursing and Midwifery Council's (NMC) has revised its revalidation criteria for registered nurses and midwives. The Trust has invested in reporting on assurance on nursing and midwifery revalidation through FileMaker 11 which, as above, requires to be uplifted to version 14. The IT Department has advised that it cannot support the costs of this uplift. The risk is therefore that that assurance on the revalidation of nurses and midwives cannot be provided without the uplift to version 14.

The Patient / Client Experience (PCE)
The Trust has in place PCE Leads to support the surveys in Autism and Child and Adolescent Mental Health areas. A PCE/10000 Voice Facilitator has also been appointed to support this work.

Nursing Workforce
A risk for the Trust is how to continue to deliver safe nursing care given the number of vacancies across services that are unable to be filled despite significant recruitment activity, and recognisng the time scales for international nurse recruitment.

Summary of SMT challenge/discussion

NQI Framework

Trust Board has approved the implementation of the NQI Framework as a mechanism for providing assurances on the quality of nursing care provided to patients in the Southern Trust. Associated processes and development and testing of audit tools continue, however, without uplift to version 14 the EDN cannot provide assurances to SMT / TB on the quality of nursing care provided within the Trust.

NMC Revalidation
As a Corporate Risk SMT is aware of the potential risks to the Trust / public / patients should nurses fail to comply with the new revalidation arrangements. The current assurance arrangements are supported by FileMaker 11, however, without uplift to version 14 the EDN cannot continue to provide assurances as version 11 is no longer supported.

Nursing Workforce
Delivery of safe nursing care given the supply situation.

Internal/External engagement

Trust Ward Sisters and nurses continue to participate in a rollout programme for implementing the NQI Framework and the NQI Framework Steering Group continues to meet bi-monthly to oversee and support the processes. Ongoing engagement of Personal and Public Involvement (PPI) Leads on involving patients in service improvement initiatives. Research and nursing leads have also engaged with the PHA leads of the Patient / Client Experience Standards and 10,000 Voices initiative to ensure cross-agency information sharing and learning.

Lynn Fee and Karyn Patterson have been nominated to lead international nursing recruitment for the five Trusts.

Human Rights/Equality

There are no perceived specific HR or equality issues within the context of the framework approach proposed. The focus of nursing quality indicators is to provide assurances on high quality compassionate care that supports Trust delivery of Human Rights and equality requirements.

International nursing recruitment will be progressed taking into account all UK requirements as well as any legislative requirements from other countries.

Southern Health and Social Care Trust

Quality Care - for you, with you

Executive Director of Nursing Report to Trust Board

9th June 2016

Executive Director of Nursing Update Report to Trust Board 9th June 2016

This report provides an update on the key nursing and midwifery governance and workforce development and training activity set out in the reports tabled in January 2016.

2.1 The ST's Nursing Quality Indicator (NQI) aims to proactively drive improvements in the quality of nursing and midwifery care and the patient experience. In 2014 the EDN funded research which examined the application of a nursing quality indicator (NQIs) framework in evidencing the impact of nursing on patient safety outcomes and the patient experience in adult in-patient wards. Proposed Framework: -

2.2

Evidencing the nursing contribution to safe, effective, person-centred care

					Domain 4
		Safe and effective process indicators	**Safe and effective outcome indicators**	**Patient experience indicators**	**Nurse's knowledge of patient's care needs**
		Review of patient records to assess compliance with evidence- based care bundles	Review of patient records to determine patient safety outcomes in relation to selected NQIs	Exploration of patient's perception of their experience of nursing care	Nurses asked to identify the patient's nursing care needs. Responses mapped against nursing care plan
	Ward level information	Patient safety outcome measures; feedback from nurses and complaints and incidents			

The research found that the proposed framework and domains provided a more robust and comprehensive understanding of the overall quality of nursing care provided as opposed to reporting on individual care elements for groups of patients. Specifically, it supports a review of the patient's experience of their care *journey* and the knowledge of the nurses caring for them. A ST NQI Framework Implementation Group, chaired by the EDN, directs and oversees the implementation of the Framework within the 4 Care directorates.

2.3 *Implementing the NQI Framework*

A scoping exercise across the four Care directorates previously identified **at least 54 separate nursing process audits being undertaken on a monthly basis.** In order to provide more structured assurance on the quality of nursing care and reduce the number

of audits (and nurses' time spent undertaking these), the NQI Framework Steering Group agreed that **only those Nursing Quality Indicators (NQIs) which the Trust is required to report / provide assurance on locally (SMT / Trust Board) and regionally should be audited**, see below in 3.0. The agreed indicators will be reviewed periodically or as required to ensure they remain valid.

2.4 Given the substantial nature of the audit tools which now includes 4 domains, the NQI Framework Steering Group agreed that 3 monthly, rather than monthly audits, would be completed, where relevant, in all directorates. **Directorate-specific monthly nursing audits will continue with the agreement of the director and senior nurses and the EDN will report on them by exception if required/necessary.**

3.1

NURSING / MIDWIFERY QUALITY INDICATORS

(includes those regional indicators which Trust is required to report on to CNO (N KPIs), Quality 2020 – Commissioning Plan Direction, QIPs (Nursing indicators) and Patient Safety Quality Improvement Initiatives

Nursing Quality Indicators (NQIs)	Reporting Mode
1. SKIN	Audit
2. Falls (Part A)	Audit
3. Nutrition (MUST)	Audit
4. NEWS / OEWS / PEWS	Audit
5. Omitted and Delayed Meds (Failure to record)	Audit
6. Nurse Record Keeping	Audit
7. Pt/C Experience Standards / 10,000 Voices	Audit
8. Professionalism (NMC Revalidation, Nurse Supervision)	Quarterly progress report
9. Preceptorship	End of year progress report
10. Delivering Care (Normative Staffing)	
11. NMC Standards to Support Learning and Assessment in Practice 2008	End of year progress report

Information from audits across the 4 domains will provide assurance on the quality of nursing care, the patient's experience of care and identify areas for improvement both at ward level and organisational level.

Given the complexity in analysing data from all 4 domains in all directorates, it was agreed that Filemaker software would be used to analyse and report on findings. This database now requires to be uplifted to Version 14 as support for current Version 11 has been withdrawn. The IT Department has advised that it cannot support the costs of this uplift (approx. £3500). Additionally, IT advises that the costs of a small number of ipads / android tablets necessary to data collection cannot be borne by its Department.

3.2 *NQI Framework Implementation Activity January – June 2016*

Post-research / Implementation Activity	Progress
Review and agree the NQIs which the Trust is required to report on regionally in line with 2016-17 requirements	Concluded
Pilot of the associated NQI audit tools to ensure that they reflect the 4 domains – see below re outcomes of the pilot of the NEWS audit tool.	Ongoing Concludes end of June 2016
Writing of database (undertaken by Systems Administrator for Nursing & Midwifery supported by Medical IT Project Manager and FileMaker)	Ongoing Concludes by mid - June 2016
Testing / re-testing the revised audit tools in preparation for uploading onto Filemaker database	Ongoing
Liaison with IT on arrangements to upload of FileMaker Version 14 and supply of mobile devices to collect data	Ongoing Upload due by mid - June 2016
Agreement on divisional / ward / team rollout arrangements which need to be in place to ensure all wards / facilities have a validated independent audit completed 4 times per year.	Ongoing Concludes mid - June 2016
Facilitated audit consistency training/awareness with identified auditors – a core recommendation to support valid and reliable reporting on audit outcomes	1st round has concluded Will be repeated as new auditors come on board
Development of *Guidance for Auditors on the Application of the NQI Audit Tools*	Ongoing Concludes mid - June 2016
Development of *Guidance for Managers on Areas for Improvement of Nursing Care* at both at ward/team and organisational level post-audit	Ongoing
Ongoing engagement with Personal and Public Involvement (PPI) Leads on post-audit service improvement initiatives	Ongoing
Development of an evaluation strategy to assess success of Framework in evidencing safe, quality nursing care and enhanced patient experience.	In development
Submission of research paper for publication in the *International Journal of Health Care Quality Assurance*	Currently being peer reviewed prior to publication
The Acute directorate NQI Steering Group members to develop criteria for nurses' involvement in non-nursing audits to ensure that nursing care and capacity is not compromised.	Ongoing

The NQI Framework Steering Group continues to meet bi-monthly to review progress on the implementation.

The new arrangements for reporting on NQIs will be analysed using FileMaker and set out in an overall dashboard of all elements across the four domains. The following is a short summary of the outcome of the pilot of the audit tool from one of the process indicators - NEWS - set within the Safe and Effective Care Indicators domain.

NATIONAL EARLY WARNING SCORE (NEWS) AUDIT					
Number of wards audited (Acute/Non Acute and MHD)				20	
Number of patients' charts audited				**162**	
Number NEWS Scores recorded in past 24 hour period / week (MHD)				854	
Number of sets of NEWS observations reviewed – (max 3 per patient)				**260**	
LOW (0-4) Score 0 Score 1-4	 123 116	**MEDIUM** Score of 3 in one single parameter Score of 5 or 6	 4 12	**HIGH** Score of 7 or above	 5

PART 1 There are 15 elements on the NEWS charts which are required to be completed at each prescribed patient contact

Elements	**No. elements completed**		**Total of elements** [260 sets of obs] x 15 elements	**% completed**
All 15 elements completed	**3,764**		**3,900**	**96.5%**
	NOT completed		**Comments** (e.g., omissions on record)	
	n=3,764	%		
Patient Identity	11	0.29	No name / DOB / HSC number	
1. Dated	16	0.42	No year / first entry on new chart not dated	
2. Timed	6	0.15	Not in required 24hr clock format	
3. Respiratory Rate	3	0.08	Value not recorded, documented incorrectly	
4. Oxygen Saturation	All completed		No issues	
5. Inspired Oxygen	All completed		Litres instead of % (needs discussion)	
6. Temperature	3	0.08	Line documented inaccurate / unclear	
7. Blood Pressure	All completed		Different symbols used e.g., numerals / dots	
8. Heart Rate	5	0.13	Line documented inaccurate / unclear	
9. AVPU	3	0.08	Absent, record inaccurate / unclear	
10. NEWS totalled	7	0.18	Absent or incorrectly scored lower/higher	
11. Calculation for NEWS	22	0.58	Incorrectly calculated / scored	
12. Monitoring frequency	8	0.18	Not completed	
13. Monitoring frequency of vital signs obs match to NEWS / man plan	28	0.74	Not in line with the NEWS clinical response or the management plan	
14. Frequency in line with actual NEWS / management plan	31	0.82	Not carried out in line with actual prescription in NEWS / management plan	
15. NEWS score initialled	4	0.10	Unclear about who carried out observations	
Summary	**136**	**3.61**		

Findings

The pilot audit showed that just 3.6% [136, n= 3,764] of NEWS elements were not completed correctly. 65% of those [88] centred around either the totalling of NEWS scores and / or the frequency of vital signs observations to be carried out as prescribed in the patient's NEWS / management plan. Whist 3.6% is small there are some issues that need to be explored and a review of the guidance is being undertaken in the Trust with a view to clarity on some of the comments above. However, some of the issues around recording the vital signs are to do with the design chart itself which does not lend itself to accurate recording. The NEWS chart is currently being reviewed by the regional Patient Safety Forum.

This issue about who is responsible for prescribing the monitoring frequency of vital signs requires local and regional discussion with medical colleagues. In addition to the agreed process for escalation, the management plan should state when the prescribed monitoring frequency is to be reviewed.

PART 2

Escalation of a deteriorating patient as per adherence to trigger response and associated algorithm

The outcome of the pilot of the audit tool for Part 2 showed that 41 out of 48 [85%] of the elements which are required to be recorded in respect of the escalation of patients had been completed. The elements that were not recorded included -

- Time of escalation to a medical officer
- The grade of medical officer that the concern was escalated to
- The time the medical officer assessed the patient could not determine, i.e., if the plan was in place within the recommended minimum of 1 hour.

Further to the pilot, and in line with regional review, the audit tool will be refined further.

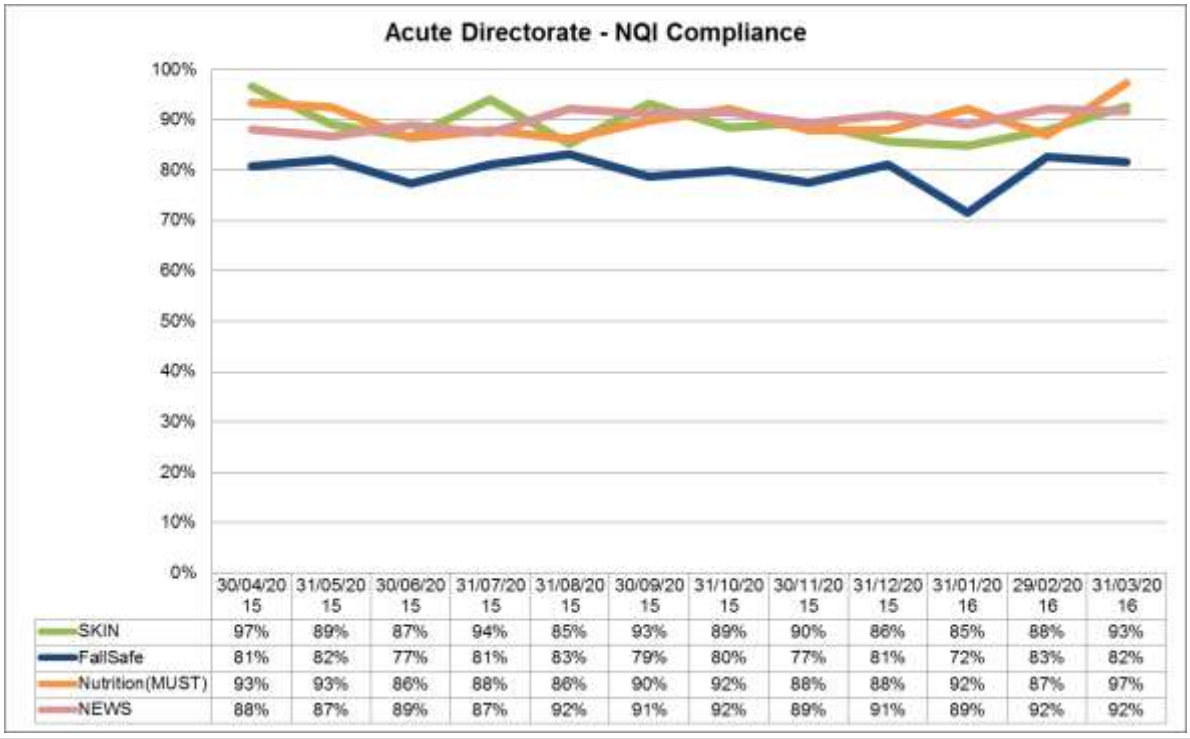
3.3

	NQI	Acute	OPPC	MHD	CYP	Report via
1.	SKIN	X	X			Audit
2.	Falls (Part A)	X	X	X		Audit
3.	Nutrition (MUST)	X	X	X		Audit
4.	NEWS / OEWS / PEWS	X	X	X	X	Audit
5.	Omitted and Delayed Meds (Failure to record)	X	X	X		Audit
6.	Nurse Record Keeping	X	X	X	X	Audit
7.	Pt/C Experience Standards / 10,000 Voices	X	X	X	X	Audit
8.	Professionalism (NMC Revalidation and Nurse Supervision	X	X	X	X	Monthly report
9.	Preceptorship	X	X	X	X	End of year
10.	Delivering Care (Normative Staffing)	X	X	X	X	

11. . NMC Standards to Support Learning and Assessment in Practice 2008	X	X	X	X	reports

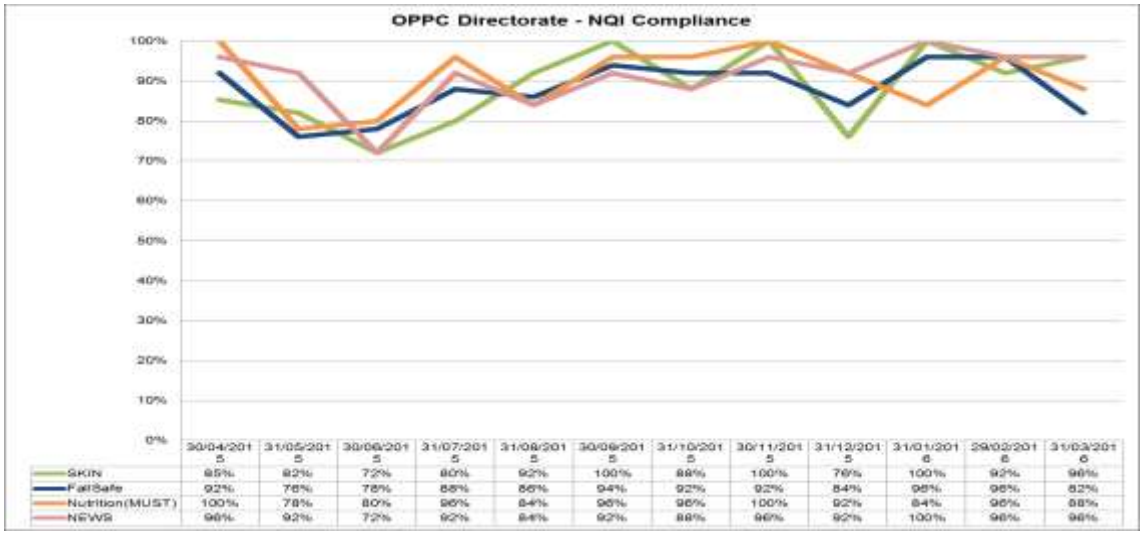
It was agreed that NQIs would be audited on a 3 monthly basis. However, as the FileMaker database to support the NQI Framework is not yet in place, monthly audits continue to be undertaken by the Ward Sisters and collated by excel with each indicators being reported on separately rather than across the 4 domains. The following is the report on audit outcomes April 2015 – March 2016.

3.4 *NQIs 1- 4 - Acute Adult Inpatient Wards*



	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016
SKIN	97%	89%	87%	94%	85%	93%	89%	90%	86%	85%	88%	93%
FallSafe	81%	82%	77%	81%	83%	79%	80%	77%	81%	72%	83%	82%
Nutrition(MUST)	93%	93%	86%	88%	86%	90%	92%	88%	88%	92%	87%	97%
NEWS	88%	87%	89%	87%	92%	91%	92%	89%	91%	89%	92%	92%

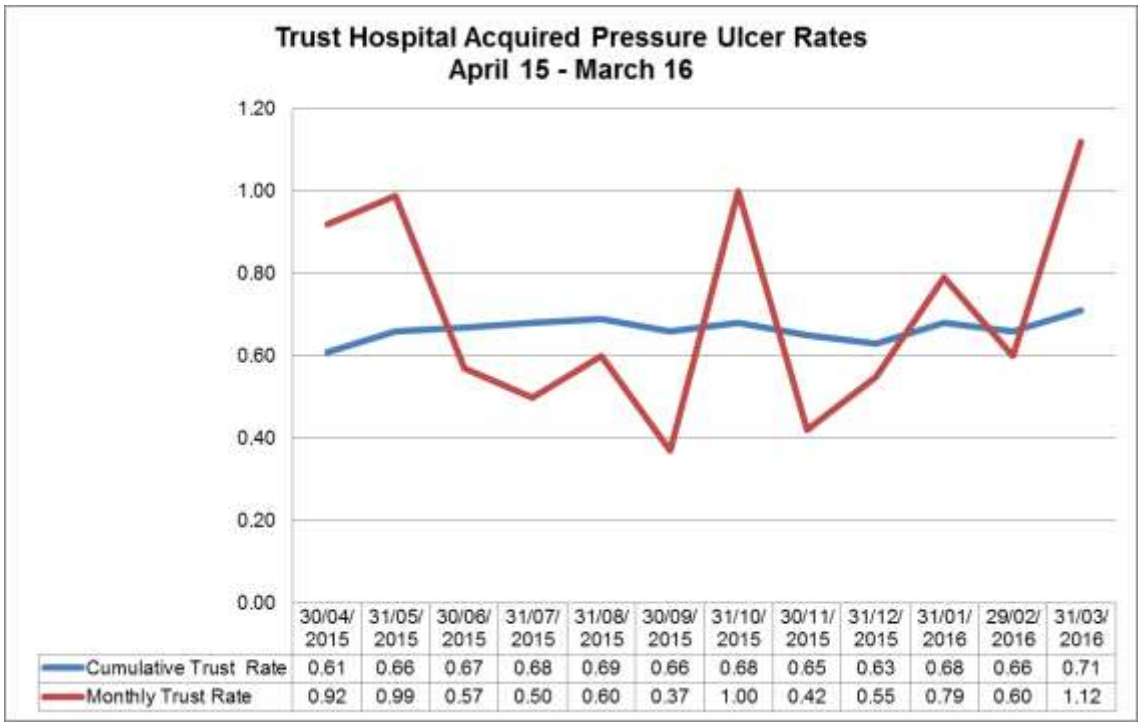
3.5 *NQIs 1- 4 - OPPC (Non-Acute) Adult Inpatient Wards*



	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016
SKIN	95%	92%	72%	80%	92%	100%	88%	100%	76%	100%	92%	96%
FallSafe	92%	76%	76%	88%	88%	94%	92%	92%	84%	96%	96%	82%
Nutrition(MUST)	100%	76%	80%	96%	84%	96%	96%	100%	92%	84%	96%	88%
NEWS	96%	92%	72%	92%	84%	92%	88%	96%	92%	100%	96%	96%

In both Acute and Non-acute Directorates nurses are consistently achieving significant or full compliance with the SKIN (pressure ulcer), Falls, MUST (nutrition) and NEWS indicators. There is continued concentrated efforts by Ward Sisters through support, education and enhanced monitoring to ensure full compliance on all indicators is achieved.

3.6 ***Southern Trust Hospital Acquired Pressure Ulcers*** *(Dec 2014 – Nov 2015)*



	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016
Cumulative Trust Rate	0.61	0.66	0.67	0.68	0.69	0.66	0.68	0.65	0.63	0.68	0.66	0.71
Monthly Trust Rate	0.92	0.99	0.57	0.50	0.60	0.37	1.00	0.42	0.55	0.79	0.60	1.12

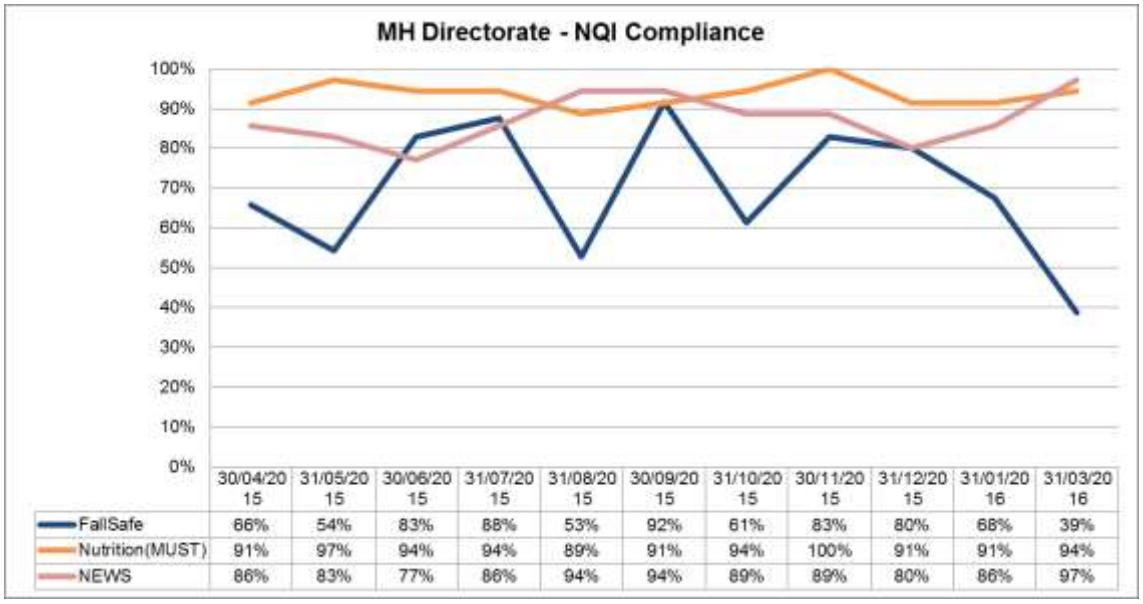
The data is taken from individual wards Safety Crosses across the Trust and cross referenced against Datix. The implementation of the SKIN Bundle and associated training over the last three years has increased staff awareness regarding the identification, grading, management and reporting of Hospital Acquired pressure ulcers.

The Public Health Agency Quality Improvement Plan Framework for 2016/7 requires Trusts to provide quarterly detail on the following: -

- Compliance with SKIN Bundle
- Total Number of Hospital Acquired Pressure Ulcers grade 2 and above
- Number of Hospital Acquired Pressure Ulcers grade 3 and 4
- Number of Hospital Acquired Pressure ulcers grade 3 and 4, which were unavoidable

To facilitate the above, the Trust's Tissue Viability Nurse Specialist and the relevant Ward Sisters have undertaken a Root Cause Analysis (RCA) on all Grade 3 and 4 Ward Acquired Pressure Ulcers identified since March 2015.

3.7 *NQIs 2 - 4 - Mental Health and Disability Directorate*

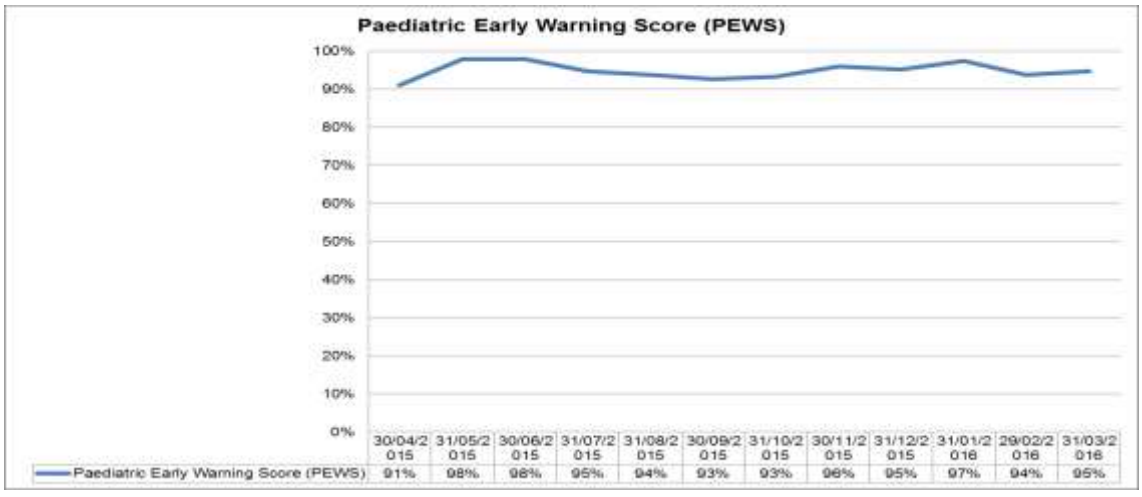


	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	31/03/2016
FallSafe	66%	54%	83%	88%	53%	92%	61%	83%	80%	68%	39%
Nutrition(MUST)	91%	97%	94%	94%	89%	91%	94%	100%	91%	91%	94%
NEWS	86%	83%	77%	86%	94%	94%	89%	89%	80%	86%	97%

In August 2015, following consideration of feedback provided by staff at Patient Safety Leadership Walk Round and review of the FallSafe audit information for a three month period the MHD Directorate Governance Group agreed that Willows and Gillis Wards would continue implementation of the FallSafe Bundle and audit of the FallSafe Bundle would continue as part of the NQIs. In all other mental health and learning disability wards only patients who are 65 years and older and patients aged 50-64 years who are judged by a clinician to be at higher risk of falling because of their underlying condition will have implementation of the FallSafe Bundle.

From June 2015 to March 2016 full compliance with the FallSafe bundle in Willows and Gillis Wards ranged from 20% to 100% (n=124). The main elements contributing to non-compliance was urinalysis (n= 27), asked about fear of falling (n=11); asked about history of falls (n=3); safe footwear (n=2). In March 2016 overall compliance was 39% (n= 13). Elements contributing to non-compliance were urinalysis (n=7) and fear of falling (n=2).

3.8 *NQI 4 - Children and Young People's Directorate*

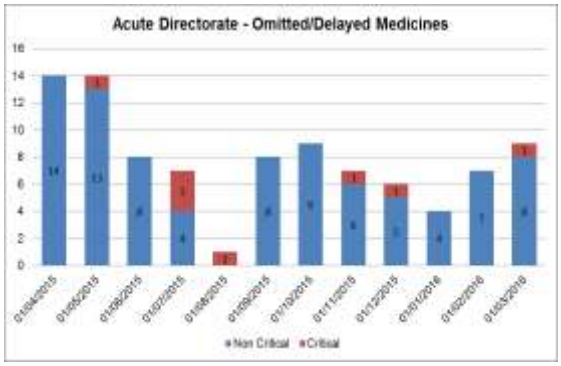


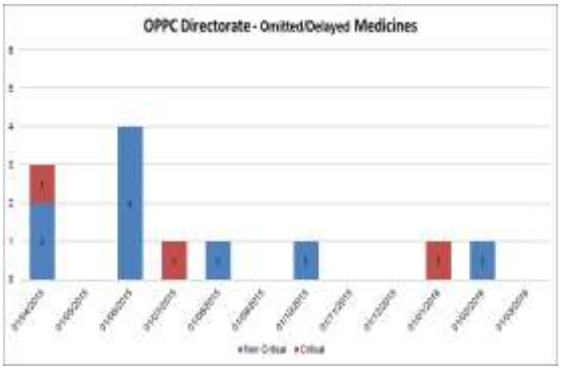
	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016
Paediatric Early Warning Score (PEWS)	91%	98%	98%	95%	94%	93%	93%	96%	95%	97%	94%	95%

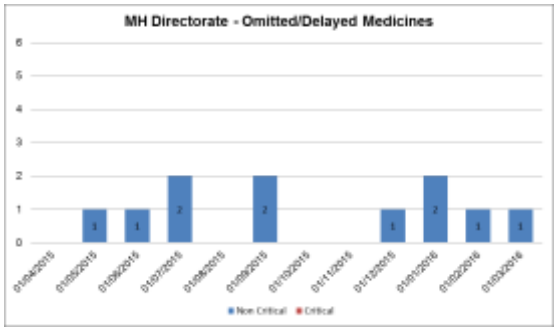
The Paediatric Early Warning Score (PEWS) audit is completed in both the DHH and CAH Children's Wards. The current PEWS template is a pilot of the new regional PEWS chart. The parameters and scoring in the new chart is more extensive than previously and feedback is currently being collated for regional review within the Quality Collaborative group. The parameters within the new chart no longer include temperature but now include blood pressure monitoring. The numerical values have changed significantly therefore has affect the current existing template on the NQOI data base which is also now under review.

3.9 *NQI 5 - Omitted / Delayed Critical Medicines* – all adult in-patient wards

Omitted / Delayed Critical Medicines have been monitored in all adult in-patient wards since March 2015 with results for each directorate as outlined below.







April 2015 – March 2016

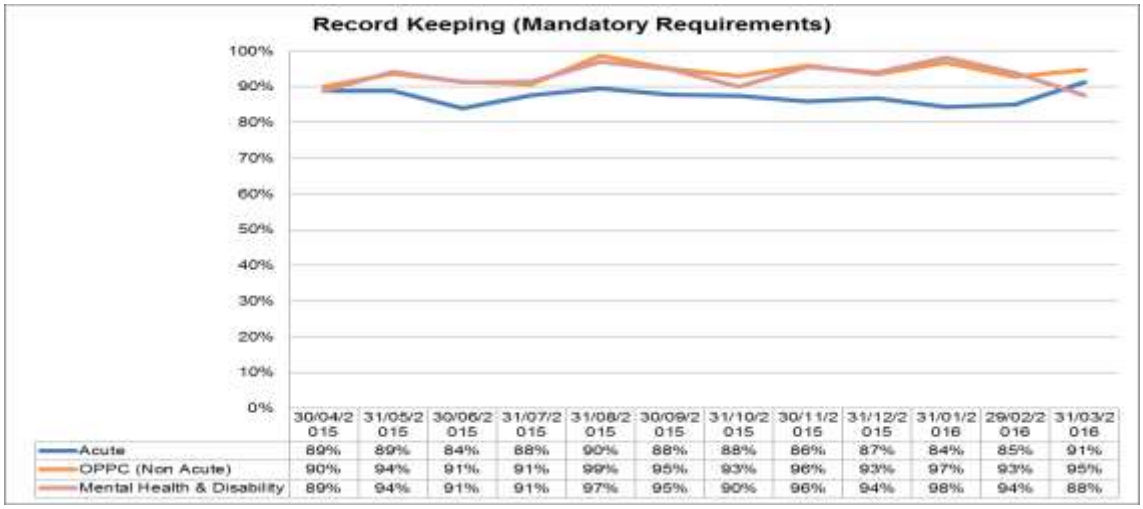
Directorate	Medicine Kardexes audited	Total number of medicine doses prescribed	Number of 'Blank' doses	Total critical medicine doses prescribed	Number of critical medicine doses that were 'Blank'
Acute	1,626	20,015	94 (0.46%)	5,587	8 (0.14%)
OPPC	314	5,403	12 (0.22%)	881	3 (0.34%)
MHD	422	5,744	11 (0.19%)	286	0
Total	**2,362**	**31,162**	**117(0.37%)**	**6,754**	**11 (0.16%)**

*Blank = no record in kardex that a medicine, including a critical medicine, had been administered at the prescribed time. This does not necessarily mean the medicine was not administered only that it was not recorded as being administered.

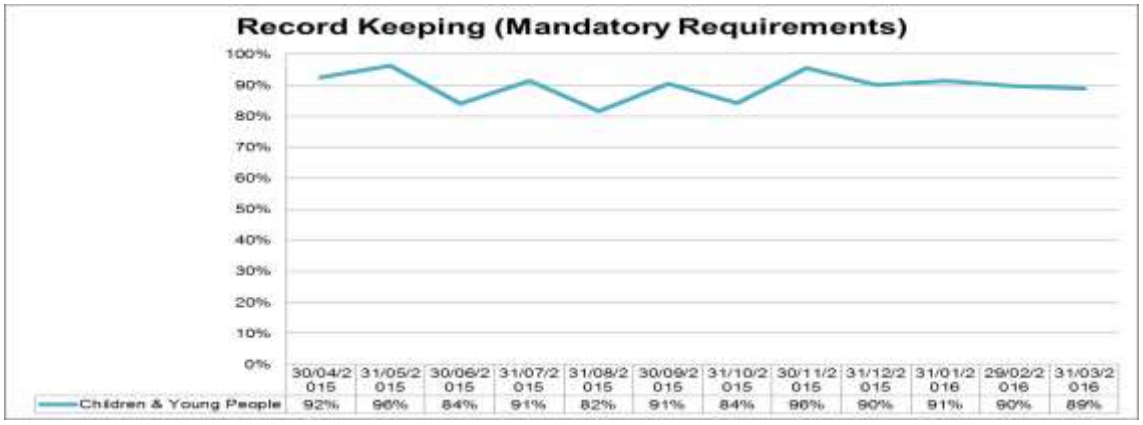
In the last 12 month period 11 out of a total of 6,754 [0.16%] prescribed *critical* medicines were recorded as 'Blank'; 8 were in the Acute Directorate, 3 in OPPC and 0 in MHD. There is a variety of reasons why a medicine may not have been administered, such as the patient was fasting, a new medicine was recently prescribed or the medicine was not available on the wards. Nurses should be commended for their diligence in this area of patient care and safety.

3.10 *NQI 6 - Recording Care : Evidencing Safe and Effective Care*

Recording care is an important element in evidencing safe and effective nursing care and is a skill and activity which the profession is constantly promoting and improving on. Over the past year the average Trust compliance with mandatory record keeping standards in Acute, Non-acute and MHD adult in-patient areas was a commendable 91%.



	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016
Acute	89%	89%	84%	88%	90%	88%	88%	86%	87%	84%	85%	91%
OPPC (Non Acute)	90%	94%	91%	91%	99%	95%	93%	96%	93%	97%	93%	95%
Mental Health & Disability	89%	94%	91%	91%	97%	95%	90%	96%	94%	98%	94%	88%



	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016
Children & Young People	92%	96%	84%	91%	82%	91%	84%	96%	90%	91%	90%	89%

The record keeping audit tools for adult and children's nursing differ and therefore cannot be compared against each other. CYP has scored an average of 90%.

The draft paediatric PEWS charts continue to be used within the Children's Wards. SHSCT CYPS comments in relation to the draft PEWS charts have been shared with the Regional Working Group. CYPS are awaiting the outcome of the collation of all regional comments and suggested amendments to the PEWS charts.

3.11 To support improvement in record keeping the EDN has identified funding for the temporary secondment of a Professional Development Facilitator. The Facilitator's role is to promoting a positive recording keeping culture amongst nurses that reflects the delivery of person-centred care and compliance with good recording keeping practices. Southern Trust Lead Nurses developed and tested a person-centred recording framework, known as the PACE (Patient-centre, Assessment, Nursing Care and Evaluation) Framework and the Facilitator is leading the rollout of the PACE Framework across all Directorates. The Framework has been successful in supporting the recording of person-centred care and the other HSC Trusts are now testing the Framework with a view to rollout within their organisations.

3.12 A regional **r**ecord keeping competency framework and self-assessment tool has been developed to support Health Care Support Workers (HCSWs) in recording care and will now be tested across all Trusts prior to full implementation.

3.13 *NQI 7 - Pt/C Experience Standards / 10,000 Voices*

Patient experience of nursing care is a central element of the NQI Framework and outcomes will contribute to assurance on the quality of nursing care. As is demonstrated in the Nursing and Midwifery Survey in 2015 nurses and midwives contribute significantly to ensuring safe, high quality care and positive experience for patients/clients in the Southern Trust. The positive messages from these findings have been shared with nurses and midwives and with members of the public as well as with those who commission services.

Recurrent funding for 10,000 Voices initiative has been secured and a permanent a Patient / Client Experience / 10,000 Voices Facilitator was recently appointed.

The collection of patient stories in unscheduled care areas has concluded and two workshops were undertaken March to support staff in interpreting patient experiences and in action planning to improve care and services in this area.

As part of the regional 2016 – 17 work plan the collection of patient stories will focus on the experiences of children / young people / parents and carers of Child and Adolescent Mental Health Services (CAMHS) and Autism services.

3.14 *NQI 8 - Professionalism - NMC Revalidation and Nurse Supervision*

NMC Revalidation

The Nursing and Midwifery Council's (NMC) revised revalidation arrangements for registered nurses and midwives came in to effect in April 2016 and includes a number of additional elements designed to improve public protection and ensure that nurses and midwives remain fit to practise throughout their careers.

Recognising the Corporate Risk to the Trust / public / patients should nurses fail to comply with the new revalidation arrangements, SMT has supported the development of a bespoke Nursing Revalidation database designed to provide assurance to the Executive Director of Nursing (EDN), Directors and managers that all nurses and midwives who require to be registered remain on the live NMC register. The first registrants to revalidate

under the new arrangements commenced in April 2016 and to date no lapses in or late registrations have occurred. The current assurance arrangements are supported by FileMaker version 11, however, as above in 3.1, without uplift to version 14 the EDN cannot continue to provide assurances as version 11 is no longer supported.

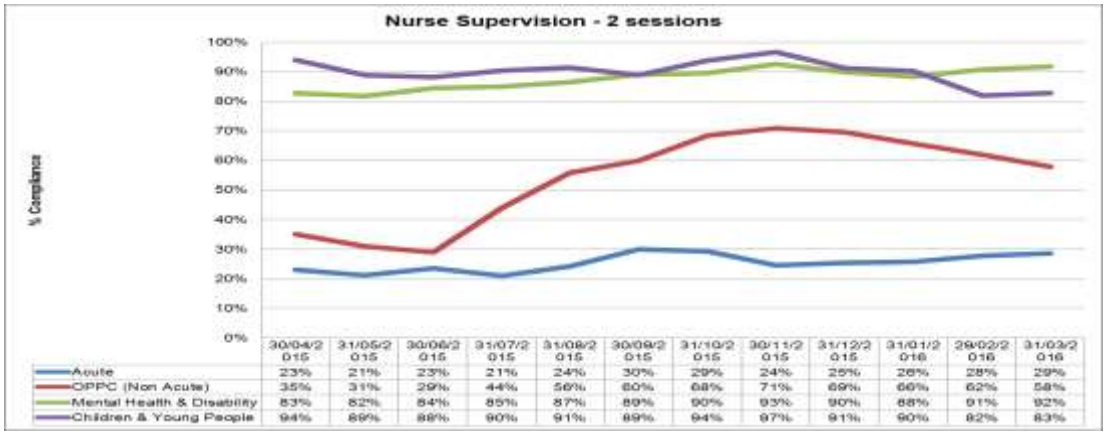
3.15 **No of Registered Nurses / Midwives in ST due to revalidate in 2106 - 17**

	Apr 2016	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2017	Feb	Mar	Total
ACUTE	52	31	23	26	13	167	72	40	11	23	19	79	**556**
CYP	15	10	8	9	3	46	25	13	5	8	2	14	**158**
HR	7	2	2	0	1	12	11	5	2	2	5	0	**49**
MEDICAL	1	0	0	4	0	0	0	0	0	1	0	1	**7**
MHD	21	8	3	10	1	33	23	6	5	6	1	16	**133**
OPPC	15	8	4	7	10	25	19	5	5	6	5	20	**129**
P&R	0	0	0	0	0	0	0	0	0	1	0	0	**1**
TOTAL	**111**	**59**	**40**	**56**	**28**	**283**	**150**	**69**	**28**	**47**	**32**	**130**	**1033**

3.16 The Nursing Governance Co-ordinators continue to support nurses, midwives and managers to ensure both organisational and registrant readiness for revalidation in April 2016. This support includes arrangements for reflective discussions on the Code and confirmation meetings. Registrants can access information on NMC Revalidation on the Trust's new Nursing & Midwifery Governance Sharepoint site.

3.17 ***Nurse Supervision***

The ST's Policy on Nurse Supervision requires that all registered nurses are able to avail of two sessions of professional supervision per year.



Ensuring nurses can access two supervision sessions has been a challenge in all directorates, particularly Acute. However, recording reflections on practice is now a core revalidation requirement and registrants must evidence how their reflections have impacted on their understanding and application of the professional Code. It is expected that this requirement will support and encourage better compliance with the supervision policy.

3.18 *NQI 9 - Preceptorship*

Preceptorship is: 'a period of structured transition for the Preceptee during which he/she will be supported by a Preceptor, to develop confidence as an autonomous professional,

refine skills, values, attitudes and behaviours and to continue on a journey of lifelong learning' (adapted from Department of Health (DH), 2010). The programme is 26 weeks duration and is co-delivered by CEC and the Practice Education Team.

Number of Preceptorship Programmes April 2015-March 2016)	Registrants commenced programme	Registrants completed Programme *to date*	Reason for non-completion	On target to complete Programme after March 2016
13	183	53	x 7 Left Trust* x 1 Long term sick leave x 2 Preceptorship period extended due to practice issues x 1 (midwifery programme) returned to nursing post	119

*Staff commenced posts in other HSCTs

3.19 *NQI 10 - Delivering Care (Normative Staffing)*

Progress regarding implementation of Delivering Care across all phases is set out as follows:

Phase 1 (Acute general and specialist medical and surgical wards)

Bi-annual reporting of implementation continues with an end of year monitoring report submitted to RHSCB 20 May 2016 reflecting 31 March 2016 position.

An element for this phase of Delivering Care is that Ward Sisters/ Charge Nurses should be supervisory. SHSCT is committed to working towards ensuring that Ward Sisters/Charge Nurses will achieve 100% supervisory status, however, with the current insufficient supply of Registered Nurses this is extremely challenging. All surgical wards are currently compliant with this standard, however medical wards to date been unable to achieve this standard 100% of the time.

RHSCB confirmed additional funding of £227,723 (letter dated 7 January 2016), to prioritise uplifts from Band 5 posts to create more Band 6 posts. This is currently in progress within the Acute Directorate, with staff expected to be in post June 2016.

Phase 2 (Emergency Departments)

The Framework detailing agreement for nurse staffing in Emergency Departments across Northern Ireland has been finalised. Given the challenging regional financial climate the Steering Group has requested updated information regarding nurse staffing from each Trust, to include staff in post (SIP) and bank and agency expenditure. This has been completed and across both Emergency Departments in SHSCT the nursing staffing *gap* has been identified as:

- Band 7 – 8.4wte
- Band 6 – 19.73wte
- Band 5 – 55.14wte
- Band 3 – 17.23wte.

This equates to an overall gap of 100.5wte, which is a funding requirement of £4,466,391. A regional bid has been submitted as part of June monitoring, with options regarding phased implementation based on agreed priorities.

Phase 3 (District Nursing)

A regional data collection exercise was conducted in 2016, following a pilot in Belfast Trust (BHSCT) using the Hurst Model currently in use across England. This data has undergone a degree of analysis with some resolution regarding variety in interpretation, however has some issues remaining to be resolved. In addition, the Public Health Agency is pursuing the introduction of District Nurses as Key Workers for palliative care. The Trust is contributing to this regional discussion.

Phase 4 (Health Visiting)

The Framework for this phase is nearing completion with a final draft for comment expected imminently.

These standards were published by the NMC in 2006 and detail the mandatory governance requirements for the Trust to ensure appropriate student supervision, support and assessment.

Mentor Register (EiMs Electronic Register)

A current mentor register is held electronically and is managed locally by Ward Sisters/Charge Nurses/Team Leaders. The administrative responsibility of this register lies with the Practice Education Team. Directorates receive status reports regarding availability of mentors on a 6 monthly basis. This provides the Nursing and Midwifery Council (NMC) and Southern Trust with the assurance that appropriate governance arrangements are embedded to measure compliance to meet the NMC standards to support learning and assessment in practice (2008).

Current Mentorship Statistics

SHSCT at time of reporting have 1254 mentors, 831 of which are currently available to mentor students. Table 1 below provides further detail and Table 2 provides this information per Directorate/Divisions.

Table 1: SHSCT Mentor Statistics

	Available	**Unavailable**	**Total Number**

Mentors	443	233	676
Sign-off mentors	370	184	554
Practice Teachers	18	6	24
TOTALS	**831**	**423***	**1254**

*Unavailable due to mentor criteria lapsed, leave reason, action plan in progress.

Table 2: Mentor Statistics per Directorate/Division*

Directorate / Division	Number of Mentors	Number of Sign-off Mentors	Number of Practice Teachers	Total
Cancer & Clinical Services	75	83	1	159
Surgery & Elective Care	64	62	0	126
Integrated Maternity & Women's Health	4	100	0	104
Medicine & Unscheduled Care	108	115	0	223
Mental Health & Learning Disability	122	73	5	200
Older People & Primary Care	147	74	7	228
Children & Young Peoples Services	156	47	11	214
TOTALS	**676**	**554**	**24**	**1254**

*The changes to the alignments of the Acute Directorate will be reflected in the next report.

Student Capacity

Number of practice areas approved for student placements	Number of educational audits carried out in past year	Max. number of students that can be accommodated at any one time
141	56	356

Due to reconfiguration of services to meet constantly evolving healthcare needs, there are ongoing challenges regarding practice placement capacity. The Practice Education Team continually work with service colleagues to increase placement capacity, particularly in light of the increased places for nurse training announced by the Minister. A regional task and finish group has been established to ensure consistency and continuity across Trusts regarding capacity of practice placements.

Mentors/Sign-off Mentors/Practice teachers CPD Activity

The PET facilitates a number of programmes and updates for mentors/ SoM/ Practice teachers throughout the year. CPD activity statistics can be seen in the table below.

Programme/Activity Title	Number of programmes/sessions facilitated April 2015 – Mar 2016	Number of mentors/SoM/PT who undertook the programme/activity
Mentorship Preparation Programme	4 (x2 nursing & x2 midwifery)	78
Nursing and Midwifery annual update	93	1074
Triennial reviews	Facilitated by line managers	172
Progression to sign-off mentor status programme	2	15 (4 due to complete summer 2016)
Model of support	5	21
Supervising mentor preparation programme	27 (3 programmes & 24 sessions in wards)	78
Practice Teacher Forum	2	13-14 each session

Challenges in Practice Placements

Mentors continue to highlight the challenge of time for mentoring, particularly the required 1 hour protected time per week that the NMC (2008) stipulate sign-off mentors should have with their final placement student. In September 2015 the Practice Education Team carried out an audit across all Directorates on the amount of time that Sign-off mentors (SoMs) were receiving with their final placement students. Results showed that the Trust was not fully compliant with this standard. An action plan has been created as a result of this audit and the Practice Education Team are continuing to work with Ward Sisters/Team Leaders/Charge Nurses and SoMs to ensure that this standard is met.

5.0 *Advanced Nurse Practitioner Programme*

The DHSSPS, through the office of the Chief Nursing Officer, has confirmed financial support for the training fees for 20-25 nurses regionally to commence an Advanced Nursing Practice Programme; with the initial focus on Paediatric and Emergency care settings.

SHSCT has contributed to the on-going debate regarding the development of this role over recent years and recognises the potential of Advanced Nurse Practitioners (ANPs) to make a positive contribution to patients across a range of clinical areas.

The entry requirements for this programme have now been confirmed which includes the Non-medical Prescribing Programme (NMP) as a pre requisite. A draft regional job description has been developed and is in current circulation for consultation. This post has a provisional regional banding agreement at Band 8a.

6.0 *Consultant Nurses and Midwives Framework*

As a result of the development of the Advanced Nursing Practice Framework, which includes core competencies and learning outcomes, a regional work-stream is now commencing to review the role of Nurse Consultants in NI. SHSCT will be involved in regional work scoping the current literature to inform the development of professional guidance to support Consultant Nurse and Midwife roles in Northern Ireland.

7.0 *Post –registration Nursing and Midwifery Education Commissioning 2015-2016*

The Trust continues to conduct annual learning needs analysis for Registrants and works closely with the DHSSPS to secure funding for those education programmes that are necessary for the nursing and midwifery workforce to continue to deliver a high standard of care.

Post registration education courses commissioned and accessed for 2015-2016 are as follows:

Programme	***Type***	***Number of staff***	***Withdrawals***	***Deferrals***	***Backfill from DHSSPS***
Specialist Practice Programmes	School Nursing	4	-	-	
	Health Visiting	10	-	-	
	District Nursing	8	-	-	
Life Support Courses	Several different courses	579			
Additional Registration	Children's	3	-	-	
Courses inside NI	7 different programmes	29	-	-	
Courses Outside NI	6 different programmes	22	-	-	
Total					£753,620.42

It is important to note that financial constraints are anticipated on this budget for the academic year commencing September 2016. Decisions to fund or not fund courses

outside and inside Northern Ireland will not occur until following June monitoring meetings.

8.0 *Clinical Education Centre (CEC)*

Southern Trust continues to fully utilise the Service Level Agreement (SLA) with the CEC. For the year April 2015 to March 2016, the utilisation was 121.59%.

9.0 *Rotation Programme*

A rotational programme was introduced into the Acute Directorate in April 2015. The first cohort of new registrants completed the programme in March 2016.

Number of staff commenced rotational programme	Number of staff completed	Reason for non-completion
11	9	2 Left Trust*

*x1 left to work in another HSCT, x1 left to relocate to Southern Ireland.

A robust evaluation of the programme with participants has been undertaken, with feedback including:

- Participants felt well supported and valued the principles of the rotational programme
- Opportunity to develop knowledge and experience
- Opportunity for skill development specific to certain areas
- Valued working with the people and patients
- Increased confidence in critical care and emergency situations.

Challenges reported included minor elements of the administration elements of the programme, which are currently being addressed.

10.0 *Open University Nursing programme (OU)*

This programme is available to Trust staff, and is a 4 year, part-time, work based programme for entry to the nursing profession (adult and mental health branches only).

Innovation in delivery of The OU PRNP

Recognising the challenges in the availability of registered nurses the Trust are currently undertaking a pilot programme for the September 2016 intake. Seven staff who passed the interview last year were funded by DHSSPS and the Trust to complete the first two modules of the nursing programme as a stand-alone model. If successfully completed, staff will commence the programme fast-tracked to Stage 2 in September 16.

In addition 32 staff have been funded by DHSSPS and the Trust to complete module K101 (the first module of OU programme) February to June 2016.

Total number currently undertaking OU programme (Years 1-4)	Number of deferred places to commence Stage 2 of programme September 2016	Number of staff funded to undertake K101 (first module of programme February -September 2016)
17	8	32

11.0 *Cause for Celebration!*

The Practice Education Team are delighted to report that six mentors from the Trust were nominated by nursing students for the 'Queen's University Belfast Nurse Mentor of the Year Awards', with Muriel Stevenson as winner in the Adult category.

Staff nominated include:

- Nichola Tally, CAMHS, Dungannon;
- Tracy Lively, Craigavon Hospital;
- Michelle Calvin, Portadown Health Centre;
- Roisin Heavin, Trasna House Lurgan;
- Paul Agnew, Trasna House;
- Muriel Stevenson, Mandeville Unit, Craigavon Hospital – winner in the Adult category!

An awards ceremony was held on Thursday 12th May 2016 in QUB to coincide with International Nurses' Day 2016.

12.0 Recruitment

The insufficient supply of Registered Nurses across the province was recognised and escalated to the Chief Nursing Officer for Northern Ireland, which resulted in a short life Task and Finish Group being established. This regional group was chaired by Mr Francis Rice in his then capacity of Executive Director of Nursing, and a final report was submitted to the Central Nursing and Midwifery Committee (CNMAC) in December 2015. This report made twelve recommendations in relation to the nursing workforce.

The Migration Advisory Committee (MAC) has entered the nursing workforce to the shortage occupation list to July 2019; albeit that employers are required to conduct a Resident Labour Market Test (RLMT) to provide ongoing evidence of shortage to enable

the continuation of recruitment outside the United Kingdom.

11.1 International

One of the aforementioned recommendations was to proceed immediately to international recruitment. Ms Lynn Fee, Assistant Director of Nursing, and Mrs Karyn Patterson, Head of Resourcing, were identified as the regional leads for this work-stream. Both a Steering Group and Working Group were established; the Steering Group chaired by Mr Hugh McPoland, and the Working Group by Ms Lynn Fee. A Tender process was conducted and a Framework established, with the decision taken to progress in the first instance with recruitment campaigns to Italy, Romania and the Philippines. TTM Healthcare was the successful company appointed for the Philippines and HCL Permanent the successful company appointed for Italy and Romania.

It is vital to note that the landscape, locally and internationally, has changed significantly from previous overseas recruitment campaigns conducted by NI Trusts in the late 1990's and early 2000's. Some changes include:

- There is now a global shortage of Registered Nurses (RNs) and Northern Ireland is coming to the global market behind other countries;
- The Philippines used to have 40 Schools of Nursing – it now has over 400;
- A Philippino Government Agency has been established to control recruitment in the Philippines – the Philippine Overseas Employment Administration (POEA);
- The Nursing and Midwifery Council (NMC), from February 2016, increased the English Language requirement to Level 7 (International English Language Testing System–IELTS);
- Registered Nurses from non-EU countries have now a two stage test of competence to undertake with the NMC.

The above changes, plus others not listed here, impact significantly upon the timeframe for recruitment RNs into NI. It is estimated that for RNs recruited from European countries the length of time from interview to entry onto the NMC Register would be approximately thirty-nine weeks, and for RNs recruited from non-European countries the length of time from interview to entry onto the NMC Register would be approximately forty-eight weeks. It is important to note that for some individuals this timeline may be shorter and for others longer. Both EU and non-EU RNs coming to NI to work will be employed as a Band 3 until NMC Registration is acquired. The focus initially is in relation to Adult Nurses.

Nursing, Human Resource (HR) and Communication leads for the five Trusts have worked with both companies to market NI in each of the three countries identified. This includes the development of microsites on both companies websites, the development of an HSC brochure (shared in hard copy and electronically), Trust specific brochures (shared in hard copy and electronically); social media campaigns across Twitter, Facebook and LinkedIn, plus a referral system directly to both companies for existing Trust staff to refer friends and family who are Registrants.

Recruitment campaigns have been scheduled until December 2016, and comprise four

campaigns to the Philippines and nine campaigns across Italy and Romania. As an estimation, we have anticipated recruiting 591 RNs for the five Trusts from the campaigns detailed above to December 2016. It is important to recall at this point the timeframes estimated for these staff from interview to achievement of NMC registration.

A business case was developed and submitted to the Department of Health Social Services and Personal Safety (DHSSPS) via Mr Hugh McPoland as Chair of the Steering Group. DHSSPS has requested a re-working of this business case in line with DHSSPS Guidance on the Completion of raised Revenue Business Case Templates and Post Project Evaluation, for June Monitoring. A current (subject to change) estimation of costs for each nurse recruited is:

- EU: £3213 (actual)
- Non-EU: £6815 (actual).

There will be a higher outlay initially as some charges HSC will pay up-front but reclaim from individuals. Given the estimation of numbers anticipated to be recruited plus the finalised costs above, the overall cost of these identified recruitment campaigns is estimated to be £3,250,000. SHSCT has also included salary costs for Ms Lynn Fee and Mrs Karyn Patterson for the duration of this project.

Whilst the focus has been on Adult RNs to date, the five Trusts have been gathering data in relation to Childrens RNs. Four out of five Trusts have highlighted the gap between the numbers of Childrens Nurses being trained and the number required to deliver services over the next twelve months. This is currently under discussion regionally.

11.2 **Local**

Whilst progressing international recruitment, some of the recommendations contained within the CNMAC report related to local recruitment approaches. This work is also being progressed through the regional Working Group and includes:

- More regular engagement with the student body across all local universities by Trust staff. The five Trusts are actioning this as a collaborative rather than on an individual Trust basis;
- All Trusts have initiated ‘open’ adverts on HSCRecruit;
- Job offers are now made to Year 3 students by all Trusts, with SHSCT also offering to Year 2 students;
- Attending jobs fairs (individual Trusts);
- Conducting ‘one-stop-shops’.

The Working Group also has representation from the Recruitment Shared Service Centre and is working to improve the recruitment experience for students and other applicants.

In addition, SHSCT is working closely with the Open University (OU) and DHSSPS to increase and better utilise available funding to increase places on this programme. Further information regarding this programme and approaches has been detailed previously in this report.

12.0 CONCLUSION

This report provides a summary of excellent high quality person-centred nursing care being provided by the nursing workforce to patients/clients in the Southern Trust. Audits of the quality nursing care have shown incremental improvement in adherence to core nursing processes and action plans are being implemented to ensure quality improvements. Senior nurses are working to embed the NQI Framework and Community Nursing teams are working to identify those indicators which would best evidence compliance with agreed quality standards in their area of nursing care. The Trust has put in place arrangements to support the implementation of the new NMC revalidation arrangements which supports professional reflections and enhances practice.

The report specifies the challenges the Trust is facing in securing and ensuring a sufficient nursing workforce both now and over the next number of years.

International Nurse Recruitment

Lynn Fee, ADoN & Nursing Lead for International Recruitment

Karyn Patterson, HR Lead for International & Nurse recruitment

Aims of Presentation

- To provide information on
  - local action
  - regional action, and
  - international recruitment

In the context of:

- The Report to CNMAC in December 2015, and its recommendations as linked to NI Workforce Planning.

CNMAC Report December 2015

- Challenges in Supply of Registered Nurses had been raised throughout 2014 into 2015 at CNMAC by Executive Directors of Nursing
- Supply worsening over this period despite all efforts to address through local recruitment and retention
- Task & Finish Group established by CNO in July 2015 which reported December 2015
- 12 Recommendations of which 8 related directly to Nurse Recruitment locally, regionally and internationally.

Local Actions

- Trust Nursing Workforce Planning Group established in June 2015 with a focus on both Recruitment & Retention
- Recruitment Actions since September 2015
  - Opening of Recruitment Criteria to include Year 2 and Year 3 students with immediate offers following interview
  - Offering permanent posts only
  - Adult Recruitment Day offering 153 posts on the one day
  - Opening of ongoing advertisement for Adult Nursing with interviews scheduled every 2 Weeks
  - Mental Health & Learning Disability Waiting List being maintained
  - Introduction of Rotation Programme for new registrants
  - Opening of Nurse Bank to Student Nurses who have successfully completed their first practice placement.

Regional Actions

- Streamlining what we do
  - Same approach no matter which Trust
  - Same criteria no matter which Trust
  - Single advertisement / interview process for HSC.
- Better Engagement with Potential Applicants
  - Information provided in modern user friendly ways
  - Face to Face Open Day Events as an HSC Family
  - Engagement with Universities throughout student life cycle
  - Information at time of advertisement on posts available.
- Children's Nursing

International Recruitment

- International Recruitment is a necessity at this time
- CNMAC recommendation to proceed immediately
- MAC Report recognises shortfall in supply and has placed Nursing on the Shortage Occupation list for the next 3 years
- Lynn Fee & Karyn Patterson to lead on behalf of the region.

International Recruitment

- Agencies appointed through Tendering Process to cover both European and Non European Countries.

- Contract Award mid-March 2016 with Project Structures established incorporating a Steering Group and Working Group.

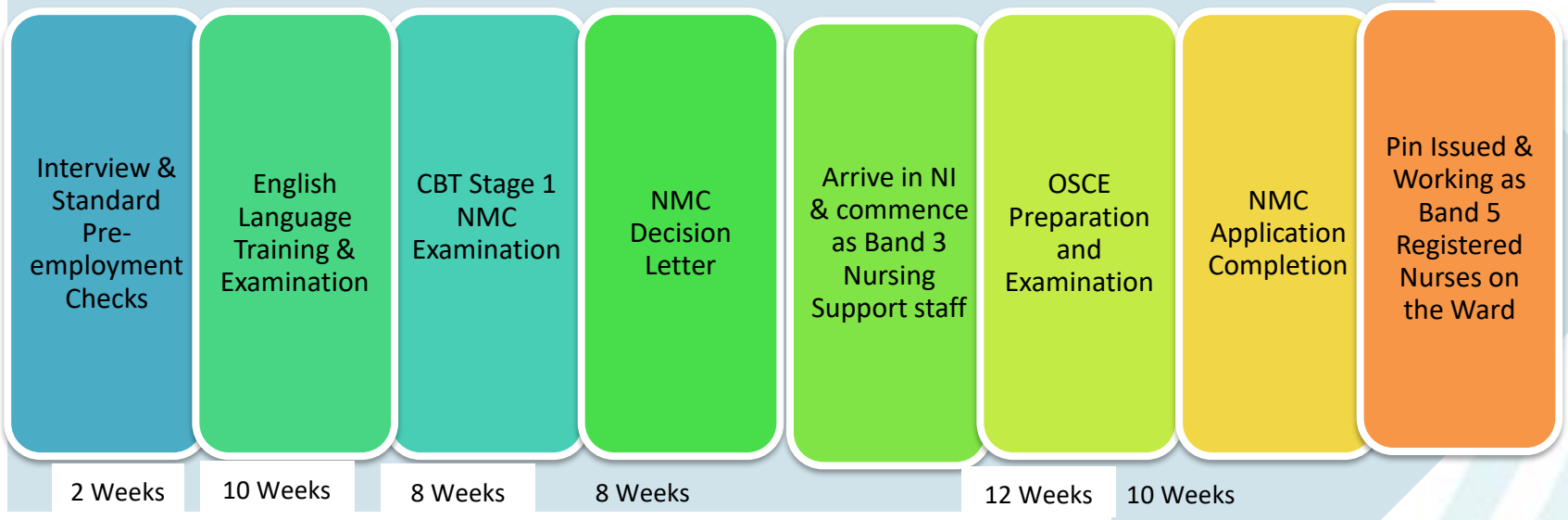
- Campaigns commenced in mid-May 2016.

Non EU Campaigns

- Philippines
  - First Campaign 13th – 22nd May 2016
    - 325 interviewed;
    - 239 offers made for HSC – 46 to Southern Trust (*28 Medicine; 10 Surgery; 8 Theatres*)
    - Next steps now in progress with a view to the first cohort arriving to NI around November 2016.
  - 3 further campaigns planned for 2016 (July, September, November).

Non EU Campaigns

Philippines Recruitment - 48 Weeks in Total

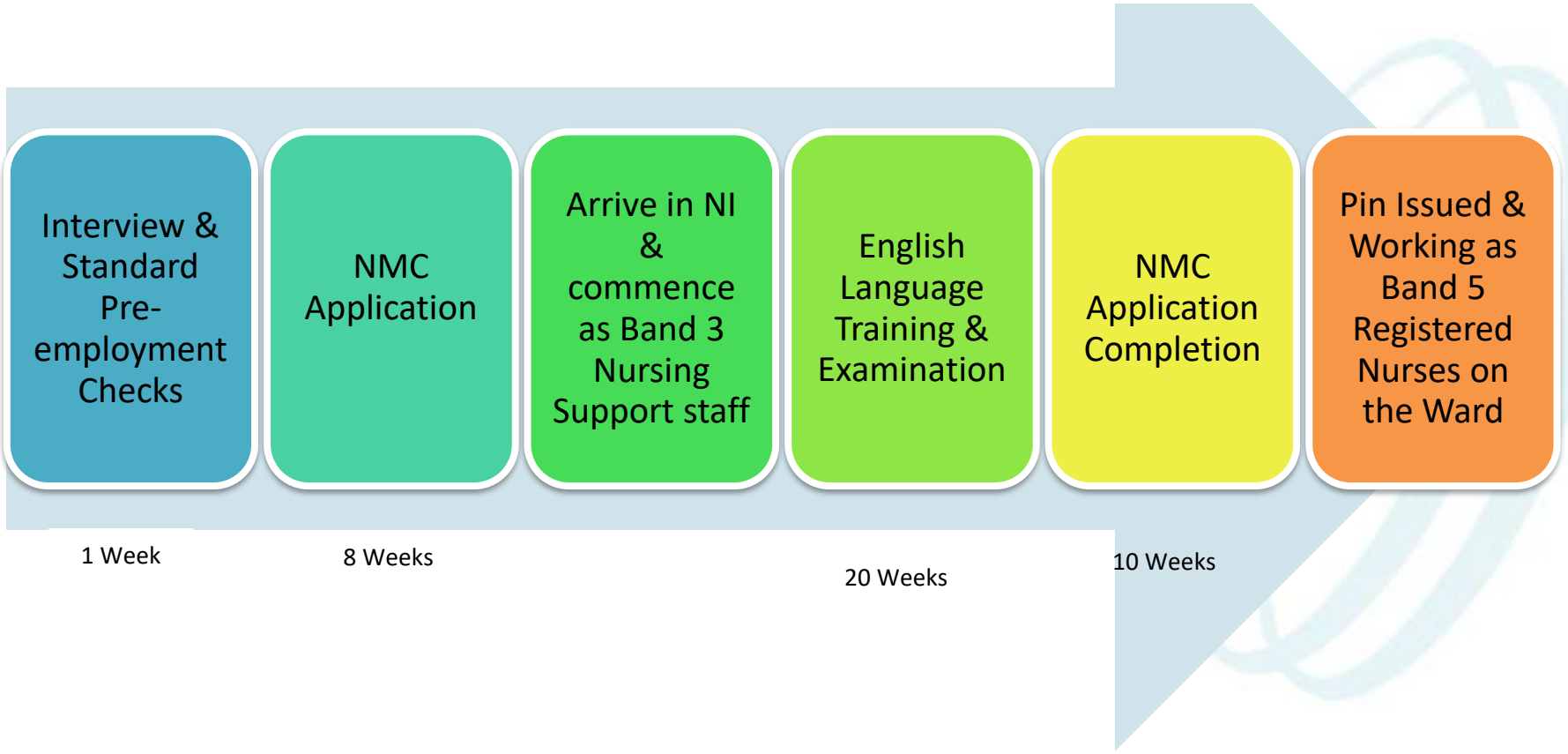


EU Campaigns

- Romania and Italy
  - First campaign 25th – 27th May 2016 for Belfast and SET:
    - A number of issues arising with performance of the Agency
    - 7 offers made
    - Steering Group decision to progress 1 further campaign which Lynn & Karyn will conduct; dual purpose to assess performance of HCL and undertake recruitment for Southern & Western Trusts.

EU Campaigns

European Recruitment - 39 Weeks in Total



Costs & Benefits

- **Financial Cost**
  - Set fee per head for each company
  - Support for English Competency Tests
  - Support for NMC clinical assessments
  - Support for accommodation on arrival

- **Benefits**
  - Securing adequate staffing for safe services
  - Ability to meet service needs
  - Reduction in Additional Hours, Bank & Agency through a stable permanent workforce

Some Challenges

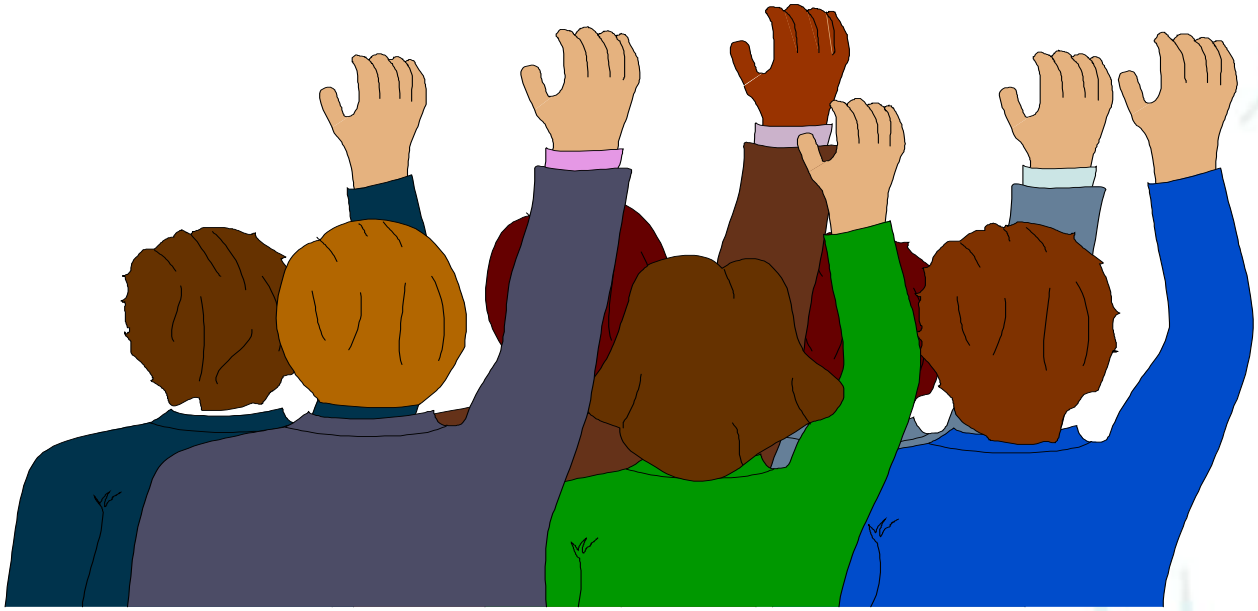
- Accommodation availability
- OSCE's (non-EU)
- Clinical support
- IELTS
- Timeframes
- Finance

Next steps

- DHSSPS Business Case in progress for June monitoring
- Vacancy monitoring and tracking of those recruited from overseas
- Continue to lobby DHSSPS re commissioned pre-registration numbers
- Continue to progress local, regional and international recruitment, collaboratively.

Thank you

Any questions?



Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

August 2016

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to one of the four domains contained within the Board Assurance Framework and to the relevant Trust Corporate Objectives as detailed below:-

Four Accountability domains contained within the Board Assurance Framework

- Domain 1 Corporate Control
- Domain 2 Safety and Quality
- Domain 3 Finance
- Domain 4 Operational Performance and Service Improvement

Corporate Objectives

1: Provide safe, high quality care.
2: Maximise independence and choice for our patients and clients.
3: Support people and communities to live healthy lives and improve their health and wellbeing.
4: Be a great place to work, valuing our people.
5: Make the best use of resources.
6: Be a good social partner within our local communities.

OVERVIEW OF CORPORATE RISK REVIEW AS AT 31st AUGUST 2016

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	8	5		13

The Corporate Risk Register has been reviewed by SMT on two occasions since the last Governance Committee meeting. Changes include:-

New risks identified by SMT or escalated from Directorate Risk Registers	• Business Services Organisation (BSO) Shared Services Centres – Payroll/Travel & Recruitment (and included in the merged workforce risk detailed below) • Lack of Data Processing Contract with BSO
Risks removed from the Register	• Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation status • Achievement of Statutory Duties/Functions - Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed. • Medical Appraisal system

Merged risks	Following risks have been combined into one workforce resourcing risk:- • BSTP/Recruitment Shared Services • Inability to recruit/retain Consultant medical staff for specific specialties • Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital • Inability to recruit registered nursing staff • GP Out of Hours Service – inability to attract adequate cover for GP shifts • Health Visiting Service – impact on families due to decreased staffing levels • Reduced ability to provide 24/7 laboratory service at Daisy Hill Hospital due to insufficient Biomedical Scientists • Failure to attract/appoint required staff and delays in recruitment processes in mental health/disability inpatient wards, community teams, supported living and day care facilities • I.T. Department – workforce shortage due to insufficient resources and long term sickness levels. Following risks have been combined into one maintenance and development of Trust Estate risk:- • Insufficient capital to maintain and develop Trust Estate • High Voltage Capacity • Anticipated failure of legacy telecoms infrastructure • Design and fabric of Aseptic Suite, Craigavon Area Hospital • Construction activity on Trust sites leading to increased risk of • significant service disruption • ICT Maintaining Existing Services
Risks where overall rating has been reduced	None
Risks where overall rating has been increased	None

SUMMARY OF CORPORATE RISKS AS AT AUGUST 2016

DOMAIN 1: CORPORATE CONTROL				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
1	**Revalidation Arrangements –** Implementation of Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	1 & 4	**HIGH**	**8**
2	**Appraisal –** lack of evidence of compliance with a fully embedded appraisal (KSF) system	1 & 4	**MEDIUM**	**10**
3	**BSO Shared Services:** Payroll/Travel and Recruitment	4&5	**MEDIUM**	**11**
4	**Data Processing –** lack of contract with BSO	1&5	**MEDIUM**	**13**
5	**Infrastructure** – Insufficient capital to maintain and develop Trust Estate (facilities, equipment, ICT Estate etc.) to support service delivery and improvement	1	**HIGH**	**14**

DOMAIN 2: SAFETY AND QUALITY				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
6	**Workforce Resourcing – Workforce Shortages**	1	**HIGH**	**21**
7	**Achievement of Statutory Duties/Functions –** robust case management processes	1	**MEDIUM**	**30**
8	**Capability of Trust systems of assessment and assurance in relation to quality of Trust services**	1	**MEDIUM**	**31**
9	**Healthcare Acquired Infections (HCAI)**	1	**MEDIUM**	**33**
10	**Safeguarding of residents from risk of potential financial abuse**	1	**HIGH**	**35**

DOMAIN 3: FINANCE				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
11	**Achievement of recurrent financial balance**	5	**MEDIUM**	**38**
12	**Management and monitoring of procurement and contracts –** lack of compliance with best practice guidance	5	**MEDIUM**	**38**
DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT				
13	**Achievement of Commissioning Plan Standards and Targets**	1	**HIGH**	**42**

DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 4 – PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: REVALIDATION ARRANGEMENTS					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
1	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016 Organizational processes and registrant support arrangements have been in place since 1st April 2016. On average 53 registrants / month [266, 8%] revalidated in the period April – August inclusive. However, **451** (**15%**) registrants are due to revalidate in the next 2 months (i.e. September or October 2016) - the months most nurses concluded their training.	• SMT agreement that 50% of Nursing Governance Co-Ordinators (NGCOs) hours would be allocated to supporting organisational and registrant readiness for revalidation. • A Professional Revalidation Support Team (an extension of the Medical Revalidation Team) has been established to support organisational arrangements and assurances. • Nursing and Midwifery Revalidation information management system to provide assurance on revalidation status of nurses and midwives in the Trust. • NMC Revalidation Implementation Group, chaired by the Executive Director of Nursing, to support and direct registrants and managers.	The Nursing Governance Co-Ordinators (NGCOs) continue to support directorate managers and registrants in preparing for effective and timely NMC revalidation. The Assistant Director of Nursing Governance and the NGCOs have developed tools and proformas to support nurses and midwives in evidencing compliance with revalidation requirements and in preparing registrants for their reflective discussion and confirmation meetings. The Nursing and Midwifery Revalidation information management system is now live and holds information on over 3,000 NMC registrants' PIN, annual fee and revalidation dates. Standard Operating Procedures have been developed to provide timely reports to nursing and midwifery managers and heads of service. Monthly revalidation reports are issued to individual nursing / midwifery managers to support local arrangements on the timely	**Executive Director of Nursing**	**HIGH**

	Although the support arrangements have met the needs of smaller numbers / month, the test will be if this significantly larger cohort successfully revalidates in September and October. If successful the risk rating will be reviewed and lowered.		reflective discussion and confirmation meetings for those they have responsibility for. Monthly revalidation reports provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progress on the implementation of the NMC revalidation arrangements. The AD Nursing Governance has worked with the AD Nursing Workforce Development and Training and Clinical Education Centre to agree a planned approach to ongoing support programmes.		

DOMAIN 1: CORPORATE CONTROL					
LINK TO CORPORATE OBJECTIVES: 1 & 4 - PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: FULLY EMBEDDED APPRAISAL SYSTEM					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	Lack of evidence re compliance of a fully embedded appraisal (KSF) system	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	<u>Knowledge and Skills Framework</u> Work ongoing with Directors and Heads of Services to support staff and managers when completing their KSF documentation to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT PDPs are now being recorded on HRPTS as a qualification. There has been a slight increase in the extent to which KSF is being implemented across the Trust – 53% as at 31st July 2016, although this is still short of the Internal Audit target of 60% by September 2016. Work is continuing to improve mandatory training levels within the Trust.	**Director of HR and Organisational Development**	**MEDIUM**

DOMAIN 1: CORPORATE CONTROL					
LINK TO CORPORATE OBJECTIVES 4 & 5 - BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE & 5 – MAKING BEST USE OF RESOURCES					
RISK AREA/CONTEXT: Shared Services Centres – Payroll / Travel & Recruitment					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
3	**Shared Services** • **Payroll & Travel SSC** – risk to accuracy of payroll as control environment not yet stabilized. Negative media publicity and impact on Trust's reputation as a good employer.	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Monthly KPI data shared with the Trust, but this is currently not complete data set • Progress updates to Audit Committee with attendance by BSO, as required • Regional audit of BSO Payroll Shared Services, currently six monthly • Trust participation in a number of grups to provide assistance on progressing improvements in Payroll Shared Services Centre	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Internal Audit Report – Payroll Shared Services, March 2016 – limited assurance • Internal Audit re-audit September 2016 • Quarterly BSO Assurance Reports circulated to Audit Committee members regarding progress on Internal Audit recommendations • Trust participation in new governance arrangements post BSTP to monitor shared services performance and achievement of benefits realisation	**Finance Director**	**MEDIUM**

	• **Recruitment Shared Services Centre (RSSC):** The speed of response / time to fill urgent posts poses a risk for front line services. This risk has the potential to increase as Recruitment Shared Services continues to be rolled out to all Trusts – there is a risk that standards will drop and the urgency of Trust services will be lost.	• Continued involvement in regional work / RSSC issues. Assurances to be sought from RSSC Head of Service regarding maintenance of standards and improvement on time to fill urgent positions. Monitoring reports on performance against standards also be provided by RSSC. • Monitoring and ongoing review of all aspects of the pre-employment checks including Occupational Health checks. • Identification of any internal issues, which may be contributing to the timeliness of recruitment exercises.	Regular engagement with RSSC managers to monitor activity and review particular operational issues of concern/shortfalls in service delivery. An issues log is maintained by the Head of Resourcing. There are also regular meetings with RSSSC and Occupational Health to specifically address any blockages and share planning information. Since May 2016, RSSC has been implementing a Recovery Plan in recognition of the level of service not yet being at the desired level and the Trust is working actively and collaboratively in the implementation of this plan. The purpose of this plan is to make improvements in key areas such as shortening the length of time taken to fill posts, improving communications and customer service, enhancing he E-Recruitment system and providing quality management information and KPI monitoring. This will involve the standardization of processes at key stages of the recruitment process, as well as the development of clear operating principles, roles and responsibilities for all stakeholders. A local action plan is also in place to address issues/ delays within the control of the Trust. Communication with Trust managers is ongoing to ensure they fulfil their responsibilities and are supported to do so via training, comprehensive user guides	**Director of Human Resources and Organisational Development**	

			and access to a local helpdesk. A permanent 'Recruitment Liaison Officer' post is being established and is currently advertised permanently (August 2016).		

DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 5 – PROVIDING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES					
RISK AREA/CONTEXT: Lack of Data Processing Contract with BSO					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
4	Lack of 'Data Processing' Contract with BSO as per Information Commissioner (ICO) guidelines. Risk of financial penalties/ fines and adverse publicity in the event of a data loss or breach.	• Trust ICT Security policy • Trust performance in application/ use of HCN re anonymized data	• This Risk requires ongoing monitoring in line with development of electronic and shared systems approaches in HSC. • The Trust has engaged Department of Legal Services (DLS) to assist with development of an appropriate contract. Risk escalated and shared on regional basis via NI Electronic Care Record Information Governance Workstream	**Director of Performance & Reform**	**MEDIUM**

DOMAIN 1: CORPORATE CONTROL (also linked to Domain 3 Finance and Domain 4: Operational Performance and Service Improvement)					
CORPORATE OBJECTIVE: 1 – PROVIDING SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: INFRASTRUCTURE – Maintenance and development of Trust Estate (facilities, equipment, ICT etc.) to support service delivery and improvement					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
5	Insufficient capital (and associated revenue) funding to maintain and develop Trust Estate (including I.T. Estate) to support service delivery and improvement Specific risks include:- • High Voltage capacity limit on supply to Craigavon Area Hospital • Anticipated failure of legacy Telecommunications infrastructure • Failure of infrastructure within drainage to remove sewage from wards at Craigavon Area Hospital • Design and fabric of Aseptic suite, Craigavon	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. • Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas:-	• On-going prioritisation and bidding process for capital in place • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k • A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly	**Director of Human Resources and Organisational Development/ Director of Performance and Reform**	**HIGH**

	Area Hospital • Construction activity on Trust sites leading to increased risk of significant service disruption • Maintenance and development of existing ICT Estate Each of these risk areas are set out below		reduced should the replacement of CAH proceed. • Work is now being progressed on the main business case for major redevelopment at CAH site. • Prioritisation of highest Estates risks being undertaken to inform allocation of available capital and revenue funding for 2016/17.		

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed. • Installation of new Combined Heat and Power plant is complete and G59 approval from NIE (to permit parallel generation) is in place. This will provide increased resilience through an additional source of supply for the site.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Anticipated failure of legacy telecoms infrastructure leading to significant service disruption and potential consequential harm to service users. **System Support:** Increased risk of in-cohesive maintenance, system support, due to gaps in out-of-hours provision of cover. Construction of the new Paediatric unit at Craigavon Area Hospital has highlighted an additional resilience risk relating to critical cable routes for telecoms and IT infrastructure	**Hardware:** • The Trust have entered into a comprehensive contract (VDCP) with BT to manage the existing network and support the structured replacement of individual legacy systems. The existing Siemens DX switches, which serve telecoms users for approximately 60% of the Trust, reach end of supported life in November 2017.At present, in the event of a failure, BT VDCP through Siemens guarantee a repair within 4/8 hours depending on service level agreement. • After November 2017, BT will no longer provide a guaranteed service agreement and it will be "best endeavours" i.e. only if parts can be sourced (used stock of whatever) etc. they will try and fix it. If the fault is software related there is unlikely to be a fix. A fault will leave the Trust without internal/external communications for a	• SMT approved Capital Funding of £342,000 (2015/16) for the provision of a Core Telephony Platform to provide the centralised telephony foundation and continuity for the existing Avaya Telephony infrastructure deployment. Planned completion end March 2016. • Requirement for additional funding to replace 5 systems on core DX sites including St Lukes, Tower Hill, Craigavon Hospital and Daisy Hill Hospital. [5 systems c£450k each] • Requirement for additional funding to replace 4 systems serving Medium and Small sites (62). [4 systems c£425k each] • Replacement of Core System and roll-out of Handsets being progressed on a phased basis – £950k revenue funding has been approved to progress this during 2016/17 • Proposals being developed for independent secure cable route to improve resilience .	**Human Resources & Organisational Development**	

		considerable period. These phone systems are well beyond their expected life and desperately need to be replaced.			

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding).	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours.	• Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July. The design team have met with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed in mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited.	**Director of Acute Services**	

	Increased risk of significant service disruption due to high degree of construction activity on Trust sites	• Use of competent 3rd parties- Professional Design Teams & Contractors- competency is part of procurement assessment • Competent staff and comprehensive procedures • Wide stakeholder engagement on all projects • Project specific information- pre-construction information, construction phase plan and Health & Safety File • Use of in-house rules 'Requirements for contractors' in work schemes • Use of work permits for higher risk work processes • Communications team & global email used for wider general & public communications • Annual plan of works	• Recruitment of 'project compliance officer' type of role who would provide a constant presence on work schemes to review Health and Safety, permit compliance, quality, etc. to be progressed in 2016/17 • Longer term planning of work schemes and allocation of funding to spread (on-site) work schemes over the entire year rather than in the 4th quarter which is generally the case. • c£500k funding approved for the creation of additional car parking spaces on the Craigavon Area Hospital site during 2016/17 • On Craigavon Area Hospital site provide an additional site entrance/ exit – design proposals to be developed 2016/17 • Updates to 'Requirements for contractors' document underway	**Director of Human Resources and Organisational Development**	

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Availability of capital (and associated revenue) funding to maintain and develop existing ICT estate, including server infrastructure, data storage, etc and support to ICT service modernization Specific risks relate to ability to implement planned upgrades / infrastructure as foundation to support developments in ICT innovation and limits these developments within the Trust All ICT resources are Currently targeted at Maintaining existing levels. Specific risks include-: Capacity to expedite/support mobile working roll out which subsequently (impacts on front line service capacity workforce risks below)	• ICT infrastructure requirements in terms of maintaining existing services have been prioritized in the IT Business plan approved by Trust Board and shared with HSCB. • Retention and disposal protocols in place • E-mail Archiving policy and procedure approved by SMT March 16.. • Bids for funding continue to be made to Capital Allocations Group and e-health division of HSCB for access to slippage. IS Technology partners utilised to provide support in line with available NR resources. Prioritisation is being given to maintaining existing services and replacement of existing devices to upgrade them and minimize support requirements. Service requests for more laptops and mobile devices are currently being declined.	• On-going prioritisation and bidding process for capital in place • Policies and procedures in place to manage ICT storage capacity. • A business case is underway to outline the full costs (including staff support) associated with further IT users. • All internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk. A number of vacancies previously held as part of corporate contingency have been released in 16/17 The Trusts technology partner Hewlett Packard is providing temporary non-recruitment staffing to support Trust operational management in 16/17 A business case is being developed to outline full costs (including staff support) associated with further IT users within the Trust. Processes in place to ensure all internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk.	**Director of Performance and Reform**	**HIGH**

DOMAIN 2: SAFETY AND QUALITY

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

RISK AREA/CONTEXT: WORKFORCE RESOURCING – WORKFORCE SHORTAGES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
6	**Workforce Resourcing Risk – Workforce shortages** The Trust is facing a number of workforce resourcing risks, including the following key risks: **Medical shortages** • Consultant Medical Staff in Dermatology, Emergency Medicine, Breast Surgery and Radiology • SAS Medical Staff in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	**Key controls to include:** • Ongoing recruitment (including overseas) campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Trust Senior Oversight Group for ED DHH • Escalation procedures in place to alert senior management of any changes in rota for ED DHH • Daily review by Senior Management of night reports and follow up on issues on ED DHH • Daily audit of notes for ED DHH • Close monitoring of all Breast referral waiting times • Submission of HSCB Unscheduled Care Escalation plan (6th May 2016)	**Dermatology Medical:** A Dermatology trainee is now required to rotate to Craigavon one day per week. This should encourage trainees to apply for Consultant posts in Craigavon. Two retired Consultants continue to undertake some Waiting List Initiatives (WLI) clinics for Dermatology. There has also been an increase in expanding nurse led clinics. However there is still a requirement for a new (3rd) Consultant post which will be difficult to fill. **Emergency Medicine:** The Southern Trust has advertised Consultant ED posts to cover on the Daisy Hill Hospital (DHH) site, but so far have been unsuccessful. 2 Consultants were recently appointed to CAH. There is another advert out closing in August 2016 for Consultant ED CAH (with sessions in DHH) – no applicants to date.	**Human Resources & Organisational Development/ Medical Director/Director of Acute Services**	**HIGH**

			The Trust is regularly raising the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. Ongoing review of ED DHH medical rota to ensure senior doctors are on duty until midnight. Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a Registrar. Recruitment of senior nursing staff to be on duty 24/7. **Breast Service** The Trust has secured the services of a part time Breast radiologist until 31st December in the first instance to support service provision. As an interim measure The Northern, South Eastern and Belfast Trusts are offering additional clinics to see a proportion of Southern Trust red flag referrals to reduce the waiting time for the triple assessment appointment to clinically acceptable levels. Transfers of patients have occurred over recent weeks and we are seeing waiting times falling. A number of our own surgical Breast medics have increased their job plan capacity which now enables them to undertake additional sessions in house , again to increase capacity and reduce		

			waiting times. The Breast service has met with Dr Gerry Millar to explore options for further GP training on the management of Breast Pain to enable these patients to be appropriately assessed and treated in their own GP surgery and further that we would train a small number of GP's with specialist interest in Breast pain who could assist with specific breast pain clinics working in conjunction with secondary care colleagues to manage this group of patients outside of the triple assessment clinics so increasing capacity for suspect cancer patients. There are further discussions planned and underway with other Trusts regarding the potential for a more sustainable network, providing cross Trust working to enable the provision the required capacity in Symptomatic breast services to meet Southern Trust demand. There are plans by the HSCB to review Breast services from a regional perspective with a view to supporting a sustainable service design to meet the needs of the whole population. This is expected to commence in the Autumn 2016 **<u>Radiology</u>:** The position remains unstable. Four consultant posts were advertised in April 2016 with only one applicant who has since been appointed. The remaining posts will be re-advertised in September 2016		

		• Business Continuity Plan for GP Out of Hours Service • Medical Managers with medical responsibility for the GP Out of Hours service • On Call Manager system for GP Out of Hours Service • Daily monitoring of GP Out of Hours rotas and appropriate contingency plans deployed based on resources available • Pharmacy Service in place in GPOoHS until March 2017 • Any concerns raised by GPs on the safety of the service will be escalated and addressed by Trust and HSCB. • Contract with Dalriada Out of Hours for additional Nurse Triage 6pm-8am from December 2015.	The Trust engaged with A Team Recruitment regarding the recruitment of medical staff at SHO level from the EU. A total of 10 doctors have now accepted offers – 2 paediatrics, 7 surgery, and 1 ED DHH. It is expected that the doctors will be ready to commence once requirements for GMC registration are processed by end of December 2016. **<u>GP Out of Hours</u>:** • The Trust has escalated the risk to HSCB and DHSSPS, and has had joint meetings. • Action Plan in place including actions from reviews. • The process of over-seas GP recruitment commenced in December 2015. • 2016/17 HSCB and Trust additional costs scheme implemented in June 2016. • Twice daily operational meetings to review medical cover and contingency actions implemented. • Capacity and demand work is ongoing. Review of workload of clinicians is ongoing by Clinical Lead. • HSCB Local Enhanced Service scheme to attract GPs to work in the service circulated to all GPs by HSCB in July 2016. • Rates have been enhanced over July and August due to annual leave	**Director of Older People and Primary Care**	

			of GPs to secure cover. • KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB. • Urgent KPI response in 20mins, Jan–Mar 84% and Apr–Jun 86% - there is an improvement in the KPI. • Vacant shifts, Jan–Mar 35% and Apr- Jun 26% - there is a reduction in the % vacant shifts.		

	Nursing shortages • Inability to recruit Registered Nurses across all areas, including Health Visiting Service	• Ward Sister/Charge Nurse management of available staff on a shift by shift basis • Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need • Escalation to Operational Director as required • Open registration for Nurse Bank • Open Recruitment for Adult Band 5 Nurses with interviews scheduled every 2 weeks • E-rostering roll out • International Recruitment • SHSCT staff attend all local university job fairs to promote working in the SH&SCT	**<u>Registered Nurses</u>:** • International recruitment is now progressing on a regional basis.. • EU and non-EU recruitment drives commenced in May 2016 with a recruitment exercise in the Philippines, Italy and Romania (92 posts have been offered for SHSCT from the Philippines to date and 17 posts offered from the campaign in Italy). A further campaign is planned for October. • Rotational Programmes continue to be a unique attraction to working in the SHSCT. Further roll out continues to be explored within and across Directorates, with anticipated interest of approximately 25-30 student nurses for a programme to commence in September 2016. • Department of Health announced increase to adult pre-registration training places by 100 commencing September 2016. Associated work has commenced to further access student placements across the Trust • SH&SCT have worked with OU and Department of Health to maximise funding and been successful to increase significantly the number of places on the OU PRNP commencing September 2016. SH&SCT have 23 staff commencing in September 2016, 7 of these staff are entering stage 2 of the programme with a further 16 commencing stage 1 of the programme. In addition 5 staff have	**Executive Director of Nursing/ Human Resources and Organisational Development**	

		Health Visiting Service: • Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA	been given a deferred place for stage 2 of the programme in 2017 • Collaborative approaches to local recruitment by the 5 HSC Trusts are being taken forward through the Regional Recruitment Working Group **Health Visiting Service:** • Ten Health Visiting students are currently training in the Trust but won't complete until September 2016. External recruitment was progressed and a new waiting list has been developed with 4 candidates and BSO is in the process of offering permanent posts. It is unlikely that all our permanent vacancies will be filled until the next cohort of students qualifies in September 2016. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. • The Trust is currently waiting for confirmation from the PHA regarding regional normative staffing range using information from regional Ecat caseload weighting tool. • This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).	**Director of Children and Young People's Services**	

	Failure to attract/appoint required staff and delays in recruitment processes in mental health/disability inpatient wards, community teams, supported living and day care facilities	• Use of Agency • Cyclical recruitment monitored and reviewed to ensure waiting lists are updated • Creation of the training role with specific interest in disability and mental health	• Additional hours for existing workforce has improved the situation temporarily • Transfer of staff to meet need is becoming increasingly difficult as many services are also stretched due to staffing pressures Introduction of a local transfer policy to assist this process • Undertake recruitment drives for adult practitioners with advertising specific to Mental Health and Disability Directorate – currently ongoing. • Undertake recruitment drives initially within CAMHS, then CAMHS & Adult Mental Health and if no success then externally for specific training posts. • Creation of local banks • Improve linkages with Southern Regional College to facilitate career advice on Health and Social Care related roles and visible presence at open days	**Director of Mental Health and Learning Disability**	

	Reduced ability to provide 24/7 laboratory service at Daisy Hill Hospital due to insufficient Biomedical Scientists New Regional IT implementations such as NIECR, BSTP and HRPTS have not included recurrent funding for local IT support	• Shadow rota in place from 1st July 2016 • Ongoing training in blood transfusion • Procedures in place in absence of Biomedical Scientist support on site	• The laboratory service is currently training as many Biomedical Scientists as is possible to function on the Daisy Hill Hospital rota. However, training in all aspects of Blood sciences and Blood transfusion takes a significant period of time. • Approval has been given to recruit 4 additional Biomedical Scientists and these are being advertised in September 2016. . The issue has been raised at the Regional Pathology Network Board.	**Director of Acute Services**	

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Statutory Functions/Duties					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
7	The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management completed. Heads of Services tasked with taking forward required actions. • Restructuring process by Heads of Service completed within the Mental Health and Learning Disability Directorate.	**Director of Mental Health and Disability/ Director of Older People and Primary Care**	**MEDIUM**

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
8	Capability of Trust systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Monitoring and assurance of implementation/ compliance with Standards and Guidelines 2. Effectiveness of processes in place to review all intelligence from incidents, complaints, litigation and user feedback to highlight areas of risk and safety to drive improvement 3. Effectiveness of processes in place to disseminate and share learning from incidents, complaints and user feedback across the organisation	• Standardised process in place for the dissemination of Standards and Guidelines across the Trust • Web-based incident reporting in place across the Trust • Screening and investigation procedures in place in operational directorates with regards to incidents and complaints • Clinical and Social Care Governance information presented in dashboard format to SMT Governance and Governance Committee using trends over time to highlight risk • Guidelines in place for Directors setting out triggers for presentation of SAIs to SMTand Trust Board • Directorate, Division and Professional Governance Fora in place with reporting arrangements to SMT Governance, Governance Committee and Trust Board • Mortality and Morbidity structure in place across all clinical specialties • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback	• Standards and Guidelines database to be updated to improve tracking of compliance and reporting functionality – September 2016 • Ongoing improvement of processes to disseminate learning across the Trust via - Learning Letters - Safety Alerts - Professional Forums - Mortality and Morbidity meetings - Incident screening processes • Develop corporate system to track compliance and report on RQIA reviews action plans – December 2016 • Develop the use of Clinical and Social Care Governance Audit to provide assurance of compliance and identify risk – September 2016 • Implementation of the Trust's Quality Improvement Framework.	**Medical Director**	**MEDIUM**

		to Chair and Chief Executive • Executive Director Reports to Trust Board • Continuous Improvement support function to front line staff – capability and capacity building for service improvement • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy .			

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: HCAI					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
9	• Risk to achievement of HCAI Priorities for Action targets • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities in Daisy Hill Hospital) within the Trust hospital network • Increasing emergence of infections (CPE/VHF) • HCAI outbreaks in tertiary services • Depletion in IPC Nurse staffing	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • CDI 'trigger' system in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement opportunities to be created with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites – this requires resource. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence • Enhanced communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Enhanced HCAI RCA information management system and system developed to further improve meta-	**Medical Director**	**MEDIUM**

	• Reduction of Microbiological medical workforce from four to two Doctors through loss of a Staff Grade and Special Registrar attachment • High bed occupancy rate and limited isolation resource • Increased Estates new builds and refurbishment reduce number of facilities available	• Close liaison between IPC Team and Patient Flow Team • Close liaison between IPC Team and Estates colleagues	analysis of C Difficile cases • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Electronic C Difficile database is under significant review and a new model is being created in this regard. • Implementation of a CDI 'trigger' system that will act as new early warning criteria to identify potential CDI outbreaks earlier • Development of Clinical Antibiotic Stewardship champions to implement new Antibiotic Stewardship Policy • Seeking funding that will support continuous drive to recruit suitable IPC staff • Appointment of locum Staff Grade and seek funding to secure this as a permanent post		

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Safeguarding of residents from risk of potential financial abuse					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
10	Safeguarding of residents within [redacted] - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust [redacted] group provided to DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel.	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board and QA by independent "critical friend" review (January 2016) • Updates routinely provided to Trust Board • Trust staff attended a meeting in Arthur Cox offices on 8th July 2016. The home owners did not meet directly with Trust staff but communicated via their solicitor. on 15th July 2016 Arthur Cox wrote to the Trust outlining a proposed way forward regarding day care meals, transport invoices (but not historical transport monies owed as per safeguarding investigations) and clients "A" (mobility car) and "B" (statutory disregard monies owed: £50). No agreement was	**Director of Mental Health and Disability Services**	**HIGH**

		• Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with Personal Informat and quarterly operational meetings with Personal Informat as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB	reached re additional payments monies owed. Arthur Cox quoted case law and invited the Trust to reconsider its position on suspension of admissions. The Trust responded via its legal advisers on 27th July 2016 advising that the Trust's decision to suspend new admissions remains in place. The Trust legal advisers considered the case law example provided and do not accept its application in this case.		

		re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			

DOMAIN 3: FINANCE

LINK TO CORPORATE OBJECTIVE 5: MAKING THE BEST USE OF RESOURCES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	Achievement of recurrent financial balance	• Contingency Plan in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Whilst it is early in the financial year and TDP approval still awaited, the first 4 months outturn would indicate in-year breakeven. It is hoped this can be maintained through a range of non-recurrent measures, including natural slippage on allocations.	**Director of Finance and Procurement and Operational Directors**	**MEDIUM**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
12	Management and monitoring of procurement and contracts – not compliant with best practice guidance Lack of regional formalised guidance/agreed approach for management of social care procurements under threshold value of £589k	• Guidance on Direct Contract Award processes issued and reminder global emails circulated regularly. Follow up training and advice available as required from Head of Purchasing and Supply • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	**GENERAL** • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013)	**Director of Finance and Procurement**	**MEDIUM**

			• Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Trust continues to highlight in Governance Statement the lack of central resource in Trust for contract monitoring • BSO PALs undertake contract monitoring for those regional contracts awarded through them **ESTATES** • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Recruitment of Phase 1 PALS team complete. Recruitment of Trust Team underway – anticipated completion November 2016 • Measured Term Contract (MTC) in place which mitigates risks to procurement for schemes <£45k • Volume of works being undertaken balanced against resources to facilitate compliance • Actions arising from Internal	**Director of HROD**	

		• Regional Steering and Working Groups established.	Audit report either complete or in progress. • Recruitment of additional Procurement Officers and 2 x replacement Estate Development Officers to be completed in second quarter of 2016/17. **SOCIAL CARE PROCUREMENT** • Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement for overthreshold contracts (c£589k). No approach agreed for allocation of funding under this value. • Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements as part of hub and spoke model with Trust staff operating under the influence of the Centre of Procurement Excellence (CoPE) • Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid	**Director of Performance and Reform; All Directors**	

			approved, however recruitment has been suspended due to financial pressures. • Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15 enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Trust proceeding to recruitment of two substantive posts further to agreement with BSO/PALs on job roles		

DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Commissioning Plan Standards and Targets					
No	**Description of Risk**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	***a) Waiting times in excess of Commissioning Plan Standards / Targets across***: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients and Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • AHP professions	INTERNAL MONITORING: 1. ***Fortnightly Operational Performance meetings:*** • Acute Directorate 2. ***Monthly Operational Performance meetings***: • Mental Health & Disability Directorate • Children and Young People's Services Directorate • Older People and Primary Care Directorate 3. ***Monthly Operational AHP Performance*** - Cross- directorate ***4. Monthly reporting to Senior Management Team and Trust Board*** 5. ***Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.***	**a) Access Times** **Outpatients** - Delivery of Service and Budget Agreement (SBA) volumes (where agreed) remains first priority within Operational Directorates. Prioritisation of Red Flag and urgent assessment/treatment. Delivery of routine patients will follow, based on chronological order. Recurrent capacity 'gaps', which have been agreed with Southern Local Commissioning Group remain in a range of specialty areas affecting routine access times across diagnostics, inpatients/daycases and outpatients. **Diagnostics** - Non-recurrent allocation received for additional Diagnostics imaging and reporting capacity (including Endoscopy) in 2015/16 and 2016/17. The volumes allocated does not address the gaps in all areas but assists with stemming the growth of long waits The additional diagnostic volumes	**Performance and Reform and Operational Directors**	**HIGH**

		EXTERNAL MONITORING: 6. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board **ACTION PLANNING:** 7. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 8. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 9. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity. The Trust is currently re:-testing market for available capacity (August 2016) Investment was received in 2015/16 to increase capacity in MRI and proposals have been submitted for a 2nd CT mobile (capital & revenue) with expect additional capacity on site in early 2017. **Inpatients/Daycases and Outpatients** - £700k of non-recurrent funding has been made available by Health and Social Care Board (HSCB) for elective areas in Q1/2 in 2016/17. This is insufficient to address the gap and as such the Trust has prioritised this to the following areas:- • Longest outpatients waits beyond clinically indicated timescales; • Outpatients waiting over 26 weeks; • Inpatient and Daycases waiting over 52 weeks; • AHPs The Trust will continue to re-direct any available internal resources to areas of greatest risk as funding becomes available or as operationally feasible (re Workforce capacity) throughout 2016/17		

	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		**AHP Access Times-** Additional capacity has been provided in AHP areas (from the £700k) funding where temporary staff can be secured. However, due to the short-term nature, the Trust has faced challenged in securing temporary resource to increase capacity. A regional demand and capacity analysis undertaken by PHA/HSCB concluded with formal gaps in capacity recognized by the commissioner. No specific funding has been provided. The Trust is seeking to prioritise within existing resources and demographic funding to address these gaps in part in 2016/17. Due to accrued backlogs, waits for routine patients will still be in excess of agreed position. Focus remains on urgent cases. **b) Diagnostic Imaging Reporting** Non-recurrent allocation for plain film reporting was received from HSCB in 2015/16 and 201617 for the recognised capacity gap in this area. Increasing demand coupled with manpower issues, is creating a more significant gap. An operational plan is in place to focus capacity on urgent and prioritised areas, including plain film chest x-ray The Trust has sourced additional capacity via two independent sector contracts which are predominantly utilised to support the gap in plain film reporting.		

			Internal additional reporting capacity has been focused on scanning and reporting CT, non-obstetric ultrasound and MRI examinations. HSCB has provided early recurrent funding for the implementation of plain film reporting by radiographers for ED films to partially address the gap. Trust has submitted proposal for training of radiographers to increase reporting capacity in plain film and non-obstetric ultrasounds. Whilst this has not been funded yet the Trust has agreed to prioritise a number of posts into training to reduce the lag time for implementation.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
	a) Out-Patient Review and Planned Treatment Backlogs ***Out-Patient Review Waiting List Backlogs in:*** • Acute; • CYPS; • MHD; and • OPPC	Internal and External monitoring controls included as in Corporate Risk 1 above. <u>ACTION PLANNING</u>: • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting	**a) Outpatient Backlog** At the July position, there were a total of 16,450 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led acute, children's and older peoples services) and 1317 for mental health services. (Visiting Specialties managed by other Trusts are excluded). Longest routine waits extend back to 2013/14. • In 2015/16 Trust diverted internal resources to provide additional capacity for review patients; 5000 additional patients were seen		**HIGH**

	b*) Planned Patient Backlogs** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale in Outpatient and AHP services.	list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	• In 2016/17 some additional review patients were prioritized for additional capacity from the £700k non recurrent allocation; however total volume of those waiting beyond clinically indicated dates has started to increase again. The Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible throughout 2016/17. Operational process are in place to ensure patients requiring clinically urgent review are prioritised. **b) Planned Patient Backlog** As at 1st August 2016, there were a total of 1560 patients on the planned treatment backlog. The longest waiting patient dates back to October 2014 and relates to Urology. 79% (1237) of the planned treatment backlog relates to Endoscopy with the longest substantial wait from January 2015. Non recurrent funding received in 2015/16 and allocated for 2016/17 is insufficient to meet the demand for new and planned repeat endoscopy. Priority is given to red flag, urgent and planned patients initially, then routine waits.		

			Operational processes have been established to prioritise those planned patients that require urgent review. In line with JAG accreditation requirements, the planned treatment backlog should not exceed 6-months. **c) AHP review backlogs** AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available however, ability to access staff on short term contracts remains challenging. Short term AHP capacity is prioritized from the £700k of non-recurrent funding made available in Q1/2.		

Southern Health and Social Care Trust

REPORT SUMMARY SHEET

Meeting Date	Trust Board 28th January 2016
Title	Executive Director of Nursing's update report on key nursing and midwifery governance activity and workforce development and training
Lead Director	Francis Rice, Executive Director of Nursing/AHPs
Corporate Objective	• Providing safe high quality care • Making best use of resources • Support people and communities to live healthy lives and improve their health and wellbeing
Purpose	Assurance and Information

Summary of Key Issues for Trust Board

High level context

Trust Board has approved the implementation of the Nursing Quality Indicator (NQI) Framework as a mechanism for providing assurances on the quality of nursing care provided to patients in the Southern Trust.

Appointing to Registered Nursing posts remains extremely challenging despite proactive recruitment activity. International nursing recruitment is now being progressed on a five Trust basis.

Key issues/risks for discussion

NQI Framework acknowledges internal and external monitoring activity and ensures collated reporting arrangements are in place. NQI Framework implementation activity is ongoing and a rollout plan is in place starting with the Acute and non-Acute adult in patient areas.

The Patient / Client Experience surveys report on and evidence the excellent care provided by all nurses and other health care workers. Their experiences will inform the future planning and development of care and services within the Trust.

The Nursing and Midwifery Council's (NMC) has revised its revalidation arrangements for registered nurses and midwives which came in to effect in December 2015. The Trust has put in place to ensure organisational and registrant readiness for the new revalidation arrangements due to commence in April 2016.

The main risk for the Trust is how to continue to deliver safe nursing care given the number of vacancies across services that are unable to be filled despite significant recruitment activity, and recognisng that early indications are that it will be Summer 2016 before any nurses recruited overseas will be entering NI.

Summary of SMT challenge/discussion

The success of the NQI Framework lies in the analysis of complex data from all 4 domains across all directorates:

- Domain 1 Safe and effective process indicators
- Domain 2 Safe and effective outcome indicators
- Domain 3 Patient experience indicators
- Domain 4 Nurse's knowledge of patient's care needs

Filemaker is the database of choice as it is currently being used and has been tested in other Southern Trust projects. To amend/update Filemaker as soon as possible to enable analysis of audits.

SMT is aware of the potential impact on the Trust should nurses fail to comply with the new revalidation arrangements, however, is confident that the systems and processes are now in place to ensure organisational and registrant readiness for commencement in April 2016.

Delivery of safe nursing care given the current recruitment challenges and need to progress international recruitment and continue rolling recruitment programme within Southern Trust. Monitor the current nursing vacancy rates within the Trust to ensure safe staffing levels.

Internal/External engagement

Trust Ward Sisters their nurses continue to participate in the programme for implementing the NQI Framework and the NQI Framework Steering Group continues to meet bi-monthly. Ongoing engagement of Personal and Public Involvement (PPI) Leads on involving patients in service improvement initiatives. Research and nursing leads have also engaged with the PHA leads of the Patient / Client Experience Standards and 10,000 Voices initiative to ensure cross-agency information sharing and learning.

Lynn Fee and Karyn Patterson have been nominated to lead international nursing recruitment for the five Trusts.

Human Rights/Equality

There are no perceived specific HR or equality issues within the context of the framework approach proposed. The focus of nursing quality indicators is to provide assurances on high quality compassionate care that supports Trust delivery of Human Rights and equality requirements.

International nursing recruitment will be progressed taking into account all UK requirements as well as any legislative requirements from other countries.

Southern Health and Social Care Trust

Quality Care - for you, with you

Executive Director of Nursing Report to Trust Board

28th January 2016

Executive Director of Nursing Update Report to Trust Board 28th January 2016

INTRODUCTION

This report provides an update on the key nursing and midwifery governance activity and workforce development and training as set out in the reports tabled in January and June 2015.

2.0 NURSING QUALITY INDICATORS (NQI) UPDATE

2.1 The Southern Trust's Nursing Quality Indicator (NQI) aims to proactively drive improvements in the quality of nursing and midwifery care and the patient experience. In 2014 the EDN funded research which examined the application of a nursing quality indicator (NQIs) framework in evidencing the impact of nursing on patient safety outcomes and the patient experience in adult in-patient wards. Proposed Framework: -

2.2

					Domain 4
		Safe and effective process indicators	**Safe and effective outcome indicators**	**Patient experience indicators**	**Nurse's knowledge of patient's care needs**
		Review of patient records to assess compliance with evidence- based care bundles	Review of patient records to determine patient safety outcomes in relation to selected NQIs	Exploration of patient's perception of their experience of nursing care	Nurses asked to identify the patient's nursing care needs. Responses mapped against nursing care plan
	Ward level information	Patient safety outcome measures; feedback from nurses and complaints and incidents			

The research found that the proposed framework (i.e., measuring care across 4 domains - Domain 1 - Nursing Care Processes, Domain 2 - Nursing Care Outcomes, Domain 3 - Patient Experiences and Domain 4 - Nurses Knowledge of Care Needed) provided a more robust and comprehensive understanding of the overall quality of nursing care provided as opposed to reporting on individual care elements for groups of patients. Specifically, collecting information across each domain for each patient supports review of the care *journey* of each *individual* patient and the nurses who care for them and evidences the contribution nurses make to the patient's experience. Post-research a Southern Trust NQI Framework Implementation Group, chaired by the EDN, was set up to direct and oversee the implementation of the Framework within the 4 Care directorates.

2.3 *Implementing the NQI Framework*

Senior nurses within the Care directorates have been auditing compliance with a range of nursing process indicators since 2011 and the EDN has bi-annually reported on the level of compliance to Trust Board. As different directorate care priorities emerged the number of monthly audits undertaken has become an increasingly onerous and time consuming task for ward/team managers and nurses. A scoping exercise across the four Care directorates identified **at least 54 separate nursing process audits being undertaken on a monthly basis.** This did not include other non-nursing audits which Ward Srs/CN are responsible for facilitating / collecting information on (12 additional audits identified in the Acute directorate alone).

In line with the emerging focus on patient-centred care, it was recognised that the audit of nursing process indicators could not capture the patient's experience of care. However, the agreed Framework will allow the profession to capture the patient's experience of their care journey and outcomes as well as assessing compliance with nursing processes. Additionally, links will be made with Personal and Public Involvement (PPI) and service improvements initiatives.

2.4 In order to provide more structured assurance on the quality of nursing care and reduce the number of audits (and nurses' time spent undertaking these), the NQI Framework Steering Group agreed that **only those Nursing Quality Indicators (NQIs) which the Trust is required to report / provide assurance on locally (SMT / Trust Board) and regionally should be audited**, see below in 3.0. The Steering Group will review the agreed indicators periodically or as required to ensure they remain valid.

2.5 To avoid duplication with the Acute directorate's NEAT[1] initiative, the Acute NQI Steering Group members undertook a mapping exercise to ensure all the NEAT components were included in the NQI Framework. Satisfied that they were the Acute director has now stood down NEAT programme.

2.6 It has been acknowledged that nurses, either periodically, or on an ongoing basis, participate in and/or contribute to clinical audits which do not have a specific nursing component. The Acute directorate NQI Steering Group members have agreed to develop a criteria to clarify / justify nurses' involvement in such audits and ensure that nursing care and/or management capacity is not compromised.

2.7 Given the substantial nature of the audit tools which now includes 4 domains, the NQI Framework Steering Group agreed that 3 monthly audits, rather than monthly, would be completed, where relevant, in all directorates. The indicators largely relate to adult in-patient wards and MHD and CYP are considering those indicators that they are required to report on regionally and which may need to be included. **Directorate-specific monthly nursing audits will continue with the agreement of the director and senior nurses and the EDN will report on them by exception if required/necessary.**

[1] NEAT stand for N=Nurse's Knowledge, E=Pt Experience, A=Assessment safety and standards T=Teamwork – all of which are contained within the NQI Framework's 4 domains, see para 2.2.

3.0 AGREED NQIs (as at October 2015)

3.1

NURSING / MIDWIFERY QUALITY INDICATORS REGIONAL REPORTING REQUIREMENT (includes those indicators which Trust is required to report on to CNO (N KPIs), Quality 2020 – Commissioning Plan Direction, QIPs (Nursing indicators) and Patient Safety Quality Improvement Initiatives	
Nursing Quality Indicators (NQIs)	**Reporting Mode**
1. SKIN	Audit
2. Falls (Part A)	Audit
3. Nutrition (MUST)	Audit
4. NEWS / OEWS / PEWS	Audit
5. Omitted and Delayed Meds (Failure to record)	Audit
6. Nurse Record Keeping	Audit
7. Pt/C Experience Standards / 10,000 Voices	Audit
8. Professionalism (NMC Revalidation, Nurse Supervision)	Quarterly progress report
9. Preceptorship	End of year progress report
10. Delivering Care (Normative Staffing)	
11. NMC Standards to Support Learning and Assessment in Practice 2008	End of year progress report

Information from audits across the 4 domains will provide assurance on the quality of nursing care, the patient's experience of care and identify areas for improvement both at ward level and organisational level.

NQIs 1 – 7 will be measured through new survey arrangements and audit tools reflecting the Framework's 4 domains. Data for Domain 1 and 2 will be collected through review of records, Data for Domain 3 and 4 will be collected through interviews with patients and the nurses caring for them. Currently, across all wards and teams, process audits are undertaken by a range of nursing staff who are mostly untrained in audit processes and which may make the audit results unreliable. To ensure future audit results are reliable independent auditors will be trained to ensure audits are validated and results reliable. As such Ward Srs/CNs / Staff Nurses may participate in auditing alongside independent auditors ONLY if they have been trained and where audits are NOT being completed on their own ward. In the first instance independent audits will be carried out in acute adult in-patient areas (Acute, OPPC and MHD).

NQI 8 – a status report on compliance is currently provided to all managers and the EDN on a monthly basis.

NQIs 9 – 11 are reported to all managers and the EDN through end - of – year reports.

Currently Ward Srs/CNs / Staff Nurses continue to undertake monthly audits on domain 1 and 2 their own wards and the outcomes for 2014 – 2015 are as set out in 3.4 – 3.12 below. Arrangements to train independent auditors within the directorates continues.

Given the complexity in analysing data from all 4 domains in all directorates, it has been agreed that the Filemaker database will be used to test analysis and reporting arrangements. Filemaker is being used as an analysis tool of choice in other Southern Trust projects, such as infection prevention and control, with good effect. Upload of data for analysis could commence by end of January with Trust wide assurance reports available by end of March/April 2016.

3.2 *NQI Framework Implementation Activity September – December 2015*

Post-research / Implementation Activity	Progress
Review and agree the core NQIs which the Trust is required to report on regionally	Concluded
Review of the associated NQI audit tools to ensure that they reflect the 4 domains	Will conclude end of Jan 2016
Testing / re-testing the revised audit tools in preparation for uploading onto Filemaker database	Ongoing
Writing of database (undertaken by Systems Administrator for Nursing & Midwifery supported by Medical IT Project Manager)	Ongoing – Aim to be concluded mid-Jan 2016
Liaison with IT on arrangements and upload of Filemaker database - necessary to support large-scale NQI audit collection, collation and reporting arrangements	Ongoing Rollout / implementation cannot commence until database and tablets available for recording audit info
Scoped and tested in the divisional / ward / team arrangements which need to be in place in order to collect, collate and report on the quality of nursing care.	Ongoing New audit tools tested in Acute, OPPC and MHD directorates adult in-patient wards. Testing in CYP to commence in early 2016
Facilitated audit consistency training/awareness with identified auditors – a core recommendation to support valid and reliable reporting on audit outcomes	Concluded Will be repeated as new auditors come on board
Development of guidance for auditors on the application of the new tools	In development - Aim to be concluded mid-Jan 2016
Development of guidance for managers on post-audit identification and prioritisation of areas for improvement at both at ward/team and organisational level	In development

Ongoing engagement of Personal and Public Involvement (PPI) Leads on service improvement initiatives	Ongoing
Development of an Evaluation Strategy to assess success of Framework in evidencing safe, quality nursing care and enhanced patient experience.	In development
Submission of research paper for publication in the *International Journal of Health Care Quality Assurance*	Currently being peer reviewed prior to publication
Auditors and Head of Services/managers to agree a timetable which will ensure all wards / facilities have a validated independent audit completed 4 times per year.	Ongoing
The Acute directorate Acute NQI Steering Group members have agreed to develop criteria to clarify / justify nurses' involvement in non-nursing audits to ensure that nursing care and/or management capacity is not compromised.	Ongoing

The NQI Framework Steering Group continues to meet bi-monthly to review progress on the implementation.

As above it was agreed that the following NQIs (regional reporting requirements) would be audited on a 3 monthly basis in those directorates where applicable. As above, as the database is not yet in place monthly audits will continue to be undertaken by the Ward Sisters and collated by excel.

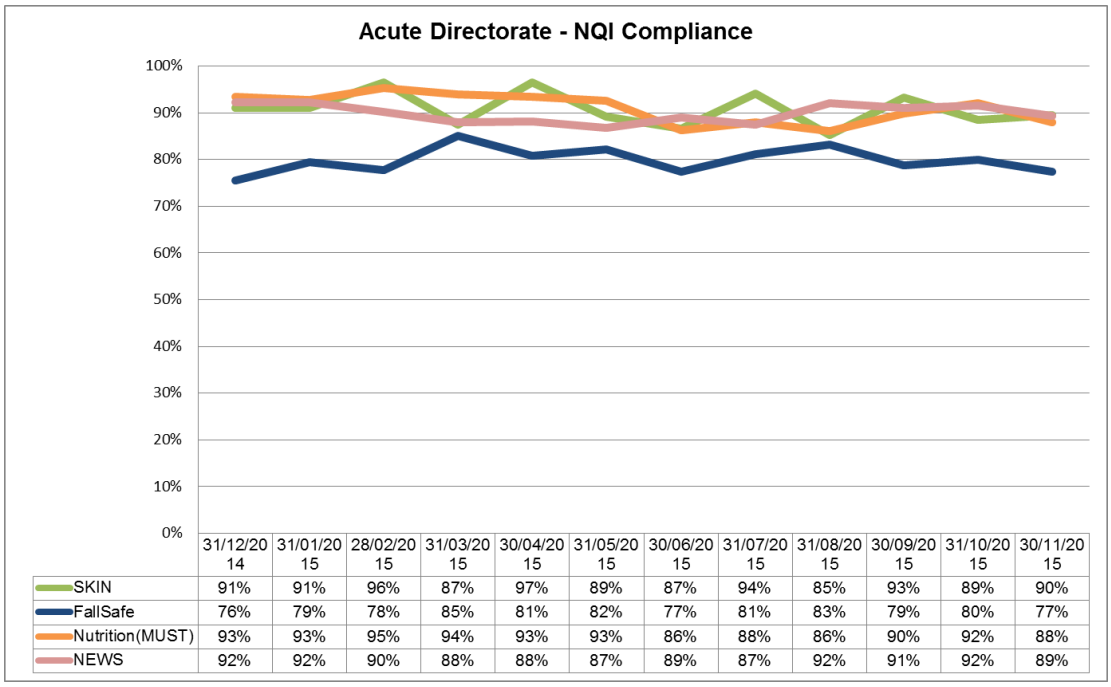
3.3

	NQI	Acute	OPPC	MHD	CYP
1.	SKIN	X	X		
2.	Falls (Part A)	X	X	X	
3.	Nutrition (MUST)	X	X	X	
4.	NEWS / OEWS / PEWS	X	X	X	X
5.	Omitted and Delayed Meds (Failure to record)	X	X	X	
6.	Nurse Record Keeping	X	X	X	X
7.	Pt/C Experience Standards / 10,000 Voices	X	X	X	
8.	Professionalism (NMC Revalidation and Nurse Supervision	X	X	X	X

As above, compliance with NQI 8 is provided to all managers and the EDN on a monthly basis and NQIs 9 – 11 are reported to all managers and the EDN through end - of –

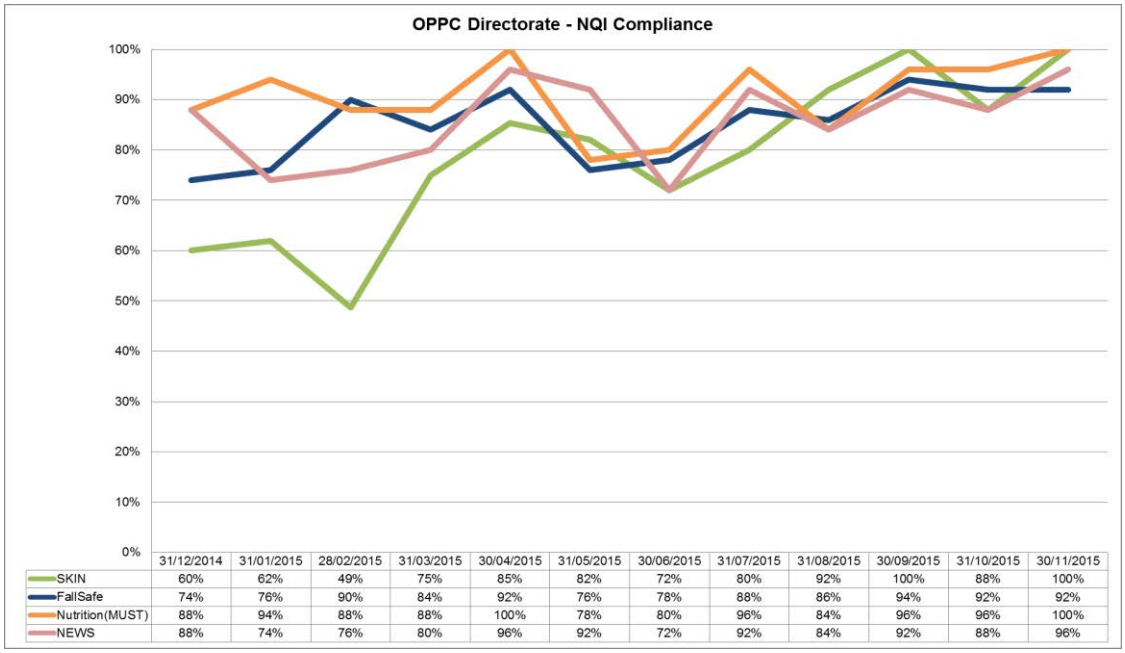
year reports.

3.4 *NQIs 1- 4 - Acute Adult Inpatient Wards*



	31/12/2014	31/01/2015	28/02/2015	31/03/2015	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015
SKIN	91%	91%	96%	87%	97%	89%	87%	94%	85%	93%	89%	90%
FallSafe	76%	79%	78%	85%	81%	82%	77%	81%	83%	79%	80%	77%
Nutrition(MUST)	93%	93%	95%	94%	93%	93%	86%	88%	86%	90%	92%	88%
NEWS	92%	92%	90%	88%	88%	87%	89%	87%	92%	91%	92%	89%

3.5 *NQIs 1- 4 - OPPC (Non-Acute) Adult Inpatient Wards*



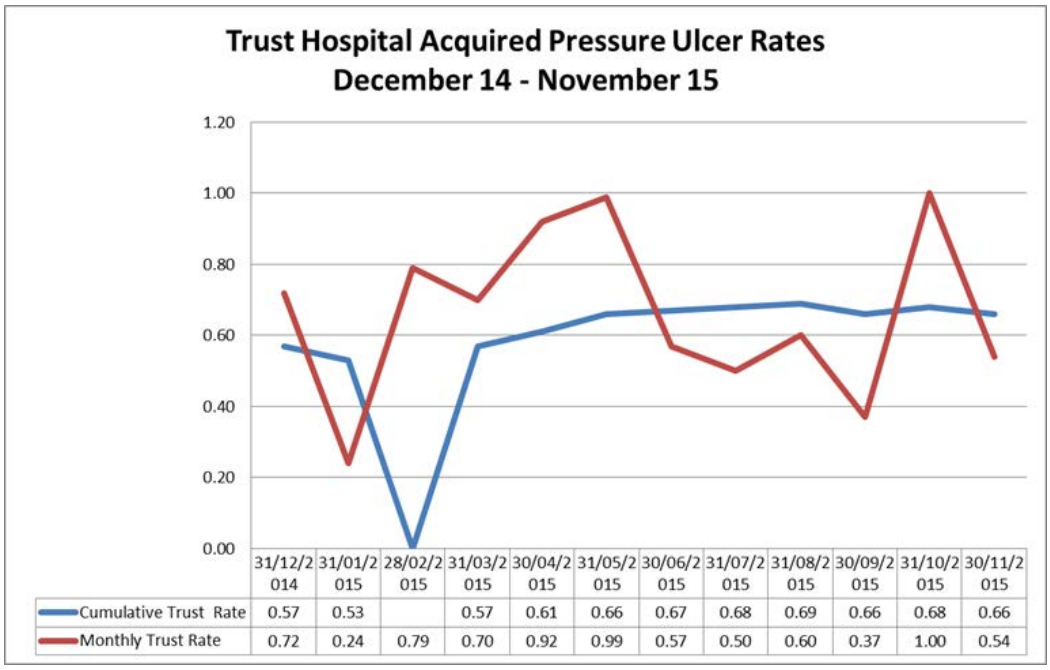
	31/12/2014	31/01/2015	28/02/2015	31/03/2015	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015
SKIN	60%	62%	49%	75%	85%	82%	72%	80%	92%	100%	88%	100%
FallSafe	74%	76%	90%	84%	92%	76%	78%	88%	86%	94%	92%	92%
Nutrition(MUST)	88%	94%	88%	88%	100%	78%	80%	96%	84%	96%	96%	100%
NEWS	88%	74%	76%	80%	96%	92%	72%	92%	84%	92%	88%	96%

OPPC AD / Lead Nurses comments

OPPC are pleased that consistently high or full compliance with all of the clinical indicators is being achieved within the non-acute wards. There will be continued concentrated efforts by ward sisters through support, education and enhanced

monitoring to ensure full compliance on all indicators is achieved.

3.6 *Southern Trust Hospital Acquired Pressure Ulcers (Dec 2014 – Nov 2015)*



	31/12/2014	31/01/2015	28/02/2015	31/03/2015	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015
Cumulative Trust Rate	0.57	0.53		0.57	0.61	0.66	0.67	0.68	0.69	0.66	0.68	0.66
Monthly Trust Rate	0.72	0.24	0.79	0.70	0.92	0.99	0.57	0.50	0.60	0.37	1.00	0.54

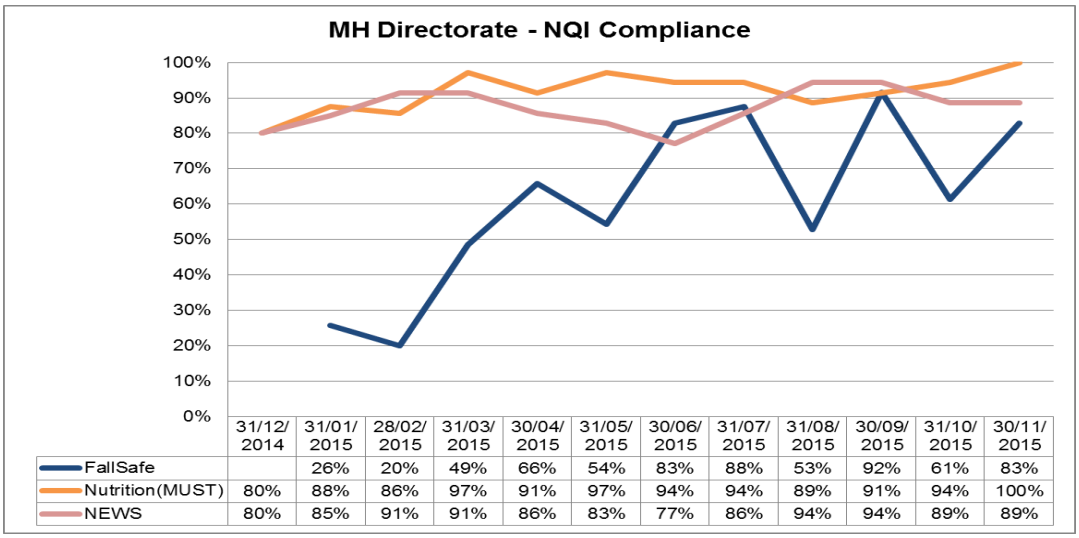
The data is taken from individual wards Safety Crosses across the Trust and cross referenced against Datix. From October 2013 26 wards have been using the Safety Cross to indicate the rate of hospital acquired pressure ulcers on individual wards. The implementation of the SKIN Bundle and associated training over the last three years has increased staff awareness regarding the identification, grading, management and reporting of Hospital Acquired pressure ulcers.

The Public Health Agency Quality Improvement Plan Framework for 2015/6 requires Trusts to provide quarterly detail on the following: -

- Compliance with SKIN Bundle
- Total Number of Hospital Acquired Pressure Ulcers grade 2 and above
- Number of Hospital Acquired Pressure Ulcers grade 3 and 4
- Number of Hospital Acquired Pressure ulcers grade 3 and 4, which were unavoidable

To facilitate the above, the Trust's Tissue Viability Nurse Specialist and the relevant Ward Sister has undertaken a Root Cause Analysis (RCA) on all Grade 3 and 4 Ward Acquired Pressure Ulcers identified since March 2015.

3.7 *NQIs 2 - 4 - Mental Health and Disability Directorate*



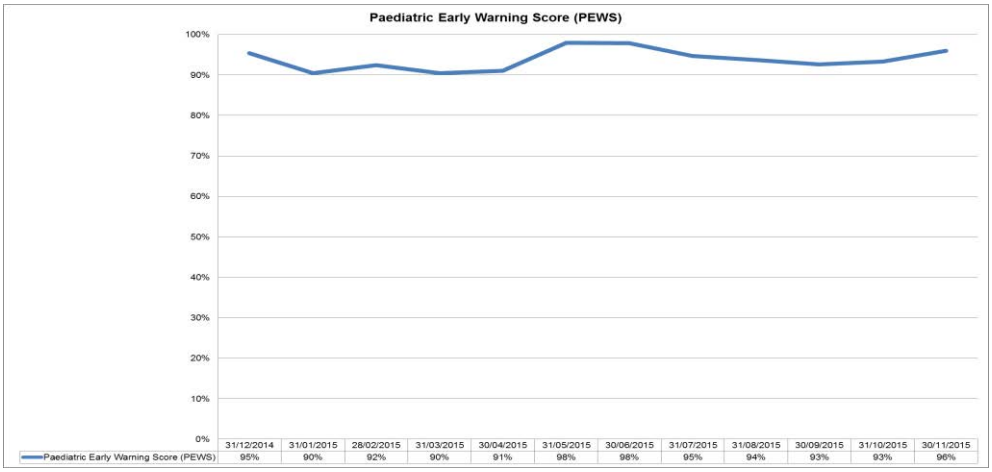
	31/12/2014	31/01/2015	28/02/2015	31/03/2015	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015
FallSafe		26%	20%	49%	66%	54%	83%	88%	53%	92%	61%	83%
Nutrition(MUST)	80%	88%	86%	97%	91%	97%	94%	94%	89%	91%	94%	100%
NEWS	80%	85%	91%	91%	86%	83%	77%	86%	94%	94%	89%	89%

MHD AD / Lead Nurses comments

In August 2015, following consideration of feedback provided by staff at Patient Safety Leadership Walk Round and review of the FallSafe audit information for a three month period the MHD Directorate Governance Group agreed that Willows and Gillis Wards would continue implementation of the FallSafe Bundle and audit of the FallSafe Bundle would continue as part of the NQIs. In all other mental health and learning disability wards only patients who are 65 years and older and patients aged 50-64 years who are judged by a clinician to be at higher risk of falling because of their underlying condition will have implementation of the FallSafe Bundle.

From August to December full compliance with the FallSafe bundle in Willows and Gillis Wards ranged from 20% to 100% (n=59). The main elements contributing to non-compliance was urinalysis (n=10), followed by lying and standing blood pressure (n=5, bed rails assessment not completed (n=3), asked about fear of falling (n=3); asked about history of falls (n=2), safe foot wear (n=1).

3.8 *NQI 4 - Children and Young People's Directorate*

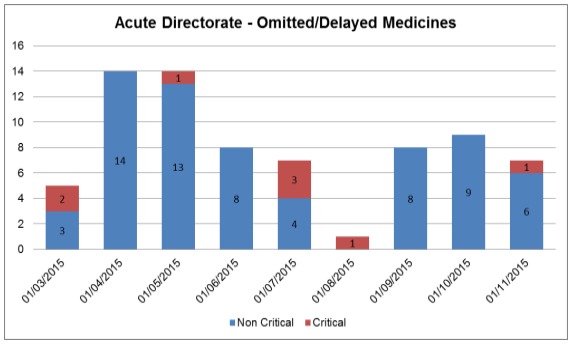


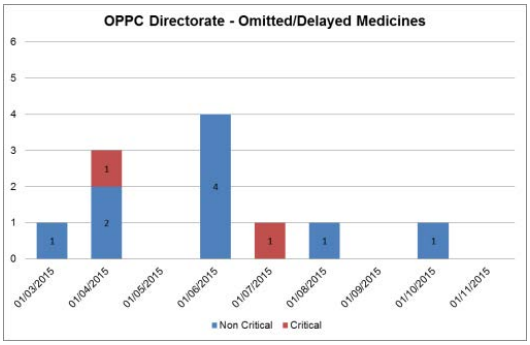
The PEWS audit is completed on both the DHH and CAH Children's Wards.

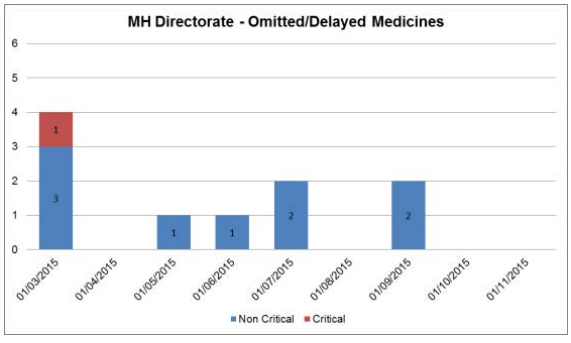
The current PEWS template in use on both acute wards is a pilot of the new regional PEWS chart. The parameters and scoring in the new chart is more extensive and feedback is currently being collated for regional review within the Quality Collaborative group. The parameters within the new chart no longer include temperature but now include Blood pressure monitoring. The numerical values have changed significantly therefore has affect the current existing template on the NQOI data base which is also now under review.

3.9 ***NQI 5 - Omitted / Delayed Critical Medicines*** – all adult in-patient wards

Omitted / Delayed Critical Medicines have been monitored in all adult in-patient wards since March 2015 with results for each directorate as indicated below.







March 2015 – November 2015 (9 Months)

Directorate	Medicine Kardexes audited	Total number of medicine doses prescribed	Number of 'Blank'* doses	Total critical medicine doses prescribed	Number of critical medicine doses that were 'Blank'
Acute	1,217	15,404	73 (0.47%)	4,234	8 (0.18%)
OPPC	239	4,019	11 (0.27%)	604	2 (0.33%)
MHD	317	4,065	10 (0.24%)	231	1 (0.43%)
Total	**1,773**	**23,488**	**94 (0.40%)**	**5,069**	**11 (0.21%)**

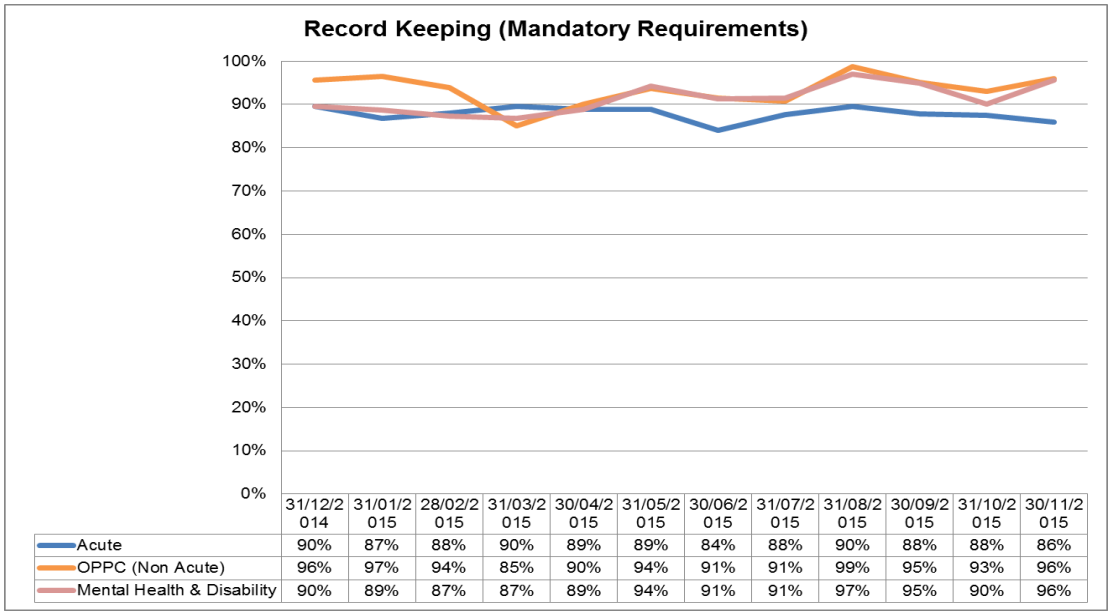
*Blank = no record in kardex that a medicine, including a critical medicine, had been administered at the prescribed time. This does not necessarily mean the medicine was not administered only that it was not recorded as being administered.

There are a variety of reason why a medicine may not have been administered, such as the patient was fasting, a new medicine was recently prescribed or the medicine was not available on the wards e.g., for a newly admitted patient who has not brought their medication in with them.

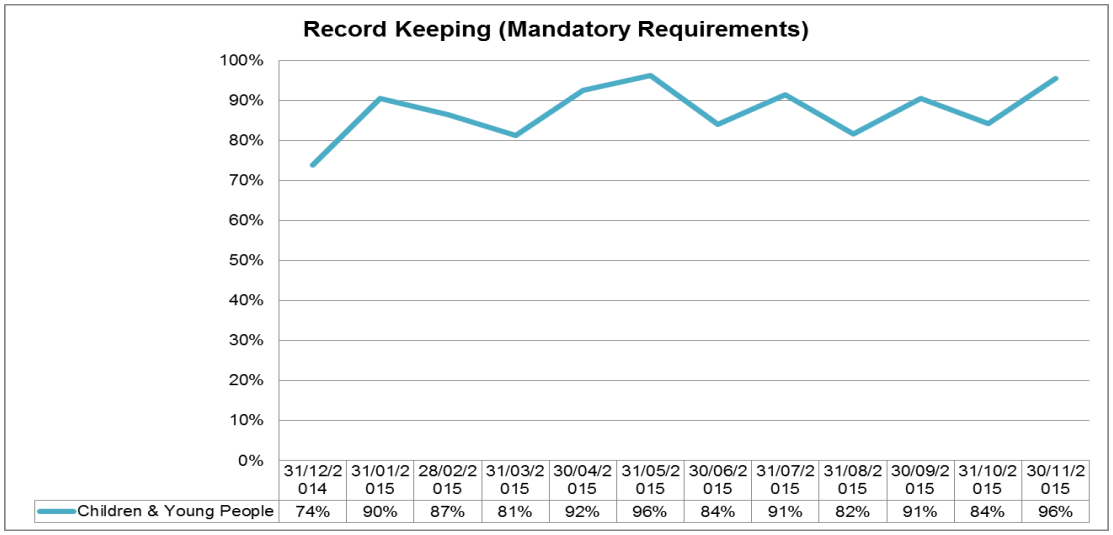
In a 9 month period the number of *critical* medicines that were recorded as 'Blank' was 11 or 0.21% of the total prescribed critical medicines. As might be expected 8 were in the Acute Directorate, 2 in OPPC and 1 in MHD. Nurses should be commended for their diligence in this area of patient care.

3.10 *NQI 6 - Recording Care : Evidencing Safe and Effective Care*

Recording care is an important element in evidencing safe and effective nursing care and is a skill and activity which the profession is constantly promoting and improving on. Nurse records are audited as part of the Trust's Nursing Quality Indicators (NQIs) Framework (see section 4) and is one on the CNO's regional Nursing Key Performance Indicators (KPIs). Over the past year the average Trust compliance with mandatory record keeping was a commendable 90%.



	31/12/2014	31/01/2015	28/02/2015	31/03/2015	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015
Acute	90%	87%	88%	90%	89%	89%	84%	88%	90%	88%	88%	86%
OPPC (Non Acute)	96%	97%	94%	85%	90%	94%	91%	91%	99%	95%	93%	96%
Mental Health & Disability	90%	89%	87%	87%	89%	94%	91%	91%	97%	95%	90%	96%



	31/12/2014	31/01/2015	28/02/2015	31/03/2015	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015
Children & Young People	74%	90%	87%	81%	92%	96%	84%	91%	82%	91%	84%	96%

The audit tools for adult and children's nurse record keeping are different and therefore cannot be compared against each other. Since March 2015 following the introduction of the PARIS system in the MHD nurse record keeping audits are undertaken on Dorsy and Gillis Wards only.

3.11 To support improvement in record keeping the EDN has identified funding for the temporary secondment of a Professional Development Facilitator. The Facilitator's role is to promoting a positive recording keeping culture amongst nurses that reflects the delivery of person-centred care and compliance with good recording keeping practices. Southern Trust Lead Nurses have developed and tested a person-centred recording framework, known as the PACE (Patient-centre, Assessment, Nursing Care and Evaluation) Framework and the Facilitator is leading the rollout of the PACE Framework across all Directorates. The Framework has been successful in supporting the recording of person-centred care and the other HSC Trusts are keen to test and rollout the framework in their organisations.

3.12 A regional **r**ecord keeping competency framework and self-assessment tool has been developed to support Health Care Support Workers (HCSWs) in recording care and will now be tested across all Trusts prior to full implementation.

3.13 *NQI 7 - Pt/C Experience Standards / 10,000 Voices*

Patient experience of nursing care is a central element of the NQI Framework and outcomes of the domain survey will contribute to assurance on the quality of nursing care. As is demonstrated in the Nursing and Midwifery Survey in 2015 nurses and midwives contribute significantly to ensuring safe, high quality care and positive experience for patients/clients in the Southern Trust. The positive messages from these findings are shared with nurses and midwives and with members of the public as well as with those who commission services.

Recurrent funding for 10,000 Voices initiative has been secured and recruitment of a permanent a Patient / Client Experience / 10,000 Voices Facilitator was recently advertised to support staff in the Trust. The collection of patient experiences continues

in unscheduled care areas with 156 patient stories and 20 staff stories being collected to date. A Trust workshop has been planned in unscheduled care areas for March to support staff in interpreting patient experiences and in action planning to improve care and services.

As part of the regional 2016 work plan further focused work which commenced in January 2016 will identify the experiences of children/young people/parents and carers of CAMHS and Autism services. In future other survey areas will include patient /client experience of the Adult Safeguarding process, dementia care and regional eye care services .

3.14 *NQI 8 - Professionalism - NMC Revalidation and Nurse Supervision*

NMC Revalidation

A significant professional change has been the Nursing and Midwifery Council's (NMC) revision of its revalidation arrangements for registered nurses and midwives which came in to effect in December 2015. The new process builds upon existing arrangements and includes a number of additional elements designed to improve public protection and ensure that nurses and midwives remain fit to practise throughout their careers.

The risks to the Trust, the public and registrants of not being able to re-register were set out in a Risk Assessment presented to SMT in February 2015. In June 2015 SMT approved an uplift of funding to extend the existing Medical Revalidation team to a Southern Trust Revalidation Support Team for ***all*** health and social care professionals who require to be registered for the purposes of their post. A bespoke database has been designed and populated and now provides monthly information and assurance to the Executive Director of Nursing (EDN) and line managers that all nurses and midwives who require to be registered remain on the live NMC register. Since it's 'go live' date in November no lapses in registration have been identified. The first registrants to revalidate under the new arrangements will be in April 2016 and the risk assessment will be reviewed after that date.

3.15 The Trust employs over 3000 registered nurses and midwives and the Nursing Governance Co-ordinators have been working with nurses, midwives and managers to ensure both organisational and registrant readiness for revalidation in April 2016. Central to revalidation is evidence of compliance with the NMC's revised professional Code (March 2015) and the Nursing Governance Co-ordinators are supporting the directorates in setting up arrangements for reflective discussions on the Code and confirmation meetings. A new Sharepoint site has been set up so that registrants can access information on NMC Revalidation, available Trust support and a Frequently Asked Questions section.

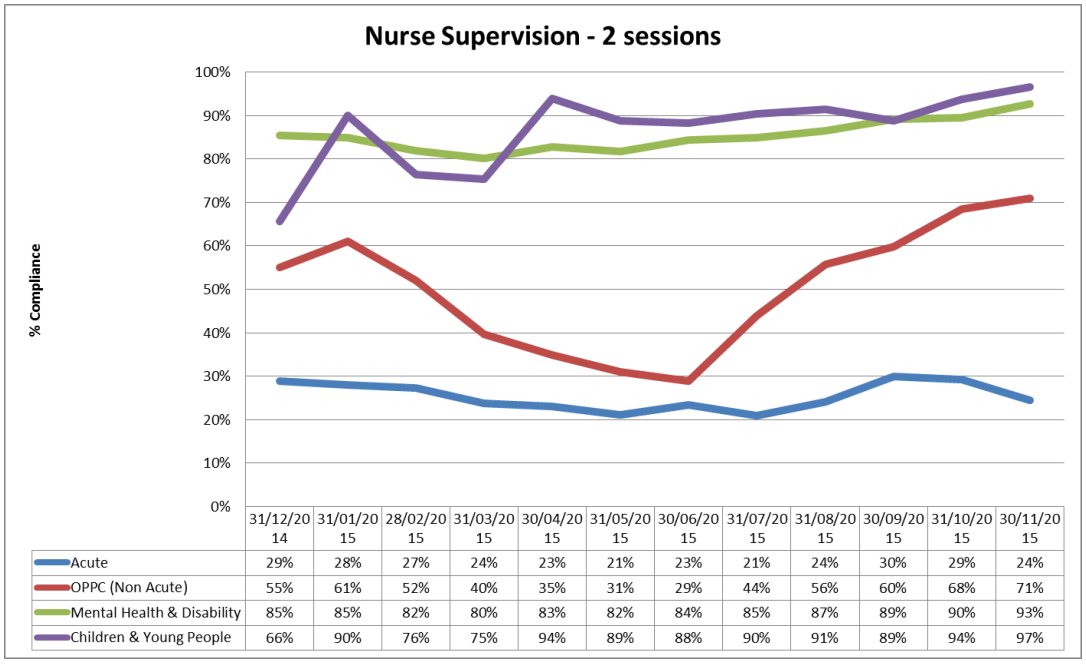
3.16 The Southern Trust NMC Revalidation Implementation Group, chaired by the EDN, continues to provide support to the registered nurses, midwives, their managers and the Nursing Governance Co-ordinators providing an oversight on the Trust's arrangements ensuring they are in place and fit for purpose.

	Apr 2016	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2017	Feb	Mar	Total
ACUTE	52	31	23	26	13	167	72	40	11	23	19	79	**556**
CYP	15	10	8	9	3	46	25	13	5	8	2	14	**158**
HR	7	2	2	0	1	12	11	5	2	2	5	0	**49**
MEDICAL	1	0	0	4	0	0	0	0	0	1	0	1	**7**
MHD	21	8	3	10	1	33	23	6	5	6	1	16	**133**
OPPC	15	8	4	7	10	25	19	5	5	6	5	20	**129**
P&R	0	0	0	0	0	0	0	0	0	1	0	0	**1**
TOTAL	**111**	**59**	**40**	**56**	**28**	**283**	**150**	**69**	**28**	**47**	**32**	**130**	**1033**

No of Registered Nurses / Midwives in ST due to revalidate in 2106 - 17 (as at 1/11/15)

3.17 *Nurse Supervision*

It is acknowledged that professional supervision enhances the delivery of safe and effective care and the Southern Trust's Policy on Nurse Supervision requires that all registered nurses are able to avail of two sessions of professional supervision per year. Ensuring nurses can access two supervision sessions has been a challenge in all directorates, particularly Acute.



	31/12/2014	31/01/2015	28/02/2015	31/03/2015	30/04/2015	31/05/2015	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015
Acute	29%	28%	27%	24%	23%	21%	23%	21%	24%	30%	29%	24%
OPPC (Non Acute)	55%	61%	52%	40%	35%	31%	29%	44%	56%	60%	68%	71%
Mental Health & Disability	85%	85%	82%	80%	83%	82%	84%	85%	87%	89%	90%	93%
Children & Young People	66%	90%	76%	75%	94%	89%	88%	90%	91%	89%	94%	97%

Whilst the trend in all directorates is generally upwards, compliance with the Southern Trust Nurse Supervision policy needs to be improved and the Trust's Nurse Supervision Implementation Group continues to explore how nurses can reflect on practice in more opportunistic ways. **Recording reflections on practice is now a core revalidation requirement and registrants must evidence how their reflections have impacted on their understanding and application of the professional Code. It is expected that this requirement will support and encourage better compliance with the supervision policy.**

3.18 *NQI 9 - Preceptorship*

An end of year report will be included in the next Executive Director of Nursing report to

Trust Board.

3.19 *NQI 10 - Delivering Care (Normative Staffing)*

Phase 1 – Acute Medical and Surgical Wards

Funding for the implementation of Phase 1 was received by the Trust in 2015 totalling £2million recurrently. The first monitoring report was submitted end of September 2015 to reflect the April 2015 to September 2015 position. This return demonstrated that funding had been allocated into all relevant ward budgets; however the implementation of 100% supervisory status for all Ward Sisters/Charge Nurses was not achieved.

The Trust has received a further communication dated 7th January 2016 from RHSCB which confirms additional 'ring-fenced' funding allocation of £227,723 to uplift fifteen Band 5 posts to Band 6 across general medical wards to support senior nursing cover and decision-making, as well as the appointment of a Band 4 support officer (aligned to the Assistant Director of Nursing: Workforce) to provide and deliver on the regular monitoring reporting requirements for all phases of normative staffing.

RQIA have requested that a consistent regional approach to patient dependency is considered. The Delivering Care Working Group will take this forward and report through the Executive Directors of Nursing to the Chief Nursing Officer.

3.20 **Phase 2 – Emergency Departments**

A regional data collection exercise was conducted in 2015 with results bench-marked across all Northern Ireland ED's. Discussions are nearing completion regionally regarding the staffing required for these departments. It is anticipated that funding will be allocated on a phased approach, for example, core ED first.

3.21 **Phase 3 – District Nursing**

Phase three is progressing in line with the original time frame, and all relevant staff have been trained in the use of the Hurst workforce data collection model. The data collected using this model will be quality assured against the information already collected via ECAT (electronic caseload analysis tool), and then analysed. As reported previously, the data being collated for District Nursing relies heavily on information entered onto the ECAT system. To date, the data submitted via ECAT for the Trust has not been fully quality assured, placing the Trust at risk of inaccurate analysis and potential resulting implications in relation to staffing levels, skill mix and caseload size. Actions are being taken within OPPC to address this.

3.22 **Phase 4 – Health Visiting**

Progress for this phase is focused on the development of an optimal caseload weighting process, which is currently being tested and is working well within the initial test site. A final proposal is due to be considered by the Delivering care Working Group in February 2016. The Working Group is also in the process of agreeing a critical reviewer for the model proposed for this phase.

3.23 *NQI 11 - NMC Standards to Support Learning and Assessment in Practice 2008*

An end of year report will be included in the next Executive Director of Nursing report to Trust Board.

3.24 **Overview of Post-Registration Education Commissioning (Academic year 14/15)**

For the academic year September 2014 to August 2015, Southern Trust commissioned the following programmes for Registered Nurses and Midwives, utilising the DHSSPSNI Post-registration education budget:-

- **Specialist Practice**

Programme	Commissioned	Completed
Community Children's Nursing	1	1
Diabetes (2 year p/t course)	One commissioned	Due to complete June 2016
District Nursing	6	6
Emergency Care (2 year p/t course)	2	Due to complete June 2016
Cardiology Nursing	1	1
Respiratory Nursing	3	3
Health Visiting	11	11

- **Short Courses:** Forty-three short courses were commissioned, with forty-two staff completing (1 staff member withdrew).
- **Stand Alone Modules:** Eighty-two stand alone modules were commissioned, with seventy-three staff completing (9 withdrawals).
- **RCN Programmes:** Sixty-four staff attended RCN programmes.
- **Additional Registration (Paeds):** Two staff commenced and are due to complete June 2016.
- **Courses Inside NI:** Ninety-five staff attended 7 courses at a cost of £22,632.
- **Courses Outside NI:** Sixteen staff attended three courses, at a cost of £29,440.
- **Life Support:** Eight hundred and seventy-two staff attended a variety of life support courses, costing £49,500.

3.25 **Recruitment**

As reported previously, the Trust continues to experience a growth in demand for Registered Nurses at a time when supply is decreasing locally and globally. In response to this the Trust established a Nursing Workforce Planning Group (NWPG) in June 2015, as well as leading on a regional exercise to ascertain the position regionally.

The Workforce Information team through the NWPG has developed a model to enable the prediction of required nursing need across Directorates. The Directorate representatives on this group are currently progressing this model and are due to report

at the next meeting in February 2016.

The Trust has been very proactive in terms of recruitment activity to attempt to go some way to addressing the need across all services. A significant and successful recruitment campaign was conducted in October 2015 under the banner of #mynursingmoment. This campaign included the development and publication of a video, radio advert, an information pack for potential applicants, e-shots, social media campaign, written local press advert and a poster campaign. This culminated in applicants being invited to a 'one-stop-shop' where interviews, pre-employment checks and Occupational Health assessments were completed. Applicants were then offered posts on the day if they were successful. An unanticipated outcome was that a 'feel-good' factor was generated for existing staff who felt that nursing was being promoted in a positive way within their workplace.

Overall, one hundred and fifty-three offers were made on the day and progress is as follows:

- 69 have confirmed acceptance of a specific post and are either started or are at pre-employment checks stage
- 21 who are on the register or due to qualify in Feb/ March 16 have not yet confirmed acceptance following offer of posts
- 56 are not due to qualify until September 2016 or beyond and therefore have not yet been offered a specific post
- 6 have now formally withdrawn from offers
- 1 we are establishing position of currently.

A further eighteen posts have since been offered following other recruitment activity.

Southern Trust also participated in the Queens University Belfast job fair and the jobs fair hosted by the Royal College of Nursing in Belfast. Attendees at both fairs were very attracted by the Trust's provision of Preceptorship and the offer of a Rotation Programme, which is currently unique across the five Trusts.

Despite this effort, vacancies continue to grow across the Trust with ninety Registered Nursing posts remaining vacant across the Trust (as at 18 January 2016). An open advertisement for Registered Nursing posts in now in place on HSCRecruit, with applications being reviewed by the Recruitment Shared Service Centre on a two weekly basis with interviews also scheduled every fortnight. On 15 January 2016 thirteen people attended for interview and ten offers of posts were made. The remaining three candidates who attended for interview are not sue to qualify until September 2016 and will therefore be contacted at a later stage with specific offers.

Please note that the Trust continues to cross-reference outcomes from the 'one-stop-shop' and ongoing recruitment activity with information held by the Recruitment Shared Service Centre, with offers still being actively made.

With the entry of Nursing to the UK Shortage Occupation List in October 2015, the Chief Nursing Officer established a Task and Finish Group, chaired by Francis Rice, to

scope and describe the current challenges in relation to the recruitment and retention of nurses across the five H&SC Trusts, and to make recommendations to the Central Nursing and Midwifery Advisory Group (CNMAC) to address these challenges. The outcomes and recommendations from this report were presented to CNMAC in December 2015. Recommendations (summarised) were as follows: -

1. Immediate commencement of international recruitment
2. Immediate increase of pre-registration nursing places across all fields of practice
3. Immediate increase of commissioned places for the Return to Practice Programme
4. Standardisation regarding guaranteed offers of Band 5 posts to staff who complete the Open University Pre-Registration Nursing Programme *and* implementation of the recommendations made to CNO in December 2014 regarding Nursing Assistants
5. All Trusts should review their recruitment processes with a view to facilitating choice through a more flexible approach
6. All Trusts should avail of opportunities presented by recruitment fairs and facilitate 'on the day' interviews
7. Development of a regional recruitment model for Band 5 RN posts
8. All Trusts to continue to work towards becoming an Employer of Choice, by providing timely information regarding availability and location of posts, as well as through the provision of induction, Preceptorship, rotation programmes, access to continuous professional development and career development opportunities
9. DHSSPSNI should commission local education providers to deliver specific professional development programmes in an effort to encourage recruitment and support retention in perceived hard to recruit to areas/specialities
10. Implementation of pay award
11. All Trusts to determine an acceptable margin of predictive recruiting against funded establishments
12. It is anticipated that the implementation of the recommendations will have an impact on independent and voluntary sector care providers. Mindful of the dependence of statutory services on such providers it is recommended that the DHSSPS carefully monitor and respond appropriately and in a timely way to any impact.

3.26 International Nursing Recruitment

As a result of the recommendations above plus the initial work already progressed by Southern Trust, the five Trusts (Executive Directors of Nursing and HR Directors) agreed to progress immediately to international recruitment. The aforementioned

Directors agreed that Lynn Fee would be the Nursing Lead for this work stream and Karyn Patterson the HR Lead.

A Notification of Intention to Tender was placed by the Procurement and Logistics Service (PALS), which closed 8th January 2016. Information days, which require interested parties to make a presentation on key areas of question and does not form part of the tendering process, are scheduled to take place 14th and 15th January 2016. The tender specification will be finalised following these days with an advertisement potentially going live from Monday 25th January 2016, with a closing date of 8th February 2016. Depending on several factors, not least of which is NMC registration requirements, it may be possible to have the first internationally recruited Nurses into the Trust in the summer of 2016. Depending on the country of origin there may be Home Office requirements to be satisfied which could impact on this timeline although initial indications are that such should not be a significant time delay, if required, given that Nursing is now on the shortage occupation list.

3.27 Band 4 Nursing Pilot

Even with all of the above activity, it is anticipated that the outcomes of all recruitment and retention initiatives may be insufficient to meet demand. With this in mind it is imperative that other options are explored to enable the continued delivery of safe nursing care for all service users. One of these is the exploration of a Band 4 role in Nursing. The Executive Director of Nursing has therefore approved a small pilot of such a role within the Acute and OPPC Directorates. It is noteworthy that whilst within Northern Ireland there is little support for such a role despite this level of role being established in other parts of the UK, the UK Government are about to embark on a consultation exercise to explore the potential role of an Associate Nurse. The Nursing and Midwifery Council are aware of this development and will be consulted as a key stakeholder.

4.0 SUMMARY / CONCLUSION

This report provides a summary of excellent high quality person-centred nursing care being provided by nurses to patients/clients in the Southern Trust. Audits of the quality nursing care have shown incremental improvement in adherence to core nursing processes and action plans are being implemented to ensure quality improvements. Senior nurses are working to embed the NQI Framework and Community Nursing teams are working to identify those indicators which would best evidence compliance with agreed quality standards in their area of nursing care. The Trust has put in place arrangements to support the implementation of the new NMC revalidation arrangements which supports professional reflections and enhances practice.

The report specifies the challenges the Trust is facing in securing and ensuring a sufficient nursing workforce both now and over the next number of years.

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

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 28th September 2017
Title:	Executive Director of Nursing Report
Lead Director:	Mrs Angela McVeigh, Executive Director of Nursing / Director of OPPC
Corporate Objective:	Safe, high quality care
Purpose:	Assurance

Summary of Key Issues for Trust Board

High level context:

- Background to the development of Trust Nursing Quality Indicator Framework
- Data on the first audit cycle of the revised Nursing Quality Indicator Framework (Based on research findings attached)

Key issues/risks for discussion:

- Trustwide Nursing Quality Indicator Quality Improvement Plan
- Executive Director of Nursing NQI Report Structure

Summary of SMT challenge/discussion:

- Management of NQI Spread Plan to Implement NQI to all areas of Nursing
- Challenges with measuring uni-professional quality within integrated teams
- Incorporation of co-design approach
- Intergration of Regional Nursing KPI requirements within NQI Framework

Internal/External Engagement:

- Senior Management Team
- Directorate Lead Nurses
- Nursing Governance Coordinators
- Nursing Quality Indicator Steering Group
- Public and Patient Involvement
- Public Health Agency
- Chief Nursing Officer

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1. Introduction

1.1 Background to the NQI Framework

Nursing Quality Indicators (NQIs), also known as nursing metrics, are used worldwide to monitor compliance with nursing care processes, impact on patient safety and the quality of nursing care. They provide quality improvement tools that enable comparisons on care quality across organisations. UK drivers include Darzi's focus on safety, effectiveness and compassion in nursing care and the Francis Report which called for comparable data on nursing outcomes.

In 2011 the Trust developed a range of Nursing Quality Indicators aimed at measuring compliance with nursing care processes. Each operational directorate developed indicators relevant to their care setting which are reported annually to Trust Board.

Following a period to test and review the 2011 framework the EDN took the decision to streamline the Trust Nursing audit plan into a single NQI structure that could be linked to existing internal and external audit reporting.

In 2014 the Executive Director of Nursing (EDN) commissioned research which aimed to identify additional elements which should be included in measuring the quality of nursing care. The research findings proposed a framework which included measuring the quality of a patient's journey across four domains:

- **Nursing Care Processes**
- **Patient Outcomes**
- **Patient Experience**
- **Nurse's Knowledge of Care Needs**

(See Appendix 1 for copy of article published in International Journal of Healthcare Quality Assurance).

1.2 Report Content

This report provides an update on the implementation of the Nursing Quality Indicator (NQI) Framework within acute and non-acute in-patient wards supported by data showing documentation compliance figures and patient and staff feedback. Work is ongoing to integrate a range of patient outcome data into the NQI reporting framework for future assurance reporting.

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1.3 NQI Framework Structure

The NQI Framework Structure combines process, outcome, patient experience and nurses' knowledge indicators as applied to individual patient journey. The Framework Domains are set out below:

Domain 1	*Domain 2*
Safe and Effective Process Indicators (Documentation domain) The elements of this domain are aligned to the areas included in the regional nursing key performance indicators and regional patient safety Quality Improvement Programme. Compliance is assessed through nursing documentation. • National Early Warning Scoring (NEWS) • Falls • Pressure Ulcers • Nutrition • Omitted medicines	**Safe and Effective Outcome Indicators (Documentation domain)** Core outcome NQIs selected were linked to the process NQIs and based on the premise that there is a relationship between processes and outcomes. • Cardiac arrest rate • Fall with an injury • Pressure Ulcer grade 2 and above • Unintentional weight loss • Additional monitoring or treatment as a result of omission of a critical medicine ***Incorporation of Domain 2 in reporting is under development***
Domain 3	***Domain 4***
Patient Experience Failure to listen to patients' and relatives' experiences has been implicated in investigations as a key factor in failing hospitals (Francis, 2013). Questions are linked to • The patient client standards • Fundamentals of nursing care • The Patients views on what aspects of nursing care are good, could be better and how the ward could be improved.	**Nurse's Knowledge of patient needs** The nurse responsible for the patient's care should be able to articulate the nursing care required to meet the patient's needs. The purpose is to ascertain if the nurse is knowledgeable about their patient, the fundamentals of nursing care for their patient and discharge planning arrangements. Questions are linked to • What nurses do like / dislike about the ward • What would make the ward better • The improvements nurses would most like to see in the ward. ***Further development of Domain 4 is ongoing to quantify the quality of nursing knowledge within the framework***

1.3 NQI Audit Cycle

The NQI audit cycle is a 3 monthly cycle which audits five randomly selected patient journeys on each inpatient ward. Each audit is undertaken by the Lead Nurse for the area using an electronic audit tool which remains under development.

The first test of this approach took place across the 25 inpatient acute and non-acute wards between 1st January and 31st March 2017 with a 'live' audit conducted 1st April to 30th June (results included in this report).

1.3 Quality Improvement Approach

Following each audit the lead nurse and ward manager produce a **Local Ward Quality Improvement Plan** which considers areas of good practice, areas for improvement and areas for immediate action which are reviewed every three months. This plan is led by the lead nurses and progress on implementation is monitored and overseen through existing operational and professional governance arrangements. Any immediate patient safety issues highlighted through the NQI audit process will be managed within the operational governance structures.

A **Trustwide NQI Quality Improvement Plan** informed by trends and findings from local audits is developed which will be used to inform Quality Improvement activities and priorities through existing Trust integrated governance and quality improvement arrangements.

1.3 NQI Framework – Areas for Improvement and Development

The NQI Steering group are presently considering the following to improve domain content and design:

- **Patient Client Experience –** Further development of Patient Client Experience Questions to strengthen links to Person Centred Care Planning, Patient Client Experience Steering Group Workplan and Patient / Nurse communication
- **Patient Outcomes –** Patient Outcomes links to the Trust Quality Indicator Dashboard
- **Nurse Knowledge –** Further development of Nursing Knowledge domain to capture cultural and behavioural nursing practices
- **Management of NQI Spread Plan** – Implementation of NQI to all areas of Nursing
- **Measuring Uni-Professional Quality** - Challenges with within integrated teams
- **Incorporation of co-design approach** – Consideration of co-design approach in future NQI design

2. NQI Audit Report Quarter 1 207/18 (April June)

Domain 1 – Nursing Documentation through NQI framework

NEWS Elements (122 Charts Audited)	Vital Signs							NEWS score correct	Frequency of observations recorded on chart	Frequency correct	Observations recorded to frequency prescribed
	Respiratory Rate	*SpO_2*	*Inspired O_2*	*Temperature*	*Blood Pressure*	*Heart Rate*	*AVPU*				
	89%	91%	94%	79%	89%	89%	93%	95%	92%	93%	75%

Falls A Elements (122 Charts Audited)	Asked about history of falls in the last 12 months	Asked about fear of falling	Urinalysis performed	Call bell in sight and reach	Safe footwear on feet	Personal items in reach	Free from Slip or trip hazards
	95%	97%	83%	98%	100%	100%	100%

Falls B Elements (90 Charts Audited)	Cognitive Screening	Bed rails assessment completed	Lying and standing Blood Pressure recorded
	84%	99%	44%

Trust Level Action: Local Quality Improvement Plans have been put in place to address this non-compliance. The EDN and Medical Director have approved the development of an Early Warning Subgroup to review the Trust's use of Early Warning Scores. This area has been highlighted recently via a coroner's inquest.

Trust Level Action: NQI Working Group (Lead Nurses) have considered the Royal College of Physicians approach to the correct method of taking lying and standing Blood Pressure and are developing guidance for Nursing staff. This work will be shared both internally in the Trust and with the regional Falls steering group for consideration for regional implementation.

Elements that are recorded as amber are being addressed via ward level NQI Quality Improvement Plans

Pressure Ulcer Elements (36 Charts Audited)	Mattress type recorded	Equipment fit for purpose	Skin inspected	Changes reported	Toileting assistance offered	Continence products used	Kept clean and dried	Nutrition tool applied	Fluid balance	Food chart updated	Assistance given with eating and drinking
	100%	83%	100%	94%	100%	83%	94%	86%	94%	78%	86%

Omitted Medicines - Number of doses prescribed (1991 doses)	Number of 'Blank' doses within previous 24 hour period	Number of 'Blank' doses that were critical medicines	Number of Medicine Kardex with reason for omitting medicine dose(s) recorded
	23 (1.1%)	6 (0.3%)	103 (85%)

Nutrition Elements (70 Charts Audited)	Was MUST Tool completed within 6 hours of admission
	90%

Domain 3 – Patient Experience captured through NQI framework

As part of the Nursing Quality Indicator processes the following questions are poised to patients:

- What has been your experience of the nursing care you have received?
- What aspects of nursing care were good?
- What aspects of nursing care could be better?
- How could the ward be improved?

The table below sets out the responses to the above questions and indicates areas highlighted by patients to inform improvement plans

What has been your experience of the nursing care you have received?	
What aspects of nursing care were good?	• [*Name*] is fantastic very caring knows patients very well, this is filtered down through all staff • All staff too many to name. • Pt is urology therefore not on correct ward but has no complaints • "well looked after" great staff • Excellent care no complaints • The attention given to patients nothing is ever a problem nurses go out their way to help • The dedication nurses show to their job very good care and attention given to me great team very professional • Excellent care staff should be paid more
Areas identified by patients for improvement	• None
Comments requiring immediate action	• None

What Aspects Could Be Better?	
What aspects of nursing care were good?	• The attention the nurses and staff give us all • Kindness, professionalism making everyone feel calm and listened too, explaining all aspects of care, treatment and recovery very well. • All • Overall an excellent ward well managed with helpful, • Knowledgeable staff nurses always make time for you and all my medications etc are always given on time, I have been on many wards and this is the best by a mile. • All of it very careful and caring • Nurses and support staff are fantastic even doing make up which is very important for my granny, this meant a lot to her. Making me comfortable and giving me pain relief promptly • Good at calming me when I panic they are very compassionate and calming
Areas identified by patients for improvement	• Friendly staff try their best even when they have not enough staff • Busy • I feel at times the nurses are overworked with trying to care for so many patients at once and could do with more help it is good as it is but maybe less bed moving if possible • have windows that can be opened • More fans for patients as it gets too warm • could sometimes answer bells quickly but they are so, so busy • staff have difficulty answering call bell at times as they are so busy • sometimes staff are so busy they cannot come straight away to help me to the toilet • would like to get to the toilet as soon as I need to
Comments requiring immediate action	• None

What aspects of nursing care could be better?	
What aspects of nursing care were good?	• As a patient I could not be anything else only pleased about every aspect of the care none in my opinion, thank you so much for all your professional care and attention n/a i have had no negative experience during of my treatment to date • It could not be better
Areas identified by patients for improvement	• Air Con in building • The only issue is that I do not like the unisex toilets • Beds/ Area for family when patient is very ill, it is like a waiting room • more staff so nurses could have more time to spend with these patients • More Fans • Longer visiting hours • TV • staff are always busy and run off their feet • More help • Likes breakfast earlier and gets it at time he likes ***ALL ISSUES ARE NOTED FOR CONSIDERATION ON LOCAL NQI QIP***
Comments requiring immediate action.	• Family had appt with consultant and he didn't come.. not happy • One of the staff was very inconsiderate I was in a lot of pain, she didn't seem to care it was very stressful on me I wouldn't remember her name she seemed to be with an older one. I hope if she is not a nurse that she never becomes one ***BOTH ISSUES ADDRESSED IMMEDIATELY BY LEAD NURSE UNDERTAKING AUDIT***

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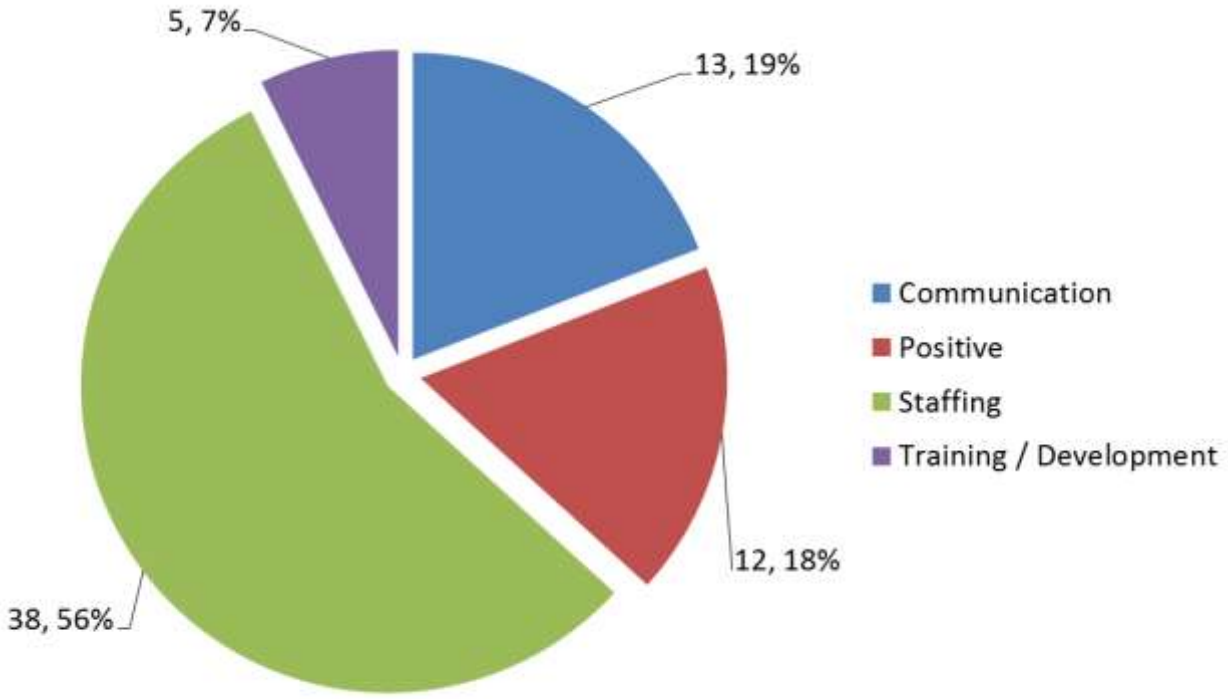
Domain 4 – Staff Experience captured through NQI framework

Nursing staff were who were caring for patients who were included in this audit were asked the following questions (total 68 responses)

- What improvements would you like to see on your ward?
- What could change to make your ward better?

The following trends were identified and have been incorporated into the Trust NQI Quality Improvement Plan (Section 3)



3. Trust NQI Quality Improvement Plan

Area/Trend	Position	Current Status	Date for Completion
Nursing Staff Feedback - Nurse Staffing Levels	• On Corporate Risk Register and control measures are in place, for example: 1. Escalation processes are in place within each Directorate to respond to immediate Registered Nurse shortages 2. Well established Nurse Bank in place for open registration 3. International recruitment plan 4. Open recruitment campaigns 5. There are mechanisms in place regionally to maximize approaches and resources in relation to local recruitment. 6. The Trust has in place an 'open advertisement' for Band 5 Adult Nurses 7. Nurse recruitment is a regional and national issue at present. Further correlation through the NQI data is required to determine the effect of the above on nursing quality and staff wellbeing.	• Continue Communication to Nursing Staff on the Trusts response to Regional and National Nursing Workforce issues • Further develop the NQI framework capability to correlate the impact of staffing levels on nursing quality and staff wellbeing.	Ongoing

Nursing Staff Feedback – Need to improve communication pathways within nursing teams and with clinical colleagues	• 'Timeout for Teams' has been endorsed by the Trusts Senior Management Team • The Trust has facilitated a number of leadership programmes which incorporate methods to improve communication • Quality Improvements to communication within patient flow have implemented. • Communication is the corporate quality improvement priority (2017/18). A number of Quality Improvement projects have been completed which focused on improving communication.	• Lead Nurse local improvement plans in place to work with ward sisters and staff nurses to improve the flow of communication to staff • The Trust are implementing a number of Always Events focusing on improving communication between patients and staff	Ongoing
Nursing Staff Feedback – Need for more dementia / delirium training	• A programme of training for dementia and delirium is in place	• Training needs analysis to be undertaken to assess nursing training needs in this area of practice.	June 2018
Nursing Documentation - Observations recorded to frequency prescribed	• Local Quality Improvement Plans have been put in place to address this non-compliance.	• The EDN and Medical Director have approved the development of an Early Warning Subgroup to review the Trust's use of Early Warning Scores. This area has been highlighted recently via a coroner's inquest.	April 2018
Nursing Documentation - Lying and standing Blood Pressure recorded	• NQI Working Group (Lead Nurses) have considering the Royal College of Physicians approach to the correct method of taking lying and standing Blood Pressure and developing guidance for Nursing staff.	• Guidance will be shared both internally in the Trust and with the regional falls steering group for consideration for regional implementation.	September 2018

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The nursing quality indicator framework tool

Dawn Connolly, Fiona Wright,

The current issue and full text archive of this journal is available on Emerald Insight at:
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The nursing quality indicator framework tool

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Abstract

Purpose – The purpose of this paper is to develop a nursing quality indicator (NQI) framework and provide a comprehensive reporting mechanism for nursing care.
Design/methodology/approach – Mixed method, including patient records audit, patient experience questionnaire, nurse self-report questionnaire and collecting ward-level information. The sample was 53 patients and 22 nurses.
Findings – Outputs from the NQI framework domains offer a more comprehensive understanding of nursing quality compared to when domains are analysed separately. The NQI framework also provides a more inclusive mechanism for assuring nursing care.
Research limitations/implications – Sample size was limited to 53 English-speaking patients who consented to participating in the study.
Originality/value – One design strength was the ability to describe individual patient care across the four domains and subsequently show relationships between nursing knowledge, nursing interventions and patient outcomes/experiences. Additionally, corroborated information from three sources (documentation review, patient and nurse responses) strengthened the conclusion that the NQI framework could provide more comprehensive assurances on nursing quality and identify care improvements.

Keywords Patient experience, Nurse's knowledge, Nursing quality indicators, Structure-process-outcome
Paper type Research paper

Introduction

In performance-managed health services across the world, there is an emphasis on "Ward-to-Board" accountability for nursing quality. Although healthcare systems may differ, all have a common goal: to improve service quality. In the 1990s, healthcare reform in the USA prompted nursing quality indicator (NQI) development. Databases such as the Californian Nursing Outcomes Coalition and the National Database of Nursing Quality Indicators™ (NDNQI®) incorporated executive and clinical information necessary for reporting on quality assurance (Montalvo, 2007; Aydin *et al.*, 2008). Over the past decade in the UK, measuring compliance by applying well-defined indicators has supported professional transparency, accountability and quality improvement (NHS Quality Improvement Scotland, 2005; Welsh Assembly Government, 2010; Northern Ireland Practice Education Council, 2011; Department of Health, Social Services and Public Safety, 2011). Measuring care based on patient experience is a relatively new consideration and is now included in many nursing care indicators (Maben *et al.*, 2012; McCance *et al.*, 2012). Different quality measures allow managers to articulate the nursing profession's contribution to quality care in tangible terms and assure hospital boards that the profession is providing safe, effective, person-centred care. NQIs also focus development activities in areas that are aligned to policy and organisational imperatives, which aim to proactively improve service quality. Including NQIs within performance management systems provides a robust framework that can support delivery and assurance on clinical and social care governance (McCance *et al.*, 2012). However, in practice, articulating nursing value through quality indicators is both a challenge and an opportunity for the profession to accurately apply indicators, i.e., obtaining empirical evidence is far from straightforward (Burston *et al.*, 2013). Defining potential indicators, demonstrating associations between indicators and nursing care, collecting and analysing data, and sharing the outcomes is complex (Doran *et al.*, 2006; Needleman *et al.*, 2009; Burston *et al.*, 2013; Heslop and Lu, 2014).

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Quality healthcare dimensions that inform the NQI framework

The American Nurses Association developed the NDNQI®, grounding it on the Donabedian framework (Gallagher and Rowell, 2003; Montalvo, 2007). Donabedian's (1988) conceptual model provides a framework for examining healthcare quality through structure, process and outcome. He believed that care quality is not only reflected in each individual category, but also in the relationship between them. Several widely recognised nursing structure, process and outcome indicators are cited in the literature including: nurse-to-patient ratio, sickness and absences, registered nurse education level and experience, hospital acquired infection, pressure ulcers, falls and medication administration (Griffiths *et al.*, 2008; Maben *et al.*, 2012). The extent to which these indicators are sensitive to nursing quality variation is unclear (Savitz *et al.*, 2005; Heslop and Lu, 2014) and inconsistent associations have been identified between structural measures and patient outcomes (Blegen and Vaughn, 1998; Aiken *et al.*, 2002; Needleman *et al.*, 2002; McGillis Hall *et al.*, 2004). Nonetheless, these pointers are frequently acknowledged as plausible NQIs within healthcare organisations (Maben *et al.*, 2012). Griffiths *et al.* (2008) consider that patient outcomes are best reflected in their experience of compassionate nursing care. Person-centred care that is respectful, compassionate and responsive to individuals is recognised as a key quality indicator and an essential component to strive for when improving healthcare systems (US Institute of Medicine, 2001; De Silva, 2014). Failure to listen to patient and relative experiences has been implicated in investigations as a key factor in failing hospitals (Francis, 2013). In a systematic review, Doyle *et al.* (2013) suggest that patient experience data, robustly collected and analysed, increases the likelihood that patient safety and clinical effectiveness improve. This supports the view that safety, effectiveness and patient experience indicators should be considered together and not in isolation.

Donabedian's model does not include antecedent characteristics that are important precursors to evaluating service quality (Coyle and Battles, 1999). The person-centred framework developed by McCormack and McCance (2010) consider nurse attributes, including professional competence, as a pre-requisite to person-centred outcomes. Nurses are expected to know their patients' nursing care needs and will apply this in professional decision making to deliver safe, effective and person-centred care. The public also expect nurses to demonstrate professional competence, sound clinical judgement and decision making (American Nurses Association, 2015; Nursing and Midwifery Council, 2015). Therefore, it is reasonable that the nurse's knowledge of patient's nursing care needs should be considered as a NQI. The contention is that if a nurse assesses and delivers nursing care appropriate to patient needs, then it is likely/expected that the patient will experience positive outcomes from that care. Overall the nursing literature indicates that: first, no single measure can give a complete picture; second, patient experience is an outcome; third, safety, effectiveness and patient experience should be considered together; and finally, nurse attributes, including professional competence, are important prerequisites to safe, effective person-centred care.

NQI framework domains

The NQI framework domains are drawn from the literature and based on the principle that optimal high-quality nursing can only be achieved if all elements (safe, effective, person-centred care) are present equally and simultaneously. This supports Donabedian's view that service quality is related to structure, process and outcome elements individually and to relationships between them. The NQI framework strengthens patient-level data analysis by linking nursing care elements related to structure, process and outcome, patient experience and nurses' knowledge. Patient-level data can be aggregated to ward and board

level to assure nursing care. The NQI framework includes four discrete but complementary domains (Table I):

(1) Safe and effective process indicators (SEPIs) were based on the UK nationally approved care bundles, i.e., national early warning score (NEWS), FallSafe, SKIN (surface, keep moving, incontinence, nutrition), Malnutrition Universal Screening Tool (MUST bundle) (Royal College of Physicians (RCP), 2012a, b; NHS Wales, 2010; BAPEN, 2011).

(2) Safe and effective outcome indicators (SEOI) were linked to process indicators and based on the premise that there is a relationship between processes and outcomes. If the care bundle processes are consistently and reliably applied, then this should result in better patient outcomes, e.g., reliably applying the SKIN bundle processes should prevent a patient from developing a pressure ulcer.

(3) Patient experience indicators were developed from primary research carried out by McCance *et al.* (2012), where eight key performance indicators, focusing on unique nursing/midwifery contributions to the patient experience, were identified using a consensus approach.

(4) Nurse's knowledge of patient's nursing care needs: the nurse responsible for the patient's care should be able to articulate the nursing care required to meet the patient's needs. The nurse caring for the patient will apply his/her knowledge to deliver safe, effective and person-centred care to meet those needs.

The NQI framework combines process, outcome, patient experience and nurses' knowledge indicators as applied to individual patients.

Methodology

Aim and objectives

We aimed to examine the NQI framework as a mechanism for reporting assurances that nursing care was safe, effective and person-centred. Our objectives were to:

(1) undertake a nursing records analysis to determine compliance with agreed evidence-based care bundles (i.e. pressure ulcers, falls, nutrition, omitted medicines and identifying the deteriorating patient);

(2) determine nursing impact using SEOI;

(3) gather information on the patient's nursing experience during their stay, collected through patient stories and analysing patient experience indicators;

NQI framework: nurses' contribution to safe, effective, person-centred care

	Domain 1 Safe and effective process indicators	Domain 2 Safe and effective outcome indicators	Domain 3 Patient experience indicators	Domain 4 Nurse's knowledge of the patient's nursing care needs indicators
Patient-level data	Review of patient records to assess compliance with evidence-based care bundles	Review of patient records to determine patient safety outcomes in relation to the selected process indicators	Exploration of patient's perception of their experience of nursing care	Nurse's knowledge of patient's nursing care needs. Responses mapped against nursing care plan and progress notes
Ward-level information	Patient safety outcome measures; feedback from nurses; complaints and incidents			

Table I.
NQI framework

(4) explore individual nurse's knowledge of the patient's nursing care needs and the nurse's experiences delivering care; and

(5) review incidents and complaints for the calendar month in which the study was carried out.

Research setting

The study was conducted in one UK healthcare organisation using a mixed method, case study approach. The focus for the study was nursing care delivered in acute and older people's wards. Three wards (medicine, surgical and older people) were selected. The data collection period was one calendar month.

Sample size

Five patients were purposively selected each week from participating wards giving 20 patients per ward: a standard sample size for assessing compliance with care bundles and in quality improvement projects that measure processes over time (Perla *et al.*, 2013). Nurses sampled were self-selected from those responsible for delivering nursing care to the participating patients.

Inclusion/exclusion criteria

To be eligible, patients were required to be 16+ years, have capacity to give consent, speak English, have been admitted to the participating ward for at least 24 hours and met the criteria for at least four SEPIs. Acutely ill patients or those receiving end of life care were excluded.

Participants

The ward sister/charge nurse identified patients meeting the inclusion criteria. After explaining the study, patients were given time to decide whether they wished to participate. Those who agreed completed a consent form. Nurses were recruited through a self-selection process from those responsible for delivering nursing care to participating patients. The researcher and ward sister/charge nurse agreed suitable dates and times for data collection.

Data collection

Data collection included: first, auditing patient records in relation to SEPI and SEOI; second, administering a patient experience questionnaire; and finally, running a self-report questionnaire, which focused on the nurse's knowledge of their patient's nursing care needs and their care delivery experience. Process indicators were measured by reviewing patient records to ascertain compliance with NEWS bundle for identifying deteriorating patient (RCP, 2012a), FallSafe care bundle (nursing elements) (RCP, 2012b), SKIN care bundle (Gibbons *et al.*, 2006), MUST (BAPEN, 2011) and administering critical medicines (National Patient Safety Agency, 2010). The related SEOI were linked to the process indicators and measured by a patient records review. The outcome indicators included cardiac arrest or unplanned admission to intensive care unit, fall or fall resulting in an injury, hospital-acquired pressure ulcer (grade 2 and above), weight loss >5 per cent body weight whilst in hospital and omitting a critical medicine dose. To facilitate analysis, data were entered into a bespoke Excel® macro-enabled spreadsheet. Patient experience indicators were applied to Sensemaker® software (a proprietary research method and tool developed by Cognitive Edge, cognitive-edge.com) to produce a bespoke patient experience questionnaire specific to this study (McCance *et al.*, 2012). Patients were asked to summarise

their nursing care experience in a story format. They were asked six questions (triads) with three pre-set responses. For each question patients were asked to place a dot within the triangle that best reflected their experience. Where requested, the researcher undertook to record the patient's experience and responses to the questions as directed by the patient. Additionally, patients were asked to rank order care aspects most important to them (pre-set responses were linked to the patient experience indicators) and to describe their nursing care experience on a scale ranging from strongly positive to strongly negative. Nurses caring for participating patients completed a short questionnaire asking them to describe their patients' nursing care needs during their shift. Their responses were compared with entries made in the patient's nursing care plan and nursing progress notes. Nurses were asked how they felt the patient might describe his/her nursing care experience. These responses were mapped against the patient's description using the same scale. Nurses were also given an opportunity to say what would improve care experiences.

Study design

The study design involved data source triangulation (patients, nurses, records) and method triangulation (questionnaires, documentation analysis). Triangulation facilitates cross-data verification thus increasing credibility and validity (Lincoln and Guba, 1985). Additionally, the researcher adhered to a strict data collection process using regionally agreed guidance for assessing consistency in care bundle application. If there were inconsistencies in application or non-compliance with a bundle, then the researcher discussed and verified information with the ward sister or specialist nurse.

Ethical considerations and research governance

We complied with the research governance framework for health and social care and good clinical practice following approval from the Office of Research Ethics Committees Northern Ireland and the HSC Trust Research Governance Committee. The risks to participants were minimised by:

- providing them with information about the study and obtaining informed consent;
- ensuring confidentiality and anonymity, where possible; and
- having mechanisms in place to deal with unforeseen issues that may arise in practice during the survey, e.g., a Distress Protocol.

Limitations

Whilst this study sample was limited to English-speaking patients and able to give consent to participate, any repeat studies should include a wider patient sample and ethnicities, and vulnerable adults whose relatives/carers may wish to report care experience on the patient's behalf.

Findings

Demographics

The sample included 42 female and 11 male patients. Most patients were 70 years and older ($n = 31$) and had been nursed on the participating ward between four and seven days ($n = 23$). In total, 22 nurses (19 females and 3 males), returned the questionnaire giving a 42 per cent response rate. Most responses were from nurses in the 18 to 30 age band ($n = 10$).

SEPIs

Compliance with the SEPIs was measured using the associated care bundle for the selected nursing care process. Resar *et al.* (2012) define a care bundle as evidence-based interventions for a defined patient population and care setting, and proposes that, when implemented together, result in better outcomes than when employed individually. Applying the care process bundle aims to achieve 95 per cent compliance, hence improving patient outcome (Resar *et al.*, 2012). Compliance with bundles uses an all-or-none measurement approach. If an individual element has not been recorded as completed, then the whole bundle compliance will be scored as 0 per cent regardless whether other elements have been documented as being completed (Resar *et al.*, 2012). Findings are presented in Table II.

We identified common departures from good record keeping across all process indicators, including:

- associated care bundle charts not always initiated;
- charts not always reviewed in a timely fashion;
- monitoring frequency not always recorded;
- prescribed monitoring frequency was not adhered to or was not recorded as being changed in line with observation;
- reason for non-compliance not always recorded;
- charts completion varied between wards and between individual nurses, e.g., a "No" response could also have meant "Not applicable" (NA); and
- the reason why a critical medicine was not administered was not always recorded.

SEOI

Patient outcomes were very positive/good (94 per cent) despite nursing records indicating variable compliance with some care bundle elements. Three patients did not have good outcomes; one who had been identified as risking malnutrition had a weight loss > 5 per cent, one had a non-injurious fall and one developed a hospital-acquired pressure ulcer (grade 2) during the hospital stay. In all three instances, the record audit showed non-compliance with the associated care bundle.

Nursing quality indicator (NQI)	Elements in bundle	Records audited	Total elements	Individual elements completed	Records with all care bundle care elements completed
NEWS	6	53	318	91% ($n = 288$)	77% ($n = 41$)
FALLS	9	53	477	92% ($n = 440$)	47% ($n = 25$)
SKIN	14	16[a]	224	66% ($n = 148$)	0% ($n = 0$)[b]
MUST	5	53	265	93% ($n = 247$)	79% ($n = 42$)
TOTAL	34	53	1,284	87% ($n = 1,123$)	
Critical medicines[c]	Records audited	Doses prescribed	Medicine doses administered		Patients having all doses administered
	53	1,027	98% ($n = 1,011$)		79% ($n = 42$)

Table II.
Safe and effective process indicators (SEPIs)

Notes: [a]As patient inclusion criteria; [b]care bundles require an "all-or-none" measurement, i.e., if an individual element has not been recorded as being completed, then the whole bundle compliance will be scored 0 per cent regardless of whether all other elements have been documented as complete (Resar *et al.*, 2012); [c]does not meet bundle definition

Patient's nursing care experience

Patient experience was gathered from patient stories, six completed questions (triads) and ranking their nursing care experience according to what was most important to them:

(1) Patient stories

Patients reported that friendliness, kindness and timely actions were key to good nursing care experiences. They valued the fundamental nursing care aspects that focused on relational and functional care aspects. For example:

> Very attentive nurses. They attend to my needs – taking me to the toilet, helping me dress, if I need help with food – they help. Excellent help getting to bed. Prompt with tablets and whatever we have to get (04A).
>
> A major aspect was asking regularly whether I was in pain and offering pain relief. The nursing staff were very caring and always listened (02C).
>
> I was prepared for surgery very professionally and the procedure was very clearly explained to me. Post-surgery nursing care has been excellent (20B).

Where patients rated their experience less positively, staffing levels, organisational factors and difference between nurses, e.g., certain nurses were better than others at giving care, were most often described.

(2) Completing the six questions (triads) (see Figure 1).

(3) Ranking patient's nursing care experience.

When asked to rank which care aspects were most important to them, feeling safe whilst in the nurse's care, having confidence in the nurse's knowledge and skills and the nursing staff having the same understanding, were the most frequently selected responses. This validated the decision to include patient experience as a key domain in this NQI framework. Most patients (89 per cent) reported that their nursing care experience was either strongly positive or positive. Four patients (7 per cent) reported "neutral" feelings and only two (4 per cent) were "not sure" about how they felt about their experiences.

Understanding the patient's nursing care needs

Nurses' responses to the questionnaire on their patients nursing care needs were compared with entries made in individual patient's nursing care plans/progress notes. Findings show that the patient's current nursing care needs were not always recorded in the nursing care plan/progress notes, however, when asked to record on a blank page all nurses were clear about their patient's current care needs at that time. Nurses were also asked how their patient might describe their nursing care experience and these were mapped against the patients' responses using the same scale, i.e., ranging from strongly positive to strongly negative. Results showed that nurses correctly predicted that their patients would say that they had a positive experience (91 per cent) or neutral experience (9 per cent). Only two nurses and their patients' responses did not correspond. Nurses also had an opportunity to say what would improve care delivery. In total, 13 nurses (60 per cent) reported that they would like more time with their patients. The most common suggestion to enhancing care delivery experience was less documentation; however, others felt that documenting patient care was an integral to nursing care and that freeing up time to be with patients included the time needed to document care given. Another shared theme related to staffing levels, specifically, better staffing levels to support patients who are restless/confused and a falls risk, and more staff at weekends as the nursing care activity does not change:

> More staff at weekends. There are no less nursing needs at the weekend so I don't understand why there is less staff (05B).

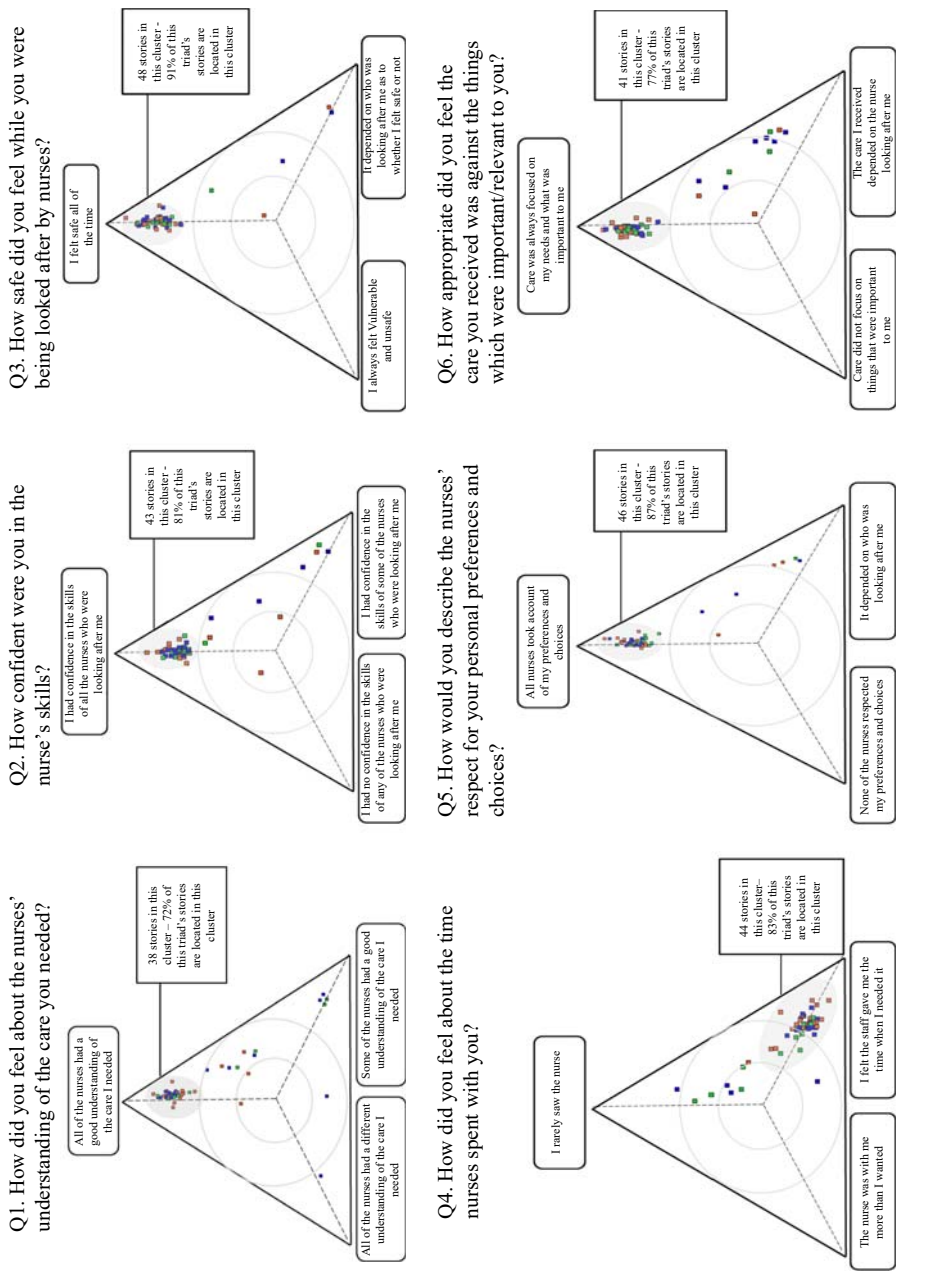

Figure 1.
Patient experience triads

From nurses' responses, findings indicate that at certain times increased workload and insufficient staffing levels affect staff well-being and nurses reported that at times they felt frustrated that they could not give patients the nursing care they would like to:

> At times feel very frustrated that I can't give the care that I would like to give due to increased pressures of workload such as restless patients decreased staff levels and the expectations of some patients and relatives (05A).

Findings summary (all four domains)

Findings show that when quality determinants represented in the framework's four domains were analysed collectively, they offer a more comprehensive understanding of nursing care quality than when each was analysed and reported separately. Figure 2 represents the overall findings from one participating ward and provides a more comprehensive and rounded nursing picture. The individual vertical columns set out the four domains and the data analysis is colour coded red, amber green rating, with further information embedded within the table cells to assist with interpretation.

Figure 2 shows that patient safety outcomes were good despite variable compliance with recording some process elements, specifically in one care bundle. Patient experience was positive and matched the nurse's predictions. When asked, the nurse's knowledge of patient's nursing needs for the shift was good even when care was not recorded in a formal care plan. If the SEPI and SEOI, and the patients' experience and nurses' knowledge are considered separately, then the interpretation is different than when all are considered together within the framework. In other words, seeing the whole picture provides greater overall nursing quality understanding than when the domains are looked at individually.

Ward-level information

We carried out a retrospective incidents and complaints review for the calendar month to check consistency with patient-level data and add rigour to data collection. There were 12 clinical incidents reported through the Datix Risk Management system; reports were mapped to NQI outcome data.

Discussion

Our aim was to examine the NQI framework as a mechanism for assuring nursing care quality. Assurance to boards is often reflected in performance levels. However, compliance with processes does not necessarily mean that the patient experienced good quality care. This study tested the NQI framework application by mapping patient's care experiences and outcomes against nurses' knowledge and prescribed care interventions. We found that when the NQI framework determinants were viewed together, they provided a more comprehensive understanding than when considered separately.

The study followed the patient's journey through all four domains. In the care processes domain, nurses reported that the requirement to evidence care given by recording each individual care process element caused them some frustration as it interrupted care delivery and restricted professional judgement. Where a nurse was allocated six patients, who each required two care processes (four hourly SKIN bundle – 14 elements and NEWS bundle – six elements), equated to recording 720 individual elements every 24 hours. We found that nurses' interpretation and recording individual bundle elements varied and with each additional care bundle variation became greater. Given that the tool for auditing care processes was based on the care bundle application, it may be timely to scope and address the challenges raised in applying the care bundles in practice. A care bundle itself does not improve patient safety. Rather, improvement is generated from re-organising work activity and better

Figure Ward A			Safe and Effective Process Indicators					Safe and Effective Outcome Indicators				Patient Experience	Nurses' Knowledge of the Patient's Care Needs		
Patient Code	Gender	Age	MUST	NEWS	SKIN	FALLS	Critical Medicines	Free from weight loss >5% body weight	Free from cardiac arrest or unplanned admission to ICU	Free from hospital acquired pressure ulcer	Free from fall or injurious fall	Patient's nursing care experience	Nurses' perception of patient's experience	Ask nurse	Care plan
01A	Female	85	0	1	18		B				Yes			Yes	Yes
02A	Female	88	2	3	18		B				Yes			Yes	Partial
03A	Female	82	2	1	18	ACD	B,J	No weight loss	Yes	Yes	Yes	Strongly positive	Positive	Yes	Partial
04A	Female	91	0	0	18	A	B,E	Low risk	Yes	Yes	Yes	Positive	Positive	Yes	Partial
05A	Female	81								Yes	Yes	Strongly positive	Positive	Yes	Partial
06A	Female	73	0	0	17	C	B	Low risk	Yes	Yes	Yes	Positive	Nil return	Nil return	
07A	Female	79	2	2	19	No triggers	B	No weight loss	Yes	Yes	Yes	Strongly positive	Positive	Yes	Yes
08A	Female	82	2	3	21	ACD	B,J	Weight loss	Yes	Yes	Yes	Strongly positive	Positive	Yes	Partial
09A	Female	89	2	0	19	F	B,S	No weight loss	Yes	Yes	Yes	Positive	Positive	Yes	Yes
10A	Male	75	1	4	19	Not completed	B	No weight loss	Yes	Yes	Yes	Strongly positive	Nil return	Nil return	
11A	Female	94	0	2	19	No triggers	B,S	Low risk	Yes	Yes	Yes	Positive	Positive	Yes	Yes
12A	Female	88	0	0	21	No triggers	B	Low risk	Yes	Yes	Yes	Positive	Nil return	Nil return	
13A	Male	77	0	2	17	C	B,G,O,S	Low risk	Yes	Yes	Fall	Neutral	Nil return	Nil return	

Figure 2.
Overall findings for one ward

staff/patient communication, which improves patient outcomes. Unchecked, audit outcomes on care processes will therefore be unreliable in providing assurance to the board that safe and effective care processes are being applied consistently across the organisation.

Findings also highlighted nurses' concerns about paper-based documentation for recording care processes. Nurse recording is discussed extensively in the professional literature (Hutchinson and Sharples, 2006; Powell, 2006; Griffiths *et al.*, 2007; Muller-Staub *et al.*, 2007) and in our study, nurses consistently expressed the view that better mechanisms for recording would improve nursing care. However, Urquhart *et al.* (2009) concluded that there was no evidence that changing record systems made any difference to nursing practice or patient outcomes. McCormack *et al.* (2015) felt that pre-determined elements within electronic records were not conducive to evaluating person-centred nursing care. We highlighted a need for clarity on exactly what care nurses are required to document, the recording's purpose and how recording can be measured and reported.

Despite care processes and recording issues, we found that patient outcomes were good. Measuring patient outcomes alongside process measures supports the framework as it adds to a more rounded view of nursing care quality. Where outcomes are found to be consistently good, consideration should be given to stepping down routine recording care processes and diverting resources to development and learning in areas where practice is deemed to be poor/less than satisfactory.

Gathering the patient's experience is key to measuring nursing quality (Griffiths *et al.*, 2008) as it identifies strengths and risks to safe and effective care. Patients in our study reported positive nursing experiences, specifically they felt safe, had confidence in the nurses' knowledge and skills and that nurses understood what was important to them, which reflects McHugh and Stimpfel's (2012) findings that quality can be measured through softer indicators such as patient satisfaction with care and hard data on mortality and morbidity rates. Selective framework domains is also supported by Doyle *et al.'s* (2013) theory on the associations between patient experience, clinical effectiveness and safety, and provides a mechanism for identifying care improvements. We highlighted a potential safety issue where several patients reported that they did not want to bother nurses:

> I don't like to annoy them – I try not to drink a lot so I don't have to go to the toilet and bother the nurses. They are very busy (03A).

This patient's perception may have unintentionally put him/her at risk of not receiving necessary care and highlights his/her anxiety not to add to the ward challenges on issues such staffing levels and time to care. If patients are to be true partners in care design and delivery, then nurses must act as patient advocates, highlighting issues and being part of the solution.

Assessing the nurses' knowledge domain, we found that nursing care plans were not always updated to reflect the patients' current/on-going needs. Acute nursing care is largely a continuous activity and nurses reported that paper-based documents did not lend itself to the recording on-going care over 24 hours. Nevertheless, nurses could describe specific nursing care needs and patient status at a point in time. All interactions between patient and staff have the potential to enhance patient care. Engaging frontline staff in quality improvement initiatives improves care delivery experience, increases job satisfaction and has a reciprocal positive impact on patient experience and outcomes (National Nursing Research Unit, 2013).

Our multifarious study employed several data collection methods reflecting the complexity of synthesising all activities necessary to generate a comprehensive nursing care quality assessment (Burston *et al.*, 2013; Needleman *et al.*, 2009; Doran *et al.*, 2006). We generated significant information on four domains and tested the framework's application, indicating what was valuable in providing comprehensive assurance to the hospital board and information on which to base nursing care improvements.

The sample size in this research was small and consideration should be given to larger scale organisational data collection methods applied across the framework's four domains. The research method was not specifically designed to secure rigorous statistical analysis, however, there is potential for further analysis using stratification and risk adjustment to benchmark across different care settings. Further research could also be directed at understanding process-outcome relationships relevant to safe, effective, person-centred nursing care.

Conclusion

The literature suggests that, given the nursing profession's complexities, no single measure can provide a complete nursing quality picture. This study proposed a more comprehensive means of assuring safe, effective, person-centred nursing care by extending the reporting elements beyond the singular compliance with care process measurement. Our study found that care experience is important to patients and ensuring a good care experience lies primarily with the nurse whose knowledge and skills are essential in shaping person-centred care (McCormack and McCance, 2010). A challenge to performance-driven organisations is to give assurance reporting a more person-centred focus. We anticipate that a pre-requisite to applying this framework is having a co-ordinated strategy for improving patient safety and patient experience in place. We used multiple sources and methods to evidence nursing quality and provide information on which to base improvements. Action planning to effect change will be monitored with regular updates locally and to the hospital board on improvements and developments. Patient safety is a central focus in board business. Outputs from this framework can indicate declining standards and will influence professional practice developments, and provide nursing teams with an opportunity for reflection and learning. Although initially designed and tested within the nursing professions, The framework can be applied as a mechanism for reporting assurance in other health and social care disciplines, and externally, such as, regulators and other public bodies.

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

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 29th September 2016
Title:	Medical Directors Report: **Medical Education and Training**
Lead Director:	Dr Richard Wright – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	For assurance

Summary of key issues and risks for Trust Board:
Medical Education and Training

Key issues:

New junior doctors joined the Southern Trust in August 2016.

GMC Trainer and Trainee survey published; improvements in many areas recognised by NIMDTA between 2014 and 2016

Key risks for discussion:

Need to raise "Competencies completed" percentage for new junior doctors from current position (Section 1.1.1)

Need to provide greater support to trainers to deliver training to junior doctors

Summary of SMT challenge/discussion:

Directors raising with AMDs to ensure competencies are completed

Directors required to ensure balance of training alongside delivery of services to patients

Medical Education and Training

1.0 POSTGRADUATE EDUCATION

1.1 Junior Doctors Induction - Mandatory Training

Following Junior Doctor changeover in August 2016 junior doctors e-declarations have been recorded on the Filemaker Postgraduate database. Below is the competency report for the mandatory training competencies for the new intake of junior doctors.

It should be noted that for the junior doctors leaving the Southern Trust, the percentage of competencies completed were generally higher, and that work is underway to remind junior doctors of the need to complete this mandatory training. Non-compliance continues to be followed up on a monthly basis in accordance with the Standard Operating Procedure. This includes reminders of modules which have expired or are due to expire in the next 40 days.

AMDs are issued with divisional competency reports on a bi-monthly basis to follow up on non-compliance.

1.1.1 Competency Report

Competency	Status of new intake as at September 2016		
	% Completed	% Not Required / Desist	% Expired
RPRB Module	82%	-	18%
RPRB Competency Assessment	75%	25%	-
BMJ Hyponatraemia	81%	-	19%
Training Tracker	76%	-	24%
Infection Control	70%	-	30%
NEWS*	78%	5%	17%
PEWS (CYPS only)	9%	88%	1%
OEWS (IMWH only)	6%	90%	3%

**Trainees in IMWH are required to complete OEWS [Obstetric Early Warning System] module in addition to NEWS / Trainees in CYP are required to complete PEWS [Paediatric Early Warning System] only. PEWS module is currently delivered face-to-face at speciality teaching sessions.*

1.2 NIMDTA Deanery Visits

The Northern Ireland Medical and Dental Training Agency (NIMDTA) carried out a series of cyclical visits and regional speciality reviews throughout the year. Below is summary and update of the most recent visits:-

1.2.1 Emergency Medicine Deanery Visit – 26th November 2015

The Deanery carried out a Deanery Visit to Emergency Medicine at both Daisy Hill Hospital and Craigavon Area Hospital sites on 26th November 2015.

Daisy Hill Hospital
The interim report for Deanery visit to Emergency Department in Daisy Hill Hospital had outlined issues including informal handover and patient care due to lack of sustainable senior supervision in the Department. Southern Trust action plan to the final report was reviewed by NIMDTA in May 2016**. (Appendix A).** The Deanery welcomed actions taken by the Trust to increase the number of Consultants and Speciality doctors at Daisy Hill Hospital and plans to formalise handover; however requested a further update in the September LEP Quality Report due on 30th September 2016. .

Craigavon Area Hospital
The interim report for Craigavon Area Hospital had outlined issues including informal handover, clinical supervision, practical experience, lack of simulation facilities and seminar room within the department for dedicated training. Trust action plan was submitted and a final report with a grading of B2: satisfactory with conditions was received. **(Appendix B).** Similar to DHH, the Deanery requested a further update for CAH in the September LEP Quality Report due on 30th September 2016.

1.2.2 Paediatric Deanery Visit – 19th May 2016

Following Deanery to Paediatrics at both Daisy Hill Hospital and Craigavon Area Hospital sites on Thursday 19th May 2016, interim reports were received as follows:-

Daisy Hill Hospital
Trainees reported that there were limited opportunities to carry out procedures or develop decision making skills in the ward or clinics and there was limited neonatal experience in the special care baby unit. A Trust Action Plan has been submitted to the Deanery Quality Management Group for review. **(Appendix C)**

Craigavon Area Hospital
Interim and final reports have been received for Craigavon Area Hospital with a grading of E: Unsatisfactory – Urgent action required. Issues raised included the excessive number of baby checks being carried out by junior doctors, lack of opportunity to attend out-patient clinics and limited exposure to neonatal unit due to inadequately staffed rotas.

The Paediatric management team are working to address issues raised. The Deanery requires a further update by 30th November 2016.

1.3 GMC National Trainee and Trainer Surveys

National Trainer Survey

The GMC National Trainer Survey Results were received with 51% of Southern Trust trainers' participating in the online survey.

Topics such as organisational culture, supportive environment, handover, time for trainers, support for trainers and supervisor training were all surveyed. General Internal Medicine in CAH and DHH scored below the national mean in a range of areas and are being addressed. Anaesthetics, Paediatrics and Obstetrics & Gynaecology all scored average or above average in the survey.

The Southern Trust recognises the difficult challenges in providing training in the context of continuing to deliver unscheduled care services particularly with increasing demands upon Acute services.

A number of courses have been run to update trainers on the skills required to deliver training to the standard expected by NIMDTA (detailed below). Consideration is being given to provide more protected time for training within job plans.

National Trainee Survey

Overall satisfaction in Emergency Department Craigavon Area Hospital scored below the national score, as did workload in General Internal Medicine in Daisy Hill Hospital.

However, on a more positive note, feedback from trainees within Anaesthetic and Geriatric Medicine improved strongly, and the Southern Trusts position overall moved in a positive direction.

GMC Top Ten Trusts in the UK 2016

The GMC 2016 anonymous National Trainees Survey has just reported results and has placed the SHSCT, no. 5 out of several hundred NHS employers with regard to reporting concerns and in the top 10% for education supervision and facilities. The top 10 ranking over 3 domains indicates a healthy culture of support for junior doctors. This is the third successive year the Trust has received a top ten ranking in at least one domain.

1.4 GMC Recognising and Approving Trainers

The Medical Education Team has recently facilitated Teach the Teacher, Supervisory Skills and Trainee Support Workshops in a bid to increase the number of GMC recognised trainers in Southern Trust. NIMDTA also hosted a Recognition Training day in Belfast on 16th September 2016. Following confirmation of numbers at this workshop we will be able to confirm accurate number of GMC Recognised Trainers within Southern Trust.

The Medical Education Team will continue to run a faculty development programme and are currently organising dates for the following workshops at both Craigavon Area Hospital and Daisy Hill Hospital in 2017:-

- Teaching the Teacher (or equivalent)
- Supervisory Skills (or equivalent) (*facilitated at NIMDTA*
- Trainee Support Workshop (formerly Doctors in Difficulty) (or equivalent)
- Equality, Diversity and Opportunity Training (online training)
- Recruitment and Selection (online training)

2.0 UNDERGRADUATE EDUCATION

2.1 Accountability Report 2015/16

The text component of the Annual SUMDE Accountability Report was passed at SMT on 7th September 2016 and has been submitted to the SUMDE office at QUB. Work is in progress to complete the Financial Statement which has to account expenditure of £1,976,230.38 SUMDE funding for 2015/16. The Financial Statement is due for submission by 30th September 2016.

2.2 SUMDE Circular 2016/17

DHSSPS circular has allocated Southern Trust with £1,939,530 SUMDE funding for 2016/17. This consists of £413,846 infrastructure funding and £1,525,684 clinical funding. SUMDE funding is 100% accountability and work will continue throughout the year towards the completion of the Annual SUMDE Financial Accountability Report 2016/17.

Appendix A

Trust Action Plan
Emergency Medicine Deanery Visit, DHH

LEP Action Plan to Deanery Visit Report

All final reports including the Trust action plan will be sent to the Director of Medical Education and copied to the Chief Executive Officer, Medical Director, RQIA, HSC Board, DHSSPS. Final reports and action plans with names redacted will be published on the NIMDTA website. These reports will be used to inform GMC of both good practice and areas of concern through the Dean's Report.

Northern Ireland mdta Medical & Dental Training Agency

	Daisy Hill Hospital		**Date Issued:** 04 December 2015 **Date Trust Response Received:** 05 January 2016
	Emergency Medicine		**Date Issued:** 12 January 2016 **(For Response by:** 02 February 2016**)** **Date Trust Response Received:** 02 February 2016 **Date Reviewed at QM:** 08 February 2016
	Cyclical		
	Dr Richard Wright, MD Mr Colin Weir, DME		**Date QM Updated Action Plan Issued:** 11 February 2016 **Action Plan Update Deadlines:** 31 March 2016 (via LEP mid-year Quality Report) **Date Trust Response Received:** 01 April 2016 **Date Reviewed at QM:** 23 May 2016
	26 November 2015		**Date QM Updated Action Plan Issued:** 19 July 2016 **Action Plan Update Deadlines:** **30 September 2016** (via LEP Quality Report)
	C : Borderline 08 February 2016		**Date Final Action Plan Issued:** **Date Final Report Uploaded to Website:** **Final Report Sent to:** Dr Richard Wright & Mr Colin Weir **Date Final Report Sent:** 11 February 2016

A1	**Excellent**	**Exceeds expectations for a significant number of GMC domains.**	**Cyclical.**
A2	**Good**	**Meets expectations under all GMC domains.**	**Cyclical.**
B1	**Satisfactory**	**Areas for improvement identified, but no significant areas of concern.**	**No automatic re-visit / Cyclical.**
B2	**Satisfactory (with conditions)**	**Areas for improvement identified. Amber concern(s) to be addressed.**	**No automatic re-visit / Cyclical / Follow Up report required.**
C	**Borderline**	**Areas of concern to be addressed (may include one red or multiple amber RAG ratings).**	**A Deanery review within 12 months (unless all concerns adequately addressed by Trust within 6 months of rated action plan being issued). The review may include a re-visit.**
D	**Unsatisfactory - Not able to assess**	**Unable to assess due to lack of trainee and/or trainer engagement with visit.**	
E	**Unsatisfactory - Urgent action**	**Urgent action required on significant areas of concern (multiple red RAG ratings).**	**Deanery review within 6 months of rated action plan being issued. This is expected to include a re-visit unless all areas have been adequately addressed within 6 months.**
F	**Unsatisfactory - Unsafe Training Environment - Immediate Action**	**Will apply if a red* RAG rating is identified or may occur if multiple red RAG ratings. Immediate action to be taken by notification to nominated Trust representative. Possible withdrawal of trainees (single or multiple red*).**	**Automatic review within 3 months. If no improvement is apparent within 3 months, the GMC Withdrawal of Approval process may be initiated.**

Visit Team Findings against GMC Standards for Training									
	Educational and/or Clinical Governance	**Area for Improvement / Area of Concern / Area of Significant Concern**	**Areas Identified by Visit Team:**	**Trust Action Plan:** Please consider the following questions when providing a Trust action plan response: 1. What has been done to date? 2. What are you planning to do? 3. When will these plans be in place?	**Lead Individual :**	**Date to be completed by:**	**QMG Comment**	**Risk Rating**	**Status**
1	Educational & Clinical Governance	Area of Significant Concern	**Patient Care.** The department is heavily dependent on locums. A lack of sustainable, adequate senior supervision could call into question the sustainability of the department for F2 and GPST training.	The QM group would like an update on the arrangements for Clinical and Educational supervisors for trainees in the department following the departure of the lead consultant and the retirement of the Associate Specialist. **Trust Response:** Since the NIMTA visit in November 2015 things have and are changing quite a bit. Dr O'Toole has moved on to the Ulster Hospital and Mr Michael McCann has taken over as Clinical Lead in the Department. With the agreement of Dr O'Reilly AMD in acute care and Mr Barry Conway Assistant Director Acute Services Mr McCann has procured four additional high quality long term (six months or more) ED Consultants, the first two of which commence in the first week in February and the others over the next few weeks. A further Specialty doctor on a long term contract is starting in mid-February and we are interviewing for a permanent (additional) Specialty doctor in February and are very likely to appoint. The Trust has just advertised for five full time permanent ED Consultants one with an interest in Paediatrics to make up a group of 8 consultants working primarily in Daisy Hill. Mr McCann has delayed his retirement in order to lead the Department through this process. We would be optimistic that we should be able to attract suitable candidates with the more attractive rota and other incentives and that we should have a			The Deanery QM group requests details of the named clinical and educational supervisors for each trainee, in addition to the lead individual(s) and timeframe for completion. This update will be requested in the LEP mid-year Quality Report due on **31 March 2016**. The QMG has concerns that the identified actions may not be achievable in a suitable timeframe. This is at risk of triggering the escalation process if progress is not evident. A copy of the *Escalation Process and Removal of Trainee*s guidance is attached. **QMG Update 23.05.16** The Deanery QM group welcomes the action taken by the Trust to increase the number of consultants and specialty doctors however a further update will be requested in the September LEP Quality Report due on **30 September 2016**. The GMC 2016 NTS results will also be reviewed in	Medium Impact / High Likelihood	Stage 2

				significantly enlarged stable permanent Consultant cadre within a number of months. In the interim the trainees will be well supported with additional senior cover both in and out of hours we will continue to deliver the high standards of training that has been the norm. **LEP Quality Report Update 01.04.16** Two substantive consultant posts have been interviewed for and successful candidates identified and due to take up posts in the forthcoming months. A further two substantive consultants post are due to be advertised shortly. We currently have two fulltime locum consultants in post and one part time and a further fulltime locum consultant staring April/May. We have just appointed a further full time substantive specialty doctor and have additional locum SHO's and a specialty doctor to support the FY2/GP rota. The Trust has done a great deal in a short time period to improve the situation and are addressing the problem regarding permanent consultants raised by the Deanery and would appreciate time to consolidate our position. Our junior doctor teaching programme is running very well and the juniors are getting lots of senior support and are getting to all of their external training.			June/July with regards to supervision.		
2	Clinical Governance	Area for Improvement	**Handover.** Handover is informal and could benefit from a more formal structure.	Formalising handover is a work in progress and the main difficulty is trying to deal with the different changeovers which occur through the working day as staff come on and off duty at different times. We are introducing a system			The Deanery QM group requests an update on this item to include details of the lead individual(s) and timeframe for completion in the LEP mid-year Quality	Medium Impact / Medium Likelihood	Stage 2

				where there will be a lead consultant during the day and another for the evening and overnight and this will co-ordinate the major handover with minor handovers for the various junior and middle grade doctors finishing shifts. There should be more time to complete this once the additional doctor's start in February and more time for non-clinical work becomes available. **LEP Quality Report Update 01.04.16** It is anticipated to develop formal handover after Easter break, when additional staff are available to assist.			Report due on **31 March 2016**. **QMG Update 23.05.16** The Deanery QM group note the planned Trust action and as a result will review the GMC 2016 NTS results in relation to handover in June/July. In addition, a further update will be requested in the September LEP Quality Report due on **30 September 2016**.		

Impact, Likelihood & Risk

The above points have been graded by the Quality Management Group in accordance with the GMC's risk and status ratings below.

'Impact'

Impact takes into account:

- Patient or trainee safety.
- The risk of trainees not progressing in their training.
- Education Experience. For example, the educational culture, the quality of formal / informal teaching etc.

An issue can be rated high, medium, or low impact according to the following situations:

High Impact: patients or trainees within the training environment are being put at risk of coming to harm. Or trainees are unable to achieve required outcomes due to poor quality of the training posts / programme.

Medium Impact: trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement. Or patients within the training environment are receiving safe care, but the quality of their care is recognised as requiring improvement.

Low Impact: issues have a minimal impact on a trainee's education and training, or the quality of provision for the patient.

'Likelihood'

Likelihood measures the frequency at which issues arise. For example, if a rota has a gap because of one-off last minute sickness absence, the likelihood of issues occurring as a result would be low.

High Likelihood: the issue occurs with enough frequency that patients or trainees could be put at risk on a regular basis. What is considered to be 'enough frequency' may vary depending on the issue. For example, if rotas have consistent gaps so that there is a lack of safe cover arrangements, the likelihood of issues arising as a result would be 'high'.

Medium Likelihood: the issue occurs with enough frequency that if left unaddressed could result in patient safety issues or affect the quality of education and training. For example, if the rota is normally full but there are no reliable arrangements to cover for sickness absence, the likelihood of issues arising as a result would be 'medium'.

Low Likelihood: the issue is unlikely to occur again. For example, if a rota has a gap because of several unexpected sickness absences occurring at once, the likelihood of issues arising as a result would be 'low'.

'Risk'

Risk if then determined by both the impact and likelihood and will result in a RAG rating according to the below matrix:

Risk Rating

LIKELIHOOD ↓ **IMPACT →**	LOW	MEDIUM	HIGH
LOW	GREEN	GREEN	AMBER
MEDIUM	GREEN	AMBER	RED
HIGH	AMBER	RED	RED*

Status Ratings

Stage 1: **INVESTIGATION** - Verification of concern is being undertaken and action plan is not yet in place.
Stage 2: **IMPLEMENTING SOLUTIONS -** Action plan(s) for improvement are in place, but are yet to be fully implemented and evaluated.
Stage 3a: **PROGRESS NOT YET APPARENT** - There is no change as of yet, but there is continuing monitoring and evaluation of actions.
Stage 3b: **MONITORING PROGRESS** - Actions are being implemented, and there is evidence of improvement through monitoring.
Stage 3c: **CONCERNS OVER PROGRESS** - The action plan has fallen behind or is likely to fall behind.
Stage 4: **CLOSED** - Solutions are verified, evidence that there has been sustained improvement over an appropriate time period.

New GMC Standards for Medical Education and Training [Jan 2016]

Theme 1: Learning Environment & Culture	**Theme 2:** Educational Governance & Leadership	**Theme 3:** Supporting Learners	**Theme 4:** Supporting Educators	**Theme 5:** Developing and Implementing Curricula and Assessments

S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. **S1.2:** The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.	**S2.1:** The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met. **S2.2:** The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety. **S2.3:** The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.	**S3.1:** Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.	**S4.1:** Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities. **S4.2:** Educators receive the support, resources and time to meet their education and training responsibilities.	**S5.2:** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Additional Comments from the Trust:	
On Behalf of the Trust: Director of Medical Education	**Signature:**
	Date:

Appendix B

Trust Action Plan
Emergency Medicine Deanery Visit, CAH

LEP Action Plan to Deanery Visit Report

All final reports including the Trust action plan will be sent to the Director of Medical Education and copied to the Chief Executive Officer, Medical Director, RQIA, HSC Board, DHSSPS. Final reports and action plans with names redacted will be published on the NIMDTA website. These reports will be used to inform GMC of both good practice and areas of concern through the Dean's Report.

Local Education Provider (LEP) Visited	Craigavon Area Hospital	**Factual Accuracy Report** (15 working days to respond)	**Date Issued:** 15 December 2015 **Date Trust Response Received:** 11 January 2016
Specialty Visited	Emergency Medicine	**Interim Report and Action Plan Timeline**	**Date Issued:** 14 January 2016 **(For Response by:** 04 February 2016**)** **Date Trust Response Received:** 08 February 2016 **Date Reviewed at QM:** 22 February 2016 **Date QM Updated Action Plan Issued:** 24 February 2016 **Action Plan Update Deadlines:** 31 March 2016 (via LEP mid-year Quality Report) **Date Trust Response Received:** 01 April 2016 **Date Reviewed at QM:** 23 May 2016
Type of Visit	Cyclical		
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr Richard Wright, MD Mr Colin Weir, DME		
Date of Visit	26 November 2015		
QMG Grading Decision & Date	B2 : Satisfactory (with conditions) 22 February 2016	**Final Report & Action Plan**	**Date Final Action Plan Issued:** **Date Final Report Uploaded to Website:** **Final Report Sent to:** Dr Richard Wright & Mr Colin Weir **Date Final Report Sent:** 24 February 2016

	Grading Outcome	Description	Deanery Action
A1	Excellent	Exceeds expectations for a significant number of GMC domains.	Cyclical.
A2	Good	Meets expectations under all GMC domains.	Cyclical.
B1	Satisfactory	Areas for improvement identified, but no significant areas of concern.	No automatic re-visit / Cyclical.
B2	Satisfactory (with conditions)	Areas for improvement identified. Amber concern(s) to be addressed.	No automatic re-visit / Cyclical / Follow Up report required.
C	Borderline	Areas of concern to be addressed (may include one red or multiple amber RAG ratings).	A Deanery review within 12 months (unless all concerns adequately addressed by Trust within 6 months of rated action plan being issued). The review may include a re-visit.
D	Unsatisfactory - Not able to assess	Unable to assess due to lack of trainee and/or trainer engagement with visit.	
E	Unsatisfactory - Urgent action	Urgent action required on significant areas of concern (multiple red RAG ratings).	Deanery review within 6 months of rated action plan being issued. This is expected to include a re-visit unless all areas have been adequately addressed within 6 months.
F	Unsatisfactory - Unsafe Training Environment - Immediate Action	Will apply if a red* RAG rating is identified or may occur if multiple red RAG ratings. Immediate action to be taken by notification to nominated Trust representative. Possible withdrawal of trainees (single or multiple red*).	Automatic review within 3 months. If no improvement is apparent within 3 months, the GMC Withdrawal of Approval process may be initiated.

Visit Team Findings against GMC Standards for Training									
	Educational and/or Clinical Governance	**Area for Improvement / Area of Concern / Area of Significant Concern**	**Areas Identified by Visit Team:**	**Trust Action Plan:** Please consider the following questions when providing a Trust action plan response: 1. What has been done to date? 2. What are you planning to do? 3. When will these plans be in place?	**Lead Individual:**	**Date to be completed by:**	**QMG Comment**	**Risk Rating**	**Status**
1	Clinical Governance	Area of Concern	**Potential Patient Safety Issue.** Trainees reported that there were often delays in triage due to pressure on space in the ED. They also reported that there was inconsistent use of triage scores by the nurses, some of whom had limited experience of triage. This has been supplied for information only.	In CAH ED, we have had a significant turnover in nursing staff. We have the majority of our nurses now trained in Manchester Triage. We also have a daily dashboard in place which monitors our triage performance against the 15 minute CEM standard.	M Burke	Complete	The Deanery QM group thank you for the response but note that this was supplied for information only; a RAG rating will not be allocated and this will be categorised as closed on the action plan.	N/A	N/A
2	Clinical Governance	Area for Improvement	**Handover** is informal and could benefit from a more formal structure through the day.	Despite trainees impression, we can confirm there is morning handover which is led by the consultant (also at 5pm and 10pm). This includes a written template which is completed by the consultant with appropriate discussion / handover of cases with the trainees. Taking this feedback on board, we now will mandate trainee involvement in the existing handover processes to ensure they benefit from this training. Copies of the handover template will also be retained for reference.	P Kerr	1 March'16	The Deanery QM group acknowledges and accepts the action provided.	Low Impact / Low Likelihood	Stage 4
3	Clinical Governance	Area for Improvement	**Clinical Supervision.** ST3+ trainees said that they were not always sure which consultant was allocated to each area within the department.	There is always one designated consultant who is in overall charge of the department. In addition there are consultants designated to be leads in each area within the department – for example, minors, majors and CDU.	P Kerr	1 March'16	The Deanery QM group acknowledges and accepts the action provided.	Low Impact / Low Likelihood	Stage 4

				There is already an existing allocation sheet in the department which trainees and other can easily reference.					
4	Educational & Clinical Governance	Area for Improvement	**Practical Experience.** ST3+ trainees reported that they would like more clarity on their allocations to streams within the department.	See comment above – the written allocation sheet is available as per point 3 above. We will however reallocate staff throughout day to meet the demands on the service. Taking this feedback on board, we will continue to reinforce these process with our current and future trainees.	P Kerr	1 March'16	The Deanery QM group acknowledges and accepts the action provided.	Low Impact / Low Likelihood	Stage 4
5	Educational Governance	Area for Improvement	**EWTR Compliance.** ST3+ trainees expressed the wish to have more autonomy in organising their rota.	The number of trainees that CAH ED has does not compare favourably with the numbers of trainees in other similar sized unit in NI (for reference see this evidenced through recent ED medical workforce plan completed by Dr G Rankin) As a consequence we would accept that our rotas would be more onerous for trainees in other similar units. The Trust would be keen to engage with the Deanery and the School of Emergency Medicine to review our current trainee numbers with a view to urgent expansion. If this can be progressed urgently the Trust will immediately move to revise rotas accordingly. In the interim, the Trust will do all it can within reason to work with our trainees to make the rota as fair as they can be. **LEP Quality Report Update 01.04.16** The Trust continues to be keen to engage with NIMDTA to urgently consider how the trainee numbers can be increased and we would welcome your view on how this can be progressed urgently. In relation to further actions linked to the existing rota and how our trainees	S O Reilly, R Wright, E Gishkori	1 March'16	The Deanery QM group thank the Trust for the action provided but note that this response does not address the concern identified. An update on how trainees could be more involved in the construction of the rota will be requested in the LEP mid-year Quality Report due on **31 March 2016**. **QMG Update 23.05.16** The Deanery QM group acknowledge and accept the action taken and this issue is now closed.	Low Impact / Low Likelihood	Stage 4

				can be better involved in this process, we can confirm that responsibility for the rota has now been passed to the senior trainees with oversight provided by one of our senior ED consultants in CAH. We believe this will help address the issues raised by our recent group of trainees.					
6	Clinical Governance	Area for Improvement	**Induction.** There may have been a breakdown in communication to ST3+ trainees about the unit induction process. ST3+ trainees should be made aware of what induction materials are available to them, and an adequate unit induction provided to all trainees in the department.	The Trust has well established arrangements for generic induction. In addition we have ED specialty induction that runs over 3 consecutive half days. On this occasion our group of trainees felt unable to attend specialty induction during their off time due to rota pressures. Recognising these pressures, in future if we encounter similar conflicts between induction and service pressures, we will use locum backfill to support attendance. We can confirm we have a large amount of induction materials / Guidelines in the department which this group of trainees appeared to be unaware of. We will reinforce in future where trainees can reference this information.	P Kerr, G Hampton and C Daly	1 March'16	The Deanery QM group request confirmation that the August induction met the trainee requirements in the **September 2016 LEP Quality Report**.	Low Impact / High Likelihood	Stage 2
7	Educational Governance	Area for Improvement	**Educational Resources/Internet Access**. There were no high fidelity simulation facilities in the hospital. The Trust was proposing to address this by the appointment of a simulation lead.	The trainees regularly have access to such facilities through the regional training program. The Trust is however currently engaged in having such facilities on site in CAH.	S O Reilly, C Weir, R Wright	Unknown	The Deanery QM group request an update on progress, to include details of the simulation appointment and on-site facilities in the **September 2016 LEP Quality Report**.	Low Impact / High Likelihood	Stage 2
8	Educational Governance	Area for Improvement	**Educational Resources/Internet Access**. Trainers reported that they had been unable to secure a much-needed seminar room in the department, despite the fact	The Trust accepts this is a gap. Approval and funding is now in place to provide a seminar room during 2016-17.	B Conway	30 June'16	The Deanery QM group request an update on the progress of this action in the **September 2016 LEP Quality Report**.	Low Impact / High Likelihood	Stage 2

			that a suitable unoccupied room had been promised to them for a number of years. This should be resolved by the Trust immediately.						

Good Practice Items from Visit Report [if applicable]

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
1. Trainee supervision has been improved by the presence of a consultant in the department until at least 22:00 on weekdays and to 17:00 at weekends.
2. Induction of first tier trainees is comprehensive.

Impact, Likelihood & Risk

The above points have been graded by the Quality Management Group in accordance with the GMC's risk and status ratings below.

'Impact'

Impact takes into account:

- Patient or trainee safety.
- The risk of trainees not progressing in their training.
- Education Experience. For example, the educational culture, the quality of formal / informal teaching etc.

An issue can be rated high, medium, or low impact according to the following situations:

High Impact: patients or trainees within the training environment are being put at risk of coming to harm. Or trainees are unable to achieve required outcomes due to poor quality of the training posts / programme.

Medium Impact: trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement. Or patients within the training environment are receiving safe care, but the quality of their care is recognised as requiring improvement.

Low Impact: issues have a minimal impact on a trainee's education and training, or the quality of provision for the patient.

'Likelihood'

Likelihood measures the frequency at which issues arise. For example, if a rota has a gap because of one-off last minute sickness absence, the likelihood of issues occurring as a result would be low.

High Likelihood: the issue occurs with enough frequency that patients or trainees could be put at risk on a regular basis. What is considered to be 'enough frequency' may vary depending on the issue. For example, if rotas have consistent gaps so that there is a lack of safe cover arrangements, the likelihood of issues arising as a result would be 'high'.

Medium Likelihood: the issue occurs with enough frequency that if left unaddressed could result in patient safety issues or affect the quality of education and training. For example, if the rota is normally full but there are no reliable arrangements to cover for sickness absence, the likelihood of issues arising as a result would be 'medium'.

Low Likelihood: the issue is unlikely to occur again. For example, if a rota has a gap because of several unexpected sickness absences occurring at once, the likelihood of issues arising as a result would be 'low'.

'Risk'

Risk if then determined by both the impact and likelihood and will result in a RAG rating according to the below matrix:

Risk Rating

LIKELIHOOD ↓ **IMPACT** →	LOW	MEDIUM	HIGH
LOW	GREEN	GREEN	AMBER
MEDIUM	GREEN	AMBER	RED
HIGH	AMBER	RED	RED*

Status Ratings

Stage 1: **INVESTIGATION** - Verification of concern is being undertaken and action plan is not yet in place.
Stage 2: **IMPLEMENTING SOLUTIONS -** Action plan(s) for improvement are in place, but are yet to be fully implemented and evaluated.
Stage 3a: **PROGRESS NOT YET APPARENT** - There is no change as of yet, but there is continuing monitoring and evaluation of actions.
Stage 3b: **MONITORING PROGRESS** - Actions are being implemented, and there is evidence of improvement through monitoring.
Stage 3c: **CONCERNS OVER PROGRESS** - The action plan has fallen behind or is likely to fall behind.
Stage 4: **CLOSED** - Solutions are verified, evidence that there has been sustained improvement over an appropriate time period.

New GMC Standards for Medical Education and Training [Jan 2016]

Theme 1: Learning Environment & Culture	**Theme 2:** Educational Governance & Leadership	**Theme 3:** Supporting Learners	**Theme 4:** Supporting Educators	**Theme 5:** Developing and Implementing Curricula and Assessments
S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. **S1.2:** The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.	**S2.1:** The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met. **S2.2:** The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety. **S2.3:** The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.	**S3.1:** Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.	**S4.1:** Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities. **S4.2:** Educators receive the support, resources and time to meet their education and training responsibilities.	**S5.2:** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

Additional Comments from the Trust:	
On Behalf of the Trust: Director of Medical Education	**Signature:**
	Date:

Appendix C

Trust Action Plan
Paediatrics Deanery Visit, DHH

LEP Action Plan to Deanery Visit Report

All final reports including the Trust action plan will be sent to the Director of Medical Education and copied to the Chief Executive Officer, Medical Director, RQIA, HSC Board, DHSSPS. Final reports and action plans with names redacted will be published on the NIMDTA website. These reports will be used to inform GMC of both good practice and areas of concern through the Dean's Report.

Local Education Provider (LEP) Visited	Daisy Hill Hospital	**Factual Accuracy Report** (15 working days to respond)	**Date Issued:** 10 June 2016 **Date Trust Response Received:** 04 July 2016
Specialty Visited	Paediatrics	**Interim Report and Action Plan Timeline**	**Date Issued:** 26 July 2016 **(For Response by: 16 August 2016)** **Date Trust Response Received:** **Date Reviewed at QM:** **Date QM Updated Action Plan Issued:** **Action Plan Update Deadlines:** **Date Trust Response Received:** **Date Reviewed at QM:**
Type of Visit	Cyclical		
Trust Officers with Postgraduate Medical Education & Training Responsibility	Dr Richard Wright, MD Mr Colin Weir, AMD		
Date of Visit	19 May 2016		

Visit Team Findings against GMC Standards for Training

	Educational and/or Clinical Governance	Area for Improvement / Area of Concern / Area of Significant Concern	Areas Identified by Visit Team:	Trust Action Plan: Please consider the following questions when providing a Trust action plan response: 1. What has been done to date? 2. What are you planning to do? 3. When will these plans be in place?	Lead Individual:	Date to be completed by:
1	Educational Governance	Area of Concern	**Practical Experience.** Trainees reported that there were limited opportunities to carry out procedures or develop decision making skills in the ward or clinics. There was limited neonatal experience in the special care baby unit.	The paediatrics trainees will be encouraged to undertake procedures as appropriate for their level. The experience in neonate is compensated for by undertaking neonatal drills (using SIM neonate, which include practical skill like intubation and insertion of chest drainage. We are developing opportunity for further training in Paediatric sub-specialist clinics such as Epilepsy, Diabetes, Infectious disease clinics and community paediatrics neurodevelopmental clinics. Regular paediatrics SIM sessions are part of the educational program.		

2	Educational Governance	Area for Improvement	**Educational Resources**. Trainers reported that the multifunction teaching room is of limited size. Trainers reported that in their view there were inadequate postgraduate facilities on the DHH site. This has been supplied for information only.	Teaching facilities will be improved as part of Changing for Children plan. A larger teaching room would be available with video conference and multi-media facilities on 6th Floor by the end of 2017. In the meantime other available DHH venues have been explored. Directorate is also developing plan to install video conference facilities in DHH based Paediatric Simulation facility. Southern Trust is also developing plans for a Medical education facility on DHH site (similar to CAH) to further enhance medical education on DHH site.		

Good Practice Items from Visit Report [if applicable]

Good Practice (includes areas of strength, good ideas and innovation in medical education and training):
There were no areas of good practice identified.

New GMC Standards for Medical Education and Training [Jan 2016]

Theme 1: Learning Environment & Culture	**Theme 2:** Educational Governance & Leadership	**Theme 3:** Supporting Learners	**Theme 4:** Supporting Educators	**Theme 5:** Developing and Implementing Curricula and Assessments
S1.1: The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. **S1.2:** The learning environment and organisational culture value	**S2.1:** The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met. **S2.2:** The educational and clinical governance systems are integrated,	**S3.1:** Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by the curriculum.	**S4.1:** Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities. **S4.2:** Educators receive the support, resources and time to meet their education and training responsibilities.	**S5.2:** Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.

and support education and training so that learners are able to demonstrate what is expected in *Good Medical Practice* and to achieve the learning outcomes required by their curriculum.	allowing organisations to address concerns about patient safety. **S2.3:** The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.			

Additional Comments from the Trust:	
On Behalf of the Trust: Director of Medical Education	**Signature:**
	Date:

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

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 24th March 2016
Title:	Medical Directors Report
Lead Director:	Dr Richard Wright – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	For assurance

Summary of Key Issues for Trust Board

High level context:

- Update on Medical Revalidation process YTD (24th March 2016) 283 doctors have successfully revalidated (1.1.1)
- Medical Appraisals 2014 – 99% completed / awaiting final sign-off (1.1.2)
- Progress on Junior Doctor Mandatory Training for February 2016 intake
- Reports on recent NIMDTA Deanery visits

Key issues/risks for discussion:

Work on achievement of Internal Audit paying patients recommendations continues.

Summary of SMT challenge/discussion:

- Right Patient Right Blood, mandatory training needs an action plan to improve – Simon Gibson is taking this forward.

Internal/External engagement:

Human Rights/Equality:
Not applicable

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1 Medical Workforce Governance

1.1 Medical Appraisal and Revalidation

The Trust's Revalidation Team continue to oversee quality control of the appraisal process and review all appraisal documentation received into the Medical Director's Office to ensure there is sufficient evidence of appropriate documentation and discussion. Where gaps are identified the appraisal documentation is returned to the Appraiser and Appraisee asking them to address the specified areas and resubmit the documentation for final approval. The current simple checklist has also been augmented to further assist doctors in the completion of the forms.

An annual report for 2014 was produced which included an analysis of the content of appraisal documentation received and an analysis of appraiser and appraisee feedback questionnaires in relation to the quality of the Trust's Medical Appraisal processes. Comparisons were drawn between the 2012 and 2013 analyses and findings indicate that the Trust's comprehensive medical appraisal and revalidation processes are very well received by the medical workforce. A report for the 2014 appraisal round is currently being developed which will also draw comparisons with the previous two years' findings. This will be available shortly.

Revalidation Recommendations:

To date (24th March 2016) 283 doctors have now been revalidated and the remaining Year Three (2015-16) doctors are set to revalidate on schedule.

Appraisal Round 2014

The 2013 appraisal round completed with a 100% completion rate. Work commenced in April 2015 for the 2014 Appraisal Round as key information became available to issue to medical staff (e.g. CLIP reports, complaints/incidents information). The current appraisal status for 2014 is as follows:-

Division/Directorate	No. of Eligible Doctors	% of 2014 Appraisals Completed/In Progress*
Children & Young People's Services Directorate	390 eligible doctors	100% complete
Mental Health & Learning Disability Directorate	27 eligible doctors	100% complete
Anaesthetics, Theatre & ICU Division	36 eligible doctors	100% complete
Surgery & Elective Care	46 eligible doctors	96% complete
Cancer & Clinical Services	32 eligible doctors	100% complete
Medicine & Unscheduled Care	68 eligible doctors	100% complete
Integrated Maternity & Women's Health	24 eligible doctors	96%complete
Emergency Medicine	14 eligible doctors	100% complete
TOTAL	**286**	**99% complete**

Table 1.0 2014 Appraisal Status as at 24th March 2016

*NB: In Progress means the appraisal paperwork has been completed and is currently awaiting final sign-off by the Appraiser of which there are only 7% of the total outstanding. These are due to be submitted by April 2016.

2 Medical Education and Training

2.1 Postgraduate Education

Junior Doctors Induction - Mandatory Training

Following Junior Doctor changeover in February 2016 junior doctors e-declarations have been recorded on the Filemaker Postgraduate database. Below is the competency report for the following mandatory training competencies as at 15th March 2016.

- Right Patient Right Blood Assessment and Module
- BMJ Hyponatremia
- Training Tracker
- Infection Control
- National Early Warning System*

*Trainees in IMWH are required to complete OEWS [Obstetric Early Warning System] module in addition to NEWS / Trainees in CYP are required to complete PEWS [Paediatric Early Warning System] only. PEWS module is currently delivered at speciality teaching sessions.

Competency Report

Competency	STATUS as at 15/03/16		STATUS as at 19/01/16		
	% Completed	% Not Required / Desist	% Completed	% Not Required / Desist	
Right Patient, Right Blood	74%	26%	79%	21%	↓
BMJ Hyponatraemia	84%	N/A	84%	N/A	↔
Training Tracker	82%	N/A	85%	N/A	↓
Infection Control	93%	N/A	91%	N/A	↑
NEWS*	82%	5%	82%	4%	↔
PEWS (CYPS only)	8%	91%	8%	90%	↔
OEWS (IMWH only)	10%	88%	8%	88%	↑

NB: status at 19/01/16 relates to junior doctors prior to changeover on 03/02/16. Current status as at 15/03/16 relates to junior doctors following changeover.

Non-compliance continues to be followed up on a monthly basis in accordance with the Standard Operating Procedure. This includes reminders of modules which have expired or are due to expire in the next 40 days. AMDs are issued with divisional competency reports on a bi-monthly basis.

NIMDTA Deanery Visits

The Northern Ireland Medical and Dental Training Agency (NIMDTA) carried out a series of cyclical visits and regional speciality reviews throughout the year. Below is summary and update of the most recent visits:-

Obstetrics & Gynaecology Deanery Visit – 15th October 2015

The Deanery carried out a visit to Obstetrics and Gynaecology at both Daisy Hill Hospital and Craigavon Area Hospital on 15th October 2015.

Further to an update from Trust regarding EWTR compliance at Craigavon Area Hospital, the final report has been received with a grading of A2: Good and the report is now closed.

Emergency Medicine Deanery Visit – 26th November 2015

The Deanery carried out a Deanery Visit to Emergency Medicine at both Daisy Hill Hospital and Craigavon Area Hospital sites on 26th November 2015.

The interim report for Daisy Hill Hospital had outlined issues including informal handover and patient care due to lack of sustainable senior supervision in the Department. Trust action plan was submitted and a final report with a grading of C: Borderline was received. The Deanery requires an update on actions for the GMC Dean's Report by 31st March 2016.

The interim report for Craigavon Area Hospital had outlined issues including informal handover, clinical supervision, practical experience, lack of simulation facilities and seminar room within the department for dedicated training. Trust action plan was submitted and a final report with a grading of B2: satisfactory with conditions was received. The Deanery requires an update on actions for the GMC Dean's Report by 31st March 2016 and September 2016.

GMC National Trainee and Trainer Surveys

The GMC National Trainee and Trainer Survey is due to open for online completion from Monday 21st March to Wednesday 4th May 2016.

2.2 Undergraduate Education

SUMDE Circular 2015/16

Circular has been received from DHSSPS with a SUMDE allocation of £1,947,930 for Southern Trust for 2015/16. Work is on-going for the completion of the SUMDE Financial Accountability Report.

QUB Clinical Placement Visits

QUB annual Clinical Placement Visits are due to take place at DHH site on Thursday 14th April 2016 and CAH on Monday 25th April 2016. The visits will focus on induction/orientation of students, opportunities for interviewing patients, opportunities for

examining patients and arrangements for ensuring students receive feedback on performance.

3 Research & Development

3.1 Charitable Funds for Research & Development

A paper has been prepared for the Endowments and Gifts Committee meeting on 21 March 2016 regarding proposals for the use of the £32,281.49 of Charitable Funds and also the allocation to be received from 2015/2016 charitable donations.

3.2 Options to enhance research activity in the Trust

Following the Research and Development presentation to Trust Board on 22 October 2015, the Medical Director asked that a paper be prepared on options to enhance research activity. The paper has been submitted and the outcome is awaited.

3.3 Meetings with Armagh City, Banbridge and Craigavon Borough Council

Dr Sharpe and Miss Knox attended the Council's first meeting of a Key Stakeholder Group in relation to Life and Health Sciences on 11 March 2016. The purpose of the Group being to provide guidance to the Council in relation to the overall strategic direction of the Life and Health Sciences sector in the area. Representatives of Almac Group, Invest NI, Enterprise NI, Southern Regional College, East Border Region and the Council were in attendance.

Key elements identified included: - the need to ensure that Colleges and Universities provided courses which resulted in potential employees for the workforce not only having the necessary academic qualifications but also the skills to fulfil the duties of posts within Companies given at present staff have to be recruited external to Northern Ireland; and in the health sector the availability of funding to enable experienced researchers have sessions of dedicated time for research through back-fill of their posts. It was suggested that consultation should take place with local Companies to obtain their views and establish feedback on staff training deficiencies etc.

3.4 Horizon 2020 Application – GEMS – Gestational, Type 1 and Type 2 Diabetes, Empowerment of Mothers through Mobile Technologies

The application co-ordinated by the Small Business Research Initiative within Business Services Organisation was submitted to meet the closing date of 12 February 2016. Two Consultants from the Trust contributed to the application; Dr Mae McConnell, Consultant Physician with interest in Diabetes and Endocrinology and Clinical Lead for Diabetes and Endocrinology and Dr Harmini Sidhu, Consultant Obstetrician and Gynaecologist.

3.5 DHSS&PS Research for Better Health & Social Care – A Strategy for Health & Social Care Research and Development in Northern Ireland (2016-2025)

The Strategy and associated Implementation Plan were launched on 11 February 2016. The aim of the Strategy is that the health, well-being and prosperity of the Northern Ireland population will benefit from excellent, world-renowned research and development in Health and Social Care that is led from Northern Ireland.

Five objectives underpin the Strategy:-

- To support research, researchers and the use of evidence from research to improve the quality of both health and social care and for better policy-making.
- To compete successfully for Research & Development funding and optimise local funding, to deliver returns on investment for health and well-being and commerce.
- To support all those who contribute to health and social care research, development and innovation by enhancing our research infrastructure, benefitting from local, national and international partnerships.
- To increase the emphasis on research relevant to the priorities of the local population.
- To disseminate research findings in such a way as to promote understanding and knowledge, support and share best practice, stimulate further research and celebrate achievement.

4 Emergency Planning/Business Continuity

4.1 Pandemic Plans

Reporting arrangements have been implemented through this report to allow Directors and Trust Board to monitor the review and testing of plans in line with requirements (Controls Assurance Standard 5.11 : Are the organisation's updated plans validated and tested through regular review and exercises?). The inventory of pandemic plans is provided in Appendix A.

4.2 Business Continuity

The Trust is required to have business continuity measures in place to enable it to anticipate, prepare for, prevent, respond to and recover from disruptions to a pre-defined level, whatever their source and whatever aspect of the business they affect.

Controls Assurance Standards require the Trust to provide evidence that appropriate plans are in place and that business continuity management measures form part of the organisation's core business and are not just an adjunct to it.

A corporate Emergency Management plan, incorporating Business Continuity is in place and is supported by a number of service/department plans. An inventory of these plans has now been compiled to facilitate monitoring of the review and testing of plans. The inventory is attached in Appendix B.

4.3 Special Incidents Plan - Chemical, Biological, Radiological, Nuclear (CBRN)

In line with DHSSPS requirements, the Emergency Planner has drafted and shared internally, a new CBRN plan to address the potential issue of contaminated casualties self -presenting at Emergency Departments. The new plan will replace the current guidance incorporated into the Acute Hospitals Major Incident Plan and will cover new guidance on the use of dry decontamination for non-caustic contaminants which Trusts are required to have implemented. The completed plan will provide clear

guidance to staff who would be directly involved in responding to such incidents (security, porters, domestic services, medical and nursing staff).

The working group established to progress this work met again on 19/1/16 to progress the actions necessary to complete the plan and to ensure preparedness for such incidents.

The plan will be completed by the end of March and will be shared internally and with other emergency responders through the multi-agency Southern Civil Emergency Preparedness Group.

4.4 Emergency Planning Training Activity

Initial Operational Response

A staff training DVD on the new arrangements for dry decontamination, "Initial Operational Response (IOR)" was made available to both Emergency Departments (EDs) and was uploaded to the Trust's e-learning platform. The short film clearly demonstrates how casualties or self-presenters contaminated with non- caustic chemical agents should be decontaminated. ED staff who would be involved in this process, (nursing, medical, security and receptionists) have watched the DVD as part of their training for the implementation of the new process.

IOR TRAINING - % STAFF WHO HAVE WATCHED IOR TRAINING DVD			
Date	**Total Number of Staff**	**Staff who have watched DVD**	**% of staff who have watched DVD**
7/12/15	98	53	62

4.4.2 HMIMMS (Hospital Major Incident Medical Management & Support)

Trust Staff continue to be nominated to attend relevant courses as they are arise. Four Trust staff (2 from CAH ED, 1 from DHH ED and a Fire Officer) attended a Hospital Major Incident Medical Management and Support (HMIMMS) course in February. Nominations will continue to be made for future courses.

4.5 Evacuation and Sheltering Guidance

In line with DHSSPS requirements, a working group was established in 2014 to develop an Evacuation and Sheltering plan for the two acute hospitals. The plan is now complete and will be presented to SMT and Trust Board for approval, after which it will be uploaded to the intranet and shared with relevant staff. Wards and Departments are now being asked to develop their own evacuation and sheltering plans.

The Emergency Planner will also share the plan with multi-agency colleagues through the Southern Civil Emergency Preparedness Group.

In 2016, the acute Hospital Evacuation and Sheltering plan will be used as a template for the development of evacuation and sheltering plans for non-acute hospitals and Trust residential facilities. The plan will also be shared with independent sector providers.

4.6 Incidents

Smoke Incident

There have been a number of incidents within the Trust since the date of the last report.
On the afternoon of Friday 26 February members of the public in Craigavon Area Hospital reported smelling smoke to nursing staff in the Blood Clinic. The staff contacted the Trust's Fire Officer who began investigating the source. Whilst this was underway, the smoke alarms went off at switchboard which invoked activation of the fire response plan.

NIFRS were contacted and took control of the incident when they arrived on site at 15.10. The smoke emission only lasted about 10 minutes. NIFRS asked for mechanical ventilation systems to be activated to extract the smoke from the basement and babies in NICU were put into incubators as a precaution.

Critical services such as getting bloods to laboratories, neo-natal transfers etc were maintained.

The relevant parts of the hospital were locked down and the public were directed to alternative access routes as a precaution.

Traffic outside the hospital became gridlocked. A gate at the back of the hospital grounds was opened and staff assisted with redirecting traffic which eased the congestion.

A holding statement was posted on social media advising an incident was underway and seeking the public's assistance in terms of staying away from the site. There was an initial surge of interest from the public which quickly subsided.

Gas Incident

On the afternoon of 9 March, a Contractor working close to the GP Out of Hours Building fractured a gas pipe. Trust HQ and some of the surrounding buildings were evacuated. An off duty police officer who happened to be in the Ramone Building, identified himself to staff and advised that there was a strong smell of gas in the building. The building was evacuated as a preacaution. NIFRS attended and set up a cordon to keep people away from the affected area. Again there were traffic problems and the back gate to the hospital site was opened which eased the congestion.

Fire Incident

On 10 March there was a fire incident on the roof of the laundry of Craigavon Hospital. It appears there was a build up of lint in the extraction fans in the laundry which caught fire when a contractor was carrying out works on the roof. The NIFRS attended but advised the incident was under control when the crew arrived; the staff at CAH had managed to put the fire out with fire extinguishers.

Emergency Support Centre Activation

On 13 March, the Emergency Support Centre team for the Armagh & Dungannon area were activated in response to a security alert in Armagh. Two ESC Managers attended the designated support centre which was established at the Recreational Centre. Cathedral Road, Armagh and looked after the welfare needs of six members of the public. The incident stood down within a few hours.

Fire Incident

On 15 March there was another fire on the roof of the laundry in CAH. As before, NIFRS were in attendance and the incident was dealt with swiftly.

Debrief

A multi-agency debrief on the incidents was carried out on 15 March, facilitated by the Emergency Planner from the local councils. A debrief report and action plan identifying the lessons learned will be prepared by the Emergency Planning and Business Continuity manager. The debrief report will be shared internally, with multi-agency colleagues and regionally through the Regional Health Emergency Preparedness Forum.

4.7 Resourcing

Temporary funding (26/10/15-31/3/16) was made available to provide a band 3 administrative resource for Emergency Planning and Business Continuity. Amongst other things the post holder has been assisting with:

- implementation of Emergency Planning performance management arrangements
- Updating Emergency Planning action plans
- Sourcing and ordering of Emergency Planning supplies
- Ensuring Emergency internal and external contact details are updated
- Liaising with directors and Emergency Support Centre Manages to update on-call rotas

A paper has been prepared to request ongoing/permanent funding for a band 5 post to improve the Trust's overall state of emergency and business continuity preparedness by providing a resource to fulfil the administrative requirements and to take responsibility for project managing elements of EP & BC work, freeing up the Emergency Planner to engage on a face to face basis with directorate/service/ department staff in relation to the development, review and testing of plans and to ensure consistency in approach across all directorates.

4.8 Exercises

The Trust's Medical Director attended an "Incident Commanders" course run by PSNI at their Hydra training suite in Steeple Barracks in Antrim.

Three Trust staff helped facilitate students at the annual desktop exercise run by the Southern Emergency Preparedness Group for the Southern Regional College. The students study emergency planning as part of their public service course.

5 Appendix A Inventory Of SHSCT Pandemic Plans at 15 March 2016

Directorate	Service	Name of Plan	Plan Owner	Date Created	Date of Last review	Date of Next Review
HROD	All HR services	Pandemic Flu Planning	Vivienne Toal	July 2014	TBA	
	Systems	E-recruitment	SEE BUSINESS CONTINUITY PLANS		TBA	E-recruitment
		Nurse Bank System				
		HSC E-locums				
MHLD	Statutory Day Care	Station Road Resource Centre, Armagh Binnion Resource Centre, Kilkeel Manor Resource Centre, Lurgan Copperfields Resource Centre, Banbridge	Bronagh McKeown	Feb 2012	TBA	
	Transport	Early Pandemic Action Plan	Barry Collins	16/3/12	12/1/16	12/1/17
	Mental Health, Learning Disability and Physical and Sensory Disability Services and SHSCT Transport	Draft Business Continuity during Swine Flu Surge	?	28/10/09	TBA	
OPPC	Statutory Day Care	Pandemic Flu Planning BCP and Guidance Meadows , Crozier Lodge and Edenderry day centres. Lisanally,, Clogher & Keady Day centres Orchard day centre and Donard day centre	Tierna Armstrong	March 2012	April 2015	April 17
	Statutory Residential Homes	Pandemic Flu Planning for Cloughreagh House ,Slieve Roe,Crozier House ,Roxborough House		March 2012	April 2015	April 2017
	Trust Domiciliary Care Service	Domiciliary Care Continuity plan	Claudine mc comiskey	March 2012	December 2015	April 2017
	Care bureau	Care bureau continuity plan	Claudine mc comiskey	April 2014	April 2015	April 2017
CYP	Children's Residential Homes	Children's Residential Homes – Swine Flu Pandemic Plan.	?	Mar 2012	TBA	
	AHP's	Child Health & Disability Division Business Contingency plan - Actions for AHP's - Preparation Stage	Pauline Douglas	Mar 2012	May 2015	May 2017
Acute	Medicine & Unscheduled Care Surgery & Elective Care Integrated Maternity & Women's Health	Acute Programme of Care - PLANNING FOR PANDEMIC INFLUENZA IN: Medicine & Unscheduled Care		Feb 2012	TBA	

	Cancer & Clinical Care Pharmacy Functional Support Social Work	Surgery & Elective Care Integrated Maternity & Women's Health Cancer & Clinical Care Pharmacy Functional Support AFC Terms and Conditions & Payment Arrangements for 7 day Working - Pandemic Flu Plan Acute Catering Services Contingency Plan (CAH, DHH, Lurgan, STH, Mullinure , Bluestone & Coffee Bars)		Sept 2012		November 2015
	Support Services	Laundry Services Contingency Plan	Kate Corley	2008	Annual	Nov 2016
		Sterile Services Contingency Plan				
		Escalation Plan for Domestic Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Anne Forbes	Sep 2011	Annual	Oct 2016
		Escalation Plan for Domestic Services in Non In-patient Community Facilities	Sandra McLoughlin	Jul 2012	Annual	Oct 2016
		Escalation Plan for Security and Portering Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Kate Corley	May 2009	Annual	Nov 2016
		Escalation Plan for Switchboard, CAH				
		Contingency Plan in Event of Total Failure of Referral & Booking Centre	Kate Corley	Sep 2011	Annual	Nov 2016
		Contingency Plan for Health Records in SHSCT	Kate Corley	Sep 2011	Annual	Nov 2016
		Contingency Plan for Admin Services in ED	Anne Forbes	Sep 2011	Annual	Oct 2016
			Anita Carroll/Katherine Robinson	August 2012	Bi-annual	Oct 2016
			Helen Forde	August 2010	Annual	Aug 2016
			Helen Forde	Jan 2015	Annual	Jan 2016

6 Appendix B Inventory Of Business Continuity Plans For Trust Services at 15 March 2016

DIRECTORATE	SERVICE	NAME OF PLAN	PLAN OWNER	CREATED	REVIEW SCHEDULE	LAST REVIEWED	NEXT REVIEW	LAST TESTED
ACUTE	Support Services	Acute Catering Services Contingency Plan (CAH, DHH, Lurgan, STH, Mullinure , Bluestone & Coffee Bars)	Kate Corley	2008	Annual	Nov 2015	Nov 2016	June 2015
	Support Services	Laundry Services Contingency Plan	Anne Forbes	Sept 2011	Annual	Oct 2015	Oct 2016	March 2015
	Support Services	Sterile Services Contingency Plan	Sandra McLoughlin	Jul 2012	Annual	Oct 2015	Oct 2016	March 2015
	Support Services	Escalation Plan for Domestic Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Kate Corley	May 2009	Annual	Nov 2015	Nov 2016	March 2015
	Support Services	Escalation Plan for Domestic Services in Non In-patient Community Facilities	Kate Corley	Sept 2011	Annual	Nov 2015	Nov 2016	March 2015
	Support Services	Escalation Plan for Security and Portering Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)	Kate Corley	Sept 2011	Annual	Nov 2015	Nov 2016	March 2015
	Support Services	Escalation Plan for Switchboard, CAH	Anne Forbes	Sept 2011	Annual	Oct 2015	Oct 2016	March 2015
	Support Services	Contingency Plan in Event of Total Failure of Referral & Booking Centre	Anita Carroll/Katherine Robinson	August 2012	Bi-annual	October 2014	October 2016	March 2015
	Support Services	Contingency Plan for Health Records in SHSCT	Helen Forde	August 2010	A nnual	August 2015	August 2016	
	Support Services	Contingency Plan for Admin Services in ED	Helen Forde	Jan 2015	Annual		Jan 2016	
	Unscheduled Care	Emergency Department	Barry Conway		Bi-annual	October 2014	October 2016	
	Cancer & Clinical Services	Cath Lab	Simon Gibson		Bi-annual	October 2014	October 2016	
	Pharmacy	Asceptic Unit	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pharmacy	Pharmacy – Medical Gas Testing	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pharmacy	Pharmacy – Cold Storage	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pharmacy	Pharmacy Automated Dispensing	Tracey Boyce		Bi-annual	August 2014	August 2016	
	Pathology & Laboratory Services	Laboratory Services: Blood Shortages Bio computer Failure	Brian Magee Tom McFarland Kevin Duffin		Bi-annual 3 yearly Bi-annual	August 2014 June 2013 July 2014	August 2016 June 2016 July 2016	
	Cancer & Clinical Services	Imaging	Jeanette Robinson		Bi-annual	November 2014	November 2016	
	Cancer & Clinical Services	Audiology	Jeanette Robinson		3 yearly	November 2014	November 2016	

	Cancer & Clinical Services	Neurophysiology	Jeanette Robinson		3 yearly	November 2014	November 2016	
		Acute Allied Health Provision – respiratory call outs	Cathie McIlroy		Annual	November 2014	November 2015 (2015)?	November 2015?
	Maternity	Maternity Services – theatres CAH and DHH	Anne McVey Patricia McStay		Annual	November 2014	November 2015	2014 but no plan in place
	Cancer & Clinical Services	Intensive Care - CAH	Mary McGeough		Annual	November 2014	November 2015	
	Cancer & Clinical Services	Emergency Theatres - CAH and Daisy Hill	Mary McGeough		Annual	November 2014	November 2015	
HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT	HCR System Failure	HCR System Failure e– Local Operating Procedures	Karyn Patterson	18/2/11	HCR has now ceased use for general operational activity and remains live only to facilitate remaining use of live waiting lists'	September 2013 Out of Operational Use – Read only Access until April 2016		
	E-recruitment	E-recruitment System Failure Operating Procedures	Karyn Patterson		In Development – system introduced April 2015			
	Nurse Bank System	Nurse Bank System Failure Operating Procedures	Karyn Patterson / Mary Averall		In Development – system upgraded May 2015			
	HSC E-locums	HSC E-locums System Failure Operating Procedures	For SHSCT – Karyn Patterson / Karen McConville		In Development – system upgraded May 2015			
	Estates	Draft Estates Business Continuity Plan	Alan Metcalfe	Jan 2012		Feb 2015		As per Trust test in 2014
PERFORMANCE & REFORM	Informatics	Business Contingency / Continuity Plan (Information Management, Information Systems, ICT, Informatics, Corporate Records, ITS Programme Managements)	Siobhan Hanna	Jan 2011	Annual	January 2015		-
	Informatics	Business Continuity Plan for Managed Print Services	Stephen Hylands	Feb 2012	Annual	December 2014		-
	Informatics	ICT Business Continuity Plan	Andrew Patterson	Nov 2009		January 2015		November 2014
	Performance & Improvement	Business Continuity Plan including flu pandemic contingency arrangements	Lesley Leeman	Mar 2012	Annual	Oct 2014		
OLDER PEOPLE & PRIMARY CARE	Domiciliary Care	CB, AD, N&M Domiciliary Care Continuity Plan V2	CB Mel Byrne AD Geraldine Rushe NM Valerie Magowan	Sept 2011	Annual	December 2015	March 2017	February 2015
	Intermediate Care, stroke and Specialist Primary	Continuity plan and support procedures in event of a major disruption to services. . 5998766	Catherine Sheeran	Nov 2011	Annual			

	Care Services.							
	Promoting Well Being	Business Continuity Plan for Promoting Well being	Gerard Rocks Lynne Smart Carolyn Agnew	March 2013	Annual	February 2015		
	Non-Acute and Day Hospitals	Non-Acute hospitals/Day Hospitals Business Continuity Plan	Pat Nugent/Catherine Sheeran	Nov 2011		Nov 2012		
	GP Out of Hours	GP Out of Hours Business Continuity Plan VI	Cathrine Reid	Mar 2011	Annual	Mar 2012 Reviewed September 2015, and being updated		
	Adastra	GP Out of Hours Contingency Protocol if there is no Access to Adastra in the Call Centre	Cathrine Reid		Annual	June 2013 Reviewed September 2015		June 2013 September 2015
The separate Continuity Plan & Support Procedures in the event of a Major Disruption to Services for OPPC **OT.DN and Social Work are currently under review as a combined OPPC Primary Care Integrated Care Team Continuity Plan. This work is being led by Nuala Gorman Head of Service ICT**	Occupational Therapy	Occupational Therapy Service – Continuity Plan & Support Procedures in the event of a Major Disruption to Services	Nuala Gorman James Todd Miceal McParland Alicia Dickson Patrick Robinson Siobhan Macari	Nov 2011	Jan 2015.	Ongoing. Review to be completed by 30.06.15		
	Memory Service	Memory Service- Continuity Plan & Support Procedures in the event of a major disruption to services V3	C&B Shane Caldwell A&D Siobhan Donaghy N&M	Nov 2011				
	Physiotherapy Service	Physiotherapy Service continuity plan & Support Procedures in the event of a major disruption to services	Teresa Ross	July 2012			May 2015	

	Care Bureau	Care Bureau Service – Continuity Plan & Support Procedures in the event of a major disruption	Claudine McComiskey	March 2014		April 2015	April 2017	
	Residential Care Homes	BCP for Crozier House, Roxborough House, Slieve Roe, Cloughreagh		Jan 2012 Jan 2011	annual	April 2015		Desk top test 11/12/13
	Access & Information Service	Access & Information Contingency Plan	Mairead Kirk	March 2012	Annual	Nov 2015	May 2016	18/11/2015
	Daycare Centre Service Continuity Plan	BCP Meadows, Crozier Lodge & Edenderry Lisanally, Keady & Clogher, Donard & Orchard	Tierna Armstrong	April 2011	Annual	April 2015		Desk top test 11/12/13
	Nutrition & Dietetic Service	Nutrition & Dietetic Service – Continuity Plan & Support Procedures in the event of a Major Disruption to Services V3	Mandy Gilmore	Nov 2011		Dec 2014		
	District Nursing Service	District Nursing Service – continuity Plan & Support Procedures in the event of a major disruption to services V3	Nuala Gorman James Todd Miceal McParland Alicia Dickson Patrick Robinson Siobhan Macari	Nov 2011	Jan 15	Ongoing. Review to be completed by 30.06.15		
	Social Work/Care	Social Work/Care - continuity Plan & Support Procedures in the event of a major disruption to services V3	Nuala Gorman James Todd Miceal McParland Alicia Dickson Patrick Robinson Siobhan Macari	Nov 2011	Jan 15	Ongoing. Review to be completed by 30.06.15		
	Podiatry	Podiatry Service - continuity Plan & Support Procedures in the event of a major disruption to services	C&B Denise Russell	Nov 2011		Nov 2014	May 2015	TBC
CYP	Children's & Young People's Services	Children's & Young People's Services	**TBA**			Feb 2012		
	Community Dental Services	Community Dental Services	Michelle Oliver	Sept 2008	Bi-annual	May 2015	May 2017	May 2017
	Executive Director of Social Work Responsibilities	Executive Director of Social Work Responsibilities	**Paul Morgan**	**Should be reflected in all PoC Emergency Plans**				
	Social Work Out of Hours Service (Trust Wide)	RESWS (region al emergency social work service)	Regional service 02895049000	May 2013	N/A	N/A	N/A	N/A

	Business Continuity Plan for AHP	Business Continuity Plan for AHP	**Pauline Douglas**		Bi-annually	May 2015	May 2017	May 2017

Minutes of Morbidity & Mortality Surgical, Anaesthetic, Radiology
Friday 19th August 2016, at 2.00pm in the Lecture Theatre, MEC

Attendance

General Surgery		**Anaesthetics**	
Dr D Curry	ST4 Urology	Dr S Arava	Consultant Anaesthetist
Dr S Dawson	ST8	Dr R Barr	ST POG
Mr E Epanomeritakis	Consultant Surgeon	Dr J Brown	Consultant Anaesthetist
Mr D Gilpin	Consultant Surgeon	Dr G Browne	Consultant Anaesthetist
Mr A Glackin	Consultant Urologist	Dr T Bennett	Consultant Anaesthetist
Mr M Haynes	Consultant Urologist	Dr H Bunting	Consultant Anaesthetist
Dr L Johnston	F2	Dr J Cochrane	Specialty Doctor
Ms C Jones	Consultant Surgeon	Dr J Crockett	Specialty Doctor
Dr S Kumar	Specialty Doctor	Dr A Cullen (Chair)	Consultant Anaesthetist
Ms J Martin	Clinical Fellow Urology	Dr C Curry	ST7
Ms H Mathers	Consultant Surgeon	Dr A Deeny	CT1
Dr R Mayes	Specialty Doctor	Dr B Donnelly	Consultant Anaesthetist
Mr G McArdle	Consultant Surgeon	Dr R Ford	Consultant Anaesthetist
Dr S McCain	ST4	Dr N Gupta	Consultant Anaesthetist
Dr P McCluggage	F2	Dr D Kumar	Consultant Anaesthetist
Dr C McCrory	Associate Specialist	Dr D Lowry	Consultant Anaesthetist
Dr S McNally	CT1	Dr D Lyness	CT2
Dr J Morrow	LAT3 Urology	Dr R Mathers	Consultant Anaesthetist
Mr A O'Brien	Consultant Urologist	Dr L Martin	Consultant Anaesthetist
Dr C Rossborough	CT2	Dr C McAllister	Consultant Anaesthetist
Dr R Spence	ST5	Dr P McConaghy	Consultant Anaesthetist
Mr R Suresh	Consultant Urologist	Dr N McDonald	Specialty Doctor
Mr M Young	Consultant Urologist	Dr R McKee	Consultant Anaesthetist
Mr M Yousaf	Consultant Surgeon	Dr T Moore	CT1
		Dr M Morrow	Consultant Anaesthetist
Trauma & Orthopaedics		Dr J Mulholland	ST2 ICU
Mr A Alam	Locum Consultant	Dr D Orr	Consultant Anaesthetist
Dr D Dawson	ST3	Dr L Parks	Consultant Anaesthetist
Dr C Gervis	F2	Dr G Paul	ST4
Dr N Gibson	Specialty Doctor	Dr M Rea	Consultant Anaesthetist
Dr F Hassan	Specialty Doctor	Dr N Rutherford Jones	Consultant Anaesthetist
Dr C Heim	SHO	Dr D Scullion	Consultant Anaesthetist
Dr E Joyce	F2	Dr S Shevlin	ST3
Mr G Khan	Locum Registrar	Dr N Siddique	Specialty Doctor
Dr J Mullan	Clinical Fellow	Dr J Sobocinski	Consultant Anaesthetist
Dr P McCormac	Specialty Doctor	Dr S Tariq	Consultant Anaesthetist
Dr G Pacha	FY2 Locum (LAS)	Dr R Thorpe	Consultant Anaesthetist
Mr S Patton	Consultant	Dr A Tolson	ST2
Dr G Rainey	Specialty Doctor	Dr R Wallace	F2 ICU
Mr S Rajkumar	Consultant		
Ms L Wilson	Consultant	**ENT**	
		Dr C Brown	CT2
Pathology & Laboratory Service		Mr T Farnan	Consultant ENT
Dr M Brown	Consultant Microbiologist	Mr P Leyden	Consultant ENT
		Dr L McCadden	ST8
In attendance		Dr C McKenna	CT1
Mr S Gibson	Assistant Director	Mr T McNaboe	Consultant ENT
Dr R Wright	Medical Director	Mr E Reddy	Consultant ENT
		Dr C Smith	ST6
Effectiveness & Evaluation			
Mr R Haffey	E&E Facilitator		
Apologies			
Mr T Doyle	Consultant T&O	Mr D McMurray	Consultant T&O
Dr M Murnaghan	Consultant T&O	Dr K O'Connor	Consultant Anaesthetist
Mr R McKeown	Consultant T&O	Dr B Watson	Consultant T&O

	Learning points from June / July 2016 Meetings

1459	**Combined meeting June 2016**
	1459 – SAI feedback
	Recommendations
	• Develop a Trust policy or guidance document for the management of repeated cancellation of an in-patients emergency surgery. This could potentially be included in the SHSCT 'A-Z of Anaesthetics for Elderly Trauma Patients.
	• Develop a Trust guidance document on pre-operative fasting. It should include standardised information for the following clinical scenarios:
	  • Management of late cancellations
	  • Management of patients who have fasted for long periods pre-operatively or
	  • Management of patients who have fasted repeatedly pre-operatively.
	Introduce an anaesthetic proforma to be included in patients' notes, to capture the progress of the anaesthetic plan prior to surgery. This would ensure that the plan is immediately clear to all staff and not lost in the body of the patient's notes.
	
	Draft guidance has been circulated by Dr T Bennett for comment.

1487	**Combined meeting June 2016** **Revision procedure** • Highlighted the importance of communication and forming an action plan that is agreeable to Anaesthetist and Surgeon • Highlight good teamwork to lead to a good outcome
1	**Updates**
1476	**Postponed procedure / Availability of out of hours PCI** Dr Cullen has shared the minutes with the lead for Cardiology – Still awaiting feedback from Dr M Moore (Chair of Cardiology PSM)
2	**Mortality with discussion** - None
3	**Morbidity** - None
4	**Inevitable deaths** - None
5	**SAI**
(i)	**Significant Event Audit Report - Organisation's Unique Case Identifier:** Personal Information redacted by the HSI Presented by Dr Cullen. (Full presentation available from Corporate Governance) An investigation and analysis of the events surrounding the admission and treatment of a patient that attended Craigavon Hospital Emergency Department with a spontaneous haemopneumothorax. 2 week history of cough, Shortness of breath and chest pain. SpO2 97% RA, HR 75, BP 155/88, Temp 36.2. Past Medical History – Right Pneumothorax. Diagnosis – Large right sided pneumothorax. Aspiration of 1200ml and Chest X Ray repeated. **<u>Further Management</u>** Admit to CDU overnight. Oxygen therapy. Repeat Chest X Ray in morning. **Next day** Transferred to ED Resus. IV access ✓. G+H ✓. 28F chest drain inserted >>>> 1400ml of blood. HB 138. Repeat Chest X Ray. Five hours later: Admitted to 2N under medics. Clerked in by F2. Plan: Daily CXRs / High Flow O2 / Analgesia. Around eight hours later: Escalated by nursing staff – 'Pale, pain and nausea'.

	Following day 1650ml of blood in drain. 'pale, dizzy and drowsy'. FBP repeated. X-Match x 2 requested. One hour later: Unresponsive to fluid bolus. NEWS 3 →5 (HR 111, BP 98/64). HB 85. 3000ml in drain. Escalated to medical registrar. 2 units PRC to be given (Commenced at Around two hours later). Referred to Gen Surgical Registrar– 'clamp drain and discuss with Thoracics'. Emergency transfer to RVH. Emergency left thoracotomy and evacuation of pleral haematoma and apical bullectomy. Discharged four days after presenting. **Why did it happen?** • Spontaneous haemopneumothorax is an extremely rare complication. This case occurred due to uncontrolled bleeding from the pleural cavity at the site where the lung pulled away during collapse. • The initial x ray showing haemopneumothorax was interpreted incorrectly as a pneumothorax. • The initial treatment in ED was for spontaneous pneumothorax and not the haemopneumothorax. **What has been learned?** 1. Primary spontaneous haemopneumothorax – extremely rare complication of pneumothorax. Can rapidly escalate to life threatening haemorrhage. 2. The importance of measuring RR (not done initially in triage) 3. The importance of the fluid level on initial Chest X Ray – if picked up would have resulted in different treatment and referral strategy 4. CDU not an appropriate location for onward management following failed aspiration 5. NEWS – Not recorded from 2300 to 0700 in CDU – 'less than ideal' 6. Admission to 2N under Respiratory Team not appropriate. 7. No mention of fluid level in initial Chest X Ray report. **Recommendations** 1. Present at M&M Meetings 2. Trust Guidelines need changed to include information on the initial management of spontaneous haemopneumothorax. 3. If following Chest Drain insertion for a seemingly primary pneumothorax 100mls or more of blood drains, followed by another 100mls of on-going bleeding over 30minutes (> 200mls/hour) then the patient should be discussed with Thoracics with the expectation that they will be accepted for transfer. If Chest X ray shows pneumothorax and obvious fluid level then intercostal drain should be inserted and referral to Thoracics if above volumes of blood evident. 4. The absence of NEWS recording in CDU needs to be addressed to improve NEWS recording. 5. Junior medical staff should escalate promptly patients that are deteriorating 6. Chest x-rays with haemothorax as well as pneumothorax should have accurate reports **Discussion** No discussion was held.
6	**Audit Update**

(i)	**Transfer of critically ill patients from Daisy Hill Hospital – an audit of 2 years work 1 January 2014 – 31 December 2015** (Full presentation available from Corporate Governance)
	
	Past data
	• Transfers 2001 = 24, 2013 = 143 (NICCATs >65%)
	• Time taken DHH 3-4 hours, NICCATs 5-6 hours
	
	Issues
	• Increase in number of critically ill patient transfers
	• Increasing demand for Anaesthetic assistance
	  • Real demand
	  • Abuse by trainees
	  • Senior most Doctor

- Lack of Nursing support

- NICCATs is dying if not dead already
- Surgical trainees training at night
- Dilemma of C/Section categories
- Paediatric transfers are rare but tricky
- ED staffing issues are affecting us
- Physician: Lack of Consultant input

Anaesthetic cover arrangement with CAH Anaesthetics
CAH 2nd on call consultant is contacted. Unsatisfactory arrangement.

Issues around it: Not immediately available 24/7 day time Sat/Sun, Trauma list. Difficult to contact when in theatre.

1 January 2014 – 31 December 2014
Total number of transfers 153.

Breakdown of transfers 2014

- CAH ICU- 94
- Ulster ICU- 8
- Antrim ICU- 7
- Belfast City ICU- 10
- RVH ICU- 17
- PICU- 6
- Mater ICU- 1
- South West Acute Hospital ICU- 1
- Altnagelvin ICU- Nil
- Causeway ICU- Nil

Transfer Teams
(Total Transfers= 153)

1. DHH Anaesthetist: 68 (45%)
2. NICCATS: 79 (52%)
3. CONNECT: 6

Staffing: Dr Aidan Cullen, Dr Ruth Ford, Dr Tim Bennett,

1 January 2015 – 31 December 2015
Total number of transfers 154.

Breakdown of transfers 2015

- CAH ICU- 92
- Ulster ICU- 7
- Antrim ICU- 3
- Belfast City ICU- 8
- RVH ICU- 16
- PICU- 20
- Mater ICU- 1
- South West Acute Hospital ICU- 1
- Altnagelvin ICU- 2
- Causeway ICU- Nil
- Others- 4 (1 to Dublin, 3 to London)

Transfer Teams
(Total Transfers= 154)

1. DHH Anaesthetists: 97 (63%)
2. NICCATS: 39 (25%)
3. CONNECT: 18 (out of 20)

	Summary • As compared to 2013 the transfer rate has gone up in 2014/15. • The number of Paediatric transfers in 2015 has gone up significantly as compared to Paediatric transfers in 2014. • The proportion of transfers undertaken by DHH Anaesthetists has increased more than 1.5 times as compared to transfers undertaken by them in 2013. • Reliance on NICCATs has decreased significantly • Despite such a higher number of patient transfers, the proportion of major critical incidents is close to nil and minor critical incidents are minimal as well. • Increase in the number of trained staff to facilitate such big number of transfers is essential • Provision of a second transfer trolley is desirable. • 24 hour Tech support (work in progress) **Discussion** The data was useful to inform and provide information to management of the number of transfers being undertaken and by which transfer teams. Over time the total number of transfers have increased and transfers involving the Daisy Hill Anaesthetics team have increased. Most of the transfers are medical transfers. Allied to this there has been an increase in the number of Daisy Hill Consultant Anaesthetists in post allowing a Consultant rota to be in place so fewer transfers will involve NICCATS. General discussion was further held on why there were delays in the NICCATs team arriving and this was felt to be due to the Doctor not being in the hospital for the NICCATs team to travel to Daisy Hill. Dr Tariq indicated that feedback has been given to NICCATs. Feedback received has indicated that those patients transferred from Daisy Hill are done so to a high standard.
(ii)	**Re-Audit Of Patient Blood Management In Adults Undergoing Elective, Scheduled Surgery 2016** **Methodology** Similar methodology to initial audit undertaken in 2015. Steps involved 1. Identify those patients who undergo surgery in September, October and November 2016. 2. Only include those patients who were transfused with red cells to meet inclusion criteria within the audit. 3. Having identified those patients having surgery in September and transfused, their case-notes can be audited in October, repeating that pattern for October and November patients if needed. Data collection will close about mid-way through January 2017 to allow plenty of time for audit and data entry. **Procedures** • Primary unilateral total hip replacement • Primary bilateral total hip replacement • Primary unilateral total knee replacement • Primary bilateral total knee replacement • Unilateral revision hip replacement • Unilateral revision knee replacement • Colorectal resection for any indication (open or laparoscopic) • Open arterial surgery e.g.: scheduled (non-ruptured) aortic aneurysm repair, infrainguinal femoropopliteal or distal bypass • Primary coronary artery bypass graft • Valve replacement +/- CABG • Simple or complex hysterectomy • Cystectomy • Nephrectomy • # neck of femur (arthroplasty)

Next steps

- Audit leads - Dr D Hull , Mrs P Watt,
  - Nominated lead from Surgery and Elective Care and ATICS to be identified
- Clinical staff to be identified to assist capture of data
- Data validation and approval to submit data externally required
- Data captured will be entered onto web-tool

Action: Nominated lead from Surgery and Elective Care and ATICS to be identified.

7 **Safety Inputs**

(i) **Resuscitation**

No cases presented.

(ii) **Microbiology - Antibiotic Stewardship – Dr M Brown**

Time Period	CAH Surgical % Antibiotic Choice Appropriate	DHH Surgical % Antibiotic Choice Appropriate
Jan - Feb 2016	77	66
Mar – April 2016	87	78
May – Jun 2016	87	82

The figures for adhering to guidelines in terms of antibiotic selection have shown improvement as the year has progressed. Please continue the improvement.

<u>Further figures for May-Jun 2016</u>

- % Indication recorded in CAH is 95%, in DHH is 96%
- Review of duration/review data recorded in CAH is 21%, in DHH is 39%
- Appropriate review needs in CAH is 76% , in DHH is 70%
- Please ensure that reviews and planned durations /review dates are better documented

- Required by NICE medicine practice guidelines
- Rounds across all areas of the Trust
  - Medicine
  - Surgery
  - O&G
  - NNU
  - Paediatric (2 yearly only at present)
- Rounds in all areas of the Trust, not just the acute sites

- Vital for 2 main reasons:-
  - 1) Individual patient safety
    - Risk of *C.difficile* and other side effects
    - Ensure sufficient treatment
  - 2) Prevention of development of antibiotic resistance
    - A global problem but also a local problem
    - Broad spectrums given unnecessarily can lead to the development of antibiotic resistance and select out resistant pathogens
    - Rising resistance can lead to a vicious circle of increasing broad spectrum prescribing and increasing resistance
    - Very limited new anti-bacterials due to poor return economically for drug companies

- Data discussed regularly at AMST Team Meetings
  - Allows focus of AMST attention on areas of low compliance
  - Allows identification of areas when guidelines may need reviewed or where education is needed
- Reviewed at the Antimicrobial Team Meeting
- Discussed at the Trust HCAI Strategic IPC Forum
- Report given to Trust Board

	• Data produced on a consultant level basis – Limitations recognised – Safety goal to ensure no significant outliers – Potential for action if persistent outlier from peers (can also lead to identification of other team members not following guidelines) • Marking Down – Do not get marked down if outwith guidelines provided reason is justified and documented – Poor documentation is one of the biggest reasons for being marked down – Individual decisions re marking down can be challenged by consultants however it is overall trends and comparison with peers that the AMST is looking at – The AMST will be concerned with areas where standards are falling over time and individuals whose figures are persistently worse than their peers rather than individual consultant monthly figures • If there is disagreement with guidelines please contact the AMST to discuss them • Areas for further development:- – T&O – 1N (First round has occurred) – Haematology (To get more regular data from official rounds in addition to weekly meeting) – ICU (To get regular AMST rounds in addition to daily microbiology rounds) – ED (Planned) – Further paediatric rounds (In discussion) **Discussion** Dr Brown reported that the data for this year have showed encouraging trends and encouraged staff to keep the trend on an upwards path. Dr Brown highlighted the importance for staff to review the duration and review dates of antibiotic prescribing and to improve documentation around this especially post procedure / post drainage. Dr Brown noted that a gram negative audit is currently being undertaken. Dr Brown was asked if this could be shared when the data and results were available.
(iii)	**Learning from Medication Incidents April 2016 - J Redpath (Unable to attend)** **Omitted/delayed medicine** ***Patient discharged on donepezil and other medicines which were prescribed however donepezil was also entered as a discontinued medicine on the same discharge prescription. This was then discontinued by GP until the patient was readmitted the following month and omission noted.*** ✓ To remove an item from the 'discontinued' section of the electronic discharge prescription: click the tick box under column 'Admission' at the right hand side of the greyed out line for this medicine. A message will appear 'Are you sure that you want to change this drug to be a non-admission drug? Click 'OK'. The medicine will still show in the medication field but will not appear in the discharge summary. ***Patient usually on Lantus® insulin 28 units with breakfast. No insulin prescribed or administered. Blood glucose at tea-time was 21.8mmol/l and patient required STAT doses of NovoRapid®.*** ✓ Prescribe insulin each afternoon for the next 24 hours. ✓ On admission, assess patients for involvement in the administration of their insulin in hospital and encourage them to prompt staff 15 minutes before a dose is due. **Contraindicated medicine** ***Patient on rivaroxaban, prescribed enoxaparin and administered both.*** ✓ Before prescribing enoxaparin, check regular medicines to confirm patient is not on an

	anticoagulant. **Wrong frequency** ***Patient prescribed and administered enoxaparin treatment dose (1.5mg/kg) in ED at 20.00. Patient then transferred to another ward and administered enoxaparin treatment dose prescribed on Kardex at 02.00.*** ✓ Check the ED flimsy for all patients transferred to confirm what medicines have been administered prior to transfer. ✓ Where a STAT dose has already been administered for a medicine that is then prescribed regularly, enter '8' in the administration record if the first dose of the prescription should be omitted as already given. **Wrong dose** ***Patient usually on warfarin 1mg every day except 2mg on Saturday. INR had been erratic during admission. Patient discharged on 2mg daily and district nurse arranged to take blood sample however clinic that dosed the patient was not informed of discharge. Patient's daughter telephoned clinic to advise patient had nose bleed. INR when checked was >8.*** ✓ Use the dose adjustment charts on the reverse of the anticoagulant chart to guide dosing. ✓ On discharge, an appointment must be made with the clinic or GP, whoever doses the patient for further management.
(iv)	**HCAI / Infection Control / Antibiotic ward round** Antibiotic ward round summaries for June and July 2016 will be attached to the minutes.
8	**Any other business**
(i)	**Consultant CLIP reports Mrs S Hanna Assistant Director of Informatics** (Full presentation available from Corporate Governance) **Overview** • HSC Improving Data Quality (Permanent Secretary - June 16) • Trust's current approach to data quality management • Risk areas and Actions **HSC Data Quality Paper** • Joint DHSSPS and HSCB • Responsibility – Trusts, HSCB, DHSSPS, PHA, BSO • Trusts asked to take necessary action to address these priorities **What is The Trust's current Data Quality approach and response to this paper?** **Culture and Ownership** Ownership: A commitment of the head, heart and hands to fix the problem and never again affix the blame" (John G Miller) • Awareness raising • Self-service data quality monitoring • Responsibility for cleansing and fixing needs be at the source of the data input. **Routine Monitoring** "Nothing exceptional was ever accomplished without positive mental attitude, enthusiasm, hard work, perseverance and monitoring." (David Gyimah Boadi) • Self-service DQ monitoring • Central monitoring and stewardship **Cleansing and Fixing** **"**Housework is something you do that nobody notices until you don't do it" Author unknown • Responsibility – at point of data input • Verify details at point of contact • Active central cleansing and exception reporting by DQ Team

	Suggestions • Is validation of CLIP reports a 1st step in understanding potential gaps and anomalies? • Should we issue a Questionnaire to help us understand? • Are there specific issues you are aware of that we can start to address? • Any other ways of doing this? **Discussion** This is a first step in the process of validation reports. It was agreed that a questionnaire be issued to identify the best approach to take and to identify any issues. Concerns were raised about the relationship / mapping between PAS and ECR. Mrs Hanna to follow up on this matter. **Action:** Mrs Hanna.
(ii)	**Regional Morbidity and Mortality Reporting System- Medical Director – Dr R Wright** Dr Wright provided an update on progress regarding the electronic Regional Morbidity and Mortality Reporting System (RMMS). This system will be introduced in 2017 however some elements are required by Trusts before this new system becomes live. Dr Wright noted that the Southern Health and Social Care Trust have made good progress in preparation for this change and are further ahead than most Trusts regionally. When the new electronic system is operational, there is the facility for the system to drill down to the level of an individual Consultant. There are some outstanding elements at this point for the Southern Health and Social Care Trust and these relate to addressing the backlog of mortality cases. Further ongoing engagement is needed.
(iii)	**Audit Calendar for M&M in 2017– Medical Director – Dr R Wright** Dr Wright reported that the plan is to follow the Regional GAIN audit calendar for 2017.
(iv)	**Blood Glucose Monitoring Chart SC insulin prescription and administration (≥14 years)** (Full presentation available from Corporate Governance) Awareness of this monitoring chart was raised at the meeting. This monitoring chart relates to patients admitted with pancreatitis and provides a tool to document and regularly update glucose measures.
(v)	**Outstanding Mortality Proformas** • A big THANK YOU for the efforts made to address this in July 2016 • All support with this issue is greatly appreciated – thank you.
(vi)	**Southern Trust Learning Letter: Neutropenic sepsis / head injury** This was shared at the meeting and will be attached to the minutes.
(vii)	**Bilirubin assay** See attachment **Action**: Information circulated by Dr Cullen to Chairs of Speciality PSMs .
9	**Date of future meeting:** Thursday 15th September 2016. (Speciality specific meetings)

Urology Department Governance Meeting Minutes. 18th October 2017.

1. Minutes of last meeting and matters arising
    a. Personal Information redacted by the USI Case referred from Medical M&M for Urology review.
        i. Presented by Ms Morrow on behalf of Mr Haynes. Patient died from sepsis related to advanced malignancy (myeloid sarcoma of uterine cervix) not renal failure as recorded. No other issues identified from discussion of the case at Urology PSM.

2. Audits Received
    a. MRI prostate audit Ms Morrow
    b. Project to be identified Ms Doherty

3. Morbidity & Mortality

Casenote	Health & Care Number	Surname	Forenames	Consultant on Discharge - Name	Corporate reporting only	Outcome 18/10/2017
Personal Information redacted by the USI				O'Brien A Mr / McAllister C Dr	IMMIX NOTE to be completed	Discussed. IMMIX NOTE completed
				O'Brien A Mr / McAllister C Dr	IMMIX NOTE to be completed.Case has been presented at Urology speciality specific M&M. Mr Glackin has advised case for next M&M.	No learning identified outside of Urology. Does not need further presentation.
				Glackin A Mr / McAllister C Dr	IMMIX NOTE to be completed.	Discussed. IMMIX NOTE completed
				Haynes M Mr / McAllister C Dr	Case has been entered on IMMIX NOTE however case to be enrolled and completed on NIECR by Consultant . Case discussed on 15/8/17	Case discussed & completed NIECR mortality pathway
				Glackin A Mr / McAllister C Dr	Case on NIECR. Awaiting Screening by M&M Chair	Case discussed & completed NIECR mortality pathway
				Glackin A.J Mr	Case on NIECR. Awaiting Screening by M&M Chair	Discussed. IMMIX NOTE completed
				O'Brien A Mr	Case on NIECR. Awaiting Screening by M&M Chair	Case discussed & completed NIECR mortality pathway
				O'Brien A Mr	Case on NIECR. Awaiting Screening by M&M Chair	Case discussed & completed NIECR mortality pathway

Personal Information redacted by the USI	O'Brien A Mr	Next urology meeting Oct 2017	Not discussed
	Haynes M Mr	Next urology meeting Oct 2017	Discussed. IMMIX NOTE completed

4. Complaints & Compliments
5. Learning from SAI's, DATIX etc.
6. Any other Business : Other issues relating to Clinical Governance.
    a. BCG pathway to be developed. Ms Doherty to lead.
7. Next meeting 15 November 2017 at 2pm Thorndale Unit CAH.

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

Minutes of a confidential meeting of Trust Board held on Friday, 27th January 2017 at 10.00 a.m. in the Boardroom, Trust Headquarters

PRESENT:

Mrs R Brownlee, Chair
Mr S McNally, Acting Chief Executive
Ms G Donaghy, Non Executive Director
Mrs P Leeson, Non Executive Director
Mrs H McCartan, Non Executive Director
Mr M McDonald, Non Executive Director
Ms E Mullan, Non Executive Director
Mrs S Rooney, Non Executive Director
Mr J Wilkinson, Non Executive Director
Mrs A McVeigh, Director of Older People and Primary Care Services/ Acting Executive Director of Nursing
Mr P Morgan, Director of Children and Young People's Services/ Executive Director of Social Work
Ms H O'Neill, Acting Director of Finance and Procurement
Dr R Wright, Medical Director

IN ATTENDANCE:

Mrs E Gishkori, Director of Acute Services
Mrs A Magwood, Director of Performance and Reform
Mr B McMurray, Acting 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)

APOLOGIES:

Mr F Rice, Interim Chief Executive

1. **CHAIR'S WELCOME**

Mrs Brownlee welcomed everyone to the meeting, particularly Ms G Donaghy, Mrs P Leeson and Mr M McDonald, the newly appointed Non Executive Directors.

The Chair congratulated the following on their recent promotions: - Mr S McNally, Acting Chief Executive; Mrs A Magwood, Director of Performance and Reform; and Ms O'Neill, Acting Director of Finance and Procurement.

The Chair reminded members of the principles of Board meeting etiquette and asked that mobile phones are turned to silent and laptops/IPads are to be used for accessing Trust Board papers only during the meeting.

2. **DECLARATION OF INTERESTS**

Mrs Brownlee requested members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 24th November 2016 were agreed as an accurate record.

4. **MATTERS ARISING FROM PREVIOUS MEETINGS**

i) Judicial Reviews and Coroner's Inquests – Enhanced support for Trust staff

Members welcomed the establishment of an internal working group to take forward strands of work.

5. **PROGRESS UPDATES**

i) Personal Information redacted by the USI

Mr McMurray referred members to the written update in their papers. In relation to the Judicial Review proceedings, Mr

McMurray confirmed that the Trust met with Senior and Junior Counsel on 15th December 2016 and has provided them with information to assist in their preparation of a responding Affidavit. He advised that Mr Gerry McAlinden has been instructed as Senior Counsel and Mr Barry Woods as Junior Counsel for the Trust and both are very experienced in these matters. The Chair asked Mr McMurray if he was satisfied that there was appropriate support for Trust staff to prepare for and during Judicial Review proceedings. Mr McMurray advised that it is senior staff who will be attending and they are well prepared. Additional support has been offered to them, but they do not wish to avail of this at this point.

Mr McMurray updated members on the Nursing and Midwifery Council (NMC) referral relating to one of the Home Owners, who Personal Information redacted by the USI. The NMC is now taking this forward as case review.

ii) Personal Information redacted by the USI

Mr McMurray verbally updated members on the current position. He advised that the gentleman has been transferred to Personal Information redacted by the USI for a period of assessment. There has been no confirmation as to whether the Judicial Review will be heard and he reminded members that this is based on the gentleman's solicitor's view that the Trust is obliged to provide a suitable secure accommodation bail address, which despite significant efforts, the Trust has been unable to secure. The Trust is attempting to procure a bespoke care package which is likely to be at a significant cost.

The Chair left the meeting for the next item.

6. MAINTAINING HIGH PROFESSIONAL STANDARDS (MHPS) EXCLUSIONS

Mrs Toal advised that under the MHPS framework, there is a requirement to report to Trust Board any medical staff who have been excluded from practice. She reported that one Consultant Urologist was immediately excluded from practice from 30th December 2016 for

a four-week period. Mrs Toal reported that the immediate exclusion has now been lifted and the Consultant is now able to return to work with a number of controls in place.

Dr Wright explained the investigation process. He stated that Dr Khan has been appointed as the Case Manager and Mr C Weir, as Case Investigator. Mr J Wilkinson is the nominated Non Executive Director. Dr Wright confirmed that an Early Alert had been forwarded to the Department and the GMC and NCAS have also been advised.

7. WAITING LIST INITIATIVES – RADIOLOGY

The Chair informed members of a letter she had received from the Radiology Department expressing their concern at the Internal Audit review of Waiting List Initiative Payments 2016/17. Dr Wright explained the scope of this assignment which was undertaken by Internal Audit at the request of the Trust to carry out a review of the payments made to the Consultants earning the most from WLI work within the Trust in the period 1st April 2015 to 31st March 2016. This review was set in the context of an initial review by the Trust following a FOI request and media coverage regarding WLI payments that identified the Southern Trust as having the highest WLI earners within Northern Ireland with one Consultant making it into the top 5 UK national list of highest earners.

Members were advised that the IA Report will be discussed at the forthcoming Audit Committee. Dr Wright explained that this has identified issues around the process and there appears to be a degree of confusion between payment for activity and payment for time, resulting in individuals being paid for more than they worked. The Trust has sought legal advice on the recovery of these alleged overpayments and DLS have indicated that to seek recovery would prove far from straightforward. The Department has been made aware of this situation and the Interim Chief Executive has submitted an application to the Department for approval for foregoing recoupment of these overpayments as they exceed the Trust's delegated authority. A response is awaited. Dr Wright stated that to pursue recovery of the overpayments may result in a number of resignations of Radiologists involved resulting in the Trust not being able to deliver on a substantial amount of clinical work. He spoke of the difficulties recruiting into this

team and stated that one Radiologist has already tendered their resignation. Mrs Gishkori welcomed a speedy resolution to ensure delays in reporting are minimised.

Mrs Rooney asked if this could be an issue in other professional areas where Waiting List Initiatives are undertaken. Mr McNally advised that the IA work included 2 General Surgery Consultants. Mrs Toal advised that the Assistant Director with responsibility for Radiology services in working through the IA recommendations is reviewing the other areas where WLI work was undertaken. Going forward, a more rigorous checking process will be put in place to ensure robust approval process is completed.

8. ENDOSCOPES

Mrs Gishkori informed members of an issue identified in the Endoscope Decontamination Unit at the Day Procedure Unit, South Tyrone Hospital when incorrect disinfectant was used in the machine to process the scopes. Mrs McCartan referred to the Root Cause Analysis proforma included in members' papers and stated that she felt this was not a useful paper in terms of outlining what the risks are. Ms Donaghy asked if patients have been informed at this stage to which Mrs Gishkori advised that a risk assessment needs to be undertaken for each patient on Endoscopy lists in STH between 9th and 16th January 2017 in order to identify the level of risk to others. Consultants are to complete this work by 30th January 2017.

Mrs Gishkori undertook to bring an updated paper to the next Trust Board meeting.

9. UNSCHEDULED CARE PRESSURES

Members discussed the briefing paper on unscheduled care pressures which provides an overview on demand and performance, as well as the operational and management responses in place and ongoing. The Chair referred to the challenge of medical capacity to support increasing demand and noted the relatively low baseline of medical staffing in the Southern Trust comparable to other sites. Mrs McCartan asked about the current status of elective surgery to which

Mrs Gishkori advised that similar to other Trusts, no elective surgery has been scheduled for routine patients from before Christmas and the situation is reviewed on a daily basis. Only red flags and the most clinical urgent surgery have been scheduled.

There was a short discussion on complex discharges in which Mrs McVeigh explained some of the challenges.

10. CORPORATE RISK REGISTER

Mr McNally presented the Corporate Risk Register. He stated that SMT had reviewed the register the previous day and agreed the removal of a number of risks. A revised Corporate Risk Register will be presented at the Governance Committee meeting on 2nd February 2017. Mr McNally advised that the SMT has agreed to do a review of the Corporate Risk Register and members were asked to forward any comments in terms of format. Ms Eileen Mullan agreed to attend a future SMT to facilitate discussion.

11. Personal Information redacted by the USI CARE HOME

Mrs McVeigh spoke to the briefing paper, advising that South Eastern Trust are the Contract Owners for the Home and the Southern Trust has three Trust residents in this care home. Allegations of poor care were reported to the local media and a safeguarding alert was raised with the Southern Trust on 12th October 2016 in respect of an alert to South Eastern Trust. Following this, the care of the three Trust residents was reviewed . Five Contract Compliance notices have been raised in respect of all 3 Southern Trust residents in the home since October 2016. The Trust Specialist Nurse for Older People has been working in partnership with the Home to address the issues raised. One family has decided to move their relative to another home and the Trust is assured that the two remaining residents have care plans in place.

Mrs McVeigh informed members of a decision by Personal Information redacted by the USI Nursing Home in Personal Information redacted by the USI to a voluntary cessation of services. There are 26 Trust residents in the home and the Trust is starting the process of relocating them in line with its contingency plan.

12. [redacted] **PRACTICE**

Mrs McVeigh advised that the Trust has agreed to take on the General Medical Services (GMS) contract for the [redacted] Practice in [redacted] for a temporary period. The Trust held an initial meeting with the non-medical workforce at [redacted] the previous day, also attended by the HSCB and Staff Side representatives.

Mr McNally advised the Trust had received a letter from the Health Minister asking the Trust to seriously consider taking on the GMS contract for the longer term (letter dated 25 January 2017 circulated at the meeting). The Trust will be meeting with the HSCB to further discuss.

13. **BREACH OF STATEMENT OF PURPOSE –** [redacted]

Mr Morgan advised that the Statement of Purpose for this Home outlines service provision for those age [redacted]. This was breached in November 2016 in order to admit [redacted] old and Mr Morgan explained the reasons why.

14. **LETTER TO PERMANENT SECRETARY RE FINANCE**

Members noted the content of a letter to the Permanent Secretary dated 18th January 2017. Mr McNally stated that in light of the current financial position and most particularly the assumption that the Trust will not have an agreed budget for 2017/18, it was now appropriate to formally raise the Trust's concerns on its ability to maintain existing services and, at the same time, breakeven. There was a short discussion on the fact that the Trust will open the new financial year with a recurrent deficit of £20.6m.

Mrs McCartan asked how soon would work commence on a recovery plan to which Mr McNally advised that the SMT has commenced this process.

Mr McNally, Mrs Magwood and Ms O'Neill left the meeting for the next item.

15. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair advised that the Remuneration Committee had met earlier that morning and made the following recommendations in respect of Senior Executive Remuneration:-

1. Acting Chief Executive - a [redacted] uplift for Mr McNally;
2. Director of Performance and Reform – a [redacted] uplift for Mrs Magwood;
3. Acting Director of Finance and Procurement – a [redacted] uplift for Ms O'Neill

Trust Board approved the Remuneration Committee recommendations.

16. **ANY OTHER BUSINESS**

i) **ED, DHH**

Dr Wright updated members on developments. He advised that the Trust's recruitment process for the Consultant ED post at DHH was unsuccessful, despite an enhanced recruitment and retention package being offered. The current permanent staffing is 1 Consultant with the vast majority of middle and senior staff being locum employees. A GMC regional inspection is due in March 2017 and if the level of Consultant supervision does not meet the required standards for a sustainable service, there is the potential that training posts would be removed.

The meeting concluded at 11.45 a.m.