		retired and returned to provide some additional support for Covid – this has enabled enhanced support in Psychiatry, Emergency Medicine, Medicine DHH, Clinical Psychology and ICU.		

Additional Actions Planned and Timescale

- Undertake a more detail look at our recruitment/vacancy data to establish a statistical summary of our recent appointments, remaining vacancies, comparison in fill rate etc. to facilitate a review of this particular risk to be determined. We believe our data evidence may allow us to review the current risk level attached to this concern. Anticipated timescale for review: 31 May 2020.

- We have received some really positive feedback from SAS and Junior doctors in DHH confirming that the new Physician Associates have had a really positive impact. We now need to explore how this model can be replicated on Craigavon site. The next batch of PA students will be due to qualify April 2021. Consideration can also be given to rotation across both sites.

- There is a need to explore options with NIMDTA around the sharing of data in relation to numbers of doctors by sub specialty who are attaining CCT awards locally each year to help us better prepare our recruitment advertising. This is only available by ad hoc request at present – but we would be keen to have this routinely. This could also feed into an update report (which we hope to produce) of the age profile of our medical staff to aid workforce planning.

CORPORATE OBJECTIVES: PROMOTING SAFE, HIGH QUALITY CARE; MAKING BEST USE OF RESOURCES; BEING A GREAT PLACE TO WORK – SUPPORTING, DEVELOPING AND VALUING OUR

STAFF				
Likelihood: Possible (3) **Impact: Major (4)** **Total Score: 12** **Risk Rating: High** **Previous Score: 12**		**RISK OWNER: Medical Director & Director of Human Resources and Organisational Development** **DATE RISK ADDED: November 2019** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
4	Risk to safe high quality care due to a high volume of locum engagements for different periods of time with varying levels of experience/training and often in hard to fill posts	• Centralised Medical Locum team now part of Integrated Medical HR team to create better joined up approach for: - Identifying issues/areas of concerns - Long term locums and recruitment linkages - Electronic "mini personnel" files for all locum doctors engaged in Southern Trust • Protocol for engagement of Medical and Dental Agency Locums in place to standardise locum booking processes. • The Department of Health /NIAO have advised Trusts regionally to complete audit of pre-employment checks to assure themselves standards are upheld. The Southern Trust has a plan in place to complete these audits. Results will be included in Controls Assurance	Head of Medical HR	Protocol document Letter to Trusts dated 5.8.2019. SH&SCT Audit Plan of pre-employment checks

		documentation. • Procurement and Logistics Services (PALs) have advised that an audit of selected contracted agencies on the current Medical Dental Framework will be carried out to ensure all checks are being undertaken. • A standard monthly report setting out all the locums currently engaged is issued on a monthly basis to relevant Associate Medical Director to improve visibility and facilitate better monitoring of placements by the service. • New Deputy Director for Workforce now in post.		

Additional actions and timescales

1. Southern Trust has drafted new guidance for managers to set out how to manage performance concerns associated with locum doctors. This has already been shared with the GMC and a meeting has been arranged with the GMC Liaison representative to gain their endorsement of this document. The final authorisation and sign off of this document has been delayed due to the onset of Covid. It is hoped this can be revisited and agreed with GMC/AMDs within the next few months.
2. Need for new Deputy Medical Directors to review the Trust governance arrangements for the engagement of locum doctors.
3. There are ongoing discussions regionally seeking a review of the regional rates of pay for locum doctors both internally and via locum agencies. This aim is to ensure we have regionally agreed reasonable rates for doctors to encourage more doctors to pick up work via our medical locum bank and reduce our reliance on agency.
4. The Medical Director and Medical HR are involved in reviewing the mandatory training requirements for locum doctors and exploring methods to strengthen the induction process for this group of doctors.

CORPORATE OBJECTIVE: 1: Promoting safe, high quality care.

Likelihood: Almost certain (5) Impact: Moderate (3) Total Score: 15 Risk Rating: High Previous score: 15	RISK OWNER: Director of Older People and Primary Care DATE RISK ADDED: Re-added June 2019 TIMESCALE FOR REVIEW OF CONTROLS: Monthly			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
5.	There is a risk that the Trust may not be able to deliver a full, timely, Out Of Hours service (OOHs) due to difficulty filling all rota GP sessions.	**Service delivery planning** • Advanced rota planning, daily reviewing contingency actions for GPs, nurses & Operational staff. • Requests via SMS / emails and telephone calls to GPs, Nurses to assist with workload. • Datix system in place to record clinical incidents – monitoring and investigations as per policy • Complaint investigation and sharing of the learning as per policy • Monthly clinical meeting with Medical Managers, Nurse Team Lead and HOS, chaired by Clinical Lead. • Regional OOHs	Head of Service (HOS) OOHs HOS OOHs HOS OOHs HOS OOHs Clinical Lead OOHs AD Enhanced	Through emails, use of the Harris system, Datix system Minutes of meeting Minutes of meeting

		meeting every quarter • SHSCT and HSCB Performance / Governance meeting every quarter • Home triage for GPs embedded in cover as advanced forward planning rather than reactionary to lengthy triage waits. • Urgent and essential appointments only (no longer seeing routine cases). • Board Assurance Paper submitted to SMT and meeting held with HSCB on 21 June 2019 when the paper was discussed. • Nurse advisors to undertake urgent triage in May 2019. Nurse performance will be monitored • Senior Managers are engaging with the Urgent and Emergency Care review team **Staffing/Resourcing**	Services AD Enhanced Services HOS OOHs HOS OOHs HOS OOHs HOS OOHs HOS OOHs HOS OOHs	Minutes of meeting Daily plans Daily plans Paper developed Daily plans Minutes of meeting, emails Daily plans

		• Dalriada provides nurse triage from 12midnight to 8 am Sunday to Thursday. SHSCT Nurse Triage on Friday and Saturday.		
		• Nurse triage incorporated into the clinical cover.	HOS OOHs	Daily plans
		• The pharmacy service is now embedded.	HSCB	Daily plans
		• Recruitment of GPs for salaried sessions and ongoing recruitment of "as and when" and salaried GPs	HOS OOHs	Recruitment of GPs
		• 4th round recruitment of nurses advisors has taken place (January 2019)	HOS OOHs	Completed recruitment of nurses
		• The Local Enhanced Scheme in place from 17/18 and for 18/19 and again in 19/20.	HOS OOHs	Emails, use of Harris system
		• KPIs monitored hourly and reported daily by HSCB to providers.	Clinical Lead OOHs	Emailing of performance and corporate dashboard
		• 2019/20 Trust additional costs scheme implemented with a specific element to encourage GP clinical cover on Saturday afternoons and evenings;	HOS OOHs	Quarterly report on hours and costs

		enhanced rates for Friday evening		
		• Medical management structure in place.	Clinical Lead OOHs	Documented management structure
		• Performance management of GPs/ Nurses and pharmacists in place	Clinical Lead OOHs	Performance reports
		• GP Clinical Forum established	Medical Director	Minutes of meetings
		• Education programme completed for GPs FY0 programme completed May 2019	Medical Director	Harris system, and emails
		• "Odyssey" decision making software for nurse triage.	HOS OOHs	Minutes of meeting
		• Flexibility in shift hours and bases offered.	HOS OOHs	Emails, use of Harris system
		Escalation		
		• HSCB unscheduled escalation plan implemented on 06 May 2016.	HOS OOHs	Early alerts
		• Escalation of unfilled sessions to on call manager when service is operational	HOS OOHs	Call recordings
		• Board Assurance briefing paper raising potential options for discussion shared with Commissioners in May 2019	AD Enhanced Services	Paper can be provided
		• Complete and escalate	Director OPPC	Completed early alerts

		the Early Alert to HSCB and DOH **Communication:** • Engagement with service users through Facebook/ Twitter /Advertising campaigns, MLAs and local newspapers to promote effective use of service. • Safety netting information advice to Service Users on initial communication to contact service again if symptoms deteriorate/ condition changes. • Engagement with LMC – meeting held on 20 June 2019.	HOS OOHs HOS OOHs AD Enhanced Services	On social media Call recording audit Minutes of meeting
Additional actions planned and timescale				
• The GP OOHs service has an action plan in place which includes measures to control the risk (March 2020) • Meeting organised with MHD services to look at direct referral pathways to OOHs Mental Health Services • Scope use of PGDs to allow Nurse Advisors to dispense medication in certain conditions rather than replacing case for triage with GP				

CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Almost Certain (5) **Impact: Moderate (3)** **Total Score: 15** **Risk Rating: HIGH** **Previous Score:15**		**RISK OWNER: Executive Director of Nursing , Midwifery and AHP's** **DATE RISK ADDED: April 2015** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
6.	**i) There is a risk to the consistent provision of high quality nursing care due to a shortage of Registered Nurses and Midwives across all Directorates within the Trust.** **Workforce update considering Covid19**	1. Escalation processes are in place within each Directorate to respond operationally to immediate Registered Nurse shortages 2. Safe care implemented across all acute wards in Craigavon and Daisy Hill Hospitals as part of HealthRoster. Further implementation of HealthRoster into Bluestone in-patient wards. 3. Measures to improve the efficacy of Roster by system users to maximise staff utilisation eg. Project board, divisional meetings Policy and standard operating procedures, and the establishment of monthly reports to Acute and Mental Health Directorate. **(paused)** Audit recommendations are also almost complete 4. Key actions regarding recruitment,	Directorate Assistant Directors Interim Assistant Director Nursing Workforce and Education Interim Assistant Director Nursing Workforce and Education	Twice daily review at operational patient safety meetings. Health Roster data Health Roster data

		retention and utilisation of current workforce being progressed through Nursing and Midwifery Workforce Action plan and relevant workstreams. **(paused)**	Interim Assistant Director Nursing Workforce and Education/Directorate Assistant Directors	Action Plan
		5. Use of bank and agency to support required staffing levels. Currently reviewing processes to maximise the use of Bank including open registration to Nurse Bank as well as progressing an action plan regarding strengthening governance processes.	Nurse Bank Manager Head of Resourcing Interim Assistant Director Nursing Workforce and Education Interim Assistant Director Patient Experience and Quality	HR reports, Bank and Agency reports
		6. International recruitment continues with expected arrivals anticipated to increase over the next number of months. Regional business case commencing for further International Nurse Contract post 2020**. (paused)**	Interim Assistant Director Nursing Workforce and Education	International Recruitment reports
		7. Robust annual recruitment schedule planned for 2020. In addition, monthly advertisement for Band 2/3 and open advertisement for Band 5 continues. **(paused)**	Interim Assistant Director Nursing Workforce and Education	Recruitment schedule
		. 8. Recruitment activities, such as job		

		Fairs, local and across the UK. Engagement with Southern Regional College and career fairs in schools and colleges. **(paused)**	Interim Assistant Director of Nursing Workforce and Education & Head of Resourcing	Executive Director of Nursing Directorate records
		9. SHSCT staff engagement with students, both within universities and whilst on placement, to encourage consideration of SHSCT as an employer	Executive Director of Nursing and Interim Assistant Director of Nursing Workforce and Education	Executive Director of Nursing Directorate records
		10. Preceptorship and induction programmes in place for new employees with optional rotation scheme for newly qualified staff Alternative methods of support being currently developed in light of social distancing measures.	Interim Assistant Director of Nursing Workforce and Education	Executive Director of Nursing Directorate records
		11. SHSCT continues to work with Department of Health to influence an increase to the supply of Registered Nurses	Executive Director of Nursing and Interim Assistant Director of Nursing Workforce and Education	
		12. Increase the numbers allocated to Open University training scheme for mental health and adult nursing inclusive of the overall increase in training places. OU has developed a pre-registration programme for Learning Disability Nursing, commencing September 2020. (Recruitment to this Programme continues for September 2020 cohort	Interim Assistant Director of Nursing Workforce and Education	DoH and Executive Director of Nursing Directorate training records

		commencement) 13. Due to ongoing ward reconfigurations operational teams are working on a daily basis reviewing staffing levels in line with bed occupancy. Healthroster reports being compiled to assist with decision making regarding staffing. 15. Surge Nursing workforce Critical care bed modelling carried out. To be repeated for potential second surge 16. Surge Nursing Workforce planning –non critical care wards principles agreed regionally 17. Deployment of year 3 Nursing and Midwifery students into practice for remaining 6 months of their programme 18. Transfer of International Nurses to Emergency NMC register	Operational teams linking in with Interim Assistant Director of Nursing Workforce and Education and Healthroster team Assistant Director ATICS & Interim Assistant Director of Nursing Workforce and Education Interim Assistant Director of Nursing Workforce and Education Interim Assistant Director of Nursing Workforce and Education and Practice Education Team Interim Assistant Director of Nursing Workforce and Education and Practice Education Team	Health Roster data Night report data CCaNNI Critical Care Services draft Surge Plan Non critical care draft paper

		18. Covid 19 Training needs analysis completed for all nursing and Midwifery staff. Clinical Education Centre delivered relevant courses 19. Nursing staff redeployed from services able to be stood down to support essential service areas to ensure maintenance of appropriate staffing levels . eg CYP , MH/LD , Acute and OPPC 20. New services / transfer of services completed to support COVID 19 effective management. eg creation of new Mental Health ED and transfer of DHH ED to CAH site . 21. A number of visits to nursing, midwifery and AHP's by the Executive Director of Nursing/Assistant Directors to ensure staff were well supported during this pandemic. Other methods of communication, eg video and email were utilized for this purpose also.	Head of Nursing & Midwifery Workforce Education and Development Directorate / cross directorate management Directorates Executive Director of Nursing and Assistant Directors	Clinical Education Centre SLA reports
	ii) There is a risk to the	• Directors Oversight group in place	Director of Mental	• Royal College Invited

	continued safe, high quality nursing care in Mental Health and Learning Disability In-patient Units. Bluestone/Dorsy and Gillis due to a shortage of registered mental health/learning disability nurses.	to oversee and co-ordinate actions from Royal College of Psychiatrists Invited Review • Regional policy position (Delivering Care) agreed for Bluestone and Gillis (not Dorsy) regarding safe nurse staffing levels, however, no funding attached • A medium to long term workforce plan is currently in development and will be presented to SMT. This will include proposals for senior on-call arrangements, management structures and development of senior clinical nursing roles. • Daily meetings with senior staff are conducted within Bluestone and Dorsy to manage patient flow and the movement of staff in response to need. • Use of flexible staffing, including bank, on-contract and off-contract agency staff ongoing in order to address unsafe staffing levels and maintain current bed numbers. • Increase in numbers of Band 6	Health and Disability; Executive Director of Nursing	Review report • Directors Oversight Group and sub-groups terms of reference and minutes • Delivering Care Phase 5a • Draft multi-disciplinary workforce plan • Draft IPT. On-call rota for Directorate implemented. . • Records of actions and daily staffing template • HR and Finance Reports • HR Reports

		staff across Bluestone, Dorsy and Gillis to work towards a senior staff nurse presence 24/7. • Ongoing engagement with staff side and staff • Implementation of Health Roster across Bluestone and Dorsy in the first instance by March 2020.	Assistant Director HROD	• Minutes of meetings and emails • HR live from December 2019
	iii) **There is a risk to the continued safe assessment and monitoring and provision of high quality nursing care in Mental Health and Learning Disability community teams due to a shortage of registered mental health, and learning disability nurses**	• Pressures monitored at a local team level by Team Lead and resources allocated on a prioritisation basis to address gaps brought about by vacancies • Pressures raised at both operational and governance meetings and shared with the work-force planning group of the Directors Oversight Group • Continued recruitment to vacant posts • Exploring the design and implementation of skills development framework for nurses at Band 5 to develop the competency of Band 6 nurses, modelled on an approach used by the Northern Trust.	Director of Mental Health and Disability; Executive Director of Nursing Acting Assistant Director Mental Health Heads of Service for respective teams	Staff in post and finance reports Minutes of meetings Monitoring of waiting lists in Primary Mental Health Care and specialist services Use of the Balance Score card for monitoring service priorities.

		• Participated in the Phase 5(b) Normative staffing project for Community Mental Health teams - awaiting approval at DOH level • Further Development of Community based services includes scoping of multi professional contribution to safe and effective care **Regional Actions** • Regional Workforce meetings with DoH • Regional meetings with RQIA • Ongoing HSCB/PHA led Regional Review of Acute Mental Health In-patient Beds and Models of care to support patient flow • Regional review for Learning Disability cross Trust placements in Acute Mental Health beds		

Additional Actions Planned and Timescale

1. Safe Care fully implemented in CAH and DHH sites. Requires further scrutiny of data and support from Directorate.
2. Recommendations from the Royal College of Psychiatrists have been considered and an overarching action plan developed. Progress will be monitored by Directors' Oversight Group.

CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE

Likelihood: Possible (3) Impact: Major (4) Total Score: 12 Risk Rating: HIGH Previous score: 12	RISK OWNER: Medical Director DATE RISK ADDED: June 2011 Reworded: August 2018 TIMESCALE FOR REVIEW OF CONTROLS: Monthly			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
7.	**Risk to patient safety due to the potential to develop a healthcare acquired infection**	1. IPC Strategy 2. Strategic and Clinical Forum meetings 3. Isolation of patients with transmittable infections and those who are immunocompromised 4. Robust handwashing processes 5. Comprehensive cleaning policies and procedures 6. Awareness of appropriate antibiotic prescribing 7. Working Group to progress IPC Strategy	Medical Director Relevant Operational Director Medical Director Lead Nurse, IPC Assistant Director – Functional Support Services Consultant Microbiologist Medical Director	1. Progress updates to Performance Committee 2. Provision of assurance at each Performance Committee meeting 3. Use of IPC checklist within ED. Policy on isolation of patients 4. Weekly presentation of audit data 5. Regular environmental cleanliness audits 6. Presentation of data on antibiotic usage 7. Progress updates to SMT
	Increasing emerging infections (CPE/VHF)	1. Ongoing ward rounds relating to antibiotic	Consultant Microbiologist	Presentation of data on antibiotic usage

		stewardship 2. Isolation and active screening of patients transferring from other hospitals, or history of admission within the last 12 months	Relevant Operational Director	Policy on isolation of patients

Additional actions planned and timescale
The VHF Management Plan is being progressed and is planned for completion by April 2020 pending regional confirmation of transfer of high risk patients. Deep dive at Governance Committee on 7.2.2019 highlighted areas where early intervention and mitigations could be strengthened. e.g. Targeted training via Trust Care Home Inreach Project for the Independent Care Sector and training for GPs on the antibiotic prescribing and infection control measures) *All IPC training for the IS Private Nursing Home sector is and will continue to be provided by the PHA. PHA is the host of the Regional Care Home In-Reach Project.* *Some GP training is offered through Microbiology and Pharmacy as well as what is on offer by HSCB and GP Federations on issues such as C diff and management of diarrhoea across primary and secondary care.*

CORPORATE OBJECTIVE: 1 – PROMOTING SAFE, HIGH QUALITY CARE

Likelihood: Likely (4) Impact: Major (4) Total Score: 16 Risk Rating: HIGH Previous score: 16	RISK OWNER: Director of Finance, Procurement and Estates DATE RISK ADDED: July 2018 TIMESCALE FOR REVIEW OF CONTROLS: Monthly			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
8.	Deterioration of exposed concrete on Daisy Hill Hospital building exterior, leading to detachment of concrete debris with a risk of loss of life / injury to service users, public and staff	1. Hammer tests carried out in October 2017 and March 2018 in order to remove loose debris. To be carried out on a minimum 6 monthly basis. 2. Temporary 'heras' fencing erected in order to create a barrier between the building and main pedestrian areas 3. Erection of scaffold (with brick catcher) and netting to underside of first floor level of phase one building in an attempt to help mitigate the risks caused by spalling concrete.	Assistant Director of Estates	1. Records available in Estates 2. Visible on site 3. Visible on site

Additional Actions Planned and Timescale

1. Regular inspections of the structure in the short term, removal of loose concrete and suitable concrete repairs as per Taylor & Boyd LLP Report (2018). It is noted that this will not mitigate the overall risk and deterioration will still occur.
2. 6 monthly hammer tests were initially being carried out until phase 1 works had been completed. The hammer test to phase 2 building has been put on hold by the operations team as there were issues with blocking blue light routes, however, after discussions with the MTC contractor, they have advised that the extent of the spalling to phase 2 buildings is significantly less than phase 1.
3. On 11.07.2018, SMT approved revenue funding of £400k to carry out interim structural repairs to the concrete heads and lintels as recommended by the Structural engineer. This work has now been completed and as a result it is hoped that this will afford the Trust 7-10 years to implement a long term solution involves over cladding and window replacement, to a value of circa £2,000,000). The initial plan was to conduct a review during September\October 2019 to establish if this risk could be downgraded. Due to other service pressures, this review has been postponed until early in the new calendar year 2020.

CORPORATE OBJECTIVE 1 – PROMOTING SAFE, HIGH QUALITY CARE

Likelihood: Likely (4) Impact: Major (4) Total Score: 16 Risk Rating: HIGH Previous score: 16		RISK OWNER: Director of Finance, Procurement and Estates DATE RISK ADDED: July 2018 TIMESCALE FOR REVIEW OF CONTROLS: Monthly		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
9.	Loss of electrical power (LV) to main CAH hospital block leading to a significant interruption to services with a risk of loss of life and/or serious harm to patient(s).	1. Competency of estates staff in carrying out emergency electrical switching and regular dummy runs do deal with various scenarios 2. Estates Operations have a formal CAH fixed breaker emergency plan in place and electrical staff have been trained in how to deal with various scenarios. Copies of the document have been placed in the main switchrooms 3. Presently, estates have an identical fixed breaker on site which can be fitted if there is a failure. This eliminates the 6 week delivery delay experienced in 2017. This breaker will still take at least 8 hours to fit once the switchboard was isolated. 4. Use of mobile phones if VOIP telephony system is lost	Assistant Director of Estates	1. Experience and training of Estates colleagues 2. Printed document in Estates office and electrical switchrooms 3. Spare circuit breaker on-site in Stores electrical switchroom. 4. Business continuity arrangements
Additional actions planned and timescale				

Phase 1a
New dual 2.0MVA transformers in Energy Centre (for future CT scanner).

If one of the fixed breaker in the Stores switchboard fails these transformers will provide a mains supply to Maternity & Ward-N. However, if there is another fault or general mains failure there will not be a standby generator to provide power.

To mitigate this risk, in the event of a fixed breaker failure and this transformer was called on, a mobile generator could be hired within a few days to provide extra resilience.
Approximate cost: £700k + 15% fees = £805k

Funding to be sourced from DOH in year 2018/19 – this element in now included in the business case for the CT Scanner

Phase 1b
New 2.0MVA generator in Energy Centre and internal fuel tanks.

This will provide standby generator power for the new transformers in the Energy Centre and give it the resilience necessary to be a clinically-rated supply.

Approximate cost: £800k + 15% fees = £920k

Funding to be sourced from DOH in year 2019/20.

Phase 1c
Replace Stores switchboard containing 4no. fixed breakers with a new board containing withdrawable breakers. This will require the switchboard to be isolated for one month and should only be done once the 2.0MVA transformers are installed in the Energy Centre and have standby generator backup.

Approximate cost: £115k + 15% fees = £132k

Funding to be sourced from DOH in year 2019/20.

A presentation was delivered to Department of Health colleagues to provide further understanding\clarity on the overall LV issue and this was received positively. CPD Estates were also present at the meeting and supported\confirmed the Trust's position.
A full business case was submitted to the DoH for review and following a series of queries from Departmental advisors some elements of the case have been revised to give further clarity and resubmitted early August 2019. The Trust secured £650k to help address some of the immediate issues and this work was all completed as at 31st March 2020. Negotiations are ongoing with DoH for the full investment.

CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES

Likelihood: Possible (3) **Impact: Moderate (3)** **Total Score: 9** **Risk rating: MEDIUM** **Previous score: 9**	**RISK OWNERS: All Directors** **DATE RISK ADDED: July 2011** **Reworded: August 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
10.	**i) Failure to comply with general procurement and contract management Department of Health guidance resulting in lack of assurance regarding VFM / risk of legal challenge**	**1.** Procurement Strategy and oversight by Trust Procurement Board, with agreed Terms of Reference. Reporting to Audit Committee from 2018/19 onwards	Director of Finance	1. Meets at least three times per year and provides Annual report to Audit Committee Annual monitoring of Direct Award Contracts by Audit Committee
		2. Use of COPEs by Trust – PALS and CPD - HP	Director of Finance	2. PALS and CPD – HP both attend Trust Procurement Board
		3. PALS KPIs reported quarterly to the Trust	Director of Finance	3. Minutes of meetings of Trust Procurement Board
		4. Internal audit assignments consider procurement and contract management arrangements in annual audit programme	Director of Finance	4. IA reports, minutes of Audit Committee meetings
		5. PALS liaison post in place, procurement advice and guidance available on	Director of Finance	5. CAG training – April 2018 Contract management

		sharepoint, training provided		training – Feb/March 2018 EProcurement training quarterly
	ii) Failure to comply with social care procurement guidelines 2018/19 resulting in lack of assurance regarding VFM/ risk of legal challenge / sector instability	1. Oversight by Trust Procurement Board, now reporting to Trust Board sub-committee from 2018/19 onwards	Director of Finance	1. Social care procurement standing agenda item on Trust Procurement Board
		2. Director of Older People & Primary Care member of regional social care procurement Board, reporting to Regional Procurement Board	Director of Older People & Primary Care/Director of Finance	2. Social care papers shared with Trust Procurement Board as appropriate
		3. Use of COPE by Trust – PALS - SCPU for <u>above</u> threshold procurement; in line with regionally agreed procurement plan.	"	3. PALS Head of SCPU attends Trust Procurement Board
		4. Trust has dedicated procurement officer who works under 'Influence' of SCPU for any agreed deviations from plan to meet local need	Director of Performance & Reform/Director of Finance	4. Internal procurement work plan in place
		5. Trust has Contract Initiation Documentation process in place to regulate award of contracts under threshold.	All Operational Directors	5. Protocol in Place
		6. New <u>under</u> threshold service contracts are being procured by	Director of Performance &	6.Internal procurement work plan in place.

		Trust staff under influence of SCPU. 7. Trust has engaged in regional process to influence development of guidance for approach to awards of contract under EU threshold. In lieu of agreed guidance, interim proposal submitted and agreed by Trust Procurement Board in March 2020.	Reform/ Operational Directors	7. Updates to Trust Procurement Board
	iii) Failure to manage social care /domiciliary care/voluntary sector contracts to ensure safe and effective care delivery to clients and VFM	1. Domiciliary Care Oversight Group in place to provide focus to domiciliary care specific contract management. 2. Professional Head of IS contracts for Domiciliary Care in Place to provide oversight on quality arrangements. 3. Independent Sector Governance group in place, cross programme and profession (finance, contracts, safeguarding, governance and operational) to review contract management issues in the regulated sector. ToR reviewed (Feb 2020) and new proposal developed for agreement. 4. Approach to guide consistent approach to performance management of contracts in place.	Director of Older People and Primary Care/ Director of Finance Director of Older People and Primary Care Director of Older People and Primary Care	1. Terms of Reference in place and Minutes of Meeting 2. Internal review/validation of payments in the domiciliary care sector conducted in 2017/18 for 6 largest providers. Process for overseeing quality and performance management in place 3. Terms of Reference in place and Minutes of Meeting 4. Standard Operating Procedures

		Workshop to review undertaken and new proposals being developed. 5. Director of Older Peoples Services member of regional Review Group and SHSCT local Review Group in Place to review learning from CoPNI report (Dunmurry Manor) 6. Action plan in place to consider learning from Console Review for voluntary sector	Director of Older People and Primary Care Director of Finance / Older People and Primary Care	5. Terms of Reference in place. Internal Trust review completed. 6. Action Plan

Additional actions planned and timescale

i) General

- Director of Finance will bring revised Procurement Strategy to Trust Board - completed
- Revision of controls assessment process for non pay commissioning in 2018/19 in line with DOH circular – March 2019- completed
- Development of composite KPIs for procurement, including Pharmacy, Estates and Social care – 2018/19 workplan. These KPIs have been agreed at Regional Procurement Board and are currently being reviewed for implementation at Trust level.
- Investment in contract management staff remains outstanding and this will be considered for investment in 2019/20 once the Trust has clear sight of its total allocations for the year ahead. Finance and Planning are working with all Directorates to understand current requirements for contract management with a view to presenting a paper at SMT for consideration. This work is progressing well and a paper is expected in January 2020. A paper proposing a number of recommendations on the way forward was presented at SMT on 4th February 2020, full approval for the action plan and investment was secured.

ii) Social Care

- Trust to develop approach to below threshold procurement, in the absence of regional guidance – completed and approved by Trust Procurement Board March 2020. Work plan for next 18 months to be developed.

iii) **Social care /domiciliary care/voluntary sector**

- Work to examine potential use of benchmarking to establish VFM in social care contracts ongoing
- Review of structures for oversight groups, including Terms of Reference, - completed February 2020 for consideration by SMT

iv) PPE and COVID19

- Finance Directorate are working closely with BSO PaLs and the PPE regional supply cell in an effort to secure sufficient PPE and feeding into the regional model
- Trust has now put in place a completely new logistical process to ensure receipt and distribution of 1.5m pieces of PPE a week
- Additional governance procedures have been put in place for those non-Trust facilities in receipt of PPE from the Trust

CORPORATE OBJECTIVE: Making Best Use of Resources

Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: Medium** **Previous Score: 12**	**RISK OWNERS: Operational Directors** **DATE RISK ADDED:** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
11	i) Breach of statutory duty of break-even in-year	1. Financial Strategy will be developed and agreed with Directors for 2020/21	Director of Finance	1. Monthly financial performance detail reports to all budgetholders. Monthly reporting to SMT, Trust Board, HSCB and DoH
		2. Formal financial monitoring system in place including forecasting year-end outturn	Director of Finance	2. Monthly monitoring returns prepared for issue to DoH and HSCB
		3. Chief Executive accountability meetings with Directors at least 3 times annually	Chief Executive	3. Minutes of meetings and agreed action plans
		4. Monthly financial accountability meetings between budget-holders and finance	All Directors	4. Minutes of meetings and agreed action plans
	ii) Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support.	1. The continual update of the Trust's recurrent deficit and reporting of same to HSCB/DoH	Director of Finance	Trust Delivery Plan, Monthly monitoring returns, Board Papers
		2. Work will commence on the financial strategy for 2020/21 on	Director of Finance/ DoH/HSCB	Minutes of SFF and DoF

		receipt of confirmation of the allocation re same		

Additional actions planned and timescale

i) Breach of statutory duty of break-even in-year

- Indicative allocations for the financial year 2019/20 were received and Directors of Finance were asked to submit their assessment of these allocations on their Trust's financial position. The initial assessment indicated an unresolved gap of some £3.6m, however, since this original submission, the Trust has submitted a balanced financial plan for 2019/20.
- Finance carried out a mid-year hard close – October/November 2019 – the purpose of which was to inform the finance strategy for the remaining months of the financial year. The outcome of this work highlighted no significant issues.
- External interim audit was also concluded in February 2020 - no significant issues to report.
- Work has commenced on preparing the draft final accounts for the financial year 2019/20, these are due to be submitted on 26th May 2020. The Director of Finance can report that, whilst, this is still work in progress, there is sufficient to support the view that we should once again be reporting a balanced position for 2019/20.
- The Director of Finance, prepared a paper "Return to Balance" – this document reminded all of the Trust's statutory duty to break-even and that as a Trust we do not have the authority to spend in excess of the budget. It set out a work plan to commence in the Acute Directorate initially and then all other Directorates. The aim is to achieve best value for money and the fair and effective use of our resources. Initial findings were presented to SMT during November 2019 and work is ongoing to produce the final out-workings of the review carried out in Acute. Director of Finance anticipated being in a position to present the final acute findings to SMT during late February 2020\early March 2020, however, this has been delayed as a direct consequence of COVID19, Revised time-line is now June 2020.

ii) Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support

- Director of Finance is continuing to work with HSCB and Department of Health in relation to the capitation inequity gap. Work during 2017/18 financial year secured a nil general savings target for the Trust going into 2018/19. Indicative allocations for 2019/20 also confirmed that once again the Trust was successful in ensuring that it will not be targeted with its business share of the overall regional efficiency target, almost £45m for the region and if it had been applied to the Trust it would have totalled £7m. All Directors continue to raise this with professional leads at HSCB/PHA and Department of Health – Ongoing.

- Director of Finance had a meeting with the DoH during March 2019. This meeting was productive and secured the DoH commitment to work with the Trust on a longer term plan.
- Director of Finance sought DoH approval for capitation to be discussed at the Strategic Finance Forum in November 2019 – a healthy debate took place and DoH agreed that whilst they had endeavoured to address some of the imbalance by not applying a savings target, the gap remained. A meeting is being arranged between DoH and Director of Finance to discuss more fully.

CORPORATE OBJECTIVE: 1 – PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: HIGH** **Previous score: 16**		**RISK OWNERS: Director of Acute Services; Director of Children & Young People's Services; Director of Mental Health and Disability Services** **DATE RISK ADDED: November 2010** **Reworded: August 2017** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
12	**Clinical risk associated with inability to manage patient care within clinically indicated timescales.** Impact of COVID-19 has and is likely to increase this risk further due to downturn in activity and impact of social distancing restrictions. **Risk associated with:** **i) inability to diagnose/assess/treat new red flag and new urgent patients within clinically indicated timescales**	Assistant Director and Heads of Service meetings Monthly Directorate SMT Performance and Governance meetings for escalation and review of risk management Quarterly External Performance meetings with Health and Social Care Board to account for performance and highlight risks in relation to patient safety and long waits 1. Prioritisation of capacity to red flag and urgent demand in the first instance 2. Mechanism in place for triage and identification of red flag and urgent new patients	Heads of Service/ Assistant Directors Director and Assistant Directors Director and Assistant Directors Assistant Directors Heads of Service	Notes and actions from meetings Reports, minutes and actions from meetings " Recorded in notes of SMT performance meeting and Trust Board performance report SMT challenge Triage outcomes recorded on Clinical system and hard copy

		3. There are mechanisms to monitor at patient tracking level, red flag referrals and agreed process for escalation	Operational Service Leads/Heads of Service	Cancer tracking team escalates via email to Operational Service Leads/Heads of Service at each stage of the 62day cancer pathway for those patients who are not progressing and may breach. Each breach is discussed at the monthly cancer performance meeting
		4. Monthly Assistant Director Cancer and Divisional Performance meetings to review/escalate situations where risk presents in managing patients within their clinically indicated timescales. Risk Assessments completed as appropriate and options developed for management of same.	Heads of Service/Assistant Director	Divisions have submitted non recurrent bids to address these backlogs. It is discussed on a monthly basis with the each division and the performance team.
		5. There are mechanisms to monitor the waiting times for new urgent patients.	Operational Service Leads/Heads of Service	Weekly/monthly waiting list reports circulated Operational Service Leads for review
		6. There is a mechanism in place to ensure that a risk assessment is undertaken prior to cancellation of urgent or red flag patients. Cancellation avoidance is the first consideration.	Assistant Director	There is Acute Guidance for the cancellation of patients. Daily process for managing elective activity in the context of unscheduled care pressures - including framework for

				considering cancellation of elective activity and "Code Black" Process Flow for cancelling Elective activity Monday-Friday. Email communication of decisions re cancellation and rescheduled. All cancellations maintained on database
		7. Monitoring of cancellations of urgent or red flag patients – inpatient and day cases	Assistant Director	Live database tracking cancellations and rescheduled date
	ii) Review or planned assessment/treatment waiting beyond the clinically indicated timescales Impact of COVID-19 has and is likely to increase this risk due to downturn in activity and social distancing restrictions.	1. There are mechanisms in place to allow clinicians to categorise reviews into urgent and non urgent for assignment to appropriate waiting lists to facilitate booking those who most need their review	Individual clinicians	Separate waiting lists on PAS for routine and urgent. Clinical outcome sheet in place.
		2. There is monthly monitoring information in place to assist with oversight and identify and escalate those requiring prioritisation	Operational Service Leads/Heads of Service	Report produced by Operational Service Leads for Head of Service review and circulated to individual clinicians as appropriate
		3. Monthly Head of Service Specialty meetings to review/escalate situations where risk presents in managing patients within their clinically indicated timescales. Risk assessments undertaken as appropriate. Additional capacity prioritised as available.	Head of Service/Assistant Directors	Minutes of Head of Service meetings

		4. Action Plan being developed to consider improvements which can be made and need to consider alternative models of care delivery e.g. teleconference/ videoconferencing to facilitate patient assessment & review and associated policies will need to be updated to reflect this change **<u>CHILDREN AND YOUNG PEOPLE'S SERVICES</u>** 5. Review of clinical templates to seek to re-balance demand for review and new patients to manage risk 6. Analysis of new to review ratios and current review practice to assure best practice	Head of Service/Assistant Directors Head of Service/Assistant Director (CYP) Head of Service/Assistant Director (CYP)	Acute SMT Performance Minutes Project work ongoing Project work ongoing
	iii) Reporting of diagnostic testing beyond the clinically indicated timescales	1. Prioritisation of capacity to accommodate red flag and urgent reporting in the first instance 2. There is a mechanism in place for identification of red flag and urgent new patients 3. Additional contracted capacity for reporting in place - imaging 4. There is weekly and monthly monitoring information in place to assist with oversight and identify key areas where diagnostics	Head of Service/Assistant Director/Clinical Director/Associate Medical Director/ Operational Service Lead	Minutes of Radiology Thursday afternoon meeting IS contracts are used to manage the scanning and reporting times and where necessary we can access this to manage investigation and reporting time. Minutes of Radiology Thursday afternoon meeting Minutes of Radiology Thursday afternoon meeting

		remain unreported and escalate those requiring prioritization		

Additional Actions Planned and Timescale

Non-recurrent funding as available will be allocated to provide additional in house and Independent Sector activity to areas to address the risk associated with inability to manage patient care within clinically indicated timescales. Areas of risk will be escalated to SMT with a view to increasing capacity at financial risk.

The Trust will continue to re-direct any available internal resources to areas of greatest risk

Ongoing engagement with clinicians in respect to what is a clinically acceptable wait for red flag/urgent patients

Acute SMT performance meetings are utilized to discuss escalations from divisional meetings and to review actions required.

Work ongoing to implement an action plan to address those waiting longer than clinically indicated timescale for review

COVID factors:

- Impact of COVID has further reduced total capacity for elective activity
- All services have taken steps to maintain as much urgent and red flag activity as possible. This has included some face to face consultations, virtual consultations and video consultations. A significant amount of validation work continues to be done - both clinical and admin focussed
- Clinical teams have worked closely with regional Clinical Reference Groups to ensure a consistent approach to prioritisation of cancer work across tumour sites with cancer surgery being focussed in DHH and also with links to IS (mainly for Breast, Urology and Gynae to date). Information is being shared regularly with the clinical team to support this work including, for example a weekly meeting with a cancer focus.
- Diagnostic services have been maintained for urgent and red flag cases where possible. There has been impact on CT whereby one of the CT scanners in CAH has been dedicated as the COVID19 scanner. Throughput has also been reduced to support cleaning between patients and social distancing.

CORPORATE OBJECTIVE: 1 - PROMOTING SAFE, HIGH QUALITY CARE

Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: High** **Previous Score: N/A**		**RISK OWNERS: Operational Directors** **DATE RISK ADDED: November 2019** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
13	There is a risk to safe, high quality care if the Trust fails to implement Phase 1 of the Mental Capacity Act (2016)	Administrative and Governance infrastructure to support the operation of short-term detentions in place with the appointment of additional Approved Social Workers, Project and Administrative staff Appointment of a number of sessional Medical Practitioners and further Approved Social Workers and designated other professionals trained to ensure the Trust can run Deprivation of Liberty (DoL) Panels to deal with Short Term Detention Orders and other longer term DoLs in the community The current Covid 19 crisis has resulted in all non-urgent contact in long term community facilities to be stood down, this includes DoLs assessments. Therefore the Trust is unable to progress with historic DoLs applications as originally planned A range of training at differing	Trust Task & Finish Group Director of Mental Health and Disability Services	Documented structure Reports and Minutes of meetings Statistics for Mental Capacity Act processes

		levels has been put in place by the Department of Health and supported by the Trust to enable staff to perform legal duties and functions Mental Capacity Act training has become mandatory for staff required to complete applications and assessments Senior staff representation on implementation working group led by the HSCB to share learning and experience between services and Trusts Ongoing engagement and communication with staff through a Task and Finish Group at which all Directorates are represented	SMT Report	Training records & total number of staff trained to each level – 2, 3, 4A, 4B & 5. Training programmes/records Papers shared as appropriate Minutes & Action Log Staff communications Minutes of meetings

Additional actions planned and timescale

IPT has been completed and resources received to enable the Trust to develop arrangements and an infrastructure to support the discharge of its statutory duties under Mental Capacity Act.

The Paris IT system has been modified to assist with processing applications under the Mental Capacity Act and other support systems are being added to PAS, QLK View to support implementation

Engagement with voluntary/ independent sector has been managed by RQIA with limited reach which is supplemented by Mental Capacity Act team where required.

CORPORATE OBJECTIVES: ALL				
Likelihood: Almost Certain (5) **Impact: Catastrophic (5)** **Total Score: 25** **Risk Rating: EXTREME** **Previous Score: N/A**		**RISK OWNER: Medical Director with Operational Directors** **DATE RISK ADDED: May 2020** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
14	i) There is a risk to patient, service user and staff safety as a result of COVID-19 pandemic. Risk associated with:- • Availability of Personal Protective Equipment (PPE)	• 'Bronze' senior management team meets three times per week • 'Bronze' operational group meets daily and by exception • Weekday telecalls with Regional Silver command • Daily communications with BSO to ensure adequate PPE supply is onsite • Weekly participation in Regional Silver PPE supply cell call • Trust operational and logistical PPE Group, chaired by DoF. • New logistical process in place to ensure receipt and distribution of PPE • Infection Prevention and Control zoning system (red, amber green and donning and doffing areas) for the use of PPE	Medical Director Medical Director/ Assistant Director, Medical Directorate Finance Director/Assistant Director, Finance Medical Director	Notes of meetings and action log " SitRep report Notes of meetings and minutes Notes of meetings and action log Receipt and distribution "pick" sheets and signed distribution\delivery schedules

	• Lack of Critical Care Provision	• Escalation plan for increase of critical care capacity	Acute Director	
		• Reduction of elective capacity on CAH site to allow for staffing capacity to assist with potential critical care surge	"	
		• Procurement of additional ICU equipment including ventilators	"	
	• Secondary Care Bed Capacity	• Development of a virtual hospital model to support admission avoidance and support service users in their place of residence	Medical Director	
		• Enhancement of Acute Care at Home Service	Director of Older People and Primary Care	
		• Employment of over 50 medical students to support alternative service provision	Medical Director	
		• Development of Paediatric urgent care service freeing capacity in the adult emergency department and also providing an alternative to inpatient admissions	Director of Children & Young People's Services	
		• Stand down of elective surgery activity to make bed space available for potential surge	Acute Director	
		• Creation of a single point of non-	Medical Director	

		elective emergency care entry on the Craigavon Hospital site maximising Daisy Hill Hospital as a dedicated medical care hub		
	• AGP including continuous positive airway pressure (CPAP) non-invasive ventilation	• Zones identified where AGP are carried out and appropriate PPE provided for staff	Operational Directors	
		• Work undertaken with care home providers to identify patients who require AGPs and fit testing provided for appropriate PPE	Director of Older People and Primary Care	
	• Potential impact on Trust Staffing Levels	• Pandemic Plan – HR Guidance	Director of HROD	Pandemic Plan
		• Provision for staff to work remotely from home where possible	All Directors	Homeworking guidance
		• Assistance to staff through Early Years to assist with child care	Director of Children & Young People's Services	Survey to staff on child care needs
		• Robust approach to PPE, training, donning, doffing, fit testing	Medical Director	PPE & Training strategy
		• Covid testing programme and contact tracing	Acute Director	SHSCT Protocol for testing
		• Social distancing has been enacted across all Trust non-clinical areas	All Directors	
		• Services are kept under constant	All Directors	

		review with staff redeployed to maintain essential services		
		• HSC Workforce Appeal and Trust Deployment Team stood up	Director of HROD	Workforce Appeal publicity, and weekly reports
		• Levels of absence actively monitored on a daily basis	All Directors Director of HROD	Daily absence reports and sit reps.
		• Staff Support Psychology Service	Director of HROD	Promotional material for service
	• Impact on Care Home Sector	• Care Home Support team strengthened to provide support to Independent Care Homes	Director of Older People & Primary Care/Executive Director of Nursing	
		• Trust is working regionally on a care home surge plan to prevent, mitigate and maintain service continuity	Director of Older People & Primary Care	
		• Trust has provided PPE to care homes when they have been unable to source adequate supplies	Finance Director	
		• Supporting care homes with patient and staff testing and with Infection Prevention and Control training and advice	Medical Director	
	ii) Risk to the safety of Trust service	• Enhanced Care Home Support	Director of Older	

	users as a result of the COVID-19 pandemic who are resident in private care accommodation	Team providing advice and support. Operates a care home forum for specific support • Dedicated Trust advice line for care homes 9.00 a.m. – 5.00 p.m. daily • Dedicated Trust telephone line and email address established for Providers to identify PPE requirements • Trust undertook modelling to establish the level of PPE required • PPE Starter Packs issued to all homes • The Trust has designated Personal Protective Equipment leads responsible for liaising with ISP care homes and Domiciliary Care agencies • Monitoring of COVID positive infections in Care Homes established for ease of identification of Homes requiring support • Independent Sector Provider Care Home support service established to allow staff to attend care homes to train and provide advice and guidance to staff • Where services allow, Trust staff are being asked to consider redeployment to support with the residential and nursing home management of service users • The Trust Head of Care Home Support Team is a central contact	People & Primary Care	

		for the Care Homes and continually receives calls and allocates support from Trust resources where required if available. • The Trust is an integral member of a regional group involved in the outworkings of the regional surge plan. All partners are subject to weekly monitoring against identified actions.		
14	iii) Risk to the Trust's ability to provide safe, high quality care as a result of the Trust's required response to Covid-19 including: • Delivery of Trust Services with COVID-19 Related Restrictions in Place • Non-Attendance at Emergency Departments of Service Users in Need of Treatment • Adult and Child Safeguarding • Elective Services	• Where possible services have created virtual clinics to provide service continuity • Where face to face assessments are required, these are conducted with appropriate Personal Protective Equipment worn • Trust communications team has raised awareness with the public that emergency departments are 'open for business and encouraging attendances where appropriate. • Trust helpline set up as a single point of contact to support families at risk • MHLD Emergency care mental health service set up which proactively encourages patient and service user attendance • Trust reviewed each elective	Operational Directors " Head of Communications Executive Director of Social Work Director of Mental Health & Disability Operational	Use of Social Media

		service to identify areas safest to consider for temporary step down and implementation of remote clinics	Directors	
		• The Trust continues to increase patient testing based on local and regional testing capacity	"	
		• Emergency dental services have been implemented		
	• Trust Staffing Levels	• Levels of absence actively monitored on a daily basis	Director of HROD Operational Directors	Daily absence reports and sit reps.
		• Services kept under constant review with staff deployed to maintain essential services	All Directors	
		• Staff Support Psychology Service	Director of HROD	Promotional material for service

Additional actions and timescales

- Development of Trust Re-start Plan – 1st June – 30th June 2020
- Trust participation in development of regional Strategic Framework for Rebuilding HSC Services

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains unchanged. 06/08/2019 - Ongoing increase in red flag referrals across multiple tumour sites continues, leading to pressures throughout pathways with 1st appointment, investigation and diagnostics and surgery- in particular urology, UGI, LGI, gynae and haematology . 2019/20 cancer trajectory has been submitted to HSCB highlighting these concerns and projecting a decreasing performance against target. This is discussed at length HSCB at Trust Cancer Performance Meetings who are very aware of the Regional pressures on cancer services. NICAN groups continue to meet to review site specific pathways and make recommendations for any changes. June 2019 Difficulty in achieving 62 day cancer access pathway due to increase in referrals and demand and delay in first appointments.	HIGH
3829	ACUTE	13/09/2016	Safe, High Quality and Effective Care	Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	09.03.2021- within ED a risk assessment is carried out if PSNI accompany patient under article 130 a joint risk is completed with nursing team. ED AMU review absconding patients with PSNI and mental health at interface meetings 24.02.2021- still ongoing issue and the staff adhering to policy and datix submitted with review taking taking place for each case. 24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating. Situation continually monitored.	HIGH
4141	ACUTE	10/03/2021		Acute AHP Accommodation	Pre-covid space was a challenge within Acute AHP departments especially in relation to equipment storage. IPC recommendations in line with COVID 19 has had a significant impact on Acute AHP accommodation in both Acute sites: Physiotherapy CAH - department is shared space with outpatient MSK services (OPPC) to facilitate doffing the Gym including the Acute T&O gym has been out of use and with outpatient services downturning/stopping Acute staff were able to branch out into outpatient space to facilitate safe distancing in the department. This also required a significant decant of physiotherapy equipment to various storage areas around the Acute site. With the Doffing move to basement the gym will be reinstated as will all equipment and as MSK outpatient Physiotherapy services resume Acute staff will be displaced yet again and there is no solution to ensure safe distancing among this clinical team going forward. Team need to be onsite and responsive to the acute clinical need at ward level to ensure patient flow and improved patient outcomes. No Gym or Hydrotherapy space for rehabilitation of our complex patients. Need IPC guidance re: how this may progress alongside outpatient use T&O Physiotherapy - due to zoning and donning/doffing routes the T&O team were fully displaced and currently are allocated to rooms in outpatient area CAH (dental) temporarily. No access to T&O Gym space for intensive rehab of patients Occupational Therapy/Speech & language Therapy CAH - OT/SLT teams moved 3 times to facilitate Covid 19 - OT are now back in original department area but have had to displace SLT staff to enable social distancing in the department. All equipment also relocated to allow staff to branch out into all available space including the pre-covid assessment rooms. The department sits on main thoroughfare of the acute site therefore has a large volume of staff and patients flowing through it and also has outpatient fertility services alongside it as well as facilitating outpatient T&O and Rheumatology hand therapy Speech & Language Therapy CAH displaced to upstairs in Ramone building with additional space provided on the Admin floor as a temporary solution due to the need to safely distance staff. Long term solution required Physiotherapy DHH - department is shared space with outpatient MSK services (OPPC). To facilitate donning the Gym has been out of use and with outpatient services downturning/stopping some of this area has also been taken up by PPE storage. Acute staff have been able to branch out into outpatient space to facilitate safe distancing in the department as able. This also required a significant decant of physiotherapy equipment to various storage areas around the Acute site. No Gym or Hydrotherapy space for rehabilitation of our complex patients. Need IPC guidance re: how this may progress alongside outpatient use Dietetics DHH - due to IPC guidance for renal unit and need for spacing of doctors/nurses in renal the Dietitians lost the use of their office space and are now decanted to small outpatient dietetic office on ground floor beside the coffee bar. Insufficient space to safe distance so we have had to stagger use. This is now shared space with outpatient virtual assessments Speech & Language Therapy DHH - Office space in DHH is also shared with Community outpatient SLT as office space and used pre-covid as a clinic room for Acute outpatients. Safe social distancing is very challenging and staff are having to stay at ward level for longer periods and utilise ward computers etc to enable reports etc to be completed Departmental space for Acute AHP's is vital: "They are not ward based staff - work across the wards as required/fluid workforce "They need to ensure clinical documentation is maintained for safety and quality of care - impacting on discharge pathways, changes in discharge plans, guidance on safe patient handling and management and focussed intervention and rehab plans	"Estates have walked OT/PT/SLT areas CAH - limited potential to create additional space - plan of works drawn up to maximise areas for safety. Same not actioned as yet and still leaves shortfall of 20+ spaces for staff "Physio Departmental RA completed "Occupational Therapy RA completed "Accommodation for SLT CAH in Ramone building - additional space required as well as outpatient clinic space "Portacabin allocated to OT/PT CAH for storage of essential equipment for patient discharge - temporary however needs to be retained as it is also used as a collection site for relatives for equipment avoiding the main hospital area	03/03/21 Outpatient OPPC services are set to resume activity onsite with the moving of doffing to basement in CAH - urgent need for additional space for staff PT Estates to review plans to maximise space as urgent across PT/OT Long term accommodation TBA for SLT Longterm storage solutions required	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4112	ACUTE	13/08/2020		AHP Staffing Deficit - Acute Services	Core Acute AHP staffing significantly below the National Average (NHS Benchmarking 2017) combined with additional unresourced demand in the system across all areas and workforce issues in particular across Physiotherapy and Speech and language Therapy contribute to risk for the service, staff and patients/service users. This relates in this instance to the core Occupational Therapy, Physiotherapy, Speech and Language therapy and Dietetic teams on CAH site Current unresourced demand in the system: - Additional ICU beds in Recovery - big demand on existing ICU staff both Physiotherapy and Dietetics - no funded resource or cover for ICU from SLT or OT - Higher Acuity patients in 2N - Elective Ward - Transition ward - Additional stroke beds (funded for 10) - Additional medical beds 3S - Non recurrent funding frailty ward - only agency OT support, unable to recruit Physio - ED waits - on average 30 waits in ED - small resource contributing to GLT ED and AMU and struggling to impact on ED numbers/prevention of admission/signposting to AC@H etc - Increased age range and acuity of patients - Patients not receiving timely assessment and appropriate level of rehabilitation to maintain patient flow or actively contribute to timeliness and experience of the patient journey - Patients under nourished, remain nil by mouth for increased length of time due to reduced dysphagia cover. - Unable to facilitate mobilisation with resulting deterioration in muscle bulk and increased morbidity, lack of facilitation of activities of daily living hence increased dependency and requirement for larger package of care on discharge which will be delayed - complex delays - Poor/variable SSNAP results - Instability of core OT/PT staffing impacts on ability to rollout ward based 7 day working - Potential for SAIs - increasing number of same in the system - Complaints received re: service provision - Inability to consistently meet professional standards - Health and wellbeing of staff compromised - Staff working outside levels of competency and under significant pressure. - Reduced morale and goodwill among teams - staff retention an issue with posts outside of acute attractive. - High risk of losing staff to other teams which may see ongoing evidence of change	Regular contact with BSO re recruitment. Requests to contract and non contract agencies for AHP staff, core staff offered additional hours, Regular review of transfer of staff from DHH especially for stroke and current 2nd ED - challenging within OT/PTdue to gaps secondary to S/L, M/L especially in COVID era and recruitment issues ongoing and as 7 day working being piloted across OT/PT teams DHH, we have utilised cross site working effectively within SLT and dietetic teams as able to meet short term need but this does not address the longterm deficits	03/03/21significant redeployment from across directorates to enable Acute AHP teams to address demand secondary to additional medical beds and Covid impact across ICU and wards. Redeployment ending through March 21 Bids in place via Annex A and NMS workstreams for additional OT/PT input to wards secondary to covid - posts to be filled Awaiting confirmation of funding for Ambulatory models to address pateint flow and ED prevention of admission Support from Acute Director for investment paper to be drafted to address the baseline gaps across Acute AHP s a whole - March 21	HIGH
1220	ACUTE	18/08/2008	Provide safe, high quality care Be a great place to work Make the best use of resources	Breakdown of laundry equipment	Laundry equipment is outdate and requires replacement to avoid frequent breakdowns and disruptions to the laundry service. Potential risk to the supply of clean linen to wards and departments due to breakdown of essential laundry equipment. The aging laundry equipment needs to be replaced to avoid breakdowns and disruption to this core service. The risk affects the laundry service provided to not only Southern Trust facilities but also to Belfast City and Musgrave Park hospitals. Replacement parts for old and ageing equipment are now obsolete, causing delays in getting equipment repaired and back into operational use. The following pieces of equipment are required in the Laundry :- 1. Continuous Batch Tunnel Washer, Press and dryers - installed in 1992 (27yrs old) approx cost £760K 2. Ironer installed in 1975 (45 yrs old) approx cost £355K 3. Lint Extractor - requirement for fire safety - approx cost £70K 4. Pharmagg No 1 100kg barrier washer - installed in 2006 (14yrs old) approx cost £105K 5. Kent Dryer 100kg x4 - installed in 1987 (32 yrs old) approx cost £315K 6. Shrink Wrapper - installed in 2002 (17yrs old) approx cost £85K 7. Ironer installed in 1991 (28yrs old) approx cost £355K 8. Continuous Batch Tunnel Washer, Press and dryers - installed in 2001 (18yrs old) approx cost £760K Impact to service delivery - risk to the supply of clean bed linen to wards and departments in SHSCT and BHSCT. Risk of infection due to insufficient supply of linen for nursing staff to change / make up beds.	Estates has advised that it is becoming increasingly difficult to maintain the laundry equipment. They are unable to obtain replacement parts for the laundry equipment as the parts are now obsolete and it will ultimately come to a point when the machines will break down and remain out of operation. 10/08/20 - Equipment breakdowns are closely monitored and recorded. Detergent concentrations are monitored closely to ensure cleaning efficacy and minimise the number of re-wash cycles. The weight of the linen being loaded into the tunnel washers is monitored closely to ensure the equipment is not overloaded as this can lead to breakdown. March 2019 - A new calender was installed and commissioned to replace one of the four calenders in the laundry. Two new 57kg washing machines were installed and commissioned to replace a 100kg washing machine that had been condemned. The frequent breakdowns also put a strain on the newly acquired equipment as they are being overused when other equipment is out of use. There is increased staff overtime due to equipment breakdowns and equipment running at reduced capacity. Additional shifts are needed to ensure provision of sufficient clean linen each day to wards and departments.	£84,000 capital funding approved to purchase a second hand ironing line 07/10/2020 Equipment breakdowns are closely monitored and recorded. Detergent concentrations are monitored closely to ensure cleaning efficacy and minimise the number of rewash cycles. The weight of the linen being loaded into the tunnel washers is monitored closely to ensure the equipment is not overloaded as this can lead to breakdowns. 10/08/20 - A CAG has been identified to commence the procurement process for a replacement tunnel washer. PaLS to arrange a meeting date as soon as possible. 28/2/2020 £50,000 capital allocation approved to purchase a second hand calender to replace No 2 calender which was beyond repair and was condemned. 11/10/19 £82,300 capital allocation approved to purchase a replacement refurbished press for the Powertrans tunnel washer as the press was beyond repair and was condemned. 1/4/19 New calender and two new washing machines installed and commissioned. List of aging laundry equipment added to capital priority list. 19/12/18 Capital funding approved and tender process completed. New equipment due to be installed and commissioned by end of March 2019. 5.4.18 Business case was recoated Nov 17 and was approved by SMT March 18. 16.8.17 Business case is still with Finance for re-costing. 12.12.16 No further update. 21.11.16 An additional option has been included and is with Finance for re-costing. 17.8.16 Business case for replacement of calenders presented to SMT - not approved. SMT has asked for an additional option to be included in the case i.e. to outsource the laundry service from another provider. 23.02.16 Business case forwarded to Finance for costing	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
773	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Theatres Endoscope Decontamination room	The interim Endoscope decontamination facilities at CAH theatres do not meet DHSSNI decontamination strategy. There are no transfer lobbies or staff gowning rooms. The process flow is severely compromised by the size of the extremely cramped unit. There is no room for expansion. The workload in the endoscope decontamination facility has increased considerably over the last number of years due to additional theatre and radiology sessions as well as additional clinics in ENT OPD and Thorndale Unit. There is inadequate space for holding the contaminated endoscopes for manual washing prior to the automated process in the endoscope washer disinfectors. This frequently creates a bottleneck and slows down the process flow and turnaround time. The endoscopes and transport trolleys have to be stored in the hospital corridor outside the endoscope decontamination room due to lack of space - increased risk of theft (trolley plus endoscopes). In the event of any prolonged endoscope washer disinfector downtime there would be significant disruption to endoscopic procedures in Theatres, Radiology, ICU or in ENT OPDand Thorndale Unit as there would be insufficient capacity to decontaminate the endoscopes on the Craigavon site. There would also be logistical issues and delays in turnaround times if the endoscopes had to be transported to another Trust site for decontamination ie Daisy Hill or South Tyrone. The endoscope washer disinfectors were installed in 2009 and have a working life of approximately 8 years. The Lancer endoscope washer disinfectors do not have the ability to perform channel patency tests to current DHSS guidance i.e. inability to perform partial blockage of the duodenal channel which is part of the quarterly channel patency testing regime. The EWD manufacturer has confirmed that they will support the FC 2/4 EWD models until 2022 for the electronics and until 2025 for mechanical parts.	Situation being monitored.	16.02.2021- draft paper re funding required has been shared with the Director of Acute Services. 10/08/20 - DOH has set up a regional RDS2 steering group to assess the current provision of decontamination services, identify any shortfalls in compliance with policy and develop a strategy to address any identified gaps. 3.10.19 Replacement EWDs are included on the capital funding list. May 2019 SHSCT provided a summary report to DOH on strategic planning relating to the decontamination of reusable medical devices 24.06.19, 8.8.18, 12.6.18, 7.3.18 Risk remains unchanged 113.9.16 Head of Decontamination Services will work with Acute Planner to explore options for a modular unit adjacent to CAH CSSD to replace the existing the interim arrangement. Given that CSSD will form part of Phase 1 for the CAH Redevelopment, a modular solution will be considered as a further interim arrangement although it will need to address existing concerns. Indicative costs to be detailed in the paper and logged for consideration under capital allocations for 17/18. 23.2.16 Following discussion at Acute senior management team with Head of Acute Planning, the risk will be addressed in the first phase of the redevelopment of the Craigavon site. On this basis it was agreed that nothing further would be done at this stage. 5.1.16 Short paper highlighting the risks shared with Planning Dept and Director of Acute Services	HIGH
3951	ACUTE	10/04/2018	Provide safe, high quality care	Delays in isolation	Due to lack of side rooms/one to one nursing/lack of bed capacity in the service. Risk of spread of infection. Failure to isolate promptly can lead to outbreaks, close of bays, increased pressure on service. May lead to potential patient harm through the spread of potentially preventable infection or due to a lack of beds.	Trust can emphasise the importance of IPC issues at bed meetings and elsewhere. A recent teaching sessions was arranged to do this amidst the winter pressures. Side rooms are often occupied for reasons other than IPC reasons. IPC reasons for isolation are often of critical importance in that severe harm can be done to other patients and staff by failure to isolate promptly. This is often not the case for other reasons patients are in side rooms and side rooms should be prioritised to maximise patient safety. The Trust should also look to ways to enhance the capacity to isolate a patient when the hospital is full and a patient needs isolated urgently e.g. where a patient could be moved out of a room to facilitate critical IPC isolation.	24.01.21- delays in ascertaining results of swabs and screening and appropriate action delayed based on same and lack of isolation rooms to accommodate this.	HIGH
3678	ACUTE	26/05/2015	Make the best use of resources3Provide safe, high quality care	Lack of accomodation for Antenatal Clinics	Lack of available rooms to undertake antenatal clinics resulting in delay in appointments and necessary repeat appointments.. inconvenient for patients	Unable to provide a one stop service to patients booking in Armagh Community Hospital as they have to return for their booking appointment when they have been scanned and a repeat scanning appointment in CAH/DHH if required. If a woman books in CAH/DHH she only requires one appointment.	12/08/20 - no change. Needs investment. Jun20 Antenatal OP setting being reviewed in conjunction with new CT scanner being built. Aug 19 Escalated from Divisional to Direcorate Risk Register Jun19 Situation continues to be monitored with the increasing demand on the service Jan18 Still ongoing risk	HIGH
3954	ACUTE	10/04/2018	Provide safe, high quality care	Lack of documentation	Root cause analyses are repeatedly picking up incidences of poor documentation e.g. lack of filling out of Clostridium difficile bundle, lack of documentation that the patient has been informed of a diagnosis of Clostridium difficile, lack of filling out of cannula charts, etc. Lack of documentation can reflect either that something that should have happened has not happened or just that it has not been documented. In the former there is a direct risk to patient safety (e.g. death from Staphylococcus aureus bacteraemia from a cannula that was not inspected properly and removed when it should have been, death from Clostridium difficile due to deterioration not being picked up due to lack of due diligence in the application of the bundle). In the latter there is still danger to the patient as staff subsequently on duty will not be able to see what was done as it is not documented. There is also significant risk to litigation to individual staff and the Trust as without documentation to say that good practice has been carried out there is no proof that it has been done.	Medical and nursing training would emphasise the importance of good documentation. Root cause analyses would emphasise the importance of this. The recurrence of this problem as demonstrated by repeat root cause analyses however would suggest that current control measures are not sufficient. When challenged regarding poor documentation excuses given are usually:- (a) A lack of education/awareness regarding aspect s of care bundles (b) A lack of time to document things due to service pressures Problem (a) could re resolved through additional education to staff through Lead Nurses, Ward Sisters and Clinical Directors to their teams where this is needed. Problem (b) can only be resolved by easing the pressure on nursing and medical staff in general. In general the experience of the IPCT is that nursing documentation is better than medical documentation, especially with regards to documenting when a patient has been informed of their diagnosis.	24.02.2021- improvements have been made but still needs continually monitored	HIGH
4142	ACUTE	24/02/2021	Provide safe, high quality care8Be a great place to work4Make the best use of resources	Recruitment and Retention issues- Trust Wards	Patient safety risk. Identification the deteriorating patients, risk on escalation of same, lack of knowledge of in house processes, potential treatment/management/discharge delays. Increased pressure placed on core team, risk of burn out/work related stress. Potential lack of escalation/risk deteriorating patient not escalated. Potential risk of failed discharge/transfer due to lack of knowledge regarding processes. Risk of non-compliance with appropriate documentation required to manage patients holistic needs.	currently focusing prioritising recruitment to this area. Complete all outstanding e-reqs Internation nurse recruitment Target year 3 nursing students to this area to attract uptake Offer all bank and agency permanent positions Daily review and redeployment of staff to support the skill mix and staff levels with 2 South	Action plan completed working collaboratively with the AD from workforce to address this	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4131	ACUTE	03/12/2020	Safe, High Quality and Effective Care	Reduction in elective capacity due to covid restrrictions-Urology ENT, Gen Surgery, Gyane and Orthopaedics	With the Covid-19 pandemic SEC ability to accommodate commissioned levels of activity is not being achieved resulting in increases in waiting times and volumes of patients on the elective and planned waiting list. As a result of increased waiting times and reduced capacity consequently patients may come to harm, increased levels of pain and discomfort and reduced quality of life	Mon-Friday 1x all day Urgent bookable on both sites CAH and DHH Due to limited elective capacity consultants clinically prioritise patients for surgery using the FSSA royal college guidelines, priority to cancer patients. Regional cancer rest meeting working towards equalising waiting times across the province. In house additionally from January 2021 on DHH site Endoscopy- weekend additional sessions in LV	15/02/2021- ICU remains open to 16 patients, surge staff from day surgery and theatres/recovery remain in-situ. Currently in surge 3 03/12/2020- full de-escalation of CCaNNi critical care surge plan- this is currently medium surge and difficult to predict. Commencement of in house additionally from Jan 2021 for endoscopy and surgical specialities and the January sessions are currently being agreed. Increase urgent bookable theatre sessions	HIGH
4143	ACUTE	11/03/2021	Best use of resources 3 Provide safe, high quality care	Replacement programme for Radiology Equipment on all Sites to replace equipment on unsupported operating systems and provide mai	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose. There is equipment currently running on Microsoft Windows XP - the support ended in April 2014 leaving risks of ransomware attacks or hacking..Failure to patch as per schedule could result in the ability to access clinical systems on radiology equipment and server infrastructure. This has been highlighted by Tenable programme and could result in the loss of essential services.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging.Patching arrangement needs to be formalised. This needs developed with 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching - regional project looking at 3rd party suppliers being led by BSO. Targeted staff awareness, devices to be replaced, upgraded or if not possible must be segregated. IT working with Radiology to highlight all devices. "	"The equipment plan has been tabled at Trust SMT. Radiology have also presented to SMT to highlight the issues. This presentation has highlighted specific urgent requirements including breast imaging and fluoroscopy across both sites to include the required ventilation. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. There is ongoing review with IT regarding patching. " ongoing review with IT in relation to patching. All 3rd party contracts to be reviewed and amended to include patching- regional project. "To be amalgamated with 8, 10 and 11. The equipment plan has been presented at Trust SMT. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. "	HIGH
3971	ACUTE	28/08/2018	Provide safe, high quality care	Access to cath lab for NSTEMI patients	Standard 18d of Cardio vascular framework that eligible NSTEMI / ACS pts should have Cor Angio +/- PCI within 72 hrs of admission. Angiography within 72 hours improves outcomes for patients. (NICE). MINAP state: The performance of angiography and coronary intervention soon is an important facet of treatment for the majority of patients.	Monitored weekly. Access elective patients. Escalate number of patients waiting for in patient cath procedures daily to AD and Director.	24/02/2021- working through as part of cardiology network plan but the target is only 33% in 72 hours due to only one cath lab. 5 /11/20 KPI for N STEMI s getting to cath lab within 72 hours has dropped to 35 % from 45% this is impacting on length of stay and bed occupancy at ward level and resulting in patients being admitted to wrong ward 10/08/20 - Regional group has been established PID document agreed. Demand and Capacity for cath lab activity to commence when templates have been distributed to the Trusts. 14/5/2020. Modular Cardiac cath lab was removed in October 2019. Access times for NSTEMIS has dropped to 33% getting to Cath lab within 72 hours . Regionally agreed to establish group to review cath lab activity re access times and demands. 24.06.19 Monitored via MINAP only 50% getting to cath lab despite modular. High volumes of inpatient activity (monitored monthly for each site) Need to secure Funding permanent for modular. Need to reduce elective to facilitate inpatient. 13.08.18 Performance team to liaise with HSCB re funding	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3981	ACUTE	05/11/2018	Provide safe, high quality care	Administrating Contrast Media within Radiology	The current framework for prescribing, supply and administration of medicines (primarily the prescription of contrast media) within Radiology across the region does not meet current legislative requirements. It is the agreed approach of the Regional Modernising Radiology Clinical Network that this current practice poses a low risk to patients and has developed as normal practice over the past number of decades to meet the ever increasing demand for contrast enhanced examination. All decisions regarding the administration of medicines in Radiology is done under the direction of senior clinical staff following local procedures, protocols and guidelines as delegated by their Clinical Director. Issues with the management of medicines within Radiology has been recognised as a national issue, which has been escalated to NHS England as a risk to Radiology services. As a long term administration of contrast media. Low Risk PGD's are being put in place within the Southern Trust to provide a degree of cover for Radiographers administering contrast media.	Currently radiographers operate under written protocols agreed by the clinical director of Radiology.	03/03/21 Radiographers received medicines management training in 2020, which is a requirement of administering contrast media under a PGD. This training has been added to the a new radiographers internal training matrix. The matrix has been colour coded for individual compliance, the percentage team compliance and arranged so that each team lead has more streamlined oversight of their staff members mandatory training. The most commonly used / higher risk contrast media / PGDs were prioritised for completion first. 7 have been completed and issued. Oral contrast administered on wards for CT scans was issued and requires all nursing staff to meet training requirements. Radiology remains in contact on the review of oral contrast administered on wards via acute standards and guidelines forum. At least 10 more PGDs have been identified. Drafts are in progress with Radiology and pharmacy. 02/06/2020 Process drawn up, agreed and is operational Mar 2020 Draft process has been prepared and further discussion to take place between ward based nursing and medical staff to determine if proposed process is workable. Dec19 A working group including radiology and pharmacy has been established with an initial meeting planned mid-December 2019. Training of radiographers required to undertake prescribing	MOD
4116	ACUTE	06/10/2020	Provide safe, high quality care Make the best use of resources	Delays in undertaking rheumatology joint injections on the routine joint injection list	Unable to administer rheumatology joint injections for patients who are on the routine list. Due to lack of available clinic space- available limited clinics are prioritised for urgent patients which means there is no capacity to deal with routine patients Delays in patients being treated writing clinically required timescale's meaning a progression/deterioration of their condition which is irreversible.	The issue of lack of clinic space has been escalated to SMT via t he Rebuild Plan which notes additional clinic space required for this speciality. Patients are triaged to the appropriate waiting list at the outset of decision to treatment. If routine patient/their GP contacts the Dept to request earlier commencement the patient consultant would retriage to determine if their are factors which would warrant moving up the waiting list and recategorising as urgent.	Additional Clinic space- still awaiting outcome of Rebuild Plan Phase 3 to know if this has been provided	MOD
4049	ACUTE	07/08/2019	Provide safe, high quality care	Inability to accept Inutero Transfers from other Units for Neonatal Cots	The Trust is currently intermittently unable to accept inutero transfers for neonatal cots from other units. This is due to current maternity staffing level difficulties. Possible harm to mothers and babies who require a neonatal cot due to specific health needs and imminent delivery, therefore requiring transfer to this specialised facility. Potental for undue distress to baby and parents.	Continual monitoring of the staffing situation to make best use of existing resources. Transfer accepted when staffing levels permit.	Jun20 continue to monitor Dec19 Specific focus on recruitment - recruitment fayre undertaken and appointments made awaiting registration within next year. Retention of staff also focus within division to retain and recruit staff	MOD
4129	ACUTE	02/03/2020	Safe, High Quality and Effective Care Make the best use of resources	No psychology provision for Gastro, Rheumatology, Neurology, Diabetes and Endocrinology	There is no psychology provision for the named specialties about from 7 hours in DHH for Diabetes which is insufficient for the cohort of patients. Patients who have psychological problems may come to harm and in the case of diabetes there may be mortality if there is not provision to get them psychological assessments/therapies. In Diabetes in particular there are several issues- eating disorder, needle phobia, deliberate insulin omission, fear of hypoglycaemia. Some of these, in particular, deliberate insulin omission can lead to death. Within Gastro, Neurology and Rheumatology dealing with long term illness can be detrimental to mental health in the absence of relaxation, stress management and cognitive coping skills to help patients adjust to living with their condition.	Have sought help from the Psychology Department however they are under resourced and unable to make any provision with out additional funding/resources Have tried to submit Extra Contractual Referrals (ECR's) for Diabetes in Particular however they do not meet the required criteria Have tried to refer to BHSCT however referrals have been returned as out of area. Have put the need for psychology services and the development of an IPT on the Acute Revenue Pressures and Priorities list however this service is competing with a huge volume of other priorities within the demography funding allocated to SHSCT.	Submission of requirement on Acute Revenue Pressures and Priorities List	MOD
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow.	09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	MOD
3940	ACUTE	26/02/2018	Provide safe, high quality care	Provision of Consultant on call rota for out of hours GI bleeds.	Inability to provide consultant cover in the out of hours period with the skills to manage patients admitted with haematemesis. Patients admitted with large haematemesis unable to be managed in a time critical manner.	Registrar manages the patient with haematemesis in the first instance. If Registrar requires support they would phone round the Gastroentrology Team if available to come in to assist.	11/08/20 - this remains a risk and has been raised with Medical Director. 31.07.19 Still ongoing raised wit Med Director Re Surgery & Gastro 10.4.18 Escalated to Directorate RR 26.02.18 Risk added to Divisional Register	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3663	ACUTE	29/04/2015	Provide safe, high quality care	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assesssement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to reitain a modular CT Scanner in DHH.	March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD
3957	ACUTE	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS	24/02/2021- review of medical staffing on DHH site currently taking place. E- Req in system for specialties. 13/05/20. Zoning introduced but issues identified with this system. Audit carried out. Medical rota is sufficient to provide daily senior review. 24.06.19 No change. Zoning introduce needs evaluated. Review workforce available.	MOD
3866	ACUTE	14/01/2017		The waiting room in the x-ray department,Lurgan Hospital needs to be revamped	Patients and staff are complaining regarding the condition of the waiting area in the x-ray department of Lurgan Hospital. It appears unclean, grubby and unhygienic. The carpet is stained and uneven. There is a crack in one of the window panes and the seating is very uncomfortable, torn and stained. There are nails sticking out of the walls were pictures have been removed and the wall paper is peeling off the walls. Pipes under the radiator are broken and the insulation is exposed. It does not give a good first impression of the department and we are not meeting the Trust's values of delivering a safe high quality service to all our service users. There have been numerous written complaints from service user regarding the condition of the waiting room Please see photographs of the waiting room and patient reviews of their experience attached Service users complaining about the seats being very uncomfortable especially for people with back problems -see patient reviews of their experience	Routine, daily house keeping Deep clean performed to try to remove stains from carpet and seats, however this was unsuccessful Patients advised to prevent their children climbing on the chairs An extra chair has been placed in the waiting room as a temporary measure for those with back problems		MOD
4133	ACUTE	29/01/2021		Unable to off load patients from ambulance when ED is overcrowded	Patients at risk due to being unable to offload patients from ambulance to ED due to overcrowding	HALO role and ongoing monitoring	09/03/2021- need to secure funding for medical gases for ambulance receiving area. Daily monitoring and escalation. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing review of escalation plan	MOD
3929	ACUTE	12/12/2017	Provide safe, high quality caMake the best use of resources	Declaratory Orders for patients who lack capacity	Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of liberty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes obo individuals without capacity.	Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievalbe not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision.	30.07.19 There will be partial implementation of Mental Capacity Act NI on 1 October 2019. This may aleviate some of the declarattory orders asTrust Authorisation panels are being set up. 7.3.18 Risk remains unchanged	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3921	ACUTE	13/11/2017	Provide safe, high quality care	Extra patients on wards	No piped oxygen or suction in extra bedspace, lack of room for manual handling/attendance at cardiac arrest in extra bedspace, lack of privacy and dignity, increased pressure on staffing, increased complaints by service users, extra patient requiring evacuation in event of fire, increased risk of cross infection	All patients to be assessed on ward at time of requirement to place extra patient, so that most mobile patient may go into the extra bedspace, or the patient with no requirement for continous oxygen or suction. portable oxygen/suction is available at ward level for emergency situations. infection control precautions must be kept to the highest standard, continue to isolate high risk patients and all staff to adhere to good IPC practice placement of patients must also take into consideration manual handling needs of the patient and again place most independent patient in extra bed space. in event of cardiac arrest extra bed should be pulled out into corridor and mobile screens etc used to screen patients who require arrest team all efforts should be made to maintain patients privacy dignity for the patient while the extra bed is in use and visiting rules shouls be strictly adhered to i.e 2 visitors per bed. patients should be encouraged to avail of day room etc if appropiate staff to be made aware that extra bed space is put into use only as a last resort and is a decision made by the director for best care option for all patients at the time of bed pressures staff to be aware of the need to explain to patients and their relatives of the reason for the extra bedspace and try to give reassurance that it will be stood down as soon as possible staff to ensure extra patient is on Immix board and patient handover for fire evacuation Where 1 additional patient is noted to pose risks, it needs to be offset against the risks associated with over crowding in ED when recuss, majors and minors are at maximum capacity resulting in delays in assessment of patients, treatment and inability to deal with blue light calls or a major incident.		LOW
3922	ACUTE	13/11/2017	Provide safe, high quality care	Lack of funding to ensure compliance with NICE guidelines that have been regional endorsed by the DHSSPSNI.	In April 2017 a Band 5 Governance Officer commenced work within the Acute S&G team as part of a secondment from the Corporate Governance team. This secondment to the Acute S&G forum ended on 31/12/17. The purpose of this audit was to ensure that an assurance framework is in place to comply with the reporting arrangements to the relevant external agencies (such as the HSCB). The outcomes from this audit are now being operationalised and outstanding actions are presented at the Acute S&G forum and Divisional Governance meeting to ensure progression. As part of this work a significant number of NICE guidelines have been identified as having an external barrier impeding implemention. This work has continued and there are now 79 listed NICE guidelines where an E proforma is required. There is a robust system in place to maintain E-proformas being sent to the HSCB as and when required. However due to COVID 19 pandemic from March 2020 / Industrial Action in November and December 2019 there has been a significant increase in the number of E proformas that are now overdue for review. The number is now 25 (32%) - this work will be deferred until October 2020 when it is agreed that the S&G NICE workplan can recommence. A copy of the updated July 2020 E proforma report provides evidence of this work. The work also provides a timely trigger for the compliance position to be reviewed in accordance with stipulated review timescales. In the past the HSCB would have reviewed 'red' status guidelines for all Trusts and for guidelines were all Trust's identified significant barriers these would have been prioritised as part of their annual work plan and there was the possibility of funding being allocated to support implementation at a local level. With effect from 01/04/2017 this is no longer the process, with all Trust' needing to manage all funding requests within existing financial resources. Given the number of competing demands this makes it very difficult to ensure that the S&G constraints are overcome and presenting a risk for the Directorate. As part of the 2020/21 workplan for the Acute S&G team workplan the 'Green Status' report is currently being reviewed to ensure those NICE guidelines that have been identified as either being fully compliant or have an internal action required to achieve full implementation are accurately reported upon.	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. The content of this report is approved by the Director of Acute Services and Director of Performance prior to submission The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified	24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less June18 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less	LOW
4095	ACUTE	02/06/2020	Provide safe, high quality care Be a great place to work	Mishandling of Patient handover resulting in an Information Governance breach	There is a risk that the handover with patients details could be mislaid anywhere on site or in the community. Patient detail not being managed in a confidential manner thereby reveling the patient's private business and exposing the Trust to a breach in public confidence.	All disciplines of staff have been informed of the recent breaches in Information Governance and the consequence of same. All wards and departments have bins with clearly visible signage indicating they are for the disposal of the confidential handover prior to the end of their shift Regular reminders at patient safety briefings to adhere to Trust governance protocols Representative in Acute have met and agreed the content on the handovers. Incident and meeting note shared with OPPC, Peads and MH directorates.	24/02/2021- continuously monitored 02/06/2020 Staff regularly reminded of necessity to adhere to Trust governance protocols.	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	LOW
4099	ACUTE	11/08/2020	Provide safe, high quality care Make the best use of resources	Neurophysiology- Due to insufficient staffing levels risk of occasional department closure days	Occasional risk to inpatients as no staff to provide service. There is the occasional inability to provide an inpatients service for EEG. EEGs are an aid to diagnosis. there is no on call/weekend or bank holiday cover	As a rule x2 staff not permitted to have annual leave at the same time however in exceptional circumstances this can occur when staffing levels are insufficient. Change the working pattern for x1 P/T member of staff which will reduce lone working days and therefore reduce risk of closure days	March 2021 - Lead due to retire in August 2021. 1 member of staff has taken a career break for 2 years. Another member of staff will shortly be going off on maternity leave. The remaining member of staff will increase their hours and be assisted by the trainee posts. Staff levels should be 3.22WTE	LOW
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, loss in confidence / negative publicity Service Capacity As of 30 June 2020 there are 2131 standards and guidelines identified on the Trust's S&G database. Of thes1622 were applicable to Acute Services (78%) Lack of suitable IT Recording System Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . In 2017/18 BSO gave the WHSCT significant funding to support a pilot of a modified Sharepoint system that would in the first instance record and track the implementation of NICE guidelines and Technology Appraisals. The Regional NICE Managers forum acted as the project group and whilst the scope of the project was not embracive of all the types of standards and guidelines endorsed regionally it was at least a starting point. The ultimate vision was that upon completion this system would then be shared across the HSC (including the HSCB/DHSSPNIS) to provide a harmonised / standardised system that would provide effective monitoring and traceability of guidance implementation. Unfortunately this pilot has not yet yielded these desired outcomes and in the interim the SHSCT continues to use an excel spreadsheet whose functionality falls well short of service requirements. Discussions have been undertaken with Mark Toal to seek out other possbile IT solutions - these have included Commercially Sensitive Information redacted by the USI. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents were data saving has not occured due to capacity issues. As a safe guard a system back up is saved on a weekly basis. There is also the added frustration that if any of the directorate governance teams are using the shared excel spreadsheet no-one else can use it. This can impact on staff not being able to carry out their administrative duties on the system at that point in time. This is inefficient and there is a risk of a lack of timely data capture. S&G Backlog S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implemenation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an assurance response to the required external agency. It also has the risk of creating 'siloed' implementation processes within each applicable directorate which in turn has the potential to produce inconsistency in any new	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. Within Acute Services a directorate S&G forum has been established - inaugral meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implemenation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implemenation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administation processe maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance statements. Meetings held 6 monthly with the Head of development & Planning to ascertain if any business cases can be supported with relevant S&G Patient Safety & Quality Manager (Acute Services) attends the regional NICE Managers meeting which provides a valuable network with the other 4 HSCTs, DHSSPSNI and HSCB Patient Safety & Quality Manager has completed a one year scholarship	10/08/20 - Risk reviewed and description of risk updated. 02/06/2020 standards still difficult to achieve with limited funding, staffing and equipment 09.03.2020, 5.12.16 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed. Due to ongoing work pressures Phase 1 (01/10/2015 to current date) and Phase 2 of the backlog review (all S&G issued from 01/04/2007 - 30/09/2015) will be undertaken from 01/01/2018 to 31/03/2018 has not been progressed as planned and will continue during 2019/20 workplan. Phase 1 (From 2017 to current date) has been completed. Phase 2 of the backlog (from April 2007 - Sept 2015) remains outstanding.	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4090	ACUTE	09/03/2020	Provide safe, high quality care Make the best use of resources Improving Health and Wellbeing	Prescribing of valproate not in line with valproate Pregnancy Prevention (PREVENT) Programme	Valproate is associated with teratogenic risks (congenital malformations, neuro-developmental disorders) in children exposed to valproate during pregnancy. Children exposed to valproate in utero are at increased risk of lower IQ and of risk of developing neurodevelopmental disorders. In 2017 and 2018 the DoH issued a number of circulars in relation to the risks of prescribing valproate in women of childbearing age (HSC (SQSD) 19/17, HSS (MD) 8/2018 and HSS (MD) 27/2018) highlighting new resources to support the safety of girls and women who are being treated with valproate. Among the recommendations to Trusts was the requirement to develop an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care. In addition, all relevant resources are to be embedded in clinical practice for current and future patients, by revising local training, procedures and protocols.	Currently valproate is prescribed to a small number of patients under the care of NHSCT Consultants, all of whom have been made aware of the various DoH circulars and associated recommendations. A number of NHSCT Consultants sit on the Regional Valproate Group, chaired by PHA. The Trust has also recently established a task and finish group to address outstanding risks in relation to the recommendations in the circulars, namely the systemic identification of all girls and women who may be prescribed valproate. The Northern Area Drugs and Therapeutics Committee also monitors the implementation of the recommendations within the circulars through the Medicines Governance Pharmacist, also a member of the Regional Valproate Group.	9 March 2020 Consultants manage their own registers of girls and women on vaproate.	LOW
4007	ACUTE	28/02/2019	Provide safe, high quality care	Risk that patients receive inappropriate care due to the misuse of point of care testing	Risks arise from the inherent characteristics of the devices themselves and from the interpretation of the results they provide. They can be prone to user errors arising from unfamiliarity with the devices. Patients are at risk of inappropriate treatment as a consequence of inaccurate results. Individuals are sharing passwords/barcodes in contravention of Trust procedures and good governance. Equipment is not being properly maintained which puts equipment at risk of malfunction leaving patients vulnerable. Internal Quality Control review and regular audits have stopped due to a lack of resources. There is a lack of Assurance around temperature control of reagents etc. which has the potential to influence the results. Patients are at risk of receiving an inaccurate test result and receiving inappropriate treatment or not receiving treatment when it is actually required. Patients could come to serious harm / death. Staff are at risk to Trust sanction or Professional body sanction, litigation, dismissal. Trust is at risk of litigation due to improper use of devices. Trust is at risk of litigation due to improper treatment based on inaccurate results or misinterpretation of results.	Training is available on all devices. Quality controls are available. DATIX web is available to report and monitor any incidents. Staff are given unique barcodes to operate Trust equipment where they are deemed competent to do so. It is the responsibility of all staff issuing a POCT device to end users to ensure that the user is adequately trained and competent to use the device.	July 2020- As of 2019 support staff have been facilitating the Biomedical Scientist over the night time period. Whilst not all nights have been covered the majority are. Efforts are being made to secucre additional resources to ensure all nights have additional staff cover. Feb20 Patient safety and quality manager mitigated the risks associated with improper use of glucometers by :1Issued a learning letter to all Acute ADs highlighting the dangers of barcode sharing, 2Redesigned and reissued an equipment safety poster to emphasise the importance of only using equipment you are trained to use and not to share barcodes. 3SOP updated to clarify that barcode sharing is a disciplinary offence and will not be tolerated- subsequently staff have disciplined. 4A quick guide was also developed and put inside every glucometer workstation in the Trust, again reminding staff that barcode sharing will not be tolerated. 5Since November 2018 Patient safety and quality manager has been auditing the glucometers and compliance has since increased 3 fold. Coordinate training and email the details are now emailed to lead nurses and available on SharePoint for everyone to access. Details shared with the bank. Staff had previously complained that training details where difficult to obtain. Equipment controller training sessions were also relaunched- this time with a POCT element. One to one training sessions/in house sessions when requested, reinforcing the dangers of barcode sharing and its disciplinary consequences. There have been no barcode sharing incidents since all this work began. As of 2019 additional resources were secured and additional staff are currently being recruited (July 2020) that should facilitate maintaining a low risk in this area.	LOW
3962	ACUTE	09/05/2018		The flooring in Theatre 4, CAH has a hole in it. The Siemens Image Intensifier wheel keeps getting stuck in this hole. To date a	The flooring in theatre 4 has a small hole in it. Unfortunately, it is in the vicinity that the radiographers park the Image Intensifier prior to starting a screening case. Recently the machine was parked here and unbeknown to the radiographer one of the wheel of the intensifier had been parked on the hole. When the Radiographer went to move the machine into position at the start of the screening case she found the machine every difficult to move laterally. To move the machine it took a lot of stretching, straining and pulling and unnecessary force. The radiographer eventually moved the machine out of the hole but in the process hurt her back. There is a manual handling and health and safety risk that need addressed immediately. If not dealt with it will increase staffs stress levels and effect their welfare and could leave the Trust open to litigation. Staff have a right to expect a safe and secure working environment.	"Raising Staff Awareness regarding the flooring in theatre 4 to help manage the risk. -Actioned 8/4/18 Round Robin e-mail to be sent to all staff with photos of the area in question. "Staff to attend yearly mandatory manual handling training-Actioned-on going. Incident reported on Datix-Actioned IR1 completed 27/4/18 Siemen's Engineer to be called to check out the intensifier as it seemed very stiff and difficult to move. Machine was out of action until checked -Actioned-Engineer checked out machine on 4.5.18. and the machine was ok'd to work by engineer and put back into action. Lead Radiographers to Liaise with theatre sister regarding the incident---Actioned 4.5.18 Theatre Sister to liaise with Urologists regarding the positioning of the machine-Actioned-Urologists happy that radiographers work to the right of the patient to avoid the area in question (3/5/18) Theatre sister to put up safety awareness signs regarding the flooring and the image intensifier machine-Actioned 4.5.18 Flooring to be fixed-Theatre sister to contact Estates to find out when flooring to be replaced-Actioned 2.5.18-Estates have assured the sister that the floor will be replaced May/June 18 Flooring temporarily mended with a metal covering-Actioned 1/5/18-however there is a "lip" on this that is difficult to push machine over especially laterally. Radiographer advised to go for medical assessment.		

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3875	ACUTE	21/02/2017	Provide safe, high quality cSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	The transfer of patient data outside the EU.	Due to insufficient availability of Radiology Registrars within the Southern Trust the Radiology Department is unable to provide the service of reporting emergency CT scans for patients between 10.00pm and 9.00am daily. In order to address the problem the The Southern Trust has an arrangement with the Independent Sector provider to report on the CT scans in the out of hours and overnight periods. given that the Ind Sector Supplier is in Australia images have to be transferred electronically and this presents a risk and potential for data loss	The risks have been assessed by BSO Legal Services, Trust Information Governance and IT. Due to the following mitigating factors it is believed this risk is of an acceptable level:-Reputable company with contracts ongoing in NHS England Company has DPA obligations in place and have been co-operative in responding to additional requests for clarification -Lack of alternative re processing of records -Consequences of a data breach (CT scan images) -Likelihood of a data breach -Impact on patient if breach occurred -Reputational damage to Trust if breach occurred - may be low - depending on number of records involved Within the specification the following has been recorded: "3.11 Confidentiality / Intellectual Property Rights. Assurances must be provided to the Trust that data and digital images are secure at all times." Ongoing monitoring of images being sent and reports being returned will also be used to ensure there has been no loss of data.	March 2021 - this will continue to be a risk as in previous years March 2020 This will continue to be a risk due to the lack of availability of senior radiologists. 21.02.17 Risk added to Acute Risk Register	VLOW

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH 10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics. 18.09.19 Remain on Register until capital allocation 24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk	HIGH	DIV
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH 20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue 10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. 18/6/19 - planned IPDC backlog continues to be a clinical risk due to no capacity. risk has been impeded by medical 'pension issue' which has resulted in reduced in house additionally. OSL/HOS continues to monitor the backlog. 28/3/19 - continue to monitor IPDC planned backlog by HOS and OSL. Validation of strugglers to ensure they are true waiters or appoint. No routine planned capacity currently on the CAH site 6/2/19 - Continue monitoring and discussed at HOS meetings	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Endoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients bding scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qfit test then prioritised for their colon. Still working on IS contract 10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional sessions 18/6/19 - planned endoscopy backlog continues to be a clinical risk due to lack of capacity. risk has been impeded by medical 'pension issue' which has resulted in reduced in house additionally. Short risk paper has been drafted for AD and Endoscopy user group. OSL/HOS continues to monitor the backlog. 28/3/19 - IS contract with medinet ends 29/3/19, they were able to complete approx 600 pts out of the contracted 822 planned. Continued risk for colonography routine planned backlog. 6/2/19 - Ongoing validation. IS contract with medinet for 822 routine planned scope patients, however, only 350 colons. Routine planned continues high risk. 20/11/18 - Endoscopy planned validation continues by the NE. Funding secured to transfer routine planned patients to SET mobile for Q4 of 2018/19. 15/10/18 - Risk assessment paper written and submitted to Director for discussion at SMT. Validation to be undertaken of planned long waiters by Nurse Endoscopists	HIGH	DIV
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	20/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 2nd surge at present 10/8/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. 18/6/19 - waiting times for Outpatients continues to be a clinical risk due to lack of capacity. risk has been impeded by medical 'pension issue' which has resulted in reduced in house additionally. Short risk paper has been drafted for AD and Director to highlight issue. OSL/HOS continues to monitor the backlog. 28/3/19 - continued capacity gap in all surgical specialties. regional discussions in ongoing re urology. Q1 2019/20 in house additionally received for breast symptomatic, chronic pain and general surgery additionally for both in house and IS 6/2/19 - Waiting times are monitored by OSL and HOS, and discussed at HOS weekly meetings. Risks highlighted at monthly performance meetings	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	11/12/2020 - New outpatients long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Only RF and urgent patients being scheduled. Outpatient accommodation increased slightly from 14/12/2020 but not to full capacity. To continue with reduced numbers due to social distancing 20/10/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic. 10/8/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic. 18/6/19 - waiting times for IPDC continues to be a clinical risk due to lack of capacity. risk has been impeded by medical 'pension issue' which has resulted in reduced in house additionally. Short risk paper has been drafted for AD and Director to highlight issue. OSL/HOS continues to monitor the backlog 28/3/19 - 30% reduced theatre capacity to continue into April 2019. Access times continue to grow for routine and urgent waits. HOS and OSL continues to monitor and validate long waiters 6/2/19 - IPDC waiting times continue to grow. Winter plan in place from Dec 18 to March 19 with 30% reduced theatre capacity. No routines to be scheduled on CAH site, capacity for RF and urgent only	HIGH	DIV
3802	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Nurse Recruitment for Adult and Paed theatres	Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available.	We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions.	11/12/2020 - request through E&G for a commissioned paediatric nursing course for 21/22. Regional recruitment plans ongoing. HOS ATICS remains on group 20/10/2020 - regional recruitment plans ongoing. HOS ATICS sits on the group. 10/8/2020 - Since the covid-19 pandemic Paediatric theatre presently being used for outpatient ENT AGPs. No paediatric surgery currently on the DHH site. Only 2 paediatric nurses Band 6 at present, out for recruitment with BSO. Continues as risk. Continuing with recruitment drives for adult theatre nursing staff. Vacancies still remain. For retention Band 5 uplift to Band 6 successfully completed. 3/9/19 - only 3 paed nurses at present (1 is 16 hours only). Further nursing gap highlighted to AD and Director - paper attached 18/6/19 - Unfortunately continued high level of vacancies in ATICS. Theatre nursing paper has been submitted to the Acute Director. Continue to run main theatres in CAH and DHH at 30% reduction. Risk remains high. 28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019. theatre sisters continue to redeploy skill across hospital sites. Risk remains high. 6/2/19 - Unsuccessful recruitment in Dec 18, continue to work with BSO to fill vacant posts. Weekly nursing rota meeting ongoing to redeploy skill across hospital sites. 30% reduction on CAH and DHH main theatre sites. Draft ATICS theatre nursing staffing risk briefing paper with AD.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3804	27/05/2016	Safe, High Quality and Effective Care	Outpatients Dept	Pre Op Assessment	Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service	Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes.	11/12/2020 - remains unchanged. Internal audit completed and addressing recommendations 2010/2020 - remains unchanged 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 18/9/19 - Lead nurse is interviewing this week for new pre-op nursing staff. Pre-op is one of the projects submitted under demography monies. 18/6/19 - Ongoing works pressures continue in pre-op due to demand. Group met to progress pre-op paper however planners will be not support without confirmed funding stream. To remain on RR. 28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff. 6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6	MOD	DIV
3800	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Anaesthetic cover for maternity services	We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards.	A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover.	11/12/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 20/10/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 10/8/2020 - no further update. Risk continues. 18.09.19 - HOS & LN's have met and are meeting again in the next month to go through figures for the nursing requirement 18/6/19 - meeting was held between gynae and ATICs, business case to be progressed. To be kept on RR 28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion. 6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres	MOD	DIV
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	11/12/2020 - remains unchanged 20/10/2020 - remains unchanged, no capital funding identified. 10/8/2020 - Still no capital funding, risk remains the same. 18.09.19 Still no capital funding risk remains the same 18/6/19 - still no capital funding identified, risk remains the same. 28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same.	MOD	DIV
750	28/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	STH Theatres and Day Procedure Unit requires UPS/IPS syste,	Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	11/12/2020 - still with estates, priority to covid 20/10/2020 - no change and remains with estates. Priority being given to covid 10/8/2020 - no change, remains a risk. Helena to e-mail Estates re plan to address IPS/UPS. 18.09.19 No change	HIGH	HOS
3993	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Agency nursing staff not trained to SHSCT protocols	Agency staff from block booking with appropriate qualifications in level 2 may not complete procedures as per SHSCT processes's. Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports. Agency staff fulling gaps in roster without skills for level and may not complete procedures as per SHSCT processw.with appropriate qualifications in level 2 may not complete procedures as per SHSCT processess Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports.	Discussed with HOS/AD agency staff can be issued with codes for e-learning gap until completed and time to roster to complete need to have suitable trained staff with level 2 care priority to manage deteriorating patients. Roster reviewed to have suitable trained staff with level 2 care on roster /priority to manage deteriotating patients.	11/12/2020 - Ongoing reliance in block booking and agency staff to fill nursing gaps throughout ATICS/SEC. Require period of induction and training 20/10/2020 - below comment not relevant Ongoing reliance in block booking and agency staff to fill nursing gaps throughout ATICS/SEC 07/09/2020- The old scanner was replaced and modular now in place. Funding sorted until March 22021 but a plan needs to be implemented from April 2021 onwards 18/6/19 - on going reliance in block booking and agency staff to fill nursing gaps. Continues to be a risk throughout ATICS/SEC 28/3/19 - BB agency to complete e-learning and practice audit, ongoing review required. 6/2/19 as below, no further update	HIGH	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3801	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	JAG Accreditation	Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same.	JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation.	11/12/2020 - remains the same, priority being given to covid pandemic 20/10/2020 - Due to covid pandemic remains unchanged, currently going into 2nd surge 10/8/2020 - Dr P Murphy is the Interim Endoscopy lead. Endoscopy waiting times continue to be an issue in achieving JAG accreditation. 18.09.19 Require a led for JAG 28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR. 6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting.	MOD	HOS
3803	27/05/2016	Safe, High Quality and Effective Care	Recovery Ward	Post op Surgical Pts in the Recovery Ward	Regularly there are patients kept over night in the recovery ward due to ongoing bed pressures within the Trust. However, this increases the risk within the recovery area due to having post op surgical pts, HDU patients (med or surg), adults male, female and children are all mixed within the area. There are post op pts being fed while pts are still being brought out from theatre intubated and pts that come round from anaesthetic can also be nauseated. Unable to get patients out in a timely manner to the wards the following day which impacts on patients being able to get out of theatres to recovery, which in turn impacts on the operating time available if patients have to be recovered in the Theatre.	ATICs try to ensure as far as possible that a limited number of patients are kept post op in the recovery ward. This is not always adhered to.	11/12/2020 - remains unchanged. Recovery are working over 3 areas to accommodate covid pandemic, which is challenging on recovery manpower. 20/10/2020 - remains challenging 2nd surge expected, recovery staffing ICU2, Hub (Urgent bookable elective) and main recovery. Staffing identified daily at communication Hub meetings between ICU, recovery and theatres 10/8/2020 - challenges in recovery due covid-19 pandemic and requirement to segregate patients. Top end of recover for 'red' AGP patients, anaesthetic hub for urgent bookable patients, main recovery for 2 x HDU, emergency and trauma however all at reduced bed capacity due to social distancing. Issue still continues with over night patients and managed locally. 18.09.19 No change it has become the mai stream of covering Mon-Thurs extra 4th nurse, with more often requiring 4th nurse on a Friday. 28/3/19 - due to continued bed pressures, recovery cstsaff with 3rd nurse Tues, Wed and Thursday nights, increasing to 4th nurse when required. Some patients continue to be kept in recovery post op which limits their enhanced recovery on the wards. 6/2/19 - continue to staff with 3rd nurse on Tues, Wed, and Thursday on night duty to cope with capacity. increased to 4th nurse dependent on bed pressures.	MOD	HOS
3880	07/03/2017	Provide safe, high quality care	Trustwide	Patients requiring review at Breast Family History Clinic	Patients requiring review at Breast Family History Clinic not being seen in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. Patients may not be seen within appropriate review.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner . Plan to recruit and additional admin person to book yearly mammograms as a rolling programme.	11/12/2020 - Downgrade to departmental Risk register please 20/10/2020 - remains unchanged 10/8/2020 - downgrade as per below, all review patients have been risk stratified. 18.09.19 downgraded to departmental 28/3/19 - no update. 6/2/19 - downgrade to departmental risk	MOD	TEAM

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4008	28/02/2019	Provide safe, high quality care	MRI Craigavon Area Hospital	SyngoVia imaging software is not covered by service contract.	This software is essential in the reporting of Breast MRI as it is used to produce contrast uptake curves that cannot be produced on the PACS reporting stations. Server breakdown - costly repair as not under contract. Software versions not being updated - missing out on new benefits and uses for example in Prostate diffusion analysis. Data security risk - software out of date - updates not carried out. Info from IT - There is a security flaw with the SQL database server, which is out of support by Microsoft and I will need to approach Siemens. Scurity risk to patient data if not protected by software and security updates Risk of software becoming obsolete and no longer usable if versions no longer supported Risk then of being unable to provide breast MRI service.	Risks to be managed on the current NIPACS system and images are being accepted as of diagnostic quality. If not of highest possible quality level.	7.8.19 This continued to be monitored and flagged in the region. Solution - to be part of NIPACS replacement BC.	HIGH	DIV
4079	16/12/2019	Provide safe, high quality care		Serious concerns highlighted following Peer Review visit of Systemic Anti - Cancer Treatment Service (SACT) November 2019.	no electronic prescribing system for Haematology chemotherapy drugs. Competency assessment for those prescribing first cycle of chemotherapy not in place SACT nursing competencies - some out of date storage of patients notes - confidentiality . SACT meetings did not include both Haematology and Oncology Increased risk of errors when prescribing drugs Inappropriate commencement of chemotherapy for a patient staff training out of date not in line with good practice Risk of breach of confidentiality lack of service development for the whole service	Corrective action plan developed to work through the concerns however regional support is required to implement electronic prescribing system for haematology chemotherapy. Medical competency framework needs to be progressed through NICaN. nursing staff to update competencies explore options for safe storage of patient notes Liaise with colleagues in Belfast trust to ensure job planning of oncologists to attend	June 2020 Awaiting regional direction re implementation of RISOH within Haematology. Nursing staff all now trained and signed off as competent in the delivery of SACT. Ongoing review to ensure all staff are up to date with competencies. SACT Multi Professional meeting occurs bi monthly with representation from both Oncology and Haematology. Ongoing review and awareness raising of the importance of Information Governance to ensure confidential information is kept secure. Regional Oncology/Haematology stabilisation plan underway with a bid submitted from Southern Trust. Dec19 Regional Support is required. Liaise with Belfast Trust to ensure job planning of oncologists to attend.	MOD	DIV
3847	24/10/2016	Provide safe, high quality care	Trustwide	AHP Capacity Deficit for Acute Oncology Staff	Lack of timely response to Oncology referrals by specialist staff and limited rehabilitation input.	Patients rehabilitation may be compromised.	22.1.18 Still ongoing risk 14.11.17 -Capacity and demand paper being revised, This need remains largely unmet 6.6.17 Regional work still ongoing Dec 16 Working with region to establish any regional developments.	LOW	DIV
4050	07/08/2019	Be a great place to work	Radiology, Craigavon Area Hospital	Lone Worker in Radiography	Risk of harm to radiography staff who may be working on their own to provide a critical service on the Daisy Hill site. There is risk to staff form adverse incidents including potential for sudden illness, accident or intruder with no immediate help at hand.	Out of hours entrances and exits are locked. Staff have access to phones and two-way radios that give the radiography staff access to portering staff in case of an emergency. Single Pane windows upgraded. Personal Panic alarm system installed. Inner doors replaced / thumb turn removed.	March 2021- Locks have been added to all rooms. Swipe access door to be installed between ED and Radiology. Radiology main doors have been replaced and have the option to become a swipe doduly 2020- As part of the 2019 support staff have been facilitating the Biomedical Scientist over the night time period. Whilst not all nightts have been covered the majority are. Efforts are being made to secure additional resource to ensure all nights have additional staff cover. June 2020 Resource was given for additional staff to be on at night and reduce the "lone-worker" risk. Two staff have been agreed - a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. Nov 19 Risk reviewed and this remains unchanged Aug 19 Resource was given for additional staff to be on at night and reduce the "lone worker" risk. Two staff have been agreed a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. 7.3.18 Risk continues to be monitored	LOW	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3799	23/05/2016	Provide safe, high quality care		Falls from height DHH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death.	See action plan attached to Risk	27.02.18 Minor works request submitted for outstanding controls. 12/12/2016 A separate risk assessment is being completed by Acute Governance in relation to falls from heights. Erection or raising of anti-climb fencing in several areas. Secure 3 external doors at exterior of ED Dept,. Enclose plant and equipment.	MOD	DIV
3978	25/09/2018	Provide safe, high quality care		CCTV System DHH Isssues	The CCTV system at DHH is digital and has been put on the Trust Network and this is causing issues from an IT security perspective. The CCTV surveillance coverage does not extend to all of the areas required. Cyber attack and the hacking of data Loss of patient information Breach of Data Protection Act 2018 Compromised safety of all personnel on site Compromised security of both Trust and personal property Inability to detect crime and footage unable to be used in prosecutions Inability to investigate incidents Compromised ability to locate missing patients from the Wards or Department.	Precautionary measures by Estates / IT Number Plate Recognition cameras at DHH entrance and exit.	Business Case to be prepared to secure funding to have all CCTV transferred onto a Single Trust Digital Platform. Identify areas that require cameras on a risk basis and complete Minor Works Form for additional cameras 7/8/20 The analogue CCTV systems at DHH can be accessed via the IP platform, however the imagery remains of analogue quality and all analogue cameras and DVRs need upgraded to IP systems. CCTV status report is being completed by Support Services which will identify short-term and long-term requirements in order that priority rating can be agreed. Encrypted storage devices have been ordered which will increase data security and download/ transfer ability. All Portering Supervisors are trained to download CCTV imagery and arrangements are in place for them to download routinely to maintain their skills and a system is being put in place to record this. Arrangements are in place with Radio Contacts to come onsite and download imagery if urgently required out-of-hours if no Supervisor is on duty. CCTV Policy has been drafted.	MOD	DIV
3985	19/11/2018	Provide safe, high quality care	Trustwide	Typing backlogs for secretarial areas	Typing backlogs due to not enough staff plus maternity leaves covered at only 50% and 0.5 WTE allocated for new consultants/services. This is never enough. This can result in late follow up of patients to other clinics, patients being added to inpatient waiting lists etc Areas with continuous backlogs are Gastro, Rheum, Respiratory, T & 0, ENT, Diabetic/Endo, RACP, Derm	If Consultants use the Clinic Outcome sheet then follow up will be documented on this and then this should not be an issue, however, this is not used everywhere. Overtime is granted occasionally to try and keep backlogs down. Service Administrators monitor this information fortnightly and continually move resources around and across all sites to try and equalise backlog typing		MOD	DIV
4036	11/06/2019	Provide safe, high quality care	Trustwide	Discharge letters not being completed	When a patient is discharged they should be given a discharge letter which will give them details of their treatment in hospital and also detail out any follow up in terms of review, investigations that are required. If the letter is not done then the appropriate review/investigations may not take place. Risk to the patient of being lost to follow up.	Raised with Heads of Service asking them to remind the doctors to complete their discharge letters. Ward clerks let the doctors know that there are outstanding discharge letters. Ward clerks will let the Sister/Nurse in Charge know. However the situation has not improved.	Feb20 - email sent to HoS asking them to remind doctors of the importance of completing accurate follow up in the Follow Up section of the discharge summary. Information was also provided for the new doctors and locums induction on completion of discharges.	MOD	DIV
3911	15/08/2017	Provide safe, high quality care Make the best use of resources		Backlog of filing in Obs and Gynae	Filing in Obs/Gynae area constantly backlogged, results are not in patients charts at time of appointments. These are held on NIECR but directorate has to make a decision. Also non signing of results by doctors is a problem, Hand held charts not being returned timely from community so filing cannot take place. Results filing then sitting on wards, in box for midwifes etc but not in chart.		17.10.17 Risk remains unchanged	MOD	DIV
3941	27/02/2018	Provide safe, high quality care		Use of 2 Work neutral detergent which is classified as 'Corrosive' without eye protection	This product is extensively used throughout the Trust in the main production kitchens, ward kitchens, staff tea rooms, for dishwashing, general cleaning and cleaning of floors etc. The use of eye protection when using this product is unrealistic and something that would be extremely difficult to enforce given its extensive use in the Trust.	Induction training, on the job training and BIC's training for Support Services staff. • COSHH awareness training (all staff) • Observation of user completing task/using chemical • Spot checks • Safe Systems of Work (Support Services staff only) • Protective aprons and gloves • Eye Protection for dilution of chemicals (Support Services staff only) • Staff reminded to continue to report incidents to their supervisor/manager • Pre-Employment Medical Advice – skin care etc • Ill Health Referrals to Occupational Health • COSHH Risk Assessment and Data Safety Sheet • SHSCT Policies and Procedures • Trained COSHH Assessor in each locality	17/12/18 - The cleaning chemicals contract is being retendered and this product will not be included in the new contract which should be introduced in April 2019. Feb 2018 A Customer Complaints Form was submitted to BSO and a request made to have this product replaced with a non-classified, 1 litre detergent, which is safe to use. BSO unable to take action as this is a regional contract and the Southern Trust was the only Trust in the region to raise concerns. This matter cannot be resolved until action is taken by BSO.	MOD	DIV
3973	28/08/2018	Provide safe, high quality care		Risk of injury when cleaning fixed beds in Bluestone	There are 68 beds of these beds in the Bluestone Unit. Hazard - manual handling (risk of musculosketal injury) and Infection Prevention and Control - areas of the bed not accessible for cleaning and no programme for cleaning underneath the bed which is fixed to the floor. Mattress type is an issue - no grips on the side of the mattress to aid moving and handling, mattress cannot be folded in half to clean. Low fixed height of the bed is an issue for manual handling.Musculosketal injury, infection control	Induction training, on the job training and BIC's training for Support Services staff. o Infection Control training o Waste management training o Manual Handling training core/refresher o Observation of user completing task/using chemical o Spot checks o Safe Systems of Work - task specific (Support Services staff only) o Protective aprons and gloves o Staff advised to wear enclosed and low footwear o Faults reporting o Staff reminded to continue to report incidents to their supervisor/manager o Staff advised to check if the load is within their capabilities before lifting it. o Staff advised to seek assistance if a load is beyond their capabilities i.e. a colleague. o Pre-Employment Medical Advice o Ill Health Referrals to Occupational Health o SHSCT Policies and Procedures	17/12/18 - Health and Safety have recommended 2 people to clean the bed. However, Domestic staff work on their own most of the day. Assistance from nursing staff required to turn the mattress during cleaning. Ergonomic assessment completed by Physio department. This risk will only be eliminated if the beds change but funding is required.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4038	11/06/2019	Provide safe, high quality care	Trustwide	Results not signed off on the wards	Hard copy patient result forms are not being signed off by the doctors on the wards. This means that the ward clerk cannot file the results and they are left on the wards where they could be misplaced or something could be missed regarding the patient's condition. If the results are not signed off there is the possibility the something could be missed regarding the patient's condition. The ward clerk cannot file the results until they are signed so the results are left on the ward and there is the potential for them to be misplaced.	Ward clerks remind the staff that they need to sign the results. Electronic sign off is being implemented. DHHS ward clerks have been told to forward unsigned results to the consultant for them to sign.	Feb 20 - Dr O'Kane has written to consultants stating that results will be destroyed and is waiting for their response. Once clarification is received from the Medical Director's office that results can be destroyed this will be acted on.	MOD	DIV
4067	24/09/2019	Provide safe, high quality care		Non Destruction of Patient Records due to Infected Blood Inquiry	Risk to staff hurting themselves as they are managing records in libraries that are full. Filing and retrieval of charts is difficult as they are very closely packed in the pigeon holes. The filing bays are heavy when moving them. Trust will not have enough space to store all the patient records so some will have to be sent to commercial off site storage which incurs a cost. Staff could hurt themselves trying to assess charts. Charts will be more difficult to retrieve which could lead to a delay in their being available.	All staff must complete their Mandatory Training. Inspection of libraries has taken place by Health Records Managers and areas of concern highlighted. A plan has been set out to transfer some of the less active charts to the commercial off site storage which will leave space for the more recent charts.	Feb 20 - request has been sent to Alphy Magennis stating the cost of retaining records as part of the IBI and requesting funding for same.	MOD	DIV
4074	20/11/2019	Provide safe, high quality care;Make the best use of resources		Incomplete Consultant of the Week Rota or Consultants not recorded on PAS	The consultant of the week rota is not always up to date or has not been recorded on PAS. This means that the ward clerks do not know which consultant to admit the patient under. This could lead to the patient not being assessed by any medical staff. If the consultant is not recorded on PAS it means that the patient cannot be admitted under the correct consultant, which could lead to the patient not being seen in the appropriate timeframe or issues relating to follow up of treatment.	Reminders have been sent to the Heads of Service asking for clarification as to which consultant is on call. Assistant Director wrote to the Assistant Directors requesting this information is given asap and also that any new consultants are recorded on PAS asap.	Feb 20 - things have improved and consultants are being added on to PAS in a more timely fashion. Nov19 risk added to Divisional Register	MOD	DIV
4077	09/12/2019			Consultants Recruited without communication to relevant Admin Management Staff	Potential for patients not to be followed up on time, patients lost in system because proper admin support was not in place. Admin Management advised too late of appointments of consultants. There is a lead in time for secretarial recruitment of at least 3 months and then a training period. No communication with admin leads re what the consultants role will be, job plans etc. Potential for patients not to be followed up on time, and phone calls from patients unanswered, patients lost in system because proper admin support was not in place. Due to consultants being recruited without knowledge of Admin Management.	Overtime is allocated to try and sort some of this.	Dec19 Have met with some HOS/Ad's to try and sort some of this and gain some insight to job roles, base area etc.	MOD	DIV
4085	18/02/2020	Provide safe, high quality care;Make the best use of resources		Fire Risk in Laundry Department CAH	Risk of fire in the laundry due to a build up of lint in the building and in the laundry equipment. This could result in possible injury to staff. Inability to provide clean linen to wards in SHSCT, BCH and MPH. Infection risk to patients if no clean linen is available at ward level.	Monthly high level cleaning. Removal of lint is included on the maintenance assistant's cleaning schedule Lint removing machine is identified on the Trust Capital Priority List	16/02/2021- daily record kept of lint removal from dryers and emptying dryers at the end of shift. Weekly fire walk around in place and record kept. Monthly high level dusting undertaken by outside contractor. 18/02/2020 the purchase of a lint remover is required when funding becomes available.	MOD	DIV
4101	03/06/2020	Provide safe, high quality care;Be a great place to work		Unavailability of MAPA Level 4 Core and Refresher Training for Security Porter	Breach of the health and safety at work act by not providing staff with the necessary training to carry out their duties At CAH there are currently 4 staff that require core training and 14 staff who require refresher training and there are a further 16 staff due refresher training later in the year - 8 in Sept and 8 in November 2020. At DHH there are currently 0 staff that require core training and 8 staff who require and there are a further 15 staff due refresher traninng later in the year. In addition new recruits and vacational staff will require core training. There is risk of injury to patients, staff and the public from unsafe practices if the security porters are undertaking security duties without core or refresher training, or there are insufficiently trained staff to undertake security duties. Without the training the security porters will have limited mitigation in their defence should criminal or civil action be taken against them if physical restraint is applied and is not deemed reasonable which would damage reputation of Trust.	MAPA core training has already been provided to staff awaiting refresher training.		MOD	DIV
3812	20/07/2016	Safe, High Quality and Effective Care	Switchboard	Lack of Emergency Major Incident Planning Software	Switchboard follows a Major Incident protocol, individually calling a list of key contacts, with a Major Incident Alert, Major Incident Declared and Major Incident Stood Down. In the event of a Major Incident declared up to 50 people may be contacted. This is time consuming, resulting in delays in key staff being notified. On site staff are individually bleeped. Switchboard staffing levels are reduced in the Out of Hours period, which will create further delays as additional staff will be required to come in. Switchboard manually record on paper as each person is contacted. Reports are available showing time of alert and numeric message. Voices over messages are not recorded.	Continue to monitor the situation. Paper completed to identify the risks shared with Acute SMT.	16/02/2021- Following a trial period Northern Trust now plans to implement the Appear App software. Southern Trust awaits to see if there are any operational issues before implementing the same here. 4/3/2020 It has moved the imessage system onto the Trust domain. System providers to complete the approval to rollout to all necessary staff. 15.5.19 Full implementation of roll out of smart phones has been completed. All Emergency calls to ext 6666 & 6000 are now being recorded. New iMessage bleeping system is now fully operational. IT are currently PEN (Security) testing the App. When complete test group will be identified & App tested prior to roll out to all Major Incident responders. 19.12.18 IT/Telecoms have rolled out new smart phones to all blackberry holders as the Appear App will not work on the blackberry phone. Implementation of the Imessage Appear App by Estates Telecoms Team has been rescheduled to April/May 2019. 5.4.18 Imessage Appear App (Emergency Planning Software) has been purchased. Trial is ongoing with the Northern Trust. SHSCT awaiting feedback from Northern trial before implementing. IT/Telecoms currently rolling out new smart phones to all blackberry holders as the Appear App will not work on the current blackberry phone. Full implementation scheduled for April/May 2018. All Emergency calls to ext 6666 & 6000 are now being recorded. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017.	MOD	DIV
3861	13/12/2016	Provide safe, high quality care	Grounds	Car Parking and Traffic Management Problems DHH	Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patients and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of collision due to disregard by drivers of one way system. Risk of injury to pedestrians entering Car Park F as no safe footway.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	17/12/18 Relocation of Pay and Display in Car Park C starting in Jan 2019 due to relocation of OOH and OPD. 27.02.18 Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3753	04/01/2016	Provide safe, high quality care		Falls from height CAH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death. 21.11.16 The new retaining wall beside the footpath up the main drive has created additional potential for harm.	None - Action Plan Attached.	13/6/19 Estates and Support Services to review outstanding actions. 23.02.18 Minor Works request submitted for outstanding controls.	MOD	DIV
3754	04/01/2016		Office(s)	Dermatology Office Risks due to file storage issues	Electric shock from electrical equipment in the office. Faulty equipment could lead to a fire which would spread rapidly due to the amount of combustible material in the office which is stored on walkways. Fire would subsequently result in damage to property. Staff may suffer smoke inhalation and/or burns. Musculoskeletal injury while moving/retrieving charts. Personal injury to members of staff due to the storage of patients charts on the floor and underneath desks. Walkways cannot be kept clear due to the volume of files processed in this office and the limited availability of shelving which also has an impact on the safe evacuation of staff from this area in the event of a fire. See Hazard no. 9 & 10. Risk of musculoskeletal injury from incorrect workstation set up.	Fire Safety training for staff. Fire Safety Policy. Fire evacuation plan. Electrical equipment is subject to Portable Appliance Testing (PAT). Manual Handling Policy is available on the intranet. Manual handling training (3 yearly for low risk staff). Limited shelving is available. DSE Procedure is available on the intranet.	1/7/19 Pilot started re charts not to go to clinics but pages and labels only, consultant to use NIECR. This will help with volume of charts in office. 12.12.16 No further update 22.02.16 Ongoing. Urgent fire risk assessment required. Please contact Vincent Burke to request this.Remind staff to complete fire safety training on an annual basis. Remind staff to report any faults with electrical equipment, mark it faulty and remove from use. Manual handling risk assessment to be completed for inanimate loads e.g. patients charts, stationery items etc and shared with staff. Request should be made for additional accommodation to facilitate the storage the storage of charts by as the current accommodation is unsafe and a high fire risk.Request to be made to Estates to measure the office to determine if it meets the requirements of Regulation 10 of the Workplace, Health, Safety & Welfare Regulations. DSE self-assessment and 12 point plan to be issued to staff. Staff to be made aware of their entitlement to eye and eyesight testing in accordance with the Trust's DSE Procedure. Staff should complete the DSE awareness via e-learning. Access should be requested via earning.support@southerntrust.hscni.net	MOD	DIV
3792	13/04/2016	Provide safe, high quality care a great place to work		Waste Storage and Handling CAH	Lack of space for waste dispersal rooms on 1, 3 and 4 North leading inappropriate storage / segration of waste and risk of leaks from contaminated clinical waste if not stored safely. Waste storage area on 1 East / 1 West and 2 East / 2 West are too small for ward requirements.	3 North waste is stored in the Sluice Room; 4 North waste is stored in a store room and 1 North waste is stored in the Domestic Store. Housekeeping arrangements are in place to ensure waste is stored as safely as possible. Staff are aware to report incidents, which are subsequently recorded on Datix. Spills are cleaned immediately. PPE is provided for staff handling waste and staff are trained in the use of PPE. Staff receive waste management training.	23/2/2018 - 4N have black and yellow bins in their dispersal now. 1N, 3N, 1W/1E, 2W/2E no progress.	MOD	DIV
3291	28/11/2012	Safe, High Quality and Effective Care	Grounds	Car Parking and Traffic Management problems CAH	Contractors taking up space. Limited entrance and exit access causing grid lock of site in the event of an emergency / major incident. Limited parking spaces around the site. Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patinets and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of injury to pedestrians as no safe footway in parts of the site.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	7/5/19 - Planning application for 2nd entrance applied for Lisnisky Lane gate is opened in emergencies. Increased level of complaints following the extension of enforcement in November 2018. Difficultt parking is resulting in patients being late / non-attendance at clinic appointments. 23/2/2018 - Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces. Additional spaces at Craigavon Area Hospital. Traffic calming measures including ramps at pedestrian crossings and speed control signage at Craigavon Area Hospital. Renewed markings on disabled spaces to ensure they are visible.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3977	25/09/2018	Provide safe, high quality care		CCTV System CAH Issues	The current CCTV system uses outdated technology (analogue) and surveillance coverage does not extend to all of the areas required. This can result in no CCTV footage available or poor quality images. 1. Compromised safety of all personnel on site 2. Compromised security of both Trust and personal property 3. Inability to detect crime and footage unable to be used in prosecutions 4. Inability to investigate incidents 5. The Trust is not fully compliance with the Data Protection Act 2018 - GDPR Compliance Assessment attached. 6. Compromised ability to locate missing patients from the Wards or Departments.	Health and Safety Risk completed and is attached. Regular checks are carried out on the CCTV system and faults are reported to Estates. Maintenance Contract with Radio Contact. Some faults in the system are unable to be repaired as the technology is outdated and require a longer-term solution - a list of outstanding faults is attached. A list of areas requiring CCTV cameras have been identified on a risk assessed basis and is attached.	£50k has been allocated to address local issues with CCTV Develop Business Case to upgrade and extend the system on a risk basis. 7/8/20 At CAH the CCTV system has been upgraded to an IP platform which has significantly improved imagery and capability and 360o degree omnidirectional cameras have been installed in some critical areas, eg ED waiting area. Number plate recognition on the CCTV camera on the main drive at CAH should be operational by 31 August 2020 and this will integrate with the CCTV IP system. Encrypted storage devices have been ordered which will increase data security and download/ transfer ability. CCTV status report is being completed by Support Services which will identify short-term and long-term requirements in order that priority rating can be agreed. All Portering Supervisors and the Portering Manager are trained to download CCTV imagery and arrangements are in place for them to download routinely to maintain their skills and a system is being put in place to record this. Arrangements are in place with Radio Contacts to come onsite and download imagery if urgently required out-of-hours if no Supervisor is on duty. Security reviews were completed in AMU and ED CAH to improve lockdown and access control and costings obtained from Estates and shared with Anne McVey, Mary Burke and Paul Smyth by Anita Carroll on 28 Feb 2020 to progress the recommendations. The recommendations for ED will need to be reviewed in light of additional access control doors installed in ED CAH due to Covid-19. CCTV Policy has been drafted.	LOW	DIV
3355	16/05/2012	Safe, High Quality and Effective Care		Actichlor plus	Risks highlighted: Ingestion of product, Skin damage due to contact, Eye damage due to contact, Unauthorised access to product, Unsafe systems of work by staff, Inhalation	All staff are trained in the safe use of this chemical i.e. induction, BICS, COSHH, food safety and on the job training and in compliance with regional guidance on colour coding. Staff are advised to wear correct PPE when using this product and during the disposal of large quantities and in the event of a large spillage. PPE includes eye protection, apron, & gloves. Safe storage of the product - product stored upright in a closed labeled container - in a cool, dry, well ventilated area. Store away from incompatible materials and sources of direct heat. Store in locked cupboard in Domestic Services store - locked if available. Staff are trained not to mix chemicals. COSHH risk assessments and safety data sheets are located in the managers/supervisors office and in sister's office in A&E. Colour coding for area. Ongoing monitoring & reviewing of COSHH risk assessments. Trust policies & procedures e.g. Health & safety at work, COSHH, Manual handling etc. Cleaning work schedules. Kitchen hygiene audits - monthly audits and spot checks. Uniform audits e.g. low and closed in shoes. Staff referral to occupational health where necessary	12.12.16 As good control measures are in place the risk rating is being reduced from Moderate to Low.	LOW	DIV
4097	08/06/2020	Provide safe, high quality care a great place to work	Trustwide	Unavailbility of MAPA Level 4 Core and Refresher Training for Security Porters	Breach of the Health and Safety at Work Act by not providing staff with the necessary training to carry out their duties. At CAH there are currently 4 staff that require core training and 14 staff who require refresher training and there are a further 16 staff due refresher training later in the year - 8 in September and 8 in November 2020. At DHH there are currently 0 staff that require core training and 8 staff who require refresher training and there are a further 15 staff due refresher training later in the year. In addition, new recruits and vacational relief staff will require core training. Risk of injury to patients, staff or the public from unsafe practices if the Security Porters are undertaking security duties without core or refresher training, or there are insufficiently trained staff available to undertake security duties. Without the training the Security Porters will have limited mitigation in their defence should criminal or civil action be taken against them if physical restraint is applied and is not deemed to be reasonable. Damaged reputation for the staff and Trust.	MAPA core training has already been provided to staff awaiting refresher.	09/12/2020- Security Porters are able to access training as required. Downgraded to divisional risk register 07/10/20 core training is currently taking place as a combination of face-to-face and virtual but no refresher courses are planned. Risk Added to register June 2020 for monitoring	LOW	DIV
3453	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Internal Bleep System Failure	Risk to patients, staff, service users in the form of: Potentially unable to activate Emergency Teams e.g. Cardiac, Stroke, Paeds, Obstetrics, ILS, etc. Unable to reach individuals in an emergency e.g. Cardiac Nurse, Stroke, Security, etc.	Daily tests carried out on all teams. Maintenance contracts in place with Multitone (bleep providers) and Estates responsible, protocols in place for activating bleeps.	16/02/2021- spare mobile phones kept at CAH & DHH switchboard as backup to give out to key responders if failure occurs. 9/3/2020, 15.5.19, 19.12.18 No further update. 5.4.18 New Multitone iMessage paging system in operation. System is now running of multiple transmitters to ensure that if there are any outages that another server provides resilience. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017.	LOW	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3777	08/03/2016			Waste Management South Tyrone Hospital	Risk of Infection from waste contaminated with blood/bodily fluids. Injury due to sharps being disposed of incorrectly into waste bags, laundry etc and coming into contact with member of staff. Risk of musculoskeletal injury from handling waste which involves carrying on the same level and also between stairwell levels, bags being overfilled. There is excessive handling of waste bags due to lack of storage facilities in wards and departments to allow waste to be placed in the bins by the users. Waste is a as result handled 3 to 4 time by staff thus increasing the risk of injury/ exposure. Risk of injury from slips, trips, falls due to the lack of storage. Lack space to provide suitable waste management arrangements leading to excessive handling result in injury to staff, leaks from contaminated clinical waste if not stored correctly. Portering staff have to go out in all-weather to move waste, from the vehicle and as all the bin storage is open to the elements.	Sharps boxes are provided for disposal of sharps. Segregation of waste. Safe Management of Healthcare Waste- 2013 (information available on the intranet). Waste management training. PPE provided for staff handling waste. Staff trained in use of PPE. Corporate Risk Assessment on Blood Borne Viruses (available on intranet). Staff aware to report incidents, which are subsequently reported on Datix. Manual handling training. Waste management training (advised not to overfill bags). Manual Handling policy. Manual handling risk assessment. Safe systems of work. Staff aware to report incidents, which are subsequently reported on Datix. Cleaning of spillages immediately. Housekeeping arrangements are in place to ensure waste is stored correctly. Staff aware to report incidents, which are subsequently reported on Datix. Cages are provided to store waste. Spills are cleaned immediately. Staff aware to report incidents, which are subsequently reported on Datix. PPE raincoats s are provided.	13/6/19 traffic and people parking at the back of the kitchen / the pad store and beside the waste area are blocking the bin lorry from getting access. There is now a chain on the area around Loane House and this has helped. The old portacabins are being dismantled mid June 2019 so this should then provide a new bin collection area for the rest of the site and may ease the problem. 12.12.16 As all the recommendations made following the HSENI Clinical Waste Inspection visit on the 1 December 2015 have now been actioned the risk rating is being reduced from Moderate to Low. 8/3/16 Domestic Services staff to be advised not to overfill bags and waste receptacles. Communication to be forwarded to ward/department managers advising their staff not to overfill bags. Manual handling risk assessment shared with staff.	LOW	DIV
4062	20/08/2019	Provide safe, high quality care Make the best use of resources		No electronic interface between SSD instrument tracking systems and TMS	There would be a delay in identifying patients and instrument sets used in the event of a look back exercise due to the lack of an electronic interface. Patient identification is currently only achievable by manually going through the patients notes to look for barcode stickers relating to the instrument sets. Possible infection risk to patients due to the length of time required to identify patients manually where there is a possibility of cross contamination. Impact on staff time and resources.	Checks are carried out manually if required	16/02/2021- an electronic interface will be developed as part of the regional Encompass project.	LOW	DIV
4063	20/08/2019	Provide safe, high quality care Make the best use of resources		Lack of Long Term Contingency for Laundry Dept	SE Trust and a private laundry in Belfast can provide contingency in the event of a short term breakdown but cannot sustain this for longer than a couple of days in the event of a major laundry equipment breakdown or loss of production e.g. loss of essential utilities or fire. Possible risk of infection to patients due to lack of clean linen	SE Trust and a private laundry in Belfast can provide short term cover in the event of breakdown but cannot sustain this for longer period.	16/02/2021 - no further update	LOW	DIV
4064	20/08/2019	Provide safe, high quality care Make the best use of resources		Aging Decontamination Equipment	Possible risk of breakdown of aging decontamination equipment. Three sterilises and three endoscope washer disinfectors are past the end of their anticipated life cycle and whilst they are still in working order there is an increasing risk of faults or breakdowns. Possible unavailability of sterile instruments / clean endoscopes leading to possible delays or cancellations of procedures	Estates maintain and service the equipment as per manufacturer's recommendations. Replacement parts are currently available.	16/02/2021- all ageing equipment is included on the capital priority list. Draft paper re funding requirements has been shared with the Director of Acute Services. 12.11.19 The Lancer Endoscope Washer Disinfector manufacturer has confirmed that they will support the EC2 /4 model until 2022 for the electronics and until	LOW	DIV
4037	11/06/2019	Provide safe, high quality care	Trustwide	Breakdown of mobile bays in Health Records	The mobile bays in Health Records in CAH and DHH are old and are breaking. This means that the staff cannot use the mechanism to move the bays but have to manually push the actual bay. Risk of member of staff hurting themselves while trying to move the mobile bays.	All staff must be trained in Manual Handling. Notices put on bays letting staff know which ones are broken. Estates notified and ask to repair as a matter of urgency.	Feb 20 - when possible charts are moved to Villa to avoid having them on the top of the shelves which puts additional pressure on the bays.	LOW	DIV
4128	26/11/2020	Safe, High Quality and Effective Care	Sterile Services	Non compliance with Regional Decontamination Strategy	possible infection risk to patients as the SSD trollies are not decontaminated in an automated trolley washer. The regional denomination strategy states that SSD's should use an automated trolley washer to decontaminate the trollies that are used to transport dirty and clean surgical instruments between SSD and wards/dept. The SSD's at CAH and DHH do not have an automated trolley washer as there is no space to install one.	Dirty instruments are enclosed inside plastic bags during transport in the SSD trollies. SSD staff manually clean the SSD trollies after the dirty instruments are removed from them and a cleaning record is kept.	16/02/2021 inclusion of an automated trolley washer in the plans for any upgrade of the SSD's	VLOW	DIV
3281	26/11/2012	Provide safe, high quality care Maximise independence and choice for patients and clients Support people and communities to live healthy lives and improve their health and wellbeing Make the best use of resources	Kitchen/Dining Room	Risk of vulnerable patients contracting E coli 0157 from very low levels of contamination of ready to eat foods	E. coli O157 is a particularly dangerous type of bacteria because it can cause serious, untreatable, illness and even death from very low-levels of contamination of ready-to-eat food. Because E. coli O157 survives at freezer, chill and ambient temperatures, measures to control cross-contamination apply to all of these environments. Although E. coli O157 is the key focus of this guidance, the measures outlined will also help in the control of other food poisoning bacteria, such as campylobacter and salmonella. The risk of E. coli O157 cross-contamination should be considered wherever raw foods such as raw meat and unwashed vegetables are handled and where ready-to-eat foods are also handled. Without strict controls, E. coli O157 can be spread throughout any food processing environment. It is therefore essential that ready-to-eat foods are at all times handled and stored in clean areas where controls ensure the environment is free from E. coli O157 contamination.	1. External inspection by Environmental Health Officers and CDCC. 2. All food handlers are trained in food safety and HACCP. 3. There is a HACCP in each facility. HACCP plans are reviewed by the Catering Manager and the Locality Support Services Manager as required. 4. Hand washing and Food Safety Audits are completed. 5. There is complete physical separation of raw and ready to eat food during delivery, handling and storage in fridges. 6. The Trust has a dress code policy which covers uniforms, the wearing of jewellery etc. and audits are conducted to measure this compliance. 7. All staff are trained on cleaning disinfection and hand washing.	12/6/19 This risk could be de-escalated to the Catering Service Risk Register due to the controls in place. 121.12.16 No further update 26.02.16 Controls have been improved in all food production . At CAH this has been completed by the building of a partition and in DHH a separate area is used , in other units measure are in place to keep these function to sepetate area/times and handling to a minimum. Additional training on all aspect of e-coli has been delivered F ood handling and staff practices continue to be monitored, and audit arrangements have been updated. Additional checks are in place at meal times. Supervision has been reviewed at CAH and there is now a lead cook on shifts. Contingency plans have been reviewed and the learning from Incident in June 2015 has been taken on board. a new contract is in place fo microbiological testing and locally ATP machines are purchased to allow more frequent sampling of surfaces and handwashing.	LOW	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3454	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Risk of Telecoms Failure Across CAH, SLH, STH, and LH	Potential for telephone lines to go down: a)Internally b)Cross-site c)Internally/cross-site/externally d)External lines only Risk 1: If lines go down internally - risk to patients and staff Risk 2: If lines go down externally - risk to members of the public	- Contracts are in place with Telecoms providers. - Protocols are in place with Estates services in relation to re-establishing telecoms links. - Mobile telephones are also available for use within A&D, and C&B localities.	December 2020: Disaster Recovery successfully tested in November 2020. Infrastructure upgrades scheduled for early 2021 which will ensure continued resilience. March2020 Full Disaster Recovery protocol in place. Tested and system coping with switching from one server to another with minimal interruption. May 2019: New Trust wide Equinox telephony system now in place which means the majority of phones run off the IP system. Fall back servers are in place to ensure resilience. Craigavon Hospital Switchboard can now provide full cover for Daisy Hill Switchboard or vice versa if required 19.12.18 New telephony system "Equinox" to be installed by Estates Telecoms at both CAH and DHH switchboards in January 2019. 5.4.18 New telephony system "Equinox" to be installed from April 2108. Significant increase in amount of VOIP handsets within the Trust. 16.8.17 Partial roll out of VOIP handsets - Estates awaiting approval of revenue funding to enable full roll out of VOIP handsets. 22.02.16 Capital funding approved to enable Estates to purchase additional hardware. Estates awaiting approval of revenue business case for roll out of VOIP handsets.	LOW	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4059	14/08/2019	Provide safe, high quality care Make the best use of resources		Midwifery Staffing Levels throughout SHSCT sites	Unable to recruit and retain Midwifery staff due to a regional and national shortage of Qualified Midwifery StaffThere is a conntinual potential for wards to be understaffed. This may result in poor outcomes for patients and babies.	The Division continues to use bank and agency staff, overtime, innovative practice such as recruitment fairs, making best use of staff in post, and ongoing staff development.	June 2020 Ongoing roles for recruitment, liaising with workforce planning re recruitment strategy. Dec19 Recruitment day undertaken and ongoing recruitment in progress	HIGH	DIV
4033	11/06/2019	Provide safe, high quality care Make the best use of resources	Trustwide	Unacceptable waiting time for Urodynamics Appointments	Delay in providing optimum care for patients waiting for Urodynamics Sessions in the Trust. Potential for harm to patients waiting an unacceptable length of time for Urodynamics Sessions.	Best use made of appointment time slots and continual monitoring of the situation.	Jun20 Due to impact of covid waiting times further extended. Dec19 Risk remains unchanged Aug19 Training of staff continues Jun19 Training of staff is ongoing	MOD	DIV
4092	30/03/2020	Provide safe, high quality care	Maternity Outpatients	Inability to store ultrasound images for future review	There is currently no storage system in maternity department to hold ultrasound images for future review. Possible risk to patients of missed diagnosis as scans cannot be stored and rescans may not be scheduled in a timely manner which could cause disease to be missed.	None currently in place	June 2020, March 2020 - New storage equipment required in the maternity department to hold ultrasound images	MOD	DIV
4076	04/12/2019	Provide safe, high quality care Make the best use of resources	Colposcopy Clinic	Waiting times for Colposcopy appointments	Delay in providing optimum care for patients waiting for Colposcopy appointments in the Trust. Potential for harm to patients waiting an unacceptable length of time.	Best use made of appointment time slots and continual monitoring of the situation.	June 2020 New Cons appointed to increase capacity, and continue to monitor waiting times. Dec19 Risk added to Divisional Register	MOD	DIV
3942	27/02/2018	Provide safe, high quality care	Delivery Suite	Possible breakdown of aging resuscitaires	Spare parts increasingly difficult to source for old models of Resuscitaire equipment currently in use in both CAH and DHH. This could lead to possible risk to newborns when high number of births on either site.	Manage number of planned deliveries coming into each hospital.	10/08/20 - A number of resusciatres have been purchased. Move to divisional risk register. Jun20 Resuscitaires procured for CAH and DHH, remainder required remain on capital listing. August 19. Remains on Capital funding list increasing of number of aging resuscitaires requiring replacement parts which are becoming increasingly difficult to source.	MOD	DIV
3996	20/11/2018	Provide safe, high quality care	Maternity/Labour Ward	Unable in DHH to implement recommendation Re "Saving babies lives"	Recommendations from Saving Babies Lives - requires At Risk fetuses to have 3 weekly fetal surveillance scans. This is being carried out on the CAH but not the DHH site. to meet the PHA / Standards Missed opportunity to intervene in high risk fetus resulting in still birth and fetal abnormalities	Currently unable to meet the requirements Only able to provide growth scans to identified high risk pregnancies on DHH site only. Recruitment of a Band 7 Scanning Midwife to train midwives and doctors to perform 3rd trimester scans and also to develop a Day Obstetric Unit on the DHH site, this e req is being held up by finance.	Jun20 Midwife now recruited and in post but not yet implemented due to covid. Dec19 Unchanged Jun19 Job Description and E-requisition for scanning midwife has been forwarded to finance for consideration for appointment of this post.	MOD	DIV
4034	11/06/2019	Maximise independence and choice for patients and clients	Fertility Clinic	Reduced capacity of Fertility Clinic	Lack of fully trained staff to provide full running capacity for Fertility Clinic. Unacceptable delays in providing this service to patients, difficulties arising from poor continuity of care.	Best use made of appointment time slots and continual monitoring of the situation. Plan to ensure that the potential for further disruption to the service is minimised. Regular meetings between service managers and clinicians to facilitate strategic planning.	June 2020 Due to covid Fertility Out Patient stood down, plan to restart services in July 2020. Dec19 Staffing compliment now increased again and demand being managed and monitored. Jun19 Continual monitoring of the staffing situation for the clinics. Training of staff is ongoing. Regular meetings between service managers and clinicians to facilitate strategic planning.	LOW	DIV
3162	13/06/2012	Provide safe, high quality care	Delivery Suite	Trium archiving system CAH & DHH	Trium archiving system is intermittently working due to:- CAH & DHH - poor quality of cabling and existing points. DHH site- Trium boxes have be damaged and require replacement.	Keep a record of patient's hospital numbers to ensure CTG scanned to facilitate archiving Inform labour ward coordinator and IT is trium not working. Complete IR1	Jun20 and Dec19 risk remains unchanged Jun19 Continues to experience IT performance problems which continue to be monitored. 22.1.18 Still ongoing risk	LOW	DIV
4032	11/06/2019	Provide safe, high quality care Make the best use of resources	Trustwide	Trophon system not in use in all relevant areas	Trophon (decontamination of transvaginal probes) system is not being used in all appropriate areas.	Tristel Wipes was being used as an alternative method of cleaning pending implementation of standard operating procedure.	June 2020, Dec19 & Aug19 Risk remains unchanged. Jun19 Implementation of SOP throughout all appropriate areas. Staff training ongoing.	LOW	DIV
4068	15/10/2019	Provide safe, high quality care Make the best use of resources		Accomodation for Antenatal/Postnatal Clinics at Ballygawley Health Centre	The accomodation previously used by the Community Midwives in Ballygawley General Practitioner surgery has been reallocated to the Children and Young People's Health Visitors. There is currently no suitable accomodation to continue running antenatal and postnatal clinics. This will impact on the safe and efficient running of antenatal and postnatal clinics until a suitable area has been established.	Situation is currently being monitored	June 2020 remains unchanged, delayed due to covid. Dec19 Awaiting Finance costings for work to proceed with works	LOW	DIV
4051	07/08/2019	Provide safe, high quality care	Delivery Suite DHH	Lack of fetal monitoring capability during transfer to main theatre from delivery suite.	Unknown fetal status during transfer. Potential risk to client and potential litigation	Intermittent ascultation may be possible only when the bed is stationary i.e when in the lift. Transfer time may take at least 10 minutes. Controls considered but discounted - Intermittent auscultation does not provide continuous contact with the fetus which is required in situations of fetal distress or during the induction process as per NICE guidelines. The only monitor that would allow continous fetal monitoring during the transfer is the Phillips Avalon FM30 which is has a battery supply to allow for CEFM during transfer.	June 2020 CTG machines on capital funding for 2020, awaitng confirmation of same. Dec19 & Aug19 Situation continues to be managed and monitored.	LOW	DIV
4091	09/03/2020	Provide safe, high quality care Be a great place to work Make the best use of resources		Staff Risk due to lift required in Brownlow Health Centre	A lift is required in Brownlow Health Centre, to easy carriage of equipment and files up flights of stairs, through fobbed doorways to clinical areas. Possible risk of injury to staff responsible for carriage of equipment and files up flights of stairs and possible damage to equipment as staff maneuvre up flights of stairs and through fobbed doorways.	Limit individual loads being carried up stairs to reduce risk to staff or equipment	June 2020 continue to monitor risk.	LOW	DIV
4061	14/08/2019	Provide safe, high quality care Support people and communities to live healthy lives and improve their health and wellbeing		Home Births Risk if Emergency and required Urgent Ambulance Transfer	There is a possible risk to birthing mothers who experience difficulty during home birth and require urgent transfer to hospital due to current increased strain on ambulance services. This may lead to possible harm to mother and baby.	Birthing mothers are continually monitored prior to and during home delivery to ensure early alert if a problem may arise.	June 2020 & Dec19 Ongoing risk identified and discussed with all women at risk when home birth risk assessment undertaken.	LOW	DIV
4069	05/11/2019	Provide safe, high quality care Make the best use of resources	Admission and Assessment Unit	Limited Security in Admission & Assessment Unit and Maternity Outpatient Department CAH	Potential for breach of Data Protection due to patient information not secure when clinics are not being held	Possible breach of patient confidentiality	Jun 2020 check if minor works has been submitted Dec19 Minor works form to be completed to review with estates.	LOW	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4043	26/06/2019	Provide safe, high quality care Make the best use of resources Support people and communities to live healthy lives and improve their health and wellbeing		Possibility of Breach of Patient Confidentiality as records are hand held	patient hand held records are in use for maternity patients which increases the potential for breach of patient confidentiality and misfiling of notes/results. sharing of personal information and breach of data protection and information governance.	continual staff awareness of need to ensure correct information filed in the correct chart.	June 2020 Increased awareness training of staff involved in filing into MHHR. Dec19 & Jun19 Continual monitoring of accurate filing	LOW	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
1135	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	IV drugs reconstituted at ward level; risk of infection; risk of wrong dose, especially if many manipulations	IV drugs reconstituted at ward level; risk of infection; risk of wrong dose, especially if many manipulations.	IV drug manual rolled out through regional MI; FY1 induction training on preparation of intravenous medicines. regional preparation templates being developed for recognised red risk IV medicines - due Jan 2014.	Results of high risks identified fed back to the regional NPSA safety alert implementation group. The Trust is complying with their recommendations as they are being issued to the service. Regional SOP's are being prepared. A regional group of medicines information pharmacists has been set up to action this initiatives.	MOD	DIV
3502	14/10/2013			Clinical pharmacy cover for Trust wards	Only 50% of Trust wards have a full clinical service and there is no clinical cover on wards at the weekends. This is resulting in poor drug history taking, no clinical checks of Kardex and/or discharge prescriptions - thus increasing the risk to patient safety as medication incident may go undetected and result in patient harm.	All new IPTs for expanding services have clinical pharmacy support included. Pharmacy skill mix has been reviewed to ensure the maximum service is provided with current staffing. Current maternity leave and recruitment issues have again increased the risk.	16.10.17 Risk remains unchanged	MOD	HOS
1150	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	Discharge medication supplied directly from ward by nursing staff	Discharge medication supplied directly from ward by nursing staff; risk of dispensing error due to untrained and inappropriate staff; labelling - not in line with legislation; incorrect prescription now dispensed; 28 day supply; no clinical check.	Where possible all discharge prescription should be supplied by the pharmacy team; where this is not possible, supply directly from a ward must be carried out in accordance with an agreed procedure. Weekend and weekday opening hours extended to reduce frequency.	17.10.17 Ongoing risk as pharmacy is not open 24/7 so some ward dispensing will still happen. Ongoing monitoring in place and ward staff encouraged to plan discharge in advance so this doesn't happen.	LOW	DIV
1121	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	Manual handling risk associated with ward orders/fluids	Manual handling risk associated with ward orders/fluids.	Trained staff in Pharmacy; new ward stock trolleys purchased and being rolled out; rate-limiting step is availability of portering staff; boxes half filled only; risk by transport driver - assessed by Back Care Co-Ordinator; second porter now working in pharmacy; risk assessments done by [redacted] heavy work shared by technical staff; following injuries some staff on light duties - increased load on other staff; roll cages ordered for ward direct delivery to reduce lifting and handling loads.	16.10.17 Ongoing risk in pharmacy due to the manual nature of some of the work in the stores areas. Ongoing monitoring and staff training in place.	LOW	DIV
1134	13/08/2008		Pharmacy	Security of drugs during transit to other hospitals	Security of drugs during transit to other hospitals; are vans locked when left unattended?; no signatures for receipt of drugs when sent with transport other than pharmacy driver.	Tamper evident seals on all boxed (but not for supplementary orders). Transport manifest now introduced - including signatures for delivery driver and for staff receiving goods on delivery.	17.10.17 Ongoing risk being monitored by the Pharmacy dispensary and store teams	LOW	DIV
1158	14/08/2008	Safe, High Quality and Effective Care	Pharmacy	No formal assessment of competency for clinical checking	No formal assessment of competency for clinical checking.	Trained staff, e.g. pharmacist/registered; department standards issued to all staff; experienced staff; clinical checking guidelines in place. Now part of VT training for band 6's and peer review being considered	Clinical checking procedures need to be developed for pharmacists.	VLOW	DIV
1119	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	Flammabile load in pharmacy too high; risk of fire	Flammabile load in pharmacy too high; risk of fire.	Discussed with Fire Safety Officer; store as much as possible in flammable cupboards; looked for alternative storage - old store re-proofed and most flammables have been moved out there; flammable cupboards in pharmacy moved to more suitable location.	17.10.17 Old CAH store has been replaced with a modern bunded flammable store remote from the hospital building. Pharmacy staff continue to monitor fire load within both the pharmacies.	VLOW	TEAM

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register		
3829	13/09/2016	Safe, High Quality and Effective Care		Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating. Situation continually monitored.	HIGH	DIREC	09.03.2021-updated 2019-ED AMU review absconding patients with PSNI and mental health at interface meetings	Risk assessment in ED if PSNI accompnay patient under article 130 a joint risk assessment is completed with nursing
4133	29/01/2021		Trustwide	Unable to off load patients from ambulance when ED is overcrowded	Patients at risk due to being unable to offload patients from ambulance to ED due to overcrowding	HALO role and ongoing monitoring	Daily monitoring and escalation. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing review of escalation plan	MOD	DIREC	09.03.2021-need to secure funding for medical gases for ambulance receiving area	
3960	30/04/2018			ED trolley for patient coming for x-ray not fit for purpose	"Cot sides of the trolleys very stiff making them very difficult to lower and lift -risk of injury "Under trolley Bucky holders either non-existent/ bent/ damaged or stuck against opening and beyond repair "Pull bars for the cot sides broken with only the screw available giving risk of sharps injury. "Cot sides in a state of disrepair with the sides very unstable and creating a hazard during the transfer of patients upon it. "Brakes on the trolleys sticking and therefore needing a greater force to transfer patients safely which in turn creates a further injury risk. "Out of 32 trolleys surveyed on the day 17 were in some way broken which is severely alarming. "Risk of serious MSK injury to staff while using this equipment as placing the detector in the Bucky requires several movements (twisting pulling and pushing) "Finger injuries when trying to place the detector in under trolley Bucky (several staff members have had near misses) "Increased risk of injury from the older trolleys as there is no assisted lifting function with staff responsible for lifting and lowering- if patient comes back suddenly staff will get injured	"Staff awareness "Conversing with ED sister in charge to have trolleys taken out of use and repaired "Patient returned to ED and transferred to working trolley "Trolleys with no under trolley buck holder used solely for Chest x-rays. "Radiographers reporting as faulty, taking out of action, putting note on and informing the sister. "Staff awareness at induction. "Yearly manual handling training.		LOW	DIV	remove it	
4035	11/06/2019	Provide safe, high quality care	Trustwide	Incomplete ED flimsy records	The ED flimsy is a record of the assessment and treatment of a patient in ED, and also any follow up required. All relevant information relating to the accurate disposal of the patient and any further follow up for the patient is to be recorded on the back page in the appropriate text boxes. The admin staff read the back page of the ED flimsy which should provide them with the information they need to discharge the patient accurately from ED and also the information they need to arrange any further referral for the patient to another clinic/service, or if the patient has had an x-ray and needs to be placed in the x-ray audit. The information is not always recorded on the back page and this means that patients are not referred on to another clinic/service and so places the patient at risk as their further treatment/follow up will not be arranged for them. There is a risk to the patient in that if the back page is not correctly filled in with any instructions as to referring the patient to another clinic/service that the patient will be lost to follow up. This has happened and has only come to light when the patient has phoned asking about their follow up.	Agreed with medical staff that all appropriate information relating to the accurate disposal and follow up of the patient must be recorded on the back page.	18/02/2020 ED Trackers started in Dec19 and they are flagging up incomplete flimsies to the doctors to try and get them to improve. ED Admin Manager attended the ED doctors induction to emphasise the need to complete the flimsy correctly.	MOD	DIV	09.03.2021-adhoc audit to be completed to provide assurance of compliance - Low risk	
3508	24/10/2013	Safe, High Quality and Effective Care	Accident & Emergency	Overcrowding in Emergency Department CAH & DHH.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow.	07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	MOD	DIV	09.03.2021 -ED have completed capacity plan all areas in acute to do same. Escalated to directorate . Ongoing workstreams	
3685	08/06/2015	Provide safe, high quality care	Trustwide	Lack of pharmacy cover.- ED DHH	Patients being admitted may wait 3-4 days for Medicine Reconciliation and this can lead to Medication prescribing errors.	Managed on a day to day basis.	07.08.2020 - Interim AD to link in with Director of Pharmacy regarding Workforce Paper 12.08.19 Still ongoing - Head of Pharmacy has put forward a business case for consideration. 11.03.19- No update 01.06.16 - Business case prepared for additional resources.	MOD	DIV	mary to come back	
4111	01/09/2020	Provide safe, high quality cafe a great place to work	Accident & Emergency	Inability to recruit and retain Nursing Staff	Inability to recruit and retain nursing staff puts both patients and staff at risk. Unable to provide timely emergency care.	Nursing workforce review undertaken in 2017 Open day held in DHH site specific 2018 Ongoing advertisement of posts Use of Bank Staff, overtime, block bookings and agency staff		MOD	DIV	09.03.2021Funding procured. Worforce review completed and agreed. Partial funding has been approved from the DoH awaitig confirmation of full funding. Ongoing international recruitment and	
1025	07/08/2008	Safe, High Quality and Effective Care		Insufficient beds in the system and high bed occupancy-AMU	Dependency levels and high bed occupancy; health and safety of patients and staff due to a sustained high level of dependency and high bed occupancy, rapid throughput and reduced length of stay; all wards, CAH and DHH.	Adequate use of equipment; redeployment of staff between wards; staff rotation; risk assessment; consultation with consultant medical staff and bed management/CSM; review staffing levels; monitor dependency levels vs skill mix and stafing levels; monitor accidents and incidents; montior sickness absence; monitor clinical incidents; monitor complaints; annual manpower planning; monitor complaints; monitor patient's stay in hospital 3 times daily - PT flow meetings.	Dec19 Arrange meeting with MB Early 2020 to update info of the current situation Aug19 Risk Assest Form to Personal In to provide update on the current situation 11.03.19- No update. 01.06.16 - No update. Work ongoing. 26.11.14 - New Medical model now in place in CAH. Discussions commenced with regard to medical model in DHH. Opening of additional winter beds in both CAH and DHH. Work commencing on creating a business case for additional medical beds on the CAH site.	LOW	DIV	09.03.2021-bed modelling exercise currently being reviewed.	

3975	28/08/2018	Provide safe, high quality care	Accident & Emergency	Shortage of ED Consultants in DHH	Risk to service delivery and quality and safety of care provided due to shortage of ED Consultants in Daisy Hill Hospital (DHH)	Longer term high quality locums obtained with commitment for next 12 - 15 months. Change in shift times to ensure longer on the floor consultant cover at night Regional support from existing ED Consultants to fill gaps on rota. Escalation arrangement at CX level where necessary Daily review by Senior Management of night reports and follow up of issues. Interview skills evenings e.g. one held on 25/01/2018 for ED trainees (ST4+) in NI to showcase DHH and assist trainees with interview preparation.	DHH Pathfinder Project is currently being rolled out and will include new models of care, including the development of a new Direct Assessment Unit and a 5 Year workforce plan to strengthen staffing levels in DHH ED. 2. In 2017 there were 1.825wte Consultants in post in DHH. 3. The Trust is on target to achieve an additional 1.6wte Consultants by March 2019. A new Consultant (0.8wte) commenced post in Jan 18 and a further 2 applicants have applied for Consultants posts. Both have been interviewed and offered the posts and one has confirmed acceptance.	LOW	DIV	take this off
2383	22/10/2009	Provide safe, high quality care Make the best use of resources	Accident & Emergency	Transfer of patients with unstable neck injuries to the Regional Centre in Belfast	Delays in transfer of patients with unstable neck injuries to the Regional Centre in Belfast resulting in: 1. Potential for poor outcome for the patient when they remain in SHSCT ED. 2 Loss of confidence in the organisation. 3. Potential for complaints, litigation for the Trust	Escalation plan within ED for patients in the department 4 hours or greater. Plan includes escalation up to ED consultant on call which facilitates dialogue with Consultant in Regional facility.	12.08.19 Draft patheway agreed ED and T&O awaiting T&O sign off 11.03.19- No update. 22.10.13 - No datix reports of any such incidents within the past year. Discussed with AMD who would like to keep risk on register for a further period of monitoring. 01.02.13 - Reviewed by Heads of Service on both sites. Trauma group established to address further issues, December 2012. 23.01.12 - No delays reported since last review. 01.10.11 Reviewed by Personal Information redacted on 27.09.11 on going monitoring of this risk by Nurse Manager & HOS	MOD	HOS	09.03.2021- MB to raise at acute governance

Southern Health & Social Care Trust

Summary of Corporate Mandatory Training by Directorate including % of Staff trained as at 30th Sept 2020

Prepared by/HR Contact: Bronagh Donnelly

Date : 30/10/2020

Key: % Trained
0% - 59%
60% - 79%
80% - 100%

Equality

Directorate	Not Trained	Trained	Head Count	% Trained
Acute Services	2683	1807	4490	40%
Chief Executive's Office	8	7	15	47%
Children & Young People's Services	811	812	1623	50%
Executive Directorate of Nursing & Midwifery and AHP's	12	27	39	69%
Finance & Procurement	80	202	282	72%
HR & Organisational Development	43	143	186	77%
Medical	74	35	109	32%
Mental Health & Disability Services	669	990	1659	60%
Older People & Primary Care	1711	1253	2964	42%
Performance & Reform	34	136	170	80%
Grand Total	**6125**	**5412**	**11537**	**47%**

Information Governance

Directorate	Not Trained	Trained	Head Count	% Trained
Acute Services	1248	3242	4490	72%
Chief Executive's Office	4	11	15	73%
Children & Young People's Services	367	1256	1623	77%
Executive Directorate of Nursing & Midwifery and AHP's	12	27	39	69%
Finance & Procurement	70	212	282	75%
HR & Organisational Development	68	118	186	63%
Medical	58	51	109	47%
Mental Health & Disability Services	333	1326	1659	80%
Older People & Primary Care	434	2530	2964	85%
Performance & Reform	34	136	170	80%
Grand Total	**2628**	**8909**	**11537**	**77%**

Safeguarding

Directorate	Not Trained	Trained	Head Count	% Trained
Acute Services	1197	3293	4490	73%
Chief Executive's Office	1	14	15	93%
Children & Young People's Services	484	1139	1623	70%
Executive Directorate of Nursing & Midwifery and AHP's	10	29	39	74%
Finance & Procurement	4	278	282	98%
HR & Organisational Development	51	135	186	73%
Medical	54	55	109	50%
Mental Health & Disability Services	466	1193	1659	72%
Older People & Primary Care	1005	1959	2964	66%
Performance & Reform	1	169	170	99%
Grand Total	**3273**	**8258**	**11537**	**72%**

	Fire Safety			
Directorate	**Not Trained**	**Trained**	**Head Count**	**% Trained**
Acute Services	2058	2432	4490	**54%**
Chief Executive's Office	5	10	15	**67%**
Children & Young People's Services	690	933	1623	**57%**
Executive Directorate of Nursing & Midwifery and AHP's	12	27	39	**69%**
Finance & Procurement	110	172	282	**61%**
HR & Organisational Development	69	117	186	**63%**
Medical	68	41	109	**38%**
Mental Health & Disability Services	639	1020	1659	**61%**
Older People & Primary Care	1604	1360	2964	**46%**
Performance & Reform	70	100	170	**59%**
Grand Total	**5325**	**6212**	**11537**	**54%**

	Manual Handling			
Directorate	**Not Trained**	**Trained**	**Head Count**	**% Trained**
Acute Services	1774	2716	4490	**60%**
Chief Executive's Office	4	11	15	**73%**
Children & Young People's Services	471	1152	1623	**71%**
Executive Directorate of Nursing & Midwifery and AHP's	5	34	39	**87%**
Finance & Procurement	75	207	282	**73%**
HR & Organisational Development	58	128	186	**69%**
Medical	59	50	109	**46%**
Mental Health & Disability Services	539	1120	1659	**68%**
Older People & Primary Care	1284	1680	2964	**57%**
Performance & Reform	37	133	170	**78%**
Grand Total	**4306**	**7231**	**11537**	**63%**

	Infection Prevention & Control			
Directorate	**Not Trained**	**Trained**	**Head Count**	**% Trained**
Acute Services	1248	3242	4490	**72%**
Chief Executive's Office	6	9	15	**60%**
Children & Young People's Services	353	1270	1623	**78%**
Executive Directorate of Nursing & Midwifery and AHP's	6	33	39	**85%**
Finance & Procurement	127	155	282	**55%**
HR & Organisational Development	69	117	186	**63%**
Medical	59	50	109	**46%**
Mental Health & Disability Services	415	1244	1659	**75%**
Older People & Primary Care	1213	1751	2964	**59%**
Performance & Reform	60	110	170	**65%**
Grand Total	**3556**	**7981**	**11537**	**69%**

	Corporate Induction			
Directorate	**Not Trained**	**Trained**	**Head Count**	**% Trained**
Acute Services	261	46	307	**15%**
Children & Young People's Services	71	18	89	**20%**
Finance & Procurement	18	5	23	**22%**
HR & Organisational Development	10	3	13	**23%**
Medical	56		56	**0%**
Mental Health & Disability Services	88	21	109	**19%**
Older People & Primary Care	163	27	190	**14%**

Received from Mary Burke on 01/07/2022. Annotated by the Urology Services Inquiry.

Performance & Reform	7	1	8	13%
Grand Total	**674**	**121**	**795**	**15%**

Departmental Induction

Directorate	Not Trained	Trained	Head Count	% Trained
Acute Services	293	14	307	5%
Children & Young People's Services	87	2	89	2%
Finance & Procurement	18	5	23	22%
HR & Organisational Development	13		13	0%
Medical	55	1	56	2%
Mental Health & Disability Services	100	9	109	8%
Older People & Primary Care	121	69	190	36%
Performance & Reform	7	1	8	13%
Grand Total	**694**	**101**	**795**	**13%**

This report has been compiled and is intended for use only by the official recipient.

If you believe the information in this report does not accurately reflect the current position, please contact the Education, Learning and Development Department.

Please remember your responsibilities under data protection legislation, for example ensure personal information is kept secure (for example not left in view of unauthorised staff or visitors), is only used for the purpose intended, and is not shared with anyone who should not have access to it. Also, once personal information has been used for its intended purpose it should be appropriately destroyed, or kept in a secure location if it is required for future use.

Southern Health and Social Care Trust

Admin Review Processes.

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
1. Triage	Pre 2014 Due to delayed triage of referrals, the decision was taken to add the referral to the OP waiting list as the clinical priority that the GP had assigned. .	2014-2017 For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals	2017-current The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process. The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging TRIAGE PROCESS April 21.docx	Current Consultant-to-Consultant referrals (including outside of Trust) are not currently manged through e-Triage so there is still a risk that these could be delayed. Remaining specialties that still do not use e-Triage are being addressed Services not using eTriage.docx	Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated Consultant to Consultant Referrals. Remaining specialties to be added to e-Triage The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary	After 7 days Non- triage of urgent and routine referrals is escalated by the Referral & Booking Centre to the Operational Support Lead for the Clinical Area After 21 days OSL to escalate to Lead Clinician and HOS and copy Assistant Director of Functional & Support Services After 28 days HOS escalates to AD & AMD to address. After 35 days

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
						AD & AMD escalates to Director of Acute
2. Undictated Clinics	Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS.	There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter	All Medical staff must understand that a letter is required for every outpatient attendance.	A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance.	The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics. A policy and guidance document needs to be developed and circulated to all Medical Staff to reiterate that a letter must be done for all outpatient attendance including for patients who do not attend. Update typing SOP to highlight that when a	When the secretary is typing the clinics she must escalate to the Consultant if there are any letters missing on Digital Dictation. <u>After 7 days</u> This is escalated to the Service Administrator. <u>After 14 days</u> Service Administrator to escalate to Lead Clinician and HOS <u>After 21 days</u> HOS escalates to AD & AMD to address. <u>After 28 days</u>

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
2. Undictated Clinics					letters is not dictated for a patient that the secretary raises with the consultant and line manager in the first instance. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters Monthly typing reports require to be produced and shared throughout all divisions At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them.	AD & AMD escalates to Director of Acute

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
3. Hospital Notes	Patient's hospital records electronically casenote tracked to a consultant and a location.	When patients hospital records were required same not in the tracked location	Current tracking system is a function on Patient Administrative System (PAS) Missing Charts are investigated and an IR1 form is completed if not found	There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.	Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas. All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible. All consultants need to be reminded regularly that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to. Business Case for IFit which is an electronic tracking system using barcode technology (as	Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period IR1's to be monitored by AD FSS Division for repeat 'Borrower' missing notes and any concerns over a particular consultant should be escalated to Clinical Director/AMD and AD

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified.	
4. Private Patients	Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner	No monitoring of patients seen privately where they are entered onto the waiting list	This is governed by the Private Patient policy	It relies on the integrity of the consultant to comply with the private patient policy.	Revise the policy for paying patients in the Trust and share with all clinical teams. Guide-to-Paying-Patients-Southern-Trust- Data Quality Release notice for recording of private patient activity	When secretaries are adding patients who were previously a private patient, to the waiting list they should ensure that Consultant has completed the appropriate forms and <u>After 7 days</u> If forms haven't been received by Private Patient Office this is

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					on PAS to be shared amongst clinical teams.  0023-18 PAS OP REFERRRAL PRIVATE	escalated to the HOS/CD. <u>After 14 days</u> HOS escalates to AD & AMD to address. <u>After 21 days</u> AD & AMD escalates to Medical Director

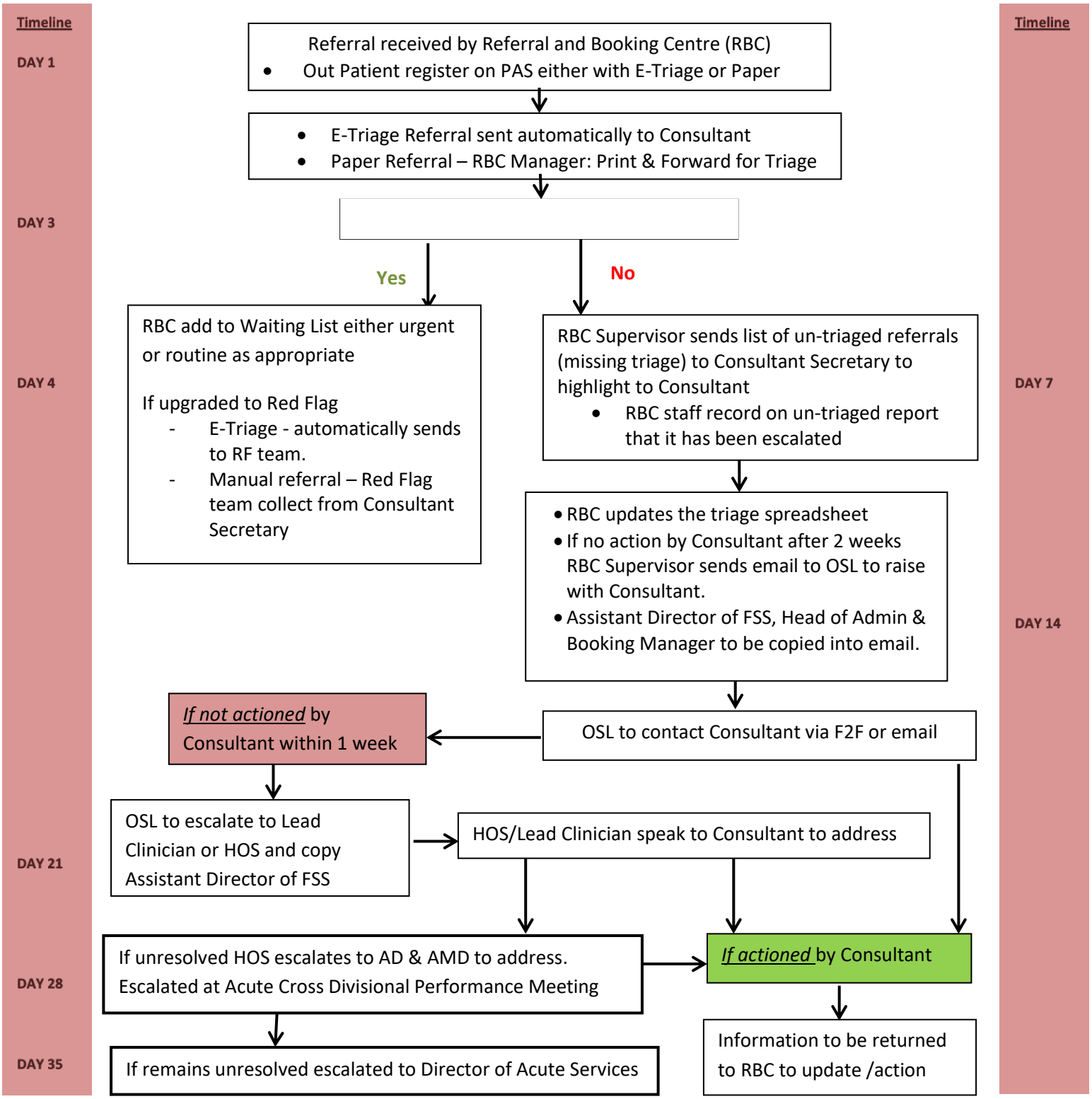
TRIAGE PROCESS

This process is developed by the Region under the IEAP (Integrated Elective Access Protocol) Referrals should be returned within 72 hrs but the Southern Trust have agreed 1 week to assist Clinicians as a more reasonable approach.

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Note: This process will incur a minimum of 5 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.
It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above.

Services not using e-triage	
ORTHOPAEDIC GERIATRICS	Planned e-triage commencement Jan/Feb 2021
HAEMATOLOGY	Planned implementation postpone due to service pressures
NEPHROLOGY	Currently taking a break from e-triage, will relook at recommencing early 2021
GENERAL MEDICINE	Minimal referrals to this service but working with service looking towards implementation early 2021
BREAST SURGERY	Consultants not currently keen on e-triage – reengaged with service
GERIATRIC MEDICINE	Currently engaging with service

Southern Health and Social Care Trust

Quality Care - for you, with you

ADMINISTRATIVE & CLERICAL Standard Operating Procedure

Title	Consultant to Consultant Referrals	
S.O.P. Section	Referral and Booking Centre	
Version Number	v1.0	**Supersedes:** v0.1
Author	Katherine Robinson	
Page Count	3	
Date of Implementation	January 2011	
Date of Review	January 2012	**To be Reviewed by:** Admin and Clerical Manager's Group
Approved by	Admin and Clerical Manager's Group	

Standard Operating Procedure (S.O.P)
Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre to recognise a referral is in place from one consultant to another.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Consultant to Consultant Referrals

The secretary for the consultant referring the patient should OP REG the patient on PAS with the OP REG date being the date the decision to refer was made (eg the clinic date)

This is done by using the Function:
DWA – ORE.

The name of the *referring consultant* should be entered into the comment field NOT the name of the consultant being referred to. Referrals should then be directed to the Referral and Booking Centre not to the secretary.

This will ensure that the patient now appears on a PTL and that the booking clerks will know who referred the patient and when.

When doing this the **Referral Source should be OC** (Other Consultant) **and NOT CON.**

Patients registered with a referral source as ‘Con’ do not appear on a PTL and can be missed.

Although all referrals are date stamped when they are received into the Referral and Booking centre – the original referral date will remain and will not be amended.

Southern Health and Social Care Trust

Quality Care - for you, with you

A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Guide to Paying Patients Version: 2
Supersedes	Supersedes: Guidelines for Management of Private Patients
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 27th March 2014 to: • Trust Senior Management Team • Trust LNC
Circulation	Issue Date: 16th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate

CONTENTS

1. INTRODUCTION

1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-

- Craigavon Area Hospital, Portadown
- Daisy Hill Hospital, Newry
- South Tyrone Hospital, Dungannon

1.2 The Trust welcomes additional income that can be generated from the following sources:-

- Private Patients
- Fee Paying Services
- Overseas Visitors

1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.

1.5 For further information please do not hesitate to contact the Paying Patient Office. [email: Personal Information redacted by the USI or http://www.southerndocs.hscni.net/paying-patients/

2. OBJECTIVES

2.1 The purpose of this guideline is to:

- Standardise the manner in which all paying patient practice is conducted in the organisation.
- Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
- Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
- Ensure fairness to both NHS patients and fee paying patients at all times.
- Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
  - record keeping
  - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.

- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.

3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.

3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.

4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.

4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:

- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
- Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
- The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
- The principles set out in Schedule 11 of the above contract (Appendix 5).

4.4 All patients treated within the Trust, whether private or NHS should, where possible:

- be allocated a unique hospital identifier
- be recorded on the Patient Administration System and
- have a Southern Health & Social Care Trust chart.

4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – click here.
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - *see Appendix 1 for examples*

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – click here. It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:

- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
- A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
- Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.

5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.

7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.

8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.

9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]

9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertaken private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.

9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:

- Patient Administration System (PAS)
- Northern Ireland Maternity System (NIMATS)
- Laboratory System
- Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:

- when this is essential for the safe treatment of the patient
- when an electronic record of the destination of the notes is made using the case note tracking system
- when arrangements can be guaranteed that such notes will be kept securely
- provided that nothing is removed from the notes

9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.

9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.

9.12.2 Accurate record keeping assists in the collection of income from paying patients.

9.12.3 It should be noted that

- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.

9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.

10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]

10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.

10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.

10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.

10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.

11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures

11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.

11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.

11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.

11.3.6 The Category 2 (room only) charge per session will be reviewed annually.

11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager

11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.

11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.

11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.

11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.

11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.

12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.

12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.

13.2 **RESIDENCY** is the therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.

13.3 Any patient attending the Trust who cannot establish that they are an ordinary resident and have lawfully lived in the UK permanently for the last 12 months preceding treatment are not entitled to free non ED hospital treatment whether they are registered with a GP or not. A GP referral letter cannot be accepted solely as proof of a patient's permanent residency and therefore entitlement to treatment.

13.4 For all new patients attending the Trust, residency must be established. All patients will be asked to complete a declaration to confirm residency, (regardless of race/ethnic origin). If not the Trust could be accused of discrimination.

13.5 Where there is an element of doubt as to whether the patient is an 'ordinary resident' eg no GP/ H&C number or non UK contact details, the Paying Patients Officer must be alerted immediately.

13.6 Emergency Department

13.6.1 Treatment given in an Emergency Department, Walk in Clinic or Minor Inuries Unit is free of charge if it is deemed to be immediate and necessary.

13.6.2 The Trust should always provide immediate and necessary treatment whether or not the patient has been informed of or agreed to pay charges .There is no exemption from charges for 'emergency' treatment other than that given in the accident and emergency department. Once an overseas patient is transferred out of Emergency Department their treatment becomes chargeable.

13.6.3 All patients admitted from Emergency Department must be asked to complete declaration of residency status.

13.6.4 This question is essential in trying to establish whether the patient is an overseas patient or not and hence liable to pay for any subsequent care provided.

13.6.5 If the patient is not an ordinary resident or there is an element of doubt eg no GP/ no H&C Number, the patient should be referred to Paying Patients Office to determine their eligibility.

13.6.6 If the person has indicated that they are a visitor to Northern Ireland, the overseas address must be entered as the permanent address on the correct Patient Administrative System and the Paying Patients Office should be notified immediately.

13.7 Outpatient Appointments

13.7.1 In all cases where the patient has not lived in Northern Ireland for 12 months or relevant patient data is missing such as H&C number, GP Details etc the patient must be referred to the Paying Patients Office to establish the patient's entitlement to free NHS treatment. This must be established before an appointment is given.

13.8 Review Appointments

13.8.1 Where possible follow up treatment should be carried out at the patient's local hospital, however if they are reviewed at the Trust they must be informed that they will be liable for charges.

13.8.2 If a consultant considers it appropriate to review a patient then they must sign a statement to this effect waiving the charges that would have been due to the Trust.

13.9 Elective Admission

13.9.1 A patient should not be placed onto a waiting list until their entitlement to free NHS Treatment has been established. Where the Patient is chargeable, the Trust should not initiate a treatment process until a deposit equivalent to the estimated full cost of treatment has been obtained.

13.10 Referral from other NHS Trusts

13.10.1 When a Consultant accepts a referral from another Trust the patients' status should, where possible, be established prior to admission. However, absence of this information should not delay urgent treatment.

13.10.2 The Trust will operate a policy of 'Stabilise and Transfer'.

14. AMENITY BED PATIENTS

14.1 Within the Trust's Maternity Service, a number of beds are assigned Amenity Beds. It is permissible for NHS patients who require surgical delivery and an overnight stay to pay for any bed assigned as an Amenity Bed. This payment has no effect on the NHS status of the patient. All patients identified as amenity will be recorded on PAS as APG and an Undertaking to Pay for an Amenity Bed form (Appendix 6) should be completed ideally before obtaining the amenity facilities.

15. GLOSSARY

Undertaking to Pay Form

Private Patients may fund their treatment, or they may have private medical insurance. In all cases Private Patients must sign an 'Undertaking to Pay' form (Appendix 3). This is a legally binding document which, when signed prior to treatment, confirms the patient as personally liable for costs incurred while at hospital and confirms the Patient's Private status. ALL private patients, whether insured or not are obliged to complete and sign an 'Undertaking to Pay' form, prior to commencement of treatment. Consultants therefore, as the first point of contact should ensure that the Paying Patients Officer is advised to ensure completion of the 'Undertaking to Pay' form.

Fee Paying Services
Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

Private Professional Services *(Also referred to as 'private practice')*

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions (Appendix 1).

- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

Non UK patients
A person who does not meet the 'ordinarily resident' test.

Job Plan
A work programme which shows the time and place of the consultant's weekly fixed commitments.

16. APPENDIX 1: SPECIFIC EXAMPLES OF FEE PAYING SERVICES - SCHEDULE 10

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:

   a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;

   b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;

   c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such nonclinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);

   d. work required for life insurance purposes;

   e. work on prospective emigrants including X-ray examinations and blood tests;

   f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;

   g. work for coroners, as well as attendance at coroners' courts as medical witnesses;

   h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;

   i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;

   j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;

   k. occupational health services provided under contract to other HPSS, independent or public sector employers;

   l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966; work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

m. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;

n. services performed by members of hospital medical staffs for government departments as members of medical boards;

o. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);

p. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;

q. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;

r. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;

s. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;

t. medical examination in relation to staff health schemes of local authorities and fire and police authorities;

u. delivering lectures;

v. medical advice in a specialised field of communicable disease control;

w. attendance as a witness in court;

x. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;

y. advice to organisations on matters on which the consultant is acknowledged to be an expert.

17. APPENDIX 2 - A CODE OF CONDUCT FOR PRIVATE PRACTICE

November 2003

Recommended Standards of Practice for NHS Consultants

An agreement between the BMA's Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland.

A CODE OF CONDUCT FOR PRIVATE PRACTICE: RECOMMENDED STANDARDS FOR NHS CONSULTANTS, 2003

Contents

Part I: Introduction

Scope of Code

1.1 This document sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice . The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.

1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

Key Principles

1.4 The Code is based on the following key principles:

- NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply
- because of a perception;
- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services;
- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer.

Part II: Standards of Best Practice

Disclosure of Information about Private Practice

1.2 Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his/her contractual duties. As part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.

2.2 Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

2.3 In circumstances where there is or could be a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

2.4 Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below);
- there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled;

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services alongside NHS Duties

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

Information for NHS Patients about Private Treatment

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

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

PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Private Patient: Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

Name of Patient:			
Address:			
Postcode:	Telephone No:		
Date of Birth:			
H&C Number:			
Name of Insurer:		**Self Funding**	☐
Insurer Policy No:			

I have been seeing this person as a private patient. They are to be admitted / referred to Hospital on _____ as an _____

Inpatient Referral	☐	**Obstetrics** ☐ Estimated Duration of Stay	**Medical** ☐ Estimated Duration of Stay	**Surgical** ☐ Estimated Duration of Stay	**T & O** ☐ Estimated Duration of Stay
Day Case Referral	☐				
Diagnostics (Inpatient or Outpatient)	☐	**Laboratory** ☐ [please detail]	**Radiology** [pleas ☐ detail]	**Other** [e.g. ☐ Pharmacy]	

Undertaking to Pay Confirmation To be completed by Consultant			
I have advised the patient named above of the estimated hospital charges and of my fees			
Signed Consultant		**Date**	
Undertaking to Pay To be completed by the person who will pay the account			
I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.			
Signed Patient		**Date**	

RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPIAL/DAISY HILL HOSPITAL [email Personal Information redacted by the USI

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE Personal Information redacted by the USI

20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

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

UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
Hospital Number:	

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ **(time)**

Ward: _____ **Consultant:** _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ **Date:** _____

Midwife's Signature: _____ **Date:** _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

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

AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

I *(name)* _____

Request that any monies due to me from patients in relation to fees from
(description of activity)

_____

_____

_____

_____

_____

_____

_____

Shall be transferred to *(Charity title and reference)* _____

For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.

This request is to take effect from (date*):* _____

Signed, sealed and delivered by: _____
(Full name in BLOCK CAPITALS)

Date: _____

In the presence of: _____

Date: _____

Address:: _____

_____

_____

_____ **Postcode:** _____

_____

23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HPSS Facilities and Staff

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

Patient Enquiries about Private Treatment

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

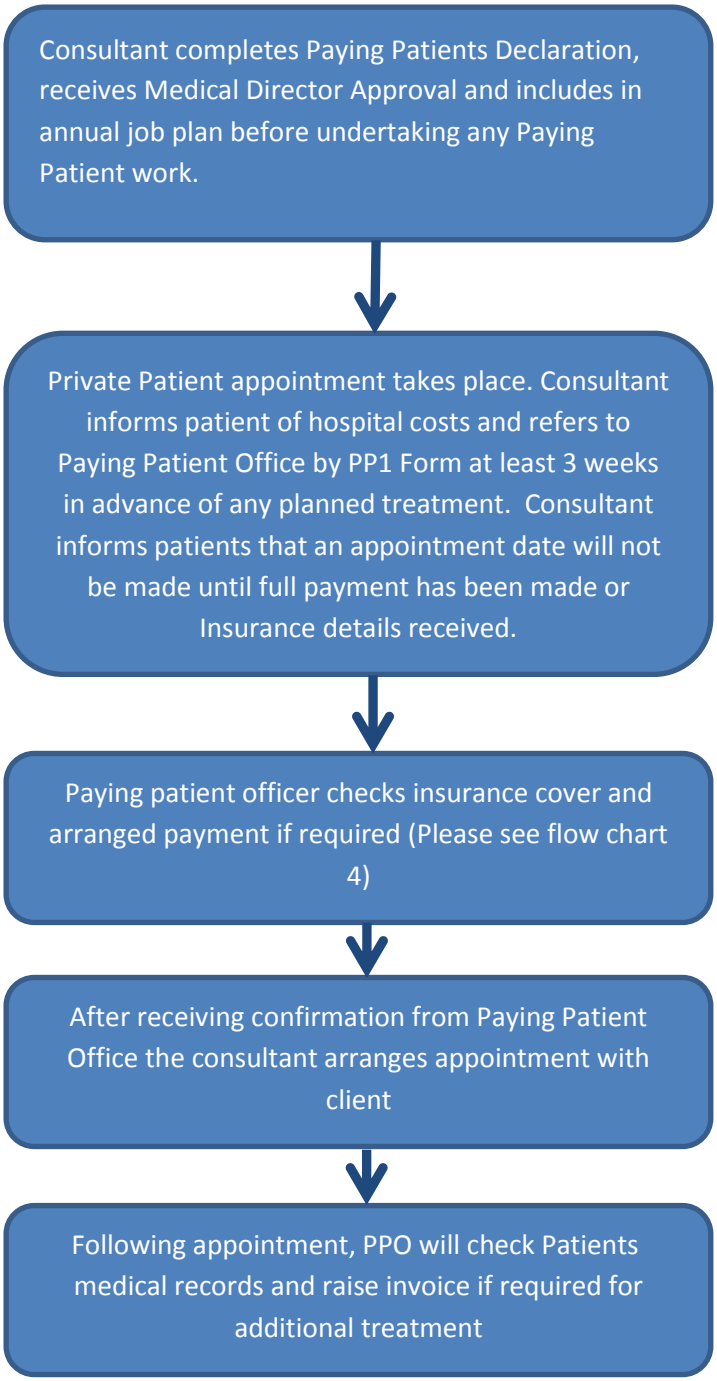
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

Promoting Improved Patient Access to HPSS Care

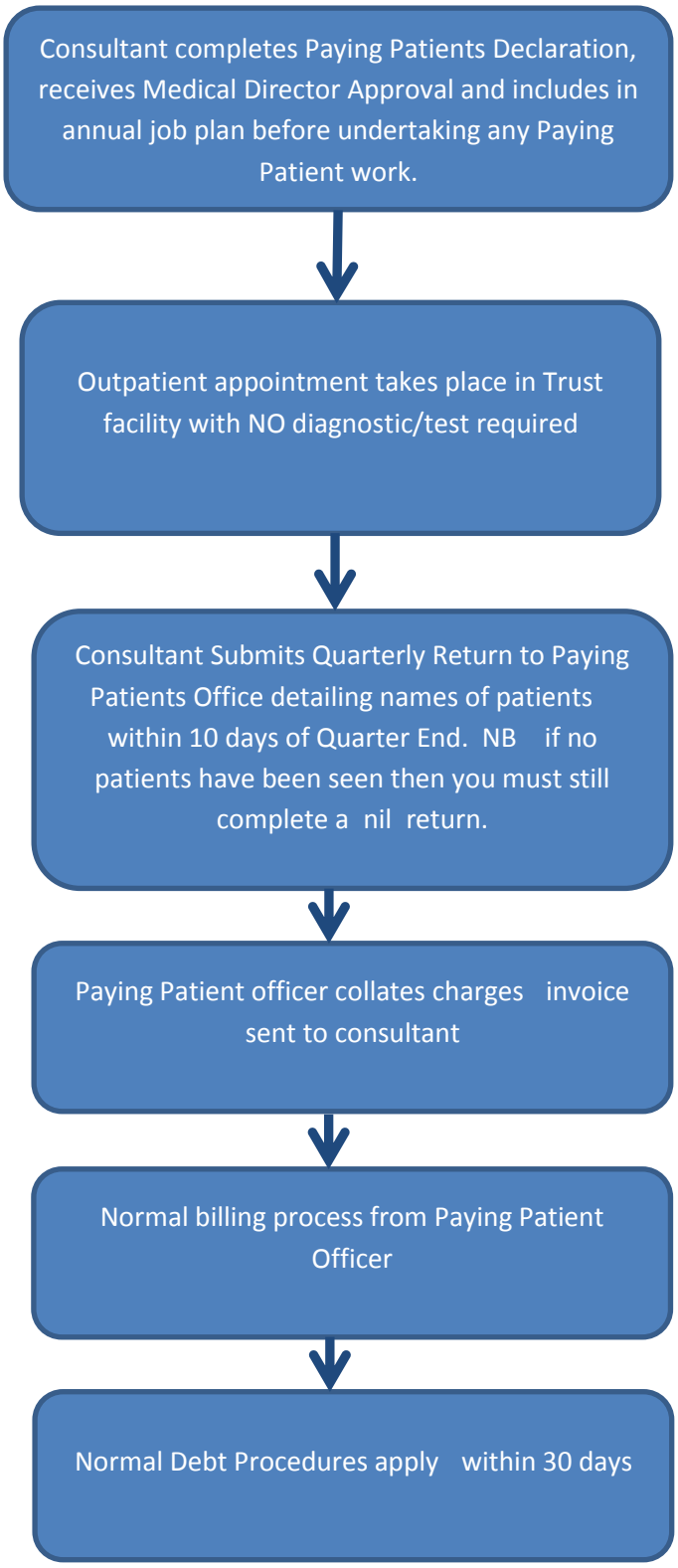
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

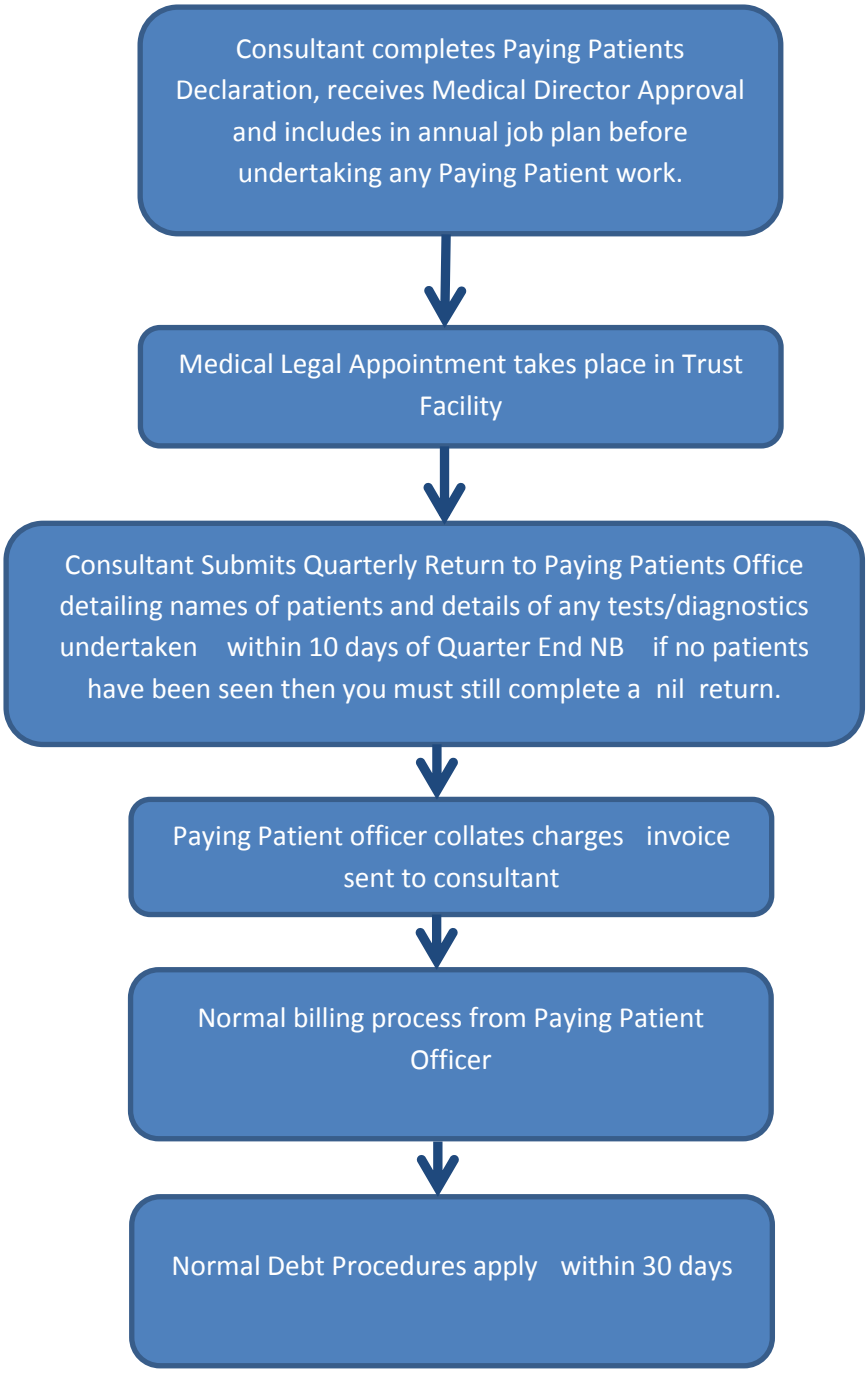
24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



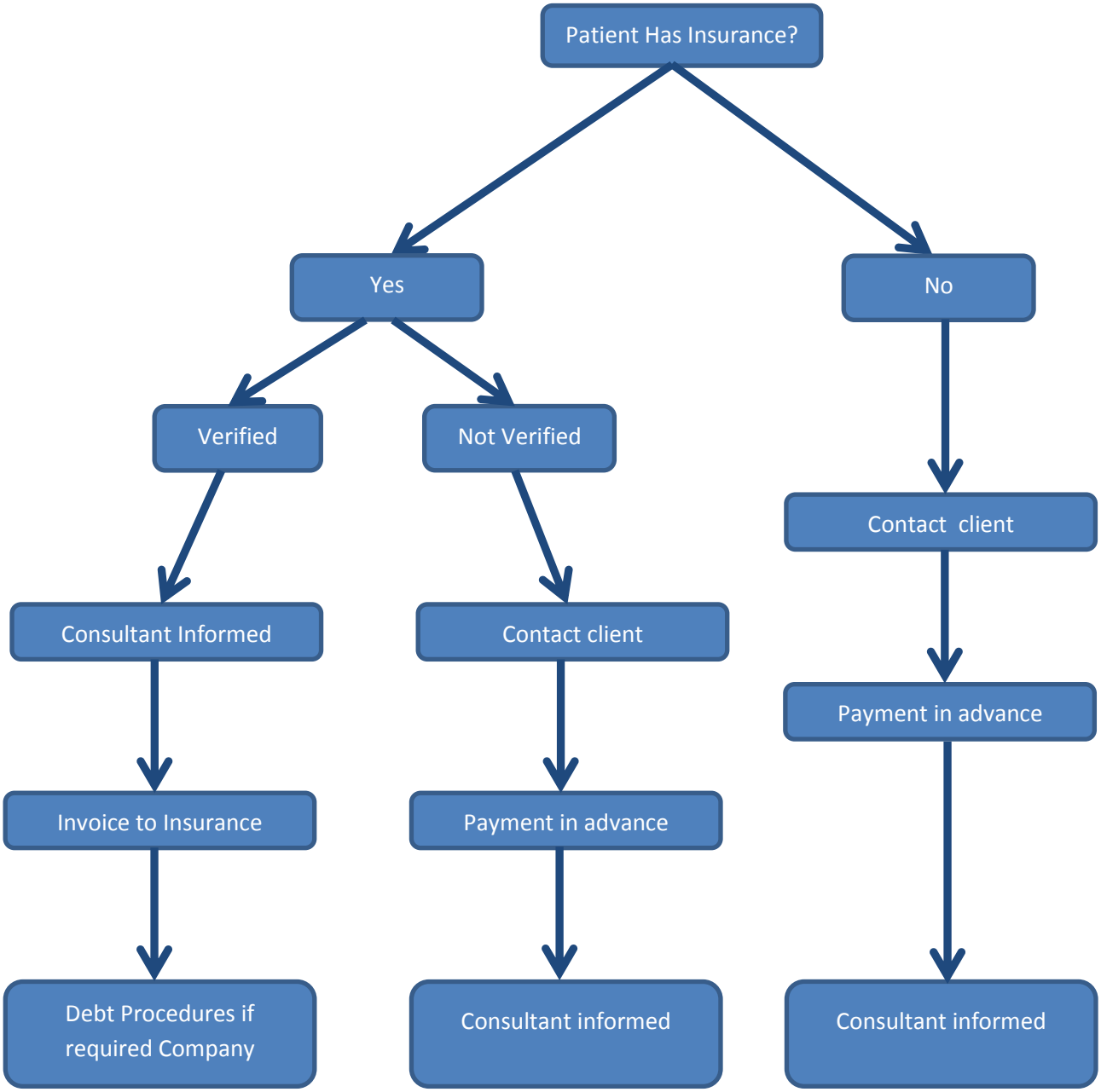
25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



27. FLOW CHART 4 – PATIENT INSURANCE



Health and Social Care Board

0023/18

Query Request Form

Requires Immediate Response: Yes

Reason for Immediate Response: Required as an action following Internal Audit review of management of private patients

---

☐	**Data Definition**	☒	**Recording Issue**
☒	**Technical Guidance**	☐	**Other**

Name: Roberta Gibney **Date:** 8th August 2018

Organisation: BHSCT **Contact Number:** Personal Information redacted by the USI

Subject Heading: PAS OP Referral Source Code – Private to NHS

a) Issue: ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

b) Response:

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

Approved by: Acute Hospital Information Group

Date: 11/09/2018 **Response Published:** Yes / ~~No~~

Email: Personal Information redacted by the USI
HSC Data Standards Helpdesk: (Personal Information redacted by the USI

These forms are available on the Information Standards & Data Quality SharePoint Site at *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*

1.0 LESSONS LEARNED

The review identified Cancer Care given by Dr 1 that did not follow agreed MDM recommendations nor follow regional or national best practice guidance. It was care given without other input from Cancer Specialist Nurses, Oncology and palliative care. It was inappropriate, did not meet patient need and was the antithesis of quality multidisciplinary cancer care.

Ensure all patients receive appropriately supported high quality cancer care irrespective of the professional delivering care.

Ensure all cancer care is multidisciplinary and centred on patients physical and emotional need.

Have processes in place to provide assurances to patients and public that care meets these requirements.

That the role of the Multidisciplinary Meeting Chair is defined by a Job Description with specific reference to Governance, Safe Care and Quality Care. It should be resourced to provide this needed oversight.

2.0 RECOMMENDATIONS AND ACTION PLANNING

The recommendations represent an enhanced level of assurance. They are in response to findings from nine patients where Dr 1 did not adhere to agreed recommendations, varied from best practice guidance and did not involve other specialist appropriately in care. They are to address what was asked of the Review by families - "that this does not happen again".

Recommendation 1.

The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.

This will be achieved by - Urology Cancer Care delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship.

Timescale – Immediate and ongoing

Assurance - Comprehensive Pathway audit of all patients care and experience. This should be externally benchmarked within a year by Cancer Peer Review / External Service Review by Royal College.

Recommendation 2.

All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.

2.0 RECOMMENDATIONS AND ACTION PLANNING
This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent. Timescale - Immediate and ongoing Assurance - Comprehensive Cancer Pathway audit and Patient experience. **Recommendation 3.** *The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly and safely.* This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members in a collaborative and equal culture. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight monthly agenda. There must be action on issues escalated. Timescale – Immediate and ongoing Assurance - Numbers of issues raised through Cancer Services, Datix Incidents identified, numbers of issues resolved, numbers of issues outstanding. **Recommendation 4.** *The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.* This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans. This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services). Timescale - 3 months and ongoing Assurance - Quorate meetings, sufficient radiology input to facilitate pre MDM QA of images - Cancer Patient pathway Audit - Audit of Recurrent MDM discussion - Onward referral audit of patients to Oncology / Palliative Care etc. **Recommendation 5.** *The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed.* This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by a safety mechanisms from

2.0 RECOMMENDATIONS AND ACTION PLANNING

laboratory services and Clinical Nurse Specialists as Key Workers. A report should be generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit / assurance. It is essential that current limited clinical resource is focused on patient care.

Timescale - 3 months

Assurance - Comprehensive Cancer care Pathway audit - Exception Reporting and escalation

Recommendation 6.

The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.

This will be achieved by - Developing a proactive governance structure based on comprehensive ongoing Quality Assurance Audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources. This should have an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other directorates.

Timescale - 3 months

Assurance - Cancer Pathway Audit outcomes with exception discussion and escalation. Data should be declared externally to Cancer Peer Review

Recommendation 7.

The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.

Timescale - 3 months

Recommendation 8.

All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance).

This will be achieved by - Ensuring the multi-disciplinary team meeting is the primary forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. As such, a clinician should either defer to the opinion of his / her peers or justify any variation through the patient's documented informed consent.

Timescale – Immediate and ongoing

Assurance - Variance from accepted Care Guidelines and MDM recommendations

2.0 RECOMMENDATIONS AND ACTION PLANNING

should form part of Cancer Pathway audit. Exception reporting and escalation would only apply to cases without appropriate peer discussion.

Recommendation 9.

The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.

Timescale - 3 months

Recommendation 10.

The families working as "Experts by Experience" have agreed to support implementation of the recommendations by receiving updates on assurances at 3, 6 and 12 monthly intervals.

Recommendation 11

The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively.

References:

1. Hoffmann, R., et al. Innovations in health care and mortality trends from five cancers in seven European countries between 1970 and 2005. Int J Public Health, 2014. 59: 341.

2. Oliver, R.T., et al. Radiotherapy versus single-dose carboplatin in adjuvant treatment of stage I seminoma: a randomised trial. Lancet, 2005. 366: 293.

3. Laguna M.P., et al EAU Guidelines: testicular cancer. https://uroweb.org/guideline/testicular-cancer/note_127-129 (accessed 26/02/2021)

4. Peer review Self-Assessment report for NICaN 2017

5. Northern Ireland Cancer Network (NICAN) Urology Cancer Guidelines (2016)

6. EAU guidelines for penile cancer: section 6.2.1 (2019)

7. NICE improving outcomes in urological cancer (2002)

8. NICAN Urology Cancer Clinical Guidelines (March 2016), Penile Cancer treatment Section 9.3 (3).

2.0 RECOMMENDATIONS AND ACTION PLANNING

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday 14 May 2021

8am via Melanie's space – Personal Information redacted by the USI

1.0	Apologies: Attendance	
2.0	Notes from last meeting  Action Notes 9.04.2021 Acute Clini	
3.0	Chairs business  Admin Review Process V13 10 May 2 Lessons learnt  LESSONS LEARNED UROLOGY OVERARCH	Melanie McClements
4.0	Electronic Sign off  SIGNOFF_2021_04_ SHSCT.pdf	
5.0	SAIs  IMWH Aoife - SAI CAH Personal Information 1april 21 - Redacted / Seamus  Personal Information Report - draft for ACG.docx  Personal Information Draft for ACG Approval.docx	AMDs/ CD

	Mark/Ted 1. Level 1 Report for March ACG.docx Level 1 SAI report for ACG.docx Level 2 report final darft for May AC	
6.0	Effectiveness and Evaluation 5) Clinical audit summary for Acute Cl Patient Safety Report Acute Governance Report May21.doc	ADs and AMDs
7.0 7.1	Monthly Acute Governance report March 2021 Acute SMT Governance Rep Complaints Position – (communication and staff attitudes main complaints) Formal Complaints – 49 (20 are new, 17 overdue but 6 for approval by AD Reopened 29 – 5 being drafted (4 with AD) 8 for meetings. Ombudsman – 0 new 2 require recommendations to be completed by end of May. Enquiries 5 outstanding • Current Complaints Current Complaints.xlsx • Weekly reopened complaints Reopened complaints at 21.4.2020.xlsx • Ombudsman Ombudsman 20.4.2021.xlsx	
8.0	Medicine Incidents March 2021 Acute.xlsx	

	Incident Management Position  Incident review position as at 19.04.2 Major Catastrophic  Major & Catastrophic Incidents weekending	
9.0	Risk Registers – additions, amendments and closures to the governance team.  Corporate Risk Register August 2020  Directorate RR March 2021.xlsx  CCS Div.HOS.TEAM RR March 2021.xlsx  FSS Div.HOS.Team RR March 2021.xlsx  IMWH Div.HOS.Team RR March 2021.xlsx  MUC Div.HOS.Team RR March 2021.xlsx  Pharmacy Div.HOS.Team RR Ma  Unscheduled Care RR March 2021.xlsx  SEC.ATICS Div.HOS.Team RR Ma	ADs & AMDs
10.0	Mandatory training  Copy of Trustwide CMT Compliance Sum	
11.0	Any Other Business	
12.0	Date of Next Meeting: 8.00 am Friday 11 June 2021 Via **Melanie's space**	

SIGN OFF REPORTS

Time period: **01/04/2021 to 30/04/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	February	March	April
Southern	52979	60787	62074
Western	30040	31626	34423
South-Eastern	13447	15571	13741
Belfast	12012	14525	11961
Northern	5908	7338	7005
Total	**114386**	**129847**	**129204**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10819	63877	16.9%
Histopathology	902	6435	14.0%
Cytology	211	10747	2.0%
Blood Sciences	97078	1299541	7.5%
Microbiology	20160	185917	10.8%
Blood Bank	34	8200	0.4%
Total	**129204**	**1574717**	**8.2%**

Total Sign Off for Southern Trust previous three months

Month	January	February	March
Total	54317	52979	60787

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	4336	49241	8009	390	72	26	0	**62074**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2128	30460	4790	232	25	25	0	**37660**
Daisy Hill Hospital	2103	14692	2519	158	47	1	0	**19520**
Lurgan Hospital	84	3096	552	0	0	0	0	**3732**
South Tyrone Hospital	3	387	59	0	0	0	0	**449**
Community	0	277	38	0	0	0	0	**315**
0	18	176	36	0	0	0	0	**230**
St Luke's	0	98	0	0	0	0	0	**98**
Drumglass Lodge Community	0	51	0	0	0	0	0	**51**
Mullinure Health & Wellbein	0	4	15	0	0	0	0	**19**
	4336	**49241**	**8009**	**390**	**72**	**26**	**0**	62074

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2128**	**30460**	**4790**	**232**	**25**	**25**	**0**	**37660**
Doctor	671	15616	1484	76	7	0	0	**17854**
Consultant	1430	9665	951	148	18	24	0	**12236**
Midwife	0	2670	2131	0	0	0	0	**4801**
Nurse	27	2093	217	8	0	1	0	**2346**
AHP	0	209	7	0	0	0	0	**216**
Pharmacist	0	207	0	0	0	0	0	**207**
Daisy Hill Hospital	**2103**	**14692**	**2519**	**158**	**47**	**1**	**0**	**19520**
Doctor	388	10945	1068	2	4	0	0	**12407**
Consultant	1673	1849	1002	156	43	1	0	**4724**
Physician Associate	30	1063	87	0	0	0	0	**1180**
Midwife	12	580	352	0	0	0	0	**944**
Nurse	0	141	10	0	0	0	0	**151**
Pharmacist	0	60	0	0	0	0	0	**60**
0	0	54	0	0	0	0	0	**54**
Grand Total	**4231**	**45152**	**7309**	**390**	**72**	**26**	**0**	**57180**

SIGN OFF REPORTS

Time period: **01/04/2021 to 30/04/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Craigavon Area Hospital	60	1251	161	0	0	0	**1472**
		Consultant	Craigavon Area Hospital	167	1042	177	24	1	24	**1435**
		Doctor	Daisy Hill Hospital	65	927	233	0	0	0	**1225**
		Consultant	Craigavon Area Hospital	17	1037	71	5	1	0	**1131**
		Consultant	Craigavon Area Hospital	114	841	93	0	0	0	**1048**
		Consultant	Daisy Hill Hospital	1016	0	12	0	0	0	**1028**
		Doctor	Lurgan Hospital	35	758	190	0	0	0	**983**
		Doctor	Lurgan Hospital	18	740	208	0	0	0	**966**
		Doctor	Craigavon Area Hospital	16	678	176	1	1	0	**872**
		Doctor	Craigavon Area Hospital	37	675	109	0	0	0	**821**
		Consultant	Daisy Hill Hospital	132	406	194	5	7	0	**744**
		Doctor	Daisy Hill Hospital	67	597	23	0	0	0	**687**
		Consultant	Craigavon Area Hospital	81	503	86	0	1	0	**671**
		Midwife	Craigavon Area Hospital	0	430	240	0	0	0	**670**
		Consultant	Craigavon Area Hospital	110	437	37	2	0	0	**586**
		Consultant	Craigavon Area Hospital	21	494	39	3	0	0	**557**
		Doctor	Daisy Hill Hospital	3	549	0	0	0	0	**552**
		Doctor	Craigavon Area Hospital	5	539	0	0	0	0	**544**
		Physician Associate	Daisy Hill Hospital	23	476	39	0	0	0	**538**
		Consultant	Daisy Hill Hospital	97	304	109	25	0	0	**535**
		Consultant	Craigavon Area Hospital	11	460	56	0	0	0	**527**
		Consultant	Daisy Hill Hospital	87	291	126	11	7	0	**522**
		Doctor	Daisy Hill Hospital	13	495	12	0	0	0	**520**
		Midwife	Daisy Hill Hospital	12	388	95	0	0	0	**495**
		Doctor	Craigavon Area Hospital	0	494	0	0	0	0	**494**
			Grand Total	**2207**	**14812**	**2486**	**76**	**18**	**24**	**19623**

SIGN OFF REPORTS

Time period: **01/03/2021 to 31/03/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	January	February	March
Southern	54317	52979	60787
Western	28163	30040	31626
South-Eastern	12409	13447	15571
Belfast	10529	12012	14525
Northern	5721	5908	7338
Total	**111139**	**114386**	**129847**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	9438	62049	15.2%
Histopathology	781	6508	12.0%
Cytology	191	10481	1.8%
Blood Sciences	100187	1338090	7.5%
Microbiology	19217	183444	10.5%
Blood Bank	33	8652	0.4%
Total	**129847**	**1609224**	**8.1%**

Total Sign Off for Southern Trust previous three months

Month	December	January	February
Total	52060	54317	52979

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3485	49316	7617	285	56	28	0	**60787**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2224	29306	4737	179	18	28	0	**36492**
Daisy Hill Hospital	1115	15315	2269	104	38	0	0	**18841**
Lurgan Hospital	89	3211	443	0	0	0	0	**3743**
South Tyrone Hospital	3	522	53	0	0	0	0	**578**
Community	3	360	32	0	0	0	0	**395**
0	51	280	47	2	0	0	0	**380**
Drumglass Lodge Communit	0	198	0	0	0	0	0	**198**
St Luke's	0	124	0	0	0	0	0	**124**
Mullinure Health & Wellbein	0	0	35	0	0	0	0	**35**
Community Health Office	0	0	1	0	0	0	0	**1**
	3485	**49316**	**7616**	**285**	**56**	**28**	**0**	60787

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2224**	**29306**	**4737**	**179**	**18**	**28**	**0**	**36492**
Doctor	580	14058	1116	54	2	1	0	**15811**
Consultant	1610	10008	1386	111	16	27	0	**13158**
Midwife	2	2783	1937	0	0	0	0	**4722**
Nurse	32	2008	280	14	0	0	0	**2334**
AHP	0	285	18	0	0	0	0	**303**
Pharmacist	0	164	0	0	0	0	0	**164**
Daisy Hill Hospital	**1115**	**15315**	**2269**	**104**	**38**	**0**	**0**	**18841**
Doctor	385	10516	924	4	15	0	0	**11844**
Consultant	717	2571	877	100	23	0	0	**4288**
Physician Associate	9	1152	68	0	0	0	0	**1229**
Midwife	0	701	376	0	0	0	0	**1077**
Nurse	0	242	18	0	0	0	0	**260**
Pharmacist	0	45	1	0	0	0	0	**46**
0	4	88	5	0	0	0	0	**97**
Grand Total	**3339**	**44621**	**7006**	**283**	**56**	**28**	**0**	**55333**

SIGN OFF REPORTS

Time period: **01/03/2021 to 31/03/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Lurgan Hospital	14	1040	198	0	0	0	**1252**
		Consultant	Craigavon Area Hospital	82	1024	123	0	0	0	**1229**
		Consultant	Craigavon Area Hospital	26	1010	64	6	0	0	**1106**
		Doctor	Daisy Hill Hospital	48	797	165	0	0	0	**1010**
		Consultant	Craigavon Area Hospital	151	665	156	4	0	24	**1000**
		Doctor	Daisy Hill Hospital	77	728	144	0	0	0	**949**
		Consultant	Craigavon Area Hospital	104	680	159	0	0	3	**946**
		Consultant	Craigavon Area Hospital	137	659	50	0	1	0	**847**
		Doctor	Craigavon Area Hospital	36	704	80	0	0	0	**820**
		Doctor	Lurgan Hospital	32	607	170	0	0	0	**809**
		Doctor	Craigavon Area Hospital	49	682	44	0	0	0	**775**
		Doctor	Daisy Hill Hospital	14	647	1	0	0	0	**662**
		Consultant	Craigavon Area Hospital	10	591	39	0	0	0	**640**
		Consultant	Daisy Hill Hospital	127	364	123	23	0	0	**637**
		Consultant	Daisy Hill Hospital	121	401	105	2	5	0	**634**
		Consultant	Daisy Hill Hospital	30	523	77	1	0	0	**631**
		Consultant	Craigavon Area Hospital	19	597	7	5	0	0	**628**
		Midwife	Craigavon Area Hospital	0	436	178	0	0	0	**614**
		Consultant	Craigavon Area Hospital	95	286	204	0	0	0	**585**
		Midwife	Daisy Hill Hospital	0	487	95	0	0	0	**582**
		Doctor	Craigavon Area Hospital	24	370	140	0	1	0	**535**
		Consultant	Craigavon Area Hospital	125	284	119	1	3	0	**532**
		Doctor	Craigavon Area Hospital	0	505	0	0	0	0	**505**
		Doctor	Craigavon Area Hospital	4	480	10	0	0	0	**494**
		Midwife	Craigavon Area Hospital	0	275	214	0	0	0	**489**
			Grand Total	**1325**	**14842**	**2665**	**42**	**10**	**27**	**18911**

SIGN OFF REPORTS

Time period: **01/02/2021 to 28/02/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	December	January	February
Southern	52060	54317	52979
Western	28181	28163	30040
South-Eastern	10313	12409	13447
Belfast	10054	10529	12012
Northern	6355	5721	5908
Total	**106963**	**111139**	**114386**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	8025	51030	15.7%
Histopathology	745	5904	12.6%
Cytology	177	9157	1.9%
Blood Sciences	87963	1175252	7.5%
Microbiology	17453	164593	10.6%
Blood Bank	23	6992	0.3%
Total	**114386**	**1412928**	**8.1%**

Total Sign Off for Southern Trust previous three months

Month	November	December	January
Total	51016	52060	54317

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2830	43550	6305	254	27	13	0	**52979**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1758	25508	4045	119	13	13	0	**31456**
Daisy Hill Hospital	953	13955	1807	132	14	0	0	**16861**
Lurgan Hospital	81	2929	327	0	0	0	0	**3337**
South Tyrone Hospital	0	517	44	0	0	0	0	**561**
0	37	110	22	3	0	0	0	**172**
Community	1	229	7	0	0	0	0	**237**
St Luke's	0	35	0	0	0	0	0	**35**
Drumglass Lodge Community	0	257	0	0	0	0	0	**257**
Mullinure Health & Wellbein	0	10	53	0	0	0	0	**63**
	2830	**43550**	**6305**	**254**	**27**	**13**	**0**	52979

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1758**	**25508**	**4045**	**119**	**13**	**13**	**0**	**31456**
Doctor	533	12203	930	40	2	0	0	**13708**
Consultant	1188	8976	1019	79	11	12	0	**11285**
Midwife	0	2541	1874	0	0	0	0	**4415**
Nurse	37	1569	199	0	0	1	0	**1806**
Pharmacist	0	129	0	0	0	0	0	**129**
AHP	0	90	21	0	0	0	0	**111**
GP	0	0	2	0	0	0	0	**2**
Daisy Hill Hospital	**953**	**13955**	**1807**	**132**	**14**	**0**	**0**	**16861**
Doctor	375	9534	789	2	3	0	0	**10703**
Consultant	569	2019	648	130	11	0	0	**3377**
Physician Associate	7	1425	20	0	0	0	0	**1452**
Midwife	1	512	310	0	0	0	0	**823**
Nurse	0	297	36	0	0	0	0	**333**
Pharmacist	0	59	0	0	0	0	0	**59**
0	1	109	4	0	0	0	0	**114**
Grand Total	**2711**	**39463**	**5852**	**251**	**27**	**13**	**0**	**48317**

SIGN OFF REPORTS

Time period: **01/02/2021 to 28/02/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]	Personal Information redacted by the USI	Consultant	Craigavon Area Hospital	201	899	173	16	2	6	**1297**
		Consultant	Craigavon Area Hospital	67	1077	124	1	0	6	**1275**
		Midwife	Craigavon Area Hospital	0	592	479	0	0	0	**1071**
		Consultant	Craigavon Area Hospital	63	805	82	0	0	0	**950**
		Doctor	Daisy Hill Hospital	88	709	128	0	0	0	**925**
		Consultant	Craigavon Area Hospital	117	624	99	5	1	0	**846**
		Consultant	Craigavon Area Hospital	18	737	54	5	0	0	**814**
		Doctor	Lurgan Hospital	26	636	148	0	0	0	**810**
		Doctor	Craigavon Area Hospital	51	603	93	2	0	0	**749**
		Midwife	Craigavon Area Hospital	0	491	163	0	0	0	**654**
		Consultant	Daisy Hill Hospital	74	383	145	15	1	0	**618**
		Midwife	Craigavon Area Hospital	0	375	207	0	0	0	**582**
		Doctor	Craigavon Area Hospital	30	511	25	0	0	0	**566**
		Doctor	Lurgan Hospital	22	466	70	0	0	0	**558**
		Consultant	Craigavon Area Hospital	3	496	39	1	0	0	**539**
		Doctor	Daisy Hill Hospital	13	521	3	0	0	0	**537**
		Doctor	Daisy Hill Hospital	74	390	69	0	0	0	**533**
		Doctor	Craigavon Area Hospital	18	408	76	0	0	0	**502**
		Physician Associate	Daisy Hill Hospital	1	491	5	0	0	0	**497**
		Doctor	Craigavon Area Hospital	17	431	38	0	0	0	**486**
		Consultant	Craigavon Area Hospital	2	463	18	0	0	0	**483**
		Doctor	Daisy Hill Hospital	13	432	28	0	0	0	**473**
		Consultant	Craigavon Area Hospital	7	424	36	0	0	0	**467**
		Doctor	Daisy Hill Hospital	18	410	22	0	0	0	**450**
		Doctor	South Tyrone Hospital	0	398	43	0	0	0	**441**
			Grand Total	**923**	**13772**	**2367**	**45**	**4**	**12**	**17123**

SIGN OFF REPORTS

Time period: **01/01/2021 to 31/01/2021**

Total Sign Off for all trusts for current month and previous two months

Trust	November	December	January
Southern	51016	52060	54317
Western	28940	28181	28163
South-Eastern	10693	10313	12409
Belfast	8850	10054	10529
Northern	6428	6355	5721
Total	**105927**	**106963**	**111139**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	8306	53113	15.6%
Histopathology	720	6033	11.9%
Cytology	180	8966	2.0%
Blood Sciences	83176	1164815	7.1%
Microbiology	18742	183445	10.2%
Blood Bank	15	7027	0.2%
Total	**111139**	**1423399**	**7.8%**

Total Sign Off for Southern Trust previous three months

Month	October	November	December
Total	47310	51016	52060

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2628	44611	6734	259	76	9	0	**54317**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1549	24090	3932	127	35	9	0	**29742**
Daisy Hill Hospital	928	15193	2125	125	41	0	0	**18412**
Lurgan Hospital	87	3714	483	0	0	0	0	**4284**
South Tyrone Hospital	0	583	67	0	0	0	0	**650**
Undefined*	62	679	53	7	0	0	0	**801**
Community	2	162	11	0	0	0	0	**175**
St Luke's	0	42	1	0	0	0	0	**43**
Drumglass Lodge Community	0	141	0	0	0	0	0	**141**
Mullinure Health & Wellbein	0	7	62	0	0	0	0	**69**
	2628	**44611**	**6734**	**259**	**76**	**9**	**0**	54317

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1549**	**24090**	**3932**	**127**	**35**	**9**	**0**	**29742**
Doctor	409	11137	910	32	3	5	0	**12496**
Consultant	1078	8877	886	93	32	3	0	**10969**
Midwife	0	2200	1935	0	0	0	0	**4135**
Nurse	36	1413	197	2	0	1	0	**1649**
AHP	26	281	4	0	0	0	0	**311**
Pharmacist	0	180	0	0	0	0	0	**180**
Physician Associate	0	2	0	0	0	0	0	**2**
Daisy Hill Hospital	**928**	**15193**	**2125**	**125**	**41**	**0**	**0**	**18412**
Doctor	348	10202	825	2	11	0	0	**11388**
Consultant	564	2242	834	123	30	0	0	**3793**
Physician Associate	11	1720	42	0	0	0	0	**1773**
Midwife	3	626	363	0	0	0	0	**992**
Nurse	1	160	37	0	0	0	0	**198**
Pharmacist	0	39	0	0	0	0	0	**39**
0	1	80	24	0	0	0	0	**105**
AHP	0	124	0	0	0	0	0	**124**
Grand Total	**2477**	**39283**	**6057**	**252**	**76**	**9**	**0**	**48154**

SIGN OFF REPORTS

Time period: **01/01/2021 to 31/01/2021**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

Personal Information redacted by the USI	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
	Consultant	Craigavon Area Hospital	86	1360	109	0	0	0	**1555**
	Doctor	Craigavon Area Hospital	58	914	103	0	0	0	**1075**
	Doctor	Lurgan Hospital	41	811	135	0	0	0	**987**
	Doctor	Daisy Hill Hospital	12	928	35	0	0	0	**975**
	Doctor	Daisy Hill Hospital	63	789	114	0	0	0	**966**
	Midwife	Craigavon Area Hospital	0	509	443	0	0	0	**952**
	Consultant	Craigavon Area Hospital	128	617	113	0	4	0	**862**
	Doctor	Daisy Hill Hospital	3	738	105	0	0	0	**846**
	Consultant	Craigavon Area Hospital	25	693	32	10	0	0	**760**
	Doctor	Daisy Hill Hospital	71	572	113	0	0	0	**756**
	Consultant	Craigavon Area Hospital	42	622	89	1	0	0	**754**
	Consultant	Craigavon Area Hospital	20	682	42	4	0	0	**748**
	Consultant	Craigavon Area Hospital	7	670	50	0	0	0	**727**
	Doctor	Lurgan Hospital	1	650	64	0	0	0	**715**
	Doctor	Lurgan Hospital	12	535	104	0	0	0	**651**
	Consultant	Daisy Hill Hospital	105	365	113	17	1	0	**601**
	Doctor	Daisy Hill Hospital	14	561	9	0	0	0	**584**
	Doctor	Craigavon Area Hospital	17	397	136	0	0	0	**550**
	Doctor	South Tyrone Hospital	0	470	46	0	0	0	**516**
	Doctor	Craigavon Area Hospital	38	394	74	0	0	0	**506**
	Consultant	Craigavon Area Hospital	16	381	105	0	0	0	**502**
	Consultant	Craigavon Area Hospital	86	324	63	14	2	0	**489**
	Consultant	Craigavon Area Hospital	12	422	42	1	0	0	**477**
	Doctor	Daisy Hill Hospital	8	458	4	0	0	0	**470**
	Midwife	Daisy Hill Hospital	3	392	72	0	0	0	**467**
		Grand Total	**868**	**15254**	**2315**	**47**	**7**	**0**	**18491**

SIGN OFF REPORTS

Time period: **01/12/2020 to 31/12/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	October	November	December
Southern	45007	51016	52060
Western	29442	28940	28181
South-Eastern	9276	10693	10313
Belfast	7379	8850	10054
Northern	4742	6428	6355
Total	**95846**	**105927**	**106963**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	7450	50109	14.9%
Histopathology	707	6614	10.7%
Cytology	152	9458	1.6%
Blood Sciences	80614	1149446	7.0%
Microbiology	18028	175478	10.3%
Blood Bank	12	8135	0.1%
Total	**106963**	**1399240**	**7.6%**

Total Sign Off for Southern Trust previous three months

Month	September	October	November
Total	45007	47310	51016

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2526	42741	6466	254	62	11	0	**52060**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1558	23699	3711	142	25	11	0	**29146**
Daisy Hill Hospital	841	14486	2150	100	37	0	0	**17614**
Lurgan Hospital	62	2949	422	1	0	0	0	**3434**
South Tyrone Hospital	0	401	55	0	0	0	0	**456**
0	64	649	93	11	0	0	0	**817**
Community	1	164	10	0	0	0	0	**175**
St Luke's	0	170	1	0	0	0	0	**171**
Drumglass Lodge Community	0	214	0	0	0	0	0	**214**
Mullinure Health & Wellbein	0	9	24	0	0	0	0	**33**
	2526	**42741**	**6466**	**254**	**62**	**11**	**0**	52060

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1558**	**23699**	**3711**	**142**	**25**	**11**	**0**	**29146**
Doctor	484	11199	903	38	2	2	0	**12628**
Consultant	1016	7028	681	101	23	9	0	**8858**
Midwife	1	2773	1876	0	0	0	0	**4650**
Nurse	57	2161	251	2	0	0	0	**2471**
AHP	0	368	0	0	0	0	0	**368**
Pharmacist	0	170	0	0	0	0	0	**170**
GP	0	0	0	1	0	0	0	**1**
Daisy Hill Hospital	**841**	**14486**	**2150**	**100**	**37**	**0**	**0**	**17614**
Doctor	308	9785	973	0	1	0	0	**11067**
Consultant	507	2607	908	100	36	0	0	**4158**
Physician Associate	9	954	24	0	0	0	0	**987**
Midwife	13	632	220	0	0	0	0	**865**
Nurse	1	219	16	0	0	0	0	**236**
Pharmacist	0	55	0	0	0	0	0	**55**
0	3	55	8	0	0	0	0	**66**
AHP	0	179	1	0	0	0	0	**180**
Grand Total	**2399**	**38185**	**5861**	**242**	**62**	**11**	**0**	**46760**

SIGN OFF REPORTS

Time period: **01/12/2020 to 31/12/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Craigavon Area Hospital	86	1108	93	2	0	0	**1289**
		Doctor	Craigavon Area Hospital	72	951	140	3	1	0	**1167**
		Doctor	Daisy Hill Hospital	53	914	121	0	0	0	**1088**
		Midwife	Craigavon Area Hospital	0	676	351	0	0	0	**1027**
		Doctor	Lurgan Hospital	17	774	108	1	0	0	**900**
		Doctor	Lurgan Hospital	18	667	202	0	0	0	**887**
		Doctor	Daisy Hill Hospital	6	604	92	0	0	0	**702**
		Consultant	Craigavon Area Hospital	21	632	35	5	0	0	**693**
		Consultant	Daisy Hill Hospital	102	396	177	8	0	0	**683**
		Doctor	Daisy Hill Hospital	49	433	100	0	0	0	**582**
		Doctor	Craigavon Area Hospital	26	475	79	0	0	0	**580**
		Doctor	Daisy Hill Hospital	26	343	206	0	0	0	**575**
		Doctor	Daisy Hill Hospital	7	513	51	0	0	0	**571**
		Consultant	Craigavon Area Hospital	3	495	71	1	0	0	**570**
		Doctor	Daisy Hill Hospital	14	481	49	0	0	0	**544**
		Midwife	Craigavon Area Hospital	0	320	220	0	0	0	**540**
		Doctor	Daisy Hill Hospital	31	463	33	0	0	0	**527**
		Doctor	Daisy Hill Hospital	9	492	14	0	0	0	**515**
		Doctor	Craigavon Area Hospital	25	339	141	0	0	0	**505**
		Consultant	Craigavon Area Hospital	84	394	21	0	0	0	**499**
		Consultant	Craigavon Area Hospital	110	286	64	16	4	8	**488**
		Doctor	Lurgan Hospital	0	445	40	0	0	0	**485**
		Doctor	Craigavon Area Hospital	22	422	36	3	0	0	**483**
		Nurse	Craigavon Area Hospital	31	376	76	0	0	0	**483**
		Doctor	Craigavon Area Hospital	4	459	11	0	0	0	**474**
			Grand Total	**816**	**13458**	**2531**	**39**	**5**	**8**	**16857**

SIGN OFF REPORTS

Time period: **01/11/2020 to 30/11/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	September	October	November
Southern	45007	47310	51016
Western	29442	27592	28940
South-Eastern	9276	8865	10693
Belfast	7379	6214	8850
Northern	4742	4949	6428
Total	**95846**	**94930**	**105927**

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	7315	53551	13.7%
Histopathology	676	6362	10.6%
Cytology	180	9827	1.8%
Blood Sciences	79629	1163333	6.8%
Microbiology	18118	174790	10.4%
Blood Bank	9	7826	0.1%
Total	**105927**	**1415689**	**7.5%**

Total Sign Off for Southern Trust previous three months

Month	August	September	October
Total	43070	45007	47310

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2338	42157	6225	210	80	6	0	**51016**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1513	24777	3766	129	40	4	0	**30229**
Daisy Hill Hospital	669	12012	1793	81	40	2	0	**14597**
Lurgan Hospital	97	3673	431	0	0	0	0	**4201**
South Tyrone Hospital	4	915	121	0	0	0	0	**1040**
0	52	510	52	0	0	0	0	**614**
Community	3	188	37	0	0	0	0	**228**
St Luke's	0	34	4	0	0	0	0	**38**
Drumglass Lodge Community	0	36	0	0	0	0	0	**36**
Mullinure Health & Wellbein	0	12	21	0	0	0	0	**33**
	2338	**42157**	**6225**	**210**	**80**	**6**	**0**	51016

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1513**	**24777**	**3766**	**129**	**40**	**4**	**0**	**30229**
Doctor	427	11246	1015	46	4	1	0	**12739**
Consultant	1050	8687	790	83	36	2	0	**10648**
Midwife	0	2141	1806	0	0	0	0	**3947**
Nurse	36	2133	155	0	0	1	0	**2325**
AHP	0	368	0	0	0	0	0	**368**
Pharmacist	0	201	0	0	0	0	0	**201**
GP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**669**	**12012**	**1793**	**81**	**40**	**2**	**0**	**14597**
Doctor	193	8076	697	0	6	2	0	**8974**
Consultant	467	1976	648	81	34	0	0	**3206**
Physician Associate	2	1047	40	0	0	0	0	**1089**
Midwife	4	518	384	0	0	0	0	**906**
Nurse	1	311	21	0	0	0	0	**333**
Pharmacist	0	34	0	0	0	0	0	**34**
0	2	50	1	0	0	0	0	**53**
AHP	0	0	2	0	0	0	0	**2**
Grand Total	**2182**	**36789**	**5559**	**210**	**80**	**6**	**0**	**44826**

SIGN OFF REPORTS

Time period: **01/11/2020 to 30/11/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	112	1473	185	0	0	0	**1770**
	Doctor	Lurgan Hospital	47	1403	213	0	0	0	**1663**
	Consultant	Craigavon Area Hospital	50	1044	92	0	0	2	**1188**
	Doctor	Daisy Hill Hospital	18	865	101	0	0	0	**984**
	Doctor	Lurgan Hospital	12	711	78	0	0	0	**801**
	Consultant	Craigavon Area Hospital	67	644	71	0	0	0	**782**
	Consultant	Craigavon Area Hospital	10	694	60	0	0	0	**764**
	Doctor	South Tyrone Hospital	1	687	73	0	0	0	**761**
	Consultant	Craigavon Area Hospital	27	647	42	3	0	0	**719**
	Consultant	Craigavon Area Hospital	17	610	50	6	0	0	**683**
	Midwife	Craigavon Area Hospital	0	366	294	0	0	0	**660**
	Doctor	Daisy Hill Hospital	3	564	82	0	0	2	**651**
	Midwife	Craigavon Area Hospital	0	341	270	0	0	0	**611**
	Nurse	Craigavon Area Hospital	20	441	108	0	0	1	**570**
	Doctor	Craigavon Area Hospital	17	489	47	0	0	0	**553**
	Consultant	Craigavon Area Hospital	29	502	19	1	1	0	**552**
	Consultant	Craigavon Area Hospital	153	373	24	0	0	0	**550**
	Doctor	Daisy Hill Hospital	52	441	46	0	0	0	**539**
	Doctor	Daisy Hill Hospital	1	532	1	0	0	0	**534**
	Doctor	Craigavon Area Hospital	15	472	41	0	0	0	**528**
	Consultant	Craigavon Area Hospital	77	377	72	1	0	0	**527**
	Doctor	Craigavon Area Hospital	1	400	99	0	1	0	**501**
	Consultant	Craigavon Area Hospital	119	291	72	18	1	0	**501**
	Consultant	Daisy Hill Hospital	81	324	86	8	0	0	**499**
	Doctor	Craigavon Area Hospital	9	439	49	0	0	0	**497**
		Grand Total	**938**	**15130**	**2275**	**37**	**3**	**5**	**18388**

SIGN OFF REPORTS

Time period: **01/10/2020 to 31/10/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	August	September	October
Southern	43070	45007	47310
Western	22875	29442	27592
South-Eastern	9431	9276	8865
Belfast	7025	7379	6214
Northern	3522	4742	4949
Total	**85923**	**95846**	**94930**

Total Sign Off for Southern Trust previous three months

Month	July	August	September
Total	53263	43070	45007

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2234	39098	5659	215	102	2	0	**47310**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1476	23476	3635	112	34	2	0	**28735**
Daisy Hill Hospital	662	10834	1476	103	68	0	0	**13143**
Lurgan Hospital	71	3065	333	0	0	0	0	**3469**
South Tyrone Hospital	0	543	48	0	0	0	0	**591**
0	25	450	74	0	0	0	0	**549**
St Luke's	0	400	4	0	0	0	0	**404**
Community	0	278	35	0	0	0	0	**313**
Mullinure Health & Wellbein	0	11	54	0	0	0	0	**65**
Drumglass Lodge Community	0	41	0	0	0	0	0	**41**
	2234	**39098**	**5659**	**215**	**102**	**2**	**0**	**47310**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1476**	**23476**	**3635**	**112**	**34**	**2**	**0**	**28735**
Doctor	382	11009	876	35	4	0	0	**12306**
Consultant	1057	7649	730	75	30	1	0	**9542**
Midwife	0	2173	1808	0	0	1	0	**3982**
Nurse	35	2133	217	1	0	0	0	**2386**
AHP	1	334	2	0	0	0	0	**337**
Pharmacist	0	178	0	0	0	0	0	**178**
GP	1	0	2	1	0	0	0	**4**
Daisy Hill Hospital	**662**	**10834**	**1476**	**103**	**68**	**0**	**0**	**13143**
Doctor	247	7255	624	0	6	0	0	**8132**
Consultant	391	1671	492	102	62	0	0	**2718**
Physician Associate	7	1331	38	0	0	0	0	**1376**
Midwife	16	349	302	1	0	0	0	**668**
Nurse	0	176	18	0	0	0	0	**194**
Pharmacist	0	38	0	0	0	0	0	**38**
0	1	14	1	0	0	0	0	**16**
AHP	0	0	1	0	0	0	0	**1**
Grand Total	**2138**	**34310**	**5111**	**215**	**102**	**2**	**0**	**41878**

SIGN OFF REPORTS

Time period: **01/10/2020 to 31/10/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Craigavon Area Hospital	66	1168	90	0	0	0	**1324**
		Doctor	Lurgan Hospital	20	976	152	0	0	0	**1148**
		Consultant	Craigavon Area Hospital	62	822	66	0	0	0	**950**
		Midwife	Craigavon Area Hospital	0	382	565	0	0	0	**947**
		Doctor	Daisy Hill Hospital	40	800	66	0	1	0	**907**
		Doctor	Craigavon Area Hospital	29	747	98	1	1	0	**876**
		Consultant	Craigavon Area Hospital	147	541	94	8	2	0	**792**
		Doctor	Daisy Hill Hospital	44	625	79	0	0	0	**748**
		Consultant	Craigavon Area Hospital	28	639	35	11	1	1	**715**
		Consultant	Craigavon Area Hospital	157	508	17	0	0	0	**682**
		Consultant	Craigavon Area Hospital	24	561	41	10	0	0	**636**
		Doctor	Craigavon Area Hospital	8	526	39	0	0	0	**573**
		Doctor	Lurgan Hospital	16	483	69	0	0	0	**568**
		Doctor	Craigavon Area Hospital	14	390	103	0	1	0	**508**
		Doctor	Craigavon Area Hospital	25	408	50	0	0	0	**483**
		Consultant	Craigavon Area Hospital	30	403	43	0	0	0	**476**
		Consultant	Craigavon Area Hospital	20	416	34	4	0	0	**474**
		Consultant	Craigavon Area Hospital	0	462	8	0	0	0	**470**
		Consultant	Craigavon Area Hospital	6	426	23	0	0	0	**455**
		Nurse	Craigavon Area Hospital	16	377	54	0	0	0	**447**
		Doctor	South Tyrone Hospital	0	411	32	0	0	0	**443**
		Doctor	Daisy Hill Hospital	5	410	27	0	0	0	**442**
		Nurse	Craigavon Area Hospital	13	320	97	0	0	0	**430**
		Doctor	Daisy Hill Hospital	17	271	134	0	0	0	**422**
		Midwife	Craigavon Area Hospital	0	237	181	0	0	0	**418**
			Grand Total	**787**	**13309**	**2197**	**34**	**6**	**1**	**16334**

SIGN OFF REPORTS

Time period: **01/09/2020 to 30/09/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	July	August	September
Southern	53263	43070	45007
Western	27688	22875	29442
South-Eastern	7841	9431	9276
Belfast	5054	7025	7379
Northern	4063	3522	4742
Total	**97909**	**85923**	**95846**

Total Sign Off for Southern Trust previous three months

Month	June	July	August
Total	55627	53263	43070

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2162	36663	5796	274	95	17	0	**45007**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1544	21458	3554	177	53	16	0	**26802**
Daisy Hill Hospital	543	10912	1661	94	42	1	0	**13253**
Lurgan Hospital	60	3020	355	1	0	0	0	**3436**
*Undefined	11	572	50	2	0	0	0	**635**
South Tyrone Hospital	4	388	62	0	0	0	0	**454**
Community	0	273	45	0	0	0	0	**318**
Mullinure Health & Wellbein	0	7	65	0	0	0	0	**72**
St Luke's	0	32	2	0	0	0	0	**34**
Community Health Office	0	0	2	0	0	0	0	**2**
Drumglass Lodge Community	0	1	0	0	0	0	0	**1**
	2162	**36663**	**5796**	**274**	**95**	**17**	**0**	45007

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1544**	**21458**	**3554**	**177**	**53**	**16**	**0**	**26802**
Doctor	375	9057	732	61	3	0	0	**10228**
Consultant	1141	7805	758	109	50	15	0	**9878**
Midwife	0	2318	1815	0	0	1	0	**4134**
Nurse	28	1871	249	7	0	0	0	**2155**
Pharmacist	0	203	0	0	0	0	0	**203**
AHP	0	204	0	0	0	0	0	**204**
Daisy Hill Hospital	**543**	**10912**	**1661**	**94**	**42**	**1**	**0**	**13253**
Doctor	148	6267	523	0	0	1	0	**6939**
Consultant	378	2473	675	94	42	0	0	**3662**
Physician Associate	9	1273	47	0	0	0	0	**1329**
Midwife	8	501	400	0	0	0	0	**909**
Nurse	0	321	14	0	0	0	0	**335**
Pharmacist	0	76	0	0	0	0	0	**76**
AHP	0	0	2	0	0	0	0	**2**
GP	0	1	0	0	0	0	0	**1**
Grand Total	**2087**	**32370**	**5215**	**271**	**95**	**17**	**0**	40055

SIGN OFF REPORTS

Time period: **01/09/2020 to 30/09/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Consultant	Craigavon Area Hospital	95	1025	92	1	0	0	**1213**
		Doctor	Craigavon Area Hospital	58	930	75	3	1	0	**1067**
		Doctor	Lurgan Hospital	20	868	173	0	0	0	**1061**
		Midwife	Craigavon Area Hospital	0	534	345	0	0	0	**879**
		Doctor	Daisy Hill Hospital	44	680	53	0	0	0	**777**
		Consultant	Daisy Hill Hospital	5	653	59	0	0	0	**717**
		Consultant	Craigavon Area Hospital	147	418	119	6	3	13	**706**
		Doctor	Craigavon Area Hospital	28	537	99	0	0	0	**664**
		Consultant	Craigavon Area Hospital	170	380	73	13	2	0	**638**
		Consultant	Craigavon Area Hospital	18	486	48	0	0	0	**552**
		Doctor	Daisy Hill Hospital	3	512	14	0	0	0	**529**
		Consultant	Craigavon Area Hospital	101	346	58	0	4	0	**509**
		Midwife	Craigavon Area Hospital	0	307	191	0	0	0	**498**
		Doctor	Craigavon Area Hospital	23	440	22	0	0	0	**485**
		Consultant	Daisy Hill Hospital	48	370	60	1	1	0	**480**
		Doctor		1	451	16	0	0	0	**468**
		Doctor	Lurgan Hospital	10	395	62	0	0	0	**467**
		Midwife	Daisy Hill Hospital	8	267	191	0	0	0	**466**
		Doctor	Daisy Hill Hospital	28	370	64	0	0	0	**462**
		Consultant	Craigavon Area Hospital	0	426	20	1	0	0	**447**
		Midwife	Craigavon Area Hospital	0	299	139	0	0	0	**438**
		Nurse	Craigavon Area Hospital	14	314	98	0	0	0	**426**
		Doctor	Craigavon Area Hospital	14	361	49	0	0	0	**424**
		Consultant	Craigavon Area Hospital	34	385	3	0	0	0	**422**
		Consultant	Craigavon Area Hospital	11	381	22	1	0	0	**415**
			Grand Total	**880**	**12135**	**2145**	**26**	**11**	**13**	**15210**

SIGN OFF REPORTS

Time period: **01/08/2020 to 31/08/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	June	July	August
Southern	55627	53263	43070
Western	27038	27688	22875
South-Eastern	7474	7841	9431
Belfast	6583	5054	7025
Northern	4504	4063	3522
Total	**101226**	**97909**	**85923**

Total Sign Off for Southern Trust previous three months

Month	May	June	July
Total	48799	55627	53263

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	1999	35642	5171	186	68	4	0	**43070**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1259	20471	2984	99	8	4	0	**24825**
Daisy Hill Hospital	641	11503	1700	87	60	0	0	**13991**
Lurgan Hospital	72	2613	297	0	0	0	0	**2982**
Undefined*	23	482	40	0	0	0	0	**545**
South Tyrone Hospital	2	355	84	0	0	0	0	**441**
Community	2	162	31	0	0	0	0	**195**
Mullinure Health & Wellbein	0	18	30	0	0	0	0	**48**
Drumglass Lodge Community	0	33	0	0	0	0	0	**33**
St Luke's	0	5	5	0	0	0	0	**10**
	1999	**35642**	**5171**	**186**	**68**	**4**	**0**	**43070**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1259**	**20471**	**2984**	**99**	**8**	**4**	**0**	**24825**
Doctor	335	9848	659	37	3	2	0	**10884**
Consultant	872	7025	597	62	5	2	0	**8563**
Midwife	0	1783	1556	0	0	0	0	**3339**
Nurse	52	1541	172	0	0	0	0	**1765**
Pharmacist	0	140	0	0	0	0	0	**140**
AHP	0	134	0	0	0	0	0	**134**
Daisy Hill Hospital	**641**	**11503**	**1700**	**87**	**60**	**0**	**0**	**13991**
Doctor	161	7138	529	2	11	0	0	**7841**
Consultant	430	1577	508	85	49	0	0	**2649**
Physician Associate	17	1660	135	0	0	0	0	**1812**
Midwife	33	670	503	0	0	0	0	**1206**
Nurse	0	448	24	0	0	0	0	**472**
Pharmacist	0	10	0	0	0	0	0	**10**
AHP	0	0	1	0	0	0	0	**1**
Grand Total	**1900**	**31974**	**4684**	**186**	**68**	**4**	**0**	**38816**

SIGN OFF REPORTS

Time period: **01/08/2020 to 31/08/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Craigavon Area Hospital	47	934	55	0	0	0	**1036**
		Consultant	Craigavon Area Hospital	75	820	81	0	0	0	**976**
		Doctor	Lurgan Hospital	28	723	138	0	0	0	**889**
		Doctor	Daisy Hill Hospital	35	736	106	0	0	0	**877**
		Consultant	Craigavon Area Hospital	26	722	43	3	0	0	**794**
		Doctor	Daisy Hill Hospital	8	761	24	0	0	0	**793**
		Consultant	Daisy Hill Hospital	118	536	120	5	1	0	**780**
		Consultant	Craigavon Area Hospital	7	618	42	1	0	0	**668**
		Midwife	Craigavon Area Hospital	0	249	414	0	0	0	**663**
		Consultant	Craigavon Area Hospital	54	518	54	2	0	2	**630**
		Physician Associate	Daisy Hill Hospital	13	481	123	0	0	0	**617**
		Doctor	Craigavon Area Hospital	13	508	63	6	0	0	**590**
		Consultant	Craigavon Area Hospital	2	555	25	0	0	0	**582**
		Consultant	Craigavon Area Hospital	152	292	84	13	0	0	**541**
		Doctor	Lurgan Hospital	21	442	69	0	0	0	**532**
		Midwife	Daisy Hill Hospital	33	312	164	0	0	0	**509**
		Midwife	Craigavon Area Hospital	0	360	128	0	0	0	**488**
		Doctor	Daisy Hill Hospital	4	390	40	0	0	0	**434**
		Physician Associate	Daisy Hill Hospital	0	429	2	0	0	0	**431**
		Doctor	Craigavon Area Hospital	19	357	42	0	0	0	**418**
		Consultant	Craigavon Area Hospital	22	376	11	3	0	0	**412**
		Consultant	Craigavon Area Hospital	40	327	36	0	0	0	**403**
		Consultant	Craigavon Area Hospital	81	306	13	0	0	0	**400**
		Doctor	Craigavon Area Hospital	0	397	0	0	0	0	**397**
		Doctor	Daisy Hill Hospital	16	339	40	0	0	0	**395**
			Grand Total	**814**	**12488**	**1917**	**33**	**1**	**2**	**15255**

SIGN OFF REPORTS

Time period: **01/07/2020 to 31/07/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	May	June	July
Southern	48799	55627	53263
Western	24242	27038	27688
South-Eastern	5727	7474	7841
Northern	4883	6583	5054
Belfast	4641	4504	4063
Total	**88292**	**101226**	**97909**

Total Sign Off for Southern Trust previous three months

Month	April	May	June
Total	40680	48799	55627

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2396	44885	5647	234	79	22	0	**53263**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1504	28400	3207	144	10	22	0	**33287**
Daisy Hill Hospital	827	12682	1860	90	69	0	0	**15528**
Lurgan Hospital	44	2720	407	0	0	0	0	**3171**
Drumglass Lodge Community	2	56	1	0	0	0	0	**59**
Community	0	425	77	0	0	0	0	**502**
South Tyrone Hospital	3	489	57	0	0	0	0	**549**
Undefined*	16	105	28	0	0	0	0	**149**
Mullinure Health & Wellbein	0	8	5	0	0	0	0	**13**
St Luke's	0	0	2	0	0	0	0	**2**
Community Health Office	0	0	3	0	0	0	0	**3**
	2396	**44885**	**5647**	**234**	**79**	**22**	**0**	53263

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1504**	**28400**	**3207**	**144**	**10**	**22**	**0**	**33287**
Doctor	596	16738	1001	59	1	5	0	**18400**
Consultant	878	7729	719	82	9	16	0	**9433**
Midwife	0	2158	1340	0	0	1	0	**3499**
Nurse	30	1594	147	2	0	0	0	**1773**
Pharmacist	0	169	0	0	0	0	0	**169**
AHP	0	12	0	0	0	0	0	**12**
GP	0	0	0	1	0	0	0	**1**
Daisy Hill Hospital	**827**	**12682**	**1860**	**90**	**69**	**0**	**0**	**15528**
Doctor	356	8244	701	2	2	0	0	**9305**
Consultant	446	2269	675	87	67	0	0	**3544**
Physician Associate	19	1469	106	0	0	0	0	**1594**
Midwife	6	459	350	1	0	0	0	**816**
Nurse	0	215	26	0	0	0	0	**241**
Pharmacist	0	26	0	0	0	0	0	**26**
AHP	0	0	2	0	0	0	0	**2**
Grand Total	**2331**	**41082**	**5067**	**234**	**79**	**22**	**0**	**48815**

SIGN OFF REPORTS

Time period: **01/07/2020 to 31/07/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Craigavon Area Hospital	52	961	127	3	1	0	**1144**
		Doctor	Craigavon Area Hospital	66	910	137	0	0	0	**1113**
		Consultant	Craigavon Area Hospital	70	900	91	1	0	0	**1062**
		Doctor	Lurgan Hospital	16	685	222	0	0	0	**923**
		Consultant	Craigavon Area Hospital	152	498	103	7	1	16	**777**
		Doctor	Craigavon Area Hospital	41	635	64	0	0	0	**740**
		Consultant	Craigavon Area Hospital	25	594	44	3	0	0	**666**
		Doctor	Daisy Hill Hospital	25	603	8	1	0	0	**637**
		Consultant	Daisy Hill Hospital	79	435	80	10	2	0	**606**
		Consultant	Craigavon Area Hospital	24	538	11	0	0	0	**573**
		Midwife	Craigavon Area Hospital	0	370	182	0	0	0	**552**
		Consultant	Craigavon Area Hospital	118	330	97	5	1	0	**551**
		Doctor	Daisy Hill Hospital	50	472	28	0	0	0	**550**
		Consultant	Daisy Hill Hospital	98	352	78	0	0	0	**528**
		Consultant	Craigavon Area Hospital	19	450	57	2	0	0	**528**
		Doctor	Lurgan Hospital	15	452	58	0	0	0	**525**
		Doctor	Daisy Hill Hospital	7	468	42	0	0	0	**517**
		Consultant	Craigavon Area Hospital	2	505	9	0	0	0	**516**
		Consultant	Craigavon Area Hospital	7	486	5	0	0	0	**498**
		Doctor	Craigavon Area Hospital	6	454	35	0	0	0	**495**
		Doctor	Craigavon Area Hospital	53	395	29	0	0	1	**478**
		Consultant	Craigavon Area Hospital	1	458	6	0	0	0	**465**
		Doctor	Daisy Hill Hospital	33	386	44	0	0	0	**463**
		Doctor	Craigavon Area Hospital	24	429	7	0	0	0	**460**
		Consultant	Daisy Hill Hospital	3	427	27	0	0	0	**457**
			Grand Total	**986**	**13193**	**1591**	**32**	**5**	**17**	**15824**

SIGN OFF REPORTS

Time period: **01/06/2020 to 30/06/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	April	May	June
Southern	40680	48799	55627
Western	18035	24242	27038
South-Eastern	4834	5727	7474
Belfast	3720	4883	6583
Northern	3162	4641	4504
Total	**70431**	**88292**	**101226**

Total Sign Off for Southern Trust previous three months

Month	March	April	May
Total	51700	40680	48799

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2954	46518	5830	234	43	48	0	**55627**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1969	30780	3581	133	16	47	0	**36526**
Daisy Hill Hospital	923	12093	1800	100	27	1	0	**14944**
Lurgan Hospital	43	3106	355	0	0	0	0	**3504**
Drumglass Lodge Community	1	209	3	0	0	0	0	**213**
Community	1	146	47	0	0	0	0	**194**
South Tyrone Hospital	0	99	22	0	0	0	0	**121**
*Undefined	17	80	13	1	0	0	0	**111**
Mullinure Health & Wellbein	0	3	6	0	0	0	0	**9**
St Luke's	0	2	2	0	0	0	0	**4**
Community Health Office	0	0	1	0	0	0	0	**1**
	2954	**46518**	**5830**	**234**	**43**	**48**	**0**	55627

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1969**	**30780**	**3581**	**133**	**16**	**47**	**0**	36526
Doctor	873	19869	1360	60	7	2	0	**22171**
Consultant	1054	7320	767	72	9	45	0	**9267**
Midwife	0	1889	1297	0	0	0	0	**3186**
Nurse	42	1558	157	1	0	0	0	**1758**
Pharmacist	0	143	0	0	0	0	0	**143**
GP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**923**	**12093**	**1800**	**100**	**27**	**1**	**0**	14944
Doctor	422	8753	808	6	3	1	0	**9993**
Consultant	476	2066	626	94	24	0	0	**3286**
Midwife	25	527	359	0	0	0	0	**911**
Physician Associate	0	494	4	0	0	0	0	**498**
Nurse	0	70	2	0	0	0	0	**72**
Other	0	116	1	0	0	0	0	**117**
Pharmacist	0	67	0	0	0	0	0	**67**
Grand Total	**2892**	**42873**	**5381**	**233**	**43**	**48**	**0**	51470

SIGN OFF REPORTS

Time period: **01/06/2020 to 30/06/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]	Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	91	1683	155	2	1	0	**1932**
		Doctor	Craigavon Area Hospital	91	1013	101	0	1	0	**1206**
		Doctor	Lurgan Hospital	24	691	192	0	0	0	**907**
		Consultant	Craigavon Area Hospital	95	725	79	0	1	0	**900**
		Doctor	Craigavon Area Hospital	53	722	68	0	0	0	**843**
		Consultant	Craigavon Area Hospital	121	523	112	16	3	45	**820**
		Doctor	Daisy Hill Hospital	11	726	41	0	0	0	**778**
		Consultant	Craigavon Area Hospital	65	572	111	3	1	0	**752**
		Consultant	Craigavon Area Hospital	23	652	33	7	0	0	**715**
		Doctor	Craigavon Area Hospital	60	596	52	0	0	0	**708**
		Consultant	Craigavon Area Hospital	3	641	25	0	0	0	**669**
		Doctor	Craigavon Area Hospital	38	563	62	2	0	0	**665**
		Doctor	Lurgan Hospital	9	602	49	0	0	0	**660**
		Doctor	Craigavon Area Hospital	27	564	40	0	0	0	**631**
		Consultant	Daisy Hill Hospital	34	524	66	0	0	0	**624**
		Consultant	Daisy Hill Hospital	88	410	113	0	0	0	**611**
		Doctor	Craigavon Area Hospital	19	533	46	1	0	0	**599**
		Consultant	Craigavon Area Hospital	169	348	55	17	1	0	**590**
		Doctor	Daisy Hill Hospital	60	466	54	0	0	0	**580**
		Consultant	Daisy Hill Hospital	66	377	97	13	1	0	**554**
		Doctor	Craigavon Area Hospital	37	485	27	0	0	0	**549**
		Doctor	Daisy Hill Hospital	120	261	144	0	0	0	**525**
		Consultant	Craigavon Area Hospital	14	505	0	0	0	0	**519**
		Consultant	Craigavon Area Hospital	33	409	44	0	1	0	**487**
		Doctor	Craigavon Area Hospital	7	464	1	0	0	0	**472**
			Grand Total	**1358**	**15055**	**1767**	**61**	**10**	**45**	**18296**

SIGN OFF REPORTS

Time period: **01/05/2020 to 31/05/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	March	April	May
Southern	51700	40680	48799
Western	24973	18035	24242
South-Eastern	6493	4834	5727
Belfast	6654	3720	4883
Northern	1731	3162	4641
Total	**91551**	**70431**	**88292**

Total Sign Off for Southern Trust previous three months

Month	February	March	April
Total	55381	51700	40680

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2647	40072	5954	84	33	9	0	**48799**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1748	26336	3896	53	18	6	0	**32057**
Daisy Hill Hospital	820	10332	1548	31	15	0	0	**12746**
Lurgan Hospital	55	3041	351	0	0	3	0	**3450**
Community	0	171	24	0	0	0	0	**195**
*Undefined	24	69	35	0	0	0	0	**128**
St Luke's	0	1	89	0	0	0	0	**90**
South Tyrone Hospital	0	80	10	0	0	0	0	**90**
Drumglass Lodge Community	0	42	1	0	0	0	0	**43**
	2647	**40072**	**5954**	**84**	**33**	**9**	**0**	**48799**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1748**	**26336**	**3896**	**53**	**18**	**6**	**0**	**32057**
Doctor	846	16493	1474	25	3	3	0	**18844**
Consultant	851	6015	890	27	15	3	0	**7801**
Midwife	3	2149	1322	0	0	0	0	**3474**
Nurse	48	1487	210	1	0	0	0	**1746**
Pharmacist	0	189	0	0	0	0	0	**189**
GP	0	3	0	0	0	0	0	**3**
Daisy Hill Hospital	**820**	**10332**	**1548**	**31**	**15**	**0**	**0**	**12746**
Doctor	360	7753	776	3	6	0	0	**8898**
Consultant	377	1681	490	28	9	0	0	**2585**
Midwife	82	438	266	0	0	0	0	**786**
Physician Associate	0	259	2	0	0	0	0	**261**
Nurse	1	96	14	0	0	0	0	**111**
Other	0	70	0	0	0	0	0	**70**
Pharmacist	0	35	0	0	0	0	0	**35**
Grand Total	**2568**	**36668**	**5444**	**84**	**33**	**6**	**0**	**44803**

SIGN OFF REPORTS

Time period: **01/05/2020 to 31/05/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Consultant	Craigavon Area Hospital	175	1465	144	0	1	0	**1785**
		Doctor	Craigavon Area Hospital	53	1040	122	0	0	0	**1215**
		Doctor	Craigavon Area Hospital	83	944	109	1	1	0	**1138**
		Midwife	Craigavon Area Hospital	0	686	315	0	0	0	**1001**
		Doctor	Lurgan Hospital	29	644	177	0	0	3	**853**
		Doctor	Craigavon Area Hospital	70	602	76	0	0	0	**748**
		Consultant	Daisy Hill Hospital	95	541	92	2	0	0	**730**
		Doctor	Craigavon Area Hospital	93	433	141	1	1	0	**669**
		Consultant	Craigavon Area Hospital	24	552	48	1	0	0	**625**
		Doctor	Craigavon Area Hospital	21	515	35	4	0	2	**577**
		Doctor	Craigavon Area Hospital	25	484	60	0	0	0	**569**
		Consultant	Daisy Hill Hospital	21	378	165	2	2	0	**568**
		Doctor	Craigavon Area Hospital	65	441	53	0	0	0	**559**
		Consultant	Craigavon Area Hospital	20	484	37	2	1	0	**544**
		Doctor	Craigavon Area Hospital	54	384	55	0	0	0	**493**
		Consultant	Craigavon Area Hospital	79	312	83	1	3	0	**478**
		Midwife	Daisy Hill Hospital	82	277	107	0	0	0	**466**
		Doctor	Daisy Hill Hospital	0	414	49	0	0	0	**463**
		Doctor	Lurgan Hospital	0	424	24	0	0	0	**448**
		Doctor	Daisy Hill Hospital	6	424	11	0	0	0	**441**
		Consultant	Craigavon Area Hospital	121	236	71	9	2	0	**439**
		Doctor	Daisy Hill Hospital	40	325	51	0	0	0	**416**
		Consultant	Craigavon Area Hospital	9	371	23	0	0	0	**403**
		Doctor	Craigavon Area Hospital	15	337	19	0	0	0	**371**
		Doctor	Daisy Hill Hospital	69	217	62	2	0	0	**350**
			Grand Total	**1249**	**12930**	**2129**	**25**	**11**	**5**	**16349**

Personal Information redacted by the USI

SIGN OFF REPORTS

Time period: **01/04/2020 to 30/04/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	February	March	April
Southern	55381	51700	40680
Western	31488	24973	18035
South-Eastern	5227	6493	4834
Belfast	8120	6654	3720
Northern	1719	1731	3162
Total	**101935**	**91551**	**70431**

Total Sign Off for Southern Trust previous three months

Month	January	February	March
Total	56354	55381	51700

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2412	33596	4526	111	23	12	0	**40680**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1612	21353	3009	98	10	11	0	**26093**
Daisy Hill Hospital	718	8848	1118	13	13	1	0	**10711**
Lurgan Hospital	55	2833	352	0	0	0	0	**3240**
Community	0	260	10	0	0	0	0	**270**
Undefined*	27	199	26	0	0	0	0	**252**
South Tyrone Hospital	0	97	11	0	0	0	0	**108**
Community Health Office	0	3	0	0	0	0	0	**3**
St Luke's	0	3	0	0	0	0	0	**3**
	2412	**33596**	**4526**	**111**	**23**	**12**	**0**	**40680**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1612**	**21353**	**3009**	**98**	**10**	**11**	**0**	**26093**
Doctor	940	14048	1353	24	1	2	0	**16368**
Consultant	645	4289	591	73	9	8	0	**5615**
Midwife	0	1784	916	0	0	0	0	**2700**
Nurse	27	1044	145	1	0	1	0	**1218**
Pharmacist	0	184	0	0	0	0	0	**184**
GP	0	3	4	0	0	0	0	**7**
AHP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**718**	**8848**	**1118**	**13**	**13**	**1**	**0**	**10711**
Doctor	344	6819	522	0	0	0	0	**7685**
Consultant	367	1496	365	13	13	1	0	**2255**
Midwife	7	271	220	0	0	0	0	**498**
Nurse	0	109	8	0	0	0	0	**117**
Physician Associate	0	110	2	0	0	0	0	**112**
Pharmacist	0	43	0	0	0	0	0	**43**
AHP	0	0	1	0	0	0	0	**1**
Grand Total	**2330**	**30201**	**4127**	**111**	**23**	**12**	**0**	**36804**

SIGN OFF REPORTS

Time period: **01/04/2020 to 30/04/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI		Doctor	Craigavon Area Hospital	179	1188	78	0	0	1	**1446**
		Doctor	Craigavon Area Hospital	125	1040	190	0	1	0	**1356**
		Doctor	Craigavon Area Hospital	71	580	247	0	0	0	**898**
		Doctor	Lurgan Hospital	30	695	147	0	0	0	**872**
		Consultant	Craigavon Area Hospital	40	661	74	3	0	0	**778**
		Consultant	Craigavon Area Hospital	89	479	102	1	2	0	**673**
		Doctor	Craigavon Area Hospital	79	521	52	0	0	0	**652**
		Doctor	Craigavon Area Hospital	16	594	37	0	0	0	**647**
		Doctor	Lurgan Hospital	0	600	36	0	0	0	**636**
		Midwife	Craigavon Area Hospital	0	407	199	0	0	0	**606**
		Doctor	Craigavon Area Hospital	60	487	44	0	0	0	**591**
		Consultant	Daisy Hill Hospital	106	296	91	0	0	0	**493**
		Doctor	Daisy Hill Hospital	2	482	2	0	0	0	**486**
		Consultant	Craigavon Area Hospital	22	438	17	3	0	0	**480**
		Midwife	Craigavon Area Hospital	0	235	235	0	0	0	**470**
		Doctor	Daisy Hill Hospital	2	455	9	0	0	0	**466**
		Consultant	Daisy Hill Hospital	39	255	125	3	10	1	**433**
		Midwife	Craigavon Area Hospital	0	308	121	0	0	0	**429**
		Doctor	Daisy Hill Hospital	27	368	23	0	0	0	**418**
		Consultant	Craigavon Area Hospital	1	385	22	0	0	0	**408**
		Doctor	Lurgan Hospital	11	346	46	0	0	0	**403**
		Consultant	Daisy Hill Hospital	32	339	26	0	0	0	**397**
		Doctor	Craigavon Area Hospital	25	336	30	0	0	0	**391**
		Doctor	Daisy Hill Hospital	1	352	35	0	0	0	**388**
		Doctor	Daisy Hill Hospital	6	237	123	0	0	0	**366**
			Grand Total	**963**	**12084**	**2111**	**10**	**13**	**2**	**15183**

SIGN OFF REPORTS

Time period: **01/03/2020 to 31/03/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	January	February	March
Southern	56354	55381	51700
Western	29664	31488	24973
South-Eastern	6845	5227	6493
Belfast	9099	8120	6654
Northern	1430	1719	1731
Total	**103392**	**101935**	**91551**

Total Sign Off for Southern Trust previous three months

Month	December	January	February
Total	48936	56354	51700

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2395	44800	4222	211	41	31	0	**51700**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1799	30984	2836	183	19	31	0	**35852**
Daisy Hill Hospital	446	10189	1071	27	22	0	0	**11755**
Lurgan Hospital	68	3152	257	1	0	0	0	**3478**
Undefined*	82	254	26	0	0	0	0	**362**
Community	0	115	17	0	0	0	0	**132**
South Tyrone Hospital	0	98	14	0	0	0	0	**112**
St Luke's	0	8	0	0	0	0	0	**8**
Mullinure Health & Wellbein	0	0	1	0	0	0	0	**1**
	2395	**44800**	**4222**	**211**	**41**	**31**	**0**	**51700**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**1799**	**30984**	**2836**	**183**	**19**	**31**	**0**	**35852**
Doctor	831	21620	1249	65	2	11	0	**23778**
Consultant	929	5061	459	116	17	20	0	**6602**
Midwife	5	1735	967	0	0	0	0	**2707**
Nurse	33	2063	158	2	0	0	0	**2256**
Pharmacist	0	176	0	0	0	0	0	**176**
Other	1	167	3	0	0	0	0	**171**
AHP	0	162	0	0	0	0	0	**162**
Daisy Hill Hospital	**446**	**10189**	**1071**	**27**	**22**	**0**	**0**	**11755**
Doctor	262	8576	559	12	14	0	0	**9423**
Consultant	180	631	155	15	8	0	0	**989**
Midwife	4	466	335	0	0	0	0	**805**
Nurse	0	262	17	0	0	0	0	**279**
Pharmacist	0	83	0	0	0	0	0	**83**
AHP	0	171	5	0	0	0	0	**176**
Grand Total	**2245**	**41173**	**3907**	**210**	**41**	**31**	**0**	**47607**

SIGN OFF REPORTS

Time period: **01/03/2020 to 31/03/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

Personal Information redacted by the USI	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
	Doctor	Craigavon Area Hospital	144	2648	190	4	1	5	**2992**
	Doctor	Craigavon Area Hospital	166	1171	129	1	0	0	**1467**
	Doctor	Lurgan Hospital	19	940	144	0	0	0	**1103**
	Midwife	Craigavon Area Hospital	0	530	543	0	0	0	**1073**
	Consultant	Craigavon Area Hospital	161	637	73	18	4	18	**911**
	Doctor	Craigavon Area Hospital	44	752	109	1	0	0	**906**
	Doctor	Craigavon Area Hospital	41	780	48	0	0	0	**869**
	Doctor	Craigavon Area Hospital	21	779	47	0	0	0	**847**
	Doctor	Lurgan Hospital	33	744	54	1	0	0	**832**
	Doctor	Daisy Hill Hospital	29	618	19	0	0	0	**666**
	Doctor	Daisy Hill Hospital	16	418	175	0	1	0	**610**
	Doctor	Daisy Hill Hospital	51	513	37	0	0	0	**601**
	Doctor	Daisy Hill Hospital	0	578	2	0	0	0	**580**
	Midwife	Craigavon Area Hospital	0	392	152	0	0	0	**544**
	Doctor	Craigavon Area Hospital	1	527	7	0	0	0	**535**
	Doctor	Craigavon Area Hospital	25	497	4	0	0	0	**526**
	Doctor	Craigavon Area Hospital	16	412	75	0	0	0	**503**
	Consultant	Craigavon Area Hospital	94	374	22	0	0	0	**490**
	Consultant	Craigavon Area Hospital	20	435	15	3	0	0	**473**
	Doctor	Craigavon Area Hospital	9	424	40	0	0	0	**473**
	Doctor	Craigavon Area Hospital	6	456	0	0	0	0	**462**
	Doctor	Daisy Hill Hospital	2	442	10	0	0	0	**454**
	Consultant	Craigavon Area Hospital	119	257	61	4	4	0	**445**
	Doctor	Daisy Hill Hospital	9	417	16	0	0	0	**442**
	Doctor	Craigavon Area Hospital	20	395	21	0	0	0	**436**
		Grand Total	**1046**	**16136**	**1993**	**32**	**10**	**23**	**19240**

SIGN OFF REPORTS

Time period: **01/02/2020 to 29/02/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	December	January	February
Southern	48936	56354	55381
Western	27867	29664	31488
South-Eastern	5833	6845	5227
Belfast	8713	9099	8120
Northern	1672	1430	1719
Total	**93021**	**103392**	**101935**

Total Sign Off for Southern Trust previous three months

Month	November	December	January
Total	46900	48936	56354

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2741	48298	4026	240	54	22	0	**55381**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2006	34618	2679	179	28	22	0	**39532**
Daisy Hill Hospital	591	10424	1100	61	26	0	0	**12202**
Lurgan Hospital	89	2781	185	0	0	0	0	**3055**
Undefined*	52	149	12	0	0	0	0	**213**
Community	2	165	32	0	0	0	0	**199**
South Tyrone Hospital	1	158	18	0	0	0	0	**177**
Downe Hospital	0	0	0	0	0	0	0	**0**
Mullinure Health & Wellbein	0	1	0	0	0	0	0	**1**
St Luke's	0	2	0	0	0	0	0	**2**
	2741	**48298**	**4026**	**240**	**54**	**22**	**0**	**55381**

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2006**	**34618**	**2679**	**179**	**28**	**22**	**0**	**39532**
Doctor	978	24105	1229	64	7	5	0	**26388**
Consultant	1008	6236	535	107	21	16	0	**7923**
Midwife	2	2104	763	0	0	1	0	**2870**
Nurse	18	2004	152	8	0	0	0	**2182**
Pharmacist	0	121	0	0	0	0	0	**121**
Other	0	40	0	0	0	0	0	**40**
AHP	0	8	0	0	0	0	0	**8**
Daisy Hill Hospital	**591**	**10424**	**1100**	**61**	**26**	**0**	**0**	**12202**
Doctor	246	8114	506	31	11	0	0	**8908**
Consultant	297	1475	227	30	15	0	0	**2044**
Midwife	48	440	362	0	0	0	0	**850**
Nurse	0	117	3	0	0	0	0	**120**
Pharmacist	0	33	0	0	0	0	0	**33**
AHP	0	245	2	0	0	0	0	**247**
Grand Total	**2597**	**45042**	**3779**	**240**	**54**	**22**	**0**	**51734**

SIGN OFF REPORTS

Time period: **01/02/2020 to 29/02/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
[redacted]		Doctor	Craigavon Area Hospital	194	1670	107	0	2	2	**1975**
		Doctor	Craigavon Area Hospital	50	1354	198	4	2	0	**1608**
		Doctor	Craigavon Area Hospital	56	1232	125	0	0	0	**1413**
		Doctor	Craigavon Area Hospital	60	832	86	0	0	0	**978**
		Doctor	Craigavon Area Hospital	30	907	10	1	0	0	**948**
		Consultant	Daisy Hill Hospital	102	648	113	0	1	0	**864**
		Doctor	Lurgan Hospital	45	742	52	0	0	0	**839**
		Consultant	Craigavon Area Hospital	149	502	55	16	5	16	**743**
		Doctor	Craigavon Area Hospital	56	597	75	1	0	0	**729**
		Doctor	Daisy Hill Hospital	22	679	21	0	0	0	**722**
		Doctor	Daisy Hill Hospital	21	503	161	0	2	0	**687**
		Consultant	Craigavon Area Hospital	121	461	91	2	7	0	**682**
		Doctor	Craigavon Area Hospital	3	643	0	0	0	0	**646**
		Doctor	Daisy Hill Hospital	45	572	27	0	0	0	**644**
		Doctor	Craigavon Area Hospital	0	636	0	0	0	0	**636**
		Doctor	Craigavon Area Hospital	1	630	4	0	0	0	**635**
		Doctor	Craigavon Area Hospital	4	572	40	0	0	3	**619**
		Midwife	Craigavon Area Hospital	0	385	214	0	0	0	**599**
		Doctor	Craigavon Area Hospital	3	586	6	0	0	0	**595**
		Consultant	Craigavon Area Hospital	90	432	28	0	0	0	**550**
		Doctor	Craigavon Area Hospital	50	442	44	2	0	0	**538**
		Consultant	Craigavon Area Hospital	38	470	30	0	0	0	**538**
		Doctor	Lurgan Hospital	16	431	80	0	0	0	**527**
		Consultant	Daisy Hill Hospital	76	414	21	9	5	0	**525**
		Doctor	Craigavon Area Hospital	28	458	29	0	0	0	**515**
			Grand Total	**1260**	**16798**	**1617**	**35**	**24**	**21**	**19755**

SIGN OFF REPORTS

Time period: **01/01/2020 to 31/01/2020**

Total Sign Off for all trusts for current month and previous two months

Trust	November	December	January
Southern	46900	48936	56354
Western	29093	27867	29664
South-Eastern	6100	5833	6845
Belfast	9278	8713	9099
Northern	1519	1672	1430
Total	**92890**	**93021**	**103392**

Total Sign Off for Southern Trust previous three months

Month	October	November	December
Total	41383	46900	48936

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2842	49438	3777	233	49	15	0	**56354**

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2151	36302	2582	191	21	15	0	**41262**
Daisy Hill Hospital	571	9392	949	42	28	0	0	**10982**
Lurgan Hospital	56	2935	175	0	0	0	0	**3166**
Undefined*	62	513	56	0	0	0	0	**631**
Community	1	154	2	0	0	0	0	**157**
South Tyrone Hospital	1	130	13	0	0	0	0	**144**
Downe Hospital	0	0	0	0	0	0	0	**0**
Mullinure Health & Wellbein	0	0	0	0	0	0	0	**0**
St Luke's	0	12	0	0	0	0	0	**12**
	2842	**49438**	**3777**	**233**	**49**	**15**	**0**	56354

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	**2151**	**36302**	**2582**	**191**	**21**	**15**	**0**	**41262**
Doctor	1006	23900	1198	66	6	6	0	**26182**
Consultant	1110	7941	666	115	15	8	0	**9855**
Midwife	6	2062	540	0	0	0	0	**2608**
Nurse	29	2302	178	10	0	1	0	**2520**
Pharmacist	0	96	0	0	0	0	0	**96**
AHP	0	0	0	0	0	0	0	**0**
Clinical Admin	0	0	0	0	0	0	0	**0**
GP	0	1	0	0	0	0	0	**1**
Daisy Hill Hospital	**571**	**9392**	**949**	**42**	**28**	**0**	**0**	**10982**
Doctor	147	6884	293	11	20	0	0	**7355**
Consultant	359	1802	233	31	8	0	0	**2433**
Midwife	64	556	409	0	0	0	0	**1029**
Nurse	1	116	14	0	0	0	0	**131**
Pharmacist	0	32	0	0	0	0	0	**32**
AHP	0	2	0	0	0	0	0	**2**
Grand Total	**2722**	**45694**	**3531**	**233**	**49**	**15**	**0**	52244

SIGN OFF REPORTS

Time period: **01/01/2020 to 31/01/2020**

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	226	1260	153	1	1	1	**1642**
	Doctor	Craigavon Area Hospital	126	1210	193	1	0	0	**1530**
	Doctor	Craigavon Area Hospital	86	1067	100	0	0	0	**1253**
	Doctor	Craigavon Area Hospital	91	1077	82	0	0	1	**1251**
	Doctor	Craigavon Area Hospital	0	1183	1	0	0	0	**1184**
	Doctor	Craigavon Area Hospital	91	869	28	2	0	0	**990**
	Consultant	Craigavon Area Hospital	42	830	43	1	0	0	**916**
	Consultant	Craigavon Area Hospital	183	646	64	9	2	8	**912**
	Doctor	Craigavon Area Hospital	10	764	8	0	0	0	**782**
	Doctor	Lurgan Hospital	20	694	46	0	0	0	**760**
	Consultant	Craigavon Area Hospital	50	681	2	1	0	0	**734**
	Consultant	Daisy Hill Hospital	122	516	63	0	0	0	**701**
	Doctor	Lurgan Hospital	3	577	91	0	0	0	**671**
	Doctor	Craigavon Area Hospital	37	548	58	0	0	0	**643**
	Consultant	Craigavon Area Hospital	97	450	53	6	5	0	**611**
	Doctor	Craigavon Area Hospital	1	583	0	0	0	0	**584**
	Doctor	Craigavon Area Hospital	21	555	3	1	0	0	**580**
	Doctor	Daisy Hill Hospital	14	537	26	0	0	0	**577**
	Doctor	Craigavon Area Hospital	0	577	0	0	0	0	**577**
	Midwife	Daisy Hill Hospital	64	293	197	0	0	0	**554**
	Doctor	Craigavon Area Hospital	32	481	29	0	0	0	**542**
	Consultant	Craigavon Area Hospital	108	362	50	14	2	0	**536**
	Doctor	Craigavon Area Hospital	0	526	3	2	0	0	**531**
	Midwife	Craigavon Area Hospital	0	345	179	0	0	0	**524**
	Doctor	Daisy Hill Hospital	1	504	1	0	0	0	**506**
		Grand Total	**1425**	**17135**	**1473**	**38**	**10**	**10**	**20091**

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event: [redacted]

HSCB Unique Case Identifier: [redacted]

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: **Female**
Age: [redacted] **years**

Responsible Lead Officer: **Dr Agnieszka Zawislak**

Designation: **Consultant Obstetrician and Gynaecologist**

Report Author: **The Review Team**

Date report signed off:

June 2015

Date submitted to HSCB:

1.0 EXECUTIVE SUMMARY

Patient A was a [redacted] old primigravida who booked for confinement in Craigavon Area Hospital (CAH) on 2/12/2019. Patient A was triaged as low risk and suitable for Midwifery Led Care (MLC) and Getting Ready For Baby programme (GRFB).

Patient A attended all routine antenatal appointments as planned.

Patient A presented four times to the Admission and Assessment (A&A) Unit with problems of reduced fetal movements at 26+5 weeks, upper abdominal pain and vomiting at 28+6 weeks and 29+1 weeks, and vaginal bleeding at 30+1 weeks.

The assessments carried out were normal, except liver function test (LFT). This was noted to be marginally abnormal on [redacted] when 28+6 weeks pregnant. Further test on [redacted] was normal, on [redacted] was again marginally abnormal. The test on [redacted] was significantly abnormal and was not actioned.

Patient A was assessed by consultants in antenatal clinic (ANC) on [redacted] when 31+2 weeks pregnant and on [redacted] when 37+2 weeks pregnant. Both assessments included detailed ultrasound scan (USS), estimated fetal growth was appropriate with healthy environment, good fluid volume and healthy placenta. The first assessment coincided at the height of coronavirus pandemic healthcare precautions.

Patient A presented in advanced labour on [redacted]. An intrauterine baby's demise was diagnosed when in delivery suite (DS). Baby A was born without signs of life later on that day. Coroner's office was contacted and coroner's autopsy was performed.

The cause of death was acute chorioamnionitis, infection of the amniotic fluid, due to Escherichia Coli, source of bacterial infection and Group B Streptococcus infection, another type of bacterial infection.

2.0 THE REVIEW TEAM

Dr Agnieszka Zawislak– Consultant Obstetrician and Gynaecology (Chair)
Mrs Joanne Mc Glade – Lead Midwife
Mrs Ursula Gaffney – Interim Risk Midwife (Left post 31st October 2020)
Mrs Joanne Gluck – Risk Midwife (Joined 1st October 2020)

3.0 SAI REVIEW TERMS OF REFERENCE

The terms of reference for the review of the care and treatment provided to patient A were:

- To carry out a review of the care and treatment provided to Patient A by the Southern Health and Social Care Trust (SHSCT) during the pregnancy and delivery using Serious Adverse Injury (SAI) methodology.
- To identify key causal and contributory factors leading to the stillbirth of Baby A
- To adhere to principles of confidentiality throughout the review
- To use a multidisciplinary approach to the review using a systems analysis methodology
- To engage with Patient A's family in line with Regional Guidance on Engagement with Service Users, Families and Carers
- To set out the findings, recommendations, and actions in an anonymous report.
- To establish what lessons are to be learned from the case.
- To report the findings and the recommendations of the review to the Director of Acute Services SHSCT, and disseminate to the staff associated with care, Patient A and her family.

4.0 REVIEW METHODOLOGY

Root cause analysis methodology was used:

- Review of hand held maternity records (HHMR)
- Review of Northern Ireland Health Electronic Care Record (NIECR) results
- Review of national and local guidelines, regulations and policies relevant to the case
  - Management of reduced fetal movements (RFM) SHSCT[1] CG0312
  - Management of Antepartum Haemorrhage (APH) SHSCT [2] CG0462
  - Management of obstetric cholestasis SHSCT [3] CG0429
  - Standard operating procedure for actioning of abnormal blood results on [4] NICER 2019
  - Standard operating procedure for taking and actioning of laboratory results 2017 [5]
- Review of clinical templates and checklists

- Review of Perinatal Mortality Review Tool (PMRT) initial report, pending
- Review of staff statements
- Review of specific issues raised by the patient during the family meeting
- Review of a list of questions supplied by Patient A
- Tabular timeline constructed and reviewed
- Review of the Datix incident report [redacted], pending
- Contributory factors analysis

- Statements were requested from
  - Doctor A ST5
  - Doctor B ST4
  - Doctor C (not received)
  - Doctor D ST2
  - Doctor E Consultant O&G
  - Doctor F Consultant O&G
  - Midwife A, Getting ready for baby (GRFB)
  - Midwife B, A&A unit
  - Midwife C, A&A unit
  - Midwife D, A&A unit
  - Midwife E, A&A unit
  - Midwife F, A&A unit
  - Midwife G, ANC
  - Midwife H, DS

Appendix 1 Tabular timeline

Appendix 2 Questions supplied by the patient

5.0 DESCRIPTION OF INCIDENT/CASE

Patient A was a [redacted] old primigravida booked for confinement in CAH on [redacted]. She had no identified risk factors at booking; therefore she was triaged for midwifery led care (MLC). The booking scan on [redacted] confirmed ongoing pregnancy; the dates were consistent with the scan findings giving the EDC on [redacted].

The anomaly scan and the routine antenatal appointments at 18+5 weeks, 23+2weeks and 24+2weeks showed no concerns.

On [redacted] Patient A self-referred to the Admission and Assessment Unit (A&A) when 26+5 weeks pregnant complaining of reduced fetal movements (RFM). Patient A was assessed by a Midwife I and Doctor A, fetal heart was heard with Sonicaid and an ultrasound was carried out by Doctor A and was normal. Patient A was reassured and allowed to go home.

The next routine antenatal appointment at Getting Ready For Baby (GRFB) on [redacted], 4 days later, showed no concerns.

On [redacted] at 08:15hrs Patient A called A&A unit, as per telephone record sheet, with complaint of abdominal pain, vomiting and query reduced fetal movements she was advised to come for assessment. At 11:45hrs routine maternal observations were normal. Patient A, who was 28+6 weeks pregnant, complained of sudden onset upper abdominal pain radiating to left side, vomiting, upper back pain and cramps, no urinary symptoms, normal bowel movements noted. Fetal movements were reported as normal. The assessment including cardio tachograph (CTG), USS, electrocardiogram (ECG), C-reactive protein (CRP), Urea, Creatinine, Full Blood Count (FBC) and Troponin levels were normal. Liver function test (LFT) showed marginal raise of ALT (41U/L), AST was normal (31U/L). Management plan was for analgesia and another LFT check in 1 week. Estimated Fetal Weight (EFW) was plotted on Customised Growth Chart (CGC) but this was not accurate.

On [redacted] at 09:45hrs Patient A called A&A unit, as per telephone record sheet, with ongoing upper abdominal pain and was advised to attend. Patient A, who was 29+1 weeks pregnant, was assessed at 14:20hrs, Early Warning Score (EWS) was recorded as 0 (normal). Urine sample showed a plus of Protein and blood and was sent for culture (MSSU). Patient A was reviewed by Doctor B and reassured. The review of the blood results showed normal results, except ALT41 U/L (normal range up to 33U/L). (Usually abnormal tests are monitored to see if they rectify itself especially if the tests are just borderline abnormal, 40's, is the upper limit of normal in pregnancy). According to the questions submitted to the panel Patient A queried possibility of gallstones but this was dismissed by the staff and she was also asked why she attended again after assessment only two days earlier. There was no CTG

5.0 DESCRIPTION OF INCIDENT/CASE

carried out during the visit with the entry in the notes “Doctor C did not want CTG”. Fetal heart rate was auscultated using sonicaid and was recorded as 146bpm.

Patient A attended for repeat LFT on Personal Information redacted by the USI, as arranged and was advised that she would be contacted with the results. Patient A told the panel that she was not subsequently contacted with the results as advised. Patient A also queried if further tests were warranted in view of reported itch. There is no record of this complaint in the notes. According to the recollection, Midwife C, the results were not available before 13:30hrs when her shift ended.

On Personal Information redacted by the USI at 09:10hrs Patient A called A&A unit, as per telephone record sheet, complaining of painless vaginal (PV) blood loss and RFM she was advised to attend. The record is erroneously dated as Personal Information redacted by the USI but this was verified by the midwife C in the statement. Patient A, who was 30+1 weeks pregnant, attended the A&A unit at 10:15hrs and complained of fresh blood noted on the pad when she woke up. At 10:30hrs Patient A was assessed by Doctor B who performed speculum examination and found no evidence of vaginal bleeding. This was reassuring and therefore patient A following normal results of CTG, USS with umbilical artery Doppler, was allowed to go home. On review of the LFT results it was noted that transaminases on Personal Information redacted by the USI were slightly raised (ALT 47U/L and AST 31 U/L) but with no history of itch, epigastric pain, or headache no further tests were deemed to be necessary.

The panel believes that in view of Patient A third attendance in A&A the review in the consultant antenatal clinic was arranged in 3 weeks (there is no indication on the form). The HART transfer form (a form used to change care from MLC to the consultant led care (CLC)) was only partially completed.

As per routine management of the transfer of care in maternity service the HART form appeared to be emailed to the Doctor I. The appointment at consultant clinic was made for Personal Information redacted by the USI.

On Personal Information redacted by the USI Patient A was reviewed by Doctor E in the antenatal clinic. The consultant was not aware of the reason of the appointment as per statement. Following discussion, Doctor E noted history of PV bleeding in form of one episode of staining, history of RFM and abdominal pain all of which had resolved. The abdominal palpation and USS carried out were normal, FMs were recorded, fetal growth plotted on the CGC was appropriate and placenta was not low lying. According to the Doctor E patient A at the end of the visit asked about the significance of abnormal liver function tests. These were checked on NIECR; Patient A was reassured that the transaminases in the level of 40s were normal during pregnancy. Review appointment was booked for 6 weeks when 37+2 weeks pregnant. Doctor E stated in the statement that the decision for follow up in 6 weeks was not in line with his usual practice but, was dictated by the timing. The lockdown was just announced and, the country was at the height of Coronavirus crisis with predictions of significant morbidity and mortality. Avoiding hospital was felt to be the safest option at the time.

5.0 DESCRIPTION OF INCIDENT/CASE

Patient A reported during the meeting that the consultant was not aware of the history of her complaints, nor the reason of the visit and was dismissive of her concerns. Patient A left upset.

On Personal Information redacted by the USI Patient A, who was 37+2 weeks pregnant was reviewed as planned in the antenatal clinic (ANC) by Doctor F, routine observations were recorded as normal. Urine sample showed leukocytes and was sent for culture, subsequently it showed no infection. The USS was carried out, including umbilical artery Doppler and was normal, estimated fetal growth was plotted on the CGC and showed appropriate growth. Patient A was offered a sweep of membranes. The offer was declined. According to Patient A recollection she complained of itch and was advised to use calamine lotion. LFT were obtained. Patient A recalls being informed that if the blood tests were abnormal she would be contacted.
There is no record of review appointment made following this visit however; the panel was able to access Patient Administration System (PAS) data where the review appointment was made for Personal Information redacted by the USI. The results of LFTs came back as abnormal. The results should have been escalated immediately to the medical staff and actioned. The results were signed by the midwife G who was redeployed due to Covid pandemic to the antenatal clinic. The panel was unable to establish who subsequently reviewed the results. It is possible that because the results were signed it appeared as they had been actioned and therefore returned to file.

On Personal Information redacted by the USI at 12:10hrs Patient A called A&A unit reporting cramps every 2 minutes from 09:00hrs that day. Telephone record sheet is incomplete; there is no record of questions being asked regarding fetal movements or, history of PV bleeding. Patient A arrived at CAH on 13:10hrs. Due to coronavirus restrictions on parking Patient A had to walk from the car park to the Maternity Unit while in established labour. At the door of maternity unit her husband handed her over to the midwife. He was not allowed to accompany Patient A. According to the A&A unit record Patient A was visibly distressed and reported an urge to push. Vaginal examination confirmed that Patient A was indeed in second stage of labour, with bulging membranes. Immediate transfer to deliver suite (DS) was organised in anticipation of imminent delivery.

At 13:19hrs, when in DS, an attempt to auscultate fetal heart failed, therefore the USS scanner was brought into the room and no fetal heart (FH) was seen. Consultant on call (Doctor F) was called to the room immediately and following further USS examination he confirmed intrauterine baby's demise. Doctor F explained the situation to Patient A and her husband.

Baby A was born at 13:41hrs with no signs of life and thick meconium staining. On perineal inspection obstetric anal sphincter injury (OASI) was diagnosed and classified as 3a (tear of less than 50% of external anal sphincter). Patient A was

5.0 DESCRIPTION OF INCIDENT/CASE

transferred to theatre at 18:35hrs for the repair of OASI. Surgery was completed at 19:29hrs, with an estimated blood loss (EBL) of 730ml during the procedure.

Coroner's office was contacted on Personal Information redacted by the USI and the decision for coroner's autopsy was made in view of unknown cause of intrauterine death.

The results showed acute chorioamnionitis due to Escherichia coli and group B streptococcus infection. The amniotic sac was necrotic, there were signs of maternal and baby's response to the intra-amniotic infection indicating ascending bacterial infection of the placenta leading to the baby's inflammatory response. The cause of baby's death was therefore the congenital infection.

The blood results on that day showed significant raise of bile acids (136) and liver function tests (AST 79U/L, ALT 131U/L) which in the absence of symptoms of obstetric cholestasis may be attributed to sepsis.

The panel believes that the antenatal care from 31 weeks onwards was adversely impacted by the first surge of Covid 19 pandemic. However, this had no major impact on the final outcome. The window of opportunity to escalate the care was missed when the abnormal results of LFT on Personal Information redacted by the USI were not actioned. This occurrence may be attributed to the covid related redeployment of staff unfamiliar with the setup of routine work in different clinical areas. Subsequent investigations and increased maternal and fetal monitoring may have had prompted earlier delivery if any untoward changes were detected. However, the clinical course of E.coli chorioamnionitis is not well understood. It is accepted that E.coli sepsis may develop very quickly and with little symptoms causing an overwhelming intra-amniotic sepsis and baby's demise. Similarly, streptococcus B sepsis may not cause any obvious symptoms until baby's demise. The intra-amniotic infection may develop with intact membranes.

6.0 FINDINGS

1. Personal Information redacted by the USI Booking scan when 13+3 weeks amenorrhoea, scan was consistent with the dates, EDC Personal Information redacted by the USI
    a. Picture of the booking scan in the maternity notes, scan was performed at National Institute for Health and Care Excellence (NICE) recommended gestation and is of good quality.
    b. For quality assurance Viewpoint or other system would be helpful in order to review/audit scans without need to pull the notes, or in case of the pictures lost from the notes.
2. Personal Information redacted by the USI Booking visit
    a. Booked for Midwifery Led Care (MLC) as no risk factors identified.
    b. History of anxiety and panic attacks in 2009 recorded - not clear if still on treatment or problem resolved, what was the degree of anxiety, or if warranted referral.
    c. Unclear why reviewed by a doctor if booked for MLC.
    d. Screening for hypertensive disease in pregnancy not completed, there are two different charts in maternity records but none was completed
3. Personal Information redacted by the USI Routine antenatal visit
    a. Visit at 18+5 weeks at ANC
    b. BP 137/84 (booking 126/72), urine clear
    c. Blood pressure not rechecked
    d. No signature of midwife and no recorded plan for review appointment
4. Personal Information redacted by the USI Anomaly scan
    a. Scan results are normal and in keeping with the original dates
    b. The results are handwritten, the results are stored for quality assurance
5. Routine antenatal clinic on Personal Information redacted by the USI
    a. Visit at 23+2 weeks at Personal Information redacted by the USI Health Centre
    b. BP 102/60, urine clear, fetal heart 136bpm, fetal movements present and discussed, all well, no concerns
6. Routine visit at GRFB on Personal Information redacted by the USI (2^{nd})
    a. Visit at 24+2 weeks

6.0 FINDINGS

b. BP 110/70, urine clear, FHR 144 bpm, FM normal and discussed

c. Mat B form, vaccines

d. No concerns, plan for review in 3 weeks

7. Unscheduled visit in A&A unit on [redacted] (1st)

   a. Complaint: Reduced Fetal Movements at 26+2 weeks

   b. Triage: partially completed, routine maternal observations normal, FHR 142 bpm

   c. Assessment by Midwife I: feels fetal movements, FHR 142bpm

   d. Assessment by Doctor A: USS with normal Doppler, placenta site anterior, fetal movements seen, EFW normal, not plotted on CGC, reassured and advised to return if another episode of RFM

   e. The management was in line with local guidelines on the management of RFM in CAH (SHSCT CG0312), saving babies lives bundle advises use of the checklist to ensure that the risk factors are not missed and the management is structured

8. Routine visit at GRFB on [redacted]

   a. 27+2 weeks

   b. BP 112/68, urine clear

   c. Presentation cephalic, position LOA, FHR 146bpm, FM present

   d. Visit to A&A with RFM noted and good current FMs, advised to contact A&A if further concerns, plan for Review in 3 weeks

9. Unscheduled visit to A&A unit on [redacted] (2nd)

   a. Telephone call record: at 08:15hrs Patient A called with abdominal pain, vomiting and query RFM, no PV bleeding, no bladder or bowel problem, advised to attend

   b. At 11:45hrs patient A attended A&A unit

   c. Triage: form incomplete, urine ketones, maternal observations: BP 117/76, pulse 97, temp 36,6, oxygen saturations (SpO_2) 100% respiration rate (resp)18 (all normal)

   d. Assessment: by midwife B 28+6 weeks, upper abdominal cramps, vomited 3-4 times, upper back pain from last night, vomiting now settled, cramps and pain persistent

   e. CTG applied, completed and assessed as normal by two midwives

6.0 FINDINGS

f. Blood for U+E, LFT, CRP, FBC, amylase obtained and sent

g. USS: FMs seen, placenta anterior low lying, Biparietal Diameter (BPD) and Abdominal Circumference (AC) and Femur Length (FL) measured, EFW 1521g <90th centile, EFW plotted on CGC imprecise, Amniotic Fluid Volume (AFV) appears normal, Doppler measured.

h. Happy to await medical assessment with blood results

i. Assessment by ST2 doctor J: results reviewed and raise in ALT noted and highlighted, detailed history recorded, examination of abdomen highlighting left upper abdominal tenderness with no guarding, differential diagnosis included muscular, cardiac origin or gastritis, plan included ECG and troponin to exclude cardiac problem, repeat LFT in a week, discussed with the registrar and agreed.

j. Consideration for liver screen including liver USS, hepatitis screen and repeat LFT if diagnosis unclear

10. Personal Information redacted by the USI unscheduled visit to A&A unit (3rd)

a. Telephone call record at 09:45hrs, confirmed by the statement: Patient A reported that attended 2 days before with vomiting had deranged LFT results, ongoing pain top of bump, no itch. On review LFT were normal, but due to raised White Cell Count (WCC) 15, patient A asked to attend for urinalysis and medical review as concerned and sore

b. At 14:20hrs patient A attends A&A unit

c. Triage: complaint right sided abdominal pain, urinalysis Protein + and trace of blood, resp 16, SpO_2 100%, pulse 89, blood pressure 116/80, temp 36.8, no record of fetal heart rate, plan for O&G review

d. Midwife J assessment: Right sided abdominal pain, EWS =0, Urine protein+ and blood - MSSSU sent (results: no significant growth)

e. Medical assessment: left upper abdominal pain, reassured, Repeat LFT, Urine analysis, Advised: paracetamol, gaviscon, recorded that keen for C/S but no explanation or action following this statement, if any concern to contact A&A

f. FH via Sonicaid 146bpm, Recorded as “Doctor C did not want CTG”, will contact patient with results

g. There is discrepancy regarding reported side of pain: midwife recorded right sided pain and doctor left sided pain

6.0 FINDINGS

h. Verbal comment by Patient A at the meeting: Patient was surprised that she was not offered CTG, felt the attitude of the doctor was dismissive, queried gallstones but advised that no indication of gallstones, no further tests were carried out despite persistent abdominal discomfort

11. Attendance for LFT on Personal Information redacted by the USI at 10:15hrs (previously arranged)

a. Triage: 29+5 weeks, attending for repeat LFTs, to be contacted with results, MSSU sent due to blood in urine, no results on ECR of the urine being sent, resp 16, SpO_2 99%, pulse 85, BP 120/80, temp 36.8, fetal heart 152bpm

b. The results were available at 11:57 according to ECR.

c. The midwife C confirmed in the statement that she had checked the lab centre before she finished her shift at 13:30

12. Personal Information redacted by the USI unscheduled visit to A&A unit (4th)

a. Telephone record sheet: 09:10hrs, erroneously dated Personal Information redacted but date confirmed in the statement, Patient A called with PV bleeding, bright red, not postcoital, woke up and found fresh blood on the pad, also blood in the toilet, no fetal movement since morning, no abdominal pain. Form incomplete: no record of advice, action, or previous attendances.

b. Triage: no record of triage

c. Midwife assessment: patient attended with PV bleeding, clinical observations blood pressure 114/74, puls75, temp36.1, resp 17, sats 98%, palpation with consent, CTG commenced

d. Medical assessment: PV spotting for 1 day, Noticed when woke up, fresh red, no clots, no dizziness, first episode of PV spotting. placenta ant clear from os, CTG normal, USS single fetus, FH seen, placenta fundal anterior, normal Doppler, AFV normal, up to date with smears, speculum no evidence of bleeding, No itch/ headache/ epigastric pain

e. LFT review: 14/03 ALT41, AST 31, GGT 25

16/03 ALT 28, AST 20, GGT 23

20/03 ALT 47, AST 31, GGT 63

f. Plan for review with consultant in 3 weeks, HART form incomplete: no reason for review, wrong gestation noted, no findings recorded

6.0 FINDINGS

g. On ECR results of HVS: normal, MSSU: no growth

h. Midwife C confirmed in the statement that there was a long list of results from approximately [redacted] which had not been actioned yet"

13. [redacted] antenatal clinic appointment with consultant

a. Temp 35.6, BP 124/75, urine noting abnormal detected (NAD)

b. History of very slight PV bleeding and RFM noted

c. FH seen, USS: EFW plotted on CGC around 50th centile, healthy environment

d. Follow up in 6 weeks (in view of Covid 19 restrictions of routine antenatal care, as explained in the statement)

e. Very scanty record in the HHMN, but both consultant and the patient stated that the consultant was not aware of the reason of this appointment, not aware of previous abnormal LFTs but checked the results on ECR, prompted by the patient, and reassured the patient.

14. [redacted] antenatal appointment with consultant

a. BP 131/80, urine one plus of leuk (urine MSSU results negative), FM present and discussed

b. Bloods for LFT were sent, according to ECR sent at 09;30hrs reported at 18:12hrs signed by re-deployed midwife G in ANC on [redacted] and results printed for doctor's review

c. USS: EFW 3263g, plotted correctly on the CGC, AFV normal, umbilical artery Doppler positive, placenta anterior

d. All well sweep offered, declined

e. No record of review appointment in the notes but on PAS review arranged for [redacted]

15. [redacted] unscheduled visit to A&A

a. 12:10hrs telephone record sheet: Patient A reporting cramps since 09:00hrs, every 2 minutes, advised to come in, no questions regarding fetal movements were recorded

6.0 FINDINGS

b. 13:10hrs attends A&A: visibly distressed with contractions, feeling urge to push

c. 13:17hrs VE: cervix (cx) fully dilated, vertex (vx) spines +1, bulging membranes

d. 13:19hrs transfer to delivery suite to room 7, unable to pick up fetal heart with CTG and sonicaid, USS confirmed no FH

e. Involuntary pushing, vertex visible on pushing

f. Consultant in the room confirmed intrauterine demise

g. 13:41hrs birth of stillborn infant [redacted]

7.0 CONCLUSIONS

1. Examples of good practice
    a. Prompt and accurate assessment of RFM
    b. Immediate USS for fetal wellbeing when attended A&A and consultant antenatal clinics
    c. Record of phone calls to A&A
    d. When repeated attendance in A&A referral to consultant led clinic
    e. Consultant availability to confirm IUD in delivery suite and subsequent explanation and management by the consultant
2. Booking visit
    a. Risk assessment incomplete – no risk of hypertension assessment despite 2 different forms in maternity records
    b. Unclear of reason/benefit of doctor review when booked for MLC
3. Lack of robust and quality assured system for review of results including contacting patients and for action of the abnormal results
    a. It appears that the results in A&A unit and in antenatal clinic are reviewed on ad hoc basis when time allows
    b. The results were not relayed to the patient on two occasions

c. The liver function tests results despite being abnormal twice did not trigger further tests despite patient presentation with abdominal pain and vomiting

d. The liver function test on Personal Information redacted by the USI was signed by re deployed midwife for doctor to review, but according to verbal report by antenatal sister the doctor saw the signature and understood that the results were actioned, the midwife was redeployed due to covid 19 pandemic

4. Plotting of the EFW on Customised growth chart on Personal Information redacted by the USI was imprecise

5. Lack of robust system for quality assured scans

   a. The scans were performed by trainees therefore maintaining consistent quality assurance of the scans may be difficult due to variable level of skills

   b. The anomaly scan results is handwritten and not amenable for quality assurance audit if required

6. Time spent in A&A on two occasions was prolonged

   a. Patient attended at 11:45 and was assessed by a doctor at 15:20

   b. Unclear if the delay was caused by staffing level or the high workload

7. Telephone record sheet in A&A unit

   a. On each occasion the sheet, which appears to be designed to aid health professionals in accurate history taking, was incomplete

   b. The sheet has no carbon copy therefore there is possibility of losing the original inserted into the MHHN when patient attends the A&A unit

8. Triage form was incomplete at each episode of care

   a. In order to be useful triage form has to be completed

   b. Or consider re-design of the form

9. The guideline on the management of RFM is overdue for update

   a. The detailed USS were performed at each visit, including Doppler's study which was good practice

   b. The structured approach as per Saving Babies Lives bundle should be considered

10. Process of HART tool referral (transfer of care within maternity service)

    a. Referral form partially completed

b. Process appears to be based on the assessment of the forms by one consultant therefore possible gaps if this consultant not available

c. Fast tract referral in this case resulted in the accepting consultant not being aware of the reason of referral

11. Antenatal care was significantly adversely affected by the restrictions to antenatal care brought by COVID pandemic

a. There was a gap in antenatal care of 6 weeks

b. The episode of care on [redacted] i.e. walking in established labour, no husband allowed in assessment unit

c. Midwife in ANC was deployed from other area

12. Abnormal results of LFTs on [redacted] not followed up when reviewed on [redacted] and [redacted]

13. Issues reported by Patient A not addressed elsewhere

a. Dismissive attitude of staff when in A&A on [redacted] and in consultant antenatal clinic on [redacted]

b. Despite abnormal results of liver function no further tests were offered despite reported episodes of abdominal pain and vomiting and itch.

8.0 LESSONS LEARNED

1. Patient factors

Patient A was a primigravida with history of anxiety and panic attacks. Patient A was booked for midwifery led care but attended four times the A&A unit with various complaints. As a result maternity care was transferred to consultant led care.

2. Working conditions

The pregnancy fell into the highly anxious time due to developing covid 19 pandemic. Maternity service was trying to prepare itself for the assumed significant morbidity and mortality caused by covid 19 by restricting the access to hospital. The usual pattern of maternity care was modified to decrease number of routine contact episodes. The impact of covid on pregnancy and delivery was largely unknown raising the level of stress among pregnant women and staff in maternity units. Some of the restrictions had detrimental impact on quality of antenatal care and made maternity units much less women friendly. Staff was deployed to different working areas raising issue of unfamiliarity. This was not localised problem.

3. Task factors

The forms which have been devised by the service to aid the work of A&A unit were not used or used incompletely. None of the triage, telephone conversation, transfer of care forms filed in the maternity notes was completed appropriately or fully. The forms seem to be more the hindrance rather than help.

The hypertension risk assessment form at booking is an obligatory part of booking risk assessment. There were two forms: one which is part of the maternity notes and the other devised by the CAH maternity service. None of those was completed. This had no impact on the outcome.

There is no structured approach to RFM. During one episode of care there were conflicting entries with regard to the RFM. There was no obvious escalation when second presentation with RFM.

4. Communication factors

Patients A was upset by the dismissive attitude of doctor C and doctor E during the appointments on Personal Information redacted by the USI and on Personal Information redacted by the USI. During the first appointment there was also a discrepancy between the recorded side of pain reported by the patient which may have had impact of the management and further discussion.

At the second appointment, which coincided with the date of first lockdown and with very frightening prediction of expected level of mortality and morbidity, the stress level may have impacted the communication. It was felt that it was unsafe to bring anyone to hospital unless absolutely necessary. It appears that the doctor was initially unaware of the previous history as the HART documentation was not available at the time. He thought he was dealing with a low risk woman who had no obstetric problem and who would be better of being seen in community by the midwife. On the other hand the patient was very anxious due to the experienced symptoms and the abnormal results.

5. Organisational factors

Lack of robust system to review results has potential to compromise patients' safety. It is vital to action abnormal results timely, especially in obstetrics. The results of abnormal liver function on Personal Information redacted by the USI, if actioned, most likely would have triggered patient's urgent review and further tests and assessment.

The results in A&A unit as reported in the statement may not be reviewed for a few days depending on volume of work, and there appears not to be protected time to review results.

Patient A was advised that the results would be communicated to her but on two occasions they were not. She assumed that the results were normal.

The unscheduled scans in A&A unit are carried out by trainees of variable level of skills. There is no quality assured system to carry out scans by fully trained member of staff and to store these results for future reviews.

6. Education and training factors

   The plotting on the customise growth chart was incorrect in one instance but this had no impact on the outcome. It is however important that all members of staff are familiar with the rules of plotting results on CGC.

   There were five liver function tests carried out between Personal Information redacted by the and Personal Information redacted by the, three abnormal (two mildly abnormal), and one normal. Liver function test when abnormal in pregnancy should trigger further tests to try and establish if this is part of the obstetric condition or an underlying liver problem including hepatitis and cholecystitis. The monitoring of abnormal tests is necessary to ensure the resolution or timely intervention.

9.0 RECOMMENDATIONS AND ACTION PLANNING

1. Quality assured system for review of the results specifying who reviews the results, who contacts the patient, where the contact with the patient is recorded, who actions the abnormal results and where this is recorded. The standard operating procedure for “actioning of abnormal blood results on NICER” should be updated, followed and audited.

2. An introduction of protected time for midwives in A&A unit in order to allow for contemporary review of results and contacting women in timely fashion.

3. A comprehensive review of the various forms used in A&A unit with possible redesign to make them more user friendly and useful in everyday practice.

4. A review of HART procedure in order to simplify the process, make it less centralised and more efficient.

5. An update of the Guideline on the Management of Reduced Fetal Movements (CG0312) should be considered in line with the national Saving Babies Lives bundle.

10.0 REFERENCES

1. Reduced fetal movements (RFM) SHSCT(1) CG0312
2.

- Management of Antepartum Haemorrhage (APH) SHSCT (2) CG0462
- Management of obstetric cholestasis SHSCT (3) CG0429
- Standard operating procedure for actioning of abnormal blood results on (4) NICER 2019
- Standard operating procedure for taking and actioning of laboratory results 2017 (5)

11.0 DISTRIBUTION LIST

Director of Acute Services SHSCT

Assistant Director of Acute Services SHSCT

Head of Midwifery and Gynaecology SHCT

Acting Acute Clinical Governance Co-Ordinator SHSCT

Lead midwives SHSCT

Staff involved

Personal Information redacted by the USI

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report for all levels of SAI reviews)

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ****If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**							
Content with rationale?	**YES**		**NO**				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed ***(if you select this option please also complete 'I' below)***			
	d) No contact or Next of Kin or Unable to contact			

[1]*Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)*		
Continued overleaf	**e)** No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONER'S OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

Appendix 1

[1]*Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI	**4. DATE OF INCIDENT/ EVENT:** 24/07/2020
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**

7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 03/12/2020, 04/03/2021 & 25/03/2021

8. SUMMARY OF EVENT:

On Personal Information redacted by the U, Personal Information redacted by the USI was admitted to the Male Medical Ward (MMW) at Daisy Hill Hospital (DHH) following a collapse outside in the street. He was being treated for aspiration pneumonia, alcohol withdrawal and rib fractures when his condition deteriorated. He subsequently had increasing oxygen requirements and was transferred to High Dependency Unit (HDU) on Personal Information redacted by the USI for AIRVO management (a humidifier with integrated flow generator that delivers warmed and humidified respiratory gases to spontaneously breathing patients). On Personal Information redacted by the USI Personal Information redacted by the USI's condition deteriorated further there was difficulty obtaining medical assistance. Personal Information redacted by the USI subsequently required intubation and ventilation and post this was transferred to the Intensive Care Unit (ICU) at the Royal Victoria Hospital (RVH) for management. He was extubated on Personal Information redacted by the U and returned to DHH on Personal Information redacted by the USI.

SECTION 2

9. SEA LEAD OFFICER: Dr A Green, Consultant Respiratory Physician	**10. TEAM MEMBERS PRESENT:** Mrs K Carroll, Head of Medicine Mr D Cardwell, Clinical Governance Manager

11. SERVICE USER DETAILS:

Personal Information redacted by the USI, Male aged Personal Information redacted

12. WHAT HAPPENED?

Personal Information redacted by the USI was brought in by ambulance to the Emergency Department (ED) of Craigavon Area Hospital on Personal Information redacted by the U. The triage nurse who saw Personal Information redacted by the USI at 09:13 noted that he appeared to be behaving strangely and that he had an altered conscious level. She documented that he was found close to his home (outside) was conscious and confused. The triage nurse noted that Personal Information redacted by the USI had an unkempt appearance. His pulse (P) was 83, blood pressure (BP) 128/69, respiratory rate (RR) 17, temperature (T) 37, oxygen saturations (SpO2) 96% and Glasgow Coma Scale (GCS) 13. The triage nurse

completed a safeguarding (APP1) form and triaged [redacted] as a priority 2 patient (to be seen within 10 minutes).

At 10:11 [redacted] was seen by Doctor 1 (ED Senior House Officer) who noted that [redacted] was a [redacted] year old male who was confused and elusive with answers. He documented that [redacted] drank copious amounts of vodka and that his last drink was the day previous. [redacted] stated that he had taken no other drugs and that the left side of his chest was sore to touch. Doctor 1 noted [redacted]'s background and social history. [redacted] was not short of breath and did not have a cough. On examination his chest was tender around the 3rd left rib. His heart sounds were normal and his pulse was regular. His abdomen was soft and non-tender. He was moving all 4 limbs, his GCS was 14, he had no obvious head or neck injury. His left eye was blood shot and the impression was that he had a query bleed and query alcohol related. The plan was to await blood results, have an ECG, a CT brain and GMAS +/- Librium.

At 13:21 [redacted] was discussed with Consultant 1 (Emergency Department Consultant) who advised that [redacted] was a vulnerable adult and needed admission for social assessment. [redacted] was accepted by MMW and he left ED at 15:43 for transfer to DHH.

On [redacted] was transferred to HDU and since then he was seen twice on a daily basis by the medical team. [redacted] was seen assessed and treated as required by a physiotherapist as he was experiencing chest secretions. He proceeded to have a CTPA which ruled out a pulmonary embolism. By [redacted] was noted to be feeling much better, sitting out and had come off AIRVO. He was reviewed by the anaesthetic team who were happy that [redacted] appeared well and his condition was controlled.

On [redacted] it was noted that some of [redacted]'s arterial blood gasses (ABG's) were abnormal and he had become breathless. It was noted that a chest x-ray from the previous day reported worsening shadowing. The plan was for an anaesthetic review as [redacted] was tired and had increased work of breathing. This review was carried out at 11:30 at which stage [redacted] was on AIRVO at 60%, 60L. His Sp02 was 100%, RR 23, BP 132/64 and P 78. He was noted as sitting in the chair and appeared frail, and whilst confused was able to understand. He was noted to be comfortable from a pain point of view and able to take deep breaths. The plan was to continue medical management as [redacted] appeared to be responding well and in the right direction. [redacted] had a further anaesthetic review at 16:45 and 20:20 as there was a reduction in his GCS. On review [redacted] appeared stable vitally, his ABG's reviewed and the plan was to continue medical management. The anaesthetic team were happy to review [redacted] again if needed. They noted that [redacted] was responding well to antibiotics and that he was comfortable from a pain point of view. They also noted they would consider CPAP/intubation if the situation dictated so.

On [redacted] became very unsettled from 00:00 until 01:00 and was climbing, was disorientated and asked for the toilet. He was re-orientated and settled back to sleep at 1am. He woke again at 04:30 when he was confused and was climbing again. Lorazepam 1mg was given intra-muscular (IM) with little effect. He settled again from 06:00 for 30 minutes and then wanted out of bed. He was given the assistance of one person at 07:00 and helped out to the chair. His bloods were obtained and sent. IV Tazocin and IV Pabrinex was administered and nebulisers given. His arterial line was intact and recalibrated. Input was recorded as 1960mls and output 1490mls.

[redacted] was seen by Doctor 2 (Staff Grade Medicine) at 08:40. She noted that [redacted] was day 5 admission following a fall and alcohol excess. It was noted that [redacted] had aspiration pneumonia, was on Librium and had a rib fracture. Doctor 2 noted that [redacted] was chesty ++, though had minimal pain and a strong cough. It was noted that [redacted] pulled off the AIRVO for 2 minutes that morning and his saturations were 94% on room air but still needed AIRVO for work of breathing. Doctor 2 noted that

there were bilateral crackles heard on Personal Information redacted by the USI's chest and reviewed his blood results. She highlighted that whilst Personal Information redacted by the USI was haemodynamically stable, he was vulnerable to deterioration and at risk of aspiration so asked for him to fast until there was a review by the Speech and Language Therapist (SLT). Doctor 2 noted that Personal Information redacted by the USI's chest x-ray looked slightly full and that there was a reduced threshold for diuretic. Doctor 2's plan included sitting Personal Information redacted by the USI out as much as possible, reduce FO2 and continue with the increased flow, chase sputum, hold intravenous fluids, review the remainder of the lab results, give 7 days of Tazocin, PRN lorazepam & document GMAWS (Glasgow Modified Alcohol Withdrawal Score.)

During the course of the morning Personal Information redacted by the USI was cared for by nurse 1 who assisted to get Personal Information redacted by the USI out to sit and encouraged deep breathing. She sent a sputum sample for testing and reduced AIRVO from 60% to 50% as per Doctor 2. Personal Information redacted by the USI's oxygen saturations were 97-100% on same. His ABG's were reviewed and to be repeated at 12:00. GMAWS at 12:00 were 3. Staff nurse 1 noted at 12:45 that Personal Information redacted by the USI was reviewed by the medical team who were happy with his ABG's. His AIRVO was to be reduced slowly with a view to stopping same. ABG's and daily bloods were to continue. At 15:00 staff nurse 1 contacted Doctor 3 (FY1) in relation to the decrease in Personal Information redacted by the USI's urine output.

Doctor 3 reviewed Personal Information redacted by the USI at 15:45 who reviewed Personal Information redacted by the USI's fluid output. His NEWS (National Early Warning Score - an early warning score is a guide used by medical services to quickly determine the degree of illness of a patient) were 4. His RR was 24, SpO2 95% on 40% 60L AIRVO, T 36.3, BP 142/70, P 89 and Egfr >60. Doctor 3 noted that Personal Information redacted by the USI was waiting on a SLT review and that he was unable to get any oral intake. His case was discussed with Doctor 2 and the plan was for 40mg IV furosemide stat, continue hourly urometer reading, repeat arterial blood gas in 1 hour and monitor K+. At 17:00 staff nurse 1 shared the results of the arterial blood gases with Doctor 3 who asked for them to be repeated again at 19:45. Staff nurse 1 noted that Personal Information redacted by the USI remained very agitated, confused and was attempting to climb out of bed.

He was seen by Physiotherapist 1 at 17:30 who noted that Personal Information redacted by the USI was agitated and he had increased work of breathing with a respiratory rate of 30. A droop in Personal Information redacted by the USI's mouth was noted though his CT brain did not detect any abnormality. AIRVO was increased to 90% oxygen on 60L Spo2 97-100%. His RR remained at 30-37. It was noted that Personal Information redacted by the USI had poor compliance with chest physio and that yanker suction was of no benefit. There was an increase in Personal Information redacted by the USI's agitation with increased attempts of chest physio and no sputum expectorated. Physiotherapist 1 noted that Personal Information redacted by the USI was at risk of fatigue due to increased work of breathing and that CPAP was unlikely to be beneficial due to compliance with mask.

Later that evening (time not documented) Doctor 4 (Registrar) was asked to see Personal Information redacted by the USI due to reduced oxygen on ABG results. Doctor 4's impression was that Personal Information redacted by the USI had aspiration but there was no suggestion that it was worsening, he had pulmonary oedema, good diuresis and mucous plugging. The plan was for repeat ABG's with hourly observations, physiotherapy, cover with Tazocin, blood cultures if temperature >38, ECG, not fit for CPAP, discuss with ICU if failure to improve, further sputum sample, test urine for legionella and pneumococcus and also short viral screen. There was then another review by Doctor 4 – again time not documented. Noted there had been a good diuresis, oxygen levels were satisfactory. Plan was to continue with the same, reduce oxygen as able, await sputum and contact medics if there were concerns regarding Personal Information redacted by the USI's condition.

At 20:00 Personal Information redacted by the USI was seen again by Physiotherapist 1 who attempted further chest physiotherapy. She noted that Personal Information redacted by the USI's cough was ineffective and he was unable to clear secretions. There was minimal sputum cleared, he became agitated and pulled off AIRVO. The plan was to review Personal Information redacted by the USI the following morning and continue AIRVO as able.

At 21:30 staff nurse 2 introduced herself to Personal Information redacted by the USI following handover. She documented Personal Information redacted by the USI's

observations as RR 23, SpO2 98% on AIRVO 60L, T 36.3, BP 130/69, P 106. His NEWS was 5 and he was on 1 hourly observations. Staff nurse 2 noted that Personal Information redacted by the USI was very unsettled in bed, climbing out and taking AIRVO off. His GMAWS was 3, GCS 14/15 and it was noted that latest ABG's which were PH 7.44, PO2 7.64, PCO2 5.77. This indicated that is oxygen levels were slightly low at this point - other levels were satisfactory. He was given 1mg of lorazepam @ 20:35 with great effect. She noted that Personal Information redacted by the USI had an arterial line to his right hand. Personal Information redacted by the USI had slight bruising and discolouration to both hands and was awaiting SLT review.

Subsequent to this Personal Information redacted by the USI's NEWS increased to 6 and this was escalated to Doctor 5 (Registrar) who advised that he would not review Personal Information redacted by the USI as the physiotherapist could deal with the AIRVO and that Personal Information redacted by the USI would have high NEWS scores. Staff nurse 2 contacted the physiotherapist for assistance. At 21:50 Personal Information redacted by the USI was given intravenous antibiotics and paracetamol and Pabrinex given as per kardex. The ABG was repeated and reported as PH 7.4112, PCO2 5.91, PO2 11.4 K+ 3.6; Na+ 142; Glu 4.4. These indicated that his oxygen level was improved from the previous reading – all other levels were still satisfactory. Nebulisers were given as per kardex as well as constant reassurance. Staff nurse 2 documented that Personal Information redacted by the USI needed 24/7 supervision.

At 23:59 Personal Information redacted by the USI was seen by Doctor 5 who noted that Personal Information redacted by the USI was agitated, there was no other clinical change and therefore lorazepam PRN should be given. No NEWS score documented in medical notes.

At 00:00 on Personal Information redacted by the USI, staff nurse 2 noted that Personal Information redacted by the USI was very confused, unsettled trying to get out of bed and pulled his arterial line out. Doctor 5 was bleeped, the situation explained and he was asked to review the patient. Doctor 5 refused to carry out a face to face review. Personal Information redacted by the USI pulled off his AIRVO and was violent towards staff and pulled off the wires attached to the monitor. Staff nurse 2 tried to reassure Personal Information redacted by the USI without success. Staff nurse 2 bleeped the Bed Manager to ask for medical assistance. Staff nurse 2 managed to get Personal Information redacted by the USI back on AIRVO 60L 70% and he settled slightly.

At 00:45 Personal Information redacted by the USI became very aggressive again and took off AIRVO, saturations probe, ECG wires and used foul language towards staff nurse 2.

At 02:00 Personal Information redacted by the USI was seen by Doctor 6 (FY1) and following discussion with Doctor 5 prescribed furosemide 50mg given intravenously, metoclopramide and diamorphine PRN. Personal Information redacted by the USI was very agitated and restless.

At 03:30 Personal Information redacted by the USI pulled his hospital gown off and monitor leads. Staff nurse 2 noted he was in and out of sleep and managed to put the saturations probe back on his toe and hospital gown. At 05:00 his saturations had decreased to 86%. He was given saline and his saturations increased slowly up to 93%. At 05:30 Personal Information redacted by the USI's saturations were 98% and he was asleep. He was given IV paracetamol, Tazocin and Prabinex given as per kardex.

At 06:30 Personal Information redacted by the USI's saturations dropped to 83% and nebulisers were given. The on call physiotherapist was bleeped as was Doctor 5. At 07:00 staff nurse 2 had no response from Doctor 5 so bleeped him again. Doctor 5 advised that he would not be reviewing Personal Information redacted by the USI. Subsequent to that Doctor 5 was contacted a third time and he came to ward, spoke to the nurse but did not review Personal Information redacted by the USI. At 08:00 staff nurse 3 (nurse in charge) documented that she had reviewed Personal Information redacted by the USI along with Doctor 5. Personal Information redacted by the USI appeared more settled, his breathing had improved slightly and it was noted that his saturations were up and down, overall similar to the start of the night. NEWS not documented in medical notes. The plan was for further physiotherapy, oxygen as required and a further chest x-ray. They felt further ABG would not change management.

The physiotherapy review took place at 07.20 (entry was written at 08.30) when it was noted that

Personal Information redacted by the USI had ongoing confusion, was unsettled in bed and kept trying to take the AIRVO off during the night. The physiotherapist noted pain described as central chest pain. Personal Information redacted by the USI's BP was 136/90, P 94 and RR 30. His SpO2 was 97% on AIRVO 60L/86% oxygen. Treatment was attempted but there was poor compliance and Personal Information redacted by the USI struggled with same and became fatigued quickly. The physiotherapist suggested a repeat x-ray to determine the cause of deterioration.

Personal Information redacted by the USI was seen by Doctor 2 at 09:15 regarding his deterioration and noted that she was worried about Personal Information redacted by the USI who had ongoing respiratory failure, a clear clinical deterioration and fluid overload. Her plan included an urgent chest x-ray, anaesthetic referral, start diuretic, see labs, micro ? meropenum, repeat gas in 1 hour and update next of kin. At 10:15 Doctor 2 attended with Doctor 7 (grade) when Personal Information redacted by the USI's breathing was laboured and his left chest wall was depressed. The plan was to have a discussion with theatres and if there was any deterioration the medical team were to be re-contacted. At 11:50 Personal Information redacted by the USI's brother was spoken to by Doctor 2. Personal Information redacted by the USI was then seen on the ward round by Doctor 8 (Consultant Physician) when advice was sought from the surgical team, cardiothoracic team and the anaesthetic team. At 12:00 Personal Information redacted by the USI was seen again by Doctor 2 as his condition had deteriorated. Doctor 7 attended also and advised that Personal Information redacted by the USI needed to be intubated and ventilated. He was transferred at 12:00 to theatres where he remained until his transfer to ICU at RVH at 18:40.

13. WHY DID IT HAPPEN?

Patient Factors

The review team noted on admission Personal Information redacted by the USI looked frail and unkempt but had no previous medical admissions and no significant medical history. Personal Information redacted by the USI was noted to be a heavy smoker, take alcohol in excess and had suffered from a fall sustaining multiple left sided rib fractures. The review team have highlighted that Personal Information redacted by the USI was agitated and as a result was difficult to manage, however this would not be uncommon for patients who are detoxifying from alcohol especially with other medical issues.

Clinical Assessment

The review team have examined the medical notes associated with Personal Information redacted by the USI's admission. They are satisfied that he was on an appropriate antibiotic and that his pain was being managed. They are cognisant of the fact Personal Information redacted by the USI was being detoxified from alcohol, this can be a difficult balance to achieve with over sedation and under sedation being issues both having potential effects on the patient. This may have had some impact on Personal Information redacted by the USI clinical course but management of this was appropriate. The day team had noted a clear plan which was documented by the Anaesthetic Team which detailed the steps to be taken if Personal Information redacted by the USI deteriorated.

The review team have identified that Personal Information redacted by the USI deteriorated on the morning Personal Information redacted by the U between 05:00 and 06:30 with his NEWS score climbing from a baseline of 5-6 overnight to a score of 8 secondary to an increase in respiratory rate (an important factor) and a drop in SpO2 this subsequently moved to 9. The review team believe a thorough medical review should have taken place then and earlier than when it did. They have clarified that the pre-determined escalation plan should have been referred to and Personal Information redacted by the USI's condition should have been escalated to the Anaesthetic Team. Whilst this may not have changed the outcome for Personal Information redacted by the USI it would have changed his immediate management. The review team have noted that a thorough (excellent) review took place at 09:15. There was a recognition that his condition had changed significantly from the previous day and an appropriate plan was initiated including an anaesthetics review. There was further deterioration over the course of the morning prompting intubation and transfer to ICU.

Supervision and Leadership

The review team have noted that after doctor 5 reviewed [redacted] at 07:00 on [redacted] there was no reference to a discussion with the consultant on call. The review team felt that the consultant on call could have been contacted at this time for advice.

Workload

HDU is an 8-bedded ward and on the night in question there were 5 patients being nursed there. The review team understand that there were 4 registered nurses on night shift which would have been the normative staffing for this clinical area. Although 1 to 1 nursing was required for [redacted] this would have been possible with these ratios.

Team Factors

The review team note that staff nurse 2 escalated [redacted]'s NEWS of 6 at 21:30 on [redacted] however [redacted] did not receive a face to face review until 23:59 that evening. The review team feel that had a medical review taken place at this time it would not have changed [redacted]'s management. They have noted that at this time [redacted]'s issue was agitation rather than concerns with his chest and breathing. Nonetheless the review team accept that this left staff nurse 2 feeling isolated and have identified that staff nurse 2 could have escalated her concerns to the site manager. The notes reference a call for assistance from the Bed Manager and the advice given was that staff nurse 2 should try liaising again directly with medical staff. The review team advise it would have been helpful for staff nurse 2 to have had additional support from senior nursing staff to impartially resolve her concerns about [redacted].

Whilst none of the review team were present on the night in question and they are relying on the documentation to formulate an opinion, they feel that the teams could have worked more effectively together to care for [redacted] on the evening of [redacted] and into the morning of [redacted]. The review team believe that effective multi-disciplinary working leads to improved patient care.

Communication and Documentation

The review team have examined the Hospital at Night handover sheet for the night in question, [redacted] was not on this handover document, this would have been an appropriate forum to do a formal handover.

The NEWS score is a key tool to assess sick patients. The review team note the trend of [redacted]'s NEWS overnight on the night in question gradually increased highlighting his gradual deterioration. This should be used as one method to communicate the issues. A trigger could also have been set by the medical team so the nursing team would know at what point to re-contact them and the urgency this would need to be done.

The review team are mindful of the fact that good communication is integral to good patient care and that all teams should work collaboratively, respecting each other's skills and contributions. The review team have commented that staff should be aware of how their behaviour may influence others and that everyone should be treated fairly and with respect. Listening to concerns of other staff members is part of this process.

In relation to documentation, whilst the review team have been able to identify good examples of clear and detailed medical entries both before and after [redacted]'s deterioration, some lacked detail e.g., time of assessment. The assessment on the morning of the deterioration was not as comprehensive as it could have been and missed so details such as NEWS scores.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

Good communication, which is clear and effective between teams is vital to ensure that the multi-disciplinary team works collaboratively to maintain or improve patient care.

Personal Information redacted by the HPS's case has highlighted that the accurate recording of NEWS is absolutely crucial in assisting with the identification of a deteriorating patient. The use of a trigger score should be used as another method of communicating changes in a patient's condition. Each member of staff needs to be fully informed about and aware of pre-discussed plans for the event of deterioration and put these into place as required. The medical/hospital at night handover meeting is a crucial part of this and needs to be facilitated by the most senior members of the team to ensure safe management of patients.

The review team have emphasised that if nursing staff are not satisfied with how a patient is being managed medically out of hours that they should escalate their concerns to the registrar and/or the site manager if necessary.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

All nursing staff will be reminded of the requirement to follow the recognised escalation process should they have ongoing clinical concerns about the medical management of a patient.

In addition the Trust will continue to review findings of NEWS audits which are carried out as part of the Nursing Quality Indicators and act on any recommendations noted.

16. RECOMMENDATIONS (please state by whom and timescale)

All nursing staff should be adequately trained in the use of the NEWS tool and be aware that they can agree trigger points with medical teams. This issue will be placed on the agenda of the Senior Nursing and Midwifery Governance Forum within 3 months of the publication of this report.

All nursing staff will be reminded of the requirement to follow the recognised escalation process should they have ongoing clinical concerns about the medical management of a patient. This should be carried out within 3 months by the Executive Directorate of Nursing.

The Trust should ensure it has arrangements in place for the safe and effective handover of patients, during the out of hours period, so therefore a complete review of the hospital at night process should be undertaken to include details of how patients are added to the report, how outcomes are listed and how discussions are noted and kept for future reference. This should be led by the Assistant Director of Acute Services with responsibility for Patient Flow within 6 months of the publication of this report.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

None.

18. FURTHER REVIEW REQUIRED? No.
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	**24.** DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2								
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) ***(complete this section for all death related SAIs)***								
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**					
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI	**4. DATE OF INCIDENT/ EVENT:** Personal Information redacted by the USI
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 11/02/2021, 16/03/2021 & 26/03/2021	

8. SUMMARY OF EVENT:

Personal Information redacted by the USI was admitted to Daisy Hill Hospital (DHH) on Personal Information redacted by the USI with a worsening shortness of breath, lethargy and decreased appetite. A diagnosis of severe Covid-19 pneumonia was made and considering his background medical conditions, including Personal Information redacted by the USI, his ceiling of care was the High Dependency Unit (HDU).

Personal Information redacted by the USI had haemodialysis (using a machine to clean and filter the blood) on Personal Information redacted by the USI. On Personal Information redacted by the USI he had an unwitnessed fall in the bathroom. At the time the floor was noted to be wet. A CT brain scan showed a traumatic subarachnoid haemorrhage (a life-threatening type of stroke caused by bleeding into the space surrounding the brain). Personal Information redacted by the USI was discussed with the Neurosurgery Team but was not for intervention by their team. His condition deteriorated and end of life comfort care was discussed with his family on Personal Information redacted by the USI and he was commenced on syringe driver. Personal Information redacted by the USI died peacefully on Personal Information redacted by the USI.

The review team wish to express to Personal Information redacted by the USI's wife and family circle their sincerest condolences on the untimely passing of Personal Information redacted by the USI.

SECTION 2

9. SEA LEAD OFFICER: Dr B Adams, Consultant Obstetrician & Gynaecologist (SAI Chair)	**10. TEAM MEMBERS PRESENT:** Mrs K Carroll, Head of Service for Medicine Mr D Cardwell, Clinical Governance Manager

11. SERVICE USER DETAILS:

DOB@ Personal Information redacted by the USI, Male, Aged Personal Information.

12. WHAT HAPPENED?

Personal Information redacted by the USI was brought by ambulance to DHH ED on Personal Information redacted by the USI arriving at 15:56. He was triaged by Staff Nurse 1 at 16:03 who noted that his presenting complaint was weakness and lethargy. It was documented that he had very low oxygen saturations (Sp02) and that he was on a nebuliser whilst in the care of the Northern Ireland Ambulance Service (NIAS) running at 15L/minute. His pulse (P) was 71 beats per minute (normal), respiratory rate (RR) 24 breaths per minute (fast), temperature (T) 36.1°C (normal), SpO2 93% (he required the nebuliser to maintain this level) and blood glucose (BM) 5.7 mmol/l (normal). He was seen by Doctor 1 (Senior House Officer (SHO)) and Doctor 2 (Specialty Registrar Emergency Department (ED). They noted that Personal Information redacted by the USI was a Personal Information redacted by the USI old male who had arrived with shortness of breath and documented that his SpO2 was 76% on room air (very low). Personal Information redacted by the USI complained of shortness of breath and lethargy for 3 days. Doctor 2 noted that Personal Information redacted by the USI had no temperature or cough, that he had a reduced appetite and that his last bowel movement was 3 days earlier. Doctor 2 also noted that Personal Information redacted by the USI had longstanding lower back pain. Personal Information redacted by the USI denied any chest pain, any palpitations and any abdominal pain.

On examination Personal Information redacted by the USI's heart sounds were I+II (normal), his lungs were clear, abdomen soft and non-tender, bowel sounds were present and his calves were soft and non-tender. The plan was for Personal Information redacted by the USI to have a chest x-ray, as per Covid pathway nebulisers, dexamethasone, oxygen, antibiotics after the chest x-ray, Covid swab and arterial blood gasses (ABG) done.

Personal Information redacted by the USI was then reviewed by Doctor 3 (Locum Consultant Physician) who noted the past medical history and documented that Personal Information redacted by the USI was not clinically well. He advised that Personal Information redacted by the USI's Echocardiogram was not consistent with Heart Failure and that he needed to be managed as a Covid-19 positive patient. Doctor 3 advised that Personal Information redacted by the USI needed to have a troponin test and d-dimers carried out.

Doctor 3 noted that Personal Information redacted by the USI's P/F ratio (is the level of oxygen measured on blood gas in comparison to the level of oxygen patient is breathing in on room air – the lower the score the sicker the patient is) was 8.4. (A P/F Ratio less than 300 indicates acute respiratory failure.) Personal Information redacted by the USI was discussed with Dr 4 (Consultant Physician) who advised there was a high chance of mortality even if Personal Information redacted by the USI went to the Intensive Care Unit (ICU); therefore given his multiple co-morbidities the ceiling of care would be in the High Dependency Unit (HDU).

At 18:45 Personal Information redacted by the USI was reviewed by Doctor 5 (Medical Registrar) and he discussed resuscitation with Personal Information redacted by the USI and his step-daughter. There was an agreement that Cardiopulmonary Resuscitation (CPR) would likely be unsuccessful and therefore not in Personal Information redacted by the USI's best interests and a Do Not Attempt CPR Order was put in place. A Covid swab was taken at this time.

Personal Information redacted by the USI Personal Information redacted by the USI was seen by Doctor 6 (Senior House Officer) as part of the clerk-in process. Doctor 6 noted that 's SpO2 was 76% on room air, that he had shortness of breath and lethargy for 3 days with a decreased appetite. They documented that Personal Information redacted by the USI had no temperature, no cough, his bowels opened 3 days previously and that he was passing urine as normal. His longstanding lower back pain was noted and again Personal Information redacted by the USI denied any chest pain, any palpations and any abdominal pain. Doctor 6 noted the past medical history to be Personal Information redacted by the USI .

Doctor 6 noted Personal Information redacted by the USI's observations to be RR 26, BP 109/52, SpO2 93% on 10L, P 80, T 37.3, and his National Early Warning Score (NEWS - determines the degree of illness of a patient and prompts critical care intervention) was 8. It was noted that Personal Information redacted by the USI's lungs were clear, abdomen soft and non-tender and bowel sounds were present. The plan was for Personal Information redacted by the USI to be treated according to the Covid pathway based on his clinical presentation, have a troponin test and a d-dimer test.

At 02:30 on Personal Information redacted by the USI, Doctor 7 (Specialty Registrar) was asked to see Personal Information redacted by the USI regarding a reduction in his SpO2. On arrival Personal Information redacted by the USI did not appear in any respiratory distress and did not have any increased work of breathing. His SpO2 was 86% on venture mask. Doctor 7 noted Personal Information redacted by the USI's past medical history and his presenting complaint. Doctor 7 noted that Personal Information redacted by the USI's SpO2 was fluctuating between 85% to 92% but mostly was 86% average. Personal Information redacted by the USI was sleeping but easily rousable and when asked stated he felt alright and had no shortness of breath and did not feel dizzy, drowsy or exhausted. On examination Personal Information redacted by the USI had chest crepitations on the left side (all over) and right base. Air entry seemed good all over. His abdomen was soft and non-tender and bowel sounds were present. At one point his SpO2 dropped to 84% and his mask was switched to 15L non-rebreather. His SpO2 gradually improved to 93% and then slowly to 96%. As Personal Information redacted by the USI was sleeping it was difficult for Doctor 7 to check if Personal Information redacted by the USI was getting drowsy with the increased oxygen so his mask was changed back to the 15L venturi mask. At that point Personal Information redacted by the USI's observations were SpO2 90-91%, BP 129/66, P 54 and T 36.5.

Doctor 7's plan was to continue with the 15L venturi mask and aim for a target of > 90% but >88% was also acceptable unless Personal Information redacted by the USI had an increased RR and reduced BP. He was to be stepped down to 10L if his SpO2 was >94% and any concerns were to be escalated. Doctor 7's impression was that Personal Information redacted by the USI was currently stable and not for HDU. Hourly observations were recommended.

At 09:00 Personal Information redacted by the USI was seen by Doctor 3 and Doctor 8 (Staff Grade) who noted the past medical history and presenting complaint. They noted that Personal Information redacted by the USI was for haemodialysis. On examination his lungs were clear and his observations were recorded as RR 18, SpO2 94.7 on 10L, T 36.5, BP 115/60, P 51 and his BM was 8.8. The plan was to discuss Personal Information redacted by the USI with the renal team and move him to a side room.

At 10:00 Personal Information redacted by the USI was seen by Doctor 9 (Consultant Nephrologist) who noted that Personal Information redacted by the USI was feeling well. His temperature was normal, SpO2 92% on 60%, BP 130/58, P 51, his chest was clear and he had no swelling. Doctor 9's plan was to proceed with haemodialysis that afternoon.

At 10:40 Personal Information redacted by the USI was seen by Physiotherapist 1. He noted that Personal Information redacted by the USI advised he was unsteady when on his feet. Physiotherapist 1 titrated Personal Information redacted by the USI's oxygen and assisted him to sit on the side of the bed and then assisted him to lie on his side. At this point Personal Information redacted by the USI's SpO2 decreased to 73% so his oxygen was increased again and he was left comfortable.

At 16:30 Personal Information redacted by the USI had his pre haemodialysis review carried out by Doctor 9 and this commenced at 16:40 and lasted for 1.5 hours.

At 17:08 the result of Personal Information redacted by the USI's Covid swab indicated that he was positive.

On Personal Information redacted by the USI, Personal Information redacted by the USI was seen by physiotherapist 2 at 09:30 when he reported that he felt much improved from the previous day, although he did report feeling fatigued following mobilising to the bathroom earlier and this took him time to recover. Personal Information redacted by the USI was alert and sitting in a chair and the plan was to review him the following day to progress his exercise tolerance.

At 10:00 Personal Information redacted by the USI was seen by Doctor 9 during the renal ward round. He was noted to be clinically stable and his SpO2 was 92% on 60%. His BP was 130/58. He was also seen by the medical team who noted that he was sitting out in a chair and alert. On examination he had mild crackles in his lungs, heart sounds were normal and he had mild peripheral oedema (swelling). The plan was to continue with Enoxaparin 20mg twice daily, chase D-dimer, daily bloods and liver function test. It was noted that Personal Information redacted by the USI was on Dexamethasone 6mg once daily for 10 days and if his oxygenation worsened he was for continuous positive airway pressure (CPAP).

On Personal Information redacted by the USI, Personal Information redacted by the USI was seen by Doctor 10 (Specialty Registrar) and Doctor 11 (Senior House Officer) at 04:00 as it was reported he had an unwitnessed fall. They were advised by nursing staff that

Personal Information redacted by the USI had gone into the bathroom to urinate, they heard a bang and found Personal Information redacted by the USI on the floor, bleeding from the nose with right supra orbital swelling. Personal Information redacted by the USI told nursing staff that he was trying to get up from the toilet and could not remember what happened afterwards. He reported that he hurt everywhere, had no chest pain, no seizures and no vomiting. Doctors 10 and 11 noted that Personal Information redacted by the USI was able to follow commands and move all 4 limbs. They noted that the floor in the bathroom was wet. A cervical collar was applied and he was transferred back to bed.

On examination Personal Information redacted by the USI was alert and his observations were RR 22, BP 97/59, SpO2 92% on 60% 15L and P 66. He had equal air entry bilaterally and his heart sounds were normal. His Glasgow Coma Scale was 15/15. His abdomen was soft and non-tender, he had no spinal tenderness and a full range of movement in all limbs. It was noted that he had minimal bleeding from both nostrils with haematoma. He had right supra orbital swelling, No rhinorrhoea (discharge from the nose) nor any battle sign/racoon eyes.

The plan was for a CT brain and CT cervical spine with neurological observations and pain relief. Personal Information redacted by the USI was to have an ECG and venous blood gasses (VBG). His clexane and aspirin were held until the report of the CT brain was available.

Doctor 11 reviewed Personal Information redacted by the USI an hour later after returning from the CT scanner. Personal Information redacted by the USI denied any chest pain, was slightly short of breath, had no nausea, vomiting and was not in pain. On examination he was sitting in the bed, alert and orientated. His GCS was 15/15 and the power in all limbs was 5/5. His SpO2 was 91% on 15L. The plan was to await the results of the CT brain, continue neurological observations, continue with oxygen and update the family.

At 05:40 Doctor 12 (FY1) received a verbal report from the CT brain which confirmed an Intraparencyhrnal haemorrhage but it could not completely exclude a fractured cervical spine because of movement artefact. It was advised that if there were clinical signs of fracture Personal Information redacted by the USI was to be re-scanned and if not his collar could be removed. Personal Information redacted by the USI reported no neck pain but discomfort and on examination there was no visible injury to his neck. There was no spinal tenderness and no paraspinal tenderness. The plan was to remove the collar and contact neurosurgery.

At 06:15 Doctor 12 reviewed Personal Information redacted by the USI before discussion with neurosurgery. Personal Information redacted by the USI was orientated to place and his GCS was 15/15. His RR was 21, SpO2 94% on 40%, BP 102/60, P 89.

At 06:35 discussions took place with the neurosurgeons when the clinical care and CT scan report was relayed. The neurosurgeons suggested one off tranexamic acid 1g and to stop clexane and aspirin. It was noted that Personal Information redacted by the USI was unlikely for neurosurgical intervention considering his co-morbidities and that if he GCS deteriorated he was to be re-scanned and reviewed. They also recommended a discussion with the haematologist which took place at 06:58. Doctor 13 (Consultant Haematologist) agreed with the neurosurgeons plan.

At 07:20 Doctor 11 updated Personal Information redacted by the USI's step-daughter.

At 10:00 Personal Information redacted by the USI had a physiotherapy assessment carried out by physiotherapist 3 (Clinical Lead Physiotherapist). Personal Information redacted by the USI complained of pain in his right arm. He had reduced air entry at the left base and his breathing pattern was irregular. His SpO2 was fluctuating between 88 - 93% on 60% oxygen and require a medical review. He was seen at 11:51 by Doctor 14 (Specialty Registrar) who noted the history to date. On examination Personal Information redacted by the USI was sitting in bed, his GCS was 15/15, and a bruise was noted at his right eye. He had chest crepitations in both lungs and it was noted that he would likely require haemodialysis.

At 12:40 he was seen by Doctor 4 who noted that Personal Information redacted by the USI's breathing is not too laboured at times. His abdomen was soft and non-tender and he had mild oedema in his feet. His GCS was 15/15 and he was not for haemodialysis that day. At 17:40 the results of the VBG were known and noted.

On Personal Information redacted by the USI Personal Information redacted by the USI was seen by Doctor 14 at 11:30. On examination he was agitated but orientated and able to follow commands. His GCS was 15/15. He looked dehydrated and was still having pain in his back. His observations were taken and his SpO2 was 96% on 60% oxygen, BP 133/67 and T 35.2. The plan was for an x-ray of his lumbar spine and shortec 2.5mg to help with pain. He was seen by physiotherapist 3 at 12:00 when he had no complaints of pain. His breathing pattern remained irregular and episodes of shallow breathing followed by increased rate/depth of effort. He was repositioned to high sitting and encouraged to breathe deeply.

At 16:20 he was reviewed in relation to increased confusion. He was rousable to speech, denied pain and able to respond to questions. He was groaning with discomfort but able to stand up and walk a few steps. His blood glucose level was 10. He was non-compliant with neurological examination and his GCS was 13/15. At this time he was able to move all 4 limbs, had no slurring of speech, was not clammy, his abdomen was soft and his bladder was palpable. He was discussed with Doctor 14 who advised a further CT brain, bladder scan and to check when his bowels last opened and commence a stool chart.

At 21:00 Doctor 10 was asked to review Personal Information redacted by the USI again and follow up on the CT brain. Personal Information redacted by the USI's airway was patent with no added sounds, his RR was 24, SpO2 91% on 60% oxygen, heart sounds normal, P 86, BP 122/82. Atrial fibrillation was noted on telemetry. Personal Information redacted by the USI's hands were warm and he was well perfused. His capillary refill time was less than 2 seconds. There was no sign of any DVT or cellulitis and his fluid intake/output was noted as fluids in 650 ml and out 550 ml.

His abdomen was soft, not peritonitic/guarding and bowel sounds were present. He was draining clear urine. His GCS was 11/15 and his BM was 10.8. Doctor 10 noted Personal Information redacted by the USI to be moving all 4 limbs normally, making groaning noises but not answering any questions and was unable to say where he was. He observed that Personal Information redacted by the USI kept putting his hand to his ear and was moving his neck by himself. His whole spine was felt and there was no obvious bony tenderness noted. He had no bony hip pain and had been mobilising by himself that day.

Doctor 10's impression was that Personal Information redacted by the USI had delirium (multi-factorial) and the plan included regular analgesia, oxycodone 1mg subcutaneously 4 hourly, ensure bowels were opening and to avoid any sedation at present. It was noted that Personal Information redacted by the USI should try to keep his oxygen in place and that he would benefit from 1:1 Nursing. This was in place from Personal Information redacted by the USI until the morning of Personal Information redacted by the USI Personal Information redacted by the USI.

On Personal Information redacted by the USI at 03:30 Doctor 12 was asked to see Personal Information redacted by the USI regarding jerking movements of his limbs, clenched fists and legs and tongue biting. The priority was to maintain Personal Information redacted by the USI's airway with head tilt. His RR was 14, SpO2 96% on 100% oxygen. His lungs were clear, chest clear and he had no increased work of breathing. His P was 69 regular, BP 188/80 which was 113/64 when re-checked. His GCS was 3/15 which improved to 7/15. Doctor 12 noted that it was difficult to assess Personal Information redacted by the USI's level of pain. The plan was that if there was any further seizure activity Personal Information redacted by the USI was to be considered for of Keppra (medicine to treat seizures) and that Doctor 12 should be re-contacted if Personal Information redacted by the USI's systolic BP increased over 170 repeatedly.

Personal Information redacted by the USI was reviewed at 06:45 by Doctor 15 (SHO) as he was having a seizure which had resolved by the time she arrived. Personal Information redacted by the USI's RR was 16, SpO2 97% on 15L, P 70 and BP 156/79. His GCS was 7/15 and he was not verbally responsive, with his left eye gazing to left side when eyelid lifted and right eye pointing forward. Personal Information redacted by the USI was drowsy post seizure and his arms were floppy. On examination he was

moving his legs himself, making groaning sounds and flexed away from pain. The impression was that the seizure was secondary to his bleed. At that time [redacted] was very unwell and he was discussed with Doctor 10 who telephoned [redacted]'s step-daughter at 07:55 to provide an update. [redacted] was then seen by Doctor 16 (Consultant Physician) who advised that [redacted] was not for haemodialysis and that no further bloods should be carried out unless there was a significant improvement. Non-essential medications were stopped and the renal team updated. [redacted] was seen by Doctor 17 (Consultant Nephrologist) at 11:30 who ruled out haemodialysis that day.

On [redacted], [redacted] was reviewed by the palliative care team who noted that he was restless and agitated, groaning to touch/movement and appeared sore on moving. It was noted that [redacted]'s step-daughter had requested use of a syringe driver to prevent fluctuating symptoms so the plan was to keep [redacted] comfortable. He was reviewed at 09:35 by Doctor 16 and again by Doctor 18 at 19:55 when there was a query about the syringe driver.

On [redacted] [redacted] was reviewed by Doctor 3 at 09:08 and the family updated. When seen by the palliative care team at 10:00 they noted a deterioration in [redacted]. [redacted] had sadly died when Doctor 19 (FY1) was called to his bedside at 12:55.

13. WHY DID IT HAPPEN?

Patient Factors

The review team understand that [redacted] was a spritely gentleman with a good outlook on life. Up until two days before [redacted] was brought to ED at DHH he had been well and independently mobile and did not require any assistance with the activities of daily living. They understand that on the morning of admission [redacted] was so unwell that he required assistance into the ambulance for his transfer. The review team have noted that [redacted] had a past medical history of [redacted] It was noted in the admission documentation that [redacted] had no previous history of falls.

Task Characteristics

The review team have identified that on the morning of [redacted], [redacted] was unaided when he went to use the bathroom and there is no recollection of him being on portable oxygen whilst mobilising. The nursing staff who were on duty can recollect that [redacted] greeted them on passing the nurses station and he appeared alert and was wearing appropriate footwear. The review team understand that patients who have low oxygen saturations are more susceptible to falls. On reflection nursing staff involved with the care of [redacted] now fully appreciate the importance of patients who have been diagnosed with Covid-19 being accompanied and using portable oxygen when mobilising.

The review team understands that [redacted] had used the toilet before he fell as he could be heard dispensing toilet paper in the area next to the bathroom. A short time later there was a noise from the bathroom and on investigation a staff nurse found that he had fallen. The staff nurse observed that the floor was wet but could not determine if the liquid was water or urine. The review team have been advised that [redacted] experienced a 1 minute loss of consciousness and he came round again by himself prior to the arrival of the medical team. As part of the assessment and examination Doctor 10 queried if [redacted] had suffered a seizure or if he had been incontinent causing a mechanical fall, but as [redacted] was alert and orientated he ruled out a seizure. Doctor 10 though the fall was more likely to have been as a result of [redacted] being hypoxic (deprived of adequate oxygen supply).

Training and Education

The review team are aware that in light of the Covid-19 pandemic, the ward on which Personal Information redacted by the USI was nursed had previously been a Surgical Ward and at the time of Personal Information redacted by the USI's admission nursing staff were caring for medical patients. The review team accept that the nursing staff who were caring for Personal Information redacted by the USI were skilled in and knowledgeable about the management of surgical patients but less so in the management of medical patients. They do understand however that some initial training was provided to nursing staff on the management of Covid-19 patients, but recognise that until the time of Personal Information redacted by the USI's fall staff did not fully appreciate how quickly these patients can desaturate when mobilising without portable oxygen. The review team have emphasised that at the time of Personal Information redacted by the USI's admission staff were dealing with a continuing global pandemic and are mindful of the fact that wards were and can continue to be opened at short notice to cater for an increasing demand. In these circumstances these wards need to have an appropriate skill mix of suitably trained staff.

Environment and Staffing

The review team are aware that Ward [redacted] is an eighteen bedded ward consisting of two, six bedded bays and six side wards (four of which had ensuites). It was identified that Personal Information redacted by the USI was nursed in sideward [redacted] and that the closest bathroom to him would have been 5/6 meters away. On the night in question the ward was staffed by three staff nurses and one healthcare assistant. It is noted that two of the staff nurses were core staff and the remaining staff nurse was employed by the Southern Trust Bank and was familiar with the workings of the ward. It was noted that the healthcare assistant was also one of the ward's core staff.

In terms of the acuity of patients being nursed at the time of Personal Information redacted by the USI's fall, the review team understand there were five confused patients, one of who required all night 1:1 supervision. As a result of this during the shift only one member of staff left the ward for breaks at a time. The review team are satisfied that the ward was adequately staffed.

The review team are mindful that as part of the SAI notification process there was information to report that the bathroom floor was wet, however they could not identify if this contributed to Personal Information redacted by the USI's fall. The review team discussed this with staff members and it was not clear if the wet floor was due to a running tap (which staff turned off on arrival) or if Personal Information redacted by the USI had been incontinent.

Policies and Procedures

The review team have noted that Personal Information redacted by the USI received good clinical care which was in line with best practice guidelines. They have noted that Personal Information redacted by the USI was managed on the appropriate falls pathway post falls and that follow up examinations were comprehensive and care was provided without delay.

Communication and Documentation

The review team have noted that the medical, nursing and allied health professional teams worked well together and had a cohesive approach to Personal Information redacted by the USI's care. It is recognised that communication with other specialities took place in a timely manner and his case was escalated through the medical management structures appropriately. It is noted that the written documentation contained in Personal Information redacted by the USI's notes was to a high standard. The review team have also determined that the family were kept fully up to date in relation to Personal Information redacted by the USI's prognosis and management plan.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

The review team have determined that there were two causative factors in Personal Information redacted by the USI's death, the first being Covid-19 and the second being an intracerebral bleed for which Personal Information redacted by the USI received appropriate treatment and care.

The review team have learned at the time of Personal Information redacted by the USI's admission there was not an in-depth appreciation of how quickly Covid-19 patients could desaturate whilst mobilising in the absence of portable oxygen.

The Clinical staff involved are now aware of the very rapid speed with which Covid patients can desaturate.

Whilst the outcome for Personal Information redacted by the USI and his family has been devastating the review team feel that the quality of care given to him at admission and after his fall was of a high standard.

Staff and Family Engagement

The review team wishes to highlight that the members of staff from whom statements have been taken, as part of this review, have been co-operative and extremely open and honest which the review team have appreciated. The review team wish to note that it is clear from the conversations which have taken place that staff have reflected on this incident, learned from it and put in place a number of changes to their practice with regard to the management of Covid-19 patients.

The review team wish also to highlight the constructive and understanding attitude of Personal Information redacted by the USI's family throughout the review process and for their patience whilst awaiting production of the report.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

1. Each ward with Covid patients has now been supplied with a number of rollators which can accommodate portable oxygen cylinders for those patients are deemed fit to be mobilising.

2. In addition for those patients that require oxygen on mobilisation, their requirement is notified on the whiteboard above each patient's bed.

16. RECOMMENDATIONS (please state by whom and timescale)

Each member of the multidisciplinary team involved in caring for patients with Covid should be made aware of:

(i) the speed with which Covid patients can desaturate during mobilization and
(ii) the need for oxygen to be available during mobilization and at a level indicated on the whiteboard above each patient's bed.

This information should be shared via a variety of mechanisms, as follows:

1. The Consultant responsible for Personal Information redacted by the USI's care will discuss this case and learning from this review at the Medical Morbidity and Mortality Meeting. This should take place within 8 weeks of the report's publication and should include cascading this learning to all doctors within the Trust.

2. The Ward Sister of the ward Personal Information redacted by the USI was nursed on will share the experience of staff and the learning from this report at the Joint Sister's (both sites CAH & DHH) meeting. This should take

place within 8 weeks of the report's publication and should include cascading this learning to ward level. 3. This report will also be discussed at the Lead Nurse Forum. This should take place within 8 weeks of the report's publication.
17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA: The SHSCT's representative on the Regional Falls Prevention Group will provide a summary of this incident and its learning outcomes to the next meeting of group for shared learning.
18. FURTHER REVIEW REQUIRED? YES / NO Please select as appropriate If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME:	**24.** DATE APPROVED:
25. DESIGANTION:	

SECTION 6

Personal Information redacted by

26. DISTRIBUTION LIST:

Personal Information redacted by the USI's family
The Health and Social Care Board
The Director of Acute Services
The Executive Director of Nursing
All Assistant Directors of Acute Services
The Head of Service for Acute Allied Health Professionals
The staff involved with Personal Information redacted by the USI's care

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2				
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) ***(complete this section for all death related SAIs)***				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

Family Engagement; Questions submitted

Was [redacted] confined to bed before his fall or was he able to get up on his own?
The review team understand that prior to his fall [redacted] was mobile on the ward and had not been confined to bed.

Why did the RVH not accept [redacted] for treatment?
The review team have been advised that following the verbal report of the CT scan Doctor 11 telephoned neurosurgery and that on the basis of [redacted]'s co-morbidities he was not for intervention/surgery as the risk would have been too high. Doctor 11 was advised to treat [redacted] conservatively and administer tranexamic acid to stop his bleed and cease [redacted]'s blood thinning medication to prevent a further bleed.

Should [redacted] have been allowed to mobilise to the bathroom? Should the nurse have directed him back to bed?
The review team are sorry that [redacted] mobilised to the bathroom unaided. The Ward Sister has reported that [redacted] appeared to be an able gentleman and was independent. All staff involved have openly acknowledged that they have had a huge learning curve with the management of respiratory patients. The Ward Sister advises that on reflection, and since this incident staff, would be expected to stop any patient who was mobilising without oxygen and return them to their bed space. Staff are regretful that they did not appreciate the effect of a patient desaturating so quickly and if similar circumstances presented themselves now staff would be better equipped to deal with them.

Did [redacted] lose consciousness?
It is noted that [redacted] experienced a 1 minute loss of consciousness.

Are falls mats available and should one have been used?
The review team understand that falls mats are available, however as [redacted] was mobile the use of one would not have been necessary.

Had [redacted] been sedated prior to the fall?
The review team understand that [redacted] had not been sedated.

Would [redacted] have recovered from his Covid-19 diagnosis if he had not have experienced a fall?
The review team are advised that it is felt that [redacted]'s Covid was so severe that even if he had not had the fall he would not have survived. It is understood that if a dialysis patient contracted covid-19 they would be at an increased risk of death.

If Personal Information redacted by the USI would have had dialysis earlier would it have helped him?

It is the understanding of the review team that Doctor 4 had taken over the care of Personal Information redacted by the USI in Personal Information redacted by the USI and he had two virtual consultations with him before calling him to clinic in Personal Information redacted by the USI when dialysis was discussed. It is noted at that time Personal Information redacted by the USI's eGFR (test to measure level of kidney function and determine stage of kidney disease) was 6 and that this would have been the point for starting a patient on dialysis, however as Personal Information redacted by the USI appeared well, and after discussion with Personal Information redacted by the USI, a decision was made to defer. The review team cannot conclude if dialysis had been started any earlier that the outcome would have been different.

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	**4. DATE OF INCIDENT/ EVENT:** Personal Information redacted by
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:**

7. DATE OF SEA MEETING / INCIDENT DEBRIEF:

8. SUMMARY OF EVENT:

On Personal Information redacted by the USI Personal Information redacted had a planned admission for a laparotomy for end colostomy. Following laparotomy it was noted Personal Information redacted had no stoma output and was therefore treated with laxatives. Personal Information redacted's condition deteriorated on the ward and he experienced abdominal pain and breathlessness. On Personal Information redacted by the USI Personal Information redacted, day 4 post procedure, Personal Information redacted by the USI returned to theatre for emergency surgery. The operation notes document that the distal end of the colon had been brought out as the end stoma. Following Personal Information redacted's second procedure he had a planned admission for post-operative support and care. Personal Information redacted was extubated on Personal Information redacted by the USI and was able to return to a general ward for nursing care on Personal Information redacted by the USI and remained there until he was fit for discharge on Personal Information redacted by the USI.

SECTION 2

9. SEA LEAD OFFICER: Mr Ted McNaboe, (Chair) Consultant ENT Surgeon	**10. TEAM MEMBERS PRESENT:** Mr David Mark, Consultant Surgeon Mrs Carly Connolly, Clinical Governance Manager

11. SERVICE USER DETAILS:

DOB: Personal Information redacted by the USI. GENDER: M AGE: Personal Information redacted

12. WHAT HAPPENED?

Personal Information redacted was admitted to theatre 3 at CAH on Personal Information redacted by the USI for formation of end colostomy which was carried out by Doctors 1 (Specialty Registrar) and 2 (Consultant Surgeon) who were assisted by Doctor 3 (FY2). The indication for the procedure was for the management of an atonic colon secondary to cauda equina symptoms caused by a spinal dermoid tumour. His midline laparotomy was carried out under general anaesthetic and there was a 10cm colonic resection at the site of the stoma. It was noted that the proximal end was delivered to the pre marked site and the procedure was completed.

The plan was for [redacted] to take 2 laxido sachets twice a day, eat and drink as able and the stoma nurse was to review the following day. At 14:40 [redacted] was transferred to the recovery ward and it was noted that the wound site was dry and the stoma was pink. He was transferred back to the ward at 16:15 when his National Early Warning Score (NEWS this is a score to detect early deterioration in a patient a low score is normal) was 0.

That evening nursing staff noted [redacted]'s catheter was draining freely and he slept for long periods during the night. His stoma was healthy/pinkish with a minimal amount of blood output.

[redacted] was seen on [redacted] at 08:15 by Doctor 1. On examination of the abdomen the stoma was noted to be slightly oedematous and no stoma output was noted. [redacted]'s NEWS was 2 and he appeared to be comfortable. The plan was for a stoma nurse review that day and for [redacted] to be mobilised. He was subsequently reviewed by the pain nurse, a physiotherapist and the stoma nurse who noted there was haemo-serous fluid in the pouch. At 11:46 his NEWS was 0 and he was not in any pain and tolerating fluids and food as normal.

At 15:15 [redacted]'s bloods were reviewed and a note made that these should be repeated the following day. At 21:00 [redacted] reported mild pain.

On [redacted] the nursing notes document at 03:10 that [redacted] had wound site pain. He was reviewed at 08:10 by Doctor 1 and Doctor 4 (Speciality Registrar) who noted that [redacted] had been unwell overnight with abdominal pain and distension. There was an area of redness around the stoma site extending into the back with query bruising. Doctor 4 noted that [redacted] had eaten breakfast and there was no stoma output as yet. The plan was for glycerine to be put into the stoma and a stoma nurse review was required. [redacted] was subsequently seen by the physiotherapist, the stoma nurse and the pain nurse. At 13:55 [redacted]'s bloods were reviewed.

At 06:00 on [redacted] it is documented in the nursing notes that [redacted] was complaining of abdominal and back pain. There was still no output from his stoma and by 06:30 [redacted] felt more unwell. His NEWS was 5 and he was administered 10mls lactulose. [redacted] was seen by Doctor 5 (FY1) who noted that [redacted] was day 3 post formation of end colostomy. She noted that [redacted] had a pressure feeling in his lower abdomen and he was tender in the lower abdomen. [redacted] had no guarding and bowel sounds were present. It was noted that the stoma was passing blood stained liquid. The wound was observed and it was noted that there was no redness, very minimal blood oozing and a bladder scan revealed 200mls of residual urine. [redacted]'s catheter was draining. [redacted] was discussed with the surgical SHO and the plan was for an abdominal x-ray, pain relief and for the rechecking of observations. When Doctor 5 was leaving the bedside [redacted]'s NEWS had improved to 1.

At 08:30 [redacted] was seen by the stoma nurse who conducted a digital examination of the stoma which noted there were no faeces. He was subsequently seen by the physiotherapist and at 12:30 had an abdominal x-ray which noted "gaseous distension of transverse colon and right colon and faecal loading" in layman's terms the dilation of the large bowel with faecal loading.

At 18:40 [redacted]'s NEWS were 3 and the FY1 doctor was contacted for the results of the blood cultures. At 19:30 nursing staff noted [redacted] pulse (P) 146 and a temperature (T) of 38.5^{O}C. They contacted Doctor 6 (Specialist Registrar) who subsequently reviewed [redacted] at 21:30. Doctor 6 noted that [redacted]'s abdomen was tender and distended and there was guarding above the stoma site. The wound was clear, however the stoma was not working. Doctor 6's plan was for a CT of the abdomen and pelvis, intravenous (IV) Tazocin (an antibiotic), IV fluids, blood cultures, routine bloods and a troponin test (to exclude heart attack).

At 23:45 Personal Information was reviewed by Doctor 7 (FY1) and Doctor 8 (Grade) who had received a telephone call from the reporting radiologist to advise, “dilated proximal large bowel with a staple line traversing the mid sigmoid colon causing complete mechanical obstruction. The distal sigmoid appears to have been brought out to the left lower quadrant.” In other words the wrong end of the colon had been brought up as a stoma.

Personal Information observations were noted as P 110, BP 157/82, RR 22, SpO_2 96% and T 38.0ºC. His white cell count (WCC) was 15, c reactive protein (CRP) 75 (bloods to indicate inflammation/ infection were slightly elevated) and the plan was for nil by mouth, IV fluids and a discussion with the radiologist in the morning.

Personal Information was seen at 01:40 by Doctor 9 (FY1) as his NEWS had increased to 7. Doctor 9 consulted with the SHO who advised there was no plan for theatre unless Personal Information became peritonitic (increased abdominal pain and tenderness). The plan was for 5mg shortec (analgesia) and then 10mg shortec when it was next due and to re-discuss if there were any further concerns.

Doctor 10 (Specialty Registrar) was asked to see Personal Information at 08:55 as he had been increasingly unwell over the previous 14 hours. His case was discussed with Doctor 11 (Consultant Surgeon) who advised that Personal Information should proceed to laparotomy. Doctor 11 subsequently carried out the re-laparotomy and fashioning of end colostomy.

Following the second procedure Personal Information required an ICU admission for post-operative care. He was extubated on Personal Information redacted by the USI and was able to return to the general ward the following day where he was nursed until his discharge home on Personal Information redacted by the USI.

13. WHY DID IT HAPPEN?

Patient Factors

The review team have noted that Personal Information is a Personal Information redacted by the USI old gentleman who has a history of Personal Information redacted by the USI and had lost control of his bladder and rectum. Personal Information was also living with chronic constipation. It is documented that Personal Information has a high BMI and experienced hypertension.

Task Characteristics

The review team understand the task identified was the formation of an end colostomy. They are mindful that this type procedure is uncommon but has well recognised complications.

The review team have noted a number of literature reviews relating to this subject area, the first being published by the Pennsylvania Patient Safety Authority (September 2016) – Incorrect End Colostomy Formation using the Distal Bowel Limb: A Rare but Serious Complication and the second; Which End is Which? published by Andre R Campbell, MD, Associate Professor of Surgery, University of California, (April 2003).

The review team understand that it can be common for patients who have this procedure to not have any stoma output for up to 2 – 3 days. In Personal Information’s case the review team have deemed it appropriate that when Personal Information’s NEWS increased on day 3 that further investigations were carried out.

In Personal Information’s case the clinicians who carried out the first laparotomy have accepted that the distal end of the colon had been brought out as the end stoma rather than the proximal end and the staple line created was causing an obstruction. The review team are aware that in patients such as Personal Information, the colon can become elongated with the formation of multiple loops. When this occurs there is a limited access and

a limited view of the colon which increases the risk of the clinician undertaking the task becoming disorientated. The review team have been advised that Personal Information had an excessively long colon and when the surgical incision was made Personal Information's bowel came out from his abdominal cavity freely. It is also noted that Personal Information's colon was loaded with significant faecal material as a result of the paralysis of his bowel. The review team are mindful that in patients with an above average BMI the procedure is more technically challenging.

It is understood that the importance of checking is always discussed whilst the procedure is underway and this took place when Personal Information's case was underway. The current advice is that a check should be carried out multiple times and if there is any doubt as to which end of the bowel is being brought out, a consultation should take place with a colleague. The review team have clarified that on table checks took place, although this is not documented in the notes. Given that the on table checks were carried out it was felt that a second opinion from another colleague was not required.

The review team are aware the majority of patients who require to have a second surgery, will have a high likelihood of requiring a placement in either high dependency or the intensive care unit.

The review team have also looked at the task of taking Personal Information back to theatre following the result of the CT scan carried out on Personal Information redacted by the USI. They understand that Doctor 8 attended the ward to review Personal Information in person following receipt of the CT scan report. They have noted Doctor 8's plan for fluids and antibiotics with a follow up contrast study. The review team accepts that it would not have been an easy decision for Doctor 8 to make regarding a return to theatre in the early hours of the morning.

Support from Central Functions

The review team have identified that the CT scan which confirmed Personal Information's distal end of the colon had been brought out as the end stoma was reported on by an independent sector provider (ISP). Whilst in the case of Personal Information the report of the scan was correct, the review team have identified that the reporting of scans by this ISP has been variable in the past which has resulted in clinicians treating those reports with caution. In Personal Information's case the review team understand that those caring for Personal Information on the night in question would have relied more on the skill of the surgical team carrying out the first operation rather than the findings of the CT report. They are mindful that had the report been reported by an in-house radiologist the findings of it may have prompted more urgent discussions about the way forward. The review team note that ISP's do not have access to previous imaging so do not have the ability to compare and contrast and nor do they have access to the Northern Ireland Electronic Care Record (NIECR) so that they can view clinical information.

The review team understand not all attending clinical teams would be aware that if a report from an ISP is not consistent with the clinical presentation or if specific questions noted on the request form have not been answered, they can contact the ISP for follow up discussions.

Supervision and Leadership

The review team acknowledge that Doctor 2 is a highly experienced and skilled clinician who was aware of the well recognised complications of this procedure and have ascertained these were being discussed in theatre at the time of the procedure taking place. The review team understands that at no time was Doctor 1 left unsupervised in theatre.

Communication

The review team understand that when Doctor 8 reviewed Personal Information on the evening of Personal Information redacted by the USI, he attempted to contact the Consultant on Call between 00:30 and 00:45 without success. At handover

the following morning, Doctor 8 ensured that Personal Information was the first patient who was discussed and the plan for contrast studies versus return to theatre was debated. The review team are satisfied that Doctor 8 was sufficiently concerned for Personal Information that he was the first patient discussed at handover.

The review team understands that Doctor 2 saw Personal Information on the morning of Personal Information Personal Information redacted by the USI and note the family have asked why Doctor 2 did not come to review Personal Information following the second procedure. Doctor 2 was not on duty again until Personal Information redacted by the USI when he was advised of Personal Information's circumstances and it was at this point he made arrangements to speak directly to Personal Information.

Family Engagement

As part of the family engagement process, which was at a meeting with Personal Information, concerns about the quantity of communication with the family have been noted. The review team have reviewed the medical documentation and can ascertain that Personal Information's wife was contacted on the morning before the second procedure and then after the second procedure was complete. The review team understand that the arrangement put in place after the second procedure was that Personal Information's wife would be contacted with a daily update however it would appear that Personal Information's family usually initiated contact with ICU before the pre-planned communication was due to take place.

The review team are mindful of the fact that when Personal Information was a patient in ICU it was at the time of the second Covid-19 surge. At this time the ICU was under extreme pressure and the ability to communicate would have been challenging and restricted access for families made face to face discussions impractical. The review team accept that this could have led to families becoming anxious and dissatisfied with access to information which they were seeking.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

The review team have determined that the bringing out of the wrong end of the colon is an uncommon but recognised complication of this type of procedure. The risk is greater in patients with a de-functioning stoma rather than a procedure where a large section of the distal bowel is being removed (in cases of colon cancer), those with a high BMI, with long redundant colons and when done through small incisions or laparoscopically.

The review team have identified that the reduced confidence in the quality and reliability of reporting by ISP's can impact on clinical decision making.

The review team have concluded that whilst there was a 12 hour delay in taking Personal Information back to theatre for his corrective procedure, he did not come to any harm during this period. However if the result of the scan would have been acted upon, Personal Information's out of hours treatment would have been different but this would not have changed his outcome.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

Personal Information case has been discussed at the Surgical Patient Safety Meeting.

The review team understands there are several suggested methods to try to prevent this from happening including instillation of fluid into the bowel to see if it comes out from the anus or performing an on table camera test into the bowel via the back passage to see if the bowel distends upwards.

16. RECOMMENDATIONS (please state by whom and timescale)

1. The recognised complications of a de-functioning stoma including the rare event of an incorrect end stoma formation should be mentioned and documented in the consent process.

2. All patients who are having a de-functioning stoma should have an on table camera test.

3. Any discrepancies between a patient's clinical presentation and results from an ISP should be discussed firstly with the ISP involved and then secondly with the on-call radiologist for a second opinion if any concerns remain.

4. The recognised complications of a de-functioning stoma should be mentioned and documented in the consent process.

5. Written information should be provided to the relatives of ICU patients which outlines how communication will take place and at what intervals.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

18. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A <u>FURTHER REVIEW IS</u> REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:

22. TERMS OF REFERENCE *(If known or submit asap)*:

SECTION 5

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME:	**24.** DATE APPROVED:
25. DESIGANTION:	

SECTION 6
26. DISTRIBUTION LIST:

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)***				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2				
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) ***(complete this section for all death related SAIs)***				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

Service User or their nominated representative

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: 26.10.2019

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: (F) Age: [redacted](yrs)

Responsible Lead Officer: Mr Eamon Mackle Consultant Surgeon

Designation: Chair

Report Author: The Review Team

Date report signed off:

Date submitted to HSCB:

[redacted]

1.0 EXECUTIVE SUMMARY

Personal Information redacted is a Personal Information redacted by the USI old female patient who was passenger in fatal road traffic collision and was brought in by ambulance to Craigavon Area Hospital (CAH) Emergency Department (ED).Following medical review it was noted Personal Information redacted's abdomen was tender with frank hematuria on catheter insertion and hypotensive, there was an obvious right femur fracture. A CT scan was carried out which confirmed extensive bilateral lung contusions, bilateral renal lacerations, possible splenic laceration and multiple pelvic fractures with associated distraction injury to the left SI joint.

Personal Information redacted was reviewed by the surgical team who contacted RVH Orthopaedic surgeon and ICU Consultant On Call. The ICU consultant agreed to accept Personal Information redacted to RVH theatre for interventional/ radiology management. The ICU Consultant advised Personal Information redacted should have an ICU review prior to transfer and to re-contact them.

An anesthetist in SHSCT reviewed Personal Information redacted and advised an anaesthetist chaperone was not required, if Personal Information redacted became unstable prior to transfer to re-contact the anesthetist. Personal Information redacted was subsequently transferred to RVH via ambulance with no anesthetist/ doctor present. On arrival to RVH NIAS were informed the RVH were not aware of the Personal Information redacted's transfer.

Mr Eamon Mackle Consultant Surgeon
Dr Elli McCormick Emergency Department Consultant
Mrs Carly Connolly- Clinical Governance Manager
Mr Mark Cochrane- Northern Ireland Ambulance Service
Mr Jim Ballard - RVH

3.0 SAI REVIEW TERMS OF REFERENCE

- To carry out a review in the care provided to Personal Information redacted, using a Root Cause Analysis (RCA) Methodology.
- To use a multidisciplinary team approach to the review.
- To provide an agreed chronology based on documented evidence and staff accounts of events
- To identify the key contributory factors which may have had an influence or contributed to Personal Information redacted's treatment and care.
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report.
- To liaise with the family and facilitate them to contribute to the review .
- To report the findings and the recommendations of the review through the Director of Acute Services SHSCT and to disseminate to the staff associated with the care and with Personal Information redacted.

4.0 REVIEW METHODOLOGY

Patients ED and Medical health records
Northern Ireland Electronic Care Record
NIAS records
Family's questions and account
Policies and Procedures

5.0 DESCRIPTION OF INCIDENT/CASE

On the Personal Information redacted by the USI at 05:32 Personal Information redacted was brought to Craigavon Area Hospital (CAH) Emergency Department (ED) by ambulance. There was a standby call received from Northern Ireland Ambulance (NIAS) for a Personal Information redacted by the USI old female passenger involved in a road traffic collision. It was noted the passenger was not wearing a seat belt and that the car collided head on with a wall. ED staff were informed Personal Information redacted had an obvious deformity to her right femur and that she had a reduced GCS score of 14/15. It was noted Personal Information redacted had alcohol on board. The trauma team was on standby awaiting Personal Information redacted's arrival.

Personal Information redacted was triaged at 05:35 by triage nurse 1.Observations recorded were pulse 134bpm, respiratory rate 20, and temperature 36.3°c.

Personal Information redacted was reviewed by the trauma team on arrival. Doctor 1 (anaesthetist ST4) and doctor 2 (surgical ST3).

Doctor 1 noted that Personal Information redacted was an unrestrained back seat passenger in a one car vehicle collision with a wall. It was noted Personal Information redacted had alcohol on board and that there was Personal Information redacted by the USI in the same car. Doctor 1 noted Personal Information redacted had no past medical history and no medication history, no known drug allergies and was up to date with vaccinations. On examination it was noted Personal Information redacted was c spine immobilised and her airway was patent. Personal Information redacted had no chest wall tenderness and had equal movement bilaterally, stats were 98%. Doctor 1 documented there was no major external hemorrhage and that Personal Information redacted had a deformed right femur. Dorsalis Pedis (DP) and Posterior Tibial (TP) pulses (foot pulses) were present. It was noted Personal Information redacted was hypotensive on arrival with a systolic blood pressure of 75. Personal Information redacted's abdomen was noted to be soft non tender but that Personal Information redacted complained of pain supra-pubically. It was documented Personal Information redacted was catheterised and that there was blood from the catheter. Doctor 1 documented Personal Information redacted's GCS score was 14/15 and there were no obvious neurological symptoms present. On log roll it was documented there was no spinal tenderness midline and a pelvic binder was applied.

Doctor 1 documented an impression of a major trauma fracture to right femur and queried a bladder injury. Doctor 1's plan was for Intravenous (IV) access by 2; 2 by O negative; catheterise; and a Thomas splint and analgesia (pain relief).

At 07:05 Personal Information redacted was reviewed by the anesthetics team doctors 3, 4 and 5. It was documented they were present on Personal Information redacted's arrival to Resus. On arrival Personal Information redacted's airway was noted to be patent, Spo2 98% on room air (RA) and her chest was clear, blood

Personal Information redacted

5.0 DESCRIPTION OF INCIDENT/CASE

pressure (BP) was 75/40, and heart rate (HR) was 111bpm. It was noted [redacted] was cold peripherally, [redacted]'s GCS score was 14/15 and that she was in pain. [redacted]'s pupils were noted to be reactive. It was documented [redacted] had no obvious head injury. [redacted] was logged rolled off vacuum pack, triple immobilisation c-spine. Intravenous Ketamine was given for pain relief for the log roll and splint application to the right leg. It was documented [redacted] had frank hematuria in her catheter. A Bair Hugger blanket was applied and 2 units of O negative blood was transfused. Following transfusion it was documented [redacted]'s BP was recorded as 115/57 and HR was 110 -107bpm. It was documented [redacted] was accompanied to the computer tomography (CT) scanner with full monitoring throughout and full c spine precautions. It was noted the transfer to the CT scan was uneventful.

At 07:45 [redacted] was reviewed by doctor 6 (ST6). Doctor 6 revisited and noted [redacted]'s history. On examination doctor 6 documented [redacted]'s observations HR 130bpm; BP 75/59. On examination it was documented [redacted] had lower abdominal tenderness and right sided tenderness. Superficial abrasions were noted on the right upper quadrant area. Doctor 6 noted [redacted] was catheterised and there was frank hematuria present, and that the log roll revealed no c-spine tenderness. It was documented bloods were done, and Transexamic Acid given along with 2 units of blood and a pan scan arranged. Doctor 6 noted the CT scan results documenting fluid around the liver (not obviously hemorrhagic), query small splenic laceration, small laceration lower left kidney and multiple severe pelvic fractures. Doctor 6 documented [redacted]'s blood results. Doctor 6 re-examined [redacted] and noted her abdomen remained soft and tender on her right side and lower abdomen, similar to previous examinations. It was documented [redacted] was hemodynamically stable. Doctor 6's plan was for general surgery to observe and orthopedics to manage [redacted]'s pelvis and fractured limb.

At 09:30 [redacted] was reviewed by doctor 7 (Core Trainee CT2). Doctor 7 noted a discussion between doctor 9 and radiology, a splenic laceration with active bleeding was queried. A plan was made for a CT angiogram and if there was nil active to transfer [redacted] to RVH. Doctor 7 noted that on re-review a plan was made for interventional radiology in RVH.

[redacted] was reviewed by doctor 1 (ST4 no time recorded). Doctor 1 documented that following PAN scan [redacted]'s systolic BP lowered to 85. Doctor 1 requested a further unit of packed red cells (PRC) from the blood bank. Doctor 1 documented orthopedics were re-contacted to review [redacted]. Doctor 1 contacted High Dependency Unit (HDU) /Intensive Care Unit (ICU) and spoke to doctor 7 (Dr George) for referral.

Doctor 1 documented the result of the CT PAN scan as extensive bilateral lung contusions; possible splenic laceration; bilateral renal lacerations, predominately in the left lower pole; multiple pelvic fractures with associated distraction injury to the left SI joint, fracture of right femur. Doctor 1 documented the orthopedic team was discussing [redacted] with Belfast hospital with a query for transfer. Doctor 1 re-contacted the surgical team for a review, and was advised a CT angiogram of abdomen and pelvis to be performed. Doctor 1 documented in the notes that given [redacted]'s hemodynamically concern was theatre or CT angiogram the best course of action. Doctor 1 documented a telephone call from Doctor 9 (radiologist) who expressed concerns for the delay. Doctor 1 advised doctor 9 of the multiple team discussions ongoing about [redacted]'s care and management. Doctor 1 documented [redacted]'s BP

[redacted]

5.0 DESCRIPTION OF INCIDENT/CASE

responded to PRC bolus.

At 10:15 Personal Information redacted was reviewed by doctor 10 (ST5 Orthopaedics). Doctor 10 documented Personal Information redacted was discussed with Orthopedic Consultant in RVH who kindly accepted Personal Information redacted to RVH. It was agreed Personal Information redacted required stabilisation and high dependency review prior to transfer for inpatient review in RVH.

At 10:40 Personal Information redacted was reviewed by consultant intensivist doctor 12. Doctor 12 documented Personal Information redacted by the HSCI was awake and alert, her airway was patent, upper wheeze was noted, pulse 125bpm, BP 96/60, RR 14/min; GCS 15/15. Doctor 12 documented Personal Information redacted by the HSCI had multiple injuries and needed definitive management. Doctor 12 noted Personal Information redacted was stable for emergency transfer and that there was no requirement for an anesthetist escort.

Personal Information redacted was reviewed by consultant anesthetist doctor 13 (ST5) (no time recorded). Dr 13 noted Personal Information redacted's history and current plan for transfer to RVH for intervention radiology. HR was documented 122bpm; BP 99/73mm, Sp02 99% on RA. Doctor 13 documented he discussed with his anesthetic colleagues and documented there was no need for an anesthetic transfer and advised staff to contact him should Personal Information redacted deteriorate prior to transfer.

At 10:45 ED notes document Personal Information redacted was transferred to RVH theatres for interventional and radiology care and management.

6.0 FINDINGS

Patient factors

The review team acknowledge this was a serious single vehicle road traffic collision involving [redacted] was a [redacted] old unrestrained back seat passenger at the time of the road traffic collusion. At the time NIAS assessed [redacted] and it was understood the extent of [redacted]'s injuries was a fractured right femur and a decision was made to transfer to CAH. [redacted]'s GCS score was reported as 14/15 however it was noted [redacted] had consumed alcohol prior to the crash.

Policies and Procedures

As part of the review the review team have reviewed [redacted]'s NIAS and ED medical notes along with current policies and procedures, in this case the Northern Ireland Major Trauma Network Call and Send procedure. The Call and Send procedure takes into account the patient's best interests and as such ensures patients are transferred directly to the Major Trauma Centre (MTC) which accommodates a range of diagnostic, critical care and specialist surgical facilities. Direct triage of patients with major or significant trauma to the MTC reduces the delay in arrival for definitive care and supports an improved outcome and survival. The review team have determined this procedure should have been implemented in CAHED Resus.

NIAS

The review team deliberated on whether [redacted] should have been brought to the RVH Major Trauma Centre directly from the scene of the accident. It was acknowledged that this was a high impact collision, with [redacted] bypassed CAH and was transferred directly to the RVH. The review team acknowledge NIAS have recently introduced a procedure to assist paramedics in their decision making for transfer to the Major Trauma Centre. The Northern Ireland (NI) Major Trauma Network Trauma Triage Tool Guidance was introduced in October 2020. The review team reviewed the procedure and determined had this been available at the time consideration may have been given for transfer to the Major Trauma Centre. The review team acknowledged there was [redacted] at the time. [redacted] was haemodynamically stable at the scene and the review team considered [redacted]'s clinical presentation did not warrant transfer to the Major Trauma Centre. The review team therefore determined [redacted] was appropriately transferred to CAHED with a transfer time of less than 45 minutes and a standby call was appropriately made.

6.0 FINDINGS

ED

The review team reviewed the ED medical notes and acknowledge a trauma team was awaiting [redacted]'s arrival. A full examination was appropriately completed and following this an impression of major trauma was made. [redacted] had an obvious fractured right femur and doctors queried if [redacted] had a bladder injury. [redacted] complained of pain in the supra-pubic area and following catheterisation haematuria was noted. The review team note CAH doctors made every effort to transfer [redacted] to Belfast for definitive treatment, multiple conversations documented between CAH doctors and Belfast evidenced this. The review team determined there was a significant delay before transfer to RVH.

The review team recognise the Northern Ireland Major Trauma Network have a call and send procedure and determined this protocol should have been activated following initial review in the ED when an impression of major trauma was made. The review team determined that had this been initiated from the onset there would not have been a delay or confusion about where to transfer. The review team acknowledge [redacted] was reviewed by anaesthetics prior to transfer and was noted to be haemodynamically stable at the time, following discussions a decision to transfer without an anaesthetist present was appropriate. NIAS have confirmed there were no issues during the transfer to the RVH.

Communication

The review team note there was a significant delay before transfer to RVH. The review team are conscious communication between specialities can be challenging especially between different Trusts. The review team are conscious that on [redacted]'s arrival to RVH theatre there was no standby team. As part of the SAI review the Governance team met with [redacted]'s mother and sister and they highlighted how distressing this was for them recounting [redacted] deteriorated after her arrival at the RVH. After a period of time a medical team arrived. [redacted]'s family have asked the question as to why there was no standby team? The review team determined [redacted] was indeed accepted by the RVH however a breakdown in communication on transfer location had evidently occurred. The review team determined that had the Call and Send protocol been initiated this would have prevented confusion on transfer location and [redacted] would have been transferred directly to the RVH ED Resus where a standby team would have been waiting.

7.0 CONCLUSIONS

The review team determined the Call and Send procedure for major trauma cases should have been initiated immediately on Personal Information redacted's arrival to CAH ED Resus. Direct triage of patients with major or significant trauma to the MTC reduces the delay in arrival for definitive care and supports an improved outcome and survival.

8.0 LESSONS LEARNED

The review team acknowledge further education is required for both ED and Surgical staff in relation to the Northern Ireland Major Trauma Network Call and Send protocol.

9.0 RECOMMENDATIONS AND ACTION PLANNING

- The report will be shared with staff involved for learning.
- The report will be presented at ED, Surgical and Anaesthetics Mortality and Morbidity (M&M) meetings for learning.
- The report will be shared with NIAS for learning.
- The report will be shared with The Major Trauma Network for shared learning.

10.0 DISTRIBUTION LIST

Personal Information redacted and family

The review team

The Health and Social Care Board.

Staff involved in Personal Information's treatment and care.

Director for Medicine and Unscheduled care

Associate Medical Director for Medicine and Unscheduled Care

Assistant Director for Medicine and Unscheduled Care

Director for Emergency Medicine
Head of Medicine and Unscheduled care.
Chair of Emergency Medicine Morbidity and Mortality meetings.
NIAS
Major Trauma Network Lead
RVH

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report for all levels of SAI reviews)

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ***If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed (***if you select this option please also complete 'I' below***)			
	d) No contact or Next of Kin or Unable to contact			

[1]*Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

Continued overleaf	**e)** No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**

Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONER'S OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)

(complete this section for all death related SAIs)

1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1]*Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

Southern Health and Social Care Trust

Clinical Audit Summary Report to Acute Directorate Clinical Governance Meeting, 4th May 2021

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
1	IV Fluids in children and Young People:	ADs		Continuous	Cases have been reviewed as below. Appendix 1 - Acute PIVFAIT_chart compli The RQIA funded Point Prevalence Audit to analyse Trust compliance with Guideline 29 has now progressed with preliminary meetings held with RQIA and the project team.	Data to be shared at the next Hyponatraemia Oversight Group meeting Acute Directorate to run a monthly information request to identify 14/15 year olds in Acute wards Acute Directorate to ensure all wards accepting 14/15 year olds send return to Clinical Audit. Outstanding cases to be reviewed with Sr Sherry / nominated staff.
2	Clinical Audit work programme, Acute Directorate	All	Operational teams		Directorate's clinical audit work programme attached. Database Clinical Audit Acute as at 29	For information.
3	HQIP reports	All	Operational teams		HQIP reports have been disseminated and to be shared or disseminated within your structures please for learning that informs improvement plans and future audit.	For information.

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
4	NCEPOD Dysphagia in people with Parkinson's Disease study	C McGoldrick	R Haffey	Data submitted Data submitted	NCEPOD are undertaking a study to look at the care of patients with Parkinson's Disease (PD) who are admitted to hospital when acutely unwell. Patient identification spreadsheet submitted to NCEPOD following approval. Case note extract and clinical questionnaires selected by NCEPOD have been forwarded to NCEPOD. Organisational questionnaires completed and submitted for Craigavon, Daisy Hill, Lurgan and South Tyrone Hospitals. The report is due for publication in the summer of 2021.	Await report
5	NCEPOD Acute Heart Failure Audit	Mrs K Carroll	Dr A Gray / nominee	To be advised	Report has been disseminated November 2018. Recommendation in the Report: Hospitals should audit against the standards contained in the final reports annually. Information request submitted re all adult patients admitted with diagnosis of Heart Failure from 1st April 19 to 31st March 2020. Kay Carroll to complete template with Dr Gray.	Kay Carroll to complete template with Dr Gray. Information request also submitted.
6	NCEPOD: Physical Healthcare of Inpatients in a Mental Health Hospital	All	R Haffey	26/03/2021 07/05/2021	• Organisational Questionnaire dissemination - Trust-Level" questionnaire for each Mental Health Trust/ Health & Social Care Trust/ Local Health Board. – submitted • 7 Clinician questionnaires to be completed via online link by Mental Health Consultants / 7 case note extracts requested	Clinical and organisational Questionnaires to be completed by MHLD
7	NCEPOD: Alcohol Related Liver Disease	All	R Haffey	30/06/2021	Organisational questionnaires to be assigned for CAH and DHH. Completion of these via online link. Mrs McVey to liaise with Dr P Murphy re nomination to complete.	Organisational Questionnaires to be completed. **Nominee to be identified by Acute to complete these.**

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
8	NCEPOD: Epilepsy	All	R Haffey		NCEPOD is undertaking a study to investigate variation and remediable factors in the processes of care of patients presenting to hospital following an epileptic seizure • Adult patients (aged 18 and over) who presented to hospital following a seizure between 1st January 2020 - 31st December 2020 and had a pre-existing epilepsy disorder or were undiagnosed at the time of the seizure and subsequently diagnosed with epilepsy. Patients discharged from the emergency department and those admitted to hospital will be included • Retrospective study period: **1st January 2020 and 31st December 2020 inclusive** • **Exclusions:** □ Patients under the age of 18 □ First seizure patients that are not subsequently diagnosed with epilepsy • **Patients will be identified retrospectively for the study** via completion of a data collection spreadsheet via ICD10 codes • **Data Collection: a clinical questionnaire** to the named clinician who was responsible for the patient's care at the time of their admission; an **organisational questionnaire,** and **case note extracts** for peer review	
9	NCEPOD: Crohn's Disease	All	R Haffey		Study currently under development.	
10	NCEPOD: Community Acquired Pneumonia	All	R Haffey		Study currently under development.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
11	National End of Life Audit (NACEL) – Round 2	Mr B Conway	Mr D Calvin, Dr G Nicholson	Report	Reports have been emailed to Director, Associate Medical Director, Assistant Director and Mrs Leeman. **<u>Update from Mr D Calvin</u>** A meeting is to be scheduled to discuss the locality findings and how we plan to address the recommendations for our Trust.	Reports to be shared / disseminated within the structures for learning that informs improvement plans and future audit
12	National End of Life Audit (NACEL) – Round 3	Mr B Conway	Mr D Calvin, Dr G Nicholson	To be advised	The NACEL Round Three elements were: • Organisational level audit: which comprises of a hospital/site overview and a Trust/Health Board overview. • Case Note Review: similar to round two, will focus on the themes of recognition of dying and individual plan of care. • Quality Survey: a survey of bereaved carers to gather feedback on their experience of care delivered during the patient's final admission into hospital. • Staff Reported Measure: NEW element. A survey to garner staff experience and confidence in delivering care to dying patients and those important to them.	
13	ED Palliative Care Audit		Dr Paul Webster and David Calvin		The audit will focus on attendances at CAH on 1st May 2019. From these attendances any patient that was 18 years/18 years plus of age and admitted to a hospital bed will be part of the audit.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
14	NHS Benchmarking Audit Managing Frailty in Acute Settings 2019	K McGoldrick	P Fearon (User Audit)	Data submitted (User Audit) Data submitted	Two elements Submissions from Craigavon and Daisy Hill Hospitals required. a) Service User Audit – 50 cases from CAH and DHH. Data collection completed and signed off for submission. b) Organisational Benchmarking data - Managing Frailty and Delayed Transfers of Care in the Acute Setting. Data submitted. Service User Audit 2019 FINAL - BLANK (Managing Frailty spec 2019 - FINAL.xls	Await report
15	NHS Benchmarking Audit Managing Frailty in Acute Settings 2020	K McGoldrick		20/11/2020	Registration for the 2020 Managing Frailty and Delayed Transfers of Care in the Acute Setting benchmarking project is now open. The project will be collecting 2019/20 financial year data. **Project key dates** • Data collection opens: 14th September 2020 • Data collection closes: 20th November 2020 • Reporting and events: February/March 2021	Await report
16	IBD UK – IBD Benchmarking Tool	Ms L Devlin	Dr Bhat	Data submitted (Survey) Data submitted (Benchmarking)	Benchmarking audit with the quality markers being drawn from the recent standards review. 3 reports will be generated – The patient survey for the site, the site specific assessment and a national report. Benchmarking data submitted by Dr Bhat.	Await report

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
17	Royal College of Emergency Medicine audits 2019-20. ➢ Mental Health	Mrs A McVey, Mrs M Burke	Dr Patton, Dr Perry, Dr Mawhinney	Report	**Methodology / Inclusion criteria** Data should be collected on patients attending from 1 August 2019 – 31 January 2020. Data is entered directly by a Doctor to the RCEM audit tool - direct entry changes the usual process for internal sign-off / approval.	**Report to be shared / disseminated within the structures for learning that informs improvement plans and future audit**
18	Royal College of Emergency Medicine audits 2020-21.	Mrs A McVey, Mrs M Burke, Mr P Smith	Dr D Patton		**Royal College of Emergency Medicine 2020/2021** • 2020/2021 Audit and QIP programme • Pilot in spring 2020, registration from July 2020, data entry from Aug 2020. • Fractured Neck of Femur • Pain in Children • Infection Control • Please note that the planned Homeless Inclusion Health topic has been postponed and replaced with Infection Control to better support safe and high quality care at the current time.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
19	Audit of the perioperative management of anaemia in children undergoing elective surgery, NHS Blood and Transplant				The NHS Blood and Transplant have indicated that in April 2020 they will be looking at an audit on the management of anaemia in children who are admitted for elective surgery. This audit will be undertaken by anaesthetists. They have not yet started to recruit, because the audit is still in its pilot stage. They will let Trusts know when an anaesthetist has signed up for the audit, or if an anaesthetist has not signed up they would like the Trust to identify one of this team. A REVIEW OF THE 2020/21 AUDIT PROGRAMME - In light of COVID-19, the Project Group has decided to postpone the audit of the perioperative management of anaemia in children undergoing elective surgery until early summer, so I will keep you advised about progress with that. Similarly, we were planning a short survey to look at the use of FFP, Cryo and PCC, but that, too, may be placed on hold. Pending resumption of those audits, we will continue to process data for and report the outstanding 3 audits.	Email has been sent to Dr Scullion and Mr Carroll and Mrs P Watt on 6/3/2020 for awareness. Update from NHS Blood and Transplant
20	NG 29 Annual Surveillance audit	All	Mrs J McConville	31/3/2022	A submission regarding the Innovative NG 29 Annual Surveillance audit was forwarded to RQIA for their consideration. Rationale for the audit: The DHSSPSNI endorsed the NICE guidance (NG 29) for intravenous fluid therapy in children and young persons. As part of the SHSCT's accountability responsibilities for Standards and Guidelines (S&G), all of the guideline's 32 recommendations have been reviewed. The outcome has provided a scoping specification of the evidence that would demonstrate that effective systems and processes are in place to ensure the NG 29 Guidance is met. Referenced in Item 1 above also. Preliminary Meeting held with RQIA prior to commencement of the audit.	Preliminary Meeting has been held with RQIA. Project team has met to process map the audit

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
21	British Thoracic Society (BTS) Pilot Audit of Outpatient Management of Pulmonary Embolism				BTS is currently running a pilot audit of Outpatient Management of Pulmonary Embolism for April 2021 (pilot audit period 1 Feb 2021- 30 April 2021, data entry period 1 April- 30 April 2021). This audit will help prepare for the National Audit which will be held later in the year (see below). If you **have been chosen to participate**, please complete your site's data entry before the end of April.	
22	British Thoracic Society (BTS) National Pleural Services Organisational Audit				The new national organisational audit of Pleural Services is currently open (national audit period 1 April – 30 April 2021, data entry period 1 April 2021 to 30 June 2021). This audit will collect information on organisational resources related to Pleural Procedures, which will inform the development of future standards. Please note that this audit will only require **one response per institution**. If you are interested in participating, please download and complete the registration from found here, and email the completed form to Personal information redacted by the USI	
23	British Thoracic Society (BTS) National Smoking Cessation Audit				The next National Smoking Cessation Audit will run in 2021 (national audit period 1 July – 31 August 2021, data entry period 1 July- 31 October 2021). Further details will be provided on the BTS website and forthcoming audit emails within the coming months.	
24	British Thoracic Society (BTS) National Outpatient Management of Pulmonary Embolism Audit				The new national Audit of Outpatient Management of Pulmonary Embolism will run in 2021 (national audit period 1 August – 30 September 2021, data entry period 1 August- 30 November 2021), depending on successful completion of the pilot. Further details will be provided on the BTS website and forthcoming audit emails within the coming months.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
25	British Thoracic Society (BTS) Call for case studies				We at BTS are keen to expand our range of case studies on the BTS website related to audit and quality improvement. If you have a project you would like to share, please contact Louise Preston via email at Personal Information redacted by the USI [redacted].	
26	Dissemination to M&M Chairs	All			Dissemination of Safety and Quality Reminders, E-Alerts and PHA Letters to M&M Chairs.	All of these three items will continue to be shared with M&M Chairs by Clinical Audit / M&M team
27	MCCD book - contingency arrangements for death certification when RM&MRS is down	All	Operational teams		The MCCD booklets are now stored on the Patient flow office, in both CAH &DHH and Sister office Ward 1, Lurgan Hospital. These booklets are for only for use in as a contingency when the NIECR system is down. A communication from the Medical Director's office has been shared regarding this matter.  Location of Paper Death Certificates.do	
28	Feedback on Process for Emailing of MCCD to GRO	All			All MCCD are to be emailed to the GRO. The attached guidance was also most recently issued to all medical staff on 28/07/2020. **Memo - Update to Process for Emailing MCCDs with IMMEDIATE EFFECT – sent to M&M Chairs 28/7/2020** • As a result of on-going difficulties in ensuring that all Medical Certificates of Cause of Death (MCCDs) are emailed to: Personal Information [redacted] - mortuary staff have agreed to undertake this process on RMMRs **with immediate effect**. • This change has been agreed with the Death Certification Branch of the DoH and the General Registrar's Office. The process of MCCD completion via RMMRs by medical staff remains unaffected, but stops short of the email step to the GRO.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
29	Morbidity and Mortality meetings	All			CMO letter on Coronavirus COVD 19 - reducing Mortality and Morbidity review advised the following: 1. All deaths in hospital should continue to be recorded on RM&MRS. This is important as the Medical Certificate of Cause of Death (MCCD) needs to be printed from that system. 2. Where possible, the MCCD should continue to be reviewed by a consultant as is currently the case. This is particularly true of those cases where COVID-19 is a suspected contributor. 3. M&M meetings should no longer be held to review all deaths occurring in hospital. Instead, Trusts will be given flexibility to determine what deaths should be reviewed and are asked to undertake a risk-based approach. This may mean that only those deaths which are related to COVID-19 or those deaths where potential harm has been caused will be reviewed. It is also understood that any such review will not take the form of a normal M&M review but may be a much more high-level review. **Update received from Chief Executive on 25/6/2020 regarding Morbidity and Mortality reviews for adult deaths in hospital** • The CMO has requested that Trusts recommence M&M reviews for all adult deaths using the RM&MRS from 1 July 2020 and this has been shared with the M&M Chairs on 26/6/2020. Additional consideration is also requested, 'I would ask that when conducting M&M reviews, that consideration is given to whether COVID-19 had a direct or indirect impact on the death, reflecting on, for example, whether a delayed referral to hospital or non-accidental injury may have been a factor in the death. This information will be extremely helpful for any future considerations and plans'. • Difficulty for new Locum appointments completing death certificate on NIECR. These new appointments require to be added to their respective M&M team on NIECR. M&M facilitators to be advised of new starts.	

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate	Action
30	Daily inpatient mortality surveillance reporting				We run a daily inpatient mortality surveillance report which is forwarded to the Chief Executive. There are two aspects to this: • Number of inpatient deaths reported to the PHA in the last 24hours, as meeting the definition (+ve C19 test within 28 days of death) • The patient is reported to the PHA Mortality Surveillance by the Doctor who has completed the Initial record of Death via the PHA reporting form **PHA COVID-19 Patient Deaths - Reporting Form** • Number of inpatient deaths enrolled on the NIECR mortality pathway containing C19 on the MCCD with negative virology. The completion of the MCCD as early in morning (pre-9am) if possible will assist with Mortality Surveillance timeframes.	
31	Independent medical Examiner	All			Memo has been sent to all medical staff. 08042021_MD_ Independent Medical Independent Medical Examiner Prototype ≠	

Appendix 1

Acute directorate (including ATICS): Paediatric IV fluid audit improvement tool (PIVFAIT) Results 1st May 2018- 25th April 2021[1]

The Acute Directorate Paediatric IV Fluid Audit Improvement Tool (PIVFAIT) assesses 9 indicators / questions for all patients aged 14-15 years who received IV fluids during their hospital admission.

The 9 indicators / questions are:

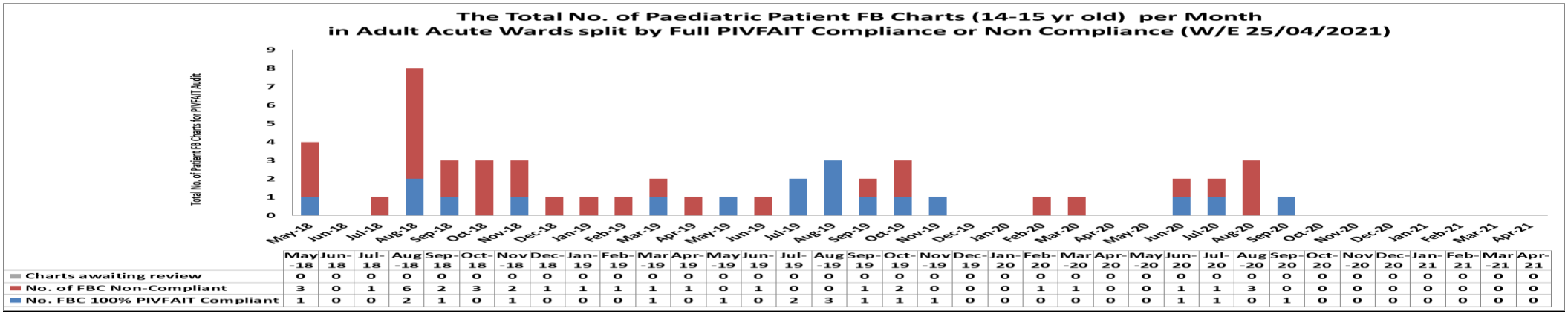
Indicator / Question		Details
1	**Patient identification**	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number
2	**Glucose Monitoring**	While the child is receiving IV fluids, is there a **Blood Glucose result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart) i.e. at least 12 hourly?
3		Were ALL **Blood Glucose** measurements greater than 3mmol/L? If answer = No; Enter Hospital Number of those below 3mmol/L for Trust audit dept. to check for treatment.
4	**Cumulative input and output totalling and fluid balance.**	Are ALL of the following amounts (in mls) recorded on the DFBC? 1. Oral/IV amounts, (all administered types of intake to be recorded). 2. Day and night totals. 3. Grand Total IN 4. Grand Total OUT 5. 24 hour Fluid Balance
5	**Patient weight**	Is there a patient weight in kgs, given on the DFBC?
6	**DFBC calculation guidance completed.**	Are the appropriate calculation guidance sections for the IV therapy completed?
7		Are there coded indications for the fluid administration provided?
8	**Electrolyte monitoring**	Is there an E&U result recorded on the DFBC, (in accordance with the 2017 Paediatric Therapy Wallchart)?
9	**12 hour assessment.**	When IV fluids are administered for longer than 12 hours. Is there a 12 hour Reassessment box* appropriately completed on the DFBC with an answer to the question: Is the infusion prescription still suitable - followed by a doctors signature? * Can be 10 - 14 hours .

Acute Directorate PIVFAIT OUTCOME

18 of the 51 FB charts (35%) recorded 100% PIVFAIT compliance in the last 32 months.

[1] Audit data is based on returns made by wards at this date.

Appendix 1



	May -18	Jun-18	Jul-18	Aug -18	Sep-18	Oct-18	Nov -18	Dec-18	Jan-19	Feb-19	Mar -19	Apr-19	May -19	Jun-19	Jul-19	Aug -19	Sep-19	Oct-19	Nov -19	Dec-19	Jan-20	Feb-20	Mar -20	Apr-20	May -20	Jun-20	Jul-20	Aug -20	Sep-20	Oct-20	Nov -20	Dec-20	Jan-21	Feb-21	Mar -21	Apr-21
Charts awaiting review	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of FBC Non-Compliant	3	0	1	6	2	3	2	1	1	1	1	1	0	1	0	0	1	2	0	0	0	1	1	0	0	1	1	3	0	0	0	0	0	0	0	0
No. FBC 100% PIVFAIT Compliant	1	0	0	2	1	0	1	0	0	0	1	0	1	0	2	3	1	1	1	0	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0

The bar chart and table show that 4 of the 11 Charts audited since Nov 19 has had full compliance.

Question Compliance	May 18	Ju 18	July 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21
1. Patient identification	75%	n/a	100%	88%	33%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	100%	100%	100%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2. Glucose Monitoring (Blood Glucose result recorded on the DFBC)	75%	n/a	100%	88%	67%	100%	100%	0%	100%	0%	50%	100%	100%	100%	100%	100%	100%	67%	100%	n/a	n/a	0%	100%	n/a	n/a	50%	50%	33%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3. Glucose Monitoring (Blood Glucose measurements greater than 3mmol/L?)	75%	n/a	100%	88%	100%	100%	100%	0%	100%	0%	50%	100%	100%	100%	100%	100%	100%	67%	100%	n/a	n/a	0%	100%	n/a	n/a	50%	50%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4. Cumulative input and output totalling and fluid balance	25%	n/a	0%	75%	100%	33%	33%	100%	100%	0%	100%	100%	100%	0%	100%	100%	100%	100%	100%	n/a	n/a	100%	0%	n/a	n/a	50%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5. Patient weight	75%	n/a	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	100%	100%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
6. DFBC calculation guidance completed	50%	n/a	0%	50%	100%	33%	67%	100%	100%	100%	50%	0%	100%	0%	100%	100%	100%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7. DFBC calculation guidance completed/a	50%	n/a	100%	88%	33%	67%	67%	100%	0%	0%	100%	100%	100%	100%	100%	100%	100%	67%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
8. Electrolyte monitoring	75%	n/a	100%	88%	67%	100%	100%	0%	100%	0%	50%	100%	100%	100%	100%	100%	50%	67%	100%	n/a	n/a	100%	100%	n/a	n/a	50%	50%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a
9. 12 hour assessment	75%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	n/a	n/a	100%	100%	n/a	n/a	100%	100%	67%	100%	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Appendix 1

Acute Directorate: ATICS: Paediatric IV fluid audit improvement tool (PIVFAIT)
Results 31st May 2019 – 25th April 2021

The Acute Directorate ATICS specific audit tool assesses 6 indicators / questions for all patients up to their 16th birthday who received IV fluids whilst in theatre.

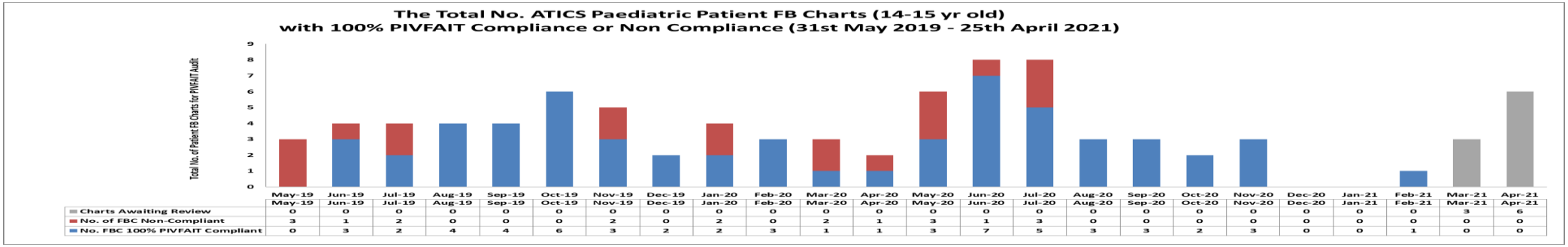
The 6 indicators / questions are:

Indicator / Question		Details
1	**Patient identification**	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number
2	**Patient weight**	Is there a patient weight in kgs, given on the DFBC?
3	**Daily Fluid Balance & Prescription Chart**	Was the appropriate Daily Fluid Balance & Prescription Chart (Child up to 16th Birthday February 2017) chart commenced?
4	**Daily Fluid Balance & Prescription Chart**	Was the fluid volume given in Theatre / Recovery appropriately transferred onto the ward fluid balance chart prior to discharge from Theatre/Recovery
5	**Daily Fluid Balance & Prescription Chart**	If Fluids continue on to ward – were calculations done and coded?
6	**Fluids prescribed**	IF fluids were given in Theatre / Recovery please provide details A) Volume prescribed. B) Actual volume given. C)Type of fluid given
Additional information		
	Fluids prescribed	Did IV fluids continue when the patient was discharged to the ward on discharge from theatre/recovery? - Please note if the child continues to receive IV fluids outside the Theatre / Anaesthetics setting then the Ward is to complete the full audit

NB: 9 x ATICs cases in the period up to 25/04/2021 remain to be audited.

Appendix 1

58 of the 78 DFB charts (74%) recorded 100% ATICS Specific PIVFAIT compliance. 9 cases await ATICS PIVFAIT review



The bar chart and table show that 24/28 charts audited since May 2020 have had full compliance.

Indicator / % Compliance by Month	May 19 (n=3)	Jun 19 (n=4)	July 19 (n=4)	Aug 19 (n=4)	Sept 19 (n=4)	Oct 19 (n=6)	Nov 19 (n=5)	Dec 19 (n=2)	Jan 20 (n=4)	Feb 20 (n=3)	March 20 (n=3)	April 20 (n=2)	May 20 (n=6)	Jun 20 (n=8)	Jul 20 (n=8)	Aug 20 (n=3)	Sep 20 (n=3)	Oct 20 (n=2)	Nov 20 (n=3)	Dec 20 (n=0)	Jan 21 (n=0)	Feb 21 (n=1)	Mar 21 (n=3)	Apr 21 (n=6)
1.Patient identification	33%	100%	75%	100%	100%	100%	60%	100%	50%	100%	67%	50%	83%	88%	100%	100%	100%	100%	100%	-	-	100%	-	-
2. Patient weight	67%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	88%	100%	100%	100%	100%	100%	-	-	100%	-	-
3. Appropriate Daily Fluid Balance & Prescription Chart	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%	-	-
4. Daily Fluid Balance & Prescription Chart - volume appropriately transferred to ward fluid balance chart	67%	100%	100%	100%	100%	100%	80%	100%	100%	100%	67%	100%	50%	100%	88%	100%	100%	100%	100%	-	-	100%	-	-
5. Daily Fluid Balance & Prescription Chart - calculations done and coded?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	75%	100%	100%	100%	100%	-	-	100%	-	-
6. Fluids prescribed	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	100%	100%	100%	-	-	100%	-	-

Appendix 1

Charts Awaiting Review from previous report-

ATICS

Theatre CAH:

9 cases from the following date is awaiting review.

- 04/03/2021 – for review
- 23/03/2021 – for review
- 28/03/2021 – for review
- 07/04/2021– for review
- 08/04/2021– for review
- 08/04/2021– for review
- 18/04/2021– for review
- 22/04/2021– for review
- 24/04/2021– for review

SHSCT Clinical Audit Work Plan

Audit type (National, Regional, Local)	HQIP Audit Level tba=to be advised	Audit Year	Audit title	Name of Junior Doctor/HCP/ Auditor	Audit lead	Site	Acute Division	Status tba=to be advised
National	1	2021-22	National Audit of End of Life Care (NACEL)	David Calvin	Barry Conway	CAH/DHH	All	Planned Audit
National	1	2021-22	NCEPOD Epilepsy Study		NCEPOD Coordinators	CAH/DHH	All	Planned Audit
National	1	2020-21	Breast cancer management pathways during the covid-19 pandemic-A national Audit	Dr N Scally	Ms Helen Mathers	CAH	CCS/SEC	Live Audit
National	1	2020-21	PROTECT-ASUC Covid 19 Pandemic response of assessment, endoscopy and treatment in AcuteSevere Ulcerative Colitis. A Multi-centre case control study	Dr G Morrison	Mr S Bhat	CAH	MUSC	Live Audit
National	1	2020-21	GlobalSurg-CovidSurg Week	Dr L Armstrong	Mr K McElvanna	CAH	SEC	Planned Audit
National	1	2020-21	Determining the optimal timing for surgery following SARS-CoV-2 infection	Dr D Angelou	Mr R Thompson	DHH	SEC	Live audit
National	1	2021-22	National Unilateral nipple discharge study		Dr N Scally	CAH/DHH	SEC	Live Audit
National	2	2021-22	Covid-19 Impact on Pancreatic Cancer Care Pathway	Dr R Fox	Mr Epanomeritakis	CAH/DHH	CCS	live audit
National	2	2020-21	The impact of COVID on maternity services	Dr R. DeCourcy-Wheeler	Dr R. DeCourcy-Wheeler	CAH/DHH	IMWH	Live Audit
National	2	2020-21	Paediatric Left Before Treatment		Dr R Spedding	DHH	MUSC	Live Audit
National	2	2020-21	HAREM Study.Had Appendicitis and Recovered/Recurred Emergency Morbidity/Mortality Dr G Nixon	Dr G Nixon	Mr D McKay	CAH	MUSC/SEC	Live Audit
National	2	2020-21	COVID Stones: An observational multi-centre cohort study investigating the clinical management and outcomes of ureteric stones during the COVID-19 pandemic in the United Kingdom	Dr Mahmoud Nosseir	Mr M Young	CAH	SEC	Continuous
National	2	2020-21	Integrate Covid-19 Emergency Care Audit	Dr B Wright	Mr E Reddy	CAH	SEC/ENT	Live Audit
National	2	2020-21	ENT UK 2 week wait telephone triage:service evaluation	Dr B Wright	Mr Ramesh Gurunathan	CAH	SEC/ENT	Live Audit
National	2	2020-21	Covid-19 Laryngectomy Impact-RCSLT	Dr Conor McKenna	Mr R Gurunathan	CAH	SEC/ENT	Planned Audit
Regional	2	2020-21	Audit of number of patients with diagnosis of gastric polyp and benign neoplasm of the stomach from 1st July 2018 to 30th June 2019	Dr K Tang	Dr Seamus Murphy	DHH	MUSC	Planned Audit
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the time taken to initial treatment for patients with confirmed urological cancer	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS	Planned Audit
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the time taken to initial treatment for patients with suspected Urological cancer	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS	Planned Audit
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department, the time taken to initial treatment for patients with confirmed urological cancer and the impact of COVID on treatment	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS	Planned Audit
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the impact of COVID on the time taken to review patients with suspected Urological cancer	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS	Planned Audit
Regional	3	2020-21	Investigation of Drug Charts in accordance with current guidelines	Dr Rait/Dr Greene	Dr M Eltom	CAH	MUSC	Completed
Regional	3	2020-21	ED Palliative Care Audit	David Calvin	Martina Thompson	CAH	MUSC	Planned Audit
Regional	3	2020-21	Audit of lumbar puncture rates and application of McDonnell diagnostic criteria for multiple sclerosis in N Ireland	Dr Jamie Campbell	Dr Jamie Campbell	CAH, DHH	MUSC	Planned Audit
Regional	3	2020-21	Standard interval dosing Vs extended interval dosing with Natalizumab in patients with Multiple Sclerosis		Dr Jamie Campbell	CAH	SEC	Planned Audit
Regional	3	2021-22	Restarting DOAC's Post -operatively in Trauma Patients	Dr J Clarke	Mr B Watson	CAH/DHH	SEC	live audit
Trust	2	2021-22	Audit of prescribing of anti-androgen medicine "Bicalutamide"		Mr M Haynes	CAH/DHH	CCS	live audit
Trust	2	2021-22	Impact of the pandemic on ectopic pregnancy outcomes	Dr Tsveta Hadjieva	Dr S Finnegan	CAH/DHH	IMWH	Planned Audit
Trust	2	2021-22	Audit of Intravenous paracetamol	Ms Melinda Furtado	Ms Sara Laird	CAH/DHH	Pharmacy	Planned Audit
Trust	2	2021-22	Ensuring Pregnancy Testing is undertaken prior to surgery	Caroline Beattie	Patricia Kingsnorth	CAH/DHH	SEC,CYP/IMWH	Planned Audit
Trust	2	2020-21	Should we change the way we cast ankle fractures	Dr P Karayiannis	Miss Veronica Roberts	CAH	SEC/T&O	Planned Audit
Trust	2	2020-21	Incidence of "cortical blow out" in DHS in Craigavon Area Hospital	Dr P Karayiannis	Mr P Magill	CAH	SEC/T&O	Planned Audit
Trust	2	2020-21	Impact of Elective Orthopaedic Telephone Clinics on waiting times and patient satisfaction	Dr P Karayiannis	Miss Lynn Wilson	CAH	SEC/T&O	Planned Audit
Trust	3	2020-21	Documentation Audit of the Blood Transfusion Process	Patricia Watt	Dr Mark Bridgham	CAH/DHH	ALL	Planned Audit
Trust	3	2020-21	Peri-operative diabetic audit	n/a	Dr Anna Laird	CAH	ATICS	Planned Audit
Trust	3	2020-21	Audit of Post operative analgesic use after 3 months	Dr B Campbell	Dr P McConaghy	CAH	ATICS	Planned Audit
Trust	3	2021-22	National Emergency Laparotomy Audit	Dr K Foreman	Dr A O'Neill	CAH/DHH	ATICS/Theatres	Planned Audit
Trust	3	2020-21	Documentation Audit of the Blood Transfusion Service	Patricia Watt	Dr Mark Bridgham	CAH	CCS	Live Audit
Trust	3	2020-21	" Go with the flow"	Dr Laura Johnston/Lauren Heatherington	Dr Shilpa Shah/Dr Veena Vasi	CAH	CYP	Planned Audit
Trust	3	2020-21	Use of Valproate in women of childbearing age in neurology service	Dr E McKeever	Dr K McKnight	CAH	IMWH	Planned Audit
Trust	3	2020-21	Obstetric complications in women of East Timor origin	Dr Colm Coyne	Dr K Niblock	CAH	IMWH	Live Audit
Trust	3	2020-21	Completion of VTE risk assessment in post natal women	Dr Laeticia Ezeilo	Dr K Loane	DHH	IMWH	Live Audit
Trust	3	2021-22	Obstetric anal sphincter injury audit	Dr G Stewart	Dr G McLachlan	CAH	IMWH	Planned Audit
Trust	3	2021-22	Sepsis	Dr B Barbulescu	Dr Cara McKeating	CAH/DHH	MUSC	Planned Audit
Trust	3	2020-21	Audit of time to diagnosis of Multiple Sclerosis when CCG service has been utilised in primary care	Dr Catherine Donaldson	Dr Jamie Campbell	CAH	MUSC	Planned Audit
Trust	3	2020-21	Audit of pulmonary embolism follow up in Craigavon Area Hospital	Dr Conor Hagan	Dr R Convery	CAH	MUSC	Planned Audit
Trust	3	2021-22	Delivery of Palliative Care in DHH General Medicine	Dr Amy Gilsenan	Dr G Sloan	DHH	MUSC	Live Audit
Trust	3	2021-22	Audit of ED Documentation to determine recorded level of burn cooling received by Paediatric patients presenting to Craigavon ED	Dr Aoife McIlduff	Dr Elli McCormick	CAH	MUSC/CYP	Planned Audit
Trust	3	2020-21	Integrated Medicines Management Pharmacy Technician	Jane Haydock	Anne McCorry	CAH	Pharmacy	Planned Audit
Trust	3	2020-21	A Service evaluation of the reformed OPAT service in the SHSCT	Lisa Lennon	Dr Geraldine Conlon-Bingham	CAH	Pharmacy	Live Audit
Trust	3	2021-22	Procalcitonin testing and antibiotic use in suspected Covid-19	Geraldine Conlon-Bingham,	Dr Cara McKeating	CAH/DHH	Pharmacy	Planned Audit
Trust	3	2020-21	Planning staff reserves for future Covd-19 outbreaks based on specialty specific risk stratification for obtaining Covid-19 infection	Dr Dimitrious Angelou	Mr David Mark	CAH	SEC	Live Audit
Trust	3	2020-21	Incidence of male breast cancer in Southern Trust		Dr Reem Salman	CAH	SEC	Live Audit
Trust	3	2020-21	How should displaced ankle fractures requiring operative management be immobilised at presentation? A review of ankle fractures requiring external fixation in the period July 2019 – July 2020.	Dr Scarlett O'Brien	Ms Veronica Roberts	CAH	SEC	Live Audit
Trust	3	2020-21	Compliance with DKA Protocol in patients admitted to DHH	Dr H Mustafa	Dr Y Abdelaal	DHH	SEC	Planned Audit
Trust	3	2020-21	Close assessment of pre-op for FESS	Dr Chin Mun Soong	Mr T Farnan	CAH	SEC	Live Audit
Trust	3	2020-21	Breast cancer management for over 70 year olds Southern Trust		Dr Reem Salman	CAH	SEC	Live Audit
Trust	3	2020-21	Acute Ligamentous knee injuries-time	Dr R Espey/Dr I Kennedy	Dr J Rankin	CAH	SEC	Live Audit
Trust	3	2021-22	Quality of biopsy sampling in suspected eosinophilic oesophagitis in SHSCT	Dr R Fox/Dr O Doherty	Mr Shivaram Bhat	CAH/DHH	SEC	Planned Audit
Trust	3	2021-22	Audit of accuracy of form V13.3 for input to National Fracture database from Trauma ward December 2020	Dr B Cunningham/Dr I Donnell	Mr Sean Patton	CAH	SEC	Live audit
Trust	3	2021-22	Compliance with local Trust prophylactic antibiotic guidelines in trauma patients-1 month follow up	Dr J Winter	Mr M Murnaghan	CAH/DHH	SEC	Planned Audit

Audit type (National, Regional, Local)	HQIP Audit Level tba=to be advised	Audit Year	Audit title	Name of Junior Doctor/HCP/ Auditor	Audit lead	Site	Acute Division	Status tba=to be advised
Trust	3	2021-22	Operative note documentation	Fiona Griffin	Mr J O'Donaghue	CAH	SEC	Live audit
Trust	3	2021-22	Comparison of LUTS assessment in Southern Trust against guidelines	Dr Sabahat Hasnain	Mr A Glackin	CAH/DHH	SEC	Planned Audit
Trust	3	2021-22	Audit into the management of intercranial bleeds	Dr L Watt	Dr M Rizeq	CAH/DHH	SEC/ATICS	Planned Audit
Trust	4	2020-21	Over transfusion in the Delivery Suite	Dr Mathew Ferguson	Mr Colin Winter	CAH/ DHH	ATICS	Live Audit
Trust	4	2020-21	Audit of neuroimaging in ICU against RCR iRefer standards	Dr T Patterson	Dr C Shevlin	CAH	ATICS	Planned Audit
Trust	4	2021-22	Audit to determine the number of true penicillin allergy patients on the AMU in CAH	Michelle Murphy	Geraldine Conlon-Bingham	CAH	Pharmacy	Planned Audit
Trust	4	2020-21	Satisfaction survey of pinnaplasty outcomes	Dr Aoife Mallon/ Dr Dominic McKenna	Mr E Reddy	CAH	SEC	Planned Audit
Trust	4	2020-21	Review of urgent cholesystectomy for acute bilairy colic, acute cholecystitis and gallstone pancreatitis	Stephanie O'Hare	Dr Susim Kumar	DHH	SEC	Planned Audit
Trust	4	2021-22	Parotid Surgery in the Southern Trust: An overview of techniques, complications and changing trends	Dr J Smith	Mr E Reddy	CAH/DHH	SEC	Planned Audit
Trust	tba	2020-21	e-CRABEL audit on standard of medical records	Dr J Beck		CAH	SEC	Planned Audit

MANAGING FRAILTY AND DELAYED TRANSFERS OF CARE IN ACUTE SETTINGS

GUIDANCE NOTES FOR THE SERVICE USER AUDIT 2019

British Geriatrics Society
Improving healthcare
for older people

Benchmarking Network

This document provides guidance on completing the service user audit element of the managing frailty and delayed transfers of care in acute settings benchmarking project.

- Trusts/UHBs are requested to select one care of older people ward or medical ward for the service user audit.
- 50 consecutive discharges should be selected for the service user audit, running simultaneously with the main data collection period (15th July to 27th September 2019).
- A project lead should be allocated on the ward to co-ordinate and collate the results and use the information to complete the service user audit data collation tab on this workbook.

INSTRUCTIONS

1 The service user audit should be completed on the excel spreadsheet on the next tab.
There is a printable version of the questions available in this workbook to assist with data collection on the ward
2 The care of older people ward should complete the service user audit for 50 consecutive service users who are discharged from the ward.
3 The service user audit should be completed on discharge from the care of older people's ward.
4 The definitions of the questions asked in the service user audit are available on the following tab.
5 The data collection period is from 15th July to 27th September 2019. The service user audit may be completed at any time during this period.
It is suggested that the data is collected on the printable versions of the service user audit and then the results entered onto the excel spreadsheet once 50 consecutive discharges have been reached.
6 Please return the completed excel spreadsheet to [redacted]
7 If you need any further help with any aspect of the older people in acute settings service user audit, please e-mai[redacted].net or cal[redacted]