SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18
CC CLINICAL AUDIT (15/16/16)

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.1 INTEGRATED GOVERNANCE STRATEGY				
1	1	As previously recommended in both the Board Effectiveness Audit 2015-16 and the Clinical and Social Care Governance Audit 2015-16, the Integrated Governance Strategy should be updated, approved and re-issued. The Strategy should accurately reflect the current committee structure within the Trust and the current reporting arrangements and requirements. **Responsible Officer:** Assistant Director Clinical & Social Care Governance (ADCSCG) **Original Implementation date:** June 2016	**Duplicate recommendation** refer to D – above - Governance Including Board Effectiveness This recommendation has not been counted in the results table above.	
1.2 CLINICAL AUDIT STRATEGY				
1	1	The Trust should develop a comprehensive Clinical Audit Strategy. The Strategy should accurately reflect the committee structure across the Trust and the reporting arrangements. It should also include a combination of national, regional and local priorities with sufficient resources identified to facilitate completion of the programme. **Responsible Officer: Head of Audit/ Assistant Director CSCG** **Original Implementation Date: 1st July 2017**	**NOT IMPLEMENTED** The Medical Director has reflected on the changing nature of Audit and the national move towards Quality Improvement (QI), rather than simply Audit. Discussion is ongoing with a view to relaunching Clinical Audit with a view to making QI a more central theme within any audit programme.	**Revised Implementation Date:** 1st September 2018
1.3 COMMITTEE STRUCTURES FOR CLINICAL AUDIT				
1	2	The Terms of Reference for the Acute Audit Committee should be approved and the committee reinstated if appropriate. **Responsible Officer: Director of Acute Services** **Original Implementation Date: 1st September 2017**	**NOT IMPLEMENTED** All structures presently in place will be reviewed.	**Revised Implementation Date:** 1st September 2018

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.4 GOVERNANCE ARRANGEMENTS AT CORPORATE LEVEL				
1	2	Management should strengthen the governance and oversight arrangements in respect of clinical audit activity. This should include the following: • An annual overarching corporate clinical audit programme, to be approved by the Governance Committee. • Regular reports covering all clinical audit should be submitted regularly to the SMT and Governance Committees to monitor progress against the programme. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As noted above, the Medical Director has reflected on the changing nature of Audit and the national move towards Quality Improvement (QI), rather than simply Audit. Discussion is ongoing with a view to relaunching Clinical Audit with a view to making QI a more central theme within any audit programme.	**Revised Implementation Date:** 1st September 2018
1	2	The CSCG team should put in place a corporate process for sharing outcomes and monitoring areas of clinical improvement, to ensure that the outcome of all audits including local audits are shared with the appropriate staff. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date:** 1st September 2018
1	2	Governance / Audit leads within Directorates complete the registration process for recording the rationale for participation in the national audits and for prioritising directorate led audits against corporate targets. **Responsible Officer: Directorate Audit Leads** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date:** 1st September 2018

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.5 DIRECTORATE LEVEL				
1	2	Directorate audit plans should be developed annually for approval at Directorate Governance Committee. These should then be submitted for approval at SMT Governance Committee. This information should be shared with the corporate CSCG team. **Responsible Officer: Directorate Audit Leads & ADCSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
1	2	Divisional audit plans should be developed annually for approval at Directorate Clinical Governance Committee. Subsequently regular reporting on progress against plans and major findings should be reported. **Responsible Officer: Directorate Audit Leads** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
1	2	Regular reports should be produced and provided to the CSCG Corporate Team by each directorate detailing progress against approved directorate plans and major findings from audits completed. **Responsible Officer: Directorate Audit Leads & ADCSCG** **Original Implementation: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
2.1 WRITTEN STANDARD OPERATING PROCEDURES (SOP) FOR CLINICAL AUDIT				
2	2	The Trust should ensure that written procedures for all aspects of the clinical audit are reviewed, updated and issued to all relevant staff as soon as possible. These should reflect current practice and link to a Clinical Audit strategy. **Responsible Officer: Assistant Director CSCG** **Original Implementation: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
2.2 DATABASE OF CLINICAL AUDITS				
2	3	There should be a central database maintained with the details of all ongoing clinical audits within the Trust, whether local, regional or national. Each directorate should have access to the relevant section within the database to allow it to be kept up to date. **Responsible Officer: Assistant Director CSCG** **Original Implementation :1st September 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
2.3 TRAINING FOR CLINICAL AUDIT				
2	2	Training for clinical audit should be considered by management. The training needs should be assessed and an appropriate training programme developed. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: Implemented**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**

Standardised reporting template for inclusion in 6 monthly audit assurance report **Appendix C**

Audit assurance report template for completion by the clinical audit lead

Audit title	
Audit type	e.g. national, regional or Trust
Host organisation	
Audit lead	
Contact details	@southerntrust.hscni.net
Time period	Continuous Snapshot (please specify dates)
Directorate	
Division / speciality	
Report accessed via	

1.0 The 3 most important performance indicators in SHSCT, as identified by the clinical audit lead.

Please include compliance against the national / regional compliance, where available

		SHSCT compliance	National or regional compliance
1.			
2.			
3.			

2.0 If appropriate, areas for improvement, actions taken and status

National, regional, Trust recommendations		
Recommendation	**Action taken**	**SHSCT status as at date**
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced

Please continue overleaf as required.

NB where an existing audit template is available e.g. NCEPOD, please submit this instead of completing section 2.0 above

Southern Health and Social Care Trust

Quality Care - for you, with you

INFECTION PREVENTION AND CONTROL STRATEGY 2018-2021

Introduction

Patient safety is always our top priority.

Every member of staff must play their part if we are to achieve and maintain the very highest safety standards.

Delivering best practice in Infection Prevention and Control (IPC) every single day is central to achieving this aim.

Health care associated infections (HCAIs) can be prevented when robust IPC measures are in place and relentlessly applied.

Thanks to our staff, this Trust has a strong reputation for its high IPC standards, but with global epidemic threats increasing and fears of antimicrobial resistance at an all-time high, we must redouble our efforts.

This strategy includes 10 elements which are designed to ensure excellence in IPC practice. It will take us all back to basics and remind us that IPC is not an option. It is everyone's responsibility.

It will require every member of staff to do their duty to protect our patients and eradicate preventable HCAIs.

We will ensure that best practice learning is shared through already existing staff forums and that Trust Board assurance is regularly provided.

The actions set out in this document will ensure that IPC is embedded at every level throughout the Trust, that use of antimicrobial therapy is prudent and that all staff, visitors and patients will be aware of the role they have to play in preventing avoidable HCAIs.

Signed by CX / Chair/ Med Dir / Dir Nursing

Contents...

Objectives

- **To deliver the highest safety standards for patients, visitors and staff.**
- **To become the best performing Trust in the UK for HCAI / IPC.**
- **To ensure IPC is embedded at every level from 'Board to Ward'.**

Co-Production Approach

Staff, union representatives and service users are members of the strategy development and implementation steering group. Specific expertise is co-opted onto the group as required. It is important to note that this strategy is a live document. Strategy group members continue to present the content and approach across all staff forums and will modify actions based on feedback received.
Strategy development and implementation steering group members.

Chair Dr Ahmed Khan, Medical Director	Dr Martin Brown, Microbiologist	Kate Corley, Head of Support Services
Anita Carroll, Acting Director Acute Services	Dr Kathryn Boyd, Clinical Director Labs	Colin Clarke, Lead Infection prevention control nurse
Simon Gibson, Assistant Director Medical Directorate	Dr James Crockett, Speciality Doctor in Anaesthetics	Geraldine Conlon-Bingham, Lead Antimicrobial pharmacist
Heather Trouton, Executive Director of Nursing (Acting)	Ruth Rogers, Head of Communications	Marilyn Trimble, Service User
Francis Lavery, RCN UK Learning Rep Lead for NI	Mark Bloomer Assistant Director Estates	

The strategy is based on the DHSSPS 'Changing the Culture' framework (2010) which lists 10 key elements for effective 'Board to Ward' assurance regarding HCAI incidence and IPC governance and practice.

GRAPHIC to be developed in line with overall campaign branding 2 hands / 10 fingers / 10 point plan

The 10 elements within this strategy are interdependent and designed to ensure excellence in IPC across the Trust. Each point in the plan includes a statement of intent followed by the key actions required to achieve the highest levels of success. The implementation plan for 2018 / 2019 is included and will be replaced annually.

1. Leadership

Senior Management Team (SMT) to prioritise Infection prevention and control throughout the Trust, ensure the implementation of the strategy, seek assurance and address poor practice. This will be achieved by:-

- Investment in multimodal strategy enhancing staffing, education, environment, surveillance and communication.
- Leadership walks by the Senior Management Team.
- Regular monitoring of IPC performance at SMT/ Trust Board & all Directors to have an IPC target connected in their own plans.
- Reviewing current level of interface with IPC staff with senior medical staff and revise if required to include CDs and AMDs
- Supporting and empowering staff to drive rapid, safe, sustainable improvement & ensure that the highest standards of best practice in clinical care are achieved and maintained. All staff to take pride in best practice, be aware of their role and responsibilities re IPC and be empowered to challenge non-compliance. Continued underperformance or non-compliance will be escalated to ensure accountability.

2. Culture

A culture of excellence in IPC is evident throughout the Trust. This will be achieved by:-

- Clear displays of IPC performance in hand hygiene / commode audits etc.
- Encouraging patients and staff to challenge non-compliance with HCAI guidelines.
- Ownership of clinical incidents by medical and nursing staff ensuring that advice given by the IPC team to safeguard patients with infections is prioritised and acted upon in a timely fashion.

3. Communication and Candour

Clinical staff communicate effectively with patients and their relatives. This will be achieved by:-

- Timely appropriate communication with patients regarding infections they have and how they will be treated.
- Creating opportunities for staff to access IPC information.
- Building public awareness and appeal for their help in improving IPC

4. Clean Hands

Hand Hygiene Policy and 'Bare below the elbow' are strictly observed. This will be achieved by:-

- Ensuring all staff understand their personal and professional responsibility in relation to the Hand Hygiene policy and fully comply.

5. Clean Place

Trust Board to receive regular updates of environmental cleanliness performance measured against regional standards. To be achieved by:-

- Ensuring that the highest standards of environmental cleanliness are achieved at all times.
- The right people in place with the correct training, and adequate monitoring arrangements.
- An extensive programme of technical, departmental and managerial audits with regular reporting of audit outcomes.

6. Isolation

Prompt decisions based on clinical risk assessments are made on the isolation of patients in line with the Trust's isolation protocol. This will be achieved by:-

- Prompt identification and isolation of patients with:- diarrhoea of unknown cause by clinical teams in consultation with patient flow; conditions requiring airborne and droplet precautions and other conditions with significant IPC implications e.g. CPE

7. Antibiotics

Antibiotics are used safely and effectively. This will be achieved by:-

- Developing a culture and robust plan to ensure prudent antimicrobial usage.
- Close monitoring to ensure the highest standards.

8. Learning

All staff are to be appropriately trained in HCAI guidance. This will be achieved by:-

- Ensuring that ALL Trust staff are skilled and fully equipped with IPC related knowledge to help minimise the risk of infection to patients, staff and visitors.
- Ensuring Bank nursing staff is skilled and fully equipped with IPC related knowledge to help minimise the risk of infection to patients, staff and visitors.
- Assurance achieved from Nursing Agencies that IPC training is appropriate and up to date.
- Staff who work in augmented care areas have bespoke ANTT training and full awareness and appreciation of the RQIA approach to auditing augmented care areas.
- Public awareness and confidence in IPC to be reaffirmed with information and knowledge as deemed appropriate. Learning regarding IPC from the public's perspective is a key proactive objective in the holistic approach to reducing HCAI incidence.
- Maintain IPCN knowledge in a specialist clinical area

9. Audit

Clinical & managerial teams, SMT & Trust Board receive regular reports with respect to various clinical audits and Infection Prevention & Control (IPC) to help monitor compliance and non-compliance at ward level against local and regional Healthcare Associated Infection (HCAI) targets. . This will be achieved by:-

- Continued development and' roll-out' of a detailed IPC audit program for the SHSCT
- Continued delivery of IPC related audit
- Sustain multi-professional collaborative working in relation to IPC audit, outcomes and action
- Timely, concise and accurate report writing in relation to audit outcomes
- Effective communication matrix to continue to develop in relation to circulation of reports to appropriate stakeholders
- A programme of IPCN & IPC Independent audit to continue and to expand

10. Closing the loop

Frequent feedback from ward to Trust Board to provide assurance that Board decisions are being effectively implemented and continuous improvement is achieved. Frequent feedback within clinical and managerial teams to ensure learning is achieved and continuous improved is sustained. This will be achieved by:-

- Monthly summary of performance in preventing and controlling HCAIs to include rates and case numbers for C Diff; MRSA; MSSA; Gram-negative bacteraemia, Pseudomonas aeruginosa; VAP; Cannula and catheter associated infections.
- RCAs need to show learning – if not account for at strategic & clinical forums. SAI learning in relation to IPC to be shared by Directorates at Board level.

IN SAFE HANDS 2018 / 2019 IMPLEMENTATION PLAN

1. Leadership

Senior Management Team to prioritise infection prevention and control throughout the Trust, ensure the implementation of the strategy, seek assurance and address poor practice.

This will be achieved by:-

- Investment in multimodal strategy enhancing staffing, education, environment, surveillance and communication.
- Leadership walks by the Senior Management Team.
- Regular monitoring of IPC performance at SMT/ Trust Board & all Directors to have an IPC target connected in their own plans.
- Reviewing current level of interface with IPC staff with senior medical staff and revise if required to include CDs and AMDs
- Supporting and empowering staff to drive rapid, safe, sustainable improvement & ensure that the highest standards of best practice in clinical care are achieved and maintained. All staff to take pride in best practice, be aware of their role and responsibilities re IPC and be empowered to challenge non-compliance. Continued underperformance or non-compliance will be escalated to ensure accountability.

1. Leadership Year 1 Implementation Plan

Area for improvement	Action planned	Desired outcome	Target date	Lead
Investment	• Develop IPC & OPAT IPTs Inc. Micro / Labs / IPC Nursing. Communications for SMT approval.	• Fully resourced team. • Improved patient safety. • Reduction in HCAIs	July 2018 (OPAT is regional)	Med Dir
Leadership walks	• Initial baseline acute leadership walks to be complete by September. • Non acute, MHD, CYP baseline to be established Oct & Nov. • Programme of monthly SMT led leadership walks to commence December 18. (Programme to be attached) • IPC Targets included in Directors' PDPs	• All staff aware of importance of best IPC practice led by SMT.	Aug / Sept Oct & Nov Commence Dec 18 By Dec 18	SMT
Performance monitoring	• IPC monthly report at Directorate SMTs • Quarterly detailed reports at SMT • Detailed monthly reports and presentations to Trust Board.	• Raised awareness of IPC as key Trust priority. • Prompt corrective action taken as required.	From Sept 18 From Dec 18 From Sept 18	Med Dir Op Dirs
Medical / IPC interface	• IPC to become standing agenda item at clinical Governance forum / IPC clinical and strategic forums.	• Enhanced interface between medics & IPC staff. • Greater ownership of IPC issues & performance amongst medical workforce.	From Sept 2018	Med Dir Op Dirs
Supporting staff	• Support education, training & consistent good practice. • Provide resources required to fulfil role. • Empower staff to challenge non compliance. • Celebrate good practice	• All staff fully understand IPC responsibility & deliver consistent best practice. • Staff at all levels take pride in practice & feel confident re IPC. • IPC is a key priority.	By Dec 18	IPC team with support from Dir Nursing team

2. Culture - Year 1 Implementation Plan

A culture of excellence of preventable infections is evident throughout the Trust. This will be achieved by:-

- Clear displays of IPC performance in hand hygiene / commode audits etc.
- Encouraging patients and staff to challenge non-compliance with HCAI guidelines.
- Ownership of clinical incidents by medical and nursing staff ensuring that advice given by the IPCT to safeguard patients with infections is prioritised and acted upon in a timely fashion.

Area for improvement	Action planned	Desired outcome	Target date	Lead
Displays of IPC performance	• IPC information displayed in each ward / department - tailored to needs of public and staff.	• Open, transparent and learning culture seeking excellence in IPC • Enhanced awareness • Improved patient safety.	Oct – Dec 18	HOS/ Lead nurses
Challenge HCAI non-compliance	• Role modelling, constructive support and accountability enhancing a culture of excellence in IPC.	• Culture of IPC excellence	Oct - Dec 18	All staff SMT,
Ownership	• Engage clinical teams in reviewing & sharing learning from clinical incidents. • Provide clarity re roles and responsibilities following review of incidents.	• Clinical incidents are owned by the clinical team. • Incidents investigated, learning implemented to minimise possibility of recurrence.	Oct - Dec 18	Clinical team in charge of the patient. With support from IPC

3. Communication and candour - Year 1 Implementation Plan

Clinical staff communicate effectively with patients and their relatives. This will be achieved by:-

- Timely appropriate communication with patients regarding infections they have and how they will be treated.
- Creating opportunities for staff to access IPC information.
- Building public awareness and appeal for public help in improving IPC

Area for improvement	Action planned	Desired outcome	Target date	Lead
Communication with patients	• Review information available. Develop new materials as required. • Medics & nurses to document all communication re life threatening infections. • Highlight cases which illustrate issue.	• Timely & clear communication with patients. • Better documentation of important conversations with patients / families & information materials provided. • Better understanding re importance of accurate documentation.	By Dec 18 By Dec 2018 Oct 2018	IPC team & comms Med Dir/ Dir Nursing. AMDs Dr Brown
Creating opportunities to access IPC information.	• Reviewed guidelines to be made available on intranet. (Ensure updated links are on all current platforms until all migrate to Sharepoint). • Launch Microguide App • Launch infectious agent toolkit	] • More readily accessible & available up to date information to support decision making.	Sept 18 July 18 Sept 18	IPC team / Dr Brown G Conlon Bingham IPC team
Building public awareness	• Develop communications strategy	• Raise awareness of IPC / patient safety as key Trust priority. Prevent spread during increased incidences of infection or outbreak.	By Sept 18	Comms team

4. Clean Hands - Year 1 Implementation Plan

Hand Hygiene Policy and 'Bare below the elbow' are strictly observed. This will be achieved by:-

- Ensuring ALL staff understand and embrace their personal and professional responsibility in relation to the Hand Hygiene [HH] and Bare below the Elbow [BBE] policy and that each individual is fully compliant.

Area for improve-ment	Action planned	Desired outcome	Target date	Lead
All staff understand Hand Hygiene & Bare Below the Elbow policy & comply with same.	• Frequent compliance audits. • Changing hearts and minds of people who don't comply by proving evidence of rationale for policies.	• Minimum of 95% compliance.	Sept 18 contin-uous	Medical, Nursing & Operational Directors. Heads of Service. Lead Nurses Ward Sist/Charge-nurses. IPC Team
	• Develop high visibility campaign refreshing previous clean hands branding. • Ensure clear signage reminding staff & visitors to wash hands.	• New campaign and signage standardised across Trust facilities.	In place by Dec 18	Communications IPCT Medical & Nursing Directors.
	• All staff fully understand the requirement to comply with HH and BBE policy. • Persistent non-compliance will be addressed by line manager/Clinical Director and if not resolved will be escalated to Assoc. Medical Director. • Ward Persistent non-compliance will be addressed by Sister/Charge-nurses & Lead nurses.	• All staff empowered to challenge non-compliance & escalate if not rectified. • Continued non-compliance will require formal review from line manager to ensure issue is rectified • All staff will be aware of the procedure to be followed where non-compliance is apparent	Dec 2018 Contin-uous	Medical, Nursing and Operational Directors Heads Of Service Lead Nurses Ward Sisters/Charge-nurses IPC Team
	• Work with supplier of hand hygiene products to ensure staff needs met and signage is clear.	• All areas to have refreshed and replaced wall mounted holders following Trust wide scoping exercise.	Dec 2018	Company, IPC Team HOS Lead Nurses Ward Sisters/Charge-nurses

5. Clean Place - Year 1 Implementation Plan

Trust Board to receive regular updates of Environmental cleanliness performance measured against regional standards. This will be achieved by:-

- Ensuring that the highest standards of environmental cleanliness are achieved at all times.
- The right people in place with the correct training, and adequate monitoring arrangements.
- An extensive programme of technical, departmental and managerial audits with regular reporting of audit outcomes.

	Action planned	Desired outcome	Target date	Lead
Ensuring highest standards of environmental cleanliness are achieved at all times.	• Lead Nurses/Ward Managers, Estates Officers, and Domestic/Support Services Managers to participate in the 3 monthly Departmental Audits, is based on a rolling programme, to assess the ward performance • Continue to Audit using the regional Audit tools, based on the RQIA standards for environmental cleanliness, which has now been transferred onto the new MICAD audit tool. • Continue to provide regular reports to the Ward, HOS and Directors on the standards being achieved and actions required. • Audit results to be discussed at SMT and Trust Board.	Provide safe clean facilities, not only from an infection control perspective but also from a visual perspective as the standard of cleaning is a high profile topic for patients, visitors and members of the public. Provide assurance to the organisation at all levels that the standards of environmental cleanliness are satisfactory.	Nov 18	HOS/ Lead Nurses/ / Support Services / Estates

Training and monitoring	• Review Environmental Cleanliness Strategy and Policy. • Invest in resources to ensure training out of the SOPs is systematic and ongoing. • Prepare Business Case to seek funding to address the shortfalls in the exiting staffing levels on Acute sites across the 24 /7 period.	All staff clear on roles and responsibilities. Level of supervision sufficient to deliver support and training. Staffing levels in place to meet the demands for cleaning 24/7.	Nov 18	Support Services
Leadership	• Leadership walk arounds to ensure expected standards are in place across all facilities	Delivery of clean and well maintained ward/ department/ facility infrastructure	Continuous	HOS/ Lead Nurses/
Put in place building fabric that supports achieving a clean environment	**Short term** Review the scores from the environmental cleanliness audits for Estates elements and investigate what works can be delivered through Minor Works/maintenance Review the Minor Works Lists and put in place a mechanism to prioritise work to be undertaken. Review how funding is allocated for Minor Works/ maintenance so that outcomes can be delivered. Identify a location so that Wards can be decanted during significant Estates works. 3 North to be considered for CAH site and a location for 6 beds in DHH.	Estates infrastructure and maintenance makes delivering cleaner facilities achievable. A process to ensure the prioritisation of IPC related works. Minor works are prioritised to support the delivery of the best outcomes from an infection control perspective. Provide a location to facilitate future Estates refurbishment projects .	Continuous Continuous Continuous Nov 18	Estates/ Support Services/ Infection control IPC/HOS/ Estates/ Support Services IPC/HOS/ Estates/ Support Services

	Long term Ensure that all new buildings/refurbishments take account of the 'cleanability' and maintenance at the design stage. Develop standard specifications for new buildings/refurbishments based on past evidence / expertise on the whole life of the materials used. (Estates, Infection control, Domestic Services)	Buildings are cleanable in the long term.		SMT/ Planning/ IPC/HOS/ Estates/ Support Services

6. Isolation - Year 1 Implementation Plan

Prompt decisions based on clinical risk assessments are made on the isolation of patients in line with the Trust's isolation protocol. This will be achieved by:-

- Prompt identification and isolation of patients with:-
  - diarrhoea of unknown cause by clinical teams in consultation with patient flow.
  - conditions requiring airborne and droplet precautions and
  - other conditions with significant IPC implications e.g. CPE

Area for improvement	Action planned	Desired outcome	Target date	Lead
Isolation of patients with diarrhoea & other conditions with IPC implications	• Increase number of isolation facilities and negative pressure rooms in the 2 acute sites initially.	• Develop a proposed strategy to put in place ref negative pressure rooms on all sites, starting with DHH. Increased capacity to deal with patient safety requirements.	commence Oct 18	Mark Bloomer
	• Raise awareness of the importance of early recognition of the potential for infectious diagnoses. • Patients to be isolated on suspicion of infection. Isolation must not be delayed pending lab results. • Given current lack of side room availability – process for prioritisation must be agreed led by IPC team. • Estates strategy for development of isolation rooms and additional side rooms to be developed.	• All patients with suspected infections isolated without delay.	commence Sept 18	Medical Director, Director of Nursing, /Mark Bloomer/ Catriona McGoldrick/I**PCT**/Anita Carroll

	• Enabling best use of isolation facilities by developing local services for testing flu and norovirus. (See IPT)	• All testing available locally particularly during winter months.	Sept 18	Geoff Kennedy, Barry Conway
	• Reducing pressure on side rooms by developing OPAT service in line with national guidance. (See IPT)	• OPAT service in place	Requires regional funding. Prep work to begin in Sept 18	Sue Devlin, Sara Hedderwick Tracey Boyce
	• IPC team to be involved in all commissioning designing or facility refurbishing across the Trust.	• The highest IPC standards should be at the heart of all design, fixtures and fittings.	commence Sept 18	Mark Bloomer Colin Clarke Martin Brown Anita Carroll/Kate Corley

7- Antibiotics Year 1 Implementation Plan

Antibiotics are used safely and effectively

- **This will be achieved by:-** Developing a culture and robust plan to ensure prudent antimicrobial usage with close monitoring to ensure the highest standards.

Area for improvement	Action planned	Desired outcome-	Target date	Lead
Developing a culture of prudent antimicrobial usage	• Review antimicrobial guidelines with clinical teams. • Provide training and feedback to all clinical teams re appropriate prescribing.	• All antibiotic guidelines on intranet are in date or in process of review. • Availability & usage of antibiotic guidelines on App enabling staff access to info at point of care.	Continuous Continuous	G Con Bing Dr Brown
	• Invest in IT systems to allow ready access to antimicrobial resistance data to inform guidelines and assist with IPC Practice & resource.	• Easy access to local epidemiological data for purposes of guidelines and IPC team.	By June 19	G Con Bing Dr Brown IPC Team
	• Reinstate regular antimicrobial stewardship rounds by addressing staffing challenges in microbiology and antimicrobial pharmacy.	• Antimicrobial stewardship rounds undertaken monthly on all acute wards, with timely feedback to staff groups. Ward rounds to be multidisciplinary involving microbiologist, pharmacist and ward consultant.	By **end Oct 19**	Medical Director / Dr Brown
	• Appropriate sampling sent to lab before prescribing AMT. • Review audit data to identify key areas of concern and address these. • Areas of concern outside Trust control to be escalated regionally.	• Determination of level of appropriate sampling and action of results. This will identify areas to target education and training	**Mar 19**	G Con Bing Dr Brown

	• Develop APP for antibiotic guidelines. Accuracy in prescribing and administering AMT. • Participation in Antimicrobial Review Kit (ARK) research to improve the review & shorten duration of antibiotic therapy.	• Availability of app will improve access to information at point of prescribing, therefore improving compliance.	Aug 18 Underway & ongoing	G Con Bing
	• During stewardship ward rounds improve engagement with clinical staff re indication for AMT.	• AMT is clearly documented in patient notes including duration and review dates.	De 18	Med Dir Dr Brown
	• Antibiotics to be reviewed daily re ongoing need/ potential for oral switch.	• Improved engagement with clinical staff during stewardship rounds where issues can be fed back	**Mar 19**	G Con Bing
	• Stewardship report to become standing agenda item at AMT meeting. • AMDs/CDs to review their areas and feedback their team performance and actions being taken to address any concerns. • Propose more frequent (bi monthly|) but shorter meetings.	• ADs and CDs feedback performance to all staff groups to JHO & staff nurse level. • Performance poster displayed in clinical areas.	Sept 18	Med Dir Dr Brown
	• Introduce training on antimicrobial prescribing & stewardship for nursing staff.	• All nursing groups trained on antimicrobial stewardship & empowered to challenge prescribing of long courses of antibiotics. Regular programme of training.	Mar 19	G Con Bing IPC team
	• Implement AMS e-learning	• Finalise & implement e-learning package.	Mar 19	Med Dir G Con Bing
	• Reduce total usage of high risk antibiotics • Reduce amount of piperacillin/tazobactam and carbapenems used in line with national targets and best performing peers.	• Review antibiotic policies with a view to decrease number of indications where piperacillin/tazobactam is first line choice, due to increasing resistance to piperacillin/tazobactam amongst *E. coli* and *K. pneumoniae* isolates	Dec 18	G Con Bing Dr Brown

8. Learning - Year 1 Implementation Plan

This will be achieved by:-

- Ensuring that ALL Trust staff are skilled and fully equipped with IPC related knowledge to help minimise the risk of infection to patients, staff and visitors.
- Ensuring Bank nursing staff is skilled and fully equipped with IPC related knowledge to help minimise the risk of infection to patients, staff and visitors.
- Assurance achieved from Nursing Agencies that IPC training is appropriate and up to date.
- Staff who work in augmented care areas have bespoke ANTT training and full awareness and appreciation of the RQIA approach to auditing augmented care areas.
- Public awareness and confidence in IPC to be reaffirmed with information and knowledge as deemed appropriate. Learning regarding IPC from the public's perspective is a key proactive objective in the holistic approach to reducing HCAI incidence.
- Maintain IPCN knowledge in a specialist clinical area

Area for improvement	Action planned	Desired outcome	Target date	Lead
Staff skilled and equipped with knowledge to help minimise the risk of infection.	• IPC training at induction	• IPC highlighted to all new Trust staff at induction.	Sept 2018 Continuous	IPCT
	• RCA / Post infection review lessons learned and shared	• RCA training for all IPC and clinical staff.	March 2019	Med Dir Nurse Dir IPCT
	• Develop and promote the role of link members to enhance best practice. • Ringfenced time for IPC Link members to attend	• Enhance knowledge base of clinical staff re IPC. Create IPC champions to drive, support and sustain this strategy. Agree roles & responsibilities.	Dec 2018	HOS Lead Nurses Ward Sister/Charge-Nurse

				IPCN
	• Continue IPC blended learning approach via IPC Training Matrix & aim to increase numbers of staff trained. • Give consideration to a Mandatory Training Passport that is transferrable between Trusts or from Employer to Trust.	• Training opportunities will remain available for ALL staff. • 5000 staff to have IPC mandatory training • Generate a positive learning culture for ALL staff • Mandatory Training Passport Achievable across all health care professions	April 2019 2021	IPCT ELD
	• Continue to provide ad-hoc IPC related training sessions as required. • All Trust Bank, Part-Time and Night staff have up to date IPC Mandatory Training. • Assurance that all Agency nursing staff have appropriate and up to date IPC mandatory Training	• All ad-hoc IPC related training sessions are delivered • Achievable through working with Nurse bank manager • Achievable by working with various agencies and seeking written approval from Agencies that staff comply with IPC mandatory Training.	Sept 2018 Continuous April 2019	IPCT Nurse Dir Lead IPCN Nursing Agencies SHSCT Nurse Bank manager
	• Expand areas covered by 'e' learning to include for e.g. prescribing & stewardship. Develop app to build on e-learning and antimicrobial prescribing within the Trust.	• Training opportunities for antimicrobial prescribing & stewardship to be created 2018-19 and made available for medical and nursing staff across the Trust.	April 2019	Consultant Micro Antimicrobial Pharmacist Nurse Dir Lead IPCN
Augmented care	• Organise twice yearly ANTT (Aseptic non touch technique) face to face training from external provider. • Maintain augmented care sisters meetings to help support and sustain learning and to promote	• All augmented care staff to complete ANTT e learning dates secured for 29 October 2018 and 8 April 2019 • Augmented care sisters meetings held 2 monthly across the Trust	April 2019	Ward Sisters/Charge-Nurses IPCNs

	collaborative working.			
IPCN Training needs	• Continue in house training from experienced IPCNs. • Arrange 1 day course in water safety and water management • IPC certificate or diploma / degree affiliated with a UK university with view to succession planning and enhancing knowledge base across trust.	• IPCN staff trained using all opportunities available & explore potential for all IPCNs to completed a University affiliated IPC course.	April 2019 Continuous	Lead IPCN IPCNs IPCT

9. Audit - Year 1 Implementation Plan

Clinical & managerial teams, SMT & Trust Board receive regular reports to monitor compliance at ward level against local and regional policies. This will be achieved by:-

- Development of detailed frequent reports
- A programme of IPCN & Independent audit to continue and to expand.

Area for improvement	Action planned	Desired outcome	Target date	Lead
Detailed reports	• IPC related Reports developed covering compliance and non-compliance:- - Missed opportunities with Hand hygiene - clinical practice inc. care bundles - dress code & Bare Below the Elbow, -Personal Protective Equipment (PPE) compliance - antimicrobial prescribing - environmental cleanliness - water management & testing - IPC risk assessment and appropriate isolation; - MRSA screening and isolation; - Effective communications with patients and carers. • Any area with a score of below *for e.g. 90%* will be required to implement a more frequent self-audit programme to help improve and sustain performance and compliance. Areas where this applies will work individually with the IPCN • All Directors will be held accountable for IPC related performance as will ADs, HOS & Lead Nurses for all wards / departments.	• Reduced HCAI incidence • Improved patient safety outcomes • To ensure PHA / PfA targets are met for 2018-19 • Continued promotion of ownership of IPC related activities • Achieving and sustaining a reversal in recent downturn in IPC performance • Continued engagement and collaborative working		

	• IPC targets will be built into Directors Personal Development Plans	with clinical teams • Directors drive IPC strategy within every directorate.		
IPC Independent audit	• Continue current IPC independent audit timetable. • Extend IPC audit to include other key areas for audit eg. . PPE wearing,	• Evidence and assurance re patient safety initiatives.		

10. Closing the loop Year 1 Implementation

Frequent feedback from ward to Trust Board to provide assurance that Board decisions are being effectively implemented and continuous improvement is achieved. Frequent feedback within clinical and managerial teams to ensure learning is achieved and continuous improved is sustained. This will be achieved by:-

- Monthly summary of performance in preventing and controlling HCAIs to include rates and case numbers for *C difficile*; MRSA; MSSA; Gram-negative bacteraemia, E Coli, Pseudomonas aeruginosa; VAP; Cannula and catheter associated infections.
- Root Cause Analysis (RCA) need to show learning – if not account for at strategic & clinical forums. Serious Adverse Incident (SAI) learning in relation to IPC to be shared by Directorates at Board level.

Area for improvement	Action planned	Desired outcome	Target date	Lead
Monthly performance summary	• Detailed reports to be provided with regular attendance / presentations / strategy implementation updates provided to clinical fora & up through SMT and Trust Board. • Establish steering group to address new targets for Gram-negative bacteraemia.	• Continuous sustainable improvement achieved. • Reduction in preventable Gram-negative bacteraemias.	Ongoing from Oct 18 continuous to March 19	IPC Team
RCA & SAI learning	• Utilising current platforms through strategic and clinical forums for shared learning assurance and accountability. • Identified learning should be shared at all ward sister meetings and all other clinical forums.	• Better learning through better sharing.	Ongoing from Oct 18 continuous to March 19	Operational Directors

Southern Health and Social Care Trust

Quality Care - for you, with you

Medical Leadership Review

2018

V-11 - 10th September 2018

Dr Ahmed Khan

DRAFT

Contents

Section 1 – Medical Leadership Structure Review Framework

1. Background and Context

- Good medical leadership has been identified as vital in delivering high-quality healthcare[1]. There is an increasing body of published literature that links the performance of units to levels of medical leadership[2].

- To achieve strong medical leadership competence doctors are required to develop strong personal and professional values, a range of non-technical skills that allow them to lead across professional boundaries, and an understanding of the increasingly complex environment in which modern health and social care is delivered[3].

- The medical leadership structure within the SHSCT last underwent a review in 2011 where medical leader's functions, responsibilities and accountabilities were considered. Additional leadership roles were introduced to support medical revalidation processes, GMC responsible officer requirements and to support the development of SAS grade doctors.

- Given the length of time since this review and the significant changes in health and social care landscape it is time to review and possibly to revise, the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a highly dynamic environment.

- The structure that emerges from the review must have the appropriate processes and resources to support the effective delivery of high quality, safe, patient focussed services, and to support education and research. It must ensure appropriate ongoing scrutiny of the clinical performance of existing services, as well as new developments.

- It must facilitate timely, transparent decision making to maximise opportunities to improve existing services, and where appropriate, develop new services for patients. It

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[1] *Warren OJ, Carnall R Medical leadership: why it's important, what is required, and how we develop it Postgraduate Medical Journal 2011;87:27-32.*
[2] *Clark J. Enhancing medical engagement in leadership. InView 2006;10:14e15.*
[3] *Darzi A. A time for revolutions – the role of clinicians in health care reform. N Engl J Med. 2009;361(6):e8.*

must encourage all clinicians contribute to the development of the Trust strategic planning and then take responsibility for contributing to its delivery.

2. Strategic Drivers

- The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate healthcare. Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental[4].

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

- Commitment is manifested by everyone in the organisation taking responsibility and making it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation[5].

2.1– HSC Collective Leadership Strategy

- Collective leadership offers us a real opportunity for creating a culture of high quality, continually improving, compassionate care and support. There is consistent evidence that collective leadership in health and social care is necessary for overcoming the challenges we face and we recognise that it will require us as leaders, both formal and informal, to have courage, commitment and determination.

2.2United Kingdom Regional Workforce Strategy Policy Direction

- All NHS UK regional Departments of Heath have endorsed leadership models that suggest clinicians need to become more actively involved in the planning, delivery and transformation of health and social care services[6,7,8,9.]

[4] *Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base (2011)*
[5] *Drath, W. H., McCauley, C. D., Palus, C. J., Van Velsor, E., O'Connor, P. M. G., and McGuire, J. B. (2008). Direction, alignment, commitment: Toward a more integrative ontology of leadership. The Leadership Quarterly, 19 (6), 635–653.*

- Current NHS Workforce Strategies are based on the concept of shared leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

- Statements that endorse and support leadership and leadership development are found throughout supporting UK NHS Workforce Development Documentation:

  - ***Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services***
    "*Health and Social Care needs excellent leadership and management. Health and Social care organisations provide increasingly complex services, requiring highly skilled managers. The pace of change is unrelenting and staff look to their managers for clear direction and support."*

  - ***Department of Health England, Next Stage Review: High Quality Care for All***
    "Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow."

  - ***NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership***
    "Effective leadership at all levels is essential to delivering the goals of NHS Scotland and ensuring high quality, safe and effective care. It is recognised that leadership development is a life-long activity and not confined to specific levels or groups of the workforce."

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[6] *Health and Social Care Northern Ireland: Workforce Development Strategy for Northern Ireland Health and Social Care Services (2009)*
[7] *Department of Health England, Next Stage Review: High Quality Care for All (2008)*
[8] *NHS Scotland Leadership Development Strategy: Delivering Quality Through Leadership*
[9] *National Leadership and Innovation Agency for Healthcare Wales*
1 HSC-*Collective Leadership strategy*

- ***National Leadership and Innovation Agency for Healthcare Wales***
  "Effective clinical leadership is pivotal in ensuring that improvement in healthcare is not only on the agenda of all NHS organisations – but becomes part of their very DNA. Transforming healthcare is everyone's business with the provision of high quality care being at the heart of everything we do. Creating a culture of visible commitment to patient safety and quality requires clinical and professional leaders to work together so that NHS Wales can meet the healthcare challenges of the future."

3. Why Invest In Medical Leadership

- Clinicians across Health and Social Care are often be asked to take on leadership roles, with responsibility for staff objectives, appraisal, and performance management, as well as all other resource management issues, without supports to help them make the necessary transformation into these roles.[10].

- Organisations that invest in leadership can equip leaders with the skills that allow them to build alliances with a wide range of professionals and across organisational boundaries to serve the needs of diverse communities with enduringly complex needs.

3.1 The benefits of investing in healthcare leadership are well documented, these include:

- *West et al* have demonstrated the link between good leadership and HR practice in healthcare and patient mortality and morbidity rates – more engaged staff, through better leadership, saves lives[11]
- The Journal of Occupational and Environmental Medicine reports that workers with good leadership were 40% more likely to be in the highest category of job well-being, with low rates of symptoms like anxiety, depression, and job stress[12]

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[10] *NHS Leadership Academy https://www.leadershipacademy.nhs.uk/reasonstoinvest/ Accessed June 2018*
[11] *West, Michael, and Jeremy Dawson. "Employee engagement and NHS performance." The King's Fund 1 (2012): 23.*
[12] *Jacobs, Christine, et al. "The influence of transformational leadership on employee well-being: results from a survey of companies in the information and communication technology sector in Germany." Journal of occupational and environmental medicine 55.7 (2013): 772-778.*

- The Corporate Leadership Council estimates that employees working for good leaders put in around 57% more effort and are 87% less likely to leave than those with poor leaders[13]
- A study in the Harvard Business Review (*Bassi and McMurrer*) provides a strong link between leadership skills and organisational performance[14]
- The Care Quality Commission's report *The state of health care and adult social care in England* highlighted that you can't have a well-performing organisation that isn't well-led. In fact, over 94% of services that were rated good or outstanding overall were also good or outstanding for their leadership and similarly, 84% of inadequate services were inadequately led[15]

4. Review of Best Practice Literature

4.1 NHS Medical Leadership Competency Framework (MLCF)

- The MLCF describes the leadership competences that doctors need to become more actively involved in the planning, delivery and transformation of health services.

- The MLCF describes leadership is a key part of doctors' professional work regardless of specialty and setting. It is already a requirement of all doctors as laid out in the General Medical Council's (GMC) publications Good Medical Practice, Tomorrow's Doctors and also Management for Doctors.

- While the primary focus for doctors is on their professional practice, all doctors work in systems and within organisations. It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professional and therefore have an intrinsic leadership role within healthcare services.

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[13] *Council, Corporate Leadership. Driving performance and retention through employee engagement. Vol. 14. Washington, DC: Corporate Executive Board, 2004.*
[14] *Bassi, Laurie & McMurrer, Daniel. (2007). Maximizing your return on people. Harvard business review. 85. 115-23, 144.*
[15] *Care Quality Commission. The state of health care and adult social care in England in 2011/12. Vol. 763. The Stationery Office, 2012.*

- Doctors also have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. The development of leadership competence needs to be an integral part of a doctor's training and learning. The MLCF is intended as an aid and driver for this and to enable a doctor in the NHS to be a practitioner, a partner and a leader.

- The Medical Leadership Competency Framework (MLCF) is built on the concept of shared leadership where leadership is not restricted to people who hold designated leadership roles, and where there is a shared sense of responsibility for the success of the organisation and its services. Acts of leadership can come from anyone in the organisation, as appropriate at different times, and are focused on the achievement of the group rather than of an individual.

4.2 Clinical Leadership Competency Framework (CLCF)

- The Clinical Leadership Competency Framework (CLCF) was developed through consultation with a wide cross section of staff, patients, professional bodies and academics, and with the input of all the clinical professional bodies throughout the UK and has the support of the chief professions officers, the professions advisory boards, the peak education bodies and the Department of Health.

- The CLCF states that while the primary focus of clinicians is on their professional practice, all clinicians, registered or otherwise, work in systems and most within organisations. It reinforces the vitally important role that clinicians have regarding influence on these wider organisational systems and thereby improve the patient experience and outcome.

- Clinicians have an intrinsic leadership role within health and care services and have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction. Therefore the development of leadership capability as an integral part of a clinician's core work is a critical factor.

4.3 Kings Fund - Leadership and Leadership Development in Health Care: The Evidence Base

- The Kings Fund Evidence Base paper on Leadership and Leadership Development (2008) highlights the importance of strong medical leadership stating medical leaders create a strong sense of team identity by ensuring: the team has articulated a clear and inspiring vision of the team's work; there is clarity about the team's membership; team members agree five or six clear, challenging, measureable team objectives; there is strong commitment to collaborative cross-team and cross-boundary working.

- The paper presents a large scale review of medical leadership models where it was found that medical or clinical leadership varied across the case study sites they assessed. The paper reports variations both between, and within organisations in the extent to which doctors felt engaged in the work of their organisations.

- Those organisations with high levels of engagement performed better on available measures of organisational performance than others. In addition, it found that in high-performing trusts, interviewees consistently identified higher levels of medical engagement.

5. Focus of Medical Leadership Review

The 2018 Trust medical leadership review will focus on strengthening four key areas:

Development Aim	Rationale	Intended Outcomes
Support Medical Leadership Development	Leadership skills should be an essential component of development all medical staff[1]. Doctors should not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments.	• Implement a Trust Medical Leadership Framework for development
Increase the Role of Succession Planning	Staff are the Trusts most valuable asset, managing, nurturing and keeping medical staff engaged and motivated important for the Trust's ability to provide high-quality care. To achieve this will require the development of a medical succession planning strategy, which must be related to the organisation's vision and strategic objectives.	• Development of a medical succession planning strategy • Creation structured opportunities for staff to develop and gain insight into more senior roles
Enhanced Accountability for Medical Leaders	Enhancing accountability for medical leadership roles can assist in ensuring ownership, setting expectations and strengthen culture[16] within clinical teams.	• Link accountability to the Trust Medical Leadership Framework • Agree performance indicators for each service area

[16] Niven, Paul R. Balanced scorecard step-by-step: Maximizing performance and maintaining results. John Wiley & Sons, 2002.

Review the Current Structure of Medical Leadership	Review the Trust medical leadership form and function, on the basis of an assessment of how fit for purpose it remains in a constantly changing environment.	• Provide an updated medical leadership structure for SMT approval

6- Review Process timeline

6.1- Throughout the review process Trust Medical Leaders and Directors were engaged through a variety of mechanisms to ensure all views, experiences and requirements are fully captured.

6.2- The following staged approach to delivering the Medical Leadership review and proposal was enacted:

Stage	Stage Title	Elements	Timeline
1	**Literature and Practice Review**	• Review of best practice literature regarding medical leadership (including NHS Medical Leadership Competency Framework) • Review of other regional Trusts / NHS UK Trusts existing Medical Leadership structures	30th May 2018
2	**Stakeholder Engagement**	• Conduct a face to face SWOT[17] analysis via a with existing Trust medical leaders (AMDs and CDs) • Engage Trust Medical Leaders (AMDs and CDs) in a qualitative and quantitative evaluation • Engage SHSCT Directors via a survey	30th July 2018
3	**Development of a Proposal Paper for SMT Approval**	• Draft of proposal paper to meet review aims for agreement by AMD's • Proposal Paper for presentation to SMT for approval	30th October 2018
4	**Implementation**	• Development of prioritised action plan for AMD approval • Development of project milestones for monitoring project progress	Jan 2019

[17] (Strengths, Weaknesses, Opportunities and Threats)
https://www.mindtools.com/pages/article/newTMC_05.htm

7. Current Trust Medical Leadership Structure

7.1- Medical Leadership Structure (since 2011)

- The Southern Health and Social Care Trust medical leadership structure last underwent review in 2011. As an outcome of this review three new sessional posts were created to support the introduction of medical revalidation and revised appraisal processes (1 Corporate Lead, 1 Consultant Lead and 1 SAS doctor lead to support Appraisal and Revalidation with a total additional allocation of 4 PA's per week which has now been reduced to 3 PAs).

- The central medical leadership structure remained unchanged as a result of the review with the number and ratios of Associate Medical Directors remaining constant. However, in the intervening years changes were made which included the consolidation and discontinuation of two AMD positions:

    - **AMD Emergency Care - *Post absorbed into Medicine and Unscheduled Care (2016)***
    - **AMD Infection Prevention and Control – *Post not retained (2015)***

7.2- The current Southern Trust Medical Leadership Structure is outlined below:

Medical Leadership Structure Today (June 2018)

Corporate AMD Roles
AMD Medical Education
AMD Research and Development
AMD Older Persons and Primary Care (Aligned to OPPC)
Operational AMD Roles (and Supporting CD's)
AMD Cancer and Clinical Services *3 x Supporting Clinical Director Roles*
AMD Children's and Young Peoples Services *4 x Supporting Clinical Director Roles*
AMD Anaesthetics and Intensive Care *3 x Supporting Clinical Director Roles*
AMD Surgery and Elective Care *3 x Supporting Clinical Director Roles*

AMD Medicine and Unscheduled Care *5 x Supporting Clinical Director Roles*
AMD Integrated Maternity and Women's Health *2 x Supporting Clinical Director Roles*
AMD Mental Health and Disability Services *3 x Supporting Clinical Director Roles*
Appraisal and Revalidation Roles
Corporate Lead for Appraisal & Revalidation
Consultant Lead for Appraisal & Revalidation
SAS Lead for Appraisal & Revalidation
Morbidity and Mortality Roles
DHH Medicine Chair & Sub-speciality chairs
CAH Medicine Chair* & Sub-speciality chairs
Trust wide Surgery Chair* & Sub-speciality chairs
Trust wide CYPS Chair
Trust wide IMWH Chair
Trust wide MHLD Chair

* *Medicine and Surgical Specialities are supported*

8. The Case for Change

- Given the significant body of evidence available on Medical Leadership development three key areas feature strongly.

8.1 Supporting and Influencing Service Planning

- Doctors in strong leadership roles have the ability to influence senior managers and shape service delivery to strengthen focus on patient well-being. Given the inherent tension between costs and patient welfare it is of vital importance there is a strong clinical voice ensuring that best value is sought for every patient on every interaction with our services.

- Furthermore, decisions made by senior management influence the amount and kind of care patients receive on the ward, the clinic, or in the community, administrative and policy changes do have the potential to have an impact on medical outcomes.

Doctors are uniquely positioned to understand the potential impact of policy or funding changes[18].

8.2 Providing a Link from Ward to Board

- Medical leaders understand the complexity of modern health care services and understand both how to optimise organisational performance and influence clinical practice. Health and Social Care is subject to an increasing level of competing demands while trying to balance the allocation of scarce resources to individual patient care and the care of communities and populations. Medical leaders are ideally suited to provide expertise when these decisions are being made as they understand what is possible, what is doable and what is affordable[19].

8.3 Performance of Frontline Teams

- There is a growing body of literature on the specific relationship between the performance of frontline organisational teams and medical outcomes. This literature confirms that patient outcomes are not a function of the potential of the technology or the skill of individual caregivers alone but also depend on the functioning of the systems in which these individuals apply medical technology to address patients' health problems. Better management of the care itself, as well as management of the organisational setting in which the care takes place, leads to better outcomes.

[18] *Darzi A (2009). 'A time for revolutions: the role of clinicians in health care reform'. The New England Journal of Medicine, vol 361, no 6, e8.*
[19] *Brook RH (2010). 'Medical leadership in an increasingly complex world'. JAMA, vol 304, no 4, pp 465–6.*

9 Consultation with Trust Medical Leadership

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

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

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

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

10. Consultation with Trust Directors

10.1 Trust Directors were asked to give their views and opinions on current medical leadership structure. A short questionnaire was provided to participants asking for views on the current medical leadership functions and roles including contribution to leading and developing services, integration with operational management teams and what opportunities exist to strengthen the medical leader role.

10.2 A summary of key findings that relate to the current medical leadership model is found in the table below.

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

Strengthening Medical Leadership Structures	• Increasing the profile and visibility of Medical Leaders • Ensure appropriate tasks are delegated • Agreement of outcome measures for each role • Build relationships and strengthen channels of communication between medical specialties • Joint Leadership development programmes with well embedded multidisciplinary approaches

10.3 The questionnaire found several areas of commonality between directorates, namely the benefit of clearly defining medical leaders roles and accountabilities, protected time to deliver in their roles and greater integration with operational management teams.

11. Comparison with Analogous Organisations

11.1 - Northern Ireland Regional Trusts

- The following comparisons of medical leadership structures with regional Health and Social Care Trusts is found below:

Northern Health and Social Care Trust	South Eastern Health and Social Care Trust
• Medical Director • Deputy Medical Director • AMDs • Clinical Director Structure*	• Medical Director • Deputy Medical directors • AMDs • Clinical Director Structure*
Western Health and Social Care Trust	**Belfast Health and Social Care Trust**
• Medical Director • Clinical Director Structure* • Lead Clinicians	• Medical Director • Deputy Medical Directors x3 (5PA each post) • Divisional Director leads • Clinical Director Structure* • Lead Clinicians**

** Lead clinicians are formal roles within the medical leadership structure

11.2 NHS United Kingdom Acute Trust Models

11 The following comparison is of two NHS UK Trusts who have published their medical leadership structures, it is important to note that terminology of medical leadership role titles is often unstandardized and responsibilities can vary widely.

Mid Cheshire NHS Foundation Trust	Warrington and Halton Hospitals
• Medical Director • 1 DMD • Clinical Director Structure* • 1 Patient Safety lead • 1 Clinical effectiveness lead •	• 1 MD • 1DMD (8 PAs) • Clinical Director Structure* • Lead Clinicians**

*Clinical Directors are equivalent of SHSCT AMD roles

**Lead clinicians are formal roles within the medical leadership structure

Section 2 – Proposed Medical Leadership Structure

12. Medical Leadership Development and Competence

12.1 The current medical leadership structure is significantly smaller than the structure that emerged following the 2011 medical leadership review. As previously noted, AMD posts for Emergency Medicine (3 PA's) and Infection Prevention and Control (2 PA's) were stood down and the duties merged into operational AMD roles.

12.2 To further integrate the role of Associate Medical Directors and Clinical Directors with the Medical Director it is proposed that one third of the cost of operational AMD and CD PA role cost is funded from the Medical Directors budget (the remaining two-thirds met from existing operational directorate funds). The revised PA funding allocation will allow a portion of medical leadership responsibilities to be aligned to the medical director formally.

12.3 A supplementary paper titled ***"Medical Management and Leadership Development Program"*** will follow.

13. Medical Leadership Fixed Term Appointments

13.1 This paper proposes that all senior medical leadership positions commencing from January 2019 are fixed-term appointments (details found in subdivision 13 below) and do not carry any expectancy of automatic renewal or conversion to any other type of appointment. A fixed-term appointment may be extended, under the conditions set by the Medical Director, provided that the total duration of service under consecutive fixed-term appointments does not exceed more than one year beyond the original appointment end date.

14. Proposed Medical Leadership Roles and Responsibilities

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

14.1 Medical Director

Role Description	**Medical Director** The Medical Director is an Executive Director and is responsible for providing assurance to Trust Board that effective systems and processes for good governance, including those arrangements to support good medical practice, are in place. • Responsible for providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. • Leadership role in the provision of safe, high quality services, support the reform and modernisation programme and drive initiatives for continuous quality improvement. • Lead responsibility for clinical governance. • Responsible Officer (RO), with statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust. • As a member of the Trust Board and the Senior Management Team have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.
Number of Posts	1 Post (Existing)
PA Allocation	10PA
Areas of Responsibility	• Medical Professional Governance including RO duties, • Clinical and Social Care Governance, • Medical Workforce Development, • Medical Education & Training • Audit & Research with Linked to QI,

	• Infection Prevention and Control • Emergency Planning
Appointment Term	Permanent Post

14.2 Deputy Medical Directors (2 part time Posts Total)

Role Description	**DMD – Workforce Development (New part time post)** The Deputy Medical Director (Workforce Development) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop a leadership and workforce development strategy, support the development of job plans, and participate in training programmes as required.
Number of Posts	1 New Post
PA Allocation	5 PA (To be funded from proposed new MD budget)
Areas of Responsibility	• Medical Appraisal & Revalidation • Job Planning • Medical Professional Governance • Litigation Oversight
Appointment Term	5 years Initially – with 1 year extension if required

Role Description	**DMD- Safety and Quality (New part time post)** The Deputy Medical Director (Safety and Qualit) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, develop a clinical governance strategy, support the development of clinical governance plans, and participate in education and training programmes as required.
Areas of Responsibility	• Morbidity and Mortality Lead • Adverse Incident / Serious Adverse Incidents • Complaints Oversight • Quality Improvement

	• Clinical Audit
PA Allocation	5 PA (To be funded from proposed new MD budget)
Appointment Term	5 years Initially with 1 year extension if required

14.3- Associate Medical Directors (10 Posts Total)

Role Description	**Associate Medical Directors (Operational Services)**
Number of Posts	8 Posts (All existing fully funded)
Areas of Responsibility	• Cancer and Clinical Services • Children's and Young Peoples Services • Anaesthetics and Intensive Care • Surgery and Elective Care • Medicine and Unscheduled Care • Integrated Maternity and Women's Health • Mental Health and Disability Services • A/E (Currently included in Medicine & unscheduled care)
PA Allocation	3 PA per post (1 PA funded from proposed new MD budget, 2 PA's from Operational Budget)
Appointment Term	4 Years Initially with 1 Year extension if required

Role Description	**Associate Medical Directors (Corporate Services)** Associate Medical Directors with professional and corporate responsibility for Medical Education and Research and Development.
Number of Posts	2 Posts (All existing fully funded)
Areas of Responsibility	• Medical Education & Training • Research and Development
PA Allocation	3 PA per post (funded from MD budget)
Appointment Term	4 Years Initially with 1 Year extension if required

14.4 Clinical Directors (22 Posts Total)

Role Description	**Clinical Directors (Operational Services)** Clinical Directors will be responsible for
Number of Posts	22 Posts (All existing funded for 1PA)
Areas of Responsibility	Assigned as per existing AMD Structure
PA Allocation	1.5 PA per post (0.5 PA funded from proposed new MD budget, 1 PA from Operational Budget)
Appointment Term	3 Years Initially with 1 Year extension if required

14.5 Lead Clinicians

Role Description	**Lead Clinicians (Per speciality basis, as identified by Operational management)** Lead clinicians will provide local departmental leadership in speciality areas. Exact activities and responsibilities will be coordinated by operational directorates however at minimum will include a lead role in oversight of speciality clinical and social care governance activity.
Number of Posts	To be decided at directorate level
Areas of Responsibility	Assigned as identified by operational directorates
PA Allocation	PA cost to be agreed and funded by responsible operational directorate (proposed 0.25 -0.5PA)
Appointment Term	2 Years Initially with 1 Year extension if required

14.6 Appraisal and Revalidation Corporate and Consultant Leads (2 Posts Total)

Role Description	**Appraisal and Revalidation Corporate Lead** The Corporate Lead Role for Appraisal and Revalidation will continue to support the Medical Director and the Head of Revalidation Team in the implementation of revalidation. A key focus of the role will be the development of quality assurance and evaluation of the Trust's medical appraisal and revalidation process.
Number of Posts	2 Posts

Areas of Responsibility	• Participate in Appraisal and Revalidation Strategic Group and Revalidation Team meetings • Evaluation and Quality Assurance of appraisers roles • Evaluation of quality assurance of training and skills development programme • Quality assurance and evaluation of Patient and Colleague Feedback • Audit of all medical appraisal documentation received • Contribute to improvement of GMC Supporting Information processes implemented by the Trust including governance information • Contribute to Department of Health working groups / RO Forums • Pre-screen of information prior to revalidation • Deputise for Responsible Officer for signing-off revalidation paperwork • Ensure College standards are communicated, understood and embedded into the appraisal process • Ensure GMC standards are communicated and understood
PA Allocation	1 PA cost per post (Currently funded from MD Budget)
Appointment Term	2 Years Initially with 1 Year extension if required

14.7 Appraisal and Revalidation Lead SAS Doctor (2 Posts Total)

Role Description	**Appraisal and Revalidation Lead SAS Doctors** To deliver at a Trust level on the Department of Health agreed Northern Ireland Charter for SAS Doctors which includes specific responsibilities to support local SAS doctors via job planning, appraisal and revalidation, support for quality improvement and capturing SAS doctor clinical activity.
Number of Posts	2 Posts
Areas of Responsibility	• Support SAS doctor job planning,

	• Support and oversee quality improvement work and promote safety & audit projects undertaken by SAS doctors • Develop systems for capturing SAS doctor activity • Provide guidance and support to SAS Doctors on compilation of supporting information for appraisal. • Development of SAS Doctor Appraiser and Mentor Roles. • Increase SAS doctor engagement across the Trust via regular link-up sessions and the organisation of an annual regional NI conference for SAS doctors. • On behalf of SAS doctors, participate in the Trust's Appraisal & Revalidation Strategic Group, Medical Forum and other committees as appropriate.
PA Allocation	1 PA cost per post (1 PA currently funded from MD budget)
Appointment Term	2 Years Initially with 1 Year extension if required

14.8 Morbidity and Mortality Chairpersons

Role Description	**Morbidity and Mortality Chairs (Per speciality basis, as identified by Operational management)** A separate paper has been developed for Morbidity and mortality. M&M chairs will be responsible for the following • Setting and maintaining the agenda for meeting in line with Trust M & M Framework • Determine, support and develop appropriate patient safety inputs to the meeting • Monitor the appropriate attendance by all relevant disciplines and professional groups • Monitoring timely completion of screening templates • Monitoring of medical staff participation in Case Presentation
Number of Posts	6 Posts (existing funded) + 4 subspecialty
Areas of Responsibility	• DHH Medicine Chair • CAH Medicine Chair • Trustwide Surgery Chair

	• Trustwide CYPS Chair • Trustwide IMWH Chair • Trustwide MHLD Chair • Sub speciality Chairs
PA Allocation	1-1.5 PA per post (depend on workload (1PA currently funded)
Appointment Term	3 Years Initially

14.9 Clinical Governance Leads and Quality Improvement Leads

- Each directorate will have the opportunity to develop Clinical Governance Lead and Quality Improvement Lead posts based on local needs. These posts will be funded from directorate budgets, an outline role description will be developed as a guide by the Medical Director.

14.10 Administrative and Clerical Support Requirements

- To support the administration of the new posts and to manage new interfaces between Medical Leaders and Operational Managers it is proposed the following new posts are allocated.

Role	Time Allocation	Supporting Band
Deputy Medical Director Support	37.5 Hours per week	1 WTE Band 4
Associate Medical Director Support	6 hours per AMD per week (10 posts)	1.5 WTE Band 3
Clinical Director Support	1.5 hour per CD per week (22 posts)	1.5 WTE Band 3
Lead Clinician & M&M leads Support	To be agreed and supported by operational directorates	To be agreed at operational directorate level

15. Proposal Costings

15.1 To support this arrangement a budget for medical leadership that is the responsibility of the medical director will be required to be established in Medical Directorate.

15.2 The proposed costing for new model would be based on:

	Proposed New Medical Director Budget (Allocation Per Post)	Operational Directorate Budget (Allocation Per Post)
Associate Medical Director (3 PA) Per Post	1 PA	2 PA
Clinical Director (1.5 PA) Per Post	0.5 PA	1 PA

15.3 The following costings for the revised medical leadership structure are as follows.

	Currently Funded	New / Additional Funding Required
Medical Director	10PA	0PA
Deputy Medical Director – part time (Workforce Development)	New Post	5PA
Deputy Medical Director – part time (Safety and Quality)	New Post	5PA
Associate Medical Directors (Operational)	24PA	0PA
Associate Medical Directors (Corporate)	8 PA	0PA
Appraisal and Revalidation Corporate and Consultant Leads	2PA	0PA
Appraisal and Revalidation SAS Lead	1PA	1PA
Clinical Directors	22PA	11PA
M&M Chairs & subspecialty chairs	6PA	3PA*

**3 PA's for M&M chairs are to formalise support for sub speciality M&M meetings in Medicine and Surgery specialities*

2 The following costings for the revised medical leadership structure administration support are as follows.

Role	Currently Funded	New / Additional Required
Deputy Medical Director Support (1 WTE Band 4)	0 WTE	1 WTE
Associate Medical Director Support (1.5 WTE Band 3)	0 WTE	1.5 WTE
Clinical Director Support (1.5 WTE Band 3)	0 WTE	1.5 WTE

**Please note this is rough estimate only*

16. Proposed Service Enhancements and Accountabilities

16.1 Service Enhancements (Measurable Outcomes)

- Pending SMT approval funding the Medical Director will devise unique role descriptors for each existing and new post will agree individual accountabilities and performance measures.

- At a corporate level the following service enhancements have been identified.

Accountability	Method of Assurance
Strengthened clinical oversight and assurance of Trust Morbidity and Mortality (M&M) Process	• Responsibility for reviewing and monitoring M&M processes and outputs and identifying areas for systems strengthening • Responsibility for initiating mortality case reviews and reporting outcomes • Twice yearly assurance reporting to SMT and Trust Governance Committee on M&M processes and outputs
Strengthened clinical oversight and assurance of Trust Adverse Incident Identification and Investigation Processes	• Responsibility for reviewing and monitoring Adverse Incident processes and outputs and identifying areas for systems strengthening • Provide clinical quality assurance of Adverse Incident Investigations • Strengthen SAI investigation teams • Twice yearly reporting to SMT and Trust Governance Committee to quality assure SAI processes
Strengthened clinical oversight and assurance of Standard and Guideline processes and outputs	• Responsibility for providing assurance on Trust Standard and Guideline processes and outputs • Support directorate governance teams in identifying appropriate 'change leads' for Standards and Guidelines received by the Trust

	• Twice yearly reporting to SMT and Trust Governance Committee to quality assure Standard and Guideline processes
Strengthened clinical oversight and assurance of Trust clinical audit process and subsequent learning outputs	• Responsibility for the creation of a Trustwide priority based clinical audit programme that considers a range of potential audit activity inputs: - National and regional audits - Standard and guidelines - Adverse incident and complaints - Medical incidents - Near miss events - Audits of local interest • Responsibility to identify audit learning from audits to improve services • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Clinical Audit processes
Strengthened Lessons Learned functions	• Responsibility for the oversight and implementation of the Trust Lessons Learned function • Responsibility for ensuring that sources of learning are identified including, national regional and local learning • Responsibility to interface with local sources of learning including litigation, complaints, SAI's and patient / staff feedback. • Twice yearly reporting to SMT and Trust Governance Committee to quality assure Lessons Learned processes
Strengthened support for Trust Quality Improvement initiatives	• Responsible for oversight of local safety and quality improvement initiatives • Support for quality improvement collaborations with national and international improvement organisations, universities, health and other social care providers. • Developing capability in the medical workforce to design, deliver and evaluate a quality and safety

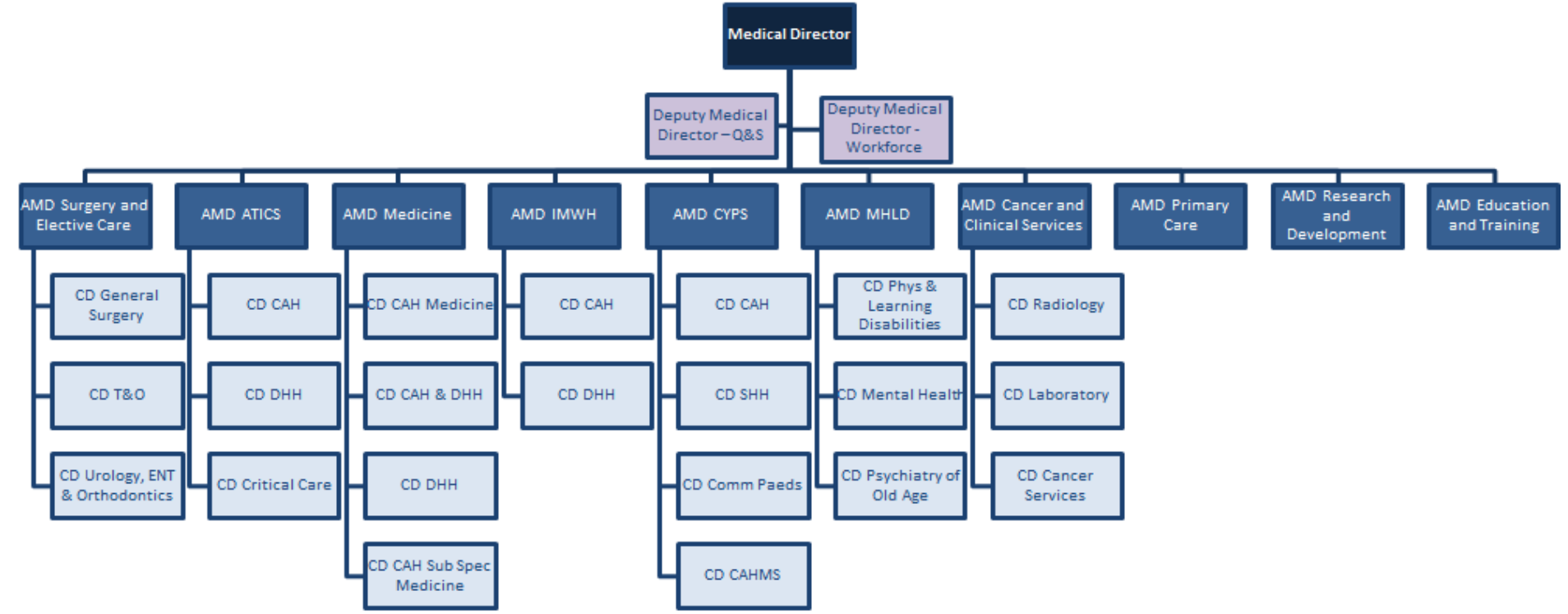
	improvement programmes. • Work with the quality improvement team towards developing a Trust quality improvement 'hub'

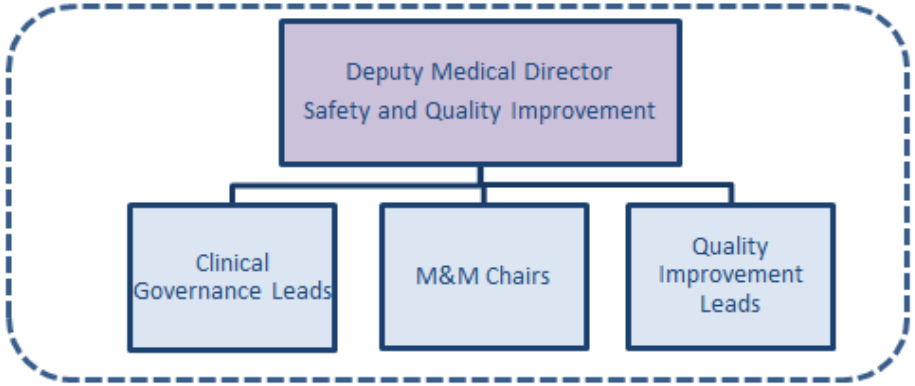
16.2 Integration with Operational Management Roles

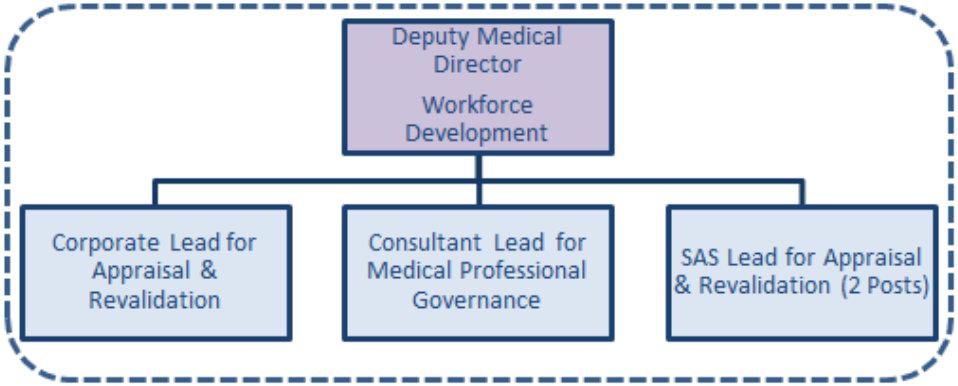
- It is proposed the following initial formal interfaces will be created / enhanced between operational managers and medical leaders. This list is not prescriptive and is aimed to set the context of a renewed phase of engagement, accountability and shared responsibility between Medical Leaders and Operational Managers.

Type of Interface	**Name**	**Composition**
Corporate Interfaces	Senior Leaders Forum	Trust Directors, AMDs and CDs (Quarterly)
	Clinical and Social Care Governance Meeting	Directorate Governance Coordinators, DMD Representation (Monthly)
	Trust SMT Attendance	Medical Director to delegate / include relevant medical leaders based on meeting requirements as required (Weekly)
Directorate Interfaces	Directorate Governance Meetings	Directorate SMT Meetings (Monthly)
	Speciality Meetings	Operational Management present at speciality meetings (Including M&M, Clinical Governance and Service Improvement meetings)
	One-to-One Director / Assistant Director meetings	Meetings to discuss Medical Leader and Operational Manager performance

Appendix 1 – Proposed Revised Medical Leadership Structure







Appendix 2 – Consultation with Trust Medical Leadership

Appendix 3 –Consultation with Trust Directors

1) How do you feel the role of medical leaders could be strengthened to increase contribution to leading and developing Trust services?

- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- Stronger links, (two way) between CD ↔ AMD ↔ Operational Director of management and service delivery issues
- Opportunities to gain a greater appreciation of the pressures/demands of operational teams/staff (nursing, SW, AHP etc)
- Look at taking forward a quality improvement project for the Trust via, for example the Scottish Fellowship Leadership programme or our Trust Quality Improvement Team
- Increased consultant protected time for governance, leadership, standards and guidelines.
- We need clarity in the leader's role and the areas that they are to be held accountable for.
- Current leaders need to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, etc.

2) How well do you feel existing medical leadership roles integrate with operational management roles with regards to leading and developing services?

- There is a very well established and legacy practice of medical staff being an integral part of MHD operational business.
- Translating this into medical leaders being part of many key Directorate and Corporate operational groups to develop policy directions, improvement plans and operationalisation of services. This can feel like it is done in professional silos in some operational services.
- It's quite good between AMD & Director. Needs more time/effort to develop the input of the CD
- Also covered by my suggestion for Question 2 point 2

- Possibly some joint training or project work would help with working relationships, appreciating that there is a lot of pressure in the system.
- Calrity re role and responsibility for medical leaders vs operational managers, need clear guidance
- Support for innovation and quality services is required
- The AMDs and CDs work very well with the ADs and their teams, given the limited time they have available for this role.
- The integration with operational management needs to perhaps have a more structured approach with clarity on roles, agendas, their remit, etc.

3) Overall how effective do you feel the current Trust medical leadership structure is contributing to the overall delivery of Trust services

- Start early- Medical trainee placements in MDT depts.
- Engage medical staff in MDT improvement plans
- PC AMD (now off) took a very refreshing and upstream approach to joined up working.
- Complete leadership training together as an MDT ethos and not in professional silo groups.
- An interface SMT and medical leadership group could be established with 4/5 key corporate annual objectives for improvement being set.
- Learning from Directorates who have good medical leadership models well embedded in MDT leadership approaches.
- M&M meetings could be more MDT focused.
- A lessons learned MDT forum that focuses on the key recurring SAI themes for change improvement.
- From the outside looking in, there are some real tensions/issues between some of the medical specialities. This needs addressed, as it can impact significantly on service development/delivery.
- It's about communication, relationship building and resolving issues, early on and face to face
- By taking a more strategic holistic overview of population health, rather than focusing solely on their own speciality.
- Varies from director to director and practitioner to practitioner
- In OPPC this I belive this works better that in some areas

- Greater profile and ownership key delegated tasks and outcomes agreed and measured
- Increased consultant protected time for governance, leadership, standards and guidelines.
- Clarity in each of the leader's role and the areas that they are to be held accountable for.
- Guidance for our current medical leaders is need so that they are clear as to how they are to assist with ongoing issues such as medical staff infection control training and compliance, medical gas prescribing, discharge process, patient flow issues, etc.

4) Any other comments /Suggestions

- Relationships is key to making a difference
- Currently Acute is experiencing difficulty in securing consultant leadership for activities such as chairing of SAI panels, change leadership for standards and guidelines, reviewing clinical guidelines and clinical audit leadership.
- This seems to be as a result of other areas having dedicated PA time for these activities. This needs to be addressed as quickly as possible as it is affecting Acute Governance.

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REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee May 2018
Title:	Clinical & Social Care Governance Report to Governance Committee
Lead Director:	Dr Ahmed Khan – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	To provide assurance to Trust Governance Committee regarding directorate management of: • Adverse Incidents • Complaints & Ombudsman's Complaints

Summary of Key Issues for Governance Committee

High level context:

- Revised report structure for Clinical and Social Care Governance Information
- Overview of trends in adverse incident reporting
- Data on Patient safety initiatives that support governance data to Quarter 4 2017/18

Key issues/risks for discussion:

- Update on Regional Patient Safety Programme
- Breakdown of Serious Adverse Incidents by type of incident
- Breakdown of Ombudsman Case Outcomes

Summary of SMT challenge/discussion:

- Reporting of NEWS Data
- Proposal for further information on falls
- Additional information added – Break down of top 10 incidents reported

Internal/External Engagement:

- Senior Management Team
- Directorate Governance Coordinators

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Contents

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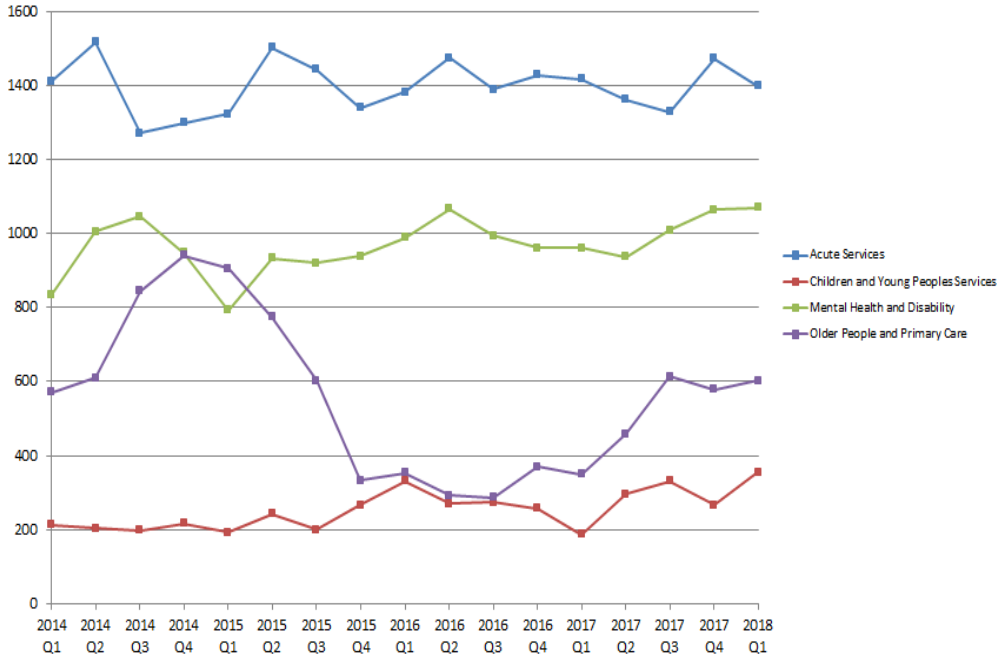
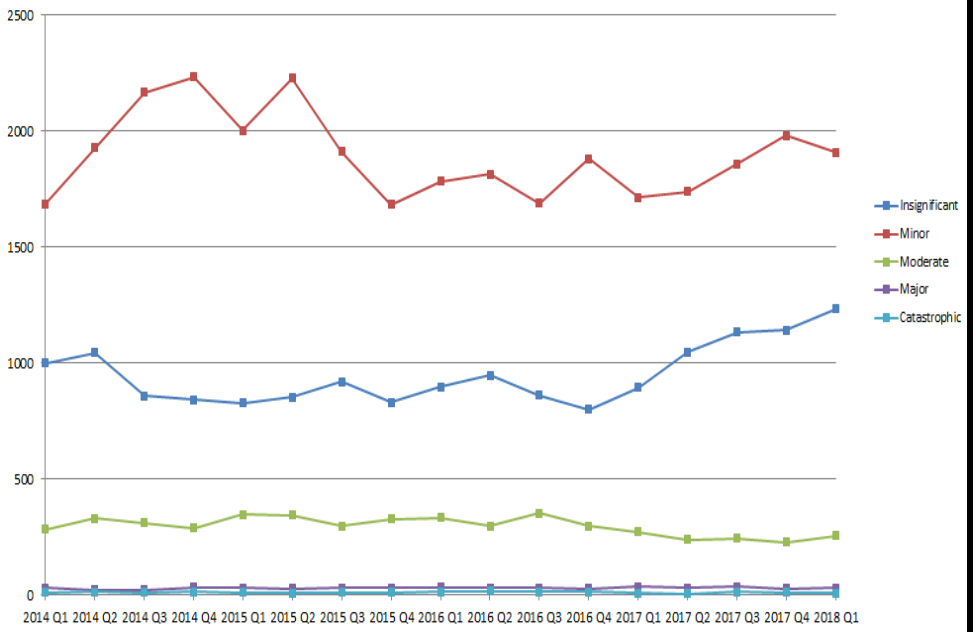
1. Adverse Incidents

Total No of Incidents Reported Over Time by Care Directorates 01 April 2014 – 31 March 2018



- Total incidents recorded
  - Quarter 4 2017 - 3382 incidents
  - Quarter 1 2018 - 3425 incidents
- Total number of incidents recorded for Quarter 1 2018 shows a slight increase from Quarter 4 2017, looking at the same period from last year there is also an increase in the number of incidents reported.

Total No. of Incidents by Severity Grading (Actual Harm) 01 April 2014 – 31 March 2018



- Quarter 1 2018 saw a slight decrease in Catastrophic incidents from 10 to 7.
- Additional information on incidents that met Serious Adverse Incident thresholds can be found in section 2 of this report.

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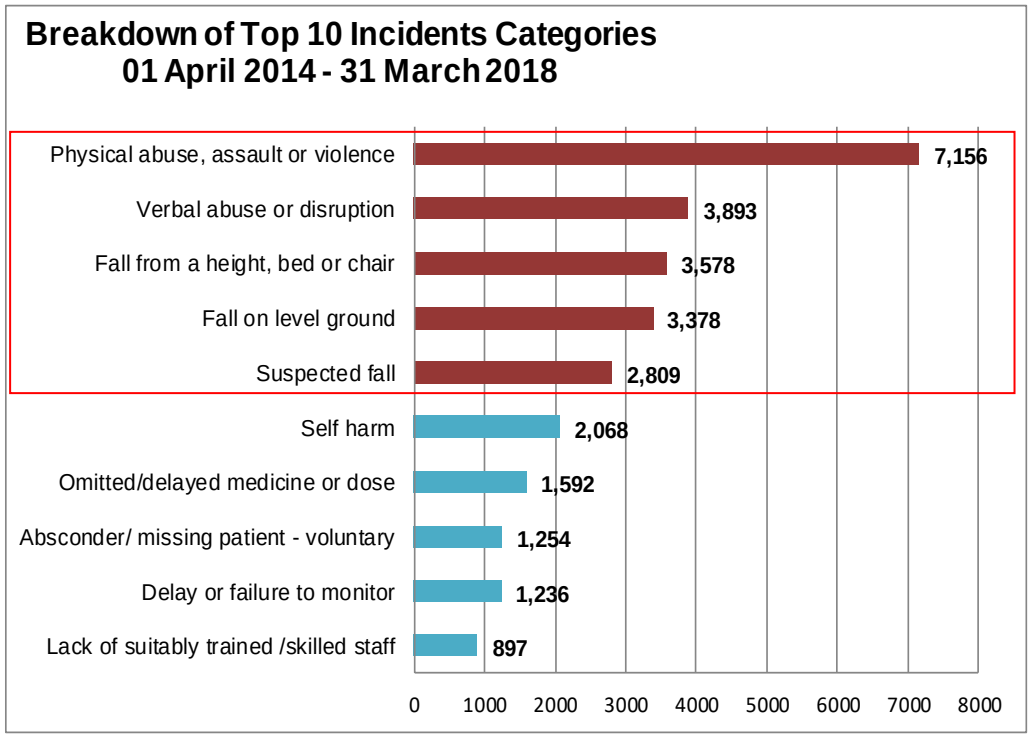

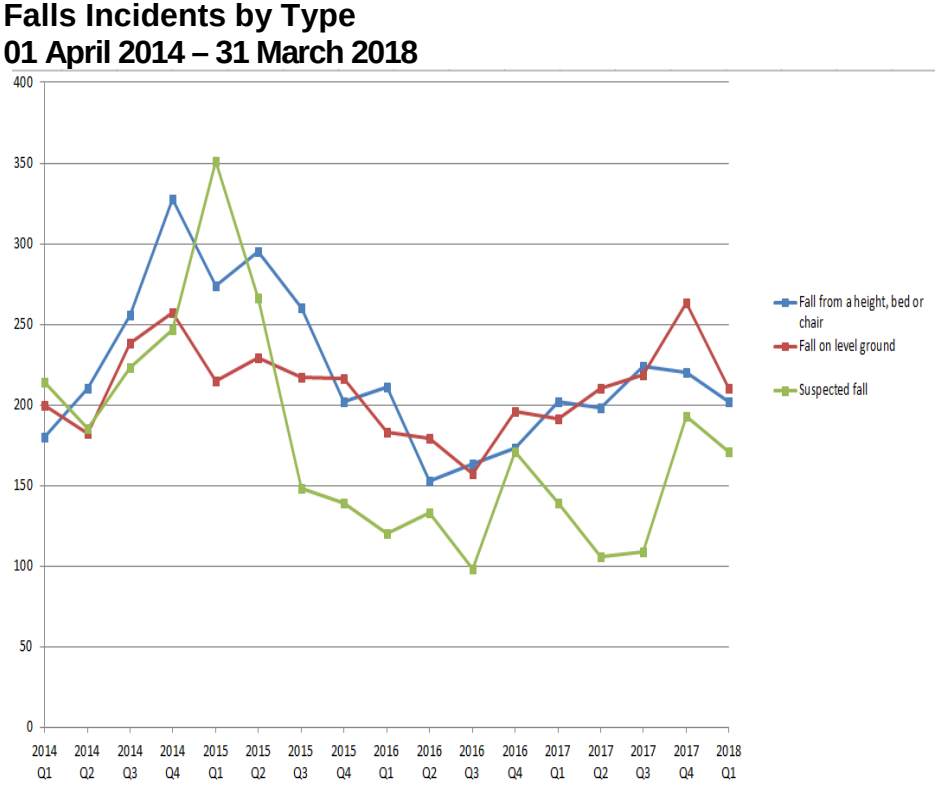

As per agreement of the previous Governance Committee meeting please see above a breakdown of the Top 10 incident categories, 1st April 2014 – 31st March 2018.

The Southern Health and Social Care Trust's most common reported incidents are abuse and falls. The following graphs further detail the trends for these incidents.

- Fall from a height, bed or chair have continued to reduce from 220 reported incidents in Quarter 4 of 2017 to 202 in Quarter 1 in 2018.
- Suspected falls have decreased from 193 in Quarter 4 to 171 Quarter 1.
- Fall from level ground have decreased from 263 in Quarter 4, to 210 in Quarter 1.

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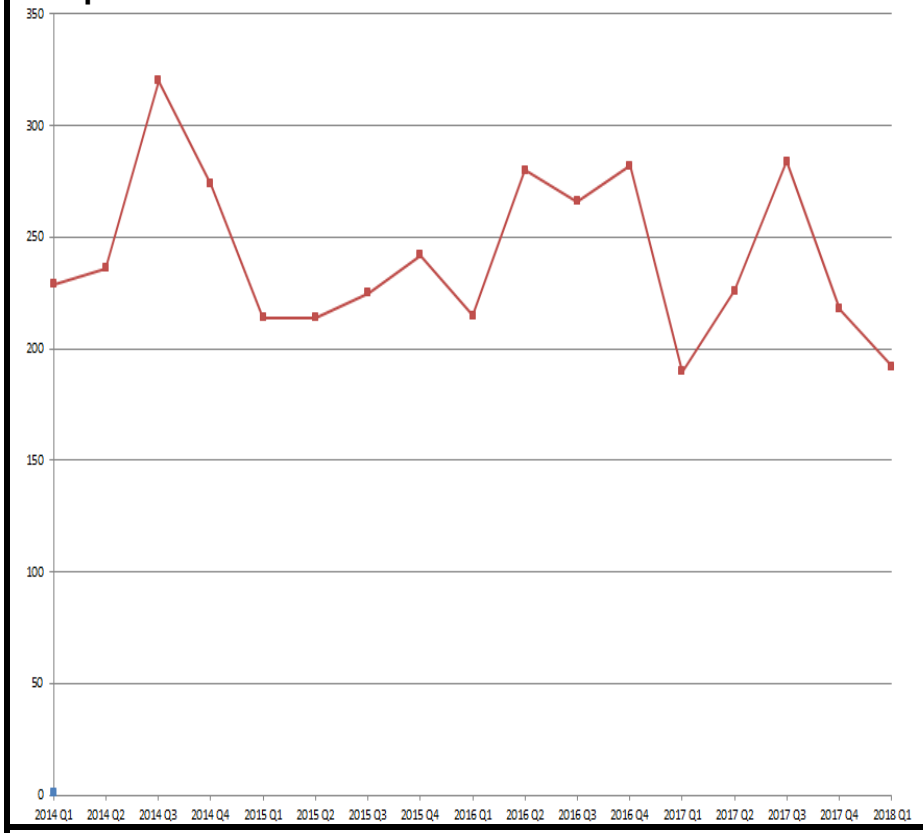
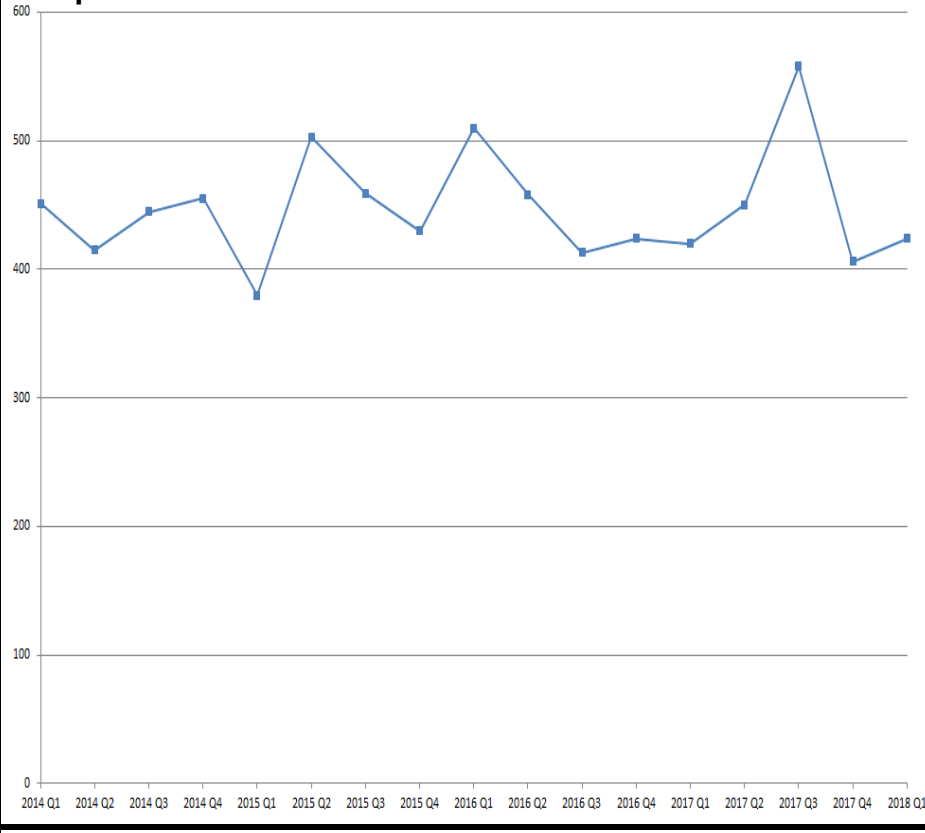
Verbal Abuse Incidents
01 April 2014 – 31 March 2018



- Although Verbal Abuse incidents remain one of the highest reported incidents there has been a decrease in the number of verbal incidents this quarter.

Physical Abuse Incidents
01 April 2014 – 31 March 2018



- Physical Abuse remains one of the highest reported incident type, this quarter these types of incidents have slightly increased since Quarter 4 2017, from 406 to 424.

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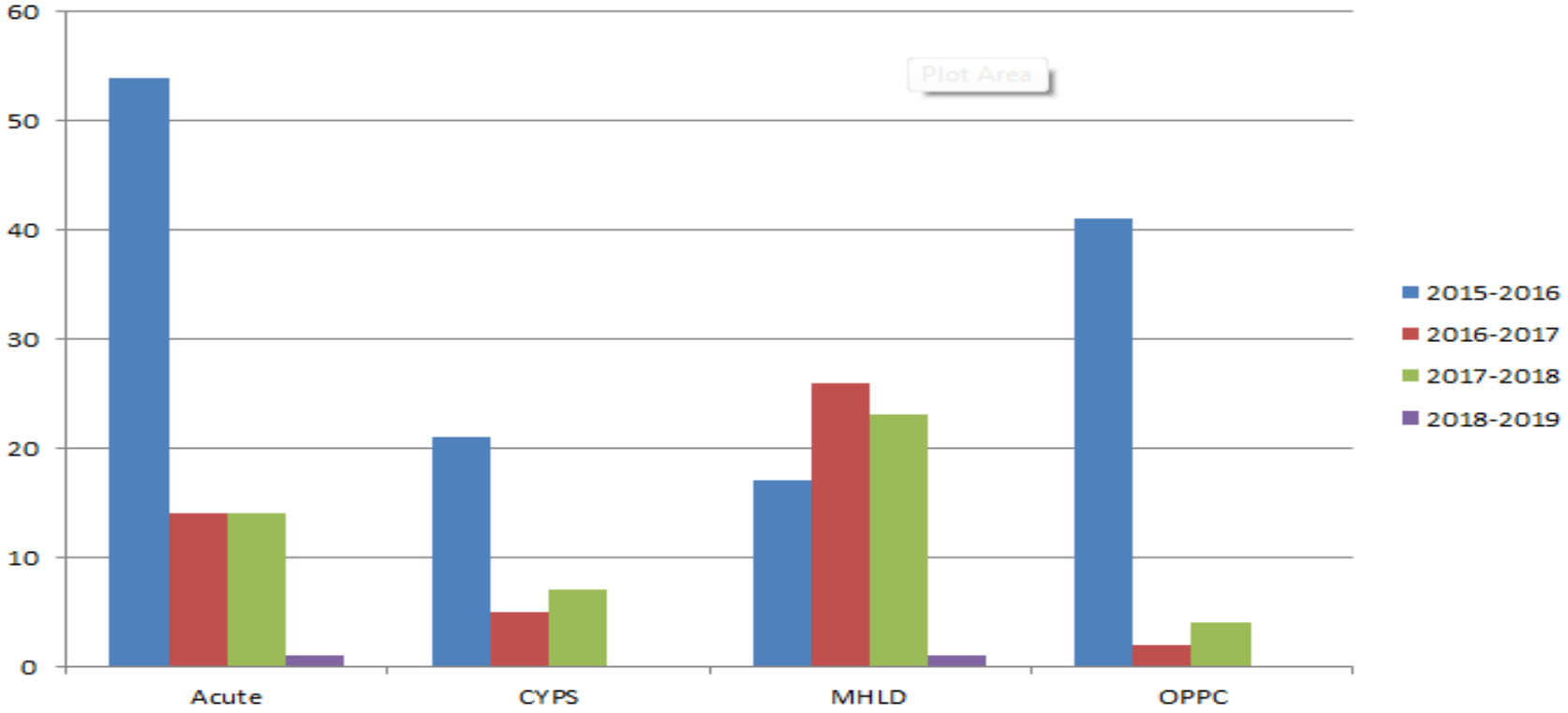
2. Serious Adverse Incidents (YTD)

Breakdown of SAI's Reported by Financial Year by Care Directorates 01 April 2015 – 12th April 2018



- Table above shows the number of adverse incidents have met the Serious Adverse Incident (SAI) criteria as the set by the HSCB.
- This number equates to (0.6%) of all adverse incidents reported via the Trust Incident Management system.

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Categorisation of SAIs 01 April 2015 – 12 April 2018 (YTD)

Area of Service	Incident Type	2015-16	2016-17	2017-18	2018-19	Total
Checking and oversight	Medication	0	1	0	0	1
	Test results	6	1	0	0	7
Equipment Related	Necessary Equipment Misused or misread by practitioner	0	0	0	0	0
	Necessary equipment not available	0	0	0	0	0
Prevention	Inpatient falls	7	0	1	0	8
Management of deterioration	Acting on or recognising deterioration	16	4	2	0	22
	Giving ordered treatment/support in a timely way	3	2	0	0	5
	Observe / review	6	1	0	0	7
No Area of Service Failure	No Area of service failure (a large number of these investigations were of expected child deaths and suicides)	50	32	12	3	97
Other	Other	3	1	1	0	5
SAI investigation in progress	SAI investigation in progress	1	1	25	5	32
N Home Falls	Not yet included in categorisation	35	0	0	0	35
Grand Total		**127**	**43**	**40**	**8**	**40**

The above table sets areas of learning which have been identified through Serious Adverse Incident Investigations.

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Position on the Progress of SAI Investigations

Timescales for the completion of Serious Adverse Incidents are set out by the Health and Social Care Board as follows:

Level 1 SAI investigations - 6 weeks

Levels 2 & 3 investigations – 12 weeks

Presently there are **31** SAI investigations currently being progressed within SHSCT, of which 5 are within the HSCB timescales for submission. There are a number of contributory factors set out below which influence the timescales of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads
- Necessary engagement with service users and their families, particularly where a death has occurred
- Where the SAI investigation spans across 2 or more Trusts

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

The table below sets out the position on the progress of SAI investigations ongoing

	Acute			CYPS			MHLD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks
Level 1	0	7	3	0	0	0	0	2	2	0	0	0
Level 2	1	2	0	0	1	1	3	8	0	1	0	0
Level 3	0	0	0	0	0	0	0	1	0	0	0	0

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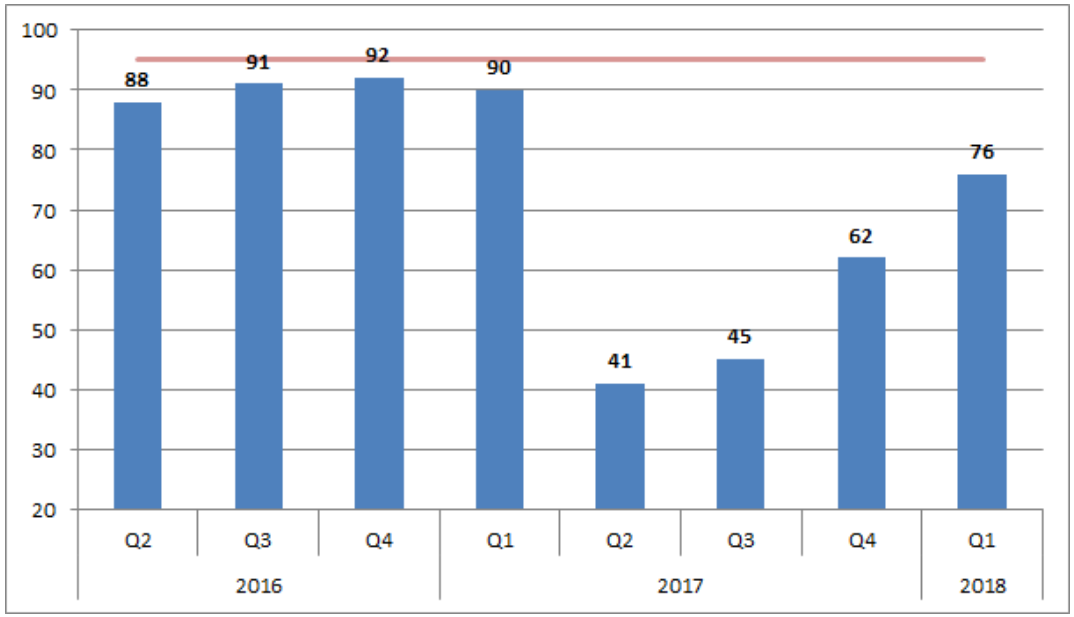
3. Patient Safety – NEWS

SHSCT NEWS Overall Bundle Compliance
Q1 2016 → Q1 2018



Introduction of Nursing Quality Indicators

In 2011 the Trust developed a range of Nursing Quality Indicators (NQI) aimed at measuring compliance with nursing care processes. The NQI audit process was formally adopted by the Trust in 2017/18.

As part of this work the bundle compliance audit regarding NEWS documentation has been revised and updated following consultation with staff and review of best practice evidence.

Notable updates to the NEWS audit process:

- NEWS charts now subject to independent rather than self-audit
- Criteria adjusted to 'raise the bar' in terms of audit detail
- Production of detailed improvement plans at both ward and Trust level

As a result of the rebasing of audits Quarters 2-4 2017 has indicated a reduction in bundle compliance. The Ward Manager's Audit was reinstated in February 18 & will run alongside the Independent Audit, with a view to driving improvement between the Independent Audit 3 monthly cycle.

The Trust has discussed the care bundle in respect of compliance with the Public Health Agency who are now leading a regional Quality Improvement project to review the auditing process to provide additional assurance across the region.

In December 2017, the Royal College of Physicians published NEWS2. The Director of Medicine and the Executive Director of Nursing have progressed with identifying nominations for a Trust wide NEWS implementation and oversight group.

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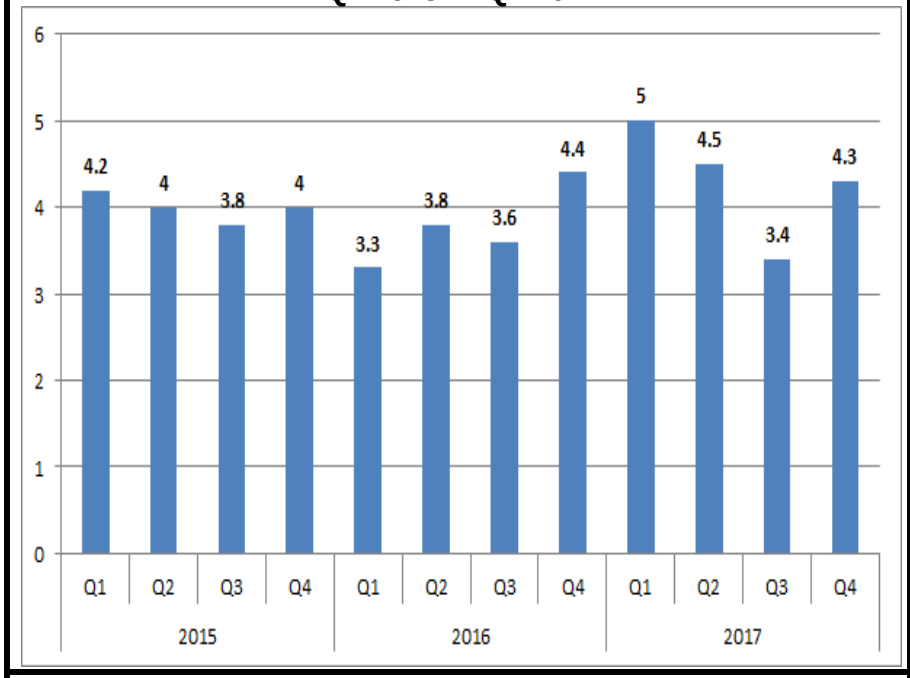
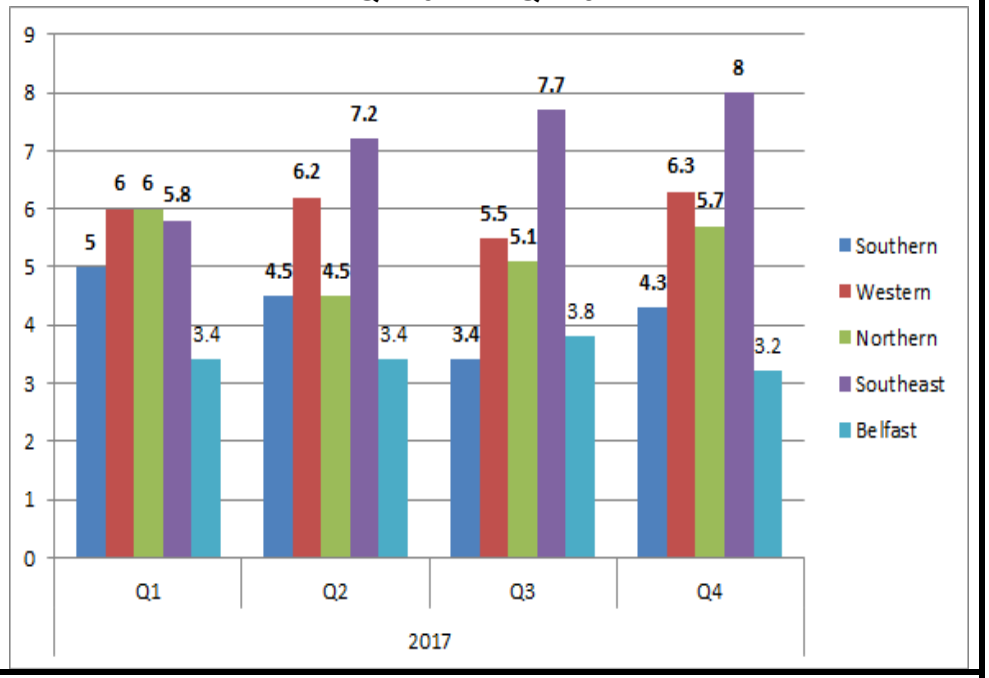
Patient Safety – Patient Falls

SHSCT Patient Fall Rate per 1,000 Occupied Bed Days
Q1 2015 → Q4 2017



- Regional Improvement Work on Falls began in 2011.
- A number of pro-active initiatives has resulted in the Trust's Falls Rate being consistently one of the best in NI, namely the implementation of elements of FallSafe Bundles A & B, the use of the Falls Walking Stick by Wards to capture details of their Patient Falls "Real Time", moving "at risk" patients to a more suitable location on the Ward, where possible.
- In line with the Region in 2017/18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.
- There is no regional target associated with patient falls.

NI Trust's Patient Fall Rate per 1,000 Occupied Bed Days
Q1 2017 → Q4 2017



- In Q4 2017 the Trust's Patient Falls Rate was 4.3 per 1,000 Occupied Bed Days
- The Trust's Rate is the 2nd lowest in NI
- Of the 26 Wards monitoring their Patient Falls/Falls rate using the Falls Walking Stick 14 wards (54%) saw a decrease Apr → Dec 17, compared to the same period the previous year

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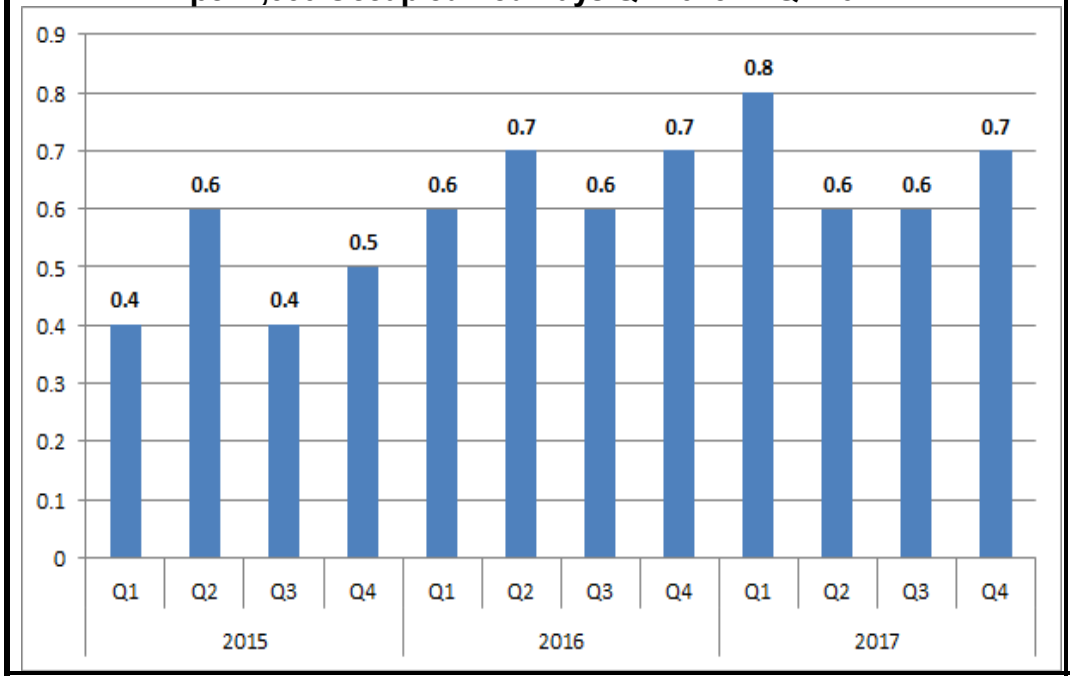
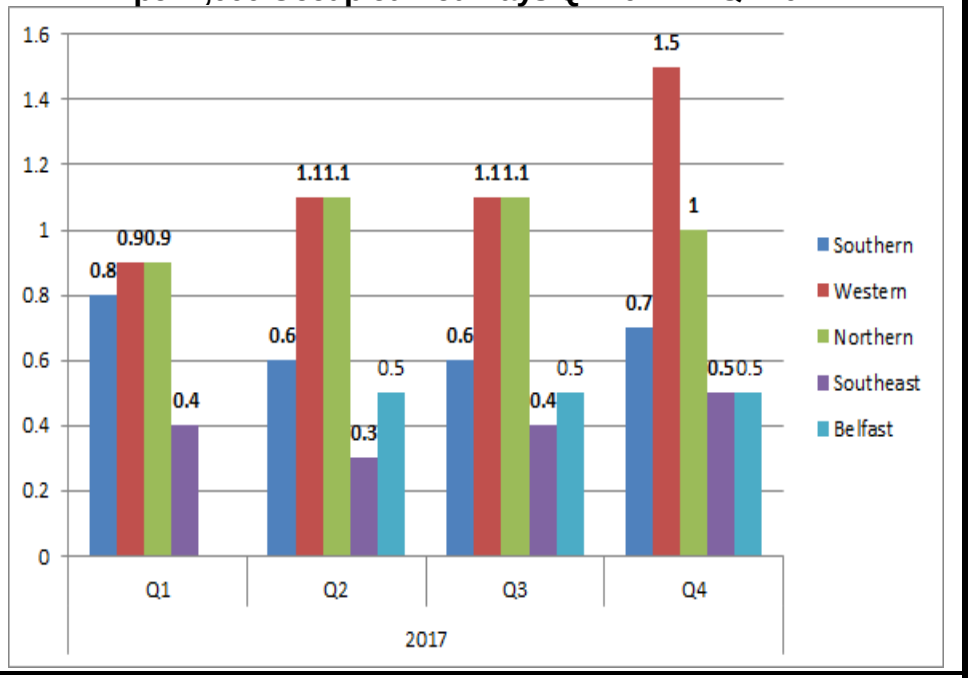
Patient Safety – Pressure Ulcers

SHSCT Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q1 2015 → Q4 2017



- Regional Improvement Work on Pressure Ulcers began 2011.
- A number of pro-active initiatives have been introduced namely the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan.
- The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on these cases within the Trust to determine those which were avoidable.

NI Trust's Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q1 2017 → Q4 2017



- All Trusts saw an increase in "Ward Acquired" Pressure Ulcers in 16/17 compared to 15/16.
- Of the 27 Wards monitoring their Hospital Acquired Pressure Ulcers/Rate using the Pressure Ulcer Safety Cross 16 wards (59%) saw their rate remain the same or decrease compared to the same period last year.
- Of the 130 Ward Acquired Pressure Ulcers reported Apr → Dec 17, 21 (16%) were Grade 3 or 4 Pressure Ulcers. RCA's conducted on 19 of the 21 cases to date concluded that only 5 were avoidable

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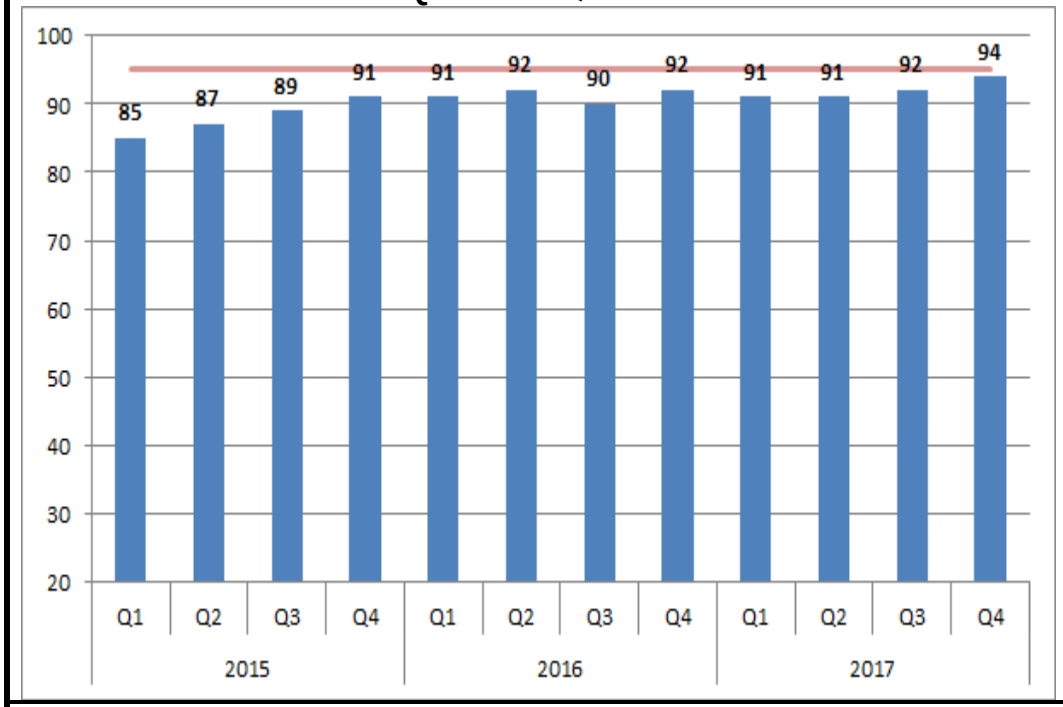
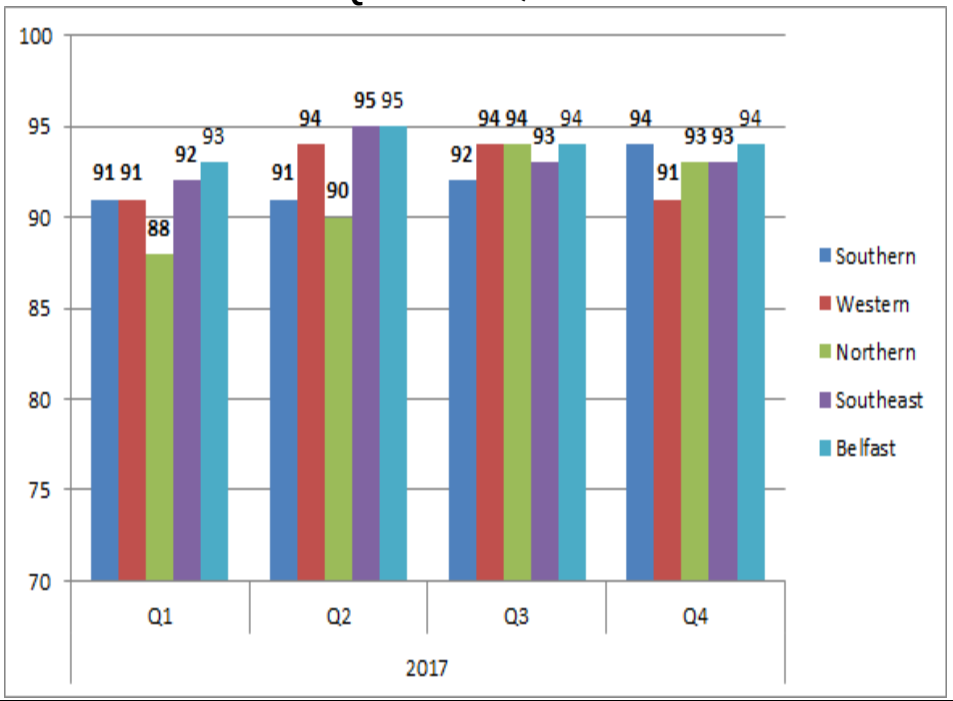
Patient Safety – Venous Thromboembolism (VTE) Risk Assessment

SHSCT VTE Risk Assessment Compliance
Q1 2015→ Q4 2017



- Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009.
- All Trust's now use a Regional Risk Assessment Tool.
- For the past 4 years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%.

NI Trust's VTE Risk Assessment Compliance
Q1 2017 → Q4 2017



- All Trusts have seen an increase in compliance since measurement began in April 2013.
- Southern Trusts overall compliance for 2017 Q4 was 94%, the highest compliance ever achieved & equal highest rate in NI
- Southern Trust's Acute Wards (CAH& DHH) have seen their Compliance Rate increase from 89.5% in Q1 to 94.3% in Q3

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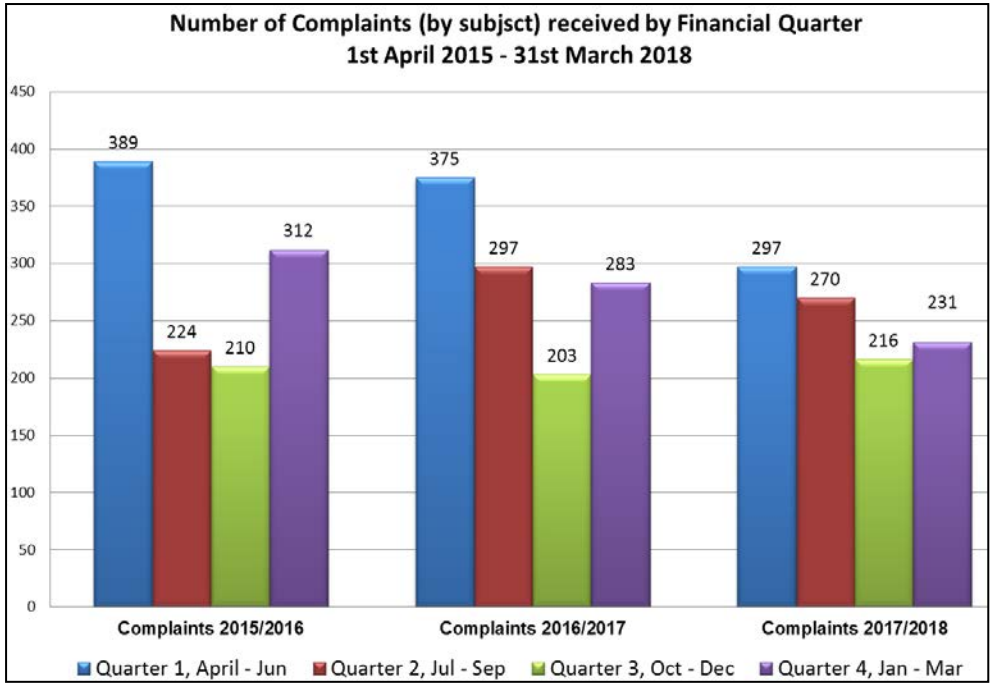
Complaints and Ombudsman's Complaints

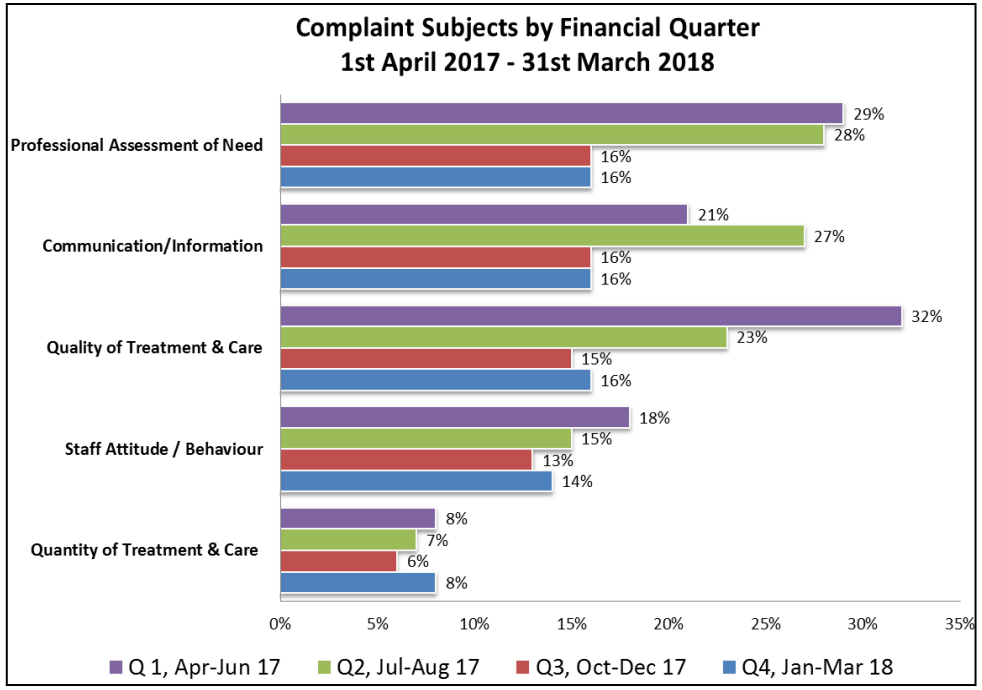
Number of Complaints Received



In Quarter 4 2017/18 the Trust received **161** formal complaints of which there were **231 complaints subjects**.

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

What Our Service Users Complained About



The number of complaint subjects for quarter 4 slightly increased to 231 from 216 in the previous quarter. However a decrease in complaint subjects can be noted for quarter 4 2017/2018 in comparison to quarter 4 in previous years.

The top five subjects of complaints remain consistent throughout each reporting period, especially within quarter 3 and quarter 4.

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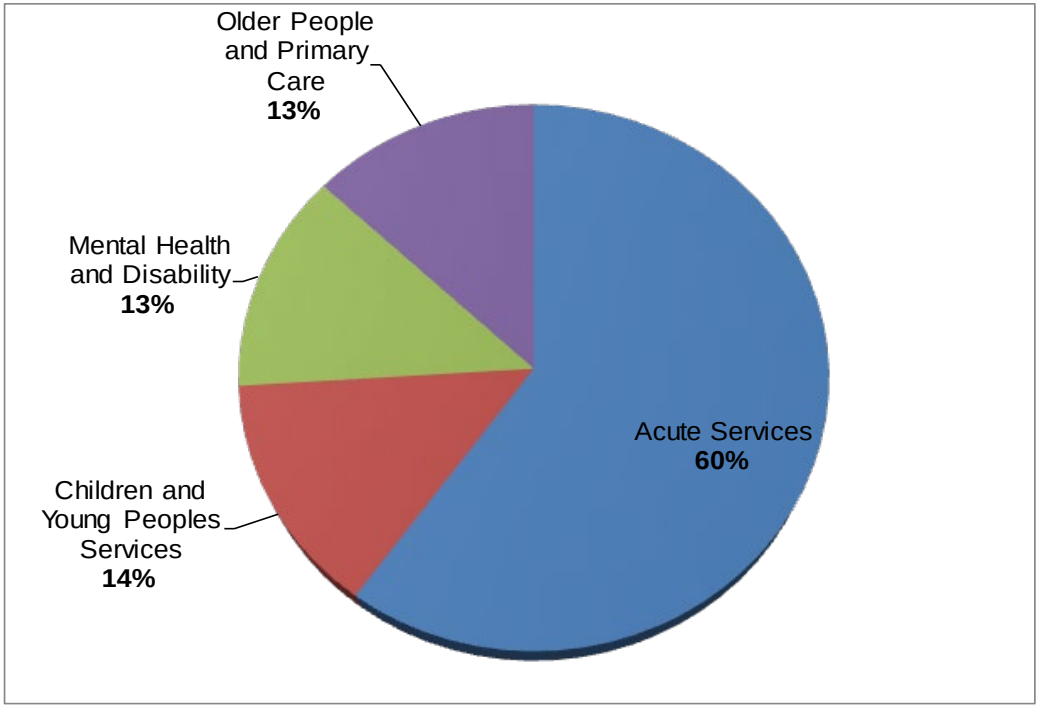
Breakdown of % of Complaints (subjects) by Directorate for Quarter 4 (1st January 2018 – 31st March 2018)



Breakdown of Number of Complaints (subjects) by Directorate and Division for Quarter 4 (1st January 2018 – 31st March 2018)

Directorate/Service Area	No of Complaints (Subjects)
Acute Services	**139**
Functional Support Services	7
IMWH - Cancer and Clinical Services	17
Integrated Maternity and Womens Health	15
Medicine and Unscheduled Care	67
Surgery and Elective Care	33
Children and Young Peoples Services	**32**
Corporate Parenting	4
Family Support and Safeguarding	15
Specialist Child Health and Disability	13
Mental Health and Disability	**31**
Learning Disability Services	8
Memory Services	2
Mental Health Service	16
Physical and Sensory Disability Service	5
Older People and Primary Care	**29**
Enhanced Services	7
Older Peoples Services	8
Primary Care	13
Promoting Wellbeing	1
Total	**231**

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The Patient Client Council Complaints Support Service

Patient and Client Council
Your voice in health and social care

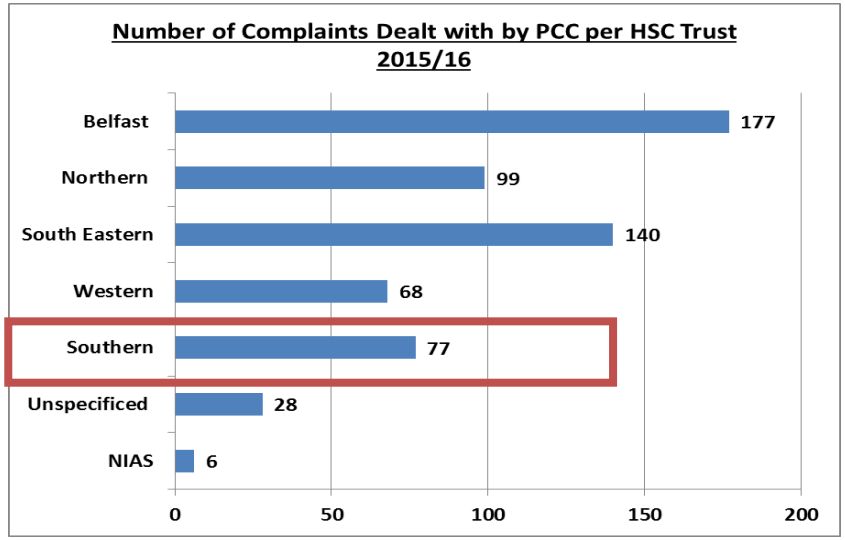
Every day thousands of people access health and social care services. Most people receive high quality services. For others, services fall short of their expectations. Having the opportunity to feed back is important. When things go wrong, people deserve an explanation, and assurances that steps have been taken to prevent the same mistakes from happening again. Every compliment, concern and complaint is an opportunity to learn and improve services.

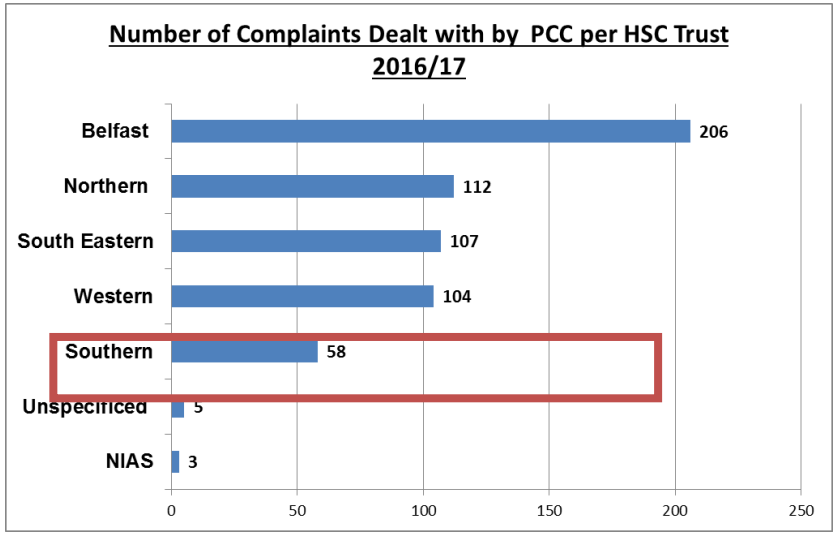
The complaints support role of the Patient Client Council is specifically defined in the Health and Social Care Reform Act 2009 as: *'providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care...'*

The PCC Complaints Support Service is a confidential, independent and free service that can help patients and clients to make a complaint about any Health and Social Care service. The PCC Complaints Support Service provides support to our clients in a number of ways, including:

- Giving our clients information on the complaints procedure and advice on how to take a complaint forward;
- Discussing a complaint with a client and drafting letters or making telephone calls for clients on their behalf;
- Helping clients prepare for and going with them to meetings about their complaint and making sure their concerns are heard and responded to;
- Helping and supporting clients to prepare a complaint for submission to the Ombudsman or other regulatory bodies;
- Referral to other agencies, for example, specialist advocacy services; and
- Help in accessing medical/social services records.

Comparison of Complaints dealt with by Patient Client Council per HSC Trusts 2015 – 2017





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Acknowledgement and Response Times for Complaint Letters per Directorate 1st October 2016 – 28th February 2018

	Acute				CYP				MHD				OPPC			
	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE
Oct 2016	**28**	100%	46%	68%	**9**	100%	100%	100%	**8**	100%	75%	100%	**8**	100%	88%	100%
Nov 2016	**53**	98%	43%	62%	**13**	100%	77%	85%	**6**	100%	83%	100%	**7**	100%	100%	100%
Dec 2016	**41**	100%	27%	33%	**4**	100%	100%	100%	**3**	100%	100%	100%	**0**	N/A	N/A	N/A
Jan 2017	**59**	100%	24%	31%	**23**	100%	78%	87%	**7**	100%	71%	86%	**6**	100%	83%	83%
Feb 2017	**57**	100%	37%	50%	**10**	100%	70%	90%	**9**	100%	89%	100%	**4**	100%	66%	66%
Mar 2017	**47**	100%	13%	21%	**11**	100%	63%	81%	**5**	100%	100%	N/A	**2**	100%	100%	100%
Apr 2017	62	92%	37%	71%	**8**	100%	100%	100%	**5**	100%	100%	N/A	**2**	100%	100%	100%
May 2017	63	94%	35%	59%	**22**	94%	77%	82%	**8**	100%	63%	88%	**3**	100%	100%	100%
Jun 2017	55	87%	47%	67%	**15**	100%	73%	93%	**12**	100%	83%	100%	**1**	100%	100%	100%
Jul 2017	**72**	67%	44%	51%	**10**	100%	70%	70%	**7**	100%	86%	100%	**3**	100%	67%	100%
Aug 2017	**47**	94%	40%	74%	**12**	100%	92%	100%	**6**	100%	100%	100%	**6**	100%	83%	100%
Sept 2017	**65**	92%	32%	44%	**18**	100%	83%	83%	**6**	100%	100%	100%	**3**	100%	100%	100%
Oct 2017	**44**	98%	39%	75%	**12**	100%	83%	92%	**11**	91%	91%	100%	**2**	100%	100%	100%
Nov 2017	**55**	88%	47%	51%	**9**	100%	89%	89%	**8**	100%	87.5%	100%	**6**	100%	83%	100%
Dec 2017	**17**	100%	24%	53%	**8**	100%	88%	88%	**2**	100%	100%	100%	**4**	100%	100%	100%
Jan 2018	**69**	91%	28%	54%	**9**	100%	65%	75%	**4**	100%	100%	100%	**8**	100%	100%	100%
Feb 2018	**34**	94%	50%	74%	**11**	100%	55%	91%	**3**	100%	100%	100%	**5**	100%	100%	100%

The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days

The table above sets out the Trust performance by directorate against these standards. 30 Days is not a formal target however is monitored by the Trust for performance purposes.

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Ombudsman Cases

Breakdown of Ombudsman cases per Financial Year, 1st March 2014 – 19th April 2018

	Local Resolution	Not Upheld	Open	Awaiting Screening	Upheld	Withdrawn	Not Accepted	Total
2014/2015	1	1	1	-	5	-	-	**8**
2015/2016	-	1		-	9	2	2	**14**
2016/2017	2	2	4	2	2	2	2	**16**
2017/2018	1	-	6	9	-	-	3	**19**
2018/2019	-	-	-	1	-	-	-	**1**
	4	**4**	**11**	**12**	**16**	**4**	**7**	**58**

When patients are not fully satisfied with the outcome from the Trust's complaint process they can choose to subsequently raise their concerns with the Northern Ireland Public Services Ombudsman. All complainants are provided with information about referring their issues to the Ombudsman at the point at which the Trust completes their investigations and closes the case with the complainant.

During the previous financial year 2017/2018, **6 new cases** have been opened by the Ombudsman regarding complaints previously raised with the Trust; of which **1 case** has reached local resolution and 3 have not been accepted. **9 cases** await screening for acceptance to initiate Ombudsman investigations.

During this current financial year to date 1 case awaits screening for acceptance by the Ombudsman's office.

We continued to work with the Ombudsman on cases raised during previous years.

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Standards and Guidelines Quality Assurance Audit (Snapshot April 2018)

OVERVIEW

An assurance audit of the Trust Standards and Guidelines process was carried out in April 2018. The audit focussed on Standards and Guidelines received into the Corporate Office between 1st February 2017 - 31st January 2018.

METHODOLOGY

10% of Standards and Guidelines received between1st February 2017- 31st January 2018 were reviewed to confirm the following:

- The Standard and Guideline had been logged on the Corporate Database
- A Change Lead has been identified, where applicable
- Any assurances outstanding to external agencies

AUDIT RESULTS

240 Standards and Guidelines were received during the time period, 24 of these were reviewed using the above criteria.

- 100% had been logged on the Corporate Database
- 8.4% (2 Guidelines) had not had a change lead appointed; however both were recent pieces of correspondence and therefore assurance on having a change lead is not required until 3 months have passed.
- There were no outstanding assurances to external agencies identified.

CONCLUSION

All Standards and Guidelines audited were managed in keeping with the Southern Health and Social Care Trust Standard and Guideline procedure. The implementation of Standards and Guidelines disseminated across the Trust is managed through operational directorate structures.

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REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee September 2018
Title:	Clinical & Social Care Governance Report to Governance Committee
Lead Director:	Dr Ahmed Khan – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	To provide assurance to Trust Governance Committee regarding directorate management of: • Adverse Incidents • Complaints & Ombudsman's Complaints

Summary of Key Issues for Governance Committee

High level context:

- Revised report structure for Clinical and Social Care Governance Information
- Overview of trends in adverse incident reporting
- Data on Patient safety initiatives that support governance data to Quarter 1 2018/19

Key issues/risks for discussion:

- Breakdown of Serious Adverse Incidents by type of incident
- Breakdown of Ombudsman Case Outcomes

Summary of SMT challenge/discussion:

- Request inclusion of Independent Sector incidents

Internal/External Engagement:

- Senior Management Team
- Directorate Governance Coordinators

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Contents

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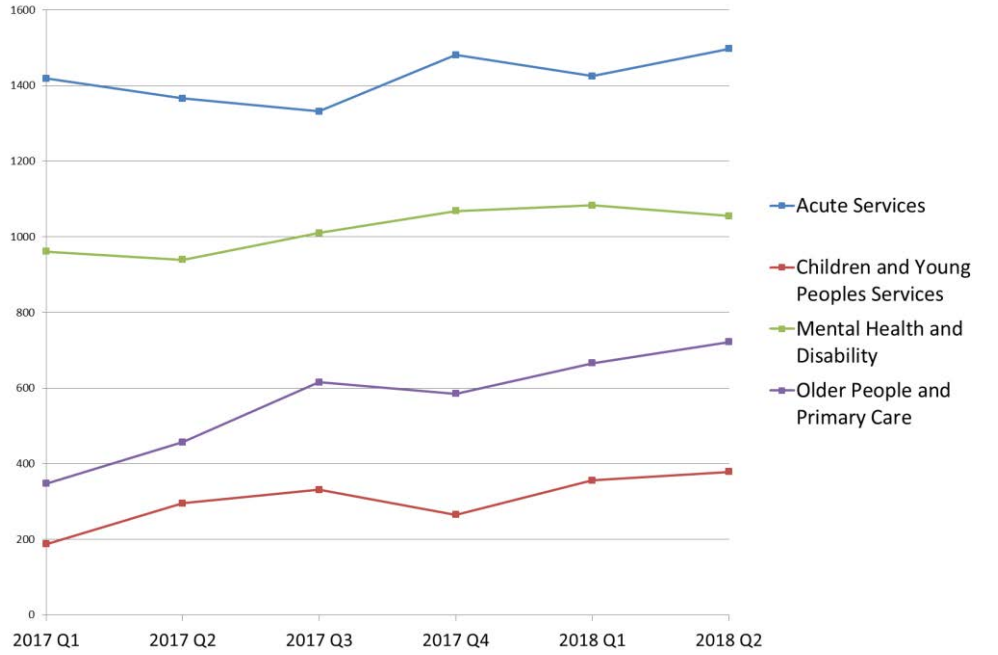
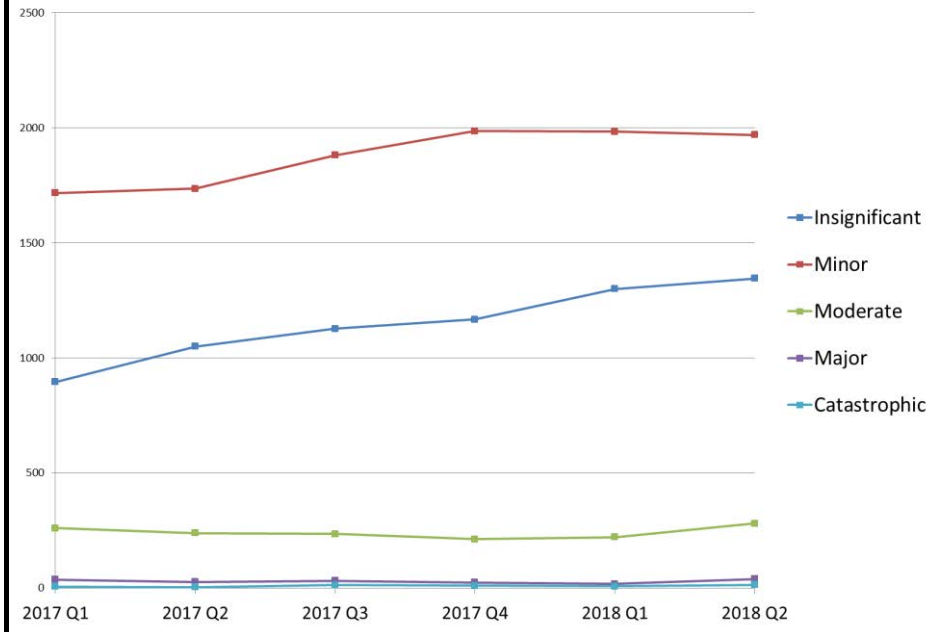
1. Adverse Incidents

Total No of Incidents Reported Over Time by Care Directorates 01 April 2017 – 30 June 2018



- Total incidents recorded
  - Quarter 1 2018 - 3530 incidents
  - Quarter 2 2018 – 3652 incidents
- Total number of incidents recorded for Quarter 2 2018 shows a slight increase from Quarter 1 2018, looking at the same period from last year there is also an increase in the number of incidents reported.

Total No. of Incidents by Severity Grading (Actual Harm) 01 April 2017 – 30 June 2018



- Quarter 2 2018 saw an increase in Catastrophic incidents from 7 to 14.
- Additional information on incidents that met Serious Adverse Incident thresholds can be found in section 2 of this report.

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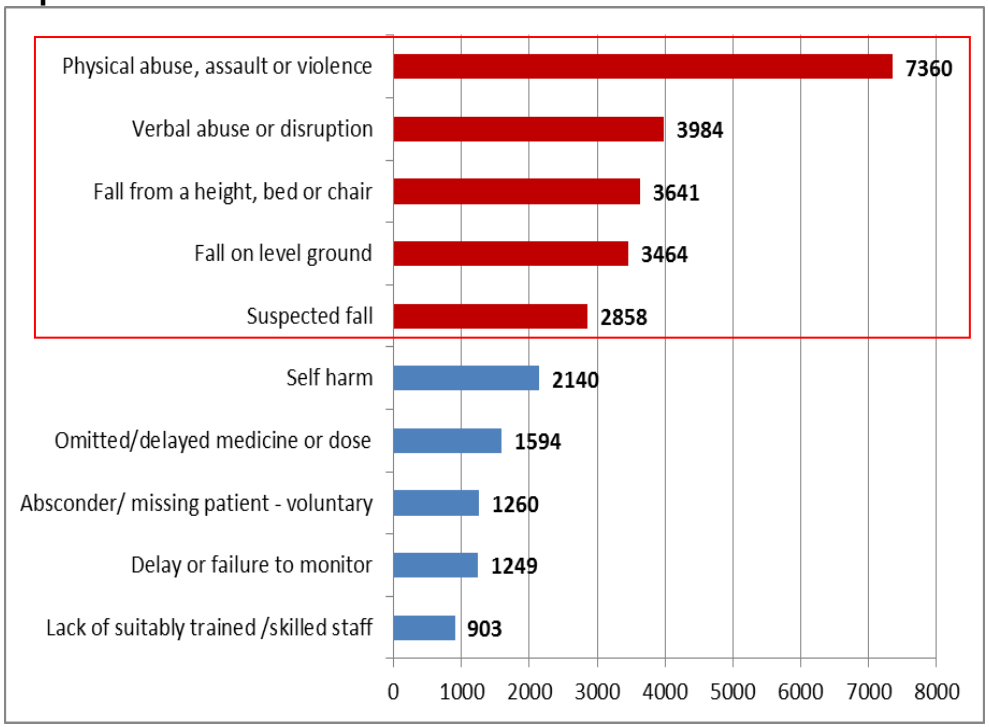
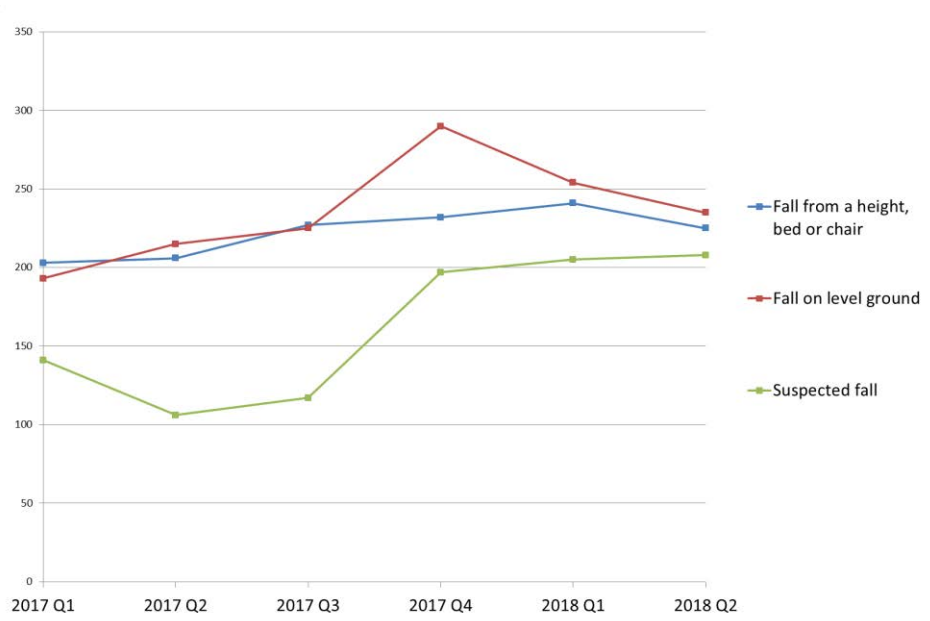
Breakdown of Top Incidents by Detail 1 April 2014 – 30 June 2018



Falls Incidents by Type 01 April 2017 – 30 June 2018



The 10 top most common reported incidents have remained the same since the last quarter.

The Southern Health and Social Care Trust's most common reported incidents are abuse and falls. The following graphs further detail the trends for these incidents.

- Fall from a height, bed or chair have continued to reduce from 241 reported incidents in Quarter 1 of 2018 to 225 in Quarter 2 in 2018. Suspected falls have slightly increased from 205 in Quarter 1 to 208 Quarter 2.
- Fall from level ground have decreased from 254 in Quarter 1, to 235 in Quarter 2.

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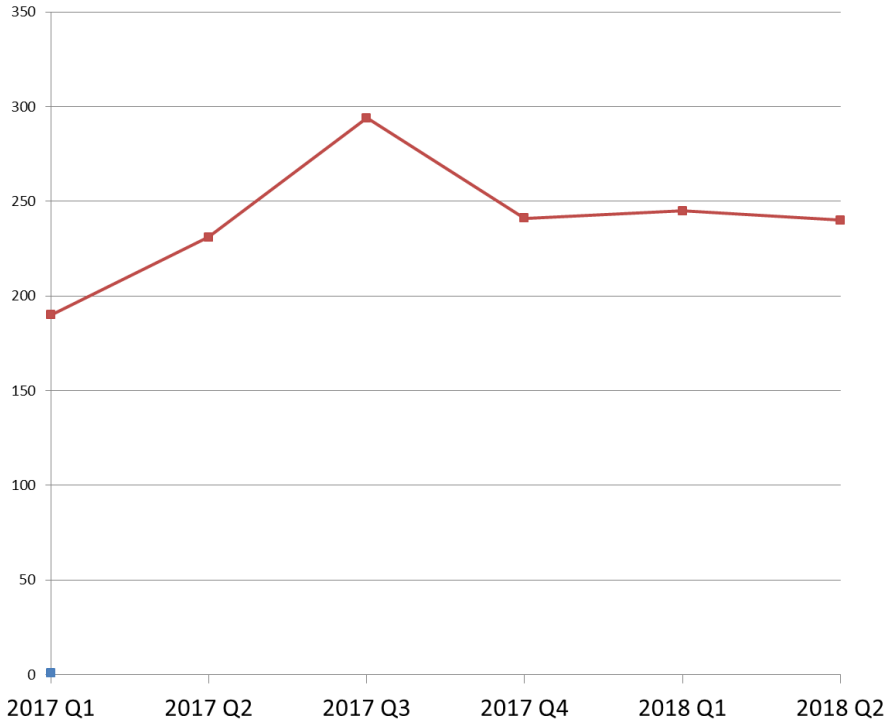
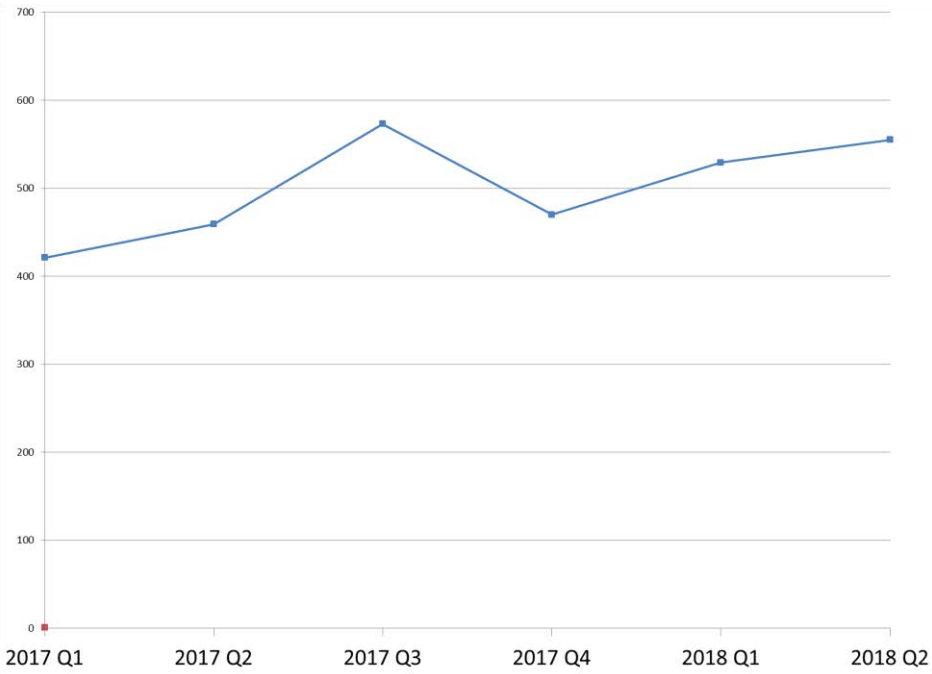
Verbal Abuse Incidents 01 April 2017 – 30 June 2018	**Physical Abuse Incidents 01 April 2017 – 30 June 2018**
	
• Although Verbal Abuse incidents remain one of the highest reported incidents there has been a small decrease in the number of verbal incidents this quarter.	• Physical Abuse remains one of the highest reported incident type, this quarter these types of incidents have increased since Quarter 1 2018, from 529 to 555.

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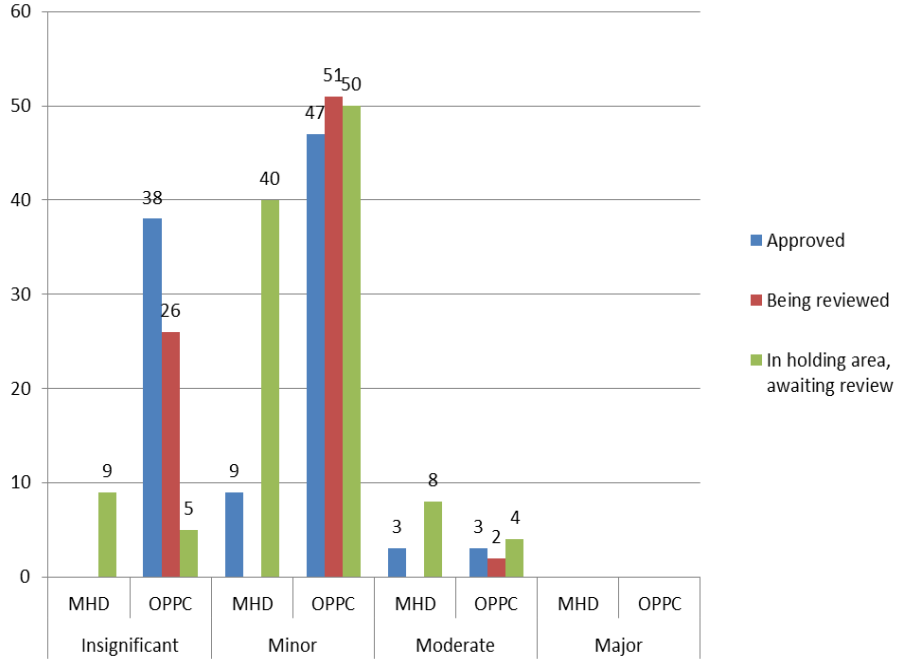
Independent Service Providers Incidents by Directorate, by Sub-category January – March 2018

	MHD	OPPC	Total
Slips, trips, falls and collisions	1	132	133
Administration or supply of a medicine from a clinical area	4	9	13
Self-harm during 24-hour care	8		8
Abuse by the staff to the patient		4	4
Accident caused by some other means		4	4
Abuse etc of Staff by patients	1		1
Self-harm in primary care, or not during 24-hour care	1		1
Abdominal organs other than digestive		1	1
Abuse etc of patient by patient		1	1
Connected with the management of operations / treatment		1	1
Infection Control		1	1

Independent Service Providers Total No. of Incidents recorded By Severity Grading (Actual Harm) January – March 2018



NB: the above grading may change as incidents are reviewed.

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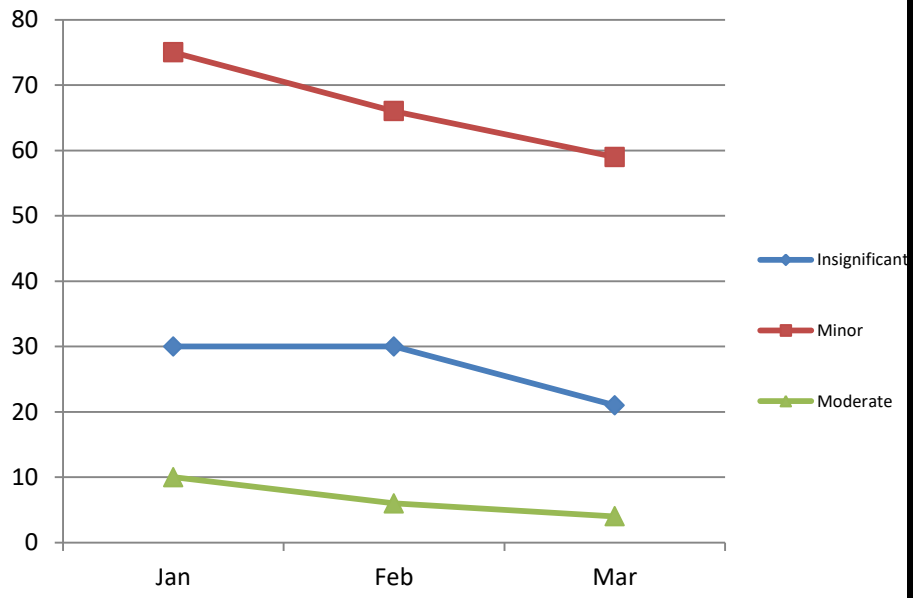
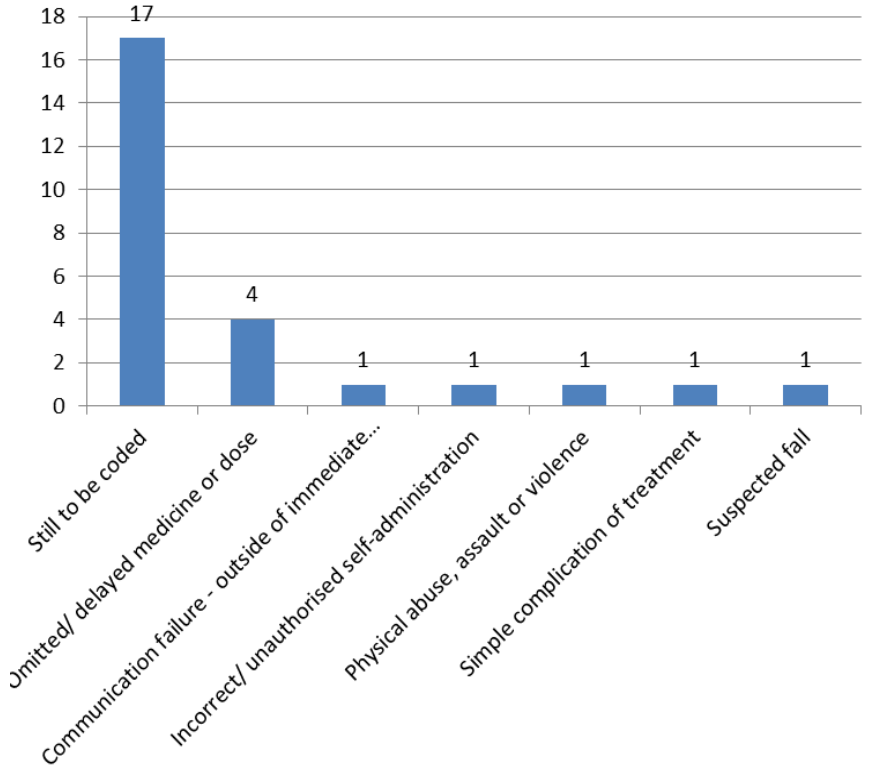
Independent Service Providers Trend Line: Incidents Involving PNH Providers by Severity Grading by Month January – March 2018



Independent Service Providers Incidents by Type January – March 2018



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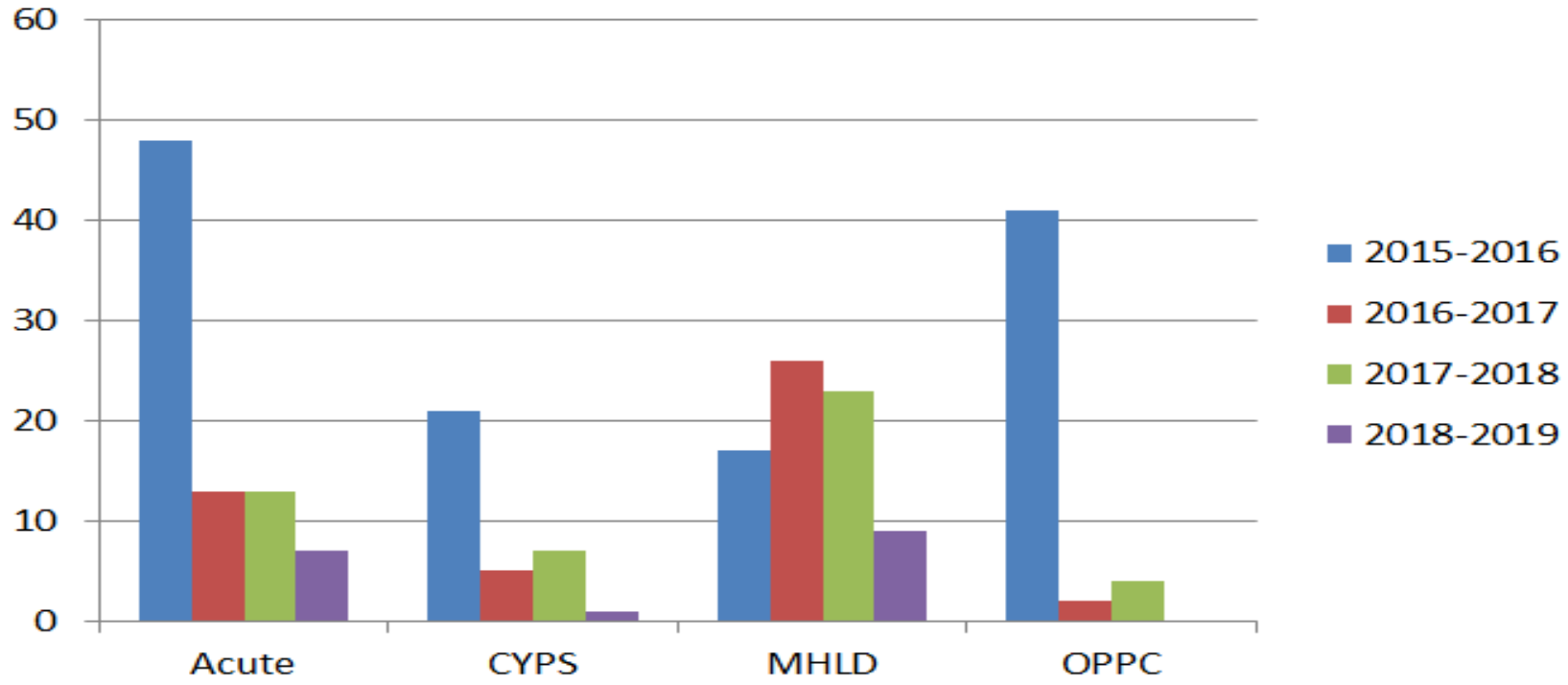
2. Serious Adverse Incidents (YTD)

Breakdown of SAI's Reported by Financial Year by Care Directorates 01 April 2015 – 1st August 2018



- Table above shows the number of adverse incidents have met the Serious Adverse Incident (SAI) criteria as the set by the HSCB.
- This number equates to (0.6%) of all adverse incidents reported via the Trust Incident Management system.

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Categorisation of SAIs 01 April 2015 – 1st August 2018 (YTD)

Area of Service	Incident Type	2015-16	2016-17	2017-18	2018-19	Total
Checking and oversight	Medication	0	1	0	0	1
	Test results	6	1	0	0	7
Equipment Related	Necessary Equipment Misused or misread by practitioner	0	0	1	0	1
	Necessary equipment not available	0	0	0	0	0
Prevention	Inpatient falls	7	0	1	0	8
Management of deterioration	Acting on or recognising deterioration	16	5	3	0	24
	Giving ordered treatment/support in a timely way	3	2	0	0	5
	Observe / review	6	1	0	0	7
No Area of Service Failure	No Area of service failure (a large number of these investigations were of expected child deaths and suicides)	50	35	21	1	107
Other	Other	4	1	2	0	7
SAI investigation in progress	SAI investigation in progress	0	0	19	16	35
N Home Falls	Not yet included in categorisation	35	0	0	0	35
Grand Total		127	46	47	17	237

The above table sets areas of learning which have been identified through Serious Adverse Incident Investigations.

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Position on the Progress of SAI Investigations

Timescales for the completion of Serious Adverse Incidents are set out by the Health and Social Care Board as follows:

Level 1 SAI investigations - 6 weeks

Levels 2 & 3 investigations – 12 weeks

Presently there are **35** SAI investigations currently being progressed within SHSCT, of which 7 are within the HSCB timescales for submission. There are a number of contributory factors set out below which influence the timescales of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads
- Necessary engagement with service users and their families, particularly where a death has occurred
- Where the SAI investigation spans across 2 or more Trusts

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

The table below sets out the position on the progress of SAI investigations ongoing

	Acute			CYPS			MHLD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks
Level 1	1	5	7	0	0	0	1	1	1	0	0	0
Level 2	0	1	1	1	0	1	3	8	1	0	1	0
Level 3	0	1	0	0	0	0	1	0	0	0	0	0

Southern Health and Social Care Trust

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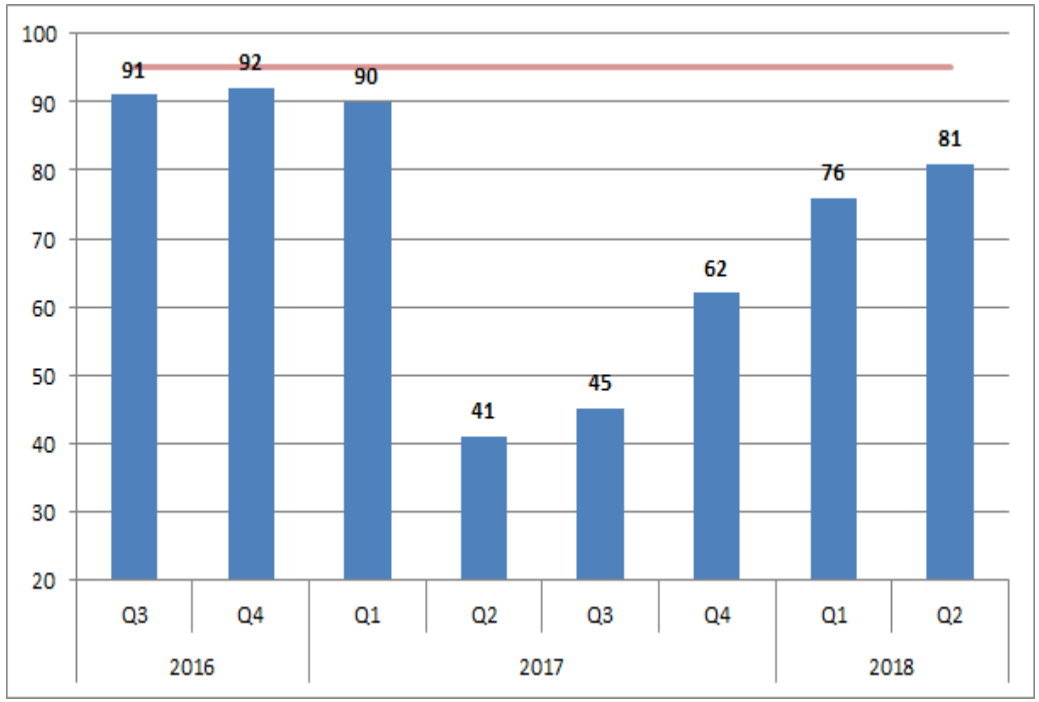
3. Patient Safety – NEWS

SHSCT NEWS Overall Bundle Compliance
Q3 2016 → Q2 2018



Introduction of Nursing Quality Indicators

In 2011 the Trust developed a range of Nursing Quality Indicators (NQI) aimed at measuring compliance with nursing care processes. The NEWS overall bundle compliance is captured through the Nursing Quality Indicator Audit Programme.

As part of this work the bundle compliance audit regarding NEWS documentation has been revised and updated following consultation with staff and review of best practice evidence.

Notable updates to the NEWS audit process:

- NEWS charts now subject to independent rather than self-audit
- Criteria adjusted to 'raise the bar' in terms of audit detail
- Production of detailed improvement plans at both ward and Trust level

As a result of the rebasing of audits Quarters 2-4 2017 has indicated a reduction in bundle compliance. The Ward Manager's Audit was reinstated in February 18 & will run alongside the Independent Audit, with a view to driving improvement between the Independent Audit 3 monthly cycle.

The Trust has discussed the care bundle in respect of compliance with the Public Health Agency who are now leading a regional Quality Improvement project to review the auditing process to provide additional assurance across the region.

In December 2017, the Royal College of Physicians published NEWS2. A Trust wide NEWS implementation and oversight group has been put in place to oversee the implementation of NEWS 2. The Group is jointly chaired by the Director of Medicine and the Executive Director of Nursing .

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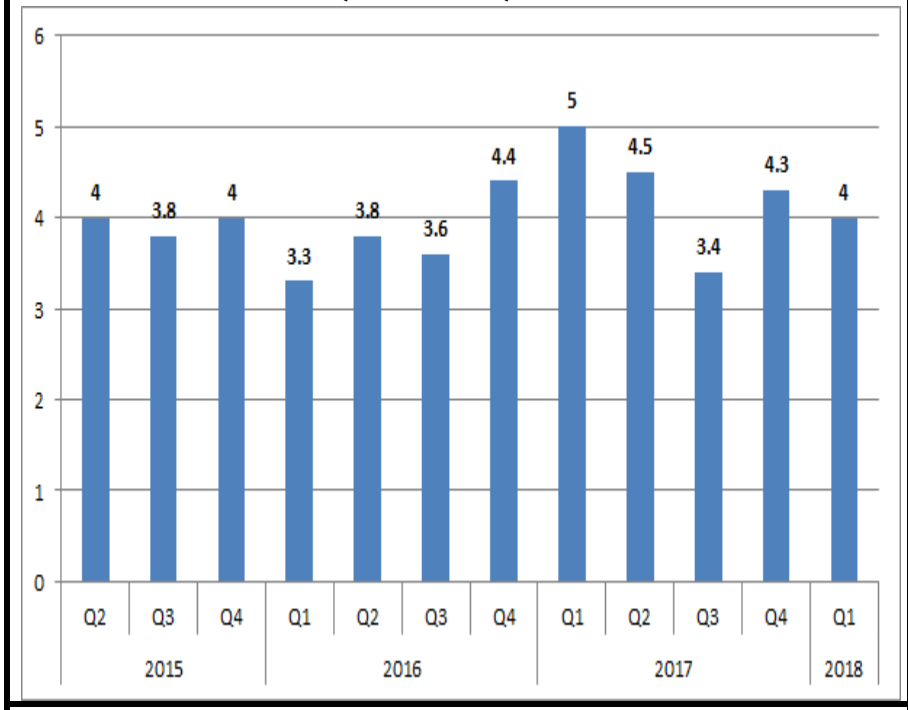
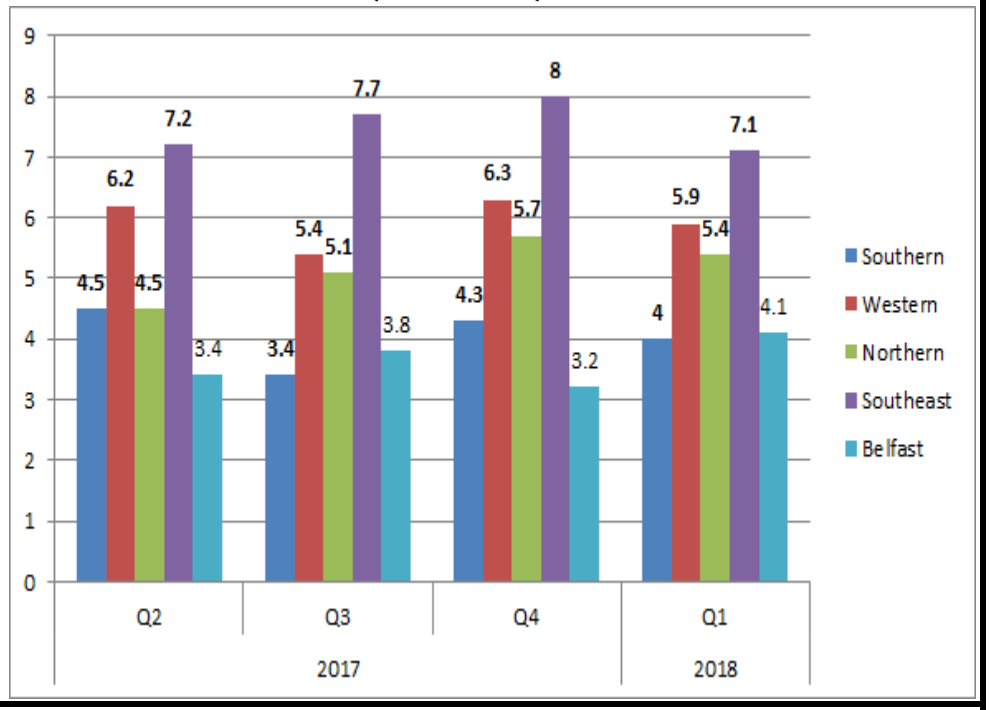
Patient Safety – Patient Falls

SHSCT Patient Fall Rate per 1,000 Occupied Bed Days
Q2 2015 → Q1 2018



- Regional Improvement Work on Patient Falls began in 2011.
- A number of pro-active initiatives has resulted in the Trust's Falls Rate being consistently one of the best in NI, namely the implementation of elements of FallSafe Bundles A & B, the use of the Falls Walking Stick by Wards to capture details of their Patient Falls "Real Time", moving "at risk" patients to a more suitable location on the Ward, where possible.
- In line with the Region in 2017/18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.
- There is no regional target associated with patient falls.

NI Trust's Patient Fall Rate per 1,000 Occupied Bed Days
Q2 2017 → Q1 2018



- In Q1 2018 the Trust's Patient Falls Rate was 4.0 per 1,000 Occupied Bed Days
- In Q1 2018 the Trust's Rate was the lowest in NI
- Of the 26 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick 14 wards (46%) saw a decrease in falls in 17/18, compared to 16/17

Southern Health and Social Care Trust

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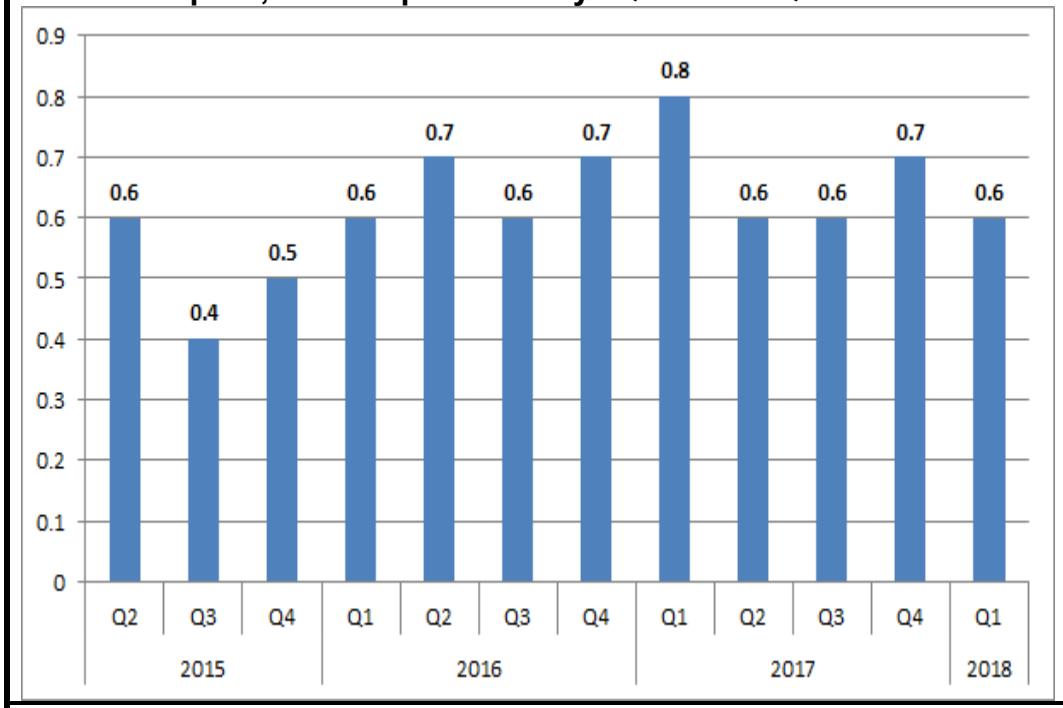
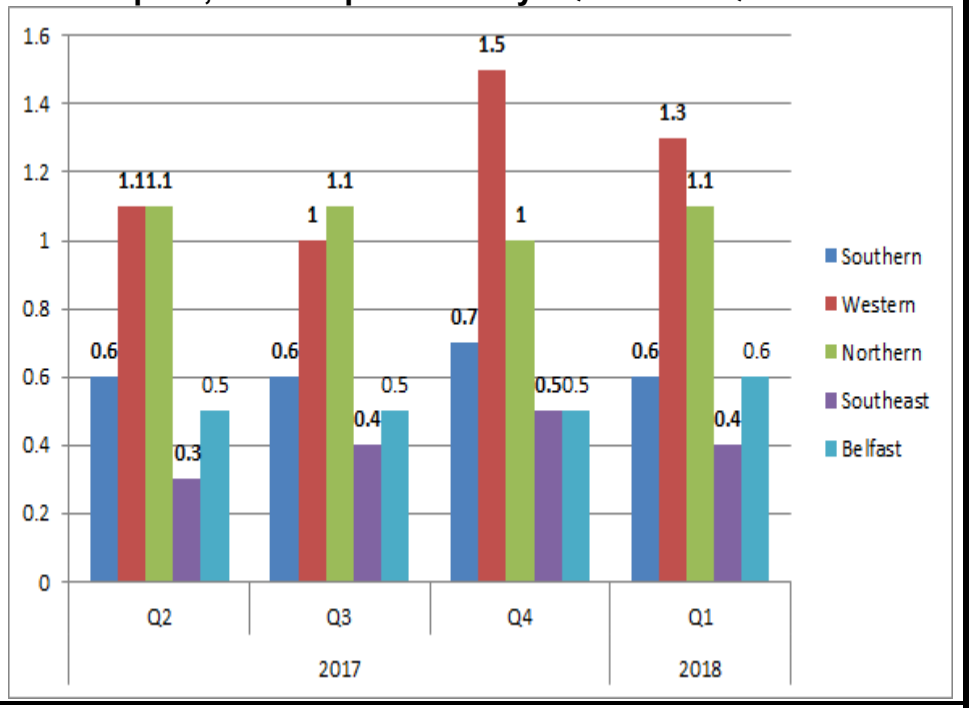
Patient Safety – Pressure Ulcers

SHSCT Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q2 2015 → Q1 2018



- Regional Improvement Work on Pressure Ulcers began 2011.
- A number of pro-active initiatives have been introduced namely the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan.
- The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on these cases within the Trust to determine those which were avoidable, with lessons learnt fed back by the Lead Nurses via Ward Manager's Meetings

NI Trust's Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q2 2017 → Q1 2018



- All Trusts saw an increase in "Ward Acquired" Pressure Ulcers in 16/17 compared to 15/16.
- Of the 27 Wards monitoring their Hospital Acquired Pressure Ulcers/Rate using the Pressure Ulcer Safety Cross 16 wards (59%) saw their rate remain the same or decrease in 17/18 compared to 16/17
- Of the 173 Ward Acquired Pressure Ulcers reported in 17/18, 26 (15%) were Grade 3 or 4 Pressure Ulcers. RCA's conducted on these cases concluded that only 6 were avoidable
- A series of Pressure Ulcer Awareness Coffee Mornings, funded by the PHA were held across the Trust in March 2018 to drive further improvement

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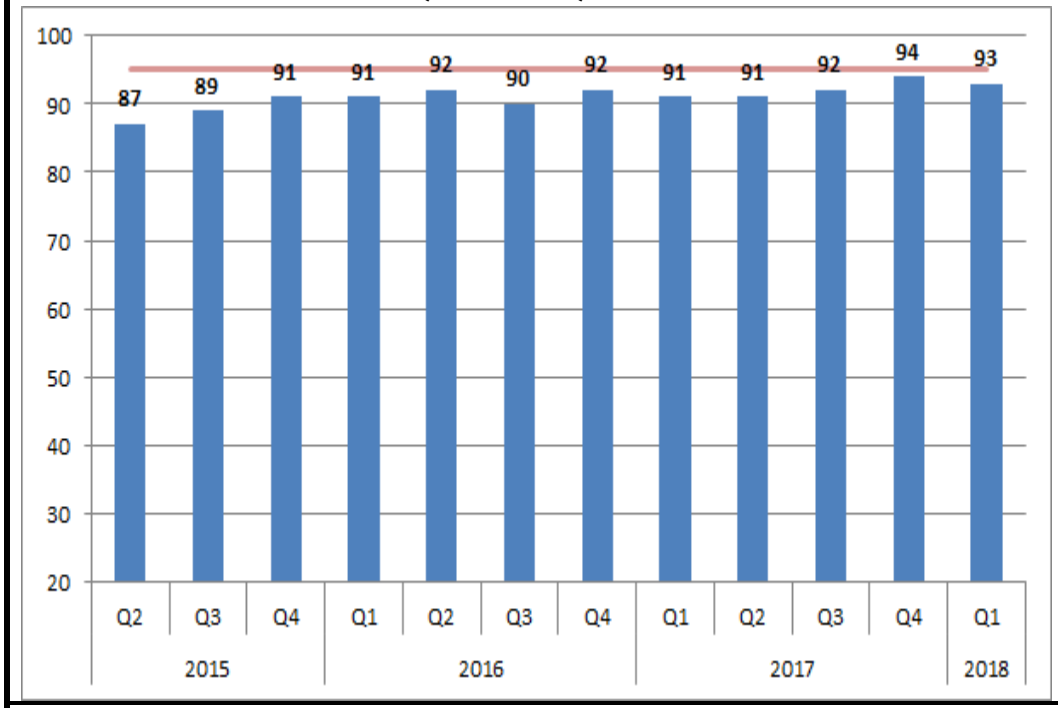
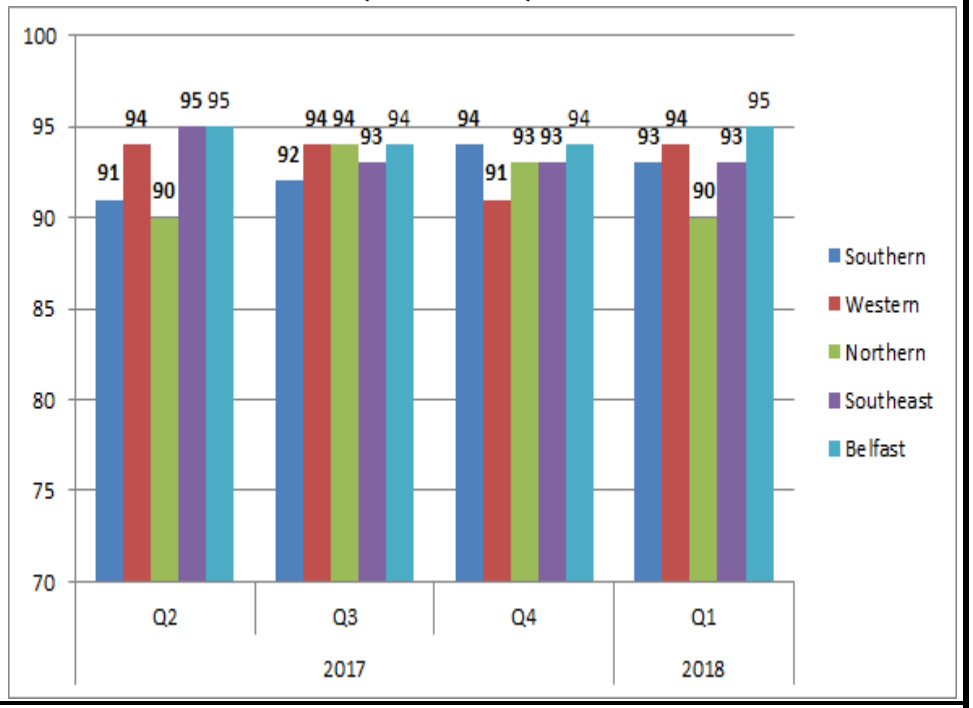
Patient Safety – Venous Thromboembolism (VTE) Risk Assessment

SHSCT VTE Risk Assessment Compliance
Q2 2015→ Q1 2018



- Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009.
- All Trusts now use a Regional Risk Assessment Tool.
- For the past 4 years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%.

NI Trust's VTE Risk Assessment Compliance
Q1 2017 → Q4 2017



- All Trusts have seen an increase in compliance since measurement began in April 2013.
- Southern Trusts overall compliance for Q1 2018 was 93%
- Southern Trust's Non-Acute Wards (Lurgan & South Tyrone) Compliance Rate was 98.3% in Q1 2018

Southern Health and Social Care Trust

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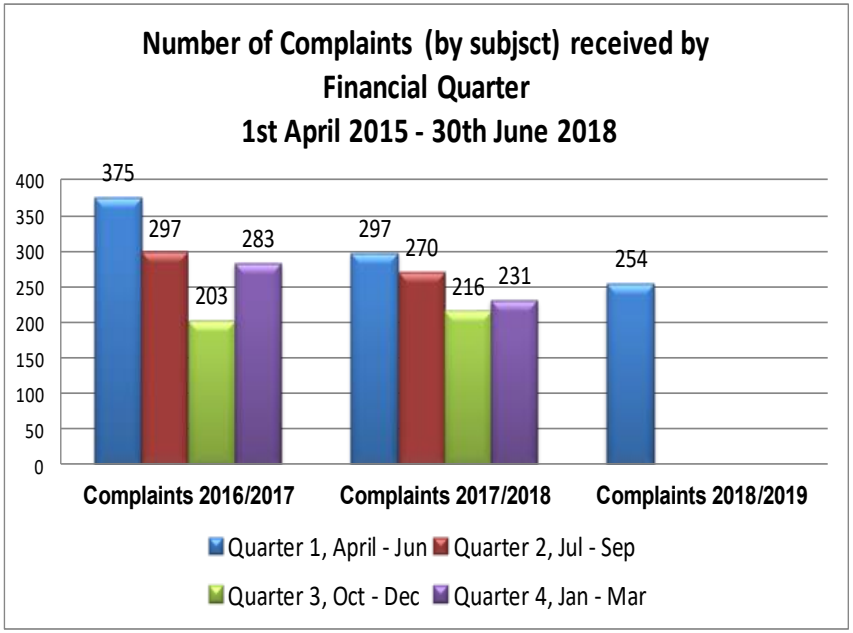
3. Complaints and Ombudsman's Complaints

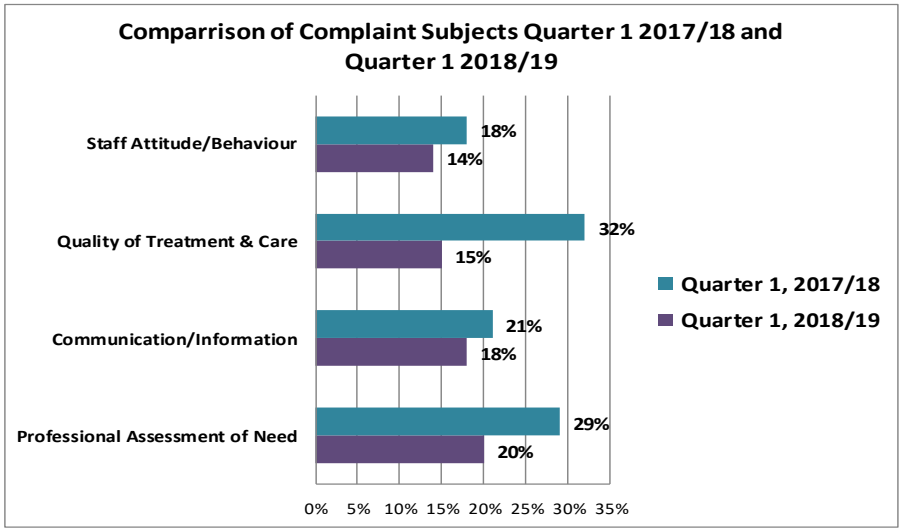
Number of Complaints Received



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

In Quarter 1 2018/19 the Trust received **161** formal complaints of which there were **254 complaints subjects**. There is a notable decrease in the number of complaint subjects in comparison to Quarter 1 in previous financial reporting years, as highlighted above.

What Our Service Users Complained About



Top 10 Complaint Subjects Q1, 2018/19

Professional Assessment of Need	20%
Communication/Information	18%
Quality of Treatment & Care	15%
Staff Attitude/Behaviour	14%
Policy/Commercial Decisions	4%
Waiting List, Delay/Cancellation Outpatient Appointments	3%
Waiting Times, Outpatient Departments	3%
Aids/Adaptions/Appliances	3%
Waiting List, Delay/Cancellation Planned Admission to Hospital	3%
Discharge/Transfer Arrangements	2%

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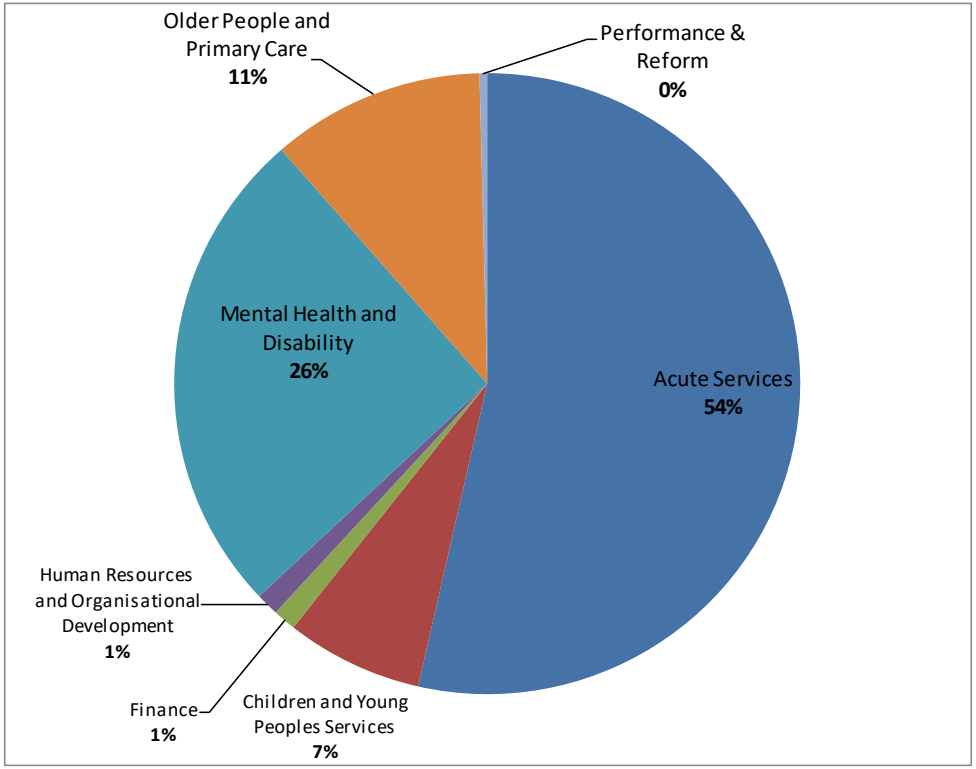
Breakdown of % of Complaints (subjects) by Directorate for Quarter 1 (1st April 2018 – 30th June 2018)



Breakdown of Number of Complaints (subjects) by Directorate and Division for Quarter 1 (1st April 2018 – 30th June 2018)

Directorate / Division	No Complaints Subjects
Acute Services	**136**
Functional Support Services	4
IMWH - Cancer and Clinical Services	30
Medicine and Unscheduled Care	47
Pharmacy	2
Surgery and Elective Care	53
Children and Young Peoples Services	**18**
Corporate Parenting	1
Family Support and Safeguarding	9
Specialist Child Health and Disability	8
Finance	**3**
Financial Accounting	3
Human Resources and Organisational Development	**3**
Employee Relations and Engagement	1
Estates	2
Mental Health and Disability	**65**
Learning Disability Services	6
Memory Services	11
Mental Health Service	42
Physical and Sensory Disability Service	6
Older People and Primary Care	**28**
Enhanced Services	10
Older Peoples Services	2
Primary Care	14
Promoting Wellbeing	2
Performance & Reform	**1**
Informatics	1
Grand Total	**254**

Southern Health and Social Care Trust

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Acknowledgement and Response Times for Complaint Letters per Directorate 1st April 2017– 30th June 2018

	Acute				CYP				MHD				OPPC			
	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE
Apr 2017	62	92%	37%	71%	**8**	100%	100%	100%	**5**	100%	100%	N/A	**2**	100%	100%	100%
May 2017	63	94%	35%	59%	**22**	94%	77%	82%	**8**	100%	63%	88%	**3**	100%	100%	100%
Jun 2017	55	87%	47%	67%	**15**	100%	73%	93%	**12**	100%	83%	100%	**1**	100%	100%	100%
Jul 2017	**72**	67%	44%	51%	**10**	100%	70%	70%	**7**	100%	86%	100%	**3**	100%	67%	100%
Aug 2017	**47**	94%	40%	74%	**12**	100%	92%	100%	**6**	100%	100%	100%	**6**	100%	83%	100%
Sept 2017	**65**	92%	32%	44%	**18**	100%	83%	83%	**6**	100%	100%	100%	**3**	100%	100%	100%
Oct 2017	**44**	98%	39%	75%	**12**	100%	83%	92%	**11**	91%	91%	100%	**2**	100%	100%	100%
Nov 2017	**55**	88%	47%	51%	**9**	100%	89%	89%	**8**	100%	87.5%	100%	**6**	100%	83%	100%
Dec 2017	**17**	100%	24%	53%	**8**	100%	88%	88%	**2**	100%	100%	100%	**4**	100%	100%	100%
Jan 2018	**69**	91%	28%	54%	**9**	100%	65%	75%	**4**	100%	100%	100%	**8**	100%	100%	100%
Feb 2018	**34**	94%	50%	74%	**11**	100%	55%	91%	**3**	100%	33.3%	33.3%	**5**	100%	100%	100%
Mar 2018	**40**	100%	33%	58%	**11**	100%	73%	73%	**10**	90%	90%	90%	**3**	100%	100%	100%
Apr 2018	**48**	98%	42%	77%	**6**	100%	67%	83%	**4**	100%	75%	75%	**3**	100%	100%	100%
May 2018	**59**	100%	46%	59%	**6**	100%	50%	50%	**9**	89%	78%	89%	**6**	100%	83%	100%
Jun 2018	**48**	100%	44%	50%	**4**	100%	100%	100%	**9**	100%	67%	89%	**3**	100%	100%	100%

The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days

The table above sets out the Trust performance by directorate against these standards. 30 Days is not a formal target however is monitored by the Trust for performance purposes.

Southern Health and Social Care Trust

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Ombudsman Cases

Breakdown of Ombudsman cases per Financial Year, 1st March 2014 –10th August 2018

	Local Resolution	Not Upheld	Open	Awaiting Screening	Upheld	Withdrawn	Not Accepted	Total
2014/2015	1	1	1	-	5	-	-	**8**
2015/2016	-	1		-	9	2	2	**14**
2016/2017	2	2	4	1	2	3	2	**16**
2017/2018	2	-	7	4	1	1	4	**19**
2018/2019	-	-	-	2	-	-	1	**3**
	5	**4**	**12**	**7**	**17**	**6**	**9**	**60**

The Trust's response to feedback about our services is based on principles of good complaint handling:

1) *Getting it right* **2)** *Being customer-focused* **3)** *Being open and accountable* **4)** *Acting fairly and proportionately* **5)** *Putting things right*

6) *Seeking continuous improvement*

When patients are not fully satisfied with the outcome from the Trust's complaint process they can choose to subsequently raise their concerns with the Northern Ireland Public Services Ombudsman. All complainants are provided with information about referring their issues to the Ombudsman at the point at which the Trust completes their investigations and closes the case with the complainant.

During the previous financial year 2017/2018, **19 cases** had been raised by the Ombudsman regarding complaints previously raised with the Trust; of which **2 cases** reached local resolution, **4 cases** were not accepted and **1 case** withdrawn. **1 case** was upheld by the Ombudsman following investigation while **7 cases** remain open within the investigation stage.

During this current financial year to date **2** cases awaits screening for acceptance by the Ombudsman's office and **1** case has not been accepted

We continued to work with the Ombudsman on cases raised during previous years.

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting	Governance Committee 6th December 2018
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Ahmed Khan Interim Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	The purpose of this paper to provide a report to Governance Committee on a number of Trust Clinical and Social Care Governance Indicators

Summary of Key Issues for Governance Committee

High level context:

- Feedback from September Governance Committee and subsequent meetings with Directors and Non-Executive Directors have informed the format of this report
- Stand down of dashboard approach to reporting
- Headline information contained in each report section
- Additional descriptive information provided on SAI and catastrophic incidents
- Inclusion of learning points relating to patient safety initiatives
- Complaints information focussing on performance

Key issues/risks for discussion:

- This is the first report in the revised format, feedback from Governance Committee will inform the development of future reporting.
- Ongoing development of reports to link corporate risks to patient outcomes and clinical and social care governance information.

Internal/External Engagement:

- SMT
- AD Medical Directors office
- AD Nursing Workforce
- Directorate Governance Coordinators
- Operational Teams

Southern Health and Social Care Trust

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Clinical and Social Care Governance Report December 2018

Introduction

Purpose of Report

This report is to provide assurance to Trust Governance Committee regarding Clinical and Social Care Governance activity based on a number of indicators agreed by the Trust Senior Management Team:

- Incident Reporting
- Serious Adverse Incidents
- Complaints / Regional Timescales for Response
- Falls
- NEWS Compliance
- Pressure Ulcer Occurrences

Incident Reporting

Incident Reporting (via Datix)

Incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognising and reporting an incident (or near-miss), no matter the level of harm, is the first step in learning to reduce the risk of future occurrence.

The Southern Health and Social Care Trust reports approximately on average 12,500 incidents per year since the introduction of the DATIX web system in 2012. The majority of our incidents continue to cause either insignificant or minor harm (Figure 2).

Figure 1 – Incidents recorded by directorate Quarter 4 2016 to Quarter 3 2018

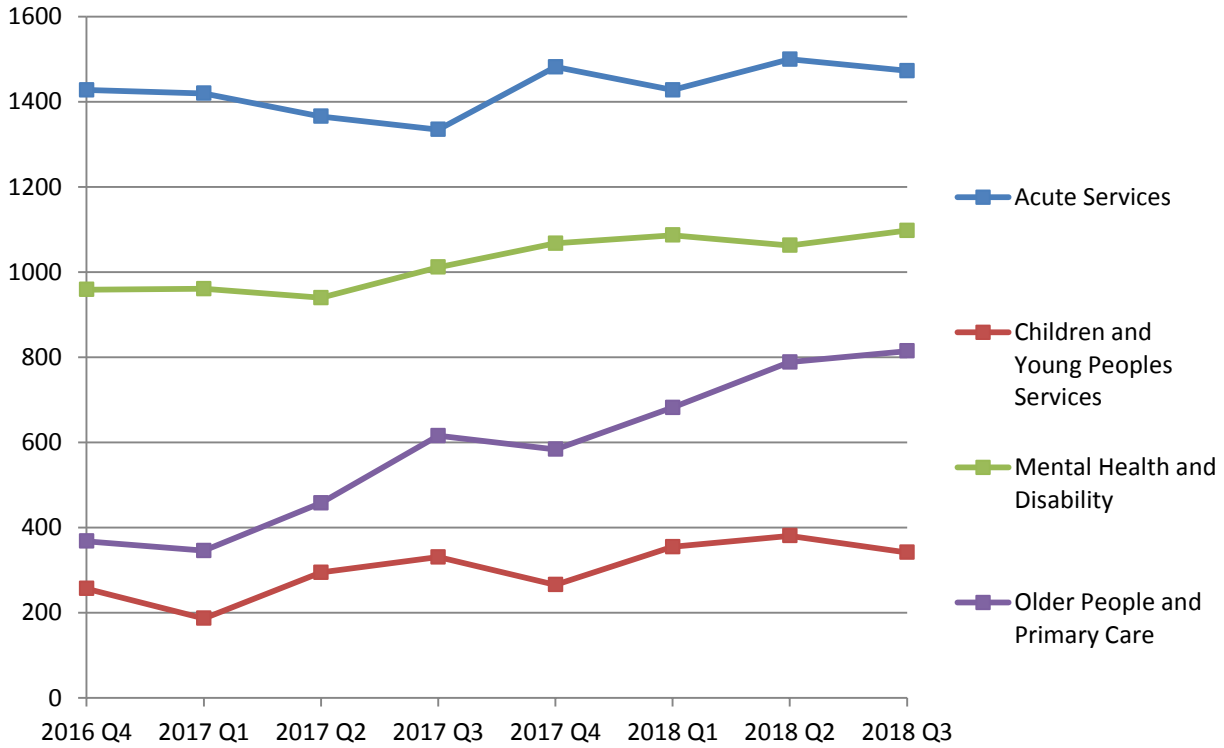
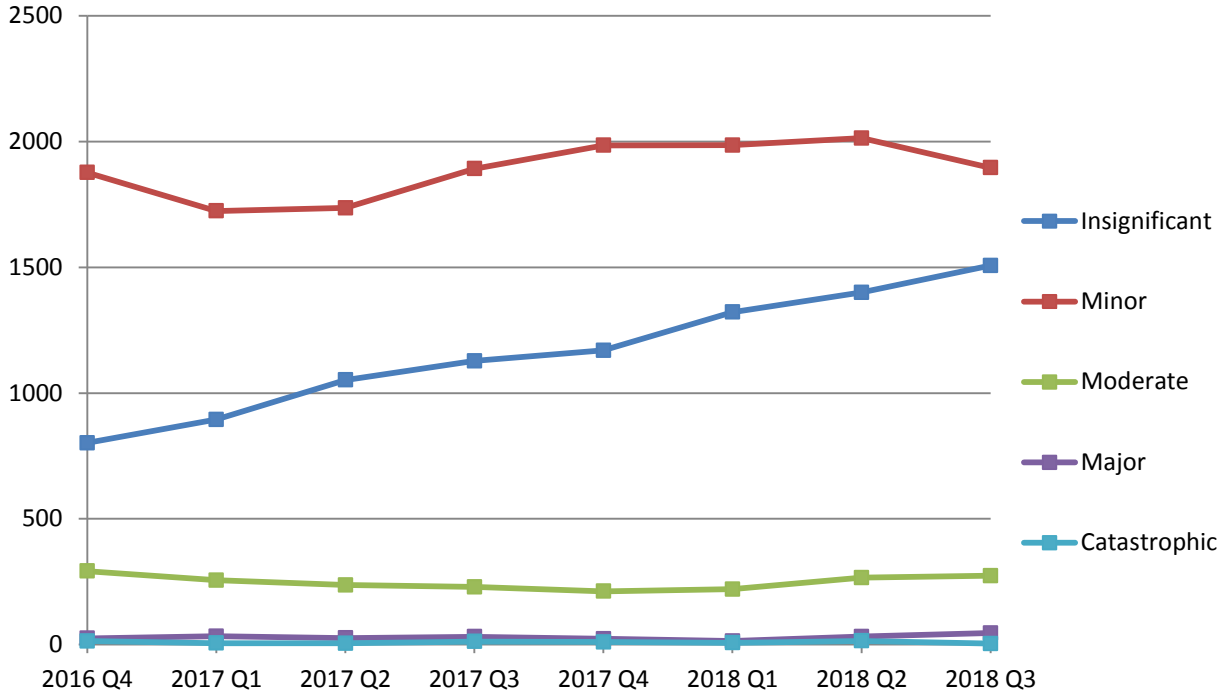


Figure 2 – Incidents by Severity Quarter 4 2016 to Quarter 3 2018



Catastrophic Incidents Quarter 3 2018

In Quarter 3 2018 there were three catastrophic incidents recorded details are provided in table 1 below.

Table 1 – Catastrophic Incidents Quarter 3 2018

Description	Action taken	Immediate Learning Identified
Patient referred to Mental Health services, was arrested on a charge of suspected homicide	Serious Adverse Incident investigation in progress	No initial learning identified.
Maternal death	SAI Investigation commenced with input from NIAS and NHSCT.	No initial learning identified.
Suspected suicide of service user known to Support and Recovery team	Serious Adverse Incident investigation in progress	No initial learning identified as yet by the review team.

The ten most frequently reported incidents for quarter 3 2018 are set out in the table below. The profile has changed slightly from the previous quarter when *'Lack of suitably trained*

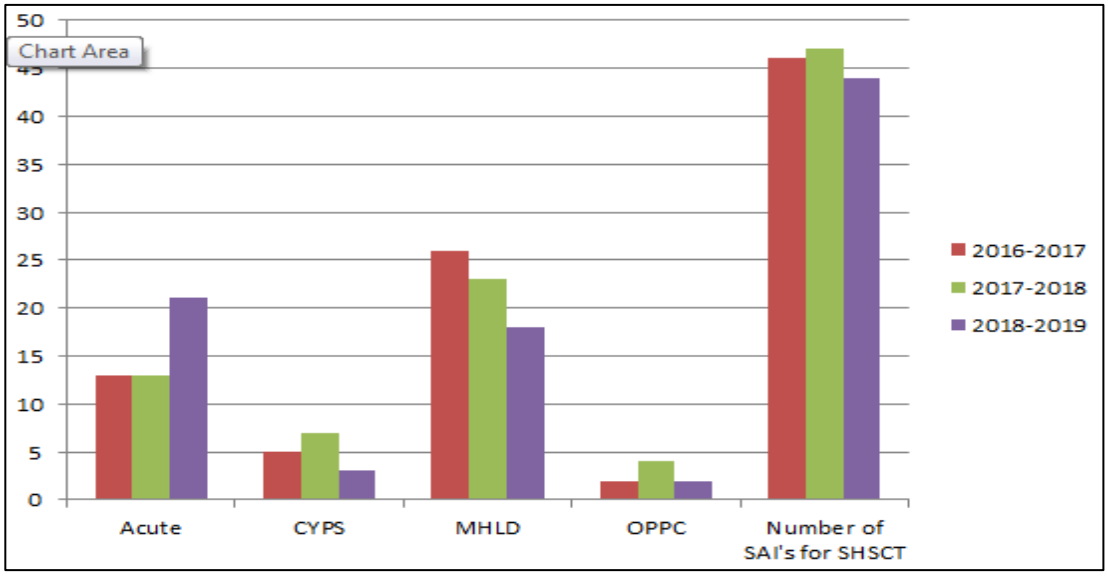
/skilled staff' featured in the top ten most frequently reported incidents, this was replaced by *'Simple complication of treatment'* (see Table 2)

Table 2 –Incidents Classification Quarter 3 2018

Incident Type	Number of Occurrences
Physical abuse, assault or violence	599
Verbal abuse or disruption	264
Fall from a height, bed or chair	262
Fall on level ground	255
Suspected fall	239
Self-harm	139
Delay or failure to monitor	124
Omitted/delayed medicine or dose	106
Absconder/ missing patient - voluntary	100
Simple complication of treatment	51

Serious Adverse Incident Investigations

Table 3 - Comparison of number SAI's from 2016



From the 1st July – 30th September 2018 there has been **7** SAI's submitted to the HSCB, details of these SAI's have been provided in Table 3 below. The Serious Adverse Incidents are in progress.

Table 4 – Serious Adverse Incidents Reported Quarter 3 2018

Directorate	Description	Identification of Immediate

		Learning and Actions
MHLD	Patient referred to Mental Health services, was arrested on a charge of suspected homicide	SAI Investigation commenced, no immediate learning or actions identified.
Acute	Maternal death	SAI Investigation commenced with input from NIAS and NHSCT.
MHLD	Suspected suicide of service user known to Support and Recovery team	SAI Investigation commenced, no immediate learning or actions identified.
MHLD	Service user known to Mental Health Services jumped from window of her home and sustained multiple fractures	Immediate contact has been made with BHSCT to discuss case.
Acute	Patient admitted to fracture ward for fractured hip, in theatre sacral pressure ulcer observed, wound undressed no reference to skin assessment on handover	SAI Investigation commenced, no immediate learning or actions identified.
MHLD	Inpatient smashed ward window in Bluestone Unit, resulted in self harm and admission to CAH for treatment of injuries	SAI Investigation commenced with WHSCT. MHLD also liaising with the Acute Directorate.
Acute	Patient attended theatre for insertion of Percutaneous endoscopic gastrostomy (PEG) feeding tube. A colonoscopy previously used on another patient was used to perform an oesophago-gastrostomy prior to full decontamination.	Team debrief carried out and staff immediately advised of policies and procedures. Analysis of systems learning will be carried out through SAI process.

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

Trust Performance compared to Regionally agreed SAI Timescales

Timescales for the completion of Serious Adverse Incidents are set out by the Health and Social Care Board as follows:

Level 1 SAI investigations - 6 weeks
Levels 2 & 3 investigations – 12 weeks

- Presently there are **44** SAI investigations currently being progressed within SHSCT
- **3** of these investigations have been paused due to ongoing investigations by external bodies (Safeguarding Board Northern Ireland and PSNI)
- **8** SAI investigations remain within the HSCB timescales for submission

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

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads.
- Necessary engagement with service users and their families, particularly where a death has occurred.
- Where the SAI investigation spans across 2 or more Trusts

Table 5 below sets out the position on the progress of SAI investigations ongoing.

Table 5 – Trust SAI Performance Against Regional Timescales

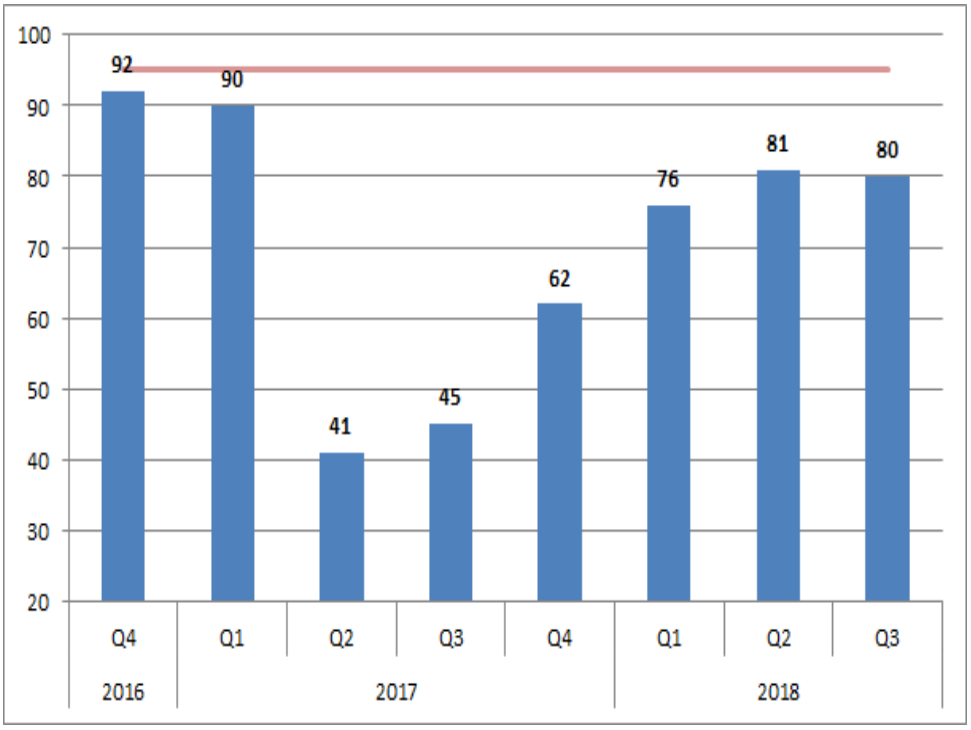
	Acute			CYPS			MHLD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks
Level 1	0	7	8	0	0	0	1	2	1	0	0	0
Level 2	3	1	1	0	1	0	3	6	4	0	1	0
Level 3	0	1	0	0	0	0	0	0	0	0	0	0

Patient Safety Indicators

NEWS Bundle Compliance

The National Early Warning Scoring System (NEWS) is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. The information assessed via the NEWS process is used to alert clinicians to the deteriorating patient and acute illness. Each Southern Trust inpatient is monitored via NEWS throughout their stay.

Figure 3 - SHSCT NEWS Overall Bundle Compliance Q4 2016 → Q3 2018



As a result of the rebasing of audits Quarters 2-4 2017 indicated a reduction in bundle compliance, subsequent action plans to address non-compliance have resulted in significant increases in compliance, one action included increasing the number of charts requiring audit and a review of the audit criteria and additional training for auditors.

Target Areas for Improvement / Actions Taken

NEWS audits currently comprise of a dual quality assurance mechanism where each ward sister carries out a weekly audit of their ward / department and the service area lead nurse conducts a monthly independent audit. Areas for improvement / systems strengthening are identified at a local level and fed back via Trust Nursing Quality Indicator processes to ensure that where appropriate, systems are changed to improve patient care.

The Trust operates a quarterly EWS Oversight Group which last met October 2018 whose role it is to provide assurance that the Trust has adequate mechanisms in place EWS training, documentation, policy and assurance auditing.

This quarter the EWS oversight group requested a point prevalence audit be carried out across all inpatient settings in addition to the existing audit programme. Summary of recommendations are below:

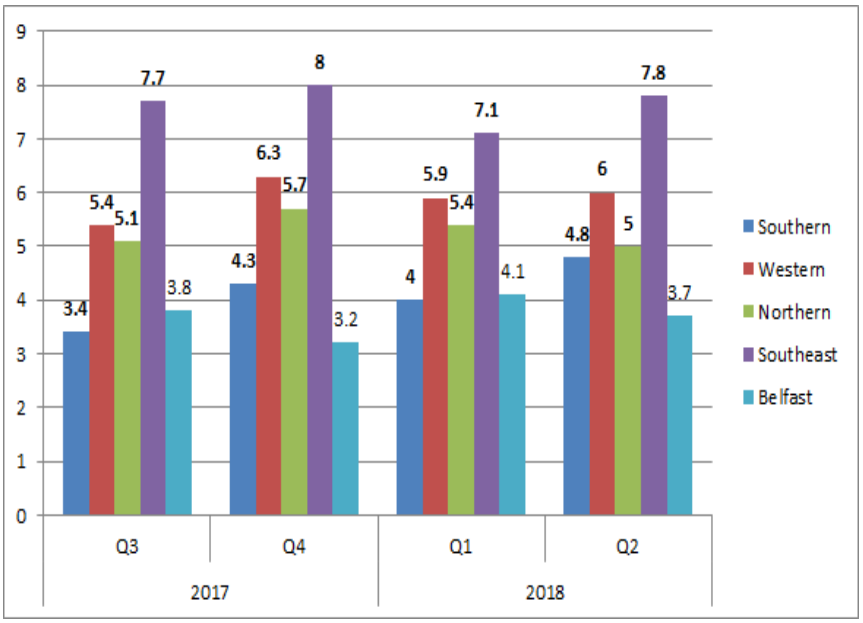
- As a result of this audit five cases were identified for an in-depth multi-disciplinary review which is in progress at time of reporting to gain a better understanding of professional judgement, escalation and management plan decisions.
- Trust to consider using an electronic alert to a dedicated review team / patient's medical team for NEWS where escalation is required
- Trust to consider dedicated Lead for implementation of the updated revised NEWS process (NEWS2)

Patient Falls

The Trust Patient Falls audit is based on elements of the Royal College of Physicians 'Fall Safe' bundle. A care bundle is a list of actions (called elements) that need to be applied consistently to patients for whom they are appropriate. The actions are selected because they have been shown to be effective through research.

This audit is carried out as part of the Nursing Quality Indicator suite by ward sisters and lead nurses.

Figure 4 NI Trust's Patient Fall Rate per 1,000 Occupied Bed Days Q3 2017 → Q2 2018



Patient Falls - Target Areas for Improvement / Actions Taken

In line with the Region in 2017/18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm, all of these incidents occurred in the acute directorate. In Quarter 2 2018 there were 6 falls that met these criteria were subject to the Post Falls Review process. Learning from these occurrences are submitted to the Public Health Agency for consideration of regional sharing of learning, the following learning points were identified:

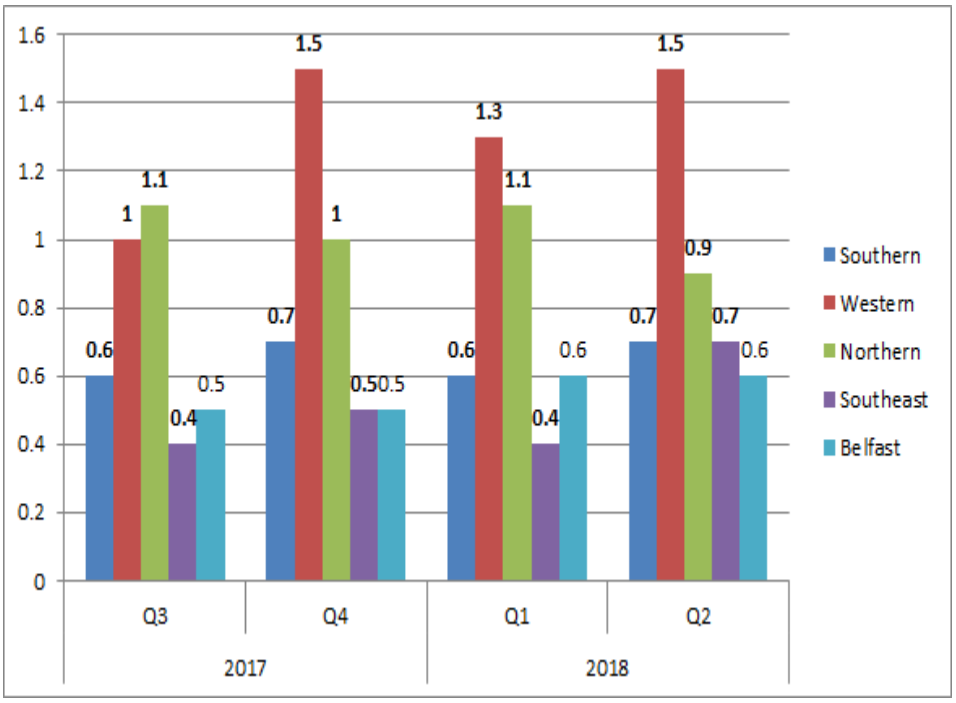
- Fall assessment should include clearly documented outcomes of assessment to inform care planning
- Importance of appropriate placement of high risk patient in observation bed spaces
- Importance of robust assessment and one to one supervision for patients suffering confusion
- Need to continuously update assessments to include lying and standing blood pressure and urinalysis when Falls B bundle is implemented

Pressure Ulcer Bundle Compliance

The Trust Pressure Ulcer audit is based on elements of the regional SKIN bundle. The focus of the regional SKIN bundle is to identify patients at risk of pressure ulcers and to conduct an case review on grade 3 & 4 Ward Acquired Pressure Ulcers to determine those which were avoidable, with lessons learnt fed back by the Lead Nurses via Ward Sisters meetings.

This audit is carried out as part of the Nursing Quality Indicator suite by ward sisters and lead nurses.

Figure 5 NI Trust's Pressure Ulcer Rate per 1,000 Occupied Bed Days Q3 2017 → Q2 2018



Target Areas for Improvement / Actions Taken

Of the 173 Ward Acquired Pressure Ulcers reported in 17/18, 26 (15%) were Grade 3 or 4 Pressure Ulcers. Reviews conducted on these cases concluded that only 6 were avoidable. Learning from these occurrences are submitted to the Public Health Agency for consideration of regional sharing of learning, the following learning points were identified:

- Importance of early identification of patients that require placement on Pressure Ulcer Pathway/SKIN Bundle/Pressure Relieving Mattress
- Pressure Ulcer documentation should include clearly recorded outcomes of assessment to inform care planning
- Importance of providing patient advice on Pressure Ulcer Prevention

Service User Formal Complaints

Number of Complaints Received

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

In quarter 3 2018, 27 subject areas were made up of 253 complaints. This was an increase of 12 from quarter 2 however a decrease of 17 from the same quarter in 2017

Comparison of Complaint Subjects Q2 2018 and Q3 2018

- 2% increase in the number of complaints relating to Communication/ Information
- 4% increase in the number of complaints relating to Quality of Treatment & Care
- 2% decrease in the number of complaints relating to Staff Attitude and Behaviour
- Professional Assessment of Need remained the same as in Q2.

Top 10 Complaints by Subject

Table 4 – Trust Complaints Received By Subject

Subject	Number
Communication/Information	50
Professional Assessment of Need	46
Quality of Treatment & Care	40
Staff Attitude/Behaviour	32
Waiting List, Delay/Cancellation Outpatient Appointments	10
Waiting Times, A&E Departments	9
Quantity of Treatment & Care	7
Property/Expenses/Finances	7
Policy/Commercial Decisions	6
Discharge/Transfer Arrangements	5

- Communication/ Information are showing as the most common subject of complaint this quarter (as it was last quarter). There is an increase of 6 complaints in total.
- Professional Assessment of Need is the second most common subject of complaint (as it was in Q2). There is an increase of two in total.
- Quality of Treatment & Care is the third most common subject of complaint (as it was in Q2). There is a decrease of 1 complaint in total.
- Staff attitude / Behaviour is the fourth most common subject of complaint (as in Q2). This is a decrease of 4 in total.
- In Quarter 2, the fifth most common subject of complaint was Policy / Commercial Decision. However, in Quarter 3 Waiting List, delay / Cancellation Outpatient Appointments has taken its place.

Percentage of Complaints by Directorate Quarter 3 2018

- Acute: 57% (144 of 253 total complaints)- decrease of 2% since Quarter 2 2018
- CYP: 14.5% (37 of 253 total complaints)- increase of 7% since Quarter 2 2018
- MHD: 12% (30 of 253 total complaints)- decrease of 6% since Quarter 2 2018

- OPPC: 15% (38 of 253 total complaints)- increase of 2% since Quarter 2 2018
- Human Resources and performance and Reform: decreased by 0.5% since Quarter 2 2018
- Office of Chair and Chief Executive: increased by 0.5% since Quarter 2 2018
- Finance: 1% - remained the same since Quarter 2 2018

Number of Complaints by Directorate and Division Quarter 3 2018

Table 5 – Complaints by Directorate and Division

Directorate/ Division	Number of Complaints
Acute Services	**144**
Functional Support Services	17
IMWH - Cancer and Clinical Services	41
Medicine and Unscheduled Care	65
Surgery and Elective Care	21
Children and Young People	**37**
Corporate Parenting	7
Family Support and Safeguarding	16
Specialist Child Health and Disability	14
Mental Health and Disability	**30**
Learning Disability Services	9
Mental Health Service	16
Physical and Sensory Disability Service	5
Older People and Primary Care	**38**
Enhanced Services	15
Older Peoples Services	5
Primary Care	18
Finance and Procurement	**3**
Financial Accounting, Control and Financial Services	3
Office of Chair and Chief Executive	**1**
Governance	1
Grand Total	**253**

Acute – 144 (of 253 complaints) in total compared to 141 (of 241 complaints) in Quarter 2 (increase of 3)

- Functional Support Services – increase of 13
- IMWH – Cancer and Clinical Services – increase of 8
- Medicine and Unscheduled Care – increase of 15
- Surgery and Elective – decrease of 29
- Pharmacy has no complaints this quarter. (2 in Quarter 2.)

CYP – 37 (of 253 complaints) in total compared to 18 (of 241 complaints) in Quarter 2 (increase of 19)

- Corporate Parenting – increase of 5
- Family Support and Safeguarding – increase of 8
- Specialist Child Health and Disability – decrease of 6

MHD – 30 (of 253 complaints) in total compared to 44 (of 241 complaints) in Quarter 2 (decrease of 14)

- Learning Disability Services – increase of 5
- Mental Health Service - decrease of 12
- Physical and Sensory Disability Service – increase of 2
- Memory Services has no complaints this quarter (9 in Quarter 2)

OPPC – 38 (of 253 complaints) in total compared to 31 (of 241 complaints) in Quarter 2 (increase of 7)

- Enhanced Services – increase of 3
- Older People Services – increase of 1
- Primary Care – increase of 5
- Promoting Wellbeing did not have any complaints this quarter (2 in Quarter 2)

Finance and Procurement

- Remained the same with 3 in total

Performance and Reform (decrease of 1)

- No complaints this quarter (1 in Quarter 2)

Office of Chair and Chief Executive (increase of 1)

- Increase of 1 (no complaints in quarter 2)

Acknowledgement and response Times for Complaint Letters per Directorate – Average % Quarter 3 2018

The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days

The table above sets out the Trust performance by directorate against these standards. 30 Days is not a formal target however is monitored by the Trust for performance purposes.

Acute

- 2 Working Day Acknowledgement – 96% (98% in Q2)
- 20 Working Day Response – 25% (44% in Q2)
- 30 Working Day Response – 42% (62% in Q2)

CYP

- 2 Working Day Acknowledgement - 92% (100% Q2)
- 20 Working Day Response - 80% (72% Q2)
- 30 Working Day Response - 83% (77% Q2)

MHD

- 2 Working Day Acknowledgement - 100% (96% Q2)
- 20 Working Day Response - 45% (70% Q2)
- 30 Working Day Response - 60% (84% Q2)

OPPC

- 2 Working Day Acknowledgement - 100% (100% Q2)
- 20 Working Day Response - 85% (94% Q2)
- 30 Working Day Response - 15% (100% Q2)

Ombudsman Cases

In Quarter 3, we received one request for further information from the Ombudsman's Office. This case is currently pending. We have not yet been notified if they are accepting it for investigation.

Four Ombudsman cases were closed within Quarter 3. Two were not accepted for investigation. One was resolved through Local Resolution and one was upheld.

Clinical and Social Care Governance SWOT Analysis – July 2018

1. SAI Investigations

	Summary of Directorate Responses
Strengths	**OPPC** • Governance office drive regional/trust/directorate policy and procedure compliance; • Governance office acts as a central point of contact and ensures SMT are communicated with throughout an investigation; ensuring members understand their role and responsibilities, in accordance with protocol, policy and the TOR. • Drafting of investigation reports using version control; • Level of scrutiny and challenge within the process from CSCG coordinator, AD's and Director; • Significance attached to SAI investigations and therefore the robustness of the investigation; • Directorate SAIs and themes tracked through local level spreadsheet. • Audit of action plans to ensure continued compliance with same **CYPS** The advantage in CYPS is the well-established clinical & social care governance team. They have strong interfaces and relationships with the operational teams which enables robust systems with regards to the SAI process. There are many aspects of C&SC governance within CYPS that work well, for example: • SMT robust assurance processes. • Working within timeframes for SAIs. • Support provided by C&SC governance team to the SAI review teams and the Chair. • Excellent engagement with family/service users. • Positive and transparent relationships with external agencies such as HSCB/Coroner/DOH (Early Alerts) and the SBNI. • Open and transparent review process – focus on learning and engagement. • C&SCG team deliver governance awareness training using innovative ways and materials. This also involves the DROs on occasions • Recent survey conducted by C&SCG team on staff's experiences and feedback on the SAI processes will be used to shape ongoing engagement in a supportive and positive learning environment. • Establishment of the CYPS multi-disciplinary Learning Forum. CYPS believe that the model established for support, transparency and learning could be replicated in other Directorates. **MHLD** • All incidents which meet the regional SAI criteria are subject to full SAI review. This includes inpatient deaths which meet SAI criteria. All other inpatient deaths are reviewed and monitored via the Morbidity and mortality process. • Trend analysis regarding SAIs is presented twice yearly at multiprofessional learning sessions with specific detailed case examples selected and also presented. • Where appropriate MHD commissions an audit/thematic review of specific incident types e.g the HTCR & Suicide SAI Audit was conducted to glean further learning. This audit is being repeated. • MHD us a rota for selection of SAI Chairperson. Typically in MH SAIs, chair is a consultant psychiatrist from another geographical sector of the Southern Trust Area who has had no involvement in the patients care at any time

	Summary of Directorate Responses
	MHD developed and issues guidance entitled "Process for the Reporting of Serious Adverse Incidents (SAI) & Reporting Early Alerts". This outlines sai criteria, key contacts and roles and responsibilities and is included in Training. AI reporting training is provided to all staff and AI review training is provided to those with responsibility for investigating/reviewing incidents. Training is provided by the MHD Governance office. Members of the SAI review teams and Chairs of SAI reviews receive specific training regarding their roles and incident investigation methodology. MHD provides review teams with guides regarding: 1. Brief Guidance on supporting MHD staff during the respectful management and review of an adverse incident / serious adverse incident, 2. Brief Guidance on the Role and Responsibilities of an SAI Review Independent Chairperson 3. MHD Suggested Format of Adverse & Serious Adverse Incident Review Meetings 4. MHD Incident Investigation Guidance. In MHD, where the patient is deceased and it is appropriate to do so families / carers are routinely informed of that an SAI review is taking place, advised of the process, the terms of reference and offered the opportunity to provide the Trust with their views/perspective either via meeting with the Trust or verbally/in writing. Family engagement activity is enhanced by the involvement of the protect life coordinator. Families are offered the draft report or provided with same if they specifically request it. They are always offered the opportunity of meeting with Trust staff to discuss the report content and/or provide comments back verbally/in writing. The same process applies when the service user is not deceased but after their formal consent to engage with the family has been sought. In some cases the Trust acts as a conduit between the family and GP should the family have queries relating to the GP. MHD has however recently written to HSCB regarding the particular difficulties surrounding the issue of involving families of victims who are not related to the service user and the protection of confidential patient information and/or ongoing criminal investigations. All reports (including the family queries/comments) are shared with the coroner (for deceased patients) and HSCB/RQIA. Adobe Acrobat Document **Acute** *Acute services has a robust and consistent system for screening of incident reports to determine whether an SEA/SAI is required, including initial time line work to allow informed screening.* *The process for final release of Acute SAI reports is well developed and includes all Acute ADs, AMDs and CDs.* *A good working relationship between the Acute M&M chairs and the Acute Governance team is developing.*

Weaknesses	**OPPC** • Training; • Lack of consistency in investigation approach; • Differences in the experience of the review team chairs and members; • Variance in review team size; • Lack of cross-directorate challenge function; • Weaknesses attributed to delays in achieving submission dates; • Improve post investigation communication to encourage and support the sharing of learning and post investigation debrief. **CYPS** • Co-operation and communication between Directorates needs to be improved, particularly with regards to joint SAI review process. • The current situation creates delay in meeting timeframes. On occasions there are significant delays. • A recent multi-disciplinary survey of the SAI process was undertaken across CYPS and overall was very positive with regards to support, processes and outcomes. However, findings also indicated that there was a need for further dissemination of learning and recommendations for staff within the operational teams. **MHLD** Due to constraints within Regional SAI Procedures and Legal / Information Governance advice, MHD has recently written to HSCB regarding the particular difficulties surrounding the issue of involving families of victims **who are not related to the service user** and the protection of confidential patient information and/or ongoing criminal investigations. MHD has requested a revision of the Regional SAI Procedure which HSCB have agreed to. The discontinuation of a regional Lay persons list from which Trusts can source independent SAI panel members reduces the ability of the Trust to enhance the level of independence, where appropriate, on reviews **Acute** *Medical staff job plans do not allow time for them to chair or participate in SAI panels – this leads to long delays in getting investigations started and then completed, as clinical activity takes precedence.* *Some cross Directorate SAIs would benefit from a 'corporate' approach and chair – often do each own part in a 'silo'- which affects the continuity and standard of the resulting report.* *No protected time to follow up actions and learning following an SAI report, to ensure that learning is embedded and actioned consistently.*
Opportunities	**OPPC** • Seek scrutiny from external to the Directorate; • Use of MD investigation teams that include independents (staff not associated with service or directorate – staff could rotate); • Seek a greater level of family liaison/involvement prior to final report being issued to the HSCB rather than presenting final report to family and offering a meeting; • Seek external evidenced based training on human factors; • Training and investigator competencies could be appraised periodically with refresher training supplied in-house, as required; • Theming of actions arising from all Trust SAI's to ensure cross directorate learning and implementation

	Summary of Directorate Responses
	CYPS Although there is a well-established cross directorate co-ordinators working group, there needs to be effective support from the operational teams to support cross directorate processes. **MHLD** • Amendments to the Regional SAI procedure in relation to engaging with families who are not related to the service user. Meeting has been set up by HSCB for 13 Aug 2018. • In 2011, the Director of Nursing & Allied Health Professions at the PHA, requested a high level review of SAIs where a suicide occurred: The review recommended: "A select list of Independent Chairpersons on a Regional wide basis should be developed. Guidance on the role of the Independent Chairperson should be developed to ensure consistent application across the Region. Training and remuneration should be agreed regionally" This list does not exist regionally. • In 2017, an RQIA led Project with representatives from Trusts, HSCB, PHA, RQIA examined learning arising from SAIs involving Suicide, Homicide and Serious Self Harm. The review submitted a number of recommendations to DHSSPSNI in order to improve SAI processes for the above incidents. It is unclear at this point what has been done in relation to those recommendations or whether or not DHSSPSNI has accepted them. **Acute** *The Acute team has good systems and processes in place but struggles with resource to complete activities in a timely manner.*
Threats	**OPPC** • Time challenges; • Availability of relevant training; • Increasing public demand for litigation/ blame; • Media scrutiny/challenges; • Challenge with future increase in complexity of care being delivered due to an aging population with co-morbidities. **CYPS** Increasing capacity of governance activity. There is a financial threat as the current funding for CYPS C&SCG department does not include funding for the full time band 6 which is essential to the effective running to the C&SCG team. • Factors to improvement are delays in cross-directorate working. **MHLD** The use of RCA and the language regarding 'investigation' creates a subtext of blame and fault finding. Any movement away from this would improve the development of a learning culture. The continued use of RCA for suicide/homicide cases is inappropriate and not regarded as the optimal methodology for investigating such incidents. The use of SAI Reports within other processes (eg coroners process, PPS process), other than in a "learning" context presents challenges in terms of maintaining an open learning culture and can be counterproductive. The complex nature of the mental health service model has in turn resulted in significantly more

	Summary of Directorate Responses
	complex SAI reports due to the patient's treatment pathway. We endeavour to complete those reports within the timescales however due to completing pressures at service level and/or within governance that is not always achieved. Some reports are also delayed due to Adult Safeguarding process delays, PSNI etc… The expectations of service users/their relatives has changed in terms of what the SAI process was intended to do and can deliver. Those expectations need to be managed **Acute** *Medical staff job plans that don't have protected time for governance activity.* *Acute Governance team resource.*

2. Standard and Guideline Compliance

	Summary of Directorate Responses
Strengths	**OPPC** • Governance office drive regional/Trust/directorate policy and procedure compliance; • Robust Directorate process in place for timely dissemination to relevant Heads of Service, AD's and Director; • Regular/weekly monitoring of S&G relevant to the Directorate by Governance office; Periodic follow-up with S&G Leads. Standing agenda item at the OPPC Directorate Governance meeting to ensure senior staff are informed. **CYPS** Well established process within CYPS. There are a number of aspects to the S&G assurance structures that are effectively managed within CYPS: • Centralisation of all S&G into the Trust and subsequent benefit to CYPS • C&SCG effectively update, monitor and review their S&G's on the corporate database. • The CYPS Governance Officer supports CYPS Trust Change Lead to identify the actions for the Trust, scope the BAT and establish multi-disciplinary cross directorate working group. • Identification and dissemination of high risk S&G e.g. fluid management/ hyponatraemia. Standing item on CYPS SMT Governance agenda. Excellent support provided from cross directorate teams. **MHLD** MHD S&G Group in place. See terms of reference.  Adobe Acrobat Document **Acute** *The Acute team has good systems and processes in place to manage standards and guidelines.*

	Summary of Directorate Responses
	The Acute AD team meet the Acute S&G lead for one hour every fortnight to manage the S&G work, to ensure the required deadlines are met
Weaknesses	**OPPC** • Monitoring of older S&G implemented before robust governance processes in place • Difficulty ensuring operational teams/managers read the full detail when screening applicability before discounting; • Difficulty in receiving assurance from teams/managers that S&G have been disseminated, read, understood and actioned by all staff; • Lack of consistency in detail recorded in BAT; • Change Leads need to take more proactive role in initial 12 month implementation phase with regular updates to Governance team rather than waiting for 12 month assurance date. • Overall Trust change lead to take a more coordinated approach across all operational directorates to ensure full inclusion and implementation. **CYPS** Capacity of change leads within the CYPS directorate. Volume of S&G's within the Trust. • It is a weakness when external agencies do not adhere to the central S&G process e.g. in social work we continue to receive S&Gs direct from SBNI, DoH and HSCB to operational ADs/Director's office **MHLD** The current corporate S&G spreadsheet is a workaround, best fit option but a bespoke S&G tracking database is needed. **Acute** *Medical staff job plans do not allow time for them to take on the role of change leads for S&Gs. Recently this has resulted in Acute being unable to secure change leads for a number of new S&Gs received by Acute.* *Some S&G that are applicable to more than one operational Directorate would benefit from a 'corporate' approach and appointment of a corporate change lead. Currently for these S&Gs, each Directorate takes their own approach which is affecting continuity across the trust* *Lack of audit activity to ensure S&Gs are embedded.*
Opportunities	**OPPC** • HOS to take ownership to ensure dissemination, discussion and understanding of all S&G relevant to their service; • HOS to ensure regular discussion, understanding and implementation of actions at team level; • Operational change leads need to take a more proactive role in managed implementation with regular updates to Governance in the initial 12 months. • Increase QI projects based on S&G compliance and evidence based practice when action planning implementation; **CYPS** Raise awareness of S&G process throughout the Trust. The Trust need to raise awareness of the

	importance of S&G. Consideration should be given to the use of survey monkey to ascertain the extent of staffs' working knowledge of S&G process. There is also an opportunity to have a conversation about establishing a joined up regional approach to the issue of S&G's to avoid duplication **MHLD** A robust, user friendly corporate S&G Tracking Database. **Acute** Strengthen the Corporate database for S&G so it becomes a useful resource for all the Directorates. Could the previous corporate screening of new S&Gs be reinstated to identify those that need a corporate approach, as they span more than one Directorate?
	OPPC • Staff engagement; • Volume of guidelines; • Volume of communications; • Service capacity/staff time to allow thorough reading of S&G and designated time to ensure dissemination, discussion and action plans; • Individual staff members need to take responsibility for their own accountability. **CYPS** Capacity within the C&SCG teams and Change Leads. Duplication of a range of external process in issuing S&Gs to Trusts. **MHLD** Multiple operational and clinical pressures place time constraints on change leaders in terms of their ability/scope to assess compliance with the S&Gs & implement changes. **Acute** Acute receives the majority of S&G within the Trust, therefore resource remains an issue. *Medical staff job plans that do not have protected time for change lead activity..*

3. Complaints

	Summary of Directorate Responses
Strengths	**OPPC** • Governance office drive regional/Trust/directorate policy and procedure compliance; • Periodic follow-up with HOS, ADs; • Robust process in place for timely dissemination to relevant Heads of Service, AD's and Director; • There are clearly defined, well understood processes for escalating and attempting to resolving issues; • Designated owners (investigators & approvers) with cascading responsibility and time

	frames; • High number of directorate complaints informally resolved through early staff engagement with complainants. **CYPS** The CYPS complaints process was reconfigured following a 10 month Institute of Health Care Improvement (IHI) project. This has resulted in a streamlined quality assured complaints process with an improvement on meeting timeframes. This is a model that could be shared with other Directorates. The model also includes service user feedback on each complaint response. C&SCG team deliver awareness raising on complaints process within CYPS. **MHLD** MHD have high compliance rate with regional complaints targets meaning a faster response time for complainants. Adherence to HSC complaints process. Availability of independent advocates in mental health and learning disability services supports the complaints process and provides further opportunity for service users/relatives to voice their concerns. User friendly/Easy read complaints documentation developed for learning disability clients. **Acute** Good systems in place to track and manage the complaints received by Acute.

Weaknesses	**OPPC** • Timely responses; • Culture to view complaints as a negative rather than an opportunity to review and improve services or at least the understanding of the client perceptions; • Ability to identify, recognise and celebrate our successes identified through complaint investigations; • Public perception of transformational change. **CYPS** Cross directorate complaints investigations. Delay impacts on timeframes for responses and, on occasions, to a significant extent Multi-disciplinary staff survey carried out within CYPS directorate to ascertain views of complaints process. Feedback identified the need for: • How to and who to investigate complaints. • Template for responses. • Clear timeframes. • Issue about quality of responses. • Local resolution where possible. • De-escalation. • Service users perspective. **MHLD** No response **Acute** Acute governance resource to assist clinicians and ward managers in responding to and managing complaints received. Can have delays as a result of clinician time available to respond to complaints. Consistent Trust training in complaint management is needed. Often staff respond in a defensive manner to complaints and do not fully answer the questions posed by the complainant. We do not have a well-developed system for sharing learning from our complaints across the Directorate.
Opportunities	**OPPC** • Encourage direct interface with complainant at an early stage in all cases where this is deemed appropriate • Integrated communication strategies to educate public and to inform public agenda/expectations of services and the complaint process; • Co-design approaches to resolution with repeat complainants in an attempt to understand why they continued to complain/did not accept the Trust response satisfied their expectations; • Periodic thematic reviews of top 3 service and/or subject complaints; • Use of more standardised form of words for common complaints across the Trust such as 'smoke-free' policy; CHC – publish Trust policy on such issues; • Recognise and celebrate our individual, team and Trust successes, within and outside the Trust.

	CYPS There is an opportunity to provide training for all staff involved in the complaints process utilising the 'Managing A Difficult Conversation' training This would equip staff to more confidently and competently deal with complainants and facilitate local resolution and de-escalation. **MHLD** No response **Acute** Could we implement the Datix complaints management section of the system? A number of Acute staff saw Datix demonstrated at a recent patient safety conference and feel that we should be able to get more out of the system. Develop Trust wide learning from complaints. Trust wide complaint training. This would reduce the number of reopened complaints and the number that end up with the Ombudsman
	OPPC • With a projected increase in population of over 20% between 2016 and 2039, including more significant growth in our ageing population will increase demand on both services and potentially increase complaint volumes; • Staff fear of litigation processes • Elected representatives challenging process • Time involved in investigations and responses, particularly complex complaints and their impact on capacity; • Increasing public expectations; • Potential impact due to lack of NI executive and assembly; **CYPS** There is a cultural barrier to staff accepting a service user's perspective. Capacity within the C&SCG team to manage the complaints process. **MHLD** Increasingly, elected representatives are placing additional pressures on operational and governance teams by seeking progress updates outside of normal timescales. Trust should converse with them to manage their unrealistic expectations. **Acute** Medical and nursing resource and training is an issue.

4. Clinical Audit

	Summary of Directorate Responses
Strengths	**OPPC** • Audit embedded into practice.

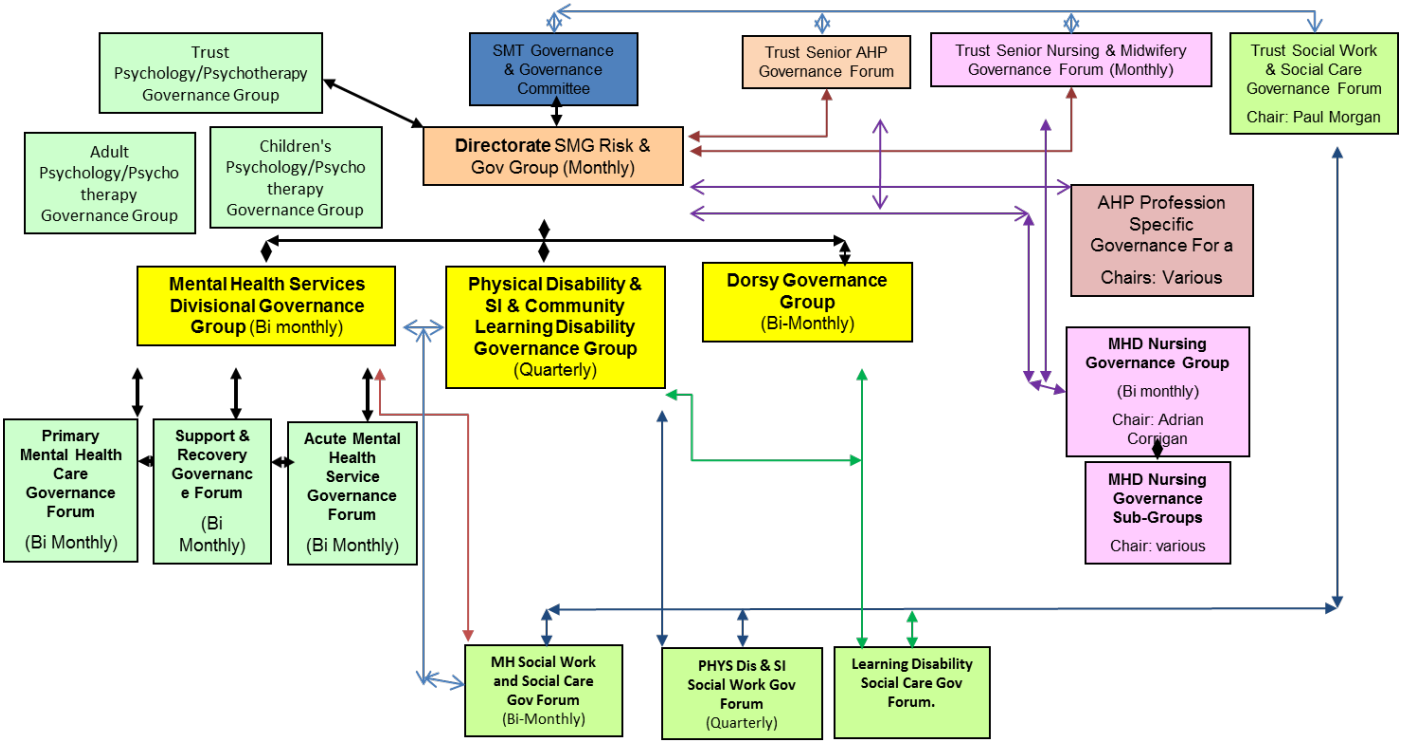
	Summary of Directorate Responses
	CYPS No response **MHLD** MHD have an audit approval pathway in place:  Microsoft Word 97 - 2003 Document The central coordination role of the CSCG Office enables links to be made between SAIs/Complaints/S&G's and feed these into the audit programme. MHD participates in National audits including the Confidential Inquiry SHMI. Where appropriate MHD commissions an audit/thematic review of specific incident types based on issues identified by other governance processes. **Acute** Pockets of good audit practice exist within Acute clinical teams.
Weaknesses	**OPPC** • Audit planned not closely linked to corporate objectives – • need to ensure the clinical audit forward plan is focussed on clinical and operational risks. **CYPS** No response **MHLD** Most audits tended to be uniprofessional and conducted by medical staff. It would be preferable to increase the number of audits in other professions, but only if those audits are tangible/practical and can lead to service improvements. It is important to avoid conducting audits for the sake of it. **Acute** Lack of acute audit facilitator resource. Apart from major national audits, results of audits undertaken as part of clinician training programmes, etc are often not shared. This could result in identified risks being hidden to management teams. There is no link between audits undertaken and the risks identified through SAIs and complaints.
Opportunities	**OPPC** • Ideas within operational teams could be progressed if focus and direction could be provided at appropriate level; • Review staff awareness programmes **CYPS** No response

	Summary of Directorate Responses
	MHLD A dedicated audit resource for the directorate would be helpful. **Acute** An Acute audit facilitator would allow collation of audit results and monitoring of implementation of associated action plans. A stronger link between audit and Quality Improvement teams within the Trust would allow for issues identified by audit to become QI projects of the future? A return to the previous level of senior leadership in audit would really help re-invigorate the whole audit system in the Trust.
Threats	**OPPC** • Availability of adequate resources; • Lack of protected time / permissions. (already stated in the protected time) **CYPS** No response **MHLD** Lack of a dedicated audit resource for the directorate. Selection and prioritisation of audits is difficult due to the number of activities which can generate topics eg Incident reporting/complaints/S&Gs/Clinical interest etc…. **Acute** Availability of resources.

MHLD
See below MHD Gov Structure. Incidents/complaints information etc. is discussed at all levels. The benefit of the service level groups are that they are as close to the operational/clinical setting as is possible and are co-chaired by clinical and operational leads and some have service user/carer representatives as part of the core membership of the governance groups.

Southern Health and Social Care Trust

Quality Care - for you, with you



From: Wright, Elaine
Sent: 13 August 2018 16:52
To: Khan, Ahmed
Cc: Devlin, Shane
Subject: RE: Re; 1:1 meeting discussion points

Thank you Dr Khan.

Kind regards

Jennifer

From: Khan, Ahmed
Sent: 13 August 2018 16:33
To: Wright, Elaine
Subject: Re; 1:1 meeting discussion points

Elaine,
Please find attached papers for my 1:1 with Shane tomorrow. I have asked Laura to print 2 copies for me.

Topics are:

- Medical Leadership Review
- CSCG Review (SWOT)
- IPC Strategy

Thanks,
Ahmed

From: Khan, Ahmed
Sent: 13 August 2018 16:30
To: White, Laura
Subject: Re; Please print attached

Laura, please colour print 2 copies of attached for my 1:1 with Shane tomorrow.
Thanks
AK

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REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee May 2018
Title:	Clinical & Social Care Governance Report to Governance Committee
Lead Director:	Dr Ahmed Khan – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	To provide assurance to Trust Governance Committee regarding directorate management of: • Adverse Incidents • Complaints & Ombudsman's Complaints

Summary of Key Issues for Governance Committee

High level context:

- Revised report structure for Clinical and Social Care Governance Information
- Overview of trends in adverse incident reporting
- Data on Patient safety initiatives that support governance data to Quarter 4 2017/18

Key issues/risks for discussion:

- Update on Regional Patient Safety Programme
- Breakdown of Serious Adverse Incidents by type of incident
- Breakdown of Ombudsman Case Outcomes

Summary of SMT challenge/discussion:

- Reporting of NEWS Data
- Additional information added – Break down of top 10 incidents reported

Internal/External Engagement:

- Senior Management Team
- Directorate Governance Coordinators

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Contents

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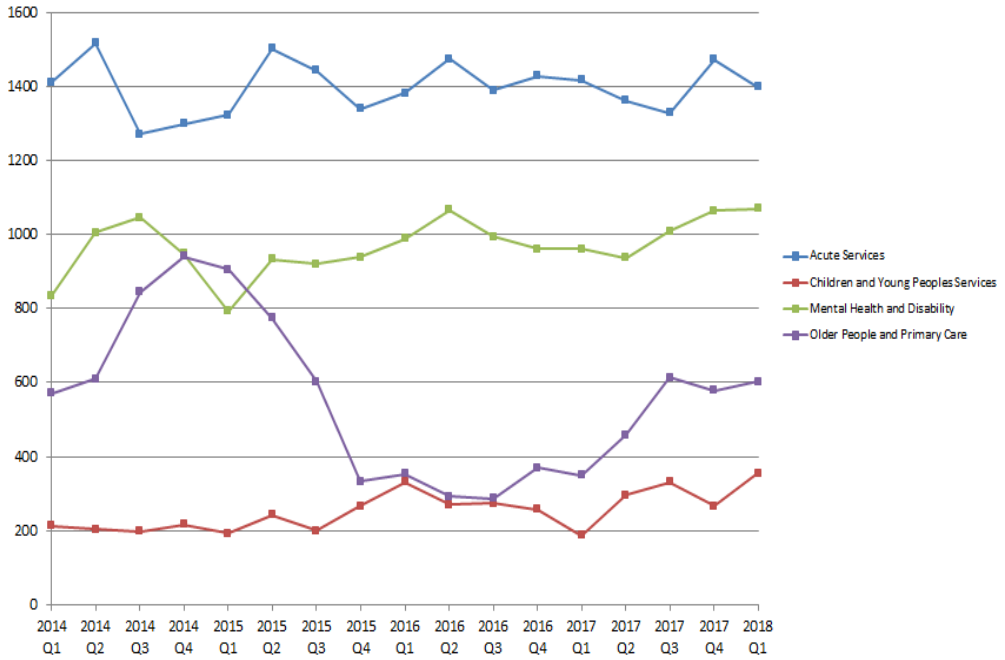
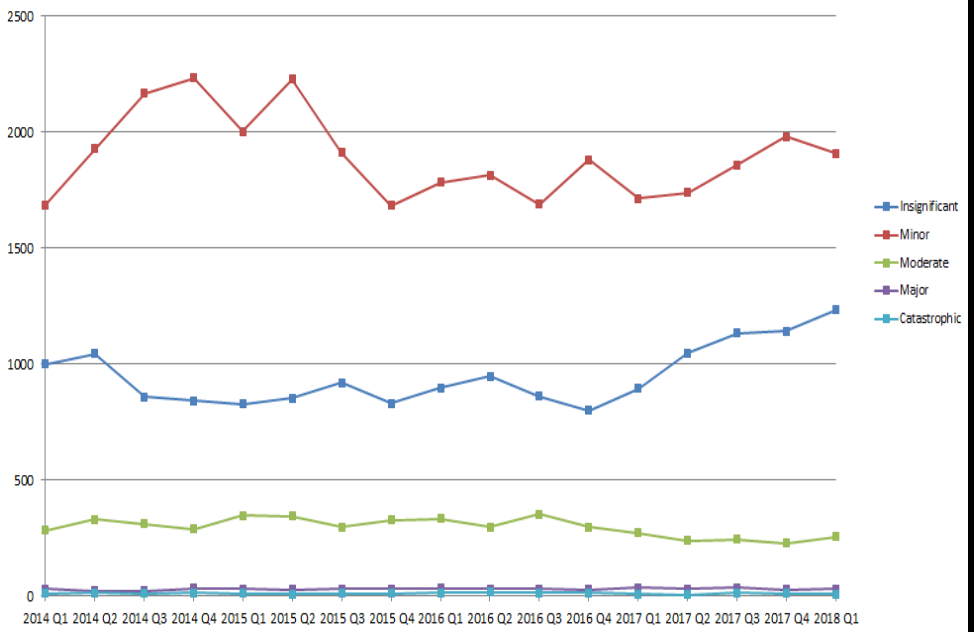
1. Adverse Incidents

Total No of Incidents Reported Over Time by Care Directorates 01 April 2014 – 31 March 2018



- Total incidents recorded
  - Quarter 4 2017 - 3382 incidents
  - Quarter 1 2018 - 3425 incidents
- Total number of incidents recorded for Quarter 1 2018 shows a slight increase from Quarter 4 2017, looking at the same period from last year there is also an increase in the number of incidents reported.

Total No. of Incidents by Severity Grading (Actual Harm) 01 April 2014 – 31 March 2018



- Quarter 1 2018 saw a slight decrease in Catastrophic incidents from 10 to 7.
- Additional information on incidents that met Serious Adverse Incident thresholds can be found in section 2 of this report.

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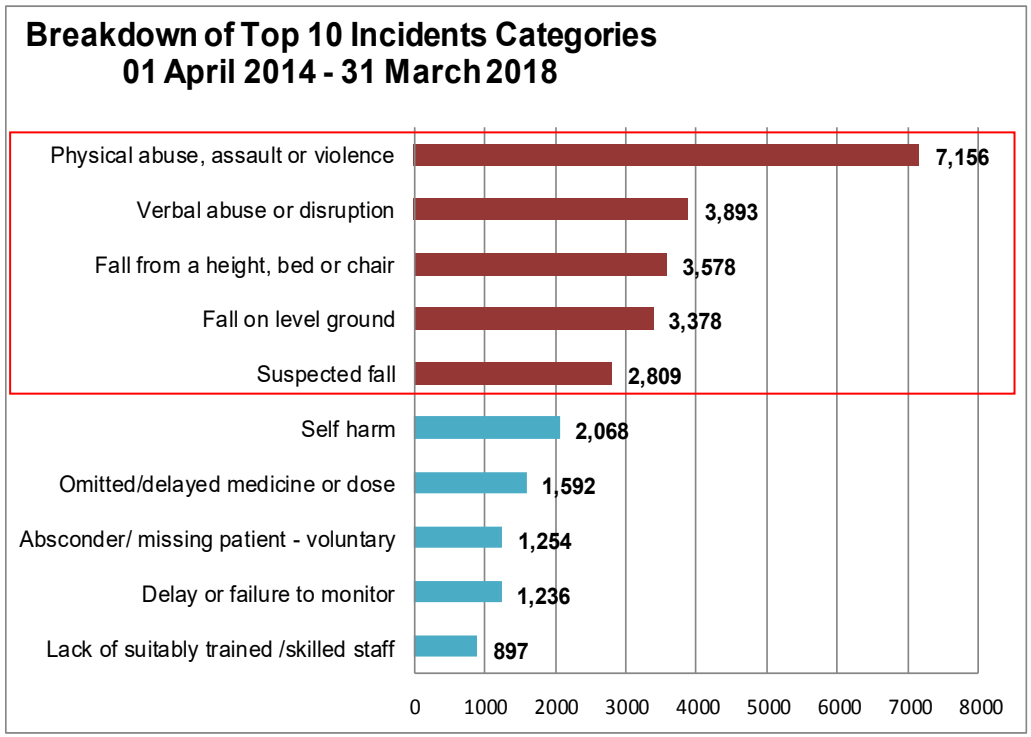

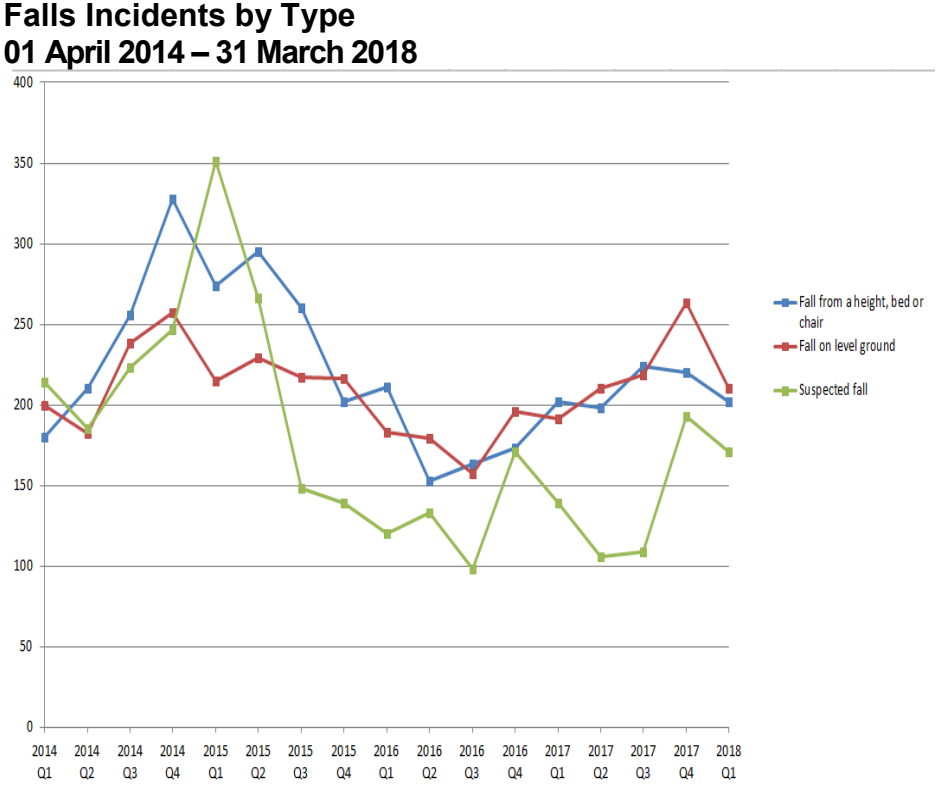

As per agreement of the previous Governance Committee meeting please see above a breakdown of the Top 10 incident categories, 1st April 2014 – 31st March 2018.

The Southern Health and Social Care Trust's most common reported incidents are abuse and falls. The following graphs further detail the trends for these incidents.

- Fall from a height, bed or chair have continued to reduce from 220 reported incidents in Quarter 4 of 2017 to 202 in Quarter 1 in 2018.
- Suspected falls have decreased from 193 in Quarter 4 to 171 Quarter 1.
- Fall from level ground have decreased from 263 in Quarter 4, to 210 in Quarter 1.

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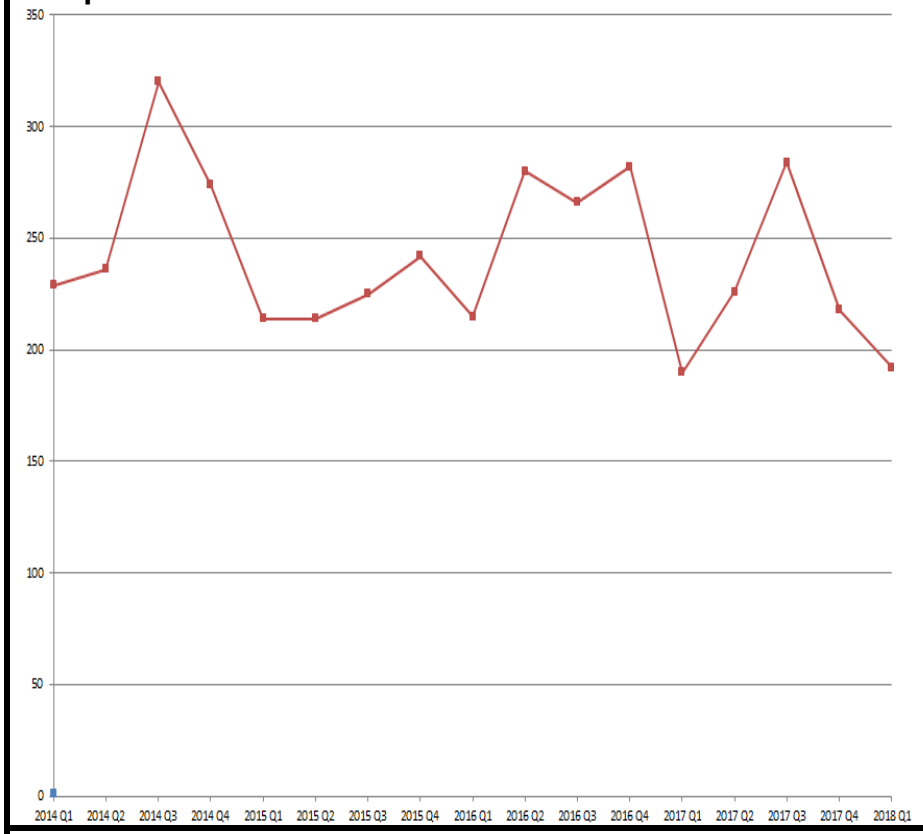
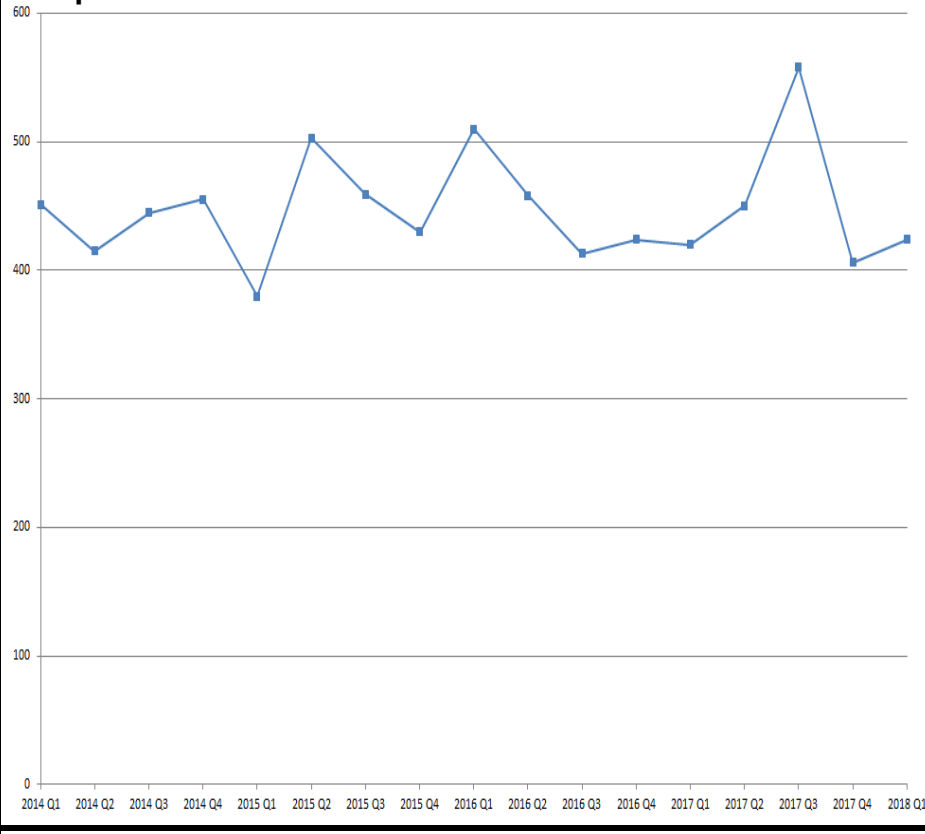
Verbal Abuse Incidents
01 April 2014 – 31 March 2018



- Although Verbal Abuse incidents remain one of the highest reported incidents there has been a decrease in the number of verbal incidents this quarter.

Physical Abuse Incidents
01 April 2014 – 31 March 2018



- Physical Abuse remains one of the highest reported incident type, this quarter these types of incidents have slightly increased since Quarter 4 2017, from 406 to 424.

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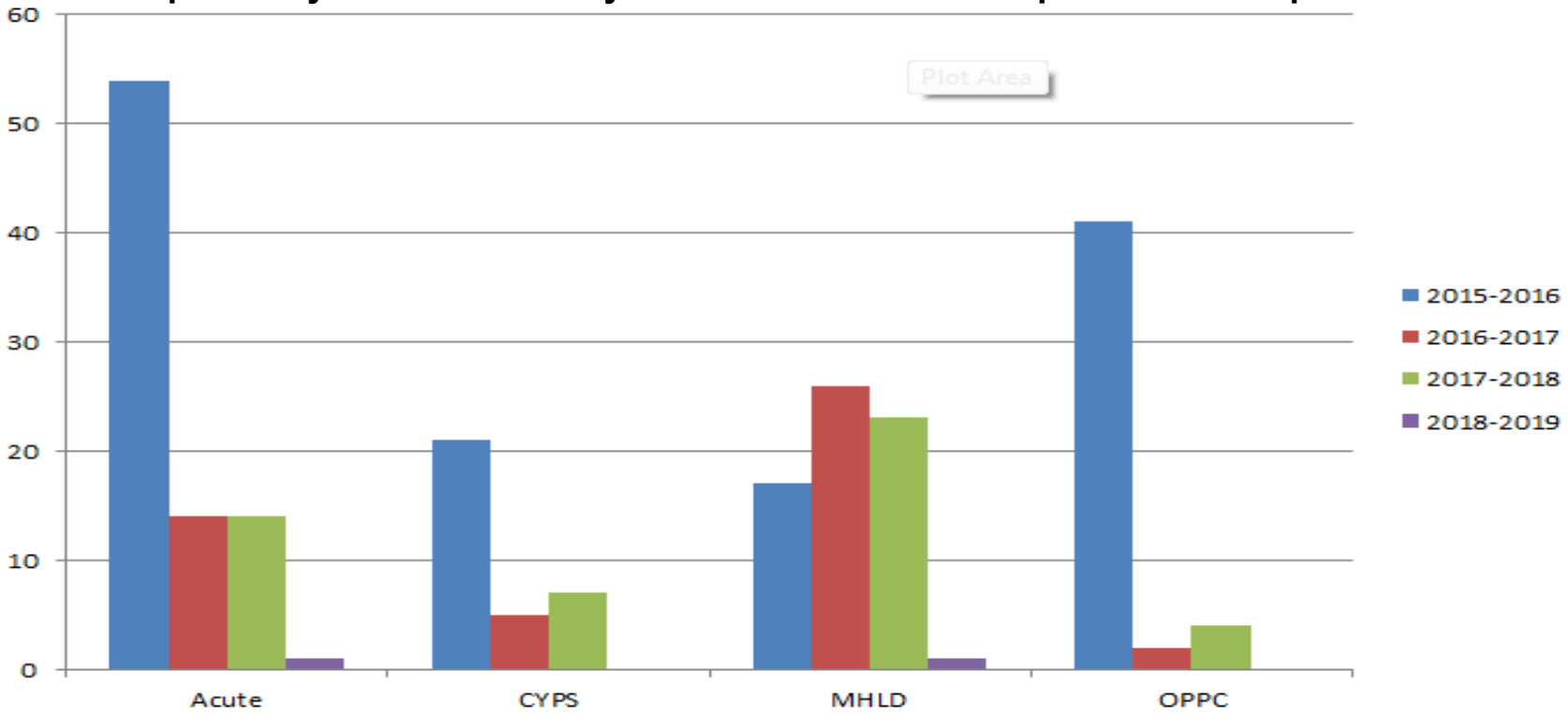
2. Serious Adverse Incidents (YTD)

Breakdown of SAI's Reported by Financial Year by Care Directorates 01 April 2015 – 12th April 2018



- Table above shows the number of adverse incidents have met the Serious Adverse Incident (SAI) criteria as the set by the HSCB.
- This number equates to (0.6%) of all adverse incidents reported via the Trust Incident Management system.

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Categorisation of SAIs 01 April 2015 – 12 April 2018 (YTD)

Area of Service	Incident Type	2015-16	2016-17	2017-18	2018-19	Total
Checking and oversight	Medication	0	1	0	0	1
	Test results	6	1	0	0	7
Equipment Related	Necessary Equipment Misused or misread by practitioner	0	0	0	0	0
	Necessary equipment not available	0	0	0	0	0
Prevention	Inpatient falls	7	0	1	0	8
Management of deterioration	Acting on or recognising deterioration	16	4	2	0	22
	Giving ordered treatment/support in a timely way	3	2	0	0	5
	Observe / review	6	1	0	0	7
No Area of Service Failure	No Area of service failure (a large number of these investigations were of expected child deaths and suicides)	50	32	12	3	97
Other	Other	3	1	1	0	5
SAI investigation in progress	SAI investigation in progress	1	1	25	5	32
N Home Falls	Not yet included in categorisation	35	0	0	0	35
Grand Total		**127**	**43**	**41**	**8**	**219**

The above table sets areas of learning which have been identified through Serious Adverse Incident Investigations.

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Position on the Progress of SAI Investigations

Timescales for the completion of Serious Adverse Incidents are set out by the Health and Social Care Board as follows:

Level 1 SAI investigations - 6 weeks

Levels 2 & 3 investigations – 12 weeks

Presently there are **32** SAI investigations currently being progressed within SHSCT, of which 5 are within the HSCB timescales for submission. There are a number of contributory factors set out below which influence the timescales of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads
- Necessary engagement with service users and their families, particularly where a death has occurred
- Where the SAI investigation spans across 2 or more Trusts

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

The table below sets out the position on the progress of SAI investigations ongoing

	Acute			CYPS			MHLD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks
Level 1	0	7	3	0	0	0	0	2	2	0	0	0
Level 2	1	2	0	0	1	1	3	8	0	1	0	0
Level 3	0	0	0	0	0	0	0	1	0	0	0	0

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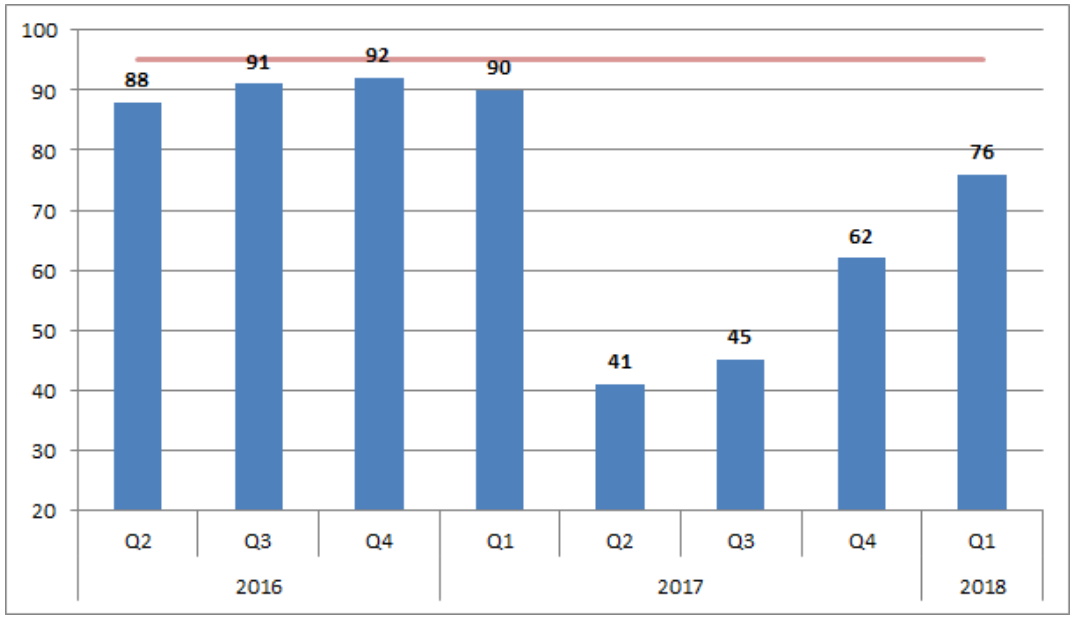
3. Patient Safety – NEWS

SHSCT NEWS Overall Bundle Compliance
Q1 2016 → Q1 2018



Introduction of Nursing Quality Indicators

In 2011 the Trust developed a range of Nursing Quality Indicators (NQI) aimed at measuring compliance with nursing care processes. The NEWS overall bundle compliance is captured through the Nursing Quality Indicator Audit Programme.

As part of this work the bundle compliance audit regarding NEWS documentation has been revised and updated following consultation with staff and review of best practice evidence.

Notable updates to the NEWS audit process:

- NEWS charts now subject to independent rather than self-audit
- Criteria adjusted to 'raise the bar' in terms of audit detail
- Production of detailed improvement plans at both ward and Trust level

As a result of the rebasing of audits Quarters 2-4 2017 has indicated a reduction in bundle compliance. The Ward Manager's Audit was reinstated in February 18 & will run alongside the Independent Audit, with a view to driving improvement between the Independent Audit 3 monthly cycle.

The Trust has discussed the care bundle in respect of compliance with the Public Health Agency who are now leading a regional Quality Improvement project to review the auditing process to provide additional assurance across the region.

In December 2017, the Royal College of Physicians published NEWS2. The Director of Medicine and the Executive Director of Nursing have progressed with identifying nominations for a Trust wide NEWS implementation and oversight group.

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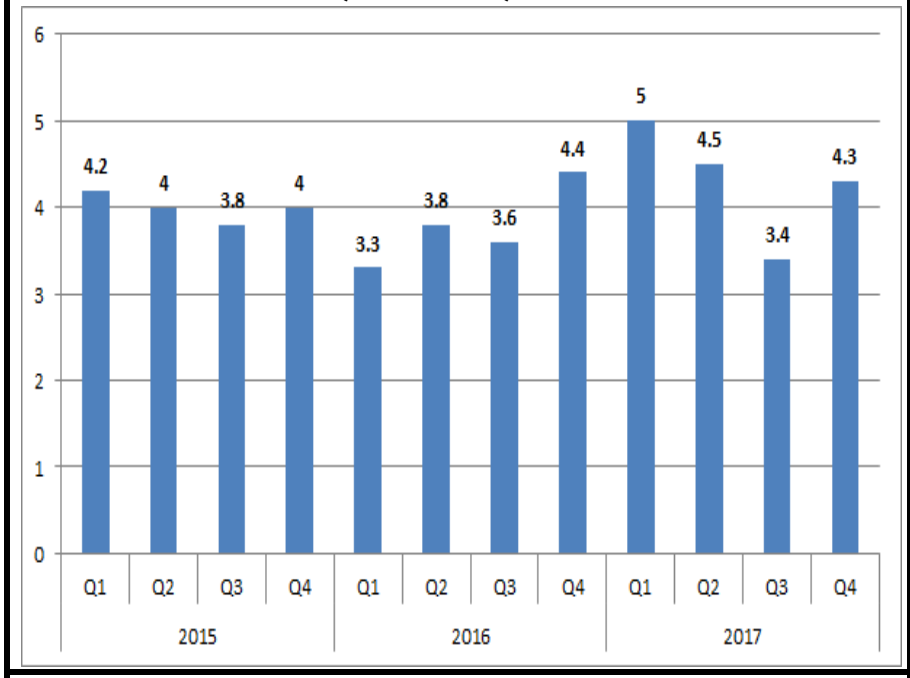
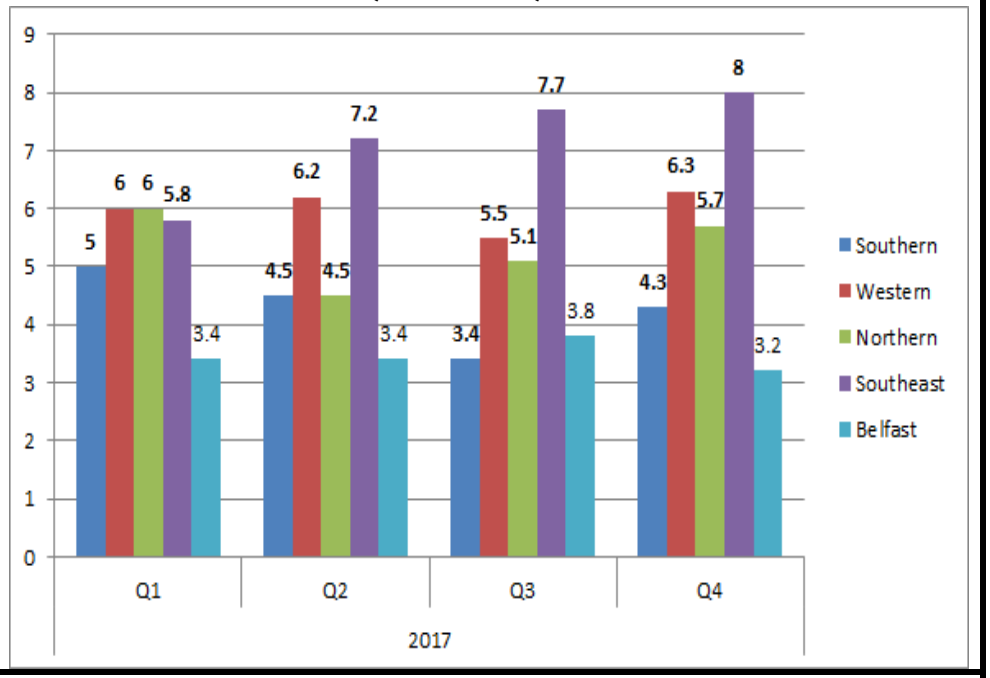
Patient Safety – Patient Falls

SHSCT Patient Fall Rate per 1,000 Occupied Bed Days
Q1 2015 → Q4 2017



- Regional Improvement Work on Falls began in 2011.
- A number of pro-active initiatives has resulted in the Trust's Falls Rate being consistently one of the best in NI, namely the implementation of elements of FallSafe Bundles A & B, the use of the Falls Walking Stick by Wards to capture details of their Patient Falls "Real Time", moving "at risk" patients to a more suitable location on the Ward, where possible.
- In line with the Region in 2017/18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.
- There is no regional target associated with patient falls.

NI Trust's Patient Fall Rate per 1,000 Occupied Bed Days
Q1 2017 → Q4 2017



- In Q4 2017 the Trust's Patient Falls Rate was 4.3 per 1,000 Occupied Bed Days
- The Trust's Rate is the 2nd lowest in NI
- Of the 26 Wards monitoring their Patient Falls/Falls rate using the Falls Walking Stick 14 wards (54%) saw a decrease Apr → Dec 17, compared to the same period the previous year

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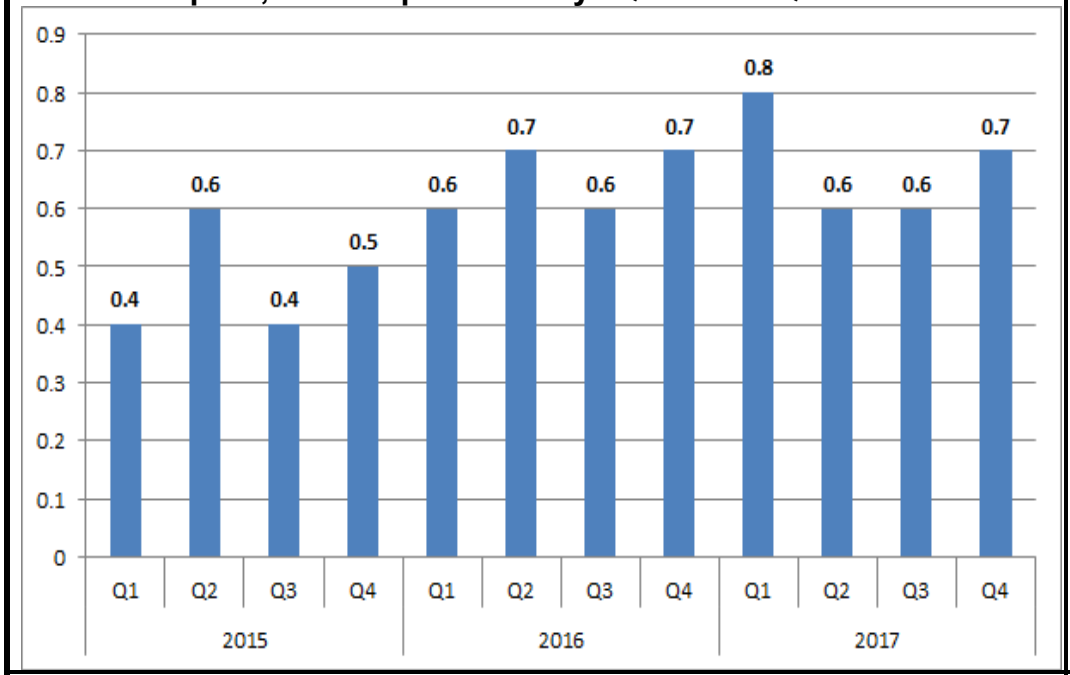
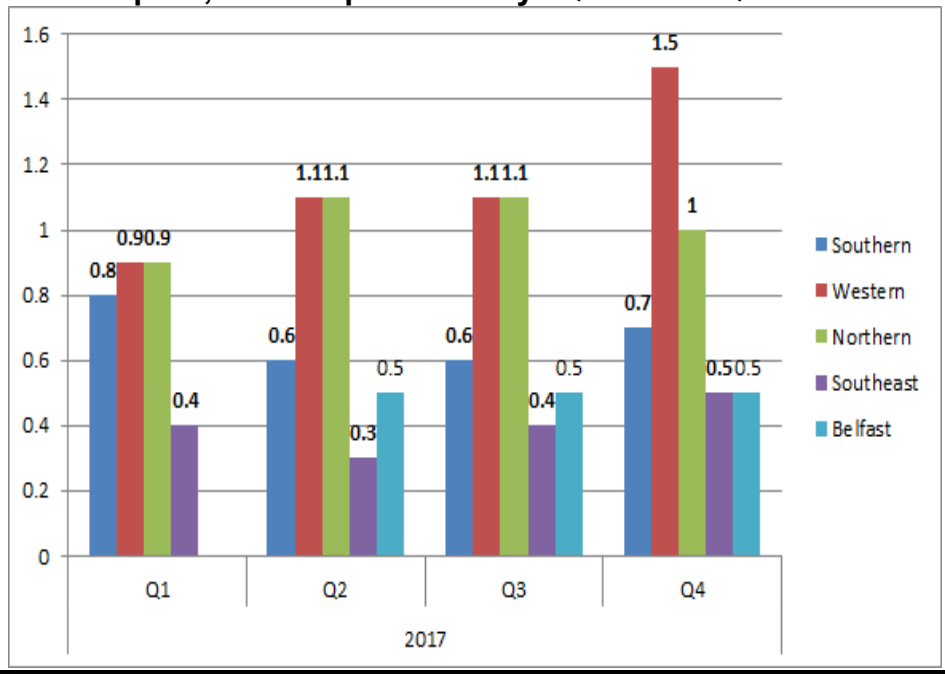
Patient Safety – Pressure Ulcers

SHSCT Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q1 2015 → Q4 2017



- Regional Improvement Work on Pressure Ulcers began 2011.
- A number of pro-active initiatives have been introduced namely the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan.
- The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on these cases within the Trust to determine those which were avoidable.

NI Trust's Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q1 2017 → Q4 2017



- All Trusts saw an increase in "Ward Acquired" Pressure Ulcers in 16/17 compared to 15/16.
- Of the 27 Wards monitoring their Hospital Acquired Pressure Ulcers/Rate using the Pressure Ulcer Safety Cross 16 wards (59%) saw their rate remain the same or decrease compared to the same period last year.
- Of the 130 Ward Acquired Pressure Ulcers reported Apr → Dec 17, 21 (16%) were Grade 3 or 4 Pressure Ulcers. RCA's conducted on 19 of the 21 cases to date concluded that only 5 were avoidable

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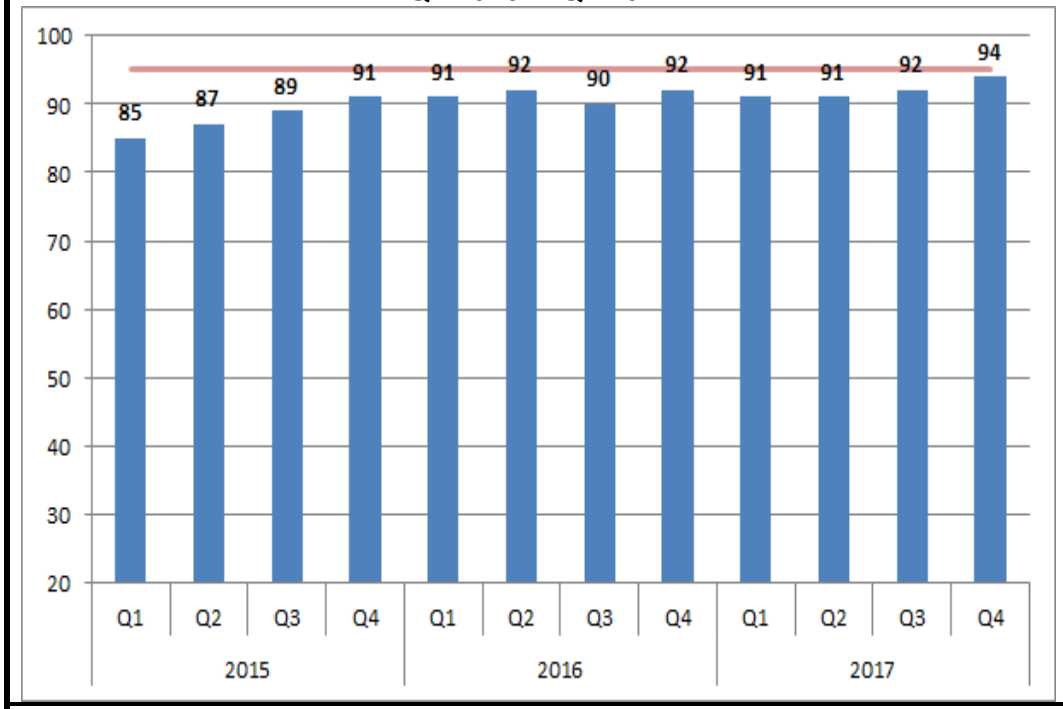
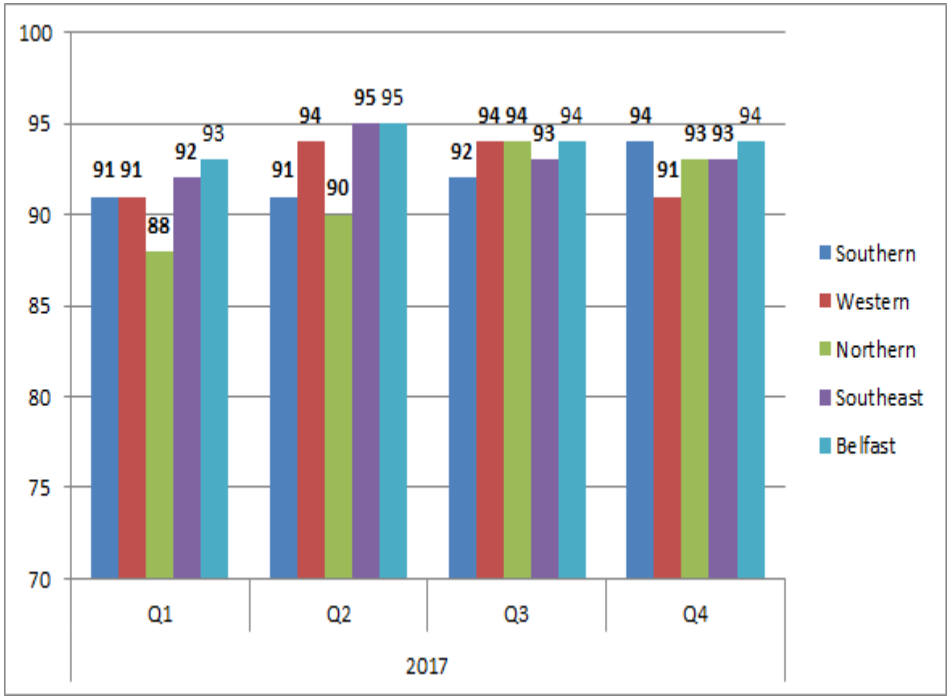
Patient Safety – Venous Thromboembolism (VTE) Risk Assessment

SHSCT VTE Risk Assessment Compliance
Q1 2015→ Q4 2017



- Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009.
- All Trust's now use a Regional Risk Assessment Tool.
- For the past 4 years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%.

NI Trust's VTE Risk Assessment Compliance
Q1 2017 → Q4 2017



- All Trusts have seen an increase in compliance since measurement began in April 2013.
- Southern Trusts overall compliance for 2017 Q4 was 94%, the highest compliance ever achieved & equal highest rate in NI
- Southern Trust's Acute Wards (CAH& DHH) have seen their Compliance Rate increase from 89.5% in Q1 to 94.3% in Q3

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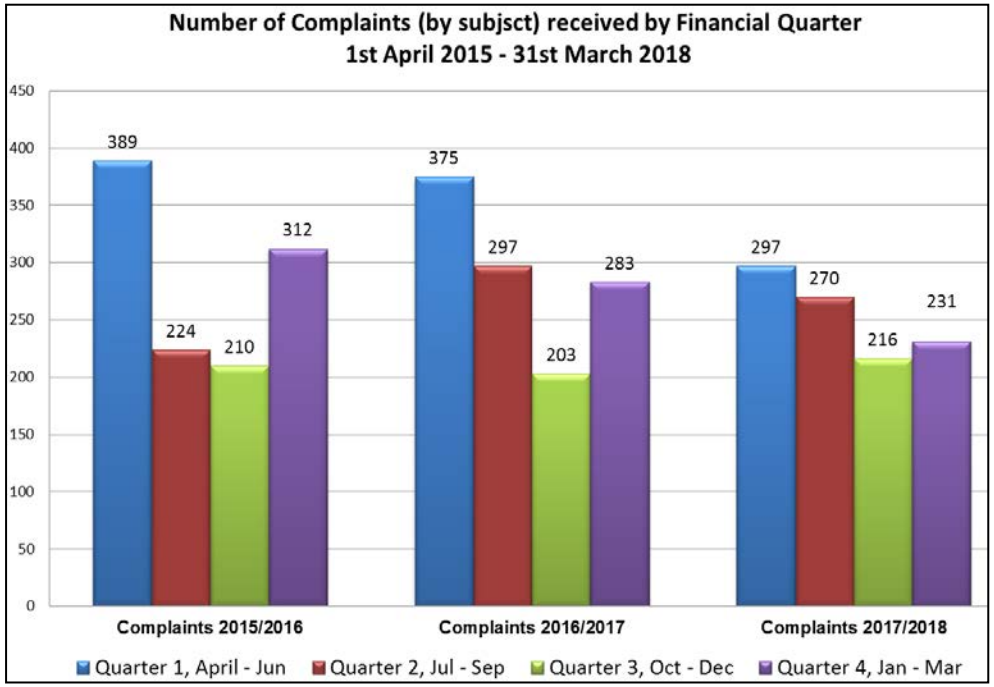
Complaints and Ombudsman's Complaints

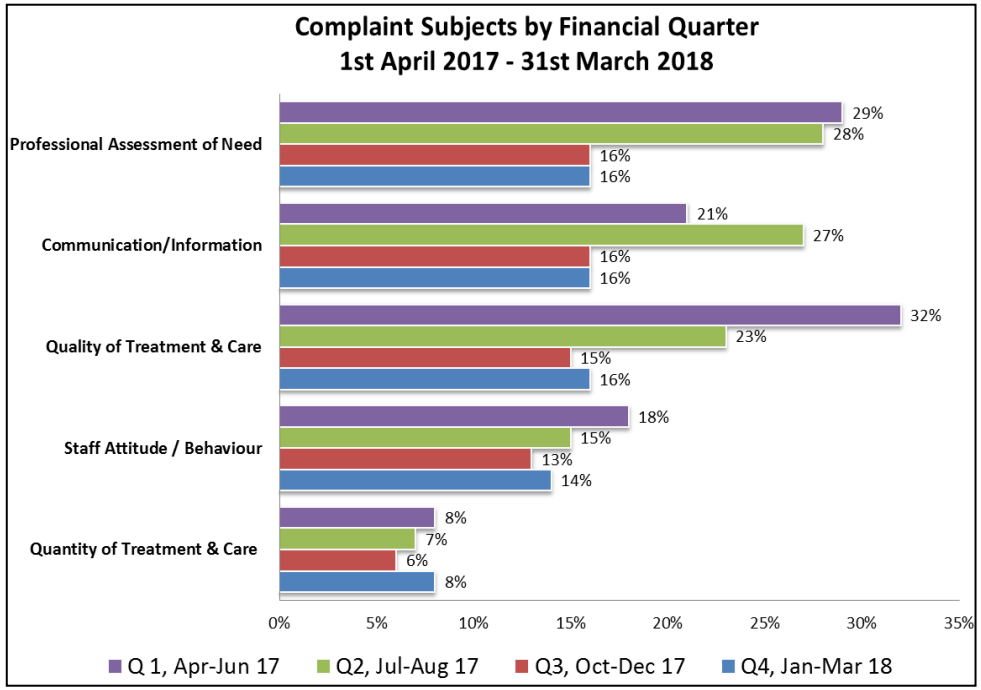
Number of Complaints Received



In Quarter 4 2017/18 the Trust received **161** formal complaints of which there were **231 complaints subjects**.

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

What Our Service Users Complained About



The number of complaint subjects for quarter 4 slightly increased to 231 from 216 in the previous quarter. However a decrease in complaint subjects can be noted for quarter 4 2017/2018 in comparison to quarter 4 in previous years.

The top five subjects of complaints remain consistent throughout each reporting period, especially within quarter 3 and quarter 4.

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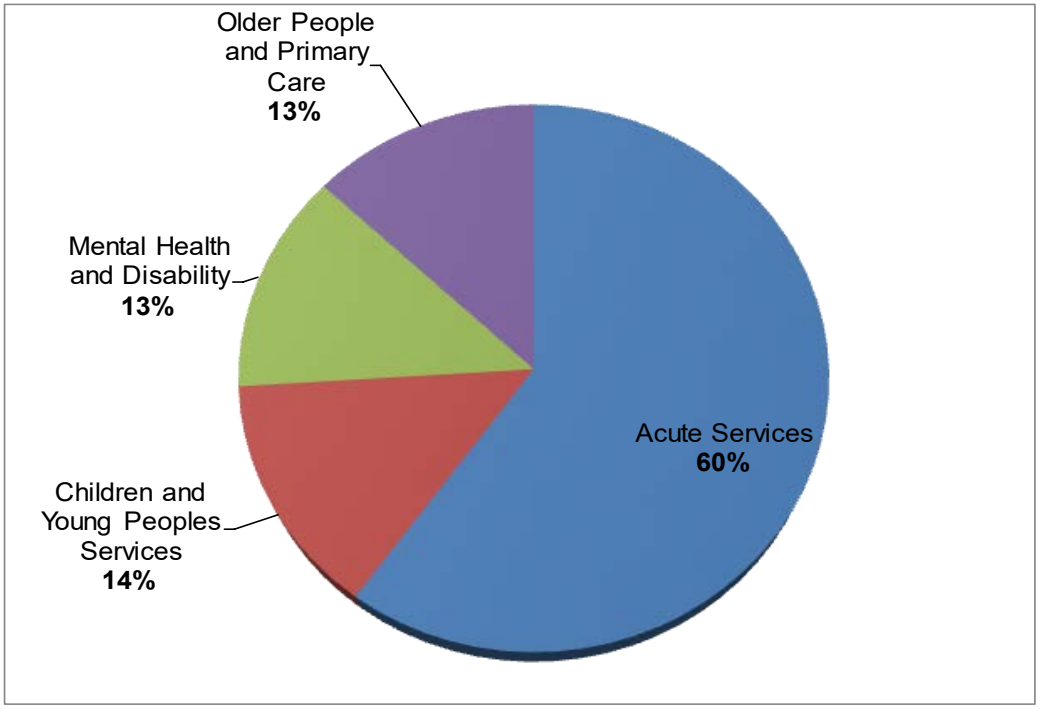
Breakdown of % of Complaints (subjects) by Directorate for Quarter 4 (1st January 2018 – 31st March 2018)



Breakdown of Number of Complaints (subjects) by Directorate and Division for Quarter 4 (1st January 2018 – 31st March 2018)

Directorate/Service Area	No of Complaints (Subjects)
Acute Services	**139**
Functional Support Services	7
IMWH - Cancer and Clinical Services	17
Integrated Maternity and Womens Health	15
Medicine and Unscheduled Care	67
Surgery and Elective Care	33
Children and Young Peoples Services	**32**
Corporate Parenting	4
Family Support and Safeguarding	15
Specialist Child Health and Disability	13
Mental Health and Disability	**31**
Learning Disability Services	8
Memory Services	2
Mental Health Service	16
Physical and Sensory Disability Service	5
Older People and Primary Care	**29**
Enhanced Services	7
Older Peoples Services	8
Primary Care	13
Promoting Wellbeing	1
Total	**231**

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The Patient Client Council Complaints Support Service

Patient and Client Council

Your voice in health and social care

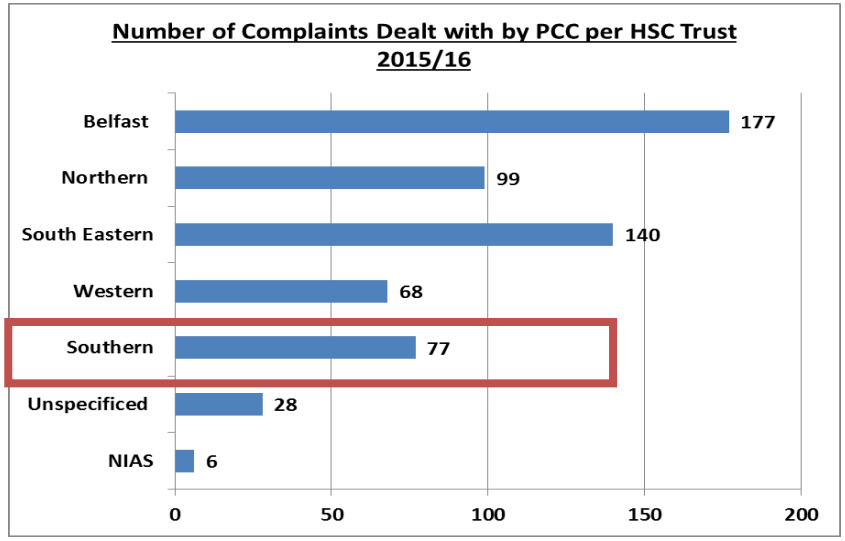
Every day thousands of people access health and social care services. Most people receive high quality services. For others, services fall short of their expectations. Having the opportunity to feed back is important. When things go wrong, people deserve an explanation, and assurances that steps have been taken to prevent the same mistakes from happening again. Every compliment, concern and complaint is an opportunity to learn and improve services.

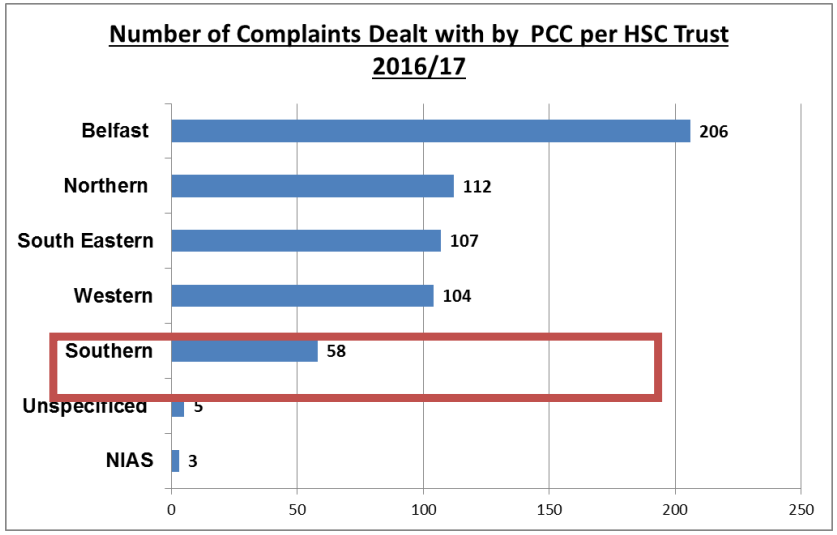
The complaints support role of the Patient Client Council is specifically defined in the Health and Social Care Reform Act 2009 as: *'providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care...'*

The PCC Complaints Support Service is a confidential, independent and free service that can help patients and clients to make a complaint about any Health and Social Care service. The PCC Complaints Support Service provides support to our clients in a number of ways, including:

- Giving our clients information on the complaints procedure and advice on how to take a complaint forward;
- Discussing a complaint with a client and drafting letters or making telephone calls for clients on their behalf;
- Helping clients prepare for and going with them to meetings about their complaint and making sure their concerns are heard and responded to;
- Helping and supporting clients to prepare a complaint for submission to the Ombudsman or other regulatory bodies;
- Referral to other agencies, for example, specialist advocacy services; and
- Help in accessing medical/social services records.

Comparison of Complaints dealt with by Patient Client Council per HSC Trusts 2015 – 2017





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Acknowledgement and Response Times for Complaint Letters per Directorate 1st October 2016 – 28th February 2018

	Acute				CYP				MHD				OPPC			
	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE
Oct 2016	**28**	100%	46%	68%	**9**	100%	100%	100%	**8**	100%	75%	100%	**8**	100%	88%	100%
Nov 2016	**53**	98%	43%	62%	**13**	100%	77%	85%	**6**	100%	83%	100%	**7**	100%	100%	100%
Dec 2016	**41**	100%	27%	33%	**4**	100%	100%	100%	**3**	100%	100%	100%	**0**	N/A	N/A	N/A
Jan 2017	**59**	100%	24%	31%	**23**	100%	78%	87%	**7**	100%	71%	86%	**6**	100%	83%	83%
Feb 2017	**57**	100%	37%	50%	**10**	100%	70%	90%	**9**	100%	89%	100%	**4**	100%	66%	66%
Mar 2017	**47**	100%	13%	21%	**11**	100%	63%	81%	**5**	100%	100%	N/A	**2**	100%	100%	100%
Apr 2017	62	92%	37%	71%	**8**	100%	100%	100%	**5**	100%	100%	N/A	**2**	100%	100%	100%
May 2017	63	94%	35%	59%	**22**	94%	77%	82%	**8**	100%	63%	88%	**3**	100%	100%	100%
Jun 2017	55	87%	47%	67%	**15**	100%	73%	93%	**12**	100%	83%	100%	**1**	100%	100%	100%
Jul 2017	**72**	67%	44%	51%	**10**	100%	70%	70%	**7**	100%	86%	100%	**3**	100%	67%	100%
Aug 2017	**47**	94%	40%	74%	**12**	100%	92%	100%	**6**	100%	100%	100%	**6**	100%	83%	100%
Sept 2017	**65**	92%	32%	44%	**18**	100%	83%	83%	**6**	100%	100%	100%	**3**	100%	100%	100%
Oct 2017	**44**	98%	39%	75%	**12**	100%	83%	92%	**11**	91%	91%	100%	**2**	100%	100%	100%
Nov 2017	**55**	88%	47%	51%	**9**	100%	89%	89%	**8**	100%	87.5%	100%	**6**	100%	83%	100%
Dec 2017	**17**	100%	24%	53%	**8**	100%	88%	88%	**2**	100%	100%	100%	**4**	100%	100%	100%
Jan 2018	**69**	91%	28%	54%	**9**	100%	65%	75%	**4**	100%	100%	100%	**8**	100%	100%	100%
Feb 2018	**34**	94%	50%	74%	**11**	100%	55%	91%	**3**	100%	100%	100%	**5**	100%	100%	100%

The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days

The table above sets out the Trust performance by directorate against these standards. 30 Days is not a formal target however is monitored by the Trust for performance purposes.

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Ombudsman Cases

Breakdown of Ombudsman cases per Financial Year, 1st March 2014 – 19th April 2018

	Local Resolution	Not Upheld	Open	Awaiting Screening	Upheld	Withdrawn	Not Accepted	Total
2014/2015	1	1	1	-	5	-	-	**8**
2015/2016	-	1		-	9	2	2	**14**
2016/2017	2	2	4	2	2	2	2	**16**
2017/2018	1	-	6	9	-	-	3	**19**
2018/2019	-	-	-	1	-	-	-	**1**
	4	**4**	**11**	**12**	**16**	**4**	**7**	**58**

When patients are not fully satisfied with the outcome from the Trust's complaint process they can choose to subsequently raise their concerns with the Northern Ireland Public Services Ombudsman. All complainants are provided with information about referring their issues to the Ombudsman at the point at which the Trust completes their investigations and closes the case with the complainant.

During the previous financial year 2017/2018, **6 new cases** have been opened by the Ombudsman regarding complaints previously raised with the Trust; of which **1 case** has reached local resolution and 3 have not been accepted. **9 cases** await screening for acceptance to initiate Ombudsman investigations.

During this current financial year to date 1 case awaits screening for acceptance by the Ombudsman's office.

We continued to work with the Ombudsman on cases raised during previous years.

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Standards and Guidelines Quality Assurance Audit (Snapshot April 2018)

OVERVIEW

An assurance audit of the Trust Standards and Guidelines process was carried out in April 2018. The audit focussed on Standards and Guidelines received into the Corporate Office between 1st February 2017 and 31st January 2018.

METHODOLOGY

10% of Standards and Guidelines received between1st February 2017- 31st January 2018 were reviewed to confirm the following:

- The Standard and Guideline had been logged on the Corporate Database
- A Change Lead has been identified, where applicable
- Any assurances outstanding to external agencies

AUDIT RESULTS

240 Standards and Guidelines were received during the time period, 24 of these were reviewed using the above criteria.

- 100% had been logged on the Corporate Database
- 8.4% (2 Guidelines) had not had a change lead appointed; however both were recent pieces of correspondence and therefore assurance on having a change lead is not required until 3 months have passed.
- There were no outstanding assurances to external agencies identified.

CONCLUSION

All Standards and Guidelines audited were managed in keeping with the Southern Health and Social Care Trust Standard and Guideline procedure. The implementation of Standards and Guidelines disseminated across the Trust is managed through operational directorate structures.

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REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee August 2018
Title:	Clinical & Social Care Governance Report to Governance Committee
Lead Director:	Dr Ahmed Khan – Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	To provide assurance to Trust Governance Committee regarding directorate management of: • Adverse Incidents • Complaints & Ombudsman's Complaints

Summary of Key Issues for Governance Committee

High level context:

- Revised report structure for Clinical and Social Care Governance Information
- Overview of trends in adverse incident reporting
- Data on Patient safety initiatives that support governance data to Quarter 1 2018/19

Key issues/risks for discussion:

- Breakdown of Serious Adverse Incidents by type of incident
- Breakdown of Ombudsman Case Outcomes

Summary of SMT challenge/discussion:

Internal/External Engagement:

- Senior Management Team
- Directorate Governance Coordinators

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Contents

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1. Adverse Incidents

Total No of Incidents Reported Over Time by Care Directorates 01 April 2017 – 30 June 2018	**Total No. of Incidents by Severity Grading (Actual Harm) 01 April 2017 – 30 June 2018**
• Total incidents recorded o Quarter 1 2018 - 3530 incidents o Quarter 2 2018 – 3652 incidents • Total number of incidents recorded for Quarter 2 2018 shows a slight increase from Quarter 1 2018, looking at the same period from last year there is also an increase in the number of incidents reported.	• Quarter 2 2018 saw an increase in Catastrophic incidents from 7 to 14. • Additional information on incidents that met Serious Adverse Incident thresholds can be found in section 2 of this report.

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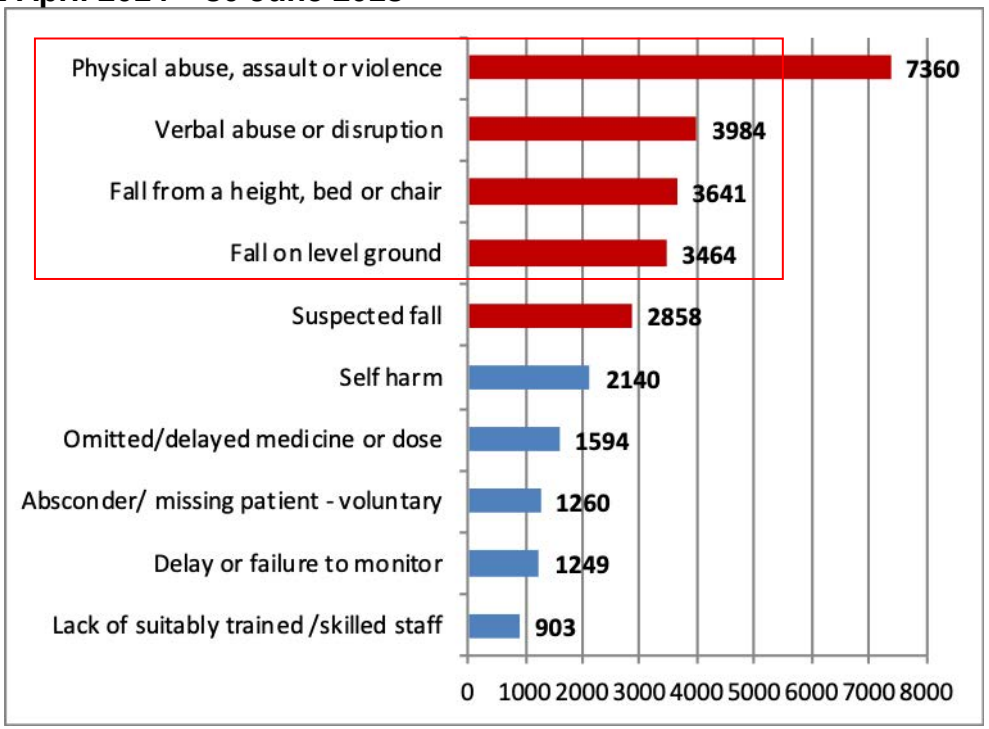
Breakdown of Top Incidents by Detail
1 April 2014 – 30 June 2018



Falls Incidents by Type 01 April 2017 – 30 June 2018

The 10 top most common reported incidents have remained the same since the last quarter.

The Southern Health and Social Care Trust's most common reported incidents are abuse and falls. The following graphs further detail the trends for these incidents.

- Fall from a height, bed or chair have continued to reduce from 241 reported incidents in Quarter 1 of 2018 to 225 in Quarter 2 in 2018. Suspected falls have slightly increased from 205 in Quarter 1 to 208 Quarter 2.
- Fall from level ground have decreased from 254 in Quarter 1, to 235 in Quarter 2.

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Verbal Abuse Incidents 01 April 2017 – 30 June 2018	**Physical Abuse Incidents 01 April 2017 – 30 June 2018**
• Although Verbal Abuse incidents remain one of the highest reported incidents there has been a small decrease in the number of verbal incidents this quarter.	• Physical Abuse remains one of the highest reported incident type, this quarter these types of incidents have increased since Quarter 1 2018, from 529 to 555.

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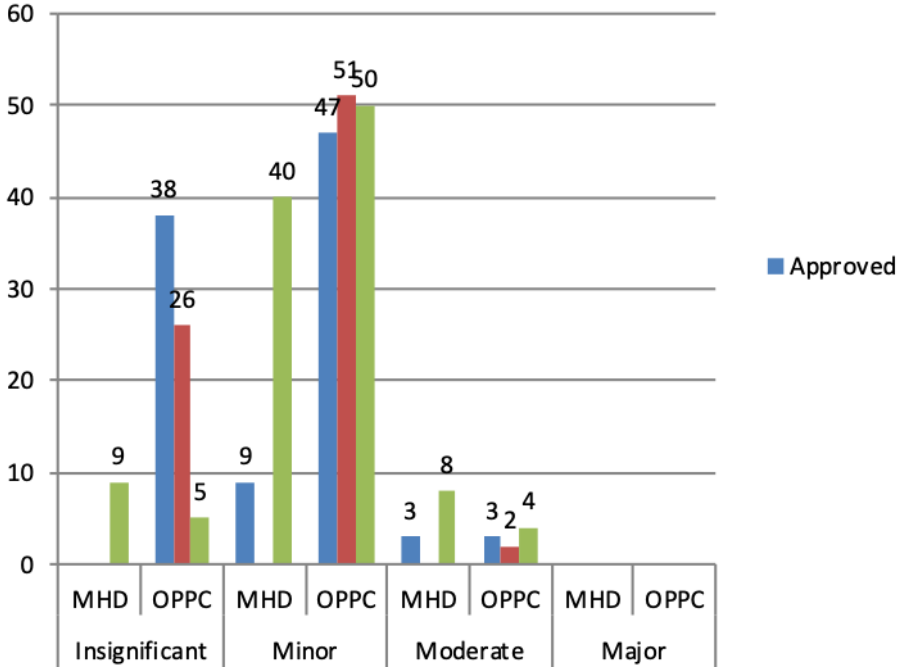
Independent Service Providers Incidents by Directorate, by Sub-category January – March 2018

	MHD	OPPC	Total
Slips, trips, falls and collisions	1	132	133
Administration or supply of a medicine from a clinical area	4	9	13
Self-harm during 24-hour care	8		8
Abuse by the staff to the patient		4	4
Accident caused by some other means		4	4
Abuse etc of Staff by patients	1		1
Self-harm in primary care, or not during 24-hour care	1		1
Abdominal organs other than digestive		1	1
Abuse etc of patient by patient		1	1
Connected with the management of operations / treatment		1	1
Infection Control		1	1

Independent Service Providers Total No. of Incidents recorded By Severity Grading (Actual Harm) January – March 2018



NB: the above grading may change as incidents are reviewed.

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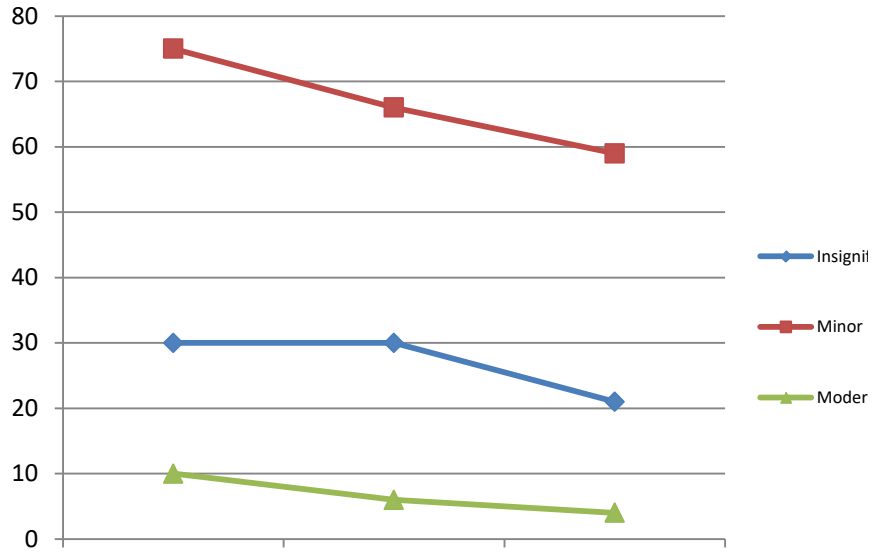
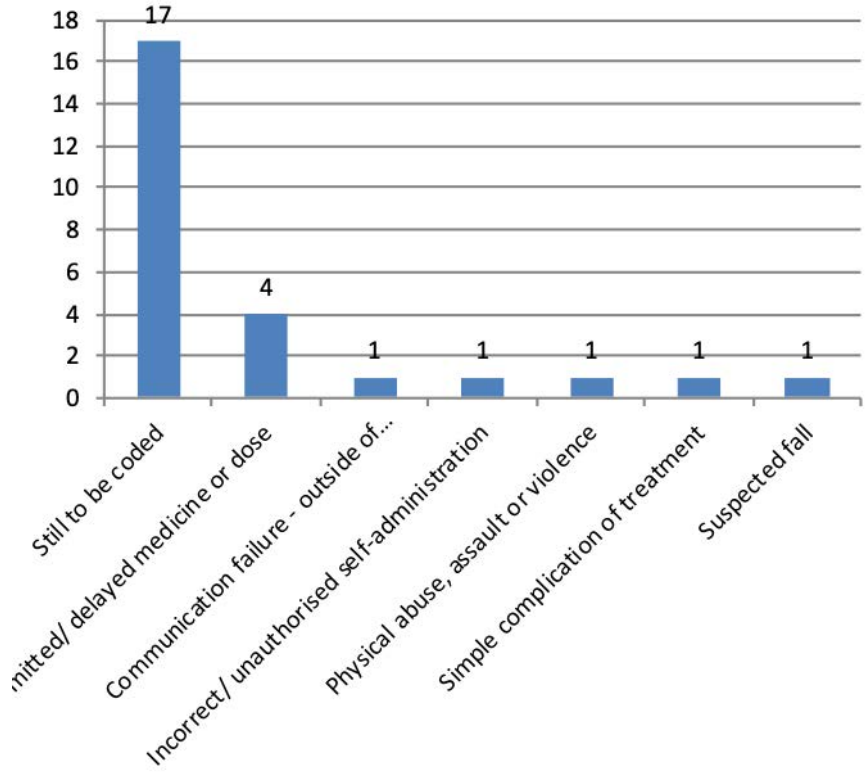
Independent Service Providers Trend Line: Incidents Involving PNH Providers by Severity Grading by Month January – March 2018



Independent Service Providers Incidents by Type January – March 2018



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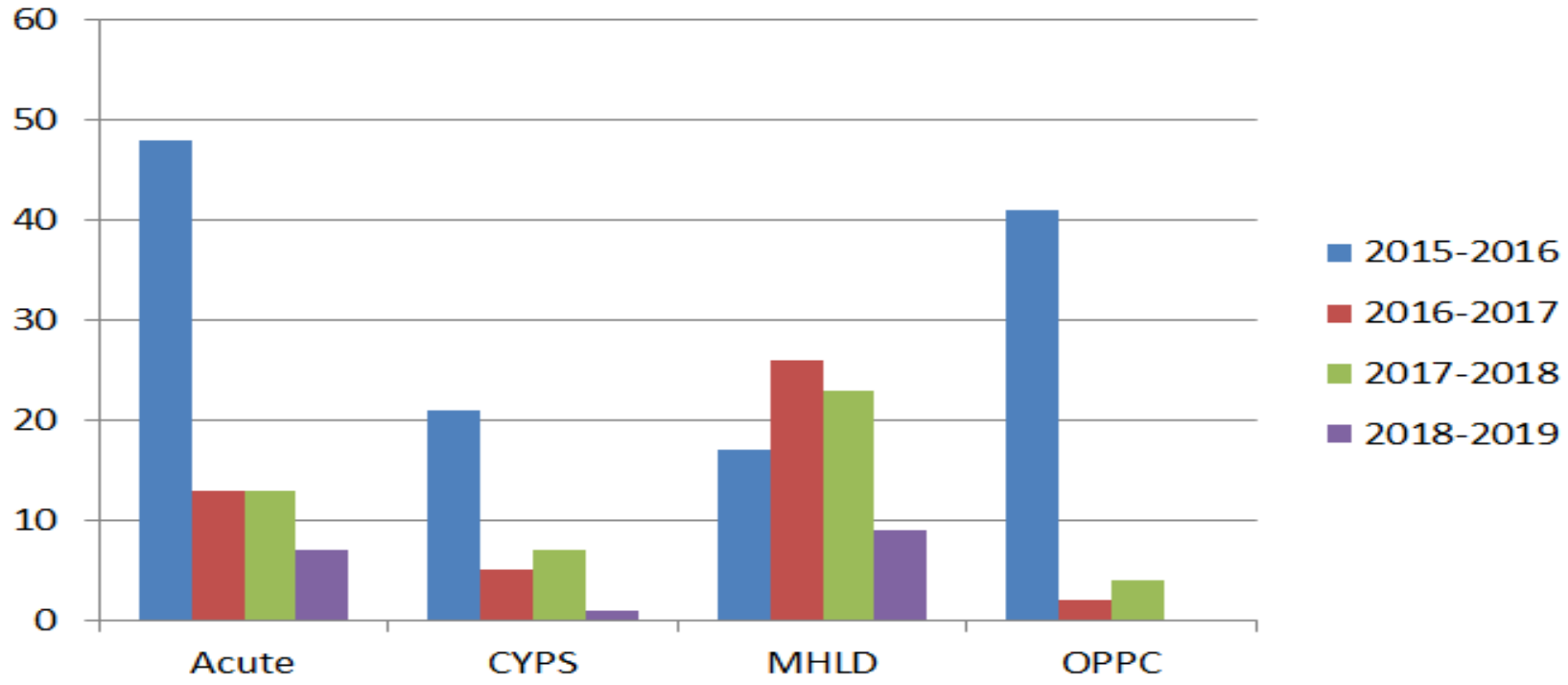
2. Serious Adverse Incidents (YTD)

Breakdown of SAI's Reported by Financial Year by Care Directorates 01 April 2015 – 1st August 2018



- Table above shows the number of adverse incidents have met the Serious Adverse Incident (SAI) criteria as the set by the HSCB.
- This number equates to (0.6%) of all adverse incidents reported via the Trust Incident Management system.

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Categorisation of SAIs 01 April 2015 – 1st August 2018 (YTD)

Area of Service	Incident Type	2015-16	2016-17	2017-18	2018-19	Total
Checking and oversight	Medication	0	1	0	0	1
	Test results	6	1	0	0	7
Equipment Related	Necessary Equipment Misused or misread by practitioner	0	0	1	0	1
	Necessary equipment not available	0	0	0	0	0
Prevention	Inpatient falls	7	0	1	0	8
Management of deterioration	Acting on or recognising deterioration	16	5	3	0	24
	Giving ordered treatment/support in a timely way	3	2	0	0	5
	Observe / review	6	1	0	0	7
No Area of Service Failure	No Area of service failure (a large number of these investigations were of expected child deaths and suicides)	50	35	21	1	107
Other	Other	4	1	2	0	7
SAI investigation in progress	SAI investigation in progress	0	0	19	16	35
N Home Falls	Not yet included in categorisation	35	0	0	0	35
Grand Total		127	46	47	17	237

The above table sets areas of learning which have been identified through Serious Adverse Incident Investigations.

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Position on the Progress of SAI Investigations

Timescales for the completion of Serious Adverse Incidents are set out by the Health and Social Care Board as follows:

Level 1 SAI investigations - 6 weeks

Levels 2 & 3 investigations – 12 weeks

Presently there are **35** SAI investigations currently being progressed within SHSCT, of which 7 are within the HSCB timescales for submission. There are a number of contributory factors set out below which influence the timescales of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads
- Necessary engagement with service users and their families, particularly where a death has occurred
- Where the SAI investigation spans across 2 or more Trusts

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

The table below sets out the position on the progress of SAI investigations ongoing

	Acute			CYPS			MHLD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks
Level 1	1	5	7	0	0	0	1	1	1	0	0	0
Level 2	0	1	1	1	0	1	3	8	1	0	1	0
Level 3	0	1	0	0	0	0	1	0	0	0	0	0

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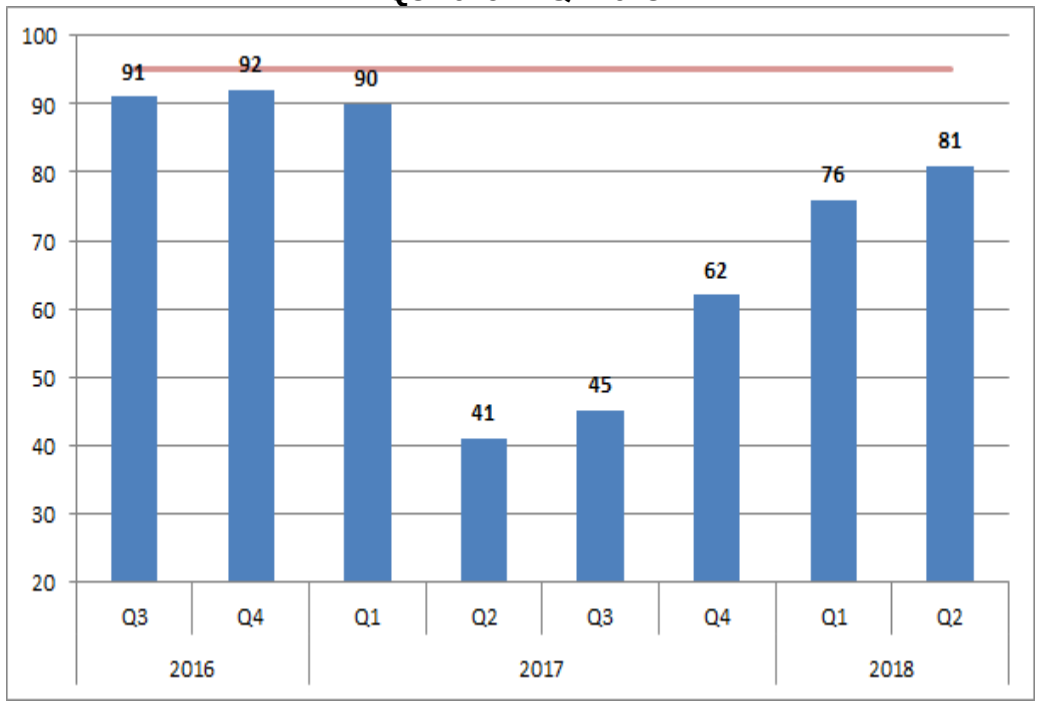
3. Patient Safety – NEWS

SHSCT NEWS Overall Bundle Compliance
Q3 2016 → Q2 2018



Introduction of Nursing Quality Indicators

In 2011 the Trust developed a range of Nursing Quality Indicators (NQI) aimed at measuring compliance with nursing care processes. The NEWS overall bundle compliance is captured through the Nursing Quality Indicator Audit Programme.

As part of this work the bundle compliance audit regarding NEWS documentation has been revised and updated following consultation with staff and review of best practice evidence.

Notable updates to the NEWS audit process:

- NEWS charts now subject to independent rather than self-audit
- Criteria adjusted to 'raise the bar' in terms of audit detail
- Production of detailed improvement plans at both ward and Trust level

As a result of the rebasing of audits Quarters 2-4 2017 has indicated a reduction in bundle compliance. The Ward Manager's Audit was reinstated in February 18 & will run alongside the Independent Audit, with a view to driving improvement between the Independent Audit 3 monthly cycle.

The Trust has discussed the care bundle in respect of compliance with the Public Health Agency who are now leading a regional Quality Improvement project to review the auditing process to provide additional assurance across the region.

In December 2017, the Royal College of Physicians published NEWS2. A Trust wide NEWS implementation and oversight group has been put in place to oversee the implementation of NEWS 2. The Group is jointly chaired by the Director of Medicine and the Executive Director of Nursing .

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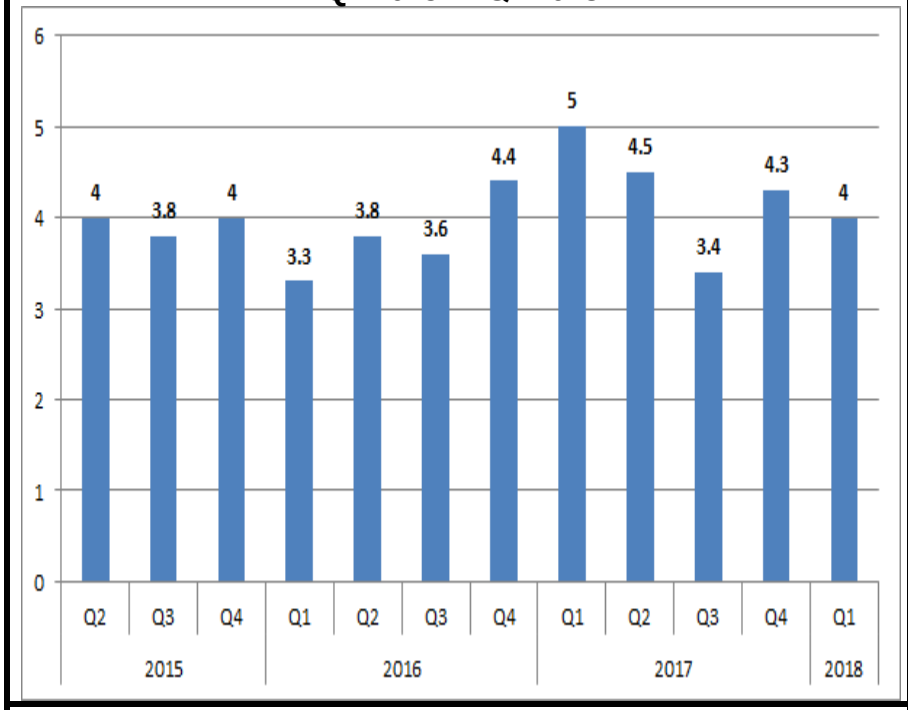
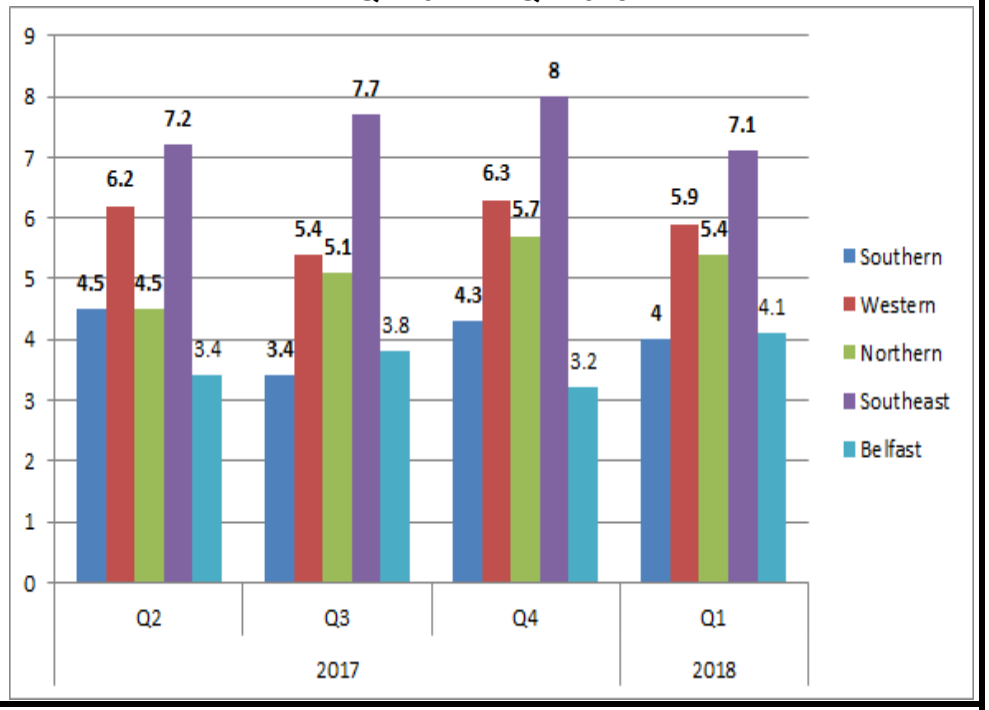
Patient Safety – Patient Falls

SHSCT Patient Fall Rate per 1,000 Occupied Bed Days
Q2 2015 → Q1 2018



- Regional Improvement Work on Patient Falls began in 2011.
- A number of pro-active initiatives has resulted in the Trust's Falls Rate being consistently one of the best in NI, namely the implementation of elements of FallSafe Bundles A & B, the use of the Falls Walking Stick by Wards to capture details of their Patient Falls "Real Time", moving "at risk" patients to a more suitable location on the Ward, where possible.
- In line with the Region in 2017/18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.
- There is no regional target associated with patient falls.

NI Trust's Patient Fall Rate per 1,000 Occupied Bed Days
Q2 2017 → Q1 2018



- In Q1 2018 the Trust's Patient Falls Rate was 4.0 per 1,000 Occupied Bed Days
- In Q1 2018 the Trust's Rate was the lowest in NI
- Of the 26 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick 14 wards (46%) saw a decrease in falls in 17/18, compared to 16/17

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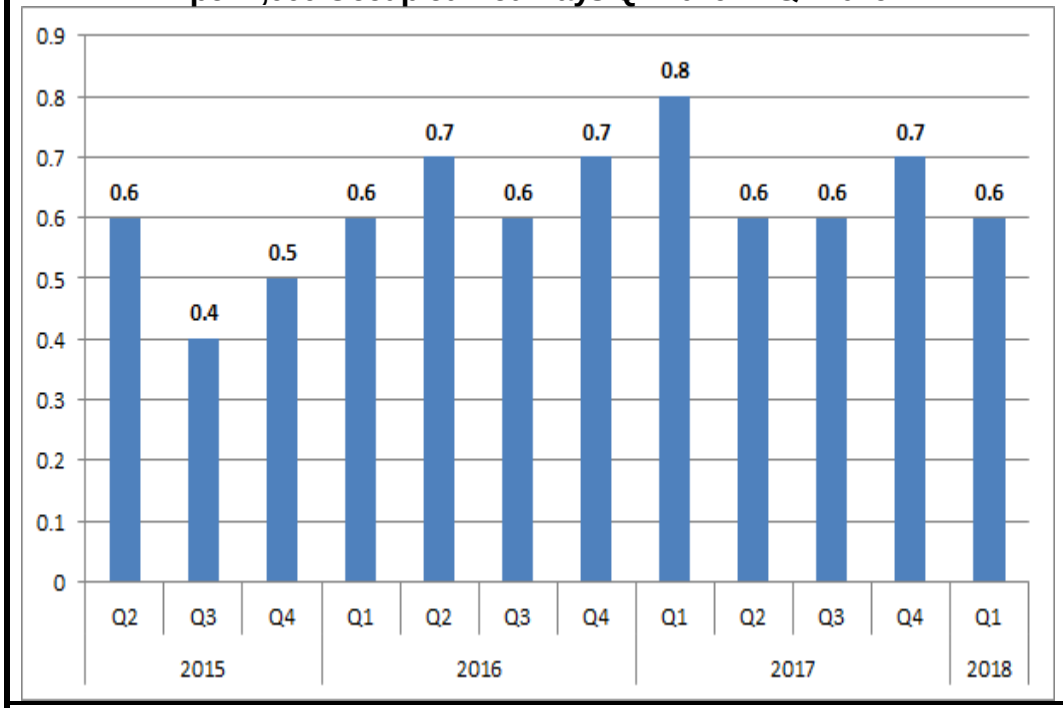
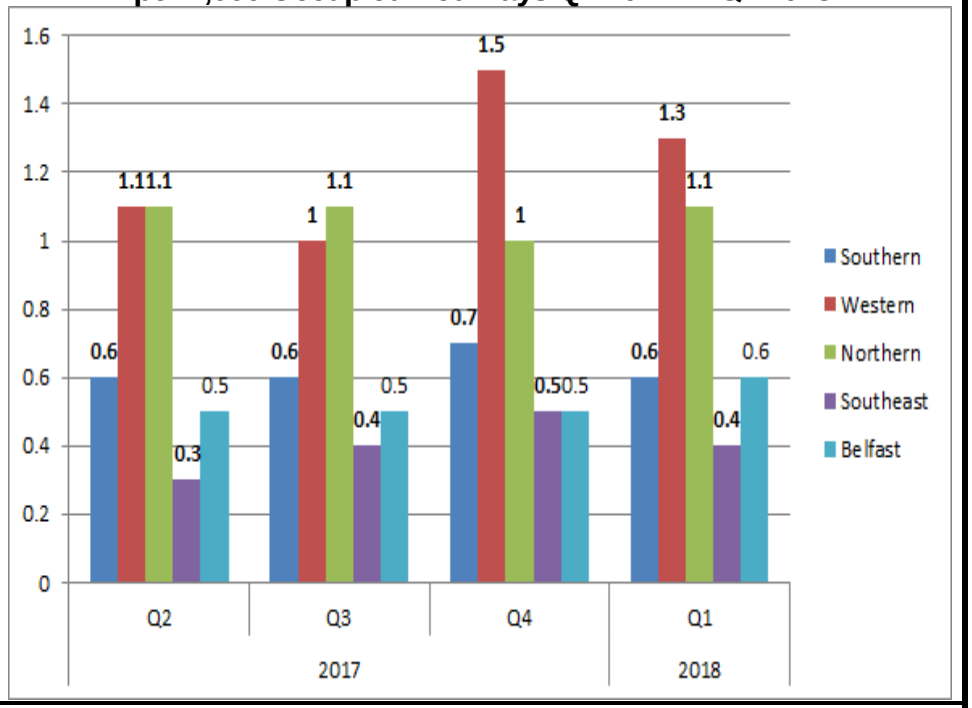
Patient Safety – Pressure Ulcers

SHSCT Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q2 2015 → Q1 2018



- Regional Improvement Work on Pressure Ulcers began 2011.
- A number of pro-active initiatives have been introduced namely the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan.
- The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on these cases within the Trust to determine those which were avoidable, with lessons learnt fed back by the Lead Nurses via Ward Manager's Meetings

NI Trust's Hospital Acquired Pressure Ulcer Rate per 1,000 Occupied Bed Days Q2 2017 → Q1 2018



- All Trusts saw an increase in "Ward Acquired" Pressure Ulcers in 16/17 compared to 15/16.
- Of the 27 Wards monitoring their Hospital Acquired Pressure Ulcers/Rate using the Pressure Ulcer Safety Cross 16 wards (59%) saw their rate remain the same or decrease in 17/18 compared to 16/17
- Of the 173 Ward Acquired Pressure Ulcers reported in 17/18, 26 (15%) were Grade 3 or 4 Pressure Ulcers. RCA's conducted on these cases concluded that only 6 were avoidable
- A series of Pressure Ulcer Awareness Coffee Mornings, funded by the PHA were held across the Trust in March 2018 to drive further improvement

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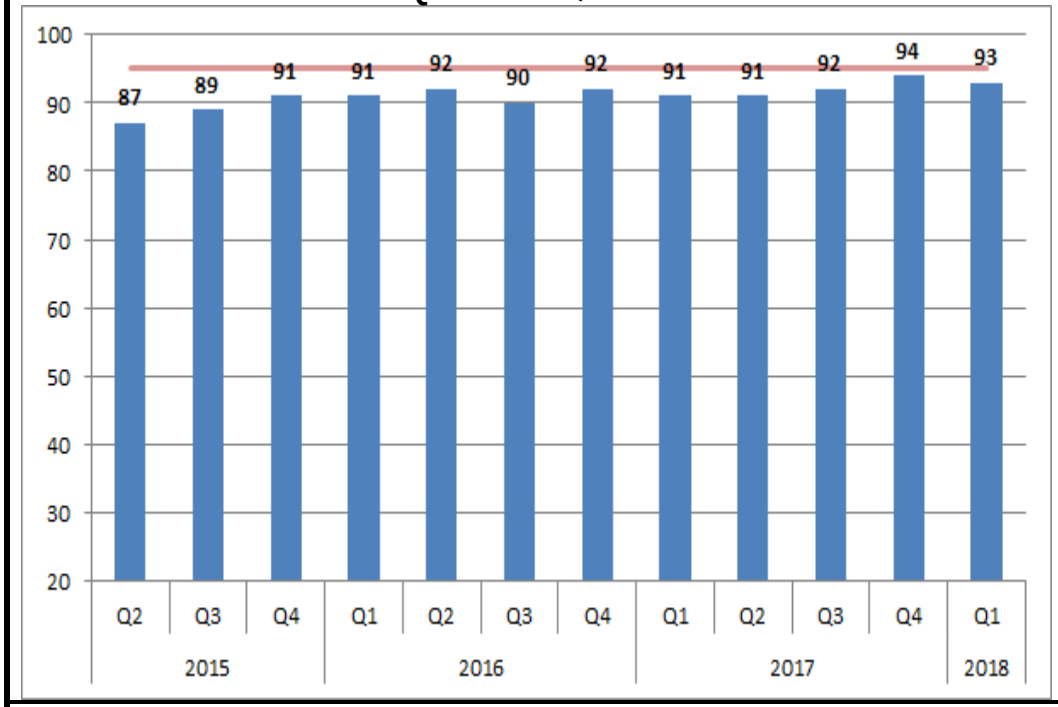
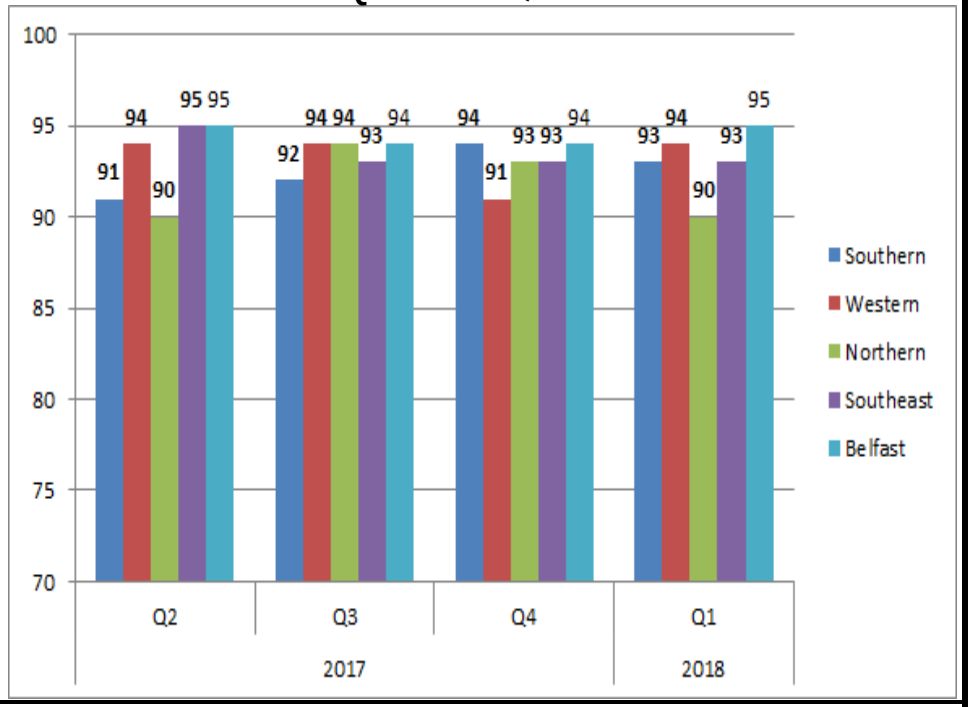
Patient Safety – Venous Thromboembolism (VTE) Risk Assessment

SHSCT VTE Risk Assessment Compliance Q2 2015→ Q1 2018



- Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009.
- All Trusts now use a Regional Risk Assessment Tool.
- For the past 4 years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%.

NI Trust's VTE Risk Assessment Compliance Q1 2017 → Q4 2017



- All Trusts have seen an increase in compliance since measurement began in April 2013.
- Southern Trusts overall compliance for Q1 2018 was 93%
- Southern Trust's Non-Acute Wards (Lurgan & South Tyrone) Compliance Rate was 98.3% in Q1 2018

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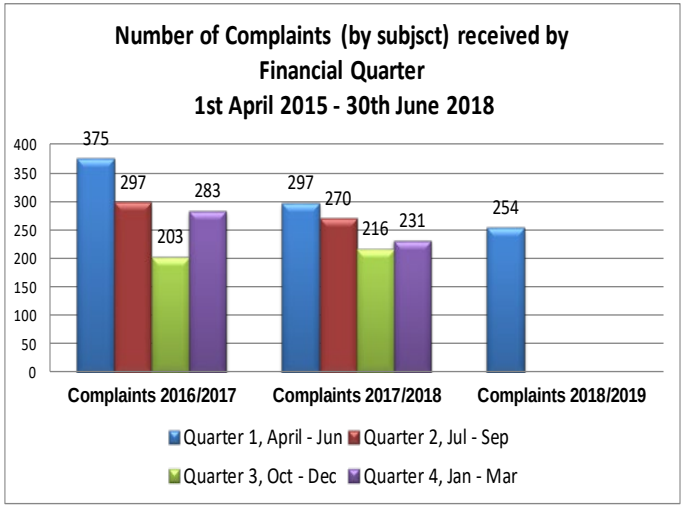
3. Complaints and Ombudsman's Complaints

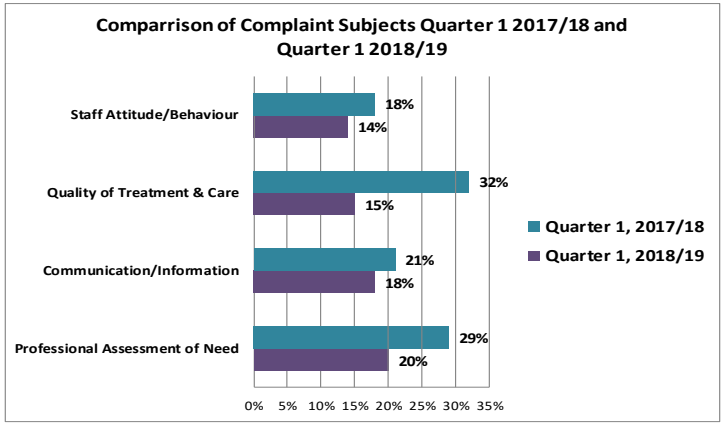
Number of Complaints Received



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

In Quarter 1 2018/19 the Trust received **161** formal complaints of which there were **254 complaints subjects**. There is a notable decrease in the number of complaint subjects in comparison to Quarter 1 in

What Our Service Users Complained About



Top 10 Complaint Subjects Q1, 2018/19

Professional Assessment of Need	20%
Communication/Information	18%
Quality of Treatment & Care	15%
Staff Attitude/Behaviour	14%
Policy/Commercial Decisions	4%
Waiting List, Delay/Cancellation Outpatient Appointments	3%
Waiting Times, Outpatient Departments	3%
Aids/Adaptions/Appliances	3%
Waiting List, Delay/Cancellation Planned Admission to Hospital	3%
Discharge/Transfer Arrangements	2%

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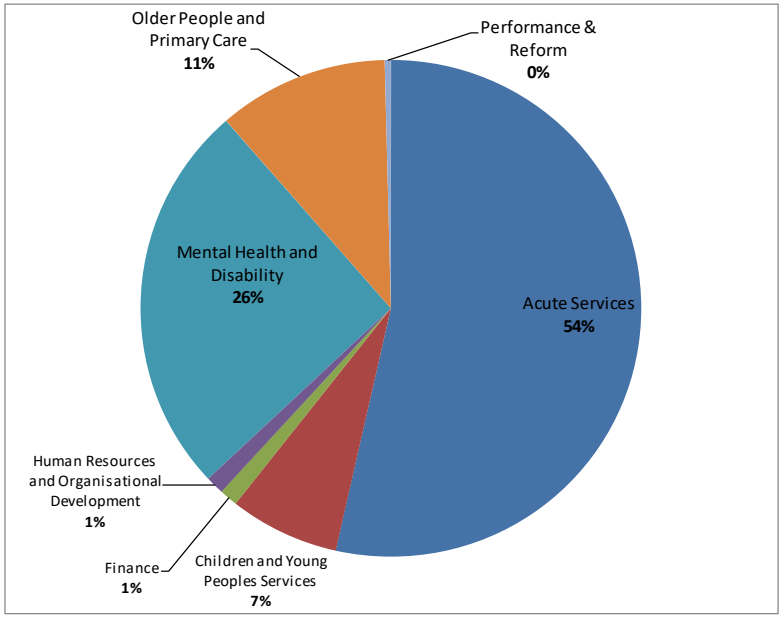
Breakdown of % of Complaints (subjects) by Directorate for Quarter 1 (1st April 2018 – 30th June



Breakdown of Number of Complaints (subjects) by Directorate and Division for Quarter 1 (1st April 2018 –

Directorate / Division	No Complaints Subjects
Acute Services	**136**
Functional Support Services	4
IMWH - Cancer and Clinical Services	30
Medicine and Unscheduled Care	47
Pharmacy	2
Surgery and Elective Care	53
Children and Young Peoples Services	**18**
Corporate Parenting	1
Family Support and Safeguarding	9
Specialist Child Health and Disability	8
Finance	**3**
Financial Accounting	3
Human Resources and Organisational Development	**3**
Employee Relations and Engagement	1
Estates	2
Mental Health and Disability	**65**
Learning Disability Services	6
Memory Services	11
Mental Health Service	42
Physical and Sensory Disability Service	6
Older People and Primary Care	**28**
Enhanced Services	10
Older Peoples Services	2
Primary Care	14
Promoting Wellbeing	2
Performance & Reform	**1**
Informatics	1
Grand Total	**254**

Southern Health and Social Care Trust

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Acknowledgement and Response Times for Complaint Letters per Directorate 1st April 2017– 30th June 2018

	Acute				CYP				MHD				OPPC			
	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE	TOTAL	2 WD ACK	20 WD RESPONSE	30 WD RESPONSE
Apr 2017	62	92%	37%	71%	**8**	100%	100%	100%	**5**	100%	100%	N/A	**2**	100%	100%	100%
May 2017	63	94%	35%	59%	**22**	94%	77%	82%	**8**	100%	63%	88%	**3**	100%	100%	100%
Jun 2017	55	87%	47%	67%	**15**	100%	73%	93%	**12**	100%	83%	100%	**1**	100%	100%	100%
Jul 2017	**72**	67%	44%	51%	**10**	100%	70%	70%	**7**	100%	86%	100%	**3**	100%	67%	100%
Aug 2017	**47**	94%	40%	74%	**12**	100%	92%	100%	**6**	100%	100%	100%	**6**	100%	83%	100%
Sept 2017	**65**	92%	32%	44%	**18**	100%	83%	83%	**6**	100%	100%	100%	**3**	100%	100%	100%
Oct 2017	**44**	98%	39%	75%	**12**	100%	83%	92%	**11**	91%	91%	100%	**2**	100%	100%	100%
Nov 2017	**55**	88%	47%	51%	**9**	100%	89%	89%	**8**	100%	87.5%	100%	**6**	100%	83%	100%
Dec 2017	**17**	100%	24%	53%	**8**	100%	88%	88%	**2**	100%	100%	100%	**4**	100%	100%	100%
Jan 2018	**69**	91%	28%	54%	**9**	100%	65%	75%	**4**	100%	100%	100%	**8**	100%	100%	100%
Feb 2018	**34**	94%	50%	74%	**11**	100%	55%	91%	**3**	100%	33.3%	33.3%	**5**	100%	100%	100%
Mar 2018	**40**	100%	33%	58%	**11**	100%	73%	73%	**10**	90%	90%	90%	**3**	100%	100%	100%
Apr 2018	**48**	98%	42%	77%	**6**	100%	67%	83%	**4**	100%	75%	75%	**3**	100%	100%	100%
May 2018	**59**	100%	46%	59%	**6**	100%	50%	50%	**9**	89%	78%	89%	**6**	100%	83%	100%
Jun 2018	**48**	100%	44%	50%	**4**	100%	100%	100%	**9**	100%	67%	89%	**3**	100%	100%	100%

The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days

The table above sets out the Trust performance by directorate against these standards. 30 Days is not a formal target however is monitored by the Trust for performance purposes.

Southern Health and Social Care Trust

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Ombudsman Cases

Breakdown of Ombudsman cases per Financial Year, 1st March 2014 –10th August 2018

	Local Resolution	Not Upheld	Open	Awaiting Screening	Upheld	Withdrawn	Not Accepted	Total
2014/2015	1	1	1	-	5	-	-	**8**
2015/2016	-	1		-	9	2	2	**14**
2016/2017	2	2	4	1	2	3	2	**16**
2017/2018	2	-	7	4	1	1	4	**19**
2018/2019	-	-	-	2	-	-	1	**3**
	5	**4**	**12**	**7**	**17**	**6**	**9**	**60**

The Trust's response to feedback about our services is based on principles of good complaint handling:

1) *Getting it right* **2)** *Being customer-focused* **3)** *Being open and accountable* **4)** *Acting fairly and proportionately* **5)** *Putting things right*

6) *Seeking continuous improvement*

When patients are not fully satisfied with the outcome from the Trust's complaint process they can choose to subsequently raise their concerns with the Northern Ireland Public Services Ombudsman. All complainants are provided with information about referring their issues to the Ombudsman at the point at which the Trust completes their investigations and closes the case with the complainant.

During the previous financial year 2017/2018, **19 cases** had been raised by the Ombudsman regarding complaints previously raised with the Trust; of which **2 cases** reached local resolution, **4 cases** were not accepted and **1 case** withdrawn. **1 case** was upheld by the Ombudsman following investigation while **7 cases** remain open within the investigation stage.

During this current financial year to date **2** cases awaits screening for acceptance by the Ombudsman's office and **1**

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting	Governance Committee December 2018
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Ahmed Khan Interim Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	The purpose of this paper to provide a report to Governance Committee on a number of Trust Clinical and Social Care Governance Committee indicators

Summary of Key Issues for Governance Committee

High level context:

- Feedback from September Governance Committee and subsequent meetings with Directors and Non-Executive Directors have informed the format of this report
- Stand down of dashboard approach to reporting
- Headline information contained in each report section
- Additional descriptive information provided on SAI and catastrophic incidents
- Inclusion of learning points relating to patient safety initiatives
- Complaints information focussing on performance

Key issues/risks for discussion:

This is the first report in the revised format, feedback from Governance Committee will inform the development of future reporting. Two additional papers have been requested linked to corporate risk. Discuss development of reports to link corporate risks to patient outcomes and clinical and social care governance information.

Internal/External Engagement:

- SMT
- AD Medical Directors office
- AD Nursing Workforce
- Directorate Governance Coordinators
- Operational Teams

Southern Health and Social Care Trust

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Clinical and Social Care Governance Report December 2018

Contents

Introduction

Purpose of Report

This report is to provide assurance to Trust Governance Committee regarding Clinical and Social Care Governance activity based on a number of indicators agreed by the Trust Senior Management Team:

- Incident Reporting
- Serious Adverse Incidents
- Complaints / Regional Timescales for Response
- Falls
- NEWS Compliance
- Pressure Ulcer Occurrences
- Venous Thromboembolism (VTE) Risk Assessment

Incident Reporting

Incident Reporting (via Datix)

Incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognising and reporting an incident (or near-miss), no matter the level of harm, is the first step in learning to reduce the risk of future occurrence.

The Southern Health and Social Care Trust reports approximately on average 12,500 incidents per year since the introduction of the DATIX web system in 2012 (Figure 1), the majority of our incidents continue to cause either insignificant or minor harm (Figure 2).

Figure 1 – Incidents recorded by directorate Quarter 4 2016 to Quarter 3 2018

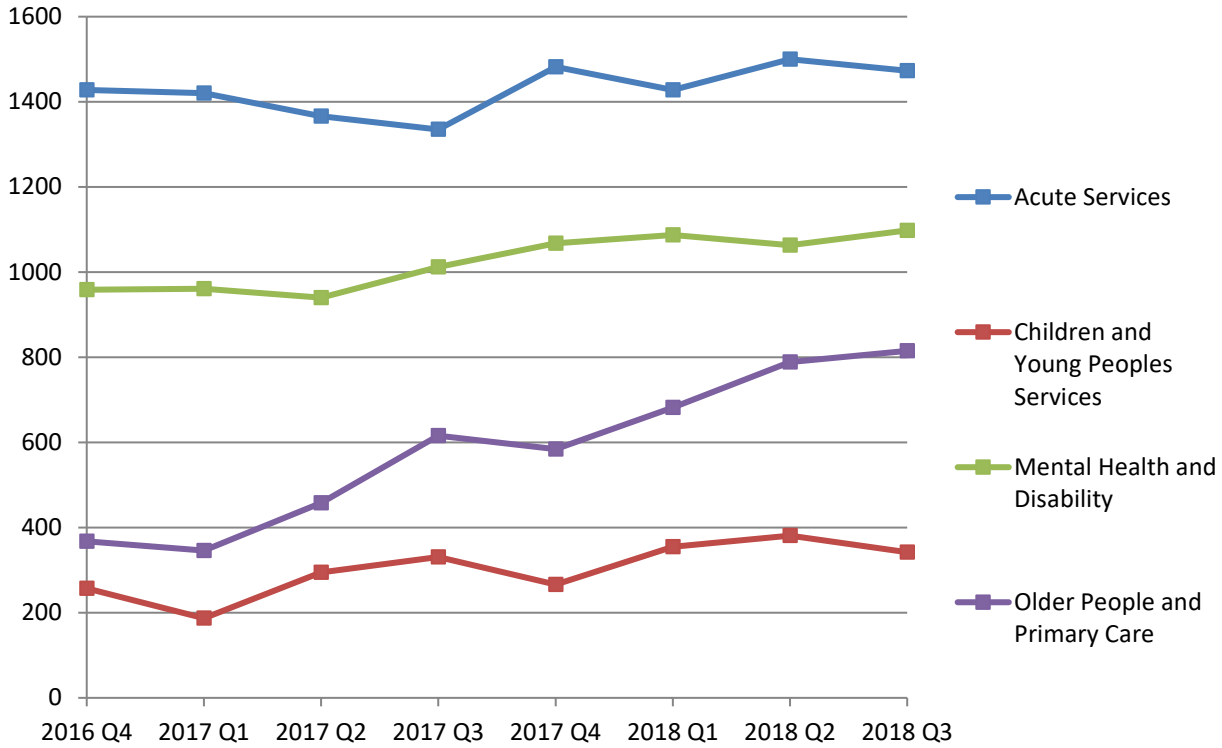
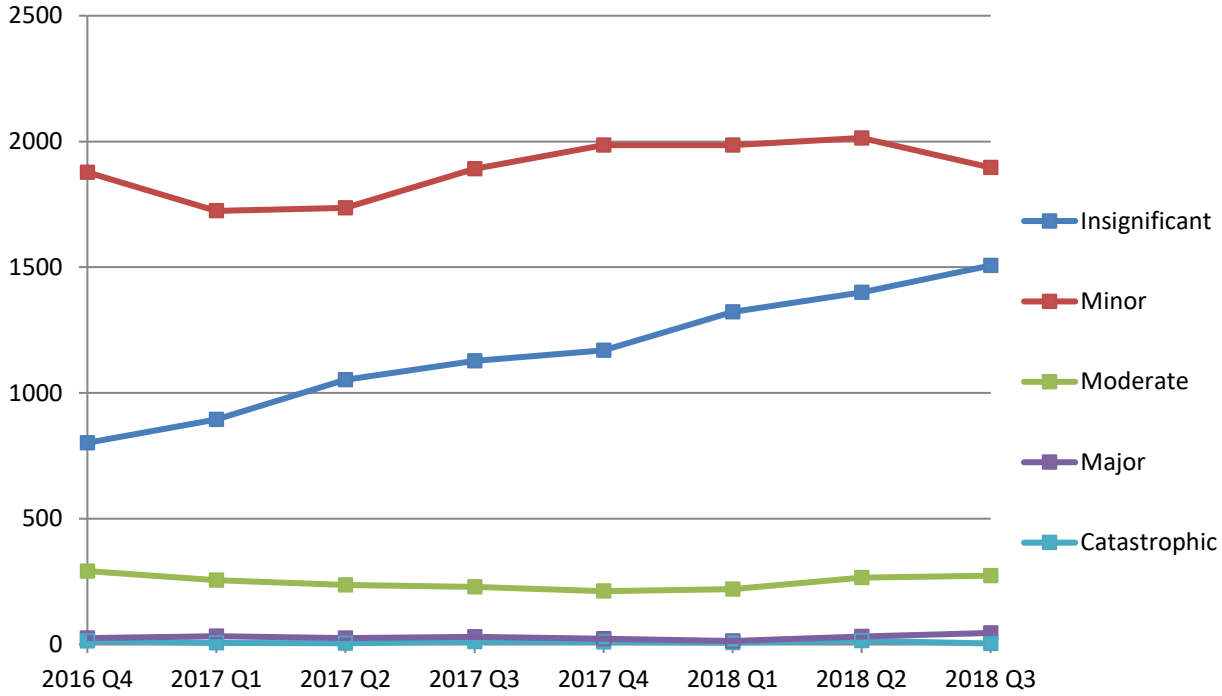


Figure 2 – Incidents by Severity Quarter 4 2016 to Quarter 3 2018



Catastrophic Incidents Quarter 3 2018

In Quarter 3 2018 there were four catastrophic incidents recorded details are provided in table 1 below.

Table 1 – Catastrophic Incidents Quarter 3 2018

Description	Action taken
Patient referred to Mental Health services, was arrested on a charge of suspected homicide	Serious Adverse Incident investigation in progress
Acutely unwell child presented to ED. Delay in response to Anaesthetists fast bleep resulting in a 40 minute delay in anaesthetic attendance at resuscitation.	Bag valve in place until arrival of Anaesthetist. Immediate debrief carried out with staff involved.
Maternal death	Serious Adverse Incident investigation in progress
Suspected suicide of service user known to Support and Recovery team	Serious Adverse Incident investigation in progress

The ten most frequently reporting incidents for quarter 3 2018 are set out in the table below. The profile has changed slightly from the previous quarter when *'Lack of suitably trained /skilled staff'* featured in the top ten most frequently reported incidents, this was replaced by *'Simple complication of treatment'* (see Table 2)

Table 2 –Incidents Classification Quarter 3 2018

Incident Type	Number of Occurrences
Physical abuse, assault or violence	599
Verbal abuse or disruption	264
Fall from a height, bed or chair	262
Fall on level ground	255
Suspected fall	239
Self-harm	139
Delay or failure to monitor	124
Omitted/delayed medicine or dose	106
Absconder/ missing patient - voluntary	100
Simple complication of treatment	51

Serious Adverse Incident Investigations

From the 1st July – 30th September 2018 there has been **7** SAI's submitted to the HSCB, details of these SAI's have been provided in Table 3 below. The Serious Adverse Incidents are in progress.

Table 3 – Serious Adverse Incidents Reported Quarter 3 2018

Directorate	**Description**	**Identification of Immediate Learning**
MHLD	Patient referred to Mental Health services, was arrested on a charge of suspected homicide	FOR SMT DISCUSSION
Acute	Acutely unwell child presented to ED. Delay in response to Anaesthetists fast bleep resulting in a 40 minute delay in anaesthetic attendance at resuscitation.	FOR SMT DISCUSSION
Acute	Maternal death	FOR SMT DISCUSSION
MHLD	Suspected suicide of service user known to Support and Recovery team	FOR SMT DISCUSSION
MHLD	Service user known to Mental Health Services jumped from window of her home and sustained multiple fractures	FOR SMT DISCUSSION

Acute	Patient admitted to fracture ward for fractured hip, in theatre sacral pressure ulcer observed, wound undressed no reference to skin assessment on handover	FOR SMT DISCUSSION
MHLD	Inpatient smashed ward window in Bluestone Unit, resulted in self harm and admission to CAH for treatment of injuries	FOR SMT DISCUSSION

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director, Associate Medical Director and Governance Co-ordinator. This process ensures areas of immediate learning resulting from incidents are identified and acted on immediately and shared with Service Users, the DHSSPSNI and HSCB through the Early Alert system as appropriate.

Trust Performance Against Regional SAI Timescales

Timescales for the completion of Serious Adverse Incidents are set out by the Health and Social Care Board as follows:

Level 1 SAI investigations - 6 weeks
Levels 2 & 3 investigations – 12 weeks

- Presently there are **44** SAI investigations currently being progressed within SHSCT
- **3** of these investigations have been paused due to ongoing investigations by external bodies (Safeguarding Board Northern Ireland and PSNI)
- **8** SAI investigations remain within the HSCB timescales for submission

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

- Appropriate Team configuration to ensure appropriate level of clinical independence and expertise
- The prioritisation of SAI investigations within existing workloads.
- Necessary engagement with service users and their families, particularly where a death has occurred.
- Where the SAI investigation spans across 2 or more Trusts

Table 4 below sets out the position on the progress of SAI investigations ongoing.

Table 4 – Trust SAI Performance Against Regional Timescales

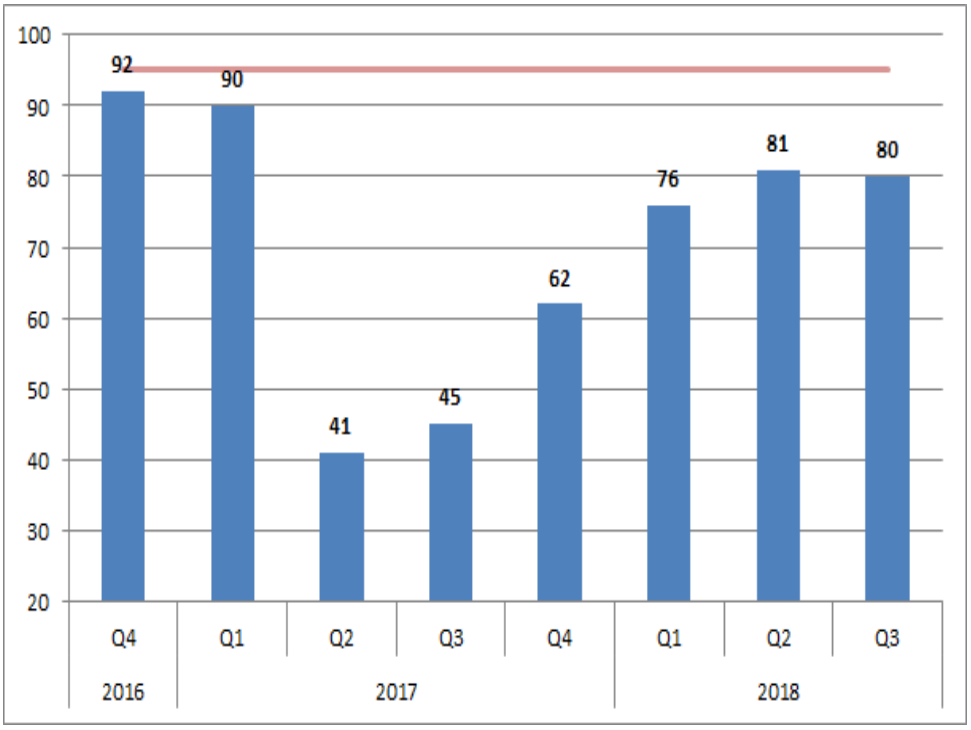
	Acute			CYPS			MHLD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks	Within HSCB Timescales	Outside HSCB Timescales < 26 weeks	Outside HSCB Timescales > 26 weeks
Level 1	0	7	8	0	0	0	1	2	1	0	0	0
Level 2	3	1	1	0	1	0	3	6	4	0	1	0
Level 3	0	1	0	0	0	0	0	0	0	0	0	0

Patient Safety Indicators

NEWS Bundle Compliance

The National Early Warning Scoring System (NEWS) is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital. The information assessed via the NEWS process is used to alert clinicians to the deteriorating patient and acute illness. Each Southern Trust inpatient is monitored via NEWS throughout their stay.

Figure 3 - SHSCT NEWS Overall Bundle Compliance Q4 2016 → Q3 2018



As a result of the rebasing of audits Quarters 2-4 2017 indicated a reduction in bundle compliance, subsequent action plans to address non-compliance have resulted in significant increases in compliance, one action included increasing the number of charts requiring audit and a review of the audit criteria and additional training for auditors.

Target Areas for Improvement / Actions Taken

NEWS audits currently comprise of a dual quality assurance mechanism where each ward sister carries out a weekly audit of their ward / department and the service area lead nurse conducts a monthly independent audit. Areas for improvement / systems strengthening are identified at a local level and fed back via Trust Nursing Quality Indicator processes to ensure that where appropriate, systems are changed to improve patient care.

The Trust operates a quarterly EWS Oversight Group which last met October 2018 whose role it is to provide assurance that the Trust has adequate mechanisms in place EWS training, documentation, policy and assurance auditing.

This quarter the EWS oversight group requested a point prevalence audit be carried out across all inpatient settings in addition to the existing audit programme. Summary of recommendations are below:

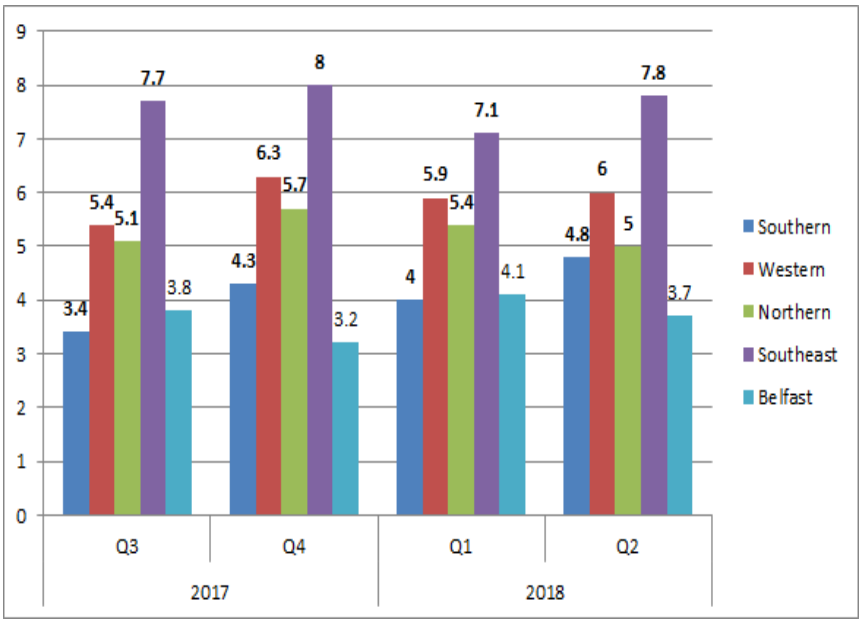
- As a result of this audit five cases were identified for an in-depth multi-disciplinary review which is in progress at time of reporting to gain a better understanding of professional judgement, escalation and management plan decisions.
- Trust to consider using an electronic alert to a dedicated review team / patient's medical team for NEWS where escalation is required
- Trust to consider dedicated Lead for implementation of the updated revised NEWS process (NEWS2)

Patient Falls

The Trust Patient Falls audit is based on elements of the Royal College of Physicians 'Fall Safe' bundle. FallSafe was a quality improvement project to study the introduction of care bundles designed to prevent inpatient falls in hospitals. A care bundle is a list of actions (called elements) that need to be applied consistently to patients for whom they are appropriate. The actions are selected because they have been shown to be effective through research.

This audit is carried out as part of the Nursing Quality Indicator suite by ward sisters and lead nurses.

Figure 4 NI Trust's Patient Fall Rate per 1,000 Occupied Bed Days Q3 2017 → Q2 2018



Target Areas for Improvement / Actions Taken

In line with the Region in 2017/18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm, all of these incidents occurred in the acute directorate. In Quarter 2 2018 there were 8 falls that met these criteria were subject to the Post Falls Review process. Learning from these occurrences are submitted to the Public Health Agency for consideration of regional sharing of learning, the following learning points were identified:

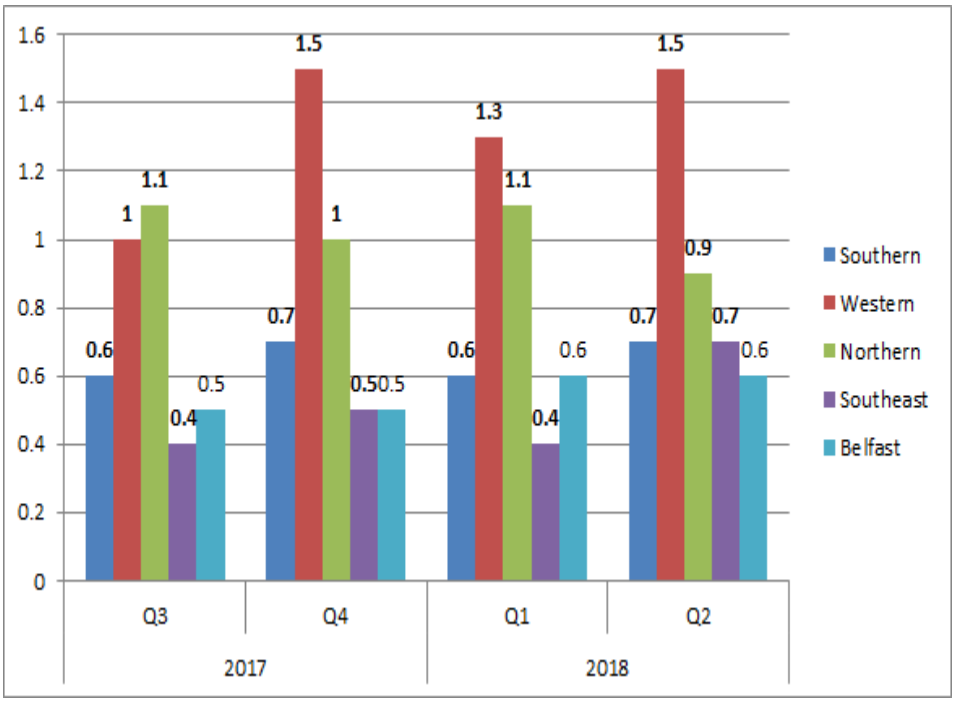
- Fall assessment should include clearly documented outcomes of assessment to inform care planning
- Importance of appropriate placement of high risk patient in observation bed spaces
- Importance of robust assessment and one to one supervision for patients suffering confusion
- Need to continuously update assessments to include lying and standing blood pressure and urinalysis when Falls B bundle is implemented

Pressure Ulcer Bundle Compliance

The Trust Pressure Ulcer audit is based on elements of the regional SKIN bundle. The focus of the regional SKIN bundle is to identify patients at risk of pressure ulcers and to conduct an case review on grade 3 & 4 Ward Acquired Pressure Ulcers to determine those which were avoidable, with lessons learnt fed back by the Lead Nurses via Ward Sisters meetings.

This audit is carried out as part of the Nursing Quality Indicator suite by ward sisters and lead nurses.

Figure 5 NI Trust's Pressure Ulcer Rate per 1,000 Occupied Bed Days Q3 2017 → Q2 2018



Target Areas for Improvement / Actions Taken

Of the 173 Ward Acquired Pressure Ulcers reported in 17/18, 26 (15%) were Grade 3 or 4 Pressure Ulcers. Reviews conducted on these cases concluded that only 6 were avoidable. Learning from these occurrences are submitted to the Public Health Agency for consideration of regional sharing of learning, the following learning points were identified:

- Importance of early identification of patients that require placement on Pressure Ulcer Pathway/SKIN Bundle/Pressure Relieving Mattress
- Pressure Ulcer documentation should include clearly recorded outcomes of assessment to inform care planning
- Importance of providing patient advice on Pressure Ulcer Prevention

Service User Formal Complaints

Number of Complaints Received

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

In quarter 3 2018, 27 subject areas were made up of 253 complaints. This was an increase of 12 from quarter 2 however a decrease of 17 from the same quarter in 2017

Comparison of Complaint Subjects Q2 2018 and Q3 2018

- 2% increase in the number of complaints relating to Communication/ Information
- 4% increase in the number of complaints relating to Quality of Treatment & Care
- 2% decrease in the number of complaints relating to Staff Attitude and Behaviour
- Professional Assessment of Need remained the same as in Q2.

Top 10 Complaints by Subject

Table 4 – Trust Complaints Received By Subject

Subject	Number
Communication/Information	50
Professional Assessment of Need	46
Quality of Treatment & Care	40
Staff Attitude/Behaviour	32
Waiting List, Delay/Cancellation Outpatient Appointments	10
Waiting Times, A&E Departments	9
Quantity of Treatment & Care	7
Property/Expenses/Finances	7
Policy/Commercial Decisions	6
Discharge/Transfer Arrangements	5

- Communication/ Information are showing as the most common subject of complaint this quarter (as it was last quarter). There is an increase of 6 complaints in total.
- Professional Assessment of Need is the second most common subject of complaint (as it was in Q2). There is an increase of two in total.
- Quality of Treatment & Care is the third most common subject of complaint (as it was in Q2). There is a decrease of 1 complaint in total.
- Staff attitude / Behaviour is the fourth most common subject of complaint (as in Q2). This is a decrease of 4 in total.
- In Quarter 2, the fifth most common subject of complaint was Policy / Commercial Decision. However, in Quarter 3 Waiting List, delay / Cancellation Outpatient Appointments has taken its place.

Percentage of Complaints by Directorate Quarter 3 2018

- Acute: 57% - decrease of 2% since Quarter 2 2018
- CYP: 14.5% - increase of 7% since Quarter 2 2018
- MHD: 12% - decrease of 6% since Quarter 2 2018

- OPPC: 15% - increase of 2% since Quarter 2 2018
- Human Resources and performance and Reform: decreased by 0.5% since Quarter 2 2018
- Office of Chair and Chief Executive: increased by 0.5% since Quarter 2 2018
- Finance: 1% - remained the same since Quarter 2 2018

Number of Complaints by Directorate and Division Quarter 3 2018

Table 5 – Complaints by Directorate and Division

Directorate/ Division	Number of Complaints
Acute Services	**144**
Functional Support Services	17
IMWH - Cancer and Clinical Services	41
Medicine and Unscheduled Care	65
Surgery and Elective Care	21
Children and Young People	**37**
Corporate Parenting	7
Family Support and Safeguarding	16
Specialist Child Health and Disability	14
Mental Health and Disability	**30**
Learning Disability Services	9
Mental Health Service	16
Physical and Sensory Disability Service	5
Older People and Primary Care	**38**
Enhanced Services	15
Older Peoples Services	5
Primary Care	18
Finance and Procurement	**3**
Financial Accounting, Control and Financial Services	3
Office of Chair and Chief Executive	**1**
Governance	1
Grand Total	**253**

Acute – 144 in total compared to 141 in Quarter 2 (increase of 3)

- Functional Support Services – increase of 13
- IMWH – Cancer and Clinical Services – increase of 8
- Medicine and Unscheduled Care – increase of 15
- Surgery and Elective – decrease of 29
- Pharmacy has no complaints this quarter. (2 in Quarter 2.)

CYP – 37 in total compared to 18 in Quarter 2 (increase of 19)

- Corporate Parenting – increase of 5

- Family Support and safeguarding – increase of 8
- Specialist Child Health and Disability – decrease of 6

MHD – 30 in total compared to 44 in Quarter 2 (decrease of 14)

- Learning Disability Services – increase of 5
- Mental Health Service - decrease of 12
- Physical and Sensory Disability Service – increase of 2
- Memory Services has no complaints this quarter (9 in Quarter 2)

OPPC – 38 in total compared to 31 in Quarter 2 (increase of 7)

- Enhanced Services – increase of 3
- Older People Services – increase of 1
- Primary Care – increase of 5
- Promoting Wellbeing did not have any complaints this quarter (2 in Quarter 2)

Finance and Procurement

- Remained the same with 3 in total

Performance and Reform (decrease of 1)

- No complaints this quarter (1 in Quarter 2)

Office of Chair and Chief Executive (increase of 1)

- Increase of 1 (no complaints in quarter 2)

Acknowledgement and response Times for Complaint Letters per Directorate – Average % Quarter 3 2018

The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days

The table above sets out the Trust performance by directorate against these standards. 30 Days is not a formal target however is monitored by the Trust for performance purposes.

Acute

- 2 Working Day Acknowledgement – 96% (98% in Q2)
- 20 Working Day Response – 25% (44% in Q2)
- 30 Working Day Response – 42% (62% in Q2)

CYP

- 2 Working Day Acknowledgement - 92% (100% Q2)
- 20 Working Day Response - 80% (72% Q2)
- 30 Working Day Response - 83% (77% Q2)

MHD

- 2 Working Day Acknowledgement - 100% (96% Q2)
- 20 Working Day Response - 45% (70% Q2)
- 30 Working Day Response - 60% (84% Q2)

OPPC

- 2 Working Day Acknowledgement
- 20 Working Day Response
- 30 Working Day Response

Ombudsman Cases

In Quarter 3, we received one request for further information from the Ombudsman's Office. This case is currently pending. We have not yet been notified if they are accepting it for investigation.

Four Ombudsman cases were closed within Quarter 3. Two were not accepted for investigation. One was resolved through Local Resolution and one was upheld.

APPENDIX 1 – TRUST RISK ASSESSMENT

SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM		Risk ID No
Directorate: Organisational	Facility/Department/Team: Medical Director	Date: **19/10/17 Update 30/04/18**
Where is this being carried out? (e.g. Trust premises/home of client/staff/ private nursing home etc) N/A	Objective(s) i.e. Corporate, Legislative requirements etc.: Safe, high quality care	

Risk Title: (Threat to achievement of objective)
Capability of Trust systems of assessment and assurance in relation to quality of Trust services.

Outline the potential for harm: *(Consider injury to client, staff, litigation, etc)*

- Potential that the provision of intelligence for assurance by Operational and Executive Directors that clinical and social care services are safe and of good quality and that standards are being met will be compromised. There is the potential that this could impact on the content of the risk management action plan set out by the Senior Management Team to ensure the delivery of the organisational strategy on C&SCG.

- Potential that learning from incidents, complaints and litigation will not be adequately identified , acted upon or disseminated across the organisation to minimise and mitigate risk of reoccurrence

- Reputational risk

Description of Risk:
(Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider)

Specific risks include:

- Monitoring and assurance of implementation/compliance to Standards and Guidelines
- Effectiveness of processes in place to review all intelligence from incidents, complaints litigation and user feedback to highlight areas of risk ,safety to drive improvement
- Effectiveness of processes in place to disseminate and share learning from incidents, complaints and user feedback across the organisation.

Control Measures in Place:
Systems/Processes in place to highlight areas of risk

- Web based incident reporting systems in place across the Trust
- Screening and investigation procedures in place in operational directorates with regards to incidents and complaints
- Operational Directorate, Divisional and Professional Governance Fora in place with a reporting arrangements to SMT Governance, Governance Committee and Trust Board
- Mortality and Morbidity Structure in place across all clinical specialities
- Standardised process in places for the dissemination of Standards and Guidelines across the organisation

Information/Organisational Intelligence

- Executive Director Reports to Trust Board
- CSCG information presented in Dash Board format to SMT Governance and Governance Committee using trends over time to highlight risk
- Mortality and Morbidity Meeting in place
- Governance Coordinators Forum in place as a key link to ADCSCG
- Risk Management Controls Assurance
- Corporate Risk Register
- Internal Audit

	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating
	likely	major	Amber - 16
ACTION PLAN OF FURTHER CONTROL MEASURES REQUIRED (risk treatment):			

Action/Treatment	Action Lead	**Start Date**	Target Date	Progress/Review Date
Improve processes to identify act on disseminate learning across the Trust via: • Learning Letters • Complaints • Safety Alerts • Professional Forums • Mortality and Morbidity Meetings • Incident Screening Processes • Litigation • Coroners Inquests	Medical Director, Assistant Director CSCG	Ongoing	Ongoing	Trust Lessons Learnt Forum in place (2nd meeting took place on the 27th April 2018) – **Update 30/04/2018** Facility in place for operational Teams to use DATIX incident Dashboards Information on complaints, Incidents, SAI are discussed at monthly via operational directorate governance arrangements **Review July 2018**
Monitoring and assurance of implementation/compliance to Standards and Guidelines	Medical Director, Assistant Director CSCG	Ongoing	Ongoing	**Update 30/04/2018** Audit on a sample of standards and guidelines completed April 2018 focused on: ➢ Logging of SG ➢ Appropriate dissemination of SG ➢ Appointment of Change Leads ➢ Number of outstanding SG assurances templates to DOH Audit indicated – 100% compliance to SG dissemination procedures Recommendations of BSO audit 2015/16 fully implemented. **Review September 2018**

Develop the use of CSCG Audit to provide assurance of compliance and identify risk.	Medical Director	Ongoing	Ongoing	
Date of first review (to be determined by risk rating)				Date of Review 30/04/18 Monthly
Predicted Risk Assessment once all control measures are implemented. (Residual Risk rating)	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)	
	Likely	Major	Amber -16	

ANTICIPATED RESOURCE IMPLICATIONS (details and cost)				£
None				
Funding identified?	**Yes**	**No**	**N/A**	**Source of funding**

Action	Date	By Whom (PRINT & SIGN)
To be managed by Facility/Department Team Manager/Leader		
Referred to Divisional Risk Register		
Referred to Directorate Risk Register	25/10/17 30/04/18	Margaret Marshall - ADCSCG
Shared with another Team/Directorate Risk Committee for information/consideration		
Referred to Corporate Risk Register		

Risk Assessor(s)		
Name (PRINT & SIGN) Margaret Marshall	Designation ADCSCG	Date 19/10/2017 Reassessed 30/04/18
Manager		
Name (PRINT & SIGN) Dr Richard Wright	Designation Medical Director	Date

MONITORING
Summary of current position

Current position and effectiveness of control measures to be monitored by Medical Directors Team			
Current Risk Rating	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)
	Likely	Major	Amber
Name (PRINT & SIGN) Margaret Marshall	Designation ADCSCG		Date of Review ➢ 19/10/2017 ➢ 30/042018

Summary of current position			
Current Risk Rating	**Likelihood**	Consequence / **Impact**	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)
Name (PRINT & SIGN)	Designation		Date of Review
Summary of current position			

Current Risk Rating	**Likelihood**	Consequence/ **Impact**	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)
Name (PRINT & SIGN)	Designation		Date of Review

LIKELIHOOD	CONSEQUENCE (POTENTIAL IMPACT)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
(5) Almost Certain (will undoubtedly recur, a persistent issue) 1:10	5	10	15	20	25
(4) Likely (will probably recur, not a persistent issue) 1:100	4	8	12	16	20
(3) Possible (may recur occasionally) 1:1,000	3	6	9	12	15
(2) Unlikely (do not expect it to happen again) 1:10,000	2	4	6	8	10
(1) Rare (can't believe it will ever happen again) 1:100,000	1	2	3	4	5

Green Risks (VLow)

Identified risks which fall in the green area are deemed as acceptable risks and require no immediate action, but must be monitored regularly. These risks must be entered onto the local Risk Register. A full risk assessment form does not need to be completed for such risks.

Yellow Risks (Low)

Identified risks which fall in the yellow area are deemed Low risk to the Trust and require action to reduce risk to an acceptable level. Responsibility for taking action would normally remain at a local level within the appropriate Directorates / Programmes / Service Areas and be entered on the Team / Service Risk Register. Where these risks cannot be managed locally they should be forwarded to the appropriate Divisional Governance Forum for consideration for further local action, resourcing, acceptance on to the Divisional Risk Register. Low risks must be entered on the local risk register and where appropriate the Divisional Risk Register for information and monitoring purposes. A full risk assessment form does not need to be completed for such risks.

Amber Risks (Moderate)

Identified risks which fall in the amber area are deemed Moderate risk to the Trust and require prompt action to reduce the risk to an acceptable level. When risks cannot be reduced locally they should be submitted to the Divisional Governance Forum for consideration for recommended action, i.e. further local action, resourcing or acceptance. Where these risks cannot be managed within the Division/ they should be referred to the Directorate Risk Register for consideration and/or addition to the Corporate Risk Register. These risks must be entered on the local risk register and where appropriate the Divisional/Directorate Risk Register. A full risk assessment form needs to be completed for such risks.

Red Risks (High)

Identified risks which fall in the red area are deemed High risk to the Trust and must be reported to the appropriate Director and Chief Executive. Immediate action is required to reduce the level of risks to an acceptable level. The appropriate Director will ensure the implementation of a time monitored action plan with regular reports to the Chief Executive and Governance Committee. These risks will be entered on to the Divisional/Directorate, and if appropriate the Corporate Risk Register(s) for monitoring by the SMT Governance Steering Group. Where the identified risks represent significant gaps in controls/assurances they will be escalated by the SMT Governance Steering Group to the Board Assurance Framework. A full risk assessment form needs to be completed for such risks.

Figure 7 – Risk Impact/Consequence Table (5x5 Matrix) **CATEGORY**

CONSEQUENCE / IMPACT

	PEOPLE (Any person affected by an Incident:Patient/Client, Staff, User, Visitor or Contractor)	**RESOURCES** (Premises, money, equipment, Business interruption, problems with service provision)	**ENVIRONMENT** (Air, Land, Water, Waste management)	**REPUTATION** (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	**QUALITY AND PROFESSIONAL STANDARDS** (including Government priorities, targets and organisational objectives)
CATASTROPHIC	Incident that leads to one or more deaths	Severe organisation wide damage / loss of services /unmet need	Toxic release affecting off-site area with detrimental effect requiring outside assistance	National adverse publicity. DHSSPS executive investigation following an incident or complaint. Criminal prosecution.	Gross failure to meet external standards, priorities.
MAJOR	Permanent physical / emotional injuries / trauma / harm.	Major damage, loss of property / service / unmet need.	Release affecting minimal off-site area requiring outside assistance (fire brigade, radiation, protection service etc)	Local adverse publicity. External investigation or Independent Review into an incident / complaint. Criminal prosecution / prohibition notice.	Repeated failure to meet external standards.
MODERATE	Semi permanent physical / emotional injuries / trauma / harm (recovery expected within 1 year). Includes RIDDOR reportable incidents.	Moderate damage, loss of property / service / unmet need.	On site release contained by organisation.	Damage to public relations. Internal investigation (high level), into an incident / complaint. Civil action.	Repeated failure to meet internal standards or follow protocols.
MINOR	Short-term injury / harm. Emotional distress. (Recovery expected within days / weeks.)	Minor damage, loss of property / service / unmet need.	On site release contained by organisation.	Minimal risk to organisation. Local level internal investigation into an incident / complaint. Legal challenge.	Single failure to meet internal standards or follow protocol.
INSIGNIFICANT	No injury / harm or no intervention required	No damage or loss, no impact on service. Insignificant unmet need.	Nuisance release.	Minimal risk to organisation, Informal complaint	Minor non compliance.

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Tel: 3756 1335

ACUTE CLINICAL GOVERNANCE ACTON NOTES

Date: Friday, 10th August 2018

1.0	**Apologies:** Trudy Reid, Esther Gishkori, Dr Philip Murphy **Attendees**: Anita Carrol, Dr Bradley, Dr Scullion, Dr Rutherford-Jones, Dr Kumar, Barry Conway, Tracey Boyce, Ronan Carroll, Mary Burke	
2.0	**Chair's Business:** • **Entitlement to free healthcare in the SHSCT** Paper re Entitlement to Healthcare in the S Brigid and Helen presented their paper. Dr Bradley raised an issue in relation to conflicting advice given by the Trust legal support – there is still a duty of care to treat a patient with a life threatening condition. The team are there for advice – they will develop a flyer that we can distribute to staff. They also have a share point site for staff information. • **Escalation Plan** Anita led the discussion on the escalation plan. Barry shared the 'Hospital Early Warning Score' Card – we have been using it each day this week as a test only. This method is in use in Antrim Hospital. Comments are still being collated • **Compliance with IPC** Anita shared that Dr Khan will be aluncing a new Trust IPC strategy in September. More information will follow. Bare below the Elbow - July 18 - Exce Meidcal staff compliance -	Brigid Quinn and Helen attending
3.0	**Matters Arising/Actions**	
4.0	**Standards and Guidelines**	
5.0	**Acute Medical Audit** The need to identify who each divisional audit lead and get	

	attendance at the Acute audit committee. At the moment risk of concerning audit findings/ appropriate action plans is hidden to the AMDs and ADs. Also later in the year each Division will be asked by the corporate tyeam to provide a list of their completed audits along with each ones top 3 learning points and associated action plans. Hence we need to get the Acute audit committee functioning effectively again.	AMDs and ADs
6.0	**SAI information** • SAI Summary spread sheet –	
7.0	**Complaints Position**  complaints and enquiries by month 2( Weekly Re-Opened Report 07.08.18.xlsx  Ombudsman weekly 010818.xlsx  Current Complaints 31.07.18.xlsx	All
8.0	**Incidents** Summary report Incidents awaiting and in review  Incident Review Position as at 02.08.1  Staffing incidents july 2018.xlsx  Staffing Incidents by Loc (Exact) and Incid  Medication incidents June 2018 Acute.xlsx Major and above report  Major and Catastrophic Incident Falls  Patient Falls by Month (April 2016 - Ju  Acute Services - Falls - July 2018.xlsx  Moderate - Catastrophic Falls Apı Pressure Ulcers  Pressure Ulcers Jun18.xlsx Violence and aggression  Violence and Aggression Incidents  Violence and Aggression Incidents	

	Absconding patients  Absconding Incidents - Acute Services (01.(	
9.0	**Regional NEWS Trigger Reset Guidance** • Update NEWS2 • GCS chart pilot in EDs and 2ss and 4n	
10.0 **SI**	**Risk Registers** – additions, amendments and closures  SEC.ATICS Div.HOS.Team RR Jul  Pharmacy Div.HOS.Team RR Jul  MUC Div.HOS.Team RR Aug18.xlsx  IMWH Div.HOS.Team RR July18.xlsx  FSS Div.HOS.Team RR July18.xlsx  CCS Div.HOS.TEAM RR July18.xlsx  Directorate RR Aug18.xlsx **Any changes to the team**	ADs & AMDs
11.0	**Management of Trust Clinical Guidelines**	
12.0	**Any Other Business** Sepsis audit – Mary raised the issue re sepsis audit no longer being fit for purpose. Mary has raised it with Mark Roberts as this is affecting our audit results. New document to come out asap.	
13.0	**Date of Next Meeting:** **Friday 7th September 2018 at 8.00 am in the Board Room, CAH**	

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

Paper re Entitlement to Healthcare in the SHSCT

1. Purpose

The purpose of this paper is to assist staff to understand some of the rules relating to entitlement to healthcare in the SHSCT.

2. Background

In the SHSCT, the process of identifying patients who are **not entitled** to free planned healthcare is carried out by Access to Health Care Team based in Ghana House, Daisy Hill Hospital and headed up by Brigid Quinn. The team is responsible for assessing an individual's entitlement to free healthcare whilst taking account of the various legislative frameworks which place a legal obligation on the Trust to identify patients who are required **to pay** for their treatment.

In recent times a high number of patients from Republic of Ireland/EU have been identified as not entitled to free healthcare. These patients have been advised by the Access to Healthcare Team that they should receive further treatment in their own jurisdiction; however it has come to light that in many cases the Trust has offered them further appointments/treatment.

Within Acute Services we need to establish a process whereby patients who are not entitled to free planned healthcare, will **NOT** be placed on waiting lists or offered further treatment. It is critical that only immediately necessary care is offered and that the pathway for planned treatment is not opened up to those patients who are not eligible for free healthcare without prior knowledge that all planned treatment will be charged for in advance.

A few recent examples where patients have been incorrectly offered ongoing treatment are listed below.

- A Brazilian national who has a visa for the RoI is receiving cancer treatment in CAH; he has no entitlement to free healthcare in NI and should be treated in the RoI as he has no visa to enter NI. The Access to Healthcare Team has spoken with the patient to confirm he is not in NI lawfully and should not be entering NI for treatment, he has received an invoice for his treatment to date which he confirmed he is not able to pay but continues to come to NI for treatment as he continued to be offered appointments.

- A patient from Canada who has come to NI as a visitor is currently receiving Urology treatment; the Access to Healthcare Team confirmed she has no entitlement to free healthcare. When asked why she came to NI for treatment, she stated her husband was born here and she thought she could access free healthcare on that basis. The GP she named as being registered with contacted CAH to confirm she was not their patient and was not registered with them. This patient is not entitled to free healthcare and continued to access treatment. The patient also hopes to return to live in Canada.
- A patient from the RoI was admitted as an Emergency and had surgery, and is currently on our waiting list to return for further surgery. The Access to Healthcare Team confirmed to her that she was not entitled to return for planned treatment free of charge. Her family continued to hold the view that if the Trust makes an offer of an appointment for further treatment she should not be charged for it.

Without an established process in place the Trust will continue to offer free planned treatment to EU/International patients who come to NI as a visitor and who do not have entitlement to receive free healthcare via the Trust appointment process.

3. Current Process

The Access to Healthcare Team has various mechanisms to establish patients who are not entitled to planned treatment.

Where a patient is identified either as an in-patient or on a waiting list and are not entitled to free planned treatment the Access to Healthcare Team will proceed to alert the Specialty of the circumstances and request that no further appointments are offered. The Specialty should confirm to the patient that they must seek follow up treatment in their own jurisdiction. Unfortunately in the majority of cases the patient will indicate to the medical staff they wish to continue their treatment within the Trust, however since the Trust no longer undertakes private medical practice there is no longer any viable route for this category of patient to continue their treatment in the jurisdiction. In cases where the patients are offered further appointments this results in them obtaining free healthcare treatment which they are not entitled to.

The Access to Healthcare Team is currently rolling out a programme to raise awareness of patients' entitlement and we are seeking help from the Acute Directorate to establish

(i) A process which will prevent patients not entitled to free planned healthcare obtaining further appointments
(ii) To raise awareness of processes in place within the medical teams

Southern Health and Social Care Trust

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SMT Report

Bare Below the Elbow / Nail Varnish / Nail Extensions:
Non-Compliant Ward Areas / Staff grouping

July 2018

Hospital	Ward/Area	Staff Grouping	Nature of Non-Compliance
CAH	1 South	Medical	Sleeves turned up at wrists only
CAH	1 South	Medical	Long sleeved blouse
CAH	2 North Respiratory	Medical	Wrist watch
CAH	2 South	Medical	Sleeves to mid forearms
CAH	3 South Short Stay	Medical	¾ sleeve top
CAH	3 South Short Stay	Nurse	Wrist watch
CAH	4 South	Medical	FitBit watch and hairband on wrists
CAH	Discharge Lounge	Nurse	Nail varnish
CAH	Elective Admissions	Medical	Sleeves to mid forearms
CAH	Elective Admissions	Medical	Wrist watch
CAH	Elective Admissions	Medical	Wrist watch
CAH	Elective Admissions	HCA	Nail varnish
CAH	Emergency Department	Medical	Nail varnish
CAH	Emergency Department	Nurse	Nail varnish
CAH	NeoNatal Unit	AHP	Wrist Watch
DHH	Female Medical	Medical	Sleeves to mid forearms

DHH			
DHH			Sleeves to mid forearms
DHH			Sleeves to mid forearms
DHH			¾ sleeve top

Directorate of Acute Services
Complaints and Enquiries/Informals

Month	Total No 2011/12		Total No 2012/13		Total No 2013/14		Total No 2014/15		Total No 2015/16		Total No 2016/17		Total No 2017/18		Total No 2018/19	
Type	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**	**Complaints**	**Enquiries / MLA / Informal**
Apr	34	13	36	18	55	17	58	11	53	23	45	21	62	26	30	11
May	46	10	57	16	66	23	44	16	28	25	39	29	54	18	47	18
Jun	70	9	27	15	40	25	51	14	48	39	58	30	51	23	40	17
Jul	33	9	31	13	41	27	43	9	51	25	28	11	64	17	46	15
Aug	25	10	41	18	32	15	45	12	27	25	69	27	40	6		
Sep	34	9	33	12	35	12	50	16	36	20	61	28	55	19		
Oct	35	17	47	12	61	20	38	19	49	14	30	24	38	23		
Nov	30	15	40	15	37	7	42	23	35	11	51	18	53	20		
Dec	44	11	27	13	32	7	30	6	39	10	40	32	11	11		
Jan	33	9	44	18	53	14	38	19	64	19	58	21	62	19		
Feb	24	10	43	19	58	9	61	18	58	23	56	19	32	15		
Mar	49	11	57	16	49	12	57	22	67	18	37	18	38	21		
Total	**457**	**133**	**483**	**185**	**559**	**188**	**557**	**185**	**555**	**252**	**572**	**278**	**560**	**218**	**163**	**61**

DIRECTORATE OF ACUTE SERVICES
Report on Re-Opened Complaints - 07 August 2018

Ref	Record name	Div	Loc (Exact)	Re-Opened	Current Stage	Ack or Holding Letter
Personal Information redacted by the USI		SEC	Urology	10.04.17	Put on hold until Martina Corrigan returns to work.	Tel Call 15.3.18
		MUC	1 North & 1 South	05.10.17	Draft Response fwd to Lynne Hainey (Ligitation) for approval by DLS before releasing to Coroner.(23.7.18) E-Mail form A McV to Ligitation (30.7.18) seeking aprova to release.	29.6.18
		SEC	3 South	13.12.17	Meeting took place 15.5.18. Notes approved. E-Mail reminder re outstanding action to Mr Young & M Corigan.(24.7.18)	N/A
		IMWH		12.2.18	To Esther for Signature (1.8.18)	N/A
		MUC & OPPC	AMU & Ramone WW	13.3.18	Written Response requested by Complainant. Meetings held 19.7.18 & 23.7.18 reresponse. Draft response to be collated	23.7.18
		MUC	1 North	22.3.18	Meeting took place 31.5.18 - notes circulated for approval (18.6.18). E-Mail reminder sent 17.7.18 & 30.7.18 y A McV	N/A
		IMWH	DHH Ward 4	5.4.18	Meeting took place on 8.6.18 . Notes with P McStay for approval (24.7.18)	N/A
		SEC/FSS	3 South	12.4.18	Meeting arranged for 21.6.18 -Meeting cancelled (18.6.18) as Mr Haynes not available. To be rearranged on Mr Haynes return to work	6.6.18
		IMWH	Maternity DHH	12.4.18	To Esther for Signature (1.8.18)	N/A
		MUC/SEC	ED/ENT/Neurology	11.5.18	Pre-Meeting organised for 20 .8.18 and meeting with complainant for 17.9.18. Ronan Carroll to chair.	23.7.18
		SEC	Surgical Assessment Unit	18.5.18	Meeting took place - 5.6.18. Notes drafted and amended with Consultant (9.7.18). Re-Circulated for approval (19.7.18)	N/A
		MUC	1 North	18.5.18	E-Mail to Dr Flannery & K Caroll re outstanding questions x 4 to be answered (26.7.18) & by A McV (30.7.18)	23.7.18
		MUC	DHH -ED & Female Med	21.5.18	Draft Response collated and circulated for approval (20.7.18)	23.7.18
		MUC	ED	28.5.18	With Anne McVey for advice on how to respond re Agency Query (30.7.18)	5.6.18
		SEC	DEAW	28.5.18	Meeting took place 26.6.18 - notes to be drafted	N/A
		SEC	Surgery OPD	1.6.18	Meeting organised for 31.7.18	4.6.18
		SEC	Urology	3.7.18	Meeting being organised by VK. Unable to secure date for October until scheduling is complete for SWAH.	
		SEC	MUC	9.7.18	Awaiting Response from K McGoldrick requested on (11.7.18) ? Required	11.7.18
		SEC	Pain Clinic	9.7.18	To Paul McConaghy, H Murray/EJ Kearney for investigation and response (23.7.18) R Carroll & M McKenna - ? Meeting required - Mr McConaghy to confirm. Case to be discussed at MDT on 1/8/18	23.7.18
		MUC	1 North	19.7.18	To K Carroll for investigation& cc'd Dr McClelland (24.7.18) Response rec'd from Dr McClelland.	23.7.18
		MUC/CCS	Gastro/Radiology	20.7.18	To J Robinson, Dr S Murphy, Dr I Yousif and L Devlin for further investigation and response (23.7.18) VK collating Response	23.7.18
		SEC	General Surgery	23.7.18	Sent to Brigeen Kelly & Wendy Clayton for investigation (24.7.18) Mr Yousef to respond obo Wendy Clayton	24.7.18
		CCS	Antenatal Ultrasound	31.7.18	To VK for advice.	

DIRECTORATE OF ACUTE SERVICES
Current Ombudsman Requests as at 01 August 2018

Trust Ref	NIPSO Ref	Patient	Div	Date Trust Received	Date Acute Received	Date Due Ombudsman	Progress	Head of Service	Handler
[redacted]		Personal Information redacted by the USI	MUC				Action Plan to be agreed. Meeting arranged for 24.08.18.	Louise Devlin	David Cardwell
			MUC				Ongoing	Ruth Donaldson	David Cardwell
			MUC				Recommendations out to A/Ds and HOS for updating 1.5.18	A McVey, R Carroll, M Corrigan & K Carroll	Vivienne Kerr
			MUC	27.06.18	27.06.18	16.07.18	Independent Professional Advice circulated. Awaiting response.	Mary Burke	David Cardwell
			SEC				Ongoing	Brigeen Kelly	David Cardwell
			MUC	25.07.18	25.17.18	08.08.18	Awaiting response from Louise Devlin.	Kay Carroll	David Cardwell
			MUC				Ongoing	Brigeen Kelly	David Cardwell
			MUC	27.06.18	28.06.18	30.07.18	Response to Director for approval 30.07.18.	Mary Burke	David Cardwell
			MUC	02.08.18	02.08.18	21.08.18	Circulated to clinicians for response.	Mary Burke	David Cardwell

DIRECTORATE OF ACUTE SERVICES
Weekly Report on Formal Complaints - 31.07.2018.

Ref	Record name	Div	Loc (Exact)	Date Received	Current Date	Investigation due	Reply due	Working Days Overdue	Current Stage	Handler
Personal Information redacted by USI		SEC	3South	20/03/2018	31/07/2018	05/04/2018	19/04/2018	74	To Ronan Carroll for approval 30.07.18.	DC
		MUC	Diabetic Clinic	24/05/2018	31/07/2018	08/06/2018	22/06/2018	28	To Anne McVey for approval 31/7/18	VK
		IMWH	Delivery Suite	29/05/2018	31/07/2018	12/06/2018	26/06/2018	26	Meeting arranged for Tues 31 July 2018	VK
		SEC	4North	30/05/2018	31/07/2018	13/06/2018	27/06/2018	25	Awaiting response from Dr Vlachogeorgos (Louise Devlin)	DC
		SEC	Pain Management Clinic	05/06/2018	31/07/2018	19/06/2018	03/07/2018	21	Awaiting response from Sinead Corr	DC
		IMWH	Maternity Admissions	06/06/2018	31/07/2018	20/06/2018	04/07/2018	20	Meeting held 23 July - notes and response to be drafted PT	VK
		MUC/SEC	ED / 4 South / Trauma Ward	14/06/2018	31/07/2018	28/06/2018	13/07/2018	13	Awaiting response from Brigeen Kelly (needs input from Mr Bunn, on A/L)	DC
		MUC	ED	15/06/2018	31/07/2018	29/06/2018	16/07/2018	12	To Anne McVey for approval 31.7.18	DC
		MUC/SEC	ED/Trauma Ward	18/06/2018	31/07/2018	02/07/2018	17/07/2018	11	Awaiting response from Brigeen Kelly (with Ronan)	DC
		IMWH	Delivery Suite	26/06/2018	31/07/2018	10/07/2018	25/07/2018	5	Awaiting response from Wendy Clarke (Joan Boyce)	VK
		SEC	3 South	27/06/2018	31/07/2018	11/07/2018	26/07/2018	4	Awaiting response from Caroline Caddell & Gillian Henry (Mr McNaboe / Mr Reddy)	DC
		MUC	ED	28/06/2018	31/07/2018	13/07/2018	27/07/2018	3	To Anne McVey for approval 26/7/18	DC
		IMWH	Antenatal Clinic	02/07/2018	31/07/2018	17/07/2018	31/07/2018	1	Awaiting response from Wendy Clarke & Dr E Bailie	VK
		IMWH	Antenatal Clinic	02/07/2018	31/07/2018	17/07/2018	31/07/2018	1	Awaiting response from Wendy Clarke / Michelle Portis	VK
		IMWH	Maternity Assessment Unit	04/07/2018		19/07/2018	02/08/2018		Awaiting response from Wendy Clarke	DC
		MUC	ED	09/07/2018		24/07/2018	07/08/2018		Awaiting response from Pauline Fearon / Lisa Small	DC
		MUC	Day Clinical Centre	09/07/2018		24/07/2018	07/08/2018		To Anne McVey for approval 2/8/18	DC
		IMWH	Delivery Suite DHH	10/07/2018		25/07/2018	08/08/2018		Awaiting J McGlade and L O'Callaghan	VK
		MUC	1 South	10/07/2018		25/07/2018	08/08/2018		Awaiting Sr Kelly, L Devlin, Dr Mohamed, Dr Beshir	DC
		MUC	ED	10/07/2018		25/07/2018	08/08/2018		Awaiting Dr McGarry, S Holmes, W Clayton, H Murray, M Corrigan and Belfast Trust	DC
		IMWH	AAU / 2 West Post Natal	13/07/2018		27/07/2018	10/08/2018		Awaiting Wendy Clarke, Annie McGeown & Lois McClurg	VK
		IMWH	AAU	13/07/2018		27/07/2018	10/08/2018		Awaiting Wendy Clarke / Lois McClurg	VK
		SEC	4 South	16/07/2018		30/07/2018	13/08/2018		Arranging meeting with the family	VK
		MUC	AMU	17/07/2018		31/07/2018	14/08/2018		Awaiting M Burke, L Cullen and P Smyth	DC
		FSS	Portering	17/07/2018		31/07/2018	14/08/2018		To Esther Gishkori for approval 2/8/18	PT
		SEC	Elective Admissions Ward	18/07/2018		01/08/2018	15/08/2018		Awaiting response from Wendy Clayton / Josephine Matthews	DC
		MUC	Cardiac Cath Lab	18/07/2018		01/08/2018	15/08/2018		Awaiting response from Kay Carroll	DC
		MUC	ED	18/07/2018		01/08/2018	15/08/2018		Response being drafted 2/8/18	DC
		MUC	ED	19/07/2018		02/08/2018	16/08/2018		Awaiting input from Wendy Clarke	DC
		MUC/SEC	Trauma Ward/Patient Flow Team	19/07/2018		02/08/2018	16/08/2018		Awaiting response from Caitriona McGoldrick	DC
		MUC	Cardiology Clinic / 2S Stroke	20/07/2018		03/08/2018	17/08/2018		To Anne McVey for approval 2/8/18	DC
		IMWH	Maternity Department, CAH	23/07/2018		06/08/2018	20/08/2018		Under investigation	VK
		IMWH	Admission/Assessment Unit	24/07/2018		07/08/2018	21/08/2018		Under investigation	VK
		SEC/MUC	DPU / Cardiology OPD	24/07/2018		07/08/2018	21/08/2018		Under investigation	VK
		FSS	Switchboard	25/07/2018		08/08/2018	22/08/2018		To Esther Gishkori for approval 2/8/18	PT
		SEC	Urology	25/07/2018		08/08/2018	22/08/2018		Under investigation	DC
		SEC	Orthopaedic Ward	30/07/2018		13/08/2018	28/08/2018		Under investigation	DC
		MUC	ED	30/07/2018		28/08/2018	28/08/2018		Under investigation	DC
		MUC	ED	30/07/2018		13/08/2018	28/08/2018		Under investigation	DC
		MUC	ED	31/07/2018		14/08/2018	28/08/2018		Under investigation	DC
		MUC	ED	31/07/2018		14/08/2018	28/08/2018		Under investigation	DC
		MUC	ED	31/07/2018		14/08/2018	29/08/2018		Under investigation	DC
		FSS	Locality Support	01/08/2018		15/08/2018	29/08/2018		Under investigation	PT
		CCS	Radiology	01/08/2018		15/08/2018	29/08/2018		Under investigation	DC
		IMWH	2 West	01/08/2018		15/08/2018	29/08/2018		Under investigation	DC
		SEC	Pain Management Clinic	01/08/2018		15/08/2018	29/08/2018		Under investigation	DC
		MUC	ED	02/08/2018		16/08/2018	31/08/2018		Under investigation	DC
		FSS	Booking Centre	02/08/2018		16/08/2018	31/08/2018		Under investigation	PT
		SEC	Urology	03/08/2018		17/08/2018	03/09/2018		Under investigation	VK
		MUC	Level 4 Rehab	03/08/2018		17/08/2018	03/09/2018		Under investigation	VK
		MUC	ED	03/08/2018		17/08/2018	03/09/2018		Under investigation	DC

DIRECTORATE OF ACUTE SERVICES
Incident Position, Awaiting and Being Reviewed - as at 02.08.18

	Awaiting Review	In Review
Functional Support Services	21	44
IMWH - Cancer and Clinical Services	92	415
Medicine and Unscheduled Care	69	230
Pharmacy	36	36
Surgery and Elective Care	31	248
	261	**976**

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Directorate of Acute Services - ATICS
Incident Position, Awaiting and Being Reviewed - as at 02.08.18

	Awaiting Review	In Review
Anaesthetics, Theatres and IC Services	**3**	**133**
Bio-chemistry Lab		1
Day Procedure/Day Surgery Unit	3	27
Emergency Department CAH		1
General Outpatients Reception/Waiting Area		1
Health Records		3
ICU (HDU)		15
Pharmacy Dispensary		1
Pre-operative Assessment Clinic		5
Recovery Unit		4
Scheduling Team		21
Theatre		40
Trauma/Orthopaedic Theatre		13
X-ray Dept (Radiology)		1

Directorate of Acute Services - CCS
Incident Position, Awaiting and Being Reviewed - as at 02.08.18

	Awaiting Review	In Review
Acute Directorate AHP's	**70**	**47**
Paediatric Ward	1	
2 West Maternity Post Natal	1	
AMU	1	
Antenatal Clinic	1	
Breast Screening Unit		2
Delivery Suite, DHH	1	
Emergency Department CAH	5	
General Outpatients Reception/Waiting Are	1	1
Haematology Clinic	7	1
Lurgan HSSC	1	
Oncology Clinic, Mandeville Unit	7	3
Pharmacy Aseptic Unit		1
Urology Clinic		1
Breast Clinic		1
CT Scanner	1	4
Day Hospital		2
ED X-ray		1
EEG Clinic		1
Male Surgical/HDU		1
MRI Unit		2
Oncology Clinic, Mandeville Unit		1
Paediatric Ward		1
Theatre		1
Trauma/Orthopaedic Theatre	1	
X-ray Dept (Radiology)		13
2 East Midwifery Led Unit		1
3 South		1
Antenatal Clinic		1

Bio-chemistry Lab	5	1
Blood Transfusion Lab	1	3
Cellular Pathology Lab	14	1
Delivery Suite, CAH	7	
Delivery Suite, DHH	2	
Early Pregnancy Problem Clinic		1
ED Majors	1	
Emergency Department	1	
Emergency Department CAH	2	
Emergency Department DHH	2	
Haematology Lab	2	1
Laboratory	2	
Microbiology Lab	1	
Neonatal Unit/SCBU	1	
Theatre	1	

Directorate of Acute Services - FSS
Incident Position, Awaiting and Being Reviewed - as at 02.08.18.

	Awaiting Review	In Review
Functional Support Services	**21**	**44**
2 North Respiratory		2
Booking Centre		1
Bronte Ward	1	
Car Park/Grounds		1
Day Hospital	1	
Day Procedure/Day Surgery Unit		1
Emergency Department	1	
Emergency Department CAH	1	
Emergency Department DHH	1	1
Entrance/Exit	2	
Female Medical		2
Female Surgical/Gynae		1
General Outpatients Reception/Waiting Area		1
Kitchen	1	1
Laundry Room	1	
Lift	1	1
Paediatric Ward		1
Patient Support Office		1
Post Room		1
Reception/Waiting Area		2
Rehabilitation Ward		6
Sterile Services Dept	6	1
Stroke / Rehab		4
Switchboard	4	
Theatre	1	9
Trauma Ward		1
Trauma/Orthopaedic Theatre		4
Ward 1, Assessment & Rehabilitation		1

Directorate of Acute Services - IMWH
Incident Position, Awaiting and Being Reviewed - as at 02.08.18.

	Awaiting Review	In Review
Midwifery and Gynaecology	**22**	**365**
1 East Maternity/Gynae	2	14
2 East Midwifery Led Unit		13
2 West Maternity Post Natal	5	75
Antenatal Clinic	1	29
Bio-chemistry Lab		1
Brownlow HSSC, Legahorry Centre	1	
Car Park/Grounds		1
Colposcopy Clinic		2
Day Procedure/Day Surgery Unit		1
Delivery Suite, CAH	4	143
Delivery Suite, DHH	2	35
General Outpatients Reception/Waiting Are	1	3
Gynae Clinic	1	3
Health Records		1
Home of client	4	7
Maternity Admissions/Assessment Unit	1	18
Maternity Ward		14
Public place		1
SAUCS (GPOOH) Kilkeel		1
SAUCS (GPOOH) Newry		1
Staff accommodation		1
Theatre		1

Directorate of Acute Services - MUC
Incident Position, Awaiting and Being Reviewed - as at 02.08.18.

	Awaiting Review	In Review
Medicine and Unscheduled Care	**69**	**230**
1 East Maternity/Gynae	1	
1 North Cardiology		24
1 South Medical		1
1 West Gynae	1	
2 North Medical	1	
2 North Respiratory		1
2 West Maternity Post Natal	1	
3 South		2
4 North	1	
Air (Respiratory) Lab	1	
AMU	5	17
B Floor	1	
Banbridge HSSC	1	
Bio-chemistry Lab		1
Canteen/Dining Room		1
Car Park/Grounds	2	1
Cardiac Catheterisation Lab		1
Cardiology Research		1
Collegelands Nursing Home		1
Coronary Care Ward		2
Corridor/Stairs	2	1
Daisy Day Clinical Centre		3
Day Hospital		1
Day Procedure/Day Surgery Unit		4
Dermatology Clinic	1	2
Dermatology Ward		1
Discharge Lounge	1	
ED Majors		1

Emergency Dental Clinic	1	
Emergency Department	5	10
Emergency Department CAH	11	58
Emergency Department DHH		13
Entrance/Exit	5	3
Female Medical		11
General Male Medical,		3
General Medicine Clinic	2	2
General Outpatients Reception/Waiting Are	1	1
General OutpatientsTreatment Room	2	
Haematology		4
Haematology Clinic	1	
Home of client	3	3
ICU (HDU)		1
Lift	1	1
Male Surgical/HDU		1
Maternity Admissions/Assessment Unit		3
MEC	1	
Minor Injuries Unit	3	6
MRI Unit		2
Non Trust GP premises	1	
Non Trust premises	2	
Paediatric Ward		1
Patient Flow Team	2	11
Patient Support Office		1
Pharmacy Dispensary		1
Public Toilets		1
Ramone Day Clinical Centre	1	
Reception/Waiting Area	2	1
Recovery Unit		1
Rehabilitation Ward		1
Renal Unit		1
Rheumatology Clinic	2	

Stroke / Rehab	2	18
Theatre		2
Ward 1, Stroke		2
Ward 2, Assessment & Rehabilitation	2	
X-ray Dept (Radiology)		1

Directorate of Acute Services - Pharmacy
Incident Position, Awaiting and Being Reviewed - as at 02.08.18

	Awaiting Review	In Review
Pharmacy	**36**	**36**
Anticoagulant Clinic		1
Day Procedure/Day Surgery Unit		1
Emergency Department CAH		1
Female Surgical/Gynae		1
Haematology Clinic		1
Non Trust premises	1	2
Pharmacy Aseptic Unit	30	1
Pharmacy Dispensary	4	22
Pharmacy Stores / Distribution		4
Silverwood Ward	1	
Trauma/Orthopaedic Theatre		1
Ward 2, Assessment & Rehabilitation		1

Directorate of Acute Services - SEC
Incident Position, Awaiting and Being Reviewed - as at 02.08.18.

	Awaiting Review	In Review
General Surgery	**28**	**114**
1 East Maternity/Gynae	5	1
1 West Gynae		3
3 South		18
4 North	3	11
4 South		3
CEAW	1	
Day Procedure/Day Surgery Unit		8
Emergency Department CAH	1	2
Emergency Department DHH		1
Female Surgical/Gynae	1	3
General OutpatientsTreatment Room		1
General Surgery Clinic		1
Male Surgical/HDU		10
Microbiology Lab		1
Oncology Clinic, Mandeville Unit		1
Orthopaedic Ward		2
Paediatric Ward		1
Physiotherapy Outpatients Department		1
Pre-operative Assessment Clinic	1	
Reception/Waiting Area		1
Surgical Assement Unit		1
Theatre	6	6
Trauma Ward		4
Trauma/Orthopaedic Theatre		7
Fracture Clinic		1
General Surgery Clinic	2	
1 East Maternity/Gynae	1	
Day Procedure/Day Surgery Unit	4	16
Orthopaedic Ward		1
Pre-operative Assessment Clinic	1	
Scheduling Team	1	3
Theatre		2
Tower Block	1	
Trauma/Orthopaedic Theatre		4

Directorate of Acute Services - Staffing Incidents July 2018

ID	Incident date	Time	Site	Division	Loc (Exact)	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	01/07/2018	1600	South Tyrone Hospital	MUC	Minor Injuries Unit	Moderate	Personal Information redacted by the USI			Being reviewed	
	01/07/2018	0800	Craigavon Area Hospital	MUC	Emergency Department CAH	Minor			as above	Approved	10/07/2018
	02/07/2018	2100	South Tyrone Hospital	MUC	Minor Injuries Unit	Moderate				Being reviewed	
	06/07/2018	2055	South Tyrone Hospital	MUC	Minor Injuries Unit	Moderate				Being reviewed	
	07/07/2018	1750	South Tyrone Hospital	MUC	Minor Injuries Unit	Moderate				Being reviewed	
	07/07/2018	2000	Daisy Hill Hospital	MUC	Stroke / Rehab	Minor			.	Being reviewed	
	09/07/2018	2055	South Tyrone Hospital	MUC	Minor Injuries Unit	Moderate			too many patients attending Unit	Being reviewed	
	09/07/2018	2030	Craigavon Area Hospital	SEC	3 South	Minor				Being reviewed	

ID	Incident date	Time	Site	Division	Loc (Exact)	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	22/07/2018	1800	South Tyrone Hospital	MUC	Minor Injuries Unit	Minor	Personal Information redacted by the USI			Being reviewed	
	24/07/2018	2000	Craigavon Area Hospital	MUC	1 North Cardiology	Insignificant				Being reviewed	
	24/07/2018	2000	Craigavon Area Hospital	MUC	1 North Cardiology	Insignificant				Being reviewed	
	24/07/2018	1900	Craigavon Area Hospital	MUC	1 North Cardiology	Insignificant			none	Approved	01/08/2018
	25/07/2018	2200	Craigavon Area Hospital	MUC	1 North Cardiology	Insignificant				Being reviewed	

ID	Incident date	Time	Site	Division	Loc (Exact)	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	29/07/2018	1415	Craigavon Area Hospital	SEC	Theatre	Minor	Personal Information redacted by the USI			Being reviewed	
	30/07/2018	1730	Craigavon Area Hospital	MUC	1 South Medical	Minor			prioritise care	Approved	01/08/2018

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Staffing Incidents by Loc (Exact) and Incident date grouped by Site

	2017 03	2017 04	2017 05	2017 06	2017 07	2017 08	2017 09	2017 10	2017 11	2017 12	2018 01	2018 02	2018 03	2108 04	2108 05	2108 06	2108 07	Total
Craigavon Area Hospital	**12**	**6**	**7**	**2**	**5**	**6**	**8**	**11**	**4**	**5**	**13**	**4**	**11**	**3**	**5**	**3**	**8**	**177**
1 North Cardiology	2	1	2	0	4	0	3	2	0	0	4	0	0	0	0	0	4	**26**
1 South Medical	0	0	0	0	0	0	1	0	1	0	1	0	0	0	3	0	1	**9**
CEAW	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**7**
1 West Gynae	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
2 North Respiratory	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	**10**
2 North Medical	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
2 South Medical	2	0	0	0	1	0	1	0	1	0	1	0	0	0	0	0	0	**11**
2 South Stroke	0	0	0	0	0	2	0	1	0	0	1	0	0	0	0	0	0	**6**
2 West Maternity Post Natal	1	1	2	0	0	0	1	0	0	0	0	0	1	0	1	0	0	**23**
3 South	1	4	1	0	0	1	1	0	2	1	0	3	0	0	0	0	1	**20**
4 North	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**
4 South	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**2**
Emergency Department	3	0	0	0	0	1	0	4	0	2	0	0	1	0	0	0	1	**13**
Antenatal Clinic	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Breast Clinic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Delivery Suite, CAH	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	**11**
MAU	0	0	2	1	0	0	1	0	0	0	4	1	0	0	0	2	0	**15**
Patient Flow Team	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Ramone Ward	2	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	**6**
Theatre	0	0	0	0	0	2	0	1	0	1	1	0	4	1	1	0	0	**14**
X-ray Dept (Radiology)	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	1	**4**
Daisy Hill Hospital	**2**	**3**	**2**	**4**	**7**	**2**	**4**	**1**	**2**	**1**	**26**	**0**	**1**	**2**	**9**	**1**	**28**	**97**
Emergency Department	0	1	0	0	1	2	1	0	0	0	0	0	0	0	0	0	0	**5**
ED Majors	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	**10**
Coronary Care Ward, Level 5	1	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0	0	**6**
DEAW	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Delivery Suite, DHH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**2**
Female Medical, Level 5	1	0	0	1	3	0	1	0	0	1	0	0	1	0	0	0	0	**15**
Female Surgical/Gynae	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
General Male Medical, Level 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**5**
Gynae Clinic	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	**2**
Maternity Ward	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**11**
Male Surgical/HDU	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**10**
Patient Flow Team	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Rehabilitation, Level 4	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Renal Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Stroke / Rehab	0	1	1	0	0	0	1	0	0	0	0	0	0	0	2	0	1	**17**
Theatre	0	0	1	0	1	0	0	0	1	0	0	0	0	0	0	0	0	**4**
South Tyrone Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	**6**
Minor Injuries Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	**6**
Totals:	14	9	9	6	12	8	12	12	6	6	26	4	12	5	14	4	14	**280**

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Information redacted by the USI	01/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Ramone Day Clinical Centre	Personal Information redacted by the USI	Nitrofurantoin		Personal Information redacted by the USI	Medication error during the prescription process	Undocumented/ unclear/ incorrect allergy status or known allergen prescribed	Minor	insignificant	catastrophic	possible	extreme
	08/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology		Ketamine	Ketamine		Administration or supply of a medicine from a clinical area	Wrong method of preparation or supply	Insignificant	insignificant	major	possible	high
	09/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Daisy Hill Hospital	Maternity Ward		Enoxaparin	Enoxaparin		Administration or supply of a medicine from a clinical area	Unknown	Minor	insignificant	major	possible	high
	21/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae		Amlodipine			Medication error during the prescription process	Undocumented/ unclear/ incorrect allergy status or known allergen prescribed	Minor	minor	major	possible	high
	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	AMU		enoxaparin			Medication error during the prescription process	Dose or strength was wrong or unclear		insignificant	major	unlikely	high
	25/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	General Outpatients Reception /Waiting Area		Warfain			Advice	Verbal direction to patient was wrong or omitted	Minor	minor	moderate	possible	high

Personal Information redacted by the USI						Personal Information redacted by the USI			Personal Information redacted by the USI							
28/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Protamine Sulphate			Administration or supply of a medicine from a clinical area	Dose or strength was wrong or unclear	Moderate	moderate	major	possible	high
29/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	1 East Maternity /Gynae		Metronidazole	Warfain		Medication error during the prescription process	Contra-indication to the use of the medication		moderate	major	possible	high
06/06/2018	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Aseptic Unit		Imatinib	Gefitinab		Preparation of medicines / dispensing in pharmacy	Wrong/ unclear drug/medicine		insignificant	moderate	possible	medium
07/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical		Metformin			Administration or supply of a medicine from a clinical area	Omitted/ delayed medicine or dose	Minor	insignificant	moderate	possible	medium
13/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Aztreonam	Aztreonam		Administration or supply of a medicine from a clinical area	Omitted/ delayed medicine or dose	Minor	minor	moderate	possible	medium
18/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South		Paracetamol	Paracetamol		Administration or supply of a medicine from a clinical area	Wrong/ unclear frequency	Minor	minor	moderate	possible	medium

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Personal Information redacted by the USI						Personal Information redacted by the USI			Personal Information redacted by the USI							
	18/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward		Co-Beneldopa	Co-Beneldopa		Administration or supply of a medicine from a clinical area	Formulation of medication was wrong	Minor	minor	moderate	possible	medium
	13/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	General Male Medical,					Medication error during the prescription process	Mismatch between patient and medicine	Moderate	insignificant	moderate	possible	medium

Personal Information redacted by the USI						Personal Information redacted by the USI										
	22/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Day Procedure /Day Surgery Unit		Macrogols			Administration or supply of a medicine from a clinical area	Omitted/ delayed medicine or dose		minor	moderate	possible	medium
	24/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Flucloxacillin			Administration or supply of a medicine from a clinical area	Omitted/ delayed medicine or dose	Insignificant	insignificant	moderate	possible	medium
	23/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward		Rasagiline	Rasagiline		Administration or supply of a medicine from a clinical area	Omitted/ delayed medicine or dose	Minor	minor	moderate	possible	medium
	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	AMU		Tazocin	tazocin		Medication error during the prescription process	Dose or strength was wrong or unclear	Minor	minor	moderate	possible	medium
	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical		Gliclazide	Gliclazide		Administration or supply of a medicine from a clinical area	Omitted/ delayed medicine or dose	Minor	minor	moderate	possible	medium
	27/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical		Furosemide	Furosemide		Administration or supply of a medicine from a clinical area	Formulation of medication was wrong	Minor	minor	moderate	possible	medium

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	29/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	2 West Maternity Post Natal					Monitoring or follow up of medicine use	Delay or failure to monitor	Minor	minor	moderate	possible	medium
	30/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical		Insulins	Insulin		Medication error during the prescription process	Omitted/ delayed medicine or dose	Minor	minor	moderate	possible	medium
	29/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	General Male Medical,					Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Minor	insignificant	moderate	possible	medium
	01/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 North Medical					Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Minor	insignificant	minor	possible	low

Personal Information redacted by the USI						Personal Information redacted by the USI		Personal Information redacted by the USI						
	04/06/2018	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Stores / Distribution		Sodium Valproate	Sodium Valproate	Preparation of medicines / dispensing in pharmacy	Formulation of medication was wrong	Minor	insignificant	insignificant	possible	low
	05/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Paracetamol	Paracetamol	Administration or supply of a medicine from a clinical area	Dose or strength was wrong or unclear	Minor	insignificant	minor	possible	low
	07/06/2018	Acute Services	Surgery and Elective Care	South Tyrone Hospital	Pre-operative Assessment Clinic		apixaban	rivaroxaban	Advice	Patient information leaflet wrong or omitted	Minor	insignificant	insignificant	possible	low
	14/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	ICU (HDU)		Quetiapine		Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Moderate	minor	minor	possible	low
	14/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	ICU (HDU)		Paracetamol	Paracetamol	Administration or supply of a medicine from a clinical area	Wrong route for administration of medication	Minor	insignificant	insignificant	possible	low
	17/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	4 North		Leuprorelin		Administration or supply of a medicine from a clinical area	Omitted/ delayed medicine or dose	Minor	insignificant	minor	possible	low
	16/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Daisy Hill Hospital	Maternity Ward				Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Insignificant	insignificant	minor	possible	low

Personal Information redacted by the USI						Personal Information redacted by the USI		Personal Information redacted by the USI						
	18/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward		Atenolol	Atenolol		reparation of medicines dispensin in pharmacy	Omitted/ delayed medicine or dose	Insignificant	insignificant	minor	possible	low
	19/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Recovery Unit		Hyoscine Butylbromide			Administration or upply of medicine rom a linical rea	Wrong/ unclear frequency	Insignificant	insignificant	insignificant	possible	low
	15/06/2018	Acute Services	Surgery and Elective Care	South Tyrone Hospital	Pre-operative Assessment Clinic		Picolax			Administration or upply of medicine rom a linical rea	Unknown		minor	minor	possible	low
	19/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	AMU					Administration or upply of medicine rom a linical rea	Medication incorrectly stored		insignificant	minor	possible	low

Personal Information redacted by the USI						Personal Information redacted by the USI			Personal Information redacted by the USI							
	19/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Emergency Department CAH		odium hloride	Sodium Chloride		Administration or supply of a medicine from a clinical area	Wrong route for administration of medication	Insignificant	insignificant	insignificant	possible	low
	18/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 South Medical		orazepa	Lorazepam		Preparation of medicines / dispensing in pharmacy	Omitted medicine or ingredient	Minor	insignificant	minor	possible	low
	19/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	2 West Maternity Post Natal		mr accine			Medication error during the prescription process	Wrong/ unclear drug/medicine	Insignificant	insignificant	minor	possible	low
	24/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		rednisolone			Administration or supply of a medicine from a clinical area	Unknown		insignificant	minor	possible	low

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Personal Information redacted by the USI						Personal Information redacted by the USI		Personal Information redacted by the USI						
	26/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 North Respiratory		anakinra		Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Moderate	insignificant	minor	possible	low
	28/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Male Surgical/HDU		Potassium Chloride And Sodium Chloride	Potassium Chloride And Sodium Chloride	Inadequate maintenance of fluids	Delay or failure to monitor	Insignificant	minor	minor	possible	low
	27/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae		Venlafaxine	Venlafaxine XL	Administration or supply of a medicine from a clinical area	Wrong/ unclear drug/medicine	Insignificant	insignificant	minor	possible	low
	28/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae		Venlafaxine	Venlafaxine XL	Medication error during the prescription process	Wrong/ unclear drug/medicine	Insignificant	insignificant	insignificant	possible	low
	29/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward		Fentanyl		Administration or supply of a medicine from a clinical area	Unknown	Insignificant	insignificant	minor	possible	low
	19/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	4 South				Medication error during the prescription process			insignificant	insignificant	possible	low

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Personal Information redacted by the USI																
	04/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Discharge Lounge	Personal Information redacted by the USI	Fentanyl		Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Minor	Controlled Drugs			
	02/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ICU (HDU)		Clozapine	Clozapine		Possible delay or failure to Monitor	Delay or failure to monitor	Catastrophic	duplicate of Personal information			
	14/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	ICU (HDU)		Quetiapine	None		Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Moderate	duplicate of Personal information			

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Personal Information redacted by the USI								Personal Information redacted by the USI							
	14/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Midazolam			Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Minor	Controlled Drugs			
	22/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	Oncology Clinic, Mandeville Unit		Cyclophosphamide			Preparation of medicines / dispensing in pharmacy	Wrong method of preparation or supply		substandard product			
	22/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	2 West Maternity Post Natal		Co-Amoxiclav			Patient's reaction to Medication	Adverse reaction when drug used as intended		adverse drug reaction			
	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical		apixaban			Medication error during the prescription process	Dose or strength was wrong or unclear	Minor	GP incident			
	28/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae		Venlafaxine	Venlafaxine		Administration or supply of a medicine from a clinical area	Wrong/ unclear drug/medicine	Minor	duplicate of 84867			

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Information redacted by the USI	01/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Ramone Day Clinical Centre	Personal Information redacted by the USI	Nitrofurantoin		Personal Information redacted by the USI	Medication error during the prescription process	Undocumented/ unclear/ incorrect allergy status or known allergen prescribed	Minor	insignificant	catastrophic	possible	extreme
	08/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 North Cardiology		Ketamine	Ketamine		Administration or supply of a medicine from a clinical area	Wrong method of preparation or supply	Insignificant	insignificant	major	possible	high
	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	AMU		enoxaparin			Medication error during the prescription process	Dose or strength was wrong or unclear		insignificant	major	unlikely	high

Personal Information redacted by the USI	28/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH	Personal Information redacted by the USI	Protamine Sulphate		Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Dose or strength was wrong or unclear	Moderate	moderate	major	possible	high
	07/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical		Metformin			Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	moderate	possible	medium
	13/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Aztreonam	Aztreonam		Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	minor	moderate	possible	medium

Personal Information redacted by the USI	13/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	General Male Medical,	Personal Information redacted by the USI			Personal Information redacted by the USI	Medication error during the prescription process	Mismatch between patient and medicine	Moderate	insignificant	moderate	possible	medium
	24/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Flucloxacillin			Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Insignificant	insignificant	moderate	possible	medium
	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	AMU		Tazocin	tazocin		Medication error during the prescription process	Dose or strength was wrong or unclear	Minor	minor	moderate	possible	medium

Personal Information redacted by the USI	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical	Personal Information redacted by the USI	Gliclazide	Gliclazide	Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	minor	moderate	possible	medium
	27/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical		Furosemide	Furosemide		Administration or supply of a medicine from a clinical area	Formulation of medication was wrong	Minor	minor	moderate	possible	medium
	30/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	Female Medical		Insulins	Insulin		Medication error during the prescription process	Omitted/delayed medicine or dose	Minor	minor	moderate	possible	medium
	29/06/2018	Acute Services	Medicine and Unscheduled Care	Daisy Hill Hospital	General Male Medical,					Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Minor	insignificant	moderate	possible	medium

Personal Information redacted by the USI	01/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 North Medical	Personal Information redacted by the USI			Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Minor	insignificant	minor	possible	low
	05/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Paracetamol	Paracetamol		Administration or supply of a medicine from a clinical area	Dose or strength was wrong or unclear	Minor	insignificant	minor	possible	low
	19/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	AMU					Administration or supply of a medicine from a clinical area	Medication incorrectly stored		insignificant	minor	possible	low

Personal Information redacted by the USI	18/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 South Medical	Personal Information redacted by the USI	Lorazepam	Lorazepam	Personal Information redacted by the USI	Preparation of medicines / dispensing in pharmacy	Omitted medicine or ingredient	Minor	insignificant	minor	possible	low
	24/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Prednisolone			Administration or supply of a medicine from a clinical area	Unknown		insignificant	minor	possible	low

Personal Information redacted by the USI	26/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	2 North Respiratory	Personal Information redacted by the USI	anakinra		Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Moderate	insignificant	minor	possible	low
	04/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Discharge Lounge		Fentanyl			Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Minor	Controlled Drugs			

Personal Information redacted by the USI	02/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	ICU (HDU)	Personal Information redacted by the USI	Clozapine	Clozapine	Personal Information redacted by the USI	Possible delay or failure to Monitor	Delay or failure to monitor	Catastrophic	duplicate of Personal Informatio				
	14/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	Emergency Department CAH		Midazolam			Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Minor	Controlled Drugs				

Personal Information redacted by the USI	25/06/2018	Acute Services	Medicine and Unscheduled Care	Craigavon Area Hospital	1 South Medical	Personal Information redacted by the USI	apixaban		Personal Information redacted by the USI	Medication error during the prescription process	Dose or strength was wrong or unclear	Minor	GP incident				

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Information redacted by the USI	21/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae	Personal Information redacted by the USI	Amlodipine		Personal Information redacted by the USI	Medication error during the prescription process	Undocumented/ unclear/ incorrect allergy status or known allergen prescribed	Minor	minor	major	possible	high
	25/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	General Outpatients Reception /Waiting Area		Warfain			Advice	Verbal direction to patient was wrong or omitted	Minor	minor	moderate	possible	high
	18/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	3 South		Paracetamol	Paracetamol		Administration or supply of a medicine from a clinical area	Wrong/ unclear frequency	Minor	minor	moderate	possible	medium

Personal Information redacted by the USI	18/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	Personal Information redacted by the USI	Co-Beneldopa	Co-Beneldopa	Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Formulation of medication was wrong	Minor	minor	moderate	possible	medium
	22/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Day Procedure /Day Surgery Unit		Macrogols			Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose		minor	moderate	possible	medium

Personal Information redacted by the USI	23/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	Personal Information redacted by the USI	Rasagiline	Rasagiline	Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	minor	moderate	possible	medium
	07/06/2018	Acute Services	Surgery and Elective Care	South Tyrone Hospital	Pre-operative Assessment Clinic		apixaban	rivaroxaban		Advice	Patient information leaflet wrong or omitted	Minor	insignificant	insignificant	possible	low
	14/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	ICU (HDU)		Quetiapine			Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Moderate	minor	minor	possible	low
	14/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	ICU (HDU)		Paracetamol	Paracetamol		Administration or supply of a medicine from a clinical area	Wrong route for administration of medication	Minor	insignificant	insignificant	possible	low
	17/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	4 North		Leuprorelin			Administration or supply of a medicine from a clinical area	Omitted/delayed medicine or dose	Minor	insignificant	minor	possible	low

Personal Information redacted by the USI	18/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward	Personal Information redacted by the USI	Atenolol	Atenolol	Personal Information redacted by the USI	Preparation of medicines / dispensing in pharmacy	Omitted/delayed medicine or dose	Insignificant	insignificant	minor	possible	low
	19/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Recovery Unit		Hyoscine Butylbromide			Administration or supply of a medicine from a clinical area	Wrong/ unclear frequency	Insignificant	insignificant	insignificant	possible	low

Personal Information redacted by the USI	15/06/2018	Acute Services	Surgery and Elective Care	South Tyrone Hospital	Pre-operative Assessment Clinic	Personal Information redacted by the USI	Picolax		Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Unknown		minor	minor	possible	low
	19/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Emergency Department CAH		Sodium Chloride	Sodium Chloride		Administration or supply of a medicine from a clinical area	Wrong route for administration of medication	Insignificant	insignificant	insignificant	possible	low

Personal Information redacted by the USI	28/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Male Surgical/HDU	Personal Information redacted by the USI	Potassium Chloride And Sodium Chloride	Potassium Chloride And Sodium Chloride	Personal Information redacted by the USI	Inadequate maintenance of fluids	Delay or failure to monitor	Insignificant	minor	minor	possible	low
	27/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae		Venlafaxine	Venlafaxine XL		Administration or supply of a medicine from a clinical area	Wrong/ unclear drug/medicine	Insignificant	insignificant	minor	possible	low
	28/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae		Venlafaxine	Venlafaxine XL		Medication error during the prescription process	Wrong/ unclear drug/medicine	Insignificant	insignificant	insignificant	possible	low
	29/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	Trauma Ward		Fentanyl			Administration or supply of a medicine from a clinical area	Unknown	Insignificant	insignificant	minor	possible	low

Personal Information redacted by the USI	19/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	4 South	Personal Information redacted by the USI			LPP Information redacted by the USI	Medication error during the prescription process			insignificant	insignificant	possible	low
	14/06/2018	Acute Services	Surgery and Elective Care	Craigavon Area Hospital	ICU (HDU)		Quetiapine	None		Administration or supply of a medicine from a clinical area	Mismatch between patient and medicine	Moderate	duplicate of Personal informatio			
	28/06/2018	Acute Services	Surgery and Elective Care	Daisy Hill Hospital	Female Surgical/Gynae		Venlafaxine	Venlafaxine		Administration or supply of a medicine from a clinical area	Wrong/ unclear drug/medicine	Minor	duplicate of Personal informatio			

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Information redacted by the USI	09/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Daisy Hill Hospital	Maternity Ward	Personal Information redacted by the USI	Enoxaparin	Enoxaparin	Personal Information redacted by the USI	Administration or supply of a medicine from a clinical area	Unknown	Minor	insignificant	major	possible	high
	29/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	1 East Maternity /Gynae		Metronidazole	Warfain		Medication error during the prescription process	Contra-indication to the use of the medication		moderate	major	possible	high
	29/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	2 West Maternity Post Natal					Monitoring or follow up of medicine use	Delay or failure to monitor	Minor	minor	moderate	possible	medium
	16/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Daisy Hill Hospital	Maternity Ward					Administration or supply of a medicine from a clinical area	Medication incorrectly stored	Insignificant	insignificant	minor	possible	low

Personal Information redacted by the USI	19/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	2 West Maternity Post Natal	Personal Information redacted by the USI	Mmr Vaccine		Personal Information redacted by the USI	Medication error during the prescription process	Wrong/ unclear drug/medicine	Insignificant	insignificant	minor	possible	low
	22/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	Oncology Clinic, Mandeville Unit		Cyclophosphamide			Preparation of medicines / dispensing in pharmacy	Wrong method of preparation or supply		substandard product			
	22/06/2018	Acute Services	IMWH - Cancer and Clinical Services	Craigavon Area Hospital	2 West Maternity Post Natal		Co-Amoxiclav			Patient's reaction to Medication	Adverse reaction when drug used as intended		adverse drug reaction			

Medication incidents

ID	Incident date	Directorate	Division	Site	Loc (Exact)	Description	Drug administered	Correct drug	Action taken	Sub Category	Detail.	Consequence	DHSSPS impact	DHSSPS potential	DHSSPS likelihood	DHSSPS risk rating
Personal Information redacted by the USI	06/06/2018	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Aseptic Unit	Personal Information redacted by the USI	Imatinib	Gefitinab	Personal Information redacted by the USI	Preparation of medicines / dispensing in pharmacy	Wrong/ unclear drug/medicine		insignificant	moderate	possible	medium
	04/06/2018	Acute Services	Pharmacy	Craigavon Area Hospital	Pharmacy Stores / Distribution		Sodium Valproate	Sodium Valproate		Preparation of medicines / dispensing in pharmacy	Formulation of medication was wrong	Minor	insignificant	insignificant	possible	low

ID	Incident date	Reporter	Div	Site	Loc (Exact)	Sev	Description	Action taken (Investigation)	Handler	Approval status
Personal Information redacted by the USI	05/07/2018	Personal Information redacted by the USI	SEC	Craigavon Area Hospital	X-ray Dept (Radiology)	Major	Personal Information redacted by the USI		Sr Joan Morton	INREV
	06/07/2018		MUC	Craigavon Area Hospital	Emergency Department CAH	Major			Sharon Holmes	FA
	07/07/2018		MUC	Craigavon Area Hospital	AMU	Major			Sr Stacey Leonard	INREV
	08/07/2018		MUC	Craigavon Area Hospital	Emergency Department CAH	Major			Paul Owen McGarry	INREV

ID	Incident date	Reporter	Div	Site	Loc (Exact)	Sev	Description	Action taken (Investigation)	Handler	Approval status
Personal Information redacted by the USI	08/07/2018	Personal Information redacted by the USI	SEC	Craigavon Area Hospital	Emergency Department CAH	Major	Personal Information redacted by the USI		Laure Martin	INREV
	08/07/2018		MUC	Craigavon Area Hospital	Emergency Department CAH	Major				AWAREV
	13/07/2018		PHARM	Craigavon Area Hospital	Pharmacy Aseptic Unit	Major				AWAREV
	14/07/2018		CCS	Craigavon Area Hospital	Delivery Suite, CAH	Major			Donna King	INREV
	15/07/2018		MUC	Craigavon Area Hospital	AMU	Major			Paul Smyth	FA
	20/07/2018		SEC	Craigavon Area Hospital	Tower Block	Major				AWAREV
	20/07/2018		MUC	Daisy Hill Hospital	General Male Medical,	Major			Siobhan Rooney	INREV
	24/07/2018		MUC	Daisy Hill Hospital	Emergency Department	Major			Paul Smyth	INREV

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ID	Incident date	Reporter	Div	Site	Loc (Exact)	Sev	Description	Action taken (Investigation)	Handler	Approval status
Personal Information redacted by the USI	28/07/2018	Personal Information redacted by the USI	SEC	Craigavon Area Hospital	Trauma Ward	Major	Personal Information redacted by the USI		Sr Rachel Wilson	INREV
	29/07/2018		MUC	Daisy Hill Hospital	Emergency Department	Major			Lynda Magowan	INREV

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Patient Falls by Month (April 2016 - July 2018)

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 02	2017 03	2017 04	2017 05	2017 06	2017 07	2017 08	2017 09	2017 10	2017 11	2017 12	2018 01	2018 02	2018 03	2018 04	2018 05	2018 06	2018 07
Fall from a Height, Bed or Chair	42	26	23	39	27	28	33	34	36	47	38	48	39	34	39	21	24	18	23	19	17	28	28	18	25	30	32	26
Fall on Level Ground	29	33	27	18	27	31	21	26	43	27	30	20	27	34	35	20	24	24	26	25	27	27	25	31	19	21	26	20
Suspected Fall	14	18	33	19	16	5	16	20	23	14	23	9	12	8	13	9	4	6	14	17	16	15	14	12	16	18	14	24

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Incidents by Incident date (Month and Year)

Fall from a Height, Be	on Level Gr	uspected Fa	Total
2016 04	42	29	14	85
2016 05	26	33	18	77
2016 06	23	27	33	83
2016 07	39	18	19	76
2016 08	27	27	16	70
2016 09	28	31	5	64
2016 10	33	21	16	70
2016 11	34	26	20	80
2016 12	36	43	23	102
2017 01	47	27	14	88
2017 02	38	30	23	91
2017 03	48	20	9	77
2017 04	39	27	12	78
2017 05	34	34	8	76
2017 06	39	35	13	87
2017 07	21	20	9	50
2017 08	24	24	4	52
2017 09	18	24	6	48
2017 10	23	26	14	63
2017 11	19	25	17	61
2017 12	17	27	16	61
2018 01	28	27	15	70
2018 02	28	25	14	67
2018 03	18	31	12	61
2018 04	25	19	16	60
2018 05	30	21	18	69
2018 06	32	26	14	72
2018 07	26	20	24	70

Acute Services - Patient Falls Incidents - July 2018

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	01/07/2018	0110	Craigavon Area Hospital	SEC	Trauma Ward	Suspected fall	Insignificant	Personal Information redacted by the USI		Staff to be vigilant in leaving confused patients on the bedpan at any time. Ensure safety whilst patient is unattended for any reason	Approved	03/07/2018
	02/07/2018	0555	Craigavon Area Hospital	MUC	AMU	Fall from a height, bed or chair	Minor				Being reviewed	
	03/07/2018	1330	Craigavon Area Hospital	MUC	1 South Medical	Fall from a height, bed or chair	Minor			To be more aware of patient that are in siderooms that may or may not have a history of falls.	Approved	10/07/2018
	03/07/2018	1830	Daisy Hill Hospital	MUC	Stroke / Rehab	Fall on level ground	Insignificant			.	Being reviewed	
	03/07/2018	1315	Craigavon Area Hospital	SEC	4 North	Fall from a height, bed or chair	Minor			As above.	Approved	06/07/2018
	04/07/2018	0545	Daisy Hill Hospital	MUC	General Male Medical,	Fall on level ground	Insignificant			nONE	Approved	09/07/2018
	04/07/2018	0430	Craigavon Area Hospital	SEC	Trauma Ward	Fall from a height, bed or chair	Minor			Patients to be closely monitored if possible due to risk of falls. Falls prevention pathway was not completed following the fall so nurse involved to be reminded of the post falls procedure to ensure that all is completed.	Approved	10/07/2018
	04/07/2018	2040	Daisy Hill Hospital	SEC	Male Surgical/HDU	Fall on level ground	Minor				Being reviewed	
	05/07/2018	0410	Daisy Hill Hospital	MUC	Emergency Department DHH	Fall from a height, bed or chair	Minor			to be shared a safety briefing	Being reviewed	
	05/07/2018	1720	Craigavon Area Hospital	MUC	1 North Cardiology	Fall from a height, bed or chair	Insignificant			Nurse patient in open bay where possible. Although he was in a sideroom for IPC not coded as unwitnessed fall same changed by HOs escallted to ward sr to ensure staff grade falls accurately	Approved	23/07/2018
	06/07/2018	0400	Craigavon Area Hospital	MUC	1 North Cardiology	Fall from a height, bed or chair	Minor			try to nurse patient who are potentially a falls risk when they come into hospital in an open bay which can be clearly observed Not graded as un witnessed fall	Approved	09/07/2018
	06/07/2018	2020	Daisy Hill Hospital	MUC	Stroke / Rehab	Suspected fall	Minor			.	Being reviewed	
	07/07/2018	0550	Craigavon Area Hospital	MUC	AMU	Fall on level ground	Major				Being reviewed	
	08/07/2018	1230	Craigavon Area Hospital	SEC	Orthopaedic Ward	Fall on level ground	Insignificant			NA	Approved	10/07/2018
	08/07/2018	1620	Daisy Hill Hospital	MUC	Stroke / Rehab	Fall from a height, bed or chair	Minor			none	Being reviewed	
	08/07/2018	1520	Craigavon Area Hospital	MUC	AMU	Fall from a height, bed or chair	Minor			patient is on 1:1 supervision due to absconding risk and aggression/agitation. medication reviewed.	Approved	13/07/2018
	09/07/2018	0600	Craigavon Area Hospital	MUC	Haematology	Fall on level ground	Insignificant			not graded as unwitnessed fall same changed by HOs and communication sent to Ward Sr to highlight to staff all unwitnessed falls must be coded unwitnsssed and to check sinfo when reviewing datix	Approved	23/07/2018

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	09/07/2018	1530	Craigavon Area Hospital	SEC	4 South	Suspected fall	Minor	Personal Information redacted by the USI		as above	Approved	18/07/2018
	10/07/2018	1825	Daisy Hill Hospital	SEC	Female Surgical/Gynae	Fall on level ground	Minor			.	Approved	13/07/2018
	11/07/2018	2130	Craigavon Area Hospital	SEC	Trauma Ward	Suspected fall	Minor			staff were well aware of this patients risk of falls and I think that every care was taken to try and prevent further falls, however if the special shift is not filled, staff cannot prevent falls.	Approved	17/07/2018
	12/07/2018	2240	Craigavon Area Hospital	SEC	CEAW	Suspected fall	Minor			Post falls GCS to be carried out for 6 hrs	Approved	18/07/2018
	12/07/2018	1200	Craigavon Area Hospital	MUC	Emergency Department CAH	Fall from a height, bed or chair	Minor				Being reviewed	
	12/07/2018	1940	Daisy Hill Hospital	MUC	Emergency Department DHH	Suspected fall	Minor			all patients with alcohol taken who are unsteady on their feet, risk assess for falls and place them on trolley in an observational area.	Being reviewed	
	13/07/2018	0005	Craigavon Area Hospital	SEC	CEAW	Suspected fall	Minor			as above	Approved	18/07/2018
	14/07/2018	0100	Craigavon Area Hospital	MUC	1 South Medical	Fall on level ground	Insignificant			?	Approved	18/07/2018
	14/07/2018	1330	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Minor			reinforce with staff if fellow patient witnesses fall it is to be considered unwitnessed -unless seen by staff falls protocol to be followed in spite of what doctors advise	Approved	18/07/2018
	15/07/2018	0450	Daisy Hill Hospital	MUC	General Male Medical,	Fall on level ground	Minor			.	Being reviewed	
	15/07/2018	0020	Craigavon Area Hospital	MUC	Emergency Department CAH	Fall from a height, bed or chair	Minor				Being reviewed	
	16/07/2018	0500	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Minor			patient had cognitive impairment and unable to follow advice good compliance with GCS recording for 24 hours	Approved	18/07/2018
	16/07/2018	0230	Craigavon Area Hospital	SEC	Trauma Ward	Fall from a height, bed or chair	Minor			Specials had been requested however none were filled on this night duty. Specials continue and nil falls since. Nursed in open bay and can be seen from nurses station.	Approved	19/07/2018
	16/07/2018	1530	Craigavon Area Hospital	SEC	Orthopaedic Ward	Fall on level ground	Minor			nil	Approved	19/07/2018
	16/07/2018	1140	Craigavon Area Hospital	MUC	AMU	Fall on level ground	Minor			un-witnessed fall	Approved	16/07/2018
	17/07/2018	1900	Craigavon Area Hospital	SEC	4 South	Fall from a height, bed or chair	Minor			as above	Approved	18/07/2018
	17/07/2018	0530	Craigavon Area Hospital	SEC	3 South	Fall on level ground	Minor			Asabove	Approved	26/07/2018
	17/07/2018	0130	Craigavon Area Hospital	SEC	4 North	Suspected fall	Minor			as above	Approved	18/07/2018
	17/07/2018	0540	Daisy Hill Hospital	CCS	Maternity Ward	Fall from a height, bed or chair	Minor			Appropriate to follow infant fall pathway	Approved	19/07/2018

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	17/07/2018	1635	Craigavon Area Hospital	CCS	X-ray Dept (Radiology)	Fall from a height, bed or chair	Minor	Personal Information redacted by the USI			Being reviewed	
	17/07/2018	0145	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Insignificant			did not require GCS as witnessed fall	Approved	18/07/2018
	18/07/2018	1400	Craigavon Area Hospital	SEC	4 North	Suspected fall	Minor			as above	Approved	19/07/2018
	19/07/2018	0030	Craigavon Area Hospital	MUC	2 North Medical	Fall on level ground	Minor			nil	Approved	24/07/2018
	19/07/2018	1435	Daisy Hill Hospital	MUC	Stroke / Rehab	Fall from a height, bed or chair	Insignificant			none	Being reviewed	
	19/07/2018	1645	Craigavon Area Hospital	SEC	4 North	Suspected fall	Minor			as above.	Being reviewed	
	19/07/2018	0645	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Minor			?	Approved	23/07/2018
	19/07/2018	1330	Daisy Hill Hospital	MUC	Stroke / Rehab	Fall from a height, bed or chair	Minor			Rein force at PSB 27/7/18the importance of following post falls protocol.	Being reviewed	
	20/07/2018	2320	Craigavon Area Hospital	MUC	AMU	Suspected fall	Minor			falls risk assessment not updated post fall	Approved	27/07/2018
	21/07/2018	1640	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Minor			/	Approved	23/07/2018
	21/07/2018	0015	Craigavon Area Hospital	MUC	2 South Stroke	Suspected fall	Minor			This gentleman has limited English and has had a stroke as well which has affected his cognition. try to keep a nurse in bay as far as possible but at night this becomes very difficult.	Approved	23/07/2018
	22/07/2018	0520	Craigavon Area Hospital	MUC	2 South Stroke	Fall on level ground	Minor			none Patient was orientated , call bell was within reach but patient failed to call for assistance. min set data ad shared learning attached	Approved	23/07/2018

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	22/07/2018	1030	Daisy Hill Hospital	SEC	Male Surgical/HDU	Fall from a height, bed or chair	Insignificant	Personal Information redacted by the USI			Approved	25/07/2018
	23/07/2018	0005	Craigavon Area Hospital	MUC	2 South Medical	Fall from a height, bed or chair	Insignificant			ost falls pathway followed ood compliance with GCS observations	Approved	23/07/2018
	23/07/2018	0235	Craigavon Area Hospital	MUC	Haematology	Fall from a height, bed or chair	Minor			atients night light to be left on . Advised to wear slippers when getting up rom bedside. To call nursing staff for assistance at night.	Being reviewed	
	23/07/2018	0245	Daisy Hill Hospital	SEC	Female Surgical/Gynae	Fall from a height, bed or chair	Minor				Approved	25/07/2018
	23/07/2018	1645	Craigavon Area Hospital	MUC	1 North Cardiology	Fall on level ground	Insignificant			/a	Approved	01/08/2018
	24/07/2018	1800	Daisy Hill Hospital	SEC	Female Surgical/Gynae	Fall from a height, bed or chair	Minor				Approved	25/07/2018
	24/07/2018	0720	Daisy Hill Hospital	MUC	Female Medical	Fall from a height, bed or chair	Minor			il	Being reviewed	
	24/07/2018	1330	Craigavon Area Hospital	SEC	4 North	Fall on level ground	Insignificant			s above	Being reviewed	
	24/07/2018	1100	Craigavon Area Hospital	MUC	1 North Cardiology	Fall on level ground	Insignificant			/a	Being reviewed	
	25/07/2018	2100	Craigavon Area Hospital	MUC	Haematology	Fall on level ground	Insignificant			one	Being reviewed	
	25/07/2018	0445	Daisy Hill Hospital	SEC	Male Surgical/HDU	Fall on level ground	Minor				Approved	30/07/2018
	25/07/2018	1815	Craigavon Area Hospital	SEC	Orthopaedic Ward	Fall from a height, bed or chair	Minor			poke to S/n on duty at time patient fell as no GCS obs carried out on patient t time of fall and although doctor informed of fall GCS obs should have been ompleted until Doctor had reviewed patient. ave spoke with SHO on call as nothing documented in patients medical otes until ward round 26/7/18 about patients review. Documented in nursing otes that xray was reviewed and was satisfactory and 'nil else ordered' owever the SHO did not physically review patient or document in patients otes	Approved	01/08/2018
	26/07/2018	0625	Daisy Hill Hospital	MUC	Female Medical	Fall from a height, bed or chair	Moderate				Being reviewed	
	26/07/2018	1745	Craigavon Area Hospital	MUC	Car Park/Grounds	Suspected fall	Minor			nable to do anything different as patient and relative declined offered help	Approved	30/07/2018

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	26/07/2018	0330	Craigavon Area Hospital	MUC	AMU	Suspected fall	Insignificant	Personal Information redacted by the USI		Shared with staff involved in reporting incident, the importance of adhering to falls protocol and recording CNS Obs correctly.	Approved	
	27/07/2018	0145	Craigavon Area Hospital	MUC	2 South Stroke	Suspected fall	Minor			High risk of fall patient should be moved out of side room if we can.	Approved	27/07/2018
	27/07/2018	0130	Daisy Hill Hospital	MUC	Stroke / Rehab	Fall from a height, bed or chair	Minor				Being reviewed	
	27/07/2018	0510	Craigavon Area Hospital	MUC	1 North Cardiology	Fall on level ground	Insignificant				Being reviewed	
	30/07/2018	1542	Daisy Hill Hospital	MUC	Emergency Department DHH	Suspected fall	Minor				Being reviewed	
	30/07/2018	0410	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Minor			/	Approved	30/07/2018
	30/07/2018	1825	Craigavon Area Hospital	MUC	AMU	Suspected fall	Minor			Protocol followed & appropriate action taken	Being reviewed	
	31/07/2018	0245	Daisy Hill Hospital	MUC	Emergency Department	Suspected fall	Minor			nil	Being reviewed	

Directorate of Acute Services
Moderate - Catastrophic Falls (1 April 2017 to 31 July 2018)

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed	Minimum Data Set Completed	Shared Learning Template
Personal Information redacted by the USI	06/04/2017	1000	Craigavon Area Hospital	SEC	CEAW	Suspected fall	Moderate	Personal Information redacted by the USI		Falls assessment not completed on adm to 3sth as pt had fall prior to admission . EAW .. falls assessment not updated on transfer to EAW or post fall Access granted to Personal information	Approved	25/04/2017	Yes	Yes
	19/04/2017	1100	Craigavon Area Hospital	MUC	2 North Haematology	Fall from a height, bed or chair	Moderate			Please see action plan attached to min data set review	Approved	09/05/2017	Yes	Yes
	23/04/2017	0950	Craigavon Area Hospital	MUC	2 North Haematology	Fall on level ground	Moderate			none- protocol was timely and in accordance with policy	Approved	05/05/2017	Yes	Yes
	24/04/2017	0135	Craigavon Area Hospital	SEC	3 South	Fall from a height, bed or chair	Moderate			Staff to be made aware of greater need to assist post operative patients when mobilising to reduce risk of further falls.	Approved	08/06/2017	Yes	Yes
	26/04/2017	0200	Craigavon Area Hospital	MUC	1 North Cardiology	Fall on level ground	Moderate			high risk patient identified on admission Frequency of urination due to frusemide for Heart failure	Approved	28/08/2017	Yes	Yes
	11/05/2017	2115	Craigavon Area Hospital	MUC	ED Resus	Fall from a height, bed or chair	Major				Approved		Yes	yes
	19/06/2017	0530	Daisy Hill Hospital	SEC	Male Surgical/HDU	Fall on level ground	Major			.	Approved	05/02/2018	Yes	Yes
	22/06/2017	0435	Craigavon Area Hospital	MUC	2 North Haematology	Suspected fall	Moderate			not graded correctly by staff nurse to be raised with staff member	Approved	28/07/2017	Yes	Yes
	28/06/2017	1255	Craigavon Area Hospital	MUC	Winter Pressures Ward(Ramone)	Fall on level ground	Moderate			Observed by staff, did not head	Approved	03/08/2017	Yes	Yes
	15/07/2017	0645	Craigavon Area Hospital	MUC	2 South Medical	Suspected fall	Moderate			need for reassessment of all risks by staff on transfer to ward	Approved	18/07/2017	Yes	Yes
	09/08/2017	0841	Craigavon Area Hospital	MUC	1 North Cardiology	Fall on level ground	Moderate			Personal information complained of pain immediately in his right hip. This man had delirium and was aggitated and was specialed 1:1 for the remainder of the night, and nursed at the nurse station.	Approved	27/11/2017	Yes	No
	17/08/2017	0200	Craigavon Area Hospital	SEC	3 South	Fall from a height, bed or chair	Moderate			The staff had assisted this man to his feet and allowed him to weight bear.	Approved	04/10/2017	Yes	Yes

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed	Minimum Data Set Completed	Shared Learning Template
[redacted]	13/09/2017	2150	Craigavon Area Hospital	SEC	Trauma Ward	Fall from a height, bed or chair	Moderate	[redacted]	[redacted]	He was reviewed by medical team immediately and had CT head which said no acute intercranial pathology demonstrated.	Approved	22/09/2017	Yes	Yes
	17/11/2017	0300	Craigavon Area Hospital	SEC	4 North	Suspected fall	Major			X-ray of hip the following day found #neck of femur.	Approved		Yes	Yes
	27/11/2017	0320	Craigavon Area Hospital	MUC	MAU	Fall from a height, bed or chair	Moderate			CNS observations were done as per protocol.	Approved	28/11/2017	Yes	Yes
	11/01/2018	0300	Daisy Hill Hospital	MUC	Emergency Department	Fall on level ground	Moderate			and are recorded on notes section.	Approved		Yes	Yes
	14/01/2018	0615	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Moderate			[redacted] was risk assessed on admission and care plan completed and was updated post fall.	Approved	25/01/2018	Yes	Yes
	14/01/2018	1330	Daisy Hill Hospital	MUC	General Male Medical,	Fall on level ground	Moderate			This man remained on bedret until surgery for #NOF on the 15/11/17	Approved		Yes	Yes
	08/02/2018	1600	Daisy Hill Hospital	MUC	General Male Medical,	Fall on level ground	Moderate			Will be discussed at safety briefing meeting after her minimum data assessment	Approved		Yes	Yes
	16/02/2018	1510	Daisy Hill Hospital	SEC	Male Surgical/HDU	Fall on level ground	Moderate			Relatives (nephew and his wife) were informed and falls pathway followed	Approved	26/02/2018	Yes	Yes
	09/03/2018	1541	Craigavon Area Hospital	MUC	Acute Medical Unit	Suspected fall	Moderate				Approved		No	No
	15/03/2018	2000	Craigavon Area Hospital	MUC	2 North Medical	Fall on level ground	Moderate			all done as per protocol	Approved	06/04/2018	No	No
	25/04/2018	2330	Daisy Hill Hospital	MUC	General Male Medical,	Suspected fall	Moderate				Approved	03/05/2018	No	No

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed	Minimum Data Set Completed	Shared Learning Template
Personal Information redacted by the USI	28/04/2018	2200	Daisy Hill Hospital	MUC	Female Medical	Fall from a height, bed or chair	Moderate	Personal Information redacted by the USI			Approved	17/05/2018	No	No
	04/05/2018	0530	Craigavon Area Hospital	MUC	3 South	Fall on level ground	Moderate				Approved		No	No
	06/05/2018	0000	Craigavon Area Hospital	MUC	1 South Medical	Suspected fall	Moderate				Approved	12/06/2018	No	No
	06/05/2018	2110	Craigavon Area Hospital	MUC	AMU	Suspected fall	Moderate			none	Approved	11/05/2018	No	No
	25/05/2018	1745	Daisy Hill Hospital	MUC	Female Medical	Fall from a height, bed or chair	Moderate			Falls protocol to be discussed at team safety brief this week.	Approved	04/06/2018	Yes	Yes
	01/06/2018	1415	Craigavon Area Hospital	MUC	AMU	Suspected fall	Moderate			none	Being reviewed		No	No
	07/07/2018	0550	Craigavon Area Hospital	MUC	AMU	Fall on level ground	Major				Being reviewed		No	No
	26/07/2018	0625	Daisy Hill Hospital	MUC	Female Medical	Fall from a height, bed or chair	Moderate				Being reviewed		Yes	Yes

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Acute Services Directorate
Pressure Ulcers Report - June 2018

ID	Incident date	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	05/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor	Personal Information redacted by the USI			Being reviewed	
	04/06/2018	Daisy Hill Hospital	MUC	Emergency Department DHH	Delay or failure to monitor	Minor			.No wound mention in ED Flimsy Sister in ED informed. 6 hrs in ED no mattress 12/06/18 Personal Information: ED feedback: grade 4 was documented on the flimsy no mattress ordered	Approved	12/06/2018
	02/06/2018	Daisy Hill Hospital	SEC	Male Surgical/HDU	Delay/failure in acting on complication of treatment	Minor			Learning points – •pressure care pathway not commenced on admission (mattress ordered and upgrade/commenced on PUMP and his skin assessments completed) •When sitting out in chair 2 hourly pressure relief for heals needs to be carried out (note he was sitting in assessed chair) •repositioning chart had gaps in completion ie, recording frequency of repositioning, when returned to bed etc	Approved	11/06/2018
	25/06/2018	Craigavon Area Hospital	MUC	1 North Cardiology	Simple complication of treatment	Minor			none	In holding area, awaiting review	
	05/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor				Being reviewed	
	18/06/2018	Daisy Hill Hospital	MUC	Emergency Department DHH	Extended stay / episode of care	Minor			Patient arrived with a preexisting grade 4 pressure sore on sacrum	Approved	28/06/2018
	25/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor			nil	Approved	29/06/2018
	01/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor			as above	Approved	29/06/2018

ID	Incident date	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	15/06/2018	Craigavon Area Hospital	SEC	Trauma Ward	Delay or failure to monitor	Minor	Personal Information redacted by the USI		This patient has many risk factors for developing a pressure sore. Staff acted appropriately in their actions. Based on my investigation, I don't think this pressure sore could have been prevented.	Approved	25/06/2018
	16/06/2018	Craigavon Area Hospital	SEC	Trauma Ward	Simple complication of treatment	Minor			Staff must ensure that elbows are checked as part of skin grade on repositioning (not currently on repo chart for grading) esp if patient is confused, agitated and very restless where friction damage potential is high.	Being reviewed	

ID	Incident date	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	14/06/2018	Craigavon Area Hospital	SEC	4 North	Simple complication of treatment	Minor	Personal Information redacted by the USI		As above	Approved	21/06/2018
	02/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor			as above	Approved	29/06/2018
	11/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor				Being reviewed	
	09/06/2018	Community	MUC	Home of client	Delay or failure to monitor	Minor				Being reviewed	
	08/06/2018	Craigavon Area Hospital	MUC	2 South Medical	Delay or failure to monitor	Minor			/	Approved	28/06/2018
	12/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor				Being reviewed	
	30/06/2018	Craigavon Area Hospital	SEC	4 South	Extended stay / episode of care	Minor				Being reviewed	
	05/06/2018	Craigavon Area Hospital	MUC	1 South Medical	Simple complication of treatment	Minor			Staff nurse that handed patient over was made aware of this datix and was reminded of importance of checking and documenting skin condition when transferring patients to other areas. All staff reminded of importance of documenting skin condition daily and documenting changes.	Approved	07/06/2018
	19/06/2018	Daisy Hill Hospital	MUC	Female Medical	Delay or failure to monitor	Minor			All patients with braden of 18 or less to be commenced on pressure pathway on admission. Patients with repositioning chart needs a frequency documented and carried out to same This will be communicated with staff via email and via team safety brief	Being reviewed	

ID	Incident date	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	04/06/2018	Daisy Hill Hospital	MUC	Female Medical	Simple complication of treatment	Insignificant	Personal Information redacted by the USI		Ensure if Braden is 18 or less to commence on Pressure pathway from admission. To be discussed with staff at team safety brief.	Approved	07/06/2018
	13/06/2018	Craigavon Area Hospital	SEC	4 North	Simple complication of treatment	Insignificant			As above.	Approved	21/06/2018
	27/06/2018	Craigavon Area Hospital	SEC	Trauma Ward	Delay or failure to monitor	Minor			This patient is very high risk for pressure damage, she is immobile and is unable to independently change her position in bed. Her repositioning charts demonstrate that she was regularly repositioned and skin checks carried out however, the blister may have been prevented if she was repositioned more frequently i.e. every 2 hours.	Being reviewed	

ID	Incident date	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	17/06/2018	Craigavon Area Hospital	SEC	Trauma Ward	Simple complication of treatment	Minor	Personal Information redacted by the USI		This pressure sore developed pre admission no issue for the staff on the ward.	Being reviewed	
	23/06/2018	Craigavon Area Hospital	SEC	4 North	Simple complication of treatment	Minor			As above	Being reviewed	
	08/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor			as above	Approved	29/06/2018
	06/06/2018	Craigavon Area Hospital	MUC	2 South Stroke	Delay or failure to monitor	Minor			Inform staff to document when patient noncompliant with pressure relief. RCA done	Being reviewed	
	06/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH	Delay or failure to monitor	Minor				Being reviewed	
	27/06/2018	Craigavon Area Hospital	MUC	Emergency Department	Delay or failure to monitor	Moderate			nil	Approved	29/06/2018
	21/06/2018	Daisy Hill Hospital	MUC	Female Medical		Minor				Being reviewed	
	28/06/2018	Daisy Hill Hospital	SEC	Daisy Day Clinical Centre		Minor				In holding area, awaiting review	

ID	Incident date	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken (Investigation)	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	30/06/2018	Craigavon Area Hospital	MUC	Emergency Department CAH		Minor	Personal Information redacted by the USI			In holding area, awaiting review	
	29/06/2018	Craigavon Area Hospital	MUC	2 South Stroke		Minor				In holding area, awaiting review	
	29/06/2018	Craigavon Area Hospital	MUC	2 South Medical		Minor				In holding area, awaiting review	
	27/06/2018	Craigavon Area Hospital	MUC	2 South Stroke		Minor				In holding area, awaiting review	
	29/06/2018	Craigavon Area Hospital	SEC	ICU (HDU)		Moderate				Being reviewed	

Violence and Aggression Incidents - Acute Services (01.04.17 - 31.07.18) Time Bands

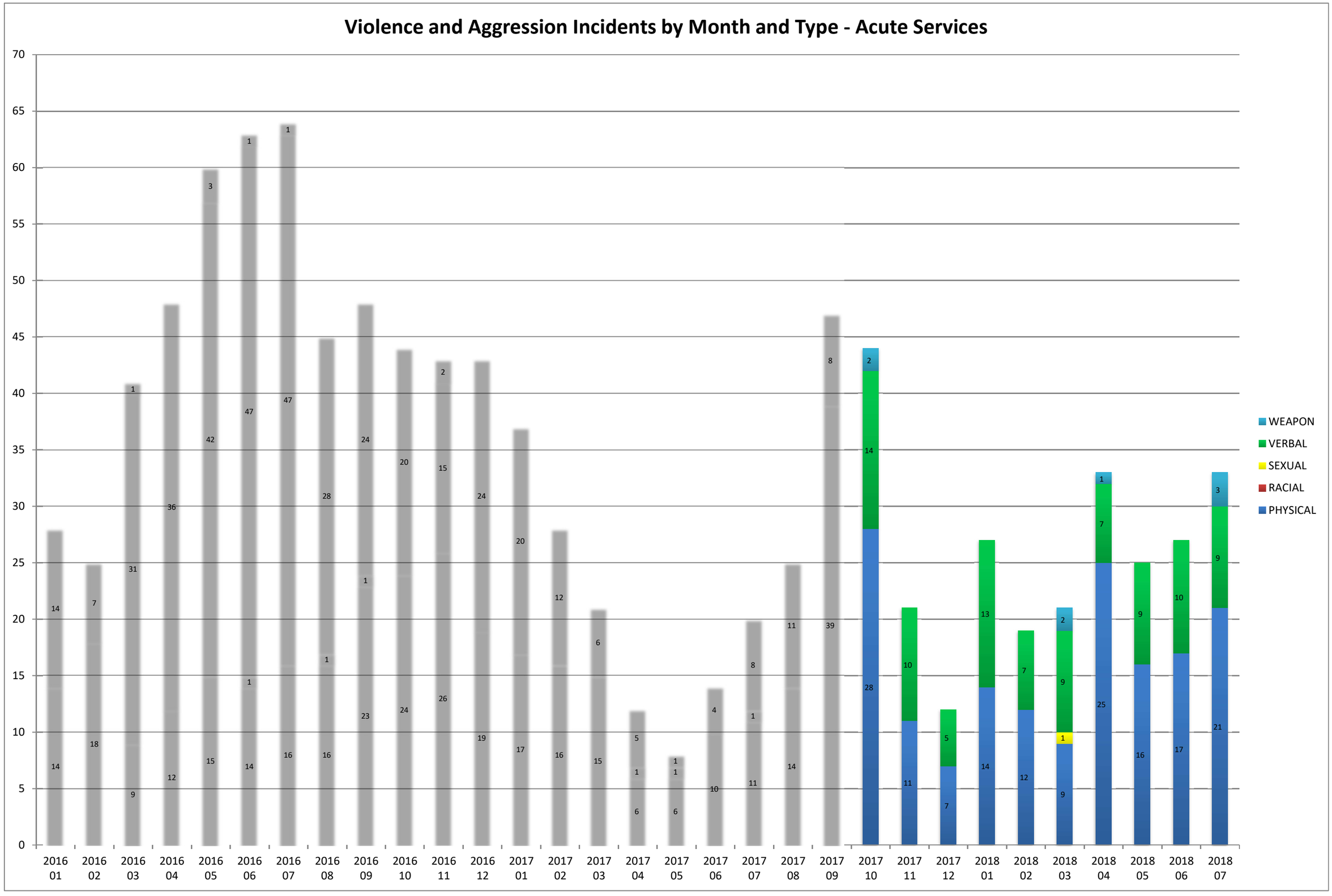
	00:00 - 07:59	08:00 - 17:59	18:00 - 23:59	Total
Craigavon Area Hospital	**144**	**131**	**153**	**428**
1 North Cardiology	9	0	6	**15**
1 South Medical	11	15	15	**41**
2 North Medical	3	4	5	**12**
2 North Respiratory	5	6	2	**13**
2 South Medical	14	5	12	**31**
2 South Stroke	3	2	4	**9**
3 South	6	6	6	**18**
4 North	5	11	6	**22**
4 South	3	3	3	**9**
Maternity Admissions/Assessment Unit	3	1	0	**4**
Emergency Department	24	19	39	**82**
Antenatal Clinic	0	2	0	**2**
Car Park/Grounds	1	1	0	**2**
Corridor/Stairs	0	2	1	**3**
CT Scanner	0	2	0	**2**
Discharge Lounge	0	5	1	**6**
ENT Clinic	0	1	0	**1**
ICU (HDU)	2	5	2	**9**
AMU	48	31	46	**125**
Orthopaedic Ward	0	1	0	**1**
Physiotherapy Outpatients Department	0	2	0	**2**
Paediatric Ward	0	0	1	**1**
Reception/Waiting Area	1	0	1	**2**
Recovery Unit	0	1	0	**1**
Sleep Lab	0	1	0	**1**
Switchboard	1	0	0	**1**
Theatre	0	1	1	**2**
Trauma Ward	5	2	2	**9**
X-ray Dept (Radiology)	0	2	0	**2**
Daisy Hill Hospital	**42**	**24**	**25**	**79**
Emergency Department	8	2	6	**16**
Coronary Care Ward	12	1	2	**15**
Delivery Suite, DHH	0	1	1	**2**
Female Medical	0	2	3	**5**
Fracture Clinic	0	2	0	**2**
Female Surgical/Gynae	0	3	1	**4**
General Male Medical,	9	5	8	**22**
Maternity Ward	1	0	1	**2**
Male Surgical/HDU	5	3	3	**11**
General Outpatients Reception/Waiting Area	0	1	0	**1**
Reception/Waiting Area	1	1	0	**2**
Rehabilitation Ward	3	0	0	**3**
Stroke / Rehab	3	3	0	**6**
Totals:	**186**	**155**	**178**	**507**

Violence and Aggression Incidents - Acute Services 01.07.18 - 31.07.18

ID	Incident date	Time	Site	Division	Loc (Exact)	Adverse event	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	01/07/2018	1030	Daisy Hill Hospital	MUC	Stroke / Rehab	Physical abuse, assault or violence	Moderate	Personal Information redacted by the USI		.	Being reviewed	
	01/07/2018	0715	Daisy Hill Hospital	FSS	Rehabilitation Ward	Physical abuse, assault or violence	Minor			.	Being reviewed	
	02/07/2018	0900	Craigavon Area Hospital	FSS	Bronte Ward	Verbal abuse or disruption	Minor			NA	Approved	26/07/2018
	03/07/2018	2230	Craigavon Area Hospital	SEC	4 North	Physical abuse, assault or violence	Moderate			As above.	Approved	06/07/2018
	03/07/2018	2245	Craigavon Area Hospital	MUC	AMU	Assault etc with a weapon	Moderate			agitated aggressive patient, difficulty sourcing placement out of AMU. security and 1:1 remain in place.	Approved	13/07/2018
	03/07/2018	2255	Craigavon Area Hospital	FSS	AMU	Physical abuse, assault or violence	Minor			None	Approved	
	06/07/2018	2325	Craigavon Area Hospital	MUC	AMU	Verbal abuse or disruption	Minor			mone	Approved	13/07/2018
	06/07/2018	1405	Craigavon Area Hospital	FSS	4 North	Verbal abuse or disruption	Minor			as above	Approved	
	10/07/2018	2030	Daisy Hill Hospital	MUC	General Male Medical,	Physical abuse, assault or violence	Minor			None	Approved	25/07/2018

Personal Information redacted by the USI	0/07/2018	1550	Craigavon Area Hospital	FSS	4 North	Physical abuse, assault or violence	Insignificant	Personal Information redacted by the USI	as above	Approved	
	1/07/2018	0400	Craigavon Area Hospital	FSS	Emergency Department CAH	Physical abuse, assault or violence	Minor		None	Approved	
	2/07/2018	0500	Craigavon Area Hospital	MUC	AMU	Verbal abuse or disruption	Minor		disruption	Approved	16/07/2018
	2/07/2018	0413	Craigavon Area Hospital	FSS	AMU	Physical abuse, assault or violence	Minor		None	Approved	
	5/07/2018	2000	Daisy Hill Hospital	MUC	Female Medical	Verbal abuse or disruption	Minor		None	Being reviewed	29/07/2018
	5/07/2018	0225	Craigavon Area Hospital	MUC	AMU	Assault etc with a weapon	Major		agitated patient continues to need security supervision while waiting on placement in RABIU	Approved	16/07/2018
	5/07/2018	0225	Craigavon Area Hospital	FSS	AMU	Assault etc with a weapon	Minor		PSNI to be called if concerns of weapons.	Approved	
	6/07/2018	2245	Craigavon Area Hospital	MUC	AMU	Physical abuse, assault or violence	Minor		Appropriate action taken.	Being reviewed	
	8/07/2018	2320	Craigavon Area Hospital	SEC	Trauma Ward	Verbal abuse or disruption	Minor		On the date detailed, staff made all efforts to de-escalate the situation however still required assistance from security staff. Staff could not have prevented the situation therefore I do not feel there are any lessons to be learnt.	Approved	23/07/2018
	9/07/2018	0100	Craigavon Area Hospital	MUC	1 North Cardiology	Physical abuse, assault or violence	Minor		difficult to secure staff for 1 1	Approved	23/07/2018
	0/07/2018	2325	Craigavon Area Hospital	FSS	1 South Medical	Physical abuse, assault or violence	Minor		None	Approved	
	0/07/2018	0155	Craigavon Area Hospital	FSS	4 North	Physical abuse, assault or violence	Minor		None	Approved	
	0/07/2018	0035	Craigavon Area Hospital	MUC	1 North Cardiology	Physical abuse, assault or violence	Minor		difficulty securing staff for 1:!	Approved	23/07/2018
	0/07/2018	0200	Craigavon Area Hospital	MUC	1 North Cardiology	Physical abuse, assault or violence	Insignificant		difficulty securing 1;1 for this patient	Approved	23/07/2018
	0/07/2018	0230	Craigavon Area Hospital	MUC	1 North Cardiology	Physical abuse, assault or violence	Insignificant		nil Difficulty in securing staff for 1:1	Approved	23/07/2018
	1/07/2018	2330	Craigavon Area Hospital	FSS	1 South Medical	Physical abuse, assault or violence	Minor		None	Approved	

Personal Information redacted by the USI	21/07/2018	2200	Craigavon Area Hospital	MUC	Emergency Department	Verbal abuse or disruption	Minor	Personal Information redacted by the USI				
	21/07/2018	0515	Craigavon Area Hospital	SEC	Trauma Ward	Verbal abuse or disruption	Minor			Staff had attempted to de escalate the situation but were unable to. The patient was at risk of harming himself or others due to his aggressive behavior and attempting to leave the ward. Lorazepam was administered as a last resort. I do not feel there are any lessons to be learnt from this incident.	Approved	23/07/2018
	21/07/2018	0240	Craigavon Area Hospital	MUC	AMU	Physical abuse, assault or violence	Moderate			This patient proved problematic and HOS + Lead Nurse informed. Security had been providing almost 24hr security, however there were some gaps they were unable to fill. Security had advised that if patient became agitated they could be fast bleeped as per normal and patient did have one to one special cover. Patient was transferred to the Regional Brain Injury Unit on 23/07/18.	Being reviewed	
	21/07/2018	0245	Craigavon Area Hospital	FSS	AMU	Physical abuse, assault or violence	Minor			None	Approved	
	21/07/2018	0910	Craigavon Area Hospital	FSS	AMU	Physical abuse, assault or violence	Minor			None	Approved	
	22/07/2018	1500	Daisy Hill Hospital	SEC	Male Surgical/HDU	Physical abuse, assault or violence	Minor			.	Approved	25/07/2018
	23/07/2018	1200	Craigavon Area Hospital	SEC	4 North	Physical abuse, assault or violence	Insignificant			as above	Being reviewed	
	26/07/2018	0300	Craigavon Area Hospital	FSS	1 South Medical	Verbal abuse or disruption	Minor			/	Approved	26/07/2018



Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Incidents by Incident date and Detail. (Month and Year)

	PHYSICAL	RACIAL	SEXUAL	VERBAL	WEAPON	Total
2016 01	14			14		28
2016 02	18			7		25
2016 03	9			31	1	41
2016 04	12			36		48
2016 05	15			42	3	60
2016 06	14		1	47	1	63
2016 07	16			47	1	64
2016 08	16		1	28		45
2016 09	23		1	24		48
2016 10	24			20		44
2016 11	26			15	2	43
2016 12	19			24		43
2017 01	17			20		37
2017 02	16			12		28
2017 03	15			6		21
2017 04	6		1	5		12
2017 05	6		1	1		8
2017 06	10			4		14
2017 07	11		1	8		20
2017 08	14			11		25
2017 09	39			8		47
2017 10	28			14	2	44
2017 11	11			10		21
2017 12	7			5		12
2018 01	14			13		27
2018 02	12			7		19
2018 03	9		1	9	2	21
2018 04	25			7	1	33
2018 05	16			9		25
2018 06	17			10		27

2018 07	21			9	3	33
Totals:	500	0	7	503	13	1026

Absconding Incidents - Acute Services (01.04.14 - 31.07.18)

	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	Total
Craigavon Area Hospital	**41**	**38**	**34**	**23**	**50**	**69**	**41**	**44**	**36**	**57**	**38**	**31**	**33**	**28**	**28**	**26**	**35**	**6**	**652**
1 North Cardiology	0	0	0	0	0	0	1	0	1	2	1	0	0	0	0	1	0	0	**6**
1 South Medical	1	0	0	1	1	2	1	0	0	0	0	0	0	1	0	0	0	0	**7**
1 West Gynae	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
2 North Haematology	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
2 North Resp/Medical	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
2 South Medical	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	**2**
2 South Stroke	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	**3**
3 South	0	0	1	0	5	2	1	0	3	1	1	0	0	1	0	0	0	0	**15**
4 North	0	0	1	0	1	1	1	0	1	0	5	5	3	1	0	1	4	0	**24**
4 South	0	0	0	0	1	0	0	0	0	0	0	0	2	0	1	1	0	0	**5**
Emergency Department	32	34	27	18	34	49	33	41	26	43	26	21	25	23	19	20	29	5	**505**
Car Park/Grounds	0	0	0	0	1	2	0	0	0	1	0	0	0	0	0	0	0	0	**4**
MAU	6	4	3	3	6	9	3	3	5	10	4	5	3	1	8	2	2	1	**78**
ICU	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Physiotherapy Outpatients Department	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Reception/Waiting Area	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Trauma/Orthopaedic Theatre	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Winter Pressures Ward(Ramone)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Daisy Hill Hospital	**9**	**25**	**19**	**15**	**21**	**10**	**19**	**18**	**26**	**33**	**28**	**32**	**30**	**25**	**27**	**26**	**14**	**5**	**377**
Emergency Department	7	20	16	11	19	4	17	17	22	27	25	28	29	28	26	26	11	5	**338**
Day Clinical Centre	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Entrance/Exit	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Female Medical, Level 5	0	0	1	0	0	0	0	1	1	1	0	1	0	0	0	0	1	0	**6**
Female Surgical/Gynae	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	**2**
General Male Medical, Level 5	2	4	0	1	0	2	0	0	0	3	2	0	1	0	0	0	0	0	**15**
Male Surgical/HDU	0	0	1	0	1	4	1	0	3	1	0	0	0	0	0	0	0	0	**11**
Reception/Waiting Area	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Rehabilitation, Level 4	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Stroke / Rehab	0	1	0	0	0	0	0	0	0	0	1	0	0	0	1	0	2	0	**5**
South Tyrone Hospital	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Day Procedure/Day Surgery Unit	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Theatre	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Totals:	**50**	**64**	**53**	**38**	**71**	**80**	**60**	**62**	**62**	**90**	**66**	**63**	**63**	**53**	**55**	**52**	**49**	**11**	**1042**

Absconding Incidents - Acute Services (01.07.18 - 31.07.18)

ID	Incident date	Time	Site	Division	Loc (Exact)	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information redacted by the USI	01/07/2018	2015	Daisy Hill Hospital	MUC	Emergency Department DHH	Minor	Personal Information redacted by the USI		none	Approved	25/07/2018
	02/07/2018	0650	Daisy Hill Hospital	MUC	Emergency Department DHH	Moderate			nil	Approved	10/07/2018
	03/07/2018	1145	Craigavon Area Hospital	MUC	AMU	Minor			none	Approved	13/07/2018
	04/07/2018	1320	Craigavon Area Hospital	MUC	Emergency Department CAH	Minor			nil	Being reviewed	
	07/07/2018	0820	Craigavon Area Hospital	MUC	Emergency Department CAH	Minor			NIL	Approved	10/07/2018
	08/07/2018	1335	Craigavon Area Hospital	MUC	Emergency Department CAH	Moderate			NIL	Being reviewed	
	20/07/2018	1445	Daisy Hill Hospital	MUC	Emergency Department	Insignificant			absconder	Approved	25/07/2018
	21/07/2018	0100	Craigavon Area Hospital	MUC	Emergency Department	Moderate				Being reviewed	
	24/07/2018	2220	Daisy Hill Hospital	MUC	Emergency Department	Major			nil	Being reviewed	
	25/07/2018	0440	Daisy Hill Hospital	MUC	Emergency Department	Moderate			nil	Approved	25/07/2018
	30/07/2018	2210	Craigavon Area Hospital	MUC	Emergency Department CAH	Moderate				Being reviewed	

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ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3726	01/09/2015	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	Registered nurses assisting during operative procedures	It has come to light that currently there are registered nurses assisted during operative procedures who have not completed nationally recognised training and this role has never been agreed or approved by the Trust. Risk of potential injury to the patient, risk to staff member in undertaking duties out with their role and job description as registered practitioners.	It has been discussed with Interim Director of Acute Services we cannot cease the practice immediately as this would impact adversely on operating lists, thereby resulting in patient cancellations. In order to reduce the risk we have stopped nurses undertaking assisting duties that would be considered a surgical in nature ie tapping on a chisel in ENT and uterine manipulation for gynae patients not having a hysterectomy. The need has been identified for surgical first assistant role, currently the Trust is working to secure funding for these roles. We are also looking at a dual role for a scrub practitioner for very minor cases only. An interim holding position has been discussed and agreed with gynae, with regards to the duties that the nursing staff can undertake until surgical first assistants are in post.	12/6/18, 10.4.18 Ongoing research 28.02.18 Risk remains the same 7.11.17 Funding to be transferred from SEC to ATICS. To research posts before recruitment commenced. 30/5/17 - Money identified for 2 x surgical practitioners. For follow up and recruitment once processes agreed 7.3.17 Unchanged	HIGH	DIV
3765	24/02/2016	Safe, High Quality and Effective Care		Reduced NIMDTA supply and inability to recruit middle grade doctors in all surgical specialties. HAN service also under pressure	Potential risk to patient safety in the OOH period. Reduced elective activity Potential for increased admissions if surgical review unable to take place in ED. Potential gaps in surgical OOH rotas leaving poor medical cover. Potential for delays in medical administration and discharge.	Offer additional locum shifts to core medical staff. Day rotas adjusted to prioritise OOH cover. Outpatient clinics reduced to release staff for core emergency cover. Agency locum approved. International recruitment commenced. NIMDTA lobbied to provide more FY1's same successful with 4 more FY1 doctors starting August 2016. Working with PHA re planning for medical workforce.	12/6/18 No change, continue to struggle to cover on call-shifts, locum shifts being offered. 10.4.18 no change, struggling in particular within urology. Offering locum shifts to cover on-call. 27/2/18 - situation remains the same. Continue to offer locum shifts to cover on-call. 30.5.17 No improvement, national issue. 7.3.17 No improvement or change 2.12.16 No further update. 24.10.16 - CAH retained a GS Middle Grade for an extra 3 months, however will go to 2 vacant middle grade positions at 01/01/17. DHH vacant middle grade positions are still being filled by locums.	HIGH	DIV
3826	19/08/2016	Safe, High Quality and Effective Care		Demand of fracture referrals outweighs fracture capacity.	Fracture patients at risk of late diagnosis and treatment.	The Trust has given permission for "at risk" fracture clinics, however, this still does not meet demand.	12/6/18 Require more non-recurrent funding to meet fracture demand, waiting confirmation of same. 10/4/18 - non-recurrent funding requested for fracture new and review. waiting time approx 4-5weeks due to easter leave 28/2/18 fracture waiting time currently 2-3wks, ongoing additionality for fracture reviews. 30/5/17 - fracture demand continues to increase and waiting time extended to 5wks for fracture clinics. 'At risk' clinics to continue to meet demand 7.3.17 Unchanged	HIGH	DIV
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.	12.06.18, 10.4.18 No change 28/2/18 requesting for fund still outstanding. New fracture accommodation is essential. Awaiting outcome. 30/5/17 - requested funding for new fracture accommodation, awaiting outcome	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
3767	24/02/2016	Organisational and workforce development		Delays / inability to recruit to all vacant posts and the flexing up of surgical beds for winter pressures is causing staffing p	Patients may experience delays in their care provision and outcomes may be affected. Staff morale is reduced due to additional hours and perceived working pressure. This can lead to sickness absence which compounds the problem.	Proactive recruitment and over recruitment at permanent level to attract staff. Use of all bank and agency - outside of contracted agencies. Additional hours / overtime offered. Closely monitored by Heads of Service and and staff reallocated across wards to manage the risk.	12/6/18 RC emailed Directors again re Risk, awaiting feedback. 10/4/18 - ongoing risk and significant pressure on wards due to high volume of vacancy. RC has emailed Directors to escalate risk, highlighting options. Awaiting feedback. 28/2/18 Ongoing international recruitment. Beds are still flexed. Risk ongoing 7.11.17 Monthly workforce international recruitment meetings ongoing 30/5/17 - unchanged, beds still at flexed status. International recruitment of overseas nurses coming into post shortly	HIGH	DIV
3920	13/11/2017	Provide safe, high quality care	Intensive Care Unit	ICU Consultant Workforce	Potential for inability to cover the department with appropriate staff for ICU	Advertisement to replace 2 ICU consultants and also 2 general anaesthetic consultants.	12/6/18 Consultant anaesthetists has been appointed awaitng start date. 10/4/18 - 1 further consultant anaesthetists retirement. Going out for advertisement again closing date Tue 17/4/18. 28/2/18 - 4 consultant anaesthetists have been appointment, waiting checks and commencement date. 7/11/17 - in progress, interviewing in the next few weeks and backfilling with Locums at present.	HIGH	DIV
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.	12/6/18 ongoing discussions with HSCB re endoscopy backlog clearance, waiting on confirmation of funding. 2nd endoscopy procedure in DHH ongoing at risk. 10/4/18 - The Trust have a plan to improve endoscopy waiting times, however, still struggling to achieve. 28/2/18 - No change in waiting times, capacity currently for RF and urgent only. Standing agenda at EUG meetings. 30.5.17 No change 7.3.17 Unchanged	MOD	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.	12/6/18 Still only 2 paed nurses trained for new paed theatre. Paediatric nursing ward team are unable to provide 2nd stage recovery in DHH paed recovery. 10/4/18 - Trained 4 and now down to 2 paeds nurses. Ongoing risk 28/2/18 - Paeds theatre operational from Mon 5/3/18. Ongoing risk to paed theatre nurses, lost 3 dual trained, to go back out to recruitment. 7.11.17 Authorisation just given from Director to progress with recruitment for the new paeds theatre in DHH. Scrutiny form has been forwarded to Dean Faloon, awaiting response before completing e-req. 30/5/17 - ongoing recruitment pressures for theatre staff nurses, this is a regional problem. Continue to go out for bank and agency	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
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.	12/6/18 - 3 nurses Tues, Wed, Thur on night duty to cope with capacity. Will reamain ongoing throughout the year at risk. 10/4/18 - Continues due to bed pressures. 28/2/18 - As below continues over winter period. 7.11.17 Due to winter pressures Tue-Thurs continue to be 3 staff nurses over night for HDU abd post op patients. Post op patients to stay over night in recovery is agreed at the 2 hours bed meetings. 30/5/17 - Currently Tue, Wed and Thur 3 staff nurses for over night HDU post op patients required. Still waiting on draft protocol comments from ADs 7.3.17 Draft protocol has been sent to AD for MUSC and Director for comment.	MOD	DIV
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.	12/6/18 - demand continues to exceed capacity. Currently recruiting to 3 postsx Band 6. 10/4/18 - Briefing Paper needs to be reviewed. EJK is meeting with Pre-op. 28/2/18 - Demand still exceeds capacity. Additionality ongoing to end of March 18. 7.11.17 Demand for pre-op continues to exceed capacity, leading to delay in getting patients fit for surgery. Risk continues 30/5/17 - POA suspension protocol discussed at THUGs and declined due to current review backlog at clinics. Continue with Ortho fit pool. 7/3/17 - POA suspension draft protocol to be circulated to THUGs group for consideration. Continuing with orthopaedic fit pool	MOD	DIV
3805	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Theatre nursing staff being redeployed during OOH to cover wards, in particularly DHH	Putting at risk the ability to provide an emergency service to theatre and hospital in general	For wards / departments to staff their own areas	12/6/18 Theatre nursing being redeployed during OOH still occurs on all sites, ongoing risk. 10.4.18 Unchanged 28/2/18 - redeployment is still an issue on both sites 7.11.17 - redeployment of theatre staff at night continues, especially on the DHH site at present 30/5/17 - Action plan still to be developed and agreed. Theatre staff still are redeployed at night 7/3/17 - ADs have met with staff side, action plan to be developed and agreed. Future meeting to be arranged	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
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.	12/6/18 - WC met with the BFH, working group has been set up with Breast team to modernise service to cope with capacity. ongoing risk to review patients. 10/4/18 - RC and WC meeting the team Wed 17/3/18 to discuss BFH. 28/2/18 - Recruitment successful and successful applicants commence beginning of April 18. 7.11.17 Recruitment for Breast fail safe with BSO at present, however on hold due to possible redeployment. 6.6.17 Transferred to SEC Risk Register following meeting with HT. Requires update.	MOD	DIV
3930	12/12/2017	Provide safe, high quality careMake the best use of resources	Anaesthetics, Theatres & Intensive Care Services	Discontinuation of guaranteed Service for Drager Oxylog Ventilators	Maintenance Company can no longer guarantee support the Drager Oxylog Ventilator for items that may be required for repair/service. There are no spare machines available to STH.	None in place	12/6/18 -currently on capital list and money has been agreed for 3 ventilators in a rolling programme. 10/4/18 - awaiting information from IMWH. With staffing issues in ATICs, hold off progressing. 28/2/18 - Oxylog Ventilator is on the capital list, awaiting 18/19 allocation	MOD	DIV
3766	24/02/2016	Best use of resources		Despite refurbishment of ward areas this financial year, due to winter pressures all work was not completed	Increased risk of infection due to poor bed spacing / inadequate side room availability and inadequate storage. Increased moving and handling risks.	Some wards have had significant refurbishment with plans for further work in the summer of 2016. Significant minor works request in place and mail box requested for some areas.	12/6/18 4th floor still outstanding. 10/4/18 - 4th floor still outstanding. 28/2/18 - No change 30.5.17 No change 7/3/17 - work goings on a phased basis in conjunction with Estates	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.	12.6.18, 10.4.18 , 28.02.18, 7.11.17, 4.7.17 Unchanged 30/5/17 - unchanged. Store is still required. On the minor works list and requires to be prioritised by the Acute Directorate. 7.3.17 Unchanged 2.12.16 On the minor works list and requires to be prioritised by the Acute Directorate	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.	12.6.18 no change 10/4/18 - awaiting information from IMWH. With staffing issues in ATICs, hold off progressing. 28/2/18 - Draft paper to be submitted re ATICS taking over maternity theatre, led by Dr Scullion. 7.11.17 Mr Carroll to discuss with H Trouton IMWH 30.5.17 No change 7/3/17 - Recruited however 1 is for Pain & Anaesthetists, still no nursing to support	MOD	DIV
3746	30/11/2015	Safe, High Quality and Effective Care	3 South ENT	Paediatric Patients treated in 3 South ENT treatment room - cannot guarantee nurses with upo to date paediatric training.	Limited paediatric trained staff includes - paediatric trained nurse may not be with patient in the treatment room - clinical outcomes if patient needs specific paediatric nursing care including resuscitation - poor patient experience and safeguarding issues.	Meeting held with Paediatric Head of Service to discuss issues on 27 November to scope the problem. Data has been requested. Further meetings planned with the aim to have a paediatric nurse with paediatric patients or inform paediatric ward of admissions.	12/6/18, 10.4.18, 28/2/18 - No change - further discussions required. 30.5.17 No change 7/3/17 - Paed nurse is required in room when child is getting a procedure, need to resolve. Ronan to discuss with Geraldine Maguire. Approx. 6 pts per week. ENT ward attender report to be run for under 16's to establish volume of occasions Paed nurse is required	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
3772	29/02/2016	Provide safe, high quality care	Trustwide	Use of Hypodermic Needles (not safer sharps) for breast biopsies	Breast biopsies at breast clinic, unsuitable for safer sharps use. The design of the safer sharp interferes with this procedure and patient safety may be compromised. Sharps injuries create potential exposure to hazardous substances as defined in the COSHH Regulations. Cannot comply with Health & Safety (sharp instruments in health care) Regulations (NI) 2013. Non catalogue hypodermic needles to be used.	All staff directly involved to have completed e-learning for sharps awareness. Added to risk register. Key staff to be informed of decision to use original hypodermic needles. Raise awareness of trust policies and procedures in relation to blood, bodily fluids, Health & Safety at work, adverse incident procedure, safe use and disposal of sharps policy. Ensure all staff suitably trained. Staff follow sharps injury flowchart. Practice of re-sheathing needles prohibited. Sharps boxes are readily available in all rooms.	12/6/18 - WC has emailed J Robinson for update, waiting on response before closing. 10.4.18, 28.2.18, 6.6.17 & 24.10.16 J Robinson and F Reddick to provide update or close. 28/2/18 When the newer needles were introduced both radiologists trialled and both found that they were unable to obtain the detail for optimum needle visualisation during FNA, Biopsy procedures.	LOW	DIV
3905	26/07/2017	Provide safe, high quality careMake the best use of resources	4 North Surgical	Oxygen and Suction not central in bay	Patient who is furthest away from O2 and suction ie at entrance of bay. Due to tubing etc being long - implication are that there is a ligature risk and suffocation risk. Call bell system is also at risk of failing due to age and poor condition.	As per email dated 8 July 2017 there are no plans to replace bed heads in 4 North/4 South in the immediate future.	12/06/18 Situation remains the same. 10/4/18, 28/2/18 - no costs at present, to email Estates. Due to ongoing bed pressures unable to close a bay. 26/7/17 Estates need to provide cost, delayed due to winter pressures 15/16	LOW	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.	12.6.18, 10.4.18, 28.02.18 Risk remains unchanged 6.11.17 remains unchanged, no UPS on anaesthetic machines or any other monitoring equipment in STH Theatres/DPU. 30.5.17 Risk remains unchanged	HIGH	HOS
1205	15/08/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards recommended in the Hine Review, increasing the risk of infection transmission.	STH have new fully compliant decontamination facility which is JAG accredited. DHH same opened Jan 2014. CAH day surgery has been refurbished with AERS and drying cabinets and is awaiting the installation of new sinks.Interim decontamination facilities for main theatres, Xray and ENT services are in place. Management of this service has been taken over by CSSD staff. Minor works upgrade to the endoscopy theatre and storage facilities is taking place to comply with JAG.	12.06.18, 10.4.18, 28/02/2018, 6.11.17 & 30.05.17 Remains unchanged. All areas compliant with Hine recommendations now. To remain on Risk Register as not achieving JAG accreditation	LOW	HOS
3299	31/12/2012		Anaesthetics, Theatres & Intensive Care Services	CAH Main Theatre Staffing Risk	Due to increase in sick leave/maternity leave within Main Theatres CAH, this has led to being unable to provide additionally with consequence risk to ENT and Urology access targets.	Avenues explored 1. Cross site working of all staff difficulties, can be stabilised through redeployment of staff nurse from Female Surgical to DPU. 2. Extra hours offered to all staff Trustwide -email to be re-circulated to al ward sisters. 3. Increased hours for parttime staff working within Trust across all sites. 4. Contacted staff on secondment. 5. Contacted staff on Maternity Leave for keeping in touch days. 6. Bank-unfortunately unable to provided the necessary number of requests. 7. Block bookings requested - staff starting who are only out of University and will be under 24 week preceptorship. 8. Staff moved from other areas to fill core sessions in CAH. 9. Excalated to line management.	12.6.8 Unchanged. Recruited only 1 theatre nurse from nursing recruitment fair. Presently trying to secure agency staff. 10.4.18, 28.02.18 Remains unchanged. 7.11.17 monthly staffing meeting with lead nurses identifying e-reqs established. Weekily theatre rota meetings ongoing to ensure cross site working. Bank and agency staff still employed to cover core sessions 30/5/17 - Theatre staff rota meeting offers cross site working. Bank, agency and additionality continue to cover core sessions. E-req has been completed for all vacant posts	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
879	04/08/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	Moving and handling risk to staff when having to move equipment around the department due to inadequate storage space	Moving and handling risk to staff when having to move equipment around the department due to inadequate storage space; equipment (hoist/microscope) being stored in changing facility.	All staff trained in moving and handling; all staff aware of where equipment is stored; staff are informed of position of equipment and of precautions to be taken when in this area.	12.06.18 Storage space continues to be an issue. 10.4.18, 28.02.18, 6.11.17 & 30.05.17 Risk remains unchanged 2.02.14 Storage space continues to be an issue. Currently seeking approval under capital works scheme for the provision of additional storage facility in DSU.	LOW	HOS

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Pharmacy Division
Divisional, HOS and Team Risk Register - July 2018

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
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 S Kilpatrick; 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
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

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
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

Medicine and Unscheduled Care Division
Division Reprot - August 2018

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
2382	19/10/2009	Provide safe, high quality careMake the best use of resources	Cath Lab CAH	No contingiency plan in place in event of cardiac catheterisation lab failing.	Risk to health and safety of patients is compromised if cardiac catheterisation lab equipment fails :- 1. Whilst the patient is on the table mid procedure 2. Loss of capacity due to failure causing impact on waiting time standards	1. Should failure occur whilst the patient is on the table mid procedure - a n arrange ment with radiology permits the short term loan of the portable image intensifier to complete the case and maintain the patients safety. 2. No controls in place	26.02.18 Awaiting update, risk remains unchanged. 1.09.16 IPT developed, Working Group Established. Awaiting confirmation of funding and equipment on NHS supply chain. 01.06.16 - business case for replacement and upgrade of equipment. Use of radiology equipment in the interim when required.	HIGH	DIV
3626	05/12/2014	Safe, High Quality and Effective Care	Accident & Emergency	Reliance of Medical Locums in ED	Sub-optimal care.	Clinical review of work by consultant in charge.		MOD	DIV
3627	05/12/2014	Provide safe, high quality care		Increasing patient dependency impacting upon ward staffing.	Dependency levels and health and safety of patients and staff due to sustained high level of dependency, a rapid throughput and reduced length of stay.		01.06.16 - International recruitment ongoing. 26.11.14 - Normative staffing level submitted and allocation of £1.5 million made to SHSCT. ADs and HOS to raise with Director to prioritise allocation of this funding to wards under most pressure.	MOD	DIV
3624	05/12/2014	Safe, High Quality and Effective Care		Lack of a Biologic Suite	Treatment of patients in facilities which are not designed for this purpose.	Use of isolation ward.	29.02.16 - Plans in place to upgrade Ramone Ward to improve the accommodation when administering biologics.	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
3625	05/12/2014	Safe, High Quality and Effective Care		Clinical mangement of Medical Outliers.	Potential for patients not to be identified correctly and therefore missed by the clinical teams.	Correct use of IMMIX and updating as per protocols by all staff.	01.06.16 - Still ongoing. Review of processes being taken forward. 29.02.16 - Requires directorate focus.	MOD	DIV
3685	08/06/2015	Provide safe, high quality care		Lack of pharmacy cover.	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.	01.06.16 - Business case prepared for additional resources.	MOD	DIV
3686	08/06/2015	Provide safe, high quality care		Lack of junior medical cover	High demand for cardiology admissions. Due to cover for night duty, annual leave, reduced number of cardiology staff available at ward level. Delays in Treatments, Discharges.	Continues to be managed	26.02.18 Still gaps in junior medical staff provision from NIMDTA and trust are sourcing this via agency contracts.	MOD	DIV
3687	08/06/2015	Provide safe, high quality care		Medical equipment in Cardiac investigations are old and some parts unable to be replaced	Due To the high demand for cardiac investigations across the trust if these equipment break or become obsolete this is risk to cardiology service	No replacement programme in place yet but replacement programme should be in place soon.	01.06.16 - New equipment ordered. Will be delivered June 2016.	MOD	DIV
3688	08/06/2015	Provide safe, high quality care		Decontamination of TOE probe	The current process for decomtamination does not meet Best Practice Guidelines	Sourcing the use of a further probe from ICU as a temporary measure. Requisitioning additional probe.	26.02.18 Another ECHO and TOE probe purchased delivery date expected by 31.01.18.	MOD	DIV
3702	21/07/2015	Provide safe, high quality care		Patients that are being outlied from medical wards are regularly not transferred under the correct physician/geriatrician.	There is a risk that patients will not be seen on a daily basis by their doctor. There is a risk that if the patient's condition deteriorates it is not managed properly. This is a delay in treatment and discharge planning.	Person in charge of the receiving ward will check at the end of their shift that the FLOW board is accurate. Person in charge of looking after the patient that has been outlied on the receiving ward must ensure patients are reviewed on a daily basis and escalate when this does not take place to the correct medical team.	01.06.16 - Guidelines sent to patient flow team advising that each evening the patient flow must check and ensure all patients outlied are placed under the correct consultant. Daily check to be carried out for 8.45am bed meeting.	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
3759	26/01/2016	Safe, High Quality and Effective Care	Diabetic Clinic, Surgical Outpatients	Diabetic Antenatal Clinic Risk	Increase in patients attending, significantly since change in threshold for Gestational Diabetes (IAD and PSG 2010). Difficulties arising due to the increase in numbers of patients who need to be seen at these clinics.. Poor pregnancy and neonatal outcomes.	The old early pregnancy room is vacated request submitted to create an additional clinic room. The clinic is commissioned for 1 Doctor; however, effort to ensure that 2 additional doctors attend. (Currently unfunded and can impact of other duties)A GP with specialist interest covers ad hoc. A Locum Physician with specialist interest covers to provide a second doctor. The Consultant from DHH has provided cover however this requires backfill in DHH. The number of CTG's at clinic has been reduced. Patients requiring steroids - Dr Sidhu assesses patients on a Thursday afternoon and if they require and admission the Diabetes Consultants try to ensure that this admission occurs on a Monday as there is no cover available over the weekend to advise on insulin doses. However it is problematic when the situation arises where it is	01.06.16 - Diabetic Antenatal Specialist Nurse recruited. Increased number of patients requiring interpreters at clinics which is slowing down appointments. 29.02.16 - Additional diabetic nurse specialists have been recruited and a second consultant for the DHH site has been advertised.	MOD	DIV
3769	25/02/2016	Safe, High Quality and Effective Care		1:1 special staffing not available when required	Patients that are confused, agitated, aggressive or have a lack of awareness of their ability to mobilise are at a greater risk to themselves or others if 1:1 care is not available. Patients at risk of harm to self or others. Loss of dignity of patient. Ward disruption	1:1 care is not always available to care for patients that are confused, agitated, aggressive or unaware of their inability to mobilise. This results in a greater risk to their safety, the safety of others increasing disruption on the ward and upsetting other	26.02.18 Guidelines developed by Lead Nurses, to be signed off at Acute Nursing and Midwifery meeting 05.03.18	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
3857	29/11/2016	Safe, High Quality and Effective Care		Increased patient confusion when moved continually around wards	There is a risk that elderly patients could have an increase of confusion or develop a delirium if they are moved from one ward environment to another. This would increase with the more moves that occur.	Increased confusion which could lead to patient distress, falls, increased requirement of medication to reduce agitation. Family's distress at relative being more confused than usual , or experiencing confusional state for the first time. In the event the hospital is under bed capacity pressures and outlying is required all Ward staff must ensure that they identify patients that are medically stable, do not have a known confusion or at risk of delirium, or have a learning disability	(Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive). It is within the outlying guidelines that patients that are confused should not be moved between wards unless for a clinical reason. This can be a challenge due to the ongoing bed capacity pressures experienced within the acute setting.	MOD	DIV
3863	21/12/2016	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeing	Renal Unit Daisy Hill Hospital	Lack of consultation rooms in Renal OPD	Nephrology outpatients are at risk. There is risk to patients from lack of education regarding drugs and diet.	Education is frequently carried out in a totally unsuitable environment which is not conducive to patients health and well being (Fire escape corridor). In addition other staff are displaced from offices to accommodate patient consultation/education including Dr McKeveney Consultant Nephrologist who is displaced fom his offie during clinics.	26.02.18 Priority No 7 on capital list.	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
3914	19/09/2017	Provide safe, high quality care		Gastoenterology/IBD Nurse Cover	As a lone worker there is no cover for her annual/sick leave which leaves a gap in the service. Unable to fill as no-one trained to undertake. The Nurse Specialist does not have sufficient capacity to see ward patients due to clinic, biologic, patient telephone helpline commitments. Telephone calls not being returned to patients within 48 hours when they contact the help line. If the IBD Nurse Specialist is not available to take the patient	As this is a single handed service with no cover there is no measure which can be put in place. There is a requirement for additional Gastroenterology/IBD Specialist Nurse. the only alternative to the Specialist Nurse not being available is for patients to attend the Emergency Department.		MOD	DIV
3923	13/11/2017	Safe, High Quality and Effective Care		Cardiac CT angio, high demand	Currently have high demand of Cardiac CT angio. Waiting Time is 55 weeks Non compliant with NICE guidelines re Chest pain diagnosis -- first referral is CT angio. Patients are waiting 55 weeks for this diagnosis which can delay	Only Two sessions per week. Have requested additional funding for a further 3 sessions of CT angio. to address waiting times.	26.02.18 Two additional sessions per week provided by review of jobs plans. The access to cardiac MRI and CT angio has been raised regionally and HSCB setting up meeting to discuss	MOD	DIV
3924	13/11/2017	Safe, High Quality and Effective Care	2 North Haematology	Haemtology/Oncology Helpine provision in the out of hours period	The service has been provided for Oncology/ Haematology patients within the Southern Trust without any additional Funding. Non compliance with the oncology/ Haematology Triage. 1.1 unable to ensure that patients receive timely and appropriate responses to their calls. 1.2 patients right to be treated with a professional standard of care. 3.3 no clearly identified triage practitioner for each span of duty the process should allow for allocation of responsibility to a nominated triage practitioner for a period of duty. on completion of this period the responsibility for advice line management and follow up of patients is clearly passed to the	Hourly checks in place in the haematology ward regarding phone messages patients advised to ring back if not contacted within 15 mins to ring back to ward or if emergency to ring 999 or go to ED. Group set up to review other options that could be resourced. Band 5 out of hours period 7 days per week and at weekend and bank holiday being costed by finance.	26.02.18 Raised regionally by HOS Oncology. Pilot re Band 3 taking phone calls in place Monday-Friday 9am-5pm, awaiting results of this.	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
3969	31/07/2018	Provide safe, high quality careBe a great place to workMake the best use of resources	Medical Admissions Unit	Risk to Staff of Assault on Acute Medical Ward	Staff at high risk of being harmed. Staff have sustained personal injury and have alleged they have been sexually assaulted in this ward.	Ongoing support for staff. Identying patients at high risk and requestion one to one. Requesting security 1 /1 for violent/aggressive patients. Review of GMAS - AD pharmacy for approval. Refurishment of nurses station - further risk assessment being carried out on same. Ongoing monitoring of same. Ongoing MAPA training for staff		MOD	DIV
3970	31/07/2018	Provide safe, high quality care		Telemetry Systems, Cardiac Monitoring Unable to purchase spare parts	Lack of Cardiac Monitoring at Daisy Hill Site. Currently 6 cardiac monitors operational but only 2 of the 10 telemetries working. The replacement of the cardiac monitoring system was raised in 2016 with the aim that we would roll out the same system installed on the CAH site. When the scoping exercise was carried out as the current system was 15 year old it was agreed that estates work was required. Concerns raised October 2017, March 2018 and again June 2018. Concerns for patient safety due to lack of cardia monitoring on DHH site. Cardiac patient are nmot being monitored as per guidelines therefore a huge risk to patients	Contingency plans that we have is to 1.Utilise HDU beds for Sick Cardiac patients, 2.Transfer our coronary patients to 1 North.		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
1022	07/08/2008	Safe, High Quality and Effective CarePro vide safe, high quality careBe a great place to work		Disruption caused due to violent/aggressive patients or relatives	Disruption caused due to violent/aggressive patients or relatives - big demand on nursing time causing time spent away from other patients; health and safety and wellbeing of visitors, patients and staff when dealing with/managing violent/aggressing patients; all wards, CAH and DHH.	Staff awareness of proactive approach; availability of security guidelines for alcohol withdrawal for inpatients; review staffing levels; medical review of patients by doctor; consultation with Consultant and Bed Manager; liaison RMN in post; personal safety in the workplace training available for all staff; violent and aggressive behaviour towards staff post incident procedure in place; policy and procedure on the management of aggression and use of restraint; transfer to suitable environment/appropriate	01.06.15 - Disruption continues to be caused due to violent and aggressive patients and/or relatives.	LOW	DIV
1025	07/08/2008	Safe, High Quality and Effective Care		Dependency levels and high bed occupancy	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	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
3050	29/11/2011	Make the best use of resources	Corridor/Landing	File Management Issues- Hospital Social Work Department, CAH.	Accomodation issue. Not enough room to store patient records in line with the Trust Retention Policy.	Records reviewed annually. Use of closed storage. Accomodation request previously submitted. AD and Corporate Records aware of issue. Review 9.12.14 discussed with Line Manager and HOS for Corporate Records. Continue to use closed records. Trial using electronic solutions in the community to be audited and then for further consideration by	26.02.16 - Health and Safety Risk Assessment completed. 26.11.14 - HOS to re look at all storage options including off site, scanning and microfilming.	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
3892	24/05/2017	Make the best use of resources Provide safe, high quality care		Unable to achieve Training Objectives	Training room being down sized resulting in reduced capacity and cancellation of ALS/ILS/BLS Impacts on training for staff throughout the trust, potential impact on patient safety. Potential for patients to be placed at risk secondary to lack of training provision.	No alternative control measure available.		LOW	DIV

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

Medicine and Unscheduled Care Division
Head of Service and Team Risk Register - August 2018

ID	Opened	Principal objectives	Location (exact)	Title
3768	25/02/2016	Safe, High Quality and Effective Care	2 South Medical	Inappropriate use of the designated Lysis treatment space in Ward 2 South Stroke.

2383	22/10/2009	Provide safe, high quality careMake the best use of resources	Accident & Emergency	Transfer of patients with unstable neck injuries to the Regional Centre in Belfast
3831	28/09/2016	Provide safe, high quality care	Day Clinical Centre	Sluice not fit for purpose

3832	28/09/2016	Provide safe, high quality care	Day Clinical Centre	Lack of storage within the DCC in DHH
3508	24/10/2013	Safe, High Quality and Effective Care	Accident & Emergency	Overcrowding in ED may result in patients coming to harm by delay in assessment and treatment.

2250	08/09/2009	Provide safe, high quality careSafe, High Quality and Effective CareImproving Health and Wellbeing Effective organisational governance		Risk to health and safety of patients presenting to the trust with chest pain.

1027	07/08/2008	Safe, High Quality and Effective Care		Risk of spread of infection due to inadequate facilities

1044	08/08/2008	Safe, High Quality and Effective Care	Wards	Safety and wellbeing of patients and staff due to lack of storage space
3509	24/10/2013	Safe, High Quality and Effective Care	Accident & Emergency	Lack of Monitoring Equipment threatens patients safety in Majors in ED

3864	21/12/2016	Provide safe, high quality careMake the best use of resources	Renal Unit Daisy Hill Hospital	Lack of isolation facilities for haemodialysis
2083	21/10/2008	Improving Health and Wellbeing Effective organisational governance		Risk of staff ill health due to environmental factors and unsuitability of office accommodation for purpose in Clanrye House DHH

Des/Pot for Harm	Controls in place
The designated lysis treatment space in 2 South Stroke is regularly used for patients to relieve bed pressures through out the hospital. If this bed is occupied when a patient requiring lysed is admitted this emergency procedure is either delayed or requiring to be carried out in the Emergency department. Both scenarios are not appropriate. The patient's condition can deteriorate or the post lysis outcome is not optimum if the procedure is not carried out in required the timeframe the procedure is carried out in ED the nurse from 2 South Stroke is off the ward for 4-5 hours thereby leaving the ward short and increasing risk for the other patients on the ward.	Produce a guideline for the appropriate use of the Lysis bed and share across the division for clarity of all staff on the ward, working in Patient flow or on call. Work closely with patient flow to ensure this bed is not used unless there are extenuating circumstances and after discussion with the HoS on site or on call.

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.
Sluice not fit for purpose due to size and location of flush on sluice and lack of space for commodes.To operationalise the sluice poses an element of risk to staff from an infection control and health and safety stance. Due to the size of the sluice the staff can not manoeuvre around to dispose of wastage. It poses also with the location of the flush lever a stretching motion to carryout task . The Sluice also has lack of storage for the commodes .	The environment is very compact for the sluice poses an element of risk to staff from an infection control and health and safety stance. To date we have had a stool to avoid the stretching.

Capacity for storage will impinge on staff workflow .The Lack of Storage within the units lends itself to overcrowding of stock items essential for the treatment of patients within the DCC.	he environment is very compact for the amount of storage needed in the treatment of the DCC patients. Due to the diversity of the type of patient a lot of different stock has to be stored.
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.

Risk of missed diagnosis in wrongly interpreting a patients ECG by junior medical staff. Patients may not receive timely and effective treatment appropriate to their diagnosis.	Where possible a senior member of medical staff will review ECG and give an opinion. Thrombolytic team should be paged immediately if patient presents with ischemic cardiac pain.

Risk of spread of infection due to inadequate facilities, e.g. lack of sidewards, bed space near sinks and sharing of equipment; all wards, CAH.	Endeavor to adhere to current infection control policy; new visiting policy guidance; use of alcohol gel Trust wide; infection control link nurses in each ward; daily monitoring by Infection Control Team; equipment controlling.

Space; health, safety and wellbeing of patients and staff due to lack of storage space, lack of bed space, not meeting department guidelines, sanitary facilities, counselling facilities, toilets and showers; lack of space for equipment; all wards, CAH and DHH.	Utilise all available space effectively.
Patients that are placed in the Cubicles in Majors that will require physiological monitoring. Patients may deteriorate in cubicle without warning alarm from monitor. CNS observations delayed due to lack of equipment. Inability to assess and monitor patients that present with illness. Delays in treatments and assessments of patients. Failure to recognise patient deteriorating.	Four new monitors replaced condemned monitors in 2012. This leaves 6 cubicles without monitoring equipment. These measures are effective but require further action. Bids for Capital have been attempted for 6 monitors but have been unsuccessful.

Augmented care area. Dialysis patients ar risk of acquiring hospital associated infection. Infection Risk.	Training in place. Cohorting of pattients where possible. Juggling of patient slots.
Staff complain of eye irritation, throat irritation, respiratory problems, residual hearing symptoms related to background noise. Two members of staff previoulsy attended Occupational Health in relation to health issues associated with the working environment. Seven members of staff occupy office. Alternative accommodation on site was considered large cost implication e.g relocating to medical records store first floor level - approx cost £28,000. Accommodation request submitted previously	2013 - Ventilation and lighting monitored by estates services. Working environment actively monitored by Acting Senior Social Worker. Staff had been offered prospect of room dividers.

Progress (Action Plan Summary)	Risk level (current)	Register Holding
01.06.16 - New process in place for protected beds. 25.02.16 - New Risk.	MOD	TEAM

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 P Smyth & M Burke on 27.09.11 on going monitoring of this risk by Nurse Manager & HOS	MOD	HOS
	MOD	HOS

	MOD	HOS
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	HOS

01.06.16 - NICE guidelines currently being reviewed. 01.02.13 Chest pain pathway to be reviewed by clinicians. 25.10.12 - Position remains unchanged from previous report - no adverse incidents reported since. 23.01.12 - Cardiology liaison service commenced 9am - 5pm Monday - Friday. 07.09.09 - a training package has been developed but no dedicated funded personnel to deliver training package to junior medical staff on an ongoing basis has been identified.	LOW	HOS

01.06.16 - Some work carried out during the last refurbishment. Negative Pressure Room in Ward 2 North Respiratory. 25.09.13 - further development of en suite side rooms planned for CAH 2 South along with work highlighted below in 1 South due to commence October 2013 negative pressure isolation rooms being installed in main block for ill patients who cannot transfer to ramone ward. 27.11.12 - Ramone Ward now operational. Work to commence on Ward 1 South in March 2013. Clear guidance and risk assessments in place. Daily review of all patients in side rooms with input from infection prevention and control team. 01.10.11 Risk reviewed by MB,KC, SB on 27.09.11. Isolation ward opened in June	LOW	HOS

01.06.16 - Storage space still not adequate. Refurbishment has helped but still falls short of appropraite standard. 26.11.14 - AD to write to locality team to raise issue of non-clinical use of clinical space on wards. 25.09.13 - refurbishment on-going. 27.12.12 - Each ward working towards refurbishment programme. 01.10.11 Reviewed 27.09.11 no change in risk. Minor works being identified at ward level to be undertaken to create more storage space.	LOW	HOS
24.10.13 - 6 monitors will cost £30k - £40k. Further bid for capital submitted.	LOW	HOS

26.02.18 Priority No 7 on capital list.	LOW	HOS
26.02.16 - Health and Safety risk assessment form completed. 2013. New fans provided to allow exchange of air.	LOW	HOS

Integrated Maternity and Women's Health Division
Divisional, HOS and Team Risk Register July 2018

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3942	27/02/2018	Provide safe, high quality care	Delivery Suite	Possible breakdown of aging resuscitaires	Spare parts no longer available for old models of Resuscitaire currently in use in both CAH and DHH. Possible risk to newborns when high number of births on	Manage number of planned deliveries coming into each hospital.	Feb18 Currently on Capital List for replacement resuscitaires	MOD	DIV
3678	26/05/2015	Make the best use of resources Provide safe, high quality care		Lack of accomodation for Antenatal Clinics	Lack of available rooms to undertake antenatal clinics resulting in delay in patients requiring additional visits.	Patients are being booked between 6 and 8 weeks and are required to come back at approx 12 weeks.	22.1.18 Still ongoing risk 14.11.17 -Current Antenatal outpatients setting is being reviewed for refurbishment to allow for an Ambulatory service with redevelopment for DOU and A+A Unit on the CAH site. 6/6/17 Participating in Trust Accomodation Group - all requirements to B Conway 30/11/16 Situation ongoing	MOD	DIV
3859	30/11/2016	Provide safe, high quality care	Community Midwifery	Unable to implement Maternity strategy Re 31 Week Antenatal apt	Unable to implement Maternity strategy in relation to 31 week antenatal appointment The Maternity Strategy recommends all women to be reviewed at 31 weeks however, do to lack of clinical space in GP surgeries and antenatal clinics we are currently unable to facilitate this. Therefore more resources are	None in place at present	27.02.18 This will be reviewed with the new antenatal pathway 14.11.17 -New updated Antenatal Pathway will include the 31 week visit. Currently to be rolled out on the CAH site and then all other sites to follow in early 2018. 6/6/17 Project - antenatal pathway commenced.	LOW	DIV
3162	13/06/2012	Provide safe, high quality care	Delivery Suite	Trium archiving system	Trium archiving system is intermittently working due to:- CAH site - 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	22.1.18 Still ongoing risk 14.11.17 Awaiting update from Wendy Clarke. 6/6/17 Plan in place working through the backlog. 30.11.16 MDI have bee asked to come and look at the boxes and to possibly replace them.Further advice required in relation to new cabling in CAH.	LOW	TEAM

Functional Support Services Division
Divisional, HOS and Team Risk Register - July 2018

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
1220	18/08/2008	Provide safe, high quality careBe a great place to workMake the best use of resources	Laundry	Essential laundry equipment needs to be replaced to avoid breakdown and disruption	Essential laundry equipment needs to be replaced to avoid breakdown and disruption to this fundamental service requirement; equipment breakdowns not only affect the service which is provided to Southern Trust facilities but also to Belfast City and Musgrave Park hospitals. Risk to the supply of clean bed linen to wards and departments. Risk of infection. Impact on service delivery by nursing staff delay in making up beds.	Regular maintenance of ageing equipment as replacement parts are becoming obsolete.	5.4.18 Business case was recosted 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 calanders 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	MOD	DIV
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
3911	15/08/2017	Provide safe, high quality careMake 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	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

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
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.	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
3813	20/07/2016	Provide safe, high quality care	Switchboard	No facility for Emergency Bleep if Switchboard is evacuated	Emergency Team alerts and a fast bleep facility can only be activated via the multitone console in Switchboard. Unable to transfer to DHH Switchboard.	Unable to implement controls. Continue to monitor. Paper completed to identify the risk.	5.4.18 iMessage system fully functional. If crisis in either CAH or DHH bleeps can be diverted to alternative Acute Hospital. External numbers now in place so that bleep system can be activated from any phone to set off Emergency teams or one-off paging. Full Comprehensive testing of the system is required before Risk could be stood down. 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
3814	20/07/2016	Provide safe, high quality care	Switchboard	Possible breakdown of aging Multitone paging console	The Current Multitone paging console used to alert teams and fast bleep is obsolete. New consoles cannot be purchased. Switchboard currently have 2 consoles in use and 2 spare which can be used in the event of a console failing. Switchboard alert teams by pressing a sequence of keys and entering a Team Code. Emergency Teams are alerted to the location of an emergency via a voiceover. In noisy areas the voiceover may be difficult to hear, the bleep holder then will ring Switchboard to find out the location of the emergency, causing a delay. Current system allows only numeric messages and voiceovers. Bleep holder will ring then extension number on the bleep to receive the message. If more than one team is required Switchboard will follow a protocol alerting each team individually, creating a slight delay. Emergency alerts only go to Multitone bleeps.	Unable to implement controls. Continue to monitor. Paper completed to identify the risk.	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. All Telephonists now have a console (SCU) between each station to ensure there is back-up. Each SCU can be put into different modes to change between CAH & DHH therefore if there is an issue with the CAH server, the SCU can page CAH via DHH. 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
3815	20/07/2016	Provide safe, high quality care	Switchboard	Inability for cross site bleeping	Currently staff working in different sites cannot bleep a member of staff in a different site for e.g. Staff in Daisyhill ring Switchboard in Daisyhill to be connected to Craigavon Switchboard who will then bleep the person needed. Estimated fix cost £20K This is becoming an increasing problem as Services are shared throughout the Trust.	Unable to implement controls. Continue to monitor. Paper completed to identify the risk.	5.4.18 New iMessage system implemented to allow cross-site bleeping. 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
3834	04/10/2016	Provide safe, high quality care		Falls from height STH	Risk from condition of buildings, possible effects from drugs/alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm, death.	See attached action plan.	27.02.18 Minor Works request submitted for outstanding controls. A separate risk assessment is being completed by Acute Governance in relation to falls from heights.	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
3861	13/12/2016	Make the best use of resources	Grounds	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.	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
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.	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.	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 [Irrelevant redacted by the USI]	MOD	DIV
3792	13/04/2016	Provide safe, high quality careBe 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	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.	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
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
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.	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
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.	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

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3281	26/11/2012	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport 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.	12.12.16 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	DIV
3807	13/06/2016		Office(s)	Falls from height on Admin Floor CAH	Fall from height. Potential for someone to climb up and fall over the balcony from the admin floor to the atrium. Unauthorised persons in restricted areas which could lead to a breach of confidentiality, risk of theft or physical attack	There is wall approx. 102m high with a stainless steel guard rail. The main door is locked at night and weekends as are Individual room	12.12.16 The window panels have been installed thus reducing the risk to Very Low. The installation of access control system has no impact on falls from heights and a separate risk assessment on access to restricted areas is required to measure this risk. Window panels to be inserted to the openings on the full length of the area of the corridors open to the atrium. Install access control system to the corridor doors and back stairwell on admin floor	VLOW	DIV
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.	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

Cancer and Clinical Services Division
Division, HOS and Team Risk Register - July 2018

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3938	30/01/2018	Safe, High Quality and Effective CareAccessible and Responsive Care	Occupational Therapy Department	Data confidentiality and Information Governance risk	Lack of storage, 3 cages in OT Dept holding 53 boxes 2017 records, held in an area with high level of patients attending. Query confidentiality and Information Governance Risk. Possible breach of confidientiality, staff tripping and litigation.	Formal request has been made to stores to collect the cages as urgent. No other controls in place.	27.02.18 Risk continues to be monitored	HIGH	DIV
3728	01/09/2015	Provide safe, high quality care	Trustwide	Serious concerns following June 2015 Cancer Peer Review	Serious concerns for skin, urology and H&N following assessment against the cancer peer review standards. Potential for Harm; The highlighted serious concerns may result in risk to patients who are/should be on the cancer pathway.	Recognised capacity gaps exist, consultation with HSCB ongoing with IPTs submitted where appropriate and participate and await the outcome of the Regional outpatient reform exercise. With regards to CNS's await outcome of the Regional CNS prioritisation project.	22.1.18 No longer serious concerns. Awaiting new Risk Assessment with accurate update. There are now action plans in place for each cancer MDT. 14.11.17 Ongoing process. Working closely with cancer MDT's to ensure compliance against standards 6/6/17 Clinical Nurse Spec workforce expansion on a 5 year period agreed by HSCB. Skin & other CNS under recruitment. 24/10/16 Fiona Reddick to provide an update 6/1/16 - The Urology & skin task/finish groups continue to meet to address peer review issues.	MOD	DIV
3191	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	14.11.17 Cancer work plan under development, Cancer trajectories in place, Weekly monitoring continues 6.6.17 Difficulty achieving 62 day performance due to delay in 1st apt, investigation and external pressures including PET scan lung/cru oncology 28/06/2016-achievement of the 62 day pathway continues to be a risk due to external factors and internal factors such as delay in first appointments, increase in red flag referrals from GPs, Reporting of diagnostics . May performance 76%. • Breast screening and assessment, Breast 2ww - currently unable to achieve this target due to increase in demand and reduction in Radiologists and Surgeons to cover this service. Routine symptomatic breast service.	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
3869	23/01/2017	Safe, High Quality and Effective Care	Trustwide	Limited Speech and Language Therapist Provision	Inability to provide adequate Speech and Language Therapy to acute based patients due to increased volume of referrals of complex patients over previous 10 years - situation escalated by inability to backfill 2 senior staff on maternity leave and complexity of patients requiring SLT assessment. Capacity to provide Dysphagia treatment significantly reduced. Delayed assessment of patients designated nil by mouth so rehabilitation potential reduced. Delayed review of patients on modified diet Delay in discharge as SLT unable to respond to request for assessment and intervention re: swallow management including information re: food/fluid textures to carers. Potential for SAIs. Patients discharged prior to assessment Limited rehabilitation to patients, hence longer length of stay in hospital. 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. Inability to achieve regional PTL waiting time targets	Several requisitions for recruitment of suitably trained staff - unsuccessful Junior locum staff employed but not skilled enough to fully meet caseload demands All core staff offered additional hours Telephone referral system manned by administration staff Triage and prioritisation of referrals Waiting list for in patients Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands Cancellation of VFS clinics which leads to distress of patients and families.	22.1.18 Situation has deteriorated and continues to be monitored. 14.11.17 Secured SLT for AMU - recruitment in process, Capacity / Demand paper being revised, Prioritisation of demand continues. 6.6.17 Remains limited due to low investment in this service.	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

Acute Services Directorate
Directorate Risk Register - August 2018

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
747	28/07/2008	Safe, High Quality and Effective Care	CAH DSU, STH - DPU, DHH. No Backup Electrical supply	All these areas 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.	12/6/18, 7/3/18, 7/11/17, 4/7/17 & 30/5/17 No change, continues to be on the minor works request. Requires to be prioritised by the Acute Directorate. 6.11.17 STH - Has UPS on all endoscopy storage cabinets 6.11.17 CAH DSU has UPS all equipment including anaesthetic machine 6.11.17 Awaiting confirmation from DHH? UPS available on all equipment Moved to Directorate RR Dec16.	HIGH
3951	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.	Risk added to Directorate RR April 2018	HIGH
3952	10/04/2018	Provide safe, high quality care	Delays in prescribing treatment for CDI	Delay in treatment of infection can be associated with increased morbidity and mortality. The enquiry into the Northern Trust Clostridium difficile outbreak said that treatment should be given to any patient with Clostridium difficile within 2 hours of diagnosis. Where such a patient is septic they should receive treatment within 1 hour as per the Sepsis 6 criteria. Failure to treat a patient promptly carries of risk of adverse consequences to the patient (e.g. pseudomembranous colitis, toxic megacolon, the need for laparotomy and subsequent stoma a formation, death) as well as a risk of subsequent litigation to the Trust and the potential for disciplinary procedures to doctors and nurses from their governing bodies.	The microbiology laboratory calls out positive C.dfficile results as soon as they are known and informs the consultant microbiologist on duty and the Infection Prevention and Control Nurses (during working hours). The microbiology laboratory is fully complaint with the Royal College of Pathology's Key Performance Indicators with regards to this matter as audits would reflect. Nursing staff when contacted should inform medical staff immediately. On certain occasions this has not happened as RCAs have reflected. On other occasions medical staff have given excuses that they have been too busy to attend within 2 hours. This more often occurs depends the out of hours periods whenever there is a relative lack of medical cover and there is a particular issue in the non-acute sites where there is no resident medical cover. A lack of awareness of the urgency of treatment has also been given as a reason for not treating promptly. There would be significant concern that this could reflect general medical busyness out of hours and that other treatments could be being delayed as doctors are overwhelmed by the volume of work out of hours. The delay in administration of treatment for Clostridium difficile is is being picked up because of the root cause analysis process but many other things are not picked up. The antimicrobial stewardship team proposed a PGD to allow	Risk added to Directorate RR April 2018	HIGH

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3953	10/04/2018	Provide safe, high quality care	Inappropriate antibiotic use (tied to stewardship issues in terms of corporate actions needed)	Inappropriate antibiotic prescribing can lead to a rise in antibiotic resistance which impacts on the safety of the entire public. It can also lead to side effects for individual patients such as Clostridium difficile infection (CDI). The risk of CDI is enhanced where antibiotic treatment is unnecessarily broad spectrum or overly prolonged. Inappropriately narrow spectrum or inadequately long courses of antibiotics can also lead to adverse outcomes for patients including recurrences of infection and death. Inappropriate prescribing most often occurs:- (a) When patients receive antibiotics when they do not have infections - this often occurs whenever a diagnosis is initially unclear and infection is in an initial differential but antibiotics are not stopped whenever the situation becomes clearer. (b) A clear diagnosis is not made e.g. a patient is designated ?LRTI ?UTI - often even when a diagnosis is subsequently made broad spectrum antibiotics are not narrowed as they should be (c) When patients receive prolonged antibiotic courses instead of getting proper source control - all guidelines advise that abscesses or infected collections should be drained promptly if at all possible The patient is at side effects from antibiotics, at risk of acquisition of multi-drug resistant organisms, at risk of Clostridium difficile and potentially death.	The Trust conducts antimicrobial stewardship rounds to reduce inappropriate antibiotic use. This service however is limited by the inadequate number of microbiologists and antimicrobial pharmacists. The Trust has far fewer microbiologists than neighbouring trusts and the number it is funded for (2) is far short of what the Royal College of Pathologists standards says it requires. The Trust only employs 1 antimicrobial parmacist in comparison to the standard 2 in other Trusts. This means that the stewardship round service is exceptionally vulnerable to leave or illness and at best only is staffed to function two thirds of the year. The service has been severely impacted by the current staffing situation in the Trust. The Trust has only had a single microbiology consultant for over a year and a half. At times there has been no locum cover and there is not capacity to do stewardship rounds when a microbiology is single-handed. Since the Trust's antimicrobial pharmacist was promoted several months ago the Trust has had only had a pharmacist effectively 1 day a week which again had a severe further impact on the antimicrobial stewardship service. Membership of the Trust's Antimicrobial Team Meeting (the main forum for communication for stewardship issues) had waned however the DIPC recently reviewed the membership of the meeting and medical leaders are now expected to attend. This has significantly improved the platform at which stewardship is	Risk added to RR April 2018	HIGH
3954	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.	Risk added to Directorate RR April 2018	HIGH

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
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.	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
773	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 ENT OPD clinics. 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 OPD 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	Situation being monitored.	12.6.18, 7.3.18 This risk remains unchanged 1.12.16 No further change 13.9.16 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

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3528	05/02/2014	Safe, High Quality and Effective Care	Pharmacy Aseptic Suite	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding) The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	Increased environmental monitoring to check for failures of sterility in the unit Expiry dates of all products prepared has been reduced to a maximum of 24 hours. A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	16.10.17 Unchanged 1.12.16 No further update. 13.9.16 Development Work ongoing 1/3/16 Work commenced for new suite. • Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July 2017. The design team have met throughout August with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed by mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited. two additional pharmacist posts were funded by HSCB to address the staffing deficit that was leading to the capacity plan model showing that the pharmacists are	MOD
3729	01/09/2015	Provide safe, high quality care	Lack of ability to recruit and retain senior decision makers in DHH ED (or inreach from Med or Surg) in OOH period	In th context of rising attendances to DHH during the 24 hour period, (specifically in the last 12 months = 10%), numerous unsuccessful medical recruitment drives to improve and stabilise the senior decision maker tier in and out of hours within the ED and clinical governance concerns, the acute directorate believe that DHH ED in its current form is not fit for purpose. Potential for Harm; There is an increased risk to patients and service users in the OOH period as there is no ready access (on the floor) to senior medical decision makers.	Immediate and ongoing: Trust seeking agency locum middle grade cover in DHH ED, or via in reach from medicine and surgery. Immediate and ongoing: abdominal pain protocol agreed and operationalised between ED and surgery Immediate and ongoing: Adverts for substantive middle grade staff in ED, and / or Surgery and Medicine to provide senio decision makers within the OOH period. Closing date 4th June Immediate and ongoing: Daily monitoring with the acute directorate. Weekly monitoring by Cx chaired oversight group.	1.12.16 Situation continues to be monitored. 15.09.2016 Consultants appointed to CAH doing outreach to DHH. Locum doctors have been engaged. Plans to readvertise for permanent staff 27.05.16 - Work of Senior Oversight Group continues. 1.3.16 - Senior Oversight Group established in September 2015 to review DHH ED Medical staffing. Group meets fortnightly. Action plan in place to manage the risk. Regular updates provided to PHA, HSCB and LCG. Ongoing efforts to secure additional medical staff through substantive trawls and in the short term through locum agencies. Immediate and ongoing: Daily monitoring with the acute directorate. Weekly monitoring by Cx	MOD

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3897	14/06/2017	Provide safe, high quality careMake the best use of resources Be a great place to work	Insufficient Consultant Radiologists to provide the necessary diagnostic reporting services for SHSST.	Due to insufficient availability of Consultant Radiologists within Northern Ireland and the UK the Southern Trust has been unable to fill the funded posts within Radiology. Therefore the Radiology Department is unable to provide a full responsive reporting service required for inpatient and outpatient examinations ie red flag, urgent and routine examinations. Delay in reporting of routine plain film x-rays has increased due to the rise in demand for inpatient CT and MRI examinations which utilise a significant proportion of Consultant capacity. we have maximised the activity of reporting radiographers and all backlog activity requires reporting by a Consultant Radiologist. Currently 12,000 plain film examinations are waiting for a diagnostic report, 6,299 of these are chest X-rays and of these 2,290 are waiting for reports longer than 28 days. The longest waiters are at 61 days. There is no mechanism for additional in-house activity for plain film reporting. Potential for harm arises due to delayed diagnosis, specifically lung carcinoma, with consequent delay in treatment and poorer prognosis.	Monitoring of waiting lists, prioritisation of Emergency Department, all red flag and urgent examinations. Maximisation of the current IS contracts with 4 ways and RRO, both of which are unable to increase their volumes. Working to procure furthur Independent Sector (IS) providers for routine reporting via PaLs and NHS supply chain. This latter action is required to deal with the backlog and to maintain the performance standard. Through the Managed Clinical Radiology Network we will seek the assistance of other Trusts within the Region with Plain Film reporting.	7.3.18 Risk remains unchanged, still significant gap in cover	MOD
3663	29/04/2015	Provide safe, high quality care	Single CT Scanner available on both CAH & DHH	No CT service available to patients when the CT is down due to essential maintenance/breakdown. Delay in diagnosis, delay in discharge. CAH major trauma will be diverted to other hospitals.	All essential maintenance is carried out at weekend or evening periods. Trauma patients are diverted. Global communication e-mail is circulated when CT is down. Transfer of urgent inpatients between CAH/DHH sites.	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. 13.9.16 No further update provided 28.6.16 Awaiting funding to replace mobile CT scanner to place 2 permanent scanners on CAH site. 1/3/16 Retaining mobile CT to July 16. 5/1/16 - Jeanette is meeting with Sandra Waddell re completing a IPT to request funding to retain the mobile CT following the 1/4/16.	MOD
3940	26/02/2018		Provision of a on-call bleeding rota	Inability to provide consultant cover every on-call night 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.	10.4.18 Escalated to Directorate RR 26.02.18 Risk added to Divisional Register	MOD

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
2979	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.	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.	MOD
3070	23/01/2012	Safe, High Quality and Effective Care	Omitted and delayed medications within Acute Directorate Wards	Wards and departments not administering medications in a timely manner. Patients are receiving an inadequate quality of service with the potential risk for harm.	Staff nurse or ward based pharmacist where possible highlights all incidents via datix. Proforma is to be completed in conjunction with the Band 6 and the staff nurse responsible for the omission or delay to reinforce learning and improve standards. Staff nurse to escalate to Ward Sister if any delays or omissions at ward level.	06.09.17 Jilly and Trudy to discuss 1.12.16 No further update. 13.9.16 Audit completed. Report circulated for learning. Showing some improvement but NQI monitoring continuing. 27.05.16 - Yearly audit taking place May/June 2016. 23.02.16 - Ongoing NQI audits continue to highlight this problem area. 24.09.15 - Focus on the number of omitted and delayed medications in SEC continues supported by lead nurses, HoS and the NEAT project. Regular audits to monitor performance in this area and learning from medicines incidents group shared across the directorate.	MOD
3304	16/01/2013	Provide safe, high quality care	Lone Workers in X-Ray after 12 midnight	Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period.	Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting.	14.11.17 Awaiting update from J Robinson 5.12.16 The lock down system is being installed W/C 12 Dec 16. 13.9.16 Situation continues to be monitored	MOD

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3733	24/09/2015	Safe, High Quality and Effective Care	Directorate's ability to recruit and retain nursing staff due to a regional and national shortage of qualified nursing staff.	There is a potential for wards to be understaffed which will result in poor outcomes for patients.	The Directorate 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.	12/06/18 - Nursing recruitment fair start of May18, 1 recruited for theatres & 1 for T&O. All measures to combat vacancies utilised and exhausted. Risk remains same. 07.03.18 Continued risk remains same 23.9.17 - Recruitment remains unchanged in that most wards have unfilled funded vacancies. Usual measures to combat these vacancies continue ie Bank, OT and agencies. 4.7.17 Unchanged 30/5/17 - international recruitment drive for staff nurses ongoing. Local interviews ongoing. Continue shortage of nurses continue - both regional and national shortage 1.12.16 International recruitment for this year finished. New nurses to start in 2017. 1 to Ward 4 North and 1 to Ward 4 South. Band 5 Recruitment day conducted on 25.11.16 13.9.16 Phase 1 international recruitment started. Induction program in place prior to staff allocation to wards. Ongoing recruitment continuing. 27.05.16 - Regional and International recruitment continues. 23.02.16 - AD of Nursing seconded to	MOD
3819	27/07/2016	Provide safe, high quality care	Shortage of Qualified Midwives for recruitment	Reduced number of midwives being trained due to reduction of intake of students. This impacts on the availability of suitably qualified midwives to fill vacant posts. This problem will increase as the number of current midwives retire from service. Potential risk of inadequate staffing to provide safe, effective and quality care for mothers and infants.	Ongoing recruitment -Utilisation of bank staff to cover rota -Regional workforce working group to address the issue across all trusts.	05/09/2017 Recruitment has been successful, minimising vacancies (now 20 wte) however due to an aging workforce and continuing shortage of available midwives we need to maintain on the Risk register. Update 1/2/17 . We have now 27 midwife vacancies primarily in CAH . Recruitment continues but shortage remains. 5.12.16 We have successfully recruited a number of new midwives. Unfortunately many will not be available for work until they qualify in 2017. 13/9/16 Ongoing recruitment.	MOD

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3922	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 audit identified 53 NICE guidelines where an E proforma is required. 34 E proformas have been submittted to the HSCB and a further 8 are pending submission once the baseline assessment has been completed and approved by Acute SMT. 11 E proformas are now due for review and work is progressing to undertake this process. A copy of the updated May 2018 E proforma report will provide 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	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	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	MOD
3957	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		MOD
3958	30/04/2018	Safe, High Quality and Effective Care	EBUS service is not funded and therefore patients are waiting 4 to 6 weeks for this investigation	Patients requiring this investigation will have delayed diagnosis. Pot for Harm - Delay in investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential that diagnosis could be Cancer.	We currently have 1 session unfunded Working with Performance team to secure additional session for staff. To reduce delays patients are being transferred to other hospitals for this procedure Need To prioritise equipment ie Scopes for this procedure		MOD

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3529	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, As of April 2018 there are 1609 standards and guidelines identified on the Trust's register. 74% (1193) of these are applicable to Acute Services Directorate. Of these, 34% (405) remain at a partial or non determined level of compliance with many identifying significant external barriers impeding the Trust's ability to comply. 689 are indicated as 'Compliant ' and 99 indicated as either N/A or Superseded. It is noteworthy to state some of this data is pending QA as part of Phase 1 and 2 review work which has not been fully completed due to service capacity. 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	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	7/3/18 & 5/12/17 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. Regionally the WHSCT is to undertake a pilot of Sharepoint to ascertain if this system would be fit for purpose for the development of a regional information system for the management of standards and guidelines. HSCB are involved in this process and funding to support this initiative is currently being sought. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and	MOD
3515	14/11/2013	Provide safe, high quality care	Ineffective Cardiac Monitoring System in certain Wards/Departments in CAH and DHH	The current cardiac monitoring system is old and unable to monitor patients in various wards/departments in the hospital site given their physical location. Monitoring is not available for certain patients and patients then may be required to move to 1 North for monitoring unnecessarily.	Appropriate selection of patients for monitoring.	14.11.17 Waiting on decision to start work with the potential of relocating coronary care beds to the HDU in DHH. 1.12.16 No further update. 13.9.16 In relation to CAH telemetry, this has now been fully implemented in the main acute wards, cathlab, and delivery suite.DHH,is awaiting funding allocation. 27.05.16 - Work in CAH will be completed with 3 months time. Costing obtained in respect of DHH work and added to Capital Estates list for consideration. 1/3/16 Now in place residual witing being carried out. 14.07.15 - Replacement system purchased and installed. Estates undertaking wiring to ensure all acute areas are covered.	LOW

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
2422	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.	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. 7/5/15 Ongoing issues remain with the number of training sessions being provided and the ability of ward Sisters to release staff to attend training due to workload and staffing pressures. The NEAT lead nurse team have commenced supporting nursing staff in medical and surgical wards providing essential written and verbal information and training to ensure patient care standards remain at a high level. With nurse revalidation commencing 15/16 it will become even more important to ensure that training is completed for all qualified nursing staff.	LOW
3956	30/04/2018	Safe, High Quality and Effective Care	Non-compliance with NCEPOD inspiration for the future	There are 21 recommendations for this NCEPOD Currently only fully compliant with 1 KPI. Patients who require Non Invasive ventilation have the potential to receive inadequate care as we are non compliant with 21 KPI	Established MuLti Disciplinary working group for the Trust. Established Sub groups to take forward key Indicators. Establish baseline and review in 6 months.		LOW
3936	03/01/2018	Be a great place to work	Lone Worker in Laboratory	Risk of harm to laboratory 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 laboratory 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.	7.3.18 Risk continues to be monitored	LOW
3929	12/12/2017	Provide safe, high quality careMak e 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.	7.3.18 Risk remains unchanged	LOW

ID	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3875	21/02/2017	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeing Make the best use of resources	The transfer of patient data outside the EEA.	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. This problem has presented itself in the Northern and Western trusts where they also have insufficient staffing. They have addressed this issue by contracting an Independent Sector company. The Southern Trust has procured an Independent Sector company which will be contracted to report on the CT scans during the above hours. The images need to be performed within the Southern Trust and then transferred outside the EEA for viewing and reporting. Reports will then be transferred to the Southern Trust PACS where they will be available to the referring clinician. It is during this process that there is a risk of data loss. The potential risk occurring during the transfer of images outside the trust is the loss of patient data. 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	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.	21.02.17 Risk added to Acute Risk Register	VLOW

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

ACUTE CLINICAL GOVERNANCE

Date: Friday, 9th November 2018 8am

1.0	**Apologies**: Dr Hogan, Mr Haynes	
2.0	**Matters Arising/Actions**	
3.0	**Result Sign off**   All Users Sept 2018 - SIGNOFF_201810_S FOR DISCUSSION WIOUTHERN FOR KATE. September's blood result's sign off, increased from 17168 to 18378 increase 1210. Dr Murphy has noticed that more of the juniors are using the system and that may be down to Kate Cunningham's help. The radiology ones still need work. The plan is do another push when the new Medical Director starts in December. Radiology results at ward level – discussions so far are that the consensus is to have them shredded as the risk is extremely low. Many of the inpatient reports in the 'piles' are already years old. Dr Yousuf and Dr McCaffrey expressed some concern re the risk. Potential malignancy as incidental findings on chest and other x-rays are emailed to consultants so that risk is covered. However Dr Yousuf reported that this does not happen for inpatients – only those who are ED patients or outpatients. If this was switched on for inpatients the POW would be inundated with emails. The same discussion was had re blood results a number of years ago and the decision was to shred the papers copy backlog on the wards and this caused no issues. We also need to check that labs are not printing paper copies of labs in DHH – Trudy to check. Maternity do print a copy as their patient's carry their own notes. Esther summarised the discussion and the decision of the group was to shred the backlog – as we will not be increasing the risk as these reports are not being used. The focus to reduce the	

	existing risk must be to promote the correct use of the electronic system. We will run a monthly report re unsigned electronic reports to monitor the change. We must move to staff signing off report or escalate them when they view them. Dr McCaffrey raised the issue of the position of the Addendum on radiology reports – Dr Yousuf said it was agreed regionally that it would be at the top of the report.	
4.0	**Hyponatraemia** Update on progress – Trudy gave an update on the Trust progress on the required paediatric training for the adult wards. The issue of telemetry for adolescents was discussed. Dr Murphy stated that the issue of telemetry should not influence which consultant cares for them – paediatricians should be caring for these children regardless. Trudy will contact Bernie re CYP telemetry. In DHH both HDU and Gynae may have an under 16 year old as BT PICU will only take up to 12 year olds. This needs to be discussed further with CYP and perhaps highlight to RQIA when they visit. Visit from Dr Simpson PHA 4th December 2018	Trudy
5.0	**Standards and Guidelines**  20181106_Agenda - Acute SG Forum meet	
6.0	**Audit Committee** Trust's Audit Assurance Report update required – AMDs to action.   Standardised reporting templates A National and clinical audit strategy Final v RQIA audit update required   RQIA Reports for Action Nov 2018.doc Acute March 2018 - SHSCT.xlsx	
7.0	**SAIs**: • SAI Summary spread sheet (report enclosed) for information.	

	 SAI Report to 30.10.18.xlsx • Recommendations  SAI Recommendations 30	
8.0	**Complaints Position** (paper enclosed) – the number and complexity is increasing. Would all teams keep pushing to get them answered. Trudy explain a project planned to look at a different way of managing complaints.  Ombudsman weekly 051118.xlsx  complaints and enquiries by month 20  Weekly Re-Opened Report 06.11.18.xlsx	All
9.0	**Incident Management Position** • Incident review position – violence and aggression incidents are on the increase. Training was discussed. The RQIA limits on the use of EMI homes is also an issue as patients have to have a dementia diagnosis to be admitted to one, yet delirium can last for many months in some patients. Esther has been having discussions re this issue with other Directorates. Acute Care at Home are also under huge pressure at the moment due to nursing shortages. Acute Care at Home is a great help to the Acute bed pressures.  Incident Review Position as at 05.11.1 • Majors and above for October 2017  Major and Catastrophic Incident • • Incidents  Pressure Ulcers QE Sept 2018.xlsx  Pressure Ulcer Oct18.xlsx  Moderate - Catastrophic Falls Api  Patient Falls by Month (April 2016 - O  Acute Services - Falls - October 2018.xlsx  Absconding Incidents - Acute Services (01.  Violence and Aggression Incidents  Violence and Aggression Incidents	

	 Violence and Aggression Incidents  Staffing incidents October 2018.xlsx	
	NEWS 2 • Implementation must be implemented in the Trust by March 2019 • Local escalation guidance will be still be on the back of the chart – however Trudy has raised regionally the issue of our inability to use the Royal College escalation guidance due to our lack of registrars at night. Sepsis will be built in to this.	Trudy Reid
10.0	**Risk Registers** – additions, amendments and closures to the Gov team. Dr Yousuf discussed the CT risk. The new CAH modular one will reduce the CAH risk significantly – to low. The DHH scanner is very old and breaks down frequently (30 days in year to date) so this is now high risk. The effect of this on stroke services and the future of this service were discussed. Anne to set up an urgent meeting next Thursday or Friday.  Directorate RR Apr18 by person resp  Directorate RR Nov18.xlsx	Anne McVey
11.0 **SI**	**Management of Trust Clinical Guidelines** Process for clinical guidelines	
12.0	**Any Other Business** • Delirium Care Bundle document – Trudy shared a paper copy of the letter from Mark Roberts on Pharmacological interventions for discussion. People in the meeting were content with the changes. • Winter ward – 3N is a bit behind time – another bay needs to be painted to give 24 beds. The winter ward should be opening at the beginning of December and this will affect consultant team working plans etc for the next month – however this can't be planned until it is decided where the beds will be and how many there will be. There will be a minimum of 18 beds. Mr Haynes accepts that it would be better to have all the medical outliers in one place for efficiency of all the staff involved. However his concern is if surgery move they will take all their nurses with them and that will challenge the new 3 south medical ward. Esther to make a decision today so rotas etc can be finalised.	Esther Gishkori
13.0	**Date of Next Meeting:**	

	Friday 14th December 2018 at 8.00 am in the Board Room, CAH	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: 3861 2510

ACUTE CLINICAL GOVERNANCE

Date: Friday, 7th September 2018

1.0	**Apologies**: Mrs Gishkori, Mrs A Carroll, Mr C Carroll , Dr Murphy, Dr McCracken, Dr Hampton	
2.0	**Matters Arising/Actions** Result sign off – Trudy gave a quick update. The junior medics were trained on the sign off procedure but they still need to be actively encouraged to use the system. M&M would be a good forum to encourage it. Also consultants need to be trained/encouraged to use it – Kate will address this and set each consultant up. Dr Moan shared his experience and plans to talk to Kate about a few technical things plus the issue of patients assigned to the wrong consultant. Mr Haynes outlined how he deals with the wrong patient issue – signs it off and forwards it to the correct consultant by asking his secretary to send it on. Options to be discussed further with Kate. Kate has also set us up to group sign off as we requested. Dr Hampton has updated Trudy about their new approach to ensuring results follow patients through their hospital stay – by sending an email to the team now responsible for the patient. Problems still exist for 'multiple scan/injury' patients where scans ordered by ED show unexpected findings – the GMC say that the consultant responsible for ordering the scan is responsible for the finding. The new ED approach needs to be publicised more so teams understand what is happening. The outstanding issue is the boxes of radiology reports, mainly x-rays, on the wards and what we do with them. We need to get someone to go through them for a payment. It would need to be a middle grade – proposal to Anita.	
3.0	**Standards and Guidelines**  Acute Services SG Forum - Agenda 04 S Report shared for information.	Caroline Beattie
4.0	**Acute Audit** Cellular pathology  Cellular Pathology Audit.docx Labs have asked that teams look at this report and action.	Trudy Reid Barry Conway

	Clinical Audit Strategy – Anne Quinn attended at 8:50am to present the new trust audit strategy. The Strategy was accepted yesterday by the Trust Governance Committee. One of the NEDS has also asked for the annual Audit conference to be reinstated. The Trust is now in a better place with clinical audit that a year ago. Anne went through the strategy and the new format for audit feedback, etc. each Directorate is to monitor their audits formally on a quarterly basis as part of the strategy. Anne's team is happy to come out to Divisions to go through the strategy in more detail with teams. Mark suggested an option using non-identifiable numbers for patients so that they can submit to national audit, to get around the GDPR issue that has arisen. Work is ongoing to try and sort this problem regionally so that NI is not left out of these vital audits for consultants. Mark will raise again at the AMD forum. Anne also reported that the paed IV fluid audit results will be going to the trust hyponatraemia meeting next week. There are a number of areas of compliance due to fluid balance records and recording calculations. The meeting recorded its wholehearted thanks to Anne for all her help in getting Acute to this stage with its audit work. Hyponatraemia  Acute Directorate Hyponataemia Audit 1  Acute Directorate February 2018 onwa  DRAFT Hyponatraemia audit	Anne Quinn
5.0	• **SAIs**: *Cervical Cytology (internal review)* – the report was presented by Barry on Dr Tariq's behalf. Report accepted.  Cervical Cytology - SEA Including Learnin [redacted] *(internal review) – the report* was presented by Barry on Dr Tariq's behalf. Report accepted.  Appendix 4 - SEA Including Learning Su [redacted] *amended report) – Trudy presented this report on Dr Murphy's behalf. Report accepted.*  SEA [redacted] 11 [redacted] x [redacted] *- Trudy and Dr Yousuf presented this report. Report accepted with an additional recommendation.*  Appendix 4 - SEA Including Learning Su [redacted] - Trudy presented this report on Dr Murpy's report. Report	

	accepted.  Appendix 4 - SEA Including Learning Su [redacted] - Trudy presented this report. Report accepted.  [redacted] Final 05 09 2018.docx [redacted] - Trudy presented this report. Report accepted.  [redacted] SEA final 05 09 2018.docx [redacted] – Mr Haynes presented this report. Report accepted.  Appendix 4 - SEA Including Learning Su • SAI Summary spread sheet  SAI Report to 4.9.18.xlsx • Recommendations  SAI Recommendations 14	
6.0	**Complaints Position**  Current Complaints 04.09.18.xlsx  Ombudsman weekly 040918.xlsx  Weekly Re-Opened Report 04.09.18.xlsx  complaints and enquiries by month 2(	All

7.0	**Incident Management Position** • Incident review position - (paper enclosed) Incident Review Position as at 04.09.1 • Majors and above for August 2016 (paper enclosed) Major and Catastrophic Incident • Reports on absconding patients, violence and aggression, pressure ulcers, staffing and falls Pressure Ulcers July18.xlsx; Moderate - Catastrophic Falls Ap; Acute Services - Falls - august 2018.xlsx; Patient Falls by Month (April 2016 - A Absconding Incidents - Acute Services (01.; Violence and Aggression Incidents; Violence and Aggression Incidents; Staffing Incidents by Loc (Exact) and Incid Staffing incidents august 2018.xlsx	
8.0	**Medication incidents** Learning from Medication Incidents .	
9.0	**Regional NEWS Trigger Reset Guidance** • update	
10.0 **SI**	**Risk Registers** – additions, amendments and closures Directorate RR Sep18.xlsx	ADs & AMDs
11.0	**Management of Trust Clinical Guidelines**	
12.0	**Patient safety Report** Acute Governance Report Sept 18.doc	
12.0	**Any Other Business** • the meeting discussed how we move forward with a robust program	

	for ensuring all the learning from our SAI/SEAs are implemented. • Mr Haynes raised the issue of general surgeons not having any paediatric training and that they feel obliged to withdraw from any paediatric surgery given the O'Hara recommendations.	
	Date of Next Meeting: **Friday 12th October 2018 at 8.00 am in the Board Room, CAH**	

Maintaining High Professional Standards in the Modern HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

Department of Health, Social Services & Public Safety
November 2005

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN HPSS

A framework for the handling of concerns about doctors and dentists in the HPSS

CONTENTS *Page*

INTRODUCTION

1. This document introduces the new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

2. Throughout this framework where the term "performance" is used, it should be interpreted as referring to all aspects of a practitioner's work, including conduct, health and clinical performance. Where the term "clinical performance" is used, it should be interpreted as referring only to those aspects of a practitioner's work that require the exercise of clinical judgement or skill.

3. Under the Directions on Disciplinary Procedures 2005, HPSS organisations must notify the Department of the action they have taken to comply with the framework by 31 January 2006.

4. The framework is in six sections and covers:

   I. Action when a concern first arises

   II. Restriction of practice and exclusion from work

   III. Conduct hearings and disciplinary procedures

   IV. Procedures for dealing with issues of clinical performance

   V. Handling concerns about a practitioner's health

   VI. Formal procedures – general principles

5. Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist.

Background

6. There has been some concern in the past about the way in which complaints about doctors and dentists have been handled. Developing new arrangements for dealing with medical and dental staff performance has become increasingly important in order to address these concerns and to reflect the new systems for quality assurance, quality improvement and patient safety being introduced in the HPSS.

7. The National Clinical Assessment Authority (NCAA) was established to improve arrangements for dealing with poor clinical performance of doctors. The Department entered into a service level agreement with the NCAA in October 2004 to provide advice and guidance to the HPSS. Since April 2005,

the NCAA has become a division of the National Patient Safety Agency, and is now known as the National Clinical Assessment Service (NCAS).

8. The new approach set out in the framework builds on four key elements:

- appraisal[1] and revalidation – processes which require practitioners to maintain the skills and knowledge needed for their work through Continuing Professional Development (CPD);
- the advisory and assessment services of the NCAS – aimed at enabling HSS Bodies[2] to handle cases quickly and fairly - reducing the need to use disciplinary procedures to resolve problems;
- tackling the blame culture – recognising that most failures in standards of care are caused by systems' weaknesses, not individuals per se;
- new arrangements for handling exclusion from work as set out in Sections I and II of this framework.

9. To work effectively these need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists maintaining their competence; and which support an open approach to reporting and addressing concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through disciplinary action. However, it is not intended to weaken accountability or avoid disciplinary action where the situation warrants this approach.

The new framework

10. At the heart of the new arrangements is a co-ordinated process for handling concerns about the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS. Whatever the source of this information the response must be the same –

- to ascertain quickly what has happened and establish the facts;
- to determine whether there is a continuing risk;
- to decide whether immediate action is needed to manage the risk to ensure the protection of patients;
- to put in place action to address any underlying problem.

[1] Appraisal is a structured process which gives doctors an opportunity to reflect on their practice and discuss, with a suitably trained and qualified appraiser, any issues arising from their work, and their development needs.

[2] In the Direction and Framework "HSS bodies" means: HSS Trusts, HSS Boards and Special Agencies

Under these new mechanisms, exclusion from work must be used only in the most exceptional circumstances.

11. All HSS bodies must have procedures for handling concerns about an individual's performance. These procedures must reflect the framework in this document and allow for informal resolution of problems where deemed appropriate. Concerns about the performance of doctors and dentists in training should be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset. The onus still rests with the employer for the conduct of the investigation and any necessary action.

SECTION I. ACTION WHEN A CONCERN FIRST ARISES

INTRODUCTION

1. The management of performance is a continuous process to ensure both quality of service and to protect clinicians. Numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures.

2. Concerns about a doctor or dentist's performance can come to light in a wide variety of ways, for example:

   - concerns expressed by other HPSS staff;
   - review of performance against job plans and annual appraisal;
   - monitoring of data on clinical performance and quality of care;
   - clinical governance, clinical audit and other quality improvement activities;
   - complaints about care by patients or relatives of patients;
   - information from the regulatory bodies;
   - litigation following allegations of negligence;
   - information from the police or coroner;
   - court judgements; or
   - following the report of one or more critical clinical incidents or near misses.

3. All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to establish the facts and the substance of any allegations. Unfounded or malicious allegations can cause lasting damage to a doctor's reputation and career. Where allegations raised by a fellow HPSS employee are shown to be malicious, that employee should be subject to the relevant disciplinary procedures.

SUMMARY OF KEY ACTIONS NEEDED

4. The key actions needed at the outset can be summarised as follows:

   - clarify what has happened and the nature of the problem or concern;
   - consider discussing case with NCAS on the way forward;
   - consider if urgent action needs to be taken to protect the patient/s;
   - consider whether restriction of practice or exclusion is required;

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member* "should be involved to any significant degree in the management of individual cases.

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
   - immediate telephone advice, available 24 hours;
   - advice, then detailed supported local case management;
   - advice, then detailed NCAS performance assessment;
   - support with implementation of recommendations arising from assessment.

10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.

11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.

14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.

17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.

19. An immediate time limited exclusion may be necessary

- to protect the interests of patients or other staff;
- where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

20. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.

21. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

22. The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting

23. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

24. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

26. At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body should be notified. Guidance on the process for issuing alert letters can be found in circular HSS (TC8) (6)/98. This framework also sets out additional circumstances when the issue of an alert letter may be considered.

27. Section II of this framework sets out the procedures to be followed should a formal investigation indicate that a longer period of formal exclusion is required.

FORMAL APPROACH

28. Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CE must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.

29. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action.

30. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

The Case Investigator's role

31. The Case Investigator:

- must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff[3] with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;
- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator

[3] Where no other suitable senior doctor or dentist is employed by the HSS body a senior doctor or dentist from another HSS body should be involved.

to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
- must assist the designated Board member in reviewing the progress of the case.

32. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.

33. The Case Investigator has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

The Case Manager's role

34. The Case Manager is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority

35. The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.

36. If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another HSS body or elsewhere be invited to assist.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

41. On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.

SECTION II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

INTRODUCTION

1. This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.

2. In this part of the framework, the phrase “exclusion from work” has been used to replace the word “suspension” which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

3. The Directions require that HSS bodies must ensure that:

   - exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
   - where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
   - all extensions of exclusion are reviewed and a brief report provided to the CE and the board;
   - a detailed report is provided when requested to the designated Board member who will be responsible for monitoring the situation until the exclusion has been lifted.

MANAGING THE RISK TO PATIENTS

4. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.

5. The purpose of exclusion is:

   - to protect the interests of patients or other staff; and/or
   - to assist the investigative process when there is a clear risk that the practitioner’s presence would impede the gathering of evidence.

6. It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

7. **Under the Directions, an HSS body cannot require the exclusion of a practitioner for more than four weeks at a time.** The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key aspects of exclusion from work

8. Key aspects include:

- an initial "immediate" exclusion of no more than four weeks if warranted as set out in Section I;
- notification of the NCAS before immediate and formal exclusion;
- formal exclusion (if necessary) for periods up to four weeks;
- ongoing advice on the case management plan from the NCAS;
- appointment of a designated Board member to monitor the exclusion and subsequent action;
- referral to NCAS for formal assessment, if part of case management plan;
- active review by clinical and case managers to decide renewal or cessation of exclusion;
- a right to return to work if review not carried out;
- performance reporting on the management of the case;
- programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
- a right for the doctor to make representation to the designated Board member

9. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director.

Exclusion other than immediate exclusion

10. A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether there is reasonable and proper cause to exclude. **The NCAS must be consulted where formal exclusion is being considered.** If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.

11. The report should provide sufficient information for a decision to be made as to whether:

    (i) the allegation appears unfounded; or

    (ii) there is a misconduct issue; or

    (iii) there is a concern about the practitioner's clinical performance; or

    (iv) the complexity of the case warrants further detailed investigation before advice can be given.

12. Formal exclusion of one or more clinicians must only be used where:

    a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of:

    - allegations of misconduct;
    - concerns around the functioning of a clinical team which are likely to adversely affect patients;
    - concerns about poor clinical performance; or

    b. the presence of the practitioner in the workplace is likely to hinder the investigation.

13. Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

14. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion

(paragraph 30 of Section I defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

15. The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 19, and the need to remain available for work paragraph 20) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

16. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

17. If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.

18. If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

Exclusion from premises

19. Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff

Keeping in contact and availability for work

20. Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HPSS employer. This caveat does not refer to time for which they are not being paid by the HPSS employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

21. The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

Informing other organisations

22. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HPSS and non-HPSS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer[4].

23. Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HPSS, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.

24. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called ‘gardening leave’ have been

[4] HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointments.

commonly used in the recent past. **No HSS body may use "gardening leave" as a means of resolving a problem covered by this framework.**

Existing suspensions & transitional arrangements

25. On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

26. The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the Department (Director of Human Resources).
- receive an assurance from the CE and designated board member that the agreed mechanisms are being followed. Details of individual exclusions should not be discussed at Board level.

Regular review

27. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[5]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

28. The HSS body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

[5] It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to CE and Medical Director. • Each review is a formal matter and must be documented as such. • The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: • A report must be made by the Medical Director to the CE: - outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed - a timetable for completion of the investigation. • The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. • The case must be formally referred back to the NCAS explaining: - why continued exclusion is thought to be appropriate; - what steps are being taken to complete the investigation at the earliest opportunity. • The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, • A further position report must be made by the CE to

	the Department indicating: - the reason for continuing the exclusion; - anticipated time scale for completing the process; - actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

29. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

The role of the Department in monitoring exclusions

30. When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.

31. When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

RETURN TO WORK

32. If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there is a case of misconduct that must be put to a conduct panel (paragraph 38 of section 1). Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.

2. It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraph 5 of Section IV refers).

3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation. [6]

4. Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.

5. HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

CODES OF CONDUCT

6. Every HPSS employer will have a Code of Conduct or staff rules, which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:

   - a refusal to comply with the requirements of the employer where these are shown to be reasonable;
   - an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of

[6] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee

doctors and dentists by their regulatory body[7];

- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

7. The employer's Code of Conduct should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Similarly the Labour Relations Agency (LRA) Code of Practice provides a non-exhaustive list of examples. Acts of misconduct may be simple and readily recognised or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.

8. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.

9. It is for the employer to decide upon the most appropriate way forward, including the need to consult the NCAS and their own sources of expertise on employment law. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively, or in addition, he or she may make representations to the designated Board member.

10. In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC.

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

11. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters

[7] In case of doctors, *Good Medical Practice.* In the case of dentists, *Maintaining Standards.*

would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

Cases where criminal charges are brought not connected with an investigation by an HPSS employer

12. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made. Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

13. If the practitioner is acquitted following legal proceedings, but the employer feels there is enough evidence to suggest a potential danger to patients, the Trust has a public duty to take action to ensure that the practitioner does not pose a risk to patient safety. Where the charges are dropped or the court case is withdrawn, there may be grounds to consider allegations which if proved would constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned.

SECTION IV. PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

INTRODUCTION & GENERAL PRINCIPLES

1. There will be occasions following an adequate investigation where an employer considers that there has been a clear failure by an individual to deliver an acceptable standard of care, or standard of clinical management, through lack of knowledge, ability or consistently poor performance. These are described as clinical performance issues.

2. Concerns about the clinical performance of a doctor or dentist may arise as outlined in Section I. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through local informal processes set out in Section I (paragraphs 15 – 17) **the matter must be referred to the NCAS before consideration by a performance panel** (unless the practitioner refuses to have his or her case referred).

3. Matters which may fall under the perfomance procedures include:

   - out moded clinical practice;
   - inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
   - incompetent clinical practice;
   - inappropriate delegation of clinical responsibility;
   - inadequate supervision of delegated clinical tasks;
   - ineffective clinical team working skills.

   Wherever possible such issues should be dealt with informally, seeking support and advice from the NCAS where appropriate. The vast majority of cases should be adequately dealt with through a plan of action agreed between the practitioner and the employer.

4. Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in Section V of this framework.

How to proceed where conduct and clinical performance issues are involved

5. It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If

a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[8].

7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

8. If the practitioner does not agree to the case being referred to NCAS, a panel hearing will normally be necessary.

HEARING PROCEDURE

The pre-hearing process

9. The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;
- all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date

[8] see paragraphs 5 and 6 in section 6I on arrangements for small organisations

should be set for the hearing;

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;
- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;
- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.[9] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

11. Arrangements must be made for the panel to be advised by:
    - a senior member of staff from Human Resources;
    - an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HPSS employer;

[9] Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the local negotiating committee.

- a representative of a university if provided for in any protocol agreed between the employer and the university.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS/NHS employer, in the same grade as the practitioner in question, should be asked to provide advice. In the case of doctors in training the postgraduate dean's advice should be sought.

12. It is for the employer to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The employer should review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The employer must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

Representation at clinical performance hearings

13. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.

14. The practitioner may be represented in the process by a companion who may be another employee of the HSS body: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the clinical performance hearing

15. The hearing should be conducted as follows:

- the panel and its advisers, the practitioner, his or her representative and the Case Manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- the Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
- the procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;
- the side calling the witness can question the witness;
- the other side can then question the witness;
- the panel may question the witness;
- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

- the Case Manager presents the management case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification;
- the practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification;
- the Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- the Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation;
- the panel shall then retire to consider its decision.

Decisions

16. The panel will have the power to make a range of decisions including the following:

<u>Possible decisions made by the clinical performance panel</u>

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;
- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

- the clinical performance problem(s) identified;
- the improvement that is required;
- the timescale for achieving this improvement;
- a review date;
- measures of support the employer will provide; and
- the consequences of the practitioner not meeting these requirements.

In addition, dependent on the extent or severity of the problem, the panel may:

- issue a written warning or final written warning that there must be an improvement in clinical performance within a specified time scale together with the duration that these warnings will be considered for disciplinary purposes (up to a maximum of two years depending on severity);
- decide on termination of contract.

In all cases where there is a finding of unsatisfactory clinical performance, consideration must be given to referral to the GMC/GDC.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. The panel may wish to comment on the systems and procedures operated by the employer.

17. A record of all findings, decisions and written warnings should be kept on the practitioner's personnel file. Written warnings should be disregarded for disciplinary purposes following the specified period.

18. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Given the possible complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

19. The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

Introduction

20. Given the significance of the decision of a clinical performance panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process.

21. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel, in arriving at their decision, acted fairly and reasonably based on:

- a fair and thorough investigation of the issue;
- sufficient evidence arising from the investigation or assessment on which to base the decision;
- whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 24 below).

22. A dismissed practitioner will, in all cases, be potentially able to take their case to an Industrial Tribunal where the fairness of the Trust's actions will be tested.

The appeal process

23. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.

24. Where the appeal is against dismissal, the practitioner should not be paid, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

The appeal panel

25. The panel should consist of three members. The members of the appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the designated board member. These members will be:

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool.[10] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[11] who must also have the appropriate training for hearing an appeal.

In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university

26. The panel should call on others to provide specialist advice. This should normally include:

- a consultant from the same specialty or subspecialty as the appellant, but from another HPSS/NHS employer [12];
- a senior Human Resources specialist.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the selected clinician is unable to advise on the appropriate level of competence, a doctor from another HPSS employer in the same grade as the practitioner in question should be asked to provide advice. Where the case involves a doctor in training, the postgraduate dean should be consulted.

27. The Trust should convene the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 29. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant's objections should be noted carefully. Trusts are reminded of the need to act reasonably at all stages of the process.

[10] See Annex A.
[11] Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.
[12] Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

28. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original performance hearing. The following timetable should apply in all cases:

- appeal by written statement to be submitted to the designated appeal point (normally the Director of HR) within 25 working days of the date of the written confirmation of the original decision;
- hearing to take place within 25 working days of date of lodging appeal;
- decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

29. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

Powers of the appeal panel

30. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.

31. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

32. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

Conduct of appeal hearing

33. All parties should have all documents, including witness statements, from the previous performance hearing together with any new evidence.

34. The practitioner may be represented in the process by a companion who may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative

will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

35. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.

36. The panel, after receiving the views of both parties, shall consider and make its decision in private.

Decision

37. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's Case Manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

Action following hearing

38. Records must be kept, including a report detailing the performance issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the clinical performance procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Industrial Tribunal.

Annex A

APPEAL PANELS IN CLINICAL PERFORMANCE CASES

Introduction

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.

2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held Northern Ireland wide list rather than through local selection. The benefits include:

   - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
   - the ability to monitor performance and assure the quality of panellists.

3. The following provides an outline of how it is envisaged the process will work.

Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with the Department, who will be responsible for administration of the list

5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the BMA, BDA, defence organisations, and the NCAS. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.

6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

7. Panel members will be subject to appraisal against the core competencies and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.

8. The level of fees payable to panel members will be set by the Department and paid locally by the employer responsible for establishing the panel.

9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competencies and /or seminars designed to provide background on the specific context of HPSS disciplinary procedures.

SECTION V. HANDLING CONCERNS ABOUT PERFORMANCE ARISING FROM A PRACTITIONER'S HEALTH

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there are concerns about the practitioner's health that should be considered by the HSS body's Occupational Health Service (OHS) and the findings reported to the employer.

2. In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.

3. The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HPSS.

HANDLING HEALTH ISSUES

4. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)[13]. The practitioner may be accompanied to these meetings (as defined in Section I, para 30). Confidentiality must be maintained by all parties at all times.

5. The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.

6. In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures (as outlined in Section IV), or misconduct procedures (as outlined in Section III) would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer

[13] In the absence of a Medical Director organisations should put in place appropriate measures as part of agreed arrangements for small organisations to ensure the appropriate level of input to the process. See section vi.

to resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

7. A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

8. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of actions a Trust might take in these circumstances, in consultation with OHS and having taken advice from NCAS and/or NIMDTA if appropriate.

Examples of action to take

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- remove the practitioner from certain duties;
- make adjustments to the practitioner's working environment;
- reassign them to a different area of work;
- arrange re-training for the practitioner;
- consider whether the Disability Discrimination Act (DDA) applies (see below), and, if so, what other reasonable adjustments might be made to their working environment.

DISABILITY DISCRIMINATION ACT (DDA)

9. Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.

10. Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non-disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

Examples of reasonable adjustment

- make adjustments to the premises;
- re-allocate some of the disabled person's duties to another;
- transfer employee to an existing vacancy;
- alter employee's working hours or pattern of work;
- assign employee to a different workplace;
- allow absence for rehabilitation, assessment or treatment;
- provide additional training or retraining;
- acquire/modify equipment;
- modifying procedures for testing or assessment;
- provide a reader or interpreter;
- establish mentoring arrangements.

11. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and HPSS Superannuation Branch**.**

Note. Special Professional Panels (generally referred to as the "three wise men") were set up under circular TC8 1/84. This part of the framework replaces those arrangements and any existing panels should be disbanded.

SECTION VI. FORMAL PROCEDURES – GENERAL PRINCIPLES

TRAINING

1. Employers must ensure that managers and Case Investigators receive appropriate training in the operation of formal performance procedures. Those undertaking investigations or sitting on disciplinary or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members have completed before they can take a part in these proceedings.

HANDLING OF ILLNESS ARISING DURING FORMAL PROCEEDINGS

2. If an excluded employee or an employee facing formal proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside formal procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

3. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner should have the opportunity to provide written submissions and/or have a representative attend in his absence.

4. Where a case involves allegations of abuse against a child or a vulnerable adult, the guidance issued to the HPSS in 2005, "Choosing to Protect – A Guide to Using the Protection of Children Northern Ireland (POCNI) Service", gives more detailed information.

PROCESS FOR SMALLER ORGANISATIONS

5. Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

6. Such organisations should consider working in collaboration with other local HPSS organisations (eg other Trusts) in order to provide sufficient personnel

to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HPSS organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

TERMINATION OF EMPLOYMENT WITH PROCEDURES UNFINISHED

7. Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

8. There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

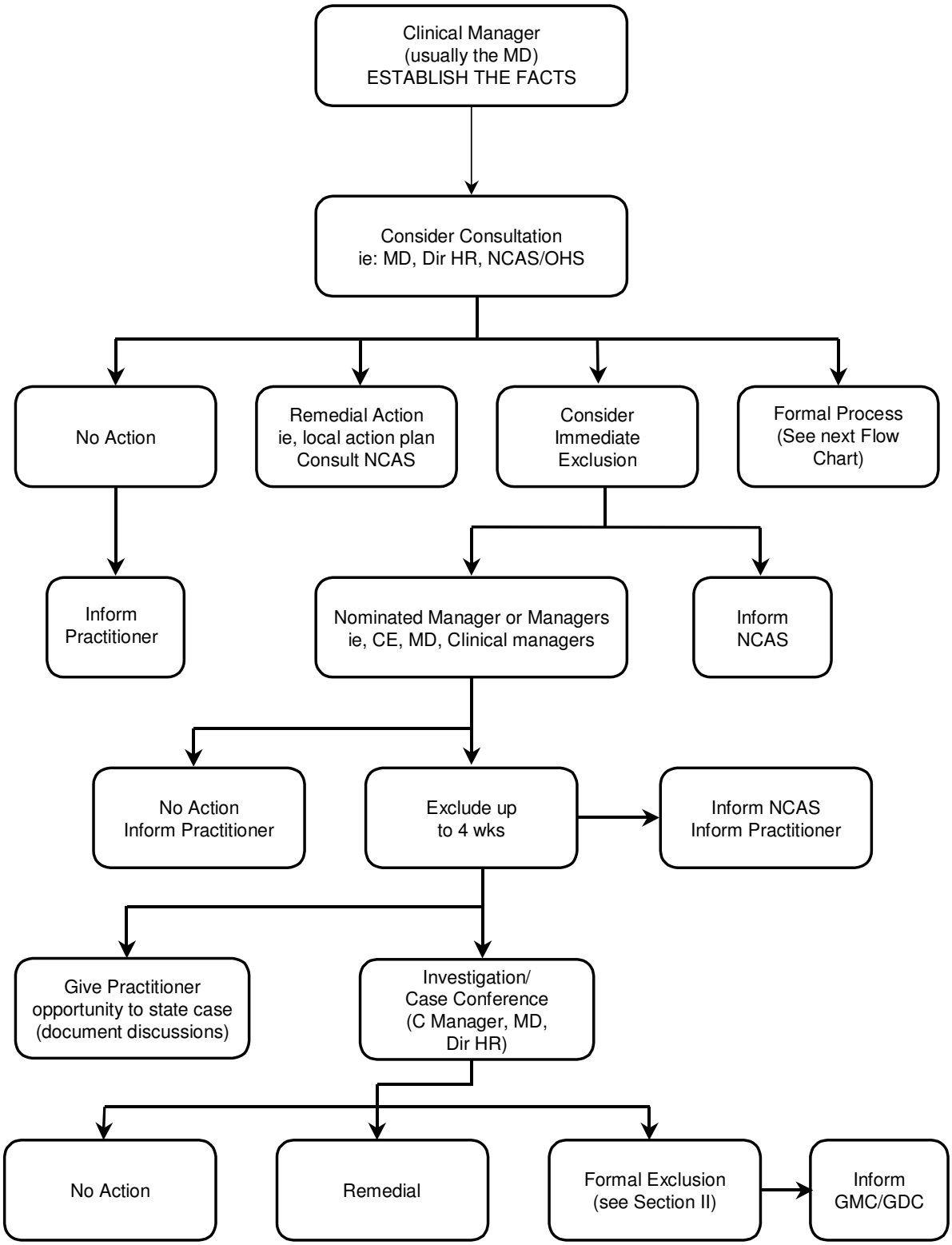
9. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning).

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

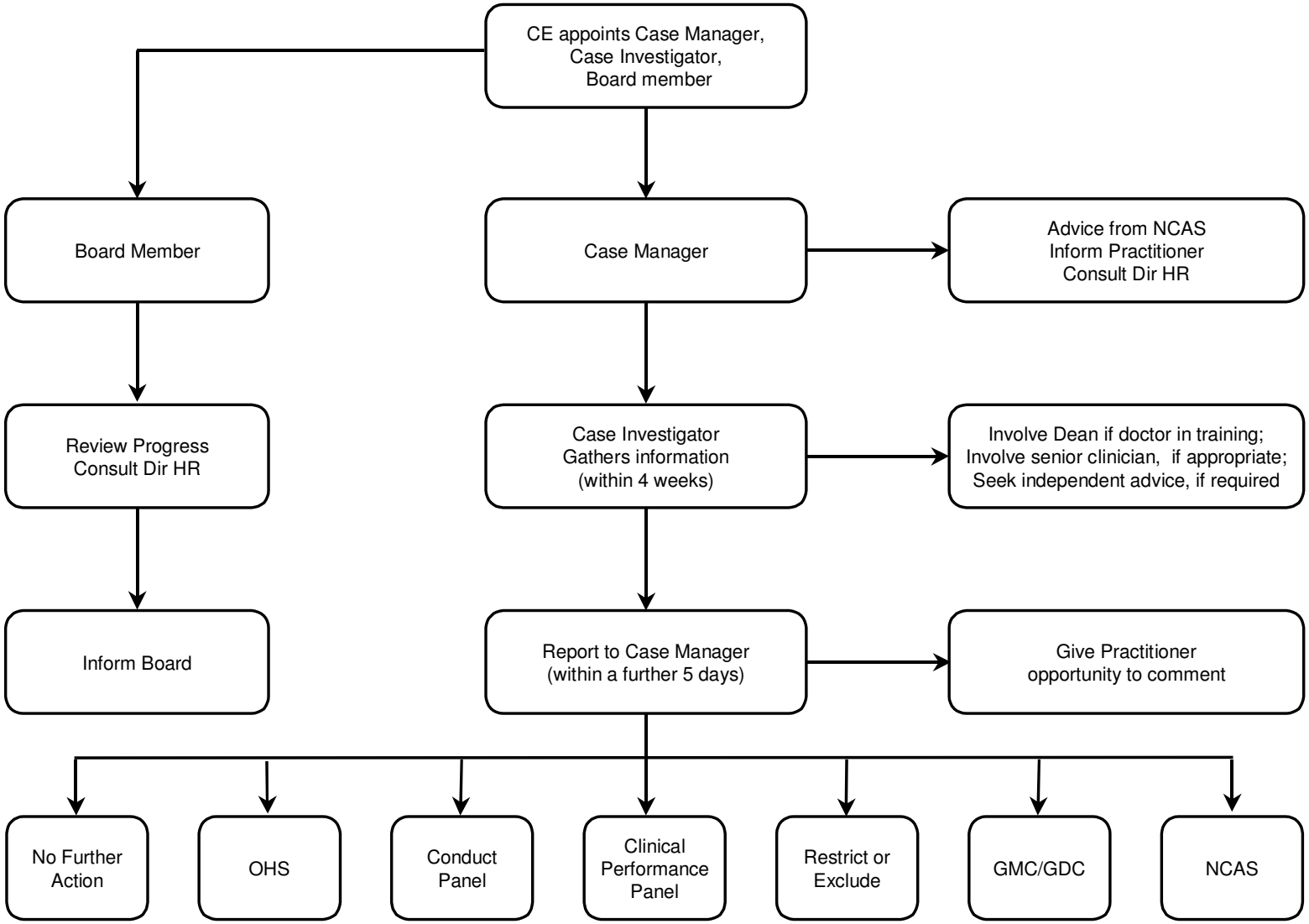
10. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

    - settlement agreements must not be to the detriment of patient safety;
    - it is not acceptable to agree any settlement that precludes involvement of either party in any further legitimate investigations or referral to the appropriate regulatory body.

INFORMAL PROCESS



FORMAL PROCESS



Gibson, Simon

From: Khan, Ahmed [redacted]
Sent: 28 September 2018 18:03
To: Devlin, Shane; Toal, Vivienne
Cc: Wright, Elaine
Subject: FW: Case Manager Determination AO'B FINAL 280918
Attachments: Case Manager Determination AO'B FINAL 280918.docx

Dear Shane & Vivienne, Please find final MHPS report. I am meeting with the clinician on Monday morning to share this report.

Have a nice weekend.

Regards,
Ahmed

From: Wright, Richard [redacted]
Sent: 28 December 2016 11:14
To: Khan, Ahmed
Subject: Confidential

Hi Ahmed. I hope you have had a good break.
I have a tricky situation with I need some help with.
Mr A Obrien is a consultant urologist. There has been an SAI which has highlighted serious potential issues re revue of patients, possible missing patient notes and undictated clinics. The SAI has indicated that there has been patient harm in at least one case.
I was going to ask Colin Weir as CD to investigate this under MHPS. Would you be prepared to act as Case manager under the MHPS framework?
Happy to discuss if need be anytime over the holiday period.
[redacted]
Regardss Richard

From: Khan, Ahmed
Sent: 19 October 2018 11:52
To: Hynds, Siobhan
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Attachments: UROLOGY.XLSX

Importance: High

FYI

AK

From: Weir, Colin
Sent: 18 October 2018 11:33
To: Khan, Ahmed; Gibson, Simon; Carroll, Ronan; Clayton, Wendy; Haynes, Mark
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Ahmed/Simon

Please for your urgent consideration and action

See email correspondence below. Please see attached excel spreadsheet and go to Oct TAB or see below in email trail

Mr O'Brien has accumulated a large backlog of dictated letters and large numbers of charts in his office.

I am his Clinical Director

I have NOT seen the review and results and recommendations into his practice, but I am assuming he is in breach of this given these findings

Can you instruct me on how you would like to proceed.

I can certainly meet his with Ronan to discuss and record outcome from any meeting with him but I need to know if any sanctions need to be put in place if he has breached any of the review requirements or if your office wish to take this over?

Colin

From: Clayton, Wendy
Sent: 18 October 2018 11:07
To: Weir, Colin
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

From: Carroll, Ronan
Sent: 17 October 2018 15:52
To: Young, Michael; Haynes, Mark

Cc: Clayton, Wendy
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Michael/Mark
Please see update from Wendy

1. Dictation to be completed
2. Notes in office

Aidan needs spoken with and asked to address dictation asap & to return notes (possible notes are for dictation)
I am in CAH tomorrow pm

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Clayton, Wendy
Sent: 17 October 2018 15:11
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

See below dictation report. There are approx 82 charts in the office on level 2. Do you need me to try and find out how long they have been there?

UROLOGY				Backlog - Number of
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinic letters to be dictated**	**oldest date of clinic letters to be dictated**
Mr Jakob				
Mr Glackin	5	6	7	06/06/2018 (1 letter)
Mr Haynes	0	0	19	26.09.18
Mr O'Brien	17	0	91	15.06.18
Mr O'Donoghue				
Mr Young	12	0	0	0
Sub Speciality Totals	**34**	**6**	**117**	

From: Clayton, Wendy
Sent: 16 October 2018 19:41
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

I have check PAS and there are 82 charts tracked out specifically to Mr O'Brien

I will ask Collette for an update typing backlog report which will show clinic/results to be dictated, hopefully this will be through tomorrow.

Wendy

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: Personal Information redacted by USI
External number: Personal Information redacted by USI
Mob: Personal Information redacted by USI

EXT Relevant redacted by the USI ***f dialling from Avaya phone.***
If dialling from old phone please dial Relevant redacted by the USI

External No. Personal Information redacted by USI

From: Carroll, Ronan
Sent: 15 October 2018 23:01
To: Clayton, Wendy; Corrigan, Martina
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Wendy
Can i ask you as a matter of urgency to update the position re Notes checked out to AOB (74) & Digital Dictation also 91 letters pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by USI

From: Corrigan, Martina
Sent: 04 October 2018 16:09
To: Carroll, Ronan
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Ronan

Please see below. if there is anything else needed I am happy to discuss

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT Personal Information redacted by USI
EXTERNAL : Personal Information redacted by USI
Mobile: Personal Information redacted by USI

From: Carroll, Ronan
Sent: 04 October 2018 12:53
To: Corrigan, Martina
Subject: FW: Return to Work Action Plan February 2017 FINAL.
Importance: High

Martina

Need AOB monitor report for September – with me being off I can only confirm the following:

Mr O'Brien was on AL in September on 4th, 17-21st and on study leave 10-12 September

CONCERN 1 –during September Mr O'Brien was not oncall, I have checked today and there is only one routine referral for Mr O'Brien added on 28 September, he does have until tomorrow evening (Friday) to clear all triage.

CONCERN 2 – I have checked as of today on PAS there are 74 charts tracked to Mr O'Brien's office, I have asked Maria to go to his office to check and she confirms that there are a large number of charts in his office, sitting in bundles on the floor, on his desk and in his pigeon holes, so this is in breach of his Action plan

CONCERN 3 –Mr O'Brien continues to use digital dictation however on checking today he has 91 letters outstanding dictation from 15 June 2018. I have included the most recent report below, in this instance he is in breach of his action plan

CONCERN 4 – adhered to – I have checked the September lists and all patients have been listed appropriately and no private patients.

Need to provide the process by which we collect the info to monitor and provide assurance for triage, Dictation, notes and PP

Process is as follows:

Concern 1 – I check NIECR I firstly look at all outstanding triage for all consultants and then filter for Mr O'Brien. On a week that he is oncall I do this daily to ensure that the red flags are triaged and then on the Monday after he has been oncall to ensure it is all up-to-date, any concerns I will contact him (which has only been once since monitoring commenced) . for today there are currently 17 awaiting triage with 14 of these were added today and 1 routine Mr O'Brien – 28 September and 2 routine – Mr Young dated 27th and 28 September 2018.

Concern 2 – I firstly check on PAS how many charts are casenote tracked to Mr O'Brien and then I go to his office on Friday AM to check that this matches. To date the most that have been in the office is 8 charts that were only put there the previous few days for action by the secretary.

Concern 3 – Katherine Robinson's team provides us all with a reports on backlog today's is included below. (of note this is provided for all specialties)

Concern 4 – I check all theatre lists for all consultants and ensure that the patients have been appropriately listed

Need to provide the process by which we can provide assurance that no other urologist is not meeting the required performance indicators

For all consultants whilst not monitoring individually I will pick up any issues when I am looking at ETriage, backlogs and theatre lists as per above. I do not monitor the casenotes in offices however I can confirm that as of today:

Mr Young = 37 tracked to his office
Mr Glackin = 0
Mr O'Donoghue = 0
Mr Haynes = 0
Mr Jacob = 0

UROLOGY – Digital Dictation

Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated
Mr Jacob				
Mr Glackin	5	6	7	06/06/2018 (1 letter)
Mr Haynes	0	0	19	26.09.18
Mr O'Brien	17	0	91	15.06.18
Mr O'Donoghue				
Mr Young	12	0	0	0

Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Hynds, Siobhan
Sent: 04 October 2018 10:05
To: Carroll, Ronan
Subject: Return to Work Action Plan February 2017 FINAL.

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinics to be typed	Results to be dictated	Results to be typed	Filing
Mr Aslam							
Mr Glackin	2 (Dec/Jan)	8 (26.01.17)	0	37 (25.01.17)	86 (Jan/Feb)	15 (31.01.17)	2 lever arch files
Mr Haynes	0	0	0	4 (Jan 17)	12 (Jan 17)	63 (Dec/Jan)	Nil recorded
Mr Jakob							
Mr O'Brien	11	0	0	20 (02.02.17)	20	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	7 (02.02.17)	1 lever arch file
Mr Suresh							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinics to be typed	Results to be dictated	Results to be typed	Filing
Mr Alsam	0	0	0	0	5 (21.02.17)	0	1 lever arch file
Mr Brown	0	0	0	0	15 (20.02.17)	0	
Mr Suresh	0	0	0	0	4 (Jan 17)	0	
Mr Glackin	3 (Jan 17)	4 (10.02.17)	2 (06.02.17)	33 (03.02.17)	30 (Feb 17)	28 (10.02.17)	2 lever arch file blocks
Mr Haynes	0	0	0	8 (23.02.17)	25 (Mid Feb 17)	0	approx 50 sheets
Mr Jakob	0	0	0	0	37 (Jan/Feb)	0	
Mr O'Brien	0	0	0	0	0	0	6 lever arch files
Mr O'Donoghue	0	0	0	4 (17.02.17)	0	11 (15.02.17)	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinics to be typed	Results to be dictated	Results to be typed	Filing
Mr Aslam							
Mr Glackin	0	8 (20.03.17)	0	19 (21.03.17)	18 (March)	6 (24.03.17)	2 1/4 lever arch files
Mr Haynes	0	0	0	34 (24.03.17)	5 (March 17)	40 (29.03.17)	ICATS & Mr Haynes - 80
Mr Jakob							
Mr O'Brien							
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Suresh							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinics to be typed	Results to be dictated	Results to be typed	Filing
Mr Alsam							
Mr Jakob							
Mr Suresh							
Mr Glackin	2 (Mar/Apr 17)	8 (13.04.17)	2 (04.04.17)	11 (10.04.17)	100 (Various)	32 (06.04.17)	2 1/2 lever arch files
Mr Haynes	0	0	0	0	25 (April 17)	10 (April 17)	45 sheets
Mr O'Brien							
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinics to be typed	Results to be dictated	Results to be typed	Filing
Mr Alsam/Suresh							1 lever arch file
Mr Jakob	0	0	0	0	58 (May)	2 (23.05.17)	
Mr Glackin	10 (April/May 17)	13 (28.04.17)	1 (04.04.17)	35 (03.05.17)	21 (May 17)	19 (16.05.17)	3 lever arch files
Mr Haynes (& ICATS)	0	0	0	4 (16.05.17)	40 (May 17)	0	65 sheets
Mr O'Brien	0	0	0	6 (11.05.17)	4	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	62 (10.05.17)	0	8 (16.05.17)	1 lever arch file
Mr Young							
Sub Speciality Totals	10	13	1	107	119	27	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Alsam/Suresh							1 lever arch file
Mr Jakob	0	2 (23.06.17)	0	23 (22.06.17)	20 (June)	8 (June)	
Mr Glackin	6 (May/June)	5 (14.06.17)	2 (06.06.17)	18 (13.06.17)	67 (May/June)	8 (14.06.17)	3 1/2 lever arch block files
Mr Haynes	0	7 (26.06.17)	0	0	0	0	60 sheets
Mr O'Brien	8 (03.05.17)	0	0	0	4	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	59 (14.06.17)	0	20 (15.06.17)	1 lever arch file
Mr Young							
Sub Speciality Totals	**14**	**14**	**2**	**100 (13.06.17)**	**91**	**36**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Alsam - No longer here							1 lever arch file
Mr Jakob	0	9 (21.07.17)	0	14 (19.07.17)	20 (21.07.17)	16 (18.07.17)	
Mr Suresh - No longer here							
Mr Glackin	23 (11.07.17)	6 (june/July)	4 (04.04.17)	18 (11.07.17)	47 (July 17)	30 (13.07.17)	3 1/2 file blocks
Mr Haynes	0	0	0	3 (20.07.17)	8 (July 17)	0	50 Sheets
Mr O'Brien	9 (27.06.17)	0	0	0	14	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	0	1 lever arch file
Mr Young	30 (Nov 16)	0	0	0	12 (May 17)	0	Approx 1 1/2 box files
Sub Speciality Totals	62	15	4	35	101	46	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Alsam	Left						1 lever arch file
Mr Jakob	0	0	0	11 (31.08.17)	0	2 (28.08.17)	
Mr Suresh							
Mr Glackin	2 (July 17)	3 (25.08.17)	6 (04.04.17)	0	75	18 (24.08.17)	2 3/4 lever arch files
Mr Haynes	0	0	0	0	10 (Aug 17)	0	40 sheets
Mr O'Brien	10 (24.08.17)	1 (02.09.17)	0	0	35	0	1 small file & Monica backlog
Mr O'Donoghue	0	0	0	0	0	4 (22.08.17)	1 lever arch file
Mr Young	38 (Nov 16)	0	0	0	31 (July 17)	0	Approx 1 1/2 lever arch files
Sub Speciality Totals	**50**	**4**	**6**	**11**	**151**	**24**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	0	0	12 (02.10.17)	35 (25.09.17)	5 (18.09.17)	1 lever arch file
Mr Suresh							
Mr Glackin	1 (Sept)	7 (10.09.17)	2 (06.06.17)	28 (12.09.17)	8 (11.09.17)	7 (22.09.17)	2 1/4 lever arch file
Mr Haynes	0	0	0	0	7 (26.09.17)	0	60 documents
Mr O'Brien	13 (27.06.16)	0	0	0	6	0	6 lever arch files
Mr O'Donoghue	0	0	0	0	0	7 (21.09.17)	1 lever arch file
Mr Young	11 (Jan 17)	17	0	2 (28.09.17)	17 (July 17)	0	1 1/2 lever arch files
Sub Speciality Totals	**25**	**24**	**2**	**42**	**67**	**19**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	0	0	6 (25.10.17)	34 (25.09.17)	5 (23.10.17)	
Mr Suresh							
Mr Glackin	4 (Oct 17)	6 (24.10.17)	2 (06.06.17)	1 (30.10.17)	81 (16.10.17)	0	2 1/2 Lever arch files
Mr Haynes	0	0	0	0	2 (29.10.17)	26 (30.10.17)	70 sheets
Mr O'Brien	13 (27.06.16)	0	0	0	3	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	14 (24.10.17)	0	21 (24.10.17)	1 lever arch file
Mr Young	20 (Jan 17)	0	0	2 (02.11.17)	14 Cons, 11 Reg, July 17	0	1 1/2
Sub Speciality Totals	**37**	**6**	**2**	**23**	**145**	**52**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	3 (29.11.17)	11 (27.11.17)	35 (20.11.17)	1 lever arch file
Mr Suresh							
Mr Glackin	3 (Nov)	3 (24.11.17)	3 (06.06.17)	2 (21.11.17)	80 (Oct)	7 (15.11.17)	3 lever arch files
Mr Haynes	0	10 (22.11.17)	0	0	1 (27.11.17)	23 (23.11.17)	60 sheets
Mr O'Brien	12 (27.06.16)	0	0	0	2	0	Approx 6 lever arch files
Mr O'Donoghue	0	0	0	14 (22.11.17)	0	11 (23.11.17)	1 lever arch file
Mr Young	3 (Feb 17)	0	0	36 (27.11.17)	15 MY, 17 Reg, July 17	0	1 1/2 lever arch files
Sub Speciality Totals	**18**	**13**	**3**	**55**	**126**	**76**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob							
Mr Suresh							
Mr Glackin							
Mr Haynes							
Mr O'Brien							
Mr O'Donoghue							
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0		3 clinics (03.01.17	20 (01.1.17)	20 (25.12.17)	1 lever arch file
Mr Suresh	0	0					
Mr Glackin	2	2	2 charts 06.06.17	21 (into jan)	37	8 (26.12.17)	2.5 lever arch files
Mr Haynes	0	10 (29.12.17	0	0	0	22 (28.12.17)	80 sheets
Mr O'Brien	12	0	0	7 clinics (29.12.17)	6	0	6 lever arch files
Mr O'Donoghue	0	0		17	0	13 (19.12.17)	lever arch file
Mr Young	Secretary on AL						
Sub Speciality Totals	**22**	**10**	**2**	**approx 100**	**63**	**63**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinics (no of charts) to be dictated**	**Clinic letters to be typed**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob	0	0	0	0	0	0	lever arch file
Mr Suresh	0	4		14 (05.02.18)	15 (05.02.18)	6	
Mr Glackin	0	12	1	1	84 (12.01.18)	9 (31.01.18)	lever arch file
Mr Haynes	0	0	0	7 (25.1.18)	2 (29.01.18)	29 (04.02.18)	lever arch file
Mr O'Brien	12	0	0	0	6		6 lever arch files
Mr O'Donoghue	0	0	0	22 (31.01.18)	0	16 (01.02.18)	1 lever arch file
Mr Young							
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	3	0	15	15	19	1 file
Mr Suresh							
Mr Glackin	6	0	10	67	2	12	1 file
Mr Haynes	0	0	0	5	0	9	1 file
Mr O'Brien	21	0	0	0	8	0	6 files
Mr O'Donoghue	0	0	0	48	0	3	1 file
Mr Young	6	0	0	0	6	0	1.5
Sub Speciality Totals	**33**	**3**	**10**	**130**	**31**	**40**	

(all within march)

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics LETTERS to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	10 (13.04.18)	0	15 (12.04.18)	0	40 (09.04.18)	2 lever arch files
Mr Suresh							
Mr Glackin	3	10	15 (28.03.18)	1	98 (02.04.18)	3	
Mr Haynes	0	0	0	0	10 (05.04.18)	15 (15/04/18)	70 sheets
Mr O'Brien	30 (06.04.18)	0	0	57 (27.03.18)	10	0	6 lever arch files
Mr O'Donoghue	0	0	0	57 (10.04.18)	0	10 (12.04.18)	1 lever arch file
Mr Young	9	0	1	0	39 (March/April)	0	2 BOXES
Sub Speciality Totals	**42**	**20**	**16**	**129**	**157**	**65**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics letters to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	2	0	3	30 (23.04.18)	0	
Mr Glackin	4	6	3	15 (25.04)	8	14	2 lever arch
Mr Haynes	0	0	0	6 (26.04.18)	12 (16.04.18)	32 (27.4.18)	
Mr O'Brien	9 (01.18)	0	0	1 (27.04.18)	14 (Reg 2017)	28	2 boxes
Mr O'Donoghue	0	0	0	26	0	12	1 lever arch
Mr Young	no sec response						
Sub Speciality Totals	**13**	**8**	**3**	**37**	**56**	**86**	

UROLOGY	Backlog - Number of charts with oldest date in brackets						
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinics (charts) to be dictated	Clinic letters to be typed	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	3	0	19	16	22	1 file
Mr Glackin	1	10	4	21 (25.05)	84 (14.05)	13	1 box
Mr Haynes							
Mr O'Brien	20	17	54 (10.04.18)	12	8	0	6 files
Mr O'Donoghue	0	0	0	0	0	6	1 lever arch file
Mr Young	15 (Jan 18)	0	0	0	38	0	2 boxes
Sub Speciality Totals							

UROLOGY	Backlog - Number of charts with oldest date in brackets							
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	10	10	0	0		40	14	1 file
Mr Glackin	1	1	3	7	27.06	84	0	2 files
Mr Haynes	0	0	0	6	29.06.18	44	0	
Mr O'Brien								6 files
Mr O'Donoghue	0	0	0	6		0	23	1 file
Mr Young	0	0	0	0		38	38	2 boxes
Sub Speciality Totals	**11**	**11**	**3**	**19**		**206**	**75**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	7	7	0		2	06.08.18	60	60	1 file
Mr Glackin	10	13	9	july	0		44	3	2 files
Mr Haynes	0	0	0		23	02.08.18	8	70	
Mr O'Brien	31		44	08.05.18	17	06.08.18	10	0	6 files
Mr O'Donoghue	0	0	0		3		0	47	1 file
Mr Young	0	0	0		12	01.08.18	0	4	2 boxes
Sub Speciality Totals	48	20	53		57		122	184	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob	0	8	0		10	03.09.18	10	0	2 files
Mr Glackin	4	19	4	06.06.18	21	23.08.18	49	29	2 files
Mr Haynes	0	9	0		6	30.8.18	15	12	85 sheets
Mr O'Brien	17				81	01.06.18	5		6 files
Mr O'Donoghue					55	28.08.18	14	0	2 files
Mr Young	11	0	2	24.08.18	0		44	0	2 files
Sub Speciality Totals	**32**	**36**	**6**		**173**		**137**	**41**	

UROLOGY	Backlog - Number of charts with oldest date in brackets								
Consultant	Discharges awaiting Dictation	Discharges to be typed	Clinic letters to be dictated	oldest date of clinic letters to be dictated	Clinic letters to be typed	oldest date	Results to be dictated	Results to be typed	Filing
Mr Jakob					18	25.09.18	30	0	3 files
Mr Glackin	5	6	7	06/06/2018 (1 letter)	11	26.09.18	29	5	1.5 files
Mr Haynes	0	0	19	26.09.18	0		55	0	115 sheets
Mr O'Brien	17	0	91	15.06.18	0				6 files
Mr O'Donoghue					15	26.09.18	12	0	2 files
Mr Young	12	0	0	0	2	27.09.18	35	0	2.5 files
Sub Speciality Totals	34	6	117		46		161	5	

Received from Ahmed Khan on 08/07/2022. Annotated by the Urology Services Inquiry.

AOB Action Plan

Concerns	Update at 22/10/16
CONCERN 1 • That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.	Update from Katherine Robinson 22/10/18 – On 4 occasions that Mr O'Brien was SOW from June to October 18 there are no outstanding referrals : UOW: 2/6/18 19/7/18 23/8/18 4/10/18
CONCERN 2 • That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing.	Update 22/10/18 – 51 charts are tracked to Mr O'Brien's office. We will do another PAS check tomorrow morning.
CONCERN 3 • That 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a	Update 22/10/18 – on last October 2018 report there are 91 patients still requiring dictation, longest wait 15/6/18

period of at least 18 months.	
CONCERN 4 • A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients.	Update 22/10/18 – A BOXI theatre report was ran of all AOB patients who have had surgery from 1/6/18 to date. • 61 patients had surgery in CAH • With information available on NIECR, PAS and TMS these patients were not PPs

Cunningham, Hannah

From: Khan, Ahmed
Sent: 24 October 2018 11:15
To: Hynds, Siobhan
Subject: FW: AOB notes and dictation
Attachments: image001.jpg

Siobhan, see email for your information.
Thanks
AK

From: Gibson, Simon
Sent: 23 October 2018 17:35
To: Clayton, Wendy; Carroll, Ronan; Khan, Ahmed; Toal, Vivienne
Cc: Robinson, Katherine; Weir, Colin
Subject: Re: AOB notes and dictation

Thanks for this Wendy; much appreciated.

Does that mean that the update "as at 22nd October" sent yesterday was possibly a little misleading as whilst it was circulated on 22nd, it actually referred to the position as at 3rd October?

Thanks for the clarity.

Sent from my Samsung Galaxy smartphone.

-------- Original message --------
From: "Clayton, Wendy" [redacted]
Date: 23/10/2018 17:18 (GMT+00:00)
To: "Gibson, Simon" [redacted], "Carroll, Ronan" [redacted], "Khan, Ahmed" [redacted], "Toal, Vivienne" [redacted]
Cc: "Robinson, Katherine" [redacted], "Weir, Colin" [redacted]
Subject: FW: AOB notes and dictation

The backlog report is generated monthly. For October 18, the report was completed 3rd Oct. At this time there were 91 outpatient letters to be dictated. The oldest of the 91 extended back to June 18. We asked Katherine to update the report as of yesterday and it was down to 16 clinical notes, oldest now 28/9/18. Therefore, from the 3/10/18 to the 23/10/18 Mr O'Brien has gone from 91 to 16 outpatients letters to be dictated.

The numbers in the report are derived from a manual count i.e the secretary feeds the information to the Service Administrator who populates the table.

We will complete actions on a weekly basis as requested:

- Outstanding dictation
- Number of charts in AOB office

Regards

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: Personal Information redacted by
External number: Personal Information redacted by USI
Mob: Personal Information redacted by USI

EXT Irrelevant redacted by the USI ***dialling from Avaya phone.***
If dialling from old phone please dial Irrelevant redacted by the USI

External No. Personal Information redacted by USI

From: Carroll, Ronan
Sent: 23 October 2018 16:54
To: Robinson, Katherine; Clayton, Wendy
Subject: FW: AOB notes and dictation

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by

From: Hynds, Siobhan
Sent: 23 October 2018 16:40
To: Gibson, Simon; Carroll, Ronan; Khan, Ahmed; Toal, Vivienne
Subject: RE: AOB notes and dictation

Ronan

Could I get a look at the actual report from the digital dictation system? We need to be clear about if and when there may have been backlogs and when these may have been cleared i.e. need to see the date of the clinical contact, the date of the dictation and the timescales in between those 2 events.

Thanks

Siobhan

From: Gibson, Simon
Sent: 23 October 2018 15:53
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Toal, Vivienne
Subject: RE: AOB notes and dictation

Dear Ronan

Are the figures of 91 and 16 both definitely accurate?

If so, this means that Aidan dictated 75 letters in one day. Can that be validated?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI (DHH)

From: Carroll, Ronan
Sent: 23 October 2018 15:05
To: Gibson, Simon; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

Can only speculate

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by

From: Gibson, Simon
Sent: 23 October 2018 15:04
To: Carroll, Ronan; Khan, Ahmed; Hynds, Siobhan; Kerr, Vivienne
Subject: RE: AOB notes and dictation

Dear Ronan

Thanks for this – how has the number gone from 91 to 16 so quickly?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI
Personal Information redacted by USI (DHH)

From: Carroll, Ronan
Sent: 23 October 2018 15:02
To: Khan, Ahmed; Hynds, Siobhan; Gibson, Simon; Kerr, Vivienne
Subject: FW: AOB notes and dictation
Importance: High

Please see updated position – apologies for the delay

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by USI
Ext Personal Information redacted by USI

From: Clayton, Wendy
Sent: 23 October 2018 13:43
To: McCaul, Collette; Robinson, Katherine
Cc: Carroll, Ronan
Subject: RE: AOB notes and dictation

Ronan

Summary:

Outpatient charts waiting dictation = 16 (Oldest 28/9/18)

Notes in office = 54

- Deceased charts
- Telephone reviews
- Awaiting dictation
- Secretary queries
- Awaiting results (DARO)

Regards

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: Personal Information redacted by USI
External number: Personal Information redacted by USI
Mob: Personal Information redacted by USI

EXT Irrelevant redacted by the USI ***if dialling from Avaya phone.***
If dialling from old phone please dial Irrelevant redacted by the USI

External No. Personal Information redacted by USI

From: McCaul, Collette
Sent: 23 October 2018 13:41
To: Clayton, Wendy; Robinson, Katherine
Cc: Carroll, Ronan
Subject: RE: AOB notes and dictation

Wendy the column highlighted clinic awaiting typing in that actual column it says awaiting dictation and there are 16 charts awaited

Collette

From: Clayton, Wendy
Sent: 23 October 2018 13:14
To: Robinson, Katherine; McCaul, Collette
Cc: Carroll, Ronan
Subject: AOB notes and dictation

Thanks for the table left on my desk. Collette – I tried to phone you

Need to clarify **number of clinics notes waiting dictation**? You have discharges awaiting dictation but not OPD

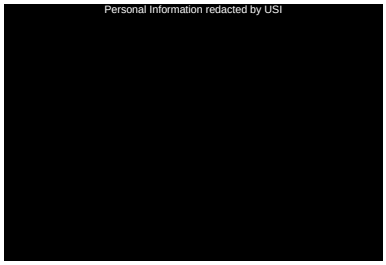
Notes:
There are 54 notes in the office. Made up of:

- Deceased charts
- Telephone reviews
- Awaiting dictation
- Secretary queries
- Awaiting results (DARO)

Wendy Clayton
Acting HOS for G Surg, Breast & Oral Services
SEC
Ext: Personal Information redacted by USI
External number: Personal Information redacted by USI
Mob: Personal Information redacted by USI

EXT Irrelevant redacted by the USI ***if dialling from Avaya phone.***
If dialling from old phone please dial Irrelevant redacted by the USI

External No. Personal Information redacted by USI



30 July 2017.

Dr. Ahmed Khan,
Associate Medical Director,
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Craigavon,
BT63 5QQ.

Dear Dr. Khan,

Re: Formal Investigation.

As you may know, I have been invited to interview by Dr. Chada, the Case Investigator, on Thursday 03 August 2017. I therefore wish to take this opportunity to register the cumulative concerns which I have had regarding the above investigation, the events leading to it and its conduct to date.

First amongst these is the relationship between 'Maintaining High Professional Standards in the Modern HPSS' issued by the Department of Health, Social Services & Public Safety (DHSSPS) in November 2005 and the 'Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance' issued by the Southern Health and Social Care Trust (SHSCT) in September 2010. 'Maintaining High Professional Standards in the Modern HPSS' (MHPS) is a framework for the handling of concerns about doctors and dentists in the HPSS. In Paragraph 3 of the Framework, the DHSSPS obliges HPSS organisations to notify the Department of the action they have taken to comply with the framework. In response to that obligation, the SHSCT formulated and issued its Guidelines in September 2010.

Paragraph 1.5 of the Trust Guidelines states that the 'guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists,

to minimise potential risk for patients, practitioners, clinical teams and the organisation'. Therefore, I believe that it is evident that the procedure by the SHSCT handles concerns about its doctors and dentists should be by and in accordance with its Guidelines, as obliged by the DHSSPS. Yet, this investigation has and continues to be conducted under MHPS, rather than under the Trust Guidelines.

In its Introduction, MHPS states that numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures. Paragraph 1.2 of the Trust Guidelines states that the document seeks to underpin the principle within the MHPS Framework that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patients harmed.

In your letter of 24 February 2017 to me, you advised that the letter of 23 March 2016 given to me was not in the context of an informal process under the MHPS Framework but rather an informal attempt at local resolution of the issues, sent to me through normal line management channels. Apart from the fact that it was given to me rather than sent to me, it should not have been in the context of the MHPS Framework in any case. Instead, SHSCT management should have discussed with me and taken remedial and supportive action to resolve the issues of concern, in accordance with the Trust Guidelines.

In your letter, you stated that it was your understanding that concerns were identified by managers within the Acute Services Directorate and that the purpose of the March 23rd letter was to set out to me those concerns on an informal basis in order to enable me to put in place measures to rectify the concerns. Your understanding would infer that I had not been aware of those concerns prior to being given the letter. I had been burdened with the same concerns prior to being given the letter, and still am. I fail to understand how receipt of a letter outlining concerns of which I had long been aware, was itself enabling, without the remedial and supportive assistance obliged of those who wrote and gave the letter. Instead, it was expected that the letter was sufficient to ensure that I took all necessary steps to address the concerns and to rectify the identified problems.

Without the support which should have been given, it would have required the displacement of other work, and particularly operative activity. The numbers of patients severely suffering while awaiting surgery, at risk of suffering poorer clinical outcomes and actually doing so, remained my greatest clinical priority before and after receipt of the letter of 23 March 2016. During the months after March 2016, I deferred my own surgery which I should have had earlier, and did not take any leave on operating days or on the operating days vacated by colleagues, in order to maximise operating capacity, so as to minimise the poor outcomes suffered by scores of patients. To have attempted to address and rectify the concerns, on my own without support, would certainly have displaced all of the additional operating carried out during the remainder of 2016.

There were 280 patients awaiting admission for surgery in November 2016, excluding those awaiting admission to the Day Surgical Unit. Patients were waiting as far back as February 2014. That number included some thirty patients requiring admission as soon as was possible. The numbers suffering due to delay in admission, at risk of poor clinical outcomes and actually suffering poor clinical outcomes, have been and remain my greatest clinical concern. So far as I am aware, these outnumber many times over, those identified by the investigation as at risk of suffering poor clinical outcomes. When I advised Mr. Weir and Mrs. Hynds of this greatest clinical concern at my meeting with them on 24 January 2017, I was asked whether I had raised this issue with management previously. In addition to advising that I had done so numerous times with all tiers of management, I also asserted that I was doing so again, there and then, and that I predicted that my doing so would not appear in any record of the meeting. It did not! On 27 March 2017, I included this omission in a written request for the Note of the meeting to be amended, and returned to me. Four months later, I still await receipt of the amended Note.

I believe that I, and the patients about whom management claimed to have been concerned, were failed by management's failure to discuss the concerns which they had and which I shared, with a view to agreeing a remedial and supportive course of action over a period of time in order to rectify the problems, as obliged by Trust Guidelines. I would have so welcomed that support. Instead, when I asked what they wanted me to do, there was no advice or support offered.

I believe that the deliverance of a letter to me on 23 March 2016 by members of Trust management, identifying concerns which they expected me to address and rectify, on my own, without remedial action and support, in breach of Trust

Guidelines, is untenable, particularly when those same concerns were deemed to be so grave as to merit a Formal Investigation and Immediate Exclusion nine months later.

In your letter of 24 February 2017, you related how the SAI investigation had alerted the Trust to a very serious issue of concern which indicated harm had come to a patient who had not been properly triaged by me as was required. I had indeed previously raised my concern that a decision had been made to proceed with a formal investigation and immediate exclusion, prior to even a draft final report of the investigating panel having been compiled. I was provided with that draft final report on 13 January 2017. I returned my comments upon the report on 25 January 2017. In doing so, I concluded that the terms of reference for the SAI investigation were prejudicial in that the investigation concerned itself with the period of time beginning with CT scanning on 24 June 2014 and ending with the patient's first urological consultation on 06 January 2016. The SAI investigation therefore failed to include that the renal lesion of concern could have been identified on CT scanning as early as December 2012. Most importantly, the patient did not come to any harm as a consequence of the delay in urological consultation. I believe that it was improper and prejudicial to have concluded that harm had been suffered by a patient before the investigation of the case had even reported. I believe that it was even more improper and prejudicial to have used that presumption of harm, which did not exist, to justify Formal Investigation and Immediate Exclusion, as you asserted.

It is also noteworthy that you made reference to my not having 'properly' triaged the letter of referral. I do believe that there is indeed a distinct difference between triage and proper triage. I believe that most, if not all, clinicians would agree that 'triage' is a process to allocate 'red flag', 'urgent' or 'routine' status to any referral in accordance with the information provided in the letter of referral. As I reported in my response to the draft final report of the SAI investigation, the patient had been a routine referral for assessment of a large, simple, right renal cyst, associated with right renal angle pain. Based upon this information, I asserted that I would have retained the routine referral status. The waiting time then for a routine urological outpatient consultation was then 66 weeks. At present, I believe it to be some 84 weeks.

I believe that 'proper' triage would have resulted in the referral status having been amended to 'Red Flag'. This would have required a review of the patient's entire history by access to NIECR. However, crucially, it would also have required a review of the digitalised imaging on NIPACS. I believe that it is a modest

proposal that this would have taken some 15 to 20 minutes to undertake. We receive 120 to 160 referrals per week. Even if the mean time required to 'properly' triage were ten minutes each, that would require 20 to 27 hours during a week when one is responsible for all inpatient care of all urological patients, including emergency and urgent surgery, and all emergency and urgent referrals from elsewhere in Craigavon Area Hospital, Daisy Hill Hospital and South West Acute Hospital. Indeed, as reported in my comments upon the draft final report of the SAI investigation, on the day upon which the referral of the case was delivered for triage, I had additionally spent three hours previewing the cases for MDM discussion that afternoon when I spent a further three hours chairing MDM, followed by further time that evening proof reading and signing letters emanating from MDM, addressed to GPs. The following day, I reviewed ten oncology patients in addition to the continued responsibilities of being urologist of the week. It was precisely for this reason that I had previously advised that I had found it impossible to conduct triage on urgent and routine referrals, as there simply was inadequate time to do so. Indeed, in March 2015, as lead clinician of MDT, I had been unable to secure the commitment of my colleagues to conduct such triage on 'Red Flag' referrals alone, as they found it too time consuming and that there was not enough time as urologist of the week to do so, as documented in the minutes of the Urology MDT Business Meeting of 02 April 2015, and even though Red Flag referrals constitute only 15% to 20% of all referrals.

Also, in relation to triage, you referred in your letter to my having failed to properly triage *as was required*. I have twice requested a copy of, or a link to, the Trust's Policy and Procedure regarding triage, and to which reference has been made. I still await a reply, a copy or a link. Moreover, the ultimate reason why any patient had to wait 66 weeks for a routine consultation following referral is because the Trust provides such an inadequate service. It is worthy of note that the SAI investigation panel did not include that inadequacy at all as a factor in the patient's delay in diagnosis. Lastly, in relation to that SAI investigation, I have yet to receive a copy of the final report of the investigating panel. I have written to the Director of Acute Services requesting a copy.

Finally, in relation to triage, one of my colleagues luckily discovered during April 2017 that a decision had been made by some person(s) in management not to place patients on a waiting lists for outpatient consultations at all, if investigations had been requested during triage, until it had been determined whether appointments were required, following receipt of the results or reports of the investigations. This had been decided without any consultation with

clinicians, never mind their agreement. Following protest, this practice has since been abandoned. So much for the 'agreed / established procedure' so often referred to, during the course of this investigation!

During 2016, I had deferred my own surgery for as long as possible, in order to operate on as many patients as I possibly could, so as to minimise the numbers suffering while awaiting admission, and suffering poor clinical outcomes, as already related. During 2016 alone, I carried out an additional 22 operating sessions, and an additional 17 Urodynamics and Oncology Review sessions. I continued to do so until my symptoms, and particularly pain, rendered it increasingly difficult to travel, to conduct clinics and to operate. In addition, I deferred my own surgery until after the departure from the Trust of a colleague who required support following concerns regarding his competence when urologist of the week.

As indicated previously, prior to my [Personal Information redacted by USI] leave, I had identified thirty patients awaiting admission, and whom I believed required to be admitted as soon as was possible. On 07 November 2016, I advised the Head of Service and my four colleagues of the ten of those patients waiting the longest periods of time, requesting that they be admitted during [Personal Information redacted by USI] leave. I had surgery on 17 November 2016. During the subsequent weeks following discharge, I had arranged operating lists and clinic sessions to be undertaken by me during January 2017. By mid-December 2016, I had become so increasingly concerned by the outcome of my surgery that I contacted the surgeon who arranged for me to be readmitted on 24 December 2016 for [Personal information redacted by USI], but who also advised that I resume [Personal information redacted by USI] This proved to be so effective that there was no need for readmission, though it was equally evident that I needed to remain on antibiotic therapy for a protracted period of time. I felt well enough to have my secretary notify patients of their planned admissions and reviews in January 2017. I felt all the more compelled to do so as only two of the above ten patients had been admitted, by 31 December 2016.

Perhaps, the one aspect of this investigative process which I have found most incomprehensible was the decision to proceed to Formal Investigation and Immediate Exclusion without having consulted with me in the first instance. If I had been Medical Director and received such information, I would have certainly wanted to assess its veracity, accuracy and reliability, not only with those who had provided and delivered the information, but also with the clinician involved. I would certainly have wanted to explore with the clinician involved the reasons for the concerns raised. It would have been for me a matter of common sense,

of courtesy and of natural justice. When requested to provide an explanation for this failure, the Medical Director, in his written reply of 30 March 2017, advised that it was not necessary as the required information was being collated by the Assistant Director of Acute Services and by the Head of Service. Instead, I was presented on 30 December 2017 with the fait accompli of Formal Investigation and Immediate Exclusion. Both were inflicted by a Medical Director, on behalf of an Oversight Group, upon a colleague recovering from surgery, even though he claimed to be unaware of the nature of the surgery or of the pathology for which it was performed. The consequences of both upon my health have been the most severe I have suffered in my lifetime, some permanently, and without enquiry since.

When I met with the Medical Director and Ms. Hainey on 30 December 2017, it did appear that the greatest issue of concern was that of 'missing' hospital charts at my home. I did advise that I had never mislaid a patient's chart and that the only patients' charts that I had ever known to have been mislaid, were mislaid by the Trust. Nevertheless, all charts were returned from my home, as directed, on 03 January 2017, so that the Medical Director could advise the Chief Medical Officer of the status of 'missing' charts. I was subsequently presented with a list of 13 patients' charts, tracked out to me, and which were still missing. These included one who had never been my patient, two who never had clinical episodes at Craigavon Area Hospital and who did not even have a Health & Care numbers, one discharged following his birth in 1993 and who had had no episodes since then and who did not have a Health & Care Number, and one who last attended in 1988, four years before my appointment. It also included a patient whose chart had been returned to Medical Records, but which remained tracked out to me, but who is currently an inpatient with her chart intact, provided by Medical records, of course!

It was reported that there were over 600 patients who had attended as outpatients at over 60 clinics, and whose outcomes were unclear. I have yet to be advised of the source of this information, though there has been a belief that it may have been an extrapolation of an audit of seven outpatient attendances conducted in October 2016. In fact, 349 of 560 patients (62%) who had attended 51 clinics, had already had outcomes dictated and implemented because of their clinical priority. There were 211 patients whose outpatient consultations had neither been dictated or outcomes returned. At the meeting of 30 December 2016, as I had been advised that I would not be able to return to work as intended, I requested a period of two weeks to process these remaining patients, explaining that I would review all of these patients by telephone, to

ensure that their current clinical status was up to date. That would have ensured that all of these patients would have been effectively reviewed, relevant correspondence dictated, charts and clinical outcomes returned and implemented, during January 2017. Instead, I was advised that the Oversight Group had directed that the utmost priority was to have the charts returned, by 03 January 2017, so that the Medical Director could see them and report to the Chief Medical Officer of the status of the 'missing' charts.

The Medical Director advised me in his letter of 06 January 2017 that he understood that the charts had been returned as directed, and that their return would be recorded, and their location tracked on PAS, back to filing, to my office or to my secretary's office, in line with Trust procedures. However, charts were not returned to my office or to my secretary's office. Having attended a meeting in the Associate Medical Directors' office on 09 March 2017, I was concerned to find the charts still there. Nevertheless, I had consoled myself that I had been able to document all of the clinical outcomes intended for each patient before returning the charts on 03 January 2017. All of these outcomes were returned, upon request, on Monday 09 January 2017. However, I was advised in June 2017, five months later, that the outcomes had not yet been registered on PAS, never mind implemented. I find it remarkable and contradictory that a Trust purporting to be so concerned about patient safety, harm and potential harm, could have considered it appropriate to insist that 'missing' charts be imminently returned so that they could be declared 'unmissing', having been advised by me that doing so would prevent the processing of those patients in the manner which I have described, and yet allow a further five months to elapse before the returned outcomes were implemented.

Even though it is clearly stated in the Trust Guidelines that the investigation must be completed within four weeks, I still had not received any communication from the appointed Case Investigator, by 16 January 2017, never mind any notification of a meeting with the appointed Case Investigator, to provide me with an opportunity to state my case and to propose alternatives to exclusion, as required by the same Trust Guidelines, within the four week period permitted. I had to resort to contacting the Case Investigator myself, on 16 January 2017, to be advised that he had a meeting scheduled to take place on Thursday 26 January 2016, the penultimate day of the four week period, with Mrs. Hynds, the Human Resources person appointed to assist him in the investigation, and that no meeting with me had been scheduled to take place at all, within the four week period.

In addition, I had not been provided with the Terms of Reference for the investigation on the day on which it was initiated, in breach of NCAS guidelines. I had not been provided with a copy of correspondence or communication with NCAS. I had not been provided with the minutes of the meeting of the Oversight Group. I had not been provided with a Record of the meeting of 30 December 2016. I had not been advised of the identity of the non-executive Board member appointed to ensure momentum was maintained, to ensure that the investigation was completed in a fair and transparent way, and to consider any representations regarding exclusion or any other aspect of the investigation.

I had to write to the Medical Director on 17 January 2017 requesting to be advised of the identity of the non-executive Board member and requesting all minutes, records and documentation pertaining to the meeting of 30 December 2017. I expressed my concern that a date had not been set for me to meet with the Case Investigator within the four week period, as required by the Trust Guidelines. I also requested the Medical Director to inform me in more detail of the reasons and justifications for immediate exclusion, so that I may be able to adequately respond to them, and to consider proposals for alternatives.

The Medical Director wrote to me on 18 January 2017, enclosing a Note of Meeting of 30 December 2016. In a later letter of 23 January 2017, the Medical Director advised that he had approved the Note of the Meeting on 18 January 2017. I wrote to the Medical Director on 14 February 2017, detailing factual errors and omissions in the Note of the Meeting. I found it most egregious that the Note included a statement, in parenthesis, attributed to my wife who had accompanied me to the meeting, and which she did not make. I received an email from Mrs. Hynds on 01 March 2017, acknowledging receipt of my letter of 14 February 2017 to the Medical Director, and undertaking to arrange for an amended Note to be sent to me, taking consideration of my comments. I sent a further email to Mrs. Hynds on 19 April 2017, advising her that I still awaited receipt of an amended Note of the meeting of 30 December 2016. I have yet to receive a reply, or an amended Note.

As a consequence of my contacting the Case Investigator on 16 January 2017, and of my letter to the Medical Director on 17 January 2017, I was advised by the Case Investigator, by telephone on 19 January 2017, that a meeting was arranged with him and with Mrs. Hynds on 24 January 2017. I was advised that the purpose of the meeting was to discuss alternatives to exclusion. I was then advised by the Case Investigator, in writing on 20 January 2017, that the purpose of the meeting was two-fold, an opportunity to state my case and to propose

alternatives to formal exclusion, even though I had not yet been provided an opportunity to discuss alternatives to immediate exclusion. On 23 January 2017, the Medical Director confirmed in writing that a date for the meeting had been proposed. The Medical Director did not advise me of any specific reasons or justifications for immediate exclusion as requested. He did however avail of the opportunity to opine that the Trust Guidelines created an expectation that investigations are completed in four weeks, even though the Guidelines explicitly assert that investigations must be completed within four weeks. That the investigation was in breach of Trust Guidelines was acknowledged at the meeting with the Case Investigator and with Mrs. Hynds on 24 January 2017. That acknowledgement was not included in the Note of the Meeting.

At that meeting, I asked for specific reasons for my immediate exclusion. None could be given. I asked for specific reasons why exclusion should be continued. None could be given. That none could be given was not included in the Note of the Meeting.

It was at that meeting that it was claimed that a fourth issue of concern was identified during the initial scoping exercise and relating to nine patients who had private outpatient consultations, and who then had prostatic resections performed as NHS patients, after waiting times significantly less than for other patients. However, it was not possible for this fourth concern to be identified during scoping of triage of NHS referrals, NHS outpatient consultations and NHS charts retained at my home. I requested how this concern had been raised or who had raised it. I was advised that I would be advised of the source. Six months later, I have still not been advised. I requested the identity of the nine patients concerned. I still have not been advised of their identity. I asked whether patients who had had private consultations and who still awaited prostatic resection had been identified, or whether NHS patients who had prostatic resections performed after a similarly short waiting time would be included in a comparative manner in such an investigation. Indeed, in a further communication from the Medical Director, dated 30 March 2017, he advised that all nine patients were classified as routine. I do not know how he could have come to such a conclusion, or who did so, on his behalf. Now, six months later and four days before interview by the Case Investigator, I have still not been advised of any further developments in the investigation of this fourth concern.

On 06 February 2017, I received from Mrs. Hynds a Note of the Meeting of 24 January 2017, inviting me to advise her of any amendments required to the factual accuracy of the Note. On 28 March 2017, I submitted to Mrs. Hynds

amendments to be made as a consequence of factual errors and omissions. I still have not received an amended Note.

I was provided with the Terms of Reference for the investigation on 16 March 2017, though NCAS guidelines stipulate that the terms of reference be provided to the practitioner when advised of the formal investigation. On the same date, I was provided with a list of seven witnesses. Dr. Chada advised in her letter of 14 June 2017 that I will have received a witness list from her at an earlier date. I have not received any such list from Dr. Chada. I have not been provided with the testimonies of any witnesses. I have not yet been provided an opportunity to see all relevant correspondence, as obliged by Trust Guidelines.

I had considered deferring this record of my concerns until after interview by Dr. Chada. However, I have decided to do so at this time after a recent experience. I had taken annual leave the week commencing Monday 10 July 2017, but had agreed upon request to be on call on Saturday 15 July and Sunday 16 July 2017. On Friday 14 July 2017, I received calls from colleagues advising me of patients acutely admitted for surgery over the weekend. There were a total of eight patients requiring urgent surgery but I was only able to operate on four due to lack of theatre capacity. Some days later, I was approached by a member of staff whom I presume has not known of this investigation but was concerned enough to advise me that an investigation was being conducted into the cases upon whom I had operated, as it had been reported that I had arranged for one or more of these patients to be admitted electively. I was shocked by this revelation. I reported this experience when I met with the Assistant Director of Acute Services, the Clinical Director and the Head of Service on Tuesday 25 July 2017. It was evident that this investigation was known to one or more of them, if not instigated by one or more of them. I find this a matter of grave concern.

I have very much appreciated the flexibility demonstrated by Dr. Chada in facilitating her interviewing me on a date which did not further compromise patient management and outcomes. I approach that interview with integrity, sincerity, accountability and with some apprehension. However, I do so convinced that there was a safer and less traumatic way of dealing with the concerns identified by management in March 2016, and which I had shared before and since. I should have been offered and provided with remedial action and support to address and resolve those concerns at that time. I believe that I was failed by management, as were the patients I care for. In December 2016, I should then have been offered remedial action and support to address those same concerns. An investigation of untriaged referrals could have been

conducted by my colleagues, without my involvement, as I provided all of those referrals in chronological order, upon request. All of the undictated outcomes could have been completed, with updated reviews, by mid-January 2017, as described above. All of the 'missing' charts would have been returned by then. I do believe that there was no need whatsoever for immediate exclusion to be imposed in December 2016, no more than was considered necessary to be continued in January 2017, thereby avoiding the consequences upon my health suffered since, and which have been further exacerbated by the administrative conduct of an investigation into my administrative practices.

Yours Sincerely,

Aidan O'Brien.