Minding service is being relaunched and there is more innovative and creative use of SDS packages. New working partnerships have been forged with other agencies to develop independent living and employment skills programme which have been highly evaluated including the STEP Programme (Supported Transition Entry Programme) which has been rolled out throughout the SHSCT area. The STEP programme has been short listed for a Trust Excellence award.

Family based short breaks services have also been further developed with increase of both short break carers and Fee paid carers, and have delivered an increase in overnight provision for children in the last 12 months .The service is currently completing an evaluation of the family based short break service in conjunction with University of Ulster.

Foster care Services (Family Placement Service)

The Trust reorganised the Family Placement Service in 2014 with a partial objective of increasing the number of foster carers available to meet the needs of children both already Looked after and new admissions to care. A dedicated "Placement coordination and foster care recruitment team" was established. This team has engaged in many innovative initiatives in terms of recruitment practices. This includes establishing a recruitment steering group which includes foster carers, representatives from the Voluntary sector and individuals with media and promotion/advertisement expertise. In addition to recruitment and promotion the Family Placement service also focusses on retention of existing foster carers and has developed a number of associated programmes and wellbeing initiatives which are availed of by foster carers.

Facts and Figures

- 1st April 2015 – 31 March 2016 new fostering approvals Total**: 41**
- 1st April 2018 – 31st March 2019 new fostering approvals Total**: 75**

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

5.4 Adult Social Care Services

Adult Protection Plans

There are many vulnerable people in the community and those who are most at risk should have in place adult protection plans following investigation. In Southern Health and Social Care Trust **304 adults referred** for investigation and identified as at risk, during the year had an adult protection plan in place at 31st March 2019. (Adult Safeguarding Returns to HSCB). This is a **13.4% decrease** from the previous year, 2017/18.

The ultimate goal of this Trust is to improve the quality of life for those with learning disabilities. This is done by providing a range of services that will support personal choice; move away from a service-led to needs-led approach and challenge and change mind-sets that may affect the individual's potential to become an integral and valued member of their community.

Learning Disability Resettlement Breakdown

Sustainable integration into the community of individuals with learning disabilities who no longer require assessment and treatment in a hospital setting is a priority for all HSCTs.

Within Southern Trust **no people** with a learning disability who were resettled in community placements had to be readmitted to hospital as a result of an irretrievable breakdown of the placement.

Individual Care Assessments

There are a significant population of carers within the region. Health and Social Care Trusts are required to offer individual assessments to those people known to have caring responsibilities.

Facts and Figures

In 2018/19, **3925 adult carers** across Physical, Learning Disability, Mental Health and Older People & Primary Care Directorate were offered individual care assessments as set against the commissioning direction target by HSCB.

This is an **increase of 19.9%** on 2017/18 and a cumulative increase of 22.3% on 2016/17.

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Direct Payments

Direct Payments provide services users and their family an element of choice in determining the care they receive.

Facts & Figures

As of March 31 2019, **direct payments are in place for 604 adults**, an **increase of 59 adults** from 2017/18's figure of 545.

Learning Disability Annual Health Checks

The total learning disability adult population in the Southern Trust area is 1737. Of the total figure, our health facilitators have completed health checks during 2018/19 for 1426, this represents 82% of the total learning disability adult population.

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5.5 Integrated Care Partnership

During 2018/19 the Southern Integrated Care Partnership (ICP) partnered with the Southern Health and Social Care Trust (SHSCT) on a range of issues to improve the health of our population.

Social Prescribing:

During 2018/19 the Southern ICP partnered and the SHSCT supported the roll-out and implementation of the mPower project. This is a European funded cross-border project around social prescribing and use of technology for those clients over 65 years living with social isolation or co-morbidities. Then in the autumn 2018, ICP partners hosted a social prescribing networking event to allow a better understanding of local services.

Diabetes:

Diabetes has been a key working area of the Southern ICP and education sessions have taken place to raise awareness of Insulin safety and to promote new pathways eg. Footcare Pathway. Joint working has seen practices nurses becoming involved with providing diabetes education and self-management for ongoing and newly diagnosed (DESMOND) education sessions for patients living with Type 2 Diabetes.

Palliative and End of Life Care:

The Southern ICP currently co-chair the Southern Palliative and End of Life Care Board that brings together the range of partners to support seamless services for patients at the end of life.

Links with our Community:

In an approach to supporting 'making every contact count', a series of workshops were held across the Southern area to support an understanding of Health Literacy with a wide range of attendees from the Third Sector, Community Pharmacy, Dental, Trust colleagues and those from Primary Care.

Project Support:

The Southern ICP supported a number of Project Extensions for Community Healthcare Outcomes (ECHOs) to enhance skills in managing patients with ENT symptoms and Neurological symptoms within the Southern area. The Southern ICP have also worked with commissioning colleagues to support a new approach to manage patients with Neurological symptoms and conditions. Following on from a

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very successful pilot in the Southern Trust, the Non-Contact Specialist Assessment Service has been rolled out. This service sees patients treatment plans starting inside two weeks and reduces the need for a face to face consultation in up to 50% of patients.

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Southern Health and Social Care Trust

Quality Care - for you, with you

Annual Quality Report 2019/2020

Quality
Safe, effective & person centred care

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Southern Health and Social Care Trust

About the Trust

The Southern Trust had a busy year 2019/20 but our staff as always rose to the challenge as evidenced in an overview of our activity below.

58,067
Inpatients

363,778
Acute Outpatients

37,077
Day Cases

154,063 **Day Care Attendances**

169,709
Emergency Department Attendances
(decreased from 177,830)

5,564
Births

562
Children looked after by the Trust
(increased from 560)

4,308
Domicilliary Care Packages provided to Older People
(increased from 4,154)

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Southern Health and Social Care Trust

Quality Care - for you, with you

Southern Trust Overview

383,541

Population of the Trust Area
(as of mid-2018)

13,612

Staff
(11,228 Whole Time Equivalents)

£299m

Estate under Management

£810m

Annual Budget

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Chief Executive Foreword

I am delighted to bring to you the Annual Quality Report for Southern Health & Social Care Trust for 2019/20. The delivery of safe, high quality services on a daily basis is something we strive for each and every day. As a Trust we deliver services to approximately 380,000 people across our area, providing both hospital and community services and it is our aim to ensure that the care which we deliver meets the needs of our service users and carers, is effective and most importantly is safe. There is 13,612 staff in Southern Health & Social Care Trust who are dedicated to supporting people to receive the services they need, when they are needed.

Supporting our staff and strengthening our workforce is crucial to the delivery of care, in doing so, we are equipping our staff with the skills to deliver safe, high quality care and to work to continuously improve this. Many staff achievements have been included and I would like to congratulate staff for all their efforts during 2019/20 and their continued commitment.

This report outlines some key achievements made in 2019/20, in terms of service delivery but importantly it highlights how we value the contribution of our service users and carers who work with us to continually improve how we deliver care. Feedback from service users and carers supports us to drive improvement.

It is important to acknowledge the emergence of the Covid-19 pandemic during the latter part of this year which presented the biggest public health challenge of our lifetime. We remain committed to improving the care we deliver and to support the recovery of our system and ultimately we will continue to strive to improve the health & wellbeing outcomes of our local population beyond Covid-19 and into the future.

Shane Devlin

Chief Executive, Southern Health and Social Care Trust

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Quality
Safe, effective & person centred

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

Theme 1

Transforming the Culture

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WIT-37063

1.1 Collective Leadership

The **HSC Collective Leadership Strategy** was launched in October 2017, introducing a consistent set of values and behaviours agreed and implemented across the HSC system.

It sets out the framework for a creating a leadership culture based on the principles of quality, continuous improvement, compassionate care and support. Articulating an ambitious new direction for leadership within HSC consisting of four interconnected yet distinct elements being present simultaneously:-

- **Leadership is the responsibility of all**
- **Compassionate leadership**
- **Shared leadership in and across teams**
- **Interdependent and collaborative systems leadership.**

The Trust continues to take action to ensure service user experience of Health and Social Care services is underpinned by these same core values regardless of where care is provided.

- We have engaged with our staff and service users to raise awareness and embed these values & behaviours, facilitating initiatives such as *Every Contact Matters* and *The 5 Fundamentals of Civility*. The HSC values and behaviours are now included in all corporate development opportunities and on all recruitment documentation.

- Trust staff and service users also participated in the development of a *Collective Leadership in Action Framework* which was co-designed by providing stories of collective leadership in action from across the system. It is representative of all professions and levels.

- Collective leadership has also been embedded into all leadership development initiatives and the Trust contributed to the regional innovative 'Collective' programme which was delivered representing all staff levels and service users with strong feedback from participants.

- We held our Leadership Conference on Tuesday 22nd October 2019 in the Armagh City Hotel; Compassionate Leadership – 'Every Contact Matters'. The event focused on 'Compassionate Leadership,' and recognising that 'leadership is the responsibility of all' we were pleased to welcome over 700 staff across all professions, bands and directorates to the conference. We were joined by three guest speakers: John Sutherland – Retired Chief Superintendent and author of Sunday Times best-seller 'Blue: A Memoir; Helen Prendergast - Chief Executive, Headstart Consultancy; and Darrell

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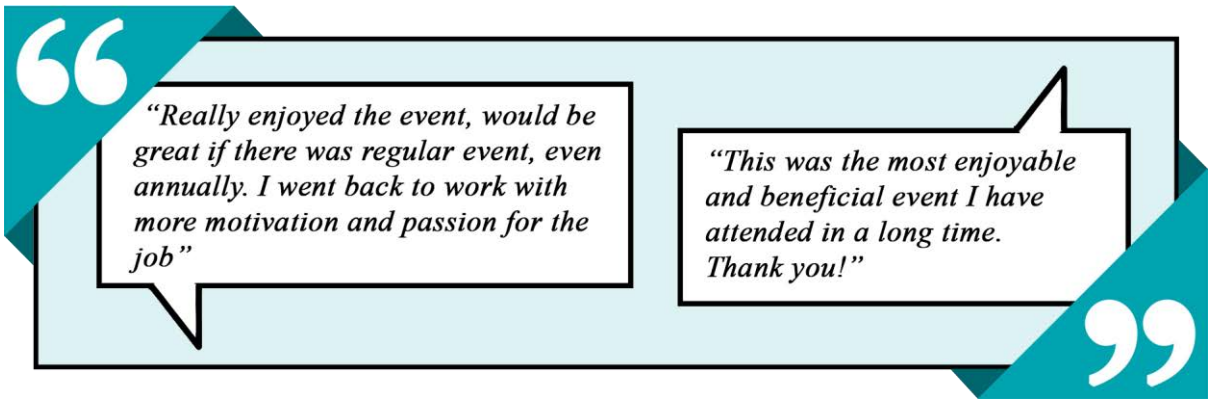
WIT-37064

Woodman - Director of Art of Brilliance Ltd and author. Each speaker brought to life the importance of compassion and compassionate leadership through their presentation and stories for reflection what this might mean to us, our teams and our service users. Staff also had the opportunity to avail of a range of health and wellbeing related checks and advice at the conference exhibition area. Feedback has shown that staff found the conference to be interesting and beneficial:



- An enhanced model to support and improve team working has been designed and cascaded across the region. This is supported by an online toolkit compromising a repository of practical tools and resources to build improvement capacity and capability. The Trust is planning to offer a '*Getting Better Together – Every Team Matters'* team based initiative in 2020/21.

- The Trust has also engaged education providers, particularly the universities. To date two sessions have been delivered to approximately 300 Year 2 and Year 3 Allied Health Professional students introducing components of collective leadership, and why it matters and the HSC Values and Behaviours raising awareness of the expectations of them as leaders entering the workplace.

Continuing to embed a culture of collective leadership is a key strategic aim. It is recognised this will help our workforce to deliver safe, high quality compassionate care despite the many challenges we face.

Staff Survey 2019

As part of the Regional HSC Staff Survey (commissioned by DoH), a survey of all Trust staff was conducted between March and April 2019.

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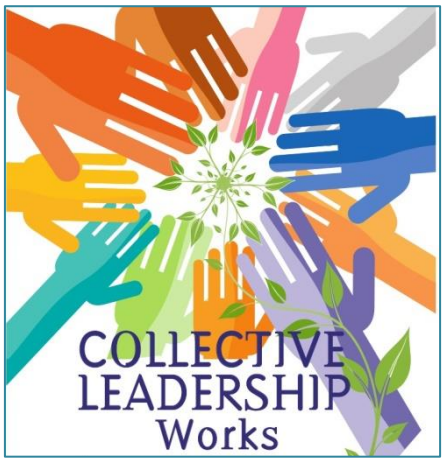
WIT-37065

The Trust overall staff engagement score on a scale of 1-5 (where a higher score is better) was **3.78**. Although this is the same score as the HSCNI average it is lower than the 2015 score of 3.81 and the highest Trust scoring of 3.87.

There were a number of <u>positive results to recognise and build on</u>:-

- Support and encouragement staff feel they get from their immediate line manager.
- Recognition that the organisation takes positive action on their health and wellbeing.
- Positive results regarding the reporting of any errors, near misses and incidents and the organisation encouraging staff to report these.
- Also 98% of staff recognise their responsibility to raise concerns.
- Responses relating to training, learning and development and performance appraisals.

There are also a number of <u>opportunities for workplace improvement</u>:-



- Staff involvement – there was a decline in the percentage of staff agreeing they are involved in changes that affect them (45%) and in their ability to make improvements happen (48%).
- Recognising and valuing staff – only 49% of staff are satisfied with the recognition or praise they get and less than half are satisfied that the organisation values their work.
- 36% of staff often think about leaving the organisation with the highest scoring reason (60%) relating to being valued for their work.
- Senior managers – a low percentage of staff feel senior managers act on staff feedback and involve them in important decisions. 34% feel communication with senior managers is effective.
- There is an increasing trend in the number of staff reporting experience of Violence, harassment, bullying and abuse at work.
- Patient / service user experience feedback – a large percentage of staff (80%) agree this is collated but only 57% receive regular updates on this feedback.

Key themes coming out of the staff survey include:-

- Communication and engagement / staff voice
- Valuing and recognising our staff
- Visible leadership
- Health and wellbeing

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WIT-37066

#HAVEYOURSAY

'The Big Coffee Conversations' - During 2019/20 we followed up the staff survey by holding conversations with groups of staff to inform the development of a **People's Strategy during 2021/22.** The sessions provided an opportunity to engage with our staff across all professions and directorates, sharing the results from our staff survey and hearing from them on what we need to focus on to 'create a great place to work'.

Specifically, staff were encouraged to share ideas relating to the key challenges that were highlighted in the staff survey results across a range of priorities. Overwhelmingly, feedback from the conversations focused on **behaviours** and highlighted the need to fully embed the organisation's values into our behaviours at work and at all levels.

Analysis of the feedback and ideas also indicated the value of **relationships** and the importance of **health and wellbeing.**

These 3 areas will now be the focus of our aim in **creating a great place to work** initiative in 2020/21**.**

2021 Plans for a Culture Assessment Survey

A key action in the implementation of the HSC Collective Leadership, includes actions to build on the information generated through the HSC staff survey to generate a baseline measurement for Collective Leadership within organisations and regionally.

Affina OD (AOD) has been commissioned to undertake a Culture Assessment Tool (CAT). The Trust plans to conduct a Trust wide Culture Assessment Survey in 2020/21 to get a baseline assessment that will support and enable improvement activities moving forward.

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WIT-37067

Equipped Workforce

The Education, Learning and Development online interactive brochure for 2019/20 was developed and circulated widely to staff.

Corporate Mandatory Training provision is regularly reviewed and improvements implemented on a continual basis.

If you are viewing the digital version of this report, click the image to open the Education, Learning and Development online interactive brochure.

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WIT-37068

1.2 Patient and Client Experience

10,000 More Voices

Patient experience is recognised as a key element in the delivery of quality healthcare. The Public Health Agency working across all Health and Social Care Trusts aims to contribute to a more patient-focused approach to services and shaping future healthcare in Northern Ireland through the *10,000 More Voices* programme which gives those who use our services an opportunity to highlight what is important to them, such as what they liked or disliked about the experience and to express 'what matters'.

Below is a list of the surveys ongoing in 2019/2020:

- **April 2019:** Experience of engaging the **Mental Health Service Service User Survey**
- **April 2019:** Experience of working in **Mental Heatlh Services Staff Survey**
- **April 2019:** Experience of **Children's Audiology Services**
- **July 2019:** Experience of **living with swallowing difficulties**
- **August 2019:** Experience of living in a **care home**

A short animation has also been produced for staff, service users and carers to explain how to complete the 10,000 More Voices surveys.

If you are viewing a digital version of this report, click the link on the image to access the animation.

How We Use the Information We Collect

- To **provide evidence of quality** of health and social care
- To **inform quality improvements** within our Trust
- To **inform regional policies and strategies** for how services are shaped in the future
- To **inform education and training** locally and regionally

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WIT-37069

Real Time User Feedback

What's your story? Your story can make a difference

The Trust is making plans to implement a regional on- line user feedback system which will provide opportunities for patients and their families to share their experiences of health and social care. This will be facilitated through Care Opinion which is recognised as the UK's leading independent non-profit feedback public platform for health and social care. Care Opinion will complement and enhance existing feedback systems within the Trust and will be launched throughout Northern Ireland in April 2020. For further information please see Care Opinion website, click here

The Trust plans to undertake communication to all service users and carers to promote the use of Care Opinion across acute and community services. Service user feedback is important to us and will be used to inform and improve our services moving forward.

Sharing the Feedback with Our Staff

Feedback that has been received during 2019/2020 has been shared widely with staff. We recognise the important of letting our staff know how much they are valued by our service users and patients.

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WIT-37070

Patient Client Experience Newsletters

The Patient Experience Newsletter focuses on patient and carer feedback and actions and initiatives to improve patient experience with the Southern Health & Social Care Trust.

Quarterly Patient Client Experience Newsletters were produced in *(if viewing the digital version of the report, click the corresponding month to open);*

- September 2019
- November 2019
- February 2020

You Said, We Listened

New Yellow Fleeces for 'Here to Help' Volunteers in SHSCT

We have been working with a service user with sensory difficulties to improve the visibility of our hospital volunteers. The 'Here to Help' volunteers are based in the foyer of both Daisy Hill and Craigavon Area Hospital and are available to help visitors find their way and give directions.

The Trust has introduced bright yellow fleeces for the helpers following feedback from Leslie Massey, a service user who is sensory impaired and uses a guide dog. He felt the original dark navy fleeces were hard to distinguish in the busy foyers of our Hospitals. Gerardette McVeigh, Volunteer Co-Coordinator explained:

"*We understand that it can be difficult for anyone to find the right department in our busy hospitals and this can be a particular challenge for those with hearing or visual impairment. We also want to make sure that everyone using our services can access them easily and so we really appreciate the help of Les who highlighted a simple change that could improve the experience of people with sensory difficulties. I would also like to thank our Sensory Disability Team who did a great job working with Les and making his suggestion a reality."*

Mr Massey added: "*I suggested yellow as it is a bright colour and the volunteers can easily be seen as you enter the hospital and volunteer also written across the back of the fleece. I have really enjoyed getting involved and making a difference to improve the experience for other people with sensory difficulties*."

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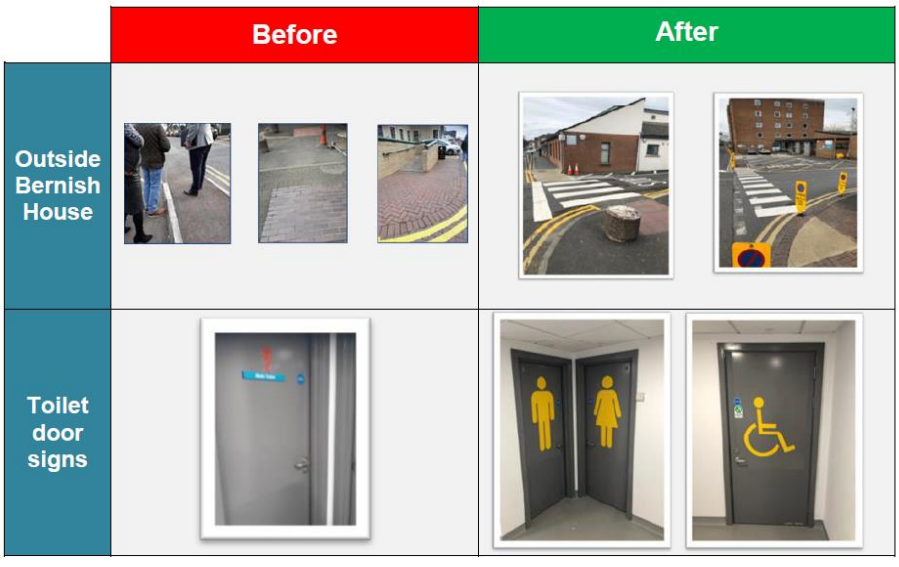
WIT-37071

Improvements to New Outpatients Department in Daisy Hill Hospital

Improvements to the Outpatients Department (OPD) in Daisy Hill completed in 2019/20. A working group was established to progress suggestions made by our service users. This has included estate improvements including external site works improvements to facilitate less abled service users (including visual impairment) as follows;

- Tactile pavings
- Zebra crossings
- Widening of pedestrian gates to facilitate wheelchair users
- Dedicated pedestrian zones & safe access to new DHH Outpatients Department (Bernish House)
- 10 additional car parking spaces in close proximity to Main Hospital Entrance and Bernish House
- Dedicated safe access crossings and pedestrian reconfiguration from Clanrye House to Main Hospital Entrance to provide safe access
- Improved visibility signage internally to facilitate those with visual impairment
- Spread of **Yellow Name Badges**
- Spread of use of "I am Deaf Card".



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WIT-37072

Accessible Toilets at Dining Room Area – Craigavon Area Hospital

Feedback by one of our service users regarding the lack of accessible toilets near the dining room in Craigavon Area Hospital also led to improvements that have made by our estates department to ensure that these are now available. Improved signage and directions to an accessible toilet now open for everyone to use within the Medical Education Centre is now established and clearly displayed.

Improved Communication Skills Training for Staff Supporting Dying and Bereaved People.

The Bereavement Forum work plan 2019-2021 was developed to address 10,000 More Voices Experience of Bereavement Report (2018) which included recommendations relating to:

- **Communication skills training** for staff supporting dying and bereaved people.
- The **dignified, respectful care of dying and bereaved people**

When asked in this survey what matters most, respondents unequivocally rated **to be treated with compassion, respect and dignity as their top priority**.

With this in mind the Bereavement Co-ordinator Sharon McCloskey and Mairead Casey, Patient Experience Facilitator arranged during Dying Matters Week 2020, 11th -17th May 2020 for the **"#Hello My Name is"** play to be taken to our Trust on 11 May 2020. This play is based on Dr Kate Granger's experience of her own diagnosis and drive to remind staff of the importance of making themselves known to patients and relatives and thereby establishing, even at a superficial level, a relationship within them, if we are truly committed to person centred care. This would be the first time the play is performed on the Island of Ireland.

Car parking in SHSCT

Recent feedback from our 10,000 More Voices surveys has been shared with the Trust's Car Parking Group. It was agreed at this group that we would organise for Translink to come along to Craigavon Area Hospital on 22 January 2020 and Daisyhill Hospital on Tuesday 25 February from 12.00 - 4.00 pm to hold a Best Value Fare and Journey Planning information drop in sessions. The aim of this was to promote the use of

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alternative methods of transport to our hospital sites to reduce demand on car parking spaces.

On the day they answered any questions staff, service users and patients had about travel by public transport and also provided information on best ticket type, and local timetables.

SharePoint

The Patient Client Experience SharePoint site is regularly updated with the live 10,000 surveys and Patient Client Experience Newsletters etc.

If viewing the digital version of the report, please click the image to access the SharePoint site (available to Southern Trust staff only).

Personal and Public Involvement (PPI)

Involving you, improving care

Personal and Public Involvement (PPI)

PPI Panel

The Personal and Public Involvement (PPI) Panel has been operational for the past 10 years and continues to work and feed into both Trust and regional priorities. Panel members are supported through a range of training and engagement opportunities, including:

- Training and skills development
- To inform the Terms of Reference and membership
- Pathway for Panel Involvement (Trust and regionally)
- Recruitment of new members
- Celebration event will be held on November 27th to celebrate 10 years of the Panel.

PPI Training

A scoping exercise led and completed by the Southern Trust's Public and Personal Involvement (PPI) Team (February – April 2019) which engaged Service Users, Carers, Education Learning and Development (ELD), Quality Improvement (QI) and the Recovery

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WIT-37074

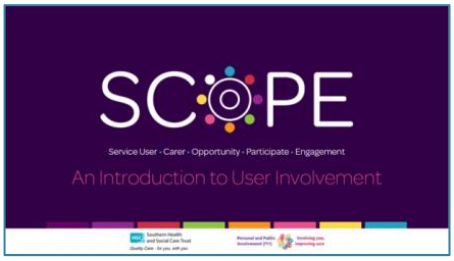
College, regional PPI Leads, Public Health Agency (PHA) and Patient Client Council (PCC) identified the need for; a Service Users/Carer induction training to increase confidence and a progression route for Service Users and Carers currently inputting to the HSC.

A training schedule is in development for 20/21.

Service Users, Carers, Opportunity to Participate and Engage (SCOPE) training:

"SCOPE Training is an innovative, co-produced training programme which support Service Users/Carers to become involved in the development and delivery of health and social care services"

A Project Team comprised of Service Users/Carers from SHSCT and the BHSCT and staff from SHSCT, BHSCT and SEHSCT and was completed via the SHSCT QI Team. This project team have collectively developed the; the SCOPE Training resource, A5 induction booklet, promotion digital resource and recruitment flyer



It is also envisaged that SCOPE training will be developed further so Service Users/Carers can become involved at a strategic level as well as those with intellectual disabilities.

Service User and Carer trainers from the PPI Panel and the Patient Client Council have been identified to co-deliver across the region.

The 3-step PPI Training Programme:

A 3-step training programme for staff has been developed to ensure consistency in training for all trust staff. The content of this training has been cross referenced with the regional Engage and Involve overview module "Introduction to PPI and Co-production" a training schedule has been developed.

Step 1: Involved and Engage ELearning (20 mins): A self-taught introduction to PPI, Co-production and User.

Step 2: Involved and Engage Training (2.5 hours) the co-delivered training supporting staff to:

- User Involvement
- Facilitation skills
- Increased PPI activity
- Measuring impact

Step 3: Involve and Engage Team Talk (45 mins) this training supports teams to embed

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WIT-37075

PPI practices, develop understanding of PPI and Co-production approaches. *Teams will be allocated a hard copy PPI Toolkit. PPI Toolkit is also available in PDF on Trust website and SharePoint.

User Involvement Week

A series of recognition events across directorates were held in November 2019 as part of the PHA Involvefest; to celebrate the success, skills and expertise of Service Users and Carers that are currently inputting to HSC Services.

Database

A Database is in development to have oversight of all User Involvement and PPI activity across the Trust. It is envisaged that the database will collate, present and monitor activity and impact of same. The first stage of implementation is to identify all Service Users/Carers groups and create a baseline of involvement. Longer term this should be able to support PPI activity and impact being measured across the Trust in line with the regional KPI's and monitoring standards.

Service User/Carer Consultants

Funding was available during 2019/20 for the establishment of a bank of Service User/Carer Consultants to draw on for ad hoc work to support the implementation of the regional PPI standards and the delivery of specific Trust PPI and co-production priorities. This bank was operational by autumn 2019 and the Service User/Carer Consultants a welcomed additional PPI resource. These roles supported the development of a range of PPI resources and projects and ensured increased PPI activity across the Trust.

1.3 Compliments and Complaints

Each year a significant number of people receive services provided or commissioned by the Southern Health & Social Care Trust. The vast majority have a positive experience and are cared for by well trained professional and supportive service staff, all of whom are highly dedicated. However like any organisation, things can go wrong and when this is the case we make it our goal to **listen, learn and improve**.

Patient Experience, involvement and feedback is extremely important in helping us assess the quality and type of services we provide. This is very important to us as we aim to continually improve. People who have used or observed our services can help us to learn and improve by sharing these experiences.

The number of formal complaints by subject received by the Trust significantly increased in 2019/20.

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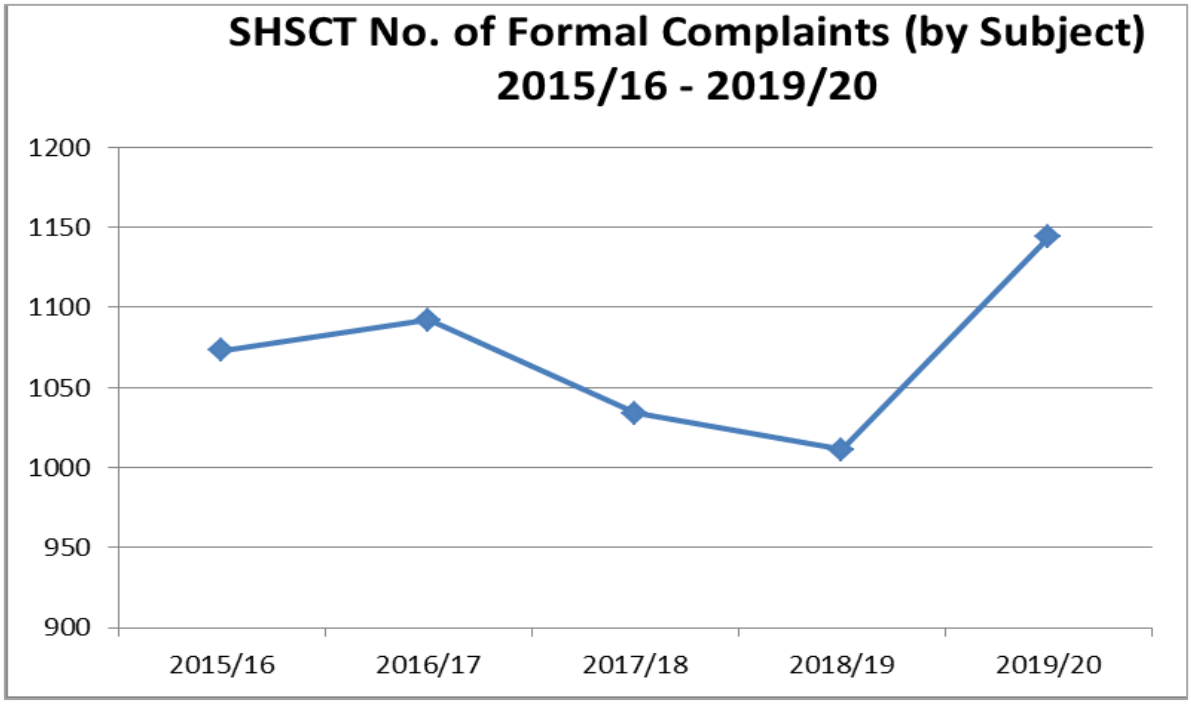
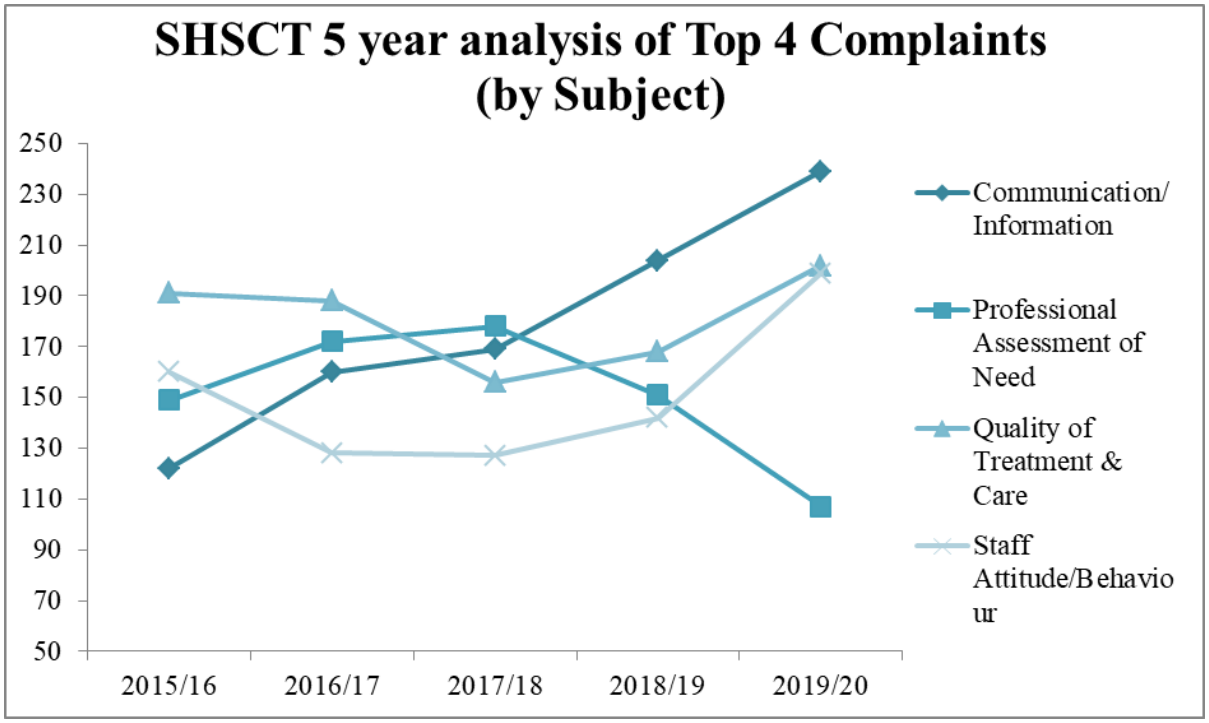


Complaints about **Treatment & Care, Staff Attitude, Communication and Professional Assessment of need remain consistent as the top four areas of complaints** across each reporting period, as shown below:



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Response Times

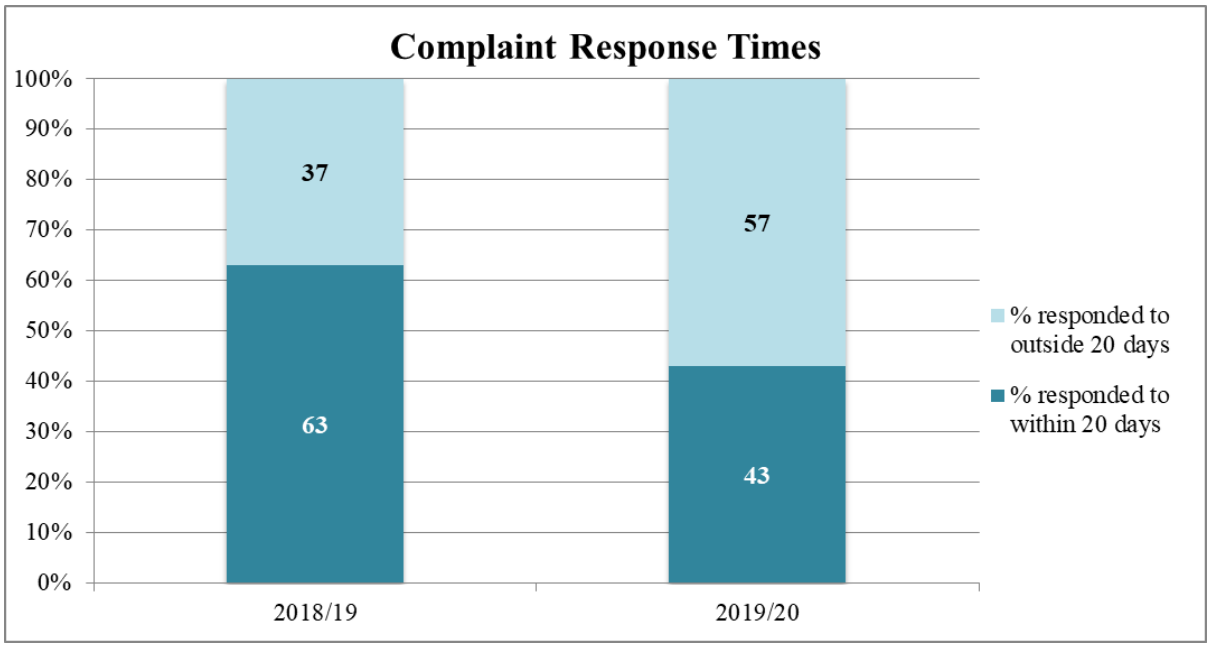
Where possible, the Trust will seek to resolve complaint issues using local resolution. This can be less distressing for our service users and their families, providing a positive outcome. However, there will be times when local resolution is not possible and the formal complaints process is required.

The HSC Complaints Policy requires Trusts to provide an **acknowledgement within 2 working days and a formal response to the complainant within 20 working days of receipt** of a complaint.

If the Trust requires more time to complete a thorough investigation, the complainant is notified formally using a holding response letter explaining the reason for the delay. The Trust often offers meetings with complainants and the relevant clinical teams to assist with resolution of their complaint. Throughout the complaints process the Trust aims to provide the complainant with a positive experience aiming to resolve the complaint.

94.03%

Complaints Acknowledged within 2 Working Days



The Trust uses all service user feedback and complaints as an opportunity to learn, and put measures in place to improve our services some examples include:

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WIT-37078

Sample of Improvements made in response to complaints:

Complaint Background	Learning
Complaint Subjects	• **Communication/Information**
Complainant dissatisfied about the care and treatment of her son during an autism assessment.	The complaint highlighted the need to ensure that parents are provided with sufficient information to prepare them for the autism assessment process. Parents/carers should be fully informed about what to expect within the assessment process. This should include the actions and interventions parents/carers may observe from the staff involved and a rationale for the actions taken by staff, for example, redirecting attention, seeing how the child responds to joint interaction, or whether they are able to tolerate moving on from playing with a preferred toy. In response to this learning a script has been developed for professionals to ensure that clear and explicit information is shared with parents/carers at the outset of the assessment process. In addition the initial appointment letter sent to parents/carers now has a link to a short information video of the assessment process on YouTube for parents/carers to view https://www.youtube.com/watch?v=DeDFnT-HLPM
Complaint Subjects	• **Communication/Information**
	The Trust made improvements by implementing monitors which display waiting times in the Department. These also display relevant information to service users while they are waiting. This is a live system which is always up to date and keeps service users informed.

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Complaint Subjects	• Quality of Treatment and Care
Complainant was unhappy with the treatment and care provided following an injury to his leg and is concerned at the fact no one had picked up that he had a clot developing which required emergency treatment when detected.	Risk Assessments are updated in relation to these cases and now carried out. Physiotherapy staff have been trained that when working to an agreed protocol to take into consideration other factors and use their clinical judgement alongside the protocols in place.
Complaint Subjects	• **Quality of Treatment and Care**
The Trust received a complaint from a client regarding a lack of communication / contact from the Physical Disability Team following a visit by an Occupational Therapist. The Trust response provided an outline of the Occupational Therapy input and advised that recommendations for housing adaptations were forwarded to the Housing Executive.	The complaint identified the importance of clear communication and clarification of timescales with clients when equipment / adaptations have been requested. Learning was also identified in relation to the provision of staff contact details to clients, providing updates to clients and the timely allocation of cases when a staff member goes on leave.

Ombudsman Cases

When service users are not fully satisfied with the outcome from the Trust's investigation into their complaint they can raise their concerns with the Northern Ireland Public Services Ombudsman. In 2019/2020, there were **25 cases** brought by the Ombudsman. Also within this time, 23 cases have been closed, 2 withdrawn and 3 not accepted for investigation, 5 are open and 1 remains pending.

The Trust is committed to working with the Ombudsman's office to resolve service user complaints, and identifying and implementing learning and continue to work with the Ombudsman on cases raised during previous years.

Below is one example of how the Trust responded and improved in light of an Ombudsman case for shared learning:

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Improvements in Light of an Ombudsman Case for Shared Learning

Summary of Event – Complaint submitted in relation to care and treatment of patient during a hospital admission. The complaint was in relation to the request for patient's Shortec medication to be withdrawn by the family. Administration of the drug was not ceased and no record made in patient's medical notes of the sensitivity of patient to this medication. The subsequent administration of this medication caused the patient to fall when mobilising to the ward toilet and following the fall patient did not receive timely and appropriate care. The investigation found a failure to appropriately complete the patient's falls risk assessment on admission, to adhere to its own falls policy by undertaking a new risk assessment when patients condition had changed and to provide appropriate supervision. The Ombudsman also found failures in keeping appropriate records regarding patients Shortec administration and complainants concerns.

Learning from Ombudsman Case – The Trust has implemented monthly audits of falls risk assessments and shares the findings for learning and the need for a dedicated Falls Co-Ordinator has been identified in addition ongoing training is to be provided and staff reminded of good record keeping.

Compliments & Suggestions

The Trust is also keen to learn from the experiences for our patients, service users and their families and what aspects made it a positive experience for them. Receiving compliments helps us identify these areas of good practice. This enables organisational learning from aggregation of individual compliments and also provides encouragement and motivates staff who receive recognition for the vital work that they undertake.

From April 2019 to March 2020 we received 6,281compliments using a new system introduced to enable us to learn from our compliments in the same way as we do from our complaints.

The table overleaf shows this number by subject where possible. An additional 30 compliments could not be attributed to specific subject areas. In total we had **6,311 compliments in the 2019/2020 year.**

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Total
Quality of Treatment and Care	1821	137	303	121	42	36	**2460**
Staff Attitude & Behaviour	1508	134	267	99	38	38	**2084**
Information & Communication	607	79	206	61	15	25	**993**
Environment	489	28	148	28	12	8	**713**

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Other	19	8	1	2	1	0	**31**
Total Compliments	**4444**	**386**	**925**	**311**	**108**	**107**	**6281**

**Social media refers to compliments received via official Facebook and Twitter accounts only.*
***Phone calls relate to calls that have been recorded/ documented in phone message books etc.*

Please see the following page for a taste of just some of the positive feedback we have received from our service users and their families.

A review of the top subject areas for both complaints and compliments emphasises the critical role of:

- **Good Communications and information;**
- **Staff attitudes and behaviours; and**
- **Quality of treatment and care.**

Each of these are integral to ensuring our service users receive a positive outcome and experience from the health and social services we provide and as a result efforts to learn from these is fundamental to our quality improvement efforts.

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WIT-37082

WE JUST WANT TO SAY... THANK YOU!

Physiotherapy Dept. Daisy Hill Hospital

"I wish to compliment XXXX and XXXX in the Physiotherapy department in Daisy Hill Hospital for their dedication and ongoing support for my son who is recovering from knee surgery. Right from when he was referred to the fracture clinic their care and attention has been exemplary. They have coordinated together to ensure that my son has had the best treatment possible."

Blossom Ward

"Our baby boy was 4 weeks old and admitted to the Blossom children's ward at Craigavon Hospital. He was very ill and we cannot thank the nurses and doctors enough for everything they did for him. They showed so much care, compassion and expertise. At a very scary and upsetting time for our family they were there for us and talked us through everything. We are especially grateful for XXXX, XXXX, XXXX, XXXX and XXXX who were absolutely amazing with our baby boy."

Day Opportunities

"I would like to commend XXXX and XXXX on the brilliant performance today. You are changing people's lives. My daughter loves attending the Tuesday Dance and Drama so much. She has been attending for four years. The show was so professionally done with so much hard work by everyone. Well done to all involved."

Domiciliary Care

"My father passed away last week and prior to this he had a team of carers visit him 4 times a day. It is very easy to say that these 4 carers are just doing what they are being paid to do, but the care, friendship and attention they provided Daddy and as a direct consequence my Mum was way above just doing their job. My Dad always looked forward to them coming to the house and they greatly helped him accept his rapid loss of independence.

You should be very proud of this team. If it's applicable we would like to nominate them for your staff recognition awards."

Minor Injuries Unit

"Many thanks to amazing staff in Dungannon Minor Injuries who looked after me last yesterday evening after a fall which resulted in a badly broken elbow. This is a fantastic service and a great team under Sister XXXX expertise. See you again."

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WIT-37083

1.4 Adverse / Serious Adverse Incidents (SAIs)

The Trust is committed to learning and encourages reporting of incidents and near misses to identify where interventions and improvements can be made to reduce the likelihood of incidents happening.

An **Adverse Incident** is "Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

A **Serious Adverse Incident (SAI)** is "An incident where there was a risk of serious harm or actual serious harm to one or more service users, the public or staff". The SAI must also meet one or more SAI criteria as defined within the *Regional Procedures for the Reporting and Follow Up of SAIs – November 2016*. SAI's are reported to the Health and Social Care Board.

Learning from incidents can reduce the likelihood of similar events reoccurring. It is an important process to capture, promote and share learning. Adverse incidents happen in all organisations providing health and social care.

We encourage an open, just learning culture. Where learning from adverse incident is identified, the necessary changes are put in place to improve practice and avoid reoccurrence.

Communicating effectively with patients and service users, at what can be a very challenging time, is an essential part of a serious adverse incident review for service users and their families. The Trust is committed to working with and supporting families throughout the SAI Review process.

Facts and Figures

During 2019/20, there were:

- **19,356** adverse incidents.
- This is an **increase of 4,279 (28.4%)** from 15,077 during the previous year.

The top 5 reported incident types and their incidence rates are as follows:

- Behaviour (including violence and aggression): **32.6%**
- Patient Accidents/ Falls: **25.7%**
- Medication/ Biologics/ Fluids: **10.4%**
- Pressure Ulcers: **4.7%**
- Communication: **2.4%**

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Medication/ Biologics/ Fluids

Medication incidents are reported and investigated by local teams to identify learning and changes to practice. A multi-professional incident review group meets monthly to review reported incidents, share learning and identify any additional actions to reduce the risk of medication incidents. A learning bulletin is produced each month which is distributed to medical, nursing and pharmacy staff. This is also highlighted at Morbidity and Mortality meetings and Patient Safety Briefs and is shared with the Trust's Governance Committee.

Audits on the use of intravenous paracetamol and omitted and delayed doses of medicines in hospital were conducted which identified areas for further improvement. An insulin safety program with clinical sisters continued, providing bimonthly education topics and material for cascade to ward staff and measuring key indicators of omitted doses, alert notices, handover, patient assessment and staff training. Completion of a half day program on diabetes delivered by the Clinical Education Centre was made mandatory for nursing and midwifery staff. Education and training was provided to junior medical staff on high risk medicines including anticoagulants, insulin and gentamicin and on key processes such as medicines reconciliation.

In Children's and Young People's Services, medication incidents are routinely reviewed by the Medicines Governance Pharmacist in partnership with clinical and community staff. A lessons learned bulletin is developed routinely and is shared across services within the Directorate.

Pressure Ulcers

An Early Alert System has been developed via Datix to notify Tissue Viability Nurses when a case has been reported and within the Acute setting all incidents of pressure ulcers are reviewed by a Tissue Viability Nurse who completes a root cause analysis on all grade 3 and 4 hospital acquired ulcers. A Pressure Ulcers board is now in place on all wards and this includes information on how to grade ulcers (complete with pictures), explains the mattress pathway and how to order a mattress along with other useful information.

The Tissue Viability Nurses are actively encouraging the reporting of pressure ulcers and have requested that the 1 hour e-learning on pressure sores becomes mandatory for acute nursing staff. As well as this work is ongoing on a review of the nursing handover template to ensure there is emphasis on ensuring relevant information in respect of pressure ulcers is handed over. Each ward is currently designating a Tissue Viability Link Nurses (Skin Champions) who will be the key contact with the Tissue Viability Service and disseminate key pieces of information to nursing staff at ward level. A Pressure Ulcer Sub Group to review documentation associated with the management of skin and prevention of Pressure Ulcers has also been established.

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Learning from Serious Adverse Incidents

The table below shows the number of deaths per directorate as a result of Serious Adverse Incidents.

Directorate	Number of Deaths (* if < 5)
Acute Services	20
Mental Health and Disability	29
Children and Young People	12
Older People and Primary Care	*
Total	**61 + ***

Asterisks (*) represents a figure less than 5 deaths. This is to help obscure their identities.

The remainder of this section details some examples of SAIs that have occurred in the Southern Trust during 2019/20. The main focus is to demonstrate what we have done and are doing in order to learn from these incidents and to recognise where improvements can be implemented.

Acute Directorate
Summary of Event
A 64 year old male patient was an inpatient in with a history of multiple myeloma, atrial fibrillation, obstructive sleep apnoea and ankylosing spondylitis. During a prolonged inpatient stay he had progressive neurological deterioration. He was extensively investigated with input from a number of teams including haematology, neurology, general medicine, intensive care medicine, virology, bacteriology and infectious diseases. The patient attended Magnetic Resonance Imaging (MRI) for a scan of his head. The patient was administered intravenous midazolam 2.5mg on the ward; a further 2.5mg was administered in the MRI scanner for agitation. On completion of the MRI scan, he was noted to be in a Pulseless Electrical Activity (PEA) cardiac arrest. The patient was intubated and cardiopulmonary resuscitation (CPR) was commenced. Return of spontaneous circulation (ROSC) was achieved and the patient was transferred to the Intensive Care Unit (ICU). Whilst in ICU, the patient required high levels of inotropic support (drugs to support circulation), but no purposeful neurological function was observed off sedation. Following discussion and agreement with the family invasive treatment was withdrawn on and the patient died the same day.
Learning from SAI
This case has been discussed at Morbidity and Mortality meetings for learning. IV sedation use has been prohibited in MRI, unless an anaesthetist is present. A form has been developed by the radiology department for patients with reduced GCS and for patients who are unable to consent and if a patient has a reduced GCS, they are monitored by a competent person and

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this monitoring must include continuous pulse oximetry and heart rate. Additional MRI compatible monitoring equipment has been acquired and the case shared with nursing staff regarding the checking procedure for Controlled Drugs. High concentration midazolam should not be used for conscious sedation outside of anaesthetic areas. As a result of this incident the Trust established a Trust Sedation Committee which will oversee the development of Trust Guidelines for conscious sedation including training and audit, as recommended in the Rapid Response Report. In addition it was recommended that there should be a recognised process for accommodating adults who require GA MRI scans within the Trust.

Mental Health and Learning Disability Services Directorate
Summary of Event
MHD reviewed a case involving the suspected suicide in the community of a female patient. The patient was known to various mental health/related services including, the resource centre, psychiatric inpatients, community addiction team and was an open case to the personality disorder service and support and recovery team.
Learning from SAI
The review team recognised the unwanted outcome of treatment in this case but in reviewing the care provided they commended the keyworker for the level of support provided to the patient and viewed her practice as an example of good practice. The keyworker communicated with the patient on a regular basis, brought her to appointments facilitating her engagement with other parts of the service and ensured that other involved services were updated in relation to the patient's needs and treatment pathway. The keyworker also brought the patient's case to the community team meeting for discussion. The review team recommended that the exemplar of good practice shown by the keyworker (KW) in this case should be shared within the wider Mental Health Services.

Children and Young People's Services Directorate
Summary of Event
12 year old female had a severe dental phobia and required dental treatment in hospital under general anaesthetic (GA). The upper right second molar (UR7) was extracted in error as it was mistaken for the upper right first molar (UR6). This was caused by the upper right first molar (UR6) being mistaken for the upper right second deciduous (baby tooth) molar (URE) which had already fallen out.
Learning from SAI
The audit identified that patient's upper right E had fallen out naturally prior to the general anaesthetic appointment. The audit team conclude that the removal of the upper right 7 was caused by the misidentification of the upper right 6 as the upper right E. The audit team consider that there were several points where this mistake could have been identified if additional checks had been implemented or different processes were in place. • The paperwork for the dental list had been annotated, after the referring dentist had completed it. • The upper right E was added for extraction and this entry introduced an element of

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confusion.

- The theatre listing form should not have any of the information altered after it has been sent to General District Hospital for processing.
- The treatment plan was completed several months prior the GA. As such, it was not acknowledged that patient's mouth could have changed between examination and treatment.

It was decided there would be a review of the Standard Operating Procedures and pathway for dental treatment of patients under general anesthetic in the community dental service to incorporate changes to practice. Primarily the need for full dental charting and implement Local Safety Standards for Invasive Procedures.

There was learning from the audit to be shared with the Community Dental Service and theatre staff.

There has also been Human Factors training for all staff involved in the theatre dental list.

1.5 Quality Improvement (QI)

Quality is something that is an integral element of each and every job role across our organisation and something that we strive for every day. Supporting an improvement culture within the Trust is central to the delivery of safe, effective, compassionate care.

Our quality improvement in-house training supports staff to:

- develop knowledge and understanding about current good practice in QI
- develop the skills of individuals whose current or future role is to deliver QI activities
- prepare for managing and / or undertaking QI projects using appropriate tools and methodologies
- promote and drive QI activities and initiatives

Quality Improvement Certificate

Cohort 7 and 8 of the Quality Improvement Certificate programme commenced in 2019/20.

Participants enrolled from multiple directorates with a large representation from Mental Health and Learning Disability and Older People and Primary Care services.

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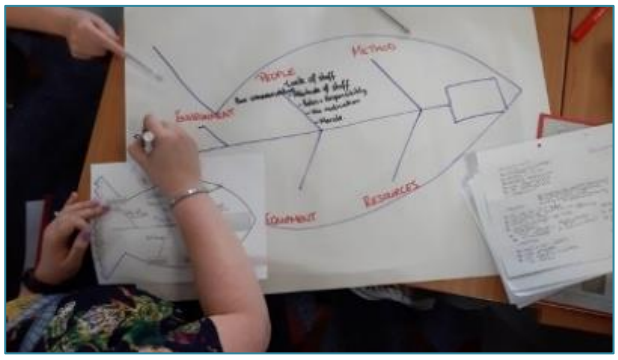
The QI Team shared tools and techniques that the participants could bring forward into their improvement projects to engage other stakeholders such as Ideas and Frustrations Boards,



Fish Diagrams and Rich Pictures, Stakeholder Analysis and Communication Plans were also key learning outcomes that provided participants with the necessary foundations to drive their project forward.

Regional QI Award

The Trust's Quality Improvement Team took a lead role in the region in establishing the first **Regional Quality Improvement Award programme for Service users** in December 2019.

This programme aims to make quality improvement tools and methodologies more accessible for service users and to create a way for Trust teams and Service Users to work together to co-produce evidence based improvements based on what matters most to our service users and carers.

Young people who access Autism Services participated in the programme. They had the opportunity to learn and apply Quality Improvement tools to a project that mattered to them and at the same time gain a recognised qualification that they can use as they enter the world of further study and work. Projects undertaken included:

- Understanding traffic congestion in Armagh.
- Development of a protocol for building and upgrading computer components to reduce waste.
- Cooking and baking tutorials to create the perfect cake.

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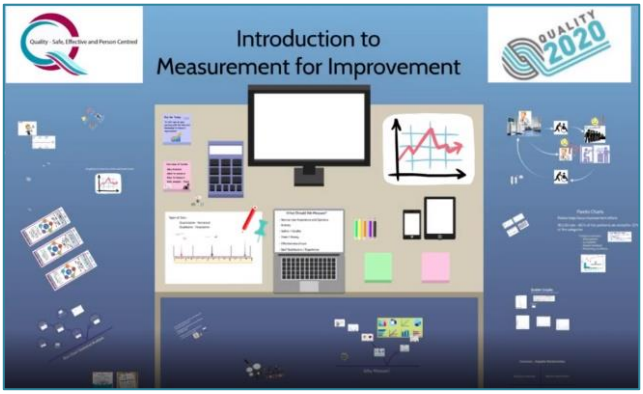
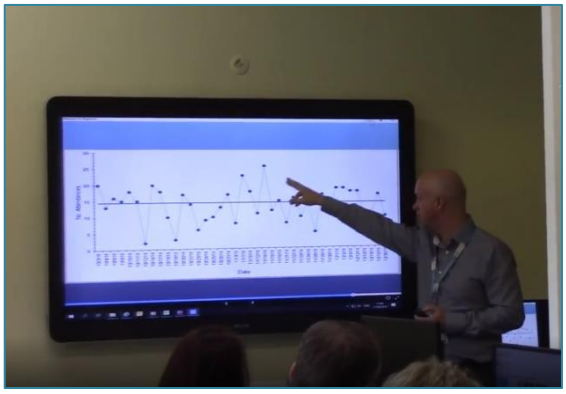
Measures for Quality Improvement Workshops

The Trust is committed to ensuring data driven improvements based on evidence and measures of success.

The first Measures for Quality Improvement Workshop took place on 17 April 2019. Staff across a range of directorates and disciplines came together to learn the theory behind run charts, scatter graphs and pareto charts before learning how to construct their own in Excel.

It is intended these workshops will support staff to be more aware of the need to measure improvements and will be better equipped to collate, analyse and present quality improvement data from their own departments. The workshops also seek to provide a strong foundation in Excel that staff can take forward more broadly in their daily work.





Flow Coaching

5 Southern Trust Staff had the opportunity to be part of the very first Northern Ireland *Flow Coaching Academy* hosted by the Western Trust. Using the 'Big Room' and Flow Coaching methodology staff were taught the fundamentals of Team Coaching and Quality Improvement tools and techniques.

The Frailty Big Room in Lurgan Hospital Launched in October 2019. The Big Room is a weekly coached meeting where people come together to build relationships, collaborate and develop a shared purpose for improvement.

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Human Factors

The Southern Trust commissioned a Human Factors Train the Trainer programme, in which 16 staff completed the course and are now part of a Human Factors faculty which aims to share the learning and deliver training to all our staff.

Human factors training looks at the role of human involvement in any situation, giving consideration to both our capabilities and limitations. It provides an understanding of the impact that organisational culture, system design, equipment and the work environment have upon human behaviour and task performance. Human Factors training is intended to raise the issue of human error to take positive steps to minimise the occurrence of incidents.

Human Factors Lunchtime Sessions

Building on this training, the Human Factors Faculty, launched lunchtime training sessions in September 2019. This programme is offered as part of the Foundation Doctor's teaching programme, covering 6 main themes: Communication, Situational Awareness, Decision Making, Stress, Fatigue and Human Error.

Scaling up improvement projects - 'GoodSAM' launch

After progressing through the QI Leader programme, Ronan McBride (Quality Improvement Facilitator and ICU Nurse) has been able to lead on improving services using Quality Improvement practices.

By engaging with key teams within the SHSCT, NIAS and GoodSAM Ltd, Ronan has helped to integrate the first web based, smart phone alerting system in Northern

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Ireland which was launched on the 28 June 2019.

Our Lead Director for Quality Improvement, Aldrina Magwood, welcomed the launch which took place in the Lough Neagh Discovery Centre. Guest speakers included the Chief Medical Officer for Northern Ireland, Dr Michael McBride, Chief Executive for NIAS, Michael Bloomfied, Chief Executive of the SHSCT, Shane Devlin and GoodSAM Medical Director, Dr Mark Wilson.

STEP Programmes

The *First Steps* programme lead by the QI Team and Postgraduate Medical Education Fellows commenced in October 2019 . This course is available to Core Trainees and ST1 - ST3 Doctors and is run in the evenings in Daisy Hill Hospital and Craigavon Area Hospital.

The purpose of the First Steps Programme is to deliver training on the basics of quality improvement in the healthcare environment to core trainees. The programme also includes a range of practical workshops for trainees to develop their quality improvement skills and gain valuable facilitation and support.

The *Core Steps* programme and is available to F1 and F2 doctors. The Core Steps programme commenced on August 2019 and aims to engage and raise quality and safety awareness with F1 and F2 Foundation Doctors. It is delivered over three evening face to face sessions with trainees encouraged to undertake a small step change project aligned to the Trust's Quality Improvement strategic aims and objectives.

Annual Quality Improvement Event

The Trust held its 6th Annual Quality Improvement Event on the 15th November 2019. It was a great success with more than 300 delegates present to hear about quality improvements undertaken in the Southern Trust over the past year.

The theme of this year's event was **'Connecting People: Making Change'** and this was reflected in the main hall presentations, parallel sessions, the 'QI cinema' and of course the ever popular Dragons' Den.

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Dragons' Den

In our Dragons' Den innovation challenge section Attendees were treated to four spectacular pitches and after what were described as "extremely difficult" deliberations, the Dragons could not decide on one winner. Eventually, it was announced that joint winners had been confirmed.

Congratulations to 'CARE Innovation' and 'The Listening Rooms', both teams were announced as the overall winners of the Dragons' Den Innovation Challenge and were awarded a bespoke two day team building opportunity for up to 12 members of each team. In addition the winning ideas are assessed for deployment within the Trust.

Oral and Poster Presentations

Staff and Service Users from a diverse range of professions and experiences delivered over 20 oral presentations on the day and presented over 150 posters, each spreading the knowledge and outcomes resulting from quality improvement projects and initiatives they had conducted throughout the preceding year.

Dementia Tour Bus

As Part of the Annual Quality Improvement week the Trust hosted two virtual experiences based on learning sessions designed to give participants a

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sense of what it may be like to have dementia or autism.

It is hoped that through these experiences, staff will have taken away ideas and solutions as to how we as a Trust can help those on the autism spectrum manage their day to day sensory needs more effectively, or on how we can tailor Trust premises and the delivery of care to improve care for service users with dementia.

Quality Improvement HUB

In February 2020 the Quality Improvement Tem relocated to their new dedicated QI Hub in the Main Building, Towerhill Complex Armagh.

The New Hub will be a dedicated QI space to deliver training, hold face 2 face QI Clinics and enables hot desking facilities for staff who wish to avail of the facilities with ready access to the QI team who can provide expertise, tools and information and resources to support and guide staff on their QI Journey.

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Quality
Safe, effective & person centred

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

Theme 2

Strengthening the Workforce

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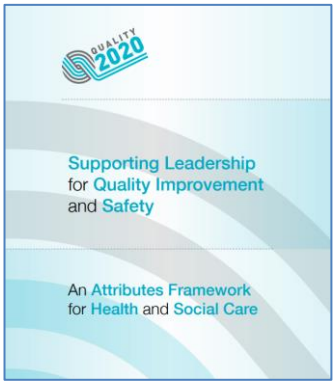
2.1 Quality 2020 Attributes Framework



The Quality 2020 Attributes Framework was developed by the Health and Social Care Safety Forum and the Northern Ireland Practice and Education Council in conjunction with key stakeholders within Health and Social Care across a diverse range of professional backgrounds. It is designed to enable staff and those in training, to fulfil the requirements of their role and, as a result, put patients and service users where they are entitled to be – the first and foremost consideration of our service.

It identifies the quality improvement and safety attributes staff require for their role and that are necessary and appropriate for the level at which they work. Through appraisal or supervision meetings or through mentorship (for those in training), staff are supported in assessing their existing attributes in relation to quality improvement and safety and, therefore, in planning the learning and development needed for them to progress in their given roles.

Overall, the primary purpose of this framework is to:

1. Assist individuals in assessing: a. their current attributes (knowledge, skills and attitudes) in relation to leadership for quality improvement and safety and their learning and development needs for their current role or for future roles.
2. Help organisations to build the capability and capacity of the workforce to participate in, and lead, initiatives which develop quality care and services.

To learn more and to view the Attributes Framework in detail, please click here. The linked document provides a breakdown of the skills and competencies required at each of the framework's 4 levels.

How are We Performing Against the Attributes Framework?

The total number of staff who have achieved Q2020 Attributes Framework Level 1 through our e-learning package is 1,790.

This includes staff that completed the following e-Learning modules:-

- Introduction to Quality Improvement & Quality Improvement Foundation (1268)
- Quality 2020 Attributes Framework Level 1 (313)
- 5 Steps to Quality Improvement (168)
- Quality Improvement Leader (41)

Total number who have achieved Q2020 Attributes Framework Level 1 through a specific face to face session = 35.

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Total number who have achieved Q2020 Attributes Framework Level 1 as part of bespoke training programmes = 8,505.

The cumulative breakdown is as follows:

1103	Staff have been trained directly by the SHSCT Continuous Improvement Team (this face-to-face contact maps to Q2020 Level 1)
306	Staff have completed Level 1 as part of the Trust's Patient Client Experience training
967	Domiciliary Care Workers have completed Level 1 as part of QCF Level 2 Award
196	Domiciliary Care Workers have completed Level 1 as part of their NISCC Induction
478	Doctors completed Level 1 as part of the Medical Revalidation process
1268	Staff attended the Trust's Annual Quality Improvement events
137	Staff completed Quality Improvement Foundation Programme (OCN Level 3 Certificate) - this maps to Q2020 Level 2
65	Staff completed Quality Improvement Leader Programme (OCN Level 5 Diploma) - this maps to Q2020 Level 3
5	Staff completed/completing MSc in Business Improvement. This maps to Q2020 Level 3. - this is a 3 year programme and small numbers commence each year e.g. 2 commencing Year 1 and 3 commencing Year
3	Staff have completed the IHI Improvement Advisor Professional Course. This maps to Q2020 Level 3
16	Staff have completed the Regional Quality Improvement in SW Programme. This maps to Q2020 Level 3
231	Staff completed the Trust Leadership Development Programme 'Taking the Lead' which includes a module on quality improvement and the completion of a 30 day service improvement project
183	Staff completed the Middle Manager Programme (ILM Level 5) which includes a module on quality improvement

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3	Staff completed the Scottish Quality and Safety Fellowship Programme (SQS Fellowship)
816	Staff completed RQF Level 2 Award
2701	Staff have attended the Trust's training session 'The Fundamentals of Civility'
27	Staff have completed / completing Nurse Band 8 Development programme: Transforming Self, Transforming Staff, Transforming Services

**Please note these figures are a cumulative total for the above projects.*

Facts and Figures

In total, 10,441 staff, which equates **to 84% of the workforce** (based on 12,381 as per TDP/OGI Target) have achieved **Level 1 on the Q2020 Attributes Framework**.

As of 31 March 2020, **5% of staff** have achieved training at **Level 2** of the Quality 2020 Attributes Framework.

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2.2 Looking After Your Staff

The Staff Health and Well-Being Steering Group continued to meet quarterly in 2019/2020 with 3 work streams

- Better physical health & wellbeing
- Better psychological health & wellbeing
- Employee experience

Trust Policies

A number of policies were reviewed and developed by the Trust and through the Staff Health and Wellbeing Steering group to support staff health and wellbeing:

- Time off for staff (launched 2019)
- Breastfeeding and Returning to Work policy (reviewed)
- Managing Stress in the Workplace Policy and Toolkit (under review)
- Management of Substance Use and Misuse (reviewed)
- Menopause Policy – in development (see below).
- Sun Safety Outdoor Policy – developed for staff working outside with provision of hats and sun cream.

Health Champions

A network of workplace health champions have been recruited and offer support with health and wellbeing updates, resources, training opportunities for sharing with their teams. Quarterly meetings took place (Apr, Sep, Dec 2019 and Jan 2020).

A U-Matter Website, www.u-matter.org.uk, was put in place for staff and site opened to public in March 2020 with onset of Covid-19 - Several Covid-19 zones created on the website and populated with information including training, health and wellbeing events and useful resources re COVID-19.

- COVID Information for staff
- Covid-19 and mental health
- Covid and staying at home
- Covid-19 and staying active at home
- Covid-19 and financial health
- Covid-19 and family health

The Umatter website was a nominee in the 2019 Trust Excellence Awards under the category of Award for improvement through innovation.

Web stats:

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(April 2019-March 2020) 165,263 page views, 32,674 user sessions

A weekly *Friday Focus* global email was commenced on health and wellbeing themes with links to new content on the Umatter website.

COVID Mental Health Sub Group

Established in March 2020 - weekly outputs developed for Umatter site on emotional and psychological issues relevant to staff members included PWB staff, Southern Trust Recovery College and Trust Psychology:

- Hope
- Anxiety
- Taking one day at a time
- Self-care and compassion
- Connections
- Loss, disappointment and unexpected gains
- Grief and bereavement
- Kindness
- Resilience
- Rest, Restorative sleep and relaxation
- Asking for help

A Staff Psychology Support Service is in place within occupational health department.

A Staff engagement processed commenced to revise Stress at Work Policy and Toolkit.

A Psychology led Staff support telephone line service was developed in response to Covid-19 and on site drop-in support services provided in CAH site.

Outreach team support available to community and acute teams needing psychological support.

Support provided to acute staff including creams, sprays with essential oils to help with ppe, alertness, calming. Support provided in directing and obtaining donations to staff including 2 x electronic massage chairs for staff relaxation, various food items and drinks.

A rolling programme of campaigns and activities was provided in support of staff health and wellbeing in 2019/2020. Staff health and wellbeing calendar developed for 2020.

- World Cancer Day 2020 – supported by a number of teams who held fruit parties / Mediterranean themed lunches, many teams fund raised for local Cancer Charities / Trust Charity of the Year. Cancer prevention guide developed for staff showing how existing staff health and wellbeing supports can help you achieve a healthier lifestyle

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(linked to 10 key cancer reduction messages). Cancer related resources and details of local cancer support services/organisations shared.

- World Sleep Day
- Daily Mile 60 Day Challenge for staff – started 15/4/19
- Men's Health Week – Men's Health Toolkit created.
- Healthy Eating Week – Daily Challenge (Sleep , Breakfast, Be Active, Hydrate, Have 5 a Day)
- Care in the Sun
- National Gardening Week 2019
- World Lupus Day
- National Walking Month
- Cycle to work day
- World Suicide Prevention Week – support numbers promoted to staff, Inspire Wellbeing Counselling and Towards Zero Suicide Awareness Training.
- Know your numbers week
- Eye health awareness week
- Backcare Awareness week – information sheet produced for staff with tips for prevention and support re MSK. Foot wear leaflet developed by physiotherapy to support staff in choosing appropriate footwear
- Stoptober – signposting to local smoking cessation services.
- World Osteoporosis Day – 20 October bone health recipes
- Alcohol awareness week - 11-17 November
- Halloween information – safety, recipes
- Stress Awareness Day – 6 November – stress management steps, understanding stress, taking action to reduce or prevent stress.
- Christmas information for staff
- Happiness calendar- monthly theme
- Anger Awareness Week (1-7 December) – factsheet and infographics on effects of anger on your health and how to manage your anger, recognising it is a natural emotion.

PWT Training

Various workshops have been provided for staff and other statutory, community and voluntary organisations staff and volunteers. Some dedicated workshops offered to staff during 2019-2020, these include:

- 1 x Suicide awareness – (6 staff attended)
- 2 x Self-care – (40 staff attended)

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- 1 x Mindfulness (8 staff attended)
- 3 x Staff carers event were held for staff members who are also carers, these events advised staff of their rights as carers, support services and organisations available to them. Relaxation therapies were also offered each day. Very positive feedback was received from staff members who attended all events. 86 staff attended.

Parenting Workshops

Keeping Your Child Safe Online – facilitated by NSPCC 24 staff participated.

Financial Wellbeing Workshops

Two workshops were held for staff provided by the NI Consumer Council on your consumer rights, shopping online and how to save on your household bills. (20 staff)

Link and Learn sessions for staff

Business in the Community offered sessions for staff on Mood Matters 23/5/19 and Care in the Sun 28/5/19 (14 staff attended)

Physical Activity

210 Trust staff participated in a 6 week Pilates and Yoga programmes across 6 Trust sites.

Ongoing virtual pilates, yoga and Tai chi classes are promoted and made available for staff currently.

20 SHSCT staff completed Leader in Running Fitness Qualification and facilitated Couch to 5k programmes in 4 locations with 90 staff participating over an 8 week period:

- **50%** of staff who participated had no previous running experience
- **100%** of staff enjoyed the programme
- **95%** of staff would recommend the C25K programme to other staff
- **55%** have continued to walk or run
- **60%** of staff would like to participate in a follow up programme
- **60%** of staff would like to participate in a follow up programme due to the support and motivation provided in a group setting

The Staff Corporate Leisure Scheme is available through local leisure centres with discounted rates for staff.

Physical activity guidance for staying active at home devised and available on Umatter for adults, families and vulnerable adults; https://u-matter.org.uk/event/2020-03-31-000000-2020-11-30-000000/stay-active

A range of physical activity campaigns are available on Umatter to encourage staff to move more and sit less.

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Cycle to Work scheme - Ongoing promotion of scheme with roadshows for staff 121 applications supported up to March 2020.

Apr-May 2019 - Distribution of 300 x free pedometers to staff at hospital sites across the Trust in advance of National Walking Month.

Healthy eating

- Recipe of the month promoted to staff with nutritional information and advice. Recipe collection available here
- Slow cooker guide shared with staff.
- 12 week weight loss guide, healthy breaks, importance of breaks, 100 calories healthy swaps to make, fruit and veg tracker, healthy portion sizes, meal planner, food diary.
- Cancer prevention guide developed and shared with staff as part of World Cancer Day.
- Free 6 week Cook it programmes offered to staff
- Report and recommendation on catering standards
- Training for catering staff
  16 catering staff trained in RSPH level 1 Award in Healthy Eating and a further 20 trained In January 2020.

Cook it!
fun, fast food for less

Corporate events

Health and wellbeing support provided at:

- 2019 QI Event- a year in view with Health 7 Wellbeing.
- 2019 Leadership Conference – information stands, health & wellbeing checks for staff (700+ staff attended)
- 2019 CYP Quality and Safety Event (160+ staff attended)
- 2019 – Organisational support and participation provided to Estates, Procurement and Finance Team for their 2 x 0.5 day health and wellbeing events for staff (21 and 22 May). (200+ staff attended)
- 11/6/19 Study Day Senior Doctors Lough Neagh Discovery Centre (attended by 50 consultants and staff doctors)
- 9/11/19 – Organisational support and participation provided to Mental Health Nurses for their health and wellbeing event 'Better You, Better Care - Creating a caring culture' project (Federation of Nursing). (70 staff attended)
- 14/2/20 – organisational support provided for staff health and wellbeing event in Bluestone Hospital. 31 staff availed of a weight, BMI and body composition check. 50 staff had a check for Atrial Fibrillation and cholesterol with the Northern Ireland Chest, Heart and Stroke Association. 186 staff had clinical obs, BMs, lung age and carbon

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monoxide. 13 staff received their flu jab. A wide range of health information was made available to staff on the day.

Team events

Health & Wellbeing Presentation has been provided to:

- 8/3/19 Joint Health Visitor Managers meeting (20 staff)
- 11/3/19 Health Visiting Team, Lurgan (25 staff)
- 15/5/19 Speech & Language Team Managers (35 staff)
- 23/5/19 Neonatal Team, CAH (10 staff)
- 3/6/19 Occupational Therapy Governance Staff meeting with all OTs working in Mental Health and Dementia (30+ staff)
- 6/6/19 Trust Contracts (15 staff)
- 20/6/19 Physiotherapy (AD) team meeting (16 staff)
- 20/6/19 Speech & Language Team (AD) (15 staff)
- 24/9/19 Physiotherapy Assistants Team Away Day (45 staff)
- 27/11/19 Occupational Therapy Team (CB) (7 staff)
- 13/12/19 Social Work Forum (87 staff)
- 5/2/2020 Induction session for Junior Doctors (40+ attended)

Staff events

- **Mindfulness:** 113 staff engagements at the 6 week Mindfulness programme - in Daisy Hill Hospital November-January 2020. Post event evaluation completed – very positive feedback.
- **Menopause event and policy development:** Mindfulness and complementary therapies provided to 30 staff to mark World Menopause Day. Supported by Trust physiotherapy who gave information on muscle and bladder issues affecting women at menopause and general health information stand provided.
  HoS HI Leading on development of a Trust Menopause Policy, supported by HI Lead Workplace Health. (*final policy was launched in Oct 2020)*
- **Heart and Blood Pressure Checks:** 117 staff availed of blood pressure checks and 55 staff received Atrial Fibrillation tests.
- **Christmas Creativity Workshops:** 3 x workshops organised for staff to join the Trust's Artist in Residence (Arts Care) to try out various arts and crafts for Christmas. (34 staff attended)
- **Regional Health and Wellbeing Charter for HSC Staff:** Led and developed by the Trust's HOS for HI (chair) of Regional Task and Finish group (within the Public Health Agency's HSC Healthier Workplaces Network). Charter signed off by SHSCT CEO and Director for HR in May 19. Approved by Network and presented to CE Forum in January 2020 and shared at and shared with Trust staff.

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Children and Young People's Services Directorate

There have been a number of initiatives to address staff wellbeing not only as part of the Trust's duty of care but as a means of improving morale to build an engaged motivated workforce who will want to remain within the Division.

Safeguarding and FIT Division have a FIT Oversight Group chaired by the Director. This group focuses specifically on staff wellbeing issues and have led on promoting a zero tolerance approach to reports of staff being subjected to threatening or bullying behaviour by service users or their support people. They have also established debriefing sessions for staff (across the CYPS Directorate) affected by their involvement with children and families who have suffered traumatic events, including serious adverse incidents or deaths. Further workshops with FIT staff are planned to review the work of the Oversight Group and the general pressures in the FIT service.

The Corporate Parenting Division have a number of staff wellbeing initiatives including links with the Trust U Matter Staff Support Service.

2.3 Induction

The Trust's Corporate Welcome is delivered via an interactive, informative online publication. Feedback continues to be positive with staff remarking upon the convenience of online completion, the extensive information available and the user-friendly layout and design. New starts must also receive a departmental induction from their line manager as soon as possible after commencing employment.

If viewing the digital version of the report, click on the image to access the Corporate Welcome Southern Trust SharePoint page (only accessible on Southern Trust systems)

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2.4 Corporate Mandatory Training

Work continues across the Trust in relation to the provision of, and reporting on, Corporate Mandatory Training (CMT):

- Liaison with Subject Matter Experts to ensure that our training needs analysis are as accurate as possible in relation to the training required by each member of staff, the method delivery and the frequency of refresher required to keep staff competent.
- Liaising with Subject Matter Experts on a regular basis to ensure that any amendments to training, eg categories, method of delivery, etc are communicated effectively to staff and managers.
- Continue to provide quarter end compliance reports to each Directorate for dissemination throughout their Divisions, this information is also posted on the Trust SharePoint page to allow Managers and staff to see their training compliance position and take action as appropriate in relation to keeping this training up to date.
- Assisting Directorates in ensuring that their Internal Audit compliance rate of 60% is maintained across the Trust, highlighting areas of concern and liaising with relevant staff to address issues and discuss ways of maintaining compliance.
- Make use of a variety of methods to actively promote CMT across the Trust, e.g. Desktop adverts, Southern-i, Connect app, etc, as well as attending various meetings as appropriate to advise and support managers.
- Ensuring that there is availability of all elements of training in a timely manner and variety of methods relevant to all staff roles to allow staff to maintain compliance as necessary.

The comparisons to the previous year's figures are outlined below:

Compliance Rates at 31st March 2019 and 31st March 2020:

Corporate Mandatory Training Element	% Compliance as of 31st March 2019	% Compliance as of 31st March 2020	Variance (%)
Information Governance Awareness	82	76	**-6**
Fire Safety	65	50	**-15**
Safeguarding	79	63	**-16**
Moving and Handling	69	56	**-13**
Infection, Prevention & Control	67	55	**-12**

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Making a Difference*	22* *commenced Oct 2018*	42	**20**

Fire Safety, Safeguarding, Moving & Handling and Infection Prevention & Control include a face-to-face element in addition to the compulsory e-learning modules on the HSC Learning Platform. Information Governance Awareness and Equality, Good Relations & Human Rights: Making a Difference are solely e-learning based training programmes.

Equality, Good Relations & Human Rights: Making a Difference was introduced on 1st October 2018 and compliance continues to increase. Some Corporate Mandatory Training compliance has dropped below the Internal Audit compliance rate of 60% and compliance has decreased. It is recognised that compliance has been impacted by the pressures of managing COVID-19; however we continue to liaise with the Subject Matter Experts to explore alternative delivery methods and formats for acceptably compliant training for all staff. We have made good progress with this is the latter half of the 2019-20 year and are working closely with Subject Matter Experts in relation to amendments to Training Needs Analysis, rolling programmes and particularly changing and diversifying training requirements, etc.

Click on the image to access the Corporate Mandatory Training SharePoint page (only accessible on Southern Trust systems) for access to the relevant resources.

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2.5 Leadership Programmes

As a Trust we want to invest in all our staff, encourage leaders at all levels and promote good team working. All our multi-disciplinary leadership and management development programmes continue to be reviewed and updated to reflect the *Regional HSC Collective Leadership Strategy*, *5 Fundamentals of Civility* and Trust Values, etc.

Alongside this the Education, Learning and Development Team have been evaluating and revising the programmes, initiatives and support they offer to Trust staff including managers and teams. This is to ensure these meet the needs of our staff and reflect our focus. This work will continue to be reviewed as we roll out programmes across the Trust to meet the needs of our staff at all levels and across professions.

The Education, Learning & Development Portfolio 2019/20 was widely circulated to keep all staff informed of the leadership and management development and skills development programmes available throughout the Trust.

Number of staff who completed leadership, management and skills development programmes in 2019/20:

187	'Introduction to Quality Improvement' E-Learning module
48	Taking the Lead – Leadership Development Programme
42	Middle Manager Programme (ILM Level 5)
106	Trust Coaching Service
44	Admin Development Programme
17	Best Practice for Administration of Effective Meetings
124	Every Conversation Matters
34	Every Contact Matters
16	New to Line Management (ILM Level 3)
161	Five Fundamentals of Civility
30	'5 Steps to Quality Improvement 'E-Learning module

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39	'Quality 2020: Attributes Framework Level 1' E-Learning module

2.6 Supervision, Coaching and Mentoring

During 2019/20 the Trust's Coaching Strategy was developed for the next three year period. The Trust's Coaching Strategy aims to support the Trust 'to deliver safe high quality health and social care services, respecting the dignity and individuality of all who use them' by strengthening how staff 'live' the HSC Values of Openness & Honesty, Excellence, Compassion and Working Together.

The Trust Vision for Coaching is to:-

- Develop resilient, reflective and resourceful leaders at all levels, fit for the future.

The purpose of the Trust's Coaching Strategy is to:-

- Embed a coaching approach to create a more effective communication style for greater staff engagement within the organisation (Engaging through Conversation – which is embedded with our *Every Conversation Matters* training);
- Introduce team/group coaching to optimise effective team working and enhance positive working relationships to enrich service delivery; and to
- Provide a sustainable pool of professionally trained coaches so we can continue to offer individual coaching to our staff.

The Trust Coaching service is available to all staff on request but is specifically offered to anyone undertaking the Trust's Leadership Programme 'Taking the Lead', all Band 7 and above New Starts, Service Users on the Quality Improvement Level 3 Award, Social Work Leadership Programme and Social Care Leadership Programme participants.

Allied Health Professionals' Supervision

Professional Registration

It is a legislative requirement that all AHP disciplines are registered with The Health and Care Professions Council in order to practice under their role specific protected titles.

100% Compliance

On 1st September 2019 all AHP professions were 100% compliant with professional registration. There were no lapses in registrations over the time period from April 2019 to August 2019.

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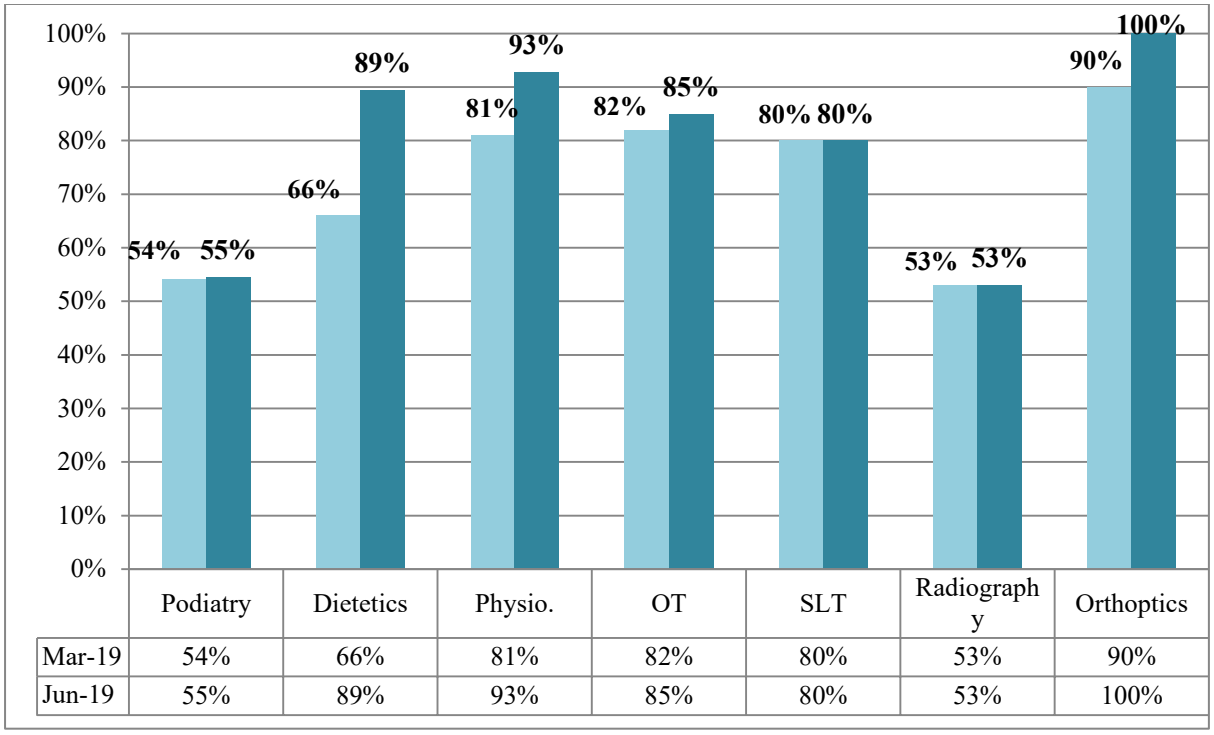
Supervision

Compliance with Supervision period ending 30th June 2019



	Podiatry	Dietetics	Physio.	OT	SLT	Radiography	Orthoptics
Mar-19	54%	66%	81%	82%	80%	53%	90%
Jun-19	55%	89%	93%	85%	80%	53%	100%

Supervision Compliance by AHP staff

Figure 1.1 sets out the supervision compliance activity for all the AHP disciplines. The continued pressures within unscheduled care coupled with recruitment challenges have impacted on formal supervision activity within some areas of Acute and community services. Whilst informal supervision continues to be a feature on a daily basis formal supervision has been challenging for some areas of care.

The AHPs Lead has worked with the professional Heads of Service in the last quarter to maximise the deployment of other supervision methods (group supervision, peer supervision, skype) which has maintained or increased compliance levels.

Post Graduate Certificate Education for Allied Healthcare Professionals

Dietitian Ms Hilary Mathieson Acute Dietetic Lead has completed the first PGCE course for AHPs during academic year 18/19 and is the first Dietitian in the region to complete this course.

Ms Tina Hughes, Acute Occupational Therapy Lead, Daisy Hill Hospital, has also successfully graduated with a PGCE from the 18/ 19 AHP cohort.

This course offers a high level of expertise in teaching roles linked to clinical/professional roles to enhance the experience of both pre and post graduate student learners. A recognition to spread this level of qualification to support expertise in training is part of the Regional

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Workforce Reviews to support local and regional education and training across trusts, Clinical Education Centre and University of Ulster.

Physiotherapy CPD

A Band 5 Passport has been piloted across MSK, Respiratory and Rehabilitation specialities and this has formed a part of the Band 5 passport that is being now adopted regionally for all rotating physiotherapy staff.

Physiotherapy continues to develop their staff -In House training e.g. Headaches, Radiology, as well as through the Clinical Education Centre for Medicines Management.

Four Physiotherapists have completed the Non- Medical Prescribing course over the summer and are awaiting annotation with HCPC and Trust registration processes.

Building Leadership capacity -Band 7 staff - three staff have recently completed the ILM course in the last few months.

Accreditation of strength and balance training (with Open College Network NI) This is used to train trust support staff, leisure centre staff etc to enable them to safely and effectively deliver strength and balance classes in the community across the localities.

Occupational Therapy Masters Module in Environmental Assistive Technology

Six Occupational Therapists from Learning Disability, Physical Disability, Acquired Brain Injury Team, Falls Prevention and Older People Services have successfully completed a Masters Module Environmental Assistive Technology. This educational programme supports the innovative use of environmental assistive technology to promote independence for people with disabilities in their own home.

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2.7 Staff Training

Vocational Workforce Development

As a Trust we want to ensure we have the right staff with the right skills in the right place at the right time to ensure consistent delivery of safe, high quality services. The Vocational Workforce Assessment Centre (VWAC) team continue to deliver Regulated Qualification Framework (RQF) Qualifications to staff throughout the Trust.

Over the past year the following groups of staff have completed a RQF Qualification:-

35	Allied Health Professions have completed a Level 3 or Level 4 Diploma in Healthcare Support Skills
45	Domiciliary Care Staff have completed a Level 2 Award in Healthcare Support Skills
101	Domiciliary Care Staff have completed a Level 2 Certificate in Healthcare Support Skills
23	Staff working in Acute Directorate completed a Level 2 Qualification in Healthcare Support Skills
18	Day Care and Supported Living staff have completed a Level 3 Award in Healthcare Support Skills
15	Staff working in OPPC & MHD Day Care, Residential & community have completed an Level 3 Diploma in Healthcare Support Skills
86	Staff working in Acute Directorate completed a Level 3 Qualification in Healthcare Support Skills
10	Staff working in CYPS Directorate have completed a Level 3 Diploma in Healthcare Support Skills

We continue to support the development of new programmes within the Trust to meet the needs of the service and in response to staffs' continuous personal development plans.

Appraisal/ Knowledge & Skills Framework

As of March 2020, **58%** of the workforce has completed their KSF personal Development plan. The Vocational Workforce Assessment Centre team continue to support and encourage staff to comply with the 60% target which was set following an Internal Audit.

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Community Children's Nursing

Exploring Play Module from the University of Sheffield

Our Community Children's Nursing Healthcare workers remained committed to enhancing their education and their knowledge with regard to children during re-deployment and periods of self-isolation or shielding by completing "Exploring Play: The Importance of Play in Everyday Life" a module developed by the University of Sheffield. They completed 7x 3 hour sessions, making online comments on their reflections and learning. They also completed an online exam and received a Certificate of Achievement.

The premise was to understand the nature and value of play through the course of our lives, across cultures and communities and to encourage everyone to think differently about play.

Play and current debates about how the nature of play changes were discussed along with questions like: - Does play help us to learn? Can it prepare young people to be successful in the adult world? Are all forms of play good for us?

Topics covered included; indoor and outdoor play, disability and play, trauma and play, play in a virtual world, intergenerational play and play activities across different cultures.

Our Healthcare workers are able to put into practice what they have learned about play with the children and young people they work with on a daily basis.

Community Children's Nursing Online Training

As part of our CCN competency training process and our commitment to deliver high quality, safe, effective care, we deliver face-to-face annual theory updates for all our Health Care Workers in the Community Children's Nursing Team.

Due to Covid-19 and associated restrictions we were unable to deliver face to face training, but wanted to ensure staff training was kept up to date.

Our solution was to provide training via YouTube and with the creativity of our Children's Training Co-Ordinator, Una Hughes and the fantastic help of Jessie Weir in the Communications Team we have been steadily adding to our YouTube Playlist to provide required theory training. Our Playlist currently includes Tracheostomy care, Suction, Enteral Feeding and Administration of medication and we are working to expand this.

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We have had very positive feedback. Staff have been able to access the training from home which has reduced footfall in the office and have allowed those who are self-isolating or shielding to complete their annual updates. Additionally staff can access the training 24/7, which helps support their commitments at home.

Social Work Social Care Regulation

The Trust continues to comply with NISCC requirements in relation to regulation of the social care workforce and the Trust continues to strive to maintain its full compliance and registration. A procedure is in place to provide assurances that individuals are appropriately registered and there is regular audit of compliance. This includes actions required for PDP, training and statutory supervision requirements. The statutory requirement for social workers to receive supervision is also audited and reported on an annual basis to the HSCB

The Trust provides a professional induction programme for newly appointed social work and social care staff. Appointees are made aware of their responsibilities in relation to the NISCC Standards of Conduct and Practice (Nov 2015) This contributes to the implementation of the NISCC Induction Standards.

Virtual Library of resources for refresher training and for new and/or redeployed social work staff

The Social Services Training Team developed innovative ways to maintain core delivery of statutory social work training during this period and to support new or redeployed colleagues in the workplace. Staff are able to access this virtual library ensuring they maintain skills and competence. A number of these are listed

- **Induction Videos**

https://www.youtube.com/playlist?list=PL7WBfM07NYCVWhxar-cRrx1jRaKzmlX1s

- **Domestic Abuse – Safeguarding Children Videos**

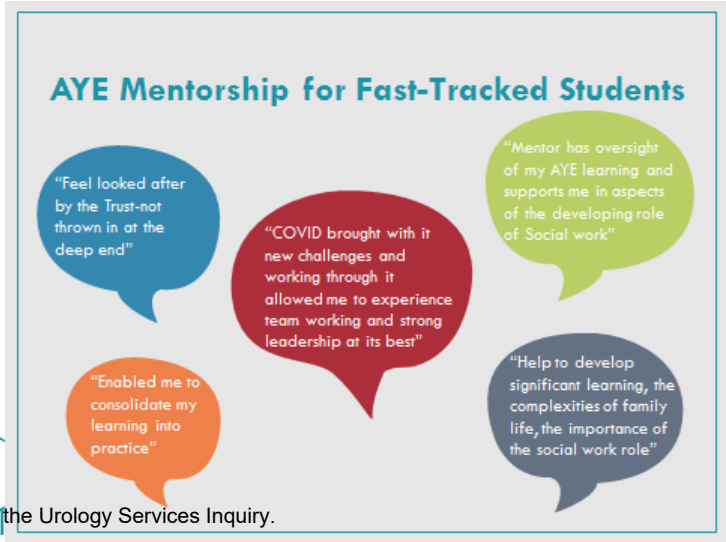
https://www.youtube.com/playlist?list=PL7WBfM07NYCX-Sx_4gop-aLkgIRQ8LsRU

- **Adult Safeguarding Videos**

https://www.youtube.com/playlist?list=PL7WBfM07NYCXTq-gkWZI-xvhFF7rOSPzF

Supporting newly qualified staff

A mentoring scheme has been established to support newly qualified social workers for their first 6 months in post. This is effective in helping staff feel part



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of the organisation and to develop their skills and confidence in practice.

Feedback highlights how positively this scheme is evaluated:

Social Services Workforce Development and Training Team Training Programmes

Social Services Workforce Development and Training (SSWD&T) Team deliver two training programmes each year. The Social Services Workforce Development & Training Programme is mainly targeted at Social Work and Social Care staff, however a number of courses are open to a wider multi-disciplinary audience. The SSWD&T Team also delivers the Multi-Disciplinary Multi-Agency Child Protection Training Programme which offers a wide range of courses across three levels in keeping with the Safeguarding Board NI Training Framework. This programme is open to multi-disciplinary and multi-agency staff who have direct contact with children and families, adult carers and parents.

A sample of areas of training provided by SSWD&T to strengthen professional practice include:

- Interface areas eg mental health and child care
- Adverse Childhood Experiences/Trauma Informed
- Signs of Safety: strengths based/safety organised approach
- Common assessment tools
- Legislation, policies and procedures common to many Directorates and disciplines e.g. Mental Capacity legislation, Restrictive Practice, Human Rights, Safeguarding, Dementia training, etc.

Overall **9527 staff attended** courses/undertook e-learning provided by Social Services Workforce Development and Training in 2019/2020. This included:

- **5506** Social work & Social Care
- **2180** Nursing & Midwifery
- **192** Medical and Dental
- **661** AHP
- **394** Admin/Clerical
- **154** Support services/Service users
- **3** Senior Executives/Non Executive Board Members
- **43** Education Authority
- **31** PSNI
- **363** Other including voluntary sector

Corporate Mandatory Children and Adult Safeguarding Training is provided to all Southern Trust staff. Staff with indirect service user contact receive Level 1 Safeguarding Training via E-Learning every 3 years. For staff with direct service user contact Level 2 Safeguarding

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Training is offered in 3-hour face to face training sessions by Social Services Workforce Development & Training Team. There is also requirement to attend refresher training every 2 or 3 years, commensurate to the job role.

During 2019/20, **3056 staff attended this face to face Level 2** Children and Adult Safeguarding Training as follows:

Working Area	Number of People
Social Work/Social Care	1093
Admin & Clerical	29
Estates	1
Medical & Dental	113
Nursing & Midwifery	1310
AHPs	378
Support Services /User Experience	52
External (ie agency staff, students, etc)	80

Professional in Practice (PiP)

Programmes are delivered in partnership with universities to Social Work staff who wish to consolidate their learning and develop professional competence in specialist areas. PiP Programmes are delivered at Consolidation, Specialist and Leadership & Strategic levels.

In 2019/20, a total of 77 staff achieved PiP credits/awards. Of this 77, 20 social workers achieved full Awards.

Social Work/Social Care Leadership

Succession planning has taken place to ensure a workforce skilled in management and leadership is available for the future. This includes both social workers and social care managers.

SSWD&T Team have supported a total of 278 staff attended a variety of leadership and management courses throughout last year.

This includes:

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- PiP Regional Supervision Course. For participants, this training provides a comprehensive understanding of the purpose, process and mandate of supervision and supports the development of individual supervision styles.
- Developing Professional Supervision Practice in Social Care Adult Services continues to provide the underpinning knowledge for RQF Level 5 Diploma in Management (Supervision Unit 511), and is offered to Social Care Managers with supervisory responsibilities.
- Five managers from Children and Adults' Services completed the Regional Leading Social Work - Stronger Together Programme and achieved their full PiP Leadership and Strategic Award
- Three managers enrolled during the reporting period and are working towards Module 1 of the Stronger Together Programme.
- Two members of the SSWD&T Team continue to study for their Doctorate in Education (focus on Secondary Trauma in Social Workers) and Doctorate in Philosophy (Social Work) (Partnership Working in Safeguarding). There is an expectation that these two members of the Team will be leading out in their specialist areas and embedding a research culture in Social Work.
- The Southern Trust had 2 candidates who successfully completed the Regional "Quality Improvement in Social Work" programme in October 2019 which is based on the IHI Improvement Safety Framework and presents a model for examining the safety and quality of service delivery for patients and service users.
- Within the reporting year, 7 Social Work staff undertook the Scottish Leadership Improvement Programme (ScIL) with completion in August 2020.
- Three senior managers have completed the SBNI Taking the Lead Programme with focus on progressing Trauma Informed Organisation. This includes the Executive Director Social Work, the Assistant Director Social Work Governance and the Lead Psychologist, CYP. A number of successful projects have commenced and are working with Department of Health to implement a Trauma Informed organisation in CYPS.
- The Trust funded 4 Social Work staff to undertake AoEC Ireland Executive Coaching Practitioner Diploma in 2019/20 which they successfully completed in June 2019. The increase in coaches within the Trust has raised the profile of coaching as a developmental method and has benefited a range of Social Work/Social Care staff on programmes and within their practice.

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Nurses and Midwives Global Leadership Development Programme

The Chief Nursing Officer as part of the 'Nursing Now' campaign had promoted the Global Leadership Development Programme. Four nurses and one midwife continue to undertake this regional programme. Although methods to deliver this programme have been altered due to the current pandemic the programme has continued with the focus to develop nurses and midwives leadership, policy-making, quality improvement and partnership working skills, in-line with the principles of both the global campaign Nursing Now and Nursing Now Northern Ireland. The programme has been extended until June 2021.

SHSCT Nightingale Challenge Programme 2020

Fourteen nurses and midwives continue on the leadership and development programme developed within the Trust to help build the knowledge and skills of the future generation of nursing and midwifery leaders.

Events on this programme have been adapted to reflect our current challenges and this programme has recently been extended until June 2021.

Many of the face to face events organised in our Trust Nightingale programme were cancelled due to Covid 19, key activities have been continuing including shadowing senior nurses, Collective Leadership, 'Every Conversation Matters' and Person-Centred Nursing Framework educational sessions. Participants have also completed Quality Improvement projects. It is anticipated that this programme will help equip our young nurses with confidence and knowledge to progress as Nurse Leaders within the organisation. A celebratory event is planned for June 2021 where our participants will present their Quality Improvement projects and celebrate completion of the programme.

The challenges faced in COVID-19 have seen much of the two programmes offering support to all participants in different ways. Two Facebook Groups have been set up by participants. The Facebook group set up by the Global Leadership Development Programme encourages participants to make links with others on Nightingale Challenge Programmes all around the world to offer support, motivation, ideas and to discuss and understand global issues.

Some of Southern Trust Nightingales and Trust staff at the programme's Induction day in February 2020.

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2.8 Nursing Overview

Quality Nursing and Midwifery Care; Assurance within the SHSCT Measurement Audits

Across the Great Divides

The Nursing Governance Team works across all Directorates within the SHSCT with our Nurses and Midwives to assure our high quality person centred care is based on best evidence. Safe high quality care however cannot be achieved in isolation.

We support multi-disciplinary working within the SHSCT and also hold membership of many profession specific and multi-disciplinary quality groups at Regional level; thereby helping to shape services by highlighting areas for improvement and working together to bring about meaningful change. During 2019-2020 we have worked Regionally with the Public Health Agency, Northern Ireland Practice Education Council (NIPEC) and other Trusts to develop and enhance quality and safety in areas such as: Falls Prevention and Management: Pressure Ulcer Prevention and Management; Medicines Safety; Always Events; Respecting Patient Privacy and Dignity through restricting Mixed Sex Accommodation in hospital wards; Regional Uniforms Steering Group; Record Keeping; Link Nurses.

Nursing Quality Indicators (NQIs)

The Nursing and Midwifery, Patient Safety, Quality and Experience team continue to support our frontline staff to ensure performance is closely monitored, that good performance is recognised and poor performance challenged. A number of audits – tailor made for each Directorate - are used to help us to get an indication of the standard of nursing and midwifery care in our wards. The audit questions cover areas of risk to patient safety and help us prevent avoidable harm to patient

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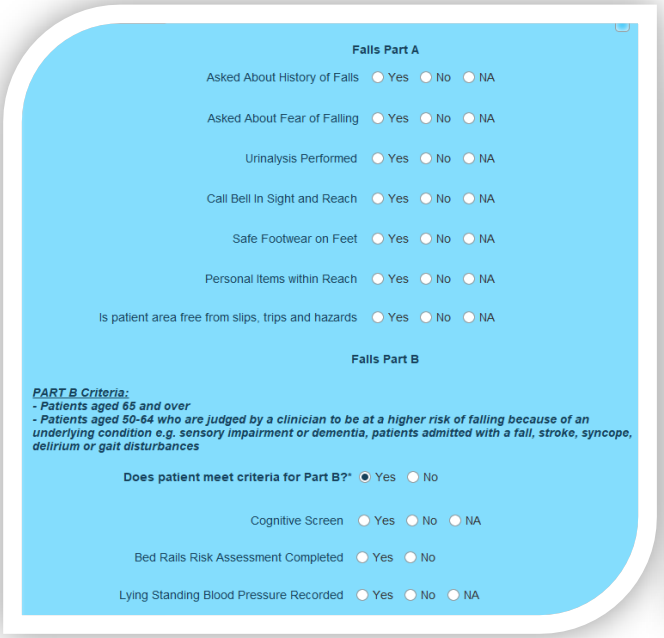


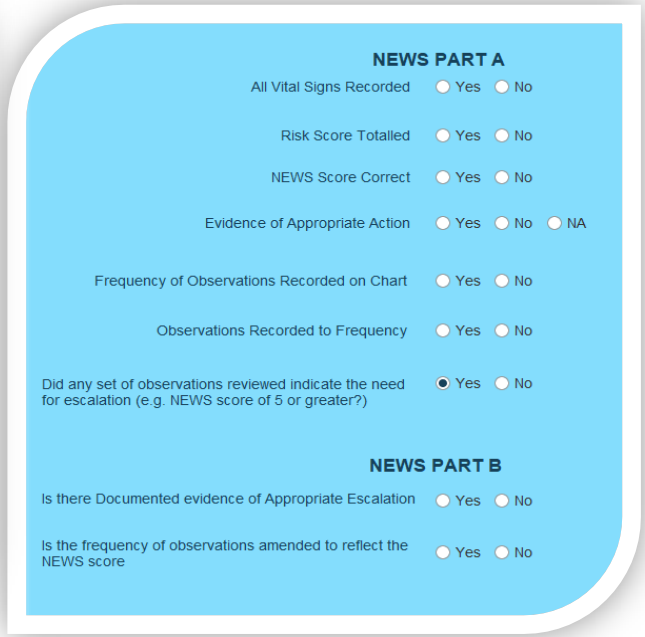
Falls Part A

Asked About History of Falls	Yes	No	NA
Asked About Fear of Falling	Yes	No	NA
Urinalysis Performed	Yes	No	NA
Call Bell In Sight and Reach	Yes	No	NA
Safe Footwear on Feet	Yes	No	NA
Personal Items within Reach	Yes	No	NA
Is patient area free from slips, trips and hazards	Yes	No	NA

Falls Part B

PART B Criteria:
- Patients aged 65 and over
- Patients aged 50-64 who are judged by a clinician to be at a higher risk of falling because of an underlying condition e.g. sensory impairment or dementia, patients admitted with a fall, stroke, syncope, delirium or gait disturbances

Does patient meet criteria for Part B?*	Yes	No	
Cognitive Screen	Yes	No	NA
Bed Rails Risk Assessment Completed	Yes	No	
Lying Standing Blood Pressure Recorded	Yes	No	NA



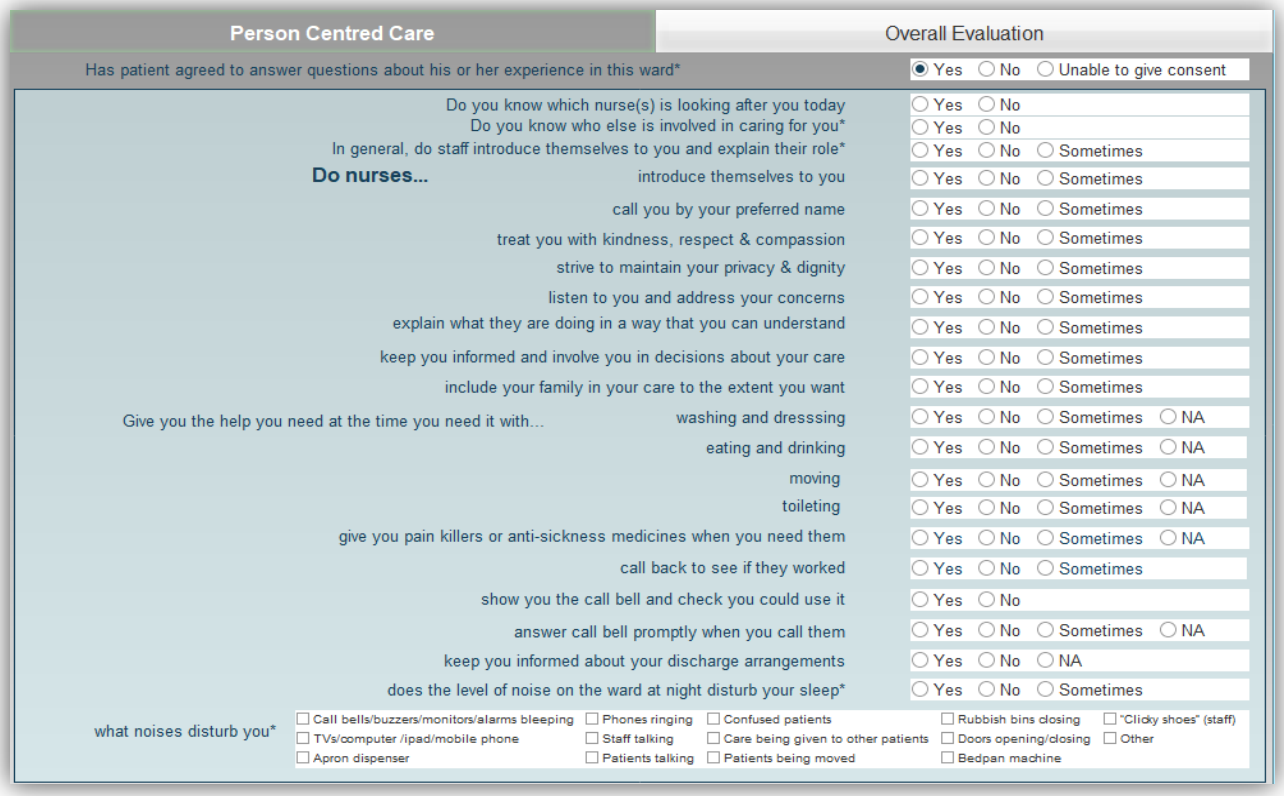
NEWS PART A

All Vital Signs Recorded	Yes	No	
Risk Score Totalled	Yes	No	
NEWS Score Correct	Yes	No	
Evidence of Appropriate Action	Yes	No	NA
Frequency of Observations Recorded on Chart	Yes	No	
Observations Recorded to Frequency	Yes	No	
Did any set of observations reviewed indicate the need for escalation (e.g. NEWS score of 5 or greater?)	Yes	No	

NEWS PART B

Is there Documented evidence of Appropriate Escalation	Yes	No
Is the frequency of observations amended to reflect the NEWS score	Yes	No

Patients are also asked about their experience by our Lead Nurses.



Person Centred Care		Overall Evaluation
Has patient agreed to answer questions about his or her experience in this ward*		Yes / No / Unable to give consent
	Do you know which nurse(s) is looking after you today	Yes / No
	Do you know who else is involved in caring for you*	Yes / No
	In general, do staff introduce themselves to you and explain their role*	Yes / No / Sometimes
Do nurses...	introduce themselves to you	Yes / No / Sometimes
	call you by your preferred name	Yes / No / Sometimes
	treat you with kindness, respect & compassion	Yes / No / Sometimes
	strive to maintain your privacy & dignity	Yes / No / Sometimes
	listen to you and address your concerns	Yes / No / Sometimes
	explain what they are doing in a way that you can understand	Yes / No / Sometimes
	keep you informed and involve you in decisions about your care	Yes / No / Sometimes
	include your family in your care to the extent you want	Yes / No / Sometimes
Give you the help you need at the time you need it with...	washing and dresssing	Yes / No / Sometimes / NA
	eating and drinking	Yes / No / Sometimes / NA
	moving	Yes / No / Sometimes / NA
	toileting	Yes / No / Sometimes / NA
	give you pain killers or anti-sickness medicines when you need them	Yes / No / Sometimes / NA
	call back to see if they worked	Yes / No / Sometimes
	show you the call bell and check you could use it	Yes / No
	answer call bell promptly when you call them	Yes / No / Sometimes / NA
	keep you informed about your discharge arrangements	Yes / No / NA
	does the level of noise on the ward at night disturb your sleep*	Yes / No / Sometimes
what noises disturb you*	Call bells/buzzers/monitors/alarms bleeping; Phones ringing; Confused patients; Rubbish bins closing; "Clicky shoes" (staff); TVs/computer /ipad/mobile phone; Staff talking; Care being given to other patients; Doors opening/closing; Other; Apron dispenser; Patients talking; Patients being moved; Bedpan machine	

The answers to questions are entered into a specially designed computer data base that allows us to map how well we are doing. We can look at results by Ward, Division, Directorate and Overall for the Trust. These reports are held on the NQI SharePoint Site to make it more user friendly and accessible for staff.

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The user friendly format is accessible to **all** relevant staff; reports shared from the bedside right up to the Chief Nursing Officer (CNO) and the Public Health Agency (PHA). If the audit findings are below what we would expect this is looked at with the area/s and improvement plans put in place and followed.

During 2019-2020 the Nursing Governance Team designed and delivered training and guidance to staff within the Acute Directorate specifically related to the NQIs. This was very well received and the learning materials are available for staff on the Nursing & Midwifery Governance SharePoint Site.

Each month the Nursing Governance Department collate, analyse and report on indicators of nursing performance in avoiding preventable harm to patients.

We share the results to support continuous improvement in providing safe, effective care and a positive experience for the people we care for.

Below is a list of audits that are completed across the directorates with Line Labelling being implemented in 2019.

Audit/Directorate	Acute & Non Acute	MHD	CYP
NEWS (A&B)	✓	✓	
FallSafe (A&B)	✓	✓	
Nutrition	✓	✓	
SKIN	✓		
Omitted Medicines	✓	✓	
Nursing Documentation (NOAT)	✓	✓	☒

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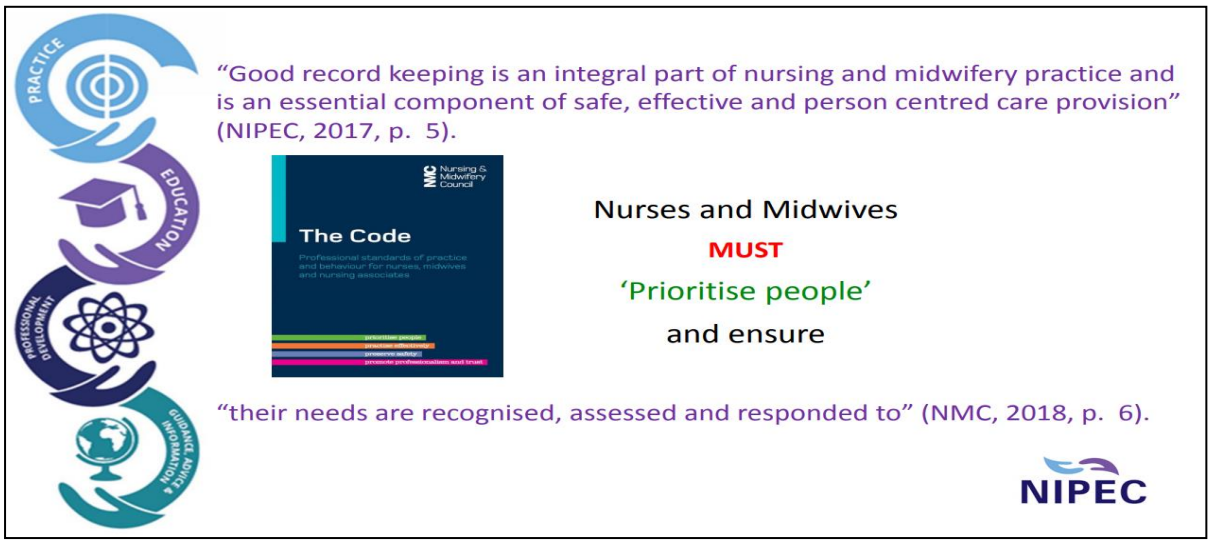
Line Labelling - *new*	✓		✓
PEWS			✓
PIVFAIT			✓
Fluid Prescription & Fluid Balance			✓

PACE (Person Centred Care Planning and Evaluation)

Our Nursing and Midwifery teams keep patients at the heart of all they do. We are committed to designing and planning our care with them. Clear documentation of our nursing care is essential to ensure patient safety.



The PACE framework is a method to improve the quality of Nursing's patient centred care planning. The Regionally agreed documentation aims to standardise how we record throughout our hospitals within Northern Ireland. Its use has been agreed by the Chief Nursing Officer, Department of Health and roll out - lead by NIPEC - continues across the Region. All adult inpatient wards within our Acute and Older Peoples Directorate now use this format.

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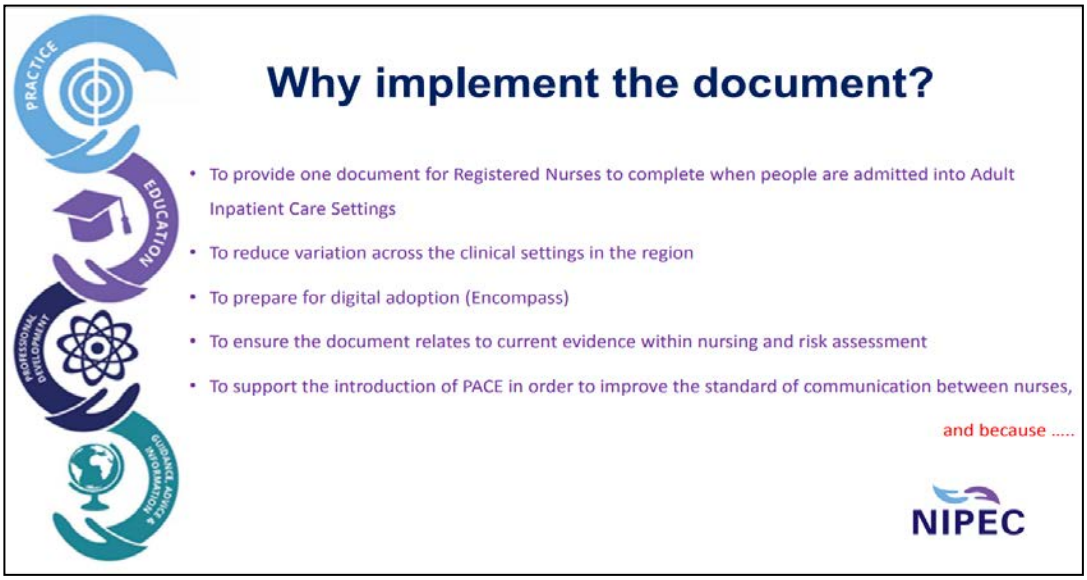

The implantation of the PACE framework within the Trust is led by designated Nursing Governance Coordinators who support and facilitate nursing teams in using the framework. The PACE project funding of 3.53 WTE was initiated in November 2019 and will cease in April 2020.

The training cycle for each ward spans 20 weeks. Three cycles have been undertaken covering twenty acute and non-acute in-patient wards and a further six wards commenced the process in February 2020. Unfortunately the remaining six ward schedules have been interrupted by the start of the COVID 19 pandemic. Going forward the recovery plan is to absorb PACE implementation in the remaining six wards into the professional nursing governance agenda.

The desired outcome of implemented change is an ongoing improvement in the record keeping standard, particularly care planning. An online audit tool (NOAT) is used to measure improvement; with staff feedback informing the impact and effectiveness of the framework.

The Executive Director of Nursing maintains oversight of the progression of the Recording Care project, presently via the Senior Nursing and Midwifery Governance Forum.

PACE implementation in Acute and Non acute wards

WARDS April August 2019	WARDs September January 2020	WARDS *February 20 April 20
Ward 3 Lurgan	2 South Medical	AMU
Loane 1	2 South Stroke	3 North
Loane 2	4 south	Elective ward

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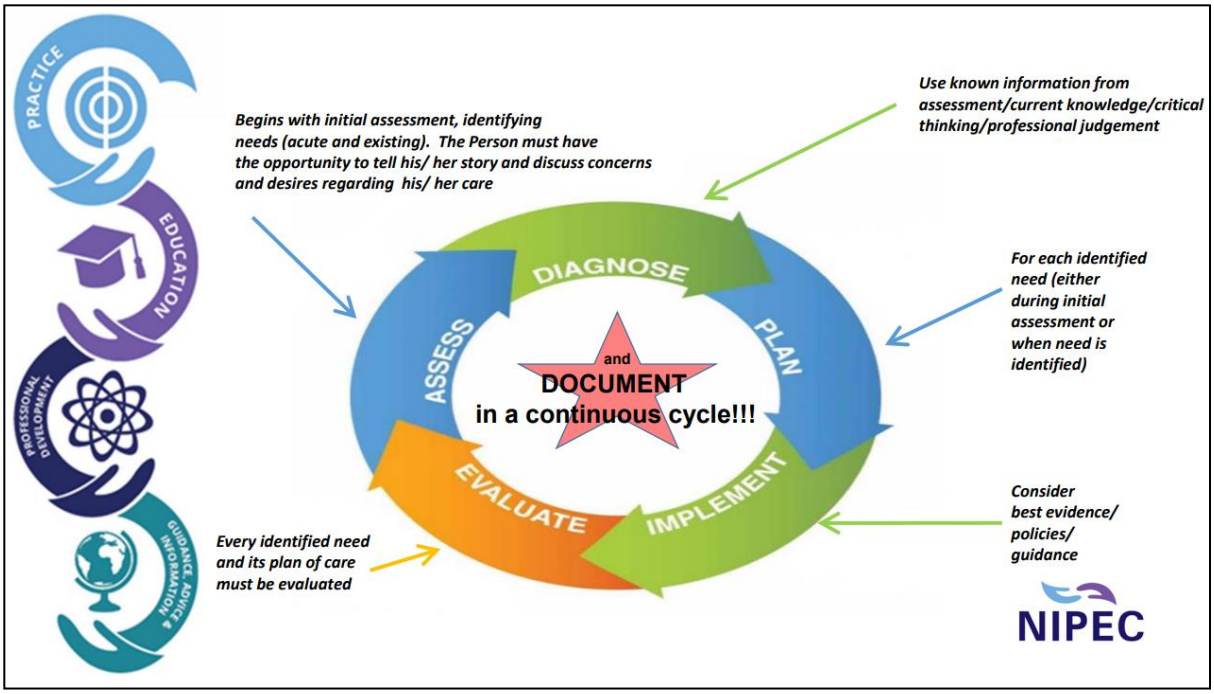
Male Medical	4 North	1 South
Level 4 DHH	Trauma	1 North
Orthopaedic	3 south	

**Implementation interrupted by COVID 19*

Final Average Audit Scores for PACE – March 2020

Audit week 1	Audit week 10	Audit week 20	Overall Improvement
48%	61%	77%	29%



ALWAYS Events

In response to 10,000 Voices feedback to the Public Health Agency (PHA), Regional Improvement Initiatives were identified to be progressed using "Always Event Quality Improvement" methodology.

2019-2020 saw a focus on the following 3 areas:

Quality Improvements

- Family Presence
- Mealtime Matters
- Noise at Night

Before starting it was important that everyone understood what Always Events can contribute to improving patient client experience.

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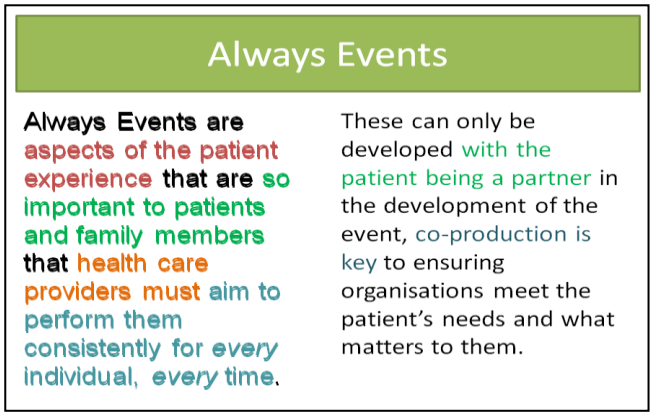
Always Events differ from other improvement methods that are often used in hospital settings because they must be based on what is important to the patient/service user and must be designed and worked through with patients and carers. In other words they must be "Co-produced".

During the year the Nursing Governance Team undertook questionnaires with patients and family members to seek their views on how they found these areas and what they felt was important to them.



The Nursing Governance team has undertaken training with staff and service users explaining the background and how to carry out this Co-production improvement method. This was combined with feedback received prior to starting the initiatives.

Areas were identified and teams set up to take the initiatives forward within the Acute and Older Peoples in-patient settings.

The pre-meeting information allowed for multi-disciplinary staff and patient's and service user representatives to have a shared understanding. Meetings were used to allow all to combine their collective experiences to tease out how best to move forward.

This work will continue in 2020-2021.

Research and Development

The *RQIA Planning to Birth at Home Guideline* was launched by the Chief Nursing Officer, (CNO) Professor Charlotte McArdle in the Long Gallery, Parliament Buildings on 14th November 2019 https://www.rqia.org.uk/planningbirthathome/. The CNO provided the opening address with women and maternity care providers speaking about their experiences of home birth and Mervi Jokinen,

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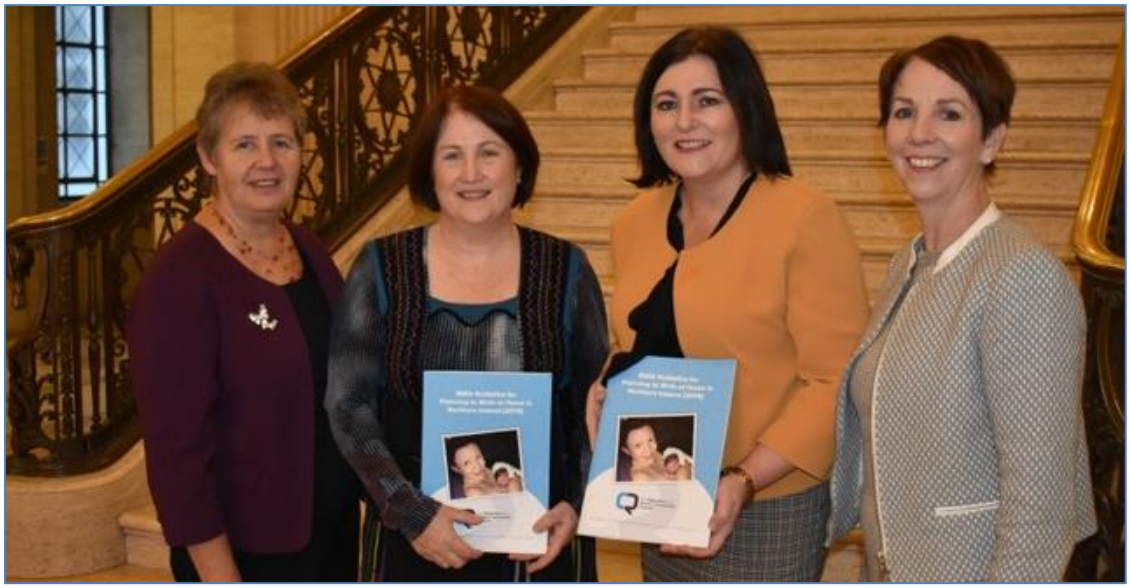
President of the European Midwives Association providing the closing address. Dr Patricia Gillen, Head of Research and Development for Nurses, Midwives and AHPs co-led on the co-production and development of the guideline and other resources including a woman and partner's information booklet. These evidence based resources for women, their families and maternity care providers will help when making decisions about planning a home birth.



L-R: Ms Mervi Jokinen; Dr Patricia Gillen, Professor Charlotte McArdle, Dr Maria Healy

In July 2019, funding was secured from RQIA to undertake a Northern Ireland Regional Individual Midwife Led Unit (MLU) Audit, Regional Case Audit of the RQIA Guideline for Admission to Midwife-Led Units in Northern Ireland & Case Audit of Northern Ireland Normal Labour and Birth Care Pathway within Midwife-led Units and Obstetric Units. This work is being co-led by Dr Maria Healy from QUB and Dr Patricia Gillen and undertaken in collaboration with maternity care provider staff. The aim is to determine the current use of the RQIA Guideline for Admission to midwife-led units across Northern Ireland, along with the utilisation of the Normal Labour and Birth Care Pathway and related maternal and neonatal outcomes. The guideline was developed in 2016 in collaboration with women and maternity care providers. The Audit is ongoing and aims to be completed by September 2020.

Funding secured from the Southern HSC Trust was matched by funding from the Public Health Agency Opportunity-led Research to undertake research on *Women and Maternity Care Providers' Experiences and Perceptions of Planned Home Birth Service Provision in Northern Ireland*. It involves a survey- one for women and one for maternity care providers followed by focus groups to further explore issues raised in responses to the survey. It aims to be completed by March 2021.

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Human Factors Train the Trainers Course was successfully completed in May 2019 by Dr Patricia Gillen and medical, nursing and Quality Improvement staff. An understanding of how human factors can impact on the quality of care provided and impact on decision-making are important for staff. The application of Human Factors knowledge and skills has been shared with doctors in training during lunchtime seminars and with nurses and midwives undertaking Band 5 & 6 Development Programmes.

In order to offer support to staff undertaking research and development activity, Patricia has provided *Academic Writing and Writing for Publication Seminars* on a number of occasions through the year to all staff. These assist staff undertaking research and development activity in the Trust who want to publicise the findings to service users and other health and social care staff or complete academic work.

Bereavement

The bereavement forum provides an opportunity to profile the work undertaken by teams to enhance the care of dying people and their loved ones and to support people as they grieve. Christmas 2019 saw the introduction of Christmas 'remembering trees' in recognition that the festive season can be an especially difficult time for bereaved people. A dedicated tree in each hospital provided patients, visitors, volunteers and staff with the opportunity to write the name of the person on their mind on a card and attach it to the tree. This was a well received initiative and the messages on the cards were both inspiring and deeply moving. We hope that the trees will become an annual opportunity in the Christmases to come.

Leadership and Quality Improvement go hand in hand

Congratulations to our Registrants who completed advanced training in Quality Improvement Methods and thanks to the Quality Improvement Team in working with our staff

Measures – 8 Registrants

OCN NI Level 3 Certificate in Quality Improvement – 8 Registrants

OCN NI Level 5 Diploma in Leading Quality Improvement – 2 Registrants

Taking the Lead Programme – 29- Registrants

Total - 56

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Examples of Quality Improvement Initiatives and Professional and Nurse Led Service Developments 2019-2020

Introduction of a chlorhexidine free trolley

S/N Anna McCann, in conjunction with Dr Paul McConaghy, has successfully introduced a chlorhexidine free trolley which has reduced the risk of anaphylaxis for theatre patients (known deaths). This commenced in Aug 2019 and was presented at the Trusts Quality Improvement Event on 15 November 2019.

Band 6, 7 and 8A OPPC Professional Fora development

Within OPPC a range of Professional Fora, have been developed with the aim of supporting nurses from within the directorate to manage the professional responsibilities and core elements of their roles to achieve expected outcomes.

The agenda for these meetings is divided into two parts. Part one focuses on sharing the learning and the second group supervision. Each meeting concludes with an opportunity to complete formal refection on learning which will contribute to a nursing revalidation portfolio. Meetings are well attended and feedback from staff is that they are of significant benefit in professionally supporting nurses.

Early recognition of autonomic Dysreflexia

In response to a recent safety alert to support staff in the early recognition of autonomic Dysreflexia, the Specialist Continence Team liaised with staff in the Rehabilitation Hospital Dublin to produce a leaflet/poster which has been widely shared with acuter/non/acute/District Nursing/Acute Care at Home (AC@H)/Northern Ireland Ambulance Service/Private Nursing homes/Emergency Departments.

Placement of Oximetry Probes

In response to a recent safety alert an A4 laminated card was produced which showed the various types of probes and where they should be placed. The card also highlights factors which may interfere with the probe readings. Each clinical area will adapt the laminated card according to the type of probes which they use. This has been shared with Non-Acute Staff: AC@H: District Nursing: Specialist Nursing Teams.

Commencement of Non-Medical Prescribers Supervision Group

Non-Medical Prescribers Supervision Group has been established to facilitate a Nursing and Midwifery Prescribing Framework within Enhanced Services (ES). It will meet twice yearly.

Nursing Quality Indicators roll out within Enhanced Services of OPPC

NQI monitoring has commenced within Enhanced Services, the 3 identified areas for review are:

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- Documentation (Short NOAT form)
- MUST
- Braden

A pilot ran from January to March 2020 across 4 teams (Continence: Palliative: Acute Care At Home: Heart Failure). It is planned that from April 2020 all teams within Enhanced Services will be audited on a monthly basis. Following a 6 month review consideration will be given to increasing the number of NQI's audited.

Appraisal- Supporting Safe Practice and Registrant Development

We value our workforce and strive to help them achieve their potential. We also need to make sure they have the knowledge and skills they need to do their job. We do this on an ongoing basis throughout the year.

In addition to this every year line managers must hold a formal meeting with each Registrant. This meeting provides protected time to reflect on individuals work and the learning and development opportunities they have had throughout the year. The discussion also considers further learning and development that would be useful for the Registrant in the coming year. Once agreed this is recorded in a "Personal Development Plan". This includes information on what has been agreed and how s/he will be supported to reach the agreed goals.

A record is kept of this "appraisal" by both the Registrant and Line Manager for reference throughout the year. Overall figures tabled below are kept centrally by the Directorate of HR & Organisational Development.

Nursing and Midwifery Registrants who had Appraisal in 2019-2020

Directorate	Registrants
Acute	964
Children's and Young People	359
Mental Health and Learning Disability	378
Older People and Primary Care	415
Executive Directorate of Nursing Midwifery and AHPs	21
HR and Organisational Development	9
Medical	1

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2.9 Revalidation of Medical and Nursing Staff

Nursing and Midwifery

Nursing and Midwifery Registration and Revalidation information is held on HRPTS and a robust system is in place within the Trust to monitor Registrations and Revalidations.

Monthly monitoring reports are issued to Managers, Heads of Service and escalated to Assistant Directors and Directors where necessary. These reports provide managers with an opportunity to remind registrants of their NMC registration and revalidation requirements and will identify registrants whose annual registration fees have not been received within NMC deadlines for payment. During the 19/20 year there were no occasions where registrants have failed to meet the NMC registration or revalidation requirements.

Medical

Medical Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. It aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council (GMC). Medical revalidation came into force across the UK on 3rd December 2012, under the General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012.

Facts and Figures

- The Southern Trust had **105 Doctors** due to be revalidated out of a possible 117. **All 105** had a positive recommendation.
- We had **12 deferrals** in this timeframe. This included 3 due to sick leave, 1 maternity leave, 5 new starts insufficient information, 2 career break and 1 'other'.

Flu Vaccine

For the 2019/2020 flu programme we continued to use the 'Peer Vaccinator Model' introduced in 2018/2019, in order to help increase flu vaccination uptake among Trust staff. It is well documented that peer vaccination is the single most effective intervention in increasing flu vaccination uptake. Also previous feedback surveys had highlighted access to the vaccine was one reason for the lower uptake, and therefore this approach helped address this.

During 2019/20 The Trust continued the Corporate Flu Steering Group, a co-ordinated flu team with representatives from all Directorates, staff groups and Trade Unions, as

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collaborative working and buy in from senior management is considered essential to a successful flu campaign.

Personnel Area	% Headcount Vaccinated 2019/20	% Headcount Vaccinated 2018/19
Front Line Staff- Health Care Workers	40%	33%
Front Line Staff- Social Care Workers	24%	17%
Non-Front-Line Staff	40%	34%
Overall Total	**36%**	**30%**

Note:
Headcount is a count of staff based on staff number with the greatest WTE and therefore a member of staff working in a number of positions, is only counted once.
Bank and block booking staff are excluded from the headcount and vaccines given count.

Facts and Figures

- Total Number of Flu **Vaccines given** as at COP 28.04.2020 (including bank, block booking, new starts and External Non-Trust staff): **5480**
- Based on the figures provided there has been a further improved uptake for the 2019/2020 programme – an **additional 7% (800staff)** of front line health care workers (HCW) and 7% (800 staff) of front line social care workers (SCW) were **vaccinated compared to 2018/19**. If we continue on this trajectory for 2020/21 we should be closer to achieving the PHA targets which is 50% for frontline HCW's and 40% for frontline SCW's.
- In 2018/19 peer vaccinators gave 287 vaccines and in **2019/20 they gave 1288** which is a **significant increase of 349%.** Moving forward this model would appear to work best for staff as they are able to receive the vaccine from a colleague at a time that suits and the peer vaccinator is able to promote the vaccine in their area.

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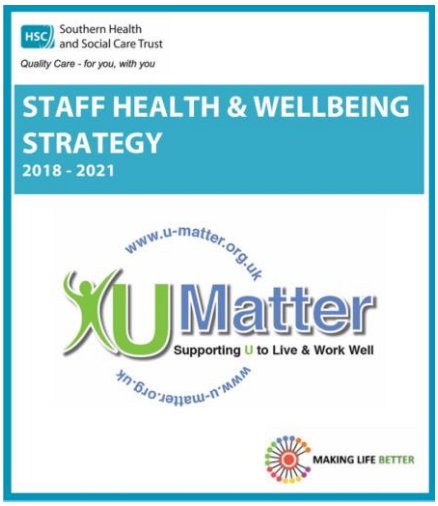
2.10 Staff Absenteeism

The Southern Health & Social Care Trust is committed to supporting and protecting the positive health and well-being of staff. The Trust's Health and Well-Being Strategy 2018-2021 sets out our action plans to support staff's physical and psychological health.



However there will be times when a staff member will be absent from work because of illness and will be supported during that period by their line manager, Human Resources and Occupational Health services. Absence is a significant cost to the organisation and can place additional pressure on colleagues who are at work. Effective absence management requires a balance between providing support to help staff remain in work / return to work as quickly as possible and taking robust action to address high levels of absence when necessary.

The table below shows the monthly percentage sickness absence trends from April 2015 to March 2020. The figures are based on working hours lost / working hours available as calculated by HRPTS based on individual staff working patterns.

The cumulative **% sickness absence rate for 2019/20** (excluding Covid-19 related sickness absence) was **5.33%** which is slightly less than the cumulative figure of 5.35% for the previous year. Including Covid-19 related sickness absence the % absence rate was 5.39%.

The top reason for both long term and short term absence in 2019/20 was mental health illness.

Regional HSC Sickness Absence during 2019/20

Trust	Cumulative 2019/20 Sickness Absence (% Hours Lost)
Western Trust	7.03%
Belfast Trust	7.36%
South Eastern Trust	6.54%
Northern Trust	6.84%
Southern Trust	5.33%

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2.11 Reducing the Risk of Hyponatraemia

In January 2018 the report into the Inquiry into Hyponatraemia-related Deaths was published. In response, several regional Department of Health work streams have been established to take forward important action points. SHSCT has a representative on work stream groups. Key Regional work stream groups continue to progress actions against the 96 recommendations outlined in the report.

Updates on Southern Trust local Hyponatremia Oversight Group work is reported at SMT and Trust Board meetings.

The full report into the Inquiry into Hyponatraemia-related Deaths and Regional update reports are available at http://www.ihrdni.org.

The remit of the Trust Hyponatraemia Oversight Group is essential but complex. Many recommendations are multifaceted and contain several components interwoven with other Trust and/or Service requirements. Furthermore progression of some recommendations is fully, or in part, dependent upon successful implementation of Regional outputs. In recognition of this the Trust agreed a Project Management approach to implementation.

Over the last 7 months a scoping exercise was undertaken to determine both the current Trust position with regard to all 96 recommendations and with the recommendations of the Internal Audit Report.

Internal Audit indicated there was a lack of clarity as to which areas within the Acute Directorate treated children and young people aged 14-16th birthday therefore a further scoping clarification exercise was carried out across all Directorates.

Of particular concern was a lack of clarity around requirements in regard to training, documentation and policy.

On the strength of the aforementioned, a detailed audit was undertaken within relevant areas in the Acute and Children and Young People's Directorates (CYP) to identify current position. The traditional RAG rating was expanded to (a) identify areas where policy sign off was outstanding but practice was as required (b) identify where recommendation was not in place because there was an acceptable over-ride (e.g. Obstetric Early Warning Score (OEWS) rather than Paediatric EWS in Labour and Maternity areas). This extra detail offered a level of assurance whilst highlighting priority areas.

Progress to Date

- Trust version of publication of a New Regional Policy for the Administration of Intravenous Fluids to Children Aged from Birth (term) until their 16th Birthday: Reducing the risk of Harm due to Hyponatremia agreed and uploaded onto Clinical Guidelines site

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- SHSCT Fluid Management Competency Framework for Nursing and Midwifery finalised and passed at SNMGF. Clinical Educators within Acute Directorate have been trained in sign off by Lead Nurse CYP Laura Spiers.
- All associated training requirements for those areas within Acute Directorate accepting CYP aged 14-16th birthday agreed. Head of Service and Lead Nurse CYP Head of Service Head of Nursing and Midwifery Education and Workforce Development Safeguarding Team, Pharmacy (Richard Clements) and CEC all worked with Acute Directorate colleagues to devise training materials at short notice to allow staff to meet requirements. A training implementation plan has been put in place within Acute Directorate.
- Acute Directorate training is held via Health Roster reports generated and included in NQIs. CYP training -currently held locally- will be added to Health Roster.
- Agreement has been reached in regard to which documentation should be used to record care, fluid management and EWS for those 14-16th birthday with Acute Directorate. Again associated training has been sourced.
- Most outstanding policy documents related to the clinical recommendations are in the final stages of completion. It is anticipated that these will be completed in 2020/21.
- A Recommendation Template was devised to enhance progression of the 96 IHRD recommendations. A Change Lead has been identified and is responsible for updating the Templates and advancing the incorporated Action Plan inclusive of timelines, sign off, communication strategy and assurance mechanisms. These have been themed within a page tiger link and will be merged further in the coming months. This streamlining will further aid progression.

To date all staff approached in relation to this work have been more than willing to work across traditional boundaries, offer help and support to colleagues. This reflects a culture willing to embrace change which is the lynchpin of any success.

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2.12 Staff Achievements

Southern Trust Excellence Awards 2019

During June 2019 the Trust held the 9th Southern Trust Excellence Awards Ceremony to celebrate and recognise the commitment, innovation and achievements of our staff and volunteers. In all, **104 nominations** were submitted for the 2019 Excellence Awards which reflected the breadth of really excellent work both at the front line and 'behind the scenes' from individual staff and teams.

The category award winners were as follows:

Taking the Lead Award: Dr Sam Thompson, *Consultant Paediatrician*

Learning in Action Award: Kate Kelly, *Infection Prevention and Control Nurse* with Annette O'Hara

Better Together Award for Team of the Year – Behind the Scenes: The Communications Team

Better Together Award for Team of the Year – Front Line: Paediatric Theatre Team, *Daisy Hill*

Innovation in Action Award: Gail Heaney, *Physiotherapist*

People's Choice Award: Dr Kathryn Boyd, *Consultant Haematologist*

Shane Devlin, Chief Executive, opened the event and had a message for all those in attendance:

> *"It always gives me great pleasure to attend the Excellence Awards and to meet the outstanding individuals and teams who make up the southern Trust. In the current climate, where staff are working exceptionally hard to meet the demand, it is fabulous to see the innovative ways in which our staff strive to deliver great care. Today also allows me to ay thank you to all staff, not just the finalist of our awards. Every day of*

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the year each and every member of the Southern Trust show huge dedication to the population that we all serve and I pay tribute to them all."

Charity Partnership

As an organisation, we also want to give back to our local community and our very generous staff whole heartedly embraced our 2018-2020 Charity Partnership with PIPS Upper Bann and PIPS Hope and Support. In total we raised **£50,268.71** over the two years for these fantastic charities through a range of events like raffles, coffee mornings, sponsored activities and a gala ball. With this money PIPS Hope and Support and PIPS Upper Bann will provide **2,010 x 1 hour Crisis Counselling sessions (each session costs £25 per hour)** for people who are at risk of suicide and people who self-harm in the Southern Trust area. All funds raised were split equally between both charities.

Christmas Family Appeal 2019

Trust Staff generously donated **834** gifts to the 2019 Christmas Family Appeal. The gifts are distributed by the Salvation Army and St Vincent de Paul to those in need at Christmas.

National Recognition for Our Allied Health Professions

Northern Ireland AHP Awards

The Children and Young Person's Directorate Neonatal AHP Service picked up an award at the 2018 Northern Ireland AHP Awards. Jayne Wilson, Physiotherapist, and Fionnuala McKerr, Speech and Language Therapist, are pictured receiving their regional award in recognition of their efforts toward improved therapeutic interventions and safety in Neonatal Services in Craigavon Area Hospital.

Chartered Institute of Personnel and Development Northern Ireland HR Awards

Denise Russell, Podiatry Manager in the Southern Health and Social Care Trust, along with the podiatry managers from the four other Trusts won the Best Talent Management Initiative award at the prestigious Chartered Institute of Personnel and Development NI HR awards, May 2019.

The Podiatry Managers developed a bespoke podiatry succession programme for podiatrists working in clinical specialist roles to develop their leadership skills and reach their full professional potential.

On presenting the award the judges said:

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They were impressed by this *"Innovative talent management approach to addressing key workforce planning and organisational issues which had a demonstrable positive impact and set new standards for good practice in its field of practice which had suffered from years of lack of investment".*

Nursing Times Workforce Award

As an outcome of the Nursing and Midwifery action plan retention work stream, the Practice Education Team (PET) undertook a review of the current preceptorship programme for new nursing and midwifery registrants. Following this review an ID scheme for newly quailed staff was piloted. Following the highly positive evaluation, the scheme has been rolled out to all nursing and midwifery preceptees who can avail of green lanyards to help with identification and support. In recognition for this piece of work the Practice Education Team were nominated for a Nursing Times Workforce Award. Although the team did not win their category at the awards ceremony in December 2020 it was acknowledged that they were amongst only 5 to be shortlisted, and were the only representatives from Northern Ireland.

Nursing Now- Year of the Nurse and Midwife 2020

This has been a particular challenging year for our Nurses and Midwives and it is poignant that the World Health Organisation declared 2020 the 'Year of the Nurse and Midwife' to celebrate the 200th Anniversary of Florence Nightingale's birth. The 'Nightingale Challenge' aimed to recruit 20,000 nurses and midwives from 1000 organisations across the world to take part in learning and networking events throughout the year.

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Quality
Safe, effective & person centred

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

Theme 3

Measuring the Improvement

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3.1 Reducing Healthcare Associated Infection

Reducing Healthcare Associated Infection: MRSA

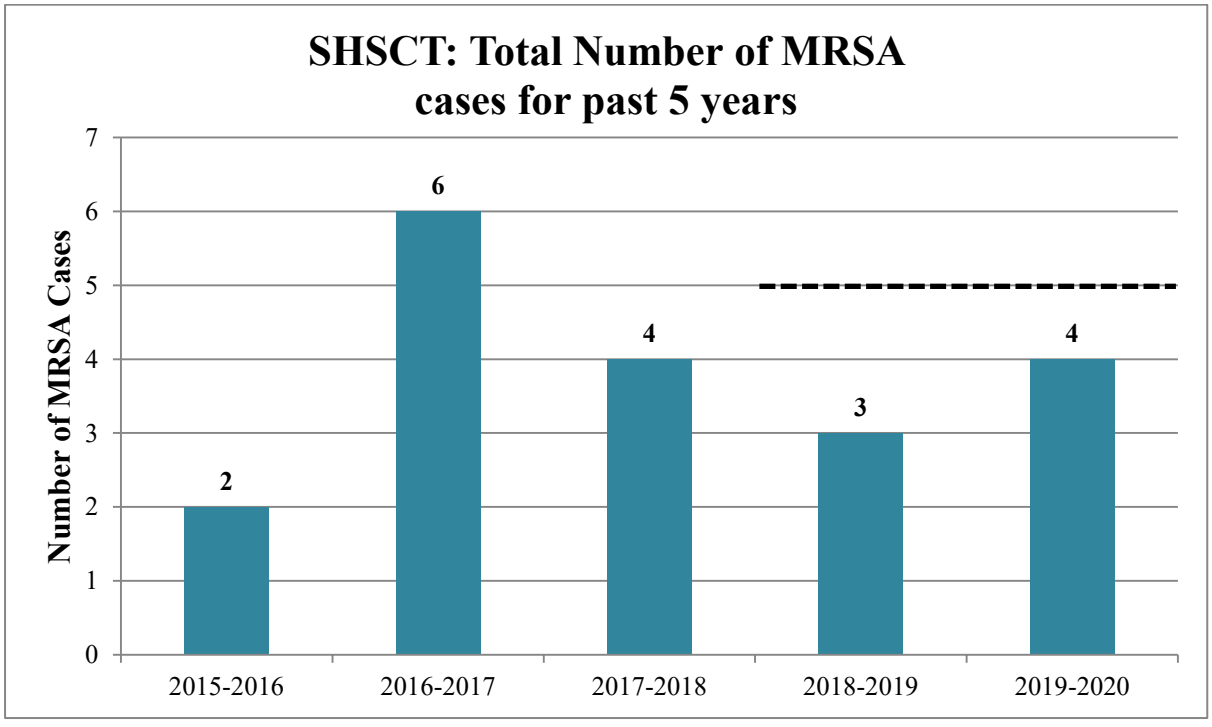
Methicillin-Resistant Staphylococcus Aureus or 'MRSA' is a type of bacteria that is resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

Staphylococcus aureus (also known as staph) is a common type of bacteria. It is often carried on the skin and inside on the nostrils and throat and can cause mild infections of the skin, such as boils and impetigo.

If the bacteria enter through a break in the skin, they can cause life-threatening infections, such as blood poisoning.

The Southern Trust's objective/goal for improvement (OGI) for MRSA bacteraemia in 2019/20 was 5 cases. There were 4 cases of MRSA bacteraemia in 2019/20.

The Infection Prevention and Control Team continue to promote peripheral vascular cannula insertion and care programme along with aseptic non-touch technique (ANTT) training with the aim that this will help reduce MRSA Bacteraemia rates. ANTT training is delivered by an external company and the focus within this training is to train the trainer. We have increased the frequency of training and have extended this to the non-augmented care areas.



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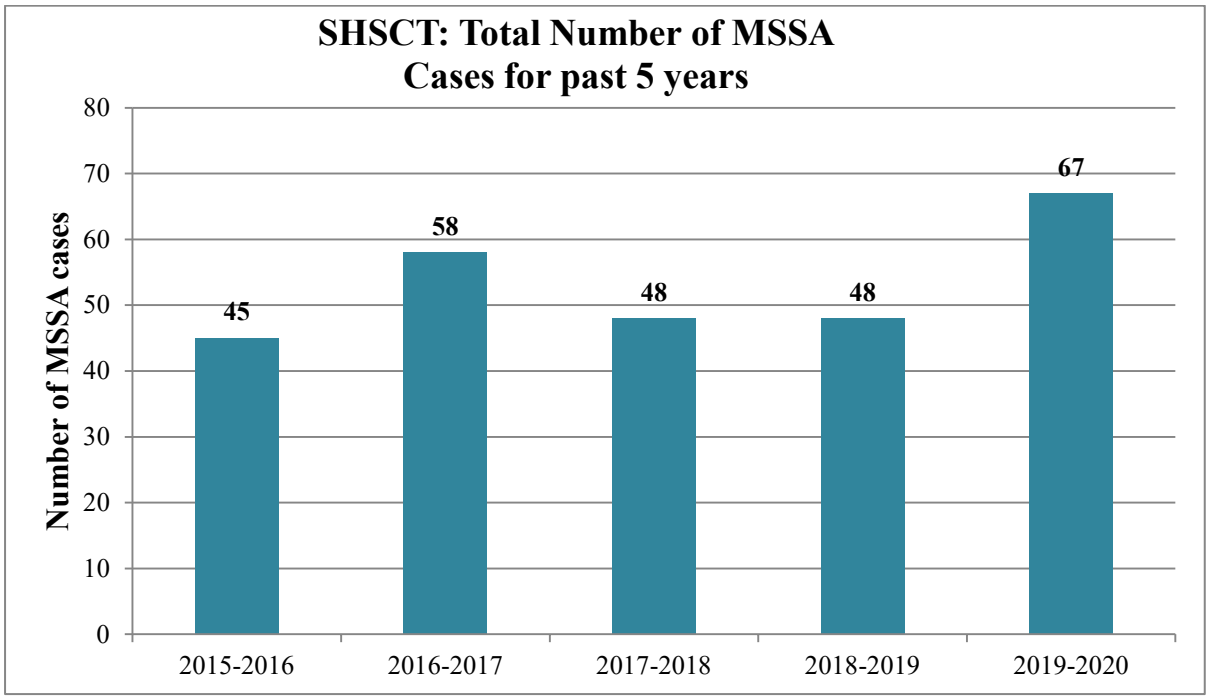
MSSA

The Southern Trust's objective/goal for improvement (OGI) for MSSA bacteraemia in 2019/20 was 34 cases. There were 67 cases of MSSA bacteraemia in 2019/20. We continue to work to reduce the overall number of cases in the SHSCT through peripheral vascular audits, addressing any non-compliance at time of audit. ANTT training is delivered by an external company and the focus within this training is to train the trainer. We have increased the frequency of training and have extended this to the non-augmented care areas. ANTT training materials are also available for staff on the SHSCT share-point site. The IPCNs are also working with the regional Infection Prevention Society to create an e-learning training module for ANTT for all staff which will be available later in 2020 on the HSC learning platform.



Reducing Healthcare Associated Infection: Clostridium Difficile Infection (C Diff)

Clostridium *difficile (C.difficile)* bacteria are found in the digestive system of about 1 in every 30 healthy adults. The bacteria often live harmlessly because the other bacteria normally found in the bowel keep it under control.

However, some antibiotics can interfere with the balance of bacteria in the bowel, which can cause the *C. difficile* bacteria to multiply and produce toxins that make the person ill.

Clostridium *difficile*, also known as C. *difficile* is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others. C. *difficile* infections are unpleasant and can

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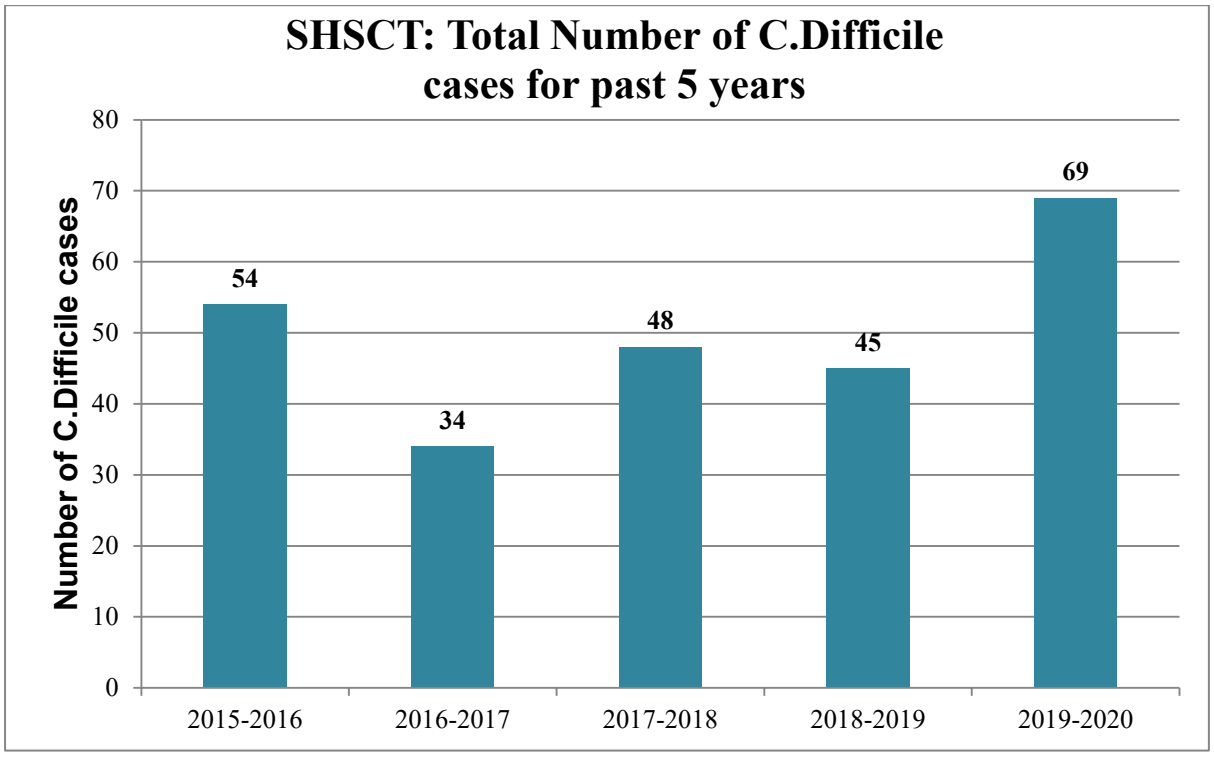
sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics.

Many C. *difficile* infections (CDI) occur in places where many people take antibiotics and are in close contact with each other, such as hospitals and care homes. However, strict infection control measures have helped to reduce this risk, and an increasing number of C. *difficile* infections now occur outside these settings.

- The Southern Trust's objective/goal for improvement (OGI) for Clostridium difficile in 2019/20 was 50 cases. There were 69 cases of CDI in 2019/20
- The Trust continues to conduct a strict surveillance programme on CDI cases. The Infection Control Team (IPCT) reviewed all 69 cases. Each case is followed up by the IPCT and a thorough review including a Post Infection Review (PIR) is carried out. Learning from these reviews is discussed by our microbiologist with clinicians and learning is also shared with staff through IPC training and through clinical forums. A database of shared learning is created and used for shared learning events across the SHSCT.



Hand Hygiene

Hand hygiene is the single, most important infection prevention and control practice (IPC) to help reduce Healthcare Associated Infections (HCAIs). The Trust promotes and monitors compliance with good hand hygiene for everyone in the healthcare environment.

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It is critical that everyone plays their part in hand hygiene - and this applies to - staff, patients, clients, carers and visitors. Whether it is soap and water used to wash hands, or an alcohol hand rub. Hand Hygiene is everyone's business.

An audit team within the Infection Prevention and Control Team regularly carry out independent audits in Hand hygiene in the clinical areas across the Southern Trust, monitoring compliance with 'missed opportunities' for hand hygiene. This is based on the WHO 5 Moments for hand hygiene.

Hand Hygiene Audits

The findings from these audits (shown in the graph below) are used to provide assurance of safe practice, help identify early areas where improvement is required and to help identify well performing areas across the Trust.

The results from these audits are fed back to staff and senior management at various platforms to evidence compliance and highlight non-compliance so interventions can be initiated.

We will continue with collaborative working with all staff across the Trust in independent hand hygiene audit. Audits from 2018/19 to 2019/20 denote a marked improvement in hand hygiene compliance.

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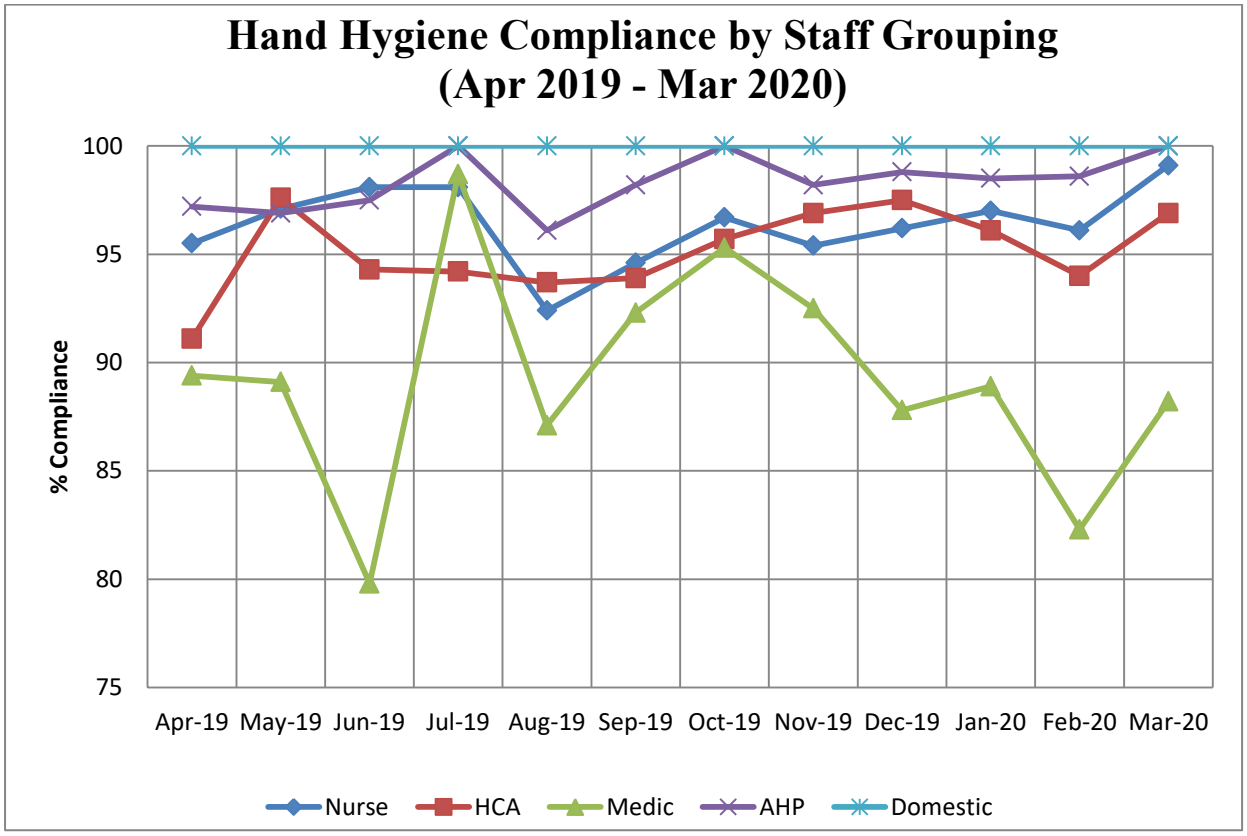
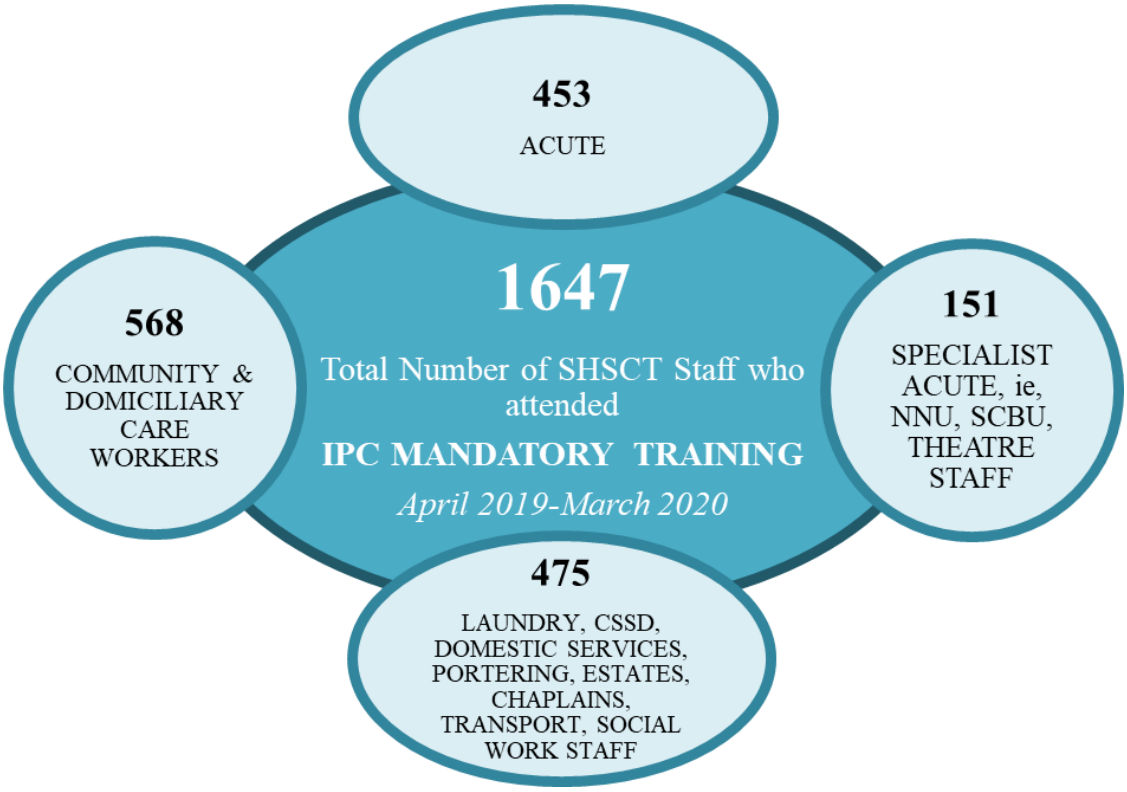


IPC Training

IPC mandatory training remained a huge focus in 2019/20 with large numbers of staff fully



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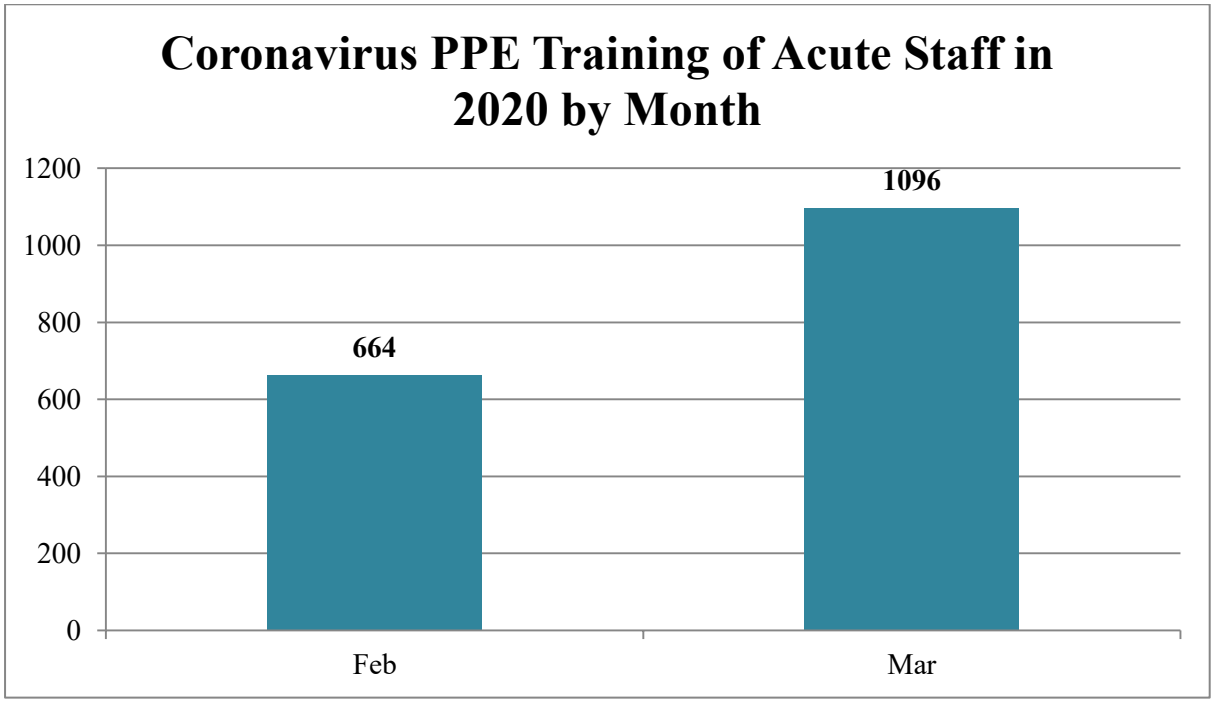
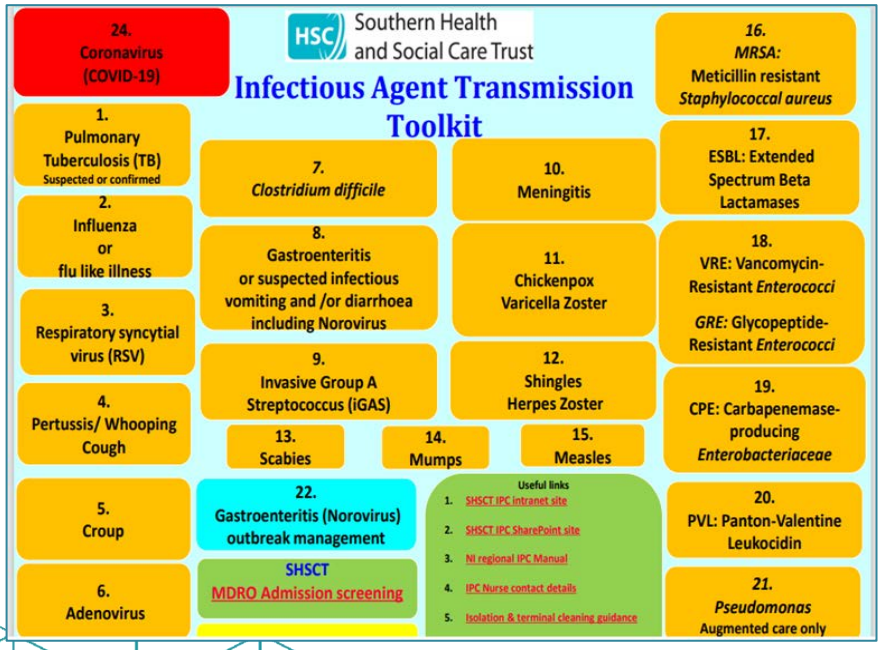
engaging as demonstrated in the graphic below:

The beginning of 2020 saw the immediate need for PPE training in preparation for the management of Coronavirus cases. IPCT responded by developing a training programme and rolling out training across SHSCT in relation to PPE and hand hygiene. This training was delivered face to face initially but training materials were developed to support staff and to allow more staff to access these materials such as videos, posters, podcasts which were uploaded to the IPC toolkit for easy access and also available on SharePoint.



Infection Control

During 2019/20 the Infectious Agent Transmission Toolkit was updated to include Coronavirus. All guidance associated with Coronavirus including training materials, videos and posters were uploaded so that staff could access at any time and download.



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3.2 Safer Surgery / WHO Checklist

Evidence from the World Health Organisation (WHO) shows that patient safety is improved during surgical operations if a list of key safety checks are made before anaesthetic is administered and before the operation begins and after it is completed. In the Southern Trust the WHO checklist is being used in all theatre areas.

The checklist is required to be signed for each patient procedure to confirm that the team is assured that all the necessary checks have been undertaken during the pre-operative, operative and post-operative phases.

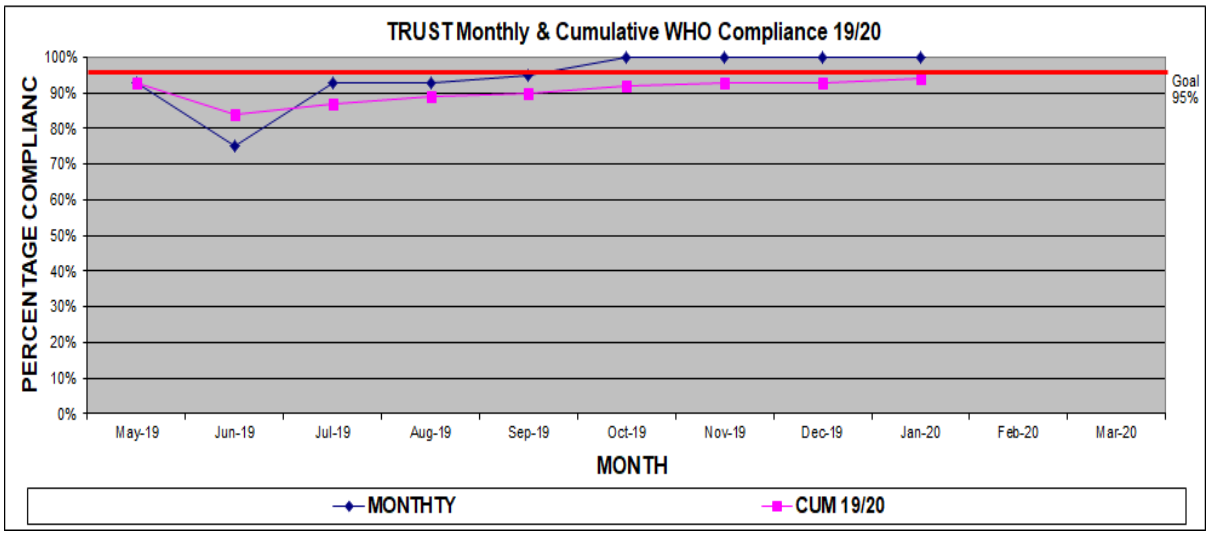
Within Southern Trust, The WHO Checklist was revised in 2013/14 and further revised in 2016 to encompass areas for improvement.

Safety measures that were added included:

- Has all single use equipment used for the previous patient been removed from the operating theatre?
- Is the date of the last menstrual period recorded?
- Recording of other relevant information e.g. MRSA
- Confirm known allergies and note on board
- Have all cannula and extension ports been flushed?

The WHO checklist is a strategic communication tool for patient safety. It is completed for all surgery and is standard practice for use in all areas in Craigavon Area and Daisy Hill Hospitals.

Changes and enhancements can be made if learning arises e.g. DATIX reporting.



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Facts and Figures

- 6 areas are included in the Audit i.e. Theatres 1-4, CAH & Theatres 5-8, CAH, Day Procedure Unit, CAH, Theatres, DHH, Day Procedure Unit DHH & Day Procedure Unit, STH, with each area auditing 10 charts per month.
- Goal of **95% or greater was achieved** from September 19 → January 20.
- **The monthly auditing undertaken from May 2019 shows the cumulative rate from** was **94%**.
- Audits for February 20 & March 20 were suspended due to the onset of the Covid-19 pandemic.

3.3 Maternity Collaborative

During 2020 the work of the Maternity Collaborative has focused on the regional implementation of physiological CTG interpretation and the introduction of the remote blood pressure monitoring as recommended by Royal College of Obstetricians and Gynaecologists (RCOG).

These two initiatives are currently being rolled out to all maternity units across the region and a leading example of collaboration in action. Regionally it was agreed to implement the RCOG pathway and to tailor it as required with a regional perspective. Funding was allocated to the five Trusts to enable the purchase of monitors and a pilot to trial FLO which unfortunately was unable to be successfully implemented in all Trusts.

The final pathway was circulated at the start of September with a 'go live' on the Craigavon site of October 2020 and to date has proved very successful with 15 women so far having this remote monitoring during the pregnancy. Each woman is provided with an information pack which contains, information leaflet, BP parameter chart, an agreement for loan of the equipment, an information sheet for recording BP readings and a BP self-monitoring plan.

Physiological CTG

Previous CTG interpretation relied on pattern recognition and didn't require knowledge or understanding of fetal physiology and the fetal response to hypoxic stress. This will have led clinicians to interpret fetal stress as distress whenever the threshold for a pathological CTG was met, leading to more intervention such as instrumental or operative delivery.

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With the introduction of physiological CTG it is hoped to address the interpretation as well as following the recommendation from 'Saving Babies Lives' version 2, that staff should be taught about 'fetal physiological responses to hypoxaemia, the pathophysiology of fetal brain injury, and the physiology underlying changes in fetal heart rate'.

The introduction of this change has meant that we have moved away from the 'traditional tick box' stickers. These stickers didn't encourage for each fetus to be treated as its own control. In an attempt to understand the baby that is in front of us as an individual, the introduction of physiology based evaluation tools aim to firstly recognise those babies who are not fit to labour. This a shift and now there is an initial evaluation to determine if a baby is fit for labour or not. Once an assessment has been undertaken there is documentation to support the decision and all further assessments are based on the intrapartum evaluation tool which requires knowledge and understanding of how the fetus defends itself and compensates during labour. The aim is to avoid unnecessary intervention while ensuring optimum perinatal outcomes.

As expected this change has necessitated significant training which has been undertaken with the multidisciplinary team and the Trust has implemented this method of assessment from 4th January 2021.

3.4 Paediatric Collaborative

Safety and Quality Conference

Approximately 167 delegates attended a very successful CYPS Safety & Quality Conference which took place on Friday 7th June 2019 in Dromantine Conference Centre. The staff from CYP Directorate came together to share the excellent ongoing work within the teams in relation to Safety and Quality.

Multidisciplinary Organising Committee was formed in January 2019. The Conference theme was to "Share the Learning" across Children and Young People's Directorate incorporating CYPS Staff and service user/carer participation. Dr A Khan, Associate Medical Director welcomed everyone to the Conference and outlined the CYP Safety & Quality Journey to date. Mr Shane Devlin, Chief Executive opened the conference with opening remarks and Mr Paul Morgan, Director of Children & Young People's Services presented awards and made the closing remarks.

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Structure of the Event

We had an early start with a mile walk led by Walking Co-ordinators from the Trust's Health and Wellbeing Team, offering an opportunity to view the beautiful grounds of Dromantine Conference Centre.

The conference consisted of 4 sessions:

1) Engaging Service Users
2) What Matters to You?
3) Break Out Sessions
4) Sharing the Learning

The first sessions consisted of five presentations from colleagues and service users from across a range of children's services. The topics included: Improving patient pathways, a parent sharing her experience of the inter disciplinary feeding clinic, updates from a co-produced service improvement initiative within Bluebell House Children's Residential Facility, Trauma informed Yoga for Looked After Children and Children with Autism and a presentation on Learning from a Serious Adverse Incident.

The input from parents to these presentations was very powerful and has led to direct improvements in safety and quality with the introduction of Sepsis 6 in paediatric wards and multidisciplinary team assessment of feeding difficulties.

The second session was facilitated by Dr Khan, Associate Medical Director this included WMTY background, progress to date within CYPS directorate such as changing for children, welcome pack, discharge leaflet, newsletter, epilepsy service, staff safety survey and clinical guideline update. Staff were encouraged to complete the 'What Matters To You' feedback exercise for 2019.

The third session consisted of five 1 hour breakout sessions and were well received by the delegates, they included:

- **Simulation**—Dr B Aljarad, Clinical Director & Dr J Lewis Consultant Paediatrician
- **Human Factors**—Dr A Khan, Associate Medical Director & Patricia Gillen
- **Coaching Workshop**—Marita Magennis & Daphne Johnston
- **10,000 Voices,** Linda Craig, Public Health Agency
- **Quality Improvement**—Paula Tally & Clifford Mitchell

The fourth and final session was designed to enable representatives from across CYPS Directorate to share their quality improvements. There were presentations from Physiotherapy services, the Neonatal Unit, Community Children's Nursing services, CAMHS, ASD, Community Dental, Dietetics and Allergy Services.

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There were numerous posters on show that demonstrated just some of the quality improvement work being completed within paediatrics. Out of 33 posters, delegates voted for their favourite. First prize was jointly awarded to Autism Services based in the Oaks on the St. Luke's Hospital site, Armagh and Valerie Magowan and Team in Occupational Therapy.

Collective Leadership Implementation Workshops

During 2019, the Children & Young People Directorate, SHSCT developed a Collective Leadership Implementation Programme. This programme was co-produced with HSC Leadership centre. Two Collective Leadership café style workshops were held in April & October 2019. These were facilitated by the HSC Leadership Centre and senior leaders within the Trust.

The aim of these workshops were to identify and agree how the CYPS Directorate can continue to enhance the care they provide to achieve the best outcomes for their children and young people. Further Focus groups were held over the summer 2019.

- Created a shared understanding of roles and responsibilities
- Embedded a Collective Leadership
- Developed a Quality and Safety Strategy – Theory into Practice, Action Plan

Paediatric Safety and Quality Strategy

Background:

In order to continue to build on previous initiatives and CYPS team's commitment to safety and quality it was agreed that a priority for 2019/2020 was the development of a 5 year Safety and Quality strategy. The strategy has been developed and refined through engagement with

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the paediatric teams, parents, children and young people's engagement. The collective leadership workshops and focus groups were the central mechanism for staff engagement.

The strategy is underpinned by HSC Strategy and is based on the IHI six domains of quality.

Purpose of the Strategy

The strategy sets out the 5 years strategic direction for Safety & Quality within the Paediatric Service, identifies key priorities and actions required to achieve the vision.

Our Vision: *"Supporting staff to deliver compassionate, safe and effective care to meet the healthcare needs of children and young people. This will be delivered in partnership with service users and their carers in a suitable and safe environment".*

The CYPS Paediatric Safety and Quality Strategy is built on three pillars: The Heart, The Head and The Hands of the service

Children, young people and carers: - **The Heart**

The delivery of safe and effective services is dependent on:

- Effective communication – with children, carers and staff
- Safe and effective care
- Positive care experience

Environment & systems: **The Head**

The delivery of safe and effective services is dependent on:

- Appropriate environment
- Technology enabled change
- Safe systems

Staff: Staff engagement & safe staffing – **The Hands**

The delivery of safe and effective services is dependent on having:

- An engaged and supported workforce
- Culture of learning
- Safe staffing

Staff Engagement sessions:

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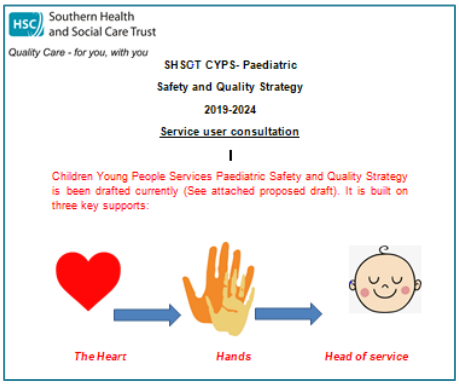

Southern Health and Social Care Trust
Quality Care - for you, with you
SHSCT CYPS- Paediatric
Safety and Quality Strategy
2019-2024
Service user consultation
Children Young People Services Paediatric Safety and Quality Strategy is been drafted currently (See attached proposed draft). It is built on three key supports:
The Heart
Hands
Head of service

Six focus groups were held across Trust sites in July and August 2019. The purpose of the focus groups was to share the draft strategy and gather views, suggestions and input. Following these sessions the Strategy was reviewed by the Core Group taking account of views and input provided.

The focus groups were well attended with 75 multidisciplinary staff attending including Paediatricians, Ward Managers, Nurses, Play Therapists, Pharmacist and AHPs. One important change made to the strategy following the staff engagement was that the strategy was changed from a 3 year to a five year strategy with a formal midpoint review.

Service User Engagement

Parents/ carers views were sought via the use of a questionnaire across both hospital and community sites.The views of children and young people were captured through questionnaire and the use of guided conversation with play therapists and nurses. The questionnaire was developed with support from the Trust PPI Team.

Some examples of the feedback given by children and young people:

- Just explain to me; what is going on and asking, are you ok?
- Good care experience – felling less nervous, staff being kind, caring, respecting
- Being asked my opinion on my care management, treatment being explained to me
- More information on my condition.

Implementation

The implementation phase of the safety and quality strategy has been interrupted by the Covid 19 pandemic in 2020. The plan is to begin reengagement with the paediatric teams in the spring of 2021 to agree our short, medium and long term priorities to take our safety and quality strategy forward.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

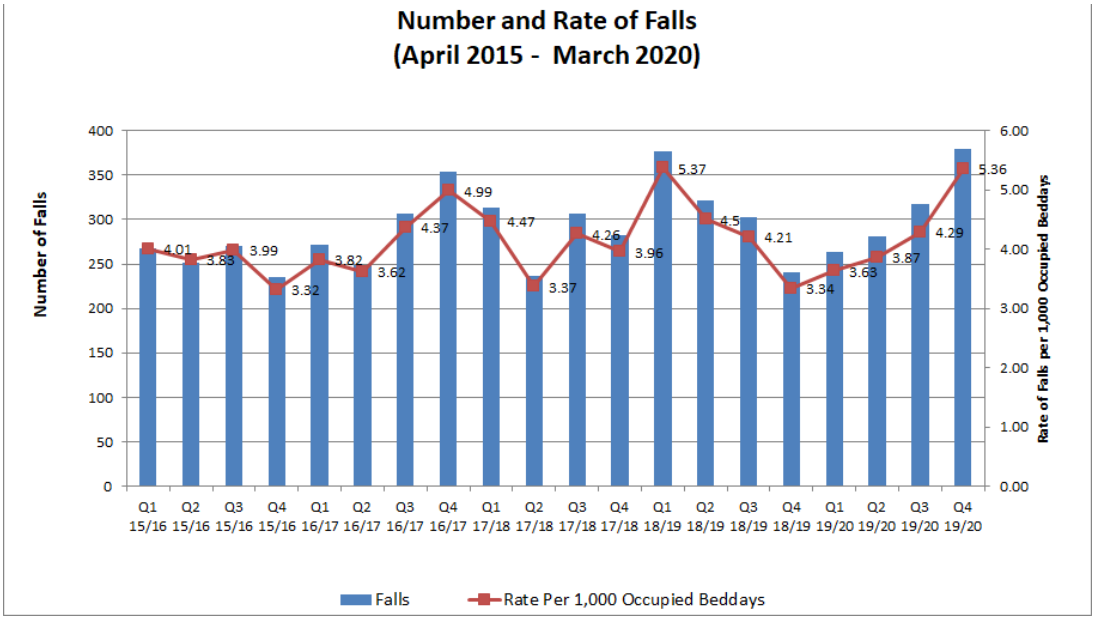
3.5 Falls

Quality 2020 Patient Falls:

Patient falls are the most common safety incident in hospitals. They can set back the recovery of a patient and can cause complications.

Falls are not always preventable. The Trust aims to reduce the level and severity of falls in our hospitals as a measure of quality and ensure the risk of falls is being managed well. This is achieved by reviewing the nursing documentation and observing practice.

When a fall occurs at ward level, an Incident Report form is submitted and reviewed by the Ward Sister and the Head of Service. If a patient sustains an injury (such as fracture or head injury) due to a fall, a review of the case is carried out. The learning from this review is shared with staff in an attempt to reduce the level and severity of falls which may occur in the future.



What does the data tell us?

Facts and Figures

- The graph shows that the Trust recorded **1240 Patent Falls** in 19/20, with a rate of 4**.28 per 1,000 Occupied Bed Days** compared to 1240 and 4.35 in 18/19
- **23 of the 1240** total Patient Falls were coded moderate or above falls, which equates to **1.9% of the total** reported
- A review of these 23 cases is undertaken using the Regional Shared Learning Template.

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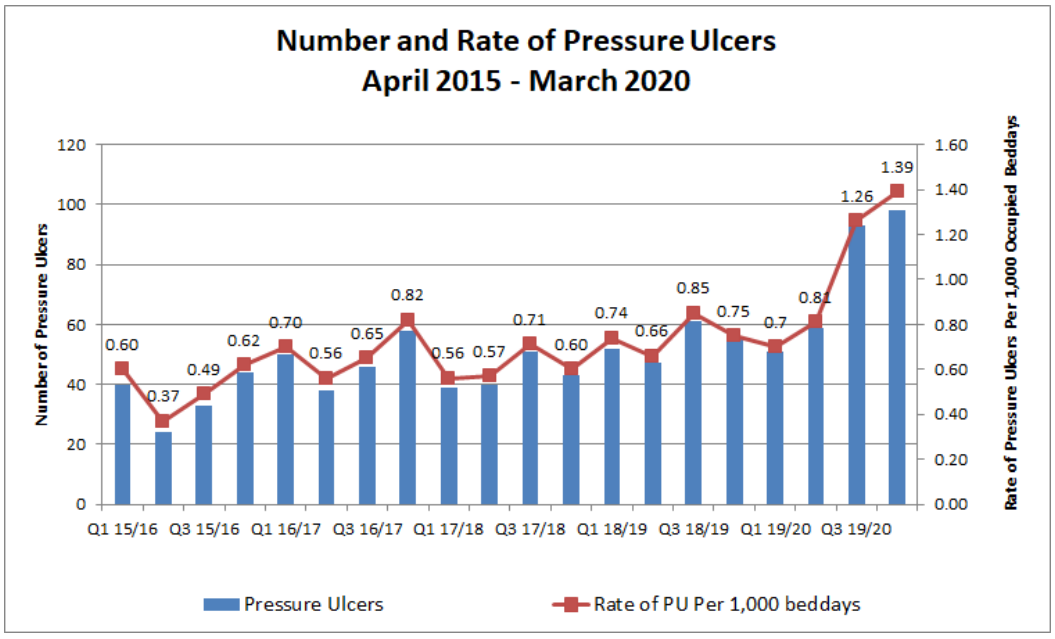
3.6 Pressure Sores

Quality 2020 Hospital Acquired Pressure Ulcers:

Preventing Pressure Ulcers are an essential aspect of patient safety. A Pressure Ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with sheer. The impact on patients can be considerable, due to increased pain, length of hospital stay and decreased quality of life; however it is acknowledged that a significant number of Pressure Ulcers are avoidable.

Anyone can develop a Pressure Ulcer but some people are more likely to develop them than others e.g. critically ill patients, patients who are immobile, the frail, wheelchair users and end of life patients. Pressure Ulcers are recorded as an incident by staff involved in the patient's care on the clinical information system (Datix) so that they can be monitored and analysed.



What does the data tell us?

Facts and Figures

- The graph shows that the Trust recorded 301 "Hospital Acquired" Pressure Ulcers in 19/20, with a rate of 1.04 per 1,000 Occupied Bed Days compared to 215 and 0.75 in 18/19. This represents a 40% increase from 18/19.
- 76 (25%) of the 301 total of "Hospital Acquired" Pressure Ulcers were graded as a stage 3/4/Deep Tissue Injury (DTI) (deep wounds). An increase of 7% from 18/19.
- A review of 64 of these 76 cases has been carried out, with 35 cases (12%) deemed to have been "avoidable". This represents an increase of 7% on 18/19.

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The rise in the number & rate of "Hospital Acquired" Pressure Ulcers was mainly due to a spike in cases in Q3 & Q4 19/20 above & beyond the annual rise in cases (18%) in these quarters.

A number of other factors also contributed to the increase in cases:

- Ward Pressures – wards were at full capacity with a high volume of admission and transfer rates/ ED attendance rates.
- High volume of Agency Staff throughout acute trust site and a high level of staff turnover.
- There is also an ongoing essential requirement for education for all agency and new staff at ward level.
- Skin was not always inspected on admission/transfer.
- Training issues associated with the introduction of new pressure relieving mattresses.
- Gap noted in process whereby not all DTI's are followed up in the Community (potential for cases to be removed from Trust's data if Pressure Damage had resolved within 2-3 weeks).

Achievements in 2019/20

An Action Plan was drawn up in January 2020. Some of the key actions were as follows:

- Reiterate to staff the importance of inspecting patient's skin on admission/transfer.
- A more proactive approach to be adopted, with additional Tissue Viability Nurse (TVN) presence on Wards, including ad-hoc Documentation Audits & timely completion of Post Incident Reviews to identify learning opportunities & feedback same to staff. (The increased presence of TVNs on the wards led to further identification & enhanced grading of cases).
- Face-to-face Ward specific training to be increased & encourage staff to complete Regional Pressure Ulcer E-Learning Module & recommending this to be mandatory every 2 years. Furthermore explore the possibility of providing a similar course for Health Care Assistances. (Increased reporting by Wards post educational and ward based learning with acute TVNS).
- Pressure Ulcer prevention was incorporated into Handover & Safety brief.
- An Early Alert System, providing "Real Time" data on Pressure Ulcers, developed using Datix to notify TVN & Patient Safety Manager when cases reported. This will allow the Tissue Viability Service especially to be more proactive with regard to the Management of patients with Pressure Damage. Monthly meetings also established to review data, analyse trends etc.
- Ward Action Plans to be introduced following Nursing Quality Indicator (NQI) Audits, to identify learning opportunities.

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What's next?

- Review/update Action Plan.
- New Grading /Staging posters and other prevention posters to be distributed to each ward trust wide for displayed on information boards.
- A Pressure Ulcer Sub Group to review documentation associated with the management of skin and prevention of Pressure Ulcers.
- A Post Incident Review will be undertaken on all Stage 3 & above Ward Acquired Pressure Ulcers in 2020/21 to determine if they were avoidable/unavoidable. These cases will be reviewed by the Pressure Ulcer Quality Improvement Team, with lessons learnt being fed back to all Wards across the Trust at Ward Manager's meetings by our Lead Nurses.
- Staff encouraged to enhance their knowledge of Prevention and Management of patients with Pressure Ulcers via the Regional E-Learning Module, CEC Pressure Ulcer Training Programme & Trust face-to-face training (post pandemic).
- Acute TVNs will liaise with community TVN more frequently regarding DTIs. Community TVN will follow-up hospital discharges to verify and validate data.
- Audit of the SKIN Bundle by all Integrated Care/District Nursing Teams, with the aim of reducing the number of avoidable "Community Acquired" Pressure Ulcers.
- The Southern Trust will continue to play an active role in World Wide Pressure Injury Prevention Day (19st November 2020), to increase awareness for pressure injury prevention and to educate the public on this subject.

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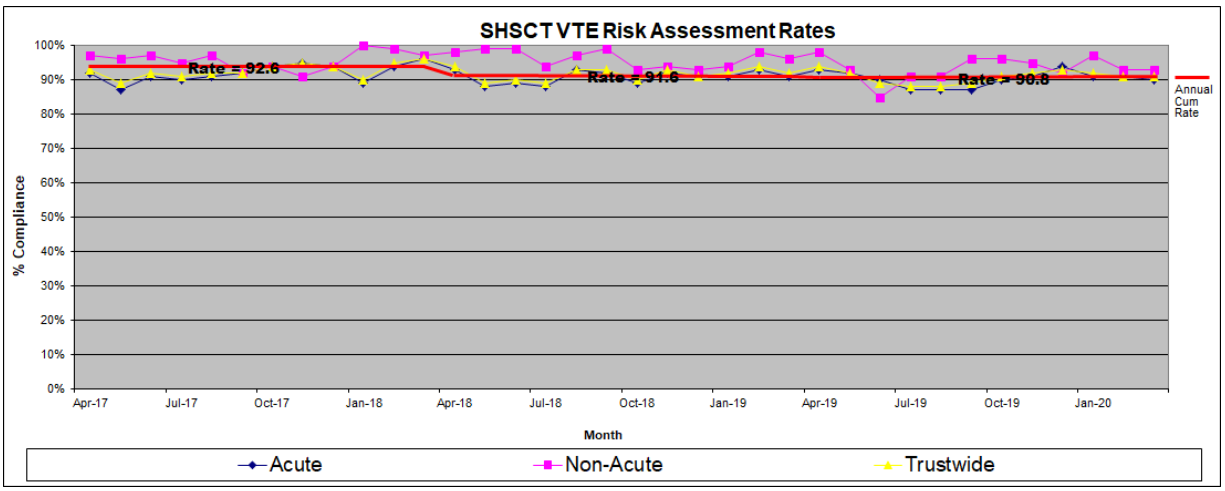
3.7 Venous Thromboembolism (VTE)

What is a Deep Vein Thrombosis and Pulmonary Embolism?

Deep venous thrombosis (a clot in a patient's leg) and pulmonary embolism (which may be referred to as a clot in the lung) are recognised complications of medical care and treatment.

These complications, known as venous thromboembolism (VTE) can cause harm or death as a consequence.

VTE is potentially preventable if patients are assessed and offered suitable preventable treatment. Therefore the Trust will seek to improve the numbers of patients who are risk assessed as an indicator of quality / safety processes.



Facts and Figures

- Almost 5,600 charts were audited during 2019/20 across the Trust. Compliance was **90.8%.**
- This represents a decreased compliance rate from the **91.6% position in 2018/19.**

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3.8 Medicines Reconciliation

It is very important that we know what medicines a patient is taking and if these are appropriate for the patient. Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated.

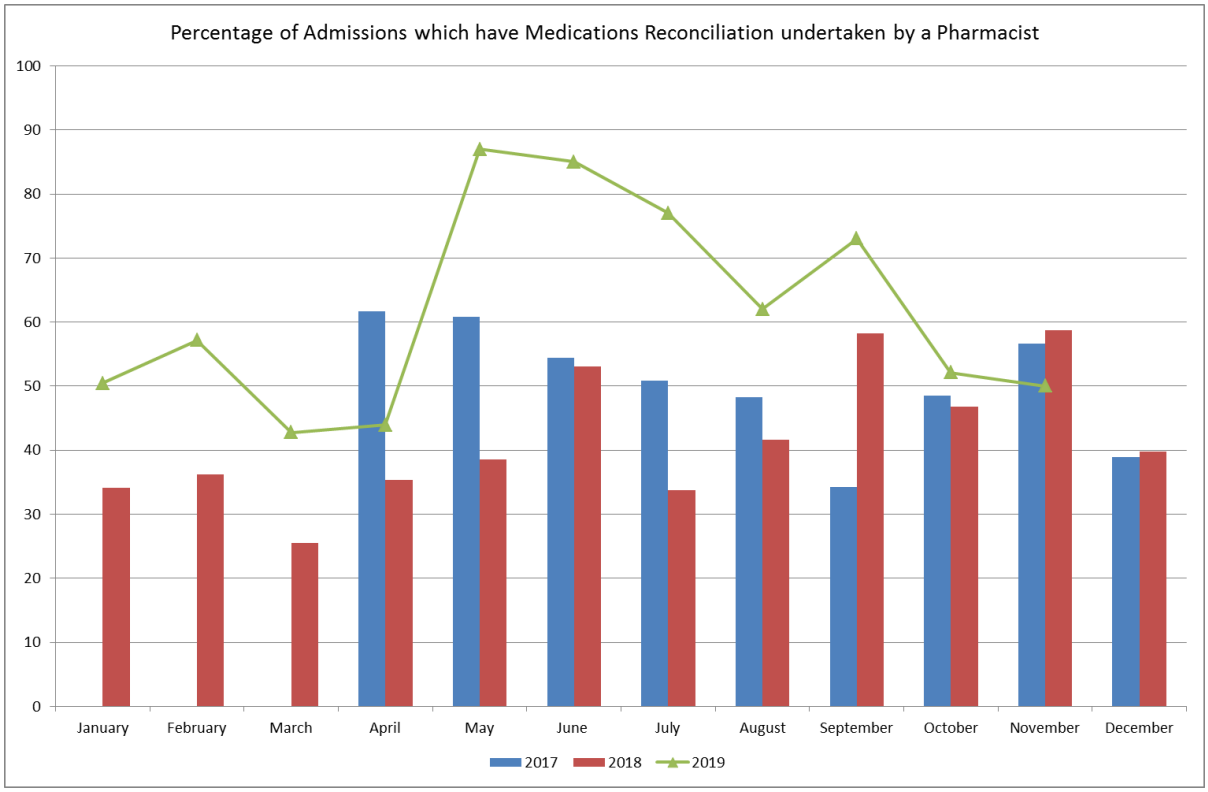
In an acute setting, medicines reconciliation should be carried out:

- Within 24 hours of admission, or sooner if clinically necessary
- When the person moves from one care setting to another
- On discharge.

Medicines reconciliation by a pharmacist is conducted wherever possible for patients admitted and discharged from hospital, however this is not possible for all patients due to the number of patients and pharmacists available, which is a recognised service gap.

Facts & Figures 2019/20

The following graphs show the data recorded on all wards in the Southern Trust that have a clinical pharmacy service. Data was collected until November 2019.



- From April-November 2019, **65% of patients** had their medicines reconciled by a pharmacist on admission. This is a **19% increase** on the positon for 2018/19.

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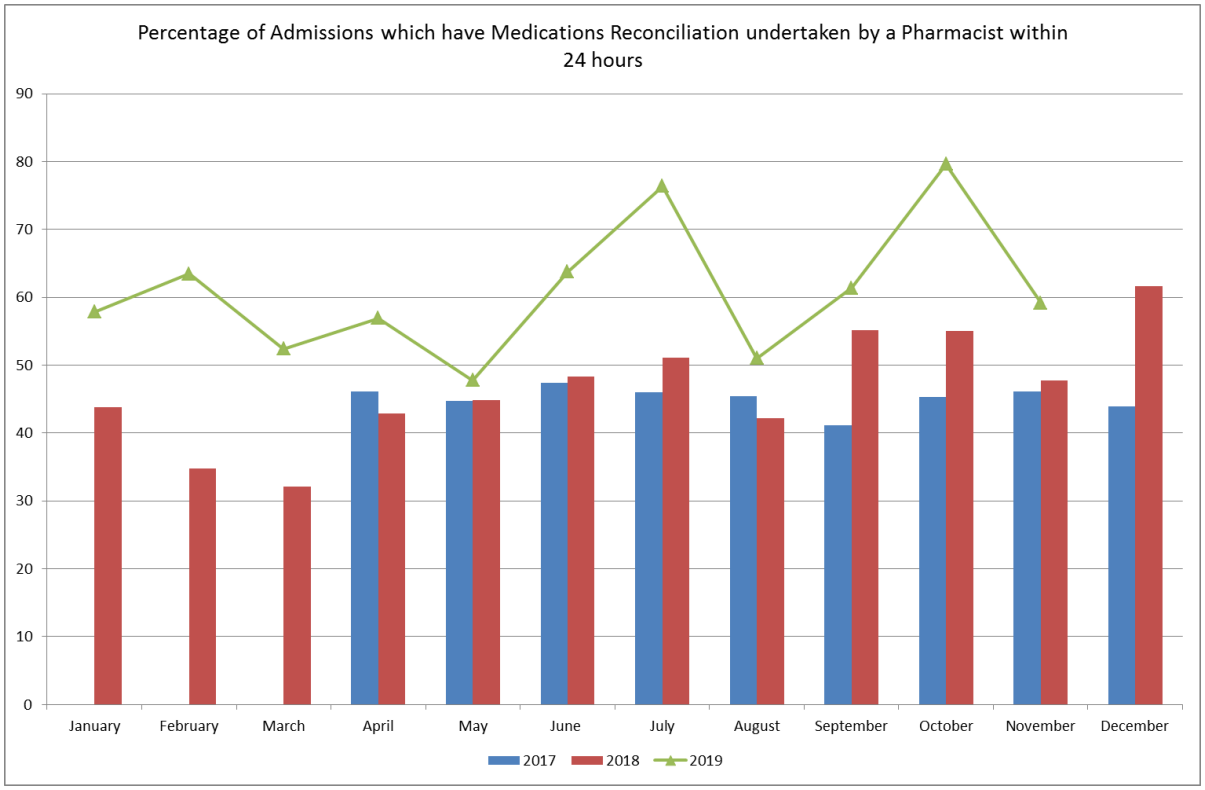
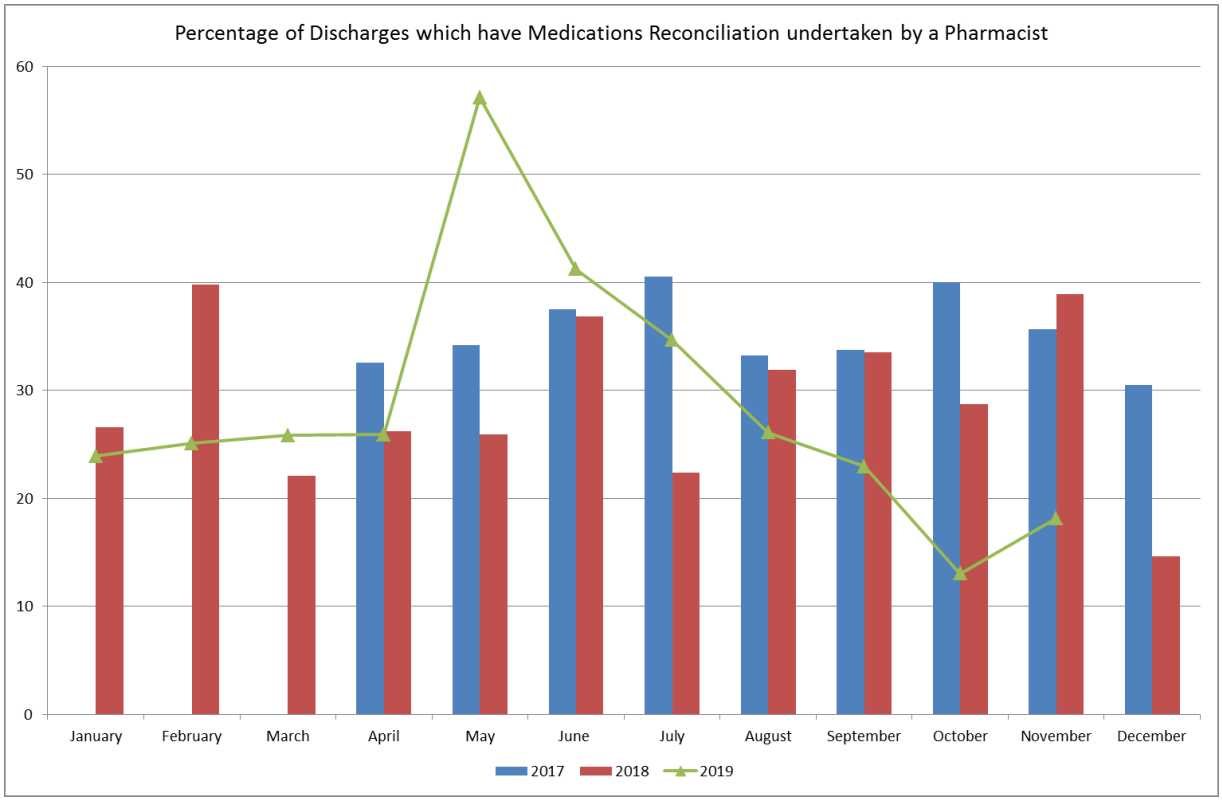


- From April-November 2019, **61% of patients** who had their medicines reconciled, had it completed within 24hrs of admission. This is a **9% increase** on the positon for 2018/19.



- From April-November 2019, **28% of discharges** had medicines reconciled by a pharmacist, which **remains the same** as for 2018/19.

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Ongoing pharmacy investment will continue to support improved safety in medicines management, as well as improving management of patient flow in our hospitals.

Pharmacist Independent Prescribing

Clinical pharmacists identify numerous discrepancies in prescribed medications during the many stages of a patient journey from admission (medication history and reconciliation), medication review during their stay and particularly on discharge via a process known as a 'clinical check'. "Discrepancies" include; omissions, errors of dose, drug-drug interactions and adverse drug reactions, which could impact on patient safety and potentially delay discharge.

Pharmacist Independent Prescribers (PIPs) were introduced in the Southern Trust in 2018 to complement the role of the junior doctors and improve patient experience through expedition of discharge, while ensuring safety and quality of discharge prescribing.

We continue to work together with the multi-professional team to shape a service to improve the quality of the patient discharge information and ultimately patient care, introducing a process which best meets the needs of the service and ultimately improves the patient experience particularly in relation to medication safety.

Omitted and Delayed Medicines

Medicines can be inadvertently omitted or delayed in hospital. This can be on admission, during the admission or on discharge and can occur during prescribing, administration or dispensing of medicines.

On admission to hospital, it can sometimes be difficult to determine what medicines a patient usually takes, which can lead to medicines not being prescribed. Access to information about GP prescribed medicines and previous discharge prescriptions through the Northern Ireland Electronic Care Record (NIECR) has greatly improved the information available to enable more accurate medicines reconciliation to occur. The work of pharmacists in Medicines Reconciliation on admission and at discharge identifies omitted and delayed medicines and is described earlier in this section.

Most medicines are administered as prescribed in hospital, with some doses withheld for valid clinical reasons. However on occasion, some doses are inadvertently omitted. This is particularly important for certain critical medicines where omission or delay is more likely to result in harm. Nursing quality indicators are used to monitor this on an ongoing basis.

An annual audit of omitted and delayed doses was conducted in September/October 2019. As medicines may be omitted for a variety of reasons the audit also determines whether or not the omission or delay was appropriate.

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For some critical medicines, an omitted or delayed dose can lead to more serious harm. Particular attention should therefore be given to reducing inappropriately omitted and delayed doses of critical medicines.

Facts and Figures

- The percentage of **omitted and delayed doses was 9.9%** in September/October 2019, **a small increase from 9.6%** in May/June 2018.
- The percentage of **omitted and delayed doses of critical medicines was 0.6%** in September/ October 2019, a **decrease from 0.7%** in May/June 2018. However these overall figures include a proportion of doses that will have been omitted or delayed entirely appropriately.
- The percentage **of inappropriately omitted and delayed doses was 3.8%** in September/October 2019. This represents an **increase from 2.5%** in May/June 2018.
- The percentage **of inappropriately omitted and delayed doses of critical medicines was 0.3%** in September/October 2019, a **decrease from 0.4%** in May/June 2018. The critical medicines most commonly involved were

Therefore while this audit demonstrates an increase in the percentage of inappropriately omitted and delayed doses of all medicines, there is also a small decrease in the percentage of inappropriately omitted and delayed doses of critical medicines where omitted and delayed doses risk more serious harm. Work continues among ward teams to minimise inappropriately omitted and delayed doses of medicines for patients.

The majority of inappropriately omitted doses were where doses had been overlooked and not administered. Handover sheets for nursing staff highlight critical medicines as an additional prompt for staff. For a number of opioid medicines, doses were inappropriately omitted due to stock not being available. Arrangements are in place to ensure a supply of medicines can be obtained if not stocked on the ward.

A pilot of the NHS Medicines Safety Thermometer was undertaken within Acute and OPPC directorate. This is a multidisciplinary tool to monitor medicines safety and includes omitted and delayed doses and the trust awaits further regional collaboration on the wider application of this tool.

On discharge, medicines are prescribed on an electronic discharge prescription which is transmitted electronically to the GP and available on NIECR. Each medicine must be entered manually and sometimes medicines can be overlooked and omitted. Before dispensing discharge prescriptions, pharmacists compare the in-patient medicines with the discharge prescription to confirm there have been no unintentional omissions. Work continues on a new

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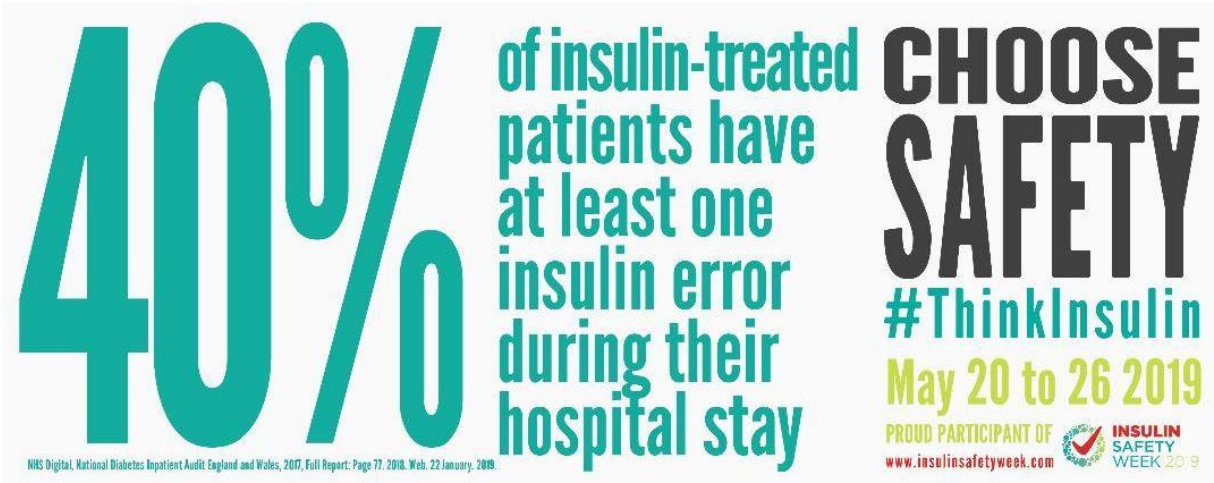
regional electronic discharge prescription which imports the GP prescribed medicines directly reducing the need for this information to be entered manually.

Insulin

The incidence of diabetes in the general population continues to rise. One in every five inpatient beds in Northern Ireland is occupied by a patient with diabetes. For patients with Type 1 Diabetes, insulin is essential and increasing numbers of patients with Type 2 Diabetes are also now treated with insulin. Insulin is also a critical medicine where particular care is required to ensure it is used safely.

The **Safe Use of Insulin Group** continues to meet and develop guidelines and protocols to support the safe use of insulin in the Trust. Specialist diabetes staff also contributed to the development of regional protocols through the **Regional Diabetes In-patient Network** and piloted an alternative insulin prescription, administration and monitoring chart. The diabetes multidisciplinary team conducted twice weekly ward rounds to review patients identified through blood glucose monitoring results as requiring specialist review, providing the opportunity to improve diabetes care, insulin safety and contribute to a letter overall patient experience. This includes opportunities to educate patients and staff.



The Insulin Quality Improvement Program with clinical sisters continued, providing education for nursing and midwifery staff and monitoring actions to reduce incidents involving omitted and delayed doses, incorrect insulin and incorrect doses. Education sessions in diabetes and insulin were also provided to foundation year one doctors.

In May 2019, the trust participated in national 'Insulin Safety Week' and in September 2019, the trust participated in national 'Hypoglycaemia Week'. These national initiatives are aimed at raising awareness of insulin safety and hypoglycaemia among staff and a range of activities and events were held. During 'Insulin Safety Week' daily global emails were sent which included signposting to online educational material, a quiz, shared learning from incidents and a key safety message regarding timing of mixed insulins. During 'Hypoglycaemia Week, global emails included signposting to trust hypoglycaemia guidelines, highlighting Hypo boxes and a quiz. Both events were supported at ward level by the Diabetes Team with

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conversations with staff to promote the material and raise awareness together with social media posts.

Anticoagulation (INR)

Anticoagulation is an important means of reducing stroke or harmful clots. For many years warfarin has been the mainstay of treatment. In recent years, other drugs have been developed that are often used first line; these are referred to as "Direct Oral Anticoagulants" or DOACs.

In the hospital setting, DOACs are used first line for patients with Atrial Fibrillation (AF), Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE). However for some patients, DOAC therapy is not suitable and they must receive treatment with warfarin or LMWH therapy.

Warfarin is unlike other medicines as there isn't a fixed dose. The dose that a patient takes will be individual to them, and may vary based on the results of blood tests that measure how long it takes for that patient's blood to clot.

Many patients on warfarin are looked after by their own doctor. However for patients who are newly started on warfarin or where their dose is very variable, they attend an anticoagulant clinic at the hospital. These clinics operate in Craigavon, Daisy Hill and South Tyrone Hospitals and there have been many developments in these clinics over the years.

For patients who have a poor time in therapeutic range resulting in poor INR control, their notes are reviewed and if suitable they are switched onto DOAC therapy. There are currently four DOACs available. These agents do not require frequent monitoring.

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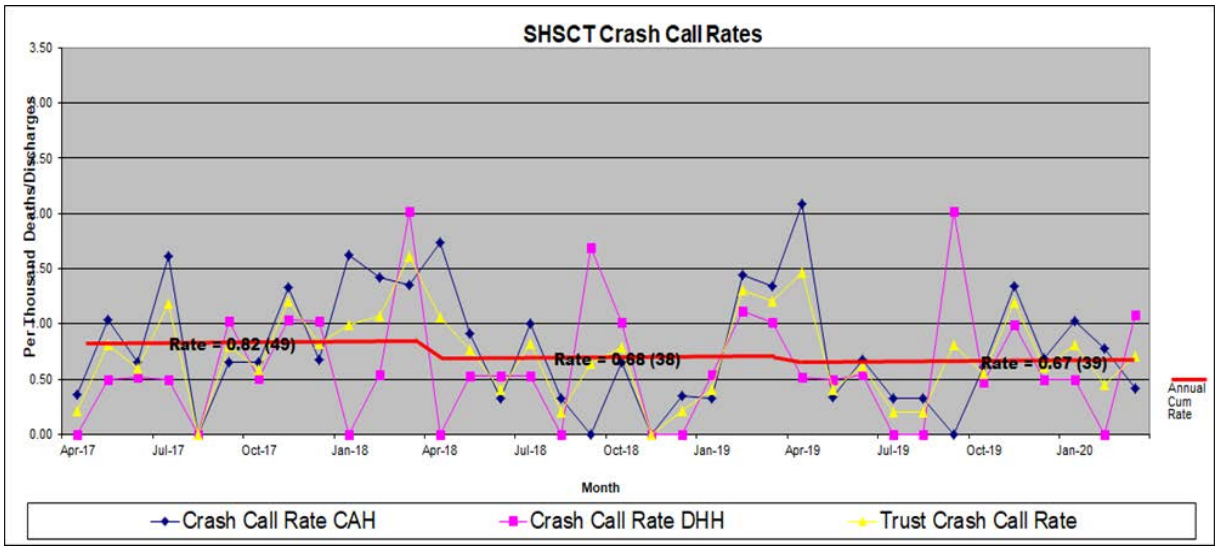
3.9 Cardiac Arrest Rates

Crash Calls

0.67 (39 Crash Calls)

Trust cumulative Crash Call rate for 19/20 was **0.67 (39 Crash Calls)** per 1,000 deaths/discharges, down from **0.68 (38 Crash Calls)** in 18/19.



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Quality
Safe, effective & person centred

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Theme 4

Raising the Standards

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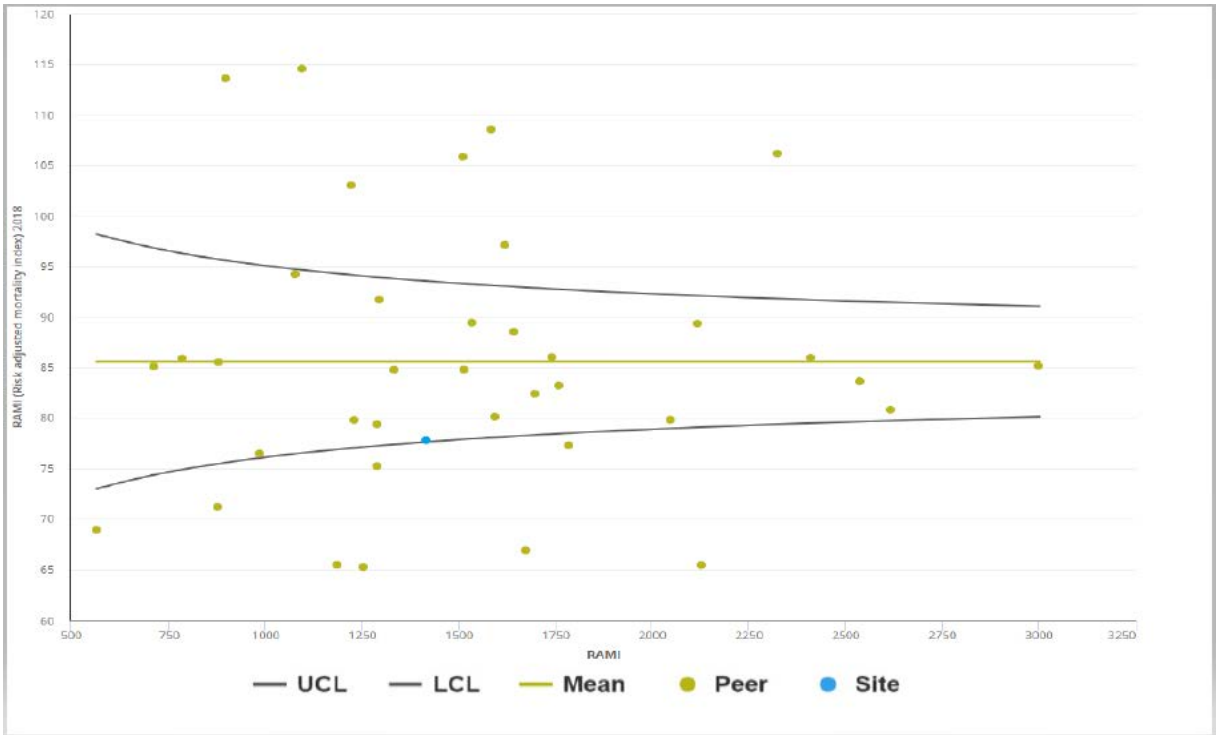
4.1 Standardised Mortality Ratio

Risk-Adjusted Mortality Index (RAMI) is an indicator that uses the characteristics of the patients treated in hospital to calculate a number of expected deaths and then compares this to the number of actual (observed) deaths. The expected number of deaths is calculated using NHS Digital data as of December 2018. A RAMI of 100 means mortality was exactly in line with expectations; over 100 means more deaths occurred than would be expected, and below 100 means there were fewer than expected deaths.

The methodology behind the RAMI is limited to just six factors, each of which is known to have a significant and demonstrable impact on risk of death. They are:

- Age - six groups;
- Admission type - elective or non-elective;
- Primary clinical classification - 260 CCS groups;
- Sex - defaults to female if not known;
- Length of stay - specific groups only; and
- Most significant secondary diagnosis



RAMI funnel plot, UK peer, January 2019 – December 2019

Funnel plot analysis shows the Trust position in relation to individual UK peer sites. Health and Social Care Board guidelines indicate that a position above the upper confidence limit in a funnel plot would require further investigation; this is not the case for the **Trust as it is sitting within confidence limits.**

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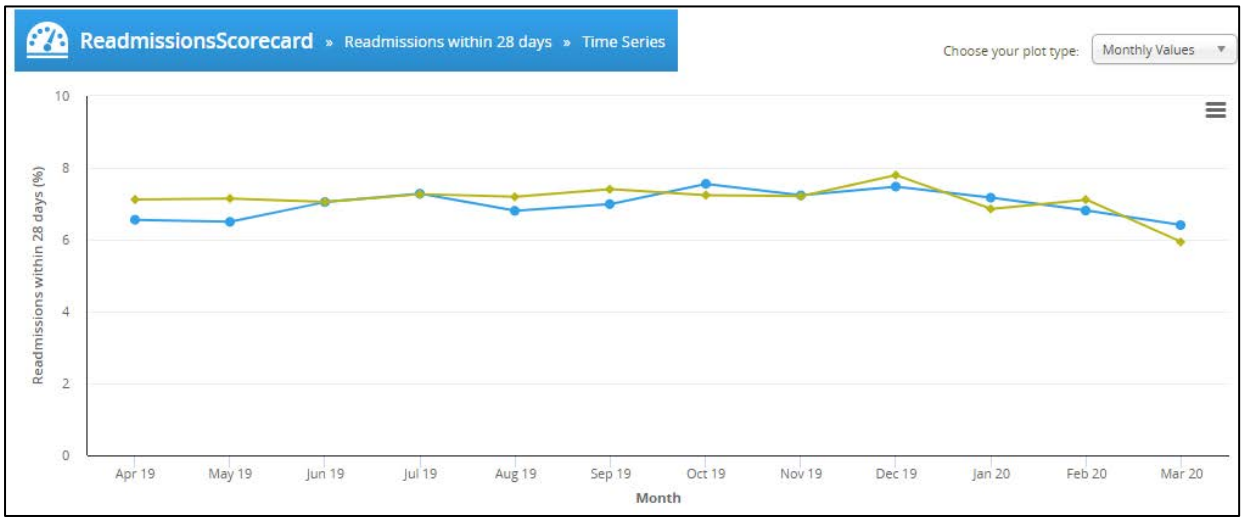
4.2 Emergency Re-admission Rate

Rate of Emergency Re-admission within 28 days of Discharge

The rate of re-admission into hospital within 30 days for patients that have been discharged from hospital is a measure of quality of care.

Re-admission can occur for a number of reasons. We use this information to allow us to review the appropriateness of discharge and the effectiveness of the support we provide after discharge.



Hospital readmissions within 28 days for 2019/20

The graph above demonstrates the Southern Trust's readmission rate (in blue) vs the CHKS peer comparator. CHKS is a leading provider of healthcare intelligence which includes hospital benchmarking that is supported by experienced NHS consultants. It converts data into actionable information that drives decision making.

Facts and Figures

During 2019/20:

- The Trust's **average readmission rate within 28 days was 7%** versus the peer comparator score of 7.13%. This is a slight increase on position from the previous year (2018/19) which was 6.9%.

Hospital Readmissions after 7 days

While it is very important to improve performance against the 4 hour Emergency Department targets, the Trust also seeks to reduce the number of patients who need to re-attend the Emergency Department within 7 days of their first visit, unless this is a planned part of their

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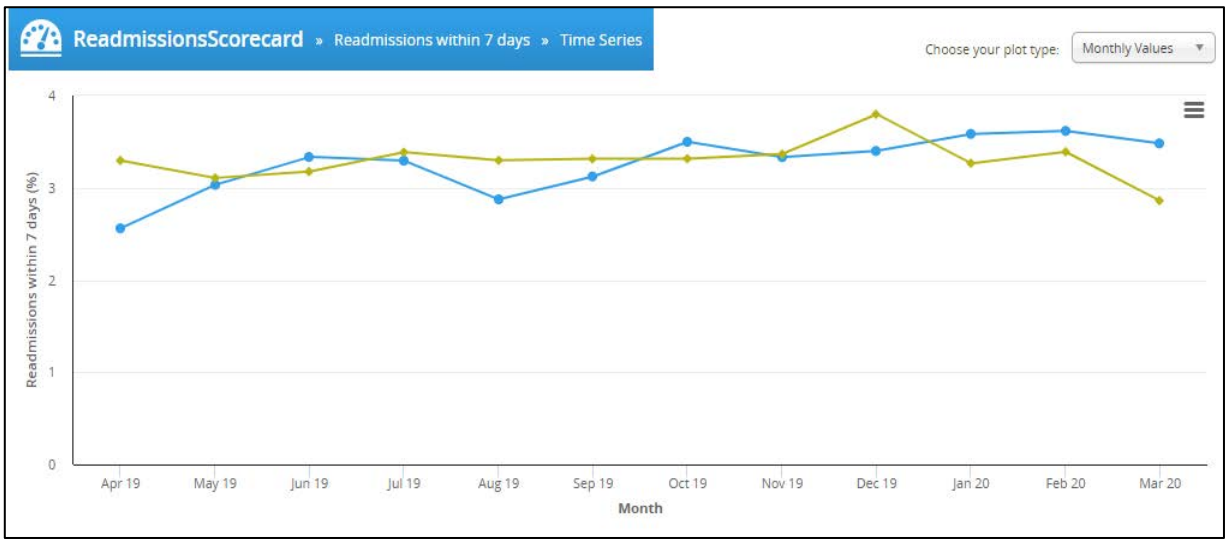
care. We believe this is one way of helping us to assess the quality of care given at the first attendance in the Emergency Department.

Facts and Figures

During 2019/20:

- the Southern Trust maintained its position with **unplanned re-attendance at Emergency Departments** within 7 days being **below the 5% target**.
- Our position was 3**.26% of total new and unplanned attendances** (see graph below), up from 3.07% during 2018/19.



Hospital readmissions within 7 days for 2019/20

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4.3 Emergency Department (ED)

The Southern Trust has two Emergency Departments (ED), Daisy Hill Hospital and Craigavon Area Hospital. The length of time people wait in emergency departments affects patients and families experience of services and may have an impact on the timeliness of care and on clinical outcomes. The Trust aims to ensure that people are seen as soon as possible and by the most appropriate professional to meet their needs.

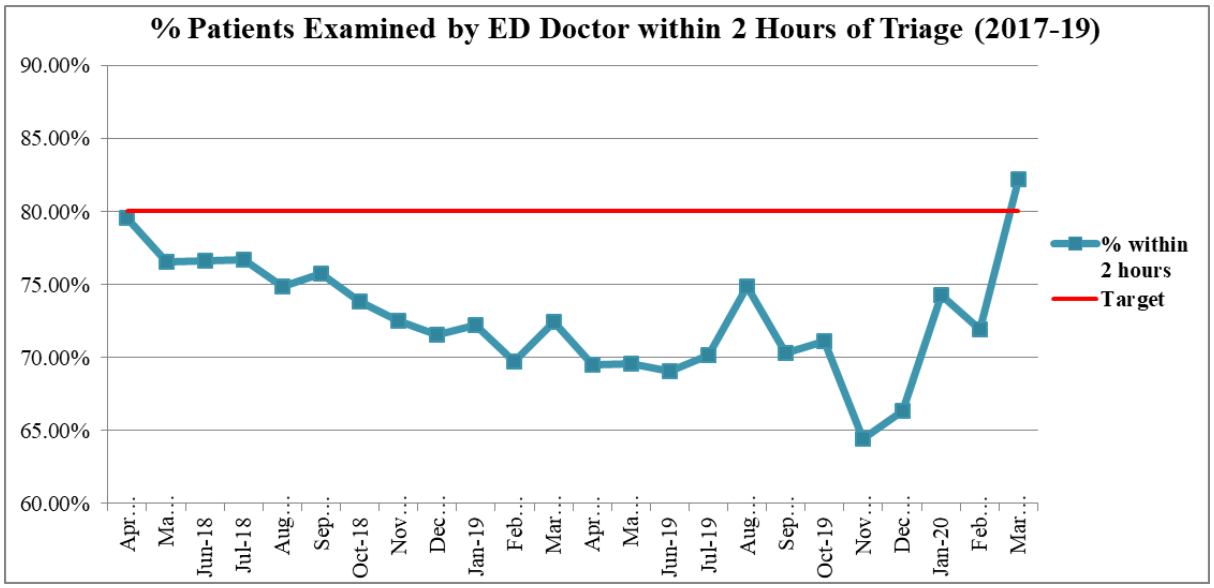
Facts and Figures

During 2019/20 there were:

- **169,709 people** who attended Southern Trust Emergency Departments and Minor Injuries Units, a **4.5% decrease** from the figure of 177,830 in 2018/19

Time to be seen by the Emergency Doctor

The Trust measures the time from Triage (or initial assessment) to the time the patient is being examined by a Doctor in the Emergency Department. Performance is measured against the percentage of patients that are examined by a Doctor within 2 hours of Triage (or initial assessment), the results are outlined below:



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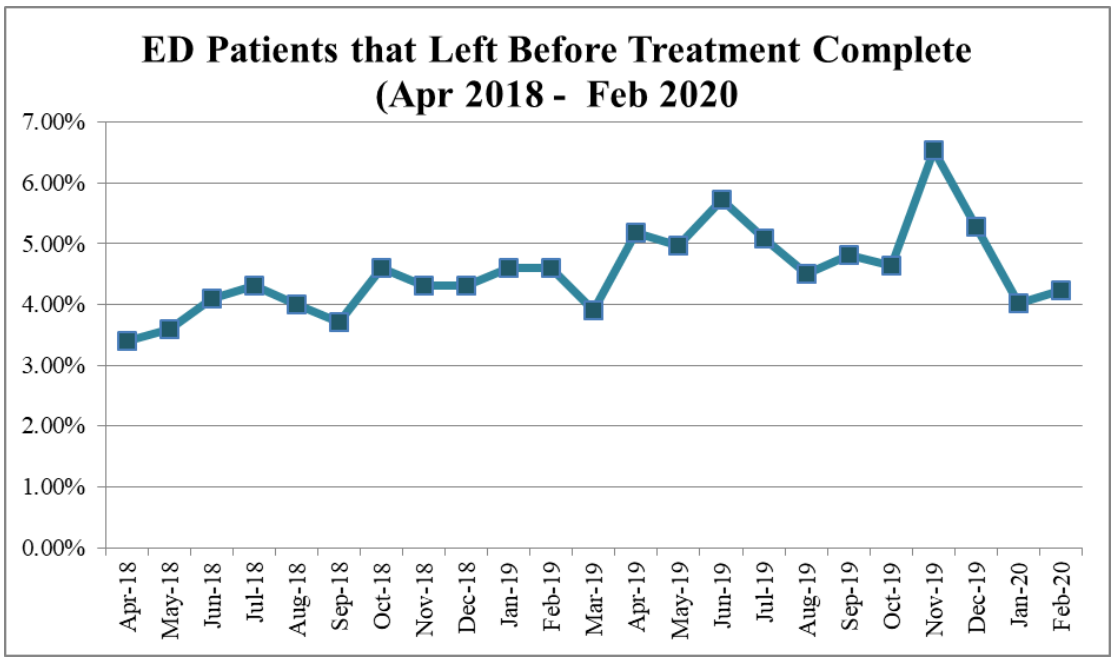
Facts and Figures

- During 2019/20, **70.86%** of patients commenced treatment within 2 hours of triage (or initial assessment). This is a decrease from the 2018/19 figure of 74.41% and below the Southern Trust's target of having at least 80% of patients having commenced treatment, following triage, within 2 hours.

Patients that Leave before Treatment is Complete

Please see the following graph for the full picture.



Facts and Figures

- During 2019/20, the average percentage of patients that left the Southern Trust's Emergency Departments before their treatment was complete was **5.0%, up from 4.3%** during 2018/19.

Emergency Department 4 Hour & 12 Hour Standards

The Trust wants to improve timeliness of decision making and treatment of patients and is working to reduce the percentage of patients who wait more than 4 hours in ED. The Trust's focus is to ensure patients are seen as soon as possible by the most appropriate medical professional.

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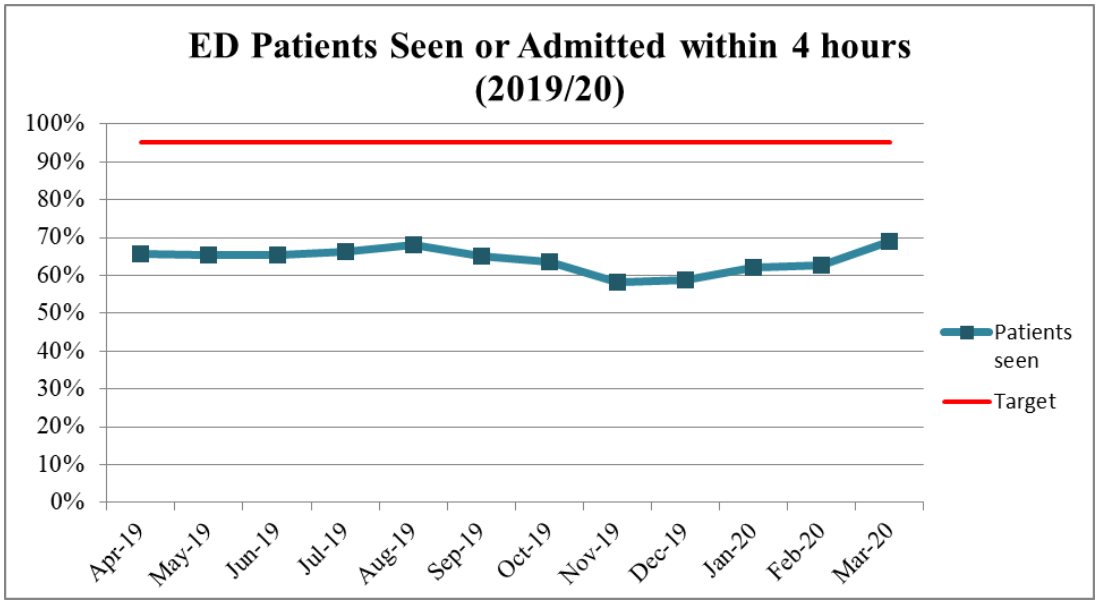
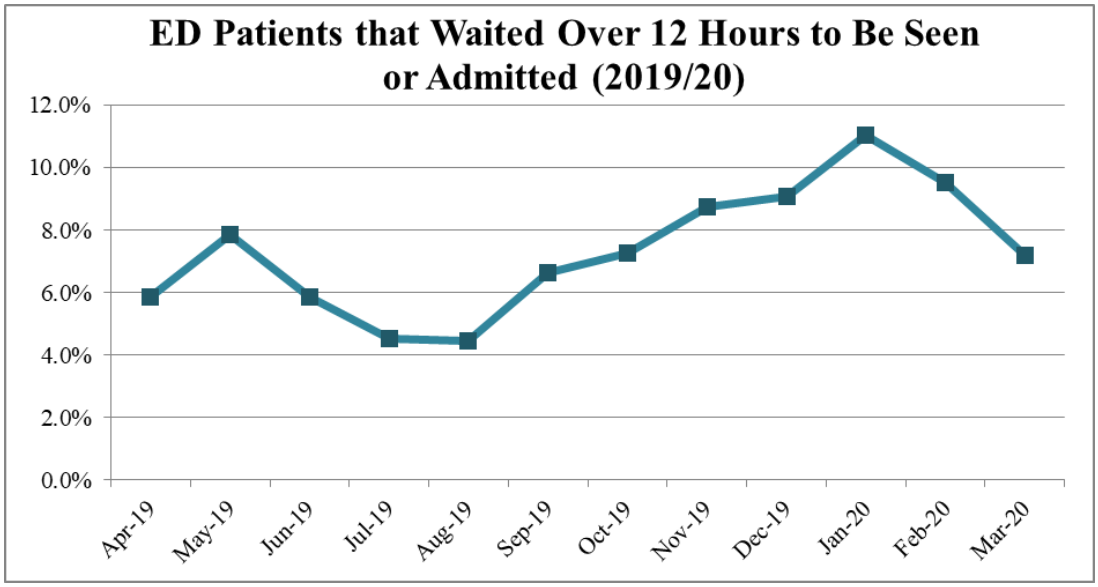
It is important to note that waits in emergency care units are often a sign of delays in the whole hospital flow system. Significant work has been undertaken to improve waiting times in emergency care units by focusing on more effective discharge and management of patients in medical receiving units.





Facts and Figures

During 2019/20 there were:

- 64.2% of these patients were seen within **4 hours**.
- 12,283 patients waited more than **12 hours**. This represents 7.2% of the total patients who attended the Emergency Departments and the Minor Injuries Units during 2019/20.

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Sepsis

The Trust participated in the new Regional Quality Improvement initiative on Sepsis, which was launched in the summer of 2019. The Regionally agreed aim was to Improve the time to First Antibiotics of patients who present to ED with Sepsis "In Hours" i.e. Mon → Fri 9:00am → 5:00pm. The definition agreed upon was NEWS of ≥ 5 OR 3 in 1 category & suspected infection.

The initial Pilot area was ED, CAH, with the Clinical Lead Dr. Suzie Budd. The Quality Improvement Team included the Lead Nurse for ED, A Pharmacist & Patient Safety. As Quality Improvement work on Sepsis was already underway it was felt that that we should audit all patients and not just those who presented "in-hours".

As part of our quality improvement approach, the following initiatives were introduced:

- Weekly meetings to review cases.
- The development of a Data Collection Tool.
- Sepsis Proforma incorporating NICE Guidance & Sepsis Sticker.

Baseline data was collected in October 2020, which revealed compliance was only 24% in-hours, 46% out-of-hours, with a 24/7 compliance rate of 39%. A review of the Baseline Audit identified 4 areas were delays occurred i.e. At Triage, From Triage to be seen by a Doctor, in prescribing & administration of antibiotics. Measures to improve compliance were:

- Raised awareness of Sepsis work with Doctors and Nurses.
- Launch of new protocol.
- Reintroduction of Sepsis Bed in Resus - challenging due to bed waits , overcrowding, critical care priorities.
- Sepsis Drawer in Resus.
- Sepsis Guidelines & proforma put on ED App.

By January 2020 compliance had risen to 100% in-hours, 35% out-of-hours, with a 24/7 compliance rate of 54%. In February 2020 24/7 compliance rate has risen to 64%, but fell back to 35% in March 2020, mainly as a result of the emergence of Covid-19, as illustrated on the below graph.

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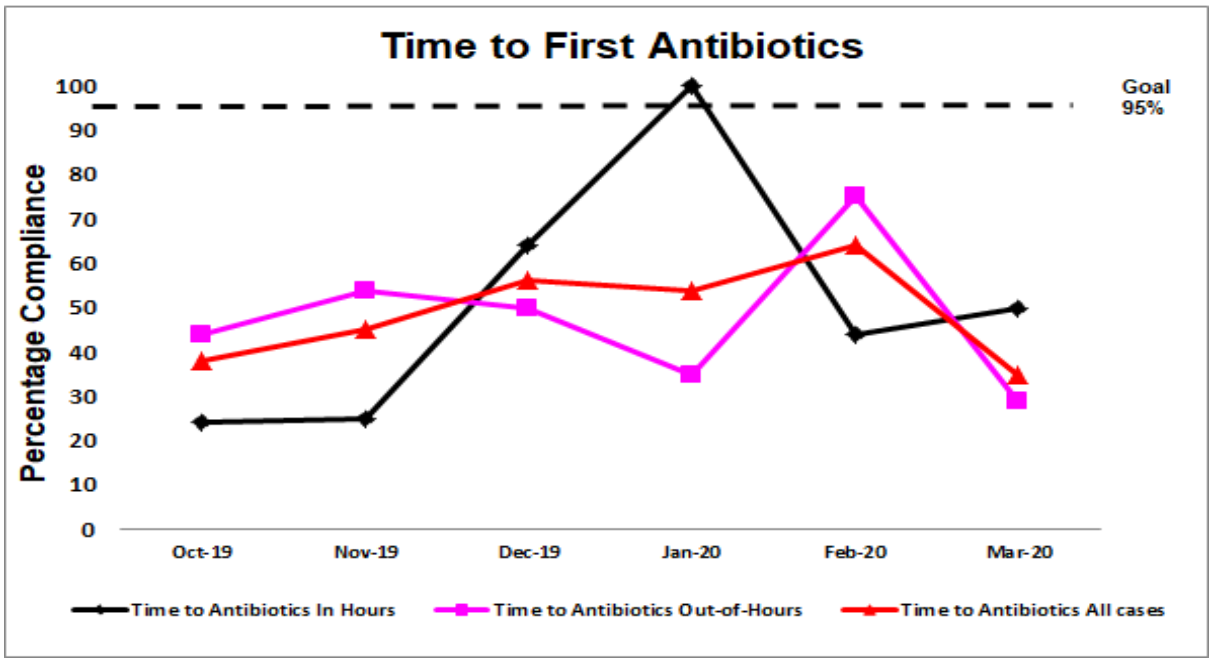

Going Forward:

Plans for 2020/21:

- Increasing membership of Team
- Enhance representation from Nursing.
- Regular slot in Emergency Department monthly newsletter.
- Agreement 20 minutes should be absolute maximum time for administration medication. Share with staff "Antibiotic is a "Critical Med".
- Embed Sepsis on Handover.
- Improved compliance with Sepsis6 Bundle.
- Pilot of Regional E-Learning Tool in Southern Trust.
- Regional E-Learning to be mandatory.
- Sepsis cases discussed at M&M.

The Emergency Department (ED) of Daisy Hill Hospital, under the Clinical Leadership of Dr. Laura Lavery commenced their Sepsis work in January 20. The documents & methodology piloted in the ED, Craigavon Area Hospital were introduced here as well. An Education Lead was also established to renew interest/engagement in sepsis work. Baseline data for January 2020 showed a 24/7 compliance rate of 38%, which had risen to 64% by March 20.

The 3rd Pilot Area was Acute Medical Unit (AMU), Craigavon Area Hospital, under the Clinical Lead of Dr. Emily Hannah began their Sepsis Quality Improvement Work in December 2019. The focus initially on cases identified "in-hours" i.e. Monday → Friday (9:00am → 5:00pm). The following initiatives were introduced:

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- Erection of Sepsis Posters.
- Development of Sepsis Sticker.
- Cases identified plotted on Ward's Run Chart Poster "Real Time".
- Sepsis added to Medical Handovers.
- Sepsis added to MDT meeting, where cases are reviewed to see what went well & what areas could be improved upon.
- Education Session for Nursing Staff.

Baseline data identified 4 cases, with a compliance rate of 75%. Following the collection of Baseline data it was agreed that going forward all cases should be audited & to assist with the spread of the Quality Improvement Work additional staff from AMU, both Medical & Nursing staff have been identified to support & lead on this work.

To showcase the work of the Pilot areas/Wards the Medical Directorate hosted a Quality improvement Event on the 4th February 2020, which was attended by 40 plus staff from across the Trust. Dr Mark Roberts MPH FRCP, Clinical Director, HSCQI was in attendance too & gave a Regional Overview of the work done to date, while Ms Geraldine Conlon, Lead Antimicrobial Pharmacist for the Trust gave delegates the 1st sight of the Regional Sepsis E-Learning Programme, which is in development to support the Sepsis Improvement Work. Work is ongoing on the development of NEWS2 within the Trust and this is nearing completion.

Next Steps:

- Launch of NEWS2
- Spread of QI initiative across the Trust

4.4 Clinical & Social Care Governance Research

During 2019/2020 the Trust continued to be committed to encouraging staff to be involved in research, development and innovation which:-

- Improves the evidence base
- Motivates staff to identify service improvements
- Leads to improvements in care, patient safety, quality and efficiency
- Provides new treatments and interventions which results in a better quality of life for patients and carers

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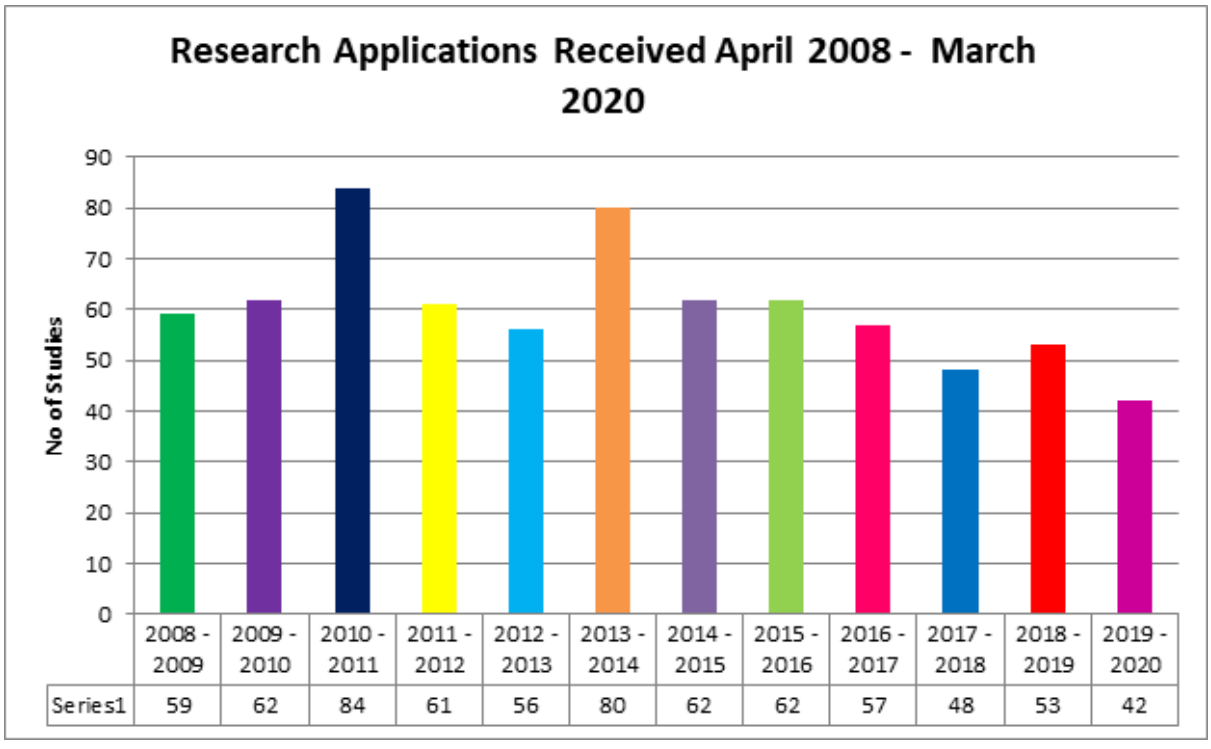
The main areas of research within the Trust included – Cancer, Cardiology, Children, Critical Care, Dermatology, Gastroenterology, Neurology, Occupational Therapy, Renal, Respiratory, Rheumatology, Social Care, Stroke, Midwifery and Nursing.

Capacity and Capability - In June 2019, Northern Ireland Trusts implemented the introduction of Capacity and Capability rather than research governance approval which removed 'clock stops'. This development brought Northern Ireland in line with England and Wales. From then delays in obtaining essential information for Studies, external to the Trust, were also included in the number of days from the receipt of a Study until Capacity and Capability could be issued.

The change led to a significant decrease in the percentage of Studies approved within 30 days i.e. in previous years the Trust always achieved 100% but the introduction of the new arrangements reduced the percentage to 52% in 2019/20.

Facts and Figures

- During 2019/20, **42 research applications** were received
- the diagram below shows the numbers received since the establishment of Research and Development in the Trust and how this year compares with previous years.



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During the year Craigavon Area Hospital and Daisy Hill Hospital have been sites for several important international and numerous national Studies. Trust Consultants have fulfilled the role of Chief Investigator for some of those Studies with the local site identified as the UK Lead Centre. Studies opened in the Trust often achieve the highest overall recruitment. Collaborative research has been on-going with local Industry and Universities both locally and nationally.

Key priorities for 2020/2021

In March 2020, the impending COVID-19 pandemic was beginning to impact the Trust and consideration was being given to undertaking Priority COVID-19 Studies determined as such by the Chief Medical Officers of England, Scotland, Wales and Northern Ireland. This Trust was the first in Northern Ireland to open the COVID RECOVERY respiratory trial early in April 2020. The overarching trial designed to provide evidence on the efficacy of candidate therapies for suspected or confirmed COVID-19 infection in hospitalised patients receiving usual standard care recruited over 200 participants and continues to recruit.

The aspiration would be for Research and Development to strive to contribute to the Trust being one of excellence with the additional priorities of:-

- Progressing Priority COVID-19 research studies
- Improving the quality of research
- Progressing the establishment of research in the area of Urology.
- Continuing to support high quality research in Social Work, Nursing, Midwifery and Allied Health Professions
- Developing collaborative research with the Ulster University and Queen's University, Belfast
- Supporting approaches to partner in the development of European Funding opportunities applications
- Working with the Armagh City, Banbridge and Craigavon Borough Council to promote Life and Health Sciences in the area and enhance funding opportunities

4.5 Nice Guidelines

"We must make quality of care as important as the quality of treatment. This means celebrating and spreading excellence in care"

(Patients First and Foremost, March 2013)

"The primary goal of the care provided must always be to make their experience, the outcome of their condition, their treatment, and their safety as good as it gets."

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(Liam Donaldson report, December 2014)

Providing safe, effective and high quality care to service users through clinical excellence should be a core objective of all health and social care providers. The effective implementation and sustained adherence to clinical standards and guidelines is a key tenet of this objective.

Clinical guidelines are considered to be essential foundation stones for informing health care decision making and can serve as the basis for policy, planning, evaluation and quality improvement. They are also the syntheses of the best available evidence on how to most effectively organise and deliver health care services for a given condition.

'NICE' stands for the National Institute for Health & Care Excellence. The role of NICE is to identify good practice using the best available evidence-based information for health, public health and social care professionals. Within Northern Ireland's HSC system formalised accountability processes are in place between the DHSSPSNI, HSCB and HSC Trusts. These processes ensure that suitable and effective assurance frameworks are in place for the dissemination / implementation / monitoring of these guidelines thereby allowing for the translation of policy into practice and ensuring the delivery of care and effective care to patients.

In 2019/20 a total of 126 NICE guidelines were regionally endorsed and received by the SHSCT. A breakdown by type is summarised in the table below.

Type of NICE guidance	Number
NICE Antimicrobial Guidelines	5
NICE COVID-19 Rapid Guidelines	4
NICE Clinical Guidelines (including updates)	52
NICE Interventional Procedures	7
NICE Technology Appraisals (including updates)	55
NICE Public Health Guidelines	3
Total	**126**

In response to the COVID-19 pandemic, which manifested itself at the end of 2019/20, four NICE COVID-19 rapid guidelines were developed and endorsed by the Chief Medical Officer in March 2020.

Title of Guidance	Date of Issue	Reference
COVID-19 Rapid Guideline Delivery of Radiotherapy	28/03/2020	NG 162
COVID-19 Rapid Guideline Delivery of Systemic Anticancer Treatments	20/03/2020	NG 161

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COVID-19 Rapid Guideline Dialysis Service Delivery	20/03/2020	NG 160
COVID-19 Rapid Guideline Critical Care in Adults	20/03/2020	NG 159

Due to the rapidly evolving COVID-19 health and social care emergency these guidelines were quickly developed to provide the front line clinical teams with the most up to date evidence on how best to care for patients who tested positive for the virus and who became acutely unwell. NICE developed these rapid guidelines in collaboration with NHS England and NHS Improvement and a cross speciality clinical group, supported by the specialist societies and royal colleges. A different approach to guideline development was adopted using a number of interim processes and methods.

Quality Improvement Initiatives

The following is an example of a quality improvement project that has been undertaken within the SHSCT to ensure that the recommendations outlined in a regionally endorsed NICE clinical guidance are visible at the patient / staff interface and embedded within current clinical practice.

Example: HSC (SQSD) (NICE NG133) 26/19 - Hypertension in Pregnancy: Diagnosis and Management – regionally endorsed on 19 August 2019

Following endorsement of this NICE clinical guideline the guidance was tabled for discussion / review by the Acute Standards and Guidelines forum on 10 September 2019. A Consultant Obstetrician agreed to take on the clinical change lead role for implementing the guidance which was assessed as low risk. In keeping with regional requirements, implementation of the guideline recommendation would be progressed over the next 12 months, with full implementation due by 19th August 2020.

Over the 12 months a total of 117 recommendations have been reviewed against current service provision and a position of compliance has been indicated on the baseline assessment tool. A total of 98 recommendations are currently met (84%). There are currently 5 recommendations that are not met due to a number of external barriers. These include the lack of a dedicated specialist Obstetrician for hypertensive disorders in pregnancy within the service and the fact that within Northern Ireland placental growth factor (PlGF)-based testing to help rule-out pre-eclampsia in women presenting with suspected pre-eclampsia is not offered.

Of the remaining recommendations a number of service improvements have been undertaken, including the following:

- NICE guidance has been presented by the clinical lead at MDT Clinical Audit meetings and will also be presented at the March 2020 meetings across both sites to ensure inclusion in next medical trainee induction programme

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- A quick reference guide is currently being developed for midwifery staff to raise awareness across the wider MDT
- A hypertension in pregnancy information leaflet has been out for consultation / PPI and is in its final stages of approval.
- Existing guidance has also been updated to reflect the new guidance requirements.

One other significant development in relation to this guidance implementation has been the Trust's involvement in a new regional care pathway for self-monitoring of blood pressure and protein in urine during pregnancy. This pathway is an alternative to regular face to face appointments for women who can be safely managed remotely for a proportion of their care and given the current impact of COVID-19 this has been an innovative service delivery model that embraces the NICE guidance within its protocols.

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4.6 National Audits

National clinical audits

The Trust's clinical audit work programme includes projects undertaken nationally in conjunction with other Trusts in Great Britain and regionally with NI, as well as those identified by staff within the Trust. This programme considers the national audits approved by the NHS England Quality Accounts List each year.

Participating in the national clinical audit programmes enables the Southern Health & Social Care Trust to:

- Compare performance with other participating Trusts in Northern Ireland, England, Scotland and Wales
- Measure healthcare practice on specific conditions against nationally accepted standards
- Benchmark reports on performance, with the aim of improving the care provided

The national audits are co-ordinated independently by external professional groups. Examples of some of these groups are:

- National Institute of Cardiovascular Outcomes Research (NICOR)
- Royal College of Psychiatrists (RCPsych)
- Healthcare Quality Improvement Partnership, (HQIP)

These national clinical audits are undertaken to demonstrate our compliance with a range of clinical guidelines and frameworks that we can benchmark our practice against. Two of these are outlined below;

1) **Myocardial Ischaemia National Audit Project (MINAP) based on NICE Guideline 94, and**
2) **NHS benchmarking Audit – Managing Frailty and Delayed Transfers of Care in Acute Settings**

1. Myocardial Ischaemia National Audit Project (MINAP)

The Myocardial Ischaemia National Audit Project (MINAP) is part of a larger on-going project that gathers information about the care provided to patients who are admitted to hospital with acute coronary syndromes (heart attacks).

Through this information we can capture the "patient journey" from when a patient goes to the Emergency Department, is diagnosed and treatment given, to their discharge from hospital. We measure ourselves against standards that are considered to be best practice in the

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UK for those having heart attacks, to see how well we are doing. If we do not meet these standards we take action to improve our services.

Why participate in this national audit?

This audit provides the Trust with assurance that;

- Clinical practice is of a high standard
- Diagnosis and investigations are appropriate and timely
- All patients are assessed by a Cardiologist on admission and are treated in a specialist cardiac ward
- Patients are discharged with the correct medication
- Follow on care is planned and appropriate referrals made

The audit team decided on 3 performance indicators;

- Medication on discharge
- Assessment by a cardiologist during admission
- Recording blood glucose level.

How did we do?

	National Average	Our Performance
1	**91%**	96% of patients were discharged on all preventative medication that they required.
2	**96%**	100% of patients were seen by a cardiologist during their admission to Craigavon Area Hospital 98% of patients were seen by a cardiologist during their admission to Daisy Hill Hospital.
3	**Continual Improvement**	82% of patients had a blood glucose recorded when admitted to Craigavon Area or Daisy Hill Hospital.

What do the results so far tell us?

The Audit has shown that we are well above the national average in ensuring correct medication is given on discharge and every patient was seen by a cardiologist during admission to Craigavon Area Hospital.

We have seen a yearly increase from 63% in 2016 to 88% in 2019, in the number of patients admitted directly to the Critical Care Unit or the Cardiology ward.

What actions have we taken as a result?

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We regularly meet with the other Health and Social Care Trusts to compare data, share learning and work together on improvements. This will ensure that wherever you receive care in Northern Ireland, the same process is used.

We have improved the time it takes for you to get the tests you need from the time you are admitted.

The process is built into training and induction for new staff.

2. NHS Benchmarking Audit – Managing Frailty and Delayed Transfers of Care in Acute Settings

The NHS Benchmarking Network was established in 1995 and currently has 360 members across England, Scotland, Wales and more recently Northern Ireland. The network exists to identify and share good practice across NHS organisations providing analysis and comparisons for members facilitating shared learning across the NHS. It provides the Trust with:

- Access to benchmarked comparisons on finance/activity/workforce/outcomes, safety & quality of services
- Access to best practice using Network Case Studies
- Opportunities to compare the Trust against peer organisations
- Access to performance standards of the best performing organisations in the NHS
- Bespoke Southern Trust report per project & inclusion in the wider member organisations report to reflect comparisions.

Each year the Network undertakes a range of projects and during 2019 the Trust participated in a range of benchmarking initiatives including Mental Health In-patients & Community Services, Emergency Care & also Managing Frailty & Delayed Transfers of Care in Acute Settings. Further information on this is detailed below.

What does Frailty Mean?

Frailty is related to getting older when we begin to loose our built-in reserves that help us recover from illness. We then become vulnerable to sudden serious changes in health, often triggered by minor events, such as a small infection or change in medication.(NHS England, 2018).

This leaves a person more likely to;

- Fall
- Take less exercise and have a poor diet
- Have long-lasting disability
- Be admitted to hospital and stay longer
- Need long-term care

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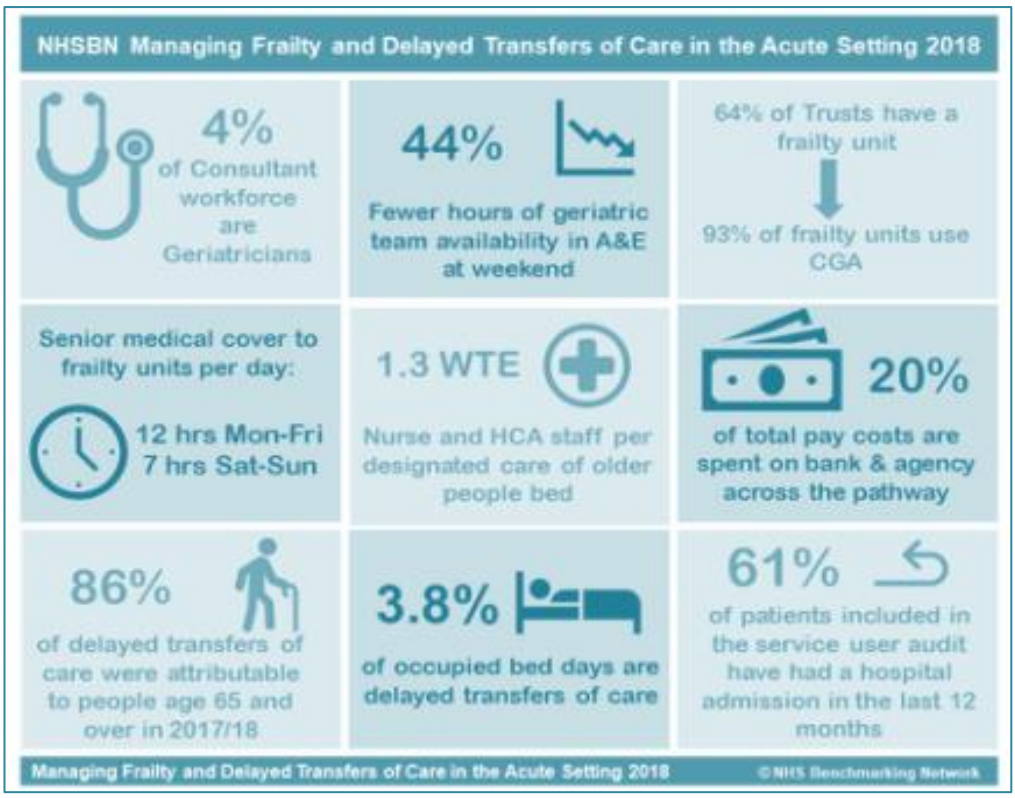
This table highlights the National situation in 2018 and highlights figures that needed to improve:



Why participate in this national audit?

This audit provides the Trust with assurance that;

- Our facilities meet the needs of frail elderly people.
- The care needs of frail patients were identified correctly both in hospital and after discharge.
- A dedicated team trained in managing frailty are looking after patients with frailty.
- We provide excellent care when compared to National Standards and Guidelines.

The audit team decided on 3 performance indicators;

- Those with frailty are cared for in the appropriate setting by a specialist team.
- Frailty is assessed in the Emergency Department prior to admission.
- A Comprehensive Geriatric Assessment is carried out to identify care needs.

What is the Rockwood Frailty Score?

- The Rockwood Frailty Scale is a global clinical measure of a person's level of vulnerability to poor outcomes. Identification of frailty helps to improve both long and short term health management.

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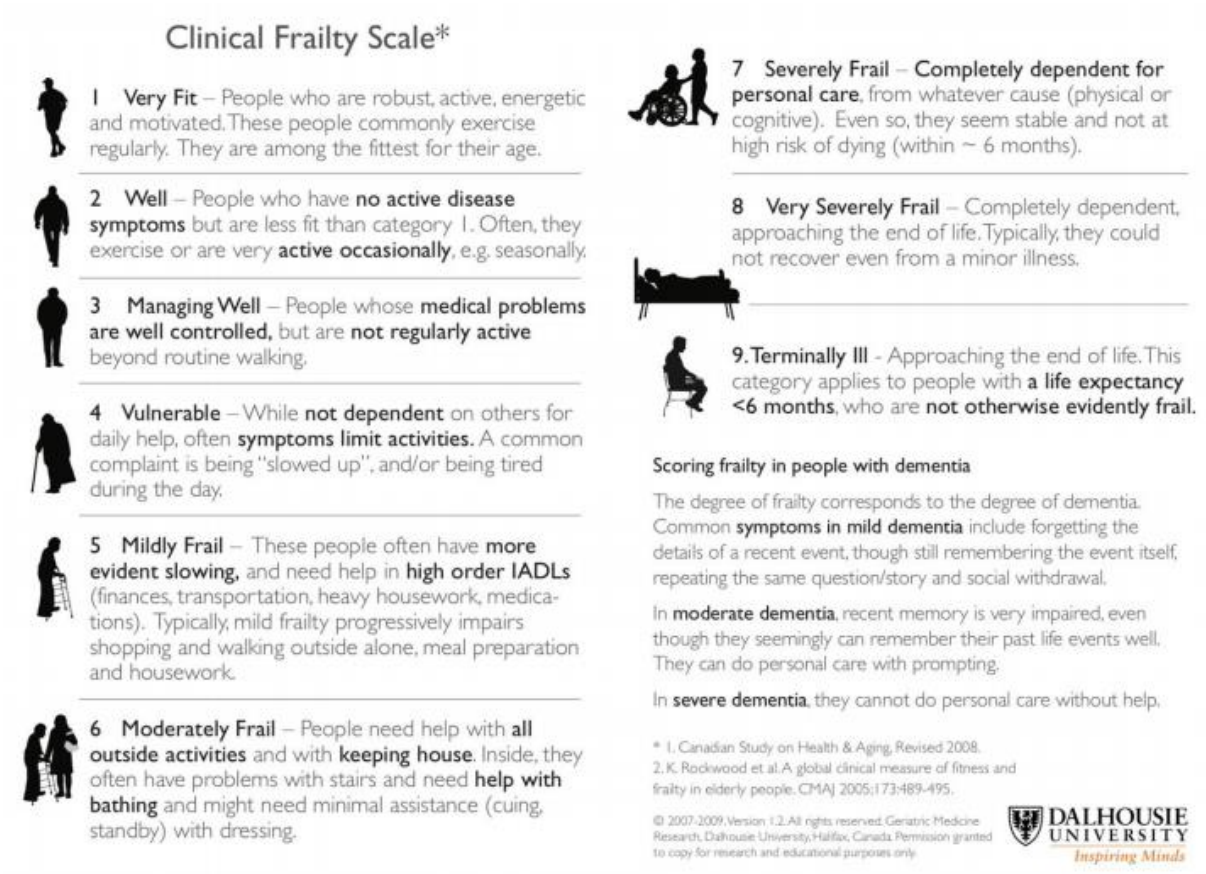

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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DALHOUSIE UNIVERSITY *Inspiring Minds*

What Actions did the Southern Trust take to Comply with Recommendations?

- A 15 bedded ward opened in September 2020.
- Staff in Emergency Departments are completing a "Rockwood Frailty Score" on those patients who may show frailty.
- An admission booklet has been developed which is more comprehensive than the previous form used. It is being piloted for use, but initial feedback is positive.
- There is now a dedicated team available for managing frailty including;
  - A Geriatrician.
  - Dedicated Occupational Health and Physiotherapy Staff.
  - Nursing Staff trained in specific care of frail patients.
- There is in-reach from community services to prepare for discharge.

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4.7 Cancer Targets

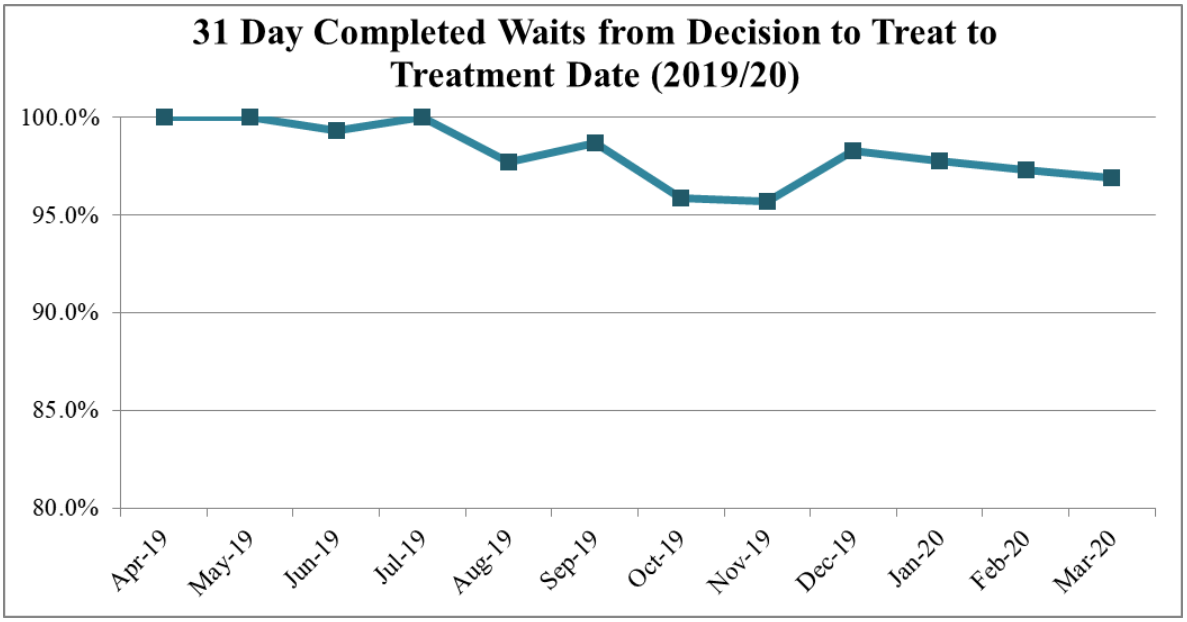
31 Day Completed Waits from Decision to Treat to Treatment Date

The Trust achieved the target for 2019/20 and was above the regional average.

As of March 2020, 30 patients waited longer than 31 days for their first definitive treatment in 2019/20. Of the patients who breached the target, 15 were skin cancer, 6 were gynecology cancers, 4 lower gastrointestinal and 3 urological.

Performance on the 31 day pathway for skin was impacted by reduced consultant capacity.

Performance against the 31 day pathway will be further impacted in 2020/21 associated with reduced capacity in line with the service re-build plans, associated with the Covid-19 management response.



62 Day Completed Waits from Referral to First Treatment Date

The Trust did not achieve the target for 2019/20, however, was above the regional average. During 2019/20, in real terms, 369 patients, out of 924, breached the 62 day target. 160 of the breaches occurred within the Urology tumour site.

Reasons for breaches included insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts.

Urology pressures have been escalated to Regional Urology Reference Group and HSCB Performance Team. The HSCB has allocated funding (June 2020) in response to Trusts Investment proposal for appointment of a 7th Consultant Urologist and continues to work with other Trusts to consider how urology capacity can be best maximized regionally.

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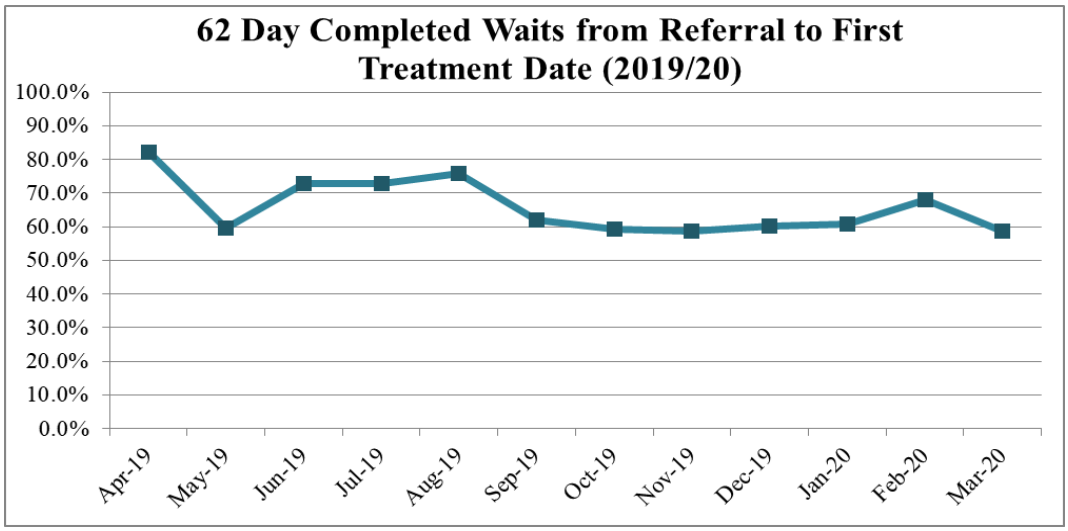
Performance against the 62 day pathway will be impacted in 2020/21 by reduced capacity aross the pathway in line with service re-build plans associated with Covid-19 management response. This will be both in-house and in the independent sector.

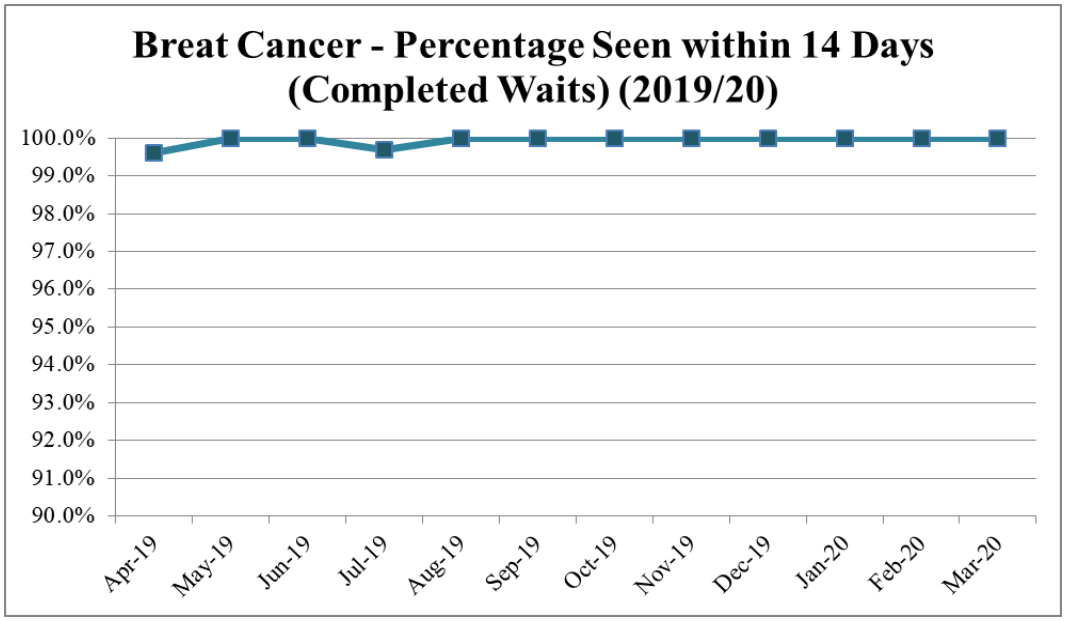


Breast Cancer – Seen within 14 Days

The Trust achieved the target for 2019/20 and was above the regional average. Performance has remained strong throughout 2019/20 with a total of 3,038 patients out of 3,040 being seen within 14 days, in comparison to 3,092 out of 3,111 in 2018/19.

Whilst additional non-recurrently funded capacity has been put in place as required to meet demand for new red flag/ urgent assessments capacity for routine new patients is insufficient to meet demand. As at 5 April2020 a total of 533 patients were on the routine waiting list, with the longest routine wait at 39 weeks.

The regional review of assessment services has not concluded



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Safe, effective & person centred

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

Theme 5

Integrating the Care

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5.1 Support in Communities

Care Bureau

The Trust operates a central administration bureau that sources packages of care for all programmes of care and completes invoicing. This bureau allows the Trust to access information for assembly questions, MLA enquiries and FOI requests.

Independent Sector Domiciliary Care

The Trust has introduced monitoring officers to give the Trust assurance that care commissioned from this sector is in line with contractual agreement, is safe and timely.

Intermediate Care Teams

Intermediate Care Teams (ICT) have continued to provide core service delivery and support earlier hospital discharges and prevent admissions e.g. through delivery of IVAB and work collaboratively with the Acute Care at Home Service to meet the generalist nursing needs of patients.

District Nursing Staff continue to support Care homes with management of syringe drivers to support end of life care and symptom management.

Integrated working within Integrated Care Teams continues with development of processes and communication systems across professionals

Communication and development of care pathways with interfacing teams progressed to provide clarity of understanding through participation at workshops eg. Implementation of Mental Capacity Act requirements for Deprivation of Liberty

Community Occupational Therapy ICT

- Development of You Tube video library to assist with equipment handover for patients and carers
- Ongoing review of Electronic induction pack for Community Occupational Therapy – maintain quality and ease of access to information for staff
- Community OT referral rates have increased currently at 7.4% increase in comparison to November 2019 and increased waiting times.
- **Admin Review within ICTs** which has streamlined processes, data collection, data quality, supporting focus on prioritising Service Users/Carer/Patients most in need. Band 4 administration managers are now in post across all teams with ICT Business Manager co-ordinating work
- **Development of First Point of Contact** has improved the ability for Service Users/Carers/external and internal agencies to get more timely, efficient response and intervention from our teams and ensuring that it is a response and intervention from

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the right person at the right time. This has also improved more efficient use of team resources, e.g. district nursing and social work in particular in relation to the Keyworker role.

- **Allocation of increased demography funding to ICTs -** to support increased demand and support capacity issues and workforce retention.

Collaborative working between Diabetes Podiatry Team and Orthotist Team

The Diabetes Enhanced Foot Protection Team and the Orthotist Team have been working in partnership on a new service improvement project for patients with active diabetic foot disease and those at high risk of diabetic foot disease.

This new collaborative way of working has several aims namely to facilitate timely referral of patients with active/at high risk diabetic foot disease and to combine our skills in wound care/ulcer management, orthotics, offloading devices and footwear in order to provide a comprehensive, effective treatment plan and improve long-term outcomes for our patients.

The Joint Vascular /Podiatry clinic

Vascular surgeons and Podiatrists both care for patients with Critical Limb Ischaemia (CLI) and foot ulceration. This condition requires immediate vascular intervention to reduce amputation and gangrene. A clinical pathway was required for urgent access to Vascular Services for diagnosis and guide to best cardiovascular and limb management.

The joint vascular and podiatry clinic commenced 3 years ago, running monthly clinical sessions for patients across the SHSST .The clinic is facilitated by Advanced Podiatrists and Mr Lewis, Vascular Consultant. Patients access the service by direct referral from GP to CAH surgical team or through Podiatry Vascular pathway. Podiatrists carry out lower limb vascular assessments on all patients attending the service with foot ulceration and those assessed with CLI are referred into the joint clinic. This joint clinic has reduced patient waiting times for vascular services, allowed patients to access services and investigations

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within the SHSST, allowing optimum clinical management for the patient. Pictured: Mr Alastair Lewis Consultant. Claire Gallagher and Neil Beggs Advanced Podiatrists.

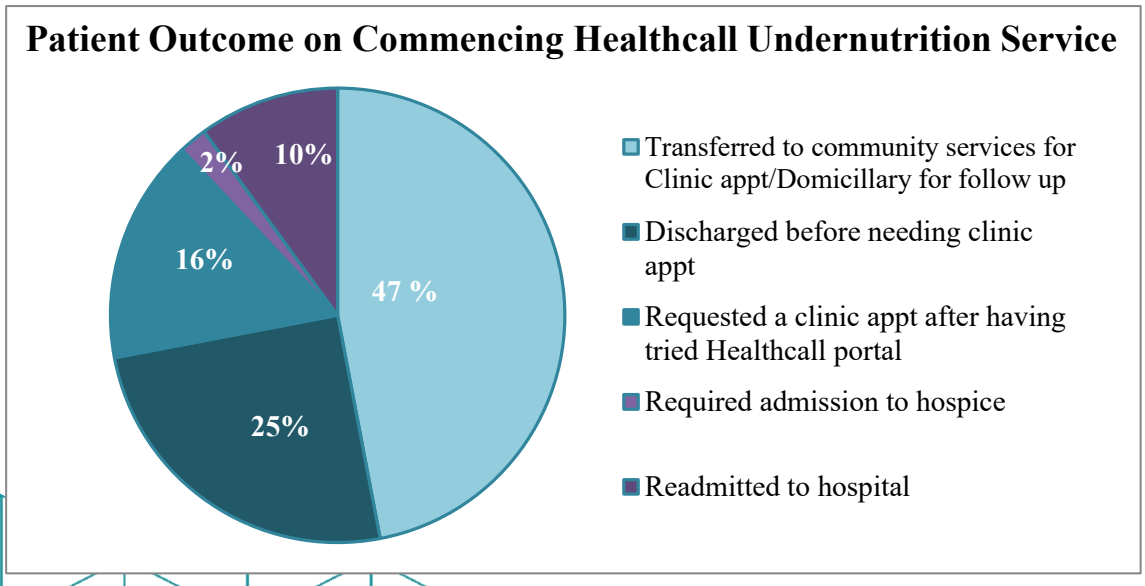
Healthcall Undernutrition Service – Remote Monitoring

Health Call Undernutrition service is a system used by the Community Nutrition & Dietetic service to remotely monitor patients in Care Homes. In 2019 the service was extended to digitally monitor nutrition support patients who had been under the care of acute dietitians and were discharged home but still required input. The intention was to bridge the time gap between acute services and awaiting a community appointment.

Patients receive an automated telephone call notification once a week and this allows a patient to self-monitor their weight, nutritional intake/appetite and compliance with any nutritional supplements. They are asked to enter their information by responding to automated questions via their phone. This information is then assessed by the Dietitian via an online portal, who is notified, for example, if the patient has lost a significant amount of weight or is not managing their supplements.

The patients are monitored via Healthcall until the patient is reviewed via face to face/telephone clinics or a domiciliary visit. In the event of the patient meeting their nutrition outcomes via the Healthcall remote monitoring service, the patient is able to be discharged. Figure 1 shows 25% of patients referred to the Healthcall portal were able to be discharged before needing a clinic or domiciliary appointment in the community, thereby maximising clinic capacity. Remote monitoring also reduced the length of treatment from 10-56 days compared to an average of 4-6 months for a patient on a community waiting list. Given the success of the Healthcall undernutrition service for remote monitoring the plan is now to roll out further across the dietetic service.

Below: Chart representing outcome of patients commenced on Healthcall to be remotely monitored.



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The Diabetes Foot Care Pathway

The regional diabetes foot care pathway for Northern Ireland was launched in November 2019 and its aim was to offer an improved foot service for adults living with diabetes in order to reduce amputations and limb or life threatening complications. There are four main tiers to the pathway and in the Southern Trust the first three tiers are delivered in the community podiatry clinics, Craigavon Area Hospital and Daisy Hill Hospital. The foot pathway delivers diabetic foot care for those people living with diabetes who are at low risk of developing a diabetic foot problem right through to those who have active diabetic foot complications. From Nov2019 to March 2020 there were 43 referrals from the enhanced foot protection team to the multi-disciplinary diabetic foot team in team in Belfast RVH.

Multidisciplinary diabetic foot team within this team there are consultant vascular surgeons, diabetologists, radiologists and podiatrists. This team takes referrals from the EFPT for the most complex and deteriorating foot conditions

Enhanced diabetic foot protection team (EFPT) hospital support is provided and podiatrists work closely with the diabetic consultants, microbiologists and radiologists. At this stage patients who have developed a complex foot problem can be referred to the multidisciplinary team

Foot protection team (FPT): This team provides early treatment and advice when a foot problem is identified. If there is no improvement then the patient is referred on to the next tier which is the Enhanced foot protection team.

Foot screening : foot assessment will be carried out by a podiatrist and then an individual care plan is agreed and an annual diabetic foot check will be arranged and carried out by either a podiatry assistant practitioner or podiatrist depending on the risk of developing a foot complication.

Early Supported Discharge for Stroke (ESD)

As part of the plan to improve and develop stroke services in Northern Ireland, transformation funding was utilised to enhance the existing Community Stroke Team to provide Early Supported Discharge for stroke survivors in the Southern Trust.

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Early Supported Discharge is an intervention for adults after stroke that allows rehabilitation to be transferred from an inpatient environment to a community setting.

The service commenced Monday to Friday 1st May 2019 and a six day model was launched on 1st July 2019

Main Aims of the project:

- Community Stroke Team will see patients within 24 hours of hospital discharge.
- Provide improved intensity and frequency of therapy to support patients in achieving the best possible outcomes after stroke.

During the period 1st May 2019 – 31st March 2020 167 patients were discharged from hospital using this pathway after experiencing a stroke.

Benefits of E.S.D. for Service Users:

- Reduced anxiety & increased confidence for service users and families.
- Improves patient outcomes in terms of functional independence and quality of life.
- Reduces length of stay in hospital.
- Increased emphasis on early intervention, rehabilitation and self-management.
- Therapy can be delivered at the intensity and duration advised in stroke guidelines.

Feedback

- 94% service users were very satisfied / satisfied with the service
- Just over 80% of respondents thought no improvements were necessary and had nothing to add to how things could be improved.
- The remaining responders alluded to 'staff shortages', 'spending a little more time with the patient' and 'delay with information'.

Non-Acute Occupational Therapy Service

The Non-Acute Occupational Therapy service has created a new way working to provide information to service users, carers and/or their families in relation to equipment that has been assessed for and provided by Occupational Therapists within the Trust. In 'normal times' this information would have been provided face-to-face, however in order to reduce unnecessary face-to-face contacts and footfall within Non-Acute Hospitals, videos have been devised to provide this same information. These videos are all available as YouTube links, so that Occupational Therapists working across any of our services can use with their patients and service users. If deemed appropriate, the links to these videos are e-mailed to the patient and/or their nominated person to provide the required instruction on fitting and adjusting the piece of equipment.

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If you are viewing the digital version of the report, click here to view the Occupational Therapy Equipment Videos.

Follow-up contact with the patient occurs to address any further queries or concerns that may arise. This has been a positive change to practice within the Non-Acute Hospital Occupational Therapy service, which has been brought about due to the COVID-19 Pandemic, and is an example of excellent work by Occupational Therapists working in many different services across the Trust.

Fiona McCourt, Advanced Practitioner Occupational Therapist in the Care Home Support Team has participated in the development of an AHP Support to COVID-19 Patient in Care Homes webinar which is part of the AHP Covid-19 series by CEC. Click here to view the webinar;

Care Home Support Team

The Care Home Support Team is a Southern Trust multidisciplinary team comprising of nursing, Social Work, Occupational Therapy, Physiotherapy and Administrative staff. The team was established to support the care of older people who are residents of the Trust and in permanent nursing and residential care home placements. The team are responsible for the ongoing review of residents in order to ensure that their placements continue to meet their assessed needs.

The Care Home Support Team work in partnership with staff from the Care Homes and closely with the RQIA, Integrated Care Teams for Older People, Acute Care at Home Team, Community Specialist Teams, Memory Services, Governance, Adult Safeguarding Gateway Team, Contracts and Finance Departments in order to support the delivery of high quality, safe and effective person centred care for older people in nursing or residential placements.

The Care Home Support Team in conjunction with colleagues from Corporate Nursing Governance, Mental Health and Disability Services and Infection Prevention Control have established a Care Home Information Support Hub in order to coordinate the support provided to a care home when the care home is dealing with symptomatic residents, a COVID positive resident or staff members and at the time of an outbreak. The Hub interrogates the information obtained through the RQIA app on a daily basis and follows up on any issues highlighted with each individual care home. This ensures that Care Homes are supported in a timely manner and connected to Trust resources as required.

Keyworkers within the Care Home Support Team also provide a minimum of a weekly support telephone call to their aligned care homes within the SHSCT area. The purpose of this call is to review the overall status of the home and check if the care home is experiencing any challenges that the Trust could assist with at that time. The Clinical Nurse Facilitator within the team is available to provide face to face syringe pump training for care home nurses and training in relation to symptom management at end of life.

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The Care Home Support Team in partnership with Mental Health and Disability Services, host a biweekly operational Care Home Managers meeting via Zoom and also a biweekly education ECHO session for care home staff. The agenda for the operational meeting and the content of the education sessions is tailored to meet the educational needs identified by the care homes.

A Community COVID-19 Screening Team has also been established and is available to swab care home residents when:

- The resident is required to have COVID-19 screening to facilitate an admission to an alternative care facility - care home/hospice/hospital
- A Symptomatic resident in a care home/supported living facility requiring screening for COVID-19 and
- COVID-19 screening is required for all residents and staff within a care home/supported living facility, following the declaration of an outbreak in that facility.

Heart Failure

Rapid access Heart Failure clinic where patients with an elevated BNP have the opportunity to have Echocardiography (as per the timeframes in the NICE guidance on Management of Chronic Heart Failure),Consultant and Heart Failure Nurse assessment all done in the one day and a plan of care is formulated. This runs weekly in DHH level 4 Cardiac Investigations with a Consultant and a Band 7 HFNS, alongside the Cardiac Physiologists.

Community Respiratory Team

- Development of Virtual pulmonary rehab via Zoom – including maintenance programme, with a SOP devised for Zoom.
- Teaching AWC via Zoom.
- Virtual ward round daily meetings to enhance communication between acute and community services and improve discharge pathway.
- Facilitated discharge scheme to include pts with COVID-19 requiring oxygen on discharge.
- Integrated working with ICS team to facilitate discharge with these pts.
- Assistance of the introduction of BiPAP for complex pts and ongoing monitoring of ABG's.
- Completing HOSAR assessment and reviews at home due to no/limited clinic space.
- Multiple training videos completed for education of other staff trust wide.
- Training and support provided to nursing homes and Dom care workers re AGPs, use of oxygen and nebulisers.
- Donning/doffing and Swabbing training provided to other staff in early stages of pandemic.

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- Due to the fear associated with hospital admissions at present we are having to deal with more complex cases at home, further exacerbated by some GP surgeries continuing to limit face to face visits.

Contraception Service

- Telephone triage system for patients with acute problems with Long Acting Reversible Contraception Methods.
- Telephone assessments followed by posting of oral contraceptive methods to patients homes
- Development of a pathway for other services to use when referring patients for emergency contraception
- Enhanced Access list developed to ensure those patients, where an unplanned pregnancy would be detrimental to their physical, mental or social wellbeing are given more timely appointments
- Working with the Nurse-Led service at the GP out of hours to develop a patient group directive that can be used by the Nursing staff at the out of hours service to provide patients with oral emergency contraception
- Development of a system where Sexual Health Nurses from the Promoting Wellbeing Division Health Hub can work at the Contraceptive Service, assessing young people aged 16-25 years for Long Acting Reversible Contraceptive Methods. These skills gained by the Nurses and pathways created can be further utilised at the Health Hubs located in the Southern Regional Colleges. Ultimately providing easier access to contraceptive methods for young people.
- Training sessions provided to Family Nurse Partnership staff around all methods of available contraception. This equips the Nursing staff from this service to have up to date information to provide their patients prior to accessing the Contraception Service.

MSK Physiotherapy:

- Developed virtual consultations via telephone, Zoom and Visconn to reach patients when they can't come to Face to Face appointments. This ensured patients could still be assessed and treated during covid period. It has facilitated new ways of working and patients have given very positive feedback on the approach used and the benefits to them in managing their symptoms and condition to aid recovery/rehabilitation.
- The MSK team developed electronic resources e.g. Leaflets, videos, advice sheets, exercise programmes, working from home advice, for patients to send to them for self-management and are now being used in primary care and ED to support other professionals to manage patients
- Specific videos developed for the headache service and pain teams which enabled patients to start and progress their treatment in their own homes.
- Multi-Disciplinary pain management classes were designed and then delivered virtually via Visconn and Zoom key new working with technology. Patient's love the interactive

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nature of the class and it allows them to see what they can do on their own and in their own homes/settings.

- MSK physiotherapy leading in MSK/Fracture hub to manage orthopaedic referrals that frees up consultant orthopaedic surgeons time and reduces waits for patients also means one stop approach saving the person time and the clinic.
- Due to move to PARIS all patient records are now electronic with all assessments, case notes and letters completed on PARIS with discharge letters to GPs and referrers now directly loaded to NIECR. This ensures that others involved in the patients care have up to date information and the patient is managed holistically.
- The Lymphoedema Service has been delivering a Healthy Legs Programme for patients with oedematous/swollen legs to increase their knowledge of and develop the skills to attain and maintain good leg health. It puts the patient at the centre of their care by ensuring they can make informed decisions about their care and long management and prevent breakdown of skin and help with wound healing.

The Lymphoedema service throughout the Covid pandemic has adapted new ways of working. The majority of our patients were initially shielding and certainly fall into the high risk category based on age and/or co-morbidities. Assessments are completed virtually by video or telephone to begin. Based on this the patient, carer or family member may be asked to take photographs of swelling and measure the affected area. This ensured that patient could progress safely with their management. This approach has improved their autonomy. Other patients were brought into clinic when required for a much shorter face to face appointment so they too could progress as appropriate.

Statutory Domiciliary Care

- Introduction of Home companions to compliment the domiciliary care service. These new companions will undertake home sitting service to help the Trust support carers.
- Competency Based medication training – only Trust to have this model for care staff regionally and increases the skills of care staff to provide safe administration of medication. .
- The service has 4 active Dementia Champions rolling out ideas on how to improve the quality of domiciliary care and share better ways of working with clients who have dementia.
- The Trust has agreed to roll out mobile phones for 1150 care workers to enable improved and timely communication with care staff and connect better with them i.e training videos, early alerts, safe practice guidance.
- The Trust is exploring the implementation of a real time monitoring system that allows staff , clients and families to leave feedback and give assurance that all clients receive care as commissioned and at the time agreed

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Rapid Access Teams/ Older People's Admission Unit

The Rapid Access Clinic (RAC)/ Older People's Admission Unit (OPAU) in Newry moved into the Direct Assessment Unit (DAU) Daisy Hill Hospital in February 2019 which was part of the Pathfinder Project. This enabled GP to directly refer frail elderly patients to the unit as an alternative to the Emergency Department (ED) and ED staff can also refer on these patients to the OPAU. It is a more conducive space of assessment for frail elderly and they are provided with a full comprehensive geriatric assessment.

Rapid Access services continue to run in Mullinure, South Tyrone Hospital and Lurgan over the 2019/20 period with GPs able to refer direct or to utilise the single point telephone line offered by the Acute Care at Home triage Doctors for direct access to these pathways.

Facts and Figures

During 2019/20:

- The Older People's Admission Unit (both DHH & CAH**) accepted 1174 referrals** from 01/04/19 to 31/03/20.
- **81%** of these referrals were not admitted to an Acute bed.

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Intermediate Care

Intermediate Care is a short term intervention to promote the independence of people following an acute hospital admission or where there has been a deterioration in functional ability due to an acute/exacerbation of their medical condition. It aims to increase their ability to live independently and minimise longer term dependence on health care services through timely, intensive therapeutic input.

The MDT consists of Occupational Therapy, Physiotherapy, Social Work and rehab support workers. The service accepts patients as "Step up" to avoid ED attendance or hospital admission from GPs, Community Nurses, OTs, Physios, Social Workers. As part of support for patient flow and improving patient experience Intermediate Care have been focusing on 'Discharge to Assess' model and working with acute colleagues to allow clients to return to community setting as soon as they are able to do so- avoiding delays.

Discharge to Assess

Facts and Figures

During 2019/20:

- **865 discharges were facilitated** through Discharge to Assess from across Daisy Hill Hospital and Craigavon Area Hospital.
- There is an estimated saving of 2-3 acute bed days for each patient discharged through this pathway. This is a **48.8% increase** from 2018/19.

Acute Care at Home

The Acute Care at Home (AC@H) team is a consultant lead service and has been operational since September 2014. The Multidisciplinary (MD) team cares for acutely ill patients in their own home or Nursing or Residential home who are at the point of hospital admission. The team responds to referrals from GPs, Acute and Non Acute Hospital medical staff, NIAS and Specialist services (Heart Failure and Community Respiratory) within an agreed time frame of 2 hours. Patients receive a comprehensive Geriatric Assessment based on Silver Book Guidelines involving full MD input and have rapid access to diagnostics (MRI, CT, Ultrasound, Xray) and laboratories in the same time as an inpatient.

The team has been able to extend its area of coverage over the last year to provide full Trust coverage.

The AC@H also welcomed 0.5 wte Band 7 Dietician to the team to further enhance its multi-disciplinary function and 1.0 wte house keeper. Both of these roles have been developed

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over this period and were firmly established to become an invaluable asset for the Covid period which was to follow.

Facts and Figures

During 2019/20:

- The Acute Care at Home (AC@H) team received **2537 referrals received** of which **1520 referrals were accepted.** This equates to an average of 127 referrals per month.
- The percentage of referrals declined due to *'no team capacity'* has **decreased from 13.9%** in the 18/19 financial year **to 12.8%** in the 19/20 financial year.
- The average length of stay on the AC@H service **decreased** for the 2019/20 financial year which was **4.56 days** in comparison to that of the previous year which had an average of **4.94 days**.
- Within the 2018/19 financial year, the AC@H service **saved 9323 hospital bed days** which equates to a 26 bedded ward at 100% occupancy. The 2019/20 financial year has seen this further improve to a 29 bedded ward having saved a total **of 10,336 bed days**.

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5.2 Mental Health

User and Carer Service Improvement Group

The principles of co-production, co-design and co-delivery continue to be embedded in all improvements in Mental Health Services. Central to this is the User and Carer Service Improvement Group (UCSIG) which is inextricably linked with the Mental Health Forum since 2009. USCIG is an essential component in delivering sustainable co-production and collective leadership. It is an independent body and its model is unique regionally.

The User Carer Service Improvement Group meets on a monthly basis and was involved in all Service Improvements in 2019/20. The group's members include Advocacy Providers, Service Users, Carers, Southern Trust Staff and 3rd Sector organisations.

A capacity building programme has been the most recent piece of innovative work. UCSIG meetings have equally involved the highly experienced alongside those being mentored at the beginning of their capacity building journey. The UCSIG/ Mental Health Forum model involves training, 1:1 mentoring and practical experience.

Mental Health Forum – Capacity Building Programme

OUR VISION (The future we visualise and move with passion towards)

"Every person with lived experience of mental health services or their carer, who has passion and commitment for involvement & coproduction with SHSCT Mental Health, can access opportunities for learning and experience that direct that passion and develop associated skills and confidence"

OUR AIM (The main way we intend to contribute to this future).

To deliver personalised capacity building, and to partner in involvement opportunities, through our unique 5 stage service-user led mentorship programme and its associated learning groups

OUR CORE OBJECTIVES (The main things that must be achieved or upheld to get there).

- To provide a recognised, structured, and responsive Capacity Building/Signposting Pathway for those with lived experience of using mental health services or their carers who express interest. To link this closely with Pathways of Southern Health & Social Care

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Trust, that also seeks to promote or develop opportunities and education for Involvement & Peer Employment.

- To deliver a personalised mentorship experience that is peer-led, strengths focused, and celebrate individual personal growth, while focusing on achievement of the Programme's 12 core competencies.
- To represent and promote the values of Mental Health Forum, contributing to continuous coproduction with Southern Health & Social Care Trust and ensuring lived experience voice and expertise is heard and valued.
- To be part of active culture change in Health & Social Care, that embraces Mutual Respect, Parity of esteem, Embedded Recovery & Coproduction, and Peer Involvement & Employment.

	12 Core Competencies of The MHF Capacity Building Programme "Coproduction Matters" These apply to ALL Programme Stages, with each stage bringing progression of that knowledge, understanding, and skill.
1	Understanding of Coproduction, PPI, and Recovery principles in context of Health & Social Care
2	Understanding of SHSCT and ImROC context, and ability to relate it to a Coproduction setting
3	Ability to confidently put Coproduction knowledge and skills into effective practice
4	Ability to identify with, and constructively use own personal expertise by lived experience to represent and benefit a wider body of opinion
5	Ability to understand, and to take personal responsibility for self-care during Coproduction (including ability to establish and maintain safe and effective sharing boundaries)
6	Ability to collaborate, demonstrating respect for both people and protocols
7	Ability to actively communicate and listen well, and to support or facilitate collaborative discussion of others
8	Ability to model, promote, and uphold good Coproduction & Recovery Practice
9	Ability to reliably attend and actively contribute in Coproduction settings where have committed to involvement
10	Ability to source, manage, effective use, and share information in line with protocol and legal requirement
11	Ability to reflect, learn, and develop capacity in Coproduction Practice
12	Ability to identify and use networking & learning opportunities, as well as support structures

Physical Health Monitoring

A small team of staff have been recruited to ensure robust physical health monitoring is offered to those with severe and enduring mental health illnesses.

We know from the evidence that those clients with a serious mental illness are more likely to develop cardio metabolic issues, have poorer physical health outcomes and that there has been insufficient screening has taken place.

The Trust has been implementing routine physical health screening checks for those clients within mental health services in line with the Lester guidance.(link below)

ncap-e-version-nice-endorsed-lester-uk-adaptation.pdf (rcpsych.ac.uk)

Each locality area has established clinics to undertake these health checks for all clients open to key workers within mental health who meet the criteria. An option for outreach is available for those who are unable to attend the clinic.

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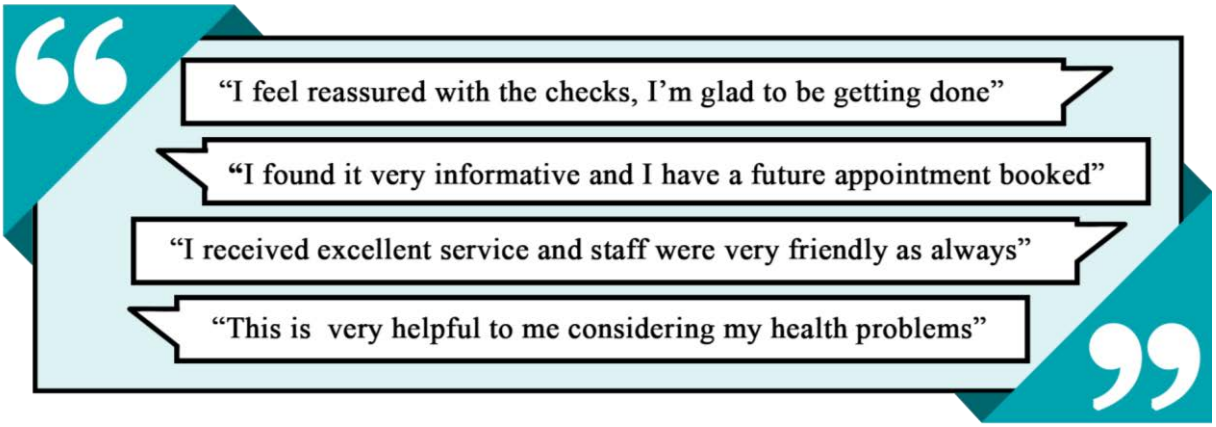
The physical health lead nurse will undertake in-reach to the Acute Mental Health unit at Bluestone and provide teaching and expertise to the teams and wards.

There is a Physical Health Expert Reference Group setup with representatives from medical, pharmacy and nursing colleagues across teams, which meets regularly and provides a Multi-Disciplinary forum for policy and pathway review and opportunities to review current practices and bring about changes based on the available and emerging evidence.

Investment has been made in ECG machines and staff training to complete this work.

This has been well received by those attending who have given their feedback with comments such as:



Health Passport

This Physical Health Monitoring program is supported by the previous development of the Health Passport and allows for a copy to be given to the client should they wish one, with details of tests undertaken and lifestyle questions and advice on the inside.

The passport helps our staff to ask the relevant questions, thereby beginning the conversations about physical health and lifestyle choices, provide information and signpost to relevant services such as smoking cessation and healthy eating cook-it programmes.

Rehabilitation Team

A rehabilitation team has been formed to support families caring for those with mental ill health. The team offers clients a pathway focused on their specific needs and aims to

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support recovery and reduce relapse to ill health. The service provides intensive support and treatment for those who require it and forms a seamless link between hospital and community services which reduces hospital admissions.

Peer Led Groups

With support from SHSCT the Health Partnership made a successful application to National Lottery for £500,000. This funding which is provided over five years will sustain peer led groups and increase support to rural areas.

Towards Zero Suicide

Towards Zero Suicide is a regional approach aiming to reduce suicide in the population who are known to Mental Health Services. In the first phase the roll out of Level 1 *Suicide Let's Talk Training* has been provided for staff in the Southern Trust.

The Southern Trust has also led the way regionally by developing the *Lived Experience Carer Advocate* work stream of the project.

Level 1 Suicide Let's Talk Training

Take the opportunity to complete the online 'Suicide Let's Talk' training available for staff via e-learning at http://www.hsclearning.com This training aims to increase participants' awareness of; the signs to look for when someone is thinking about suicide, guidance on what to say and how to ask a person directly about suicide, and signposting a person to support services to help them stay safe for now.

Please note if staff have personal experience of suicide, they may find this training emotionally challenging and should consider speaking to someone before deciding to commence.

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5.3 Children's Social Care Services

The Executive Director of Social Work's Statement of the Governance arrangements in place for safe and effective social work and social care services across the Trust is available for 2019/20.

This statement provides an assessment of the Trust's performance in effectively and efficiently delivering the Delegated Statutory Functions.

The Trust provides regular reports to the Health and Social Care Board in relation to a number of service areas for example:

- Children's Homes Annual Monitoring Reports (to RQIA only)
- Adoption Panel Annual Report.
- ARIS Monthly Adoption Report.
- Trust Child Protection Trends and Statistical Quarterly Reports.
- A range of PFA targets – Priority 5 Monthly Returns.
- Unallocated Cases Monthly Performance Reports.
- Quarterly returns on Youth Homeless.
- Notification of Unregulated Placements.
- Carers Assessments.
- Direct Payments.
- Education, Training and Employment statistics.
- Trafficked children/Separated Children.

The Trust led on a Multi-Agency Audit in relation to the Framework for Harmful Sexual Behaviour (HSB). A Multi-Agency Action Plan has been agreed to progress awareness, assessment and intervention in relation to HSB. The work is being led by a Southern Area Multi-Agency Harmful Sexual Behaviour Group chaired by the Assistant Director for Safeguarding and Family Support who also participates in the Regional HSB Group contributing to the Regional Action Plan for Harmful Sexual Behaviour.

Youth Homelessness:

A Review of the delivery of Youth Homelessness Service was completed resulting in an earlier engagement with the Youth Homeless social worker at the Gateway Single Point of Entry. This early engagement has promoted family engagement and safety plans supported by family networks to avert or support young people age 16-17 years at risk of homelessness

Infant Mental Health Strategy

The Trust led in the development of a Multi-Agency Southern Area Infant Mental Health Strategy 2020 – 2025 which was launched on 29 November 2019. It represents a commitment

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by statutory, voluntary and community organisations to promote positive infant mental health from the ante-natal period through to children aged 3 years of age.

The Strategy takes account of the Regional Infant Mental Health Framework (2016) along with learning from a Southern Area Multi Agency Stakeholder Event (May 2019), and results from scoping exercises undertaken in 2019 with key stakeholders within and outside the Trust. Parents provided comment on the accessibility of the Strategy. As a result of this the strategy document is accompanied by a 'Strategy on a Page' summary poster. A Southern Area Infant Mental Health Multi- Agency Strategic Group has been established to lead the implementation of the 5 Year Strategy.

Children with Disability Services (CWD):

This cohort of children and families were amongst the hardest hit during the pandemic. Children with a Disability are amongst the most vulnerable and susceptible to the impact of a reduction of services. Therefore when schools and many other social outlets which we take for normal were no longer accessible, many families began to experience very considerable stress and in some instances led to crisis and potential breakdown.

The CWD social work teams across the Trust amalgamated much of their staff resources and engaged with the Voluntary and Community sector and planned bespoke interventions for children and families. Based on assessment of need 30 of the most vulnerable children were identified and who were most impacted upon by absence of schools and other social outlets and supports.

Social workers on a daily basis delivered range of activities and bespoke packages out of home to the above identified cohort of children. Due to the success, an additional 84 Children collectively received over 400 individual sessions of activities delivered directly by social workers and community voluntary partners.

This community based support was an invaluable service to many families which avoided breakdown for some of the most vulnerable.

Welfare Reform Group:

This multi-agency cross Directorate working group was established by the Executive Director of Social Work in response to the impact of welfare reform, poverty and COVID on the

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

vulnerable members in the Southern Trust area .Membership includes voluntary groups, education, council, Trust staff and is co-chaired by one of the Trust's Non-Executive Directors. The purpose of the group is

- A focus on supporting/enabling others (statutory/Voluntary/Community), who work with vulnerable families and communities.
- A commitment to a co-ordinated approach in all we do and avoiding duplication.
- To act as a Strategic pressure group/voice, to raise issues/concerns at a Regional and Departmental level, as they effect the Southern Area.
- A willingness to share our learning, across all age groups, with relevant regional forums.
- How we can influence/support breaking the poverty cycle, for families and communities(empowerment; accessibility; employment; education) and to develop strong strategic and operation alliances across the sectors

Moving Towards a Trauma Informed Organisation: Project Maple

Project Maple is a unique initiative in collaboration with the Social Work Strategy, Finance, Estates and Children and Young Peoples Services. A Trauma informed approach highlights the important of the physical environment and how its impacts affects individuals, recognising that it can have a physiological and emotional impact and responds by creating supportive environments that resist re-traumatisation.

Trauma Informed environments ensure physical safety from harm and danger, support mental health, emphasise consistency, predictability and facilitate social connection, community building and participation in design of the space. Therefore(as the attached photos highlight) a piece of ground outside Lisanally House has been converted to improve the quality of contact for our Looked After Children (0-14 yrs. old) with their parents, siblings and extended families in an outdoor play area based on feedback and design by young people. The outcome has resulted in improving their family time together, creating positive memories, reducing anxieties and stigma related to attending Social Services buildings.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Looked After Children

Facts and Figures

- During 2019/20, there were **1044 LAC reviews** in 2019/20.
- **40** of these were held outside of timescale (initial, 3mth review & subsequent 6mthly reviews – if a change of placement review is included in out of timescale figure, this becomes **41**)

Permanency Planning

Facts and Figures

- There were **562 LAC children** as of 31/03/2020 and of these, 545 fulltime looked after children had a permanency plan in place.

Children identified as being at risk are seen and spoken to within 24 hours

Facts and Figures

- There were **757** Child Protection referrals during 19'20
- **750** were seen & spoken to within 24hrs
- the remaining 7 within 48 hrs following attempts being made by Social Worker's to contact family

Direct Payments

- The provision of direct payments by a Health and Social Care Trust enables families to locally source the care they require, allowing the individual to choose how they are supported within their community.
- Direct Payments continue to be promoted to families by social workers in the Children with Disabilities Teams.
- Direct Payments enable families to locally source the care they require, allowing the individual to choose how they are supported within their community.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Facts and Figures

During 2019/20 there were:

- **269 children received direct payments**.
- This figure has **increased from 213** children in March 2019 and 210 children in March 2018.

Education, Training & Employment

Facts and Figures

During 2019/20 there were:

- **241 individuals** subject to the Leaving and After Care Act.
- **228** were in education, training and employment.
- 13 have an Eduction, training or employment status of 'other' (sick/disabled, parent, carer).

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

WIT-37207

5.4 Adult Social Care Services

Adult Protection Plans

There are many vulnerable people in the community and those who are most at risk should have in place adult protection plans following investigation.

Facts and Figures

During 2019/20 there were:

- **259 adults referred** for investigation and identified as at risk, during the year had an adult protection plan in place at 31st March 2020. (Adult Safeguarding Returns to HSCB).
- This is a **15% decrease** from the previous year, 2018/19.

The ultimate goal of this Trust is to improve the quality of life for those with learning disabilities. This is done by providing a range of services that will support personal choice; move away from a service-led to needs-led approach and challenge and change mind-sets that may affect the individual's potential to become an integral and valued member of their community.

Learning Disability Resettlement Breakdown

Sustainable integration into the community of individuals with learning disabilities who no longer require assessment and treatment in a hospital setting is a priority for all Health and Social Care Trusts.

Within Southern Trust **no people** with a learning disability who were resettled in community placements had to be readmitted to hospital as a result of an irretrievable breakdown of the placement.

Individual Care Assessments

There are a significant population of carers within the region. Health and Social Care Trusts are required to offer individual assessments to those people known to have caring responsibilities.

Facts and Figures

During 2019/20 there were:

- **2510 adult carers** across Physical Disability, Learning Disability, Mental Health and Older People & Primary Care services who were offered individual care assessments.
- This is **a decrease of 36%** on 2018/19.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Direct Payments

Direct Payments provide services users and their families an element of choice in determining the care they receive.

Facts and Figures

During 2019/20:

- **Direct payments are in place for 606 adults**, an **increase of 2 adults** from 2018/19's figure of 604.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Brian Godfrey
Head of Safety Strategy Unit
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

17th October 2016

Dear Brian

World Quality Day 2016

Further to your recent correspondence in relation to the above, I can advise that the Trust has an ongoing commitment to improving quality in the delivery of all our health and social care services. Key principles of our Quality Improvement Framework include senior leadership to support capacity and capability building of all our staff in service improvement methodologies and providing opportunities to listen, learn and recognise all who contribute on the basis of a "no improvement too small" ethos.

To this end, the Trust is hosting a '*Quality & Safety in Action*' event on Wednesday 19th October to coincide with this year's **NHS FabChange Day,** the biggest day of collective action for improvement in the NHS. Our annual event is a celebration of the wide range of quality improvement and safety initiatives underway within Southern Health & Social Care Trust enabled by the commitment of our staff to improving our services. I have enclosed a copy of the Programme for your information.

The Trust plans to use the outputs from this event to mark World Quality Day on the 10th November 2016. This will include distribution of our Quality Improvement Newsletter and Vox Pops from our improvement event speakers and attendees sharing their experience of the day. Communication will be both internal and external using local press and social media to highlight evidence of changes made and efforts underway to enhance quality and safety of Southern Trust services.

In addition, Mrs Margaret Murphy, patient safety advocate and Steering Committee Member, WHO World Alliance for Patient Safety, will share her own personal story and formally launch the Trust 'Quality Network' on 21st November 2016.

I am pleased to extend an invitation to you and/or your team should you wish to attend any of our upcoming events. If you require any further information in respect of our upcoming events or the Trust's wider quality improvement agenda please contact Aldrina Magwood, Acting Director of Performance and Reform in the first instance at [redacted]

Personal Information redacted by the USI

Yours sincerely

Francis Rice

Interim Chief Executive

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

From the Head of Safety Strategy Unit
Brian Godfrey

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC Trust Chief Executives

Castle Buildings
Stormont Estate
Belfast BT4 3SQ

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

Your Ref:
Our Ref: HE1/19/89507

Date: 31st May 2019

Dear colleagues

HSC TRUST ANNUAL QUALITY REPORTS 2018/19

As you will be aware, World Quality Day 2019 will be held on Thursday 14 November 2019. As in previous years, I would be grateful if you could arrange for your Annual Quality Reports (AQRs) for 2018/19 to be published during this week.

I would also ask that your organisation gives consideration to a quality-related activity which might take place or be profiled during World Quality week. This could be any initiative that relates to quality. It does not necessarily have to be a large scale initiative or event but should be one that contributes to the quality agenda in a positive way. I leave it up to each Trust to decide on the most effective initiative to focus on and I would be grateful if you could provide me with information on planned initiatives nearer to the event.

In summary, Trusts should:

- Use the recommended metrics and standardised measurements in the Minimum Dataset when preparing their AQRs **(Annex A)**;

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- Publish AQRs during w/c 11 November 2019 to coincide with World Quality Day on 14 November 2019; and,

- Advise the Department of quality improvement and innovation activities/initiatives that you are showcasing to coincide with World Quality Day.

As an outworking of the Hyponatraemia Inquiry, I have been asked to incorporate some changes into the AQRs in order to implement Recommendations 82 and 83. A standard wording relating to SAIs will be issued shortly to all Trusts and I would ask that you incorporate this into the SAI section of the AQR. A table of numbers of SAI deaths, by Directorate, should also be included, as well as a brief summary of any local learning that has been identified. A separate communication will be issued from me shortly to outline these changes in more detail.

I would like to thank you for your continued support and contribution in producing the AQRs for your organisation. They act as an important showcase to the public of the quality improvement and innovation activity being delivered by your staff in support of the principals underpinning Q2020. It is also important to reflect Q2020 in your business plans and other corporate documentation. I would encourage you to review the visibility of your valuable quality improvement and innovation activity, including your AQRs, on your organisation's website and in publications.

Yours sincerely

Personal Information redacted by the USI

Brian Godfrey
Head of Safety Strategy Unit

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

ANNEX A

GENERAL GUIDELINES FOR DRAFTING REPORTS

- Where a definition/measure is specified for a particular theme/item this should be used. Trusts may add further detail/measures/information as they feel appropriate for any theme.
- Where a measure is reported it should reflect performance of all areas of the Trust as opposed to sample audit data or where this is used it should be clearly described as such.
- Graphs do not have to be used for each measure but where used – one graph only should be used.
- Some themes were identified that could be added to individual Trust reports as considered appropriate:
  - Environmental Responsibility
  - Corporate Social Responsibility
  - Public Health Improvement

The main body of the report should cover the following Themes:

Theme 1: TRANSFORMING THE CULTURE
Theme 2: STRENGTHENING THE WORKFORCE
Theme 3: MEASURING THE IMPROVEMENT
Theme 4: RAISING THE STANDARDS
Theme 5: INTEGRATING THE CARE

The following pages show the information that should be collated under each of these headings.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

THEME/GOAL 1: TRANSFORMING THE CULTURE

Introduction

- Values and behaviours, Mission Statement and vision of the Trust
  This may include the organisational development or core principles or indeed even IIP. It should also encapsulate the HSC Staff Survey which was bench marked previously and described some of the feedback.

Patient and Client Experience

- Report on Trusts participation in 10,000 voices around Acute, Unscheduled, Elective and community care. Information should highlight areas involved.
- PPI – paragraph explaining key work.

Complaints and Compliments

- Number reported and responded to within timeframes for 18/19 year, including the percentage in two days.
- Top 5 categories of complaints and improvements made in relation to these. Include a narrative of how the Trust has responded and improved in light of an Ombudsman case for shared learning.

Adverse Incidents / Serious Adverse Incidents (SAIs)

- Trusts' recorded top five types of adverse incidents and work that is ongoing to address these.
- Include standard SAI paragraph.
- Include Narrative on SAIs and improvements made – Two or Three.
- Include Table of SAI deaths by Directorate
- Include examples of learning.

How the organisation learns

- Regional event.
- Safety Messages.
- Briefings.
- Leadership walk-rounds.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- Clinical attributes training such as SQE or SQB and SAFEtember.

Quality Improvement

- Each Trust to report on work undertaken to deliver a culture that focuses on quality improvement e.g. SQE, SQB/CORE, SAFEtember. This can refer to outcomes from the Taskforce 3 attributes framework work.

THEME/GOAL 2: STRENGTHENING THE WORKFORCE

- Induction
- Mandatory Training
- Clinical Attributes Framework
- IIP
- Money for staff development (Costed Learning Plans)
- Leadership programmes
- Supervision, coaching and mentoring. For supervision we could include educational supervision, postgraduate training, training tracker and undergraduate functions
- Staff achievements section.
- Looking after your staff (e.g. smoking cessation work). Context in preparation for "smoke free" which includes Smoke free, Hear 4 U, Flu vaccination and Fit testing
- Revalidation of medical and nursing staff - % of positive recommendations for revalidation
- Staff absenteeism
- Staff training:- knowledge, skills, framework, PCFS, Mandatory Equality
- Reducing the risk of Hyponatraemia, Infection prevention, RPRB,
- Clinical attributes framework
- Inclusion of profession - specific appraisal rates for all eligible professional staff. (Further guidance will be issued on this).

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

THEME/GOAL 3: MEASURING THE IMPROVEMENT

Infection rates – (C Diff, MRSA)

- Hand Hygiene – to include information on independent hand hygiene audits
- Five year dataset
- To use number of cases and rates and make comparison to PHA target.
- Can include any other infection control information considered appropriate.

Safer Surgery / WHO Checklist

- "Safer Surgery" section should include audit data – this can be continuous or periodic audit.
- Maternal QI
- Paediatric QI

Falls

- To reflect regional falls work done with PHA/Safety Forum – (all wards)
- To show number and rate for a minimum of two years

Pressure Sores

- To reflect the regional pressure sore work done in conjunction with the PHA and Safety Forum and to show the number of rate for a minimum of two years.

VTE

- To report on % compliance with the risk assessment. Trusts should report all audit data available and where audit does not include all areas – the selection of wards should be described. Run chart going back two or more years.

Medicines Management

- All Trusts to include work on:
  - Omitted & delayed doses
  - Medicine reconciliation to be included as mandatory
  - At least one other piece on improvements from selected from list below:
    - INR's

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- Insulin

Cardiac arrest rates

THEME/GOAL 4: RAISING THE STANDARDS

Standardised Mortality Ratio – Funnel chart. Include clear description and any additional information.

Emergency Re-admission rate – To use CHKS data monthly points in graph form if available for at least two years.

Emergency Department

- To report 4 and 12 hour standards, including comparison with 17/18 and 18/19 year.
- SEPSIS 6 within ED
- Additional quality measures include:
  - Time to be seen by ED Doctor/ENP (All patients)
  - People who leave without being seen
  - Actions taken to make improvements to performance in these standards.
  - Re-attendance at ED on a monthly basis

NICE Guidelines – ensuring compliance.

National Audits

- A minimum of two should be included – one nationally and one with RQIA.
- Timeframe: National Audit report is 'published' within 18/19 (even if based on data collected during 17/18).
- Pieces to include 'next steps' to outline what action will be taken.

Cancer Standards targets to be included as a quality matrix

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

THEME/GOAL 5: INTEGRATING THE CARE

Community Care

- Examples of improvement work undertaken by Trusts to meet the needs of community clients e.g.:
  - Telemonitoring
  - Support Nursing Homes
  - Rapid Access Teams
  - Intermediate Care
  - Facilitating Early Discharge
  - Home Treatment
  - District Nursing
  - Acute care at home
  - Health Visiting

  This will reflect some social care input and should support the Transforming Your Care agenda.

Mental Health

- Mental Health: To report on progress on work carried out with the Safety Forum around:
  - Crisis planning – forward planning
  - Physical care of the mentally ill (Schizophrenia Report Nov 2012).
  - Delirium bundles. Lithium pathway or antipsychotic cardiac screening but would be guided by an update from the Safety Forum

Social Care

13/14 indicators produced by HSCB to continue to be used for 18/19 reports (see Annex B). These should be included under the Theme/Goal 5 – Integrating the Care)

Theme 1 - Effective Health & Social Care

- Children Protection – children seen within 24 hours

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- Looked after Children
  - Reviews / Care planning
  - Permanence plan
- Adult Safeguarding
  - Adult Protection Plan
- Carers Assessments
- Resettlement of Adults with a Learning Disability

(For further guidance see Annex B)

Theme 2 - Delivering Best Practice in Safe Health and Social Care Settings

Delivery of Best Practice

- Direct Payments for Children
- Education & Training for Young People leaving care
- Children's Disability Transition
- Direct Payments for Adults
- Approved Social Work – mental health

(For further guidance see Annex B)

Update on Integrated Care Partnerships

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

ANNEX B

Annual Quality 2020 Reports - Social Care Indicators

CHILDRENS SOCIAL CARE SERVICES

Theme 1

Effective Health and Social Care

1. It is essential that children and young people identified as potentially at risk are seen by a social worker and receive a timely response for assessment. Regional child protection procedures require that children identified as being at risk are seen within 24 hours.
   In this reporting period (Trust Inserts*) % of children or young person were seen within 24 hours of a Child protection referral being made. (Source: HSCB-Priority 5 Return).

2. Children who become looked after by Health and Social Care Trust's must have their living arrangements and care plan reviewed within agreed timescales in order to ensure that the care they are receiving is safe, effective and tailored to meet their individual needs and requirements and preserves and maintains the rights under the United Nations Convention on the Rights of the Child and Article 8 of the European Convention on Human Rights (ECHR), enshrined by the Human Rights Act 1998.

   In this reporting period * % of looked after children within the (insert Trust*) Health and Social Care Trust were reviewed within regionally agreed timescales. (Source: DSF/Corporate Parenting Returns 10.3.17/10.3.18)

3. Every looked after child needs certainty about their future living arrangements and through Permanency Planning, this Trust aims to provide every looked after child with a safe, stable environment in which to grow up. A sense of urgency should exist for every child who is not in a permanent home.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Permanency planning starts at first admission to care and continues throughout the lifetime of the child or young person's case until permanency is achieved. In this reporting period *% of all looked after children in care for more than 3 months have a Permanency Panel Recommendation (CP 10.3.26).

Theme 2

Delivering Best Practice in Safe Health and Social Care Settings

1. The provision of direct payments by a Health and Social Care Trust enables families to locally source the care they require. Allowing the individual to choose how they are supported within their community. * % is the number of children receiving Direct Payments as set against the HSCB commissioning direction target DSF/Corporate Parenting Returns (5.9).

2. Research tells us that young people who leave care do not always achieve the same levels in education, training, and employment as other young people in the community. * % of young people known to leaving an aftercare services in the *Health and Social Care Trust are engaged in education, training, and employment. DSF/Corporate Parenting Returns (10.4.10)

3. The transition from children to adult for those children and young people who have a disability is best assisted by a transition plan. *% of disabled children has a transition plan in place when they leave school within the * Health and Social Care Trust. Source: DSF/Corporate Parenting Returns (10.1.7)

ADULT SOCIAL CARE SERVICES

Theme 1

Effective Health and Social Care

1. There are many vulnerable people in the community and those who are most at risk of abuse, neglect or exploitation should have in place adult protection plans following investigation. In * Health and Social Care Trust *% of adults referred for investigation and identified as at risk of abuse, neglect or exploitation, during the year had an adult protection plan in place at 31st March 2018. (Adult Safeguarding Returns to HSCB)

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

2. There are a significant population of carer's within the region. Health and Social Care Trusts are required to offer individual assessments to those people known to have caring responsibilities. During this period adult carers * were offered individual care assessments as set against the commissioning direction target by HSCB. DSF/Corporate Parenting Returns (5.1)

3. The ultimate goal of this Trust is to improve the quality of life for those with learning disabilities. This is done by providing a range of services that will support personal choice; move away from a service-led to needs-led approach and challenge and change mind-sets that may affect the individual's potential to become an integral and valued member of their community.

   Sustainable integration into the community of individuals with learning disabilities who no longer require assessment and treatment in a hospital setting is a priority for all HSCTs. Within * HSCT x% of people with a learning disability who were resettled in community placements had to be readmitted to hospital as a result of an irretrievable breakdown of the placement.

Theme 2
Delivering Best Practice in Safe Health and Social Care Settings

1. As reported at 1.3 direct payments provide services users and their family an element of choice in determining the care they receive.
   * Received direct payments as set against the commissioning direction target DSF/Corporate Parenting Returns (5.8 & 5.9).

   * Of carers received direct payments as set against the commissioning direction target. DSF/Corporate Parenting Returns (5.10)

2. The Learning Disability Service Framework Standard 20 outlines the importance of adults with a learning disability having an annual health check.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Within * Health and Social Care Trust *% of adults with a learning disability had an annual health check.

3. Sometimes it is necessary, for the protection of an individual, and to prevent harm to themselves or others, to detain people in hospital for assessment under the Mental Health Order.

   Applications can be made by an Approved Social Worker or by the persons nearest relative. Good practice says that it is preferable that applications for assessment should not be a burden born by families, in order to preserve on-going relationships and not to threaten necessary support during and after detention in hospital. These actions are always considered alongside an individual's human rights, particularly Article 5 and Article 8 of the ECHR In *HSCT x% of applications for assessment were made by ASWs. (DSF 9.1 & 9.1c)

(Approved at Regional Governance Meeting, 2 July 2014)

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

From the Head of Safety Strategy Unit
David Wilson

HSC Trust Chief Executives

Castle Buildings
Stormont Estate
Belfast BT4 3SQ

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

Your Ref:
Our Ref: HE1/20/305150

Date: 8th July 2020

Dear colleagues

HSC TRUST ANNUAL QUALITY REPORTS 2019/20

As you will be aware, Annual Quality Reports act as an important showcase to the public of the quality improvement and innovation activity being delivered by your staff in support of the principals underpinning Q2020.

I understand that Trusts are facing additional pressures this year dealing with Covid - 19. Therefore I am lifting the time restriction on publication of your Annual Quality Report by November and instead ask that they are completed and on your organisations website before 31st March 2021.

I would also ask that you include a section in this year's report on how your Trust has learnt from the Covid-19 pandemic and how it will move forward.

In summary, Trusts should:

- Use the recommended metrics and standardised measurements in the Minimum Dataset when preparing their AQRs **(Annex A)**;

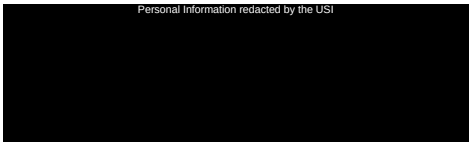
Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.
INVESTORS IN PEOPLE

- Include a section in this year's report on how your Trust has learnt from the Covid-19 pandemic and how it will move forward;

- Publish AQRs before 31st March 2021.

I would like to thank you for your continued support and contribution in producing the AQRs for your organisation.

Yours sincerely



David Wilson
Head of Safety Strategy Unit

Cc Dr M McBride.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.
INVESTORS IN PEOPLE

ANNEX A

GENERAL GUIDELINES FOR DRAFTING REPORTS

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- Report on Trusts participation in 10,000 voices around Acute, Unscheduled, Elective and community care. Information should highlight areas involved.
- PPI – paragraph explaining key work.

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- Trusts' recorded top five types of adverse incidents and work that is ongoing to address these.
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- Include Narrative on SAIs and improvements made – Two or Three.
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- Leadership walk-rounds.

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THEME/GOAL 2: STRENGTHENING THE WORKFORCE

- Induction
- Mandatory Training
- Clinical Attributes Framework
- IIP
- Money for staff development (Costed Learning Plans)
- Leadership programmes
- Supervision, coaching and mentoring. For supervision we could include educational supervision, postgraduate training, training tracker and undergraduate functions
- Staff achievements section.
- Looking after your staff (e.g. smoking cessation work). Context in preparation for "smoke free" which includes Smoke free, Hear 4 U, Flu vaccination and Fit testing
- Revalidation of medical and nursing staff - % of positive recommendations for revalidation
- Staff absenteeism
- Staff training:- knowledge, skills, framework, PCFS, Mandatory Equality
- Reducing the risk of Hyponatraemia, Infection prevention, RPRB,
- Clinical attributes framework
- Inclusion of profession - specific appraisal rates for all eligible professional staff. (Further guidance will be issued on this).

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

THEME/GOAL 3: MEASURING THE IMPROVEMENT

Infection rates – (C Diff, MRSA)

- Hand Hygiene – to include information on independent hand hygiene audits
- Five year dataset
- To use number of cases and rates and make comparison to PHA target.
- Can include any other infection control information considered appropriate.

Safer Surgery / WHO Checklist

- "Safer Surgery" section should include audit data – this can be continuous or periodic audit.
- Maternal QI
- Paediatric QI

Falls

- To reflect regional falls work done with PHA/Safety Forum – (all wards)
- To show number and rate for a minimum of two years

Pressure Sores

- To reflect the regional pressure sore work done in conjunction with the PHA and Safety Forum and to show the number of rate for a minimum of two years.

VTE

- To report on % compliance with the risk assessment. Trusts should report all audit data available and where audit does not include all areas – the selection of wards should be described. Run chart going back two or more years.

Medicines Management

- All Trusts to include work on:
  - Omitted & delayed doses
  - Medicine reconciliation to be included as mandatory
  - At least one other piece on improvements from selected from list below:
    - INR's

- Insulin

Cardiac arrest rates

THEME/GOAL 4: RAISING THE STANDARDS

Standardised Mortality Ratio – Funnel chart. Include clear description and any additional information.

Emergency Re-admission rate – To use CHKS data monthly points in graph form if available for at least two years.

Emergency Department

- To report 4 and 12 hour standards, including comparison with 17/18 and 18/19 year.
- SEPSIS 6 within ED
- Additional quality measures include:
  - Time to be seen by ED Doctor/ENP (All patients)
  - People who leave without being seen
  - Actions taken to make improvements to performance in these standards.
  - Re-attendance at ED on a monthly basis

NICE Guidelines – ensuring compliance.

National Audits

- A minimum of two should be included – one nationally and one with RQIA.
- Timeframe: National Audit report is 'published' within 201/20 (even if based on data collected during 2019/20).
- Pieces to include 'next steps' to outline what action will be taken.

Cancer Standards targets to be included as a quality matrix

THEME/GOAL 5: INTEGRATING THE CARE

Community Care

- Examples of improvement work undertaken by Trusts to meet the needs of community clients e.g.:
  - Telemonitoring
  - Support Nursing Homes
  - Rapid Access Teams
  - Intermediate Care
  - Facilitating Early Discharge
  - Home Treatment
  - District Nursing
  - Acute care at home
  - Health Visiting

  This will reflect some social care input and should support the Transforming Your Care agenda.

Mental Health

- Mental Health: To report on progress on work carried out with the Safety Forum around:
  - Crisis planning – forward planning
  - Physical care of the mentally ill (Schizophrenia Report Nov 2012).
  - Delirium bundles. Lithium pathway or antipsychotic cardiac screening but would be guided by an update from the Safety Forum

Social Care

13/14 indicators produced by HSCB to continue to be used for 2019/20 reports (see Annex B). These should be included under the Theme/Goal 5 – Integrating the Care)

Theme 1 - Effective Health & Social Care

- Children Protection – children seen within 24 hours

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- Looked after Children
  - Reviews / Care planning
  - Permanence plan
- Adult Safeguarding
  - Adult Protection Plan
- Carers Assessments
- Resettlement of Adults with a Learning Disability

(For further guidance see Annex B)

Theme 2 - Delivering Best Practice in Safe Health and Social Care Settings

Delivery of Best Practice

- Direct Payments for Children
- Education & Training for Young People leaving care
- Children's Disability Transition
- Direct Payments for Adults
- Approved Social Work – mental health

(For further guidance see Annex B)

Update on Integrated Care Partnerships

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

ANNEX B

Annual Quality 2020 Reports - Social Care Indicators

CHILDRENS SOCIAL CARE SERVICES

Theme 1

Effective Health and Social Care

1. It is essential that children and young people identified as potentially at risk are seen by a social worker and receive a timely response for assessment. Regional child protection procedures require that children identified as being at risk are seen within 24 hours.
   In this reporting period (Trust Inserts*) % of children or young person were seen within 24 hours of a Child protection referral being made. (Source: HSCB-Priority 5 Return).

2. Children who become looked after by Health and Social Care Trust's must have their living arrangements and care plan reviewed within agreed timescales in order to ensure that the care they are receiving is safe, effective and tailored to meet their individual needs and requirements and preserves and maintains the rights under the United Nations Convention on the Rights of the Child and Article 8 of the European Convention on Human Rights (ECHR), enshrined by the Human Rights Act 1998.

   In this reporting period * % of looked after children within the (insert Trust*) Health and Social Care Trust were reviewed within regionally agreed timescales. (Source: DSF/Corporate Parenting Returns 10.3.17/10.3.18)

3. Every looked after child needs certainty about their future living arrangements and through Permanency Planning, this Trust aims to provide every looked after child with a safe, stable environment in which to grow up. A sense of urgency should exist for every child who is not in a permanent home.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Permanency planning starts at first admission to care and continues throughout the lifetime of the child or young person's case until permanency is achieved. In this reporting period *% of all looked after children in care for more than 3 months have a Permanency Panel Recommendation (CP 10.3.26).

Theme 2

Delivering Best Practice in Safe Health and Social Care Settings

1. The provision of direct payments by a Health and Social Care Trust enables families to locally source the care they require. Allowing the individual to choose how they are supported within their community. * % is the number of children receiving Direct Payments as set against the HSCB commissioning direction target DSF/Corporate Parenting Returns (5.9).

2. Research tells us that young people who leave care do not always achieve the same levels in education, training, and employment as other young people in the community. * % of young people known to leaving an aftercare services in the *Health and Social Care Trust are engaged in education, training, and employment. DSF/Corporate Parenting Returns (10.4.10)

3. The transition from children to adult for those children and young people who have a disability is best assisted by a transition plan. *% of disabled children has a transition plan in place when they leave school within the * Health and Social Care Trust. Source: DSF/Corporate Parenting Returns (10.1.7)

ADULT SOCIAL CARE SERVICES

Theme 1

Effective Health and Social Care

1. There are many vulnerable people in the community and those who are most at risk of abuse, neglect or exploitation should have in place adult protection plans following investigation. In * Health and Social Care Trust *% of adults referred for investigation and identified as at risk of abuse, neglect or exploitation, during the year had an adult protection plan in place at 31st March 2019. (Adult Safeguarding Returns to HSCB)

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

2. There are a significant population of carer's within the region. Health and Social Care Trusts are required to offer individual assessments to those people known to have caring responsibilities. During this period adult carers * were offered individual care assessments as set against the commissioning direction target by HSCB. DSF/Corporate Parenting Returns (5.1)

3. The ultimate goal of this Trust is to improve the quality of life for those with learning disabilities. This is done by providing a range of services that will support personal choice; move away from a service-led to needs-led approach and challenge and change mind-sets that may affect the individual's potential to become an integral and valued member of their community.

   Sustainable integration into the community of individuals with learning disabilities who no longer require assessment and treatment in a hospital setting is a priority for all HSCTs. Within * HSCT x% of people with a learning disability who were resettled in community placements had to be readmitted to hospital as a result of an irretrievable breakdown of the placement.

Theme 2
Delivering Best Practice in Safe Health and Social Care Settings

1. As reported at 1.3 direct payments provide services users and their family an element of choice in determining the care they receive.
   * Received direct payments as set against the commissioning direction target DSF/Corporate Parenting Returns (5.8 & 5.9).

   * Of carers received direct payments as set against the commissioning direction target. DSF/Corporate Parenting Returns (5.10)

2. The Learning Disability Service Framework Standard 20 outlines the importance of adults with a learning disability having an annual health check.

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Within * Health and Social Care Trust *% of adults with a learning disability had an annual health check.

3. Sometimes it is necessary, for the protection of an individual, and to prevent harm to themselves or others, to detain people in hospital for assessment under the Mental Health Order.

   Applications can be made by an Approved Social Worker or by the persons nearest relative. Good practice says that it is preferable that applications for assessment should not be a burden born by families, in order to preserve on-going relationships and not to threaten necessary support during and after detention in hospital. These actions are always considered alongside an individual's human rights, particularly Article 5 and Article 8 of the ECHR In *HSCT x% of applications for assessment were made by ASWs. (DSF 9.1 & 9.1c)

(Approved at Regional Governance Meeting, 2 July 2014)

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Minutes of a Virtual Trust Board meeting held on Thursday, 28th October 2021 at 10.15 a.m.

PRESENT

Ms E Mullan, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services /Executive Director of Social Work
Dr M O'Kane, Medical Director / Interim Director of Mental Health and Learning Disability Services
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mrs A Magwood, Director of Performance and Reform
Mr B Beattie, Interim Director of Older People and Primary Care
Mrs M McClements, Director of Acute Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs R Rogers, Head of Communications
Mrs S McKinney, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary *(Minutes)*

APOLOGIES

None.

1. CHAIR'S WELCOME

The Chair welcomed everyone to the virtual meeting including Mrs Susan McKinney, Boardroom Apprentice 2021. At this point, the

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Chair particularly welcomed five members of Trust staff from the Mental Health and Disability Services Directorate and stated that she would appreciate their feedback in terms of what they will learn at today's meeting and how they take this learning back to their colleagues. Regular public attendees were also welcomed to the meeting.

The Chair reminded everyone regarding some aspects of virtual meeting etiquette and the business of the meeting proceeded.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflicts of interest in relation to any matters on the agenda. None were declared.

3. SERVICE IMPROVEMENT/LEARNING FROM SERVICE USER EXPERIENCE

'Voice of the Patient'

At the outset, the Chair advised circumstances had not permitted the 'Voice of the Patient' item to proceed as planned, however Mrs Trouton would share a number of experiences that have come through 'Care Opinion' and also provide background to the tool and its functionality within the Southern Trust. The Chair stated she had raised with a number of colleagues, her thoughts on how the Patient and Client Experience Committee, with the support of the Patient Client Council, can enable patients and their families to share their personal journeys with the Trust into the future.

Mrs Trouton provided an overview of Care Opinion with a focus on the recent pilot that commenced in June 2021 within the Acute Wards and now moving out to other areas. The aim of the pilot is to seek real-time feedback from patients and to address any concerns they have prior to discharge. To date, there have been 1328 participants in the scheme and members noted the emerging themes, along with the changes planned or already implemented to improve the patient experience. Mrs McClements provided assurance that all learning is being taken on board and staff are working hard to address any issues.

At this point Ms White, Royal College of Nursing Rep added to the positive feedback referred to in the presentation and put on record her sincere personal thanks to staff across various departments for the exceptional care she along with other family members have received.

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Members welcomed the presentation and on reflection, the Chief Executive stated that from inception, Care Opinion had been about capturing the voice of the patient, but also about giving a voice to the patient/client to enable the Trust to make improvements. Mrs Magwood commended the work from a Quality Improvement perspective and stated as the organisation works to improve services, the approach taken in bringing in the patient experience at an early stage is very welcome. She added that whilst standards are essential from a Clinical Governance perspective it is important that data that drives improvement from an experience point of view is fully optimised.

Mr Wilkinson added that the Patient and Client Experience Committee have been privileged to follow the tool from its inception and pointed out it is only one of the ways feedback can be gleaned from service users and clients. He stated that this first hand real time feedback and learning is critical to inform the journey of improved service delivery and highlighted a helpful pilot with Junior Medics which has yielded valuable learning in terms of their relationship skills with patients.

Mrs McCartan asked if this was an electronic bespoke package. Mrs Trouton explained the online system can be accessed by anyone through an app enabling them to upload service user feedback at any time and can also be utilised as a data analysis tool by staff prior to patients leaving hospital. Mrs McCartan welcomed the positive assurance provided in terms of seeking to provide safe quality care. Mrs Toal advised this exceptional tool has reinforced the staff recognition theme alluded to at the Board Workshop in September. She welcomed the valuable information available to assist with the development of the People Plan and drive this from an improvement and training point of view, as well as staff recognition.

In conclusion, the Chair thanked Mrs Trouton for the informative presentation and asked that work would continue on looking at ways to create a safe space for patients and service users to share their real life experiences.

4. CHAIR'S REMARKS

The Chair spoke of the sustained pressure across the health and social care system which continues to increase on a daily basis and shared some statistics on attendances and admissions across the Southern Trust over the four week period since 30th September 2021. She asked all present to be mindful of the ongoing pandemic situation and emphasised the importance of the public knowing the plans for the

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months ahead and what measures are being taken to protect them. To that end the Chair welcomed recent publications/announcements regarding Autumn/Winter surge planning, along with the £230m funding reallocation to the Department of Health (DoH). She also commended the rolling out of the booster and flu vaccination, along with all measures that prevent the spread of Covid 19 and was delighted to record a special recognition award had been given to all Southern Trust staff by the Newry Chamber of Commerce, as thanks to all Health Care staff for the vital role they have played in helping to care for citizens across the locality.

5. CHIEF EXECUTIVE'S EMERGING ISSUES

The Chief Executive informed members of a number of emerging issues.

- **Surgical services in the Southern Trust**

Work is progressing regionally and locally to develop plans for surgical services in Northern Ireland. The Trust is currently looking at a change in model and will undertake a consultation process for any changes required. The Chief Executive advised that updates will be provided to Trust Board.

Action – Chief Executive

Ms Donaghy raised the workforce issues amongst Doctors and asked how optimistic the Trust was in terms of being able to secure additional surgeons for this area and also the plan to carry out more integrated work on a regional basis. In responding the Chief Executive stated that the recruitment and retention challenge facing surgical services is an issue for all Trusts and the Trust is involved, along with the other Trusts, in regional discussions to develop plans for surgical services. Mrs McClements advised that recruitment to general surgery has been progressing, however to date no appointments have been made and she alluded to the need to reconfigure these posts in keeping with surgical career pathways and training perspectives. The Trust is currently optimising its own surgical pool to make best use of the current resources and in terms of recruitment, promoting the Southern Trust as an attractive employer of choice. Dr O'Kane concurred and added that as a result of the pandemic, general surgery has become a disincentive for trainees, along with an unattractive Work Life Balance for staff. She emphasised the surgical team was keen to promote improved efficiency, making sure waiting times are positively impacted and perusing ways of optimising the working capacity and attracting staff into the Organisation because they

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will see this has a significant training opportunity. All forms of virtual training have been exploited throughout the pandemic; however it is imperative that trainees and surgeons themselves get hands on experience to avoid deskilling, which is becoming an increasing concern across the region. Ms Donaghy welcomed the matter was being progressed both locally and regionally.

- **Winter Planning**

Members were reminded about a number of significant challenges including longer patient waiting times and staff burnout along with major capacity gaps across all Trusts. Major Service decisions will be required over the winter period and these will be communicated through Trust Board appropriately.

- **New Planning Model**

In light of the future HSCB closure, discussions are underway with regards to the Future Planning Model. The recently consulted model outlines a move towards a greater Integrated Care System (ICS). A regional consultation has taken place. Members were advised Trust Chief Executives will meet Department of Health Officials in November 2021 with regards to how health and social care will be planned and delivered in the future.

- **Senior Management Structures**

The Chief Executive presented the outcome of Senior Management Team engagement on internal restructuring. The new structure comprises a Deputy Chief Executive and six corporate Directorates. Members asked a number of questions in relation to recruitment to these posts and the 3 current vacant posts at Senior Executive level to which the Chief Executive responded.

The Chair requested Item 8, would be taken next on the agenda.

STRATEGY

8. TRUST SERVICE DELIVERY PLAN INLCUDING RESILIENCE PLAN TO ADDRESS WINTER PRESSURES AND ANY SUBSEQUENT WAVES OF COVID19 PANDEMIC OCTOBER 2021 – MARCH 2022

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

The Chair introduced the item and emphasised the importance of Trust staff and the Southern population understanding the measures and plans in place in light of the challenges ahead over the next 4-6 month period. The Chief Executive pointed out the document was one of five Resilience Plans for submission to the DoH by Trusts to address predicted Winter pressures. He emphasised how important the document was in light of the enormity of the pressures right across the region.

Mrs Magwood outlined the key elements and stated the document demonstrates service delivery proposals to address the predicted increase in unscheduled care as well as reflecting the ongoing response to the Covid pandemic and the regionally predicted further 'surge'. She asked members to be mindful of the fluidity of the plan as the organisation reacts and responds to operational services as the need arises.

At this point members were referred to page 43, Appendix 1 which outlines the approach the Southern Trust will adopt to address the anticipated challenges, focusing specifically on three key areas:

- Measures to avoid ED attendance/acute hospital admissions
- Optimising Flow - Bed Capacity/Discharge
- Regional Interface and extreme contingency bed 'spaces'

Members considered the detail and Mr McDonald asked if the GP Out of Hours (GP OoH) Service had been ruled out as a potential source in terms of assisting with avoiding admissions/ED attendance. In response, Mrs Magwood pointed out that the detail within the Winter plan is an enhancement or an addition to normal services and reminded members GP OoH works as part of the organisation's core response to avoiding admissions. Mrs Magwood advised she had identified by exception, the areas the Trust is doing something different/more of throughout the Winter period. She stated the ability to enhance the cover already provided at GP OoH has not been included within the plan and explained the rationale for this. Mr McDonald continued by asking if there was evidence to suggest GP OoH could become a more resilient service throughout the winter months to which Mr Beattie confirmed there were early indications of an increased interest from GPs. He referred to the skill mix approach adopted by the Trust in prior years which has been helpful and stated work will continue to build further robustness and reliance within the service.

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Mr Wilkinson asked if the Trust was likely to get additional funding to support the resilience plan and in relation to outcomes, what evidence is available to show that these mitigating processes do have an impact. In responding Ms Teggart advised, the Trust has set aside £1.7m of its annual budget allocation for the Winter Plan. She also advised the Trust is awaiting the outcome of a bid for additional funding, lodged as part of the October Monitoring Round, with a further round expected in January 2022. Mrs Magwood assured members the winter period is extensively monitored at Operational level by the Trust SMT and the Trust undertake continual evaluation to assist learning and further decision making year on year. From a regional perspective, outcomes from other Trusts are closely monitored and a regional group analyses information. Learning is shared regionally throughout the winter period.

At this point Mrs Magwood referred to a number of pressures including Acute Hospital Bed Capacity and uncertainty in the financial context. Members noted the potential impact on the Trust's ability to deliver against plans. Mrs Magwood assured members that mitigation factors have been put in place and the Trust is currently involved in regional modelling, however the support of the local Community and Political representatives is required to assist in getting through the winter period.

Ms Donaghy referred to the gap in Acute beds and asked if decisions required on thresholds for admission/discharge would require regional agreement. Mrs Magwood assured members that all alternative pathways are explored and welcomed the work of the Acute Care at Home Team, providing hospital level care at home. Dr O'Kane added there was evidence of robust decision making by clinical teams which has assisted in favourable conversion rates.

The Chair recorded appreciation for the comprehensive overview and mitigations in place to assist the Trust and regional counterparts through the challenging winter period.

6. MINUTES OF MEETING HELD ON 30TH SEPTEMBER 2021

The minutes of the meeting held on 30th September 2021 were agreed as an accurate record and duly signed by the Chair.

The Board approved the minutes of the meeting held on 30th September 2021.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

7. MATTERS ARISING FROM PREVIOUS MEETING

Members noted the progress update from the relevant Directors to issues raised at the previous meeting.

CULTURE

9. PEOPLE PLAN

The Chair welcomed Mrs Toal and Mrs Williamson to present the work to date on the strategy document 'Our People 2021-2024' and members were reminded this will be one part of a fully integrated set of three strategic documents; Corporate Plan; Safety, Quality & Experience and Our People.

At the outset, Mrs Toal referred to the recent Board workshop convened in September 2021 which had been very productive in feeding into the thinking behind the strategy, with the document's principle outcome being 'A framework for transforming our workplace…… transforming our care'.

Mrs Toal and Mrs Williamson outlined the purpose and key components of the plan advising that the next 5 months would be used to engage with the workforce on the content of the framework and build awareness and understanding, to create the connections and conditions to enable our people to come forward in active support of its implementation and to agree key areas of focus across each directorate. Members noted a formal launch of the published framework is expected in April 2022.

Discussion ensued and members welcomed the ethos of the plan and the priorities, 'Wellbeing, Belonging and Growing' being key to creating the culture the organisation is striving to achieve. In particular members reflected on the importance of dealing with behaviour inconsistent with Trust values. Whilst challenges were acknowledged, there was an emphasis on the need to empower staff to embrace the movement to cultural change through listening and support. It was stated the plan should be permeated with actions and suggestion made that it may be beneficial to look at a model creating a network of staff working as cultural champions and first leaders.

As regards next steps, Mrs Toal emphasised the vital role leaders within the organisation have to play and stated the next 5 months will be crucial

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in terms of engaging with this cohort and Directorate teams will be working to develop their people priorities.

In conclusion, the Chair thanked both Mrs Toal and Mrs Williamson for the informative presentation and good progress to date. She invited members to consider both individually and what the Trust Board collectively can do to be 'the first followers' in making this a lasting change. The Chair requested all responses to be forwarded by 3rd December 2021.

Action – Chair

10. TRUST ANNUAL QUALITY REPORT (ST1077/21)

Mrs Magwood presented the Trust's Annual Quality Report for approval and reminded members the document is published in response to the DoH's Quality 2020 Strategy. She stated the report provides an overview of the 2020/21 year with respect to how the Trust performed against a range of core indicators of quality and includes some examples of improvements led by staff. The report also outlines how the Trust responded to the Covid19 pandemic, detailing service changes and workforce mobility and resilience during a significantly challenging period. Members noted across the region, all Trusts publish their Annual Quality Report to coincide with World Quality Day on 11th November 2021. The Chief Executive commended the detail within the document and stated it clearly reflected the excellent flavour of services staff deliver across the Southern locality.

In conclusion, Mrs Magwood advised the Southern Trust Connect App has been shortlisted as part of the 'Belfast Telegraph' I.T. Awards taking place on 5th November 2021 and she commended the work undertaken by both Trust Human Resources and Organisational Development and I.T. teams on the project.

The Board approved the Trust Annual Quality Report 2020/21 (ST1077/21)

Dr O'Kane left the meeting at this point.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

ACCOUNTABILITY

11. PERFORMANCE COMMITTEE

- **Committee Chair Report from 2nd September 2021**
  Mrs Leeson presented her Committee Chair Report from the meeting held on 2nd September 2021.

- **Committee Annual Report 2020/21 (ST1078/21)**
  Mrs Leeson presented the Committee Annual Report 2020/21 for approval.

  The Board approved the Committee Annual Report 2020/21 (ST1078/21)

- **Revised Terms of Reference (ST1079/21)**
  Mrs Leeson presented the Committee Terms of Reference for approval.

  The Board approved the Committee Terms of Reference (ST1079/21)

12. GOVERNANCE COMMITTEE

- **Committee Chair Report from 9th September 2021**
  Ms Mullan presented her Committee Chair Report from the meeting held on 9th September 2021.

- **Minutes of meeting held on 13th May 2021**
  Ms Mullan presented the minutes of the Governance Committee meeting for information purposes.

13. PATIENT & CLIENT EXPERIENCE COMMITTEE

- **Committee Chair Report from 16th September 2021**
  Mr Wilkinson presented his Committee Chair Report from the meeting held on 16th September 2021.

- **Minutes of meeting held on 17th June 2021**
  Mr Wilkinson presented the minutes of the Patient and Client Experience Committee meeting for information purposes.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- **Committee Annual Report 2020/21 (ST1080/21)**
  Mr Wilkinson presented the Committee Annual Report 2020/21 for approval.

  The Board approved the Patient & Client Experience Committee Annual Report (ST1080/21)

14. ENDOWMENTS & GIFTS COMMITTEE

- **Committee Chair Report from 4th October 2021**
  Ms Donaghy presented her Committee Chair Report from the meeting held on 4th October 2021.

- **Minutes of meeting held on 15th June 2021**
  Ms Donaghy presented the minutes of the Endowments and Gifts Committee meeting for information purposes.

- **Committee Work Programme 2022 (ST1081/21)**
  Ms Donaghy presented the Committee Work Programme 2022 for approval.

  The Board approved the Committee Work Programme 2022 (ST1081/21)

15. AUDIT COMMITTEE

- **Committee Chair Report from 14th October 2021**
  Mrs McCartan presented her Committee Chair Report from the meeting held on 14th October 2021.

- **Minutes of meeting held on 15th June 2021**
  Mrs McCartan presented the minutes of the Audit Committee meeting for information purposes.

- **Committee Work Programme 2022 (ST1082/21)**
  Mrs McCartan presented the Committee Work Programme 2022 for approval.

  The Board approved the Committee Work Programme 2022 (ST1082/21)

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

16. REPORT TO THOSE CHARGED WITH GOVERNANCE 2020/21

Members discussed the final report as presented to the Audit Committee on 14th October 2021.

Ms Teggart pointed out the audit had raised four Priority 2 and four Priority 3 recommendations all of which are being progressed or are fully implemented at this point. She referred to the accrual in relation to holiday pay and advised Trust's still await direction from the DoH on the matter. Mrs McCartan advised that as Chair of the Audit Committee she had requested a paper be prepared for the meeting scheduled for February 2022 in advance of year end preparation work.

17. APPLICATION OF TRUST SEAL (ST1083/21)

Ms Teggart sought approval for the Application of the Trust Seal to contract documentation as outlined in members' papers.

The Board approved the Application of the Trust Seal (ST1083/21)

18. MID-YEAR ASSURANCE REPORT

Ms Teggart presented the draft Mid-Year Assurance Statement for information and stated the document had also been reviewed by the Audit Committee on 14th October 2021. She reminded members that the DoH continue to pause a number of key governance activities including the Mid-Year Assurance Statement; therefore there is no requirement to formally submit to the Department, however the Trust continue the progress internally.

19. CHAIR AND CHIEF EXECUTIVE'S BUSINESS AND VISITS INCLUDING NON-EXECUTIVE DIRECTORS' BUSINESS AND VISITS

The Chair drew members' attention to the written report detailing events the Trust Chair and Chief Executive had attended since the previous meeting, together with details of some good news stories and innovative work across the Trust. A list of Non-Executive Directors' business and visits was also noted.

20. ANY OTHER BUSINESS

The Chair asked the Executive Directors of Medicine, Social Work, Nursing and Finance if there were any other issues relating to their

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professional roles they wished to bring to the Board's attention. There were none noted.

At this point, in response to the Chair's request for feedback on the meeting, Mr Entee stated that it had been a positive experience to hear about the breadth of items discussed by the Board and he particularly welcomed the focus on patient care and the appreciation of staff by Trust Board members. He asked about community and voluntary sector reporting to Trust Board to which the Chair advised that the Trust Board has an annual cycle of reporting in place which covers information from a range of areas and welcomed Mr Entee to attend a future meeting to hear more.

In conclusion, the Chair recorded thanks to everyone for their attendance and participation in the virtual meeting and advised the next meeting would take place on Thursday, 27th January 2022 at 9.45 a.m.

The meeting concluded at 1.30pm

SIGNED: _____ DATED: _____

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

From the Head of Safety Strategy Unit
Brian Godfrey

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC Trust Chief Executives

Castle Buildings
Stormont Estate
Belfast BT4 3SQ

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

Your Ref:
Our Ref: HE1/19/89507

Date: 31st May 2019

Dear colleagues

HSC TRUST ANNUAL QUALITY REPORTS 2018/19

As you will be aware, World Quality Day 2019 will be held on Thursday 14 November 2019. As in previous years, I would be grateful if you could arrange for your Annual Quality Reports (AQRs) for 2018/19 to be published during this week.

I would also ask that your organisation gives consideration to a quality-related activity which might take place or be profiled during World Quality week. This could be any initiative that relates to quality. It does not necessarily have to be a large scale initiative or event but should be one that contributes to the quality agenda in a positive way. I leave it up to each Trust to decide on the most effective initiative to focus on and I would be grateful if you could provide me with information on planned initiatives nearer to the event.

In summary, Trusts should:

- Use the recommended metrics and standardised measurements in the Minimum Dataset when preparing their AQRs **(Annex A)**;

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- Publish AQRs during w/c 11 November 2019 to coincide with World Quality Day on 14 November 2019; and,

- Advise the Department of quality improvement and innovation activities/initiatives that you are showcasing to coincide with World Quality Day.

As an outworking of the Hyponatraemia Inquiry, I have been asked to incorporate some changes into the AQRs in order to implement Recommendations 82 and 83. A standard wording relating to SAIs will be issued shortly to all Trusts and I would ask that you incorporate this into the SAI section of the AQR. A table of numbers of SAI deaths, by Directorate, should also be included, as well as a brief summary of any local learning that has been identified. A separate communication will be issued from me shortly to outline these changes in more detail.

I would like to thank you for your continued support and contribution in producing the AQRs for your organisation. They act as an important showcase to the public of the quality improvement and innovation activity being delivered by your staff in support of the principals underpinning Q2020. It is also important to reflect Q2020 in your business plans and other corporate documentation. I would encourage you to review the visibility of your valuable quality improvement and innovation activity, including your AQRs, on your organisation's website and in publications.

Yours sincerely

Personal Information redacted by the USI

Brian Godfrey
Head of Safety Strategy Unit

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

ANNEX A

GENERAL GUIDELINES FOR DRAFTING REPORTS

- Where a definition/measure is specified for a particular theme/item this should be used. Trusts may add further detail/measures/information as they feel appropriate for any theme.
- Where a measure is reported it should reflect performance of all areas of the Trust as opposed to sample audit data or where this is used it should be clearly described as such.
- Graphs do not have to be used for each measure but where used – one graph only should be used.
- Some themes were identified that could be added to individual Trust reports as considered appropriate:
  - Environmental Responsibility
  - Corporate Social Responsibility
  - Public Health Improvement

The main body of the report should cover the following Themes:

Theme 1: TRANSFORMING THE CULTURE
Theme 2: STRENGTHENING THE WORKFORCE
Theme 3: MEASURING THE IMPROVEMENT
Theme 4: RAISING THE STANDARDS
Theme 5: INTEGRATING THE CARE

The following pages show the information that should be collated under each of these headings.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

THEME/GOAL 1: TRANSFORMING THE CULTURE

Introduction

- Values and behaviours, Mission Statement and vision of the Trust
  This may include the organisational development or core principles or indeed even IIP. It should also encapsulate the HSC Staff Survey which was bench marked previously and described some of the feedback.

Patient and Client Experience

- Report on Trusts participation in 10,000 voices around Acute, Unscheduled, Elective and community care. Information should highlight areas involved.
- PPI – paragraph explaining key work.

Complaints and Compliments

- Number reported and responded to within timeframes for 18/19 year, including the percentage in two days.
- Top 5 categories of complaints and improvements made in relation to these. Include a narrative of how the Trust has responded and improved in light of an Ombudsman case for shared learning.

Adverse Incidents / Serious Adverse Incidents (SAIs)

- Trusts' recorded top five types of adverse incidents and work that is ongoing to address these.
- Include standard SAI paragraph.
- Include Narrative on SAIs and improvements made – Two or Three.
- Include Table of SAI deaths by Directorate
- Include examples of learning.

How the organisation learns

- Regional event.
- Safety Messages.
- Briefings.
- Leadership walk-rounds.

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- Clinical attributes training such as SQE or SQB and SAFEtember.

Quality Improvement

- Each Trust to report on work undertaken to deliver a culture that focuses on quality improvement e.g. SQE, SQB/CORE, SAFEtember. This can refer to outcomes from the Taskforce 3 attributes framework work.

THEME/GOAL 2: STRENGTHENING THE WORKFORCE

- Induction
- Mandatory Training
- Clinical Attributes Framework
- IIP
- Money for staff development (Costed Learning Plans)
- Leadership programmes
- Supervision, coaching and mentoring. For supervision we could include educational supervision, postgraduate training, training tracker and undergraduate functions
- Staff achievements section.
- Looking after your staff (e.g. smoking cessation work). Context in preparation for "smoke free" which includes Smoke free, Hear 4 U, Flu vaccination and Fit testing
- Revalidation of medical and nursing staff - % of positive recommendations for revalidation
- Staff absenteeism
- Staff training:- knowledge, skills, framework, PCFS, Mandatory Equality
- Reducing the risk of Hyponatraemia, Infection prevention, RPRB,
- Clinical attributes framework
- Inclusion of profession - specific appraisal rates for all eligible professional staff. (Further guidance will be issued on this).

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

THEME/GOAL 3: MEASURING THE IMPROVEMENT

Infection rates – (C Diff, MRSA)

- Hand Hygiene – to include information on independent hand hygiene audits
- Five year dataset
- To use number of cases and rates and make comparison to PHA target.
- Can include any other infection control information considered appropriate.

Safer Surgery / WHO Checklist

- "Safer Surgery" section should include audit data – this can be continuous or periodic audit.
- Maternal QI
- Paediatric QI

Falls

- To reflect regional falls work done with PHA/Safety Forum – (all wards)
- To show number and rate for a minimum of two years

Pressure Sores

- To reflect the regional pressure sore work done in conjunction with the PHA and Safety Forum and to show the number of rate for a minimum of two years.

VTE

- To report on % compliance with the risk assessment. Trusts should report all audit data available and where audit does not include all areas – the selection of wards should be described. Run chart going back two or more years.

Medicines Management

- All Trusts to include work on:
  - Omitted & delayed doses
  - Medicine reconciliation to be included as mandatory
  - At least one other piece on improvements from selected from list below:
    - INR's

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- Insulin

Cardiac arrest rates

THEME/GOAL 4: RAISING THE STANDARDS

Standardised Mortality Ratio – Funnel chart. Include clear description and any additional information.

Emergency Re-admission rate – To use CHKS data monthly points in graph form if available for at least two years.

Emergency Department

- To report 4 and 12 hour standards, including comparison with 17/18 and 18/19 year.
- SEPSIS 6 within ED
- Additional quality measures include:
  - Time to be seen by ED Doctor/ENP (All patients)
  - People who leave without being seen
  - Actions taken to make improvements to performance in these standards.
  - Re-attendance at ED on a monthly basis

NICE Guidelines – ensuring compliance.

National Audits

- A minimum of two should be included – one nationally and one with RQIA.
- Timeframe: National Audit report is 'published' within 18/19 (even if based on data collected during 17/18).
- Pieces to include 'next steps' to outline what action will be taken.

Cancer Standards targets to be included as a quality matrix

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

THEME/GOAL 5: INTEGRATING THE CARE

Community Care

- Examples of improvement work undertaken by Trusts to meet the needs of community clients e.g.:
  - Telemonitoring
  - Support Nursing Homes
  - Rapid Access Teams
  - Intermediate Care
  - Facilitating Early Discharge
  - Home Treatment
  - District Nursing
  - Acute care at home
  - Health Visiting

  This will reflect some social care input and should support the Transforming Your Care agenda.

Mental Health

- Mental Health: To report on progress on work carried out with the Safety Forum around:
  - Crisis planning – forward planning
  - Physical care of the mentally ill (Schizophrenia Report Nov 2012).
  - Delirium bundles. Lithium pathway or antipsychotic cardiac screening but would be guided by an update from the Safety Forum

Social Care

13/14 indicators produced by HSCB to continue to be used for 18/19 reports (see Annex B). These should be included under the Theme/Goal 5 – Integrating the Care)

Theme 1 - Effective Health & Social Care

- Children Protection – children seen within 24 hours

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

- Looked after Children
  - Reviews / Care planning
  - Permanence plan
- Adult Safeguarding
  - Adult Protection Plan
- Carers Assessments
- Resettlement of Adults with a Learning Disability

(For further guidance see Annex B)

Theme 2 - Delivering Best Practice in Safe Health and Social Care Settings

Delivery of Best Practice

- Direct Payments for Children
- Education & Training for Young People leaving care
- Children's Disability Transition
- Direct Payments for Adults
- Approved Social Work – mental health

(For further guidance see Annex B)

Update on Integrated Care Partnerships

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

ANNEX B

Annual Quality 2020 Reports - Social Care Indicators

CHILDRENS SOCIAL CARE SERVICES

Theme 1

Effective Health and Social Care

1. It is essential that children and young people identified as potentially at risk are seen by a social worker and receive a timely response for assessment. Regional child protection procedures require that children identified as being at risk are seen within 24 hours.
   In this reporting period (Trust Inserts*) % of children or young person were seen within 24 hours of a Child protection referral being made. (Source: HSCB-Priority 5 Return).

2. Children who become looked after by Health and Social Care Trust's must have their living arrangements and care plan reviewed within agreed timescales in order to ensure that the care they are receiving is safe, effective and tailored to meet their individual needs and requirements and preserves and maintains the rights under the United Nations Convention on the Rights of the Child and Article 8 of the European Convention on Human Rights (ECHR), enshrined by the Human Rights Act 1998.

   In this reporting period * % of looked after children within the (insert Trust*) Health and Social Care Trust were reviewed within regionally agreed timescales. (Source: DSF/Corporate Parenting Returns 10.3.17/10.3.18)

3. Every looked after child needs certainty about their future living arrangements and through Permanency Planning, this Trust aims to provide every looked after child with a safe, stable environment in which to grow up. A sense of urgency should exist for every child who is not in a permanent home.

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Permanency planning starts at first admission to care and continues throughout the lifetime of the child or young person's case until permanency is achieved. In this reporting period *% of all looked after children in care for more than 3 months have a Permanency Panel Recommendation (CP 10.3.26).

Theme 2

Delivering Best Practice in Safe Health and Social Care Settings

1. The provision of direct payments by a Health and Social Care Trust enables families to locally source the care they require. Allowing the individual to choose how they are supported within their community. * % is the number of children receiving Direct Payments as set against the HSCB commissioning direction target DSF/Corporate Parenting Returns (5.9).

2. Research tells us that young people who leave care do not always achieve the same levels in education, training, and employment as other young people in the community. * % of young people known to leaving an aftercare services in the *Health and Social Care Trust are engaged in education, training, and employment. DSF/Corporate Parenting Returns (10.4.10)

3. The transition from children to adult for those children and young people who have a disability is best assisted by a transition plan. *% of disabled children has a transition plan in place when they leave school within the * Health and Social Care Trust. Source: DSF/Corporate Parenting Returns (10.1.7)

ADULT SOCIAL CARE SERVICES

Theme 1

Effective Health and Social Care

1. There are many vulnerable people in the community and those who are most at risk of abuse, neglect or exploitation should have in place adult protection plans following investigation. In * Health and Social Care Trust *% of adults referred for investigation and identified as at risk of abuse, neglect or exploitation, during the year had an adult protection plan in place at 31st March 2018. (Adult Safeguarding Returns to HSCB)

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

2. There are a significant population of carer's within the region. Health and Social Care Trusts are required to offer individual assessments to those people known to have caring responsibilities. During this period adult carers * were offered individual care assessments as set against the commissioning direction target by HSCB. DSF/Corporate Parenting Returns (5.1)

3. The ultimate goal of this Trust is to improve the quality of life for those with learning disabilities. This is done by providing a range of services that will support personal choice; move away from a service-led to needs-led approach and challenge and change mind-sets that may affect the individual's potential to become an integral and valued member of their community.

   Sustainable integration into the community of individuals with learning disabilities who no longer require assessment and treatment in a hospital setting is a priority for all HSCTs. Within * HSCT x% of people with a learning disability who were resettled in community placements had to be readmitted to hospital as a result of an irretrievable breakdown of the placement.

Theme 2
Delivering Best Practice in Safe Health and Social Care Settings

1. As reported at 1.3 direct payments provide services users and their family an element of choice in determining the care they receive.
   * Received direct payments as set against the commissioning direction target DSF/Corporate Parenting Returns (5.8 & 5.9).

   * Of carers received direct payments as set against the commissioning direction target. DSF/Corporate Parenting Returns (5.10)

2. The Learning Disability Service Framework Standard 20 outlines the importance of adults with a learning disability having an annual health check.

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Within * Health and Social Care Trust *% of adults with a learning disability had an annual health check.

3. Sometimes it is necessary, for the protection of an individual, and to prevent harm to themselves or others, to detain people in hospital for assessment under the Mental Health Order.

   Applications can be made by an Approved Social Worker or by the persons nearest relative. Good practice says that it is preferable that applications for assessment should not be a burden born by families, in order to preserve on-going relationships and not to threaten necessary support during and after detention in hospital. These actions are always considered alongside an individual's human rights, particularly Article 5 and Article 8 of the ECHR In *HSCT x% of applications for assessment were made by ASWs. (DSF 9.1 & 9.1c)

(Approved at Regional Governance Meeting, 2 July 2014)

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Health and Social Care Board

Performance and Corporate Services

HSC Board Headquarters
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Our Ref: MB334
Date: 26 June 2015

Mrs Aldrina Magwood
Acting Director of Performance & Reform
Southern HSC Trust
Trust Headquarters
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

Dear Aldrina

Review of OP booking processes

Earlier this year, the HSCB Scheduled Care Team carried out a series of reviews of OP booking processes in all Trusts to assess compliance with the Integrated Elective Access Protocol (IEAP), with a particular focus on chronological management of patients.

The final version of the Report detailing the findings of the review in the Southern Trust is enclosed. The Report confirms that generally there is a high level of compliance with IEAP in the Trust. There are however a number of recommendations detailed in the appendix to the Report which will further strengthen the arrangements, and these should be addressed by the end of December 2015.

If you have any queries in relation to this Report or the actions to be taken, please contact Sara Long Personal Information redacted by the USI Assistant Director of Performance Management.

Yours sincerely

Personal Information redacted by the USI

MICHAEL BLOOMFIELD
Director of Performance and Corporate Services

Enc Outpatient Pathway Review
Appendix 1

cc Sara Long, PMSI
David McCormick, PMSI
Maria Wright, PMSI
Rosemary Hulatt, PMSI

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Southern Trust – Appendix 1 RBC		
SUBJECT	**RECOMMENDATION**	**TIMESCALES**
Centralisation of registration function	No actions arising.	
Registration of referrals within 1 working day of receipt	No actions arising.	
Prioritisation of referrals: **Daily Triage for Red Flags** **Within 3 working days for other referrals**	1. Where the 3-day turnaround standard is not being met, a process should be agreed with clinicians whereby the referrers' priority is accepted and the booking staff proceed to book urgent appointments. 2. The areas outlined with particular challenges with late triage / missing referrals should be escalated as a matter of urgency. 3. A process should be put in place to ensure that all staff who book or make changes to appointments make the correct amendment to clinical priority type.	By the end of September 2015
Acknowledgement letter to patients within 5 working days of receipt / urgent booking letter issued	4. The regional guidance on booking principles should be implemented. Any patient to be appointed within 6 weeks of receipt of referral does not require an acknowledgement letter.	By the end of September 2015
Capacity planning at an operational level developed to support achievement of maximum waiting time guarantees	5. A process should be implemented to ensure that services provide 6 weeks' notice to RBC of clinic cancellations in respect of planned leave. Persistent lack of notice should be escalated and addressed. 6. Clinic should be established on PAS where these are not in place for some paediatric services.	By the end of September 2015

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	7. Late notification of additional clinics should be addressed and minimised where possible. 8. A process should be put in place to ensure all rotas are available to the RBC in a timely manner to support the booking cycle.	
Booking Processes – All patients will have the opportunity to book their appointment	No actions arising	
Management of patients who Cancel or DNA their appointment	No actions arising.	
Training	9. All booking staff should receive refresher training on the IEAP standards on a regular basis.	By the end of December 2015
Geriatric Medicine Outpatient Pathway (Not booked Via RBC)	10. The use of clinical priority for patients to be appointed within days / a week should be reviewed and changed to urgent to more appropriately reflect clinical priority. 11. The Acute and OPPC directorate should further scope the range and variation of practice by secretaries across sites and explore options for integration of elements within the RBC where possible. 12. The principles of the IEAP should be applied to all areas where outpatients are administered with clear and consistent training for all staff. This may require upgrades / changes in the use of PAS functionality to support clinic management.	By the end of September 2015

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Health and Social Care Board

Performance Management and Service Improvement Directorate

SOUTHERN HEALTH AND SOCIAL CARE TRUST

OUTPATIENT PATHWAY REVIEW

JANUARY 2015

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

Contents

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Introduction

The HSCB highlighted apparent issues in relation to the chronological management of outpatients at the Trust Performance Management meetings. It appeared that some patient appointments were not being made in chronological order with some routine patients being seen within 3 weeks while others were waiting over 9 weeks. The HSCB decided to undertake a short pathway review to assess the systems and processes currently in place for the booking of outpatient services regionally to ensure they support the consistent application of the Integrated Elective Access Protocol (IEAP).

Methodology

Outpatient specialties identified for review

The performance against chronological management at speciality level within each Trust was analysed and those specialties with a higher percentage of routine new outpatients being seen out of chronological order were selected for review. In addition specialties where there was a particular concern regarding patients currently waiting over 9 weeks were also selected for review.

The specialties identified for review were;

1. Dermatology
2. Geriatric Medicine
3. Ophthalmology (Belfast Outreach)
4. Paediatrics
5. Urology

Review Process

Each Trust was advised of the review process and specialties and dates agreed for review visits by PMSI staff. PMSI wrote to Trusts detailing the terms of reference for the review, the specialties involved, the agreed dates and Data Access Agreement in advance of the visits.

A template was developed to ensure a consistent approach across all Trusts/Sites and to provide a structure to the review. This allowed reviewers to ensure the Trust's compliance with the Integrated Elective Access Protocol (IEAP) with a particular focus on patients being booked in chronological order, allowing for clinical priority.

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Staff from the HSCB's Elective Care Service Improvement Team held an initial meeting with the Trust Managers with responsibility for the booking office processes to discuss the format of the review and to go through the template and talk about the processes that were in place. They then visited the booking offices within each site speaking to the booking staff with responsibility for registration, managing the waiting lists and booking patients appointments. The team looked at the overall pathway for referrals from arriving within the Trust to discharge recording, although the main focus was the chronological management of patients using the IEAP guidelines.

The team spent time with the individual booking and administrative staff, for all of the previously identified specialties, on site directly observing working practices and discussing operational policy.
The team carried out random audits on patients that had been taken out of chronological order to ascertain why the patient had been seen earlier. The review focused on operational practice, highlighting areas of good practice as well as areas for improvement. Trust managers facilitated the process.

A Trust report was produced at the conclusion of each visit; this was informally shared with the Trust to discuss the findings and quality assure for factual accuracy.

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Outpatient Review Findings (Referral & Booking Centre)

All of these specialties except Geriatric Medicine are administered by the central Referral and Booking Centre (RBC). Geriatric Medicine is not centrally administered and is currently managed by consultant secretaries on each site. The report will present the findings for the RBC managed specialties, followed by a section outlining the geriatric medicine arrangements.

1. Registration and Triage

Registration

(a) The process for centralised receipt of referrals is robust. Referrals are received into a central point in Craigavon Area Hospital where they are opened, date stamped and sorted into specialty / team. Exceptionally, if a referral goes directly to consultants or other departments, secretaries know to date stamp and forward to the RBC where the referral is registered using the date of the date stamp.

(b) The standard for registration of referrals within one working day is being met.

(c) The process of registration, including correct recording of referrers' clinical urgency and other key information is robust and referrals forwarded to clinicians for triage.

Triage

In the SHSCT, red flag referrals and appointments are managed by a dedicated team. They are not administered by the RBC and are therefore not part of this review. Where red flags are downgraded, they will be forwarded to the RBC.

(d) For urology, a new process of triage and booking was introduced in December 2014, and referrals are now hand delivered to the Thorndale Unit in the main OPD, several times a day for triage and referrals which have already been triaged collected and updated on PAS. For the majority of urology referrals, daily triage is now achieved, but there is a long-standing issue with turnaround time from one consultant and referrals not returned from triage continues to be a key issue for booking staff.

(e) For the remainder of specialties, the turnaround time for triage is:

- Paediatrics
    - The majority are within the 3-day standard, but there are occasions where it is considerably longer. At the time of the visit, a referral

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from 1st October 14 had not been returned. There are also issues with lack of response when these are escalated.
    - Consultants may also forward referrals to community teams or ambulatory service but do not advise the RBC where the registration will remain open.
    - Delays in triage can also lead to patients are being able to selected for booking from the PTL (as there are not details etc.) and this will lead to patients being selected out of turn
- Dermatology
    - Referrals are triaged on a daily basis
- Ophthalmology (Belfast Outreach)
    - Referrals are triaged same day (Mon / Thu) when the consultants are on site in CAH. For

(f) When referrals are returned from triage, the PAS registration is updated and patients added to OPWL. On examination of patient level information for those patients who attended within 0-3 weeks, there were instances of priority type not reflecting the urgency with which patients attended. For example, a patient was referred as urgent, and booked into an urgent OP slot, but the priority type on PAS was routine. The red flag trackers, some secretaries and RBC staff have contributed to this and would indicate that further training is required with regard to updating PAS registration following triage or when clinical priority is changed.

(g) All un-named referrals are pooled.

(k) The Trust no longer issues an acknowledgement letter to routine patients on the outpatient pathway. This was stopped several years ago when waits were shorter and it delivered a financial saving for the Trust. However, as waits have increased, the RBC admits that they are now dealing with increasing levels of referrer / patient queries, which is not a good use of valuable resources.

(l) There was a good local understanding of the timeframes within which urgent patients were to be booked and each clerk could describe these when asked.

2. Clinic templates

(a) The clinic templates are carved out to new urgent, new routine and review slots in line with best practice. A small number of dedicated Protected Review slots have been allocated for patients following MDTs, although trackers will ask RBC if they can book into other slots where they need to. Good communication exists which helps maintain awareness of demand and capacity.

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(b) For Urology, since December 14, all clinic slots are designated red flags. Unallocated slots are notified to the RBC who book with patients from the PTL, selecting urgent patients first, and then proceeding to routines. Urgent patients are mostly being booked within 4-6 weeks, but the waiting time for new routine patients is currently at 40 weeks.

(c) Available slots released from red flags for PTL patients can range from 2-6 slots depending on the day, but there never no slots freed up. Given the length of routine waits, there are plans in place to increase the number of clinic slots but these were not yet in place at the time of the visit.

(d) The RBC manages urology templates for clinics at CAH, South Tyrone and also in the SWAH as there was high demand for clinics in Enniskillen to facilitate patients from the west of the Trust. Patients may have their new appointment at CAH/STH but can be reviewed at SWAH.

3. Chronological Management

(a) In the period April – October 2014, the number of new routine patients who were appointed in less than 6 weeks varied from 4% (urology) to 17% (paediatrics).

(b) There are instances where the clinical priority of the patient may change during the course of their wait and may contribute to patients appearing to be appointed out of chronological order

(c) There are some instances where non-RBC staff have booking rights, but this is limited and whilst it does not largely appear to interfere with chronological management, there were examples of where priority type was not correctly changed and should be addressed via training.

(d) Timeliness of rotas is an issue (with the exception of dermatology) and is not always in line with the timescale required to support the booking cycle. For dermatology, capacity between ICATS and consultant clinics is being flexed to optimise booking, however the process for this is not always timely and leads to last minute booking and duplication (i.e. re-triage) and is not ideal.

(e) Following triage in paediatrics, some patients will be suitable to be seen at staff grade clinics on a general consultant list. Waiting times for these clinics is much shorter than the general consultant clinics, and may be the main contributor to patients appearing to be selected out of turn.

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(f) Also in paediatrics, some clinics are only built at short notice and although staff will always attempt to select from the PTL, this will depend on patient availability. In addition, referrals not back from triage will impact on good chronological selection as missing referrals cannot be booked in turn.

(g) For the Paediatric allergy clinics, booking staff are not permitted to book patients across CAH/DHH. There is one consultant on each site and they will not see the other's patients, even though the sub-specialisation is the same. Clinic slot times are 30 minutes for new and review patients, which is longer than typical slot times. This gives a potential for 8 slots in a typical four hour session, but some clinic templates only have 3 new and 3 review. Recently one was changed to 1 new and 5 review with approval of the Head of Service. The CAH consultant is on S/L and his clinics have been cancelled. Patients are not offered the opportunity to be seen at DHH. CAH patients will remain on a growing waiting list whilst the DHH patients continue to be appointed which contributes to poor chronological management at service level. This is outside the control of the RBC and needs to be addressed by the Directorate.

(h) In some specialties, e.g. urology and ophthalmology, the RBC will be contacted by referrers with information about a change in clinical priority and a second referral usually sent in. Staff will administer this on the system, retaining the patient's original date but amending the clinical priority and appointment type. This can mean that sometimes urgent patients will appear to have waited longer than routines.

4. Booking Processes

(a) PTLs have been developed and are produced weekly, but can be refreshed any time if required. All staff, from the RBC manager to the supervisors and clerks were clear on the importance of using the PTL and all clerks observed were using the PTL as the primary tool to identify patients for booking. Supervisors and clerks work together to identify the capacity available and escalate shortfalls.

(b) The process for booking new routine and review patients is in line with regional guidance. In the new urology model, all patients are now telephone booked.

(c) Additional clinics are a feature of most specialties, but the period of notice is an issue. Short notice clinics are frequently notified at a week (or less) notice, which means that the booking process cannot be followed and patients are contacted by phone. Even though patients will be selected from the PTL, it will contribute to patients being seen out of turn. This will also affect the paediatric consultants who

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don't have set days of the week for their clinics (which are built at short notice) and this should be addressed by the Children and Young People's Directorate.

(d) There is a general issue with short notice of cancelled clinics and six weeks' notice is not always provided. Patients already booked into clinics have to be re-booked and this will contribute to patients beings seen out of turn.

5. Managing DNAs and Cancellations

(a) Where patients have had a choice in the date and time of their appointment and subsequently DNA, they are usually discharged, although this will vary within specialties. Where a clinical decision is made to reappoint at DNA, the patient will be selected in turn from the PTL.

(b) Where patients cancel an appointment, the process for re-booking within 6 weeks is robust and patients are advised that in the event of a second cancellation they will be discharged.

(c) A second appointment will usually be made at the time of cancellation and this will appear as if patients are being seen out of order. However, in Urology, it is rarely possible to re-book a patient at the time of cancellation due to lack of available slots and patients will be re-booked in turn.

6. Training

(a) Staff are aware of the IEAP and were able to show examples of local policies and procedures to follow. There is an ongoing process for refresher training on IEAP, which will include specific training for all relevant staff on correct recording of clinical priority type. The RBC Manager is happy to consider making this a more formal process.

<u>Outpatient Review Findings (Geriatric Medicine)</u>

(a) Geriatric Medicine outpatients are not managed centrally via the RBC, but continue to be administered by consultant secretaries. Clinics take place on the Craigavon, South Tyrone, Daisy Hill, Lurgan and Mullinure sites. This visit focussed on the CAH site, but from discussion with supervisors the findings are largely applicable to all sites. In addition, patients will be booked into other clinics by fracture liaison staff

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to be seen by Ortho-geriatricians and these are not managed by geriatric medicine staff.

(b) Secretaries on each site, for each consultant, administer patients for clinics on those sites. Where an individual consultant has clinics on two sites, their patients will be administered by different secretaries.

(c) The IEAP for the outpatient pathway has not been implemented and therefore the processes for management of referrals from receipt of referral to discharge are not in line with the remainder of the Trust's processes or with regional guidance.

(d) There are clear examples of good practice, including:

- daily triage
- timely notification of leave
- robust management of patients who cancel or DNA
- fast access appointments for many clinics, including TIA

(e) However, there are fundamentals not in place such as:

- Referrals are not routinely date stamped on receipt (some may have the date hand-written)
- Referrals are not registered until after they have been seen / graded by the consultant, although this is usually within 1-2 days.
- The referrer's priority is not recorded on the registration. It is always recorded as per the consultants' priority.
- Clinical priority is not given as urgent or routine, rather an indication of when the patient needs to be appointed. Patients registered on PAS as routine
- Patients are not managed on a waiting list and are booked directly in clinics.
- Clinic templates are set up only for new routine patients
- Patients to be seen within a matter of days will be telephoned. Other patients receive fixed appointments.
- There is no ability to book into clinics on other sites, even for the same consultant.
- There is no PTL.

(f) From discussion with the secretaries, the main contributor to patients appearing to be seen out of chronological order is the practice of recording most referrals as routine. For example, consultants will direct patients to be a TIA clinic either within 1-2 days or next week. The patients to be seen within 1-2 days are considered as "urgent" as they need to be booked first and the patients to be seen

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next week as “routine” as they will be booked next. However, all are defaulted and registered on the system as clinical priority 1 = routine. In comparison, a number of routine patients waited > 9 weeks for an appointment with an ortho-geriatrician who has fracture clinics and these are infrequent, with long waits. Clearly, there is an issue over the use of the routine category for the TIA / other rapid access clinics which would explain a significant proportion of the routine patients seen within 3 weeks whilst others waited longer.

(g) The range of clinics within geriatric medicine are complex and span acute and community services, with both the Acute and Older People & Primary Care Directorates involved. The processes for referral management etc. should be brought in line with regional best practice with a reduction in duplication where possible. There would be merit in the Trust scoping the potential for consolidation of suitable elements into the RBC and this will require additional clerical resource into the RBC. The ability to maintain rapid access for e.g. TIA patients must be secured.

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Stinson, Emma M

From:	Leeman, Lesley
Sent:	24 June 2022 16:28
To:	Stinson, Emma M
Subject:	REquest for information - Aldrina Magwood - SHSCT Review of OP booking processes
Attachments:	MB334 - ltr to Aldrina Magwood re Review of OP booking processes.pdf; ATT00001.htm; Southern Trust Appendix 1.pdf; ATT00002.htm; Southern Trust OP Pathway Review.pdf; ATT00003.htm

Emma
Aldrina has requested that the follow information is issued to her for response to S21 Can you forward for her please

Lesley

Lesley Leeman
Interim Director of Performance and Reform
Southern Health and Social Care Trust

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

If I'm sending this email outside of regular hours, it's because it suits my work pattern just now and, importantly, I don't expect you to read, respond or action it outside of your regular hours.

-----Original Message-----
From: Leeman, Lesley Personal Information redacted by the USI
Sent: 29 June 2015 22:20
To: Carroll, Anita Personal Information redacted by the USI
Cc: Lappin, Lynn Personal Information redacted by the USI
Subject: Action - SHSCT Review of OP booking processes

Anita
Can I assume you will collate the necessary action plan to address the issues identified in Acute Services.
I am linking directly with CYP and OPPC regarding their actions and we can arrange to collate the responses into a single response on behalf of the Trust if you are content?

Lesley

Lesley Leeman
Assistant Director Performance Improvement Southern Health and Social Care Trust Trust Headquarters
68 Lurgan Road Portadown BT63 5QQ

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Direct Dial Office: Personal Information redacted by the USI
Blackberry : Personal Information redacted by the USI
'You can follow us on Facebook and Twitter'

From: Magwood, Aldrina
Sent: 26 June 2015 23:38
To: McVeigh, Angela; Burns, Deborah; Morgan, Paul
Cc: Carroll, Anita; Leeman, Lesley; Metcalfe, Fionnuala T
Subject: Fwd: SHSCT Review of OP booking processes

Please see attached Report from a review of outpatient booking / compliance with IEAP booking procedures carried out by HSCB in January 15 . It sets out key findings in acute, paediatrics and geriatric medicine. Also attached as appendix is an action plan with timelines etc

Lesley - please link via directorates to draft initial response including any issues surrounding the proposed actions included in the recommendations / action plan

Fionnuala- please BF 30th July

Thanks
Aldrina

Sent from my iPad

Begin forwarded message:
From: "Beth Minnis" Personal Information redacted by the USI
To: "Magwood, Aldrina" Personal Information redacted by the USI
Cc: "Michael Bloomfield" Personal Information redacted by the USI >, "Sara Long" Personal Information redacted by the USI ,
"David McCormick" Personal Information redacted by the USI , "Maria Wright" Personal Information redacted by the USI ,
"Rosemary Hulatt" Personal Information redacted by the USI
Subject: SHSCT Review of OP booking processes "This email is covered by the disclaimer found at the end of the message."

Dear Mrs Magwood

Please find attached correspondence sent on behalf of Michael Bloomfield, Director of Performance and Corporate Services, HSCB.

Beth Minnis | PA to Michael Bloomfield | Director of Performance and Corporate Services | Health and Social Care Board | 12-22 Linenhall Street | Belfast BT2 8BS | Tel: Personal Information redacted by the USI

"The information contained in this email and any attachments is confidential and intended solely for the attention and use of the named addressee(s). No confidentiality or privilege is waived or lost by any mistransmission. If you are not the intended recipient of this email, please inform the

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sender by return email and destroy all copies. Any views or opinions presented are solely those of the author and do not necessarily represent the views of HSCNI. The content of emails sent and received via the HSC network may be monitored for the purposes of ensuring compliance with HSC policies and procedures. While HSCNI takes precautions in scanning outgoing emails for computer viruses, no responsibility will be accepted by HSCNI in the event that the email is infected by a computer virus. Recipients are therefore encouraged to take their own precautions in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000."

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Integrated Elective Access Protocol

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Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Draft for approval
Date	27 April 2020

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Integrated Elective Access Protocol

Version

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

The Integrated Elective Access Protocol Review Group consisted of;

Marian Armstrong, BHSCT,
Roberta Gibney, BHSCT
Andrea Alcorn, NHSCT,
Christine Allam, SEHST,
Anita Carroll, SHSCT,
Paul Doherty, WHSCT,
Deborah Dunlop, WHSCT,
Sorcha Dougan, WHSCT,
Donagh Mc Donagh, Integrated Care
Geraldine Teague, PHA
Linus Mc Laughlin, HSCB

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Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

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Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

DRAFT

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

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- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.6 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic, inpatient and AHP waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for treatment.

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

1.2.1 The Department of Health (DOH) has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

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1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtually,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an

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electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be "fit, ready, and able" to come in (TCI).

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1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 All patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, vulnerable adults, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered vulnerable for whatever reason have their needs identified and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

1.3.11 Trusts have a responsibility to ensure that children and vulnerable adults who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment

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are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 CAPACITY

1.4.1 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners.

1.4.2 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets. Capacity should be linked to Service and Budget agreements.

1.4.3 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions.
- Session length.
- Average procedure / slot time.
- Average length of stay.

1.4.4 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients, diagnostics and AHPs at service level.

1.4.5 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.4.6 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and length of stay (LOS) targets and agreeing plans to deliver them.

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1.4.7 Theatre sessions should be maximised.

1.4.8 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.4.9 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.4.10 Trusts should ensure that ongoing capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.4.11 In summary, the intention is to link capacity to the Service and Budget Agreement, i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively.

1.5 BOOKING PRINCIPLES

1.5.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.5.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.5.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

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1.5.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.5.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.5.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.5.7 Principles for booking Cancer Pathway patients:

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
d) Patients will be contacted by telephone twice (morning and afternoon).
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

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1.5.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.5.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments.
b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.5.10 Principles for Booking Review Patients;

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic, where possible.
b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.

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c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.5.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

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1.7 VALIDATION

1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

DRAFT

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.

2.1.4 Fixed appointments should only be used in exceptional circumstances.

2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, vulnerable adults, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

1. Red flag (suspect cancer),
2. urgent and
3. routine.

No other clinical priority categories should be used for outpatient services.

2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

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2.2.4 Patient appointments for new and review should be **partially booked.**

2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.

2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

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2.3 NEW REFERRALS

2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

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2.5 REASONABLE OFFERS

2.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

2.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

2.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

2.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

2.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

2.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

2.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

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2.6 REVIEW APPOINTMENTS

2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

2.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

2.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

2.6.5 Telephone review appointments should be partially booked. If the patient cannot be contacted for their telephone review they should be sent a partial booking letter to arrange an appointment.

2.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

2.7.1 DNAs – New Outpatient

If a patient DNAs their new outpatient appointment the following process must be followed:

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they

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are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or vulnerable adults) where a second appointment should always be offered.

2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

2.7.1(d) *Where patients are discharged from the waiting list (ref 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.

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2.7.2 DNAs – Review Outpatient

If a patient DNAs their review outpatient the following process must be followed:

2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*

2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.2(f) Where a patient DNAs a fixed review appointment, including a telephone review, where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

2.7.2(g) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts

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should ensure that there are locally agreed processes in place to administer these patients.

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

If a patient cancels their outpatient appointment the following process must be followed:

2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

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2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.

2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

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2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

2.12.1 Registrations that have been opened on PAS should **not** be left open. When a patient referral for a new outpatient appointment has been opened on PAS, and their referral information has been recorded correctly, the patient will appear on the waiting list and will continue to do so until they have been seen or discharged in line with the earlier sections of this policy.

2.12.2 When a patient has attended their new outpatient appointment their outcome should be recorded on PAS within **three** working days of the appointment. The possible outcomes are that the patient is:

- added to appropriate waiting list,
- discharged,
- booked into a review appointment or
- added to a review waiting list.

If one of the above actions is not carried out the patient can get lost in the system which carries a governance risk.

2.13 TIME CRITICAL CONDITIONS

2.13.1 All referrals for new patients with time critical conditions, should be booked in line with the agreed clinical pathway requirement for the patient and within a maximum of the regionally recognised defined timescale from the receipt of

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the referral (e.g. for suspect cancer (red flag) and rapid access angina assessment the timescale is 14 days).

2.13.2 Patients will be contacted by phone and if telephone contact cannot be made, a fixed appointment will be issued.

2.13.3 If the patient does not respond to an offer of appointment (by phone and letter) the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.

2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.

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2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re;

- Acute activity definitions.
- Effective Use of Resources policy.

2.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage)
- Biologic therapies activity.
- Cancer related information.
- Centralised funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Outpatients who are to be treated for Glaucoma.
- Management of referrals for outpatient services.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.

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- Consultant virtual outpatient activity.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

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3.1 INTRODUCTION

3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.

3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, vulnerable adults, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations.** Local booking polices should be developed accordingly.

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3.2 KEY PRINCIPLES

3.2.1 Referrals into Trusts should be pooled as the norm where possible.

3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for diagnostic services.

3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable)**.** Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.

3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.

3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

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3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.

3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.

3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.

3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.

3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.

3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

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3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.

3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.

3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

3.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointments, and
- at least **one** offer must be within Northern Ireland (NI), except in those cases where there are no alternative providers within NI.

3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less

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than three weeks' notice) and refuses it they will not have their waiting time reset.

3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.

3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

3.6.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a session appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable follow up date should be discussed and agreed with the clinician.

3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.

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3.6.3 Follow up patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.

3.6.4 Follow up patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

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3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.

3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

3.9 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

3.9.1 DNAs – Diagnostic Appointment

If a patient DNAs their diagnostic appointment the following process must be followed:

3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or vulnerable adults) where a second appointment should be offered.

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3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

3.9.1(d) *Where patients are discharged from the waiting list (ref 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

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3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.

3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*

3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.2(f) Where a patient DNAs a fixed follow up appointment, including telephone follow ups, where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

If a patient cancels their diagnostic appointment the following process must be followed:

3.9.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

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3.9.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

3.9.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

3.9.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

3.10.2 The patient should be informed of the cancellation and the date of the new appointment.

3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.

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3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.12.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for session template changes.

3.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.13.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

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3.14 TECHNICAL GUIDANCE

3.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

3.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

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4.1 INTRODUCTION

4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.

4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, vulnerable adults, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

4.2 KEY PRINCIPLES

4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.

1. active,
2. planned and
3. suspended.

4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for inpatient and daycase services.

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4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.

4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.

4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment.

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will

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be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.

4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.

4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.

4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

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4.5.3 A reasonable offer is defined as:

- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
- at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.

4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.

4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

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4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.

4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within **two** working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.

4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.

4.7.2 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).

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- A recommended maximum period not exceeding **three** months.

4.7.3 No patient should be suspended from the waiting list without a suspension end date.

4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.

4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

4.7.9 Recommended practice is that no more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

4.8 PLANNED PATIENTS

4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.

4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between

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interventions. They will not be classified as being on a waiting list for statistical purposes.

4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.

4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

4.9.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

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4.10 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR ADMISSION

DNAs – Inpatient/Daycase

4.10.1 If a patient DNAs their inpatient or daycase admission, the following process must be followed:

4.10.1(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second date should be offered or whether the patient can be discharged.

4.10.1(b) Where the clinical decision is that a second admission should be offered, the admission date must be agreed with the patient. Trusts should put in place local agreements with clinicians regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or vulnerable adults) where a second appointment should always be offered.

4.10.1(c) Patients who DNA and are not discharged but offered a second date will have their waiting time clock reset to the date of the DNA.

4.10.1(d) Where the clinical decision is that a second date should not be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original date, a clinical decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

4.10.1(f) If the patient DNAs the second admission offered then the above steps should be followed.

4.10.1(g) Where a patient DNAs a fixed admission date (i.e. they have not had the opportunity to agree/ confirm the date and time of their admission), they should be offered another date.

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4.10.1(h) If the patient DNAs this second fixed admission, they will be removed from the waiting list and the steps in 4.10.1(e) should be followed.

4.10.1(i) Where a patient DNAs a pre-assessment appointment they will be offered another date. If they DNA this second pre-assessment appointment, they will be removed from the waiting list and the above steps in 4.10.1(e) should be followed.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

If a patient cancels their inpatient/ daycase admission the following process must be followed:

4.10.2(a) Patients who cancel an agreed reasonable offer will be given a second opportunity to book an admission, which should ideally be within **six weeks** of the original admission date.

4.10.2(b) If a second agreed offer of admission is cancelled, the patient will not be offered a **third** opportunity.

4.10.2(c) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second admission, the Trust may exercise discretion to offer a third admission - this should include seeking a clinical review of the patient's case where this is appropriate.

4.10.2(d) Where a decision is taken not to offer a further admission, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

4.10.2(e) Where a patient CNAs a pre-assessment appointment they should be offered another date. If they CNA this second pre-assessment appointment, the above steps should be followed, as per 4.10.1(h).

4.10.2(f) Patients who cancel their procedure (CNA) will have their waiting time clock reset to the date the Trust was informed of the cancellation.

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4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.

4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.

4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

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4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

4.13.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Recording inpatients who need to be added to the 28 day cardiac surgery waiting list.
- Recording paediatric congenital cardiac surgery activity.
- Centralised Funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Patients who are added to a waiting list with a planned method of admission.
- Pre-operative assessment clinics.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Patients waiting for a review outpatient appointment.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

GUIDANCE FOR MANAGEMENT OF ELECTIVE ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

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5.1 INTRODUCTION

5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services.

5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.

5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

5.1.4 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people's own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.

5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.

5.1.7 Fixed appointments should only be used in exceptional circumstances.

5.1.8 In all aspects of the AHP booking process, additional steps may be required for **children, vulnerable adults, those with physical/learning difficulties**

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and those who require assistance with language. Local booking polices should be developed accordingly.

5.2 KEY PRINCIPLES

5.2.1 All referrals, appointments and AHP waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list and allocated according to urgency of the treatment. Trusts will manage new patients in two priorities, i.e.

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.

5.2.3 Patient appointments for new and review should be **partially booked.** Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.

5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.

5.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

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5.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

5.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.

5.2.9 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

5.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

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5.4 CALCULATION OF THE WAITING TIME

5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.

5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.

5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

5.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

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5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

5.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

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5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

5.6.5 Telephone review appointments should be partially booked. If the patient cannot be contacted for their telephone review they should be sent a partial booking letter to arrange an appointment.

5.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

5.7.1 DNAs – New AHP Appointments

If a patient DNAs their new appointment, the following process must be followed:

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(b) Under exceptional circumstances the AHP professional may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with AHP professionals, regarding those referrals or specialties where patients may be at risk (e.g. paediatrics or vulnerable adults) where a second appointment should always be offered.

5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

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5.7.1(d) *Where patients are discharged from the waiting list (ref 5.7.1(a)) they should be advised to contact the Trust booking office within* ***four*** *weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the* ***four*** *week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the* ***four*** *week period they cannot be reinstated*.

5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.

5.7.2 DNAs – Review Appointments

If a patient DNAs their review appointment the following process must be followed:

5.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

5.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where

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unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.

5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.

5.7.2(f) Where a patient DNAs a fixed review appointment, including a telephone review, where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

5.7.3 **CNAs –** Patient initiated cancellations (new and review)

If a patient cancels their AHP appointment the following process must be followed:

5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include

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seeking a clinical review of the patient's case where this is appropriate.

5.7.4 Trusts have a responsibility to ensure that children and vulnerable adults who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.

5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

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5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers. Transfers should not be a feature of an effective scheduled system.

5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

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5.12 TECHNICAL GUIDANCE

5.12.1 See also Public Health Agency; https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015 re Guidance for monitoring the Ministerial AHP 13 week access target.

5.12.2 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

5.12.3 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage).
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

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Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

August 2019

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INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the relevant Corporate Objectives contained within the Trust's Corporate Plan 2017/18 – 2020/21 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

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Risk scoring is based on likelihood and impact as summarized in the Risk Assessment Matrix below.

Risk Likelihood Scoring Table			
Likelihood **Scoring Descriptors**	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

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OVERVIEW OF CORPORATE RISK REVIEW AS AT AUGUST 2019

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	3	8	0	11

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page	Movement from last review
1	**BSO Shared Services** • Payroll/Travel • Recruitment • Lack of Data Processing Contract	1&4	**MEDIUM**	**5**	Unchanged
2	**Cyber Security**	1	**HIGH**	**12**	Unchanged
3	**Medical Workforce shortages and vacancies**	1	**HIGH**	**18**	Unchanged
4	**GP Out of Hours**	1	**HIGH**	**21**	New risk
5	**Registered Nursing Workforce Shortages**	1	**HIGH**	**26**	Unchanged
6	**HCAI**	1	**HIGH**	**33**	Unchanged
7	**Deterioration of exposed concrete on building exterior, Daisy Hill Hospital**	1	**HIGH**	**35**	Unchanged
8	**Loss of electrical power to main hospital block, Craigavon Area Hospital**	1	**HIGH**	**36**	Unchanged
9	**Compliance with procurement and contract management guidance**	1&4	**MEDIUM**	**38**	Unchanged
10	**Breach of statutory duty of break-even in-year** **Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support.**	4	**MEDIUM**	**42**	Unchanged
11	**Clinical risk associated with inability to manage patient care within clinically indicated timescales**	1	**HIGH**	**44**	Unchanged

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CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Possible (3) **Impact: Moderate (3)** **Total Score: 9** **Risk Rating: MEDIUM** **Previous Score: 9**		**RISK OWNER: Director of Finance & Procurement** **DATE RISK ADDED: August 2016** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre:-** **Payroll & Travel** The risk that staff pay and travel reimbursements are inaccurate due to the control environment of the Business Services Organisation (BSO). This has the potential for financial hardship for staff, negative media attention and reputational damage for the Trust.	1. A range of KPIs have been agreed with BSO for each Trust which identifies where there has been improvement or deterioration and triggers appropriate action 2. The Trust has a process of reimbursing staff as quickly as possible once an underpayment is identified as quickly as is feasible 3. Once an overpayment has been identified, BSO enact the overpayments policy 4. Annual Internal Audits	Assistant Director of Finance Assistant Director of Finance Assistant Director of Finance Assistant Director of Finance	1. Monthly KPIs 2. Payroll data 3. Schedule of Overpayments and Recovery Plan 4. Internal Audit reports and action plans

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		5. Regional audit of BSO Payroll Shared Services, currently twice a year	Assistant Director of Finance and Internal Audit	5. Audit reports and action plans
		6. Trust wide communication to all managers to remind all in respect of timely completion of paperwork	Assistant Director of Finance	6. Global communications
		7. Trust active participation in a number of regional groups to provide guidance, assistance and challenge to achieve necessary improvements	Finance Directorate	7. Minutes of meetings

Additional actions and timescales

1. Progress updates continue to be provided to Audit Committee and from October 2018 onwards, BSO have been providing a written report in advance of each Audit Committee.
2. Ongoing review of Internal Audit recommendations. For those that are the responsibility of the Trust, they will be picked up and reported on at the IA Forum initially before going to Audit Committee.
3. Ongoing attendance at Customer Forums and Business as Usual meetings.
4. Ongoing attendance of Director of Finance at Customer Assurance Board which has been established to oversee 3 new payroll workstreams in an attempt to address the issues.

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CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: MEDIUM** **Previous Score:12**		**RISK OWNER: Director of Human Resources and Organisational Development** **DATE RISK ADDED: August 2016** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre -** • **Recruitment and Selection** The delays in recruitment and selection pose a risk to service continuity for front line services	1. Implementation and monitoring of a local operational and service improvement plan to progress a range of local resourcing solutions. 2. Use of Bank and Agency for short/medium term interim cover, where possible and subject to appropriate approvals. 3. Internal Audit reviews of RSSC and Trust Recruitment & Selection. 4. Trust participation at Head of Service / Deputy Director level in regional Strategic Resourcing Innovation Forum (SRIF), with 4 workstreams each with a 12-month workplan to deliver and report to HR Directors.	Head of Resourcing	1. Resourcing Operational and Service Improvement Plan 2. Monthly Bank Block Booking and Agency reports 3. Internal Audit assurance reports 4. SRIF annual work plans and dashboard

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		5. Bi-monthly customer forum and monthly operational review meetings with RSSC to escalate issues requiring to be addressed. 6. Trust representation on Operational Group within SRIF to meet monthly and develop/implement key service improvements. 7. Monthly KPI data shared with the Trust which identifies where there has been improvement or deterioration and triggers appropriate action. Trust management information reports issued to Directorates in relation to vacant posts. 8. Trust wide communications in relation to managers' roles and responsibilities for recruitment and selection, as well as associated Key Performance Indicators. 9. Alignment of Resourcing Team Leaders to support Directorates taking action to minimise any delays in the recruitment process in conjunction with RSSC 10. Development and introduction of new approach to reduce pre-employment checks for internal (within Trust) and inter-Trust appointments.		5. Minutes of Customer Forum 6. Minutes of Operational SRIF Group 7. Monthly RSSC Performance Reports and Directorate vacancy reports 8. Global communications to Trust managers, process documents and user guides 10. Process documents for Pre-Employment checking process

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		11. Development and launch of new HSC Recruitment and Selection Framework and associated guidance for managers 12. In-house recruitment days for various staff groups, supported by Trust Resourcing Team 13. Updates to HSC recruitment website in order to increase numbers of applicants and improve the applicant experience		11. HSC Recruitment and Selection Framework and associated guidance for Managers 12. Notes of Planning meetings/action plans 13. New website operational from 14th January 2019

Additional actions and timescales

1. Significant piece of work to be undertaken in conjunction with service directorates to further streamline corporate waiting lists and Trust approach to maintaining these. The start date for this has been delayed due to the need to divert resources to Transformation activity. Alternative models of recruitment have been discussed and tested as part of the regional SRIF group, and implementation has started in the Trust for some groups of staff (Admin & Clerical posts; Nursing Assistants) but requires further planning prior to wider implementation for other high-volume staff groups during 2019/20.
2. Further improvements to the depth and quality of management information produced from the E-Recruitment system – timescale dependent on progression of a 'Change Request' by the BSO Business Services Team. This is now in the final stages of development and is due to be rolled out across the Trust in early September 2019.
3. Engagement events with key stakeholders organised via the regional SRIF group throughout 2019/20, to ensure their continued involvement in the process of design and implementation of solutions.
4. Roll out of Recruitment and Selection skills training for managers during 2019/20.
5. Launch of HSC 'branding' and advertising concepts to increase applicant traffic to the recruitment website is the subject of ongoing discussion with DOH in relation to funding and HSC-wide implementation. Timescale for this is outside the control of the Trust.

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CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: MEDIUM** **Previous Score:12**		**RISK OWNER: Director of Performance and Reform** **DATE RISK ADDED: August 2016** **Reworded: August 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre -** Absence of a MoU or Agreement between the Trust (as the data controller) and the BSO (as the data processor) in relation to the processing of personal data of staff, patients and clients. This would have an impact if there were a data breach or dispute as there are no clear roles and responsibilities outlined by the Trust and BSO. The new DPA 2018 and Article 28 of GDPR places a clear responsibility on the Data Processor and this needs to be clearly documented and agreed by all parties. The current absence of a Data Processing Agreement with BSO means that we are breaking the law and if a data breach occurs, the Trust is very likely to be fined. ICO guidance clearly states that there should be a contract in place between the Data Controller and Data Processor	1. Both organisations adhere to the Data Protection Act 2018 and the ICT security framework. 2. This issue is on the e-health agenda for awareness and also on the SIRO regional meeting agenda. 3. BSO has provided a letter of assurance outlining the controls they have in place, but no signed agreement between the two organisations which needs to be progressed by the task and finish group. 4. Draft agreement provided by BSO, but does not provide sufficient assurance.	Regional IGAG group chaired by the Department of Health SIRO regional forum and E-Health Programme Board	1. Minutes of meetings 2. Minutes of meetings 3. Letter on file from BSO Draft agreement

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Additional actions and timescales
1. Agenda item for the Strategic Information Group which includes Information Governance issues. Director of Performance & Reform, SHSCT is a representative on this group. 2. Chair of Information Governance Advisory Group agreed to write to the BSO to request changes to draft agreement for sign off 29th August 2019

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Likelihood: Likely (4) **Impact: Major (4)** **Risk Rating: HIGH**		**RISK OWNER: Performance and Reform Directorate (Cybersecurity Lead)** While this risk will be led by P&R from a cybersecurity assurance perspective, this risk is a corporate risk requiring ownership by Directorates as follows: • **Performance & Reform Directorate** (in relation to assurance of 'technical' ICT **DEFEND & RECOVER** / back up processes) • **Medical Directorate** (in relation to lead role in assuring effective Emergency Planning) • **Operational Directorates** (in relation to assurance of effective Business Continuity Plans to **RESPOND** to potential incidents)		
		DATE RISK ADDED: July 2017 **Reworded: June 2018**		
		TIMESCALE FOR REVIEW OF CONTROLS: Monthly		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
2	The key risk emanating from a cyberattack is potential for **significant business disruption.** Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, HSC information, systems and infrastructure may become unreliable, not accessible (temporarily or permanently), or compromised by unauthorised 3rd parties, including criminals. This could result in unparalleled HSC-wide disruption of services due	**1.REGIONAL**: In the context of Northern Ireland, with a single Health and Social Care structure, and also a single HSCNI network, with Regional diagnostic services and NIECR, the impact in Northern Ireland of a cyber attack affecting the Network or Regional Data Centres has been assessed as potentially a National Civil Contingency (NCSC). Therefore, critical to managing risk at local level is the work progressed at regional level to mitigate risk through the Cybersecurity Programme Board and the extant policy and processes for Regional Emergency Planning led by the Chief Medical Officer. Letter from Permanent Secretary 11th Feb 2019 - all Investment & implementations	1. Regional Cyber Security Programme Board (Director P&R) established 2nd May 2018. 2. Regional Cyber Security Officers Forum established in June 2018. First meeting January 2019 - meetings scheduled bi-monthly.	Minutes of meetings This Group makes recommendations to Regional Programme Board Minutes of meetings and Action List – all papers posted onto SharePoint.

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	to the lack of/unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendances or diagnostic services such as Labs or NIPACs) or data contained within. This could lead to a range of impacts or core service areas for example: • Service disruption impacting on operational service delivery including waiting times, delayed urgent clinical interventions, suboptimal clinical outcomes etc. • Risks in the ability to deliver safe care in the community, for example, accessing electronic records for the c. 5,000 clients in receipt of domiciliary care. • Potential for unauthorised access to Trust systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations. • This could potentially bring liabilities for the Trust including potential fines and reputational damage.	decisions on Cyber Security across the HSC must receive advanced approval from Regional Cyber Security Programme Board. **2.<u>LOCAL - TRUST LEVEL CONTROLS:</u>** If information systems are not available, the Trust needs to consider contingencies to accessing information on patients, clients, care packages in the community etc Current controls to DEFEND, RESPOND and RECOVER are as outlined below.	Trust Internal Cyber Security Task and Finish Group has been established to take forward recommendations of internal reports as appropriate in line with regional Cyber Security Programme Board	Minutes of meetings and Action List - all papers posted onto SharePoint.

Additional actions and timescales

1. Regional “faux” cyber security exercises to test user behaviours, service continuity / disaster recovery plans not yet arranged by BSO.

There are three aspects to the management of this risk within the Trust, as outlined below.

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		Key Current Controls	Who monitors the control?	How is it evidenced?
	1. DEFEND: To maximise the Trust's technical defences to minimise the risk of a cyber attack;	**1. <u>Technical Infrastructure</u>** • HSC security hardware (e.g. firewalls) • HSC security software (threat detection, antivirus, email & web filtering) • Server / Client 'Patching' regime • 3rd party Secure Remote Access • Data & System Backups **2. <u>Policy, Process</u>** • Regional and Local ICT/Information Security and Incident Management Reporting Policies and Procedures All Trust IT Policies updated and approved at Scrutiny Committee - July 2019. • Data Protection Policy • Change Control Processes • User Account Management processes • Disaster Recovery Plans • Awareness raising • IT Risk training for senior managers (advanced) and front line staff (basic).	Head of IT Bi-monthly reporting to Cyber Task and Finish Group and Quarterly Reporting to Governance Committee Regional Policy – not yet developed Head of IT	IT Self-Assessment against NCSC10 Steps (I) IT Audit (I) Network Information Systems (NIS) self-assessment carried out & submitted to 'Competent Authority' in May 2019 Technical Risk Assessments, or Penetration Tests (E) FourSys (Network Security Expert) Report May 2017 Findings of Phishing Exercise reported to SMT Awareness sessions held in August and September 2017. Cyber assimilated event in January 2018. Action plan to be followed up by Cyber Task and Finish Group. Global emails, 'SIRO says' campaign highlighted in desktop messages and Southern-I IT risk training completed March and April 2019. Further session scheduled for May 2019.

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		• Resources – 2017/18 -SMT agreed financial resources to support additional capacity into ICT defence including: 2 wte Band 6 and 1 wte Band 7 to support progress of Priority 1 actions from IA and Foursys report. Band 7 Cyber Manger in post; 2x Band 6 Temporary EOI posts in place. Permanent Band 6 posts advertised and closed 2-4-19; to be appointed by end of May 2019. It is unlikely that a team of 3 staff will be suffice to manage the risks that vulnerability scanning is revealing		Dedicated Cyber Security Team (3 staff in post July 2019).

Additional actions planned and timescale

The following recommendations remain outstanding to maximise technical defences (subject to funding and regional approval as per Permanent Secretary letter):

Priority 2:
Vulnerability Scanning (Purchased and currently being installed)
Managing User Privileges (On-going with MS Security Consultant)
Incident Management (being considered at regional Programme Board)
Monitoring (being considered at regional Programme Board)

Priority 3:
Secure Messaging
Education and Awareness (Regional IT Security Training Module agreed to be updated with Cyber Security Module to be signed-off by by Regional Cyber Security Programme Board)

1. Cyber Risk Register has been completed and will be reviewed at Cyber Task and Finish Group meeting
2. Vulnerability scanning has commenced and is highlighting vulnerabilities with building management systems such as CCTV, call systems and 1 CT scanner to date. A log of hardware costs to address these risks is being created and will be tabled at Cyber Task and Finish Group and will be shared at Regional Cyber Programme Board for awareness and funding approval. The first tranche of funding from the Regional E-health Programme Board has been allocated to address high priority cyber risks.
3. A Project Team has been established to progress the implementation of recommendations made by 2 Internal Audits

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		Key Current Controls	Who monitors the control?	How is it evidenced?
	2.RESPOND: Services to consider how they would deliver safe and effective care in the event of diagnostics, appointment and client information being unavailable and plan for this;	**1. Policy, Process – Operational Services** • Emergency Planning & Service/Business Continuity Plans • Corporate Risk Management Framework, Processes & Monitoring • Regional & Local Incident Management & Reporting Policies & Procedures **2, <u>User Behaviours - influenced through:</u>** • Regional IT Security Module updated to include Cyber Awareness. • Induction Policy • Mandatory Training Policies, particularly Information Governance • HR Disciplinary Policy • Professionals Academic training includes DPA • Contract of Employment • 3rd party Contracts / Data Access Agreements • Communication and Awareness • Cyber Incident Response Planning meeting with Medical Directorate	Emergency Planning Team – Medical Directorate Cyber Security Task and Finish Group Human Resources and Organisational Development, Education, Learning and Development/Line Managers Corporate Policy Review Group Assistant Director Informatics	Business Continuity Plan – logs Minutes of meetings To be made Mandatory Corporate Mandatory Training reports Corporate Policies Regional desktop Cyber exercise carried out in June 2019.
Additional Actions planned and timescale				
Business Continuity Plans need to be updated by all services to plan for a cyber attack				

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		Key Current Controls	Who monitors the control?	How is it evidenced?
	3. RECOVER: To test and improve 'Back up and Recovery' of critical information systems in the Trust and BSO to be assured that in the event of a cyber attack, data can be recovered by IT as quickly as possible to minimise impact on services.	There are 3 levels of restore available PC Level; Application and Server. PC restore is fully tested; Application level and Server restore require agreement to bring down specific systems which has not yet been performed in the Trust. However there have been system upgrades and outages that have required the IT team to restore. Therefore there is some level of intelligence for a range of applications and servers. Additional disaster recovery infrastructure has been purchased and to be installed in DHH – testing to be scheduled when operational.	IT Controls Assurance Board (CAB) meets weekly Head of IT	Minutes and full audit trail from LanDesk. Task & Finish Group

Additional Actions Planned and Timescale
Some Applications and Servers require Full Restore Testing. Task & Finish Group to agree applications to be tested and a schedule of downtime.

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CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Almost Certain (5) **Impact: Moderate (3)** **Total Score:15** **Risk Rating: HIGH** **Previous score: 15**	**RISK OWNER: Director of HROD and Medical Director** **DATE RISK ADDED: July 2015** **Reworded: March 2019** **TIMESCALE FOR REVIEW OF CONTROLS: Four weekly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
3	Risk to Patient safety due to medical workforce shortages and vacancies within some specialties including: • Emergency Medicine • Radiology • General Medicine • Acute Medicine • Paediatrics • Stroke • Intensivists • Haematology • Trainee doctors	1. Monitoring of vacancy position through Medical Staffing and Directorates 2. Analysis and improvement of recruitment and advertising strategies 3. Locum agencies to fill gaps 4. Collaborative working with other Trusts, when required 5. Independent Sector 6. Greater use of alternative roles through advanced practitioners – nursing and AHPs and more recently Physician Associates 7. International recruitment 8. Escalation of pressures to HSCB and DOH 9. Adverts now include a sentence asking for expression of interest from doctors who would wish to apply for Consultant posts, but are not yet eligible. A formal log is being kept. 10. Trust is currently involved in training of Physician Associate Students, and have appointed first qualified PA	Director of HROD Medical Director	1,2,3,7 Papers to SMT

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		11. Regional support from existing ED Consultants was agreed in principle to fill gaps on rota if at a critical point. Escalation arrangement at Chief Executive level where necessary 12. Expansion of Clinical Co-ordinators in the out-of-hours period to improve the trainee experience of FY1s. 13. Appointment of overseas doctors via the Medical Training Initiative scheme.		

Additional Actions Planned and Timescale

1. Ongoing efforts to increase capacity of internal banks/locums to reduce reliance on expensive agency locums. The Clinical Fellow model is working well for the ED department.

2. Work to progress to determine if Clinical Fellow model could be expanded into Medicine from February 2019. The AMD and CD are currently reviewing the proposal paper that was used to secure Clinical Fellows in ED to determine if this is something they want to pursue for August 2019.

   Directors of Human Resources and Medical Directors met on 10th August to discuss medical workforce issues relating to payment rates, and standardizing across HSC. Director of Human Resources in Northern Trust is leading a regional workstream to review these issues with first meeting taking place on 22 November 2018. This meeting had representation from HR, Medical Director and Finance – all of whom agreed to work together to try and determine the best way to handle this issue on a regional basis.

3. Transformation Implementation Group (TIG) process for medical recruitment in place to seek to avoid further destabilisation of Trust services through greater collaboration – this involves the Medical Directors information sharing details of any new posts that they plan to advertise with their regional counterparts for information purposes.

4. The Southern Trust has revised its guidance for Consultants Covering Absent Colleagues and has proposed an increase in rates which was agreed by SMT at the end of 2018 and is pending BMA LNC agreement which is expected within the next few weeks. This could result in more internal cover being offered from within the Trust and also will allow the Trust to offer bank contracts to

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consultants directly to avoid agency commission charges particularly for longer term locum bookings.

5. A meeting took place with NIMDTA and the Medical Director's Office to discuss the critical shortfall in Junior Trainee Doctors since 1st August 2018.NIMDTA is currently carrying out an exercise to establish the funding associated with all training posts and specialties. A working group has been established within the Southern Trust chaired by Gail Browne (Director Medical Education) to scope out where this Trust sits in comparison with the region using the data available to us with a view to documenting this to NIMDTA and DOH by the end of January/early February 2019.

6. The Southern Trust has offered three Physician Associates 'New Graduate Year' posts. All three Physician Associates commenced in post on 20th March 2019. Two are based in Daisy Hill Hospital in Medicine and ED and 1 is based in Craigavon in Haematology and Care of the Elderly.

7. An IPT was approved in principle at Strategic Investment Committee on 11.03.19 for four MTI trainees for Medicine in Daisy Hill. The four priority areas have been identified as Renal, Respiratory Gastroenterology, and Cardiology. The Trust has been liaising with the Royal College of Physicians in an attempt to progress this urgently.

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CORPORATE OBJECTIVE: 1: Promoting safe, high quality care.				
Likelihood: Almost certain (5) **Impact: Moderate (3)** **Total Score: 15** **Risk Rating: High** **Previous score: N/A**		**RISK OWNER: Director of Older People and Primary Care** **DATE RISK ADDED: Re-added June 2019** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
4.	There is a risk that the Trust may not be able to deliver a full, timely, Out Of Hours service (OOHs) due to difficulty filling all rota GP sessions.	**Service delivery planning** • Advanced rota planning, daily reviewing contingency actions for GPs, nurses & Operational staff. • Requests via SMS / emails and telephone calls to GPs, Nurses to assist with workload. • Datix system in place to record clinical incidents – monitoring and investigations as per policy • Complaint investigation and sharing of the learning as per policy • Monthly clinical meeting with Medical Managers, Nurse Team Lead and HOS, chaired by Clinical Lead.	Head of Service (HOS) OOHs HOS OOHs HOS OOHs HOS OOHs Clinical Lead OOHs	Through emails, use of the Harris system, Datix system Minutes of meeting

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

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

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

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

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CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Almost Certain (5) **Impact: Moderate (3)** **Total Score: 15** **Risk Rating: HIGH** **Previous Score:15**		**RISK OWNER: Interim Director of Nursing , Midwifery and AHP's** **DATE RISK ADDED: April 2015** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
5.	**i) There is a risk to the consistent provision of high quality nursing care due to a shortage of Registered Nurses and Midwives across all Directorates within the Trust.**	1. Escalation processes are in place within each Directorate to respond operationally to immediate Registered Nurse shortages	Directorate Assistant Directors	Twice daily review at operational patient safety meetings.
		2. A risk assessment approach is being rolled out across all Acute wards	Interim Assistant Director Nursing Workforce & Education, Assistant Director Nursing Governance and Acute Assistant Directors	Risk Assessments
		3. Pilot of safe care completed and evaluated. Currently further rollout of safe care being implemented across all acute wards in Craigavon and Daisy Hill Hospitals as part of Health Roster	Interim Assistant Director Nursing Workforce and Education	Health Roster data

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		4. Measures to improve the efficacy of Roster by system users to maximise staff utilisation eg. KPI's, standard operating procedures, check and challenge meetings and the establishment of monthly reports to the Directorate. Audit recommendations are also being progressed through all Health Roster workstreams	Interim Assistant Director Nursing Workforce and Education	Health Roster data
		5. Key actions regarding recruitment, retention and utilisation of current workforce being progressed through Nursing and Midwifery Workforce Action plan and relevant workstreams	Interim Assistant Director Nursing Workforce and Education/ Directorate Assistant Directors	Action Plan
		6. Use of bank and agency to support required staffing levels. Currently reviewing processes to maximise the use of Bank including open registration to Nurse Bank.	Nurse Bank Manager Head of Resourcing	HR reports, Bank and Agency reports
		7. International recruitment	Interim Assistant Director Nursing Workforce and Education and Head of Resourcing	International Recruitment reports
		8. Robust annual recruitment schedule. In addition, monthly advertisement for Band 2/3 and open advertisement for Band 5	Interim Assistant Director Nursing Workforce and Education	Recruitment schedule

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

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

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		• Increase in numbers of Band 6 staff across Bluestone, Dorsy and Gillis to work towards a senior staff nurse presence 24/7.		• HR Reports
		• Ongoing engagement with staff side and staff		• Minutes of meetings and emails
		• Escalation process in place with regard to safe staffing levels, noting challenges to no management on-call arrangements.		• Escalation process
		• Implementation of Health Roster across Bluestone and Dorsy in the first instance by March 2020.		Implementation will commence October 2019 with the aim to 'go live' December 2019
	iii) **There is a risk to the continued safe assessment and monitoring and provision of high quality nursing care in Mental Health and Learning Disability community teams due to a shortage of registered mental health, and learning disability nurses**	• Pressures monitored at a local team level by Team Lead and resources allocated on a prioritisation basis to address gaps brought about by vacancies	Director of Mental Health and Disability; Executive Director of Nursing	Staff in post and finance reports
		• Pressures raised at both operational and governance meetings and shared with the work-force planning group of the Directors Oversight Group	Acting Assistant Director Mental Health	Minutes of meetings Monitoring of waiting lists in Primary Mental Health Care and specialist services
		• Continued recruitment to vacant posts	Heads of Service for respective teams	Use of the Balance Score card for monitoring service priorities.

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		• Exploring the design and implementation of skills development framework for nurses at Band 5 to develop the competency of Band 6 nurses, modelled on an approach used by the Northern Trust. • Participated in the Phase 5(b) Normative staffing project for Community Mental Health teams, this is awaiting approval at DOH level • Further Development of Community based services includes scoping of multi professional contribution to safe and effective care **Regional Actions** • Regional Workforce meetings with DoH • Regional meetings with RQIA • Ongoing HSCB/PHA led Regional Review of Acute Mental Health In-patient Beds and Models of care to support patient flow • Regional review for Learning Disability cross Trust placements in Acute Mental Health beds		

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Additional Actions Planned and Timescale

1. Complete risk assessments for all Acute wards (both sites) by September 2019.

2. Pilot of Safe Care across 4 wards in CAH now completed. Lessons learned being collated with roll out across Acute by March 2020.

3. Establish a suite of reports from Roster for the Acute Directorate incrementally by September 2019.

4. Further roll out of Health Roster in planning stage for MHLD, 6 wards in Bluestone commencing October 2019

5. Recommendations from the Royal College of Psychiatrists will be considered and an action plan developed at the Directors' Oversight Group in August 2019. A visit to Merseycare took place on 6th August 2019 for learning, including implementation of the patient safety thermometer and "No Force First."

6. Mental Health and Learning Disability Recruitment Day planned for 28 September 2019.

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

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	Increasing emerging infections (CPE/VHF)	1. Ongoing ward rounds relating to antibiotic stewardship 2. Isolation and active screening of patients transferring from other hospitals, or history of admission within the last 12 months	Consultant Microbiologist Relevant Operational Director	Presentation of data on antibiotic usage Policy on isolation of patients

Additional actions planned and timescale
The VHF Management Plan is being progressed and is planned for completion by end of September 2019. Deep dive at Governance Committee on 7.2.2019 highlighted areas where early intervention and mitigations could be strengthened. e.g. Targeted training via Trust Care Home Inreach Project for the Independent Care Sector and training for GPs on the antibiotic prescribing and infection control measures) *All IPC training for the IS Private Nursing Home sector is and will continue to be provided by the PHA. PHA is the host of the Regional Care Home In-Reach Project.* *Some GP training is offered through Microbiology and Pharmacy as well as what is on offer by HSCB and GP Federations on issues such as C diff and management of diarrhoea across primary and secondary care.*

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

Additional Actions Planned and Timescale

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

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

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Additional actions planned and timescale

Phase 1a

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

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

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

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

Phase 1b

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

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

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

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

Phase 1c

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

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

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

A presentation was delivered to Department of Health colleagues to provide further understanding\clarity on the overall LV issue and this was received positively. CPD Estates were also present at the meeting and supported\confirmed the Trust's position.
A full business case was submitted to the DoH for review and following a series of queries from Departmental advisors some elements of the case have been revised to give further clarity and resubmitted early August. The Trust is hopeful of some in year funding to support some of the above works.

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

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

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		6. New <u>under</u> threshold service contracts are being procured by Trust staff under influence of SCPU.	Director of Performance & Reform/ Operational Directors	6.Internal procurement work plan in place.
	iii) Failure to manage social care /domiciliary care/voluntary sector contracts to ensure safe and effective care delivery to clients and VFM	1. Domiciliary Care Oversight Group in place to provide focus to domiciliary care specific contract management.	Director of Older People and Primary Care/ Director of Finance	1. Terms of Reference in place and Minutes of Meeting
		2. Professional Head of IS contracts for Domiciliary Care in Place to provide oversight on quality arrangements.	Director of Older People and Primary Care	2. Internal review/validation of payments in the domiciliary care sector conducted in 2017/18 for 6 largest providers. Process for overseeing quality and performance management in place
		3. Independent Sector Governance group in place, cross programme and profession (finance, contracts, safeguarding, governance and operational) to review contract management issues in the regulated sector		3. Terms of Reference in place and Minutes of Meeting Internal Audit review of contract management in 2018/19
		4. Approach to guide consistent approach to performance management of contracts in place	Director of Older People and Primary Care	4. Standard Operating Procedures
		5. Director of Older Peoples Services member of regional Review Group and SHSCT local Review Group in Place to review learning from CoPNI report (Dunmurry Manor)		5. Terms of Reference in place. Internal Trust review completed.

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		6. Action plan in place to consider learning from Console Review for voluntary sector	Director of Finance / Older People and Primary Care	6. Action Plan

Additional actions planned and timescale

i) General

- Director of Finance will bring revised Procurement Strategy to Trust Board - completed
- Revision of controls assessment process for non pay commissioning in 2018/19 in line with DOH circular – March 2019- completed
- Development of composite KPIs for procurement, including Pharmacy, Estates and Social care – 2018/19 workplan. These KPIs have been agreed at Regional Procurement Board and are currently being reviewed for implementation at Trust level.
- Investment in contract management staff remains outstanding and this will be considered for investment in 2019/20 once the Trust has clear sight of its total allocations for the year ahead. Finance and Planning are working with all Directorates to understand current requirements for contract management with a view to presenting a paper at SMT for consideration.

ii) Social Care

- Trust to further develop approach to below threshold procurement, working with other HSC organisations during 2018/19 and 2019/20 pending issue of reginal guidance on below threshold procurement.

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

- Work to examine potential use of benchmarking to establish VFM in social care contracts ongoing
- Review of structures for contract management underway

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

CORPORATE OBJECTIVE: Making Best Use of Resources				
Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: Medium** **Previous Score: 12**	**RISK OWNERS: Operational Directors** **DATE RISK ADDED:** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
10	**i) Breach of statutory duty of break-even in-year**	1. Draft Financial Strategy will be developed and agreed with Directors for 2019/20	Director of Finance	1. Monthly financial performance detail reports to all budgetholders Monthly reporting to SMT, Trust Board, HSCB and Department of Health
		2. Formal financial monitoring system in place including forecasting year-end outturn	Director of Finance	2. Monthly monitoring returns prepared for issue to DoH and HSCB
		3. Chief Executive accountability meetings with Directors at least 3 times annually	Chief Executive	3. Minutes of meetings and agreed action plans
		4. Monthly financial accountability meetings between budget-holders and finance	All Directors	4. Minutes of meetings and agreed action plans

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	ii) Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support.	1. The continual update of the Trust's recurrent deficit and reporting of same to HSCB/ Department of Health 2. Work has commenced on the financial strategy for 2019/20	Director of Finance Director of Finance/ Department of Health/HSCB	Trust Delivery Plan, Monthly monitoring returns, Board Papers Minutes of SFF and DoF

Additional actions planned and timescale

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

- Indicative allocations for the financial year 2019/20 have been received and Directors of finance were asked to submit their assessment of these allocations on their Trust's financial position. This was submitted in July 2019 and indicates at this stage an unresolved gap of some £3m. Discussions are ongoing between the Trust, HSCB and DOH
- Finance will once again carry out a mid-year hard close – October/November 2019 – the purpose of which is to inform the finance strategy for the remaining months of the financial year.
- The Director of Finance, prepared a paper "Return to Balance" – this document reminded all of the Trust's statutory duty to break-even and that as a Trust we do not have the authority to spend in excess of the budget. It set out a work plan to commence in the Acute Directorate initially and then all other Directorates. The aim is to achieve best value for money and the fair and effective use of our resources.

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

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

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

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

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

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	iii)	**Reporting of diagnostic testing beyond the clinically indicated timescales**	1. Prioritisation of capacity to accommodate red flag and urgent reporting in the first instance 2. There is a mechanism in place for identification of red flag and urgent new patients 3. Additional contracted capacity for reporting in place - imaging 4. There is weekly and monthly monitoring information in place to assist with oversight and identify key areas where diagnostics remain unreported and escalate those requiring prioritization	Head of Service/Assistant Director/Clinical Director/Associate Medical Director/ Operational Service Lead	Minutes of Radiology Thursday afternoon meeting IS contracts are used to manage the scanning and reporting times and where necessary we can access this to manage investigation and reporting time. Minutes of Radiology Thursday afternoon meeting Minutes of Radiology Thursday afternoon meeting

Additional Actions Planned and Timescale

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

Develop an internal plan to facilitate veering of clinical activity on a short term basis within specialties to address clinical risk. For example, in Gynae, new routines were replaced with Red Flag slots for a period of time during a period of peaks in referral rate. This addresses one risk, however this type of action may impact on other areas in the patient pathway.

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

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

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

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Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

August 2020

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the relevant Corporate Objectives contained within the Trust's Corporate Plan 2017/18 – 2020/21 as detailed below:-

Corporate Objectives

1: Promoting safe, high quality care.
2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

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Risk scoring is based on likelihood and impact as summarized in the Risk Assessment Matrix below.

Risk Likelihood Scoring Table			
Likelihood **Scoring Descriptors**	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Updates are in red font for ease of reference

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OVERVIEW OF CORPORATE RISK REGISTER AS AT AUGUST 2020

LOW	MEDIUM	HIGH	EXTREME	TOTAL
	3	10	1	14

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page	Movement from last review
1	**BSO Shared Services** • Payroll/Travel • Recruitment	1&4	**MEDIUM**	**5**	Unchanged
2	**Cyber Security**	1	**HIGH**	**10**	Unchanged
3	**Medical Workforce shortages and vacancies**	1	**HIGH**	**16**	Unchanged
4	**Locum Engagements**	1	**HIGH**	**19**	Unchanged
5	**GP Out of Hours**	1	**HIGH**	**21**	Unchanged
6	**Registered Nursing Workforce Shortages**	1	**HIGH**	**26**	Unchanged
7	**HCAI**	1	**HIGH**	**34**	Unchanged
8	**Deterioration of exposed concrete on building exterior, Daisy Hill Hospital**	1	**HIGH**	**36**	Unchanged
9	**Loss of electrical power to main hospital block, Craigavon Area Hospital**	1	**HIGH**	**37**	Unchanged
10	**Compliance with procurement and contract management guidance**	1&4	**MEDIUM**	**39**	Unchanged
11	**Breach of statutory duty of break-even in-year** **Destabilisation of services due to the inability to secure recurrent funding and over reliance on non-recurrent support**	4	**MEDIUM**	**44**	Unchanged
12	**Clinical risk associated with inability to manage patient care within clinically indicated timescales**	1	**HIGH**	**46**	Unchanged
13	**Compliance and Implementation of the Mental Capacity Act (2016) Phase 1**	1	**HIGH**	**51**	Unchanged
14	**Risk to safe, high quality care as a result of Covid-19 Pandemic**		**EXTREME**	**54**	New risk added on 14.5.2020

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CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Possible (3) **Impact: Moderate (3)** **Total Score: 9** **Risk Rating: MEDIUM** **Previous Score: 9**		**RISK OWNER: Director of Finance, Procurement and Estates** **DATE RISK ADDED: August 2016** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre:-** **Payroll & Travel** The risk that staff pay and travel reimbursements are inaccurate due to the control environment of the Business Services Organisation (BSO). This has the potential for financial hardship for staff, negative media attention and reputational damage for the Trust.	1. A range of KPIs have been agreed with BSO for each Trust which identifies where there has been improvement or deterioration and triggers appropriate action 2. The Trust has a process of reimbursing staff as quickly as possible once an underpayment is identified as quickly as is feasible 3. Once an overpayment has been identified, BSO enact the overpayments policy 4. Annual Internal Audits	Assistant Director of Finance Assistant Director of Finance Assistant Director of Finance Assistant Director of Finance	1. Monthly KPIs 2. Payroll data 3. Schedule of Overpayments and Recovery Plan 4. Internal Audit reports and action plans

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		5. Regional audit of BSO Payroll Shared Services, currently twice a year	Assistant Director of Finance and Internal Audit	5. Audit reports and action plans
		6. Trust wide communication to all managers to remind all in respect of timely completion of paperwork	Assistant Director of Finance	6. Global communications
		7. Trust active participation in a number of regional groups to provide guidance, assistance and challenge to achieve necessary improvements	Finance Directorate	7. Minutes of meetings

Additional actions and timescales

1. Progress updates continue to be provided to Audit Committee and from October 2018 onwards, BSO have been providing a written report in advance of each Audit Committee. An updated progress report prepared by BSO which covers all outstanding recommendations was presented at February 2020 Audit Committee. Mid-year review of BSO Payroll remains limited.
2. Ongoing review of Internal Audit recommendations. For those that are the responsibility of the Trust, they will be picked up and reported on at the IA Forum initially before going to Audit Committee.
3. Ongoing attendance at Customer Forums and Business as Usual meetings.
4. Ongoing attendance of Director of Finance at Customer Assurance Board which has been established to oversee 3 new payroll workstreams in an attempt to address the issues.

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CORPORATE OBJECTIVES: 1 & 4 – PROMOTING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES				
Likelihood: Likely (4) **Impact: Moderate (3)** **Total Score: 12** **Risk Rating: MEDIUM** **Previous Score:12**		**RISK OWNER: Director of Human Resources and Organisational Development** **DATE RISK ADDED: August 2016** **Reworded: July 2018** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
1	**Shared Services Centre -** • **Recruitment and Selection** The delays in recruitment and selection pose a risk to service continuity for front line services	1. Implementation and monitoring of a local operational and service improvement plan ('Inspire, Attract, Recruit') to progress a range of local resourcing solutions. 2. Use of Bank and Agency for short/medium term interim cover, where possible and subject to appropriate approvals. 3. Internal Audit reviews of RSSC and Trust Recruitment & Selection. 4. Trust participation at Head of Service / Deputy Director level in regional Strategic Resourcing Innovation Forum (SRIF), with 4 workstreams each with a 12-month workplan to deliver and report to HR Directors.	Head of Resourcing	1. Resourcing Operational Plan and SMT updates 2. Monthly Bank Block Booking and Agency reports 3. Internal Audit assurance reports 4. SRIF annual work plans and dashboard

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		5. Customer review meetings and fortnightly Team Leader Clinics with Regional Shared Services Centre to escalate issues requiring to be addressed. 6. Regular analysis of recruitment data to identify specific issues/problems and to trigger appropriate action e.g. follow up with relevant managers/ Recruitment Shared Services Centre. Trust management information reports issued to Directorates in relation to vacant posts and requisition requests in the approval process monthly. 7. Trust wide communications in relation to managers' roles and responsibilities for recruitment and selection, as well as associated Key Performance Indicators. 8. Alignment of Resourcing Team Leaders to support Directorates taking action to minimise any delays in the recruitment process in conjunction with RSSC 9. Development and introduction of new approach to reduce pre-employment checks for internal (within Trust) and inter-Trust appointments. 10. HSC Recruitment and Selection Framework and associated guidance for managers		5. Minutes of Customer Forum 6. Monthly RSSC Performance Reports and Directorate vacancy reports 7. Global communications to Trust managers, process documents and user guides 8. Process documents for Pre-Employment checking process 9. HSC Recruitment and Selection Framework and associated guidance for Managers

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Additional actions and timescales

1. Significant piece of work to be undertaken in conjunction with service directorates to further streamline corporate waiting lists and Trust approach to maintaining these. The start date for this has been delayed due to the need to divert resources to Transformation activity. Alternative models of recruitment have been discussed and tested as part of the regional SRIF group, and implementation has started in the Trust for some groups of staff (Admin & Clerical posts; Nursing Assistants) but requires further planning prior to wider implementation for other high-volume staff groups during 2020/21.

2. Development of point of need skills training for recruiting managers – September 2020.

3. Roll out of Band 4 Recruitment support roles across all Directorates – December 2020.

4. Launch of HSC 'branding' and advertising concepts to increase applicant traffic to the recruitment website is the subject of ongoing discussion with DOH in relation to funding and HSC-wide implementation. Timescale for this is outside the control of the Trust. SHSCT branding and recruitment advertising/campaign promotion to be further developed with the Trust's contracted media provider – September 2020.

5. Commence introduction of regular overview reporting on time to fill for key groups of staff/professions to SMT – September 2020.

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Likelihood: Likely (4) **Impact: Major (4)** **Risk Rating: HIGH**		**RISK OWNER: Performance and Reform Directorate (Cybersecurity Lead)** While this risk will be led by P&R from a cybersecurity assurance perspective, this risk is a corporate risk requiring ownership by Directorates as follows: • **Performance & Reform Directorate** (in relation to assurance of 'technical' ICT **DEFEND & RECOVER** / back up processes) • **Medical Directorate** (in relation to lead role in assuring effective Emergency Planning) • **Operational Directorates** (in relation to assurance of effective Business Continuity Plans to **RESPOND** to potential incidents)		
		DATE RISK ADDED: July 2017 **Reworded: June 2018**		
		TIMESCALE FOR REVIEW OF CONTROLS: Monthly		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
2	The key risk emanating from a cyberattack is potential for **significant business disruption.** Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, HSC information, systems and infrastructure may become unreliable, not accessible (temporarily or permanently), or compromised by unauthorised 3rd parties, including criminals. This could result in unparalleled HSC-wide disruption of services due	**1.REGIONAL**: In the context of Northern Ireland, with a single Health and Social Care structure, and also a single HSCNI network, with Regional diagnostic services and NIECR, the impact in Northern Ireland of a cyber attack affecting the Network or Regional Data Centres has been assessed as potentially a National Civil Contingency (NCSC). Therefore, critical to managing risk at local level is the work progressed at regional level to mitigate risk through the Cybersecurity Programme Board and the extant policy and processes for Regional Emergency Planning led by the Chief Medical Officer. Letter from Permanent Secretary 11th Feb 2019 - all Investment & implementations	1. Regional Cyber Security Programme Board (Director P&R) established 2nd May 2018. 2. Regional Cyber Security Officers Forum established in June 2018. First meeting January 2019 - meetings scheduled bi-monthly.	Minutes of meetings This Group makes recommendations to Regional Programme Board Minutes of meetings and Action List – all papers posted onto SharePoint.

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	to the lack of/unavailability of systems that facilitate HSC services (e.g. appointments, admissions to hospital, ED attendances or diagnostic services such as Labs or NIPACs) or data contained within. This could lead to a range of impacts or core service areas for example: • Service disruption impacting on operational service delivery including waiting times, delayed urgent clinical interventions, suboptimal clinical outcomes etc. • Risks in the ability to deliver safe care in the community, for example, accessing electronic records for the c. 5,000 clients in receipt of domiciliary care. • Potential for unauthorised access to Trust systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations. • This could potentially bring liabilities for the Trust including potential fines and reputational damage.	decisions on Cyber Security across the HSC must receive advanced approval from Regional Cyber Security Programme Board. **2.<u>LOCAL - TRUST LEVEL CONTROLS:</u>** If information systems are not available, the Trust needs to consider contingencies to accessing information on patients, clients, care packages in the community etc Current controls to DEFEND, RESPOND and RECOVER are as outlined below.	Trust Internal Cyber Security Task and Finish Group has been established to take forward recommendations of internal reports as appropriate in line with regional Cyber Security Programme Board	Minutes of meetings and Action List - all papers posted onto SharePoint.

Additional actions and timescales
There are three aspects to the management of this risk within the Trust, as outlined below.

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		Key Current Controls	Who monitors the control?	How is it evidenced?
	1. DEFEND: To maximise the Trust's technical defences to minimise the risk of a cyber attack;	**1. <u>Technical Infrastructure</u>** • HSC security hardware (e.g. firewalls) • HSC security software (threat detection, antivirus, email & web filtering) • Server / Client 'Patching' regime • 3rd party Secure Remote Access • Data & System Backups **2. <u>Policy, Process</u>** • Regional and Local ICT/Information Security and Incident Management Reporting Policies and Procedures All Trust IT Policies updated and approved at Scrutiny Committee - July 2019. • Data Protection Policy • Change Control Processes • User Account Management processes • Disaster Recovery Plans • Awareness raising • ICT Business Continuity Plan Version 4.1 • IT Risk training for senior managers (advanced) and front line staff (basic). • Resources – 2017/18 -SMT agreed financial resources for Internal Cyber Security Team to support progress of Priority 1 actions from Internal Audit and Foursys report.	Head of IT Bi-monthly reporting to Cyber Task and Finish Group and Quarterly Reporting to Governance Committee Regional Policies – not yet developed by Deloitte - August 2020 Head of IT	IT Self-Assessment against NCSC10 Steps (I) IT Audit (I) Network Information Systems (NIS) self-assessment carried out & submitted to 'Competent Authority' in May 2019 Technical Risk Assessments, or Penetration Tests (E) FourSys (Network Security Expert) Report May 2017 Findings of Phishing Exercise reported to SMT Cyber assimilated event in January 2018. Action plan to be followed up by Cyber Task & Finish Group.Global emails 'SIRO says' campaign highlighted in desktop messages and Southern-I IT risk training programme Dedicated Cyber Security Team (1 x Band 7 and 3 x Band 6 staff in post September 2019). P/T 1 x Band 4 Admin Jan 2020

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		• Regional Network Security Review underway	Network Security Project Board	ANSEC Data Discovery and Analysis – Trust report & Workshop July 2020 To submit ANSEC report to Cyber Programme Board 3rd September 2020 – delayed.

Additional actions planned and timescale

Policy, Process

Regional Security Policies currently being developed. Work underway with Cyber Teams and Deloitte.

The following recommendations remain outstanding to maximise technical defenses (subject to funding and regional approval as per Permanent Secretary letter):

Priority 2:

Incident Management (Regional Cyber Incident Response Plan was agreed at Regional Cyber Programme Board 6/12/2019 - Launched internally June 2020 – Southern-i.

Monitoring (being considered as regional procurement through Cyber Programme)

Priority 3:

Secure Messaging is on the regional Cyber work stream list for 2020/21– Programme Board 3rd Sept 2020 update list.

Education and Awareness (Regional Cyber Security E-learning module has been created - To be launched on 3rd September 2020 at Regional Cyber Programme Board.

1. Vulnerability scanning is ongoing, but is not licenced for full Trusts assets – this was increased to 15,000 devices in March 2020, but Trust has almost double this. Raised at Regional level – cannot report on full vulnerabilities.
2. In addition, the level of vulnerabilities raised is placing demands on the ICT Operational to manage risk. There is not enough resources to do this. A paper is being produced by the Head of IT to identify resource gaps.
3. Project Team continues to progress the implementation of recommendations made by 3 Internal Audits. 2017-18; 2018-19; 2019-20. Updates discussed at Cyber Task & Finish Group on 14th August 2020.

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		Key Current Controls	Who monitors the control?	How is it evidenced?
	2.RESPOND: Services to consider how they would deliver safe and effective care in the event of diagnostics, appointment and client information being unavailable and plan for this;	**1. Policy, Process – Operational Services** • Emergency Planning & Service/Business Continuity Plans • Corporate Risk Management Framework, Processes & Monitoring • Regional & Local Incident Management & Reporting Policies & Procedures **2, <u>User Behaviours - influenced through:</u>** • Regional IT Security Module updated to include Cyber Awareness. • Induction Policy • Mandatory Training Policies, particularly Information Governance • HR Disciplinary Policy • Professionals Academic training includes DPA • Contract of Employment • 3rd party Contracts / Data Access Agreements • Communication and Awareness • Cyber Incident Response Planning meeting with Medical Directorate	Emergency Planning Team – Medical Directorate Cyber Security Task and Finish Group Human Resources and Organisational Development, Education, Learning and Development/Line Managers Corporate Policy Review Group Assistant Director Informatics	Business Continuity Plan – logs Minutes of meetings To be made Mandatory - To be launched on 3rd September at Regional Cyber Programme Board Corporate Mandatory Training reports Corporate Policies Regional desktop Cyber exercise carried out in June 2019. A further exercise to be arranged March/April 2020 - was postponed due to Covid-19

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Additional Actions planned and timescale				
Business Continuity Plans need to be updated by all services to plan for a cyber attack				
		Key Current Controls	**Who monitors the control?**	**How is it evidenced?**
	3. RECOVER: To test and improve 'Back up and Recovery' of critical information systems in the Trust and BSO to be assured that in the event of a cyber attack, data can be recovered by IT as quickly as possible to minimise impact on services.	There are 3 levels of restore available PC Level; Application and Server. PC restore is fully tested; Application level and Server restore require agreement to bring down specific systems which has not yet been performed in the Trust. However there have been system upgrades and outages that have required the IT team to restore. Therefore there is some level of intelligence for a range of applications and servers. Additional disaster recovery infrastructure has been purchased and to be installed in Daisy Hill Hospital for virtual servers (Zerto) – testing to be scheduled.	IT Controls Assurance Board (CAB) meets weekly Head of IT	Minutes and full audit trail from LanDesk. Task & Finish Group
Additional Actions Planned and Timescale				

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CORPORATE OBJECTIVE: PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Almost Certain (5) **Impact: Moderate (3)** **Total Score:15** **Risk Rating: HIGH** **Previous score: 15**	**RISK OWNER: Director of HROD and Medical Director** **DATE RISK ADDED: July 2015** **Reworded: April 2019** **TIMESCALE FOR REVIEW OF CONTROLS: Four weekly**			
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
3	Risk to Patient safety due to medical workforce shortages and vacancies within some specialties. At this time, specialties particularly vulnerable include: • Geriatric Medicine/Acute Care at Home • Stroke • Acute Medicine • Community Paediatrics • Haematology • Oncology • Psychiatry Old Age • Trainee doctors	1. Monitoring of vacancy position through Medical Staffing and Directorates 2. International recruitment 3. Analysis and improvement of recruitment and advertising strategies 4. Collaborative working with other Trusts, when required 5. Use of Independent Sector 6. Greater use of alternative roles through advanced practitioners – nursing and AHPs and more recently Physician Associates 7. Escalation of pressures to HSCB and DOH	Director of HROD Medical Director	• Updated list of Trust posts out with international recruitment – updated by Associate Medical Directors • Increase in use of social media platforms for advertising • SHSCT Paper re NI training numbers • Recent appointments of Physician Associates

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		8. Adverts now include a sentence asking for expression of interest from doctors who would wish to apply for Consultant posts, but are not yet eligible. A formal log is being kept and doctors notified when posts advertised. 9. Trust is currently involved in training of Physician Associate Students and have appointed first qualified PA's in 2019. Continue to participate in regional scheme. 10. Expansion of Clinical Co-ordinators in the out-of-hours period to improve the trainee experience of FY1s. 11. Appointment of overseas doctors via the Medical Training Initiative scheme in Renal DHH, Gastro DHH and a further one due to start in Cardiology DHH soon. 12. Updated LNC process & approved rate agreed for consultants covering absent colleagues. All consultants now on our bank and able to claim additional work electronically. 13. Locum agencies continue to be used to fill vacant posts on block booking or ad hoc basis		• Sample advert with the sentence regarding those doctors who have yet to get Certificate of completion of training

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		14. *(COVID19 specific)* Temporarily recruited 50 Medical Student Technicians (band 4) & 33 FYi1 doctors. Development of Medical Student Technician role and establishment of a Medical Student Technician bank so they can continue to provide cover after return to university.		

Additional Actions Planned and Timescale

- Formal review of recruitment metrics against each speciality is required, with a view to reviewing current level of risk. Since 2017 there has been a significant increase in number of consultants in post. This includes appointments in specialties that were considered on the list of vulnerable specialties (referenced in Risk Description). For instance 229 consultants in post in 2017 that increased to 259 consultants in post by June 2020. Since 2017 to date there has been a significant improvement in % of appointees from total vacancies. This indicates improvements in the recruitment process. In 2017 51.79% appointed but this increased to 70.18% by 2019. Review to be completed by end of September 2020.

- Additional support needed for international doctors from an induction perspective. A case for 3 PAs to enable a programme of work to support international doctor is due to be presented to SMT in September 2020.

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

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

Additional actions and timescales

1. Southern Trust has drafted new guidance for managers to set out how to manage performance concerns associated with locum doctors. This has already been shared with the GMC and a meeting has been arranged with the GMC Liaison representative to gain their endorsement of this document. The final authorisation and sign off of this document, along with a new governance framework for locums, has been delayed due to the onset of Covid, but will be followed up for completion by end of October 2020.
2. The Medical Director and Medical HR are involved in reviewing the mandatory training requirements for locum doctors and exploring methods to strengthen the induction process for this group of doctors.

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CORPORATE OBJECTIVE: 1: Promoting safe, high quality care.				
Likelihood: Almost certain (5) **Impact: Moderate (3)** **Total Score: 15** **Risk Rating: High** **Previous score: 15**		**RISK OWNER: Director of Older People and Primary Care** **DATE RISK ADDED: Re-added June 2019** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
5.	There is a risk that the Trust may not be able to deliver a full, timely, Out Of Hours service (OOHs) due to difficulty filling all rota GP sessions.	**Service delivery planning** • Advanced rota planning, daily reviewing contingency actions for GPs, nurses & Operational staff. • Requests via SMS / emails and telephone calls to GPs, Nurses to assist with workload. • Datix system in place to record clinical incidents – monitoring and investigations as per policy • Complaint investigation and sharing of the learning as per policy • Monthly clinical meeting with Medical Managers, Nurse Team Lead and HOS, chaired by Clinical Lead.	Head of Service (HOS) OOHs HOS OOHs HOS OOHs HOS OOHs Clinical Lead OOHs	Through emails, use of the Harris system, Datix system Minutes of meeting

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

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

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

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

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

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		regarding recruitment, retention and utilisation of current workforce being recommenced through Nursing and Midwifery Workforce Action plan and relevant workstreams.	Workforce and Education/Directorate Assistant Directors	
		4. Use of bank and agency to support required staffing levels. Currently reviewing processes to maximise the use of Bank including open registration to Nurse Bank as well as progressing an action plan regarding strengthening governance processes.	Nurse Bank Manager Head of Resourcing Interim Assistant Director Nursing Workforce and Education Interim Assistant Director Patient Experience and Quality	HR reports, Bank and Agency reports
		5. International recruitment is paused although web based interviews have recommenced in August 2020. Regional business case commencing for further International Nurse Contract post 2020.	Interim Assistant Director Nursing Workforce and Education	International Recruitment reports
		6. Monthly advertisement for Band 2/3 and open advertisement for Band 5 continues. Currently reviewing processes for recruitment as well as facilitating Band 4 student nurses with Band 5 posts across the Trust.	Interim Assistant Director Nursing Workforce and Education	Recruitment reports

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		7. Recruitment activities, such as job Fairs, local and across the UK. Engagement with Southern Regional College and career fairs in schools and colleges. **(paused)**	Interim Assistant Director of Nursing Workforce and Education & Head of Resourcing	Executive Director of Nursing Directorate records
		8. SHSCT staff engagement with students, both within universities and whilst on placement, to encourage consideration of SHSCT as an employer **(paused)**	Executive Director of Nursing and Interim Assistant Director of Nursing Workforce and Education	Executive Director of Nursing Directorate records
		9. Professional welcome re-commencing October 2020. Preceptorship programme continues via Zoom. Induction programmes in place for new employees with optional rotation scheme for newly qualified staff.	Executive Director of Nursing team	Executive Director of Nursing Directorate records
		10. SHSCT continues to work with Department of Health to influence an increase to the supply of Registered Nurses	Executive Director of Nursing and Interim Assistant Director of Nursing Workforce and Education	
		11. Increased numbers allocated to the Open University Nurse pre-registration programme for Mental Health and Adult Nursing inclusive of additional new places for Learning Disability and Paediatric Nurse training, commencing September 2020	Interim Assistant Director of Nursing Workforce and Education	DoH and Executive Director of Nursing Directorate training records

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		12. Due to ongoing ward reconfigurations operational teams are reviewing staffing levels in line with bed occupancy. Healthroster reports being compiled weekly to assist with decision making regarding staffing.	Interim Assistant Director of Nursing Workforce and Education and Directorate/cross Directorate Management	Health Roster data Night report data
		13. Surge Nursing workforce Critical care bed modelling carried out. To be repeated for potential second surge	Interim Assistant Director of Nursing Workforce and Education and Healthroster team Assistant Director ATICS	CCaNNI Critical Care Services draft Surge Plan
		14. Surge Nursing Workforce planning – non critical care wards principles agreed regionally	Interim Assistant Director of Nursing Workforce and Education and Healthroster team Assistant Directors Acute	Non critical care draft paper
		15. Covid-19 Training Needs Analysis completed for all Nursing and Midwifery staff. Clinical Education Centre delivered relevant courses	Executive Director of Nursing Team	
		16. New services/transfer of services completed to support Covid-19 effective management e.g. creation of new Mental Health ED and transfer of DHH ED to CAH site	Acute and Mental Health Directorate Assistant Directors and teams	

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		17. A number of visits to nursing, midwifery and AHP's by the Executive Director of Nursing/Assistant Directors to ensure staff were well supported during this pandemic. Other methods of communication, eg video and email were utilized for this purpose also.	Executive Director of Nursing team	
	ii) There is a risk to the continued safe, high quality nursing care in Mental Health and Learning Disability In-patient Units. Bluestone/Dorsy and Gillis due to a shortage of registered mental health/learning disability nurses.	• Directors Oversight group in place to oversee and co-ordinate actions from Royal College of Psychiatrists Invited Review • Regional policy position (Delivering Care) agreed for Bluestone and Gillis (not Dorsy) regarding safe nurse staffing levels, however, no funding attached • A medium to long term workforce plan is currently in development and will be presented to SMT. This will include proposals for senior on-call arrangements, management structures and development of senior clinical nursing roles.	Director of Mental Health and Disability; Executive Director of Nursing	• Royal College Invited Review report • Directors Oversight Group and sub-groups terms of reference and minutes • Delivering Care Phase 5a • Draft multi-disciplinary workforce plan • Draft IPT. On-call rota for Directorate implemented.

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		• Daily meetings with senior staff are conducted within Bluestone and Dorsy to manage patient flow and the movement of staff in response to need.		• Records of actions and daily staffing template
		• Use of flexible staffing, including bank, on-contract and off-contract agency staff ongoing in order to address unsafe staffing levels and maintain current bed numbers.		• HR and Finance Reports
		• Increase in numbers of Band 6 staff across Bluestone, Dorsy and Gillis to work towards a senior staff nurse presence 24/7.		• HR Reports
		• Ongoing engagement with staff side and staff		• Minutes of meetings and emails
		• Implementation of Health Roster across Bluestone and Dorsy in the first instance by March 2020.	Assistant Director HROD	• HR live from December 2019
	iii) There is a risk to the continued safe assessment and monitoring and provision of high quality nursing care in Mental Health and Learning Disability community teams due to a shortage of registered mental health, and learning disability nurses	• Pressures monitored at a local team level by Team Lead and resources allocated on a prioritisation basis to address gaps brought about by vacancies	Director of Mental Health and Disability; Executive Director of Nursing	Staff in post and finance reports
		• Pressures raised at both operational and governance meetings and shared with the work-force planning group of the	Acting Assistant Director Mental Health	Minutes of meetings Monitoring of waiting lists in Primary Mental Health Care

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		Directors Oversight Group • Continued recruitment to vacant posts • Exploring the design and implementation of skills development framework for nurses at Band 5 to develop the competency of Band 6 nurses, modelled on an approach used by the Northern Trust. • Participated in the Phase 5(b) Normative staffing project for Community Mental Health teams - awaiting approval at DOH level • Further Development of Community based services includes scoping of multi professional contribution to safe and effective care **Regional Actions** • Regional Workforce meetings with DoH • Regional meetings with RQIA • Ongoing HSCB/PHA led Regional Review of Acute Mental Health In-patient Beds and Models of care to support patient flow • Regional review for Learning Disability cross Trust placements in Acute Mental Health beds	Heads of Service for respective teams	and specialist services Use of the Balance Score card for monitoring service priorities.

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Additional Actions Planned and Timescale

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

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

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

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	Increasing emerging infections (CPE/VHF)	1. Ongoing ward rounds relating to antibiotic stewardship 2. Isolation and active screening of patients transferring from other hospitals, or history of admission within the last 12 months	Consultant Microbiologist Relevant Operational Director	Presentation of data on antibiotic usage Policy on isolation of patients

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

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

Additional Actions Planned and Timescale

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

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

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

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Additional actions planned and timescale

Phase 1a

New dual 2.0MVA transformers in Energy Centre (for future CT scanner). – this is now complete

The residual risk - If one of the fixed breaker in the Stores switchboard fails these transformers will provide a mains supply to Maternity & Ward-N via the new LV board in the Energy Centre.

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

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

Phase 1b

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

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

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

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

Phase 1c

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

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

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

A presentation was delivered to Department of Health colleagues to provide further understanding\clarity on the overall LV issue and this was received positively. CPD Estates were also present at the meeting and supported\confirmed the Trust's position.
A full business case was submitted to the DoH for review and following a series of queries from Departmental advisors some elements of the case have been revised to give further clarity and resubmitted early August 2019. The Trust secured £650k to help address some of the immediate issues and this work was all completed as at 31st March 2020. Negotiations are ongoing with DoH for the full investment. The DoH has now approved the outline business case totally £7.4m, however, it has been agreed for the current financial year only 2020/21, so work will be a phased programme aligned to how and when funding is released.

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

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

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

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

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		4. Approach to guide consistent approach to performance management of contracts in place. Workshop to review undertaken and new proposals being developed.	Director of Older People and Primary Care	4. Standard Operating Procedures
		5. Director of Older Peoples Services member of regional Review Group and SHSCT local Review Group in Place to review learning from CoPNI report (Dunmurry Manor)	Director of Older People and Primary Care	5. Terms of Reference in place. Internal Trust review completed.
		6. Action plan in place to consider learning from Console Review for voluntary sector	Director of Finance / Older People and Primary Care	6. Action Plan

Additional actions planned and timescale

i) General

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

ii) Social Care

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

Received from Aldrina Magwood on 15/07/2022. Annotated by the Urology Services Inquiry.

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

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

iv) PPE and COVID19

- Finance Directorate are working closely with BSO PaLs and the PPE regional supply cell in an effort to secure sufficient PPE and feeding into the regional model
- Trust has now put in place a completely new logistical process to ensure receipt and distribution of 1.5m pieces of PPE a week
- Additional governance procedures have been put in place for those non-Trust facilities in receipt of PPE from the Trust
- The Trust has also secured DoH funding approval for a temporary logistical store to facilitate the ongoing need to pick and deliver significant volumes of PPE

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

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		2. Work will commence on the financial strategy for 2020/21 on receipt of confirmation of the allocation re same	Director of Finance/ DoH/HSCB	Minutes of SFF and DoF

Additional actions planned and timescale

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

- Indicative allocations for the financial year 2020/21 have been received and Directors of Finance were asked to submit their assessment of these allocations on their Trust's financial position. The initial assessment indicated an unresolved gap of some £7m. Bilateral meetings are due to take place early September to agree the next stage.

- Finance will complete a mid-year hard close – October/November 2020 – the purpose of which will be to inform the finance strategy for the remaining months of the financial year.

- The Director of Finance, prepared an update on "Return to Balance" – this document reminded all of the Trust's statutory duty to break-even and that as a Trust we do not have the authority to spend in excess of the budget. It set out the key findings and recommendations from the Acute phase and also sought approval to move to the second phase which is within Mental Health and Disability. All recommendations were accepted and approved and work will commence within Mental Health and Disability.

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

- Director of Finance is continuing to work with HSCB and Department of Health in relation to the capitation inequity gap. Work during 2017/18 financial year secured a nil general savings target for the Trust going into 2018/19. Indicative allocations for 2019/20 also confirmed that once again the Trust was successful in ensuring that it will not be targeted with its business share of the overall regional efficiency target, almost £45m for the region and if it had been applied to the Trust it would have totalled £7m. All Directors continue to raise this with professional leads at HSCB/PHA and Department of Health – Ongoing.
- Director of Finance had a meeting with the DoH during March 2019. This meeting was productive and secured the DoH commitment to work with the Trust on a longer term plan.
- Director of Finance sought DoH approval for capitation to be discussed at the Strategic Finance Forum in November 2019 – a healthy debate took place and DoH agreed that whilst they had endeavoured to address some of the imbalance by not applying a savings target, the gap remained. A meeting is being arranged between DoH and Director of Finance to discuss more fully.

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

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

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

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

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		remain unreported and escalate those requiring prioritization		

Additional Actions Planned and Timescale

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

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

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

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

Work ongoing to finalise an action plan to address those waiting longer than clinically indicated timescale for review – anticipated February 2020.

COVID factors:

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

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CORPORATE OBJECTIVE: 1 - PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: High** **Previous Score: N/A**		**RISK OWNERS: Operational Directors** **DATE RISK ADDED: November 2019** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
13	There is a risk to safe, high quality care if the Trust fails to implement Phase 1 of the Mental Capacity Act (2016)	Administrative and Governance infrastructure to support the operation of short-term detentions in place with the appointment of additional Approved Social Workers (ASWs), Project and Administrative staff Appointment of a number of sessional Medical Practitioners and further Approved Social Workers and designated other professionals trained to ensure the Trust can run Deprivation of Liberty (DoL) Panels to deal with Short Term Detention Orders and other longer term DoLs in the community Trust Panels established twice weekly The current Covid 19 crisis has resulted in all non-urgent contact in long term community facilities to be stood down, this includes DoLs	Trust Task & Finish Group Director of Mental Health and Disability Services	Documented structure Reports and Minutes of meetings Statistics for Mental Capacity Act processes Updated list of recently recruited doctors for MCA Medical Reports Updated list of Bank ASWs for Trust Panels August 2020 - Action Plan post Covid shared with Department of Health for extension to 01.05.2021 to cover the period of unlawful

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		assessments. Therefore the Trust is unable to progress with historic DoLs applications as originally planned A range of training at differing levels has been put in place by the Department of Health and supported by the Trust to enable staff to perform legal duties and functions. Mental Capacity Act training has become mandatory for staff required to complete applications and assessments Senior staff representation on implementation working group led by the HSCB to share learning and experience between services and Trusts		liability. Legacy reviews and extensions have been progressing with negotiation on a home by home basis ensuring compliance with PPE/social distancing/remote working measures SMT report Further supported training sessions ongoing with frontlline staff and delivered by Trust staff who were Clinical Education Centre trainers. August 2020 – Two workshops delivered by a specialist external trainer for Trust Panel members Training records & total number of staff trained to each level – 2, 3, 4A, 4B (no longer required) & 5. Non CEC trained must print off once completed (doctors send to MCA Administration and to re-validation). Other staff print on-line certificate and record as part of their Personal Development Plan (PDP) and share copy with line

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		Ongoing engagement and communication with staff through a Task and Finish Group at which all Directorates are represented		manager. Papers shared as appropriate Minutes & Action Log Staff communications via Sharepoint and Southern-i

Additional actions planned and timescale

IPT has been completed and resources received to enable the Trust to develop arrangements and an infrastructure to support the discharge of its statutory duties under Mental Capacity Act. August – IPT 2020/21 submitted.

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

Engagement with voluntary/ independent sector has been managed by RQIA with limited reach which is supplemented by Mental Capacity Act team where required – will be re-established post Covid with priority to Nursing Homes.

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

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

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

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

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

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

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

Additional actions and timescales

- Development of Trust Re-Build Plans. Phase 3 Rebuild Plan (October – December 2020) is in development and will be submitted to the Department of Health on 23rd September 2020.
- Trust ongoing participation in development of regional Strategic Framework for Rebuilding HSC Services
- The Directorate of Finance, Procurement and Estates has received DoH approval to lease a storage area to facilitate storage, picking and distribution of PPE – this also secures completion of a recommendation contained within the DoH audit

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WIT-37456

E-File : Workforce Planning/
R Wright One Direction Repots

ONE DIRECTION – Ten Steps to Success

Meaningful Job Planning for Consultants and SAS doctors working with the Southern Health and Social Care Trust

July 2018

R E R Wright

Version 3

18th July 2018

ONE DIRECTION -10 steps forward

Meaningful Job planning for Consultant and SAS doctors working with the Southern Health and Social Care Trust

Context

Since the introduction of the 2003 Consultant Contract a regular annual job plan review has been recommended to maximise opportunities for the Trust and the doctor to work together to provide effective patient care. Participation in the process is both a professional and contractual obligation. Job planning in NI has traditionally been based upon a number of key documents such as the *Step by Step guide for Consultants in Northern Ireland*- BMA(Last updated June 2016) , BMA *Job planning for Staff and Associate Specialist and Specialty doctors: Introduction* (Last updated February 2017). In addition The Southern HSC Trust recently commissioned an internal Audit of the Job Planning process, *SHSCT-Management of Consultant Medical Staff 2017/18* (April 2018) which has highlighted a number of areas for improvement. Within the UK NHS Improvement has produced a highly relevant paper entitled *Consultant Job planning: a best practice guide* (July 2017).

In addition, the SHSCT is keen to improve the delivery of the job planning process and the effectiveness relevance of job planning for both the doctor and the Trust. This paper incorporates the best practice described in these papers, outlining specifically how the Trust will address the job planning challenges over the next few years keeping the delivery of care to our patients and clients as its main focus. It will also address the specific terms of reference set out below as outlined by the Chief Executive.

Terms of Reference

1. Improved Engagement with Doctors resulting in a high percentage of contemporaneously agreed meaningful job plans that address the Trust , the Doctor's and most importantly the patients' needs
2. Improved compliance with internal Audit job planning recommendations
3. Improving attractiveness of SHSCT as an employer of medical staff thus improving recruitment and retention
4. Sustainability of process

Methodology

A review of the current relevant published documents as outlined above was undertaken. Note was taken of views expressed at the job planning review group together with individual discussions with a range of AMDs CDs Ads Directors and Medical HR staff.

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Principles underpinning the job planning process

- The job plan should be developed in a spirit of partnership
- It should be a prospective agreement setting out duties, responsibilities and objectives
- It should cover all aspects of professional practice
- It may be modelled wholly or partly on the previous year's plan
- The plan may be wholly or partly be team based
- It should include local, regional or national objectives
- It should include personal objectives
- Resources and support required are agreed and stated
- The process is separate from, but linked to appraisal

Current Trust Position

The job planning process and guidance will ideally be approved in conjunction with the BMA Local negotiating Committee (LNC) in the spirit of collaboration and mutual respect. It is important to create the right climate by adopting a non threatening partnership approach rather than a coercive one. Trust job planning guidance should be applied fairly and consistently. The current updated guidance is with LNC for consideration at present. This process may take several months, however this should not hold up further improvements to the job planning process as outlined below.

An active process of engagement with AMDs , CDs ,Ads and medical staffing is ongoing in a bid to drive the current years job planning process as far as is possible within the current system and good progress is being made with a high level of engagement.

Job Planning and Appraisal

Although job planning and medical appraisal inform each other, they should be separate processes. Doctors have told me that they currently feel a disconnect between the two processes. The previous doctors' appraisal should be made available to the Clinical Director(CD) or other job planner who should be aware of the contents and in particular the Personal Development plan (PDP) prior to the JP meeting. This will require cooperation between the appraisal team and the medical workforce job planning team, however, the introduction of the new on line doctor appraisal system in 2018 should make this technically much easier with only minimal additional administration time. It is a shared responsibility of the job planner and the individual doctor to bring relevant appraisal issues to the job planning discussion

- **Recommendation 1 The CD or AMD conducting the Job Plan review should be aware of the key issues raised at the previous appraisal , taking note of and where practical facilitating the agreed personal development plan (PDP) as part of the prospective job plan**

Making Technology Work

- In order to minimise the administrative burden, effective use of electronic and digital systems should be available in line with best practice. This Trust already utilises the *'Allocate'* (formerly *Zircadian*) system. This is the most common system used for this purpose in the UK. A number of suggestions for further improvement have come from the Associate Medical Directors (AMD) Job Plan review group which have been partly implemented. This programme of improvement should continue. Already this year significant training opportunities have been provided from the supplier and the in house medical management scheme.
- Discussion with AMDs, ADs (Associate Directors) and CDs (Clinical Directors) has suggested that there is limited added value in having a third 'sign off' often at Director Level. The current three stage system presents the opportunity for unnecessary delays in the sign off process. There is acknowledgement that service directors need an assurance about the process, but the consensus was that this could be better facilitated in the form of directorate reports that could be provided by the medical staffing /*Allocate* team on a regular perhaps twice yearly basis.
- There was consensus that it would be useful for the *Allocate* system be set up to send systematic email prompts to both the doctor and the CD in advance of their sign off date and when a JP is overdue.

Recommendation 2. The Trust should continue to offer further training opportunities for staff regarding the use of 'Allocate' in a systematic and planned way together with ad hoc training opportunities.

Personal information redacted by USI

Recommendation 3. Further simplification of the sign off and notification process should be implemented as agreed with the AMD group with a reduction from 3 to 2 signatories. 'Allocate' should be asked to send timely alerts to job-planners and doctors to remind them of renewal dates

Making Job Planning a prospective annual process

- The recent internal Audit clearly demonstrates that currently a significant percentage of doctors do not have an annual job plan review and that it is often retrospective rather than prospective rendering the process less meaningful. Acknowledgement needs to be given to increasingly complex patterns of working such as the 'consultant of the week' model.
- Linking the job planning cycle to the Trust's business planning cycle would be helpful in aligning organisational objectives and would make it easier to predict when job planning should occur. Flexibility will need to be given to job planners (CDs and AMDs) within their own job plan to allow intense periods of job planning activity at certain times of the year.

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Whilst work continues currently to deliver the 2018 JPs, to ensure Job plans are in place PROSPECTIVELY for April 1st 2019 the following cycle should be implemented. This is based upon the *NHS Improvement* paper entitled 'Consultant Job planning: a best practice guide (July 2017).'

Quarter 2- July – September

Clinical director sends out preparation for and invitation for job plan review, giving 6 weeks notice. Appraisal documentation shared with CD.

Quarter 3 October to December

Team Job planning meeting to discuss and agree objectives, SPAs and any required rota changes. CD, Associate Directors, Service Managers Consultants and SAS doctors present.
JPs entered on Allocate by 31st December allowing 3 months for mediation/appeal if required.
JP consistency team (See later) check a proportion of JPs for consistency and fairness

Quarter 4 January to March

Mediation and/or appeals

Quarter1 April to June

Job plan effective 1 April

Recommendation 4 The directorates should implement a systematic, timely prospective process similar to that outlined including team meetings with doctors CDs Ads and Service managers within quarter 2

When a job plan is not agreed

Consultants are expected to engage in the annual job planning process; failure to do so could constitute one of the grounds for deferring pay progression for the year in question. Doctors however should NOT be penalised for failing to meet objectives for reasons beyond their control. Both employers and consultants have a responsibility to identify potential problems with achieving objectives as they emerge rather than waiting for an annual job plan review meeting.
Where a job plan is not agreed because it is in dispute, the doctor should not suffer any detriment whilst a potential mediation or appeals process is progressed. The informal process of facilitation with a third party as outlined in the terms and conditions of the consultant contract. Experience in this cycle has shown that this is can be an effective means of achieving resolution of difficult issues.
Formal appeal may considered by either party if facilitation is unsuccessful.

Medical Job Plan Consistency Committee

A proportion of job plans (as high a percentage as practical) should be reviewed by a committee to ensure Trust job planning guidance is being followed with a consistent and fair approach.
Membership
The committee should consist of a Medical Director representative, Associate Medical directors, human resource medical staffing representative, and relevant CDs as required
Purpose
To ensure consistency and an even handed approach across the Trust. It is NOT a mediation or appeal forum.

Recommendation 5 A Medical Job Plan Consistency Committee should be established reporting to the job planning lead (see later)

Making Job plans Competitive and Attractive

- Doctors should understand what is expected of them by the Trust and know they are being treated fairly with other team members.

- Job plans should contain an agreed baseline of commitments detailing attendance and activity expectations for the year ahead. These should be transparently reviewed and agreed, and be clearly documented for future reference. Activity expectations should be based on a minimum of 42weeks in the working year. A job plan covers the whole of the week, including – where relevant – weekends and nights (to ensure consistent delivery of high quality patient care).

- Supporting professional activities (SPAs) underpin direct clinical care and should be linked to clear objectives. The Academy of Medical Royal Colleges estimates that 1 to 1.5 SPAs per week are the minimum for a consultant's continuing professional development (CPD) for revalidation purposes. The Trust supports this view. Additional SPAs may be awarded for specific responsibilities or duties by agreement . There is a view held by many Trust doctors that currently the SHSCT average SPA allocation is lower than other comparable Trusts within Northern Ireland. Our current average SPA allocation is currently 1.68 PA for full time consultants only. The range is from 0.375 PA to 2.75 PA ..... and our current non DCC PA (including SPA, APA and other external duties) allocation average is 2.52 PAs

It is my view that given the current recruitment and retention difficulties it would be worth guaranteeing each new consultant a minimum of 2.5 SPAs at the time of appointment and 1.5 SPAs for SAS doctors at the time of appointment, both for a period of 3 months initially during which time there would be a job plan review. This would facilitate induction for new staff and would be an attractive package for recruitment and would solve the increasing difficulties we are having in getting new job plans approved by the Royal Colleges because of

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the SPA issue. After 3 months the SPA allocation could be reduced to 1.5 and 1 SPAs for Consultants and SAS doctors respectively with additional non clinical Pas (SPA/APA) agreed locally for specific roles. Such measures would be likely to have an immediate impact on recruitment if jobs were explicitly advertised with this on offer. We already offer an average of 2.52 non clinical Pas to all other consultants. Ideally We should work towards reducing the range so that most consultants can expect 2.5 non clinical SPAs made up of SPA and APA

Currently full time SAS doctors receive an average SPA allocation of is 1.55 PA across the Trust with a range is from 0.75 PA to 2.00 PA
In line with our ambition of developing SAS doctors we should consider working towards an allocation of 1.5 SPA

This would help to imbed the Consultant and SAS group as valued staff members, would be transparently fair and would allow the CD share much of the current administrative burden around the team. It would be consistent with the principles of the *HSC leadership strategy 2018* by encouraging leadership roles at the coal face and could be used creatively to move forward major pieces of project work as required by the Trust. In my view such a move would send a powerful message to potential job applicants that this organisation is a good place to work for doctors.

Recommendation 6 **Move to a position where each new consultant receives a minimum of 2.5 at initial appointment and 1.5 for SAS Doctors.**

- *Flexibility of SPAs in relation to off site working*

There is a growing awareness that within NI some Trusts offer some flexibility about a proportion of their SPAs being worked off site. Within our own Trust this already offered in some departments. The AMD job plan JP review task force have reviewed this issue and have accepted this has some value when appropriately managed. This as yet is not widely implemented.
It is my view that all doctors should be offered the opportunity of working up to 1 SPA off site as long as they can evidence the work they have done through the appraisal process. A number of parameters would need to be understood by all. For instance, the doctor would need to remain available to be called on site should an emergency arise and that their annual appraisal needs to show that their CPD requirements are being met. These parameters have been clearly outlined within the Draft Trust Job Planning guidance document.

Recommendation 7 **The Trust should offer the opportunity to every doctor to work 1 Core SPA off site.**

- *Emergency on call for senior doctors*

There is a growing body of evidence to show that emergency on call work becomes more problematic for a doctor as they grow older associated with increasing stress. There is also a

body of evidence that shows an increase in the number of adverse incidents related to out of hours working as doctors grow older. This is increasingly stated as a factor contributing to early retirement for doctors. In my view each team should consider the minimum number of doctors required to provide a sustainable out of hours on call service with a clear indication that older doctors have a reasonable expectation of coming of the on call rota prior to the normal retirement age. Teams would then be able to forward plan for service provision on this basis. It is my belief this would help retention of staff in the long term.

Recommendation 8. The Trust should facilitate senior doctors to come off the on call rota if requested. Local teams should agree criteria and timescale

- **Sustainability**

A job planning lead should be appointed for the Trust with clinical credibility. This could be similar to the current appraisal lead as a stand alone post or possibly as one of the roles of a deputy medical director with 1 PA time allowance to oversee and coordinate the job plan process. Their roles and responsibilities would include potential challenge to AMDs over process and would and include a reporting remit to SMT and Trust board. In order to support this role and facilitate the job planning administration team within medical HR it is likely that some additional administration support will be required for this team. The medical HR team believe a full time band 4 post would be appropriate to cover the workload and proactively manage the system

Recommendation 9
A clinical job planning lead should be appointed who reports job planning status and issues to SMT on a quarterly basis. This should be supported with appropriate administrative resource within medical HR staffing

- **Ongoing Oversight**

A Senior Job Planning Oversight Committee (JPOC) should be established perhaps meeting quarterly to oversee progress and strategic direction. It would receive reports from the Job Planning lead and consider suggested changes to the job planning guidance. It would consider implications of any potential changes to the consultant contract and take note of new best practice guidance from relevant national or regional bodies.
It would be chaired by the Medical Director and include the Director of HR, Finance Director and Operational Directors. It could be supported by an AD from the Medical Director's office

Recommendation 10
A Job planning strategic oversight committee should be established set strategic direction, review progress receiving reports from the job planning lead and reporting to SMT

Conclusion
The above report has considered current best practice recommendations and the issues raised within our recent internal audit report related to Trust Job Planning. It has considered

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the Terms of Reference outlined by the Chief Executive and made 10 major recommendations to address the issues raised.

TOR 1

Improved Engagement with Doctors resulting in a high percentage of contemporaneously agreed meaningful job plans that address the Trust, the Doctor's and most importantly the patients' needs.

The new easy to understand job planning timetable aided by a simplified allocate prompt and sign off system will allow JPs to be agreed prospectively rather than retrospectively. The Job Planning lead will drive the process forward with fairness ensured by the consistency committee resulting in an open and transparent process The formal link to appraisal and agreed objectives will enhance both the JP and appraisal systems

TOR 2

Improved compliance with internal Audit job planning recommendations

As above. The JP lead will report regularly to SMT and through them to Trust Board on behalf of the Medical Director resulting in direct accountability for the process. The simplified process will ensure timelier processing of JPs. The Consistency committee will ensure that JP principles are adhered to.

TOR 3

Improving attractiveness of SHSCT as an employer of medical staff thus improving recruitment and retention

The enhanced commitment to Non DCC time is likely to have a positive effect on recruitment and retention whilst ensuring that important roles required by the Trust are fulfilled.
Offering 2.5 SPAs to all new start consultants would be a powerful recruitment tool.
A more flexible approach to limited off site SPA time is potentially a decisive factor in doctors making a choice between prospective employers.
The commitment to link appraisal agreed objectives to the JP process will further demonstrate how the Trust values its staff.
The reasonable expectations for older consultants to withdraw from the on call rota in a planned and coordinated manner is likely to assist with retention as this has been raised as an issue by leaving doctors at their exit interviews

TOR

Sustainability of process

The appointment of a clinical lead to drive the process and the establishment of the Job planning oversight committee together with the changes to the cycle and sign off process should ensure sustainability and deliverability over the next few years.

Summary of Recommendations (10 Steps to success)

Recommendation 1 The CD or AMD conducting the Job Plan review should be aware of the key issues raised at the previous appraisal , taking note of and where practical facilitating the agreed personal development plan (PDP) as part of the prospective job plan.

Recommendation 2 The Trust should continue to offer further training opportunities for staff regarding the use of 'Allocate' in a systematic and planned way together with ad hoc training opportunities.

Recommendation 3 Further simplification of the sign off and notification process should be implemented as agreed with the AMD group with a reduction from 3 to 2 signatories. 'Allocate' should be asked to send timely alerts to job-planners and doctors to remind them of renewal dates.

Recommendation 4 The directorates should implement a systematic, timely prospective process as outlined including team meetings with doctors ,CDs Ads and Service managers within quarter 2

Recommendation 5 A Medical Job Plan Consistency Committee should be established reporting to the job planning lead

Recommendation 6

Move to a position where each new consultant receives 2.5 SPA and 1.5 Spa for SAS doctors at the time of appointment. An early job plan review should then determine the need for any non clinical Pas above 1.5 and 1 respectively

Recommendation 7 The Trust should offer the opportunity to every doctor to work 1 flexible SPA off site.

Recommendation 8

The Trust should facilitate senior doctors to come off the on call rota if requested. Local teams should agree criteria and timescale

Recommendation 9

A clinical job planning lead should be appointed who reports job planning status and issues to SMT on a quarterly basis

Recommendation 10

A Job planning strategic oversight committee should be established set strategic direction, review progress receiving reports from the job planning lead and reporting to SMT

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