Urology Services Inquiry

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

Dr Gillian Rankin
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

14 April 2022

Dear Madam,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours faithfully

Personal Information redacted by USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 8 of 2022]

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

WARNING

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

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

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

IMPORTANT INFORMATION FOR THE RECIPIENT

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

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

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

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

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

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon **on 26th May 2022.**

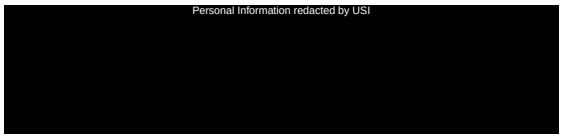
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon **on 19th May 2022**.

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

Dated this day 14th April 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 8 of 2022]

General

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

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

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

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

Your position(s) within the SHSCT

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

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

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

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

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

Urology services/Urology unit - staffing

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

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

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

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

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

    I. What is your knowledge of and what was your involvement, if any, with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role, if any, in that process?

IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

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

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

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

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

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

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

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

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

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. Are you aware of any concerns having been raised about the adequacy of support staff availability? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

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

24. Were concerns from administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

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

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

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

Engagement with unit staff

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

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

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

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

Governance – generally

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

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

34. Please set out and describe every layer of governance assurance of which you were a part whilst in your role as Director of Acute September 09 – March 13, to include any committees, or sub-committee's or steering groups. Your answer could helpfully address the following queries:

(i) Were you a part of any Governance Committee/governance sub-committee; if so
(ii) Title of Governance Committee
(iii) When were you part of this committee?
(iv) Who else was on this committee?
(v) Were you required to provide assurances as part of this committee?
(vi) Were these assurances provided orally (in meetings or conversations) or documented in the form of a report?
(vii) If orally / in meetings – were there minutes of these meetings, if so please provide.
(viii) Did you provide any written reports concerning assurances?
(ix) Who was tasked with writing this report?
(x) Did you have input concerning the findings/assurances provided in the report / investigation of information within the report?
(xi) What assurances were you required to provide?
(xii) Where these reports required or optional?
(xiii) How often were you required to provide these reports?
(xiv) Did your Committee / report rely on any assurances?
(xv) What assurances did your committee rely on?
(xvi) Were these assurances checked for accuracy?
(xvii) Whose responsibly was it to quality check these assurances?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concerns regarding the urology unit

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

(i) The Chief Executive(s) - the Inquiry understand the post holder to have been Mairead McAlinden;
(ii) the Medical Director(s) - the Inquiry understand this to have been John Simpson;
(iii) the Assistant Directors - Heather Trouton and Ronan Carroll;
(iv) the Associate Medical Director - the Inquiry understand this to have been Eamon Mackle and Charlie McAllister;
(v) the Clinical Director - the Inquiry understand this to have been Robin Brown;
(vi) the Head of Service, namely Martina Corrigan, and
(vii) the consultant urologists in post.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of

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

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

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

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

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

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

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

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

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

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

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

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

52. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q66 will ask about any support provided to Mr. O'Brien).

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

Mr. O'Brien

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

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

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

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

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

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

(i) what risk assessment did you undertake, and

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

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

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

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

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

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

65. Did you raise any concerns about the conduct/performance of Mr O'Brien? If yes:
(a) outline the nature of concerns you raised, and why it was raised
(b) who did you raise it with and when?
(c) what action was taken by you and others, if any, after the issue was raised
(d) what was the outcome of raising the issue?

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

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

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

Learning

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

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

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

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

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

73. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done? If not, please explain why.

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

NOTE:

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 8 of 2022

Date of Notice:

Note: An addendum amending this statement was received by the Inquiry on 1 June 2023 and can be found at WIT-96714 to WIT-96750. Annotated by the Urology Services Inquiry.

Witness Statement of: Dr Gillian Rankin

I, Gillian Rankin, will say as follows:-

General

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

1.1 I was appointed interim Director of Acute Services on 1 December 2009. I was appointed as Director of Acute Services on 1 March 2011 and I retired from the post on 31 March 2013. The post held responsibility for all acute services in Craigavon Area Hospital and Daisy Hill Hospital with the exception of paediatrics and neonatology services. There was also a day surgery suite in South Tyrone Hospital which was managed through the theatre service. The role covered both operational and governance responsibilities of the range of services including medical and surgical services, maternity services, diagnostic, theatre and intensive care services,

laboratories, hospital support services such as patient and staff food, domestic and portering and decontamination services.

1.2 Issues in relation to the urology service were raised with me on my first day in post i.e., 1st December 2009. This was through a meeting chaired by the Chief Executive, which alerted me to the current and on-going issues. The regional Review of Urology had reported but was not yet signed off by the Minister. The development of the Implementation Plan for Team South Urology had commenced and I subsequently chaired a weekly /fortnightly meeting with the consultants involved to get agreement on the implementation plan and its implementation.

1.3 In early 2010, I commenced a weekly performance meeting with the full system of Assistant Directors (ADs) and Heads of Service in order to lead the weekly review of how each specialty was delivering on the various clinical elements of the Integrated Elective Access Protocol. This required 'deep dives' by services in terms of data and ensured a daily focus on delivering the activities required by the commissioner, HSCB, and agreed in the Service and Budget Agreement.

1.4 In early 2010, I also commenced two meetings on governance. These were both held monthly. One of these included the Associate Medical Directors and ADs in a review of all the data used in the governance of services. The second meeting included the ADs and used the same reports with a deeper review of the data updated to the previous month.

1.5 These processes of regular meetings reviewing reports and data on both performance and governance provided collective energy and held the system to account in a supportive system for delivery of safe and high quality care. The emphasis was on quality improvement and learning from mistakes and this was evidenced through the Trust Review of Clinical and Social Care Governance led by the Chief Executive in 2010.

1.6 With regards to urology there were several issues regarding the service and some specific issues in relation to a single consultant. The key issues for the service

were the demand and capacity gap which was present and increased during my tenure in post. It was expected that this would be addressed both through the implementation of Team South Urology and through the improvement of clinical practices within the Trust.

1.7 The specific issues in relation to Mr O'Brien related to the need to change behaviour in relation to some clinical practices and some administrative practices. The range of issues included:

a. Triage of red flag referrals i.e., referrals of people with potential cancer and non-urgent referrals.
b. The scheduling of patients for surgery without due regard to urgency and chronological order.
c. The surgical operation of cystectomy.
d. The use of IV antibiotics for inpatients.
e. Referral of patients requiring prostatectomy or cystectomy to the Belfast Trust and the implementation of the regional MDM (Multidisciplinary Meeting) to discuss each patient with cancer and agree their treatment.
f. Service capacity gap which impacted on the waiting time for patients for outpatient clinics, day case surgery, inpatient surgery and review outpatient appointments; and breaches of the 31 day and 62 day standards for patients with diagnosed cancer.
g. Failure to read test results when received and before filing the patient notes, irrespective of whether the patient has an outpatient appointment booked.
h. Disposal of some patient notes and information in the bin of a consultant's office.

1.8 The details of these issues and all communications on these issues are set out in full detail in response to Questions 50, 57 and 67.

1.9 There were a considerable number of meetings, actions and decisions taken by myself and others to address all the issues. These are set out in detail in several

responses to questions below, with all the available communications of email, memos, letters and reports attached. The full details can be found mainly in response to Questions 13, 29, 50, 57 and 64.

1.10 One of the clinical issues in relation to Mr O'Brien resulted in a 'Local Review of Cystectomies' under the Maintaining High Professional Standards Process in 2010.

1.11 The other issues were managed through the rigorous application of existing systems of data reporting and developing new methods of working to mitigate the risks of the behaviour which was causing the issue.

1.12 On reflection, while there was a significant demand pressure on the urology service, there was a general resistance to change in clinical behaviour in the service. Nonetheless, when change was required in order to implement improvements for patients and to implement Team South Urology as part of the regional Review of Urology, two consultants did make these changes in their personal behaviour. However, Mr O'Brien did not always make the changes required and there were times when change was agreed and implemented for a period of time before he reverted to the previous behaviour. He therefore was unable to, or chose not to, amend his behaviour.

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

2.1 I have retained no documents from the Southern HSC Trust which relate to my tenure in either of the posts of the Director of Older People and Primary Care or the Director of Acute Services. Any documents I reference or attach below are documents

which have been provided to me by the Trust in the context of my preparation of this Witness Statement in the period since my Section 21 Notice was served on 14 April 2022.

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

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

3.1 I have answered to the best of my ability all the following questions in this Section 21 notice.

<u>Your position(s) within the SHSCT</u>

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

4.1 My occupational history is as follows:

a. 1977 qualified in medicine from Queens University Belfast.
b. 1977-1980 various hospital junior hospital jobs in Belfast.
c. 1980-1981 GP trainee resulting in achieving MRCGP.

d. 1981-early 1990s educational medicine in South Belfast, including a Medical Management role and a regional project on Immunisation Action.

e. 1993 Head of Service Development and member of Senior Management Team leading to Director of Service Development in South and East Belfast HSC Trust. I cannot recall specific dates and the paper work is no longer available, therefore the year of 1993 is to the best of my knowledge.

f. April 2007 - November 2009 Director of Older People and Primary Care Southern HSC Trust.

g. December 2009 – February 2011 Interim Director of Acute Services Southern HSC Trust.

h. March 2011 – 31 March 2013 Director of Acute Services Southern HSC Trust.

i. 2013 - 2015 part time consultancy to NHS Kernow, Cornwall.

j. 2013 - 2019 part time with HSCB and PHA, undertaking regional Medical Workforce Planning responsible to PHA Medical Director, chairing RISOH implementation responsible to Director of E-Health HSCB, and leading Regional Oncology Transformation Project responsible to Chair of NICAN.

k. August 2019 – present, I am retired.

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

5.1 My Trust employment history is as follows:

a. April 2007 Director of Older People and Primary Care.

i Job Summary: 'The Director of Older People and Primary Care will be responsible through the Chief Executive for the development and delivery of safe, high quality primary care and non acute hospital services to older people within the Southern Trust, as well as lead Director for the Trust's Health and Wellbeing and Community

Development services. He/She will lead the strategic planning of these services and ensure effective multidisciplinary working and the most efficient use of resources to promote health and well being and support people to live independent lives in the community. He/She will provide clear leadership and oversee the management of all staff in the Directorate. In addition, the jobholder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives and be a member of Trust Board.'' The job description is an accurate reflection of the duties of the post. *S21 No 8 of 2022, 1. Director of OPPC JD*

b. December 2009 -31 March 2013 Interim Director of Acute Services and substantive appointment as Director of Acute Services.

i The Job Summary is: ''The Director of Acute Services will be responsible for the development and delivery of safe, high quality emergency and elective hospital care within the Southern Trust. He/She will lead the strategic planning of the Trust's Acute Services and ensure effective multidisciplinary working and the most efficient use of hospital beds and other resources. He/She will provide clear leadership and oversee the management of all staff involved in Acute Services. In addition, the postholder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives.''

ii Key Result areas: Service Delivery 2 ''Responsible to the Chief Executive for delivery of effective clinical and social care governance within acute hospital services, including the successful delivery of agreed Patient Safety Programmes, and the reporting of appropriate indicators to provide assurance to the Chief Executive and Trust Board''.

iii Key Result areas: Quality 8. Ensure high standards of governance including the effective assessment and management of risk.''

iv Key Result areas: Quality 10. ''Ensure that robust performance management arrangements are developed and implemented within the Directorate''.

5.2 The job description is an accurate reflection of the duties of the post. *S21 No 8 of 2022, 2. Director of Acute Services JD 2011*

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

6.1 Director of Older People and Primary Care reported to the Chief Executive (Colm Donaghy and Mairead McAlinden). The post holds responsibility for the staff and the quality and performance of service by 4 Divisions each led by an Assistant Director. Each Assistant Director had several Heads of Service managing individual or smaller groups of services. The Director post was supported by an Associate Medical Director for Primary Care who was a GP in the local community with sessions appointed within the Trust. The 4 divisions were:

a. Primary Care Services i.e., District Nursing, Allied Health Professional services in community, Social Work Services for Older People. The post holder was Brian Beattie.
b. Long stay geriatric wards and Specialist community services e.g., Heart Failure, Integrated Care, Early Discharge Stroke Services, GP Out of Hours Service, Lurgan Hospital, Armagh Community Hospital geriatric wards, South Tyrone Geriatric wards. The post holder was Angela McVeigh.
c. Community Domiciliary Service directly provided by the Trust, Residential Homes (5), Commissioning of Nursing Home Places and domiciliary care and assurance of care quality. The post holder was Brendan Whittle.
d. Health Promotion, Community Development with teams in each locality. The post holder was Melanie McClements.

6.2 Director of Acute Services reported directly to the Chief Executive - Mairead McAlinden. The role held responsibility for acute services in Craigavon Area Hospital (CAH), Daisy Hill Hospital (DHH) and Day Surgical Services in South Tyrone Hospital

(STH). All hospital services including support services in CAH and DHH, with the exception of paediatrics and neonatology, came under the remit of the role. The directorate had 5 Assistant Directors leading divisions all of which were responsible for the staff from all disciplines and services across both CAH and DHH and where appropriate STH. These Assistant Directors all had several Heads of Services managing smaller groups of services. The 6th Assistant Director assisted the Director in strategic issues and the Best Care Best Value Trust Programme. The Director role was supported by the appointment of a consultant from the division as an Associate Medical Director (AMD). Each AMD was supported by one or more Clinical Directors (CD) depending on the spread of specialties in the division. These divisions were:

a. Medicine and unscheduled care including outpatients, inpatient wards, emergency medicine, Minor Injury Units, cardiac catheterisation laboratory. The post holder was Barry Conway.
b. Surgery and elective care including outpatients, inpatient wards, managing outpatients departments and pre-operative assessments, managing administrative staff who worked with consultants to arrange lists of specific patients for each day case or main theatre session. The post holder was Heather Trouton.
c. Cancer and Clinical Services including radiology (including breast screening service), operating theatres, intensive care, day cancer services, and allied health professionals working in acute services. The post holder was Ronan Carroll.
d. Maternity services including community midwives, obstetric units, gynaecology. The post holder was Anne McVey.
e. Support Services including domestics, portering, telephony, canteens and patient and staff meals, decontamination of instruments, bed laundry, Referral and Booking Centre, administrative staff. The post holder was Anita Carroll.
f. Pharmacy for the Trust including pharmacy requirements for the provision of medicines safely for all inpatients in both hospitals, management of Controlled Drugs, medicines governance. The Head of Pharmacy was Dr Tracey Boyce.

g. Best Care Best Value development role and strategic support. The post holder was Simon Gibson.

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

7.1 The urology service is fully within the remit of Acute Services in the Trust. Urology is a surgical speciality and was managed within the Surgery and Elective Care Division covering both acute and emergency treatment and elective planned treatment. This role included both the operational management and governance of the service including the quality and safety of care and performance against access targets. There were dedicated urology inpatient beds and agreed patient pathways from the Emergency Department for treatment as a day patient or as an inpatient. Surgeons and specialist nurses used booked theatre sessions, outpatient rooms and investigation/treatment rooms for eg for cystoscopy. Details of the governance systems which I used to execute my responsibility are set out in response to Question 33.

7.2 The service was managed through a Head of Service for Urology Mrs Martina Corrigan, who reported to the Assistant Director for Surgery and Elective Care Mrs Heather Trouton, who reported to myself as the Director.

7.3 While theatres, intensive care and other services used by the urology staff were managed through the Cancer and Clinical Services Division, the urology staff were accountable through the Surgery and Elective Care Division.

7.4 The Referral and Booking Centre which was the point of referral for GPs into the Trust was managed by the Support Services Division.

7.5 The role of the AMD is integral to the delivery of patient safety, quality and standards. The post holder plays a key role in ‘’using the resources of the Directorate to deliver, in both quality and quantity, the activity and targets agreed for the Directorate’’. The job description for the AMD Surgery and Elective Care is *located in*

S21 No 8 of 2022, 3. Associate Medical Director JD. Mr Eamon Mackle was the AMD during my tenure.

7.6 The role of the AMD is supported by the Clinical Director for the speciality. The CD also has a key role in governance and professional practice standards. The job description for a CD is *located in S21 No 8 of 2022,* 4. *General Surgery CD JD.* Ms Sloan, Mr Hall and Mr Brown were Clinical Directors with responsibility for urology during my tenure.

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

8.1 The roles of the Operational Director (in this case Director of Acute Services) and the Medical Director are different in terms of operation and governance. All the other roles below Director level flow from the differences.

8.2 The operational director was fully responsible for delivery and the quality of service supported by the Assistant Director, who was supported by the Head of Service. Each Assistant Director may have had several Heads of Service reporting to them.

8.3 The SHSCT Review of Clinical and Social Care Governance of September 2010 sets out the role of the Operational Director as:

> ‘’accountable for reporting, actioning (i.e. learning from and mitigating risk), managing and monitoring patient and client safety and quality of care. This includes the management of incidents, complaints and risk registers, This function will also be accountable for implementing appropriate clinical audit and

monitoring and reporting against agreed clinical indicators and patient safety standards.''

8.4 The Medical Director (MD) as the Professional Executive is defined as the following from the SHSCT Review of Clinical and Social Care Governance September 2010:

a. ''Providing the organisation with independent and resolved professional expert advice, consultancy and audit in order to assure the organisation on the current standard of each of the professional workforce groupings''
b. ''Providing professional advice and guidance to the organisation as to the indicators to be used to provide intelligence to the organisation on the safety and competence standards of the relevant workforce''
c. ''Provide independent assurance to the organisation on the compliance with these standards, and an 'alert' function at corporate level in relation to professional issues arising from the analysis of the service indicators''

SHSCT Review of Clinical and Social Care Governance September 2010 is located in S21 No 8 of 2022, 5. 20100906 Review of CSCG Sept 2010 and 6. 20100906 Review of CSCG Sept 2010 A

8.5 The Medical Director provided advice and assurance to both the Chief Executive and Trust Board on matters in relation to clinical practice and quality and safety concerns. A key result area in the MD job description is to ''work with other Directors to inform, support and provide assurance on the effective identification and management of clinical and organisational governance concerns, ensuring that any learning is incorporated into professional practice and systems''.

8.6 The document the ''Role of SHSCT Medical Director'' sets out the clear position as a result of the Clinical and Social Care Governance Review, *located in S21 No 8 of 2022, 7. Role of the Medical Director 2010.*

8.7 While the AMD role provided clinical leadership for the delivery of safe and high quality patient care, they were professionally accountable in this role to the Medical Director who necessarily needs to be medically qualified. The personnel specification for the role of Director of Acute Services does not require a medical qualification.

8.8 The Clinical Director (CD) supported the AMD in this clinical leadership role. Each AMD may have had 2 or more CDs depending on the span of specialties in the division. Therefore while the AMDs were accountable to the Director for the leadership role for the delivery of safe and high quality care, they also had a ‘’dotted line’’ relationship with the Medical Director reflecting the line of professional accountability.

8.9 The format of assurance used for the Senior Management Team Governance meeting held monthly were reports at each meeting on the following:

a. Performance report setting out by speciality the waiting times and the numbers of people waiting for outpatients, day case and inpatient elective surgery and the review backlog position. This report was provided by the Performance and Reform Directorate and developed over time to use a traffic light system to identify trends against each parameter. Urology was a separate specialty amongst several surgical specialties and the separate performance metrics were set out. Examples of this report are attached for March 2010 and April 2010 *located in S21 No 8 of 2022, 8. 20100429 Performance Report to TB and 9. 20100527 Performance Report to TB.*

b. Report covering Risk Management, Complaints, Adverse Incidents, Litigation and Patient Safety. Discussion was held on each area of patient safetyincluding discussion on which areas should be included in the corporate Risk Register. An example of this report is *located in S21 No 8 of 2022, 10. 20100428 SMT Gov Report - Risk Management Complaints*

c. Reports on actions achieved and in progress against external inspections provided by the Director of Acute Services. An example report regarding an external inspection such as the RQIA Inspection of Maternity Services – Intrapartum Review April 2010 is *located in S21 No 8 of 2022, 11. RQIA Review of Maternity Services - Intrapartum Care April 2010.*

8.10 The Reports to Trust Board Governance followed the same format and approach as described above. This meeting occurred quarterly. Examples of the Performance Report for Trust Board in March 2011 and on 28 March 2013 are *located in S21 No 8 of 2022, 12. 20110421 Performance Report A, 13. 20110421 Performance Matrix 10_11 End of Year Assessment B, 14. 20130328a Performance Report to TB and 15. 20130328b Performance Report to TB*. The Medical Director's Reports on Patient Safety, and Quality Improvement Plan, and on Environmental Cleanliness for Trust Board on 25 October 2012 are *located in S21 No 8 of 2022, 16. 20121025 MD Report TB A, 17. 20121025 MD Report TB B and 18. 20121025 MD Report TB C.*

Urology services/Urology unit - staffing

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

9.1 The urology service /unit in the Trust pre-existed the regional Review of Urology Services.

9.2 The Regional Urology Review was endorsed by the Minister on 31 March 2010.

9.3 The letter from Hugh Mullen, Director of Performance Management and Service Improvement HSCB, of 27 April 2010, sets out the regional arrangements to take forward the implementation process across the 3 urology teams and the 5 Trusts.

9.4 The first meeting of the Urology Project Implementation Board was planned for 1 July 2010. *The relevant document can be located in Ongoing Discovery March 2022, Acute, Document No 77, Dr Gillian Rankin, 20100430 E re Regional Uro Review k.*

9.5 The role of the Director of Acute Services was to lead the development of the implementation plan within the Trust to meet the requirements of the regional review and once agreed with the HSCB to implement the plan. This role was supported by the Director of Performance and Reform in the Trust (and supporting staff) in the development of the business case, the supporting work required with clinicians in the existing urology service, the on-going clarification work required with the HSCB to achieve the final implementation plan.

9.6 In my role of leading the development of the implementation plan and subsequently the implementation of the plan, I chaired a weekly/fortnightly meeting with the urology consultants, AMD, AD, Head of Service, senior staff from Performance and Reform, HR and finance staff. This meeting to develop and agree the implementation plan was required over a period of around 16 months, until early 2011. I also represented the Trust, along with Mr Young, Consultant Urologist, and the Director of Performance and Reform on the Regional Implementation Project Group set up by Hugh Mullen, Director HSCB.

[10] What, if any, performance indicators were used within the urology unit at its inception?

10.1 The performance indicators already in use in urology prior to the setting up of Team South Urology, are the performance indicators required by the IEAP published by the DoH in 2008. This required the implementation of systems and procedures for receipt of referrals, triage of referrals, booking of an outpatient appointment as the result of the referral and management of waiting lists for outpatients, ICATS and elective admissions for treatment within specific time standards. These procedures were to be implemented in 2009 and were therefore already in place when I took up post.

10.2 The performance metrics (from the IEAP) in respect of elective treatments relevant to the urology service were:

a. Triage of the GP referral within 3 working days;
b. A maximum waiting time of 13 weeks for inpatient and day case admissions;
c. A maximum waiting time of 9 weeks for 1st outpatient appointment;
d. A maximum waiting time of 9 weeks for a diagnostic test;
e. Sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis;
f. 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days.

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

11.1 The 'Integrated Elective Access Protocol' (IEAP) published by DOH in April 2008 predated my appointment into the role of Interim Director of Acute Service. I am unable to answer precisely when the document was disseminated to the urology consultants. However, the requirements of the Protocol had been implemented in all services by the time I came into post, and in the separate meetings with 2 consultant urologists on 7.12.2009, the requirements of the IEAP formed part of the agenda with each consultant and each consultant was clearly aware of the requirements. *The relevant documents can be located in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service and 20091207 Ref35 - Urology Mtg.*

11.2 There were no subsequent protocols during my time in the post.

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

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

12.1 The IEAP was used as the framework against which the performance of each service including urology was measured and reported. These reports were provided by the Performance and Reform Directorate in the Trust and updated weekly for the Senior Management Team and monthly for Trust Board.

12.2 The reports were published and used for discussions on action and assurance as follows. Within the Acute Directorate at:

a. Directors weekly meeting with all ADs and Heads of Service to discuss achievement against IEAP targets, supported by a senior member of staff from Performance and Reform -
    i. Outline plans for action were agreed at this meeting which may have required follow up with individual services and clinicians. The notes of these weekly meetings are no longer available. On 18 January 2010, I sent an email to the ADs, all Heads of Service and the Grade 5 staff, setting out the clinical risk and the need to set up a weekly meeting to review delivery of the March PTLs (Primary Targeting List) i.e., the list of patients needing to be treated by the end of March. This meeting became the standing weekly performance meeting as it was still required after the end of March 2010. *Relevant documents located in S21 No 8 of 2022 folder, 19. 20100118 URGENT Daily Meetings at 9am, 20. 20100118 URGENT Daily Meetings at 9am A1, 21. 20100118 URGENT Daily Meetings at 9am A2,*
    ii. This weekly meeting ensured that the detailed position with regard to each service up to the preceding day was available for all Heads of Service and ADs, and that all necessary actions to optimise capacity for each clinical modality were explored and actioned where possible. This often required cross-divisional working such as ensuring that all theatre lists were being fully utilised for

surgeons, and additional sessions at weekends were made available in each hospital site where possible (CAH, DHH and South Tyrone for day cases).

iii. An example of an action from the weekly Performance meeting is the email from Katherine Robinson, Head of the Referral and Booking Centre, on 6 July 2010 setting out a spreadsheet by specialty of the list of amended outpatient clinics, the reason for the amendment and the impact on the numbers of appointments for new patients and review patients. *The relevant documents can be located in S21 No 8 of 2022,* 22. – 50. *20100706 E from K Robinson - 20100706 E from K Robinson A28.*

b. Director and all ADs weekly Performance meeting for 3 weeks out of 4 week period:

i. The specific Governance meeting took place on the 4th week. The SABA (Service and Budget Agreement) performance by division was a standing item on the agenda for ADs to update on the position, any new concerns and how plans to address were progressing. The SABA was the agreed position with the Commissioner regarding the volumes of specific clinical activity to be undertaken by a service and was therefore a means of monitoring the progress against the in year requirements. An agenda for the meeting on 13 April 2010 is attached as an example of these meetings. Urology service pressures would have been discussed under the SEC performance. The urology business case and implementation plan was led by Sandra Waddell under item 5 located in S21 No 8 of 2022, 51. *20100413 Acute Performance Agenda*

c. Director 1 to 1 management meetings with the Assistant Director and the AMD - These occurred monthly or sometimes weekly due to the urgency of some issues. The notes of these meetings are no longer available.

d. Specifically arranged meetings regarding specific areas of pressure -– Relevant document located in *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin 20101206 Uro Issues re Long Wait Pts* for a specific meeting with the urologists chaired by the Director and attended by the consultants, AMD, AD and Head of Service.

e. The Urology performance against targets was also on the Directorate Risk Register as follows:
    i. Risk 2991 on 26 May 2011 –''Cancer Performance Risk with the highest risk in urology. The actions were an escalation policy, action plans drafted, meeting with the urology team and working towards 1 stop clinics.''
    ii. Risk 3166 on 25 June 2012 –''Urology Access Waiting Times. Increased from 36 weeks for inpatients and day cases. (at this point 36 weeks was the agreed backstop position with the HSCB). First ICATS appointment increased from 17 weeks. Currently being addressed via approval to go to the Independent Sector and appointment of new consultants.''
    iii. Risk 3191 on 3 September 2012. ''62 day cancer performance. Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and regional issues. Action: daily monitoring of referrals of patients on 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Monthly performance meetings with AD/HoS and escalation of all late triaging.'' with actions to develop one stop pathways for haematuria and prostate cancer.

f. The risks were also evidenced on 2 divisional Risk Registers i.e., Surgery and Elective Care, and Cancer and Clinical Services.
    i. 943 on 7 April 2011. Urology cancer pathway delay. Action: 1 October 2011 1 stop prostate clinic commenced, 6 October 2011 1 stop haematuria clinic commenced, 23.January 2012 1 stop

prostate clinic fully operational. *The relevant documents can be located in S21 No 8 of 2022,* 59. *2009 - 2013 CCS Risk Register, 60. 2009 - 2013 Acute Risk Register, 61. 2009 - 2013 SEC Risk Register.*

12.3 Within SMT the weekly Performance Report set out achievements against targets with specific focus on those services which were not achieving targets or the agreed position for a service where the HSCB and the Trust agreed there was a capacity gap, such as urology. Where urology was not meeting the IEAP requirements, the service performance was also discussed at the SMT monthly Governance meeting. *The relevant documents can be located in S21 No 8 of 2022, 55. 20100128 Performance Report to TB, 8. 20100429 Performance Report to TB and 9. 20100527 Performance Report to TB.*

12.4 Trust Board Governance Reports and Trust Board Performance Report set out urology performance against IEAP targets and the actions which had been agreed with HSCB and internally within the Trust to address the shortfalls. *The relevant documents can be located in S21 No 8 of 2022, 12. 20110421 Performance Report A and 13. 20110421 Performance Matrix 10_11 End of Year Assessment B.* Specific examples of this include:

a. The corporate Risk Register as at November 2011 under Objective 1 relating to the achievement against PfA targets and review appointments to secure timely assessment and treatment states: ‘’the Business Case for Team South Urology now approved (July 2011)’’; and ‘’urology is included in the references to non-recurring bid for additional resources submitted to HSCB, OP Review Backlog plan submitted to RHSCB and action plan in place’’. *The relevant document can be located in S21 No 8 of 2022, 56. 20111206 CRR.*

b. The corporate Risk Register as at October 2012 under Objective 1 relating to the Achievement of Priority for Action Access targets and review appointments to secure timely assessment and treatment states: Independent Sector contracts re-let for 2012/2013 include urology;

Business Case for Team South Urology approved (July 2011). 3 urologists will be in post from November 2012.; Outpatient Review Backlog -the longest waits remain in urology and ophthalmology. Actions taken to address this are set out.'' *The relevant document can be located in S21 No 8 of 2022,* 57. *20121204 CRR.*

12.5 There were occasions when the service performance required a specific meeting led by the Chief Executive with the Medical Director and the Director of Acute Services. *The relevant documents can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes and in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service and 20091207 Ref35 - Urology Mtg.*

12.6 The Trust also analysed the demand against the capacity available in order to understand the capacity gap. This was then agreed by the Director of Performance and Reform with the HSCB. A backstop position was agreed for the Trust service to meet i.e., a new wait time in weeks which was outside of the time standards of the IEAP. It was also agreed with the HSCB how to treat the remaining patients whether by additional in-house theatre lists (Waiting List Initiative WLI) and/or referral to the Independent Sector for in year treatment. *The relevant document can be located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100430 E re Regional Uro Review.*

12.7 Evidence of additional meetings and actions regarding the urology service meeting the IEAP performance targets to include emails:

a. 27.7.2010 Minutes of meeting regarding the interface between urology and primary care to discuss pathways with primary care for review patients which includes actions and person responsible.
b. 5.10.2010 email of request to increase the number of cystoscopies per session and response from service that there was no obstacle to increasing the number, in order to address long waits for urology diagnostics

c. 22.9.2010 email from Aldrina Magwood, AD in Performance and Reform regarding the actions needed and support from Performance and Reform to address the urology cancer pathway delays

d. 4.1.2010 email from Head of Service to AD and Director regarding the work with Mr Young, Consultant Urologist and Service Lead on long waiting cystoscopies.

On 9th June 2011 I chaired a meeting with Mr O'Brien, Mr Mackle AMD and Mrs Trouton, AD to discuss a range of issues including performance to meet the requirements set by the HSCB for Team South Urology, review backlog, patient admission for surgery, urodynamics, pooled lists and the cancer pathway. The Issues and Actions from the meeting which were sent to Mr O'Brien on 1st July 2011 are attached. *The relevant documents can be located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100727 Mtg re Uro Primary Care, 20101005 E re Cystoscopies, 20100922 Uro CA Pathway, 20100909 E re Urology Cancer Pathway, 20110701 Actions from Mtg to AOB K.*

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

I. What is your knowledge of and what was your involvement, if any, with this plan?

II. How was it implemented, reviewed and its effectiveness assessed?

III. What was your role, if any, in that process?

IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

i. What is your knowledge of and what was your involvement, if any, with this plan?

13(i)(a) The development of the Review Backlog plan was undertaken by the AD for Surgery and Elective Care and the Head of Service with the consultant urologists, supported by a senior member of Performance and Reform. The Director signed off the plan and necessary actions to address the backlog. The actions in the plan with identified leads and involved individuals were:

i. To draw up protocols for patients with raised PSA to be managed by the GP;
ii. Non consultant staff who support outpatients clinics will be required to have an action plan for the patient having a justifiable reason for bringing the patient back for review;
iii. Agree patient pathways for 8 different clinical areas;
iv. Prevent growth of the review backlog;
v. Agree pathways to be shared with GPs;
vi. Continue working through backlog patient letters and taking forward the outcome of this action;
vii. Arrange for virtual clinics that take place in consultants' offices in order to ensure that all activity is captured.

13(i)(b) The Action Plan for the Urology Service -12 August 2010 located in *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin,* 2010 Action Plan for Pt Pathways also included the following actions relevant to the review backlog with the person responsible identified and the target date:

i. Benchmark the N:R ('new to review') ratio with GB peer;
ii. Discussion with the GPwSI (GP with Special Interest) regarding increasing numbers of patients seen at ICATS sessions and numbers of reviews;
iii. Review consultants' templates;
iv. Work up clinic templates based on BAUS guidelines for 3 hour, 3.5 hour and 4 hour sessions;

v. Management of review backlog –draft protocols and share with GPs;
vi. Meet the consultants' secretaries regarding clinic templates;
vii. Model up current capacity based on current clinic templates and revised clinic templates;
viii. Update report on position with regard to review backlog.

13(i)(c) Additionally, the Urology Nurse Coordinator commenced chart, letter and results reviews on review patients for subsequent discussion with the consultant in order to agree the best pathway for the patient. On 15 April 2010, the AD sent an email to the Director in relation to the review backlog in each specialty. The progress report with regard to urology stated:

> "Urology –Shirley Tedford Urology Coordinator has commenced a review of all Patient Centre letters starting with the oldest. She is stratifying those who require urgent review, those who could be discharged due to a clinical indication, those who could be taken off the review BL due to an administrative issue and those who require review but not urgently. This is a government strategy to ensure all clinical risk patients will be seen as soon as possible. Mr Akhtar does do review backlog clinics and we would be seeking to utilise these clinics as far as possible for urgent patients."

13(i)(d) A general comment regarding all surgical specialties in the email was: ''We will also seek to agree clear processes around the appropriate review of patients to reduce the build up of review backlog in the future''.
Relevant documents located in S21 No 8 of 2022, 59. 20100415 E re Review Backlog HT, 60. 20100415 E re Review Backlog HT A.

ii. How was it implemented, reviewed and its effectiveness assessed?

13(ii)(a) The Plan was implemented and reviewed through publication of the numbers waiting each month and the trend in this data, i.e., reducing or remaining static. This data was reviewed at the weekly meeting of the Director with ADs and

Heads of Service supported by a senior member of Performance and Reform staff with the latest data. Actions were discussed and agreed and if more detailed discussion was required then a specific meeting was set up to discuss the necessary action. These issues were also routinely discussed at the Director's 1 to 1 meetings with each AD and each AMD. The notes of both sets of meetings are no longer available.

iii. What was your role, if any, in that process?

13(iii)(a) The Director was responsible operationally for the reduction in the Review backlog. Most actions were undertaken by the surgical division. Some evidence of actions taken to address the issue by the Director were:

i. To explore the interface with primary care to seek new review pathways, where clinically safe, to review patients in primary care. This could reduce the numbers of patients being reviewed in secondary care. *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100727 Mtg re Uro Primary Care.* This was subsequently followed by a small workshop involving the consultants and a group of GPs to discuss 3-4 clinical pathways which had been drafted for discussion. Emails regarding this workshop are attached. Emails regarding this workshop are *located in S21 No 8 of 2022, 61. 20101130 E Urology Pathway Meeting.*

ii. The evaluation of specialties against the Review Backlog Checklist was sought by myself from each AD. The response from the AD for SEC on 3 August 2010 is attached, and it states that the discussion in the division identified ''compliant with a lot of the suggestions, or audits/work in place to provide some of the information, it did provide some new food for thought.'' *located in S21 No 8 of 2022, 62. 20100803 Review Backlog Checklist, 63. 20100803 Review Backlog Checklist A.*

iii. Seeking the involvement across divisions in the development of clinical pathways which needed to reflect the patient journey from primary care,

through the emergency department and then appropriate hospital treatment. The email from Mr Conway, AD for Medicine and Unscheduled Care ('MUSC'), sets out the key points from the AMD for Emergency Medicine regarding some draft urology clinical pathways which were in development. *Relevant document can be located at S21 No 8 of 2022, 64. 20100915 Feedback on draft Urology pathways.*

iv. A meeting chaired by myself on Outpatient Clinics and the Review Backlog Checklist with all ADs on 21 September 2010. My email regarding this and the Review Backlog Checklist are attached.

v. Formal discussion and subsequent letters to each consultant regarding the New to Review ratios for their patients. The data published in the regional Review identified that the New to Review ratios for consultants in the Southern Trust were higher than their colleagues in other Trusts. This therefore was a contributing factor to the Review Backlog and needed to be addressed. After discussion with the consultants at a Team South Project Team meeting letters were sent to each consultant. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp, 20101022 Ltr to MA Reg Uro Imp, 20101022 Ltr to MY Reg Uro Imp.*

vi. A further meeting was chaired by myself on 9th June 2011, which was attended by Mr O'Brien, Mr Mackle, AMD, and Mrs Trouton, AD. The review backlog was one of the issues discussed and further action was discussed. The action notes state: ''Also to ensure that responsibility is taken to manage all outpatient appointments in such a way as to only review those who clinically require review and hereby reduce the formation of a review backlog unnecessarily.'' ''A discussion was also had regarding appropriate communication with patients who have had their review appointment delayed due to the current backlog of review appointments.'' The Issues and Actions from this meeting held on 9th June 2011, sent on 1 July 2011 to Mr O'Brien is attached. *Relevant documents located in Relevant to*

iv. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

13(iv)(a) From memory, my recall is that there were periodic improvements in the review backlog in urology, but it was not possible to sustain these. This was in part due to the following factors:

i. Increasing demand which was greater than the service could treat;

ii. Insufficient clinic sessions available to review all those patients in the backlog given that the 3 consultants were working full time and working additional in house sessions at weekends/evenings to treat patients needing day case or inpatient surgery;

iii. Insufficient progress was made on some of the actions required to fully address the backlog - an example of this was that both Mr Young and Mr Akhtar agreed to amend their clinic templates but Mr O'Brien refused to amend his clinic templates in October 2010. The clinic templates for all 3 consultants were amended to reflect the BAUS guidance with effect from mid November 2010. However, Mr O'Brien's clinics started to overrun by 2 hours for each clinic and this was not a sustainable position for the associated nursing and support staff needed at each clinic. The result was that the number of new patients per clinic for Mr O'Brien was then reduced by 2 new patients. This meant that Mr O'Brien saw 5 fewer new patients each week than if he had adopted the BAUS guidelines for clinic templates; and the number of reviews required would have reduced if he had agreed to move from his ratio of 1:2.04 and to adopt the BAUS guidelines of a new to review ratio 1:2;

iv. Frequent periods of 6 or 12 months when the full quota of junior staff in training were not placed in the Southern Trust. This has an impact on the numbers of patients who can be seen in an outpatient clinic.

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

14.1 The Implementation Plan for Urology was reflected in the following documents:

a. SHSCT Summary of Corporate Risks as at November 2011 under Objective 1 relating to the Achievement of PfA Access targets and review appointments to secure timely assessment and treatment. *The relevant document can be located in S21 No 8 of 2022, 56. 20111206 CRR.*
   I. Specific statement in the Action Planned /Progress Update (November 2011) is the 'Business case for Team South Urology now approved (July 2011).
   II. Urology is included in the references to non -recurring bid for additional resources submitted to HSCB, OP Review Backlog plan submitted to RHSCB and action plan in place.

b. SHSCT Summary of Corporate Risks as at October 2012 under Objective 1 relating to the Achievement of Priority for Action Access targets and review appointments to secure timely assessment and treatment. *The relevant document can be located in S21 No 8 of 2022,* 57. *20121204 CRR* Specific statements under Action Planned/Progress Update (November 2012) are:
   I. Independent Sector contracts re-let for 2012/2013 include Urology.
   II. Business Case for Team South Urology approved (July 2011). 3 urologists will be in post from November 2012.
   III. Outpatient Review Backlog. The longest waits remain in Urology and Ophthalmology. Actions taken to address this are set out.

14.2 It was the responsibility of the Director of Acute Services to ensure that the Implementation Plan was reported in SMT and Trust Board Governance reports. These are indicated above.

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

15.1 The urology unit in the Southern Trust had existed for many years prior to the Regional Review of Urology Services. Two of the three urology consultants had been in post for many years when I came into post. The Implementation Plan was therefore a development and extension of the existing service to cover a wider catchment population within a clear set of performance metrics.

15.2 There is a range of issues identified in the Team South Implementation Plan to deliver the 26 recommendations as relevant to Team South Urology in the Regional Review of Urology Services. The actions required to address these issues were discussed in detail and at length with the 3 consultants in post during this period and all other relevant staff. These discussions primarily involved the Director, AMD, AD, Head of Service and Performance and Reform senior staff. Agreement to address each of these issues was reached and agreed to be addressed over a period of time. There were also detailed discussions on a weekly basis with the clinicians, Head of Service and senior manager from Performance and Reform and the Urology Services Coordinator.

15.3 The main issues were:

a. The agreed capacity gap which existed between the population need and the available capacity in the SHSCT prior to the additional patient caseload from new postcodes. The analysis of referrals to the urology service had identified a 98% increase in referrals between 2007/2008 and 2012/2013. S21 No 8 of 2022, 65. *20130308 E re Demand Capacity Triage.* The new 5

consultant model agreed with HSCB in the urology business case would address this gap in consultant staff, assuming the BAUS guidelines were adopted and the new model would also have capacity for the additional population to be served from the south west region of NI.

b. The Review backlog to be funded separately on a non-recurrent basis outside the Team South Implementation Plan. Further detail on the actions taken to address the Review Backlog are found in response to Question 13.

c. Revised outpatient clinic templates to meet BAUS guidance to be agreed and implemented. This would increase the numbers of new patients and review patients being seen in each outpatient clinic. Prior New to Review ratios were higher than urology peers in Northern Ireland and contributed to the size of the review backlog. After agreement with each consultant the Director sent a formal letter to each consultant setting out the requirement for change and the ratios to be achieved over a period of time. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp, 20101022 Ltr to MA Reg Uro Imp, 20101022 Ltr to MY Reg Uro Imp* Further detail on the Review Backlog is found in response to Question 13.

d. It was agreed to reach BADS (British Association of Day Surgery) targets for short stay and day case rates over a period of time. This was achieved during my tenure.

e. The ICATS model had been set up with referrals going through the consultant with onward referral to the General Practitioner with Special Interest (GPwSI). Clinical protocols were needed for review patients, and clinic templates were reviewed.

f. Specialist nurses' review of the use of their clinical time.

15.4 It should be noted that there was a period of time between the agreement and submission of the Team South Implementation Plan to HSCB in November 2010 and the approval to proceed in July 2011. The detailed process of developing and finalising the job plans for the 5 consultant model took several months with several points requiring further discussion and clarification with the HSCB. The 5 consultant model job plans were signed off in March 2012 in order to proceed to recruitment for the 2 new consultant posts.

15.5 In April 2012 Mr Akhtar, one of the 3 consultants, resigned [redacted]. While recruiting for the permanent posts a temporary locum consultant was appointed from August 2012, and 2 substantive consultants were appointed commencing in September 2012 and November 2012. During this period there was also a member of the Urology team identified in the Implementation Plan who was on long term sickness absence which contributed to the pressures on consultant time. There were also gaps in the specialist trainees available to the SHSCT Urology service over several training years at this time.

15.6 Both Mr O'Brien and Mr Young chose which job plan in the 5 consultant model they wished to undertake. Mr O'Brien chose the job plan which included outpatient sessions and a day case list in Enniskillen. He commenced this job plan in January 2011. Mr Young commenced his new job plan in a similar time period. (Mrs Martina Corrigan provided the information contained in the last 3 sentences at my request.)

15.7 It was only after the appointment of the full team of 5 consultants that the Implementation Plan could be fully achieved and I was not in post after the end of March 2013.

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

16.1 There were clear staffing challenges during the period I was in post. These were as identified in the response to Question 15. They were:

a. Resignation of a consultant in April 2012 with a consultant gap until August 2012.
b. Long term sickness absence of the GPwSI who provided the ICATS service on a contract of 7 sessions per week. This meant that this workload was undertaken by the consultants.
c. Gaps in specialist trainees and Staff Grade doctors in the unit. A permanent speciality doctor was appointed in November 2012. It had not been possible to recruit to this post previously due to a lack of candidates. The gaps in specialist trainees in urology were not within the control of the Trust as trainees were allocated by the Deanery in NI into designated training places across Northern Ireland.

16.2 While there were the above staffing pressures, the Trust worked strenuously with the HSCB to agree the capacity gap to seek funding for both additional inhouse sessions where staff wished to undertake these sessions and for funding to transfer some patients (depending on the procedure required) to the Independent Sector.

16.3 Additionally, due to the difficulty in having a full complement of specialist trainees in the urology unit, discussion and agreement was reached to use the funding to appoint Clinical Fellows to the unit. This would ensure 2 days per week of service to the unit and a commitment to the out of hours on-call rota. The remaining sessions were for research. I do not have information on when Clinical Fellows were in post during my tenure.

16.4 There were 2 Urology specialist nurses in post full-time and 1 Lecturer Practitioner in Urology Nursing for 2 sessions. These senior specialist nurses were able to undertake work within their scope of practice which would otherwise have been done by the medical team.

16.5 It is clear that the demand for urology services and the growth in the demand over the preceding years, along with the need to provide safe high quality care, led to the setting up of the Regional Review of Urology Services. However, until the review

reported, the implementation plans were developed and approved, and subsequently implemented with additional consultants, the urology service in the Southern Trust was not adequately staffed or resourced.

16.6 The main issues were a combination of a lack of sufficient resources and the less than optimal use of the existing resources. The discussions with the urology service improved the use of resources in many ways, but during my tenure the service was still on a trajectory of improvement in this regard.

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

17.1 The staffing pressures are set out in Questions 15 and 16. I was constantly aware of gaps in consultant posts in all specialties and recruitment to fill vacant posts was routinely discussed at 1 to 1 meetings with the AD and AMD, and at Senior Management Team performance meetings. The position in relation to the recruitment of consultants was routinely part of the weekly and monthly Performance Reports.

17.2 I do not have any information on specific dates when I was made aware of consultant pressures as this was routinely on my agenda.

17.3 In relation to junior staff, I received an email on 6.8.2010 from Mr Young, Clinical Lead for Urology, regarding junior staff and the need to clarify the funding for same and specifically for the Action Plan for Urology. *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100806 E from M Young re Junior Uro Drs.*

17.4 My action in response to Mr Young was to request the Head of Service to clarify the budget position before proceeding. This was the corporate requirement across all services due to the budgetary constraints imposed on the HSC by the DoH at this stage. No post would proceed to recruitment without a clear funding position and agreement by SMT Scrutiny that the post would proceed to recruitment.

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

18.1 Please also see my responses to Questions 15,16, and 17. In summary:

a. Consultant vacancy from April-July 2012, with a locum appointed from August 2012. 2 new permanent consultants commenced later in 2012. Other mechanisms to manage the caseload were consultant sessions contracted out to the Independent Sector and additional in-house sessions where existing consultants agreed to undertake these on Saturdays.
b. Specialty trainee placements are not the responsibility of the Trust but of the Deanery in NI. It should also be recognised that urology is a national recruitment process, which at times can disadvantage Northern Ireland.
c. Permanent middle grade staff were appointed when there were suitable candidates. However, there were long periods during my tenure when this post was vacant, despite going to recruitment.

18.2 The impact of these vacancies undoubtedly put the service under increasing pressure, in addition to the increased workload already present due to capacity issues. The key areas of pressure where a lack of junior medical staff has the greatest impact are the numbers of review patients who can be seen at an outpatient clinic, and on the inpatient ward and the on-call rota for the ward. In relation to on call for the inpatient ward, known locums (usually urology trainees from other units) were booked in order to ensure the ward on call rota was safe and covered at all times.

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

19.1 As with all services where there are vacancies at consultant or junior level there will be service pressures. However, during my tenure there was only a single period of consultant vacancy from April to July 2012, i.e., 4 months until a locum consultant was appointed. The implementation of Team South was dependent on the recruitment of an additional 2 consultants and this occurred during late 2012.

19.2 The more significant pressure was the referral volume and resulting patient workload, which was one of the significant reasons for regional review.

19.3 Gaps in middle grade and junior staff also have an impact, but perhaps more so on the difficulty in sustaining a viable inpatient service and on call rota. This was the subject of discussion as needed and the inpatient service used known locums to cover the on call rota when required.

19.4 These vacancies, while putting additional pressure on the provision of the service, must also have impacted on other important areas of work such as quality improvement and clinical audit. However the Implementation Plan for Team South set out many areas of service and quality improvement required which took time to discuss, agree and implement, for example, the development of new clinical pathways for specific urological conditions which included the primary role in reviewing patients.

19.5 I have no data to evidence any change in activities such as clinical audit due to the vacancies.

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

20.1 The only change in responsibilities that I am aware of are those for the existing consultants when implementing the 5 consultant model of the Team South component of the regional Review. Each of the consultant job plans were agreed with the Southern Trust clinicians, the HSCB and subsequently approved by the Regional Speciality Advisor for urology.

20.2 Each job plan contained an agreed number of clinical sessions for outpatient clinics, day case surgery, main theatre surgery for inpatients, SPA time, ward round time, administrative time. Travel time to and from clinics based at other locations to Craigavon Area Hospital was also taken into account in each job plan with specific reference to how far away the outpatient clinic took place and the time requirement for travel. The 2 pre-existing consultants at the time of implementation of the review determined which of the 5 job plans they wished to adopt. Both Mr O'Brien and Mr Young adopted their new job plans in early 2011. (The information in the last sentence was provided by Mrs Martina Corrigan at my request.) The overview of the draft job plans for the 5 consultant model are attached. *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20111206 Proposed Uro Job Plans.*

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

21.1 My role in terms of governance of the service remained the same throughout my tenure. The means by which the governance responsibilities were delivered was strengthened through the corporate SHSCT Clinical and Social Care Governance Review 2010, led by the Chief Executive, Mrs Mairead McAlinden. This resulted in the appointment of a senior post for each Directorate to support the Director in all governance issues such as SAI process management and links to Morbidity and Mortality meetings. The person appointed as the Governance coordinator in Acute Services was Mrs Margaret Marshall. This was in addition to the creation of a corporate post of AD for Governance in the Performance and Reform Directorate, who had a co-ordinating function across all Directorates. The post holder Mrs Deborah Burns also chaired a Governance Working Body which reviewed trends and disseminated learning, and was a direct link with SMT Governance to provide them with operational intelligence form the Directorate Governance Forum.

21.2 The corporate support for the web based Datix system for incident reporting, risk register reporting and support for clinical audit were also given greater focus recognising their importance in the governance of services.

21.3 A further process was led through the Director of HR and Organisational Development, which completed in 2010. The Trust engaged the Beeches Management Centre to undertake a review of the Associate Medical Director role within the Trust. The review also considered the role of the Clinical Director. This review confirmed the following principles for the roles of the AMD and CD (quoting from a DRAFT sent on 15 April 2010 from The Director of HR and OD to the Director of Acute Services):

a. "A professional accountability role to the Director on service issues including on patient safety /clinical governance issues,
b. An ability to carry the confidence of colleagues through difficult situations and provide professional leadership,
c. Recognition that AMDs and CDs are part of the Directorate management team that is tasked with achieving Trust objectives,
d. A commitment that AMDs and CDs will consider the needs of the speciality/specialties Trust-wide for which they are appointed and have dedicated time for each site."

21.4 This assured the clarity of the role and accountability on completion of the review and acceptance at the Job Planning steering Group in 2010.

21.5 This support made it possible to focus on the many aspects of governance. In February 2010 I commenced the process of seeking each AD to set out the divisional processes of governance regarding IR1s (Form to record Clinical Incidents) and SAIs. These processes had not been systematically in place prior to this date. Details of this process are found in the response to Question 33. These became standing items on the routine monthly meetings between Heads of Service and clinicians, Assistant Directors and Heads of Service, and the Acute Directorate Governance meeting and Acute Clinical Governance meeting with AMDs and ADs. The details of these two

governance meetings held monthly in the Acute Directorate are found in response to Question 33, points (i) and (ii).

21.6 There was no difference to the governance of urology in comparison to all other acute specialties.

21.7 The Terms of Reference for the Review of Clinical and Social Care Governance, the final Report of the Review and the Review Action Plan for implementation of Approved Recommendations 1 October 2010 are attached. *S21 No 8 of 2022, 66. 20100924 Review of CSCG Governance Committee Final, 67. 20100924 Review of CSCG Governance Committee Final A1, 68. 20100924 Review of CSCG Governance Committee Final A2, 69. 20110217 for info action IMPLEMENTATION PLAN CSCG REVIEW 2010, 70. 20110217 for info action IMPLEMENTATION PLAN CSCG REVIEW 2010 A1*

[22] Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. Are you aware of any concerns having been raised about the adequacy of support staff availability? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

22.1 There were different types of administrative staff available to the urology consultants:

a. Personal secretary. The regionally funded allocation of funding for consultant secretaries in all specialties was 0.5wte. In the Southern Trust, as the consultant urologists had always had 1 wte allocated to each consultant, the Trust determined that it would continue this position when

implementing the 0.5wte for other consultants. (Mrs Heather Trouton at my request provided the information contained in this paragraph.)

b. Access to a typing pool within each division. This meant that the personal secretary had access to other administrative staff to get letters typed. (Mrs Trouton confirmed the use of the typing pool at my request.)

c. Primary Targeting List (PTL) staff, i.e., staff who worked specifically within the surgical division to identify patients in order of urgency and chronological order for day case or inpatient theatre list. The identification of patients to be scheduled for specific lists in theatre was always undertaken with the consultant who determined the time required for each patient within a fixed theatre session. Each speciality had linked PTL staff who worked with the consultants in the specialty.

22.2 I am not aware of any indication of pressures within administrative staff allocated for urology. I am not aware of any administrative staff allocated for urology nurses other than the ward clerk for the inpatient ward.

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

23.1 The personal secretaries were allocated to each consultant. The typing pool was accessed by the secretaries of all the surgeons in each hospital. If there was pressure on typing letters on a timely basis this was identified and temporary additional capacity was created to address the backlog.

[24] Were concerns from administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

24.1 I am not aware of any concerns raised by administrative support staff during my tenure, other than a backlog in typing. Additional capacity was brought into the typing pool to address the backlog of letters needing to be typed.

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

25.1 The Head of Service, Mrs Martina Corrigan, was responsible for the day to day running of the urology unit. This post was responsible to the Assistant Director of Surgery and Elective Care, Mrs Heather Trouton. The AD was responsible to the Director of Acute Services, myself (Dr Gillian Rankin), who in turn was responsible to the Chief Executive, Mrs. Mairead McAlinden.

[26] What, if any role did you have in staff performance reviews?

26.1 As the Director I was responsible for the staff performance reviews of those staff who were directly accountable to the Director, i.e., the 6 Assistant Directors.

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

27.1 The Director role was subject to performance review on an annual rolling basis. The objectives for a Director for an incoming year were agreed with the Chief Executive ('CEx') and then reviewed by the CEx with the Director on a 6 monthly basis. The IPR documents available at this stage are attached (2010-2011, 10/11 -11/12 as at end February 2012 and as at end August 2012).
Relevant documents are located at S21 No 8 of 2022, 71. IPR Proforma - Acute 2010-11, 72. IPR Proforma - Acute 2010, 73. IPR Form 2011 2012 and 74. IPR Form 2011 2012 - August 2012

Engagement with unit staff

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

28.1 Regular meetings where the Director met with all senior staff (consultants and senior nurses and Head of Service) were:

a. Team South Implementation meetings held weekly or fortnightly for a period of approximately 18 months. Details of these meetings are set out in response to Question 29.
b. Best Care Best Value meetings held as open brainstorming meetings seeking ideas from staff regarding modernisation of services, reforming pathways and ideas for simplification for patients using services. These were held, by memory, approximately 6 monthly.
c. Chief Executive, Medical Director and Acute Services Director met medical consultants in Craigavon Area Hospital and Daisy Hill Hospital separately for an open forum on issues raised prior to the meeting or at the time of the meeting. These meetings were monthly or bimonthly.
d. Walk about informal discussions with staff at all levels across both hospitals including urology inpatient ward. As the Director I tried to be in each ward on a regular basis, i.e., every 3-4 months.

28.2 It should be noted that current issues of patient safety and governance were also raised at the weekly /fortnightly urology team implementation meetings. This may have involved the 3 consultants or an individual consultant where discussion would have followed the main meeting with only that consultant involved. An example of this can be found in the *email of 6.12.2010* from the Head of Service to the Director on the current position by consultant of long waiting patients and the actions already agreed

with each consultant. *Relevant document located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101206 Uro Issues re Long Wait Pts*

28.3 Specific meetings not held on a regular basis included the following:

a. 1 December 2009 meetings re range of governance issues chaired by the Chief Executive, with the Medical Director, AMD, AD, Acting Director of Performance and Reform, AD of Performance, Interim Director of Acute Services. The range of issues on the agenda included:
    i Demand and capacity and the need to optimise the use of clinical sessions;
    ii Quality and safety - Medical Director to discuss with Mr Fordham seeking an urgent professional opinion on:
        A The appropriateness and safety of the current practice of IV antibiotics;
        B Triage of referrals and 1 consultant refusing to meet the current standard of triaging within 72 hours;
        C Red flag requirements and 1 consultant refusing to adopt the regional standard that all potential standards require a red flag and are tracked separately;
        D Chronological management of theatre lists for theatre with 1 consultant keeping patients' details locked in the desk.
    iii Action agreed that if there was no compliance, correspondence would be sent regarding the implications of a referral to NCAS if appropriate clinical action was not taken. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.*

b. 7 December follow up meeting with Mr Young, Consultant Urologist after 1 December meeting. Key points of discussion are set out. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service*

c. 7 December follow up meeting with Mr O'Brien, Consultant Urologist after 1 December meeting. Key points of discussion and the necessary actions are set out with agreed actions by Mr O'Brien to review current patients waiting to determine if urgent or routine, to put all urgent patients on to immediate lists, and other immediate actions with key staff. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Urology Mtg*.

28.4 Other specific meetings were held with individual clinicians and these will be detailed in subsequent question responses.

28.5 Given the time commitment required to work with urology clinicians in order to work through all the issues set out in the Urology Team South Implementation Plan over an intensive period of 16 months, it is possible to say that the Director spent considerably more time with the urology clinicians than the clinicians in any other specialty in acute medicine across a range of over 16 specialties across both hospitals.

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

29.1 Specific meetings with urology staff included the following.

<u>Weekly / Fortnightly meetings on Implementation of Team South Plan</u>

29.2 With regard to the implementation of the Team South Plan this required weekly/fortnightly meetings to which the 3 consultants were invited and which were attended usually by at least 2, if not 3, consultants. The weekly/fortnightly meeting was timed in order to best suit the consultants with regard to their fixed clinical sessions of outpatient clinics and theatre lists, and lasted between 1-2 hours. These meetings took place over a period of approximately 16 months until early 2011 with occasional meetings cancelled due to leave of key people or other pressures.

(Information on the length of the period over which we met regularly was fact checked with Mr Mackle and Mrs Trouton at my request.)

29.3 These meetings were used to discuss and seek agreement on the changes necessary to address the range of issues set out by the Team South Implementation Plan. These issues are outlined in response to Question 15. These meetings were chaired by myself as Director and supported by the AMD, AD, Head of Service and an AD or other staff from the Performance and Reform Directorate. Other senior staff who attended for specific issues included the specialty urology nurses, Director of Performance and Reform, AD for HR aligned to Acute Services, Medical HR re job planning, Senior Finance office aligned to Acute Services.

29.4 Some of these weekly meetings became a review meeting with the HSCB senior staff present in order to discuss the progress made with regard to implementation of Team South.

29.5 The issues of changing the behaviour of the consultant team to meet the required new to review ratio of patients and new clinic templates in outpatient clinics, to increase the day case rate and lower the inpatient elective workload, and to meet BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was also unusual for the Director to have to formally write to each consultant setting out the requirements for change tailored to each individual's practice. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp, 20101022 Ltr to MA Reg Uro Imp, 20101022 Ltr to MY Reg Uro Imp.*

29.6 It should be noted that the HSCB had previously undertaken a study of new to review ratios for all specialties in approximately 2008-2009, and indicated to Trust's the requirements by speciality as determined by the national specialty professional

body or association. The HSCB Project Initiation Document for this approach is attached. S21 No 8 of 2022, 75. *20101102 HSCB SBA Capacity Assessment PID.*

29.7 Discussions had been held with the consultants in each specialty separately and changes implemented with varying degrees of difficulty across all other specialties. However, the greatest difficulty in making the change in outpatient new to review ratio was with the urology team.

29.8 At these meetings all the updated correspondence with the HSCB, and any clarifications in relation to job planning was made available. The discussions and actions required after the Regional Implementation Board meeting formed part of the agenda of the Trust weekly/fortnightly meeting. It should be noted that both the Trust Clinical Lead for urology and the Director were members of the Regional Implementation Board. Notes were made of key points of discussions and any actions required for each meeting. Those notes which are still available and other communications regarding the Team South Implementation are:

a. Initial Southern Trust Steering Group meeting agenda and email from myself as Director to staff attending on 13 May 2010. *Relevant documents are located in S21 No 8 of 2022, 76.-80. 20100423 Steering Group Meeting 13th May 2010 – A4*
b. Email from Sandra Waddell to AD and Head of Service after the Steering Group meeting requesting to seek Western Trust representatives to join the Steering Group. *Relevant documents are located in S21 No 8 of 2022, 81.-83. 20100514 E re Team South Urology Steering Group – A2*
c. Action note from urology review project meeting on 24.5.2010 from Head of Service to consultants and relevant staff. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100527 Action Note from Mtg K*
d. Action note of urology review project meeting on 7.6.2010 with actions required (and next meeting on 14.6 2010) from Head of Service to consultants and relevant staff. *Relevant documents located in Relevant to Acute, Evidence*

Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100609 Action Note Uro Team Mtg K,

e. Team South Implementation Plan sent by myself to Beth Molloy, HSCB, Dr Diane Corrigan, Public Health Agency, and Lyn Donnelly, SLCG, on 24 June 2010. Same Implementation Plan sent by myself to the Chief Executive on 8 July 2010. *Relevant documents are located in S21 No 8 of 2022, 84. 20100624 Uro Implementation Plan to BM and* 85. *20100708 E to CX re Regional Review of Urology Services,* 86. *20100708 E to CX re Regional Review of Urology Services A.*

f. Notes of Regional Review Implementation Board meeting sent by Beth Molloy, HSCB and sent by Director to relevant Trust staff 15.7.2010 *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100715 Uro Review Project Imp Mtg.*

g. Agenda (draft) for Urology review meeting with HSCB for meeting on 26.7. 2010 with Director amendments for agenda. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100715 Uro Review Project Imp Mtg, 20100726 Regional Mtg HSCB.*

h. Outpatient clinic projected sessions for modelling from HSCB 29.7.2010 and brought to 5pm meeting with consultants - *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100729 E re Uro Data.*

i. HSCB statement on Service modelling and Director notes Notes 9.8 2010. *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100809 Uro Service Review Modelling.*

j. Emails from Head of Service to consultants about attending the urology departmental meeting to discuss the speciality interest for the 2 new consultant posts on 13.9.2011 after a request by Mr Akhtar, Consultant Urologist - *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110913 E re Specialist Interest Mtg.*

k. Agenda for Team South Project meeting 20.9.2010 with HSCB with draft KPIs and LUTS pathway. *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100920 Agenda Uro Review Project Mtg.*

l. Regional consultant comments regarding ICATS and requirements in Regional Review and Director email to Director of Performance and Reform regarding difficulties and return email regarding securing use of slippage funding against the growing backlog 6.10.2010. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101006 E re Uro Review Imp Gp Action, 20101006 E re Uro Review Imp Gp Action 2.*

m. Revised Demand of activity for Team South 11.10.2010 with Director comments. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101011 Revised Demand for Uro Service Model.*

n. Emails regarding the administrative time in job plans ('old' and 'new' contracts) prompted by email from HSCB to Director of Performance and Reform 12.10.2010. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101012 E Re Uro Job Plans.*

o. Team East pathways sent by Beth Molloy, HSCB and sent by Director to relevant staff on 13.10.2010 and noted for Urology project meeting the following week. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101013 E Uro Review Imp Mtg K, 20101013 E re Patient Pathways*

p. Beth Molloy HSCB to Director on 14.10.2010 with notes of Regional Implementation Board meeting of 1.10.2010 and sent by Director to consultants, AMD and Director of Performance and Reform. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101014 Note of Uro Review Imp Mtg.*

q. Email from Director to consultants, AMD and others regarding the Action Points from the regional meeting held on 1 October 2010. *Relevant documents are*

located in S21 No 8 of 2022, 87. 20101015 E re Uro Mtg Action Points, 88. 20101015 E re Uro Mtg Action Points A.

r. Mr Young email to Director on 15.10.2010 with comments on the impact of regional approach to pathways and a false statement in Beth Molloy notes of the 1.10.2010 meeting regarding benign cystectomies being sent to the Belfast Trust. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101015 E from M Young to Dr Rankin.*

s. Outline proposed job plans for the 5-consultant model of 6.12.2011. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20111206 Proposed Uro Job Plans*

t. Urology Team South Summary of 5 consultant model 5.12.2011 requested by the Director from senior member of Performance and Reform staff for a further discussion with consultants the following week. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20111205 Uro Mtg December K.*

u. Notification that the Job Plans had been approved by the Specialty Advisor sent for information on 29.2.2012 with dates for advertisement of recruitment in the Belfast Telegraph and the BMJ on 10.3.2012. *S21 No 8 of 2022, 89. 20120229 E re 3 Uro Posts.*

Weekly Performance Meetings

29.9 Weekly Performance meetings with all ADs and Heads of Service including the Head of Service for urology. The Head of the Referral and Booking Centre also attended. Standing items on the agenda were information for each specialty on:

a. The number of GP referrals sent to the Referral and Booking Centre which had been triaged or were waiting for triage with specific reference to red flag referrals;

b. Inpatient and Day Case waiting times;

c. Cancer pathways: 14 day for breast cancer, and 31 and 62 pathways for all other cancers;
d. The review backlog numbers and trends.

29.10 Actions by specialty were identified at a high level for more detailed planning after the meeting.

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

30.1 Virtually all meetings with urology staff regarding patient care and safety were scheduled meetings due to the need to identify a suitable time which did not impact on the consultants' clinical schedules. These meetings were scheduled with the urgency required and all are detailed in responses to other questions. The only two informal meetings that I can recall are detailed below.

30.2 These two meetings, which were not scheduled but which were required on an urgent basis, were as follows:

a. A meeting at my request of myself as Director, Mr Mackle as AMD and Mr O'Brien, Consultant urologist. The meeting took place at the end of a working day after Mr O'Brien had completed his main theatre list. I had been notified that day that Mr O'Brien had not been triaging his red flag referrals and was travelling to the BAUS Conference in Barcelona the following day. Mr Mackle and myself impressed on Mr O'Brien the requirement and importance of triaging red flag referrals. The permission to attend the conference the following day was refused unless the red flag referrals were triaged before travelling the following day. This resulted in the red flag referrals being triaged and Mr O'Brien travelled to the conference. I have no notes of this short discussion which took place in late April 2010. The red flag referrals continued to be

triaged appropriately for a period of time. (The approximate timing of this meeting with Mr O'Brien was confirmed to me by Mr Mackle.)

b. The second meeting was at my request. I had been hearing from several people that Mr O'Brien did not appear to be himself. He was operating in theatre that day, and I left a message for him to please come and have a chat with me on his way out of the hospital after completing his theatre list. At around 6pm, Mr O'Brien joined me in my office. I said there were people concerned about him and I was therefore concerned for his welfare. I asked if there was anything which I could help him with or did he need to talk to anyone in the Trust or seek help with occupational health. He said he did not need help and was very surprised at the approach from me, but thanked me for it. I have no notes of this meeting and cannot date when it took place, except that it was likely to have been after the period of weekly /fortnightly meetings with the urologists to agree the implementation plan for Team South Urology.

30.3 The existing weekly /fortnightly meeting over approximately a 16-month period to agree the Implementation Plan for Team South was a forum in which other concerns could be raised by anyone attending the meeting.

30.4 In response to Question 31 below, I have outlined the different ways all members of staff could, and did, raise issues informally.

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

31.1 The medical and professional managers worked openly together and there was a sound and good relationship. There would have been almost daily contact between these people even if there were no meetings. The Director's office, all the Assistant Directors, and many of the Heads of Service (including urology) were based side by side in a single corridor on the first floor at the front of the hospital,

just above the entrance and exit of Craigavon Area Hospital. The AMDs were all based in CAH and could exit the hospital via the corridor of offices in order to speak with any of the staff. There were therefore many informal conversations on a daily basis, but these would not have been minuted. If any conversation with me raised an important issue, a meeting would then have been arranged by me to discuss same.

31.2 A strong sense of openness and camaraderie existed which was encouraged by the Director in order to support people in difficult roles given the emergency and elective pressures in all roles. Many of the staff had worked together for several years, although perhaps in different roles.

31.3 Whilst there were service pressures and difficult issues in urology, there was respect for each member of the team, whether ward nursing staff, specialist nurse, consultant or manager. The Director witnessed this respect during difficult discussions around the implementation of Team South for urology. This was the cultural tone set in the Trust by the Chair of Trust Board, the Chief Executive and Directors. As Director of Acute Services, I was known for my open-door policy where any member of staff could bring a concern and discuss this with me. Many consultants used this over the period of my tenure, whether by calling into the office during the day or on the way out of the hospital in the evening or by email at any time of the 24 hours. Whilst I was formally based in CAH, I also spent time in Daisy Hill Hospital mainly and other facilities. It was well known that, if I needed to be contacted when not physically in CAH, my Personal Secretary would always be able to contact me with an urgent matter. Thus, all staff had ready and frequent access to me to raise an issue at any time.

Governance – generally

[32] What was your role in relation to the Directors of Human Resources and Organisational Development, the Heads of Service for Urology, the Medical Directors, Clinical Directors, consultants and other clinicians in the urology unit,

including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

32.1 The Director of Acute Services was operationally responsible for the day to day safety of patient care and the quality of service. This role was accountable to the Chief Executive. The role held the accountability for the quality of care provided by clinicians and all healthcare staff working in acute services. The post holder was supported in this by ADs, AMDs, CDs, Heads of Service, who also held accountability in each of their roles. The Director's role was supported by colleagues at Senior Management/Director level, i.e., Medical Director, Director of HR and OD, and Director of Performance and Reform, all of whom were accountable to the Chief Executive. Specifically, the Medical Director provided an assurance role to Trust Board on the quality and safety of patient care, with the Director of Nursing providing quality assurance to Trust Board on the nursing staff in the Trust.

a. Chief Executive was Mrs Mairead McAlinden,
b. Medical Director was Dr Patrick Loughran and then Dr John Simpson,
c. Director of Performance and Reform was Mrs Paula Clark,
d. Director of HR and OD was Mr Kieran Donaghy,
e. Director of Nursing was Mr Francis Rice,
f. Assistant Directors were Mrs Heather Trouton (Surgery and Elective Care) and Mr Ronan Carroll (Anaesthetics, Theatres and Intensive Care and Radiology),
g. AMD was Mr Eamon Mackle (Surgery and Elective Care) and Dr Charles McAllister for Anaesthetics and Intensive Care,
h. Clinical Directors for General Surgery and Urology were Ms Samantha Sloan, Mr Sam Hall, and Mr Robin Brown,
i. Head of Service for urology and ENT was Mrs Martina Corrigan.

[33] Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was

being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

33.1 The clinical governance arrangements for the urology service were part of the responsibility of the Head of Service, reporting to the Assistant Director, reporting to myself as Director, and subsequently to the Chief Executive. The Clinical Director reporting to the Associate Medical Director also had responsibility with regard to the clinical governance of services within their role. The assurance of safety of patient care was carried out mainly through analysis of regular data and supported by informal intelligence gathered in discussions with staff at all levels on walking around and having informal conversations. The data I used is set out below. These systems of reporting on recent and current data and identifying any trends were put in place corporately through both the Performance and Reform Director, and through the Medical Director.

33.2 The range of data is listed below:

a. Performance position by service on outpatient waits, inpatient and day case waits, cancer pathways performance against 14-day, 31-day and 62-day standards, and review backlog position and trends for each in the period since the last meeting.

b. Data on Reported Incidents logged into the Datix system, by level of severity and trends, Risk Registers, report on patient complaints and compliments and trends. New SAIs were set out with the level of action required to investigate. Progress reporting on the completion of current SAI Reports, and progress towards implementing the actions from previous SAIs.

c. Implementation of Requirements identified by Inspections by RQIA (announced and unannounced inspections) and other external bodies such as for laboratory inspections; and compliance against previously issued standards from NICE or

other external bodies, and an indication of newly issued standards for assessment regarding compliance.

33.3 The systems I put in place as Director of Acute Services to provide oversight of clinical and social care governance in Acute Services were as follows:

a. In February 2010, having discussed with the ADs the setting up of governance processes in each division, I sent an email to the group requesting each AD ''to set out the divisional processes to record IR1s, identify SAIs, share IR1s/SAIs with clinicians and managers, identify and record actions and lessons learned, share information with the staff involved i.e. complete the feedback loop. ….Please send to my office by 24th February 2010.'' In response, I received a document from each AD over the subsequent weeks, including the document setting out the process within Surgery and Elective Care (including urology) which was then implemented. The email from myself to ADs on 9 February 2010 and the SEC response from the AD on 14 April 2010 are *located in S21 No 8 of 2022, 20100209 For Action Clinical Governance and Risk Procedures E and RE For Action Clinical Governance and Risk Procedures SEC*. This commenced a more systematic approach to governance in Acute Services, which led to the setting up of 2 new Governance meetings for the Directorate. These are detailed below.

b. From April 2010, I chaired a monthly Acute Clinical Governance meeting on a Friday at 8am. The meeting included all the AMDs (or CD if the AMD could not attend), the ADs (or Head of Service if AD could not attend), the Acute Clinical Governance Co-ordinator, and Managers from the Medical Directorate to report on Clinical Incident reporting. The focus was on clinical governance, clinical incidents, SAIs and learning, any issues arising from M and M meetings, new standards received by the Trust and any concerns raised by any member of the group. Each AD was expected to report on these issues by division and AMDs to report on SAIs and actions required to address any issues identified. Attached are the agenda and notes of the meeting held on 16 March 2010, the agenda for the meeting held on 12 May 2010, papers for the

meeting on 12 May 2010 including Risk Register for Acute Services, Risk Register for SEC division, Acute Services incidents with major/catastrophic consequences 1.1.10 -31.3.2010, Acute Services Accepted internal RCAs action and learning to 14 May 2010, RCA Report on Incident Mrs M McE Ref D 20117, Summary of Medication Incident Reporting Oct-December 2009, Report on Formal Complaints 12 May 2010, Standards and Guidelines Report 23 July 2010 on current work on NPSA Alerts and list of work to commence (for meeting on 27 July 2010. *Relevant documents are located in S21 No 8 of 2022, 91. 20100416 Acute Clinical Governance Mtg First Agenda, 92. 20100416 Acute Clinical Governance Mtg Action Notes, 93.-115. 20100512 Acute Clinical Governance Meeting – A22.*

c. Acute Governance meetings which took place monthly with ADs, and Heads of Service if required on specific service issues, Acute Clinical Governance Coordinator, and staff from the Medical Directorate for Clinical Incident reports and the Complaints manager for the Complaints Report. The agenda and approach was similar to that described in para b above, but with more detail than time allowed at the Friday 8am meeting. The papers for the meeting were the same monthly reports attached to the above point. The standing items on the agenda were reporting by division for:

    i Risk Register
    ii Incident reporting including Serious Adverse Incidents (SAIs) and Root Cause Analysis (RCAs)
    iii Complaints
    iv Patient Safety Programme Report
    v NICE/TRIM Guidance
    vi Professional Governance issues including Medicines Governance Report
    vii Specific Governance Issues for example Health Care Acquired Infection (HCAI) levels, blood safety, hyponatraemia
    viii Effectiveness and Evaluation programme
    ix Enhanced Reporting of deaths for information

The agenda and notes of a meeting are attached. *Relevant documents are located in S21 No 8 of 2022, 116.-122. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 – A6,* 123. *20100330 Action Notes Acute Governance Mtg.*

33.4 Procedures in place particularly after the implementation of the SHSCT Review of Clinical and Social Care Governance (Report September 2010) when systems and processes were strengthened and streamlined and staff were more aware of their individual responsibilities in governance included:

a. The requirement for staff in any role to complete an incident form if they believed a clinical incident had occurred and that this be reviewed and actions taken by a relevant group, e.g., at ward level, or consultant level or manager. These incidents were recorded on the Datix system and reports then provided through the Medical Directorate.

b. Heads of Service and then ADs to have procedures in place for regular discussion and determination of risks with actions to mitigate agreed within the service – as described above in point (i). These were then discussed and agreed which risks became Directorate risks for the Director to bring to the SMT discussion.

c. If a member of staff – usually a clinician - believed that an SAI had occurred there was a clear procedure that this was brought immediately to either the Acute Clinical Governance Coordinator when they were in post, or to the Director or AD if the Director was unavailable and out of the Trust. This led to a discussion on the severity of the SAI and the determination of what level of investigation was required according to the policy set out by the DOH. The Director would also inform the Medical Director and the Chief Executive of the SAI and discuss the relevant actions required to investigate this. *Relevant documents are located in S21 No 8 of 2022,* 5. *20100906 Review of CSCG Sept 2010 and 6. 20100906 Review of CSCG Sept 2010 A*

[34] Please set out and describe every layer of governance assurance of which you were a part whilst in your role as Director of Acute September 09 – March 13, to include any committees, or sub-committee's or steering groups. Your answer could helpfully address the following queries:

(i) Were you a part of any Governance Committee/governance subcommittee;

34(i)(a) Yes I was a member of 4 Governance Committees named in point (ii) below.

if so

(ii) Title of Governance Committee;

34(ii)(a) I was a member of:

i. Governance Committee of Trust Board
ii. SMT Governance
iii. Acute Clinical Governance Group as chair
iv. Acute Governance Group as chair.

(iii) When were you part of this committee?

34(iii)(a):

i. December 2009 – March 2013
ii. December 2009 - March 2013
iii. April 2010 -March 2013
iv. December 2009 – March 2013

(iv) Who else was on this committee?

34(iv)(a)

i. Trust Board members
ii. Senior Management Team
iii. AMDs, ADs, Acute Clinical Governance Coordinator, managers from Medical Directorate to bring information on incidents
iv. As point iii. without the AMDs

(v) Were you required to provide assurances as part of this committee?

34(v)(a)

i. Yes the reports were provided by the Medical Director and Performance and Reform Director and any questions were answered by myself, or the Medical Director or the Performance and Reform Director.
ii. As point i.
iii. AMDs and ADs provided assurance
iv. ADs provided assurance

(vi) Were these assurances provided orally (in meetings or conversations) or documented in the form of a report?

34(vi)(a) Always as a written report in published papers.

(vii) If orally / in meetings – were there minutes of these meetings, if so please provide.

i. Governance Committee of Trust Board minutes attach
ii. SMT Governance minutes attach

iii. Acute Clinical Governance minutes. *Relevant document located in S21 No 8 of 2022, 92. 20100416 Acute Clinical Governance Mtg Action Notes,*

iv. Acute Governance minutes. *Acute Governance minutes, 123. 20100202 Acute Governance Notes*

(viii) Did you provide any written reports concerning assurances?

34(viii)(a) I wrote reports on Actions arising out of external inspections, and compliance against standards.

(ix) Who was tasked with writing this report?

34(ix)(a) The AD who was responsible for the service involved, or myself as the Director.

(x) Did you have input concerning the findings/assurances provided in the report / investigation of information within the report?

34(x)(a)

i. No

ii. No

iii. Report taken from SMT report as in ii.

iv. Report taken from SMT report as in ii.

(xi) What assurances were you required to provide?

34(xi)(a)

i. Answering questions from members of Trust Board

ii. Answering questions from colleagues at SMT
iii. I was seeking assurance from the team within Acute Services
iv. I was seeking assurance from the team within Acute Services

(xii) Were these reports required or optional?

34(xii)(a)

i. Required
ii. Required
iii. Required
iv. Required.

(xiii) How often were you required to provide these reports?

34(xiii)(a)

i. Quarterly
ii. Monthly
iii. Monthly
iv. Monthly.

(xiv) Did your Committee / report rely on any assurances?

34(xiv)(a)

i. The report was the main source of assurance information

ii. The report was the main source of assurance information
iii. While this was the main source of assurance information there could have been additional more detailed information available.
iv. While this was the main source of assurance information there could have been additional more detailed information available.

(xv) What assurances did your committee rely on?

34(xv)(a) As at 34(xiv)(a) above.

(xvi) Were these assurances checked for accuracy?

34(xvi)(a) The written reports were compiled from corporate systems outside of the Acute Directorate albeit supplied by information on the operational performance occurring in the Acute Directorate. Any additional information was softer intelligence which was checked prior to bringing into discussion.

(xvii) Whose responsibly was it to quality check these assurances?

34(xvii)(a)

i. Directors of Performance and Reform, Medical Director and Director of Acute Services

ii. As point i. above
iii. AD and AMD
iv. AD

34(xvii)(b) Please note that I was only in post as Interim and then Director of Acute Services from 1 December 2009 until March 2013 and not September 2009.

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

35.1 The oversight of the quality of the urology service was undertaken as described in my responses to questions 33 and 34 above.

35.2 The line of accountability was from the Head of Service, to AD, to Director, to Chief Executive and to the Chair of Trust Board. Other members of SMT provided data which supported the oversight function namely:

a. Performance metrics by the Director of Performance and Reform who also managed the interface with the HSCB to agree remedial action against IEAP targets which required funding non recurrently or recurrently, e.g., for additional in-house activity or funding and agreement to move some patients to the Independent Sector for surgery.

b. Data on, for example, clinical incidents and patient complaints were reported by the Medical Director.

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

36.1 The Director of Acute Services was responsible for the oversight of the performance metrics. The data was provided on a weekly basis by speciality by the Performance and Reform Directorate in the Trust. This was used at the weekly performance meeting chaired by the Director and at the SMT weekly meeting when the Director was accountable for setting out the agreed actions to address any issues of loss of performance of a specific service or a service not meeting the required standards.

36.2 If funding was required to address remedial action given the capacity gap in the urology service agreed with the HSCB, this was the responsibility of the Director of Performance and Reform to agree with the HSCB the volume of activity and funding required for additional in-house theatre sessions or outpatient clinics or referral of selected patients (determined by the procedure required) to the Independent Sector.

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

37.1 I assured myself regarding patient risk and safety in urology services through regular review at 2 monthly Directorate meetings, the Acute Clinical Governance meeting with AMDs and ADs; and the Acute Governance meeting with ADs. These meetings are described in detail in my response to Question 33 above. The data considered at each meeting was as follows:

a. Clinical incidents and particularly those rated at the highest level in the Datix system.
b. SAIs -- progress with completing reports and implementation of resulting action in completed reports.

   Any 'Never' events according to the NPSA Never Events Framework (2010/2011) at the time. As the Director of Acute Services, I had sought agreement within the Directorate to use this framework within acute services which would require a full SAI if a 'Never Event' had occurred. This approach was endorsed by the SMT Governance meeting in August 2010. *Relevant document located in S21 No 8 of 2022, 124. 20100824 E re Never Events Incident Reporting and 125. 20100824 E re Never Events Incident Reporting A1.*
c. Risk Register for division and service as provided by the manager of the Risk Register managed in the Medical Directorate.
d. Patient complaints and actions required to address systemic and specific issues through a report provided by the Complaints manager. Examples of such reports are located in *S21 No 8 of 2022, 126. PS Acute Services 3rd Quarterly Report 2011 and 127. 2nd Quarter PS Enquiries Report 2012.*
e. Report on compliance against standards such as NICE and list of work to commence. The report on Standards and Guidelines Report 23 July 2010 setting out current work on NPSA Alerts and list of work to commence is

attached. *Relevant document located in S21 No 8 of 2022, 128. 20100727 Update on Clinical Standards and Guidelines and 129. 20100727 Update on Clinical Standards and Guidelines A.*

f. Progress with actions after external inspections with the AD managing the service responsible for the update. An example if the RQIA Review of Maternity Services -Intrapartum Care April 2010 attached. *Relevant document located in S21 No 8 of 2022,* 11. *RQIA Review of Maternity Services - Intrapartum Care April 2010.*

37.2 Any particular subject which required more detailed discussion was discussed further at a separately arranged meeting with relevant staff i.e. clinicians and managers.

37.3 In summary, this data was supported by the systems and managers identified in order to assure patient safety and quality of care, and to implement actions as a result of learning from complaints, incidents and SAIs. This approach is evidenced in the documents attached in this response.

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

38.1 Concerns could be raised with the Director either informally by speaking to me immediately if required, by arrangement with my office, or by email at any stage of the 7 day week. A reply to an email sent at any time during the week was acknowledged, usually within a few hours and rarely left until the following working day.

38.2 Concerns could be raised with the Head of Service, the AD, the CD, the AMD or other member of staff outside the Directorate, the Chief Executive or with a Non Executive Director of the Trust if that was more acceptable. The Chair and Non Executive Directors of Trust Board undertook regular walk arounds and meetings with

staff and areas of concern could and often were raised. These were subsequently passed to the Director for attention. All serious issues relating to patient safety would have been brought to the Director's attention, and depending on the urgency and seriousness of the issue, immediate discussion with the AMD and AD could be arranged for the same day. If not urgent, the issue was put on the agenda for the next 1 to 1 meeting with both the AD and AMD separately.

38.3 The Review of Clinical and Social Care Governance had clearly set the tone for learning and improvement with a 'no blame' culture. Over time, with the open approach and response to raising issues of concern as a means of learning and improvement, more clinicians and staff raised concerns, some of which had been longstanding. The confidence of staff to be able to raise issues in a 'safe' environment requires time to develop, as staff generally do not wish to be exposed as doing something wrong or stating on behalf of colleagues that something is wrong. The growth in confidence to be able to raise issues and to use this for change for the better and not be blamed was clear during my tenure as an increasing number of staff raised issues. However my opinion is that this trajectory of improvement in the openness of the culture needed to continue in order for the Trust to become an organisation which more readily deals with issues and systems which do not provide optimal care.

38.4 In relation to concerns emanating from outside, i.e., from patients, there was a process for handling informal and formal concerns. During my tenure the Complaints Policy was changed to recognise that a complaint made informally i.e., verbally, was just as important as a written formal complaint. The Trust Policy on the management of complaints required all responses to complaints to come back through the Director's office for signing. This ensured that there was a full and detailed response to the complaint, as often draft replies were returned to the appropriate managers or clinicians for more information to be added.

38.5 The monthly Governance meeting within the Acute Directorate reviewed the monthly report on Complaints and analysed any trends and specific issues which required action. The Trust Board Complaints (and Compliments) Committee also assured Trust Board, through a written quarterly report from Acute Services, that all

relevant actions learnt from complaints were being taken. The Director of Acute Services attended these quarterly meetings to give an account of the recent complaints and to answer questions. Attached are the following reports:

a. Report to HSCB for December 2009 on closed complaints (1 December 2009),
b. The Directorate Report on Formal Complaints for February 2010 discussed on 12 May 2010,
c. 2 Patient Support Enquiries Report for Acute Services.

Relevant document located in S21 No 8 of 2022, 130. 20091201 - 20091231 HSCB Report re Complaints, 104. 20100512 Acute Clinical Governance Meeting A11, 105. 20100512 Acute Clinical Governance Meeting A12, 126. PS Acute Services 3rd Quarterly Report 2011 and 127. 2nd Quarter PS Enquiries Report 2012.

[39] Did those systems or processes change over time? If so, how, by whom and why?

39.1 The systems and processes changed over time through the strengthening of the governance function and support across the organisation as described in the SHSCT Review of Clinical and Social Care Governance Report September 2010.

39.2 On the implementation of this review, the development of a deeper understanding of clinical governance with staff and creating a greater sense of openness in the organisation enabled staff to respond by raising more of their concerns. The Trust and senior staff openly recognised that out of clinical incidents comes learning which needs to be known, understood and actions implemented to prevent recurrence.

39.4 The Terms of Reference of the Review, the Review of Clinical and Social Care Governance Report September 2010 are attached. The latter was disseminated to all Directors by the Chief Executive and by myself as Director to the ADs, AMDs and CDs. The email from myself to ADs, AMDs and CDs with the Implementation Plan of the

Review is attached. *Relevant documents are located in S21 No 8 of 2022,* 5. *20100906 Review of CSCG Sept 2010 and 6. 20100906 Review of CSCG Sept 2010 A, 69. 20110217 for info action IMPLEMENTATION PLAN CSCG REVIEW 2010, 70. 20110217 for info action IMPLEMENTATION PLAN CSCG REVIEW 2010 A1*

[40] How did you ensure that you were appraised of any concerns generally within the unit?

40.1 I ensured I was appraised of concerns generally in a number of ways including:

a. Regular monthly 1 to 1 meetings with the AD and AMD. These meetings occasionally became more frequent if there were urgent issues for discussion and resolution.

b. Informal discussions in passing with most ADs on a daily basis and with many AMDs several times a week. The offices of the Director and all ADs were in close proximity, with offices side by side along a corridor at the front of the hospital above the entrance/exit. All the AMDs were based in Craigavon Area Hospital. CDs were based in both Craigavon Area Hospital and Daisy Hill Hospital. It was important to be available for discussions with clinicians in both hospitals and therefore the Director and all ADs spent time each week in both hospitals.

c. During the period of discussion on the Team South Implementation for urology, there were weekly /fortnightly discussions over approximately 18 months with the urology consultants and issues of concern could be raised during or after these meetings.

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

governance issues were not being identified, addressed and escalated as necessary?

41.1 The corporate Review of Clinical and Social Care Governance September 2010 was implemented from late 2010 and fully embedded through 2011. This was a key vehicle in the Trust for strengthening governance processes and procedures.

41.2 Given the frequency of meetings with urology staff, the clear systems and processes of accountability and monthly and weekly reporting on the service, it was reasonable to assume that governance issues recognised by any member of staff would be identified, addressed, and escalated as necessary. Despite considerable time being spent with this service, it is always possible to strengthen systems and processes. At the time many issues regarding the urology service were raised with me and necessary actions taken. These have been detailed already with regard to performance metrics and other clinical issues. Other issues are detailed in response to Question 50.

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

42.1 Concerns regarding urology are documented as follows:

a. Briefing Report for the Confidential Section of the Trust Board meeting held on 30 September 2010, requested by the Chief Executive and written by the Director of Acute Services. This Confidential Briefing for Trust Board set out the position regarding the concerns and actions regarding IV therapy, the operation of cystectomy, the cancer pathway requiring the movement of radical pelvic surgery to the Belfast Trust. The Review of a Local Concern under the Maintaining High Professional standards guidance in relation to the operation of cystectomy was set out as the action against the higher rate of cystectomies previously in the Trust The Briefing document is attached. *S21 No 8 of 2022,*

131. 20100930 Trust Board Confidential Briefing Note, 132. 20100930 TB Confidential Minutes

b. A verbal update on progress against each specific issue was given by the Director of Acute Services at the following meeting of the Trust Board in the Confidential section on 25 November 2010. *Relevant documents located in S21 No 8 of 2022, 133. 20101125 Trust Board Confidential Briefing Note,* 134. *20101125 TB Confidential Minutes.*

c. The versions of the Corporate Risk Register with the date of the version identified the following issues in relation to urology:

i December 2009 identifies the Review Backlog team being established to undertake a range of actions under Control Measures. Urology was not specifically mentioned but would have been one of several specialties with a review backlog at the time. The weaknesses identified include:

- A Arranging additional clinics to target Review Backlog patients – not feasible in current financial position
- B Reduce the current number of new patients within outpatient template, not feasible as performance targets will then be breached
- C Recruit additional medical staff to address shortfall in capacity -not feasible in current financial situation.

ii June 2010 identifies the review backlog with the same comments on actions and weaknesses as set out in the bullet point above.

iii November 2011 in relation to the Achievement of PfA access targets and review appointments. The Risk areas included are:

- A A number of inpatient IP/DC/OP waiting times significantly beyond access standards
- B Outpatient reviews in a number of specialties significantly beyond clinical review timescales

C A range of key controls are identified, and progress updates to include: ''The urology business case now approved (July 2011).''

iv October 2012 under the Achievement of PfA targets the Action Planned/Progress Update section identifies the action ''in relation to Independent Sector contracts re-let for urology; and Urology Business case approved, 3 urologists will be in post November 2012.'' General reference to risk to maintaining March 2012 access position including agreed backstops. With reference to the Outpatient Review Backlog, there is specific reference to the'' longest waits are in urology and Ophthalmology. '' The Trust anticipates a rolling backlog in reviews until recurrent demand /capacity gaps have been addressed.''

d. Acute Directorate Risk Register identifies the following numbered risks which remain as on-going risks throughout my tenure:

i 2991 Cancer Performance Risk with decrease in performance. Highest risk is in urology. Added to the Register on 26 May 2011.
ii 3166 Urology Access waiting times increased from 36 weeks for inpatients and day cases. Added to the Register on 25 June 2012.
iii 3191 62 day cancer performance risk. Added to the Register on 3 September 2012.

e. Divisional Risk Registers for both divisions of SEC and CCS.
i 2943 and 2942 urology cancer pathway delays identified in April 2011.

42.2 Further detail contained in each of these Risk Registers is set out in response to Question 67. *Relevant documents located in S21 No 8 of 2022, 135. 20091209 Corporate Risk Register, 136. 20100621 Corporate Risk Register, 56. 20111206 CRR, 57. 20121204 CRR, 53. 2009 - 2013 Acute Risk Register, 54. 2009 - 2013 SEC Risk Register, 52. 2009 - 2013 CCS Risk Register.*

42.3 The specific issues in urology will also be referred to in monthly meetings within the Directorate, and may also be captured in the Datix system. However, no further documents are available to me at this stage which would evidence these concerns.

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

43.1 Systems in place for collecting patient data included:

a. Complaints and compliments were recorded. Complaints, both formal and informal, were always investigated and written responses provided to the complainant. The letter of response was read and signed by myself as the Director and, on occasion, further investigation was required before the response was finalised and sent. There were a small number of occasions when I decided to meet with the complainant with relevant staff in order to understand the issue in greater depth and to discuss the response. A report on the total number of complaints and compliments was published and discussed at a Trust Board Committee. The complaints were analysed according to the reason for complaint. The Director attended the Committee meeting to answer both general questions on trends and specific questions on individual complaints. The Committee met quarterly. An example of the quarterly Report is located in *S21 No 8 of 2022, 127. 2nd Quarter PS Enquiries Report 2012.*

b. Reports from the Referral and Booking Centre were used to identify the numbers of patients referred to urology, the timing of triage of referrals and whether this was within the required time standard, and the booking times into outpatient clinics.

c. Performance metrics on waiting times for patients and whether their assessment and treatment met the required standards, for example, for cancer 31 and 62 day pathways.

d. Clinical Incidents which happened with individual patients were discussed at divisional and directorate governance meetings, and SMT Governance meetings.

e. SAIs with individual patients and implementation of learning from these investigations were discussed and actioned within Acute Services.

f. Learning points resulting from the Trust Mortality and Morbidity meetings held with consultants and supported through the Medical Directorate. The attached email resulted from the first meeting of the Acute Clinical Governance Group when the AMD for Surgery and Elective Care sought learning points from M and M meetings to be made available into the Acute Governance forum located in *S21 No 8 of 2022, 137. 20100419 E to MD re Acute Clinical Governance Group.*

43.2 All of these systems were used to identify specific issues in the service, in addition to the softer intelligence obtained through open systems and discussion with staff.

43.3 The issues identified through the systems referenced above included:

a. An SAI identified the failure to read test results before patient filing;
b. Breaches in the 31 and 62 day cancer pathway;
c. The numbers and length of waits for outpatient appointments, for inpatient and day case surgery;
d. The time delay between receiving a GP referral and the consultant triaging the referral dependent on the urgency placed on the referral by the GP;
e. The numbers and length of wait for a urology diagnostic procedure.

43.4 Further detail on each of these issues is set out in my response to Question 50 below.

43.5 Other issues were picked up through 'soft' intelligence and not through systems. On reflection, this position inevitably leads to learning, which is set out in my response to Questions in the 'Learning' section near the end of this Witness Statement.

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

44.1 In respect of Referral information in the Referral and Booking Centre, in this instance the recording of the referral was the key role of a specific group of staff employed purely for this purpose. Therefore, such a system and the reporting from this system was accurate and reports were reviewed weekly.

44.2 In respect of performance against the parameters set out in the IEAP, the electronic systems, PAS and CAPPs, were set up regionally to record patient data against each parameter and provide the required reports for the Trusts and Commissioner to monitor performance. These systems provided reports and performance metrics were reviewed weekly. The CAPPs system was fully implemented by summer 2010 and thereafter provided accurate reports of each patient and milestones along the cancer pathways.

44.3 Prior to summer 2010 and the full implementation of CAPPs I have a vague recollection of a concern that the data may have been incomplete. In this regard, I know that on 17 May 2010 I requested an urgent review by the AD for Surgery and Elective Care and the AD for Cancer and Clinical Services of the position regarding red flag referrals as I had picked up informally that there may have been breaches in the 31 and 62 day pathways which were not evident in the data. I sought "an indication of whether or not we have a problem quickly in a few days and then we can take from there. I will b'f for next week.'' The system used to record the actions on the 14 day breast pathway and 31 and 62 day pathway for all other patients diagnosed with

cancer was, as mentioned above, the CAPPS regional system. *Relevant document is located in S21 No 8 of 2022, 138. 20100517 E re Referral Guidelines Uro MDTs*

44.4 Whether or not there was in fact a problem I am now unable to recall (I have no documentation regarding the source of the informal information, whether the information was proven to be correct or not, or any detail regarding the specifics of the problem, if it was in fact identified to be a problem). However, I do recall that the accurate recording of all data was promptly confirmed. This was clear from subsequent meetings held by the Head of Cancer Services with the urology consultants regarding the implementation of the regional MDM after local testing of the MDM process.

44.5 A process which changed over time was the move to staff themselves inputting information directly into the Clinical Incident recording system, Datix. Initially, the incident forms were completed manually and then centrally put into the system for recording and reporting at a later stage. Staff were trained from late 2010 through 2011, and then were required to input the data where the incident happened, e.g., on the ward, in the outpatients department, in the radiology department or in the decontamination unit. The recording of incidents and rating the severity of the incident required all staff to understand the value of recording such incidents for learning purposes. The reporting on Datix was therefore down to staff to report and the leadership and openness of the culture in each department (whether an inpatient ward, a day treatment unit or the emergency department) had a significant influence on whether all incidents were reported.

44.6 While the Review of Clinical and Social Care Governance, and the actions taken such as strengthening governance systems in the Trust and the training of staff, contributed to more open recording, there could still have been incidents which were not reported. This should have decreased over time as staff became more used to the process, and there was evidence at the time to support this position. This system therefore depended on human factors and therefore could never be said to identify every incident. In my opinion, though, I think that all the Serious Adverse Incidents were reported, recognised and lessons learnt. These again were subject to staff reporting them in the first place.

44.7 In reference to the concerns listed in response to Question 50, the routine systems in place at the time did not automatically identify each of these concerns. New systems of monitoring were required to identify those concerns not automatically identified.

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

45.1 As Director of Acute Services I was not involved in setting any performance objectives for consultant medical staff and for specialty teams. The Medical Director was responsible for the performance and appraisal of consultant medical staff.

[46] How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

46.1 Job planning and appraisal for existing medical consultants was the responsibility of the Medical Director. The operational director would inform of the changes to be discussed in job planning if needed to address performance metrics. New job plans as required to implement the requirements for Team South urology fell within the remit of myself as Director of Acute Services. This was fully supported by the AMD involved.

46.2 Early in 2010, the Chief Executive set up a process to review and standardise the approach to the quantification of ‘’Supporting Professional Activity’’ (SPA) time in each consultant’s job plan. The review took several months and involved all the Directors and clinicians in management roles. The review resulted in an agreed standardised approach to SPAs across all consultants. The process also clarified the

process whereby clinicians could undertake leadership roles outside the Trust whether within NI or the UK.

46.3 I have no examples which I can recall where issues came to light due to a problem with appraisal. There were examples of staff needing changes in their job plan for various circumstances such as long-term sickness absence or return after maternity leave. These were usually worked through, agreed and implemented without significant problems.

46.4 There was an issue in relation to Mr O'Brien's job plan which Mr O'Brien set out in an email to Mr Mackle on 26 August 2011. This email had been preceded by a meeting chaired by myself on 9th June with Mr O'Brien, Mr Mackle and Mrs Heather Trouton, AD, when job planning was one of the issues discussed. The email summarising the issues and actions from the meeting are attached *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110701 Actions from Mtg to AOB K..* Mr Mackle was therefore unable to reach agreement with Mr O'Brien on the job plan and referred the process for mediation with Mr Clegg, senior manager in Medical HR. This was the usual practice when there was a failure to agree a job plan. Mr Mackle notified the AD and Head of Service that the facilitation process had begun, in an email on 1 September 2011. I was aware of these events, but was not directly involved. (Mr Mackle provided the detail on the referral for mediation, which I was not able to recall.) *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin,20110826 E re Results and Reports of Investigations, and in S21 No 8 of 2022, 139. 20110901 E to MC and HT re AOB Draft Job Plan.*

46.5 In my experience both job planning and appraisal worked well in the Trust with recourse to mediation if there were unresolved difficulties between the parties as identified above.

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

47.1 The route of identifying a governance concern could have been informal through a conversation and a member of staff raising a concern or formal through information being reported through such systems as:

a. Datix, the clinical incident recording system;
b. Serious Adverse Incident reporting;
c. Patient complaint;
d. Risk identification and placing on the risk register;
e. External inspections from RQIA;
f. Accreditation processes, e.g., laboratory accreditation requirements and food hygiene requirements;
g. Receipt of a Safety Notice from DoH for immediate action.

47.2 If the route was informal through conversation with myself as Director, the approach to the concern was agreed and linked into one of the systems set out above. This ensured that informally raised concerns moved into the formal governance process.

47.3 With the exception of the Serious Adverse Incident, the governance process was taken through the line management process of managers and clinicians in CD and AMD roles. Therefore, the Head of Service and CD took appropriate action and if they deemed the risk to be moderate to serious, they raised this with the AD and AMD who in turn raised the risk with myself as Director. The data on the risk would then be further detailed and discussed at the service monthly meeting led by the Head

of Service, and the divisional monthly meeting led by the AD, and/or both the Acute Services monthly Governance meetings with the AMDs and ADs.

47.4 With regard to a SAI, it was the responsibility of the AMD or AD to raise this immediately with myself as Director. In discussion with the AMD and the AD for Governance (Mrs Debbie Burns) and subsequently, once appointed, the Governance Coordinator for Acute Services (Mrs Margaret Marshall), the level of risk which the incident posed was discussed and then the level of investigation required. Determining the level of severity and the level of investigation was important as it determined whether an independent external chair was required to lead the investigation. In addition to this process, I would have informed the Chief Executive (Mrs Mairead McAlinden) and the Medical Director (Dr Patrick Loughran and Dr John Simpson) of the SAI and proposed actions.

47.5 The actions needed and the implementation of the actions should then be recorded in both the Datix system for clinical incidents, and also the risk register for risks.

47.6 Actions required against external inspections or accreditation processes had separate specific action plans developed.

47.7 All of the above systems were reviewed monthly in the Directorate processes as set out, and at a higher level at the monthly SMT Governance meeting and the quarterly Trust Board Governance meeting.

47.8 Examples of the reporting and actions required are evidenced in the following:

a. Risk Registers of Surgery and Elective Care and Cancer and Clinical Services, Acute Services Directorate 2009 – *Relevant documents located in S21 No 8 of 2022, 53. 2009 – 2103 Acute Risk Register, 54. 2009 - 2013 SEC Risk Register, 54.2009 - 2013 CCS Risk Register.*
b. Example of Datix with clinical incidents – *Relevant document located in S21 No 8 of 2022, 140. Surgery Incidents 2009 - 2013 pdf*

c. RQIA Review of Maternity Services –Intra-Partum Care Report with actions in April 2010–*located in S21 No 8 of 2022, 11. RQIA Review of Maternity Services - Intrapartum Care April 2010.*

47.9 An example of the agendas or Action Notes taken for the monthly Acute Directorate Governance meetings identify the level and breadth of reporting which was used for assurance purposes. An example of an action taken from discussion at the first meeting of the Acute Clinical Governance Group is set out in an email from myself to the Medical Director Dr Loughran, in relation to an issue raised by the AMD for Surgery and Elective Care, Mr Mackle. *Relevant documents are located in S21 No 8 of 2022, 116.-122. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 – A6, 20100330 Action Notes Acute Governance Mtg.* located in *S21 No 8 of 2022, 137. 20100419 E to MD re Acute Clinical Governance Group, 91. 20100416 Acute Clinical Governance Mtg First Agenda, 92. 20100416 Acute Clinical Governance Mtg Action Notes,*

[48] Did you feel supported in your role by general management and medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

48.1 Yes; I felt supported in the role by both general management and the medical line management hierarchy.

48.2 I had immediate access as needed to the Chief Executive at any stage and the Medical Director, the Director of HR and Organisational Development, and the Director of Performance and Reform.

48.3 It would have been unusual not to talk with the Chief Executive every day, either formally in meetings or informally at the end of the working day. As the Chief Executive chaired the weekly meeting of the Senior Management Team (SMT), this was often an opportunity for informal discussion on any issue of concern. The urology service and the issues as set out were not infrequently the subject of discussion.

48.4 Formally, the urology service performance and the need to agree funding for additional in house lists or a contract with the Independent Sector to address the long waiting times was discussed at the SMT meeting under the agenda item on the Performance Report almost on a weekly basis.

48.5 An example of such support is the actions taken by the Chief Executive when I commenced in post. These were:

a. Support from colleagues to commence a process called the Acute Services Contingency Plan meeting - This was a weekly meeting during December 2009 through to February 2010 chaired by myself, which involved senior clinicians and managers in Acute Services in the process of identifying service areas which required urgent action to improve and streamline i.e., quality improvements which could also bring productivity benefits i.e., better use of resources. This resulted in an opening of views across senior staff, created some energy for change and enabled the celebration of some short-term gains. The agendas for this meeting on 8 January 2010 and 12 February 2010 are attached and demonstrate the breadth of issues and resulting workstreams which had been raised by clinicians and managers for improvement work in acute services. The process also resulted in some longer-term improvement programmes such as 'The Productive Theatre' which resulted in streamlining of systems in managing theatres and the goods and services required. The meeting of 5 February identified the widening of the brief for Sarah Tedford, IMAS to include the review backlog in terms of an analysis of the backlog by sessions and actions needed across all specialties. Agendas for 2 such meetings and the Action Notes of the meeting held on 5 February 2010 are attached. *Relevant documents are located in S21 No 8 of 2022, 142. 20100108 Acute Contingency Agenda, 143. 20100212 Acute Contingency Agenda, 144. 20100205 Acute Contingency Mtg Notes.*

b. The benefit of the support of a senior member from the Interim Management and Support service in NHS England (IMAS) staff for a period of 4 months with the specific view to:

   i Undertake a review of Urology Services identifying opportunities for expansion and efficiency gains;
   ii Review the elective pathway focussing on outpatient booking processes;
   iii Consult on the Perfect Operating Theatre.

48.6 This support was put in place by the Chief Executive in discussion with Hugh Mullen, Director HSCB, and resulted in significant development work within urology and wider systems as set out in the Urology Services Action Plan, 22 January 2010. This process laid the ground-work for the subsequent development of, e.g., clinical pathways to implement Team South Urology. The final report, NHS IMAS Closure Report, from Sarah Tedford, the IMAS manager who undertook the work, is attached, along with her final email to Hugh Mullen. *The relevant document can be located in Ongoing Discovery March 2022, Acute, Document No 77, Dr Gillian Rankin, 20100430 E re Regional Uro Review k and in S21 No 8 of 2022, 145.-147. 20100429 Closure Report S Tedford – A2, 148.-150. 20100129 Urology Action Plan Update – A2*

48.7 Additional examples in relation to urology were the support made available by:

a. Director of Performance and Reform to develop the business case to implement Team South Urology, to lead on writing the implementation plan once this was agreed with clinicians, and to lead the discussions with the HSCB on the detailed activity required to be planned into the 5 consultant model job plans.
b. Support from a senior manager from Performance and Reform with up to date data on the weekly performance of each specialty against the range of performance metrics, for example, the number of patients waiting and the time of the longest waiting patient by specialty. This was brought to the weekly performance meeting which I, as Director, chaired.

c. The Medical Director and the Director of HR and Organisational Development were both available to discuss performance concerns and the appropriate action to be taken. The detail of these discussions are set out in response to Questions 57 and 58.

48.8 In relation to the medical line management hierarchy, I was fortunate to be supported in the role by 5 Associate Medical Directors (AMDs) and their linked Clinical Directors (CDs). I met with each AMD on a monthly basis for a 1 to 1 meeting where each of us raised issues for discussion. The AMDs also attended meetings involving specialties in their portfolio, such as the urology weekly/fortnightly meeting on the implementation of Team South Urology, which the AMD for Surgery and Elective Care attended. I had at least weekly contact with some of the AMDs who dropped into my office informally for discussion as issues arose. This was a key source of informal or soft intelligence.

48.9 I did not meet as regularly with the CDs unless they were involved in key issues or were deputising for the AMD in relation to a particular issue. However I made sure that I was able to meet them informally as often as possible.

Concerns regarding the urology unit

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

(a) The Chief Executive(s) - the Inquiry understand the post holder to have been Mairead McAlinden;

(b) the Medical Director(s) - the Inquiry understand this to have been John Simpson;

(c) the Assistant Directors - Heather Trouton and Ronan Carroll;

(d) the Associate Medical Director - the Inquiry understand this to have been Eamon Mackle and Charlie McAllister;

(e) the Clinical Director - the Inquiry understand this to have been Robin Brown;

(f) the Head of Service, namely Martina Corrigan, and

(vii) the consultant urologists in post.

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

49(a) Chief Executive.

i. I interacted with the Chief Executive both formally and informally in relation to urology matters. The meeting chaired by the Chief Executive on 1 December 2009 is an example of a formal meeting, as is the formal request by email to set out a Briefing Note for the Confidential Section of Trust Board of 22 September 2010.

ii. Matters relating to the performance in urology, the implementation of Team South Urology and the issues around patient safety and quality of care were discussed at the following meetings with the Chief Executive: 1 to 1 monthly meetings, SMT weekly meeting covering performance, SMT Governance meeting on patient safety and quality of care.

iii. I am unable to recall the dates and specific details of the other informal discussions regarding the urology service I had with the Chief Executive but I can confirm that informal discussions would have taken place.

49(b) The Medical Director, Dr Patrick Loughran followed by Dr John Simpson.

i. I met with the Medical Director for 1 to 1 discussions on a regular basis although not monthly. I also saw the Medical Director frequently each week at other meetings such as SMT. There was ongoing discussion about issues of concern and developments of interest. Some of these informal discussions would have mentioned the urology service.

ii. Formal discussions involving the Medical Director regarding Mr O'Brien are set out in detail in my response to Questions 57 and 58 below.

49(c) The Assistant Directors, Mrs Heather Trouton and Mr Ronan Carroll.

i. Many examples of the dates and notes of meetings involving both ADs on the issues in urology are set out in the response to several questions in this document.

ii. Routinely, I discussed the management, performance and governance of the urology service with Heather Trouton at 1 to 1 monthly meetings (or more frequently if required), and the cancer pathway monitoring, theatre issues and MDM process with Ronan Carroll at 1 to 1 meetings held monthly.

iii. Both ADs were present at the weekly Performance meeting, the Directorate Acute weekly meeting, the Acute Governance Group monthly meeting, and the Acute Clinical Governance Group monthly meeting.

iv. As the ADs offices were based in the same corridor as my office I usually saw both ADs informally on most days.

v. An example is the meeting and discussion with Mr O'Brien which included Mrs Trouton and Mr Mackle held on 9 June 2011regarding performance

issues. The attached email sets out the Issues and Actions recorded at the meeting and which were sent to Mr O'Brien on 1 July 2011. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110701 Actions from Mtg to AOB K.*

vi. Other examples of meetings where urology issues were discussed are set out in response to Question 50 or they are not available at this stage.

49(d) The Associate Medical Director for Surgery and Elective Care, Mr Eamon Mackle and the AMD for ATICS (Theatres and Intensive Care) Dr Charles McAllister.

i. I met with Mr Mackle and Dr McAllister separately on a monthly basis as I did with each of the 5 AMDs. They were also present at the Acute Clinical Governance Group meeting held monthly from April 2010. They were both completely supportive of setting up this forum which had not existed previously.

ii. Both Mr Mackle and Dr McAllister often dropped into my office for informal conversations at least once a week in addition to the meetings mentioned above.

iii. The examples of when Mr Mackle attended meetings with myself to discuss issues surrounding urology, or to meet the urologists on difficult issues are documented in responses to several questions, and specifically in Questions 50,57 and 58.

49(e) The Clinical Director. Ms Samantha Sloan, followed by Mr Sam Hall, followed by Mr Robin Brown.

i. I did not routinely meet with these clinicians. However, in relation to urology and the role they were required to undertake regarding the treatment of IV

therapy, I met with each of them with Mr Mackle when they took up the role of Clinical Director. I do not have dates and notes of these meetings.

49(f) The Head of Service. Mrs Martina Corrigan.

i I saw Martina Corrigan almost daily for most of my tenure. This was through both the weekly Performance meeting which I chaired and Martina attended, or through the weekly/fortnightly meetings regarding the implementation of Team South Urology. Other specific meetings regarding the urology service performance required Martina's attendance as the person with day to day responsibility for the service.

ii In addition to these meetings, as Martina's office was based along the same corridor as my own, I often went to her office to ask how the service was functioning and, as often happened, this resulted in seeking more detailed information on a range of issues over my tenure. Several emails illustrating these requests and responses are set out in response to other questions. Examples are the detailed email response of 6 December 2010 from Mrs Corrigan to myself regarding long waiting patients in preparation for the weekly/fortnightly urology meeting on the implementation of Team South Urology; and the email of 6 April 2011 regarding breaches and seeking a plan from Mr O'Brien for each patient. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin 20101206 Uro Issues re Long Wait Pts, 20110406 E re AOB Cancer Breaches*

49(g) The consultant urologists. Mr Michael Young, Clinical Lead and Consultant Urologist, Mr Aidan O'Brien, Consultant Urologist, Mr Mehmood Akhtar, Consultant Urologist.

i. I met with this group of consultants with a range of other staff with regard to the implementation of Team South Urology on a weekly /fortnightly basis for a period of up to 18 months from January 2010.

ii. I also met with the urologists separately as a group or as individuals in relation to specific issues. All of these meetings where records are available, have been documented in relation to responses to other questions, specifically in response to Questions 29, 50, and 57.

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

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

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

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

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

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

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

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

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

50.1 There were several areas where issues or problems in urology services were encountered. These were set out in a meeting held by the Chief Executive on 1 December 2009. Those who attended the meeting included the Medical Director, Director of Performance and Reform, AMD for surgery and elective care, and Director of Acute Services. This meeting set out several areas requiring action. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.* The Medical Director, the Director of Acute Services and the AMD met with Mr Young, Consultant Urologist, on 7 December 2009 to discuss the issues raised by the Chief Executive at the meeting of 1 December. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service* The Medical Director and the Director of Acute Services met with Mr O'Brien, Consultant Urologist, on 7 December 2009 to discuss the issues raised by the Chief Executive at the meeting of 1 December 2009. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Urology Mtg*.

50.2 The list of issues encountered with the urology service in relation to performance against the PfA access targets and clinical areas are set out below. They are:

a. Triage of red flag referrals i.e. referrals of people with potential cancer and non-urgent referrals.

b. The scheduling of patients for surgery without due regard to urgency and chronological order.
c. The surgical operation of cystectomy.
d. The use of IV antibiotics for inpatients.
e. Referral of patients requiring prostatectomy or cystectomy to the Belfast Trust and the implementation of the regional MDM (Multidisciplinary Meeting) to discuss each patient with cancer and agree their treatment.
f. Service capacity gap which impacted on the waiting time for patients for outpatient clinics, day case surgery, inpatient surgery and review outpatient appointments; and breaches of the 31 day and 62 day standards for patients with diagnosed cancer.
g. Failure to read test results when received and before filing the patient notes, irrespective of whether the patient has an outpatient appointment booked.
h. Disposal of some patient notes and information in the bin of a consultant's office.

50.3 The response will take each of the above issues in order and respond to the points below against each one.

50.4 I have set out the full detail of all correspondence available to me at this stage in order to ensure full disclosure of relevant material. This necessarily means that some issues or problems have a lengthy response due to the fact that they continued over long periods of months or years. If an issue was a single instance the response is necessarily shorter.

50.5 Responses to other questions regarding the specific issues covered in Question 50 refer to the detail set out below where this is possible.

50.6 <u>Triage of red flag referrals</u>

a. The IEAP identifies a clear standard of 1 working day within which all red flag referrals should be read by the consultant and the pathways for action set out for the patient to be booked by the booking staff in the Referral and

Booking Centre (RBC). The Trust had set up the RBC as a single central point to receive all GP referrals. All referrals were logged on the referral system in the RBC and the subsequent action by the consultant was also logged with the time interval between receipt of the referral and the determination of the necessary action by the consultant. This ensured that there was a clear record of triage times for both red flag and non urgent referrals for each specialty and by consultant.

i I was first made aware of this issue at the meeting chaired by the Chief Executive on 1 December 2009. The Action notes of the meeting are attached. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.*

b. The steps taken to risk assess the potential impact was seeking data from the Referral and Booking Centre in order to know the number of referrals awaiting referral and how long they had been waiting.

c. and d. Delays in the consultant determining the necessary action for a specific patient referral is one of the first steps in the secondary care pathway contributing to the quality of patient care.

i The steps taken to mitigate the risk were to identify at the weekly performance meeting chaired by myself the previous week's data on whether urology service had triaged referrals within the time standard required. Katherine Robinson, the Head of the RBC, attended the weekly meeting and provided the data. However, if she was aware of a breach between these meetings she raised this with the Head of Urology, Martina Corrigan. The 3 consultants usually did triaging of referrals on a weekly rotational basis. When it was identified that Mr O'Brien was not triaging referrals within the time standards on the weeks when he was due to triage referrals, Martina Corrigan in discussion with the consultants agreed that one of the other

consultants would undertake the triage process on behalf of the Mr O'Brien.

ii Individual meetings were also held with Mr O'Brien on 7 December 2009 *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Urology Mtg* and on subsequent occasions. An example of a further meeting relating to the failure to triage red flag referral letters was in April 2010. This meeting with Mr O'Brien is detailed in my response to Question 30 under point 1. However, Mr O'Brien did not always accept that triaging referrals within a time standard was necessary.

iii A further example of the type of activity undertaken is a meeting I held with the AD, Head of Service and Head of Cancer Services to discuss breaching of urology patients in the cancer pathway. The Head of Cancer Services was responsible for tracking patients who had suspected or confirmed cancer along the 31 day and 62 day pathways. The CAPPs system was used to record and monitor the patient's progress along this pathway, and was used to formulate the required report to the HSCB for each patient breaching the 62-day pathway. This meeting resulted in the identification of breaches of patients of Mr O'Brien and a letter being sent to him co-signed by the myself and Mr Mackle. Mr O'Brien responded by ''committing to triage referrals within a week and red flag referrals within a day conditional on the cohort of three consultants being sustained.'' *Attach documents: Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100909 E Uro Referral Breaches, 20100909 E Uro Referral Breaches 2, Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp.*

d. In addition to the weekly report from the RBC, additional reports were sought if there was any indication that referral letters were not being triaged as required.

e. The assurances were given by the Head of the RBC who provided the data as a report from the RBC IT system and Martina Corrigan, the Head of Service for Urology, who had the day to day intelligence on the ground with the service.

f. The system put in place to rectify this problem was successful in identifying when referrals had not been triaged in the required timescale. However, the 'work around solution' depended on other consultants being prepared to address the fact that their colleague, Mr O'Brien, was not always and reliably prepared to undertake this work in an acceptable manner, i.e., within the required time standards.

g. Answered above at f.

50.7 Scheduling of patients for urology surgery with due regard to clinical urgency and chronological order.

a. This issue was raised by the Chief Executive in the meeting of 1 December 2009. The issue of scheduling patients in chronological order within the categories of urgent and non-urgent is a requirement of good clinical practice, whether this is for an outpatient appointment, or for day case or inpatient surgery.

b. The steps taken to risk assess the impact and to consider any impact on patient care and safety were to review the lists of people waiting for day case and inpatient surgery. As Mr O'Brien had no control over the booking process for an outpatient appointment as this was the role of the RBC, the focus was on the inpatient waiting list. The process of scheduling patients for both day case and inpatient surgery was usually undertaken by the

consultant supported by a specific scheduler in the administrative staff. The process for scheduling Mr O'Brien's patients for surgery was changed to include the Head of Service in addition to the Operational Support Lead for Surgery and Elective Care.

c. Answered above at b.

d. The scheduling of individual patients for a specific day case list and inpatient list on a specific day had been previously undertaken by Mr O'Brien with his secretary. No one else had been involved, or perhaps been allowed to be involved, in this process. The process implemented to address the issue was that the Head of Service and the Operational Support Lead (OSL) for SEC would work with Mr O'Brien to schedule patients for each list. Mr O'Brien chose to use a different type of ranking of urgency which had 4 levels rather than was the usual practice of 3 levels. (Mrs Martina Corrigan confirmed for me at my request that this was the process put in place to manage the booking of Mr O'Brien's patients for surgery.) This on occasion, resulted in the amending of a patient's urgency ranking for surgery, resulting in minor changes in dates for a patient's surgery. These changes linked to the clinical indication for surgery necessarily are the judgement of the clinician.

e. The assurance that these systems were working as anticipated was through the OSL and Head of Service who reported to the AD, and myself. The assurances were tested by an evaluation of all those patients on the waiting list for surgery with particular reference to those waiting for surgery due to a diagnosis of cancer. In the detailed review of long waiting patients undertaken on a frequent basis the length of waits against the referral date was reviewed as a matter of routine in order to identify any patients waiting outside their order by urgency and chronology.

f. Answered at e above.

g. The systems put in place with the OSL and Head of Service working with Mr O'Brien were successful as they removed the sole control of the scheduling of surgery from Mr O'Brien, and ensured that the scheduling rules were applied. The performance indicators were the evaluation of the list of patients waiting and performance reports setting out the Primary Targeting List (PTL) for surgery and how long each patient had waited.

h. Answered at g above.

50.8 Surgical operation of cystectomy (excision of the bladder)

a. The concern was raised by the Commissioner on 1st September 2010 through a letter sent to Dr Loughran, Medical Director, and copied to myself and Mr Mackle, AMD. Dr Corrigan drew the Trust's attention to a slightly increased rate of cystectomy for benign pathology in Craigavon Area Hospital when compared with the rest of the NI region. The number of patients identified was of the order of 2-4 per year. The letter from Dr Corrigan to Dr Loughran is attached. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100901_Re Urology, 20100901_Re Urology_ATTACHMENT 1, 20100901_Re Urology_ATTACHMENT 2*

b. The immediate step taken was a meeting held on 1st September between Dr Loughran, Mr Mackle, Mr Donaghy Director of HR and Organisational Development and myself. At this meeting it was agreed that a formal independent review of the appropriateness of the treatment of cystectomy was required. The action determined was to commence a 'local review' in line with the guidance provided by the document 'Maintaining High Professional Standards in the HPSS''. This process included a case note review of each patient who has undergone a cystectomy in the previous 10 years.

i Mr Young and Mr O'Brien were to be informed of the meeting, they were to be met by myself and Mr Mackle in the next few days to discuss both the review of cystectomies by an independent assessor, and the use of IV therapy. (The latter clinical issue is set out fully in point (iv)). A Memorandum sent by Dr Loughran on 2nd September 2010 to myself and copied to Mr Mackle records the discussion held on 1st September. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100902_Memo_DrRankin_PLlw*

ii The letter of 8 September 2010 from myself to the Director of HR and OD sets the ''context for screening of a performance concern regarding the surgical procedure of cystectomy''. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100908 Ltr to KD re Cystectomies*

iii The Terms of the Local Review –the Review -Brief--into the incidence of cystectomies was set out in a document to formalise and document the review process in order to share with Mr Young and Mr O'Brien. This document is located in *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100914_FW Confidential -- Urology letter from Dr Corrigan_ATTACHMENT 1*

iv The Review Brief was shared with Dr Corrigan as requested by the Chief Executive, in the attached email. *The relevant document can be located in S21 No 8 of 2022, 151. 20100911_Urology letter from Dr Corrigan*

v Both clinicians undertaking this procedure (Mr Young and Mr O'Brien) were kept informed of the process.

vi The Trust Board were informed of this screening of a performance concern through a written confidential briefing of September 2010 which was presented to the confidential section of Trust Board by the Director of Acute Services. *The relevant document can be located in S21 No 8 of 2022, 131. 20100930 Trust Board Confidential Briefing Note*

vii The issue of the operation of cystectomy was discussed at the Regional Review Implementation Group for urology in October 2010. The notes of the meeting reflected that all cystectomies for malignant and benign pathology would be referred to the Belfast Trust for surgery. Mr Young who represented the Trust clinically at the meeting emailed Beth Molloy, HSCB on 9. November 2010 to seek a correction to the notes where he recalled that there had been agreement that benign cystectomies would be performed locally, and that this had been clearly noted by Mr Mark Fordham, the independent consultant urologist to the review. Mr Young made the point that the skills needed to be retained locally for urologists and also for when it is required to work with the gynaecologists when they run into difficulty with the urinary tract.

viii Beth Molloy replied to Mr Young on 9 November 2010 stating that she would make the change requested.

ix Mr Fordham replied to Mr Young on 9 November 2010 stating that ‘’it would be reasonable for a patient requiring an operation such as cystectomy to have it performed by someone who is performing them regularly. However, as there are no ‘rules’ about operations for benign disease the surgeon can decide themselves.’’ *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101109 E re Notes of Uro Review Imp Mtg*

c. Answered at b above

d. Answered at b above

e. Answered at b above

f. The assurance through the Review process was concluded in March 2011. On 11 March 2011, an email was sent by Dr Loughran, Medical Director, to Dr Corrigan, Consultant in Public Health Medicine, HSCB, setting out the

updated position in relation to the Review of Cystectomies. In this letter he stated: ''You are also aware that the Southern Trust has looked at all benign cystectomies for the past 3 years with a view to making a judgement of the appropriateness of the decision making and operative indication.

i This internal review has been undertaken by our AMD for Surgery and Elective Care who is a general surgeon. Thirteen case notes have been examined.

ii This review is now at the point where we need an independent assessor, and have engaged a specialist urologist with no previous knowledge of the urology service in NI, who is expected to visit the Trust at the end of March. I will advise when this screening has been completed.''

iii The independent urologist was Mr Marcus Drake, Consultant urologist, University of Bristol. The Report by Mr Drake dated 25.3.2011 is attached. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin 20110311 E to D Corrigan re IV Antibio and Cystectomies and in S21 No 8 of 2022, 152. 20110325 Mr Marcus Drake Report.*

iv After the screening review of the case notes had been undertaken and a report made available by Mr Drake, a meeting was held on 29 July 2011 of the Medical Director, Director of Acute Services and the AMD. This meeting resulted in the email sent by Dr Loughran to Mr Mackle stating that after the meeting in 'Gillian's office this morning', it is now clear that the Marcus Drake Report is a final report and is ''somewhere between supportive and indeterminate''. He stated that 'it is my view that the Trust should do no more with this group of patients. I believe the case should be closed''. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110729 E Uro Review*

v On 5 August 2011 Mr Mackle sent an email to Dr Corrigan copied to Mr O'Brien, Dr Rankin and Dr Simpson setting out the conclusions reached by Mr Drake. He stated that ''essentially he did not have

any major concerns regarding the overall practice. He felt that this group of patients can be very complex and difficult to manage." *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110805 Cystectomies in the ST.*

g. The operation of cystectomy ceased to be undertaken in CAH as an elective procedure after August 2011. All patients requiring a planned cystectomy for either malignant or benign reasons were referred to Belfast. . (Prior to having full access to all the relevant documents, I clarified with Mr Mackle that the requirement to move the operation of cystectomy to the Belfast Trust included those for benign diagnoses.

i The operation of cystectomy as an emergency procedure, or as an unplanned procedure required during planned surgery, remained as a potential future occurrence but with valid reasons for the procedure

ii Such an example is patient Patient 71 who required planned surgery involving both a urologist and a gynaecologist in theatre together. The surgery took place in 2012 and, while cystectomy was not planned and was not on the theatre list as a planned procedure, it was deemed necessary when in theatre. (At my request Mrs Martina Corrigan clarified the date of patient Patient 71 surgery.)

h. Answered at g above.

50.9 Use of IV antibiotics

a.

i The concern regarding the use of IV antibiotics was raised with me by the Chief Executive at the meeting held on 1 December 2009. The use of IV fluids and IV antibiotics had become part of local urological practice for the treatment of recurrent UTIs over many years and had been identified in

spring 2009 during an audit of bed usage. It was considered to be unusual. At that time the Trust discussed with the clinicians involved and subsequently took expert advice. The therapy was deemed not to be evidence-based. About 35 patients were in the cohort at that stage, and it was agreed that each member of the cohort would be reviewed with a view to ceasing IV therapy.

ii When I came into post the cohort had reduced considerably to approximately 10 patients. The Commissioner had sought assurance that this treatment had ceased, and that no patient had central venous access – required for the injection of the antibiotics.

iii The actions taken were as follows:

A Request a further review of the cohort of patients by the consultants in order to cease the practice.

B Implement a process which required the consultant urologist to discuss a patient in respect of whom they wish to prescribe antibiotics with the Clinical Director and the consultant microbiologist, Dr Damani. This process would ensure that no patient was prescribed IV antibiotics inappropriately. The email of 6.7.2010 from the Head of Service to the Director, with an update on those patients still receiving IV antibiotics, identifies that none of these patients had been discussed with the Clinical Director and consultant microbiologist. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100706 E re IV Antibiotics Fluids*.

C In terms of assurance that these processes were or were not working, regular information on the cohort of patients previously receiving IV therapy was reviewed and any recent use of IV therapy highlighted. It was then checked if the decision to treat with this

therapy had been taken jointly in discussion with the Clinical Director and the consultant microbiologist. The attached email of 24 August 2010 identifies the patient cohort and the position of this cohort as at July 2010 and updated for August 2010. The list showed that both Mr Young and Mr O'Brien had continued the practice of IV therapy in both months. The numbers of patients treated with IV therapy in July was 13 (Mr O'Brien treated 9 patients and Mr Young treated 4 patients) and in August it was 3 patients (Mr O'Brien treated 2 patients and Mr Young treated 1 patient). The number of patients treated using IV therapy had reduced but was still continuing. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100824 e IV Antibiotics Fluids K.*

D In order to address this continuing practice the Director of Acute Services discussed this with the Medical Director. The timing of this coincided with the letter from Dr Corrigan of 1 September 2010 which identified an issue regarding the operation of cystectomy, in addition to concerns regarding the continuing use of IV therapy. Both issues were discussed at the meeting on 1st September between Dr Loughran, Mr Mackle, Mr Donaghy (Director of HR and Organisational Development) and myself. The letter from Dr Corrigan is attached. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100901_Re Urology, 20100901_Re Urology_ATTACHMENT 1, 20100901_Re Urology_ATTACHMENT 2* .

E On 2 September as an outcome of the meeting held the previous day, the Medical Director wrote to the Director of Acute Services seeking assurance that the practice of treatment with intravenous therapy had stopped completely. The Director of Acute Services wrote to the 2 consultant urologists on 2 September 2010 inviting both consultants to attend a meeting with myself and Mr Mackle regarding the continuing practice with 3 patients. *Relevant to Acute,*

Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100902 Ltrs to MY and AOB

F The Director sought an updated position on 2 September 2010 on patients receiving IV therapy prior to the meeting with the consultant urologists. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100902 E IV Antibiotics Fluids K.*

G The Director had to cancel the planned meeting due to unforeseen circumstances and wrote to both consultants seeking a new date to meet in the following week*. Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100903 Ltr to AOB, 20100903 Ltr to MY*

H While I have no recovered document regarding the subsequent meeting with the consultants and Mr Mackle, I wrote to Dr Loughran on 14th September 2010 to say:' "here are the documents Mr Mackle and I used to discuss with Mr Young and Mr O'Brien separately last Thursday. You may wish to use in your response to Dr Corrigan.'' *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100914_FW Confidential --Urology letter from Dr Corrigan, 20100914_FW Confidential -- Urology letter from Dr Corrigan_ATTACHMENT 1, 20100914_FW Confidential --Urology letter from Dr Corrigan_ATTACHMENT 2 .*

I A process was implemented through the Urology Services Co-ordinator to bring to the Head of Service or AD attention if a patient had been booked to come into the ward for IV antibiotics. Attached is an email from the Urology Services Co-ordinator regarding a discussion with Mr O'Brien regarding 2 patients and an amendment to the pathway which supported oral antibiotics out of hospital. In response to this email, Heather Trouton reminded her that any

patient booked for IV therapy on the ward was to be notified prior to arranging admission. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100910 E re Pts for IV Fluids Antibio K*

J A new pathway was set out and agreed with the consultants in which the nurse-led service saw this cohort of patients regularly and arranged for oral antibiotics through the community co-ordinator for antibiotics. The new pathway is attached and explicitly states: ‘’Please note that there are unlikely to be circumstances accepted by the Commissioner or the Southern Trust where the use of IV fluids and antibiotics is an evidence based or acceptable treatment for a patient with recurrent UTIs’’. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100910 E re Pts for IV Fluids Antibio K*

K Evidence of the fact that the urology service (in this instance the inpatient ward, and the urology services coordinator) was fully alert to the admission of patients requiring IV therapy is found in the email of 14 September 2010 when the Head of Service alerted the AMD, AD, Director and CD about a patient who had been admitted to the ward with pyelonephritis which required treatment with IV therapy. It was identified that there had been no discussion with the CD and the consultant microbiologist about this patient. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100914 E re IV Fluids Antibio* The AD followed this up and the fact that the CD should have been involved in the decision. She received a reply from the Urology Services Coordinator that the patient’s renal function had been deteriorating and treatment had to be started, but that she would ensure it did not happen again. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100916 E re IV Fluids Antibio.*

L In September 2010 I wrote to Mr O'Brien regarding a different issue and took the opportunity to advise Mr O'Brien that he was not to advise patients whom he had previously treated with IV therapy, of their new pathway of treatment until after the necessary discussion with the CD and consultant microbiologist. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100927 Ltr to Mr AOB re Pts referred to Belfast.*

M Evidence that the process set in place to ensure the best treatment for patients is set out in the minutes of the multidisciplinary case discussion held on 3 patients sent by Shirley Tedford Urology Services Coordinator to Ms Sloan, Mr O'Brien and Dr Rajendra. The notes of the multidisciplinary meeting were sent by myself to Dr Loughran on 21 October 2010. *The relevant document can be located in S21 No 8 of 2022, 153.-155. 20101021 E Progress with Cohort of Patients – A2*

N Further corporate action followed evidenced by the following actions and emails regarding same:

I October 2010 - Dr Damani consultant microbiologist to Mr Young regarding the prescribing of antibiotics by junior medical staff and trainee registrars in urology. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 201010289 E re Ltr to M Young*

II 18.11.2010 - Dr Damani to the Medical Director and the Director of Acute Services regarding good compliance with antibiotic prescribing guidelines by the general surgical wards. He indicated that they would be starting antibiotic ward rounds in urology the following week. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101118 Surg Antibiotic Ward Round.*

O The Implementation of the new pathway without resort to IV therapy was not always accepted easily by all patients. The example of this is set out in the email of 23 November 2010 from a patient, Shirley Gray, to Shirley Tedford, Urology Services Coordinator. In response the AMD stated that, if Mr O'Brien disagreed with the process, then he was to raise this with the Director of Acute Services, the Medical Director and himself. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101203 E re Pt SG.*

P For assurance there was continued monitoring to check on the cessation of IV therapy by both consultants. Examples of occasional breaches to the required procedure for a discussion on each patient whom Mr O'Brien wished to treat with IV therapy are evidenced through emails from 15 June 2011, 30 January 2012:

I On 15 June 2011, Mr Mackle wrote to Mr O'Brien regarding the requirement that a meeting was required with Ms Sloan, the CD, and a microbiologist if he wished to admit a patient for IV antibiotics. He recalled a meeting to discuss this practice with Mr O'Brien the previous week, and a letter following a previous meeting with himself and the Director about the same issue. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110615 E to AOB re Antibiotics and Urp Pts*

II On 7 February 2012, Mr Mackle wrote to Mr Hall, CD, copied to Mr O'Brien regarding a patient who had been admitted and given IV therapy without a multidisciplinary discussion. Hr Hall was asked to formally investigate this incident. The email is attached. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20120207 E IV Antibiotics.*

Q An example of good practice is set out in the email of 5 July 2012 when the surgical admission of a patient for a urology procedure was detailed through a full multidisciplinary discussion prior to admission. The patient was infected with both Klebsiella and MRSA and such a detailed plan was paramount for the patient's safety and care.

b. As outlined at a above.

c. As outlined at a above.

d. As outlined at a above.

e. As outlined at a above.

f. As outlined at a above.

g. The system and agreement with the consultants put in place was largely but not completely successful. The number of patients who were subsequently treated with IV therapy were of the order of one or two per year. Mr O'Brien required repeated reminders of the process to be followed such as the meeting chaired by myself on 9th June 2011 involving Mr O'Brien. The Issues and Actions from the meeting on 9th June 2011 are set out in the Memo of 1st July from Mrs Trouton, AD to Mr O'Brien. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110701 Actions from Mtg to AOB K.*

h. As outlined at a above.

50.10 (v) Referral of patients requiring prostatectomy or cystectomy for malignant and benign conditions to the Belfast Trust and the implementation of the regional MDM (Multidisciplinary Meeting)

a. The regional review implementation determined in 2010 that all planned radical pelvic surgery for malignant and benign conditions would be undertaken in the Belfast Trust. This required the consultants in other Trusts to refer these patients to the Belfast Trust once it had been determined that radical pelvic surgery was required. This process of referral to another clinical unit within a speciality is usually undertaken through the regional MDM process where a patient is discussed and the collective decision recorded and implemented. The receiving consultant or clinical unit has therefore agreed the referral of the patient.

b. The members of the MDM are necessarily the consultants in the specialty, radiologists presenting the diagnostic test results, pathologists presenting on the pathology of the malignancy, the oncologists setting out the chemotherapy and radiotherapy required for the patient before or after surgery. All these specialties require to the present for an effective MDM process. The MDM process also discusses the discharge of the patient back to the original Trust for follow up care.

c. After the regional decision was taken to move all radical pelvic surgery to the Belfast Trust, there were difficulties setting up the regional MDM process through the Belfast Trust. This was due to the lack of a consultant oncologist for the urology service at that time within Belfast. The Southern Trust set up the local MDM to test systems and prepare for linkage with the Belfast Trust.

d. In May 2010, the HSCB issued the document ‘’Referral Guidelines from NICAN Regional Urology Network’’ as agreed at 8.10.2009. This document sets out clearly those conditions to be managed locally and those conditions to be referred to the Belfast Trust. The Director sent these to the AD for Surgery and Elective Care and the AD for Cancer and Clinical Services. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100517 E re Referral Guidelines Uro MDTs*

e. The difficulties setting up the local MDM process and linking to the regional process are set out in a letter from Mr Akhtar, Consultant Urologist (leading on the local MDM process), to the Head of Cancer Services on 8 July 2010. The

substantive reply from the Head of Cancer Services sets out the progress being made against each issue. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100708 Lt re Uro MDM Issues K, 20100728 Response to Mr Akhtar K*

f. On 19 August 2010, Mr Young, Consultant urologist, raised with the AD for Surgery and Elective Care the issue of confusion regarding patients needing radical prostatectomy and referral to the Belfast Trust. He denied seeing any letter requiring this to be the position. Mr Mackle AMD agreed that there was a lack of clarity. The AD took action in writing to Beth Molloy, HSCB regarding the need for clarity. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100819 E re Uro Surgery*.

g. On 9 September 2010, the Director held a meeting with senior staff to review 'where we are' in the urology cancer pathway implementation as part of the Team South implementation. This meeting also updated on the details of the local MDM, links to the regional MDM and the appointment of a consultant oncologist for urology in the Belfast Trust. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100909 Uro Info AP*.

h. On 10 September, the AD for Surgery and Elective Care spoke with Beth Molloy, HSCB, regarding the transfer of radical surgery to Belfast, identifying a lack of clarity around the referral process and the MDM would not occur until the oncologist was appointed in October. This was agreed by Beth Molloy, HSCB. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100910 E Uro Oncology.*

i. On 17 September 2010, the AD for Surgery and Elective Care emailed Beth Molloy, HSCB, copied to Dr Corrigan, HSCB, identifying 2 patients who required cystectomy due to malignancy. The recent agreement of transferring patients from October when the oncologist was in post was now not possible as the oncologist was only coming into post in December. Dr Corrigan responded stating that' "the patients needed to be referred asap to the Belfast service''. The AD responded

saying that the patients would be referred that afternoon to the Belfast Trust. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100917 E re Urgent Cystectomies K*

j. The Director wrote formally to Mr O'Brien after receiving information that he had written to 3 patients, the GP and Mr Hagan Consultant Urologist, Belfast Trust, indicating to the patient, (in advance of a care pathways being agreed), his preferred management of the case. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100927 Ltr to Mr AOB re Pts referred to Belfast*.

k. Given the issues previously set out and for assurance that all patients who should be referred to the Belfast Trust had been referred, the Director sought an update on the position from the Head of Service on 30 September 2010. The update identified that 5 patients had been transferred successfully; the first link between the local and regional MDM had taken place and all the theatre lists in CAH has been filled with other urgent patients (after release when patents were transferred to Belfast*). Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100930 E re Belfast Pts Update.*

l. In August 2011 I became aware that there may have been a lack of understanding regarding cystectomy for benign reasons. For the avoidance of doubt I wrote to the 3 consultant urologists on 7 September 2011, despite the fact that this position had been fully clarified at the meetings regarding the implementation of Team South. This letter is attached. *The relevant document can be located in S21 No 8 of 2022, 156. 20110907 E For Comment Correspondence to Urologists A.*

m. As I was about to go on summer leave I also took the step of emailing the Medical Director and Director of HR and Organisational Development seeking a meeting to discuss this issue. The email of 5 September 2011 is attached. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110905 E re HR Mtg re Consultant Urologist K.*

n. The issues regarding the presence of an oncologist from the Belfast Trust attending the MDM continued until the end of 2011, as evidenced by emails from Mr Akhtar to the Director and the Director to the Director in Belfast Trust, Caroline Leonard. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110810 Oncologist for Uro MDM, 20111004 E re Uro MDT, 20111006 E re Uro MDT*

50.11 Service capacity gap which impacted on the waiting time for patients for outpatient clinics, day case surgery, inpatient surgery and review outpatient appointments; and breaches of the 31 and 62 day standards for patients with diagnosed cancer.

a. Each of these areas of clinical activity if delayed can create risk for patients or impact on their quality of life. Each area of clinical activity by specialty was identified in the weekly performance reports which were produced by the Performance and Reform Directorate. These reports were used by the Director of Acute Services in the weekly performance meeting with ADs and Heads of Service, and the report was used at the weekly SMT meeting. The data was also reported in a written report at a higher level to Trust Board on a monthly basis with particular focus on services which were breaching the time standards or their performance showed a worsening position.

b. Given the capacity gap in urology when I came into post, in part due to the significant increase in referrals from GPs, the issue of performance to meet the time standards was always on the agenda for action. The action had 2 strands:

i Ensuring that the Trust made best use of the resources it had. This was the responsibility of the Director of Acute Services, with support from the Performance and Reform Directorate.

ii Demonstrating to the Commissioner and seeking agreement for additional resources on a non-recurrent basis for additional in-house

activity or referrals to the independent sector. The regional review of urology when implemented would bring additional recurrent resources.

c. With the pressures in the urology service, the Chief Executive in discussion with the HSCB sought the support of NHS IMAS (Interim Management and Support) in December 2009. Ms Sarah Tedford from South West NHS England worked with the Trust during the first 3 months of 2010 to provide an analysis of the work needed and learning from her previous experience. This resulted in some immediate actions (email of 29 January 2010), the attached final Action Plan (email of 29 April 2010), and the closure letter to Hugh Mullen, HSCB (email of 29 April 2010). *The relevant documents can be located in S21 No 8 of 2022, 148. 20100129 Urology Action Plan Update, 149. 20100129 Urology Action Plan Update A1, 150. 20100129 Urology Action Plan Update A2, 145.-147. 20100429 Closure Report S Tedford – A2.*

d. The examples of the ongoing work including action planning, specific actions taken where information identified additional measures were needed, and assurance that plans were translating into the reduction of waiting times are set out below:

i Emails of 27 and 30 April 2010 between Beth Molloy, HSCB and Paula Clarke, Director of Performance and Reform regarding the use of slippage or non-recurrent funding for additional in-house sessions to maintain the waiting times as at 31 March 2010 for patients waiting for urological diagnostic investigation or outpatient review. *The relevant document can be located in S21 No 8 of 2022, 157. 20100427 Regional Urology Review HM (APPENDICIES REPEATED IN NEXT EMAIL), 158. 20100430 E re Regional Uro Review k*

ii Development of the Action Plan for Patient Pathways to address Urology Review Backlog 2010. *The relevant document can be located in S21 No 8 of 2022, 60. 20100415 E re Review Backlog HT A.*

iii The Director led on one of the actions in the Review Backlog Plan. Details are set out in response to Question 13 (lll) *20100727 Mtg re Uro Primary Care*

iv Work to address the breaches in the 31 and 62 day pathway for patients with cancer. Email from Aldrina Magwood, AD Performance and Reform to AD Surgery and Elective Care regarding the tasks needed and the priority of these. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100922 Uro CA Pathway.*

v Acting on an issue raised by one of the urologists at the Urology Implementation meeting on the number of cystoscopies undertaken by session. Agreement to increase the number per session as there were no constraints was sorted the following day. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101005 E re Cystoscopies*

vi Actions taken to address long wait cystoscopies and plans to address these. Email from the Head of Service to the AD and Director of 4.11.2010. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101104 Uro Waits.*

vii In preparation for the weekly meeting with the consultants regarding the Team South Implementation plan, there were occasions when the opportunity had to be taken to discuss significant pressures in the service and long waiting patients. The Director requested an update on the pressures from the Head of Service prior to the meeting. The detailed response is set out in the email of 6 December 2010 from the Head of Service to the Director. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101206 Uro Issues re Long Wait Pts*.

viii Action taken by the Head of Service contacting Mr O'Brien regarding breaches and seeking a plan for each patient. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110406 E re AOB Cancer Breaches.*

ix Prior to the end of the contracting year at the end of March, there was pressure to ensure that all those patients waiting within the agreed time backstop with the HSCB by specialty were actually seen and treated. The emails of 11 February 2013 and 7 March 2013 demonstrate some of the pressures to be addresses to achieve this within urology. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20130211 PTL of Pts, 20130211 E re PTL patients 2, 20130307 E re action issues on SMT perf.*

50.12 Failure to read test results when received before filing patient records.

a. A significant clinical incident occurred regarding the retaining of a swab after surgery on 15th July 2009, which was only identified when the patient was admitted as an emergency in July 2010. The post operative CT scan was undertaken in October 2009 as planned and identified an abnormality. Although not identified as a retained swab, one of the differential diagnoses was recurrence of the patient's cancer. A Root Cause Analysis (RCA) review of the case was required and undertaken. The final report of the RCA was taken to SMT in December 2011. The RCA identified that due to a backlog in outpatient reviews, the patient was not seen in outpatients in the 12 months after surgery, at which stage she was admitted as an emergency.

b. A draft of the report had been shared with the Commissioner as required and this resulted in the letter from Dr Corrigan to Mrs D Burns, AD for Clinical and Social Care Governance, on 14 November 2011. In this letter, Dr Corrigan states that ''the report records that it was the practice of the patient's consultant urologist not to review laboratory or radiology reports until patients attended for their outpatient appointment. … I believe this highlights an area where the Trust would have considered action to be appropriate. …. I am writing to ask whether this issues has been taken forward, for example by considering whether there is a need for a formal Trust policy, such as review of all test results by medical staff before filing, whether or not the patient is awaiting outpatient review.''

c. While the draft report was formally shared with Dr Corrigan, resulting in her letter of 14 November 2011, the issue of medical staff reviewing test results before filing, whether or not the patient is awaiting an outpatient appointment was understood by the Trust as a clinical risk and as learning from the RCA prior to the receipt of this letter. The Trust took the necessary action to understand the current practice of medical staff in each speciality. In the Directorate of Acute Services this was to discuss and assess the risk in each specialty through discussion with the consultants at specialty meetings. The AD for Surgery and Elective Care sent an email on 25 July 2011 regarding the issue to all Heads of Service for further assurance (after previous discussion) that test results were being read as soon as the results were available. The Head of Service for urology sent this email to the consultant urologists on 27 July 2011 and this resulted in an email response from Mr O'Brien on 25 August 2011. In this email Mr O'Brien raised 11 points regarding the potential impacts of reading the results of tests when they are received. This resulted in the email from Mr O'Brien being forwarded to the AMD, Mr Mackle, who raised this with myself identifying a governance issue as Mr O'Brien does not review the results until the patient appears back in outpatients.

d. A conversation followed with Mr O'Brien without success in terms of changing his clinical behaviour. The email sent by myself to Mr Mackle, the AD and Head of Service of 8 September outlines a high level plan as I was going on summer leave. The AD replied to state that she would look at the processes in other specialties in order to present current working processes in other areas should the need occur. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110826 E re Results and Reports of Investigations, 20110908 E re Results and Reports of Investigations, 20111209 SAI DB K, The relevant document can be located in S21 No 8 of 2022, 159. 20101221 RCA Retained Swab, 160. 20101221 RCA Retained Swab A1.*

e. Assurance that behaviour had changed was very difficult at that stage as there was no mechanism to record that any consultant had read the test results they had ordered at a point in time. A consultant could routinely order over 100 tests –both blood tests and diagnostic tests—in a week. Both the laboratory system and the

regional radiology system did not report on results which had been left unread at a certain time after the report on the test was made available. The Trust undertook the implementation of the reporting process for the laboratory i.e. blood test results. In relation to the need for a report from the regional radiology system, a software upgrade was sought through the Business Services Organisation (BSO) to enable such a report to be made available. From memory the facility for a consultant to 'tick a box' when they had read a radiology result was made available in 2012. (The information in the last sentence was confirmed by Mr Mackle at my request.) A report on which results had been left unread was then feasible. However I do not recall this being made available during my tenure.

f. This resulted in the reliance on the consultant behaviour to read test results in relation to radiology when they were received, without a system of assurance at that point in time.

50.13 Disposal of some patient notes and information in the bin in a consultant's office.

a. This disposal of some notes and charts from a patient file being placed in the office bin was identified by a member of support staff and reported, which prevented the patient notes being destroyed. The office in question was that of Mr O'Brien. The notes found in the office bin included items such as Fluid Balance charts from previous admissions. As a result there was a Disciplinary Investigation of Mr O'Brien in relation to this concern. (Mr Mackle confirmed the detail contained in the previous sentences as I was unable to fully recall this.) This was set up according to the Trust Policy for such an event in June 2011 and the panel consisted of Mr Robin Brown, Clinical Director Surgery and Consultant Surgeon Daisy Hill Hospital, and Mrs Zoe Parks, Senior Manager Medical HR. In this process Mr O'Brien admitted and agreed that it was inappropriate that he had sought to dispose of patient information. He stated it was in error and would not do this again.

b. The result was that Mr O'Brien was issued with an Informal Warning from Mr Brown on 19 August 2011. I attach both the Report of the Disciplinary Investigation and the Issue of the Informal Warning from Mr Brown on 19 August 2011. Located in Relevant to HR, reference no 63, 20110600 Ref 63 Disciplinary Report Mr AOBrien, 20110819 Ref63 Issue of InformalWarning MrAOBrien.

c. I was not involved in any part of this process, but was aware of the incident, the investigation process, and the result of the disciplinary process.

d. The monitoring of whether such an event would recur is dependent on staff such as the original member of support staff who reported the incident. It was assumed that, with an informal warning on his record, Mr O'Brien would not repeat the event. These were the means by which the agreements in place were taken forward.

e. There were no repeat events during my tenure.

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

(a) **properly identified,**

(b) **their extent and impact assessed,**

(c) **and the potential risk to patients properly considered?**

51(a)(i) The issues set out in in response to Question 50 were identified after the event and in one case, the SAI, it was some time after the event. The latter issue identified some time after the event was the failure to read test results prior to the filing of patient notes. This was identified during the investigation into a serious adverse event which took place in 2009. The details are set out, in response to Question 50, to include the potential risk to patients and the steps taken to mitigate any future such

events across the whole consultant body. The issue of failing to read test results was only picked up because of the SAI as no system was then available to identify this risk.

51(a)(ii) In relation to the performance metrics, scheduling of patients for surgery and triaging of red flags identified, the reporting systems available to the Trust were the means by which the problem was identified. These issues were properly identified.

51(a)(iii) The use of IV therapy was identified prior to my tenure and I cannot comment on whether it was properly identified.

51(a)(iv) The issue of the frequency of the operation of cystectomy was identified by the Commissioner in relation to the analysis of the expected number of specific surgical procedures for a population. This issue was properly identified through analysis of the population data by the Commissioner.

51(a)(v) The issue of disposal of notes was identified by a vigilant member of support staff who recognised the significance of what she had found in a consultant's office. With a manual record this would be the only way of identifying this issue and was therefore appropriately identified.

51(a)(vi) The issue of communicating with patients a preferred treatment pathway prior to referral to another consultant in the Belfast Trust was identified after 3 such discussions had taken place. There was no system in place to identify this occurrence.

51(a)(vii) This demonstrates the range of methods and systems involved in identifying concerns or the lack of systems at the time of occurrence

51(a)(viii) Most of the issues, once identified, were quantified in terms of the number of patients affected and over what time period they had been affected. This included triage of red flag referrals, surgical operation of cystectomy, use of IV therapy, referral of patients requiring radical pelvic surgery to Belfast, service capacity gap and 31 and 62 day cancer pathway breaches. In all of these cases the subsequent monitoring was already, or soon became, a permanent process within acute services.

51(a)(ix) The potential risk to patients, either as a potential risk to their length of life or their quality of life, was recognised in undertaking the actions detailed in response to Question 50.

[52] What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q66 will ask about any support provided to Mr. O'Brien).

52.1 I am not aware of additional support offered to urology staff, although offers may have been made at specific times. However the urology unit, as with many other specialties in the Trust, was a small specialist team who had daily contact with their Head of Service and ease of access to their AD, Director, Assistant Director of HR based within the hospital, and access to Occupational Health on the Craigavon Area Hospital site.

[53] Was the urology department offered any support for quality improvement initiatives during your tenure?

53.1 The Trust set out key corporate approaches for quality improvement in which all services across the Trust could engage. This was initially 'Best Care Best Value' in 2010 and an AD in Acute Services was available, with additional support from Performance and Reform, to work with services seeking to undertake specific quality improvement projects.

53.2 In time the 'Best Care Best Value' approach moved to the 'LEAN' methodology, a recognised method of quality improvement with a related academy already established in the UK. Again, details of this approach were widely circulated and discussed at team meetings at all levels. It was not imposed on any service, but rather the service was asked if they wished to have support to take a quality improvement

project forward. The achievement of quality improvement projects was celebrated in the Trust at showcase sessions for staff.

53.3 I have no recall of urology participating in quality improvement projects as set out above, but recognise that this may be a lack of memory on my part at this remove.

53.4 However, it would in my view be reasonable to view the implementation of Team South Urology, including the need for new clinical pathways for patients, as, in effect, a very large quality improvement project, resulting in significant improvements for patients.

Mr. O'Brien

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

54.1 My role as Director meant that I held responsibility for the quality of care provided by Mr O'Brien as with all consultants working in acute services. The quality of care included timely access to assessment and treatment and the safety of the care provided. As mentioned already above, I took up post as Director of Acute Services on 1 December 2009 and I first met Mr O'Brien on 7 December 2009 when he attended a meeting with myself, Dr Loughran (as Medical Director) and Mr Mackle (as AMD). Over the following 12 -16 months, with the implementation of Team South and the weekly/fortnightly meetings held chaired by myself, I met Mr O'Brien most weeks and sometimes twice a week.

54.2 Once the implementation plan was agreed and detailed job planning underway through the Clinical Director, I would not have seen Mr O'Brien weekly, but perhaps monthly at Medical Staff meetings held in the hospital. However he had access to see me at any time if needed and I also could arrange to see him if required.

Evidence of many additional meetings involving Mr O'Brien have been set out in previous responses to questions (e.g., Question 50).

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

55.1 I was responsible for the development of the job plans for the new 5 consultant model. This included getting agreement with the HSCB externally and the consultants in post in the Trust before going to recruitment on the additional posts. My understanding is that both of the existing consultants, once the 5 consultant job plans were agreed, chose which job plan they wished to undertake.

55.2 I did not engage personally with Mr O'Brien on the formulation of his job plan, which was one of the 5 job plans. The details of the total activity required from the service in terms of new and review outpatient appointments, day case surgery and inpatient surgery numbers were agreed by the Director of Performance and the HSCB. This formed the basis of job planning where broadly equal numbers of patients would be seen by each of the 5 consultants.

55.3 The discussions on the detail of job plans across all 5 consultants was undertaken through the AMD and Clinical Director with the Clinical Lead for urology Mr Young, supported by a senior manager from Performance and Reform and the Head of Service. This was the usual process. Mr O'Brien was also involved in this process.

55.4 Any issues raised during the process of developing and agreeing the 5 job plans were discussed and involved the HSCB relevant staff as needed.

55.5 The difficulties in reaching agreement with Mr O'Brien regarding his previous job plan (prior to taking a new job plan as part of the 5 consultant model) were encountered and required mediation. The details are set out in response to Question 46.

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

56.1 Some of the issues surrounding the urology service and Mr O'Brien in particular were made known to me on my first day in post 1 December 2009. This was through a meeting chaired by the Chief Executive which included the Medical Director, the AMD and AD for Surgery and Elective Care, Director and AD for Performance and Reform.

56.2 The issues raised in that meeting in relation to Mr O'Brien are detailed in response to Question 28. This meeting discussed demand and capacity, the practice of using IV antibiotics, triage of referrals, red flag requirements and chronological management of lists for theatre.

56.3 At this meeting or subsequently, I may have been made aware of how long each issue had existed, but I cannot now recall this information. The Action Notes of the meeting held by the Chief Executive on 1 December 2009 are attached. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.*

56.4 The issue of the surgical operation of cystectomy was made known to the Trust through a letter from Dr Corrigan, Consultant in Public Health Medicine, PHA, of 1st September 2010. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100901_Re Urology, 20100901_Re Urology_ATTACHMENT 1, 20100901_Re Urology_ATTACHMENT 2 .*

56.5 The failure to read test results prior to filing the patient's notes was identified during the Root Cause Analysis into the serious adverse incident of a retained swab

at surgery. The clinical incident happened in 2009, and the report was completed in October 2010 after I, as Director, had requested the RCA. The issue of Mr O'Brien not reading test results prior to patient filing was identified in 2010 and immediate actions put in place. *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110826 E re Results and Reports of Investigations*

56.6 The issue of discussing a treatment plan with patients prior to their agreed referral to the Belfast Trust only occurred at the point of referral of these initial patients in September 2010. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100927 Ltr to Mr AOB re Pts referred to Belfast.*

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

57.1 For ease of reference, the information sought in Questions 57 and 58 will be set out together for each instance of raising a concerns or concerns.

57.2 The meetings which considered concerns about Mr O'Brien, whether with him or with others, are set out below with all the details available at this point in time. The meetings and concerns are set out in chronological order.

a. <u>December 2009.</u>

i The 1 December 2009 meeting was regarding a range of governance issues in urology and was chaired by the Chief Executive, with the Medical Director, AMD, AD, Acting Director of Performance and Reform, AD of Performance, Interim Director of Acute Services. The range of issues discussed and

further detail is set out in response to Question 28 and at the beginning of the response to Question 50.

ii The action agreed at this meeting was that, if there was no compliance, correspondence would be sent regarding the implications of a referral to NCAS if appropriate clinical action was not taken.

iii The Action note of this meeting is attached. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.*

iv Two follow-up meetings occurred after the 1 December meeting. They were:

A 7 December follow up meeting with Mr Young, Consultant Urologist. Key points of discussion are set out. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service.*

B 7 December follow up meeting with Mr O'Brien, Consultant Urologist. Key points of discussion and the necessary actions are set out with agreed actions by Mr O'Brien, to review current patients waiting to determine if urgent or routine, and to put all urgent patients on to immediate lists. Other immediate actions with key staff are outlined. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Urology Mtg*.

b. <u>September 2010</u>

i A concern was raised by the Commissioner on 1st September 2010 through a letter sent to Dr Loughran, Medical Director, and copied to myself and Mr Mackle, AMD. Dr Corrigan drew the Trust's attention to a slightly increased rate of cystectomy for benign pathology in Craigavon Area Hospital when compared with the rest of the NI region. The number of patients identified are of the order of 2-4 per year. The letter from Dr Corrigan to Dr Loughran is attached. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100901_Re Urology,*

20100901_Re Urology_ATTACHMENT 1, 20100901_Re Urology_ATTACHMENT 2 .

ii The immediate step taken was a meeting held on 1st September between Dr Loughran, Mr Mackle, Mr Donaghy Director of HR and Organisational Development and myself. At this meeting it was agreed that a formal independent review of the appropriateness of the treatment of cystectomy was required. The action determined was to commence a 'local review' in line with the guidance provided by the document 'Maintaining High Professional Standards in the HPSS''. This process included a case note review of all patients who had had a cystectomy in the previous 10 years.

iii The letter from the Commissioner also identified the continuing use of IV therapy, which the Director of Acute Services was planning to discuss with the Medical Director.

iv Both issues were discussed at the meeting on 1st September between Dr Loughran, Mr Mackle, Mr Donaghy Director of HR and Organisational Development and myself.

v Mr Young and Mr O'Brien were to be informed of the meeting, they were to be met by myself and Mr Mackle in the next few days to discuss both the review of cystectomies by an independent assessor, and the use of IV therapy. A Memorandum sent by Dr Loughran on 2nd September 2010 to myself and copied to Mr Mackle records the discussion held on 1st September. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100902_Memo_DrRankin_PLlw.*

vi The letter of 8 September 2010 from myself to the Director of HR and OD sets the ''context for screening of a performance concern regarding the surgical procedure of cystectomy''. *Relevant to Acute, Evidence Added or*

Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100908 Ltr to KD re Cystectomies.

vii The Terms of the Local Review –the Review Brief--into the incidence of cystectomies was set out in a document to formalise and document the review process in order to share with Mr Young and Mr O'Brien. This document is attached. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100914_FW Confidential --Urology letter from Dr Corrigan_ATTACHMENT 1*

viii The Trust Board were informed of this screening of a performance concern through a written confidential briefing of September 2010 which was presented to the confidential section of Trust Board by the Director of Acute Services. *S21 No 8 of 2022, 132. 20100930 Trust Board Confidential Briefing Note,*

ix The ''Local Review '' was completed in March 2011 with the final report by the independent expert Mr Marcus Drake, Consultant Urologist, University of Bristol. The Report by Mr Drake dated 25.3.2011 is attached. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin 20110311 E to D Corrigan re IV Antibio and Cystectomies and, in S21 No 8 of 2022, 152. 20110325 Mr Marcus Drake Report*

x After the screening review of the case notes had been undertaken and a report made available by Mr Drake, a meeting was held on 29 July 2011 of the Medical Director, Director of Acute Services and the AMD to discuss the final report by Mr Drake. This meeting resulted in the email sent by Dr Loughran to Mr Mackle stating that after the meeting in 'Gillian's office this morning', it is now clear that the Marcus Drake Report is a final report and is ''somewhere between supportive and indeterminate''. He stated that 'it is my view that the Trust should do no more with this group of patients. I believe the case should be closed''. *Relevant to Acute, Evidence Added or*

Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110729 E Uro Review.

xi On 5 August 2011 Mr Mackle sent an email to Dr Corrigan copied to Mr O'Brien, Dr Rankin and Dr Simpson setting out the conclusions reached by Mr Drake. He stated that ''essentially he did not have any major concerns regarding the overall practice. He felt that this group of patients can be very complex and difficult to manage'. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110805 Cystectomies in the ST.*

xii The operation of cystectomy ceased to be undertaken in CAH as an elective procedure after August 2011. All patients requiring a planned cystectomy for either malignant or benign reasons were referred to Belfast. (Prior to full documentation being available to me, Mr Mackle confirmed at my request whether this requirement included referral of those patients requiring cystectomy for benign reasons.)

xiii In relation to the operation of cystectomy and the Trust's response further detail is set out in response to Question 50 (iii).

xiv After the meeting on 1st September 2010 with reference to the continuing use of IV therapy, the following action was taken.

A On 2 September as an outcome of the meeting held the previous day, the Medical Director wrote to the Director of Acute Services seeking assurance that the practice of treatment with intravenous therapy had stopped completely._The Director of Acute Services wrote to the 2 consultant urologists on 2 September 2010 inviting both consultants to attend a meeting with myself and Mr Mackle regarding the continuing practice with 3 patients. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100902 Ltrs to MY and AOB*.

B The Director sought an updated position on 2 September 2010 on patients receiving IV therapy prior to the meeting with the consultant urologists. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100902 E IV Antibiotics Fluids K.*

C A new pathway was set out and agreed with the consultants in which the nurse-led service saw this cohort of patients regularly and arranged for oral antibiotics through the community co-ordinator for antibiotics

D The Director wrote to Mr O'Brien regarding this issue of discussing treatment pathways with patients prior to their referral to the Belfast Trust for treatment and took the opportunity to advise Mr O'Brien that he was not to advise patients whom he had previously treated with IV therapy, of their new pathway of treatment until after the necessary discussion with the CD and consultant microbiologist.
Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100927 Ltr to Mr AOB re Pts referred to Belfast.

E There is further detail on this issue set out in response to Question 50 point (iv).

c. <u>22 October 2010</u>

i After further discussion at the weekly/fortnightly meeting regarding the implementation of Team South Urology, I wrote to Mr O'Brien regarding referral triage and amending clinic templates to reflect different new to review ratios.

ii The letter from myself to Mr O'Brien dated 22 October 2010, indicates a previous related letter from myself and Mr Mackle to Mr O'Brien, to which

Mr O'Brien has replied on 27th September 2010. In my letter of 22 October 2010, the following points are made:

A a commitment to triage referrals within a week and red flag referrals within a day, conditional on the cohort of consultants being sustained

B refusal to amend clinical practice to undertake new appointments in 20 minutes and review appointments in 10 minutes

C lack of undertaking to reduce new to review ratios to 1:2 as an interim step through clear discharge pathways with primary care

D ''we are writing to ask you to reconsider these issues which have been in discussion over many months. Please confirm by Thursday 28th October your agreement to amend clinic templates.''

E The letter attached sets the context of the meeting and the outcomes of the meeting held on 27th September 2010. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp*

d. 9th June 2011

i A meeting was chaired by myself on 9th June 2011, which was attended by Mr O'Brien, Mr Mackle AMD and Mrs Trouton, AD. There were a range of issues discussed including:

A Detail of Mr O'Brien's current job plan to be sent to Mr Mackle in order to create a new job plan as per Trust action for all consultants by the end of June 2011

B The review backlog. The note of the meeting states ''Also to ensure that responsibility is taken to manage all outpatient appointments in

such a way as to only review those who clinically require review and hereby reduce the formation of a review backlog unnecessarily.'' ''A discussion was also had regarding appropriate communication with patients who have had their review appointment delayed due to the current backlog of review appointments.''

C Patient admission for surgery, to be on the morning of surgery and not prior to surgery for IV fluids and IV antibiotics.

D Urodynamics and the time required by Mr O'Brien to review the results of this test

E Pooled lists in order to manage all daycase patients in a chronological manner

F Cancer pathway and the issue of Specialist Interest in Urology.

G The Issues and Actions from this meeting held on 9th June 2011, sent on 1 July 2011 to Mr O'Brien is attached. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110701 Actions from Mtg to AOB K.*

e. Early September 2011

i I became aware that there not have been a crystal clear understanding of the Commissioner's position regarding the procedure of planned cystectomy for benign pathology. This had partly originated by the response from Beth Molloy, HSCB in November 2010 when she had appeared to accept Mr Young's challenge to the minutes of the regional meeting on 1 October 2010 with regard to cystectomy for benign disease. This however had been addressed in the Trust weekly meetings.

ii As a result I wrote to the 3 consultants to ensure absolute clarity and asking them to make ''the necessary referral to Belfast for any patient who in your judgement requires an elective cystectomy as this procedure has not been commissioned as part of the urology service in the Southern Trust.'' The letter of 7th September 2010 is attached. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp, 20101022 Ltr to MA Reg Uro Imp, 20101022 Ltr to MY Reg Uro Imp.*

iii As I was concerned that this might not be carried forward by all consultants, I emailed the Medical Director and Director of HR and Organisational Development on 5th September 2010 seeking a meeting regarding the issue. The email is attached. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100908 Ltr to KD re Cystectomies.*

iv I have no recovered documentation and cannot confirm if the meeting took place. From recall, I was about to go on summer leave and may have been seeking to alert colleague Directors of a potential issue when I was on leave.

v However I can confirm that all subsequent patients who required an elective cystectomy for benign disease were referred to Belfast from that point onwards.

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

58.1 Details are set out in response to Question 57.

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

(i) **what risk assessment did you undertake, and**

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

58(i)(a) From memory the Risk Assessment model in use at the time scored the level of risk for an individual patient with the number of patients impacted into a red, amber or green level from highest to lowest risk. This method was used when recording the risk on the Risk Register. The actions taken by the managerial and clinical teams recognised the levels of risk involved, as demonstrated by the actions taken and set out against each issue of concern in point (ii) below.

58(ii)(a) The steps taken to mitigate against the potential impact of patient care and safety were:

a. The single point of contact for all GP referrals ensured that all referrals to urology were visible in the IT system by the Referral and Booking Centre. The timely triage or delay to triage of these referrals was also visible and monitored by the RBC. The initiation of a weekly performance meeting which included the manager of the RBC meant that any delays were brought into discussion weekly and the necessary actions taken if these were not already in place.

b. The failure to read test results prior to filing the patient notes was identified through a Root Cause Analysis Report, on a serious adverse incident which occurred in 2009. This clinical risk for patients attending Mr O'Brien was not formally known prior to the RCA Report on the serious adverse incident. There was no system in place within the Trust at that time to monitor this. Possible mitigation which became available later was with the implementation of the new

regional Radiology system it was eventually possible to see on the system which reports had been read by the consultant who had ordered the test. This ensured that reporting could be in place, once the requisite report software was written and the system updated. As the radiology system was implemented as a regional system this reporting function only became available after the Root Cause Analysis report was completed and the problem would have been difficult to identify earlier through formal systems. I do not recall whether a report on the monitoring of the consultant sign off of test results in the radiology system was made available during my tenure.

i The laboratory IT system was developed to ensure that there was sign off of each blood test by the doctor who had ordered the specific blood tests. Any discrepancies were monitored and followed up. This process of developing reporting was undertaken within the Trust by the Laboratory Head of Services in the Acute Services Directorate and was not linked to a regional system.

ii The scheduling of patients in order of urgency and chronology was addressed through a stronger process of scheduling involving the Head of Service and the Operational Support Lead scheduling patients with Mr O'Brien, a process not required with other consultants. This ensured that Mr O'Brien no longer had sole control of booking patients for surgery.

iii Patients requiring the operation of cystectomy for either malignant or benign conditions were transferred to the Belfast Trust as part of the implementation of the regional review of urology.

iv The use of IV therapy for patients with recurrent UTIs was addressed through the development of a multidisciplinary process of discussion involving the consultant urologist, the CD for surgery and a consultant microbiologist prior to the treatment commencing for each patient. This ensured that the use of oral antibiotics was fully discussed and IV

therapy avoided. This was one of the areas of concern set out in a Confidential Briefing for Trust Board in September 2010. The Briefing is attached. *S21 No 8 of 2022, 131. 20100930 Trust Board Confidential Briefing Note,*

v The procedure of cystectomy in the Southern Trust was the subject of a Performance Review regarding a Local Concern which resulted in a case note review of all patients' notes for the preceding 5 years by an independent consultant urologist, Details of this process are set out in response to Question 50 (iii). This was one of the areas of concern set out in a Confidential Briefing for Trust Board in September 2010. *S21 No 8 of 2022, 131. 20100930 Trust Board Confidential Briefing Note.*

vi The communication with patients regarding a preferred treatment prior to referral to the Belfast Trust was the subject of a letter from myself as Director to Mr O'Brien. There were no further instances after the initial occurrence with 3 patients.

vii The disposal of notes from a patient file was addressed through a formal Disciplinary process resulting in an Informal Warning.

viii The detailed processes of governance were further developed during my tenure in post as evidenced above and with weekly and monthly scrutiny through reports and discussion with relevant staff. The attached emails set out the initiation of:

A a systematic process within each division to identify, record and learn from incidents and risks

B a weekly performance meeting to manage the waiting times and ensure plans were in place to address these. *S21 No 8 of 2022,* 90. *20100209 For Action Clinical Governance and Risk Procedures E S21 No 8 of 2022, 19. 20100118 URGENT Daily Meetings at 9am,*

C I also initiated a monthly Acute Clinical Governance Group meeting which involved the AMDs and ADs in the scrutiny and assurance of a range of clinical governance reports and information.

ix The extent of the issues i.e the number of patients impacted was fully documented on a frequent basis. This is evidenced by the weekly performance reports which set out the exact number of patients waiting for each clinical setting, and the numbers breaching the cancer pathway. The breaches to the cancer pathway required a detailed report for each patient to be sent to the HSCB. This set out the specific times on the 62 pathway for interim milestones along the pathway for each patient who breached the pathway standards. Each report came through the Director's office for sign off and sending to the HSCB.

x Tracking of cancer patients from red flag referral to first treatment by day 62, was undertaken through a different IT system, the regional CAPPs system. The full adoption of the reporting systems and monitoring of the pathway for red flag patients was completed by summer 2010.

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

60.1 These are the areas where agreement was reached between Mr O'Brien and myself, the AMD, AD and Head of Service. The Medical Director was also involved in the discussion on some issues with Mr O'Brien to reach agreement on the way forward. The detail is set out in responses to earlier questions and principally in response to Question 50 but, in summary, the position was as follows:

a. IV therapy was to be stopped for all patients in the cohort receiving such treatment - A new pathway for these patients was agreed between the consultants including Mr O'Brien and Shirley Tedford, the Urology Services Coordinator in September 2010.If in the view of Mr O'Brien a patient still required admission for IV therapy, then he was required to discuss the patient with the Clinical Director for Surgery and a consultant microbiologist to reach multidisciplinary agreement of the best approach for the patient which may have been oral antibiotics.

b. Triaging of red flag referrals and non urgent referrals was to be completed in the time standards set out in the IEAP for NI - This was agreed on more than one occasion.

c. Scheduling of patients for theatre by urgency and chronological order - The Head of Service was aware of the different approach to scheduling taken by Mr O'Brien and took active steps on a permanent basis to ensure the correct approach was taken in discussion with him when scheduling each theatre list. The Head of Service was supported in this approach by the OSL for Surgery. This approach was accepted by Mr O'Brien.

d. All Radical pelvic surgery patients to be referred to the Belfast Trust from summer 2010 - The process to undertake this was put in place in September 2010, as was required through the Implementation of the Urology Review. This was not a matter of agreement with consultants, rather a requirement for patient safety to ensure that surgery was being undertaken by a smaller group of surgeons who were undertaking these major procedures more frequently than would have occurred in a smaller urology unit such as CAH.

e. Adoption of different new to review ratios in outpatient clinics in order to implement the Team South Urology service model and release outpatient time for new referrals and review appointments - Whilst this was not formally agreed by Mr O'Brien, the new clinic templates were commenced mid November 2010. After implementation an adjustment with 2 fewer new patients per clinic had to

be adopted due to over running of Mr O'Brien's clinics by 2 hours on a regular basis.

f. Failure to read test results before filing patient notes - This was communicated as a consultant responsibility to undertake.

g. Disposal of patient notes in the bin - Mr O'Brien admitted he had done this in error and would not repeat it. He was issued with an Informal Warning.

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

61.1 IV therapy:

a. If a patient was booked for admission to the ward to receive IV therapy, the Urology Services Coordinator was notified by the ward. This information was passed to the Head of Service who checked to see if a multidisciplinary meeting had taken place regarding the patient and agreement reached regarding the proposed treatment. This was a new process introduced to assure the best treatment was offered to the patient and reduce /remove the IV therapy treatment.

b. A new patient pathway was developed by the Urology Services Coordinator which included the use of oral antibiotics through a community route, which the Coordinator could manage with referral to the consultant is needed.

61.2 Triaging of red flag referrals and non urgent referrals within time standards -

a. Measures taken to mitigate the risk included weekly reporting on the triaging of non-urgent referrals through the Head of Service of RBC. The reporting set out the exact numbers of patients triaged outside the time standards by consultant

and specialty. This was discussed at the weekly performance meeting initiated by the Director in early 2010 and continued through to the end of March 2013. This ensured that immediate action could be taken if the triage standards were not being met. The approach of a weekly performance meeting with focussed reporting and immediate actions being taken had not been taken prior to myself being in post.

61.3 Scheduling of patients for theatre in order of urgency and chronology. The theatre schedulers were responsible for scheduling patients for theatre. The consultant was responsible for determining the case mix of patients for a particular theatre list to seek the best use of a 4-hour theatre session. It had previously been difficult for schedulers to persuade the consultant to change his preferred patients for a specific theatre list. With support from and follow up by the Head of Service as needed, the schedulers were able to assure the scheduling in the appropriate order. This therefore mitigated the risk of inappropriate scheduling of patients. This approach strengthened what had happened previously.

61.4 All radical pelvic surgery patients to be referred to the Belfast Trust from September 2010:

a. The referral of patients was undertaken by administrative staff after the patient's diagnosis had been made locally in Craigavon Area Hospital. This ensured that there were no patients who were not referred and were listed for surgery wrongly in Craigavon. This was an entirely new approach required as a result of the implementation of the urology review.

61.5 Adoption of different new to review ratios for patients in outpatient clinics. This was being implemented at the point in time when I retired. I cannot comment on how successfully this was implemented.

61.6 Failure to read test results prior to filing patient notes:

a. This was communicated to all consultants as a responsibility of the consultant who ordered the tests. This was already routinely undertaken by almost all consultants as the accepted normal approach. Some time after the issue had been identified through the investigation of the retained swab Root Cause Analysis, the regional radiology system was able to provide functionality for a consultant to 'tick a box' when they had read a test result. This should have allowed the development of a report which identified which test results had not been read by a consultant at an agreed time period after the results were reported by the radiology department. I cannot recall whether such a report was developed and available in the time I was in post. Therefore I cannot recall whether there was a new process put in place to identify the failure to read test results within a given time period. This would have been the optimal approach to monitoring through data.

61.7 Disposal of patient notes in the bin. There are no metrics which can be used in regards to the contents of a manual patient record. With an electronic patient record, an audit is possible to reveal notes which are deleted, by whom and the date and time of deletion. It was therefore not possible to put in place a system other than vigilance by those working closely with Mr O'Brien and the domestic staff emptying the office bin.

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

62.1 IV therapy.

a. The ward admissions to the dedicated urology beds (emergency and elective admissions) were visible to the Urology Services Coordinator. The ward senior nursing staff were aware of the change required and notified the Urology Services Coordinator is such an admission was planned. If the admission was

an emergency then the necessary action to review the treatment was required after the admission but was still required to review and amend the treatment pathway as needed. If the Urology Services Coordinator was on leave the ward notified the Head of Service. The standard against which the practice of IV therapy was judged was the advice of the independent expert sought and advised in 2009 prior to my commencement in post in December 2009.

62.2 Triaging of red flag referrals and non-urgent referrals within time standards.

a. The time standards used were those set out in the Integrated Elective Access Protocol, NI 2008. The systems put in place were monitored weekly at the weekly performance meeting chaired by myself as Director, using data from reports of IT systems.

62.3 Scheduling of patients for theatre by urgency and chronology.

a. The metrics in place were the detailed list of patients waiting for dates for their surgery, the PTL lists. These were routinely reviewed by the schedulers and Head of Service in order to schedule appropriately and for the Head of Service to set out the position with reports from Performance and Reform on the longest waiters for particular procedures, their urgency and their date of listing for surgery which determined the length of wait. This position by service was outlined in the routine performance report. The standards used were those set out in the IEAP.

62.4 All radical pelvic surgery patients to be referred to the Belfast Trust.

a. After the date of implementation in September 2010, the schedulers would not have scheduled such procedures for theatre.

62.5 Adoption of different new to review ratios and clinic templates for patients in outpatient clinics.

a. The new clinic templates were implemented in November 2011, even though Mr O'Brien did not accept them in principle.

62.6 Failure to read test results before filing of patient records.

a. The regional radiology system, at the time when this issue was identified, did not have the visible functionality to let a consultant sign off a test result. Therefore it was not possible at that stage to write and deliver a report which would identify which results had been read and which results had not been read. Subsequently on request by the Trust this functionality was made available regionally as a software development. However at this point I cannot recall implementing a system whereby the reading of test results was reported on, reviewed and any necessary action taken. It may be that a system of reviewing this data was not implemented during my tenure in post.

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

63.1 IV therapy:

a. The system of having a multidisciplinary discussion for each patient where the use of IV therapy was being considered worked as long as each consultant remembered and chose to adopt the process. There were a very small number of occasions where this process was not adopted. This resulted in further clarification with the consultants and reminders of the new process. The position was eventually reached where there were no further patients in the old group receiving IV therapy. This position is evidenced in the letter sent by Dr Loughran as Medical Director to Dr Corrigan, Consultant in Public Health Medicine, Public Health Agency, on 11 March 2011. Attached letter of 11 March 2011 from Dr Loughran to Dr Corrigan –*Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin 20110311 E to D Corrigan re IV Antibio and Cystectomies*.

b. However there continued to be occasional instances of patients receiving IV therapy, which were highlighted as required and appropriate action taken. Without the full cooperation of the consultant, this was not a fool proof solution to managing this practice.

63.2 Triaging of red flag referrals and non urgent referrals within the time standards:

a. The systems put in place gave the Trust the information on a weekly basis. This meant that red flag referrals were at most 3 days outside the time standard. Therefore the position was not fully remedied, but had a backstop against which the Trust could monitor and take remedial action. Without moving to a daily report, it is difficult to see what else could have been put in place.

63.3 Scheduling of patients for theatre in order of urgency and chronology:

a. The Head of Service and OSL scheduled patients with Mr O'Brien i.e., the scheduling process was not left in the hands of the surgeon, thus ensuring that the rules were applied. This remedied the situation in each meeting to schedule Mr O'Brien's patients for theatre.

63.4 All radical pelvic surgery patients to be referred to the Belfast Trust:

a. The referral process was undertaken by administrative staff once the diagnosis had been made and the outline treatment pathway identified. This was therefore taken out of the hands of the surgeons. This approach worked without fault.

63.5 Adoption of different new to review ratios for patients in outpatient clinics, and adopting BAUS clinic templates:

a. The revised clinic templates were implemented in November 2010. This included an increase in the number of reviews seen at every clinic. The number of new patients subsequently had to be reduced due to regular over runs of the

clinics held by Mr O'Brien. This resulted in 2 fewer new patients being seen in each clinic. This is evidenced by the template for booking outpatients used by the RBC to book each consultants' outpatient clinics.

63.6 Failure to read test results before filing of patient notes:

a. I have no evidence to identify if this issue was addressed satisfactorily by Mr O'Brien, after he was clearly informed that this was a consultant responsibility to undertake on a timely basis. If the reporting process from the radiology system as set out in response to Question 62 (vi) was implemented, this would have remedied the position and provided the opportunity for regular monitoring.

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

64.1 To my knowledge, Mr O'Brien raised a total of concerns across 3 occasions regarding patient care and safety during my tenure in post. Two of these concerns were raised by Mr O'Brien in response to requests from myself as Director of Acute Services regarding clinical behaviour. There was one concern regarding patient safety raised by the 3 consultant urologists including Mr O'Brien. This was raised in a letter on 18th January 2010. The concerns are detailed below along with the action taken in response:

a. I received a letter sent on 18 January 2010 from the 3 consultant urologists including Mr O'Brien, outlining concerns regarding the potential appointment of a locum consultant urologist in order to help address the urgent list of patients awaiting surgery. The letter also raised the issue of ''compromised inpatient care and safety as a result of the recent ward reconfiguration''. The action taken

was an immediate meeting held by the Director on the day of receipt of the letter 18 January 2010. The meeting involved all three consultant urologists, Mr Mackle AMD, myself and, from memory, Dr Loughran. Each of the issues was discussed and actions agreed as set out below:

i In relation to the appointment of a locum consultant, a range of measures to address the long waits for theatre were agreed which would ensure that no patient was waiting longer than 16 weeks at the end of March. This required the surgeons working additional hours and on the basis of this agreed position, the Trust agreed to cancel the locum appointment.

ii In relation to the compromise to inpatient care and safety as a result of the recent ward reconfiguration, the recent correspondence from Dr Loughran, Medical Director, regarding the process of clinical incident reporting was discussed and consultants advised to identify concerns over safety. Consultants were requested to immediately report any cases whereby patient safety was compromised so that urgent action could be taken. The letter of 20 January 2010 sent to the consultant urologists after the meeting also stated ‘’We would further appreciate if you could let Dr Rankin know when you have submitted the required forms so that she can ensure a speedy process.’’ *S21 No 8 of 2022, 161. 20100125 E to Dr Loughran re Consultant Urologists, 162. 20100125 E to Dr Loughran re Consultant Urologists A1*

b. Re-referral triage and amending clinic templates to reflect different new to review ratios. The letter from myself to Mr O’Brien dated 22 October 2010, indicates a previous related letter from myself and Mr Mackle to Mr O’Brien, to which Mr O’Brien had replied on 27th September 2010. While the initial concern was not raised by Mr O’Brien, the correspondence identifies the concerns which he continues to hold with regard to implementing certain aspects of the implementation of Team South Urology. These are set out below. In my letter of 22 October 2010, the following points are made:

i A commitment to triage referrals within a week and red flag referrals within a day, conditional on the cohort of consultants being sustained

ii Refusal to amend clinical practice to undertake new appointments in 20 minutes and review appointments in 10 minutes

iii Lack of undertaking to reduce new to review ratios to 1:2 as an interim step through clear discharge pathways with primary care

iv ‘‘We are writing to ask you to reconsider these issues which have been in discussion over many months. Please confirm by Thursday 28th October your agreement to amend clinic templates.’’ The letter attached sets the context of the meeting and the outcomes of the meeting held on 27th September 2010. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp*

c. On 25.8 2011 Mr O’Brien sent an email to the Head of Service regarding the request to read test results when they are received and before filing the patients notes. Mr O’Brien’s email set out 11 bullet points relating to concerns about the request sent through the office of the Assistant Director. Mr O’Brien’s concerns related in the main to how the process will be done, the time implications and whether there are legal implications to this proposed action. Mr O’Brien’s email was forwarded to Mr Mackle, AMD, who forwarded it on to myself on 26 August 2011 with the comment: ‘‘I think this raises a Governance issue as to what happens to the results of tests performed on Aidan’s patients. It appears that at present he does not review the results until the patient appears back on OPD.’’

i On 8 September 2011 I sent a reply to Mr Mackle, AMD, Heather Trouton, AD, and Martina Corrigan, Head of Service. As I was just about to go on summer leave for 2 weeks, I asked Heather Trouton to address with the consultants the “whole area of how results are read when they arrive rather than waiting for review apt’’. ‘‘The secretaries need to be given a

brief as to what is expected of them and this would need discussed and agreed. Perhaps a protocol for secretaries is needed when there is currently system in place which I hope is not more widespread. Can I leave this with you until I return?''

ii On 8 September 2011, Heather Trouton replied to me: ''Yes. I will initially look at the processes in other specialties, a) to ensure they have robust processes in place, b) to be able to present current working processes in other areas should the need occur.'' *20110908 E re Results and Reports of Investigations*

d. I have no evidence of further emails on this subject, although my usual practice would be to follow this up with the AD on my return from leave and usually at a regular 1 to 1 meeting.

[65] Did you raise any concerns about the conduct/performance of Mr O'Brien? If yes:

a. outline the nature of concerns you raised, and why it was raised

b. who did you raise it with and when?

c. what action was taken by you and others, if any, after the issue was raised (d) what was the outcome of raising the issue?

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

65.1 There were several areas of concern regarding Mr O'Brien which are set out in responses above, in particular at Questions 50 and 56. I was not involved in raising many of these concerns as they were already known prior to my tenure in post.

65.2 However I was involved in addressing these concerns and any new concerns once they had been raised.

65.3 In September 2010, concerns were raised by the Commissioner, through the letter written by Dr Corrigan, to which the Trust responded. I led the process of response to the concerns raised with the AMD leading the process of the Local Review. Dr Loughran handled the interface with the Commissioner and also took the final decision regarding the Local Review on the basis of the independent report of the review of cases.

65.4 In September 2011, I raised concerns regarding the risk identified that all the consultants required clarification that the operation of planned cystectomy for benign pathology was no longer an operation to be performed in CAH. I wrote to the 3 consultants on 7 September 2011. I also alerted the Medical Director and Director of HR and Organisational Development of this position as I was going on summer leave. However the position was accepted by the consultants and no further action was required.

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

66.1 I have detailed in response to Question 30, point 2, the offer made to Mr O'Brien by myself regarding the use of Occupational Health. Apart from this I am not aware of any other approach of support to Mr O'Brien through HR and Occupational Support, although this may have been made by other members of staff in the Trust. I cannot explain why this was the case, except to say that at that time it was highly unusual for a consultant to seek help or respond to an offer of help, as this was seen as possible sign of weakness.

66.2 With regard to support for Mr O'Brien by his clinical colleagues, the weekly rotation of triaging GP referrals for both red flag and non-urgent referrals was often undertaken by agreement by one of the other 2 consultants, who were aware of the delay in Mr O'Brien triaging referrals. This support was in place for some lengthy periods during my tenure in post. I have no knowledge of any further support for Mr O'Brien by clinical colleagues.

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

67.1 The specific concerns raised by Mr O'Brien and others were not written down in Trust Governance documents. I am unable to give an explanation for this. However it would not have been usual practice at that time to record such specific issues as raised by Mr O'Brien in Trust Board, or Directorate Risk Registers. These Risk Registers generally identified risks which existed across a range of systems in the Trust or across a full directorate. The specificity of risk would more likely be identified in divisional risk registers. This may have been the position on the journey of recording risks at that time and may have subsequently been further developed.

67.2 By way of example to my comments above the following may illustrate. The Trust Corporate Risk Registers of December 2009, June 2010, November 2011 and October 2012 all make reference to performance issues against the Priorities for Action Performance targets across a range of specialties, and the outpatient review backlog. Urology is mentioned as having the longest review backlog. The actions such as re-let contracts to the Independent Sector including urology, the approval of the urology business case in July 2011 with recruitment of 2 new urology consultants from November 2012 are documented in these Risk Registers.

67.3 The Acute Services Directorate Risk Register documents the following risks:

a. On 26 May 2011, the Cancer Performance Risk across specialties with urology being the highest risk. The actions of using an escalation policy, with action plans drafted, meeting with urology teams and working towards 1stop clinics for prostate and haematuria are documented.

b. On 25 June 2012, the urology waiting times had increased from 36 weeks for inpatients and day cases, and first ICATS appointments increased from 17 weeks. Both were being addressed through approval to go to the Independent Sector, and appointment of new consultants.

c. On 3 September 2012, the 62 Cancer Performance targets (not specific to urology) not being met due to an increase in red flag referrals, capacity issues, inability to downgrade and regional issues. The actions taken were daily monitoring of referrals of patients on the 62 day pathway, escalations to the Head of Service/Assistant Director when patients do not meet the interim milestone on the pathway, monthly performance meetings with AD/Head of Service and escalation of all late triaging.

67.4 The divisional risk registers for both Surgery and Elective Care and Cancer and Clinical Services both document the following risks:

a. On 7 April 2011, urology cancer pathway delays. The actions were the commencement of the 1 stop prostate clinic on 1 October 2011, with full implementation by 23 January 2012; and the commencement of the 1 stop haematuria clinic on 6 October 2011. In January 2012, it was documented that there were no delays for patients at the 1 stop prostate clinic.

67.5 There were many meetings regarding the issues raised about and by Mr O'Brien. Whilst these were not formally called 'Governance' meetings, the agendas of these meetings reflected the patient safety concerns and the actions needed to address them.

67.6 Some examples of such meetings, which are available at this point in time, include the following (with reference to where more detail about each meeting can be found in this document):

a. 1 December 2009 meeting chaired by the Chief Executive. Detail set out in response to Questions 28 and 57.

b. 7 December 2009 meeting held by myself and the Medical Director with Mr O'Brien. Detail is set out in response to Questions 28 and 57.

c. 20 January 2010 meeting held by the Medical Director, Director of Acute Services, AMD Surgery and the 3 consultant urologists. This meeting was held to discuss the range of concerns raised in a letter of 18 January 2010 by the urology consultants. Details of the meeting are set out in response to Question 64.

d. 1 September 2010 meeting of the Medical Director, Director of Acute Services, Director of HR and Organisational Development and the AMD for Surgery regarding the letter from Dr Corrigan on the number of cystectomies being carried out in CAH. Detail can be found in response to Question 50 (iii).

e. 27 September 2010 meeting with Director of Acute Services, AD and AMD Surgery and Elective Care regarding referral triage and clinic templates. Details of this meeting and subsequent letter are set out in response to Question 64.

f. 30 September 2010, a Briefing Report was included in Trust Board papers and the Director of Acute Services spoke to it at the confidential section of the meeting. An update on progress was given verbally at the subsequent meeting of Trust Board on 25 November 2010. Details are set out in response to Question 42 (i).

g. 9 June 2011 meeting held by the Director of Acute Services with Mr O'Brien, the AD and AMD for Surgery and Elective Care regarding a full range of clinical and performance issues. Details can be found in response to Question 57 (iv).

h. 29 July 2011 meeting of the Medical Director, Director of Acute Services and the AMD for Surgery and Elective Care to consider the final report by the Independent Expert reviewing the case notes of patients who had had cystectomies. Detail of the meeting is set out in response to Question 57 (ii).

i. The following meetings within the Acute Services Directorate would also have raised issues with regard to urology and Mr O'Brien:

    i Acute Services Directorate Governance meeting
    ii Acute Services Clinical Governance Group meeting
    iii 1 to 1 meetings with the Chief Executive, the Assistant Director and the Associate Medical Director for Surgery and Elective Care. Minutes or notes of such meetings raising the relevant issues are not available to me at this stage.

Learning

[68] Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

68.1 I am not aware of any new governance concerns arising out of the provision of urology services during my tenure in post until the end of March 2013.

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

69.1 On reflection, and setting out the range and number of issues in urology services, I believe that the following is clear:

a. The service was under considerable pressure due to increasing referrals; and was insufficiently resourced to meet the catchment population needs. The long term absence of the ICATS urology doctor (contracted for 7 sessions per week), contributed to the consultant pressures as they had to see all referrals in outpatients.

b. There was also additional pressure due to the consultant clinical behaviour of Mr O'Brien which meant that smaller numbers of patients were seen in each outpatient clinic and more patients were reviewed than consultant peers would review. There was also little appetite in the service to agree protocols with primary care to review certain cohorts of patients.

c. There was poor professional practice which had been longstanding. It proved to be difficult to get agreement with Mr O'Brien to change this behaviour. When change in his behaviour was agreed, the specific behaviour was not always sustained and he would revert to previous poor practice. An example of this was when Mr O'Brien agreed to triage referrals within the required time standards; it became apparent subsequently that this change in behaviour was not sustained and required regular checking.

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

70.1 There are several points of learning from a governance perspective which are set out below:

a. When a service is under pressure with insufficient resources to meet the population need for a prolonged period, it might be reasonably assumed that the risk level within the service may increase.

b. A service under pressure to meet population need may have little appetite or space for the development of implementation plans and then implementing this change. However, it could reasonably be assumed that most services and the senior staff in those services would welcome the opportunity for growth of the service and improvements in services for patients.

c. Systems to collect data, to provide the full functionality required to identify staff behaviour, and provide the required reports to monitor this behaviour are not always available at the point in time when needed (reference the regional radiology system).

d. Governance systems which require action on behalf of all staff, e.g., being open about concerns or completion of clinical incident data on the Datix system, take time for staff to be trained, time for the processes to become embedded, and time for staff confidence to use them to build. This process is a journey of improvement for a large organisation rather than an overnight change.

e. It is difficult to monitor all consultant behaviour. If there is evidence of agreed changes in behaviour not being sustained then additional action should be considered, particularly where this involves what might be regarded as required clinical consultant behaviour especially when this is outside the accepted 'normal' behaviour of peers.

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

71.1 I believe that there was a failure to engage fully in the following ways:

71.2 There was resistance to change in clinical behaviour. Resistance to change was the general sense in the urology service. However, when change was required in order to implement improvements for patients, two consultants did make these changes in their personal behaviour. Examples of changed behaviour are changing clinic templates and the new to review ratios to reflect BAUS guidance; setting up the local MDM (Multidisciplinary meeting) in preparation for the regional MDM; agreeing new patient pathways such as 1-stop clinics. These 2 consultants also undertook additional work, such as triaging on behalf of Mr O'Brien when he failed to cooperate in undertaking this process in the required time standards. Mr O'Brien tested the new clinic templates and his clinics regularly overran by 2 hours. He therefore was unable to, or chose not to, amend his behaviour in outpatient clinics.

71.3 It is difficult to state what could have been done differently within the Trust, and without reference to outside professional bodies, to change the behaviour of a single consultant who was resistant to change and refused to acknowledge that there was a requirement to work within a clinical system where the DoH, the Commissioner (HSCB), and the Trust had set out the parameters. Examples of such requirements are the time standards set out in the DoH IEAP, the HSCB requirements to use BAUS guidance for outpatient clinic templates and numbers of review appointments, and the challenge made to the referral of the initial cohort of patients to Belfast for radical pelvic surgery. However, perhaps earlier action may have been appropriate in seeking an external assessment of competence to practice.

71.4 In terms of other issues in the service, there was full support to obtain agreement and funding for both in-house additional theatre lists (where the consultants

wished to undertake these) and referral to the Independent Sector when there were too many patients for the service to treat as inpatients or day cases in a given time period to meet an agreed backstop. However, due to the service pressure of increasing referrals, the backstop agreed with the HSCB for inpatient and day case treatment moved to a longer waiting time during my tenure. This was the case in other clinical specialties both within the Trust and in other Trusts, and was largely due to a lack of resources to meet the population need. The lack of resources was a combination of insufficient funding, and lack of sufficient trained staff in the specialty. The process of working with the Commissioner was led by the Director of Performance and Reform and is evidenced by documents attached to earlier responses. This directorate also provided detailed weekly support and performance data in order that managers and clinicians could take appropriate action; and support for the reform of patient pathways.

71.5 The Chief Executive, Medical Director and Director of HR and Organisational Development engaged fully in discussing the most serious issues and determining the course of action, as set out in earlier responses.

71.6 In terms of other clinical staff in the urology service, the clinical staff in managerial roles and the managers involved, there was not a failure to engage. There was full engagement on the development of the implementation plan for Team South Urology, the week to week performance pressures, and the clinical areas which required more detailed management such as IV therapy. This is evidenced by the documents referenced in response to previous questions which cover all aspects of the service, some of the numerous meetings, correspondence, and actions taken to mitigate risk and improve clinical care for patients. The collective energy and time devoted to the urology service during my tenure from myself, all managers and senior clinicians significantly out ranked the collective time spent with any other speciality or service in Acute Services.

[72] Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been

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

72.1 Systems of performance management and governance systems to assure the Trust of the quality of care were rigorously developed and implemented within the Trust and in Acute Services, as demonstrated through responses to earlier questions and the evidence provided. As these systems were used to monitor data on action taken by clinicians, then remedial action to mitigate risk can only be taken after the event i.e. after a consultant has failed to triage referrals in the required time standard. This process was used for some of the issues raised in urology i.e.,

a. triaging of referrals
b. performance management of outpatients, review backlog, day case and inpatient theatre waits.

72.2 The process to monitor and prevent recurrence of clinical behaviour was used in some instances for example:

a. The use of IV therapy, where action was taken through the multidisciplinary discussion prior to treating the patient - However, if the consultant chose not to use the directed approach to multidisciplinary discussion prior to patient treatment, the preventative approach did not work on these occasions.

b. The movement of radical pelvic surgery to the Belfast Trust was an action taken prior to the patient's definitive treatment.

72.3 Failure to read test results prior to filing the patient notes was the most difficult issue to handle as there was no systematic way to monitor the process at that point in time. In this regard, there was a mistake in handling this issue, which the existing systems could not rectify immediately. As Director, I was not able to identify any

method by which this issue could be managed, other than waiting for further development of the functionality of the radiology system.

72.4 Whilst remaining vigilant across the range of issues and weekly monitoring for many of them, the overriding issue was that of entrenched clinical behaviour by the consultant which was made more difficult to manage as often a change in behaviour towards improvement was not sustained permanently, despite it being agreed by Mr O'Brien. On reflection, this type of behaviour should have been recognised for what it was, and identified and discussed by me with SMT colleagues when more formal action could have been considered. Formal action could have been considered with the Medical Director and the Director of HR and Organisational Development. In conclusion, I did not fully utilise the arrangements which were available at the time in order to address the continuing clinical behaviour which did not meet the standards required.

[73] Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done? If not, please explain why.

73.1 The governance arrangements were reviewed in 2010 through the Review of Clinical and Social Care Governance. This resulted in organisational change resulting in the following:

a. The developing culture of openness and learning from mistakes;
b. Clear lines of accountability and reporting through the Chief Executive to Trust Board for both operational and professional lines of accountability;
c. Embedding of deeper systems of governance and staff training in these, e.g., Datix completing to report on clinical incidents;
d. Easier recognition of SAIs and processes to investigate and learn from them;

e. Recognising the importance and value of patient complaints to improve the patient journey through services.

73.2 The review resulted in the appointment of:

a. An AD for Governance in the Performance and Reform Directorate who chaired a Governance Forum where all clinical leads and senior managers met to discuss governance issues and raise concerns;
b. A Governance Coordinator for each operational Directorate who provided support to the Director and directorate in embedding governance systems with staff.

73.3 My view is that the governance systems and processes at that time were largely fit for purpose with the systems available at the time. Staff needed to become fully confident about using the systems with the view of improvement in patient care, and not detriment to themselves.

73.4 However a gap was a reporting process to identify the timeliness of consultants reading test results when available to them. I was not able to rectify this position while in post.

73.5 In a healthcare scenario where all clinical activities are recorded electronically in a live system, it would be possible to set an alert in the system for any clinical behaviour which was unacceptable. An example would be an alert for a patient being admitted for IV therapy. Such a system would avoid the need for the alert to be dependent on a person identifying this instance.

73.6 When all patient records become electronic rather than manual, the act of deletion of part of a clinical record would be auditable and therefore readily identified.

73.7 I cannot comment on the continuing fitness for purpose of the existing governance systems after my retirement in March 2013.

Urology Services Inquiry

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

74.1 I have nothing further to add to the responses already set out in response to Questions 1 -73.

NOTE:

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

Statement of Truth

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

Signed: Personal Information redacted by USI

Date: 14th June 2022

Section 21 Notice Number 8 of 2022

Attachments

Attachment	Document Name
1	1. Director of OPPC JD
2	2. Director of Acute Services JD 2011
3	3. Associate Medical Director JD
4	4. General Surgery CD JD
5	5. 20100906 Review of CSCG Sept 2010
6	6. 20100906 Review of CSCG Sept 2010 A
7	7. Role of the Medical Director 2010
8	8. 20100429 Performance Report to TB
9	9. 20100527 Performance Report to TB
10	10. 20100428 SMT Gov Report - Risk Management Complaints
11	11. RQIA Review of Maternity Services - Intrapartum Care April 2010
12	12. 20110421 Performance Report A
13	13. 20110421 Performance Matrix 10_11 End of Year Assessment B
14	14. 20130328a Performance Report to TB
15	15. 20130328b Performance Report to TB
16	16. 20121025 MD Report TB A
17	17. 20121025 MD Report TB B
18	18. 20121025 MD Report TB C
19	19. 20100118 URGENT Daily Meetings at 9am
20	20. 20100118 URGENT Daily Meetings at 9am A1
21	21. 20100118 URGENT Daily Meetings at 9am A2
22	22. 20100706 E from K Robinson
23	23. 20100706 E from K Robinson A1
24	24. 20100706 E from K Robinson A2
25	25. 20100706 E from K Robinson A3
26	26. 20100706 E from K Robinson A4
27	27. 20100706 E from K Robinson A5
28	28. 20100706 E from K Robinson A6
29	29. 20100706 E from K Robinson A7
30	30. 20100706 E from K Robinson A8
31	31. 20100706 E from K Robinson A9
32	32. 20100706 E from K Robinson A10
33	33. 20100706 E from K Robinson A11
34	34. 20100706 E from K Robinson A12
35	35. 20100706 E from K Robinson A13
36	36. 20100706 E from K Robinson A14
37	37. 20100706 E from K Robinson A15
38	38. 20100706 E from K Robinson A16
39	39. 20100706 E from K Robinson A17

40	40. 20100706 E from K Robinson A18
41	41. 20100706 E from K Robinson A19
42	42. 20100706 E from K Robinson A20
43	43. 20100706 E from K Robinson A21
44	44. 20100706 E from K Robinson A22
45	45. 20100706 E from K Robinson A23
46	46. 20100706 E from K Robinson A24
47	47. 20100706 E from K Robinson A25
48	48. 20100706 E from K Robinson A26
49	49. 20100706 E from K Robinson A27
50	50. 20100706 E from K Robinson A28
51	51. 20100413 Acute Performance Agenda
52	52. 2009 - 2013 CCS Risk Register
53	53. 2009 - 2013 Acute Risk Register
54	54. 2009 - 2013 SEC Risk Register
55	55. 20100128 Performance Report to TB
56	56. 20111206 CRR
57	57. 20121204 CRR
58	58. 20091201 Uro Service Mtg Notes
59	59. 20100415 E re Review Backlog HT
60	60. 20100415 E re Review Backlog HT A
61	61. 20101130 E Urology Pathway Meeting
62	62. 20100803 Review Backlog Checklist
63	63. 20100803 Review Backlog Checklist A
64	64. 20100915 Feedback on draft Urology pathways
65	65. 20130308 E re Demand Capacity Triage
66	66. 20100924 Review of CSCG Governance Committee Final
67	67. 20100924 Review of CSCG Governance Committee Final A1
68	68. 20100924 Review of CSCG Governance Committee Final A2
69	69. 20110217 for info action IMPLEMENTATION PLAN CSCG REVIEW 2010
70	70. 20110217 for info action IMPLEMENTATION PLAN CSCG REVIEW 2010 A1
71	71. IPR Proforma - Acute 2010-11
72	72. IPR Proforma - Acute 2010
73	73. IPR Form 2011 2012
74	74. IPR Form 2011 2012 - August 2012
75	75. 20101102 HSCB SBA Capacity Assessment PID
76	76. 20100423 Steering Group Meeting 13th May 2010
77	77. 20100423 Steering Group Meeting 13th May 2010 A1
78	78. 20100423 Steering Group Meeting 13th May 2010 A2

79	79. 20100423 Steering Group Meeting 13th May 2010 A3
80	80. 20100423 Steering Group Meeting 13th May 2010 A4
81	81. 20100514 E re Team South Urology Steering Group
82	82. 20100514 E re Team South Urology Steering Group A1
83	83. 20100514 E re Team South Urology Steering Group A2
84	84. 20100624 Uro Implementation Plan to BM
85	85. 20100708 E to CX re Regional Review of Urology Services
86	86. 20100708 E to CX re Regional Review of Urology Services A
87	87. 20101015 E re Uro Mtg Action Points
88	88. 20101015 E re Uro Mtg Action Points A
89	89. 20120229 E re 3 Uro Posts
90	90. 20100209 For Action Clinical Governance and Risk Procedures E
91	91. 20100416 Acute Clinical Governance Mtg First Agenda
92	92. 20100416 Acute Clinical Governance Mtg Action Notes
93	93. 20100512 Acute Clinical Governance Meeting
94	94. 20100512 Acute Clinical Governance Meeting A1
95	95. 20100512 Acute Clinical Governance Meeting A2
96	96. 20100512 Acute Clinical Governance Meeting A3
97	97. 20100512 Acute Clinical Governance Meeting A4
98	98. 20100512 Acute Clinical Governance Meeting A5
99	99. 20100512 Acute Clinical Governance Meeting A6
100	100. 20100512 Acute Clinical Governance Meeting A7
101	101. 20100512 Acute Clinical Governance Meeting A8
102	102. 20100512 Acute Clinical Governance Meeting A9
103	103. 20100512 Acute Clinical Governance Meeting A10
104	104. 20100512 Acute Clinical Governance Meeting A11
105	105. 20100512 Acute Clinical Governance Meeting A12

106	106. 20100512 Acute Clinical Governance Meeting A13
107	107. 20100512 Acute Clinical Governance Meeting A14
108	108. 20100512 Acute Clinical Governance Meeting A15
109	109. 20100512 Acute Clinical Governance Meeting A16
110	110. 20100512 Acute Clinical Governance Meeting A17
111	111. 20100512 Acute Clinical Governance Meeting A18
112	112. 20100512 Acute Clinical Governance Meeting A19
113	113. 20100512 Acute Clinical Governance Meeting A20
114	114. 20100512 Acute Clinical Governance Meeting A21
115	115. 20100512 Acute Clinical Governance MeetingA22
116	116. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10
117	117. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 A1
118	118. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 A2
119	119. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 A3
120	120. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 A4
121	121. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 A5
122	122. 20100201 Agenda and Papers for Acute Monthly Governance Mtg 2 2 10 A6
123	123. 20100202 Acute Governance Notes
124	124. 20100824 E re Never Events Incident Reporting
125	125. 20100824 E re Never Events Incident Reporting A1
126	126. PS Acute Services 3rd Quarterly Report 2011
127	127. 2nd Quarter PS Enquiries Report 2012
128	128. 20100727 Update on Clinical Standards and Guidelines
129	129. 20100727 Update on Clinical Standards and Guidelines A
130	130. 20091201 - 20091231 HSCB Report re Complaints
131	131. 20100930 Trust Board Confidential Briefing Note

132	132. 20100930 TB Confidential Minutes
133	133. 20101125 Trust Board Confidential Briefing Note
134	134. 20101125 TB Confidential Minutes
135	135. 20091209 Corporate Risk Register
136	136. 20100621 Corporate Risk Register
137	137. 20100419 E to MD re Acute Clinical Governance Group
138	138. 20100517 E re Referral Guidelines Uro MDTs
139	139. 20110901 E to MC and HT re AOB Draft Job Plan
140	140. Surgery Incidents 2009 - 2013 pdf
141	141. 20100330 Action Notes Acute Governance Mtg
142	142. 20100108 Acute Contingency Agenda
143	143. 20100212 Acute Contingency Agenda
144	144. 20100205 Acute Contingency Mtg Notes
145	145. 20100429 Closure Report S Tedford
146	146. 20100429 Closure Report S Tedford A1
147	147. 20100429 Closure Report S Tedford A2
148	148. 20100129 Urology Action Plan Update
149	149. 20100129 Urology Action Plan Update A1
150	150. 20100129 Urology Action Plan Update A2
151	151. 20100911_Urology letter from Dr Corrigan
152	152. 20110325 Mr Marcus Drake Report
153	153. 20101021 E Progress with Cohort of Patients
154	154. 20101021 E Progress with Cohort of Patients A1
155	155. 20101021 E Progress with Cohort of Patients A2
156	156. 20110907 E For Comment Correspondence to Urologists A
157	157. 20100427 Regional Urology Review HM
158	158. 20100430 E re Regional Uro Review k
159	159. 20101221 RCA Retained Swab
160	160. 20101221 RCA Retained Swab A1
161	161. 20100125 E to Dr Loughran re Consultant Urologists
162	162. 20100125 E to Dr Loughran re Consultant Urologists A1

Job Description

JOB TITLE	Director of Older People & Primary Care
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Director of Older People and Primary Care will be responsible through the Chief Executive for the development and delivery of safe, high quality primary care and non acute hospital services to older people within the Southern Trust, as well as lead Director for the Trust's Health and Wellbeing and Community Development services. He/She will lead the strategic planning of these services and ensure effective multidisciplinary working and the most efficient use of resources to promote health and well being and support people to live independent lives in the community. He/She will provide clear leadership and oversee the management of all staff in the Directorate. In addition, the jobholder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives and be a member of the Trust Board.

KEY RESULT AREAS

Service Delivery

1. Lead the co-ordination of multidisciplinary teams to deliver high quality health and social care to older people and ensure the effective and efficient use of all resources to achieve all relevant targets with a particular emphasis on those relating to care in the community and rehabilitation.

2. Work closely with the Director of Acute Services to secure appropriate integration of hospital and community based services aimed at reducing inappropriate hospital admissions and lengths of stay.

3. Work closely with the independent sector to expand the use of supported living, domiciliary and day care as alternatives to residential care.

4. Ensure the co-ordination of the primary care workforce to deliver high quality care and achieve all relevant targets emanating from *Caring for People Beyond Tomorrow* and other strategic frameworks.

5. Work closely with General Practitioners, community and voluntary sector partners, and public sector agencies to promote the health and well being of the Trust's population.

6. Develop and embed expert patient, specialist services, latest technology and other mechanisms to support people with a chronic illness to better manage their condition.

Quality

7. Ensure that the needs of patients, clients and their carers are at the core of the way the Trust delivers its preventative services, primary care and services to older people.

8. Ensure high standards of governance within the directorate including the effective assessment and management of risk.

9. Ensure the Trust's primary care and services to older people comply with all professional regulatory and requisite standards.

10. Ensure that robust performance management arrangements are developed and implemented within the Directorate

11. Lead innovation and change to underpin the modernisation of primary care and service delivery to older people.

12. Lead quality initiatives such as Investors in People and Charter Standards in the Directorate.

Strategic Planning and Development

13. Continually review, develop and deliver the Trust's strategic plan for the delivery of primary care and services to older people in the Trust in line with regional strategies, Ministerial and HSSA priorities.

14. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

15. Financial and Resource Management

16. Responsible for the management of the Trust's H&WB, primary care and older people services budgets and ensure the meeting of all financial targets within the Directorate.

17. Participate in contract and service level negotiations with commissioners.

18. Lead the development of capital investment strategies for older people and primary care services, ensuring these reflect and contribute to meeting targets set by the Health & Social Care Board (HSCB) and the Trust's Corporate Plan.

People Management

19. Provide clear and strategic leadership to all staff in the directorate and ensure the Trust has a highly skilled, flexible and motivated workforce to provide high quality care.

20. Lead the development and implementation of workforce modernisation initiatives in the Directorate.

21. Ensure that management structures and practices in the directorate support a culture of effective team working, continuous improvement and innovation

Corporate Management

22. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

23. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

24. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.

25. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

26. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

27. Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

28. Maintain staff relationships and morale amongst staff.

29. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

30. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

31. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

32. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

33. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

34. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - Standards of attendance, appearance and behaviour

35. All employees of the Trust are required to be conversant with the Trusts policy and procedures on records management. Trust Directors are responsible to the Chief Executive for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of

Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

36. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION

JOB TITLE Director of Older People & Primary Care

Ref No 73211007

Notes to applicants:

1. ***We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;**

2. ***You must clearly demonstrate on your application form how you meet the required criteria – failure to do so will result in you not being shortlisted****. Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn*

ESSENTIAL CRITERIA – *these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so will result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE

1. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 5 years experience in a senior management[2] role in a major complex organisation[3].

2. Have at least 3 years experience of managing major change programmes addressing significant[4] organisational, managerial or service change.

3. Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[4] improvements.

4. Have a minimum of 2 years experience working with a diverse range of both internal and external stakeholders in a role which has contributed to the successful implementation of a significant[4] change initiative.

5. Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation[3], securing value for money by effective prioritisation and driving efficiencies.

6. Hold a full current driving license valid for use in the UK and have access to a car on appointment[5]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE, TRAINING & SKILLS

7. Have an ability to provide effective leadership to enable transformation of services.

8. Demonstrate evidence of high level skills in;
   (a) effective planning and organisation
   (b) Governance and Risk Management
   (c) Financial Control
   (d) People Management

9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

10. Demonstrate effective communication skills to meet the needs of the post in full.

DESIRABLE CRITERIA – *these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted*

1) Experience in managing a range of services within a health and / or social care setting.

The following further Clarification on the terms used in the Specification is provided below;

[1] 'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification

[2]'senior management' is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation

[3]'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders

[4]'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

[5]This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the qualities set out in the NHS Leadership Qualities Framework. Whilst candidates should be prepared to provide examples of their competence against any of the leadership qualities, particular attention will be given to the following elements;

- Effective and strategic influencing
- Seizing the future
- Drive for results
- Leading Change through people
- Holding to Account
- Drive for Improvement
- Self Management

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Southern Health and Social Care Trust

Job Description

JOB TITLE	Director of Acute Services
INITIAL LOCATION	Trust Headquarters, Craigavon Area Hospital
REPORTS TO	Chief Executive
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Director of Acute Services will be responsible through the Chief Executive for the development and delivery of safe**,** high quality emergency and elective hospital care within the Southern Trust. He/She will lead the strategic planning of the Trust's Acute Services and ensure effective multidisciplinary working and the most efficient use of hospital beds and other resources. He/She will provide clear leadership and oversee the management of all staff involved in Acute Services. In addition, the postholder will have a corporate role as a member of the Trust's senior management team that will include helping to shape the Trust's overall objectives.

KEY RESULT AREAS

Service Delivery

1. Ensure the co-ordination of multidisciplinary teams to deliver safe, high quality and equitable emergency and elective hospital care to the Trust's population and lead the effective and efficient deployment of all resources to achieve all relevant targets. This will include achieving waiting times and accessibility timeframes.

2. Responsible and accountable to the Chief Executive for delivery of effective clinical and social care governance within acute hospital services, including the successful delivery of agreed Patient Safety Programmes, and the reporting of appropriate indicators to provide assurance to the Chief Executive and Trust Board.

3. Work closely with other Directors to secure an appropriate balance between hospital and community based services and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.

4. Actively promote the development of clinical and professional networks across the Trust.

5. Lead the strategic development and integration of specialty and sub-specialty services across the Trust's hospital network, ensuring implementation of an effective and efficient service configuration in line with Commissioner intent.

6. Work closely with other Directors to ensure efficient patient flows into, through and out of acute hospital care, including the effective management of discharge planning in liaison with community services.

Quality

7. Ensure that the needs of patients and their carers are at the core of the way the Trust delivers acute hospital care.

8. Ensure high standards of governance including the effective assessment and management of risk.

9. Ensure the Trust's acute care services comply with all professional regulatory and requisite standards and the discharge of statutory functions.

10. Ensure that robust performance management arrangements are developed and implemented within the directorate.

11. Lead innovation and change to underpin the modernisation of acute hospital care in the Trust.

12. Lead quality initiatives in the Directorate to improve the patient experience.

Strategic Planning and Development

13. Ensure the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies, Ministerial and HSSA priorities.

14. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

Financial and Resource Management

15. Responsible for the management of the Trust's acute services budget and ensure the meeting of all financial targets within the directorate.

16. Participate in contract and service level negotiations with commissioners.

17. Lead the development of capital investment strategies within acute services, ensuring these reflect and contribute to meeting targets set by the HSSA and the Trust's Corporate Plan.

People Management

18. Provide clear and strategic leadership to staff within the directorate and ensure the Trust has a highly skilled, flexible and motivated workforce to provide high quality acute hospital care.

19. Ensure that staff working in Acute Hospital Care are trained and developed in line with professional standards as defined by the relevant Executive Director for that professional workforce and as agreed by the Senior Management Team.

20. Lead the development and implementation of workforce modernisation initiatives.

21. Ensure that management structures and practices support a culture of effective team working, continuous improvement and innovation.

22. Ensure the full engagement of all professional staff working in acute services.

Corporate Management

23. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

24. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

25. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.

26. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

27. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

28. Review individually, at least annually, the performance of immediately subordinate staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

29. Maintain staff relationships and morale amongst staff.

30. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

31. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

32. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

33. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

34. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

35. Adhere at all times to all Trust policies/codes of conduct, including for example:
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37. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works.

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Southern Health and Social Care Trust

PERSONNEL SPECIFICATION

JOB TITLE Director of Acute Services

Ref No 73211002

Notes to applicants:

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3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn*

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The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE

1. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 5 years experience in a senior management[2] role in a major complex organisation[3].

2. Have at least 3 years experience of managing major change programmes addressing significant[4] organisational, managerial or service change.

3. Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[4] improvements.

4. Have a minimum of 2 years experience working with a diverse range of both internal and external stakeholders in a role which has contributed to the successful implementation of a significant[4] change initiative.

5. Had personal accountability for a budget for a minimum of 3 years, in a major complex organisation[3], securing value for money by effective prioritisation and driving efficiencies.

6. Hold a full current driving license valid for use in the UK and have access to a car on appointment[5]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE, TRAINING & SKILLS

7. Have an ability to provide effective leadership to enable transformation of services.

8. Demonstrate evidence of high level skills in;
   (a) effective planning and organisation
   (b) Governance and Risk Management
   (c) Financial Control
   (d) People Management

9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

10. Demonstrate effective communication skills to meet the needs of the post in full.

DESIRABLE CRITERIA – *these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted*

1) Experience in the managing of a range of services within a health and / or social care setting.

The following further Clarification on the terms used in the Specification is provided below;

[1] *'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification*

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[4]'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

[5]This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

PLEASE NOTE:

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the qualities set out in the NHS Leadership Qualities Framework. Whilst candidates should be prepared to provide examples of their competence against any of the leadership qualities, particular attention will be given to the following elements;

- Effective and strategic influencing
- Seizing the future
- Drive for results
- Leading Change through people
- Holding to Account
- Drive for Improvement
- Self Management

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Reference Number:

Southern Health and Social Care Trust
Associate Medical Director – Surgery/Elective Care

Job Description

JOB SUMMARY

The appointee will provide clinical leadership in the Acute Services Directorate, Surgery/Elective Care Division for: medical people management; reform and modernisation, patient and client safety, quality and standards; medical education and research governance.

- To contribute strategically as a member of the Directorate Management Team
- To provide clinical leadership to relevant medical staff in the Directorate and promote the corporate values and culture of the Trust.
- Ensure excellent communication between clinicians, Directorate management team and the Medical Directors Office
- To take responsibility for performance management including appraisal of designated clinicians
- To provide leadership to medical staff to enhance collaboration on Reform and Modernisation agenda

KEY RESULT AREAS:

Strategy Development:

- Contribute to strategy development as part of Directorate Senior Management Team.
- To advise the Management Team of Directorate priorities and pressures and contribute to the development of an Annual Directorate Management Plan and Trust Delivery Plan

Service Delivery

- To function as a member of the Directorate management team with responsibility to contribute to strategic development and operational excellence.
- Provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the directorate
- Use the resources of the Directorate to deliver, in both quality and quantity, the activity and targets agreed for the Directorate
- To support the Trust in planning a response to major incidents and outbreaks.

Professional Leadership

- To develop and lead a team of Clinical Directors and Specialty Leads to assist the Trust in the redesign, modernisation and improvement of service delivery and ensure a senior professional clinical lead on the major Trust facilitiesl
- To identify and make provision for the training and development needs of designated medical staff in the Directorate and facilitate research activity in the Directorate
- To ensure the highest standards of clinical effectiveness and medical practice in the Directorate, including the implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines and Regional and National Reports
- Contribute as an effective member of Directorate Governance Committee
- To place Patient Safety at the centre of Directorate activity

Medical Education and Research

- Be responsible for the delivery and development of Medical Education and Research within the Directorate

Leading the Medical Team

- Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff and to ensure that personal and professional development plans are in line with corporate objectives

- Implement the consultant contract, within the Directorate, ensuring the contract supports modernisation, quality improvement and achievement of access targets

- Provide leadership in the effective implementation and monitoring of Modernising Medical Careers and The New Deal for Junior Doctors.

- Ensure that doctors within the Directorate comply with arrangements for the assessment of fitness for clinical work and be responsible within the directorate for professional standards and regulation of doctors

- Ensure that a process is in place within the directorate for proper appraisal of all grades of doctors, including locum tenens, in line with regional guidance.

- Take part in the recruitment process for new doctors or ensure that other colleagues do so effectively

- Influence the modernisation of the workforce as systems for delivering care change

- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

Quality & Information Management

- Support the development of clinical indicators and outcome measures relevant to the Directorate clinical specialities.

- Ensure a programme of multi-professional clinical audit is implemented within the Directorate that supports the Trust integrated governance strategy and support the development of benchmarking activities within the Directorate

- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the Directorate

Collaborative Working

- Actively promote the development of clinical and professional networks across primary, secondary and social care.

- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated

- Promote and develop effective multi-professional team working and communication.

Corporate Responsibilities

- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Associate Medical Director – Surgery/Elective Care works. Other duties of a similar nature and

appropriate to the grade may be assigned from time to time by the Medical Director/ Director of Acute Services.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

July 2007

Southern Health and Social Care Trust
Associate Medical Director – Surgery/Elective Care

Personnel Specification:

Title of Post: **Associate Medical Director – Surgery/Elective Care**

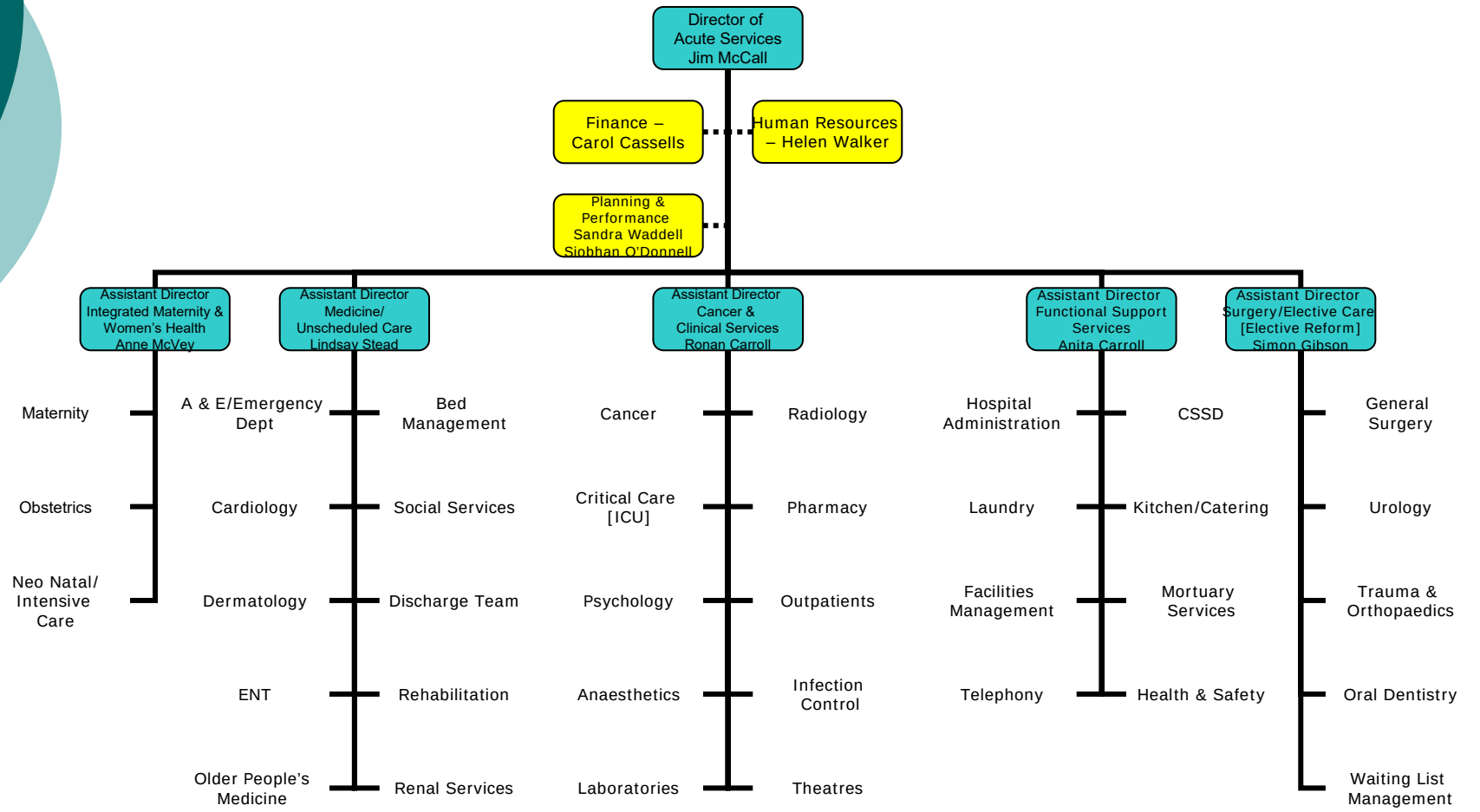
Knowledge, skills and experience required:

- Hold a medical or dental qualification, GMC registration and specialist accreditation.
- Demonstrate evidence of leadership within a team that led to successful service development and/or quality improvement.
- Demonstrate evidence of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.
- Have excellent communication skills, both orally and in writing.
- Be prepared to undertake clinical management development.

SHORTLISTING

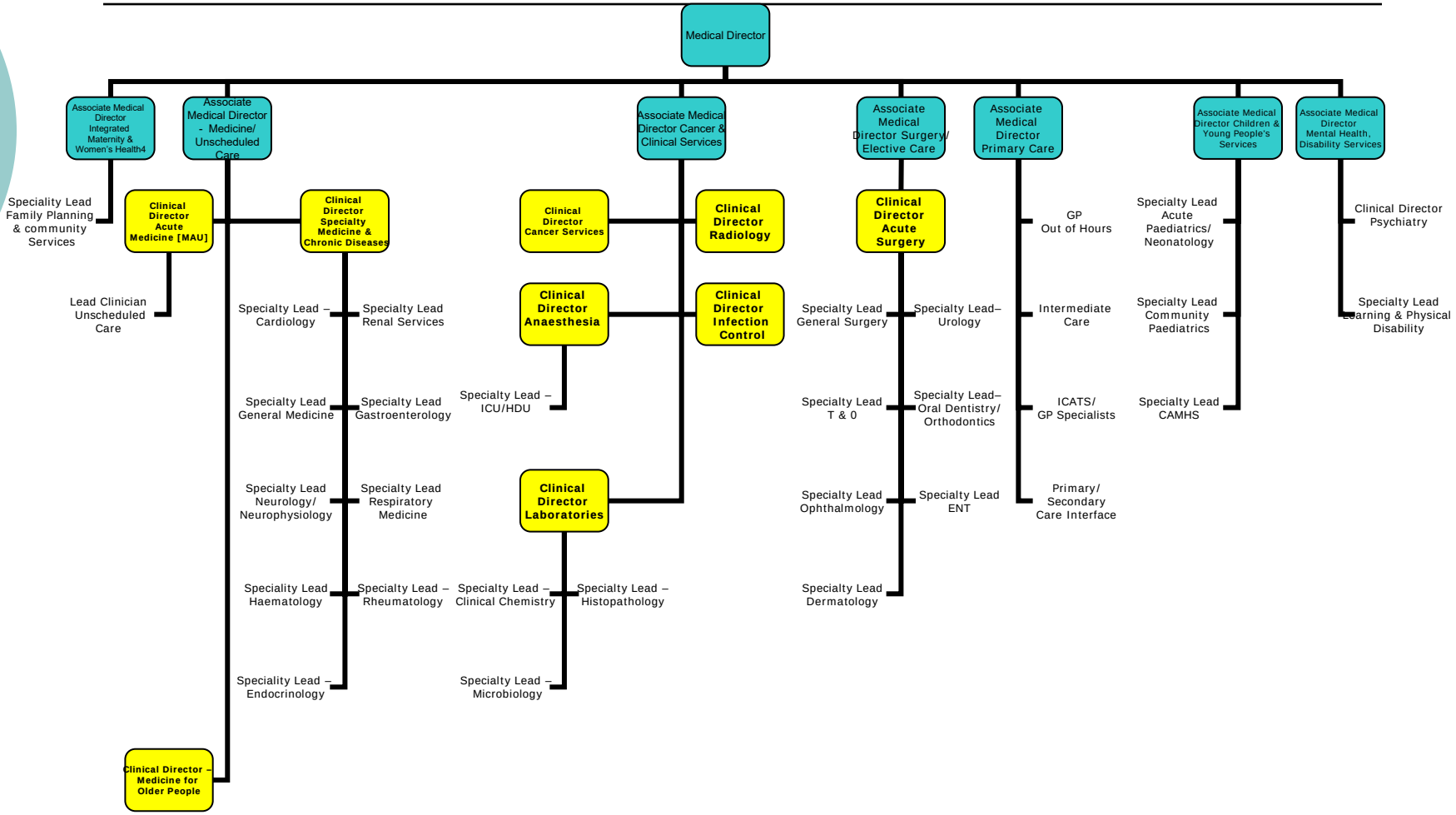
A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified

Directorate of Acute Services



Medical Management/Structures will be confirmed following appointment of Medical Director

Medical Directorate Structure



Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

Tile of Post:	Clinical Director – General Surgery Daisy Hill Hospital
Directorate/Division:	Acute Services Directorate
Responsible to:	Director of Acute Services
Operationally Responsible to:	Associate Medical Director
Accountable to:	Chief Executive
Hours:	Salaried Part Time position

KEY RESPONSIBILITIES

OPERATIONAL EFFECTIVENESS OF SERVICES

Operational Management

- Attends Directorate wide meetings with Service Director, AMD, and Assistant Directors etc.
- Holds a regular Divisional meeting for medical staff – often as Chair of meeting.
- First port of call for Assistant Directors for issues arising at Divisional level.

Service Development:

- Provides a medical perspective on protocols/pathways related to service improvements within the Division.
- Actively participates in discussions about service change and medical capacity.
- Leads the medical aspects of service change at Divisional level, and contributes to the implementation of required multi-disciplinary change.

Budgetary Awareness:

- Takes account of the financial implications when making decisions in conjunction with Assistant Directors and with the support of Finance staff. (for example, taking account

of medical staffing/locum costs within service delivery and development; cost of sickness absence, approval of doctors expenses etc).

GOVERNANCE AND PROFESSIONAL PRACTICE STANDARDS

Divisional Governance Forum

- Participates in Divisional governance activities/meetings, as agreed with Associate Medical Director.
- Working with the Trust/Directorate Governance manager to ensure effective clinical governance.
- Involved in complaints investigation and resolution, critical incident reporting and follow-up, risk management and audit.

Standards

- Providing advice to Assistant Director and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidance etc.,
- Assisting in the preparation for external inspections.
- Working with relevant managers and colleagues on implementation plans to address issues highlighted by external audits/reviews (e.g. RQIA, CMOs office, Child Protection etc.,) overseeing development and roll out of implementation plans in conjunction with the Director/ADs.

Public Health and urgent operational issues

- Contributes to the roll out of contingency plans, working with identified leads and the Associate Medical Director. (e.g. Swine flu, hyponatraemia)

Education and Research

- Contributes to decisions to resolve tensions at Specialty level between the demands of service delivery and training.

Note: Some Clinical Directors have an education and training remit

MEDICAL MANAGEMENT

Appraisal

- Undertakes appraisal for a number of Consultant staff (usually 5-6).
- Assures AMD that appraisals have been completed and reports on common issues arising.

Job Planning

Participates in Job Planning as agreed with Associate Medical Director (delegated function).

Application of Medical HR policies

- Undertakes a management role in the application of relevant medical HR policies and the provision of advice to medical colleagues, in areas such as.
  - Annual leave
  - Study leave
  - Performance
  - Sickness

- Liaises with Human Resources for appropriate advice and support.

- May be the nominated person for the Directorate in specific HR policies.

Communication

- Facilitates good communication with medical staff, formally through meetings and informally through other opportunities.

- Liaises with other clinical managers in support of good multidisciplinary team working.

- Acts as a primary communication point within the Division for management and medical colleagues.

This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Review of Clinical and Social Care Governance

For Approval

September 2010

1. Context

The Southern Health and Social Care Trust (the Trust) is committed to **providing safe, high quality care**. Key to the achievement of safe, quality care is effective structures, systems and processes to ensure that standards for services, care and our workforce are agreed, understood, implemented monitored and reported, and that where these standards are not met, this is known at all levels in the organisation and effective actions are taken to address any gaps.

In the current and future environment, with increasing expectations and reducing resources, it is even more important that Trust Board and staff at all levels are focused on the delivery of safe care, that there are systems in place to measure and assure our compliance with key standards, and that there are systems and processes to quickly and effectively address any gap in compliance which could impact on the delivery of safe care. Where compliance is not possible within our resources, it is equally important that the Trust understands the constraints in achieving compliance and communicates these to our commissioner and DHSSPS.

Service Reviews from England and elsewhere have highlighted organisational and practice issues which have resulted in poor quality, and in some cases unsafe care. The Mid Staffordshire NHS Foundation Trust Enquiry and the resultant reports provide an important framework against which to judge our capability to provide safe, high quality care.

It is in this context that the Senior Management Team of the Trust commissioned a Review of Clinical and Social Care Governance arrangements within the Trust.

2. Purpose and Objectives of Review

A Review of Clinical and Social Care Governance (CSCG) was commissioned by the Acting Chief Executive and SMT in March 2010 with the remit to critically appraise the Trust's current operational and assurance systems in relation to CSCG, including processes, capacity, capability and outcomes from the current system (see Appendix 1 for Terms of Reference). Triggers for the review included:

- A recent internal review of the assurance mechanisms for CSCG which recommended structural change, including the appointment of a Head of Governance, to improve co-ordination and assurance mechanisms.
- Concerns and issues raised through engagement with professional teams about the effectiveness of the Trust's current CSCG systems and processes, and their understanding and ownership of same.
- The Trust's desire to ensure that recommendations and learning from independent inquiries relating to CSCG issues, such as The Mid Staffordshire NHS Foundation Trust Inquiry, should be assessed and acted upon.

During the latter half of 2009 the Trust commenced a diagnostic exercise, benchmarking our systems of care against the initial Mid Staffordshire Report (2009) (MS1). This first Mid-Staffordshire

report detailed at a very operational level what had actually occurred within that organisation. While conducting this diagnostic within the Southern Trust it was evident that although there were no major operational shortcomings identified with respect to patient safety and quality of care, a number of significant system and organisational issues were emerging, including:

- The Trust's ability to capture and report issues of safety and quality of care in a systematic and timely way.
- At service team level, a lack of understanding of the roles and responsibilities within the organisation for clinical and social care governance, resulting in a lack of confidence and ownership of their role, combined with a lack of capacity to respond to the increasing CSCG agenda.
- The respective roles and responsibilities for the provision of professional guidance and advice to the organisation and the responsibility and accountability for the delivery of safe and quality care and workforce standards were not clear.
- A lack of a proactive, co-ordinated approach across Directorates and the organisation as a whole to the identification and management of safety and quality concerns.

During the period of the Trust's diagnostic exercise, the second Mid Staffordshire Report (2010) (MS2) was released. This second report provided an in depth analysis as to the underlying organisational and structural causes of the actual operational incidences and resultant quality and safety issues. The organisational issues identified included poor and overly complex CSCG structures which enjoyed little clinical engagement and

support and which did not provide the SMT and the Trust Board of that organisation with robust and timely information on compliance with safety and quality standards. The lack of effective systems to inform the SMT and Trust Board of safety issues, service or workforce risk was also highlighted.

This combination of findings from the Trust diagnostic and the second Mid Staffordshire Report gave rise to the Acting Chief Executive and SMT to commission a full review of Trust CSCG responsibilities, processes, capacity, capability and outcomes.

During the course of the Review, a number of additional considerations emerged:

- The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010 was laid before the Assembly in June 2010, to come into force on 1 October 2010. These Regulations place significant responsibilities on the Trust and the Medical Director in relation to the conduct, safety and competence of the medical workforce, and requires the Medical Director to review the Trust's clinical indicators relating to outcomes for patients, to identify any issues arising from that information that relates to variation in individual medical performance/practice, and to ensure the Trust addresses any such issues. The Responsible Officer role (see Appendix 2) is a significant additional role for the Medical Director.
- The Department and Regional Board have adopted a more rigorous approach to seeking assurance from Trusts in relation to compliance with standards of care. A process is now in place

that a statement of compliance, identification of any gaps in compliance and a Trust Action plan to address such gaps is required to be submitted.

3. Review Methodology

The key themes explored in depth during the review are set out in Section 2 and include:

- The definition, communication and understanding of responsibility, accountability and reporting mechanisms for CSCG (TOR).
- The effectiveness of current incident reporting, risk assessments and complaint management, together with other information, to manage risk and ensure as an outcome of current processes lessons are learned and risk is mitigated and/or managed (TOR).
- The degree to which clinical teams and front line operational staff are engaged and involved in CSCG systems, processes and assurance mechanisms (TOR).

With respect to the MS2 the Trust's current position on CSCG was benchmarked against key high level findings in the 2010 report, some of which included:

- "…..Formulaic approach which appeared to value process over substance"
- "…… a corporate focus on process at the expense of outcomes"

- "….the Trust often did not apply effective remedial action"
- "The structure had several layers of management between divisional governance groups and the board"
- "There was serial filtering of information and ……the board were distanced from the reality of complaints"
- "There were a very complicated, incomprehensible structure of committees and it was very unclear which committee reported to which or what the functions were"
- "Clinical teams were not fully engaged with governance"

The Review, while intending to satisfy its TOR and benchmark the organisation against the findings of MS1 and MS2, has adopted a very basic and fundamental template on which to assess the current CSCG system and make recommendations for improvement. Four basic questions were considered in the examination of the current roles, responsibilities, accountability arrangements and systems, and the resolution of these questions have shaped and informed the SMT recommendations:

1. What does the Trust mean by clinical and social care governance – what are its components?
2. Who is responsible and accountable for delivering these components?
3. How does the Trust deliver these components?
4. What products does the Trust get from these components, and will these products address the recommendations of MS1 and MS2?

The methodology adopted within the Review has considered each of these questions against the current position and has derived recommendations for improvement, based on best practice literature and interviews with all key staff groups including the Medical Directorate and the CSCG team within that, professional governance staff from Medicine, Nursing, Social work and AHP'S and operational staff from all Directorates and all disciplines. The emerging issues and associated professional views have been presented to SMT on an ongoing basis and worked through in a series of SMT workshops. The recommendations emerging from these workshops are presented within this paper.

4. Review Findings (1)

Through the process of the Review, a number of key principles were discussed and agreed by the SMT:

- Effective decision making is as close to the point of service delivery as possible.
- Clarity and singularity of responsibility and accountability, ensuring clear lines of accountability within the organisation.
- An in-depth understanding and agreement of the 'professional' Executive Director role and responsibilities, to provide the organisation with resolved professional guidance, advice and expertise in relation to standards for quality and safety of care and of the professional workforce (medical, nursing, social work and AHP).
- The operational management of services carries the responsibility and accountability for the safety and quality of

those services and of the workforce delivering the care, supported by the Executive Directors when appropriate in relation to professional workforce matters.

- Clear arrangements are needed to ensure shared learning across the organisation.
- Effective organisational intelligence is critical to the identification and effective management of patient and client safety and service quality, and this must be available both corporately and at all levels in the organisation.
- These principles are underpinned by the organisations continued commitment to a culture of openness, transparency and fairness.

In responding to the first two key questions:

1. What does the SHSCT mean by clinical and social care governance – what are its components AND

2. Who is responsible for delivering these components?

The Review findings were that:

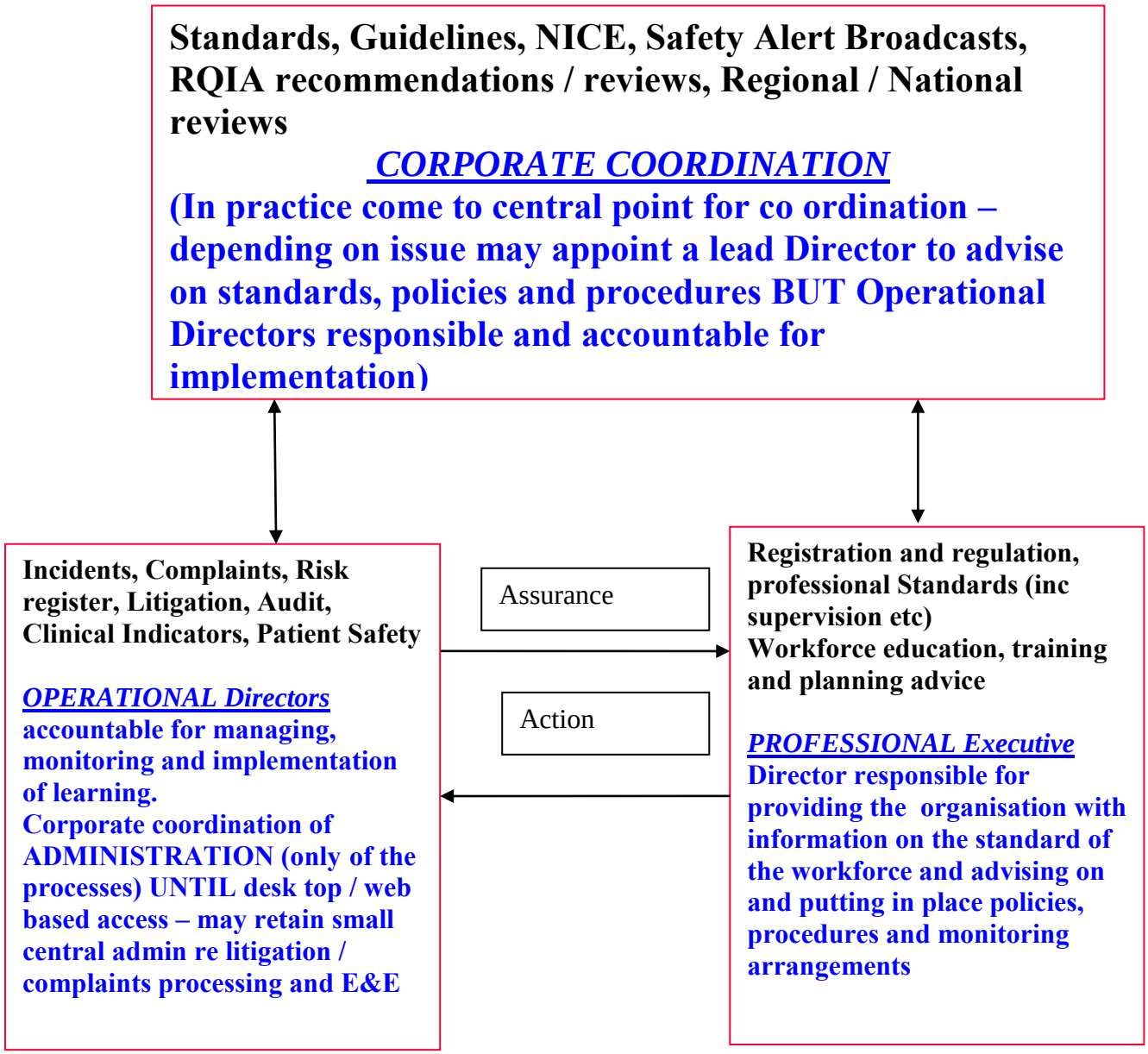
- The components of CSCG are not clearly described within Trust documentation, nor are they fully understood. There is lack of clarity with respect to current roles and accountability for elements of CSCG.

There is a need to promote understanding and clarity at all levels of the organisation surrounding the principle of Integrated Governance and where the newly defined CSCG component fits into the picture

4.1 SMT Recommendations on Review Findings (1):

- The SMT have agreed 3 simple components of CSCG within the Southern Trust which is described in diagrammatic form overleaf with further definition and clarity on the roles within the 3 components set out below the diagram.
- To provide context for the new definition of CSCG, the Trust Integrated Governance Strategy will require revision and dissemination to front line staff as part of a CSCG road show.

Three Core Components of CSCG



4.1.2 Professional Executive Function:

It is recommended that the Executive function within the Trust (Medical Director/ Responsible Officer, Director of Nursing & AHP and Director of Social Work) is defined as:

- Providing the organisation with independent and resolved professional expert advice, consultancy and audit in order to assure the organisation on the current standard of each of the aforementioned professional workforce groupings.
- Providing professional advice and guidance to the organisation as to the indicators to be used to provide intelligence to the organisation on the safety and competence standards of the relevant professional workforce.
- Provide independent assurance to the organisation on the compliance with these standards, and an 'alert' function at corporate level in relation to professional issues arising from the analysis of the service indicators.
- Provide the organisation with professional expertise and guidance as to the appropriate training and development requirements for each of the relevant professional workforces and provide assurance that the workforce is adequately skilled to provide safe quality care.

Given this definition, it provides clarity that the Executive function is neither a line management nor an operational role, and cannot be held accountable for delivering the actions required to ensure workforce standards and quality and safety of care. This accountability clearly lies with the operational Director charged with delivering this service, who must provide assurance to the Executive function that action is taking place to ensure a workforce of an acceptable standard and safe and high quality care is delivered.

If an Executive Director is concerned about any aspect of compliance with agreed workforce standards or the outcome of clinical indicators in any area of the Trust, it has been agreed that he/she should initially address this concern with the Operational Director, as the latter has the responsibility and authority to take action to resolve the issues arising. However should the Operational Director be unable to comply, the Executive Director has the responsibility and authority to report this to the Chief Executive, who will then, if appropriate, report this to the corporate organisation including Governance Committee and Trust Board.

Further work on the mechanisms for standard setting, monitoring and auditing the various aspects of workforce standards is recommended as a follow on piece of work post the review.

Under this function the review also raised the issue of the non registered work force and the lack of clarity around how their requirements for regulation, assessment, education, training and workforce planning advice. Each Director has agreed to take a section of the non registered workforce and ensure that they are receiving the same support as the professional workforce.

Finally the process of dealing with professional underperformance and conduct issues has been reviewed under this function. As a direct result processes for dealing with these issues have been agreed at SMT and for medical staff are aligned to regional guidance. It is recommended that these are again communicated to the service via CSCG road shows and that operational staff

involved in implementing these processes are trained in the roles they are being asked to undertake.

The above clarity in definition of the Executive function and how it integrates with the Operational function provides clear accountability arrangements for staff of all professions via their line management structures and should lead to an assurance that workforce standards are defined, understood, actioned and audited.

4.1.3 Operational Director Function

It is recommended that the Operational Service Director function is accountable for reporting, actioning (i.e. learning from and mitigating risk), managing and monitoring patient and client safety and quality of care. This includes management of incidents, complaints and risk registers. This function will also be accountable for implementing appropriate clinical audit and monitoring and reporting against agreed clinical indicators and patient safety standards. However decisions on what will be audited and which indicators will be monitored will be a corporate SMT decision involving Executive Director professional expert advice and analysis.

Operational Service Directors and their service divisions/teams should be the vehicle for reporting incidents, responding to complaints, actioning both and learning lessons from them to mitigate future risk. Therefore, as a result of evidence gleaned through the review, SMT have concluded that these same teams should therefore have ownership of the processes for recording

and managing these issues. The current paper based systems for recording and then subsequent transfer to a remote information management system (Datix) is to be transformed with the roll out of a web based version of Datix, available on clinical desktops for immediate capturing and follow up on incidents, complaints and risk. This roll out and future management of the information system will be the responsibility of the Informatics division.

Litigation will remain a small corporate function but links with the Operational function will be strengthened and formalised in order to support operational action and learning of lessons on issues of concern arising during litigation and when a case is closed.

In order to assist service teams with the management of their CSCG operational elements, each Directorate will have an additional whole time equivalent (wte) at Band 8 within the Directorate management structures to assist with both CSCG and operational matters. This post will act as a focal point for the Service Director with respect to CSCG, and will work through and with the Associate Medical Directors (AMDs) and Assistant Directors (ADs) to achieve a coordinated and comprehensive CSCG system.

One other requirement in the definition of the Operational component of CSCG is that the roles of AMD, AD and HOS need strengthened in terms of CSCG and their roles and accountability clarifed. This has already commenced with a review and amendments to the AMD job descriptors for new or replacement posts

4.1.4. Corporate Coordinating Function

This function will provide a corporate oversight of CSCG for the organisation, and specifically in relation to trends, exceptions, and organisational wide issues arising from non compliance with standards of care, incidents, complaints, risk and audit. It will provide a management structure for the small central team described earlier which includes litigation, central audit support and will also provide corporate information from the Datix system. This function will be led by a Senior Manager.

SMT also envisage that this function will provide a single corporate point of receipt, compliance testing and action planning for all standards, guidelines, NICE, Safety Alert Broadcasts, RQIA recommendations / reviews and Regional / National reviews.

In order to address and action corporate trends, issues, standards and guidance to be implemented the senior manager responsible for this function will chair a governance working body which brings together all Directorates, professions and expertise within the Trust on a regular basis to plan, implement and monitor these issues. The membership of this body will include Directorate representation at AMD, AD and Band 8 Operational Governance lead, Professional Governance ADs, Medical, Pharmacy and Dental representation and will be chaired by the Corporate Senior Manager.

Following on from the definition of other roles including the Executive Director and Service Director function, SMT have recommended that this function and the senior manager leading it is line managed by the Chief Executive's office to ensure its ability to act corporately and independently, and that it can provide, through the Chief Executive, arbitration in cases of non compliance or dispute.

5.0 Review Findings (2)

In relation to the third question 'How does the Trust deliver these components', the Review findings were as follows:

- The links between service Directorates and SMT Governance require improvement in order to ensure reduced filtering of information, robust, timely analysis of the individual Directorate and corporate position and ensure correct interpretation and implementation of corporate strategic intent

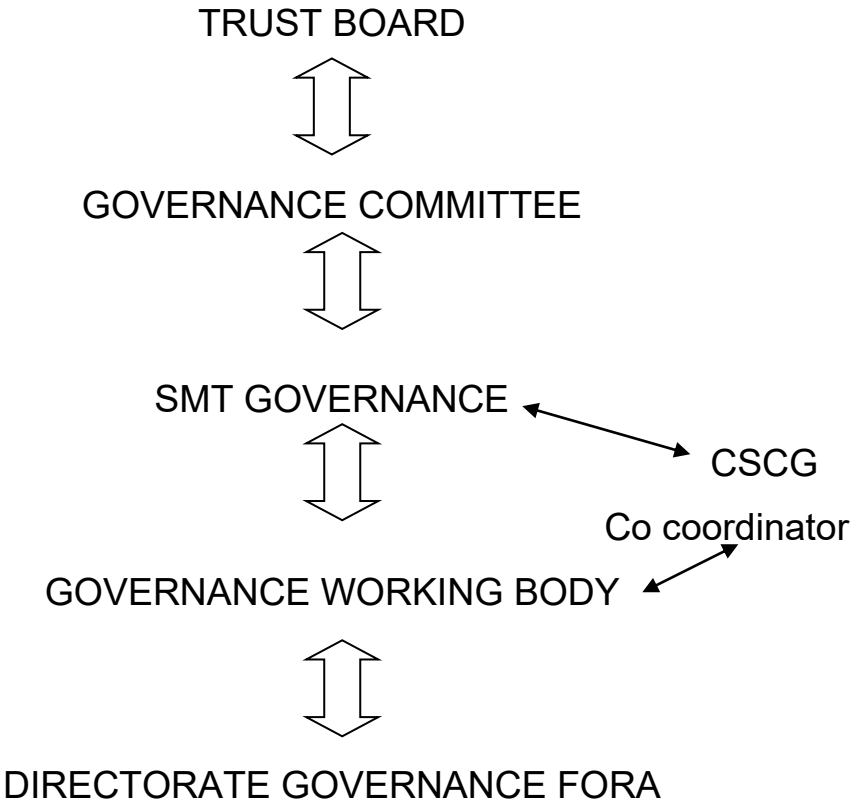
- The links between service directorates, Governance committee and Trust Board require strengthening in relation to organisational intelligence, information, analysis and timeliness.

5.1 SMT Recommendations on Review Findings (2)

5.1.1 Adoption of the three components of CSCG and their functions will address the above issues and effectively connect the operational service delivery arm of the organisation to the strategic arm. The following diagrammatic representation of how the

elements of the model would interact demonstrates the connectivity and clarity required.

ORGANISATIONAL CONNECTIVITY



The SMT defined the products which the Trust must get from these components as:

- Clarity of responsibility and accountability

- Ownership and engagement at all levels of the organisation
- Deeper understanding and appreciation of CSCG risks across the organisation at a corporate level
- Robust systems for identification of levels of compliance with standards and guidelines (service and workforce). And action planning to address compliance gaps
- Cross organisational learning systems.

The focus on three distinct but integrated elements of CSCG which are clearly defined will provide significant benefit to each level of the above diagram as listed below

Directorate Governance Fora:

- Ownership and control over their clinical incidents, complaints, risk and audit, with timely information available to all clinical teams for action and monitoring
- A direct link to all other directorates to assist with cross directorate learning through the governance body.
- A link and working partnership with professional governance expertise through the governance working body
- A direct link through the coordinator to SMT governance

Governance Working Body:

- Ability to review trends and exceptions and disseminate learning
- Plans, implements and reviews organisational wide CSCG issues including reviews, guidance and standards

- A direct link with SMT Governance to provide them with operational intelligence and to assist with prioritisation of implementation at an operational level.
- Allows integration of professional and service issues and priorities

CSCG Senior Manager:

- Chairs Governance Working Body and ensures standards, guidance, alerts etc planned, implemented and reviewed.
- Provides SMT Governance with robust, well analysed information to support decision making, prioritisation and awareness re exception and trends, thus enabling improved information to support the Governance Committee.
- Provides a system alert at corporate and Directorate level.
- Ensures that corporate strategic intent is interpreted correctly at operational level and can be implemented.
- Can also provide support to individual directors and their band 8, AMD's and AD's with regard to trends, exceptions and learning.

SMT Governance and Governance Committee:

- Provides capacity for focus on strategic and operational direction of CSCG based on good intelligence and sound information.
- Allows focus on critical issues, organisational risks and decisions on prioritisation of CSCG issues.

- Facilitates each individual and the corporate team to be aware of and action trends, exceptions and implement standards and guidelines to ensure patient safety and quality

The SMT would seek endorsement of these recommendations by Governance Committee.

Following endorsement, these recommendations will be translated into new organisational structures for consultation with the wider workforce within the Trust. It is proposed to complete this consultation exercise by end of November 2010

APPENDIX 1

Terms of Reference

TERMS OF REFERENCE

REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE ARRANGEMENTS

Context

The Trust has moved to implement new arrangements designed to ensure an effective assurance framework for Clinical and Social Care Governance within the Southern Trust.

Under this model, direction will be provided by the Senior Management Team working through a new post of Head of Governance. The Head of Governance will lead a "virtual" integrated Clinical & Social Care Governance (C&SCG) Team with the aim of providing assurance that Trust services are delivered to the appropriate standards in relation to quality and safety of care, and that any risks in relation to quality and safety are effectively identified and managed.

This process is designed to ensure the identification and effective control of risks within the Trust's Board Assurance Framework, assurance on the effectiveness of the Trust's C&SCG arrangements, and the provision of expert advice and support to Directorate Governance arrangements.

The Trust was not successful in making an appointment when the post was advertised internally within the Trust in January 2010 and has decided to advertise externally for the post.

Due to the urgent nature of the work to be undertaken the Chief Executive has commissioned a review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information and systems available to provide assurance on the safety and quality of our care.

Review Terms of Reference

The Trust has agreed to appoint a project manager on an interim basis for three months.

The aim of the review is to assess the effectiveness of the Trust's clinical and social care governance mechanisms in relation to:

- The appropriate and timely identification of risks in relation to the safety and quality of clinical and social care.
- The use of adverse incident reporting, 'near misses', risk assessments, complaints and other information sources to inform the identification of such risks.
- The effectiveness of current systems, processes, capabilities and capacity in providing effective management of such risks.
- Systems to ensure that lessons are learned from these internal processes and embedded throughout the Trust.
- Systems to draw and evaluate learning from elsewhere and use this information to assess and where necessary improve safety and quality of care.
- Clinical engagement and involvement in clinical and social care governance systems, processes and assurance mechanisms.
- Processes for ensuring the implementation of standards and guidelines.
- Support to and within Directorates to effectively implement the above.
- The selection, capture, measurement and reporting of safety and quality indicators and information to provide robust assurance to SMT Governance, Governance Committee and Trust Board on the safety and quality of Trust services.
- The definition, communication and understanding of responsibility, accountability and reporting mechanisms for clinical and social care governance.

The Project Manager will undertake a process of in-depth engagement with key stakeholders to ensure this assessment of

effectiveness is robust, and to ensure ownership for any associated recommendations for improvement. Part of this engagement process will be the establishment of the 'Virtual Clinical and Social Care Governance Team' as to act in support of the Project Manager and as a key stakeholder group.

This assessment and engagement process will inform the Project Manager's recommendations to SMT Governance in relation to current and planned future clinical and social care governance arrangements, and will complement and integrate with the development of an action plan which ensures the findings and learning from the report into Mid-Staffordshire NHS Foundation Trust are implemented within the Southern Trust.

This assessment, recommendations and action plan will be presented to SMT Governance by the end of June, with updates on progress being provided on a monthly basis for the duration of the Review.

The project manager will report to the Chief Executive for the duration of the project.

March 2010

APPENDIX 2

Medical Profession (Responsible Officers) Regulation (Northern Ireland) 2010

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÂNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Tel: Personal Information redacted by USI
E-mail gail.anderson Personal Information redacted by USI

July 2010

Dear Sir/Madam

The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010

I enclose for your information a copy of the above named Statutory Rule which was made on 23rd June 2010 and will come into operation on 1st October 2010.

If you require further copies, these can be purchased from The Stationery Office, 16 Arthur Street, Belfast, BT1 4GD. Alternatively, the Regulations are available on the OPSI website at www.opsi.gov.uk.

Yours faithfully

Personal Information redacted by USI

Gail Anderson
Human Resources Directorate

STATUTORY RULES OF NORTHERN IRELAND

2010 No. 222

HEALTH AND PERSONAL SOCIAL SERVICES

The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010

Laid before the Assembly in draft

Made - - - -	*23rd June 2010*
Coming into operation -	*1st October 2010*

The Department of Health, Social Services and Public Safety makes the following Regulations in exercise of the powers conferred by section 45A of the Medical Act 1983(a) and section 120 of the Health and Social Care Act 2008(b).

PART 1

General

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010 and shall come into operation on 1st October 2010.

(2) In these Regulations—

"the 2008 Act" means the Health and Social Care Act 2008;

"the Act" means the Medical Act 1983;

"clinical practice" includes medical practice or professional practice;

"the Department" means the Department of Health, Social Services and Public Safety;

"Health and Social Care Regulation and Quality Improvement Authority" means the body established under the Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003(c);

"a Health and Social Care Trust" means a body established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991(d);

"hospital" has the same meaning as in Article 2(2) of the Health and Personal Social Services (Northern Ireland) Order 1972(e);

(a) 1983 c.54; sections 45A to 45F were inserted by section 119 of the Health and Social Care Act 2008 (c. 14).
(b) 2008 c.14.
(c) S.I.2003/431 (N.I.9) renamed by section 1(2)(a) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 c.1 (N.I.)
(d) S.I.1991/194 (N.I.1)
(e) S.I.1972/1265 (N.I.14)

"HSC body" means any of the bodies listed in section 1(5) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(a);

"medical practitioner" except in regulation 5(1)(b) means a fully registered person within the meaning of the Act who holds a licence to practise under the Act;

"medical services" means services provided by a medical practitioner;

"non-departmental public body" means a body, other than a Northern Ireland department, established by a statutory provision to perform functions conferred on it under that statutory provision or any other statutory provision;

"Northern Ireland Blood Transfusion Service" means the special agency established by Order(b) under Article 3 of the Health and Personal Social Services (Special Agencies)(Northern Ireland)Order 1990(c);

"Northern Ireland Medical and Dental Training Agency" means the special agency established by Order(d) under Article 3 of the Health and Personal Social Services (Special Agencies)(Northern Ireland)Order 1990;

"nursing home" and "residential care home" have the same meanings as in the Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003;

"practising privileges" means the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital;

"Primary medical services performers list" means the list prepared in accordance with regulation 4 of the Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004(e);

"the Regional Agency for Public Health and Social Well-Being" means the body established under section 12 of the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"the Regional Business Services Organisation" means the body established under section 14 of the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"the Regional Health and Social Care Board" means the body established under section 7 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

"a special health and social care agency" means a special agency established under Article 3 of the Health and Social Services (Special Agencies) (Northern Ireland) Order 1990.

(3) The Interpretation Act (Northern Ireland)1954 shall apply to these Regulations as it applies to an Act of the Assembly(f).

PART 2

Responsible Officers

Designated bodies

2.—(1) The designation of bodies for the purposes of section 45A of the Act is prescribed as follows.

(2) The bodies listed in Part 1 of the Schedule are designated bodies.

(3) The bodies listed in Part 2 of the Schedule, to the extent that they do not fall within Part 1 of the Schedule, are designated bodies only if and for so long as they employ or contract with one or more medical practitioners.

(a) 2009 c.1(N.I.)
(b) S.R. 1994 No.175
(c) S.I. 1990/247 (N.I.3)
(d) S.R. 2004 No.62
(e) S.R.2004 No.149 as amended by S.R.2008 No.434
(f) 1954 c.33(N.I.)

Duty to nominate or appoint responsible officers

3.—(1) Subject to the following provisions of this regulation, every designated body must nominate or appoint a responsible officer.

(2) When a responsible officer nominated or appointed in accordance with paragraph (1) ceases to hold that position, the designated body must nominate or appoint a replacement as soon as reasonably practicable.

(3) A body listed in Part 2 of the Schedule which is a designated body by virtue of regulation 2(3) is not required to nominate or appoint a responsible officer if, and for so long as, there is no prescribed connection under regulation 8 between that body and any medical practitioner.

Duty to nominate or appoint additional responsible officers in cases of conflict of interest or appearance of bias

4.—(1)A designated body must nominate or appoint a second responsible officer where—

(a) the designated body has nominated or appointed a responsible officer in accordance with regulation 3; and

(b) there is a conflict of interest or an appearance of bias between that responsible officer and a medical practitioner in respect of whom that officer has responsibilities under regulation 9 or 11 ("the relevant practitioner").

(2) In considering whom to nominate or appoint as a second responsible officer in accordance with paragraph (1), the designated body must ensure that there is no conflict of interest or appearance of bias between the person to be nominated or appointed and the relevant practitioner.

(3) Where a second responsible officer has been nominated or appointed in accordance with paragraph (1), that responsible officer, and not the first responsible officer, has the responsibilities specified in regulation 9 or 11 in relation to the relevant practitioner.

Conditions for nomination or appointment of responsible officers and for remaining as responsible officers

5.—(1) The following conditions must be satisfied in order for a person to be nominated or appointed as a responsible officer of a designated body under regulation 3 or 4—

(a) the person must be a medical practitioner; and

(b) the person must, at the time of appointment, have been a medical practitioner throughout the previous 5 years, and for this purpose "medical practitioner" means a person who was fully registered under the Act at the relevant time.

(2) A responsible officer must continue to be a medical practitioner in order to remain as a responsible officer.

Nomination or appointment of one person as responsible officer for two or more designated bodies

6. The same person may be nominated or appointed as the responsible officer for two or more designated bodies where each designated body concerned is satisfied that—

(a) the person satisfies the conditions in regulation 5;

(b) the person has the capacity to carry out their responsibilities under regulation 9 or 11 for each body; and

(c) no conflict of interest is likely to arise.

Nomination of responsible officer by the Department

7. The Department may nominate a responsible officer for a designated body where—

(a) the designated body has failed to nominate or appoint a responsible officer in accordance with regulation 3 or 4; or

(b) the designated body has nominated or appointed as a responsible officer a person who does not meet the conditions in regulation 5.

Connection between designated bodies and medical practitioners

8.—(1) For the purposes of section 45B of the Act, and subject to the following provisions of this regulation and to regulation 10, a designated body has a prescribed connection with a medical practitioner in the following circumstances—

(a) the designated body is the Northern Ireland Medical and Dental Training Agency and the medical practitioner is a doctor in training managed by the Agency;

(b) where sub-paragraph (a) is not applicable, the medical practitioner is on the designated body's primary medical services performers' list;

(c) where neither sub-paragraph (a) nor (b) applies, the medical practitioner is employed by the designated body;

(d) the designated body owns or manages a hospital and the medical practitioner has practising privileges in respect of that hospital;

(e) where none of the preceding sub-paragraphs applies, the designated body is a body referred to in paragraphs 15 to 17 of the Schedule and the medical practitioner is a member of that body;

(f) where none of the preceding sub-paragraphs applies, the designated body is the Independent Doctors' Federation and the medical practitioner is a member of that body.

(2) Where a medical practitioner would otherwise have a prescribed connection with more than one designated body under paragraph (1), the prescribed connection is as follows—

(a) in any case where paragraph (1)(a) (doctor in training) applies, the prescribed connection is in accordance with that paragraph;

(b) in any case where paragraph (1)(b)(medical practitioner on the primary medical services performers list) applies, the prescribed connection is in accordance with that paragraph;

(c) subject to sub-paragraph (d), in any case where paragraph (1)(c) (medical practitioner employed by a designated body) applies, the prescribed connection is in accordance with that paragraph;

(d) where a prescribed connection with more than one designated body arises under paragraph (1)(c) —

(i) the medical practitioner has a prescribed connection with the designated body for whom the medical practitioner carries out most of their clinical practice, and

(ii) if there is no significant difference in the amount of clinical practice which the medical practitioner carries out for each designated body—

(aa) if one and only one of the designated bodies concerned is an HSC body, the medical practitioner has a prescribed connection with that body, and

(bb) in any other case, the medical practitioner has a prescribed connection with the designated body which is located the shortest distance from the medical practitioner's address as registered with the General Council;

(e) in any other case—

(i) the medical practitioner has a prescribed connection with the designated body for whom the medical practitioner carries out most of their clinical practice, and

(ii) if there is no significant difference in the amount of clinical practice which the medical practitioner carries out for each designated body—

(aa) if one and only one of the designated bodies concerned is an HSC body, the medical practitioner has a prescribed connection with that body, and

(bb) in any other case, the medical practitioner has a prescribed connection with the designated body which is located the shortest distance from the medical practitioner's address as registered with the General Council.

(3) Where—

(a) a medical practitioner ("M") would otherwise have a prescribed connection with a designated body;

(b) M has a prescribed connection with a designated body under Regulations made under section 45A of the Act in relation to England, Wales or Scotland ; and

(c) M carries out most of M's clinical practice in England, Wales or Scotland,

M does not have a prescribed connection with a designated body under this regulation.

(4) For the purposes of paragraph (2)(d)(ii)(bb) and (2)(e)(ii)(bb) the location of a designated body is the address of its principal office.

Responsibilities of responsible officers: prescribed connection under regulation 8

9.—(1) The responsible officer for a designated body has the following responsibilities relating to the evaluation of the fitness to practise of every medical practitioner who has a prescribed connection with that body by virtue of regulation 8.

(2) The responsibilities referred to in paragraph (1) are—

(a) to ensure that the designated body carries out regular appraisals on medical practitioners in accordance with paragraph (3);

(b) to establish and implement procedures to investigate concerns about a medical practitioner's fitness to practise raised by patients or staff of the designated body or arising from any other source;

(c) where appropriate, to refer concerns about the medical practitioner to the General Council;

(d) where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the General Council, to monitor compliance with those conditions or undertakings;

(e) to make recommendations to the General Council about medical practitioners' fitness to practice;

(f) to maintain records of medical practitioners' fitness to practise evaluations, including appraisals and any other investigations or assessments.

(3) The responsible officer must ensure that appraisals carried out under paragraph (2)(a) obtain and take into account all available information relating to the medical practitioner's fitness to practise in the work carried out by the medical practitioner for the designated body and for any other body, during the appraisal period.

(4) Procedures under paragraph (2)(b) must include provision for the medical practitioner's comments to be sought and taken into account where appropriate.

(5) Responsible officers must co-operate with the General Council and any of its committees, or any persons authorised by the General Council, in connection with the exercise by them of any of their functions under Part 3A or 5 of the Act.

Connection between designated bodies and medical practitioners who are responsible officers

10.—(1)Where a medical practitioner is the responsible officer for a designated body (body A) in accordance with these Regulations, the prescribed connection between that medical practitioner and a designated body for the purposes of section 45B of the Act, is as follows.

(2) Subject to paragraph (3), the medical practitioner has a prescribed connection with a designated body (body B) in the following circumstances—

(a) where body A is a Health and Social Care Trust, body B is the Regional Agency for Public Health and Social Well-Being;

(b) where body A is the Regional Health and Social Care Board, body B is the Regional Agency for Public Health and Social Well-Being;

(c) where body A is the Northern Ireland Blood Transfusion Service, body B is the Regional Agency for Public Health and Social Well-Being;

(d) where body A is the Regional Agency for Public Health and Social Well-Being, body B is the Department;

(e) where body A is the Northern Ireland Medical and Dental Training Agency, body B is the Department;

(f) where body A is the Health and Social Care Regulation and Quality Improvement Authority, body B is the Department;

(g) where body A is not a body referred to in sub-paragraphs (a) to (f) body B is the Health and Social Care Regulation and Quality Improvement Authority.

(3) The medical practitioner who is the responsible officer for the Department does not have a prescribed connection with a designated body under these Regulations.

Responsibilities of responsible officers: prescribed connection under regulation 10

11.—(1) The responsible officer for a designated body has the following responsibilities relating to the evaluation of the fitness to practise of every medical practitioner who has a prescribed connection with that body by virtue of regulation 10.

(2) The responsibilities referred to in paragraph (1) are—

(a) to take all reasonably practicable steps to ensure that the medical practitioner undergoes regular appraisals in accordance with paragraph (3);

(b) to take all reasonably practicable steps to investigate concerns about a medical practitioner's fitness to practise raised by patients or staff of the body for whom the medical practitioner is the responsible officer, or arising from any other source;

(c) where appropriate, to refer concerns about the medical practitioner to the General Council;

(d) where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the General Council, to monitor compliance with those conditions or undertakings;

(e) to make recommendations to the General Council about the medical practitioners' fitness to practice;

(f) to maintain records of the medical practitioners' fitness to practise evaluations, including appraisals and any other investigations or assessments.

(3) The responsible officer must take reasonably practicable steps to ensure that appraisals under paragraph (2)(a)—

(a) are carried out by the body for whom the medical practitioner is the responsible officer; and

(b) obtain and take into account all available information relating to the medical practitioner's fitness to practise in the work carried out by the medical practitioner during the appraisal period.

(4) Procedures under paragraph (2)(b) must include provision for the medical practitioner's comments to be sought and taken into account where appropriate.

(5) Responsible officers must co-operate with the General Council and any of its committees, or any persons authorised by the General Council, in connection with the exercise by them of any of their functions under Part 3A or 5 of the Act.

Provision of resources to responsible officers

12.—(1) Subject to paragraph (2), each designated body must provide the responsible officer appointed or nominated for that body with sufficient funds and other resources necessary to enable the officer to discharge their responsibilities for that body under regulations 9 and 11.

(2) Where the designated body does not employ its responsible officer, the body must provide the resources referred to in paragraph (1) to—

(a) where the responsible officer is employed, the employer of the officer; and

(b) in any other case, the responsible officer.

(3) Where a medical practitioner has a prescribed connection with a designated body by virtue of sub-paragraph (d), (e) or (f) of regulation 8(1), the medical practitioner must provide the designated body with sufficient funds necessary to enable the responsible officer nominated or appointed for that body to discharge their responsibilities under regulation 9 relating to that medical practitioner.

(4) The designated body must determine the amount of the sufficient funds referred to in paragraph (3) and provide to the medical practitioner a written demand for the sum required to be paid.

Duty to have regard to guidance

13. In discharging their responsibilities under regulations 9 and 11, responsible officers shall have regard to the following—

(a) guidance given by the Department in accordance with section 45C(2) of the Act;

(b) guidance given by the General Council, including Good Medical Practice and guidance on fitness to practise procedures to the extent that it relates to the nomination or appointment of responsible officers or their prescribed responsibilities.

PART 3

Additional Responsibilities of Responsible Officers

Additional responsibilities of responsible officers: prescribed connection under regulation 8

14.—(1) Where a responsible officer has responsibilities under regulation 9 in respect of a medical practitioner who has a prescribed connection with a designated body in accordance with regulation 8, the responsible officer has the following additional responsibilities.

(2) In relation to monitoring medical practitioners' conduct and performance, the responsible officer must—

(a) review regularly the general performance information held by the designated body, including clinical indicators relating to patient outcomes;

(b) identify any issues arising from this information relating to medical practitioners, such as variations in individual performance; and

(c) ensure that the designated body takes steps to address any such issues.

(3) In relation to ensuring that appropriate action is taken in response to concerns about medical practitioners' conduct or performance, the responsible officer must—

(a) initiate investigations with appropriately qualified investigators;

(b) ensure that procedures are in place to address concerns raised by patients or staff of the designated body or arising from any other source;

(c) ensure that any investigation into the conduct or performance of a medical practitioner takes into account any other relevant matters within the designated body, for example wider concerns about operational or systems issues;

(d) consider the need for further monitoring of the medical practitioner's conduct and performance and ensure that this takes place where appropriate;

(e) ensure that a medical practitioner who is subject to procedures under this paragraph is kept informed about the progress of the investigation;

(f) ensure that procedures under this paragraph include provision for the medical practitioner's comments to be sought and taken into account where appropriate;

(g) where appropriate—

(i) take any steps necessary to protect patients,

(ii) recommend to the medical practitioner's employer that the medical practitioner should be suspended or have conditions or restrictions placed on their practice, and

(h) identify concerns and ensure that appropriate measures are taken to address these, including but not limited to—

(i) requiring the medical practitioner to undergo training or retraining,

(ii) offering rehabilitation services,

(iii) providing opportunities to increase the medical practitioner's work experience,

(iv) addressing any systemic issues within the designated body which may have contributed to the concerns identified,

(i) maintain accurate records of all steps taken in accordance with this paragraph.

Additional responsibilities of responsible officers: prescribed connection under regulation 10

15.—(1) Where a responsible officer has responsibilities under regulation 11 in respect of a medical practitioner who has a prescribed connection with a designated body in accordance with regulation 10, the responsible officer has the following additional responsibilities.

(2) In relation to monitoring medical practitioners' conduct and performance, the responsible officer must—

(a) review regularly the general performance information held by the designated body, including clinical indicators relating to outcomes for patients;

(b) identify any issues arising from that information relating to medical practitioners, such as variations in individual performance; and

(c) take all reasonably practicable steps to ensure that the designated body addresses any such issues.

(3) In relation to ensuring that appropriate action is taken in response to concerns about medical practitioners' conduct or performance, the responsible officer must take all reasonably practicable steps to—

(a) ensure that the body for whom the medical practitioner is the responsible officer initiates investigations with appropriately qualified investigators;

(b) ensure that procedures are in place to address concerns raised about the medical practitioner by patients or staff of that body or arising from any other source;

(c) ensure that any investigation into the conduct or performance of a medical practitioner takes into account any other relevant matters within that body;

(d) consider the need for further monitoring of the medical practitioner's conduct and performance and take steps to ensure that this takes place where appropriate;

(e) ensure that a medical practitioner who is subject to procedures under this paragraph is kept informed about the progress of the investigation;

(f) ensure that procedures under this paragraph include provision for the medical practitioner's comments to be sought and taken into account where appropriate;

(g) where appropriate—

(i) take any steps necessary to protect patients,

(ii) recommend to the medical practitioner's employer that the practitioner should be suspended or have conditions or restrictions placed on their practice, and

(h) identify concerns and ensure that appropriate measures are taken to address these, including but not limited to—

(i) requiring the medical practitioner to undergo training or retraining,

(ii) offering rehabilitation services,

(iii) providing opportunities to increase the medical practitioner's work experience,

(i) maintain accurate records of all steps taken in accordance with this paragraph.

Duty to have regard to guidance

16. In discharging their responsibility under regulations 14 and 15, responsible officers shall have regard to the following—

(a) guidance given by the Department in accordance with section 120(6) of the 2008 Act; and

(b) guidance given by the National Clinical Assessment Service division of the National Patient Safety Agency(a), to the extent that it relates to the nomination or appointment of responsible officers or their prescribed responsibilities.

Provision of resources to responsible officers

17.—(1) Each designated body must provide its responsible officer with sufficient funds and other resources necessary to enable the officer to discharge their responsibilities for that body under regulations 14 and 15.

(2) Where the designated body does not employ its responsible officer, the body must provide the resources referred to in paragraph (1) to—

(a) where the responsible officer is employed, the employer of the officer, and

(b) in any other case, the responsible officer.

(3) Where a medical practitioner has a prescribed connection with a designated body by virtue of sub-paragraph (d), (e) or (f) of regulation 8(1), the medical practitioner must provide the designated body with sufficient funds necessary to enable the responsible officer nominated or appointed for that body to discharge their responsibilities under regulation 14 relating to that medical practitioner.

(4) The designated body must determine the amount of sufficient funds referred to in paragraph (3) and provide to the medical practitioner a written demand for the sum required to be paid.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 23rd June 2010

L.S.

Diane Taylor
A senior officer of the
Department of Health, Social Services and Public Safety

(a) See S.I.2001/1743

SCHEDULE 1

PART 1

Regulation 2(2)

Designated bodies

1. A Health and Social Care Trust.

2. The Regional Health and Social Care Board.

3. The Regional Agency for Public Health and Social Well-Being.

4. The Department.

5. Northern Ireland Medical and Dental Training Agency.

PART 2

Regulation 2(3)

Designated bodies which employ or contract with medical practitioners

6. A Northern Ireland department.

7. Health and Social Care Regulation and Quality Improvement Authority.

8. Northern Ireland Blood Transfusion Service.

9. Regional Business Services Organisation.

10. A non-departmental public body.

11. Faculties of medicine at universities and colleges of further education.

12. Special Health and Social Care Agencies.

13. Pharmaceutical companies.

14. The Independent Doctors' Federation.

15. The faculty of occupational medicine.

16. The faculty of public health medicine.

17. The faculty of pharmaceutical medicine.

18. Any organisation engaged in the provision of treatment for disease, disorder or injury by or under the supervision of a medical practitioner.

19.—(1) Any organisation which carries out surgical procedures (including all pre-operative and post-operative care associated with such procedures) for—

(a) the purpose of treating disease, injuries or disorders;

(b) subject to sub-paragraph (2), cosmetic purposes, where the procedure involves the use of instruments or equipment which are inserted into the body; or

(c) the purpose of religious observance.

(2) The following cosmetic procedures are excepted from sub-paragraph (1)(b)—

(a) ear and body piercing;

(b) tattooing; and

(c) the removal of hair roots or small blemishes on the skin by the application of heat using an electric current.

20.—(1) Subject to sub-paragraph (2), any organisation which carries out diagnostic and screening procedures involving—

(a) the use of X-rays and other methods in order to examine the body through the use of radiation, ultrasound or magnetic resonance imaging;

(b) the use of instruments and equipment which are inserted into the body to—

(i) view its internal parts, or

(ii) gather physiological data; and

(c) the use of equipment in order to measure and monitor complex physiological characteristics in major organ systems of the body and to examine bodily tissues, fluids and cells for the purposes of obtaining information on—

(i) the causes and extent of disease, or

(ii) the response to a therapeutic intervention.

(2) The taking and analysis of blood samples is excepted from sub-paragraph (1) where—

(a) the procedure is carried out by means of a pin prick; or

(b) it is not necessary to send such samples to a specialist facility for analysis.

21. Any organisation which is engaged in the analysis and reporting of the results of the procedures referred to in paragraph 20.

22. Any organisation which engages in the management of—

(a) supply of blood, blood components and blood derived products intended for transfusion;

(b) the supply of tissues and tissue derived products intended for transplant, grafting or use in a surgical procedure; and

(c) the matching and allocation of donor organs intended for transplant, and of stem cells and bone marrow intended for transfusion.

23. Any organisation engaged in the provision of medical services in slimming clinics, including the prescribing of medicines for the purposes of weight reduction.

24. A residential care home.

25. A nursing home.

26. A body engaged in the practise of alternative and complementary medicine.

27. A body engaged in the provision of first aid treatment and established for that purpose.

28. A body engaged in the provision of treatment in a sports ground or gymnasium where it is provided for the sole benefit of persons taking part in sporting activities and events.

29. A body engaged in the carrying out of any of the activities authorised by a licence granted by the Human Fertilisation and Embryology Authority under paragraph 1 of Schedule 2 to the Human Fertilisation and Embryology Act 1990(a).

30. A body engaged in the provision of residential accommodation for a person, together with treatment for drug or alcohol misuse, where acceptance by the person of such treatment is a condition of the provision of the accommodation.

31. A body engaged in the provision of medical advice in cases where immediate action or attention is needed, or triage provided, over the telephone or by electronic mail and established for that purpose, and for the purposes of this provision "triage" means the assignment of degrees of urgency to diseases, disorders or injuries in order to decide the order and place of treatment of patients.

(a) 1990 c.37 Paragraph1 of Schedule 2 was amended by the Human Fertilisation and Embryology Act 2008 (c.22), section 11 (2), Schedule 2, paragraphs 1 and 2 and section 66, Schedule 8, Part 1 and by S.I. 2007/1522.

32. An organisation engaged in the provision of medical services (otherwise than in a hospital) in which such services are provided only under arrangements made on behalf of service users by an insurance provider with whom the service users hold an insurance policy, other than an insurance policy which is solely or primarily intended to provide benefits in connection with the diagnosis or treatment of physical or mental illness, disability or infirmity.

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations establish arrangements for the introduction of "responsible officers" ("ROs") under the Medical Act 1983 ("the Act"). ROs will be appointed by health care organisations and will have responsibilities relating to the evaluation of the fitness to practice of doctors who work in the organisation. The regulations come into operation on [ ] 2010.

Part 1 of the Regulations contains general provisions: regulation 1 contains citation, commencement date and interpretation provisions.

Part 2 of the Regulations deals with the appointment of ROs and their responsibilities under the Act.

Regulation 2 and the Schedule specify the bodies which are "designated bodies" under the Act. These are the bodies that will be required to nominate or appoint ROs. Regulation 2(2) and Part 1 of the Schedule list bodies that are always required to have ROs, for example Health and Social Care Trusts; regulation 2(3) and Part 2 of the Schedule list bodies that will be required to have ROs only while they employ or contract with doctors, for example a Northern Ireland department.

Regulation 3 sets out the duty on designated bodies to nominate or appoint ROs. A body is not required to have an RO if all the doctors who work for that body already have a connection under the Regulations with another designated body (see regulation 8).

Regulation 4 requires designated bodies to nominate or appoint an additional RO in cases where there is a conflict of interest or appearance of bias between a doctor and the original RO.

Regulation 5 sets out the conditions that must be met for a person to be nominated or appointed as an RO: the person must be a registered medical practitioner, which under current legislation means a licensed doctor; they must also have been a registered doctor for the preceding 5 years. A responsible officer must continue to be a registered medical practitioner.

Regulation 6 sets out the conditions that must be satisfied for a person to be nominated or appointed as an RO for more than one designated body: the person must be capable of carrying out the ROs' responsibilities for each body concerned, and there must be no conflict of interest.

Regulation 7 provides that the Department may nominate an RO for a designated body when the body has failed to do so, or has appointed someone unsuitable.

Regulation 8 sets out the "prescribed connection" between designated bodies and doctors. When a doctor is linked to a designated body under this regulation, the RO for that body has responsibilities in respect of the doctor under regulation 9. Doctors in training are linked to the Northern Ireland Medical and Dental Training Agency which is responsible for their training. Where a doctor is on the performers' list held by the Regional Health and Social Care Board, that organisation will be the designated body for the doctor. Where the doctor is an employee of a designated body (and is not on the performers' list), the employing organisation will be the designated body for that doctor. Where a doctor is providing services to patients in an independent hospital, the body managing that hospital will be the designated body for that doctor. Where none of the other provisions applies, the doctor will be linked to the professional body of which they are a member. The regulation also sets out an order of priority in the event that the doctor could be connected to more than one body.

Regulation 9 sets out the responsibilities of ROs in relation to doctors who are connected with the designated body under regulation 8. ROs are required to evaluate doctors' fitness to practise. This includes ensuring that regular appraisals are carried out, developing procedures to address any concerns about doctors' fitness to practise, and reporting concerns to the General Council where appropriate.

Regulation 10 sets out the prescribed connection between designated bodies and doctors who are themselves ROs. It is necessary to have special provisions in these cases because ROs cannot be responsible for evaluating themselves.

Regulation 11 makes provision similar to regulation 9 in respect of ROs' responsibilities in relation to doctors who are connected with the designated body under regulation 10.

Regulation 12 contains a requirement for designated bodies and medical practitioners to provide resources to ROs, and regulation 13 contains a duty for ROs to have regard to guidance.

Part 3 contains additional responsibilities for ROs under section 120 of the Health and Social Care Act 2008.

Regulation 14 sets out the additional responsibilities for ROs in respect of the doctors for whom they are responsible under regulation 8; these include monitoring doctors' conduct and performance and investigating and taking appropriate action to deal with concerns about doctors.

Regulation 15 makes similar provision for ROs' responsibilities in relation to doctors for whom they are responsible under regulation 10.

Regulation 16 contains a duty for ROs to have regard to guidance, and regulation 17 concerns the requirement for designated bodies and medical practitioners to provide resources to ROs.

An impact assessment has been prepared in relation to these Regulations and is available from the Department of Health, Social Services and Public Safety, Castle Buildings, Stormont, Belfast, BT4 3SQ.

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STATUTORY RULES OF NORTHERN IRELAND

2010 No. 222

HEALTH AND PERSONAL SOCIAL SERVICES

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Role of SHSCT Medical Director

As part of the Review of Clinical and Social Care Governance undertaken during 2010, the role, the responsibility and accountability of Executive and Operational Directors within the Trust has been clarified and re-defined.

Clear lines of accountability and responsibility have been agreed in line with Executive and Operational Director roles. This has implications for current responsibilities of some Directors, including the Medical Director.

The purpose of this paper is to clearly set out the role of the Medical Director post implementation of the agreed recommendations of the Review of Clinical and Social Care Governance, as endorsed by the Governance Committee on 7 September 2010.

Role of Medical Director

1. The Medical Director, from 1 October 2010, has taken on the role of **Responsible Officer** for the Trust. This role carries lead responsibility and accountability for:

- The effectiveness of medical appraisal of the medical workforce, for quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.
- The provision of expert advice and assurance to the organisation in relation to the Trust's processes for addressing concerns about a medical practitioner's fitness to practice (as set out in the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance).
- The designated Trust officer for referring concerns about a medical practitioner to the General Medical Council.
- Providing professional advice to SMT as to the appropriate **indicators of safety, quality and performance**, to inform and commission the measurement of such indicators as part of SMT Governance, to regularly review this information, and to provide assurance or expert input into necessary steps to address any issues arising from same.
- Providing regular 'Responsible Officer' reports on the medical workforce to SMT, Governance Committee and Trust Board

2. The designated lead Director for strategic management of **Patient Safety** initiatives, and is the link Director with the Patient Safety Forum and other regional Fora. While the operational responsibility and accountability for patient safety rests with operational Directors, this Lead Director role includes:

   - Participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the organisation and providing strategic and professional advice on implementation.
   - Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by SMT, within the wider Clinical and Social Care Governance arrangements of the Trust.
   - Reviewing and monitoring the impact of Patient Safety Initiatives and providing regular Patient Safety reports to SMT, Governance Committee and Trust Board.

3. The quality of **medical education and training** within the Trust, including:
   - Line management of the AMD for postgraduate Medical Education, induction and training for Junior Doctors, QA/evaluation of training and supporting operational Directors to address issues arising from Deanery and PMETB evaluation and inspections.
   - Accountable for the quality of undergraduate training including delivery of QUB Accountability Framework and utilisation of SUMDE budget, and the provision of Annual Report to Trust Board.

4. The strategic management of the clinical aspects of **HCAI and Infection Control** within the Trust, including the line management of the Infection Control Team. This role includes responsibility for CAS for infection control and provision of Infection Prevention and Control Annual Report to Trust Board. The Director of Acute Services is responsible for environmental hygiene.

5. The strategic and operational management of **Research and Development** within the Trust, including the line management of the AMD for Research and Development and associated support staff. This role includes responsibility for CAS for

Research and provision of Research and Development Annual Report to Trust Board.

6. The strategic management and co-ordination of effective **Emergency Planning** within the Trust, including **Pandemic Planning**. This role includes responsibility for CAS for Emergency Planning and provision of Annual Report to Trust Board.

7. The effective governance and management of the **Litigation** function within the Trust, including effective integration with wider clinical and social care governance systems and engagement and involvement of other Directorates. Lead decision-maker for management of medical negligence (Director of HROD role as lead Director in relation to public and employee liability, health and safety related litigation, etc). Provision of regular reports to SMT, Governance Committee and Trust Board to provide assurance of effectiveness of Litigation function, systems and processes.

8. Professional lead in relation to **Information Governance**, specifically the Trust's nominated Caldicott Guardian, and chair of Trust Information Governance Committee.

9. Lead Director for the management of ECRs and Drug Requests for Southern Trust patients, and responsible for medical evaluation, decision-making and liaison with Commissioner in relation to same.

Infrastructure of Medical Directorate

To support the Medical Director to undertake the role as defined in the previous section, the infrastructure required in the Medical Directorate is as follows:

Band 8B (to support RO role – appraisal, standard setting/monitoring)
Band 7 (Emergency Planning and HCAI)
Band 6 (Patient Safety co-ordination and monitoring
Band 4 Personal Secretary to Medical Director
Band 3 PA support to Band 8B/7/6
AMDs for Research, Medical Education and CD/ICT for HCAI

Southern Health and Social Care Trust

Quality care – for you, with you

PERFORMANCE MANAGEMENT REPORT

Priority for Action
Standards and Targets

And

Key Corporate Performance Indicators

March 2010

Version	1.0 TB
Presented to Board of Directors	29/04/10
Author of report:	Dawn Livingstone
Presented by:	Paula Clarke

For information/approval

TO: **Board of Directors**

FROM: **Paula Clarke Acting Director of Performance & Reform**

DATE: **29 April 2010**

SUBJECT: **Monthly Performance Management Report**

PURPOSE

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance for March against:

- Priority for Action (PfA) 2009/10 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance

The report will highlight areas of risk for management action

SUMMARY OF KEY POINTS

Indicators highlighted as 'Red' status associated with PFA targets include:

RECOMMENDATIONS

- Diagnostic reporting urgent within 2 days (imaging and non-imaging) – Implementation of NIPACS for imaging will assist achievement of this target over the coming year.
- IP/OP Access Target -Delays in securing investment introduced risk as non-recurrent solutions had to be sustained for longer than anticipated. PMSID acknowledged that particular specialty areas will not meet the agreed targets but will not exceed 17 weeks; these are Urology, Endoscopy, T&O, and MRI services. The majority of breaches in March (99.6%) were in these specialities. The number of breaches represented 8% of total elective IP/DC seen in month and 5% of the total number of first outpatients assessed and treated within the 9/13 week standards.
- Fractures - Fracture performance continues to be variable due to the inability to provide trauma operating sessions 7 days per week. The Trust is working with commissioners to finalise agreement on investment for establishing this service. Performance in fractures is also affected by sub-specialisation.
- Care Leavers in ETE – The Trust has just recruited an Employability Worker to focus on Education, Training and Employment with 19 year olds which will impact on this target over the coming year.
- HCAI - Considerable work has and continues to be progressed to achieve the MSSA target. This work includes a comprehensive package of infection control measures including a project regarding the maintenance of peripheral venous cannulas which has been identified as the main cause of MSSA.
- Renal - Medical staff from the Trust's vascular team have completed training to undertake fistula creation and have recently commenced this service locally. This target will remain challenging due to the high number of dialysis patients who may choose not to have a fistula inserted or redone. Regional review of definitions of this target is under discussion to take account of these issues.
- Family Support Pathway – Recruitment/retention issues, increased referrals and the need to redeploy staff to key pressure points has introduced risk to achievement of this target. Measures are currently being implemented to address capacity issues relative to staff vacancies.

WHICH TRUST CORPORATE OBJECTIVE DOES THIS PAPER PROGRESS OR CHALLENGE?			
Provide safe, high quality care.	*P*	Be a great place to work.	
Maximise independence and choice for our patients and clients.	*P*	Make the best use of resources.	*P*
Support people and communities to live healthy lives and improve their health and wellbeing.	*P*	Be a good social partner within our local communities.	

(Indicate which of our key strategic objectives are progressed (P) or challenged (C))

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
We will treat people fairly and with respect.	*P*	We will value and give recognition to staff and support their development to improve our care.	
We will be open and honest and act with integrity.	*P*	We will embrace change for the better.	*P*
We will put our patients, clients, carers and community at the heart of what we do.		We will listen and learn.	

(Indicate which of Trust values are progressed (P) or challenged (C)

RISKS, CONTROLS AND ASSURANCE	
Risk	Risks discussed at SMT on 21 April 10, management actions noted.
Control	P
Assurance	P

(Indicate if: (i) new risk identified or risk is addressed (ii) if this provides/will provide control or assurance)

REVIEWED BY:	Date
Senior Management Team	Date 21/04/10
User forums/Community groups whose views have been sought	
	Date

CONTENT

CONTEXT

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance for March against:

- Priority for Action (PfA) 2009/10 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance

2. REPORTING

The PfA standards and targets and KPIs of corporate performance are presented in this performance report within the key domains defined within the performance management framework.

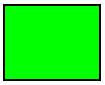
- Efficiency of Care Delivery
- Access & Targets
- Clinical and Social Care Quality
- Workforce – detailed reporting via HR & OD Directorate Report
- Finance – will be reported through the Monthly Finance Report

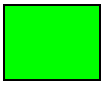
The level of performance will be assessed against each target/KPI as follows:

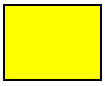
	Standard achieved / target achieved
	Standard substantially achieved / target substantially achieved
	Standard partially achieved / limited progress towards achievement of target
	Standard/target not achieved

3 SUMMARY REPORT

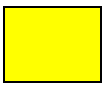
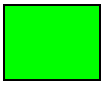
3.1 DOMAIN: EFFICIENCY

Target/Indicator	Baseline	Target	Actual		Comments
PFA Diagnostic Reporting From April 2009	**Sept 08 (Imaging & Non-Imaging)**	**Apr 09**	**Mar 10**		Whilst progress has been made there remains some risk with the ability to achieve the target for urgent reporting prior to implementation of NIPACS (estimated implementation commencement within SHSCT - March 10).
-all urgent tests reported within 2 days	**26%**	**100%**	**82%** (Imaging) **63%** (Non-imaging)		
-75% of routine within 2 weeks	**77.9%**	**75%**	**79%** (Imaging) **88%** (Non-imaging)		
-100% of routine within 4 weeks (Target rolled over from 2008/09)	**89.3%**	**100%**	**91%** (Imaging) **94%** (Non-imaging)		
PFA 4.4 Timely Hospital Discharge From April 2009, -90% complex discharges within 48 hours	**Mar 08** **98.6%**	**Mar 10** **90%**	**Apr-Mar 10** **96.2%** (1399/1455)		The Trust has achieved the complex discharge target but narrowly missed achievement of the complex element > 7 days.
-no. complex discharge will take longer than seven days	**0**	**0**	**7**		The trust also narrowly missed the non-complex within 6 hours target although there is regional acceptance that this target is challenging.
-all other patients should be discharged within six hours Target rolled over from 2008/09	**96.3%**	**100%**	**97%** (27881/ 28829)		No comparative NI average is available for cumulative period at present.

PFA Priority Area 6- Mental Health Hospital Discharge By March 2009, - 75% of admissions discharged < 7days	**Sept 08** **96%**	**Mar 09** **75%**	**Apr-Mar 10** **99.5%** **(1686/1695)**		Target achieved.
-all other patients discharges being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09	**0**	**0**	**1**		Target narrowly missed.
- All Mental Health patients discharged from Hospital to receive a follow-up visit within 7 days of discharge.		**100%**	**91%**		Target assessment criteria and definitions yet to be determined.
PSA 6.1 Mental Health Unplanned Admissions -<u>By March 2010</u>; reduce the number of admissions to mental health hospitals by 5% Target rolled over from 2008/09	**Mar 08** **1196** **Annual Admissions**	**Mar 10** **1136** **Ave Monthly admissions should not exceed 95**	**Apr-Mar 10** **1079**		Target achieved with average number of admissions per month at around 90.
PFA Priority Area 7 Learning Dis: Hospital Discharge By March 2010, - 75% of admissions discharged <	**Nov 07 – Mar 08** **cumulative** **66%**	**Mar 10** **75%**	**Apr-Mar 10** **80%** **(44/55)**		At the end of March there were 6 current inpatients deemed medically fit not yet discharged. Five are waiting over 90 days.

7days -all other patients discharged being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09 (This monitoring excludes current inpatients) - all patients discharged to receive continuing care plan to receive visit within 7 days	**0** **Baseline to be established**	**0**	**3** **Monitoring not in place**		Delays associated with complexity of requirements and difficulty in identifying appropriate community resettlement places.
KPI ALOS Episodic Average Length of Stay for Elective and Non Elective Admissions to Hospital	**Process Average 2008/09** **5.5 Non-elective** **1.16 Elective**	**To be agreed**	**Mar 10** **5.71 Non-elective** **1.26 Elective**	 	Average LOS in March is slightly higher than the process average
KPI: OP DNA % patients who 'Did not attend' an OP appointment and did not advise the hospital in advance.	**CHKS Peer 2008/09** **8.7%**	**CHKS Current Peer** **8.8%**	**April – Mar 10** **6.5% Total**		Further detail analysis by new and review will be provided at Specialty level to Directorates
PFA -Day Case Rate By March 2011, all Trusts are required to achieve an overall day surgery rate of not less than 75% for the	**Baseline SHSCT 2007/08** **55.6%** **2008/09 (Basket of 24)**	**Target March 11** **75%**	**Apr-Feb 10 Cumulative** **62.4%** **(coding level 83.2% therefore % subject to**		Detailed reporting by procedure included in Appendix I.

'basket' of 24 procedures	**59.5%**		**change)**		
KPI : % Discharges Coded -cumulative coding position	**March 2008/09** **- 98.4%**	**Target** **100%**	**April – Mar 10** **83.8%**		
KPI : Freedom of Information (FOI) % requests responded to within 20 days	**SHSCT Baseline 2008** **87.5%** **(Regional range 50% - 95%)**	**Target** **100%**	**Mar 10** **44%** **(5/9 requests – responded to within 20 day limit)**		To allow for the 20 day time lag responses are monitored one month in arrears i.e. Mar position is those monitored in Feb. Trust average April-Feb was 76.8%.
KPI : Staff Access to Intranet Number of staff as a percentage of the total Trust staffing complement, who have access to the Trust Intranet	**SHSCT Baseline March 2009** **55.72%**	**Internal Target** **55%**	**Mar 10** **69.27%**		Target achieved.
KPI : IT Helpdesk response Calls received by IT Service Desk resolved on first contact. This will be measured against the baseline at March 2009	**SHSCT Baseline March 2009** **6.61%**	**Target** **33%**	**Mar 10** **19.04%**		Temporary capacity gap in trained staff available is impacting on achievement of this target.

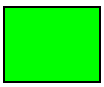
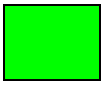
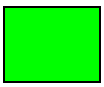
KPI Partial Booking of OP Appointments **%** Consultant led New and Review Appointments partially booked (Excs. Obstetrics) **%** Community led New and Review Appointments partially booked	**March 08** **94.1% (New)** **72% (Review)** **54.8% (New)** **4% (Review)**	**Target Sept 08** **100%**	**Mar 10** **96% (New)** **88% (Review)** **88.5% (New)** **43% (Review)**		The booking of all hospital consultant-led appointments has been consolidated into the centralized Booking Centre at CAH.
KPI – Complaints 72% of complaints responded to within 20 working days	**March 08** **65.6%**	**Target** **72%**	**Feb 10** **78%** **(54/69)**		To allow for the 20 day time lag this position is being reported a month in arrears.

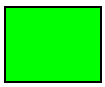
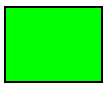
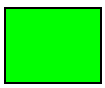
New targets for which monitoring arrangements have yet to be established

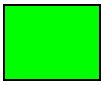
PFA 4.1 Unplanned Admissions
By March 2010 50% of unplanned hospital admissions related to exacerbation of severe chronic conditions are reduced.

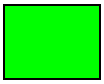
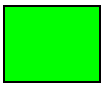
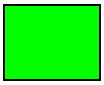
SHSCT submit a return monthly to PMSID on the numbers who have commenced case management. The Trust is awaiting guidance on definitions and peer comparison.

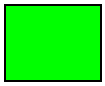
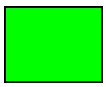
3.2 DOMAIN: ACCESS & TARGETS

Target/Indicator	Baseline	Target	Actual		Comments
PFA 3.1: Waiting Time Arthritis Drug Therapies By March 2010, no patients should wait longer than 9 months to commence specialist drug therapies for treatment of severe arthritis, By March 2011 – 21 weeks Target increased from 2008/09	**Mar 09 for 9 month position** **n/a** **Mar 08 for 21 week position** 18	**Mar 10** **0** **Mar 11** 0	**Mar 10** **0** **Mar 10** 7 (patients waiting over 21 weeks)	 	The 9 month target has been achieved. The trust is now working towards the achievement of the 21 week target by March 2011 and is currently on track.
PFA 3.2 IP/DC, OP & Diagnostic Access Targets By March 2010, no patient will wait longer than -9 weeks for a first OP appointment (excluding backstop specialties) - OP backstop target (over 9 but <17 weeks Urology, Scopes, T&O) -9 weeks for a diagnostic test, and -13 weeks for IP/DC treatment (excluding backstop specialties) - IP/DC backstop target (over 13 but <17 weeks Urology, Scopes, T&O) **Standard rolled over from 2008/09.The 9/9/13 week 08/09 target must be sustained month on month in 2009/10.**	**Mar 08 (No. of patients waiting)** **OP: 1624** **Diag: 188** **IP/DC: 1614**	**Mar 10** **OP: 0** **Diag: 0** **IP/DC: 0**	**Mar 10** **OP: 0 breaches** **301 OP within 17 week backstop** **Diag: 0 breaches** **IP/DC: 2 breaches** **201 IP/DC within 17 week backstop (1 pt breach >17 weeks)**	    	**OPs -** 301 OPs - confirmed Totals for Backstop Areas (over 9 but under 17 weeks): 178 Urology, 123 T&O. **IP/DCs -** 203 Inpatient / Daycases – Confirmed Breaches: 2 x General Surgery 13 week Breaches 1 x Orthopaedics 17 week Breach. - Confirmed Totals for Backstop Areas (over 13 but under 17 weeks): 75 Urology, 90 Scopes, 35 T&O. See additional reporting page 30.

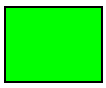
PFA AHP Access By March 2010 -no patients should waiter longer than 9 weeks from referral to commencement of AHP treatment. -the 13 week target achieved in March 09 should be sustained Target increased from 2008/09	**Mar 09** **322** **0**	**Mar 10** **0** **0**	**Mar 10** **0** **0**	 	Target achieved.
PFA Fractures -By March 2010, 95% of patients will wait no longer than 48 hours for inpatient fracture treatment. - no patient should wait longer than 7 days for treatment Target rolled over from 2008/09	**Mar 09** **75.6%** **0**	**Mar 09** **95%** **0**	**April - Mar 10** **78.4%** **(409//522)** **10**		Target not achieved.
PFA Cancer By March 2009, - 98% of cancer patients will commence treatment within 31 days and -95% of patients urgently referred with suspected cancer will begin treatment within 62 days - all urgent GP referrals for breast cancer are seen in 14 days and Target rolled over from 2008/09	**Mar 08** **99%** **96%** **100%**	**Mar 09** **98%** **95%** **100%**	**Mar 10** **Position As at Feb 10** **100%** **(79/79)** **96%** **(22/23)** **100%**	  	Due to the 31 and 62 day time lag these targets are reported retrospectively and the target position cannot be finalised until May 2010.

PFA A&E Access From April 2009, 95% of patients treated & discharged or admitted within 4 hrs Standard rolled over from 2008/09 No. of 12 hour breaches	**Mar 08** **SHSCT 95.2%** **CAH 92.9%** **DHH 97.1%**	**Mar 09** **SHSCT 95%** **CAH 95%** **DHH 95%** **0**	**Apr-Mar 10** **SHSCT 93%** (119627/ 128624) **CAH 90%** **DHH 94.5%** **4** (4/128624)	  	The reduced performance experienced by the Trust is mirrored regionally with the NI Average for Feb 82% and Mar 79.8%.
PFA 4.2 Care of Older People From April 2009, -no older person with continuing care needs will wait more than eight weeks for a completed assessment, -with the main components of care met within a further 12 weeks Standard rolled over from 2008/09	**Mar 08** **99.2%** **100%**	**Mar 09** **100%** **100%**	**Mar 10** **100%** **100%**	 	Target achieved.
PSA 5.3 Care leavers By March 2010, ensure that at least 70% of care leavers aged 19 are in education, training or employment Revised target	**Mar 09** **36** Care leavers **33 (92%)** In ETE	**Mar 10** **-** **46**	**Mar 10** **33** Care leavers **17** (51.5% - In ETE)		

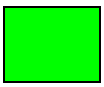
PSA 5.4: Care leavers By March 2010 increase to 175 the number of care leavers aged 18-20 living with their former foster carers or supported family Revised target.	**Mar 09** **27** **(End of Month position)**	**Mar 10** **21**	**Mar 10** **27**		Target achieved.
PSA 6.3 Mental Health Assessment and Treatment By March 2010 -ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health, excluding psychological therapies, Target increased from 2008/09 -pyschological therapies to sustain 13 week maximum wait Target rolled over from 2008/09	**Mar 09** **26** **Mar 08** **94**	**Mar 10** **0** **0**	**Mar 10** **0** **(No. on PTL over 9 weeks)** **0**	 	Target achieved.
PSA 7.3 Specialised Wheelchairs By March 2010 - ensure an 18 week maximum waiting time for 90% of all wheelchairs New target	**31 Jul 09** **90%**	**Mar 10** **90%**	**Mar 10** **97%** **(4/121 waiting over 18 weeks)**		Target achieved.
PFA – Autism By March 2010 -ensure that all children wait no longer than 13 weeks for	**31 Jul 09** **0**	**Mar 10** **0**	**Mar 10** **0**		Target achieved.

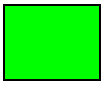
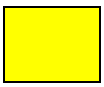
assessment, and - a further 13 weeks for commencement of specialist treatment New target	**0**	**0**	**0**		
PFA – Acquired Brain Injury By March 2010, -ensure a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment New target	**31 Jul 09** **0**	**Target Mar 10** **0**	**Mar 10** **0**		Target achieved.
PFA 7 – Housing Adaptations (Major Housing Adaptations) By March 2010 - all lifts/ceiling track hoists to be installed within 22 week of OT assessment/ option appraisal **(Minor Housing Adaptations)** By March 2010 - all minor urgent works to be completed within 10 days - New target	**31 Oct 09** **92.3%**	**Target Mar 10** **100%** **100%**	**Mar 10** **100%** **(0/0 >22 weeks)** **87.2% (41/47)**	 	Target achieved. Estimated performance for minor adaptations.

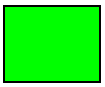
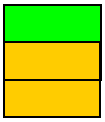
3.3 DOMAIN: CLINICAL AND SOCIAL CARE QUALITY

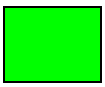
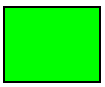
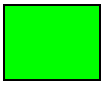
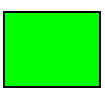
Target/Indicator	Baseline	Target	Actual		Comments
PFA - HCAI In the year to, by March 2010, ensure a -35% reduction in the number of hospital patients with staphylococcus aureus (MSSA) bloodstream infections (including MRSA), and a -35% reduction in cases of clostridium difficile infections compared to 2007/08 Target increased	**2007/08** **MRSA 14 Episodes** **MSSA 38 Episodes** **C Diff 134 Episodes**	**Mar 10** **MRSA 20 Episodes (Ave 1.7 p/mt)** **MSSA 34 Episodes (Ave 2.8 p/mt)** **C Diff 99 Episodes (Ave 8.25 p/mt)**	**Apr-Mar 10** **MRSA/ 15 Episodes** **MSSA 41 Episodes** **C Diff 49 Episodes**	  	Additional reporting on Healthcare Associated Infection is included in section 4.0. Target achieved for MRSA and C Diff. Whilst the MSSA element of the target has not been achieved a comprehensive package of infection control measures has and continues to be progressed.
PSA 3.6 Renal By March 2010, -at least 60% of patients should receive dialysis via a fistula Target increased	**Mar 09** **36.8%**	**Mar 10** **60%**	**Mar 10** **40%** **(38/96)**		This target continues to be at risk. Patient Choice is impacting on achievement of this target. Regional review of definitions is ongoing.
PFA 4.1 Community Care By March 2010 -45% of people in care management have their assessed care needs met in a	**Mar 08** **43.7%**	**Mar 10** **45%**	**Mar 10** **45.2%** **(1700 people)**		Target achieved.

domiciliary setting. Target increased					

PFA 4 – Direct Payments By March 2010, -number of direct payment cases increases to 1,250 Target increased	**Mar 09** **361**	**Mar 10** **241 (SHSCT target)**	**Mar 10** **495**		Target achieved.
PFA Family Group Conferences During 2009/10 -ensure that at least 500 cyp whose assessed need is on levels 1,2 or 3 of the Hardiker model have participated in a FGC. Target rolled over from 2008/09	**2008/09** **58**	**Mar 10** **96** **(Ave 8 per month)**	**Apr-Mar 10** **130 (inc 2 from Trust)**		Target achieved.

PSA 5.2 Family support interventions By March 2010 -provide family support interventions to 2000 children in vulnerable families each year New Target	**Oct 08 – March 09** **153** **306** **Extrapolated for full year**	**Mar 10** **384** **(Ave 32 per month)**	**Apr-Mar 10** **403** **(cumulative position)** **(Ave 34 per month)**		Target achieved.
PFA 5.3 - Foster Carers By March 2010, - increase foster carers by 300 (NI target) from the March 2006 total	**Mar 06** **217**	**Mar 10** **275**	**Mar 10** **289**		Target achieved.
PSA 5.1 - Children in Care By March 10 90% of children admitted to residential care prior to admission should -have had formal assessment & placement matched through Children's Resources Panel	**Baseline Q1 09** **67%**	**Target Mar 10** **90%**	**Mar 10** **89%** **(8/9 children)** **(Q1 average position Apr-June 67%)** **(Q2 average position July-Sept 57%)** **(Q3 average position Oct-Dec 88%)**		Target, based on assessment of Q4 (Jan-Mar) performance has narrowly been missed.
-Every child taken into care should have a plan for permanence	**Baseline not available**	**100% (based on No. of children taken into care April-Sept 09)**	**75%** **(49/65)**		Newly established target - clarification awaited on how this target will be assessed.

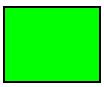
and timescale agreed within six months					
PSA 6.2 M Health Resettlement By March 2010, resettle 60 patients from hospital to appropriate community places from March 2006 position. Target Rolled over from 2008/09	**2006/07 0** **2007/08 6** **2008/09 14 Cumulative Position**	**Mar 10** **12 (cumulatively - achieved in 2008/09)**	**Apr – Mar 10** **6 (includes resettlements commenced)** **20 Cumulative Position**		PMSID reporting is now in-year (09/10) and not cumulative performance. Trust achieved the original target in 2008/09.
PSA 7.1 Learning Disability Resettlement By March 2010 -resettle 90 learning disability patients from hospital to appropriate places in community from March 2006 position. Target rolled over from 2008/09	**Mar 07** **0** **2008/09 18 Cumulative Position**	**Mar 10** **17**	**Apr- Mar 10** **4 (includes resettlements commenced)** **22 Cumulative Position**		PMSID reporting is now reporting on in-year resettlement numbers and not the cumulative position. Trust achieved the original target in 2008/09.
Surgical Site infections(SSI) Bundle compliance rate -orthopaedics (all elective hips & knees) **SSI rate** (Hips only) **Bundle**	**Oct 08** **15%** **Q2 2008 0%**	**Mar 09** **95%** **-**	**Mar 10** **100%** **Q4 2009 0% (NI Ave: 0.6%)**	 	The NI Safety Forum is seeking to standardise how all Trusts measure the Bundle Elements. This may have an impact on overall Bundle Compliance in the months ahead until any new practices are embedded

Compliance rate -Caesarean Section (audit of 20 cases per month **SSI Rate** (C-section)	**CAH 5%** **DHH 5.26%** **Q2 2008** **CAH 9.2%** **DHH 19.2%**	**95%** **95%** **25% reduction on Q4 2008 SSI Rate (as of Feb 09) – Target 14.21% (NI Average 14.5%)**	**80%** **86.36%** **Q4 2009** **CAH 8.3%** **DHH 4.4%** **(NI Ave: 12%)**	  	successfully. Although figures fluctuate slightly month on month. The drop in the bundle compliance rate largely relates to one element of the bundle where no documentary evidence existed on the patients notes to suggest they had received the Admission Advice Leaflet. SSI Infection rates, available as a quarterly position, are now included in reporting.
Central Line Infections -Infection Rate per 1000 line days **-Compliance with bundle**	**Oct 08** **CAH 3%** **DHH 3%** **CAH 30%** **DHH 0%**	 **1.17%** **1.17%** **95%** **95%**	**Mar 10** **0%** **0%** **50%** **100%**	   	This target measures the number of central line catheter-related bloodstream infections Measurement reflects all Central Lines at CAH & DHH and compliance with the care bundle elements. Figures fluctuate month on month.
Ventilator Acquired Pneumonia (VAP) - Ventilator days between infections	**Oct 08** **517**	**Mar 10** **300**	**Mar 10** **665**		This target aims to achieve 95% compliance with all bundle elements in ICU in CAH.

- Compliance with bundle	**100%**	**95%**	**97.5%**		Overall Bundle Compliance failed to achieve 100% for the 1st time in 21 months.
Crash Call Rate -Rate per 1000 deaths/discharges Monitoring rolled over from 2008/09	**Oct 08** **CAH 3.7** **DHH 0.9**	**Mar 10** **1.89** per 1000 deaths/ discharges	**Mar 10** **CAH 2.18 per 1000** **DHH 1.29 per 1000** **(NI Range 0 – 7.5)**	 	This QIP target is focused on reducing crash calls in A&E, ICU and coronary care. Crash calls increased on both sites in Feb although the figure is subject to monthly fluctuations. During the 11 month period April-Feb the Trust average was 1.9 per 1000 deaths/ discharges
MEWS Modified Early Warning Scoring System	**Sept 09** **CAH 94.44%** **DHH 100%**	**Mar 10** **95%**	**Mar 10** **CAH 97.8%** **(pilot ward)** **DHH 100%** **(pilot ward)**	 	The target was to achieve 95% compliance of MEWS on Pilot Wards at CAH & DHH which has been achieved. The aim to introduce measurement across all wards by March 10 was also achieved with the following compliance: 92% CAH 94% DHH 99% Non Acute Hospitals.
Mental Health Indicators	**Oct 08**	**Mar 09**	**Mar 10**		These targets focus on

-%compliance with multi-disciplinary review -%compliance with risk assessment -%compliance with patient/carer involvement in TP	**CAH 79% SLH 67%** **CAH 63% SLH 17%** **CAH 88% SLH 100%**	**100%** **100%** **100%**	**CAH 100% SLH 50%** **CAH 100% SLH 100%** **CAH 96% SLH 88%**	  	inpatient review, assessment and compliance with patient/carer involvement in treatment planning All are sampled by random audit of 30 active casenotes each month

KPI - Crude Mortality Rate Deaths as a percentage of total hospital deaths and discharges	**CHKS Peer** **2007/08 1.98%** **2008/09 1.92%**	**Current Peer** **Apr - Feb 10** **1.74%**	**SHSCT** **2007/08 1.22%** **2008/09 1.18%** **Apr – Feb 10** **1.19%**		The mortality rate provided shows the Trust average against a peer group of District General Hospitals. This has been extract from the 'CHKS' comparative benchmarking tool. See additional reporting page 49.
KPI – Re-admission rate Discharges from the Trust that are re-admitted to the Trust again within 28 days as a percentage of total discharges	**CHKS Peer** **2007/08 6.5%** **2008/09 6.6%**	**Target** **Apr – Feb 10 6.3%**	**SHSCT** **2007/08 5.3%** **2008/09 5.2%** **Apr – Feb 10 5%**		The re-admission rate provided shows the Trust average against a peer group of District General Hospitals. This has been extracted from the 'CHKS' benchmarking tool. See additional reporting page 49.

KPI Environmental Cleanliness Cleanliness Matters Strategy indicates that 85% or above is an acceptable level of cleanliness.	**KPMG baseline** **DHH 90%** **STH 88%** **CAH 84%**	**Target** **85%**	**Mar 10** **DHH 92%** **STH 94%** **CAH 93%**		Target achieved. The Trust averaged 94% on this weighted score for all risk categories. Additional reporting included.
KPI – Looked After children Number who received no visit	**Mar 08** **6**	**Target** **0**	**Mar 10** **0**		Target assessment criteria has yet to be determined.
KPI – Child Protection Registrar Number of children on CPR over 2 years	**QE Mar 09** **7.4%** **(31/420)**	**Target** **to be established**	**Mar 10** **7%** **(34/467)**		Target to be defined.
KPI – Unallocated Child Care Cases	**Apr 08** **37** **Apr 09** **119**	**Target** **0**	**Mar 10** **168** **(141 in Feb)**		Target assessment criteria has yet to be determined. See additional reporting in section 4.0.
KPI – Health & Care Number % of potential H+C matches that are achieved each month for acute system transactions	**Dec 08 Baseline** **96%**	**Internal Target** **100%**	**Mar 10** **90%**		Regional comparators are not yet available.

Priority 5 (Target 7) PFA – Assessment of Children at Risk From April 09 -all Child protection referrals should be allocated within 24 hours of receipt		**Mar 10** **100%**	**Mar 10** **100%** **(79/79)**		This target counts all child protection referrals on an individual child basis. Target assessment criteria yet to be determined.
By March 2010, -90% of family support referrals should be allocated to a social worker within 20 days for initial assessment		**90%** **(initial assessment)**	**84 %** **(202/240)**		Performance around family support services is below expected due to issues around recruitment/retention, increased number of referrals and need to redeploy staff to key pressure points.
Assessments Completed - initial assessments should be carried out within 10 working days from date of allocation of referrral to social worker		**100%** **(within 10 days (initial))**	**75%** **(133/177)**		
- 90% of cases deemed to require family suppport pathway assessment should be allocated within 20 working days		**90% within 20 days** **(pathway)**	**21%** **(6/29)**		

New targets for which guidance and definitions have yet to be fully established –

Respite Targets: HSCB have recently completed an audit of respite care. Trust responses will inform the new monitoring arrangements for the actual PFA targets..

PFA Respite – dementia
By March 2010
-provide an additional 1200 dementia respite places compared to March 2008 further 100 by March 2011 total New target monitoring

PSA 7.2 – Respite Physical and sensory disability
By March 2010
-improve access to Physical/sensory disability by providing an additional 100 respite packages per year compared to March 2008 and a further 100 by March 2011

PSA 7.4 – Respite Learning Disability
By March 2010
-improve access to learning disability by providing an additional 100 respite packages a year compared to March 2008 and a further 100 by March 2011

Trust end of year position on additional respite packages provided in 09/10

April 09 - March 10	Service Provision (Packages)		
	Dementia	Learning Disability	Physical / Sensory Disability
Total	335	68	34
Over/Under Performance	+119	+49	+15

Nb: figures have been rounded to the nearest whole number

3.4 DOMAIN: WORKFORCE

Target/Indicator	Baseline	Target	Actual		Comments
PFA 9.1 Each Trust should reduce its level of absenteeism to 5.5% in the year to March 2010, reducing to 5.2% in the year to March 2011	**2008/09** **4.94%**	**Mar 10** **5.50%**	**Apr-Mar 10** **5.05% (cum % days lost)**		This target has been achieved.

4.0 Analysis, Additional Information and Exception Reporting by Domain

4.1 Access & Targets

- IP/DC/OP
- Fracture
- Renal

4.2 Clinical and Social Care Quality

- Healthcare Associated Infection
    - C Diff Analysis
    - MRSA Analysis
    - MSSA Analysis
    - Hand Hygiene
    - Compliance with Antibiotics
    - HCAI Related Deaths
- Quality Improvement Targets (Patient Care Indicators)
- Children & Young People Reporting
    - Unallocated Child Care Cases
- Re-admission Rates with Peer comparison
- Mortality Rates with Peer comparison

Appendix I – Quarterly PFA Supplementary Report **(to be added for TB)**
Appendix II – Daycase Rates by procedure
Appendix III - (Environmental Cleanliness Report)

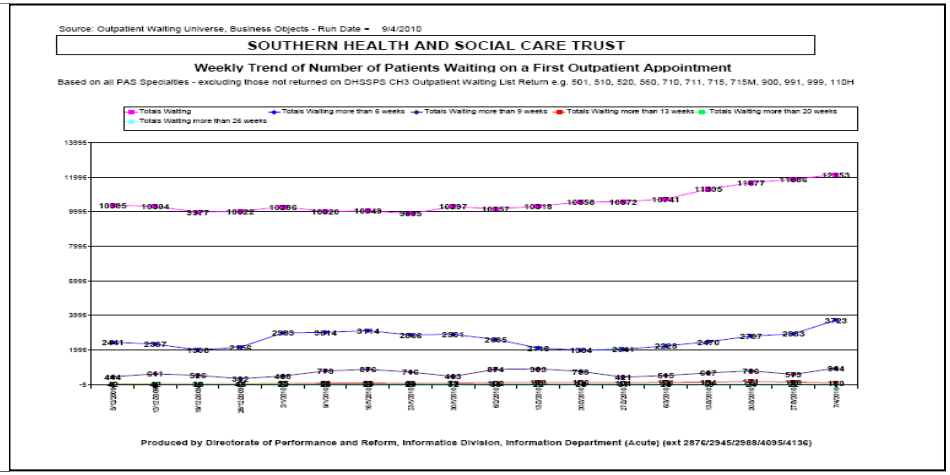
4.1 Access & Targets

Elective access targets: The Trust continues to work with the local Commissioner and Health and Social Care Board to secure the level of investment required for the development of recurrent solutions to ensure the maintenance of access targets is sustainable.

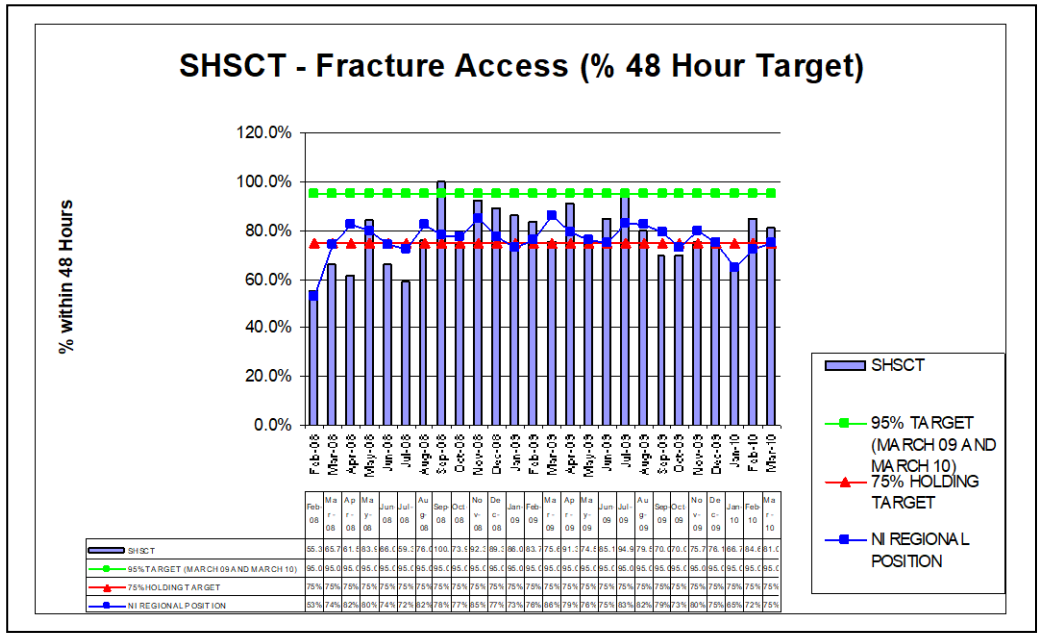
- Recurrent investment has been secured for ENT, neurology, Allied Health Professions and Pain Management services.
- Management efforts continue to focus on securing the recurrent investments required for gynaecology, endoscopy, ophthalmology and Trauma & orthopaedics services.
- Discussions regarding the future local urology service model have been initiated in parallel with consultation on the regional urology review.
- The Trust is also working with the BHSCT and SEHSCT to secure the additional local service capacity required for SHSCT in respect of visiting regional services, specifically oral surgery and neurophysiology.

Delay in securing investment has however introduced risk to achievement of access targets as non-recurrent solutions have had to be sustained longer than anticipated leading to cost and operational pressures. Key areas of risk for the achievement of access targets in year have been discussed with, and recognised by, the Performance Management & Service Improvement Division in respect of urology, endoscopy, trauma & orthopaedics and MRI services. Whilst the Trust continues to work towards sustaining its access times for these areas it is anticipated that these services will not be delivered within the current access standards but will not exceed a 17 week access time position.

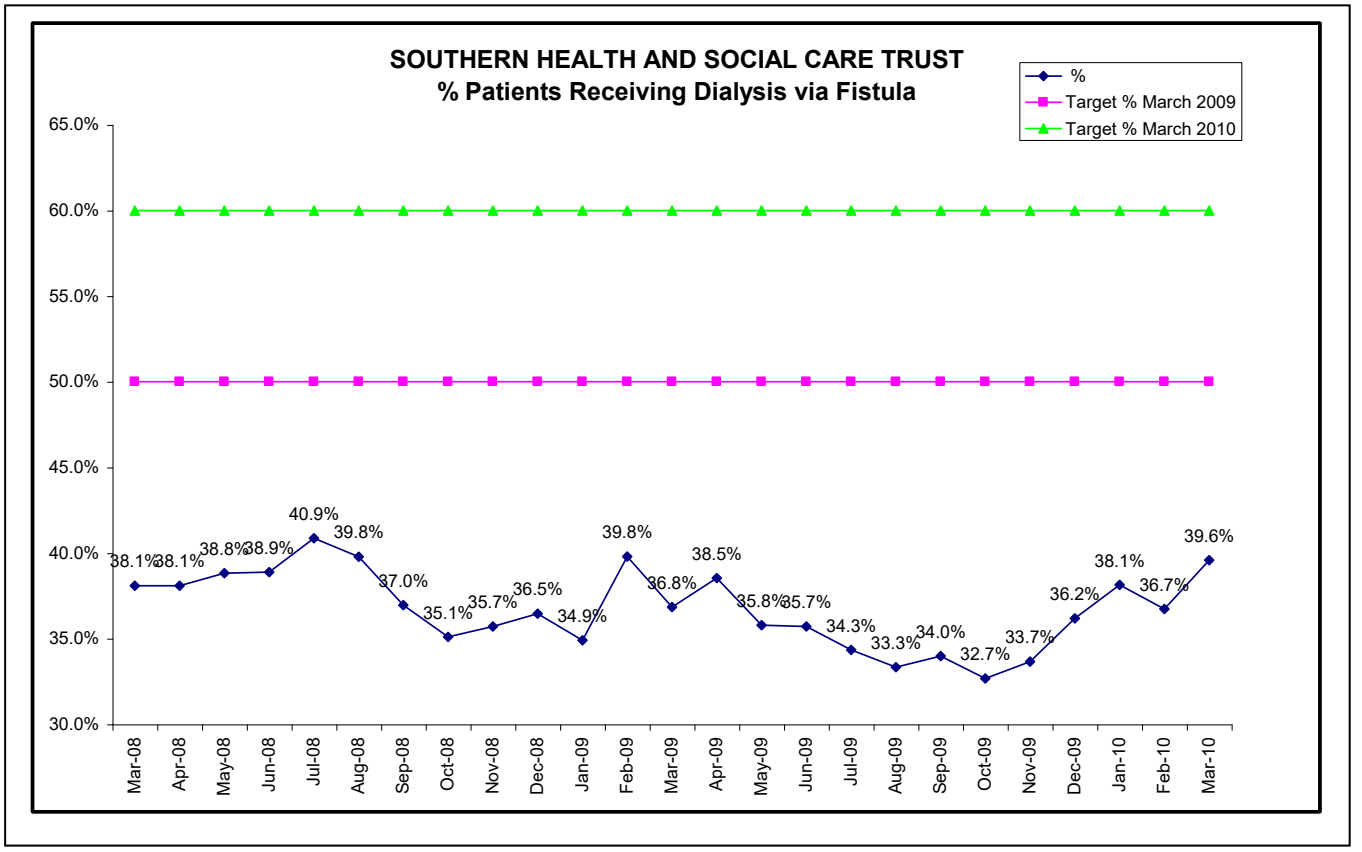
Robust operational and monitoring arrangements have been established to ensure maximisation of capacity to minimise the volume and impact of any access standard breaches.



Fractures: Until recurrent investment is secured for a 6 consultant model that enables weekend fracture lists to be delivered 52 weeks of the year, this target remains at risk. A business case has been submitted and is under discussion with the commissioner and HSCB. In the interim analysis is underway to review demand for routine, urgent and sub specialist work.



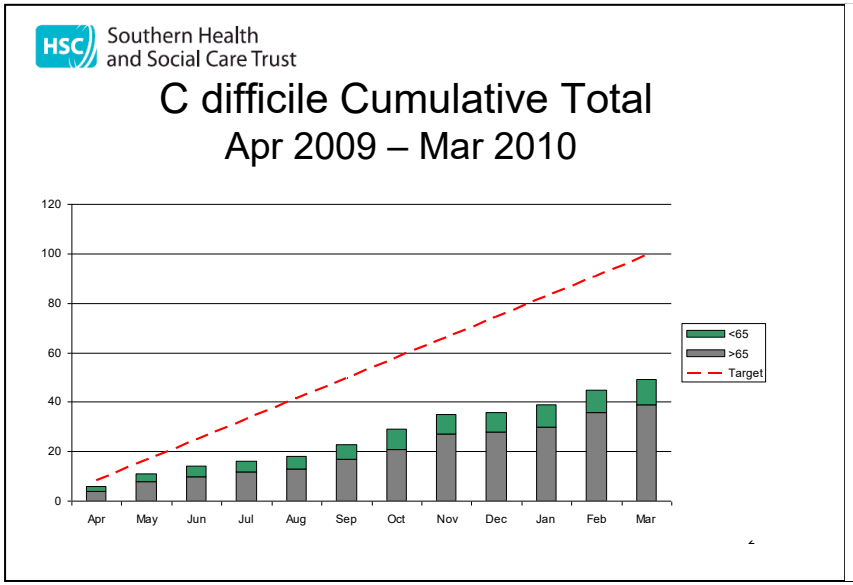
Renal – dialysis via fistula: This target is unlikely to be achieved in year. The ability to achieve the target is reliant on the uptake of the current patient cohort. Medical staff from the Trust's vascular team have completed training to undertake fistula creation and have recently commenced this service locally. This was previously provided by a visiting service from Belfast Trust. This target however remains at risk of achievement due to the high number of dialysis patients refusing to have a fistula inserted or, if the fistula failed, to have it redone. Regional review of definitions of this target is under discussion to take account of the numbers of patients suitable.



4.2 CLINICAL AND SOCIAL CARE QUALITY

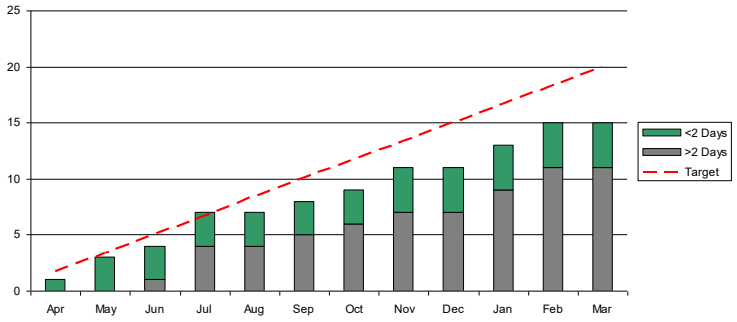
HEALTH CARE ASSOCIATION INFECTION

To provide a comprehensive assessment of performance against healthcare associated Infections a multi-dimensional view of performance is required. The following information is monitored by the Trusts Strategic Forum and Clinical Forum in line with the new Trust arrangements for the strategic management of healthcare associated infection. Regional comparative information is collated and validation by the Communicable Disease Surveillance Centre (CDSC) and this information will be included quarterly as available.



Southern Health and Social Care Trust

MRSA Cumulative Total
Apr 2009 – Mar 2010



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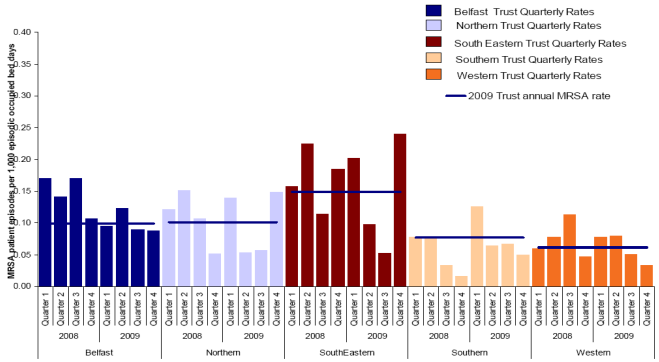
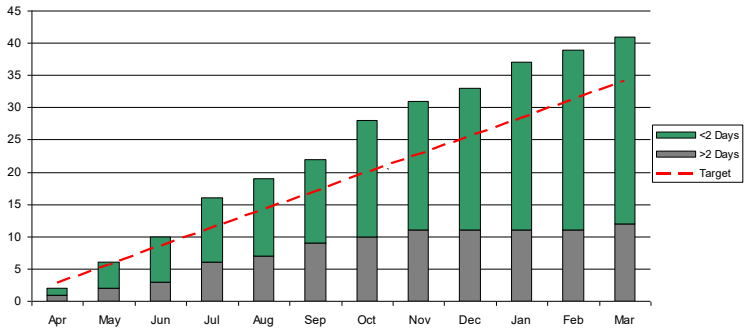
MRSA CDSC Data December 2009



Southern Health and Social Care Trust

MSSA Cumulative Total

Apr 2009 – Mar 2010

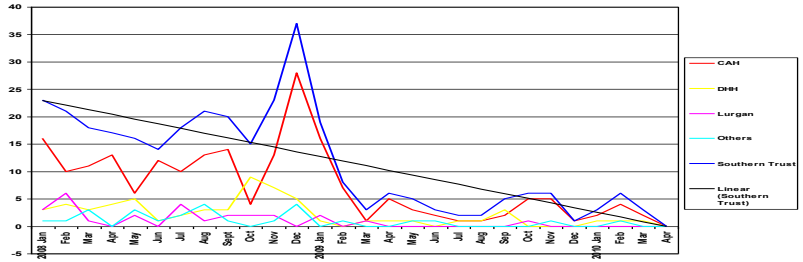


4

C Diff Analysis

Southern Health and Social Care Trust

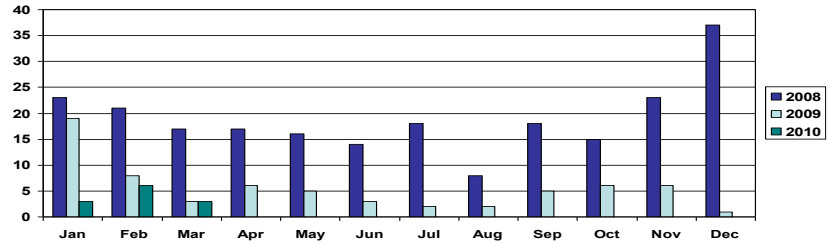
C difficile
Jan 2008 – 19 April 2010



1

Southern Health and Social Care Trust

New cases of C diff
2008-2010



2

Southern Health and Social Care Trust

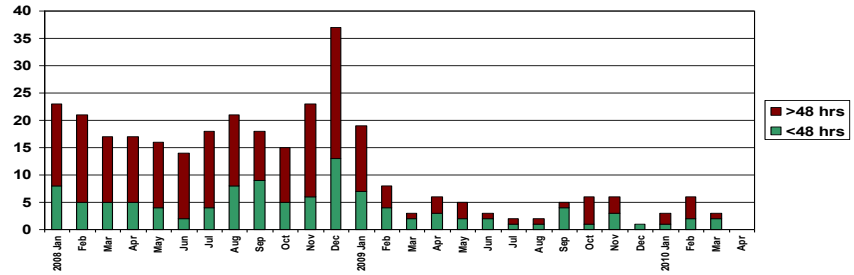
Last Case of C diff
As of 19 April 2010

Hospital	Last Date	Days
CAH	20/03/2010	30
DHH	16/03/2010	34
LGH	22/10/2009	179
STH	06/11/2009	164
MUL	30/06/2009	293
SLH	08/02/2010	70
Bluestone	20/09/2008	576

6

Southern Health and Social Care Trust

New cases of C diff
Jan 2008 – 19 April 2010

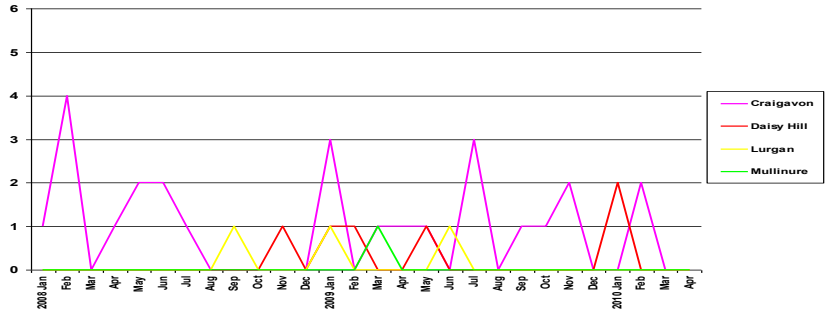


3

MRSA Analysis

Southern Health and Social Care Trust

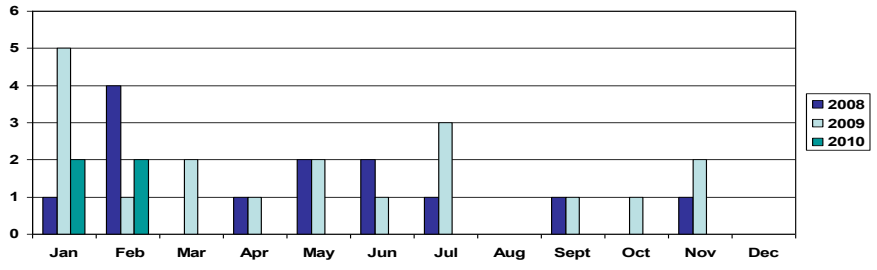
MRSA by Hospital
Jan 2008 – 19 April 2010



1

Southern Health and Social Care Trust

New cases of MRSA
2008-2010

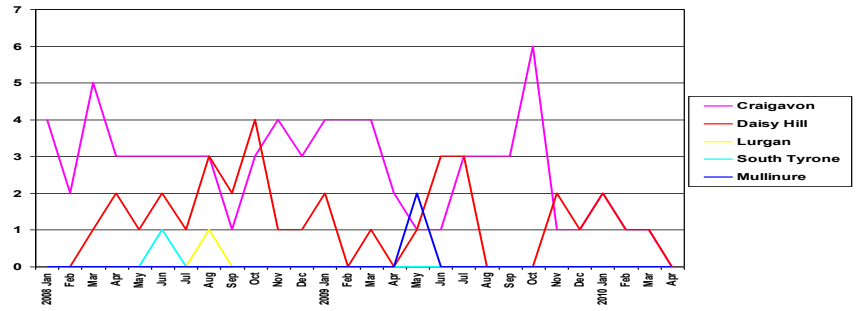


3

MSSA Analysis

Southern Health and Social Care Trust

MSSA by Hospital
Jan 2008 – 19 April 2010



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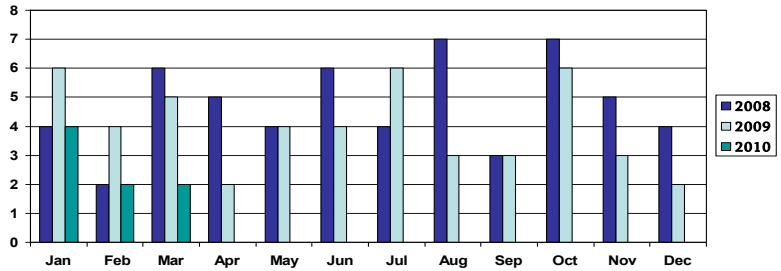
Southern Health and Social Care Trust

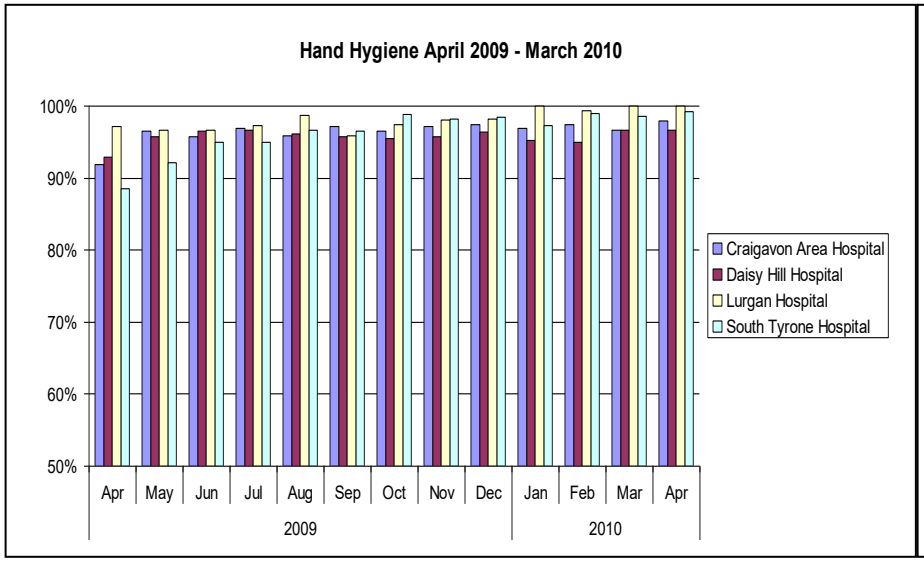
New cases of MSSA
2008-2010

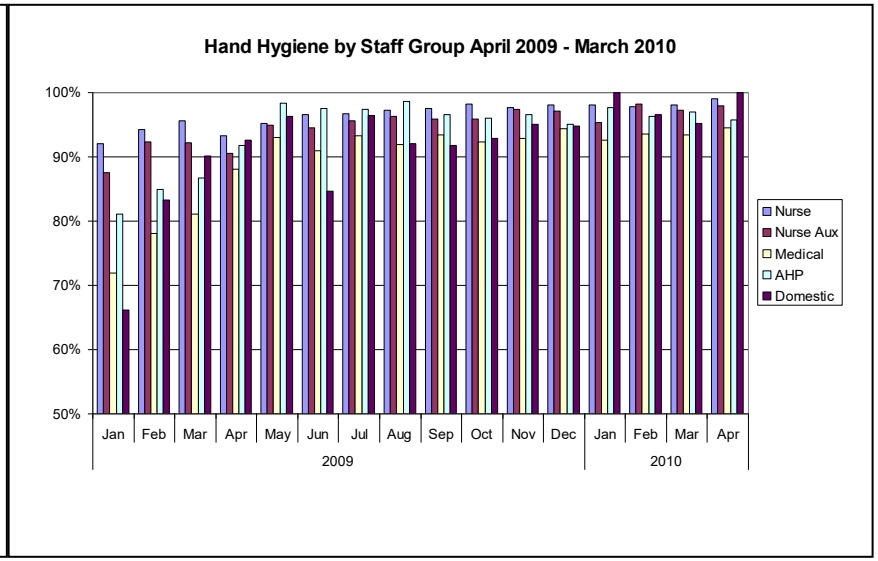


3

Hand Hygiene Compliance Audits

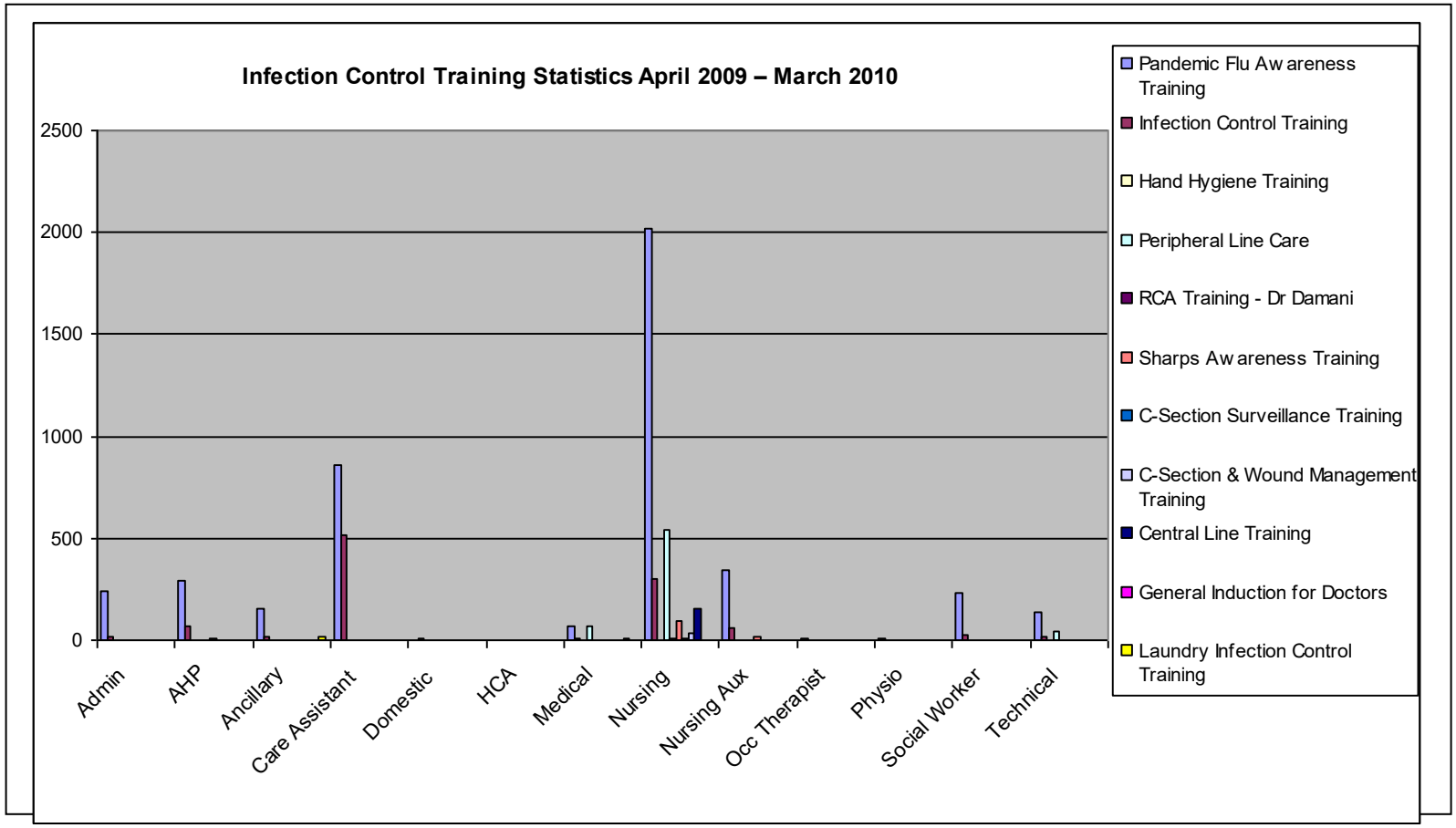
Hand hygiene has been well established as one of the key components to reduce healthcare associated infections. In December 2008, the SHSCT successfully launched the hand hygiene campaign Safe Hands Save Lives which has resulted in a substantial increase in hand hygiene compliance across the Trust.

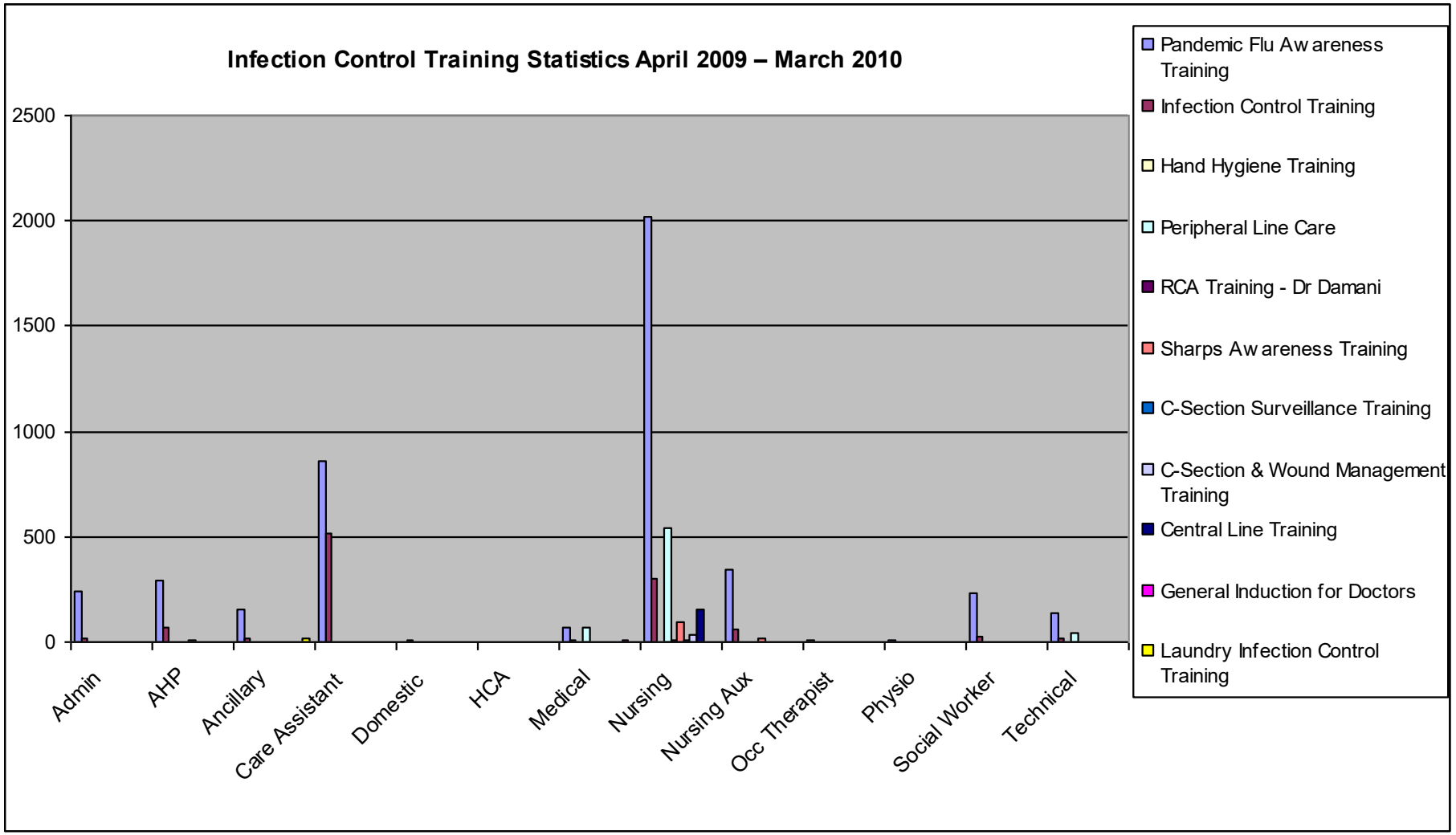




Infection Control Training (April – Mar 2010)

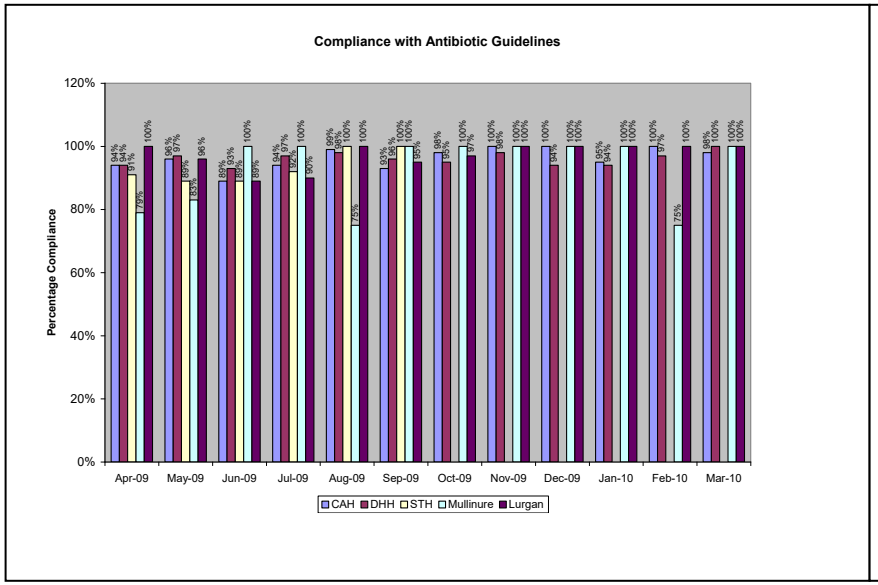
Course Title	Admin	AHP	Ancillary	Care Assistant	Domestic	HCA	Medical	Nursing	Nursing Aux	Occ Therapist	Physio	Social Worker	Technical	Total
Pandemic Flu Awareness Training	242	291	158	855	1	1	69	2019	342	8	6	235	134	**4361**
Infection Control Training	20	69	16	516	9	0	5	302	63	0	0	29	13	**1042**
Hand Hygiene Training	0	0	0	0	0	0	0	2	0	0	0	0	0	**2**
Peripheral Line Care	3	0	0	0	0	0	71	537	0	0	0	0	39	**650**
RCA Training - Dr Damani	0	0	0	0	0	0	1	10	0	0	0	0	0	**11**
Sharps Awareness Training	0	5	0	0	0	0	3	92	13	0	0	0	0	**113**
C-Section Surveillance Training	0	0	0	0	0	0	0	6	0	0	0	0	0	**6**
C-Section & Wound Management Training	0	0	0	0	0	0	0	31	0	0	0	0	0	**31**
Central Line Training	0	0	0	0	0	0	0	152	0	0	0	0	0	**152**
General Induction for Doctors	0	0	0	0	0	0	10	0	0	0	0	0	0	**10**
Laundry Infection Control Training	0	0	17	0	0	0	0	0	0	0	0	0	0	**17**
Total	**265**	**365**	**191**	**1371**	**10**	**1**	**159**	**3151**	**418**	**8**	**6**	**264**	**186**	**6395**

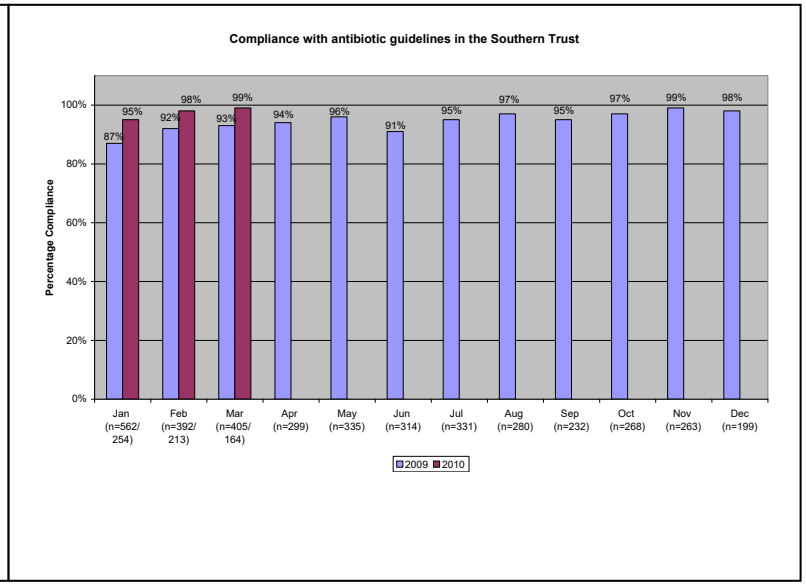




Compliance with Antibiotics

Hospital	No. Antibiotics audited											
	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10
CAH	147	134	134	157	139	87	109	65	91	96	48	49
DHH	102	154	138	135	109	113	120	144	68	132	128	85
STH	11	9	9	12	7	3	0	0	0	0	0	0
Mullinure	14	12	5	7	4	7	4	17	4	4	4	1
Lurgan	25	26	28	20	21	22	35	37	36	22	33	29





Health Care Acquired Infection – Related Deaths

Monitoring of HCAI deaths SHSCT, is now based on the date the death is registered and is fully aligned with the Central Services Agency / NI Stats & Research Agency reporting.

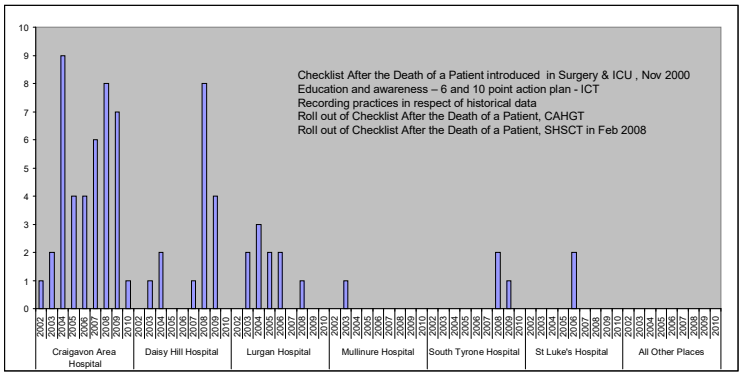
As part of the review of arrangements for monitoring death related data, processes have been established with Associate Medical Directors to take forward issues arising from the morbidity & mortality meetings, including providing assurances that cases where HCAI was recorded on the death certificate are discussed.

Clostridium Difficile – Annual trend by hospital site and breakdown by Quarter for 2009

No deaths were recorded for Jan-March 2010

Number of SHSCT deaths with *Clostridium Difficile* mentioned and recorded as the underlying cause on death certificate, 2002 – 2008 (validated)

Jan – Dec 2009[P] & 1 Jan – 11 Apr 2010[P] (unvalidated)

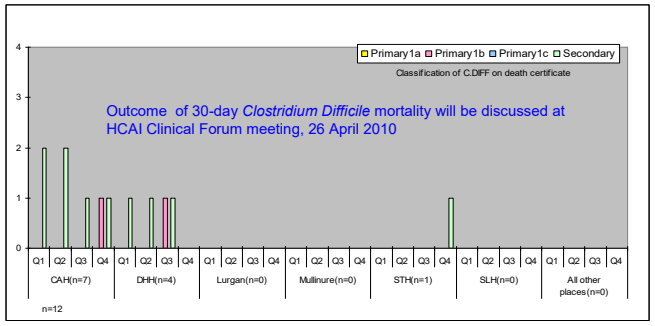


[P] – Provisional data pending publication of the Registrar General's Annual Report for 2009 & 2010

NB Excludes deaths in all other places between 2002 – 2008, as this information is aggregated regionally in the Registrar General's Annual Report

Number of SHSCT deaths with *Clostridium Difficile* mentioned and recorded as the underlying cause on death certificate:

January – December 2009[P] (unvalidated)



P – Provisional data pending publication of the Registrar General's Annual Report for 2009

Source: NI Stats & Research Agency and Central Services Agency / Business Services Organisation combined weekly submission of HCAI death related data

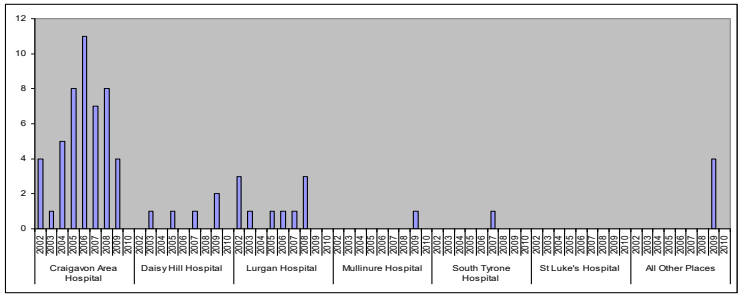
This graph shows a significant drop in the number of deaths with *Clostridium Difficile* mentioned on the death certificate in 2009 (n=12), in comparison to 19 hospital CDI deaths in 2008.

MRSA – Annual trend by hospital site and breakdown by Quarter for 2009

No deaths were recorded in Jan-March 2010

Number of SHSCT deaths with MRSA mentioned and recorded as the underlying cause of death certificate, 2002 – 2008 (validated)

Jan – Dec 2009[P] & 1 Jan – 11 Apr 2010[P] (unvalidated)

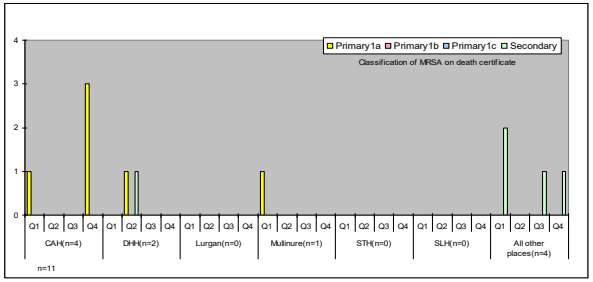


[P] – Provisional data pending publication of the Registrar General's Annual Report for 2009 & 2010.

NB Excludes deaths in all other places between 2002 – 2008, as this information is aggregated regionally in the Registrar General's Annual Report.

Number of SHSCT deaths with *MRSA* mentioned and recorded as the underlying cause on death certificate, Regional overview:

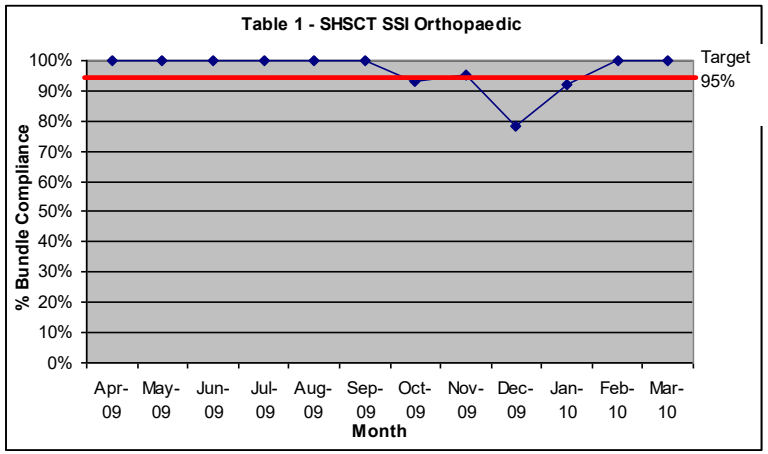
January – December 2009[P] (unvalidated)

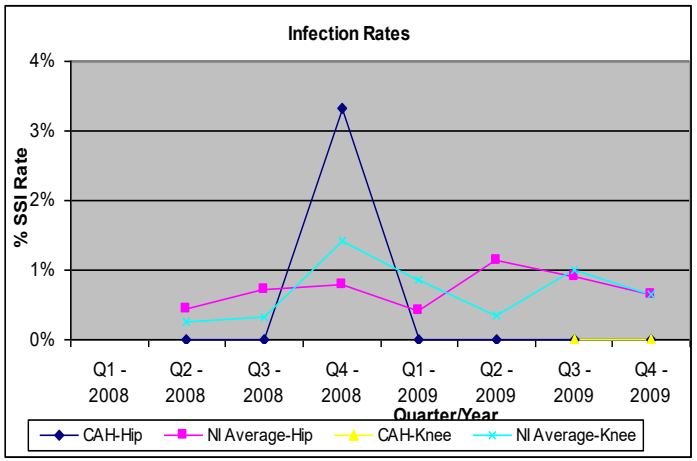


This dataset is provisional pending publication of the Registrar General's Annual Report for 2009

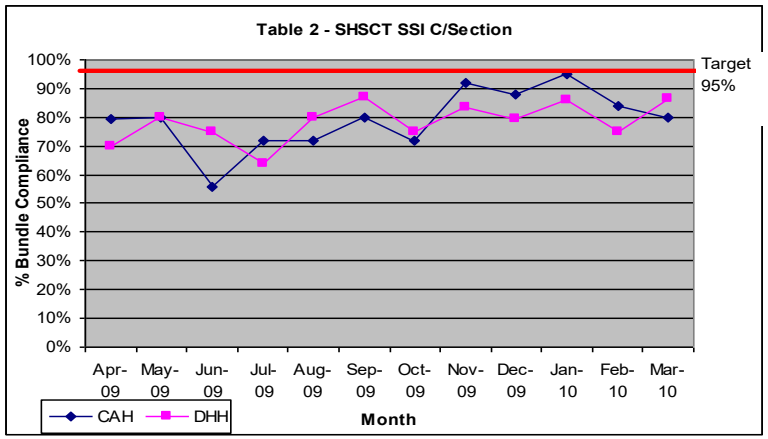
11 MRSA related deaths in SHSCT in 2008 & 2009.

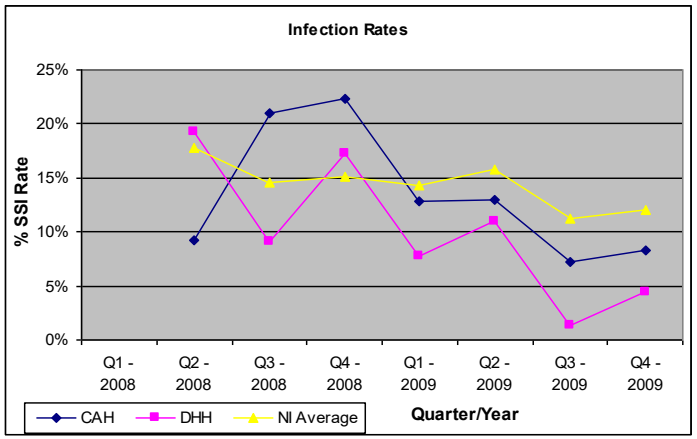
QUALITY IMPROVEMENT TARGETS (Patient Care Indicators)



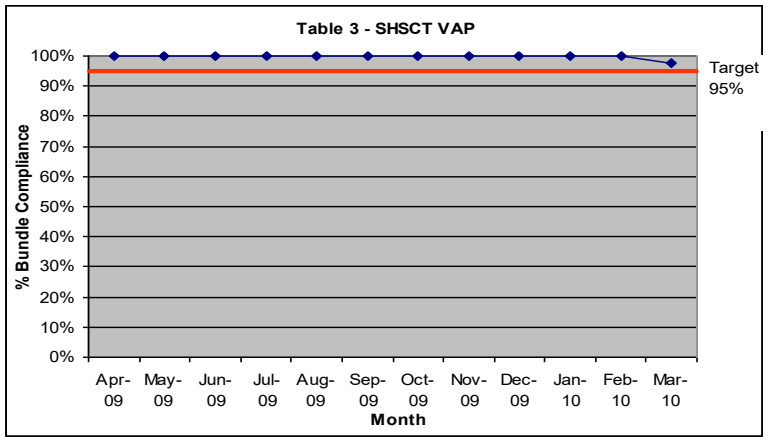


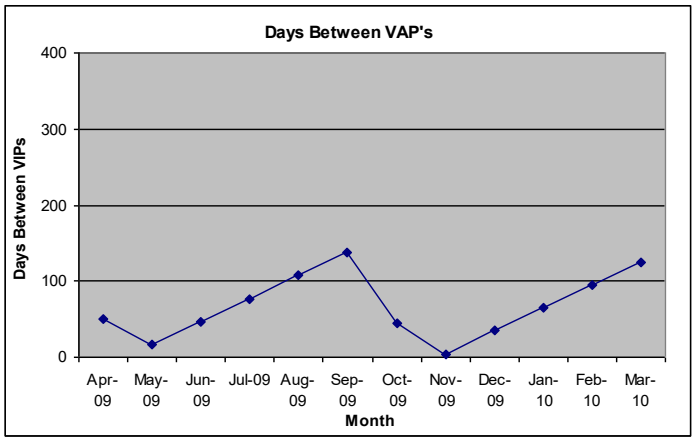
Overall Bundle Compliance was 100% for the 2nd consecutive month. Q4 2009 SSI Rates for both hip & knee protheses remain at 0%. The NI Average for hip protheses is 0.65% & the NI Average for knee prothesis was 0.65%.



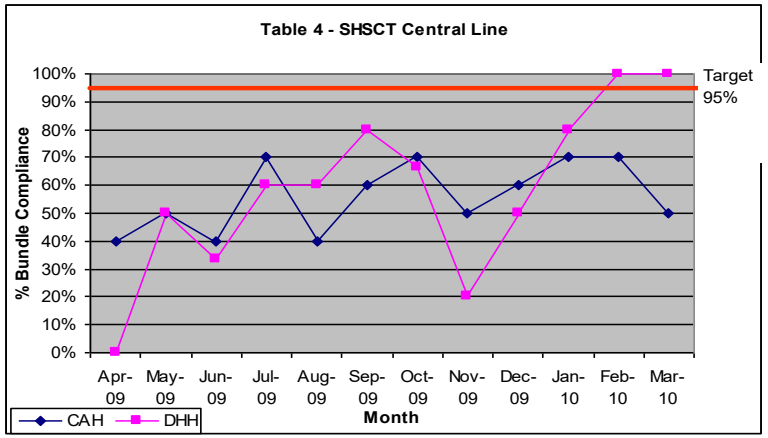


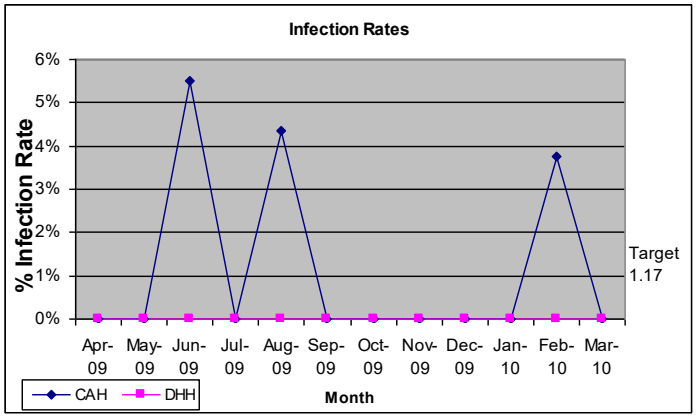
Bundle Compliance at CAH dropped to 80% in March. Non-compliant elements appropriate hair removal 3/25, Normothermia & Glucose Control 1/25. At DHH Compliance rose to 86.36% with only non-compliant element appropriate hair removal 3/22. Q4 SSI Rates show CAH at 8.3%, DHH at 4.4% & Trust at 6.35% all well under NI Average of 12% & on course to achieve Trust goal of 25% reduction of Trust Q4 Rate 08 i.e. 18.95% to 14.21%.



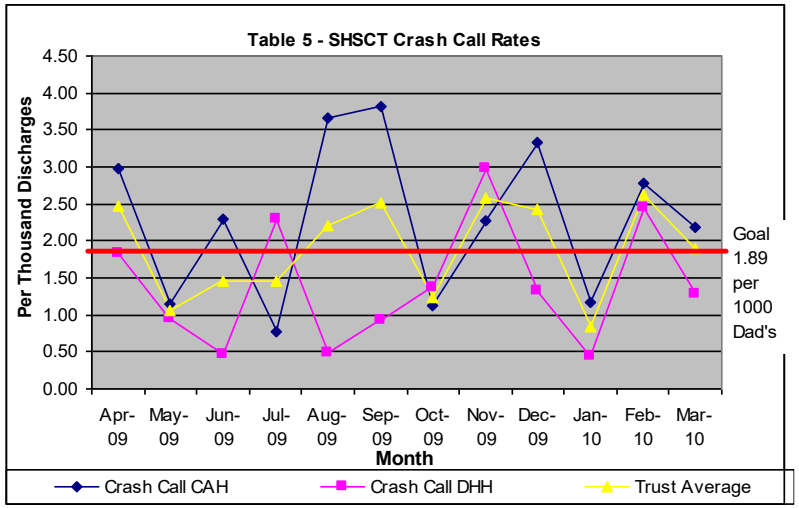


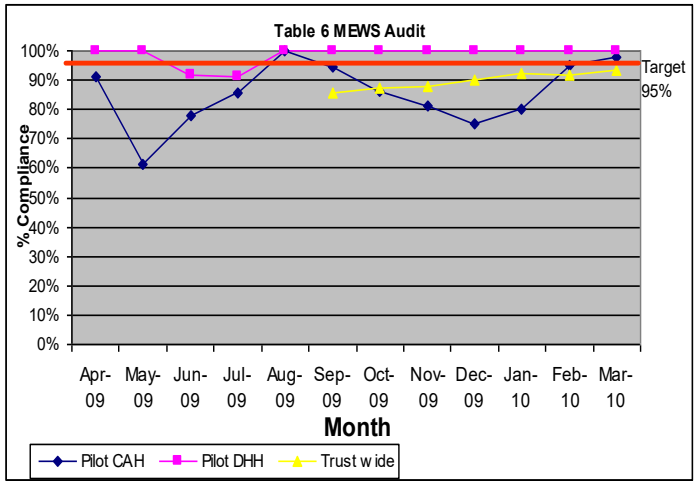
Overall Bundle Compliance failed to achieved 100% for the 1st time in 21 months. Non-compliant element 1/40 pts did not have a Sedation Break. Vent Days between VAP stands at 665 while Calendar Days between VAP stands at 125. Trust Goal for 09/10 was to achieve a period of 300 Vent Days between Vamp's. This target was achieved twice during 09/10.



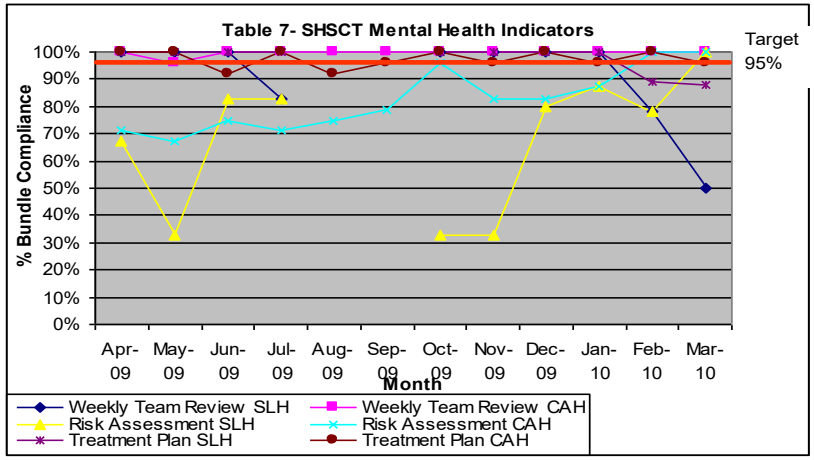


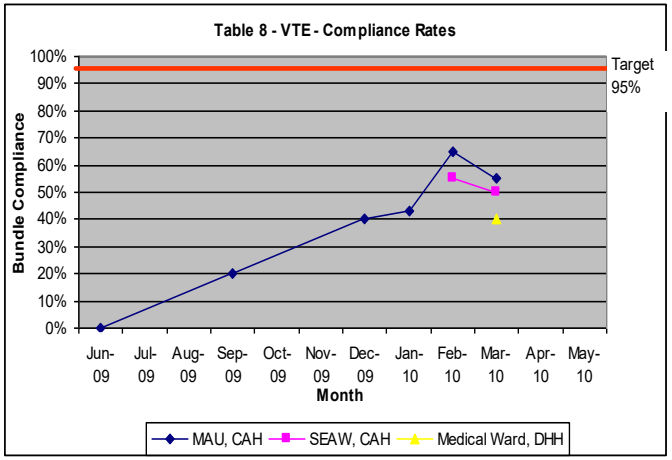
CAH - In 2 of the 5 pts audited in ICU & 3 of 5 pts on the wards there was a failure to document that the pts Central Line was checked on each of the days it was in. DHH - 100% for the 2nd consecutive month. No infections in March. Trust Outcome Goal for 09/10 was to maintain or reduce the 08/09 Infection Rate of 1.17per thousand line days. This was achieved with the Infection Rate being reduced to 0.98 per thousand Line Days.





The Trust's Crash Call Rate for 09/10 was 1.89 per thousand deaths/discharges, which was the goal set by the Trust. The goal of achieving 95% compliance of MEWS on Pilot Wards at CAH & DHH was also achieved & the auditing of MEWS Trust wide has been embedded with greater than 90% compliance achieved on all sites.

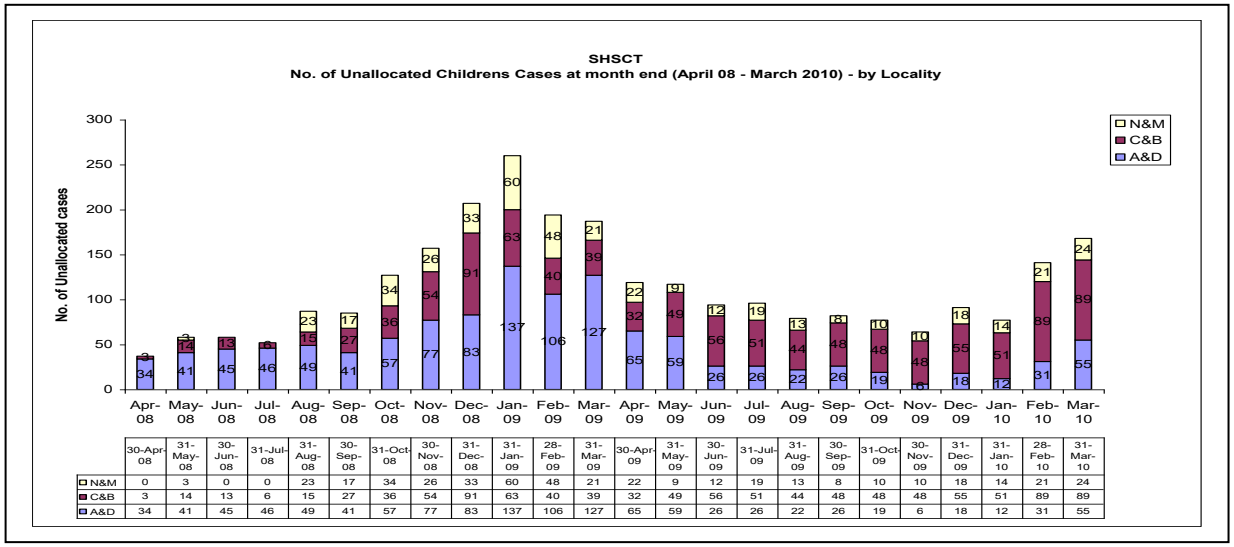




Mental. Health - 30/32 pts had W.T.R. recorded in notes, 29/32 had the timetable for actions set/agreed, while 29/32 had evidence of action carried out. 30/32 had the pts involved in the M'disc Care Plan, while 31/32 had their Mental, Physical & Social Care need addressed. VET - Auditing of compliance is now underway in 3 of the 4 Pilot Wards. The delay in the introduction of the Risk Assessment Forms has resulted in less progress being achieved that the Team would have hoped for.

CHILDREN AND YOUNG PEOPLE REPORTING

Unallocated Child Care Cases



	30-Apr-08	31-May-08	30-Jun-08	31-Jul-08	31-Aug-08	30-Sep-08	31-Oct-08	30-Nov-08	31-Dec-08	31-Jan-09	28-Feb-09	31-Mar-09	30-Apr-09	31-May-09	30-Jun-09	31-Jul-09	31-Aug-09	30-Sep-09	31-Oct-09	30-Nov-09	31-Dec-09	31-Jan-10	28-Feb-10	31-Mar-10
N&M	0	3	0	0	23	17	34	26	33	60	48	21	22	9	12	19	13	8	10	10	18	14	21	24
C&B	3	14	13	6	15	27	36	54	91	63	40	39	32	49	56	51	44	48	48	48	55	51	89	89
A&D	34	41	45	46	49	41	57	77	83	137	106	127	65	59	26	26	22	26	19	6	18	12	31	55

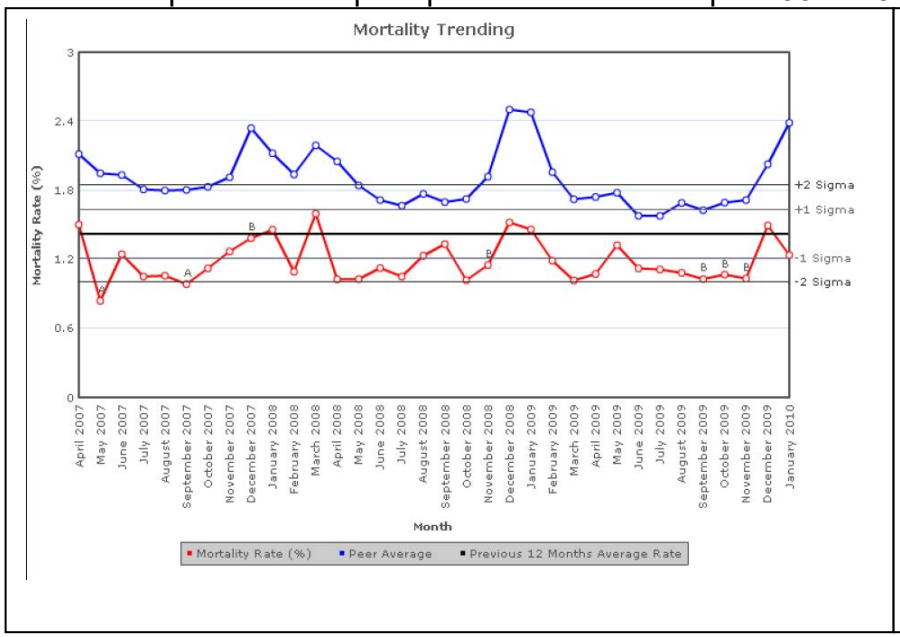
Action taken to mitigate risks and strengthen our system:

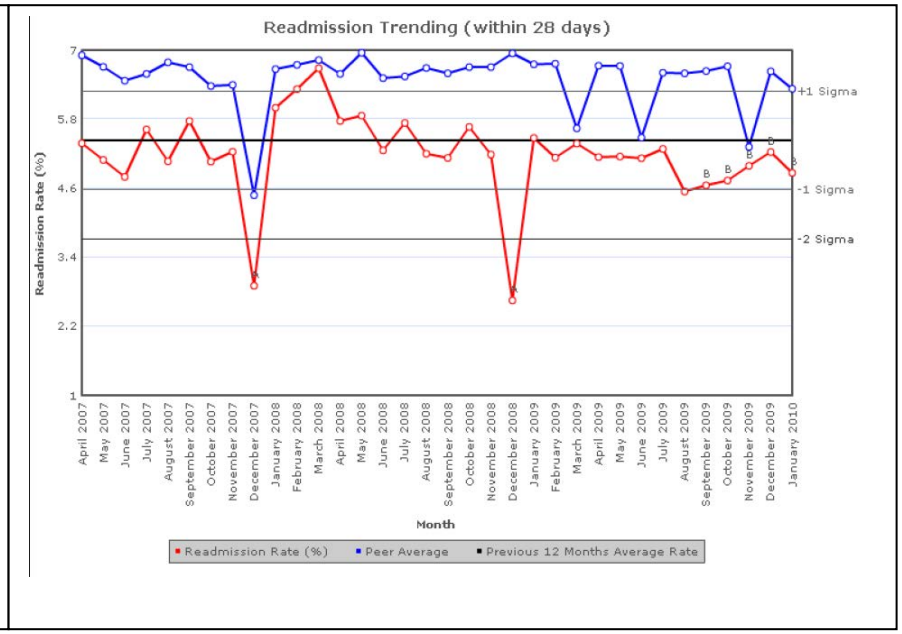
a. There are no unallocated child protection cases. All such cases are allocated and responded to.
b. Heads of Service, the APSW for Gateway and Team Managers regularly monitor, review and prioritise unallocated cases for allocation.
c. Across Gateway and FIT Services there are still a number of staff vacancies. Within FIT newly recruited staff are expected to take up post by the end of May and a number returning from sick leave by the end of April.
d. Measures have been implemented to address capacity issues relative to staff vacancies including (a) redistributed work across teams and (b) redeployed staff to key pressure points.

CLINICAL AND QUALITY INDICATORS

The mortality and re-admission trending positions above have been extracted from CHKS benchmarking tool. This shows high level performance against crude mortality (which is not risk adjusted) and re-admissions within 28 days. Processes are being established via the Medical Directors office to analyse these indicators at specialty/consultant level and identify any significant variance for further analysis. (Reporting is subject to change associated with updated clinical coding positions.)

Red Line - represent the SHSCT performance from April 2007 to Jan 2010.
Solid Black Line - represents the Trusts own average performance in the previous 12 months and the standard variations on the positive and negative sides of this average (Sigma +/-1 and +/- 2)
Blue line – represents the peer performance from April 2007 to Jan 2010.





Appendix I – Quarterly PFA Supplementary Report

Southern Health and Social Care Trust

Performance Management for 2009/10

'Supplementary PFA Targets'

Return Template – QE March 2010

PERFORMANCE MANAGEMENT 2009-10

PRIORITY AREA 1: IMPROVING HEALTH AND WELL-BEING

Target Area	Responsibility	Update on progress
Trusts should, by March 2010, establish screening arrangements for abdominal aortic aneurysm.	Trusts	Screening arrangements are organised regionally therefore the Trust is awaiting regional guidance.
Trusts should, by March 2010, make arrangements to extend the scope of antenatal screening for foetal anomalies.	Trusts	**Target Achieved** All Ultrasonographers in the Southern Trust are trained to perform heart imaging on the 22 week scans. The Trust has requested and would welcome greater clarity on how this target should be met.

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

Target Area	Responsibility	Update on progress
Trusts should ensure that, by March 2009, a dedicated paediatric and neo-natal intensive care transport service is in place on a 24/7 basis.	Belfast Trust	**Target - Not Applicable** Priority led by Belfast Trust. No Southern Trust response required.
The Northern Ireland Ambulance Service should ensure that, by March 2009, paramedic administered thrombolysis is available throughout Northern Ireland.	NIAS	**Target Achieved** Currently thrombolysis is administered in the community by nurse led cardiac ambulance from Craigavon Area Hospital. The Trust continues to keep administration of Thrombolysis under review particularly in light of changing practice in conjunction with the use of its cardiac cath lab facilities for Primary PCI. Thrombolysis service is offered through activation of the Cardiac ambulance from Craigavon Area Hospital covering the Craigavon and Banbridge / Armagh and Dungannon legacy geographical areas. In the Newry and Mourne area Daisy Hill Hospital paramedics bring patients to the hospital if thrombolysis is required. It is expected that NIAS will offer thrombolysis in SHSCT during 2010 / 2011. The European Cardiology guidance has identified Primary PCI as the treatment of choice with Thrombolysis as second. Discussions are on-going regionally regarding Primary PCI and how it can be taken forward.

By March 2011, increase critical care capacity by two beds, or by the outreach equivalent compared to the position in March 2008.	Trusts	**Target – Partially Achieved (Pending Commissioner Approval)** To achieve this priority investment is required. A business case has been completed and is under discussion with the Commissioner to address the requirement to improve our critical care capacity across both Acute hospital sites. It includes the development of the critical care outreach service for both sites and the procurement of the RP7 Robot for the Daisy Hill Hospital site specifically.

PRIORITY 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

Target Area	Responsibility	Update on progress
By March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services. Update on actions being taken to focus on the definitions document developed by the Regional Palliative Care Group including comment on the 5 objectives contained in the monitoring guidance. Terms of Reference for Trust Steering Group Progress on the development and implementation of Palliative Care Service Improvement Plan.	Trusts	**Target Achieved** The Trust has in place a Palliative Care Steering Group Chaired by the Director of Older People's Services and Primary Care and representative of services across acute, community and primary care to coordinate the development of palliative care services including cancer and non cancer conditions which are reflected in the standards in the Cardiovascular, Respiratory and Stroke Strategies. The Trust has in place a range of specialist and generalist palliative care practitioners who work as part of a team. A second Palliative Care Consultant was appointed this year. A range of cancer specific and community Macmillan nurses work as a team providing services in both hospital and community settings. The Macmillan Dietician has developed nutritional guidelines which will be launched this year. The Trust has worked with Macmillan Cancer Care to put in place two secondments, one for a Palliative Care Service Improvement Lead and a second for a Lead Palliative Care Practitioner. The Liverpool Care Pathway is used in all Trust Hospitals and is being rolled out in GP Practices, community services and Private Nursing Homes. The Trust is working with the Southern Area Hospice to introduce a Specialist Palliative Care Nurse to work in the Trust. The Trust Palliative Care Pharmacist has worked with the Trust GP advisor and Medical Director for GP Out of Hours to develop guidelines on symptom control for GPs. The Trust is working with Macmillan to put in place an information pathway for cancer. Further work is required to develop the range of Allied Health Professional services in palliative care. The Trust will be developing a proposal to put in place a pilot service

		for cancer survivors using the skills of AHPs linked to the services provided by voluntary and community groups. QE Sept 09 Update: The work identified above continues. The hospice funding specialist palliative care nurse commences post on the 1 October 2009 and will work in the Armagh/Dungannon area. Part of the post will focus on palliative care for patients with non cancer conditions. The Trust is represented on the Regional Palliative Care Steering Group and has completed the self assessment for the palliative care PfA target. The Trust is now developing an implementation plan for the roll out of the standards which will include process mapping both the cancer and non cancer palliative patient care pathways. QE December 09 Update: A Palliative care workshop involving all stakeholders including voluntary and statutory is planned for February 2010, which will facilitate the development of an action plan with regards to the PfA target. QE March 10 update: The Terms of reference for the Palliative care steering group will be agreed by the group at the next meeting in April 2010. The Trust has appointed both the Service Improvement Lead for Palliative Care and Education Facilitator for Palliative Care. The Trust Palliative Care Service Improvement Lead will work in partnership with the Regional Palliative Care Lead to complete the service improvement plan in line with the regional plan. This will support the implementation of the strategy and support the achievement of related targets and standards. The Trust will work in partnership with the regional Service Improvement Lead and other key stake holders on regional objectives identified in the Regional Service Improvement Leads work plan such as Clinical Prognostic Indicators, regional data sets, palliative care registers, advanced care plans and key worker. The Macmillan Education facilitator is currently undertaking a training needs analysis across all programmes of care in the Trust in relation to Palliative care. The Trust has commenced commissioning modules for some of the specialist nurses from non cancer services to commence Sept 2010. A Trust Palliative Care workshop with key stakeholders was held 15 February 2010 with representation from Acute including Palliative care Consultants, and Senior

		Managers; Older People and Primary care including Palliative care community team, Physical Disability, Pharmacy, Respiratory, Heart Failure, Parkinson's and District Nurse community teams, Primary Care and the Hospice. The regional lead for palliative care presented an overview of the PFA target and the strategy and key themes of the strategy such as key worker, Clinical Prognostic Indicators, Service Improvements and Advanced Care Plans were discussed. The outcomes from the workshop are being developed into the Trust service improvement plan which is to be approved by the Palliative care Steering Group. Funding has been secured from the Commissioner to continue with the appointment of the Liverpool Care Pathway facilitator in the community and independent sectors to ensure full implementation of the end of life pathway. The specialist Heart Failure, COPD, Stroke and Dementia teams have also been trained in the use of the Liverpool Care Pathway. The Macmillan Nursing team participated in the holistic assessment tool, the Trust will implement the recommendations when available. Carers assessment are offered to carers. The Trust has developed a Carers strategy and fully engage with carers groups in the area. The Carers co-ordinator is invited to attend team meetings within the Older Peoples and primary Care Directorate. Carers of patients who have been cared for by the District Nursing, heart failure, COPD and Macmillan nurses receive a bereavement visit and provided with appropriate information including regionally agreed bereavement booklet. The Trust has implemented a policy on management of the death of a patient across all care settings and the Bereavement Coordinator is currently attending team meetings to create awareness and promote implementation. The Enteral Tube Feeding Co-ordinators are currently developing enteral tube feeding guidelines which will support palliative care patients who have an enteral tube inserted. The Trust has launched evidence based nutritional guidance for cancer patients which has been approved by the British Dietetic Association. It has held a workshop with key stakeholders regarding implementation of the guidance. The Macmillan Dietitian is developing an implementation plan which will include key stakeholders both statutory and Independent sectors. She is also working with NICaN to explore regional implementation. The guidelines have been implemented for use in District Nursing teams. The Trust work in partnership with Marie Curie and provide an Out of Hours roving

		team to visit patients in their own home with Palliative care needs. The Marie Curie manager has met with Specialist Primary Care teams to create awareness and promote access to the service. One Parkinson's Disease Nurse Specialist and two Specialist Nurses for Older People have been appointed. Palliative care is a key aspect of these professionals role. Macmillan Education facilitator is facilitating a "buddying" model of support and learning development for non-cancer palliative care within Heart Failure, COPD, and Parkinsons with the Palliative Care teams. The Trust GP Out Of Hours service receive special notices from GPs regarding palliative care patients, if Patients are seen in Out Of Hours service their own G.P receives information before 9.00 the next morning. The GP Out Of Hours service have indicated their willingness to participate in a palliative care pilot regarding the Emergency Care Record. The Palliative care pharmacist coordinated a Palliative care Pharmacy workshop focussing on Heart Failure, Renal and Cancer for specialist teams, both acute and community in March 2010.

PRIORITY 6: MENTAL HEALTH SERVICES

Target Area	Responsibility	Update on progress
From April 2009, implement a stepped care model and ensure no patient waits longer than 13 weeks from referral to assessment and commencement of treatment for mental health issues including psychological therapies, reducing to nine weeks by March 2010, other than psychological therapies.	Trusts	**Target Achieved** For the first 12 months, March to February 2010, the Southern Trust's Mental Health Referral and Booking Centre has triaged and booked 4668 appointments for patients referred to the Primary Mental Health Care Service. The Trust has successfully achieved the 9 week PTL in February and March 2010 and maintained the 13 week target for psychological therapies. As part of the development of a stepped care model of service delivery a GP Liaison Committee is being set up. This will further facilitate the on-going dialogue between Primary Care and Mental Health Services, focusing on all 3 service areas, Acute, Recovery and Support, and Primary Mental Health Care. The Trust is in the process of recruiting into its Primary Mental Health Care Service which will deliver services at steps 2 and 3 of the stepped care model.

		The focus for the next 12 months will be on the development of steps 4 and 5 of the model – the Recovery and Support services. This will included the roll out of the "Choice and Partnership Approach" to the Recovery Teams and the development of a Shared Management Model in collaboration with Primary Care. Progressing this plan is contingent on securing resources in 2010/11.
A Local Domestic Violence Partnership should be established in each Trust area which should, by September 2009, have produced and begun the implementation of a local DV action plan based on the regional DV strategy and action plan. By March 2010, each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences held in their area during the year.	Trusts	**Target Achieved** Domestic Violence Partnership: Target has been achieved. We have established a Southern Area Domestic Violence partnership and action plan Multi-Agency Risk Assessment Conference training has now been completed and the Trust has participated in 100% Multi-Agency Risk Assessment Conferences which commenced in January 2010.

Appendix II – Daycase Rates by Procedure

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CALCULATION OF % DAYCASE RATES FOR ALL BASKET OF PROCEDURES

Figures Exclude IS Activity

Run Date 09/03/10

PROCEDURE	SITE	FY2009/10 (April - February) DAY CASES	ELEC ADMIS	% DAY CASE RATE
Anal Fissure	CAH	18	0	100.0%
	DHH	4	2	66.7%
	STH	7	0	100.0%
Anal Fissure exc IS		29	2	93.5%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Arthroscopy	CAH	110	68	61.8%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Arthroscopy exc IS		110	68	61.8%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Bunion Operations	CAH	0	3	0.0%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Bunion Operations exc IS		0	3	0.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Carpal Tunnel Decompression	CAH	94	4	95.9%
	DHH	48	10	82.8%
	STH	77	0	100.0%
Carpal Tunnel exc IS		219	14	94.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Circumcision	CAH	39	30	56.5%
	DHH	24	3	88.9%
	STH	17	0	100.0%
Circumcision exc IS		80	33	70.8%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Correction of squint	CAH	0	0	#DIV/0!
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Correction of squint exc IS		0	0	#DIV/0!

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
D&C/ Hysteroscopy	CAH	280	111	71.6%
	DHH	205	21	90.7%
	STH	149	0	100.0%
D&C/ Hysteroscopy exc IS		634	132	82.8%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Excision of Breast Lump	CAH	20	8	71.4%
	DHH	11	1	91.7%
	STH	10	0	100.0%
Excision of Breast Lump exc IS		41	9	82.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Excision of Dupuytrens Contracture	CAH	6	3	66.7%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Excision of Dupuytrens Contracture exc IS		6	3	66.7%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Excision of Ganglion	CAH	12	2	85.7%
	DHH	0	0	#DIV/0!
	STH	23	0	100.0%
Excision of Ganglion exc IS		35	2	94.6%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Extraction of Cataract (with/ without implant)	CAH	0	0	#DIV/0!
	DHH	0	0	#DIV/0!
	STH	440	0	100.0%
Extraction of Cataract exc IS		440	0	100.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Haemorrhoidectomy	CAH	8	17	32.0%
	DHH	0	5	0.0%
	STH	2	0	100.0%
Haemorrhoidectomy exc IS		10	22	31.3%

*** Note - Manual Adjustment made in November - 2 Patients [redacted] & [redacted] seen in STH but transferred to CAH and had an overnight stay. These patients have been excluded from STH as and IP and included in CAH IP figures.

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Hydrocele	CAH	7	2	77.8%
	DHH	0	13	0.0%
	STH	3	0	100.0%
Hydrocele exc IS		10	15	40.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Inguinal Hernia	CAH	51	76	40.2%
	DHH	12	88	12.0%
	STH	46	0	100.0%
Inguinal Hernia exc IS		109	164	39.9%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Laparoscopic Cholecystectomy	CAH	23	159	12.6%
	DHH	0	118	0.0%
	STH	0	0	#DIV/0!
Laparoscopic Chol exc IS		23	277	7.7%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Laparoscopy	CAH	219	93	70.2%
	DHH	63	30	67.7%
	STH	42	0	100.0%
Laparoscopy inc IS		324	123	72.5%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Myringotomy/ Grommets	CAH	162	35	82.2%
	DHH	77	0	100.0%
	STH	57	0	100.0%
Myringotomy/ Grommets inc IS		296	35	89.4%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Operation on Bat Ears	CAH	0	19	0.0%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Operation of Bat Ears exc IS		0	19	0.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Orchidopexy	CAH	6	3	66.7%
	DHH	6	1	85.7%
	STH	1	0	100.0%
Orchidopexy exc IS		13	4	76.5%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Reduction of Nasal Fracture	CAH	81	25	76.4%
	DHH	18	0	100.0%
	STH	12	0	100.0%
Reduc of Nasal Fracture exc IS		111	25	81.6%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Removal of Metalware	CAH	8	25	24.2%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Removal of Metalware exc IS		8	25	24.2%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Sub Mucous Resection	CAH	13	104	11.1%
	DHH	41	9	82.0%
	STH	27	0	100.0%
Sub Mucous exc IS		81	113	41.8%

*** Note - Manual Adjustment made in August - 1 Patient [Personal Information redacted by USI] seen in STH but transferred to CAH and had an overnight stay. This patient has been excluded from STH as and IP and included in CAH IP figures.

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Termination of Pregnancy	CAH	0	0	#DIV/0!
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Termination of Pregnancy exc IS		0	0	#DIV/0!

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Tonsillectomy	CAH	3	454	0.7%
	DHH	107	13	89.2%
	STH	0	0	#DIV/0!
Tonsillectomy exc IS		110	467	19.1%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
TURP	CAH	2	52	3.7%
	DHH	21	6	77.8%
	STH	1	0	100.0%
TURP exc IS		24	58	29.3%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Varicose Veins	CAH	29	34	46.0%
	DHH	0	5	0.0%
	STH	5	0	100.0%
Varicose Veins exc IS		34	39	46.6%

TRUST TOTAL	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
TRUST TOTAL	CAH	1191	1327	47.3%
	DHH	637	325	66.2%
	STH	919	0	100.0%
TRUST TOTAL Exc IS		2747	1652	62.4%

Appendix III – Environmental Cleanliness Report

Southern Health and Social Care Trust

Environmental Cleanliness Report

Prepared by: Functional Support Services
13/4/2010

Contents

Section

1. Introduction

The Environmental Cleanliness Committee provides assurance that standards of cleanliness within Trust facilities are met in a number of ways including the measurement of environmental cleanliness standards.

The Trust uses the Cleanliness Matters Toolkit (49 elements) issued by the DHSSPS as part of the Environmental Cleanliness Strategy, in order to undertake internal Departmental Audits. The results from Departmental Audits in hospitals across the Trust are included in section 3 of this report.

There were a limited number of Departmental Audits conducted at Craigavon Area Hospital during the month of March due to staffing issues, particularly in relation to Supervisors and Managers, and audits were prioritized in terms of risk. No Departmental Audits were carried out at Mullinure due to a ward closure.

From May 2009 the Infection Control Nurses Association (ICNA) audit tool instead of the Cleanliness Matters Toolkit has been used to conduct Managerial Audits. Managerial Audit results measured against the ICNA audit tool are included in section 4 of this report.

A Senior Management team decision was taken in January 2010 to issue the ICNA audit tool to ward/department managers in order that they can undertake the audit and populate action plans for their own area so ward/department managers are aware of the issues likely to arise out of RQIA inspections and take appropriate action pro-actively. This process has commenced however the results have not been included in this report.

The Cleanliness Matters Toolkit measures the standard of cleanliness and 85% or above indicates an acceptable level of cleanliness. Items to be cleaned are broken down into 49 generic elements with specific environmental cleaning standard requirements (eg floors, walls, furniture, bed frames, medical devices etc). The overall scores are weighted taking into account all risk categories ie very high, high, moderate and low risk category areas.

The RQIA uses the ICNA audit tool for their inspections. This audit tool is divided up into 10 sections, under the following headings:-

- Environment
- Ward/departmental kitchens
- Handling and disposal of linen
- Waste management
- Departmental waste handling and disposal
- Safe handling and disposal of sharps
- Management of patient equipment (general)
- Management of patient equipment (specialist areas)
- Hand hygiene
- Clinical practices

The ICNA level of compliance categories are as follows:-

Compliant	85% or above
Partial compliance	76 to 84%
Minimal compliance	75% or below

The overall score is an average of the audit scores and the rating can only be compliant if all the scores are 85% or above. Weighting is not applied to ICNA audit scores.

The Environmental Cleanliness audits carried out by Trust staff measure the standard of cleanliness within a sample of rooms on a ward and these have tended to concentrate on ward/clinical areas whilst the Environment Section of the ICNA tool also includes utility rooms and domestic stores.

The following are some of the main differences between the two audit tools:-

- The ICNA tool assesses the cleanliness and maintenance of equipment such as lockers, chairs and tables whereas the Cleanliness Matters Toolkit measures cleanliness.

- The Cleanliness Matters Toolkit concentrates more so on the fabric of the building and includes entrances/exits, doors, light fittings, radiators and external grounds whereas these are not included in the ICNA tool.

- Patient equipment including commodes, drip stands etc, drug trolleys and patient wash bowls are included in the Cleanliness Matters Toolkit whereas in the ICNA tool they are included under Management of Patient Equipment Section rather than the Environment Section.

- The ICNA tool picks up on decontamination from a segregation point of view however the Cleanliness Matters Toolkit is only concerned with the cleanliness of the sinks and not the purpose of the sinks.

- The ICNA tool requests evidence of an effective pre-planned programme for curtain changes. This is not measured under the Cleanliness Matters Toolkit.

- The INCA tool assesses cleaning equipment (colour coding, storage of mops and buckets). These areas are not covered under the Environmental Cleanliness audits however Support Services will be implementing practice audits which will pick up on these issues.

- The Environmental Cleanliness audits cover the cleanliness of the kitchen whereas the ICNA tool section on kitchens is divided into Ward and Departmental and is similar to a kitchen inspection as it considers the operations within the kitchen, eg temperature recordings.

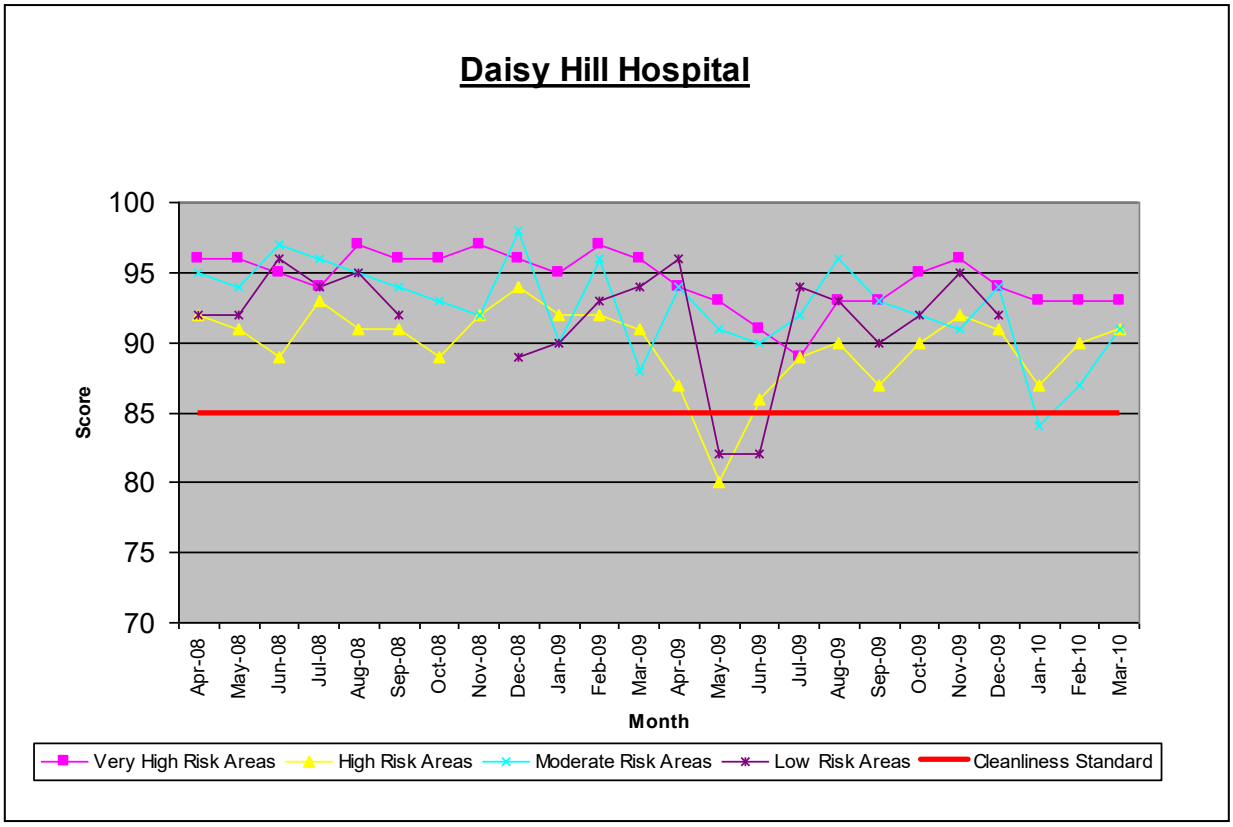
The DHSSPSNI hosted a workshop in 2009 to consider the various audit tools used in HSC settings and a Steering Group has been established to review the Cleanliness Matters Toolkit with a view to harmonising with other tools such as the ICNA tool. Workstreams have been set up to take forward work on developing a common approach to audit, standard definitions and cleaning plans, and training for staff involved in the audit process.

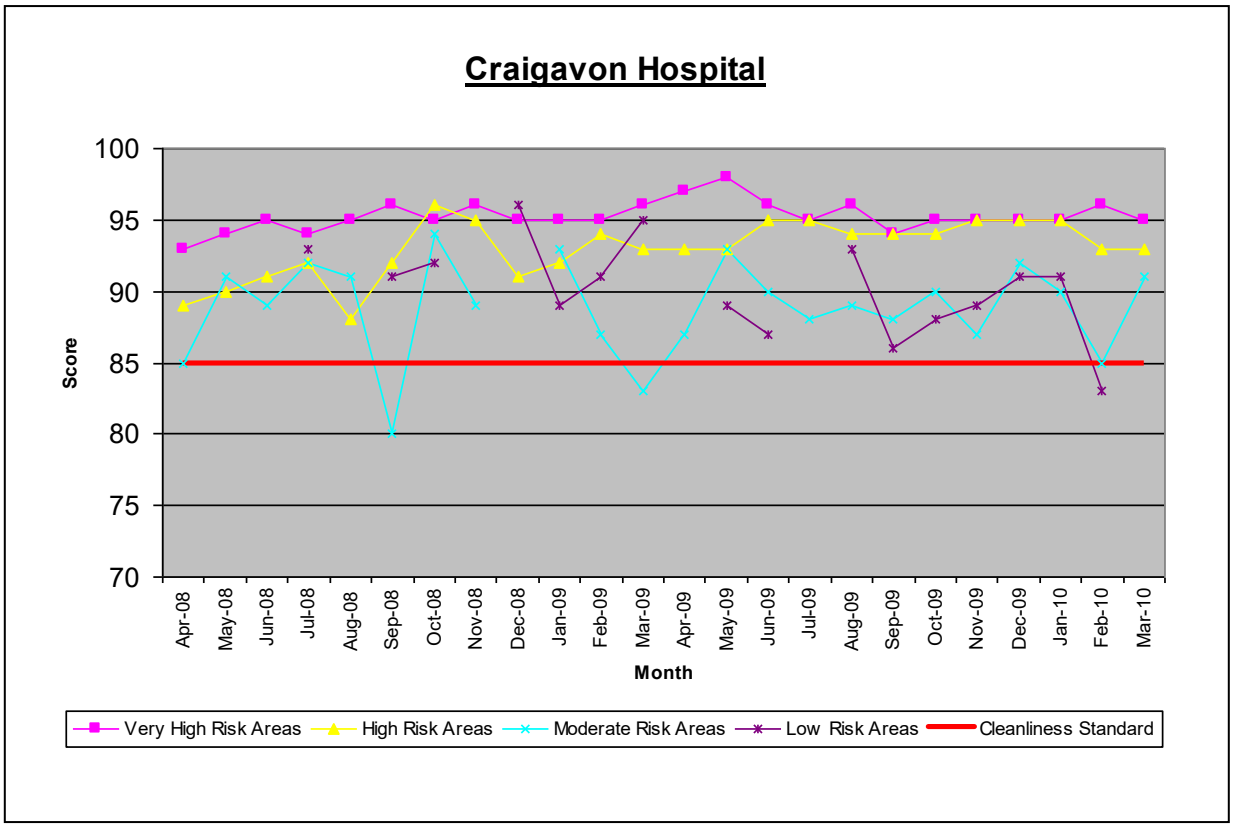
2. Departmental Audit Results - Summary of Overall Weighted Scores using the Cleanliness Matters Toolkit

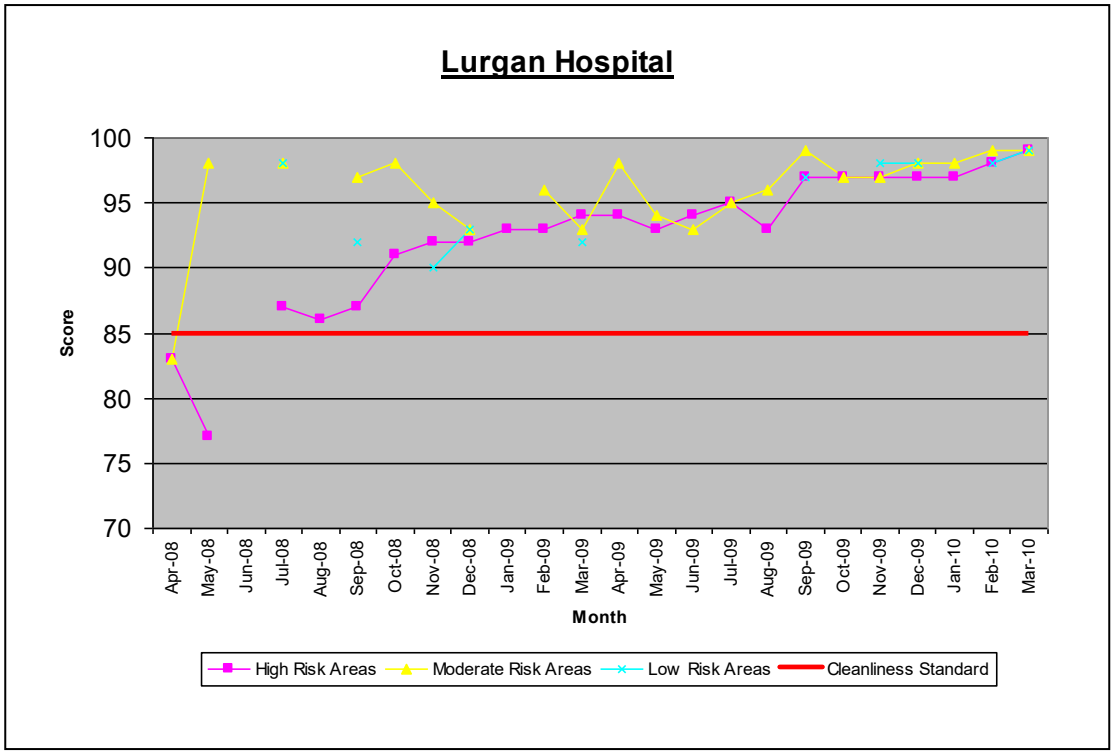
Hospital	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
St Luke's	85	93	88	86	88	84	90	94	90	85	91	93	90	93	90	91	94	91	90	95	90	86	95	94
South Tyrone	85	89	89	86	86	90	87	90	90	89	89	92	89	93	90	90	90	90	89	91	92	93	93	94
Longstone	85	89	91	89	87	92	91	88	94	93	92	93	91	89	90	90	88	94	90	84	93	92	87	93
Mullinure	93	90	90	91	94	95	91	94	93	95	94	96	95	95	96	91	84	85	88	96	95	96	98	
CAH	90	92	92	93	91	91	95	94	94	93	93	92	93	94	93	93	93	92	93	92	94	93	91	93
Lurgan	83	85		92	86	91	94	93	93	93	94	93	96	93	93	95	94	98	97	97	97	98	98	99
DHH	94	93	94	94	95	94	92	94	95	93	95	93	92	87	88	90	93	91	93	93	93	89	90	92
Bluestone						86	84	89	95	91	95	93	95	95	92	90	95	92	91	92	92	94	91	90
Average	88	90	91	90	90	90	91	92	93	92	93	93	93	92	92	91	91	92	91	93	93	93	93	94

The scores reflect the overall weighted score for each hospital taking into account all risk categories ie very high, high, moderate and low risk category areas.

3. Departmental Audit Results - Breakdown of Scores for each Hospital



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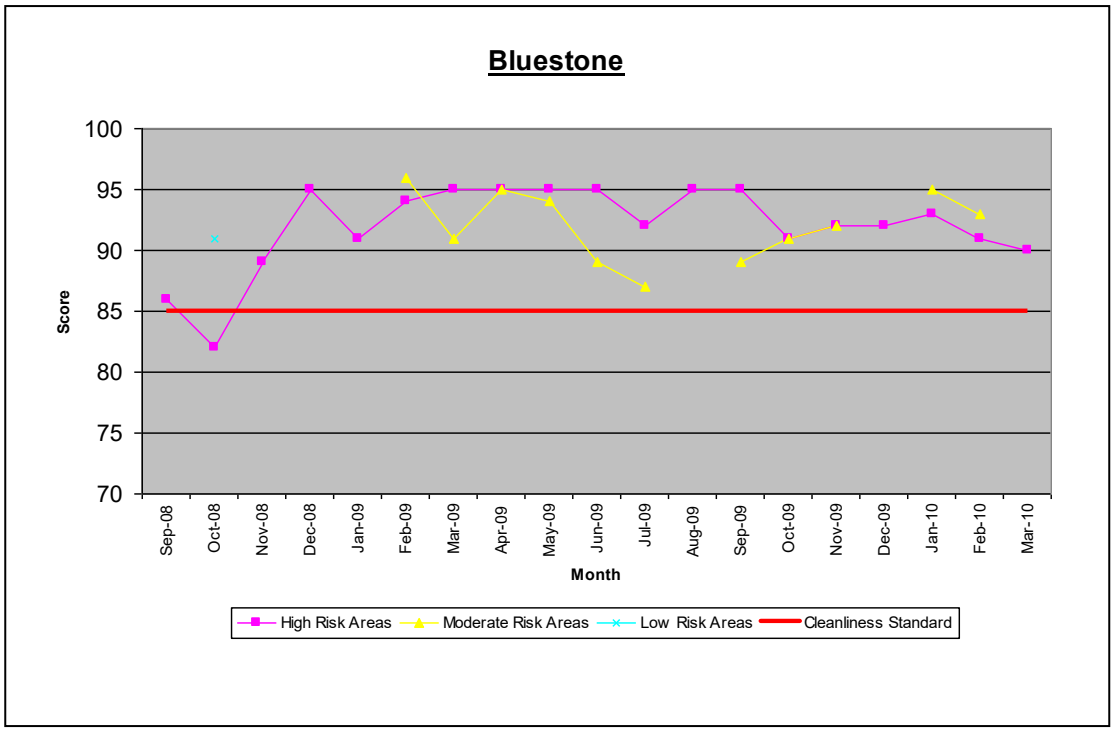
Month
High Risk Areas
Moderate Risk Areas
Low Risk Areas
Cleanliness Standard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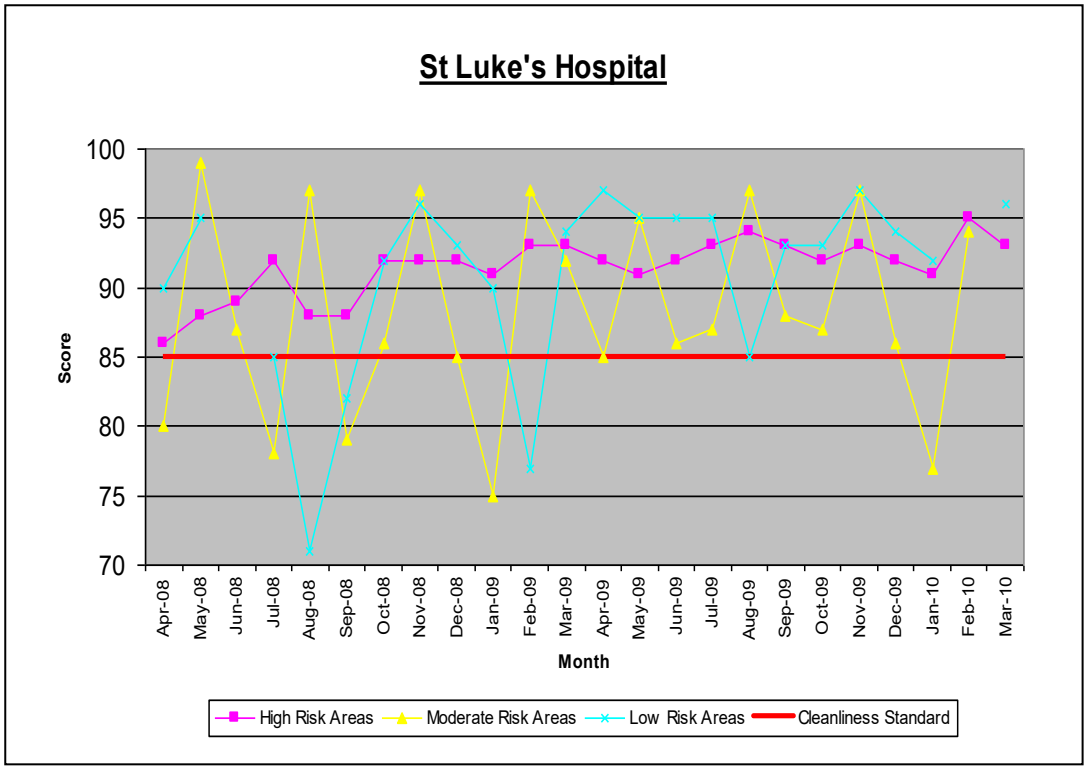
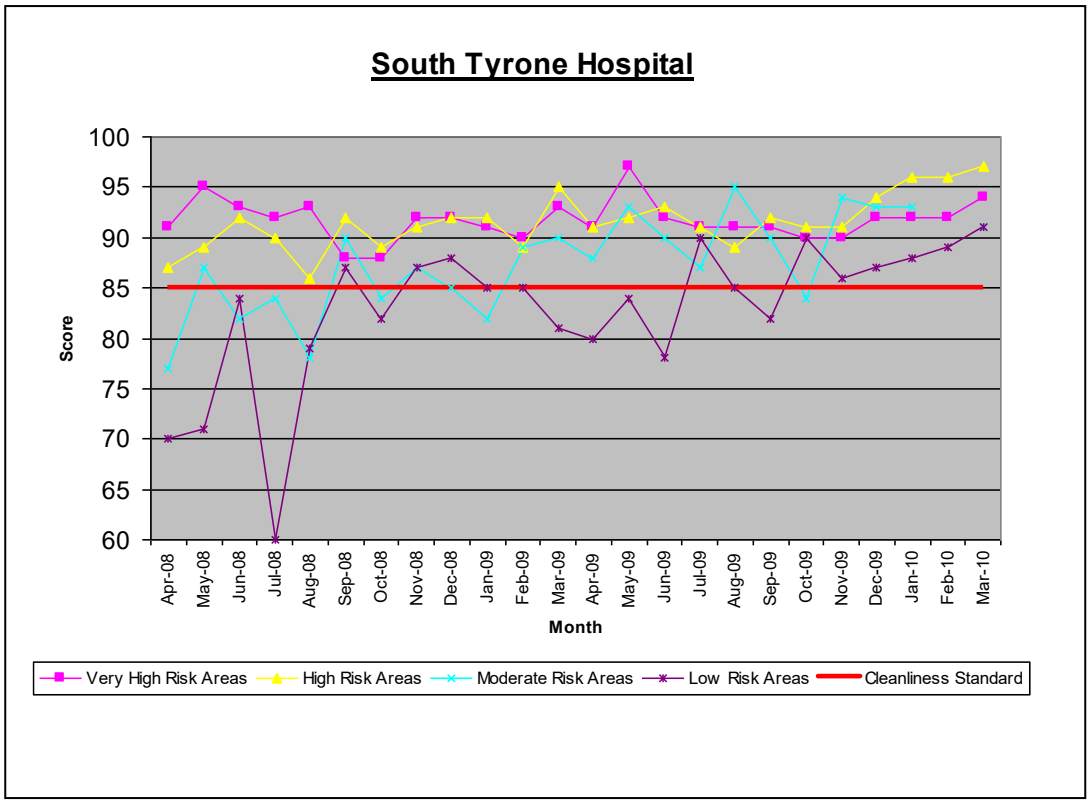
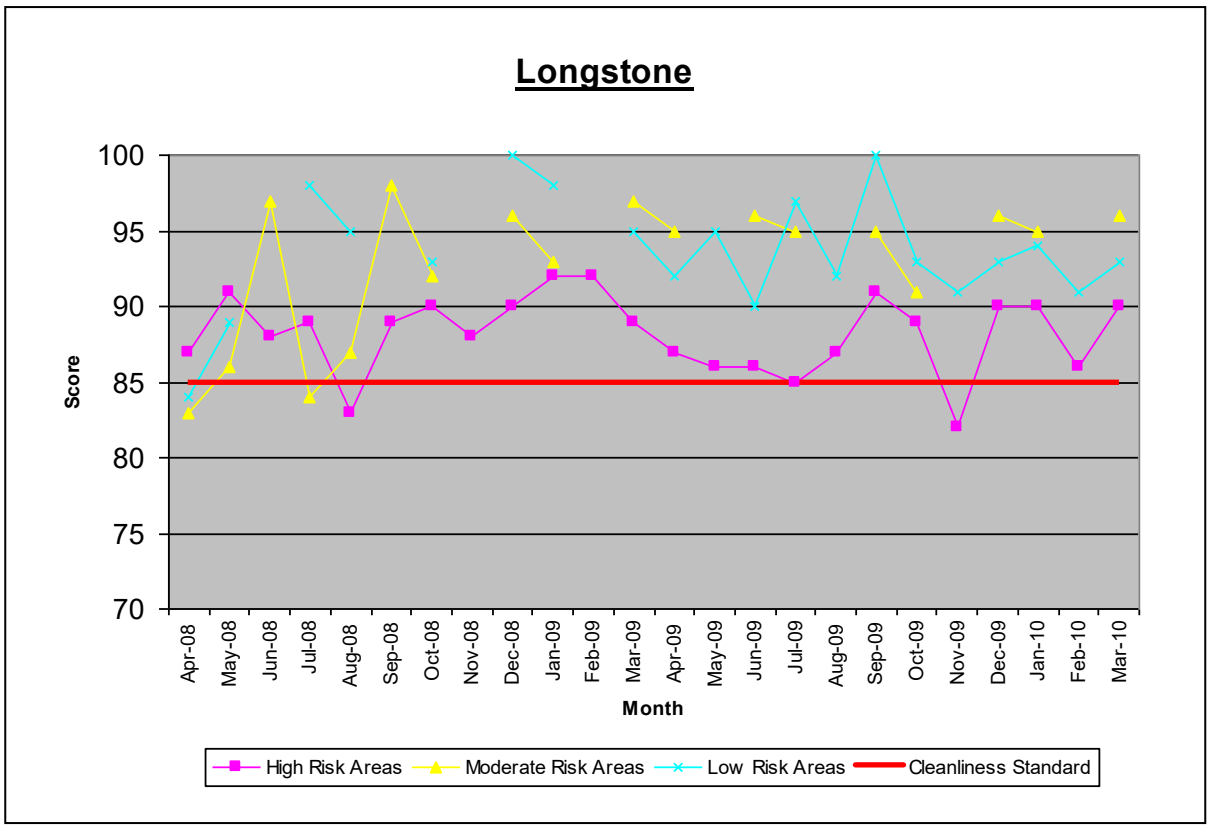
Cleanliness Standard





Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.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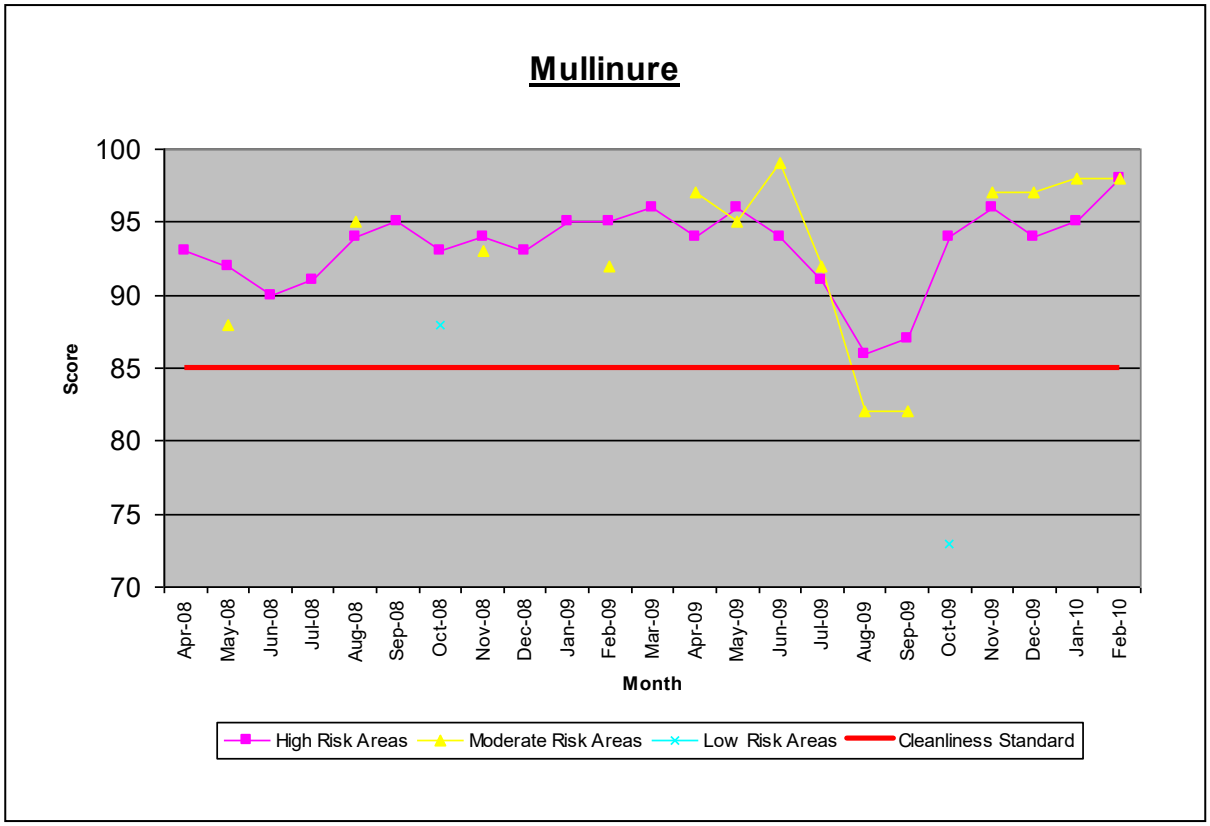
Month
High Risk Areas
Moderate Risk Areas
Low Risk Areas
Cleanliness Standard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Jan-10
Feb-10
Month
High Risk Areas
Moderate Risk Areas
Low Risk Areas
Cleanliness Standard

4. ICNA Audit Results

197 Managerial Audits have been undertaken between May 2009 and March 2010 using the ICNA toolkit. The following table shows the overall range of compliance.

Audit of Infection Control Standards		
Level of Compliance	**Score Range**	**No. of Scores which fall into this range**
Compliant	85% or above	57
Partial compliance	81 to 84%	18
Partial compliance	76 to 80%	24
Minimum compliance	66 to 75%	48
Minimum compliance	51 to 65%	30
Minimum compliance	50% or less	20
Total No. of Audits carried out		**197**

Level of Compliance	
Compliant	85% or above
Partial compliance	76 to 84%
Minimal compliance	75% or below

Summary of minimum compliance scores

In terms of the minimum compliance scores within the range 66-75% these scores contains some areas within wards at St Luke's Hospital in respect of safe handling of sharps, and disposal of Linen; some kitchen and environment areas within Craigavon Hospital and Daisy Hill Hospital.

For those areas that scored 51-65% this category contains some ward kitchens in CAH and some environmental scores in X-Ray at CAH.

For those areas that scored 50% or less:

- a Ward Kitchen at CAH, and some environment scores in Occupational Therapy and Physiotherapy at CAH.
- Waste Management at Day Procedure Unit at DHH,
- the environment and waste management in Cherryvilla at Longstone
- the environment on A Floor at South Tyrone Hospital and some wards in St Luke's Hospital.

5. Exception Report

This exception report includes items which are outstanding from Action Plans developed following either internal Environmental Cleanliness or RQIA Unannounced Inspections. These items relate mainly to the fabric of the buildings. Cleaning issues and small repairs which have been addressed have not been reflected in this report.

Facility	Dept	Work Required	Update March 2010
CAH	Areas including Elms, Maples, Laundry, Cedars & Stores	General Refurbishment	
CAH	Transport	Painting	
CAH	Lifts	Refurbishment	
CAH	A&E	Rolling programme for repainting needs to be established. Wheelchairs to be checked for damage to upholstery and repaired or replaced.	All areas have been painted to date. Wheel chairs not completed.
CAH	Outpatients	ENT needs refurbished and redecorated. Refurbishment of dirty utility	Outstanding has been put on the environmental cleanliness priority works list.
CAH	Wards	Refurbishment of ward kitchen.	Outstanding has been put on the environmental cleanliness priority works list
DHH	A&E	Provide patient bathroom or shower area. Refurbishment of domestic store, toilet beside domestic store and dirty utility. Macerator or washer disinfector required in the department. Scrub sink in resus is required. Repainting of walls in Fracture Waiting Area.	Refurbishment of DHH A&E included in Capital Priorities submission to DHSSPS. Interim work also in planning for 10/11.
DHH	Wards	Some repairing and floor replacement	
DHH	Changing Areas	Refurbishment of changing rooms.	
Longstone	Donard, Mourne,	Some painting required & some flooring in some areas needs	

	Sperrin, Cedarwood	replaced.	
South Tyrone	Various floors	Some ceiling tiles needs to be replaced, some painting required.	
St Lukes	Various Wards & Villas	Some painting & ceiling tiles replacement, flooring in some areas needs replaced.	

General Comments from RQIA

- National Colour Coding has been implemented with the exception of some items which are not available as stock items. Posters displaying colour coding information are being developed and will be displayed in domestic stores.
- There are a lot of water taps throughout the wards and departments which do not comply with HTM64 as they are not sensor taps.
- System to be established to ensure that mattresses are checked on beds and couches to ensure that they are not damaged or stained.
- Cleaning schedules for wards and departments to be updated and agreed arrangements to be put in place for their display in the wards and departments.
- Infection Control Training for staff to be provided on a rolling basis.
- Storage of bedpans at ward level to be agreed and suitable racks provided in all sluice/dirty utility rooms.
- Sharps and waste management training to be provided to staff.
- Toilet rolls and paper hand towels to be made available in dispensers. Trials of hand towels have taken place and the new contract is due to commence 1/5/2010. It had been originally scheduled to start 1/12/2009 but the date was extended.

Southern Health and Social Care Trust

Quality care – for you, with you

PERFORMANCE MANAGEMENT REPORT

Priority for Action
Standards and Targets

And

Key Corporate Performance Indicators

April 2010

Version	1.0 TB
Presented to Board of Directors	27/05/10
Author of report:	Dawn Livingstone
Presented by:	Paula Clarke

For information/approval

TO: **Board of Directors**

FROM: **Paula Clarke Acting Director of Performance & Reform**

DATE: **27 May 2010**

SUBJECT: **Monthly Performance Management Report**

PURPOSE

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance for April against:

- Priority for Action (PfA) 2009/10 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance
- Service and Budget Agreement (April-March 2010) – Year End Performance Position (Appendix I)

PFA standards and targets for 10/11 have not yet been formalised hence this report reflects performance for April against 09/10 targets. A number of PFA targets will change and new targets added. This report will be updated to reflect performance against the 10/11 position once PFA has been finalised and reporting systems established.

SUMMARY OF KEY POINTS

Indicators highlighted as 'Red' status associated with PFA targets include:

- PFA: IP/DC, Diagnostic & Outpatient Access Target – Page 11 – **update awaited on OP final position**
- PFA: Fractures – Page 12
- PFA: Renal dialysis via fistula – Page 16

RECOMMENDATIONS

- IP/OP Access Target -Delays in securing investment introduced risk as non-recurrent solutions had to be sustained for longer than anticipated. PMSID acknowledged that Urology, Endoscopy, T&O, and MRI services would not meet the agreed targets at year end but would not exceed 17 weeks. Recurrent investment has now been confirmed wholly and partially for a number of specialty areas and the Trust is developing implementation plans to address capacity gaps. Interim plans are also being developed to ensure that any slippage funding is fully utilised to ensure access targets are maintained were possible. No use of the independent sector is being made at this stage as a result, this month 66 IP/DCs and 1 OP within these specialty areas breached the 17 week backstop target and 266 OPs and 10 IP/DC breached the 9/13 week target.

- Fractures - Fracture performance continues to be variable due to the inability to provide trauma operating sessions 7 days per week and issues associated with sub-specialisation. The HSCB has confirmed recurrent investment for T&O and the Trust is developing an implementation plan to secure the additional sessions required.

- Renal Fistula - This target will remain challenging due to the high number of dialysis patients who may choose not to have a fistula inserted or redone. Regional review of definitions of this target is under discussion to take account of these issues and the Trust awaits a position on the way forward.

WHICH TRUST CORPORATE OBJECTIVE DOES THIS PAPER PROGRESS OR CHALLENGE?			
Provide safe, high quality care.	*P*	Be a great place to work.	
Maximise independence and choice for our patients and clients.	*P*	Make the best use of resources.	*P*
Support people and communities to live healthy lives and improve their health and wellbeing.	*P*	Be a good social partner within our local communities.	

(Indicate which of our key strategic objectives are progressed (P) or challenged (C))

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
We will treat people fairly and with respect.	*P*	We will value and give recognition to staff and support their development to improve our care.	
We will be open and honest and act with integrity.	*P*	We will embrace change for the better.	*P*
We will put our patients, clients, carers and community at the heart of what we do.		We will listen and learn.	

(Indicate which of Trust values are progressed (P) or challenged (C)

RISKS, CONTROLS AND ASSURANCE	
Risk	Risks discussed at SMT on 21 April 10, management actions noted.
Control	P
Assurance	P

(Indicate if: (i) new risk identified or risk is addressed (ii) if this provides/will provide control or assurance)

REVIEWED BY:	Date
Senior Management Team	Date 19/05/10
User forums/Community groups whose views have been sought	
	Date

CONTENT

CONTEXT

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance for April against:

- Priority for Action (PfA) 2009/10 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance
- Service and Budget Agreement (April-March 2010) – Year End Performance Position (Appendix I)

PFA standards and targets for 10/11 have not yet been formalised hence this report reflects performance for April against 09/10 targets. A number of PFA targets will change and new targets added. This report will be updated to reflect performance against the 10/11 position once PFA has been finalised and reporting systems established.

2. REPORTING

The PfA standards and targets and KPIs of corporate performance are presented in this performance report within the key domains defined within the performance management framework.

- Efficiency of Care Delivery
- Access & Targets
- Clinical and Social Care Quality
- Workforce – detailed reporting via HR & OD Directorate Report
- Finance – will be reported through the Monthly Finance Report

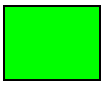
The level of performance for April will be assessed against 09/10 targets/KPIs, at present, as follows:

	Standard achieved / target achieved
	Standard substantially achieved / target substantially achieved
	Standard partially achieved / limited progress towards achievement of target
	Standard/target not achieved

3 SUMMARY REPORT

3.1 DOMAIN: EFFICIENCY

Target/Indicator	Baseline	Target	Actual		Comments
PFA Diagnostic Reporting From April 2009	**Sept 08 (Imaging & Non-Imaging)**	**Apr 09**	**Apr 10 (non-imaging)**		Regional reporting for imaging services is currently being developed with the implementation of NIPACS – therefore the imaging figures quoted are as at March 10. Non-imaging however reflects the April 10 position.
-all urgent tests reported within 2 days	**26%**	**100%**	**82%** **(Imaging – Mar 10)** **51%** **(Non-imaging – Apr 10)**		
-75% of routine within 2 weeks	**77.9%**	**75%**	**79%** **(Imaging – Mar 10)** **91%** **(Non-imaging – Apr 10)**		
-100% of routine within 4 weeks (Target rolled over from 2008/09)	**89.3%**	**100%**	**91%** **(Imaging – Mar 10)** **94%** **(Non-imaging – Apr 10)**		
PFA 4.4 Timely Hospital Discharge From April 2009, -90% complex discharges within 48 hours	**Mar 08** **98.6%**	**Mar 10** **90%**	**Apr 10** **88%** **(143/162)**		
-no. complex discharge will take longer than seven days	**0**	**0**	**0**		
-all other patients should be discharged within six hours Target rolled over from 2008/09	**96.3%**	**100%**	**96%** **(2394/2484)**		

PFA Priority Area 6- Mental Health Hospital Discharge By March 2009, - 75% of admissions discharged < 7days -all other patients discharges being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09 - All Mental Health patients discharged from Hospital to receive a follow-up visit within 7 days of discharge.	**Sept 08** **96%** **0**	**Mar 09** **75%** **0** **100%**	**Apr 10** **100%** **(131/131)** **0** **87%** **(60/69)**	  	
PSA 6.1 Mental Health Unplanned Admissions -By March 2010; reduce the number of admissions to mental health hospitals by 5% Target rolled over from 2008/09	**Mar 08** **1196** **Annual Admissions**	**Mar 10** **1136** **Ave Monthly admissions should not exceed 95**	**Apr 10** **86**		
PFA Priority Area 7 Learning Dis: Hospital Discharge By March 2010, - 75% of admissions discharged <	**Nov 07 – Mar 08** **cumulative** **66%**	**Mar 10** **75%**	**Apr 10** **100%** **(5/5)**		At the end of April there were 5 current inpatients deemed medically fit not yet discharged. All are waiting over 90 days.

7days -all other patients discharged being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09 (This monitoring excludes current inpatients) - all patients discharged to receive continuing care plan to receive visit within 7 days	**0** **Baseline to be established**	**0**	**0** **Monitoring not in place**		Delays associated with complexity of requirements and difficulty in identifying appropriate community resettlement places.
KPI ALOS Episodic Average Length of Stay for Elective and Non Elective Admissions to Hospital	**Process Average 2008/09** **5.5 Non-elective** **1.16 Elective**	**To be agreed**	**Apr 10** **4.77 Non-elective** **0.85 Elective**		
KPI: OP DNA % patients who 'Did not attend' an OP appointment and did not advise the hospital in advance.	**CHKS Peer 2008/09** **8.7%**	**CHKS Current Peer** **8.8%** **(Apr-Feb10)**	**Apr-Feb 10** **6.5% Total**		
PFA -Day Case Rate By March 2011, all Trusts are required to achieve an overall day surgery rate of not less than 75% for the 'basket' of 24	**Baseline SHSCT 2007/08** **55.6%** **2008/09** **(Basket of 24)**	**Target March 11** **75%**	**Apr 10** **Cumulative** **62.2%** **(coding level 83.8% therefore % subject to change)**		Further work is currently being undertaken to establish peer comparators for each procedure within the

procedures	**59.5%**				basket.
KPI : % Discharges Coded -cumulative coding position	**March 2008/09** **- 98.4%**	**Target** **100%**	**Apr 10** **83.8%**		
KPI : Freedom of Information (FOI) % requests responded to within 20 days	**SHSCT Baseline 2008** **87.5%** **(Regional range 50% - 95%)**	**Target** **100%**	**Apr 10** **76.8%**		To allow for the 20 day time lag responses are monitored one month in arrears i.e. Apr position is those monitored in Mar.
KPI : Staff Access to Intranet Number of staff as a percentage of the total Trust staffing complement, who have access to the Trust Intranet	**SHSCT Baseline March 2009** **55.72%**	**Internal Target** **55%**	**Apr 10** **69.59%**		
KPI : IT Helpdesk response Calls received by IT Service Desk resolved on first contact. This will be measured against the baseline at March 2009	**SHSCT Baseline March 2009** **6.61%**	**Target** **33%**	**Apr 10** **18.45%**		Temporary capacity gap in trained staff available is impacting on achievement of this target.

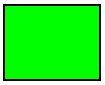
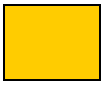
KPI Partial Booking of OP Appointments **%** Consultant led New and Review Appointments partially booked (Excs. Obstetrics) **%** Community led New and Review Appointments partially booked	**March 08** **94.1% (New)** **72% (Review)** **54.8% (New)** **4% (Review)**	**Target Sept 08** **100%**	**Apr 10** **96.5% (New)** **88% (Review)** **85.7% (New)** **45% (Review)**		The booking of all hospital consultant-led appointments has been consolidated into the centralized Booking Centre at CAH.
KPI – Complaints 72% of complaints responded to within 20 working days	**March 08** **65.6%**	**Target** **72%**	**Mar 10** **70%** **(62/88)**		To allow for the 20 day time lag this position is being reported a month in arrears.

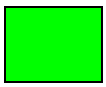
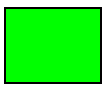
New targets for which monitoring arrangements have yet to be established

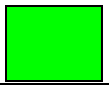
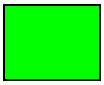
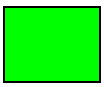
PFA 4.1 Unplanned Admissions
By March 2010 50% of unplanned hospital admissions related to exacerbation of severe chronic conditions are reduced.

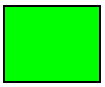
SHSCT submit a return monthly to PMSID on the numbers who have commenced case management. The Trust is awaiting guidance on definitions and peer comparison.

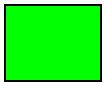
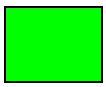
3.2 DOMAIN: ACCESS & TARGETS

Target/Indicator	Baseline	Target	Actual		Comments
PFA 3.1: Waiting Time Arthritis Drug Therapies By March 2010, no patients should wait longer than 9 months to commence specialist drug therapies for treatment of severe arthritis, By March 2011 – 21 weeks Target increased from 2008/09	**Mar 09 for 9 month position** **n/a** **Mar 08 for 21 week position** 18	**Mar 10** **0** **Mar 11** 0	**Apr 10** **0** **Apr 10** 3 (patients waiting over 21 weeks)	 	The 9 month target has been achieved. The trust is now working towards the achievement of the 21 week target by March 2011 and is currently on track.
PFA 3.2 IP/DC, OP & Diagnostic Access Targets By March 2010, no patient will wait longer than -9 weeks for a first OP appointment (excluding backstop specialties) - OP backstop target (over 9 but <17 weeks Urology, Scopes, T&O) -9 weeks for a diagnostic test, and -13 weeks for IP/DC treatment (excluding backstop specialties) - IP/DC backstop target (over 13 but <17 weeks Urology, Scopes, T&O) **Standard rolled over from 2008/09.The 9/9/13 week 08/09 target must be sustained month on month in 2009/10.**	**Mar 08 (No. of patients waiting)** **OP: 1624** **Diag: 188** **IP/DC: 1614**	**Mar 10** **OP: 0** **Diag: 0** **IP/DC: 0**	**Apr 10** **OP: 259 breaches** **346 OP within 17 week backstop (1 pt breach >17 weeks)** **Diag: 2 breaches** **IP/DC: 10 breaches** **369 IP/DC within 17 week backstop (66 pt breaches >17 weeks)**	    	**OPs -** 597 OPs - Confirmed Breaches, 6 Orthoptic, 243 x Ophthalmology, 9 x Oral Surgery 9 Week Breaches; 1 x Urology 17 Week Breach. - Confirmed Totals for Backstop Areas (over 9 but under 17 weeks): 196 Orthopaedic, 142 Urology **Diagnostics** – 2 Urodynamic breaches reported (reporting for new regional NIPACS system is still under development therefore the Trust is currently reliant on manual systems). **IP/DCs -** 445 Inpatient / Daycases – Confirmed Breaches: 10 x General Surgery 13 week Breaches; 4 x Orthopaedics, 62 Urology 17 week Breaches - Confirmed Totals for Backstop Areas (over 13 but under 17 weeks): 72 Urology, 271 Scopes, 26 T&O. See additional reporting page 30.

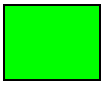
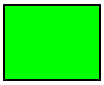
PFA AHP Access By March 2010 -no patients should waiter longer than 9 weeks from referral to commencement of AHP treatment. -the 13 week target achieved in March 09 should be sustained Target increased from 2008/09	**Mar 09** **322** **0**	**Mar 10** **0** **0**	**Apr 10** **24** **0**	 	Breaches: 23 OT, 1 Podiatry.
PFA Fractures -By March 2010, 95% of patients will wait no longer than 48 hours for inpatient fracture treatment. - no patient should wait longer than 7 days for treatment Target rolled over from 2008/09	**Mar 09** **75.6%** **0**	**Mar 09** **95%** **0**	**Apr10** **63.8%** **(30/47)** **1**		Cumulative average performance for 09/10 was 78.4%
PFA Cancer By March 2009, - 98% of cancer patients will commence treatment within 31 days and -95% of patients urgently referred with suspected cancer will begin treatment within 62 days - all urgent GP referrals for breast cancer are seen in 14 days and Target rolled over from 2008/09	**Mar 08** **99%** **96%** **100%**	**Mar 09** **98%** **95%** **100%**	**Apr 10** **Position As at Mar 10** **100%** **(71/71)** **96%** **(33/35)** **100%**	  	Due to the 31 and 62 day time lag these targets are reported retrospectively and the target position cannot be finalised until May 2010.

PFA A&E Access From April 2009, 95% of patients treated & discharged or admitted within 4 hrs Standard rolled over from 2008/09 No. of 12 hour breaches	**Mar 08** **SHSCT 95.2%** **CAH 92.9%** **DHH 97.1%**	**Mar 09** **SHSCT 95%** **CAH 95%** **DHH 95%** **0**	**Apr 10** **SHSCT 90.1%** **(10481/11637)** **CAH 85.3%** **DHH 92.5%** **0**	  	09/10 average performance for SHSCT was 93% - CAH 90% and DHH 94.5%
PFA 4.2 Care of Older People From April 2009, -no older person with continuing care needs will wait more than eight weeks for a completed assessment, -with the main components of care met within a further 12 weeks Standard rolled over from 2008/09	**Mar 08** **99.2%** **100%**	**Mar 09** **100%** **100%**	**Apr 10** **100%** **100%**	 	
PSA 5.3 Care leavers By March 2010, ensure that at least 70% of care leavers aged 19 are in education, training or employment Revised target	**Mar 09** **36** **Care leavers** **33 (92%)** **In ETE**	**Mar 10** **-** **46**	**Apr 10** **33** **Care leavers** **16** **(48% - In ETE)**		

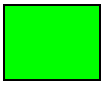
PSA 5.4: Care leavers By March 2010 increase to 175 the number of care leavers aged 18-20 living with their former foster carers or supported family Revised target.	**Mar 09** **27** **(End of Month position)**	**Mar 10** **21**	**Apr 10** **27**		
PSA 6.3 Mental Health Assessment and Treatment By March 2010 -ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health, excluding psychological therapies, Target increased from 2008/09 -pyschological therapies to sustain 13 week maximum wait Target rolled over from 2008/09	**Mar 09** **26** **Mar 08** **94**	**Mar 10** **0** **0**	**Apr 10** **6** **(No. on PTL over 9 weeks)** **0**	 	Includes 3 Acute MH breaches
PSA 7.3 Specialised Wheelchairs By March 2010 - ensure an 18 week maximum waiting time for 90% of all wheelchairs New target	**31 Jul 09** **90%**	**Mar 10** **90%**	**Apr 10** **96%** **(3/85 waiting over 18 weeks)**		
PFA – Autism By March 2010 -ensure that all children wait no longer than 13 weeks for	**31 Jul 09** **0**	**Mar 10** **0**	**Apr 10** **0**		

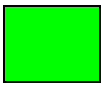
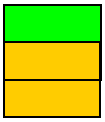
assessment, and - a further 13 weeks for commencement of specialist treatment New target	**0**	**0**	**0**		
PFA – Acquired Brain Injury By March 2010, -ensure a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment New target	**31 Jul 09** **0**	**Target Mar 10** **0**	**Apr 10** **0**		
PFA 7 – Housing Adaptations (Major Housing Adaptations) By March 2010 - all lifts/ceiling track hoists to be installed within 22 week of OT assessment/ option appraisal **(Minor Housing Adaptations)** By March 2010 - all minor urgent works to be completed within 10 days - New target	**31 Oct 09** **92.3%** **100%**	**Target Mar 10** **100%** **100%**	**Apr 10** **-** **100% (42/42)**	 	No installations were completed in April. There are currently 6/25 patients waiting over 22 weeks. Funding issues have been resolved in the interim therefore the target will be met from May onwards.

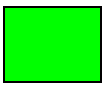
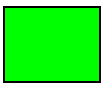
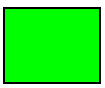
3.3 DOMAIN: CLINICAL AND SOCIAL CARE QUALITY

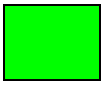
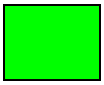
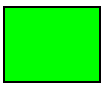
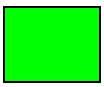
Target/Indicator	Baseline	Target	Actual		Comments
PFA - HCAI In the year to, by March 2010, ensure a -35% reduction in the number of hospital patients with staphylococcus aureus (MSSA) bloodstream infections (including MRSA), and a -35% reduction in cases of clostridium difficile infections compared to 2007/08 (based on those over 65 years of age) Target increased	**2007/08** **MRSA 14 Episodes** **MSSA 38 Episodes** **C Diff 134 Episodes**	**Mar 10** **MRSA 20 Episodes (Ave 1.7 p/mt)** **MSSA 34 Episodes (Ave 2.8 p/mt)** **C Diff 99 Episodes (Ave 8.25 p/mt)**	**Apr10** **MRSA/ 0 Episodes** **MSSA 0 Episodes** **C Diff 0 Episodes (Exc. Over 65)**	  	Additional reporting on Healthcare Associated Infection is included in section 4.0.
PSA 3.6 Renal By March 2010, -at least 60% of patients should receive dialysis via a fistula Target increased	**Mar 09** **36.8%**	**Mar 10** **60%**	**Apr 10** **41%** **(39/96)**		This target continues to be at risk. Patient Choice is impacting on achievement of this target. Regional review of definitions is ongoing.
PFA 4.1 Community Care By March 2010 -45% of people in care management have their assessed care needs met in a domiciliary setting. Target increased	**Mar 08** **43.7%**	**Mar 10** **45%**	**Apr 10** **45.5%** **(1735 people)**		

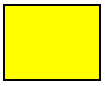
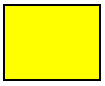
PFA 4 – Direct Payments By March 2010, -number of direct payment cases increases to 1,250 Target increased	**Mar 09** **361**	**Mar 10** **241 (SHSCT target)**	**Apr 10** **510**		
PFA Family Group Conferences During 2009/10 -ensure that at least 500 cyp whose assessed need is on levels 1,2 or 3 of the Hardiker model have participated in a FGC. Target rolled over from 2008/09	**2008/09** **58**	**Mar 10** **96** **(Ave 8 per month)**	**Apr 10** **26**		Apr-Mar 10 130 (inc 2 from Trust)

PSA 5.2 Family support interventions By March 2010 -provide family support interventions to 2000 children in vulnerable families each year New Target	**Oct 08 – March 09** **153** **306** **Extrapolated for full year**	**Mar 10** **384** **(Ave 32 per month)**	**Apr 10** **32**		Apr-Mar 10 403 (cumulative position)
PFA 5.3 - Foster Carers By March 2010, - increase foster carers by 300 (NI target) from the March 2006 total	**Mar 06** **217**	**Mar 10** **275**	**Apr 10** **292**		
PSA 5.1 - Children in Care By March 10 90% of children admitted to residential care prior to admission should -have had formal assessment & placement matched through Children's Resources Panel	**Baseline Q1 09** **67%**	**Target Mar 10** **90%**	**Apr 10** **50%** **(2/4 children)**		
-Every child taken into care should have a plan for permanence	**Baseline not available**	**100% (based on No. of children taken into care April-Sept 09)**	**73%** **(52/71)**		Based on April-Oct 09 Newly established target - clarification awaited on how this target will be assessed.

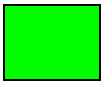
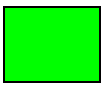
and timescale agreed within six months					
PSA 6.2 M Health Resettlement By March 2010, resettle 60 patients from hospital to appropriate community places from March 2006 position. Target Rolled over from 2008/09	**2006/07 0** **2007/08 6** **2008/09** **14 Cumulative Position**	**Mar 10** **12 (cumulatively - achieved in 2008/09)**	**Apr 10** **1 (includes resettlements commenced)** **21 Cumulative Position**		
PSA 7.1 Learning Disability Resettlement By March 2010 -resettle 90 learning disability patients from hospital to appropriate places in community from March 2006 position. Target rolled over from 2008/09	**Mar 07** **0** **2008/09** **18 Cumulative Position**	**Mar 10** **17**	**Apr 10** **1 (includes resettlements commenced)** **23 Cumulative Position**		
Surgical Site infections(SSI) Bundle compliance rate -orthopaedics (all elective hips & knees) **SSI rate** (Hips only) **Bundle**	**Oct 08** **15%** **Q2 2008 0%**	**Mar 09** **95%** **-**	**Apr 10** **100%** **Q4 2009 0% (NI Ave: 0.65%)**	 	The NI Safety Forum is seeking to standardise how all Trusts measure the Bundle Elements. This may have an impact on overall Bundle Compliance in the months ahead until any new practices are embedded

Compliance rate -Caesarean Section (audit of 20 cases per month **SSI Rate** (C-section)	**CAH 5%** **DHH 5.26%** **Q2 2008** **CAH 9.2%** **DHH 19.2%**	**95%** **95%** **25% reduction on Q4 2008 SSI Rate** (as of Feb 09) – **Target 14.21%** (NI Average 14.5%)	**84%** **88%** **Q4 2009** **CAH 8.3%** **DHH 4.4%** (NI Ave: 12%)	  	successfully. SSI Infection rates, available as a quarterly position, are now included in reporting.
Central Line Infections **-Infection Rate** per 1000 line days **-Compliance with bundle**	**Oct 08** **CAH 3%** **DHH 3%** **CAH 30%** **DHH 0%**	 **1.17%** **1.17%** **95%** **95%**	**Apr 10** **0%** **0%** **70%** **100%**	   	This target measures the number of central line catheter-related bloodstream infections Measurement reflects all Central Lines at CAH & DHH and compliance with the care bundle elements. Figures fluctuate month on month.

Ventilator Acquired Pneumonia (VAP) - Ventilator days between infections - Compliance with bundle	**Oct 08** **517** **100%**	**Mar 10** **300** **95%**	**Apr 10** **796** **97%**	 	This target aims to achieve 95% compliance with all bundle elements in ICU in CAH.
Crash Call Rate -Rate per 1000 deaths/discharges Monitoring rolled over from 2008/09	**Oct 08** **CAH 3.7** **DHH 0.9**	**Mar 10** **1.89** per 1000 deaths/ discharges	**Apr 10** **CAH 2.28 per 1000** **DHH 0.88 per 1000** **(NI Range 0 – 7.5)**	 	This QIP target is focused on reducing crash calls in A&E, ICU and coronary care.
MEWS Modified Early Warning Scoring System	**Sept 09** **CAH 94.44%** **DHH 100%**	**Mar 10** **95%**	**Apr 10** **CAH 100%** **(pilot ward)** **DHH 100%** **(pilot ward)** **All Wards CAH - 93% DHH 96% Non-Acute - 97%**	 	

Mental Health Indicators	**Oct 08**	**Mar 09**	**Apr 10**		These targets focus on inpatient review, assessment and compliance with patient/carer involvement in treatment planning All are sampled by random audit of 30 active casenotes each month
-%compliance with multi-disciplinary review	**CAH 79% SLH 67%**	**100%**	**CAH 100% SLH 100%**		
-%compliance with risk assessment	**CAH 63% SLH 17%**	**100%**	**CAH 96% SLH 100%**		
-%compliance with patient/carer involvement in TP	**CAH 88% SLH 100%**	**100%**	**CAH 100% SLH 86%**		

KPI - Crude Mortality Rate Deaths as a percentage of total hospital deaths and discharges	**CHKS Peer** **2007/08 1.98%** **2008/09 1.92%**	**Current Peer** **Apr - Feb 10** **1.74%**	**SHSCT** **2007/08 1.22%** **2008/09 1.18%** **Apr – Feb 10** **1.19%**		The mortality rate provided shows the Trust average against a peer group of District General Hospitals. This has been extract from the 'CHKS' comparative benchmarking tool. See additional reporting page 49.
KPI – Re-admission rate Discharges from the Trust that are re-admitted to the Trust again within 28 days as a percentage of total discharges	**CHKS Peer** **2007/08 6.5%** **2008/09 6.6%**	**Target** **Apr – Feb 10 6.3%**	**SHSCT** **2007/08 5.3%** **2008/09 5.2%** **Apr – Feb 10 5%**		The re-admission rate provided shows the Trust average against a peer group of District General Hospitals. This has been extracted from the 'CHKS' benchmarking tool. See additional reporting page 49.

KPI Environmental Cleanliness Cleanliness Matters Strategy indicates that 85% or above is an acceptable level of cleanliness.	**KPMG baseline** **DHH 90%** **STH 88%** **CAH 84%**	**Target** **85%**	**Apr 10** **DHH 91%** **STH 92%** **CAH 92%**		The Trust averaged 93% on this weighted score for all risk categories. Additional reporting included.
KPI – Looked After children Number who received no visit	**Mar 08** **6**	**Target** **0**	**Apr 10** **1**		Target assessment criteria has yet to be determined.
KPI – Child Protection Registrar Number of children on CPR over 2 years	**QE Mar 09** **7.4%** **(31/420)**	**Target** **to be established**	**Apr 10** **8%** **(35/479)**		Target to be defined.
KPI – Unallocated Child Care Cases	**Apr 08** **37** **Apr 09** **119**	**Target** **0**	**Apr 10** **218** **(168 in Mar)**		Target assessment criteria has yet to be determined. See additional reporting in section 4.0.
KPI – Health & Care Number % of potential H+C matches that are achieved each month for acute system transactions	**Dec 08 Baseline** **96%**	**Internal Target** **100%**	**Apr 10** **93%**		Regional comparators are not yet available.

Priority 5 (Target 7) PFA – Assessment of Children at Risk From April 09 -all Child protection referrals should be allocated within 24 hours of receipt		**Mar 10** **100%**	**Mar 10** **100%** **(79/79)**		This target counts all child protection referrals on an individual child basis. Target assessment criteria yet to be determined.
By March 2010, -90% of family support referrals should be allocated to a social worker within 20 days for initial assessment		**90%** **(initial assessment)**	**84 %** **(202/240)**		Performance around family support services is below expected due to issues around recruitment/retention, increased number of referrals and need to redeploy staff to key pressure points. April update to be finalised.
Assessments Completed - initial assessments should be carried out within 10 working days from date of allocation of referrral to social worker		**100%** **(within 10 days (initial))**	**75%** **(133/177)**		
- 90% of cases deemed to require family suppport pathway assessment should be allocated within 20 working days		**90% within 20 days** **(pathway)**	**21%** **(6/29)**		

New targets for which guidance and definitions have yet to be fully established –

Respite Targets: HSCB have recently completed an audit of respite care. Trust responses will inform the new monitoring arrangements for the actual PFA targets..

PFA Respite – dementia
By March 2010
-provide an additional 1200 dementia respite places compared to March 2008 further 100 by March 2011 total New target monitoring

PSA 7.2 – Respite Physical and sensory disability
By March 2010
-improve access to Physical/sensory disability by providing an additional 100 respite packages per year compared to March 2008 and a further 100 by March 2011

PSA 7.4 – Respite Learning Disability
By March 2010
-improve access to learning disability by providing an additional 100 respite packages a year compared to March 2008 and a further 100 by March 2011

Trust end of year position on additional respite packages provided in 09/10

April 09 - March 10	Service Provision (Packages)		
	Dementia	Learning Disability	Physical / Sensory Disability
Total	335	68	34
Over/Under Performance	+119	+49	+15

Nb: figures have been rounded to the nearest whole number

3.4 DOMAIN: WORKFORCE

Target/Indicator	Baseline	Target	Actual		Comments
PFA 9.1 Each Trust should reduce its level of absenteeism to 5.5% in the year to March 2010, reducing to 5.2% in the year to March 2011	**2008/09** **4.94%**	**Mar 10** **5.50%**	**Apr 10** **4.77%** **(cum % days lost)**		

4.0 Analysis, Additional Information and Exception Reporting by Domain

4.1 Access & Targets

- IP/DC/OP
- Fracture
- Renal

4.2 Clinical and Social Care Quality

- Healthcare Associated Infection
    - C Diff Analysis
    - MRSA Analysis
    - MSSA Analysis
    - Hand Hygiene
    - Compliance with Antibiotics
    - HCAI Related Deaths
- Quality Improvement Targets (Patient Care Indicators)
- Children & Young People Reporting
    - Unallocated Child Care Cases
- Re-admission Rates with Peer comparison
- Mortality Rates with Peer comparison

Appendix I - Service and Budget Agreement (April-March 2010) – Year End Performance Position
Appendix II - Environmental Cleanliness Report

4.1 Access & Targets

Elective access targets: The Trust continues to work with the local Commissioner and Health and Social Care Board to secure the level of investment required for the development of recurrent solutions to ensure the maintenance of access targets is sustainable.

- Recurrent investment has been secured for ENT, neurology, Allied Health Professions and Pain Management services.
- Management efforts continue to focus on securing the recurrent investments required for gynaecology, endoscopy, ophthalmology and Trauma & orthopaedics services.
- Discussions regarding the future local urology service model have been initiated in parallel with consultation on the regional urology review.
- The Trust is also working with the BHSCT and SEHSCT to secure the additional local service capacity required for SHSCT in respect of visiting regional services, specifically oral surgery and neurophysiology.

Delays in securing investment introduced risk as non-recurrent solutions had to be sustained for longer than anticipated. PMSID acknowledged that Urology, Endoscopy, T&O, and MRI services would not meet the agreed targets at year end but would not exceed 17 weeks. Recurrent investment has now been confirmed wholly and partially for a number of specialty areas and the Trust is developing implementation plans to address capacity gaps. Interim plans are also being developed to ensure that any slippage funding is fully utilised to ensure access targets are maintained were possible.

Robust operational and monitoring arrangements have been established to ensure maximisation of capacity to minimise the volume and impact of any access standard breaches.

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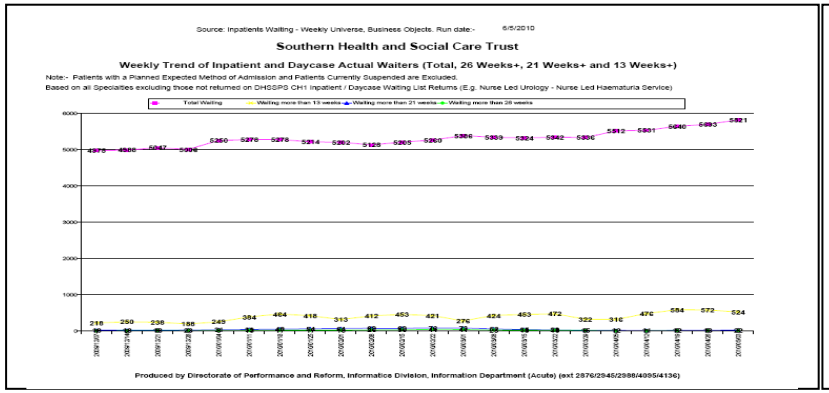

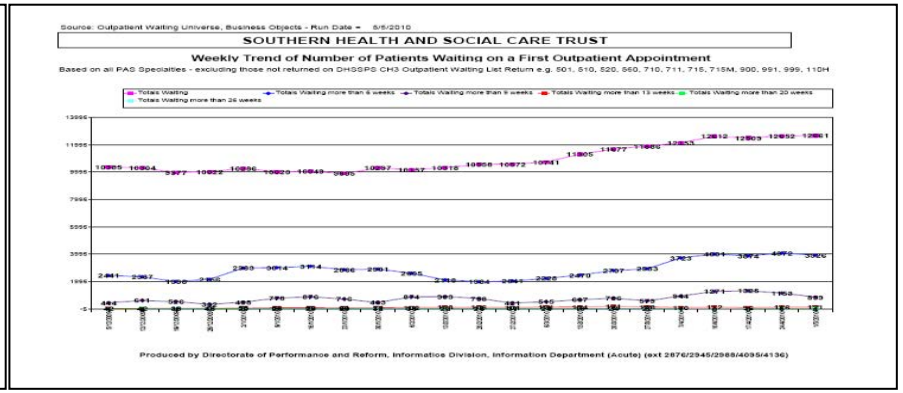

Fractures: The HSCB has confirmed recurrent investment for T&O and the Trust is developing an implementation plan to secure the additional sessions required.

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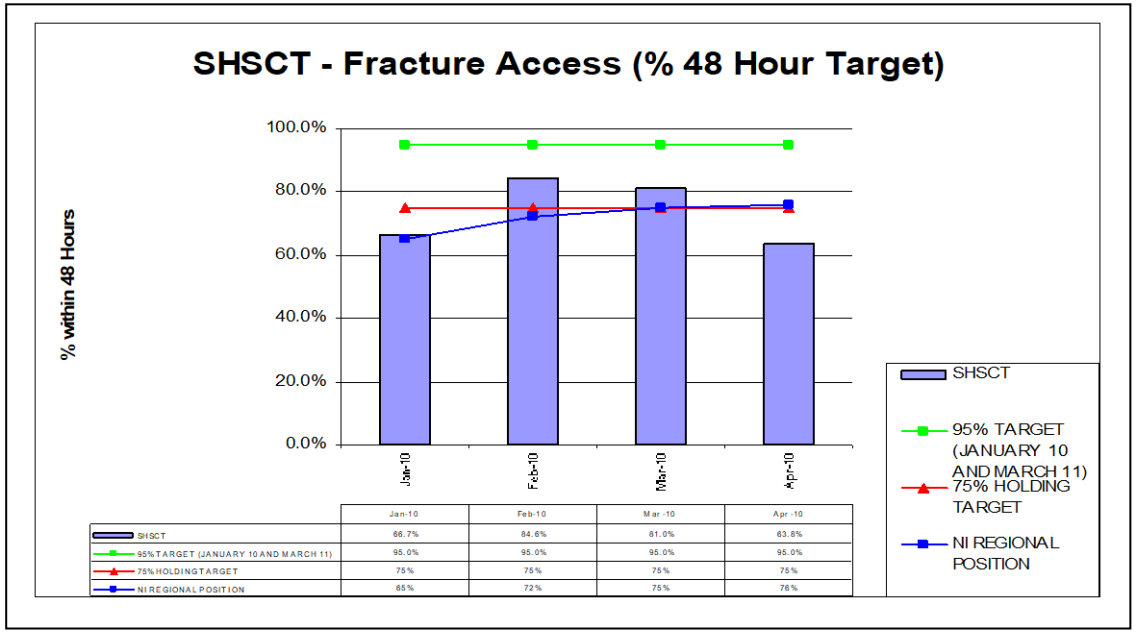
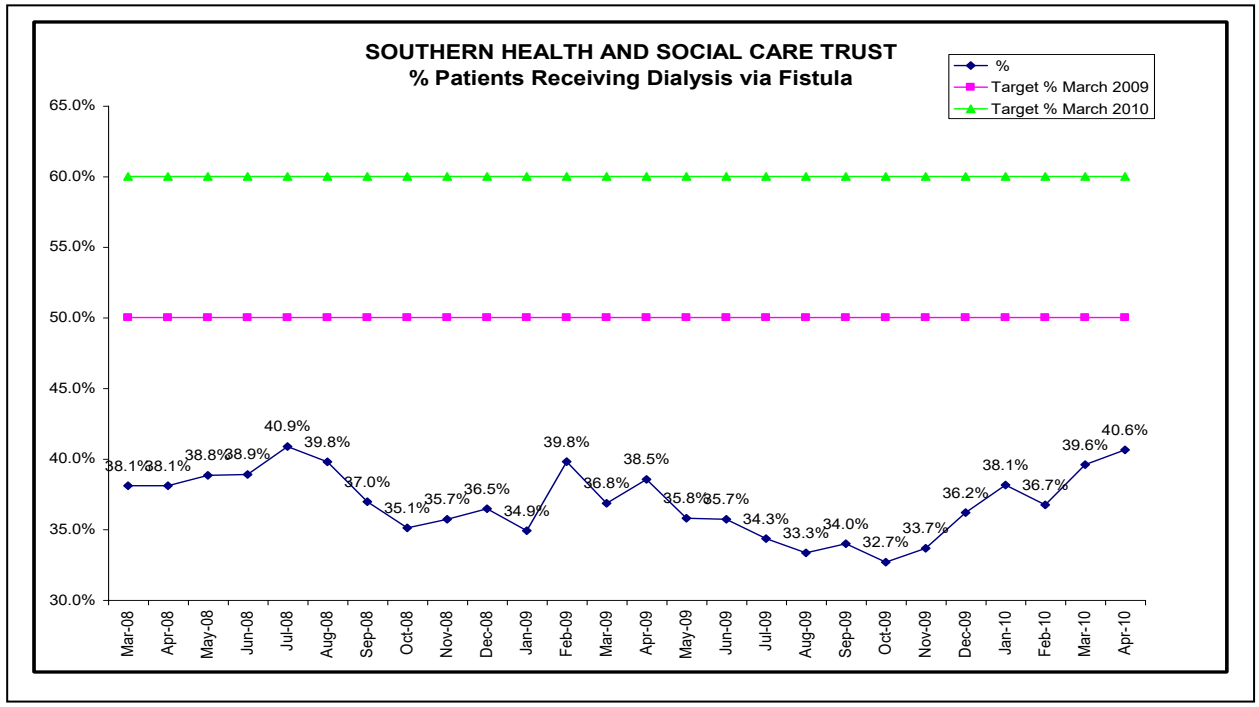


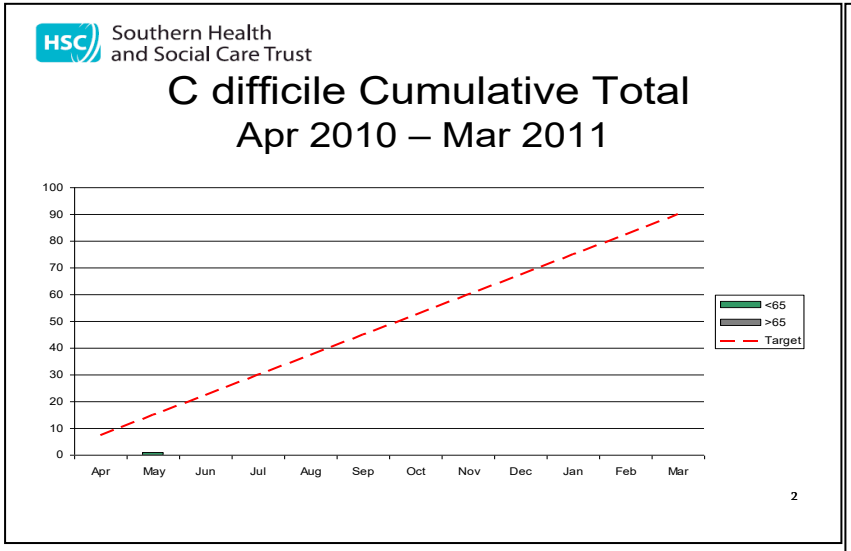
Renal – dialysis via fistula: This target was not achieved in 09/10. The ability to achieve the target is reliant on the uptake of the current patient cohort. Medical staff from the Trust's vascular team have completed training to undertake fistula creation and have recently commenced this service locally. This was previously provided by a visiting service from Belfast Trust. This target however remains at risk of achievement due to the high number of dialysis patients refusing to have a fistula inserted or, if the fistula failed, to have it redone. Regional review of definitions of this target is under discussion to take account of the numbers of patients suitable.

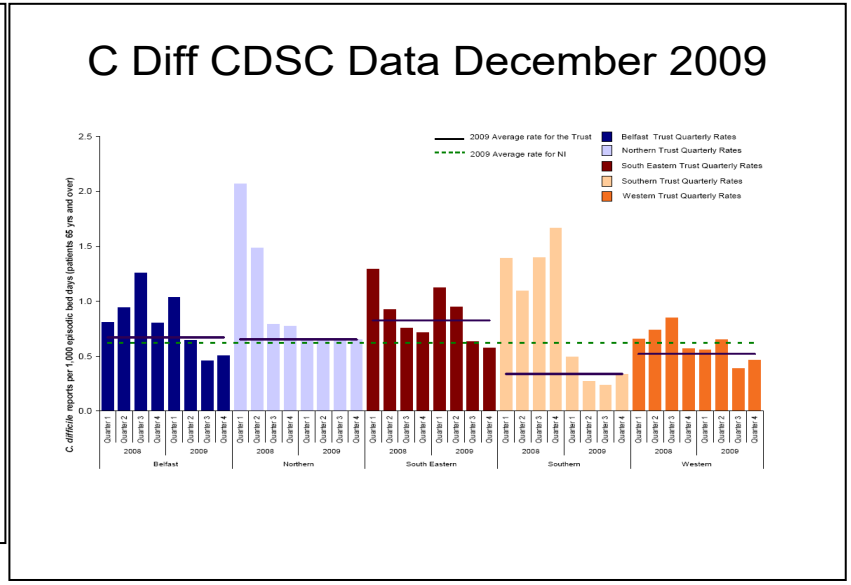


4.2 CLINICAL AND SOCIAL CARE QUALITY

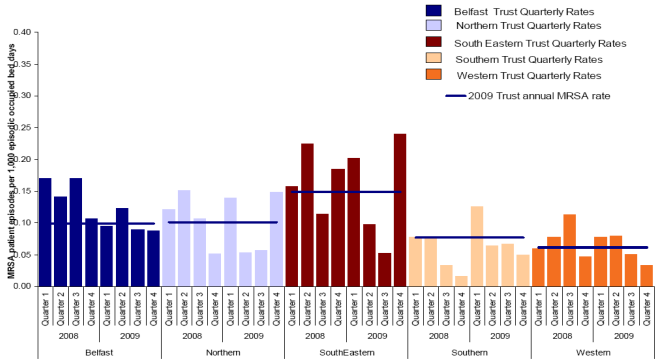
HEALTH CARE ASSOCIATION INFECTION

To provide a comprehensive assessment of performance against healthcare associated Infections a multi-dimensional view of performance is required. The following information is monitored by the Trusts Strategic Forum and Clinical Forum in line with the new Trust arrangements for the strategic management of healthcare associated infection. Regional comparative information is collated and validation by the Communicable Disease Surveillance Centre (CDSC) and this information will be included quarterly as available.

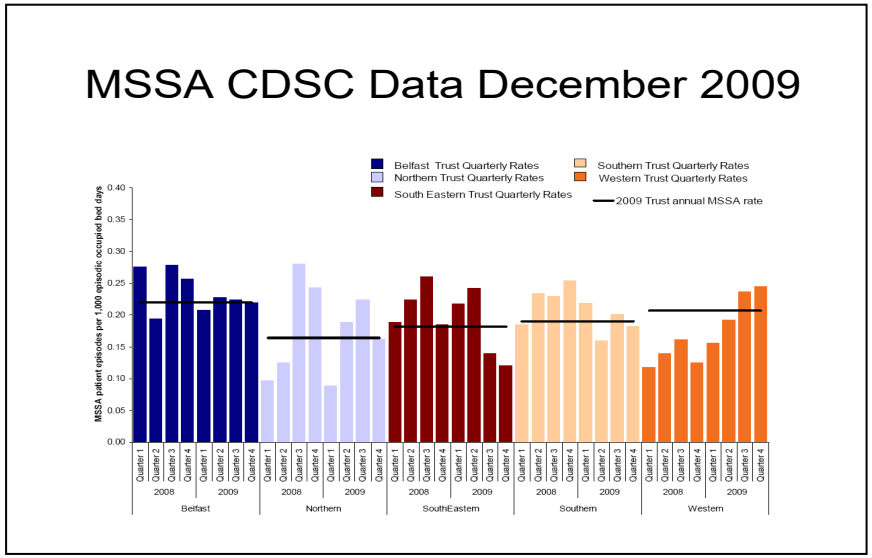




MRSA CDSC Data December 2009



No MSSA cases noted for April

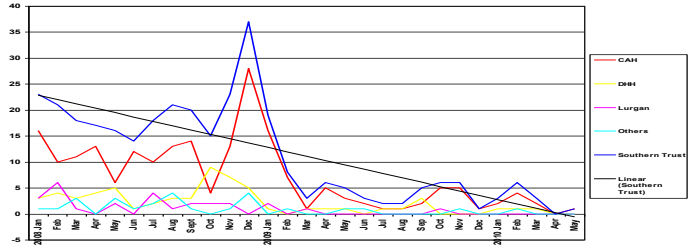


C Diff Analysis

Southern Health and Social Care Trust

C difficile

Jan 2008 – 17 May 2010



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Southern Health and Social Care Trust

Last Case of C diff

As of 17th May 2010

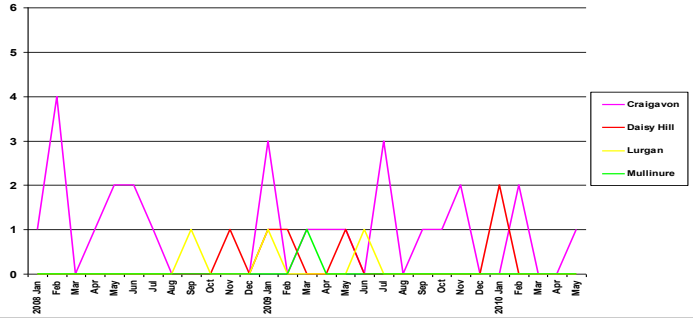
Hospital	Last Date	Days
CAH	08/05/2010	9
DHH	16/03/2010	62
LGH	22/10/2009	207
STH	29/03/2010	49
MUL	30/06/2009	321
SLH	08/02/2010	98
Bluestone	20/09/2008	604

6

MRSA Analysis

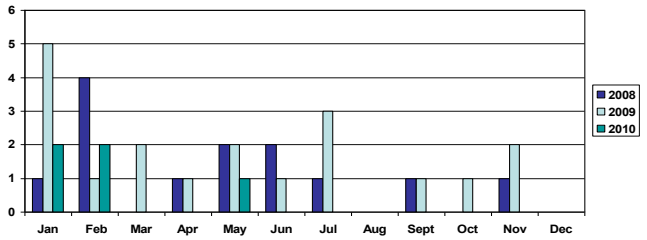
Southern Health and Social Care Trust

MRSA by Hospital
Jan 2008 – 17 May 2010



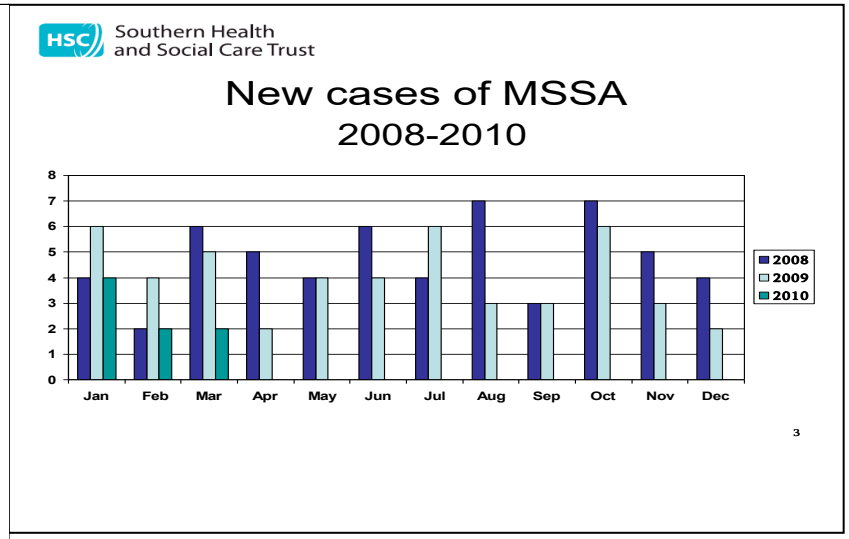
Southern Health and Social Care Trust

New cases of MRSA
2008-2010



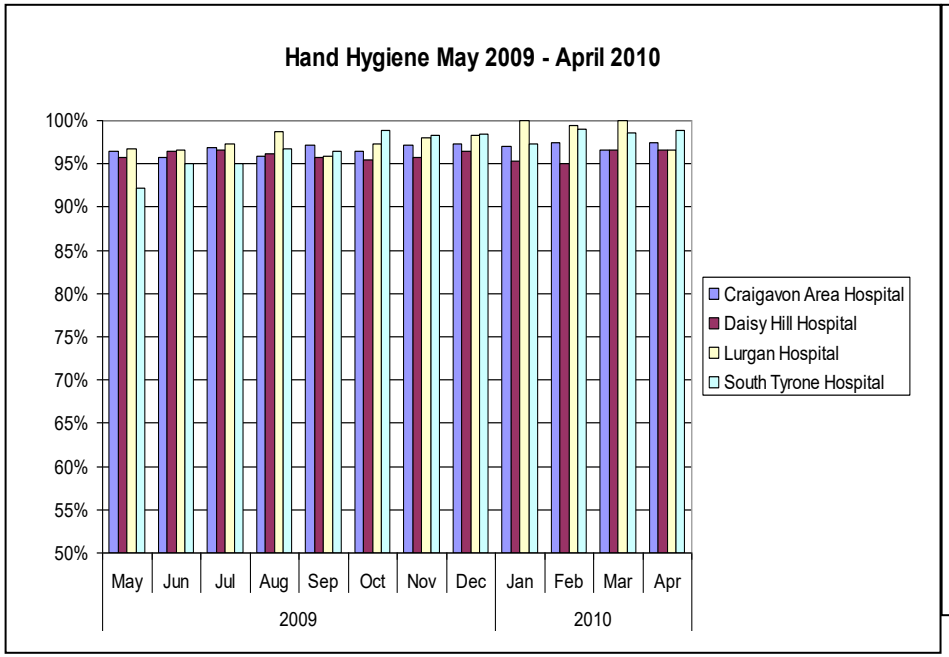
3

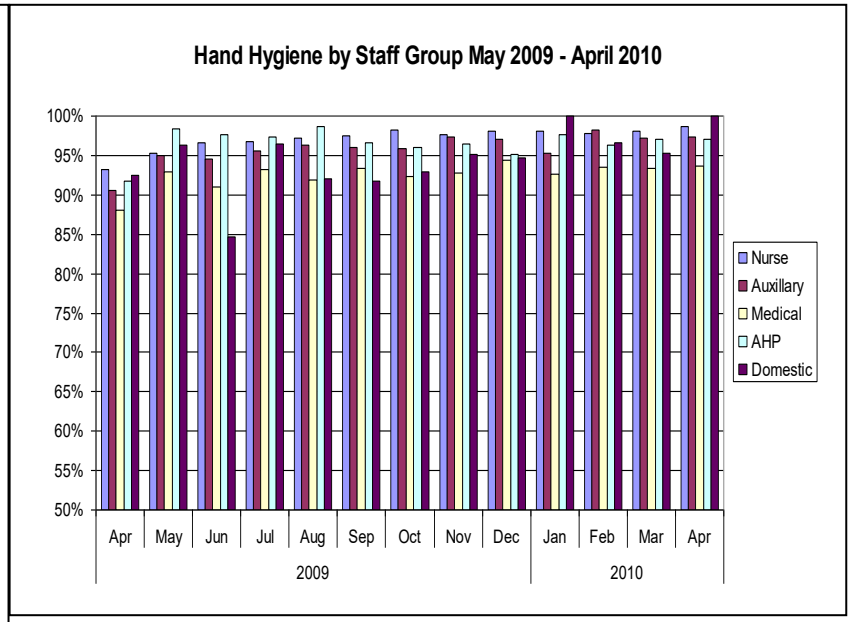
MSSA Analysis



Hand Hygiene Compliance Audits

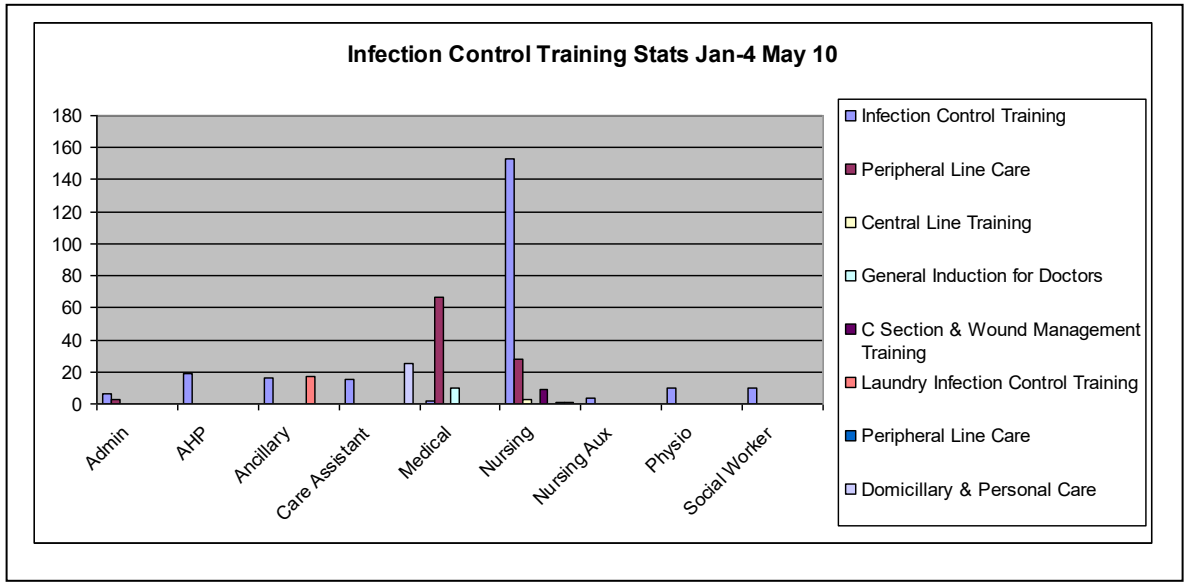
Hand hygiene has been well established as one of the key components to reduce healthcare associated infections. In December 2008, the SHSCT successfully launched the hand hygiene campaign Safe Hands Save Lives which has resulted in a substantial increase in hand hygiene compliance across the Trust.





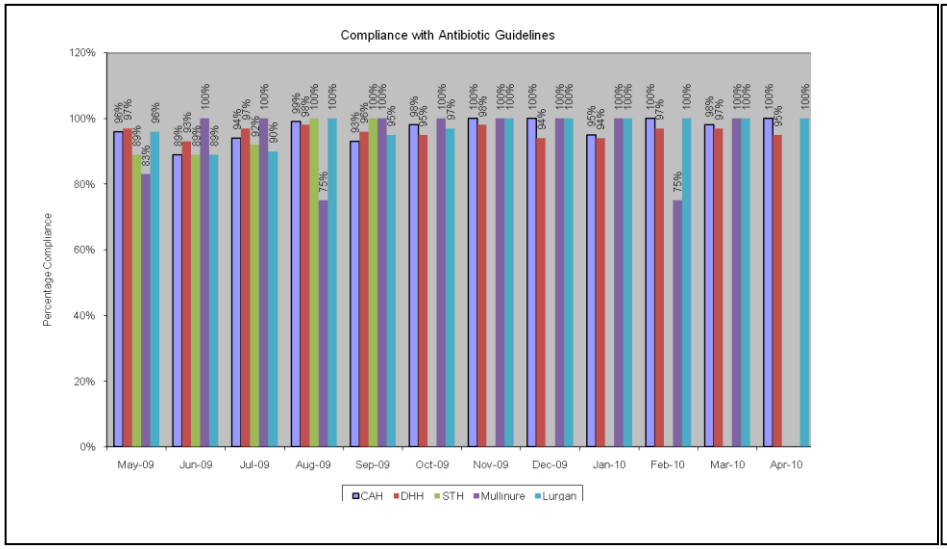
Infection Control Training (Jan-4 May 2010)

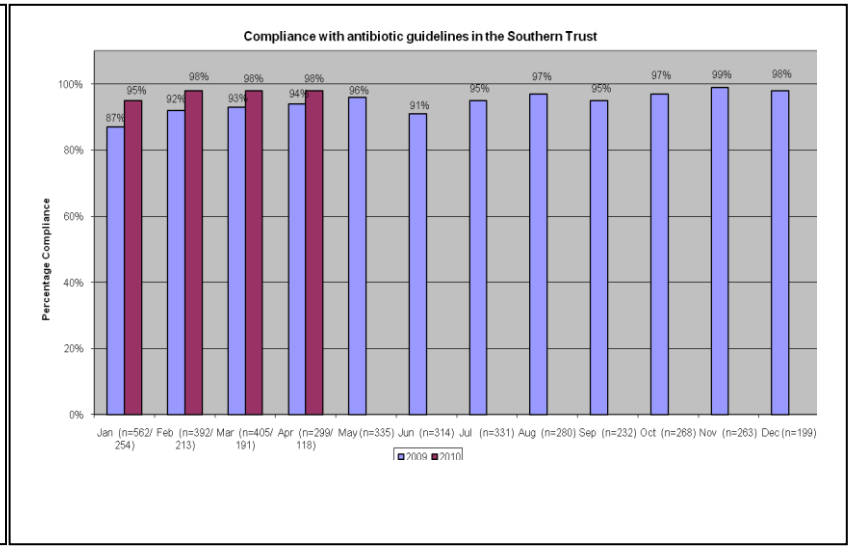
Course Title	Admin	AHP	Ancillary	Care Assistant	Medical	Nursing	Nursing Aux	Physio	Social Worker	Grand Total
Infection Control Training	6	19	16	15	2	153	4	10	10	235
Peripheral Line Care	3	0	0	0	67	28	0	0	0	98
Central Line Training	0	0	0	0	0	3	0	0	0	3
General Induction for Doctors	0	0	0	0	10	0	0	0	0	10
C Section & Wound Management Training	0	0	0	0	0	9	0	0	0	9
Laundry Infection Control Training	0	0	17	0	0	0	0	0	0	17
Peripheral Line Care	0	0	0	0	0	1	0	0	0	1
Domicillary & Personal Care	0	0	0	25	0	1	0	0	0	26
	9	**19**	**33**	**40**	**79**	**195**	**4**	**10**	**10**	**399**



Compliance with Antibiotics

Hospital	No. Antibiotics audited											
	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10
CAH	134	134	157	139	87	109	65	91	96	48	49	44
DHH	154	138	135	109	113	120	144	68	132	128	112	54
STH	9	9	12	7	3	0	0	0	0	0	0	0
Mullinure	12	5	7	4	7	4	17	4	4	4	1	0
Lurgan	26	28	20	21	22	35	37	36	22	33	29	22





Health Care Acquired Infection – Related Deaths

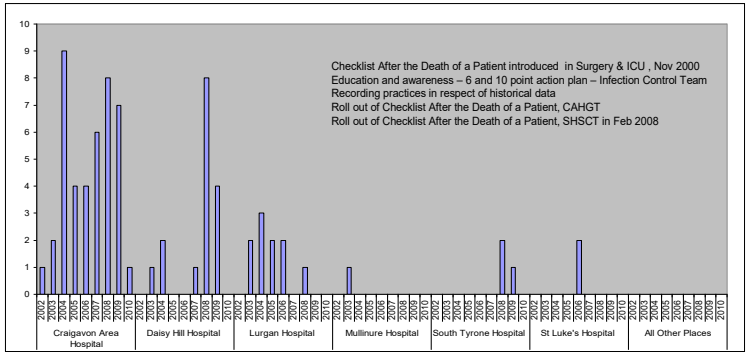
Monitoring of HCAI deaths SHSCT, is now based on the date the death is registered and is fully aligned with the Central Services Agency / NI Stats & Research Agency reporting.

As part of the review of arrangements for monitoring death related data, processes have been established with Associate Medical Directors to take forward issues arising from the morbidity & mortality meetings, including providing assurances that cases where HCAI was recorded on the death certificate are discussed.

Clostridium Difficile – Annual trend by hospital site and breakdown by Quarter for 2010

Number of SHSCT deaths with *Clostridium Difficile* mentioned and recorded as the underlying cause on death certificate, 2002 – 2008 (validated)

Jan – Dec 2009[P] & 1 Jan – 09 May 2010[P] (unvalidated)

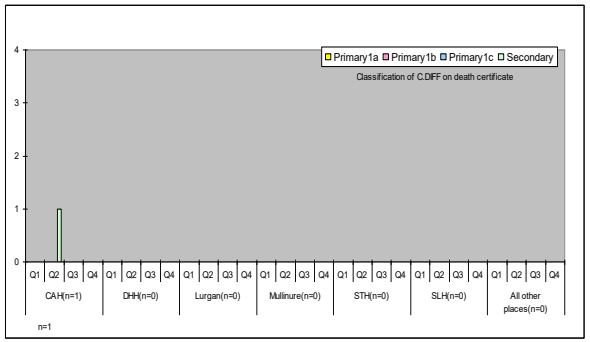


[P] – Provisional data pending publication of the Registrar General's Annual Report for 2009 & 2010

NB Excludes deaths in all other places between 2002 – 2008, as this information is aggregated regionally in the Registrar General's Annual Report

Number of SHSCT deaths with *Clostridium Difficile* mentioned and recorded as the underlying cause on death certificate

1 Jan – 09 May 2010[P] (unvalidated)



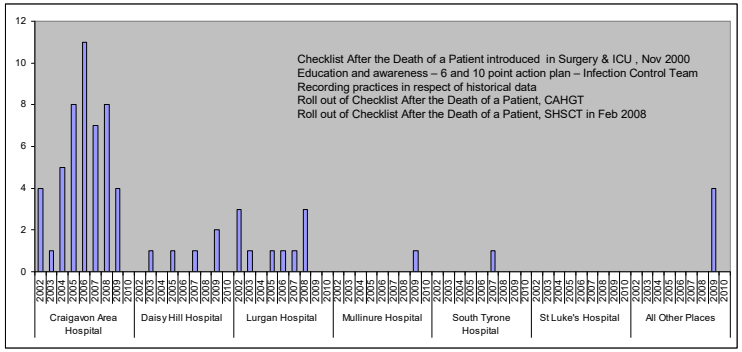
[P] – Provisional data pending publication of the Registrar General's Annual Report for 2010.

MRSA – Annual trend by hospital site and breakdown by Quarter for 2010

No deaths were recorded in Jan-9 May 2010

Number of SHSCT deaths with MRSA mentioned and recorded as the underlying cause of death certificate, 2002 – 2008 (validated)

Jan – Dec 2009[P] & 1 Jan – 09 May 2010[P] (unvalidated)

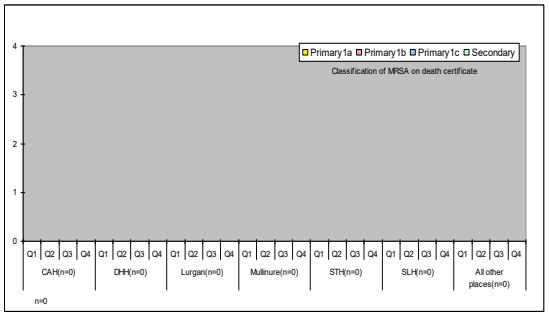


[P] – Provisional data pending publication of the Registrar General's Annual Report for 2009 & 2010.

NB Excludes deaths in all other places between 2002 – 2008, as this information is aggregated regionally in the Registrar General's Annual Report.

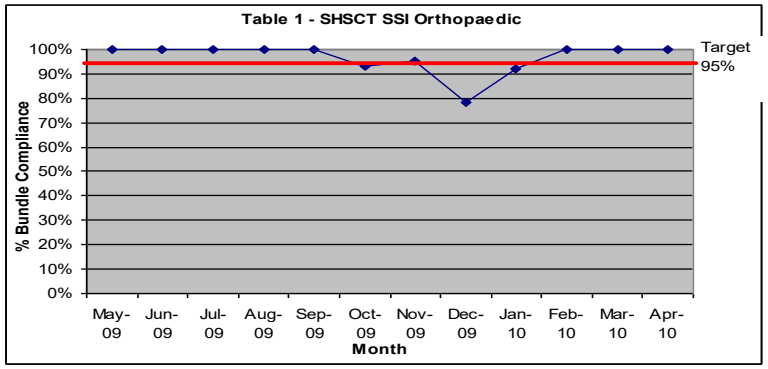
Number of SHSCT deaths with *MRSA* mentioned and recorded as the underlying cause on death certificate

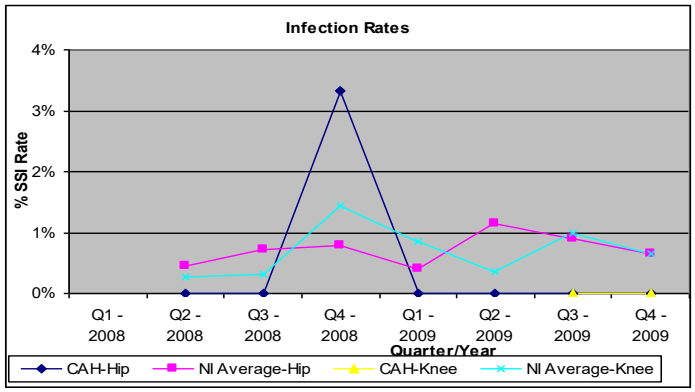
1 Jan – 09 May 2010[P] (unvalidated)



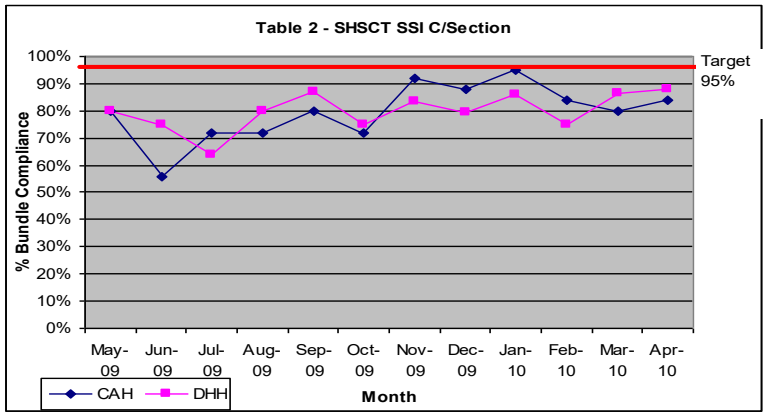
This dataset is provisional pending publication of the Registrar General's Annual Report for 2010.

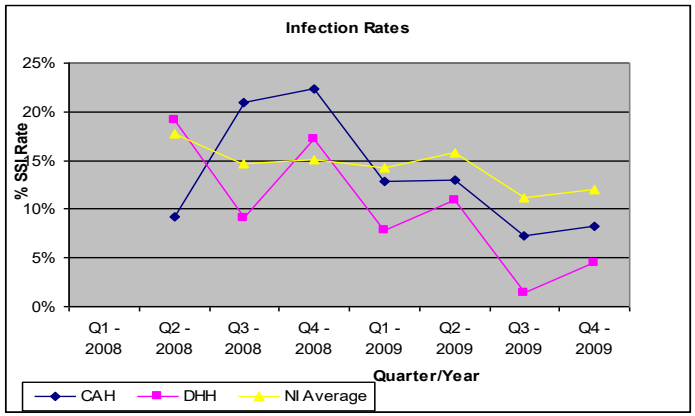
QUALITY IMPROVEMENT TARGETS (Patient Care Indicators)



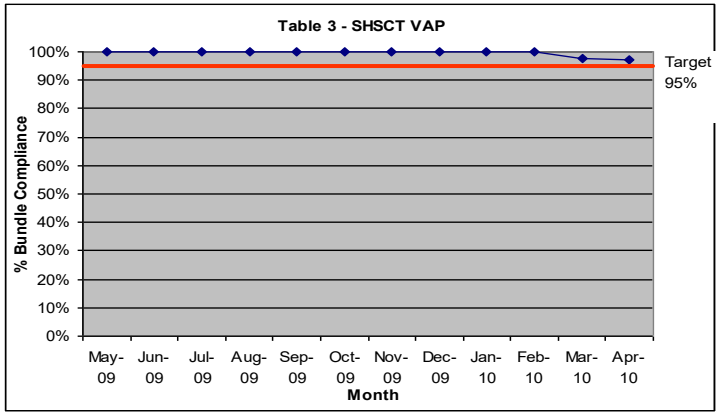


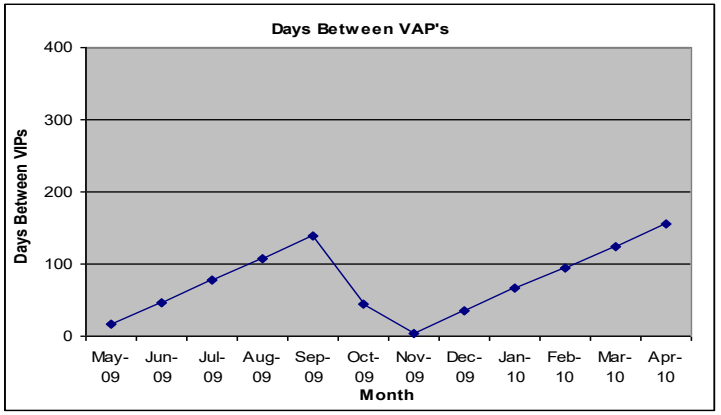
Overall Bundle Compliance was 100% for the 3rd consecutive month. Q4 2009 SSI Rates for both hip & knee protheses remain at 0%. The NI Average for hip protheses is 0.65% & the NI Average for knee prothesis was 0.65%.



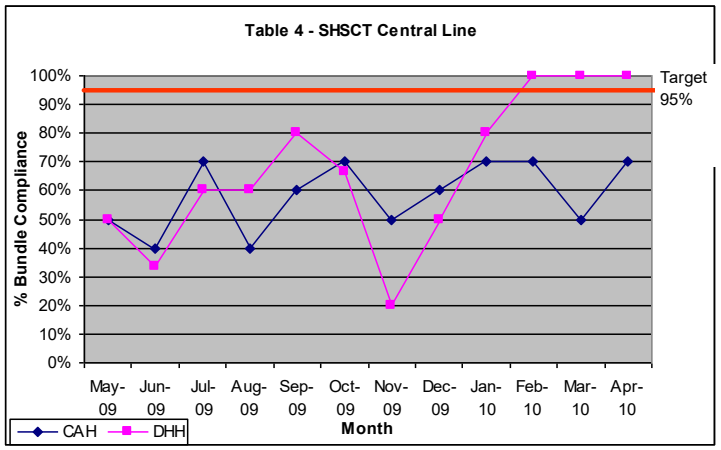


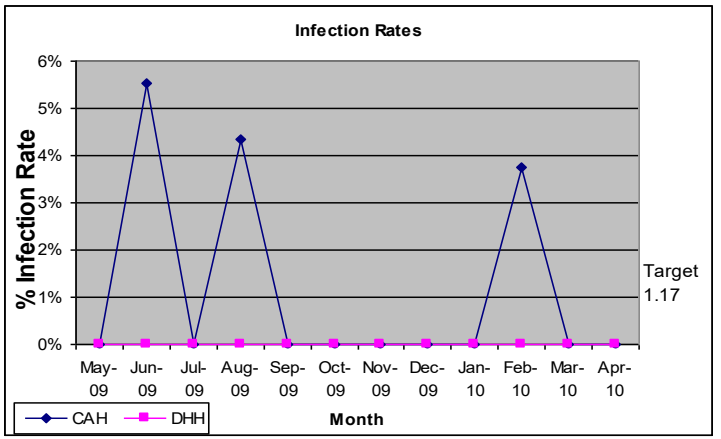
Non-compliance issues - Inadequate documentation - 4/25 pts at CAH & 1pt at DHH. Hair Removal - 2/25 pts at CAH & 2/25 pts at DHH had self-shaved prior to their elective C/Section & there was no documentary evidence in the pts Med Records that they had received the Admission Advice Leaflet, which addresses appropriate hair removal. Initiatives to address same have been initiated on both sites.



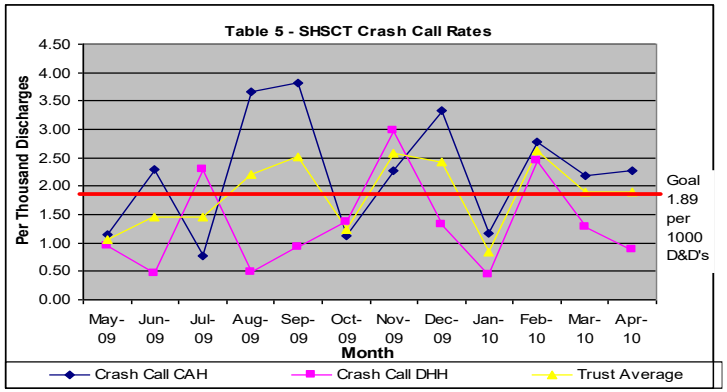


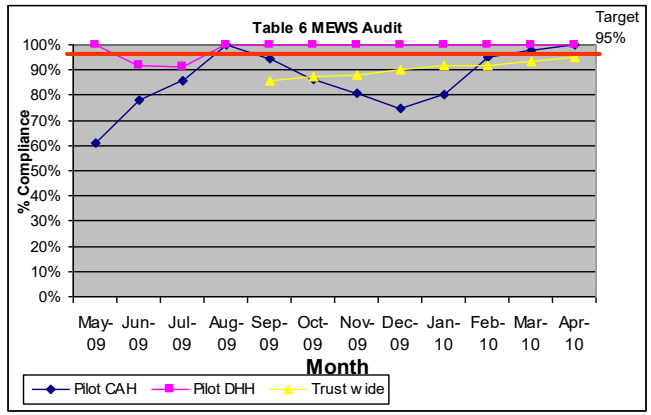
Non-compliant element 1/33 pts did not have a Sedation Break. Vent Days between VAP stands at 796 while Calendar Days between VAP stands at 155.



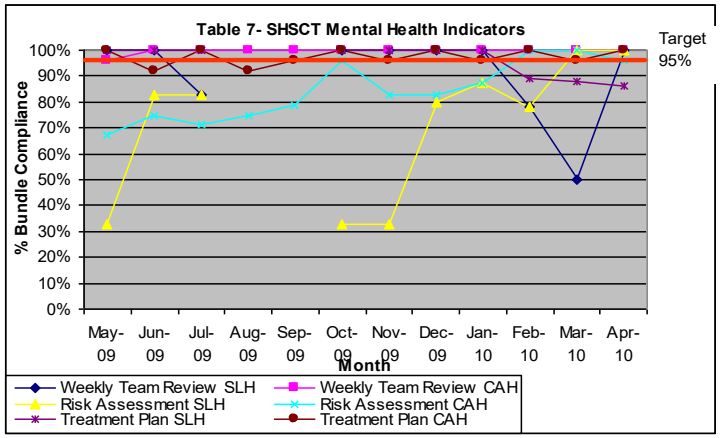


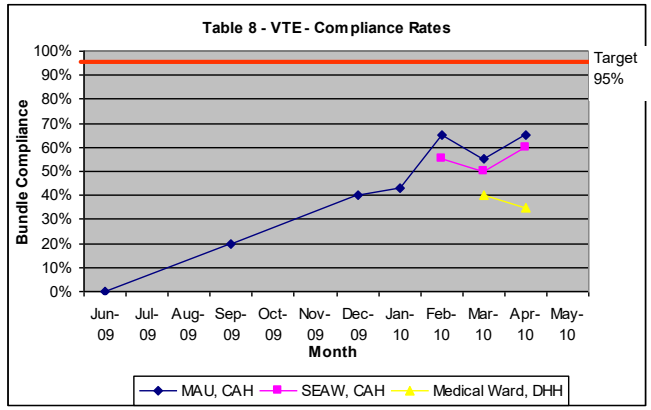
Non-compliant element at CAH - Daily Review of Central Line - In 3 out of 10 patients audited it was not documented on the Central Line Insertion Record & Monitoring Form that the line was checked daily. A further Audit of same on the relevant Wards commenced in May. Compliance at DHH 100% for the third consequetive month.





Trustwide MEWS Auditing reached the goal of 95% compliance for the first time this month

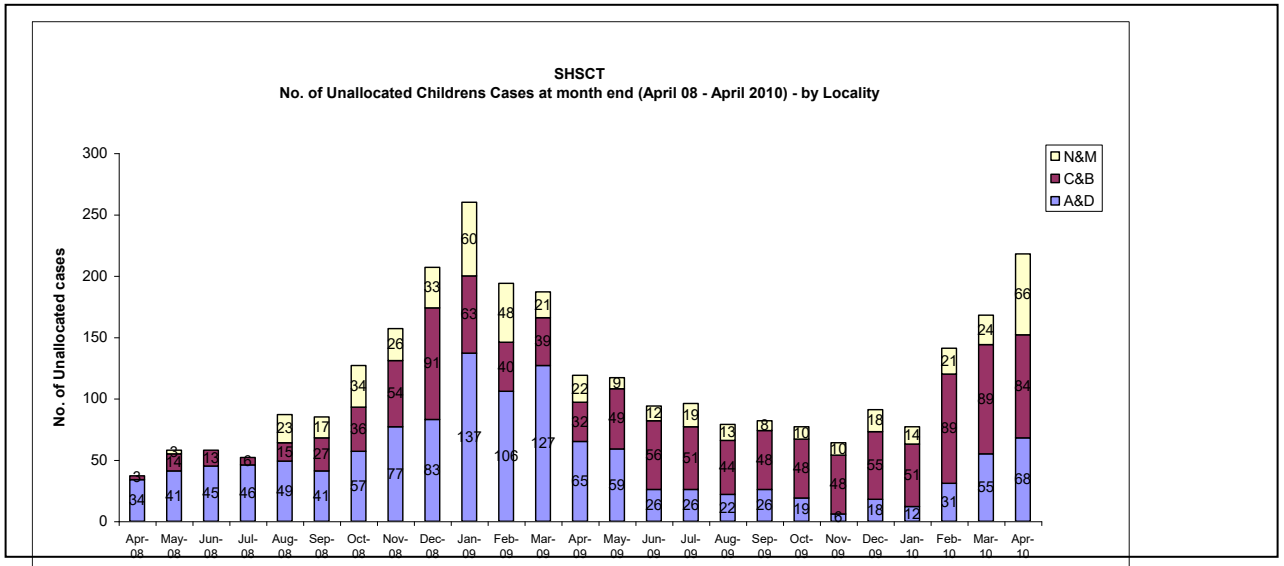




Mental. Health - Risk Ax - On 1 occasion the patient's Risk Ax was not signed by the Dr & Nurse on adm. M'disc Care Plan - In 1 case the Care Plan was not in place & the pt was not involved in same. VTE - Compliance with the use of the Risk Ax Form is gradually improving & each Pilot Ward are working on initiatives to improve same. the Risk Ax has been introduced in Surgery, DHH & Baseline data will be available next month. Appropriate thromboprophylaxis is 70% or above in our 3 Pilot Wards

CHILDREN AND YOUNG PEOPLE REPORTING

Unallocated Child Care Cases –



	30-Apr-08	31-May-08	30-Jun-08	31-Jul-08	31-Aug-08	30-Sep-08	31-Oct-08	30-Nov-08	31-Dec-08	31-Jan-09	28-Feb-09	31-Mar-09	30-Apr-09	31-May-09	30-Jun-09	31-Jul-09	31-Aug-09	30-Sep-09	31-Oct-09	30-Nov-09	31-Dec-09	31-Jan-10	28-Feb-10	31-Mar-10	30-Apr-10
N&M	0	3	0	0	23	17	34	26	33	60	48	21	22	9	12	19	13	8	10	10	18	14	21	24	66
C&B	3	14	13	6	15	27	36	54	91	63	40	39	32	49	56	51	44	48	48	48	55	51	89	89	84
A&D	34	41	45	46	49	41	57	77	83	137	106	127	65	59	26	26	22	26	19	6	18	12	31	55	68

Action taken to mitigate risks and strengthen our system:

a) There are no unallocated child protection cases. All such cases are allocated and responded to.

b) Heads of Service, the APSW for Gateway and Team Managers regularly monitor, review and prioritise unallocated cases for allocation.

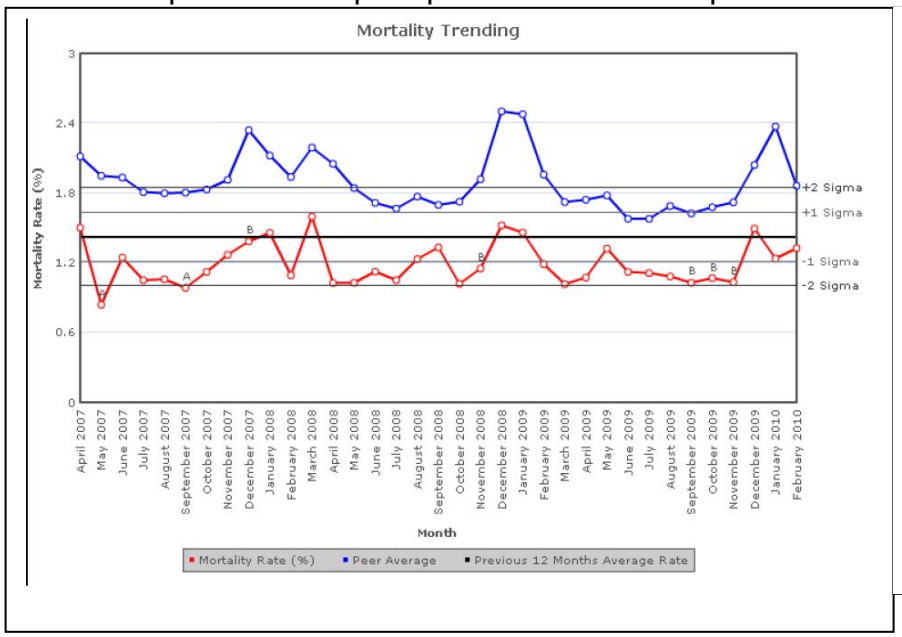
c) Across Gateway and FIT Services there are still currently a number of social work vacancies plus a number of staff on maternity leave/sick leave.

d) Measures have been implemented to address capacity issues relative to staff vacancies including (a) redistributed work across teams and (b) redeployed staff to key pressure points.

CLINICAL AND QUALITY INDICATORS

The mortality and re-admission trending positions above have been extracted from CHKS benchmarking tool. This shows high level performance against crude mortality (which is not risk adjusted) and re-admissions within 28 days. Processes are being established via the Medical Directors office to analyse these indicators at specialty/consultant level and identify any significant variance for further analysis. (Reporting is subject to change associated with updated clinical coding positions.)

Red Line - represent the SHSCT performance from April 2007 to Feb 2010.
Solid Black Line - represents the Trusts own average performance in the previous 12 months and the standard variations on the positive and negative sides of this average (Sigma +/-1 and +/- 2)
Blue line – represents the peer performance from April 2007 to Feb 2010.

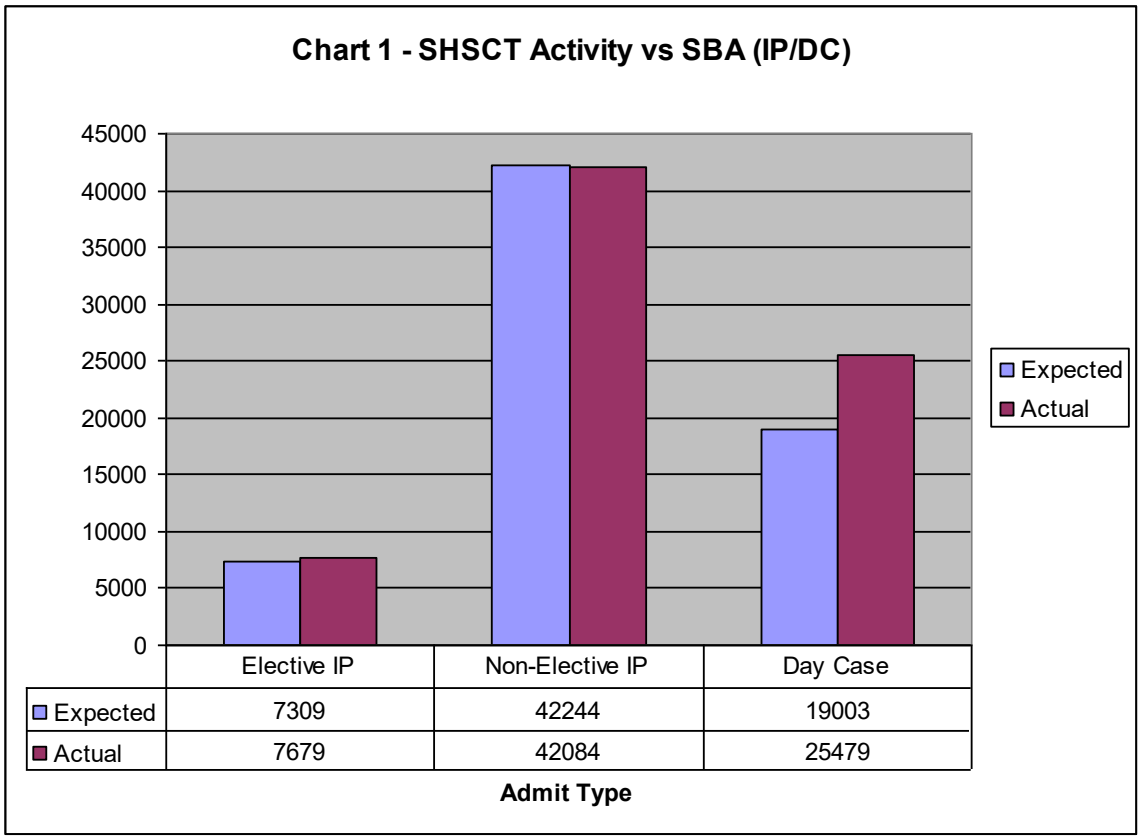


Appendix I - Service and Budget Agreement (April-March 2010) – Year End Performance Position

This summary report relates to hospital inpatient, day case and consultant-led outpatient activity performance against agreed Service and Sudget Agreement (SBA) volumes. The charts provide a summary of performance by admit and attendance type for the cumulative period April – March 2010. Activity excludes any additional in-house sessions or work undertaken in the independent sector, which is outside core funded SBA baselines.

The HSCB have indicated in 10/11 that over performance, greater than 2%, above the SBA volume will attract additional funding, which is indicatively estimated at 50% of Strategic Resource Framework costs. Conversely underperformance will result in a funding retraction. Achievement of SBA volumes will therefore be a key focus with Directorate teams in-year.

Currently the Trust is undertaking negotiations to agree a number of SBA volumes or 10/11 which are felt to be out of alignment with existing capacity and to establish baselines for service developments.

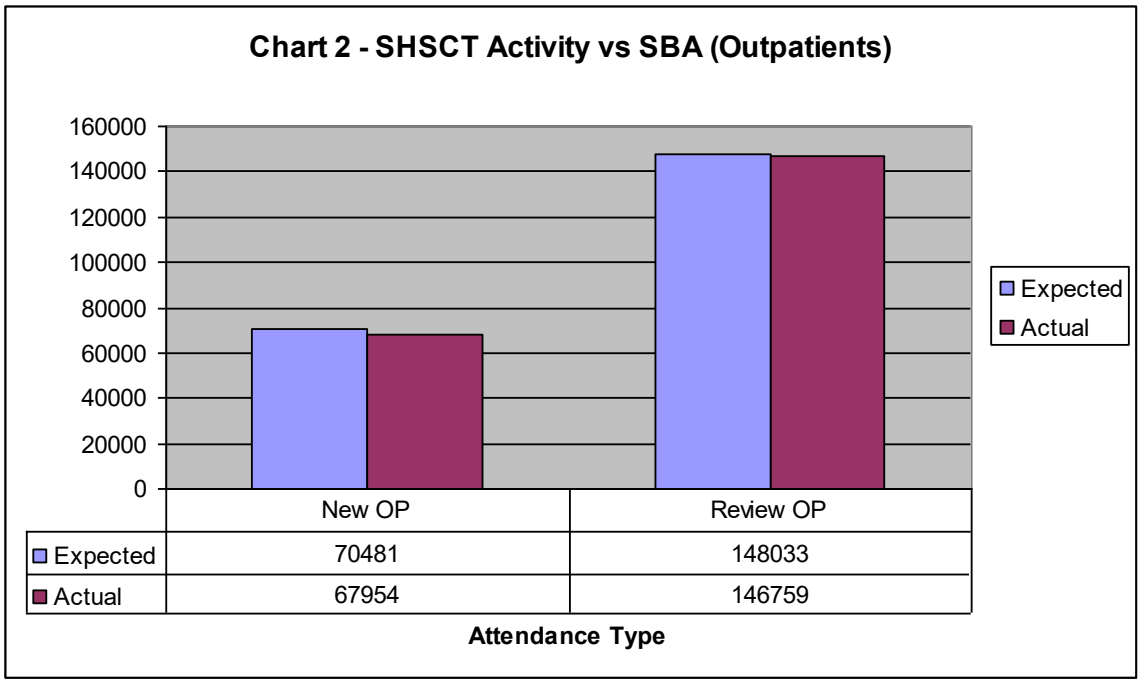


	Elective IP	Non-Elective IP	Day Case
Expected	7309	42244	19003
Actual	7679	42084	25479

Source: RMS (Small adjustments have been made where specialty volumes remain to be finalised)

- Overall Elective inpatients activity is slightly above SBA (5%)

- Non elective care is performing marginally below SBA (-0.38%), in line with strategic direction.
- Day Case performance is well above SBA (34%).



Source: RMS (Small adjustments have been made where specialty volumes remain to be finalised)

- Outpatient activity is under for both attendance types, -3.4% for New and -0.86% review
- Some adjustments are required to SBA in line with changes to service models, for example, the development of ICATS models.

Appendix II – Environmental Cleanliness Report

Environmental Cleanliness Report

Prepared by: Functional Support Services
11/5/2010

Contents

Section

1. Introduction

The Environmental Cleanliness Committee provides assurance that standards of cleanliness within Trust facilities are met in a number of ways including the measurement of environmental cleanliness standards.

The Trust uses the Cleanliness Matters Toolkit (49 elements) issued by the DHSSPS as part of the Environmental Cleanliness Strategy, in order to undertake internal Departmental Audits. The results from Departmental Audits in hospitals across the Trust are included in section 3 of this report.

There were a limited number of Departmental Audits conducted at Craigavon Area Hospital during the month of April due to staffing issues, particularly in relation to Supervisors and Managers, and audits were prioritized in terms of risk.

From May 2009 the Infection Control Nurses Association (ICNA) audit tool instead of the Cleanliness Matters Toolkit has been used to conduct Managerial Audits. Managerial Audit results measured against the ICNA audit tool are included in section 4 of this report.

A Senior Management team decision was taken in January 2010 to issue the ICNA audit tool to ward/department managers in order that they can undertake the audit and populate action plans for their own area so ward/department managers are aware of the issues likely to arise out of RQIA inspections and take appropriate action pro-actively. This process has commenced however the results have not been included in this report.

The Cleanliness Matters Toolkit measures the standard of cleanliness and 85% or above indicates an acceptable level of cleanliness. Items to be cleaned are broken down into 49 generic elements with specific environmental cleaning standard requirements (eg floors, walls, furniture, bed frames, medical devices etc). The overall scores are weighted taking into account all risk categories ie very high, high, moderate and low risk category areas.

The RQIA uses the ICNA audit tool for their inspections. This audit tool is divided up into 10 sections, under the following headings:-

- Environment
- Ward/departmental kitchens
- Handling and disposal of linen
- Waste management
- Departmental waste handling and disposal
- Safe handling and disposal of sharps
- Management of patient equipment (general)
- Management of patient equipment (specialist areas)
- Hand hygiene
- Clinical practices

The ICNA level of compliance categories are as follows:-

Compliant	85% or above
Partial compliance	76 to 84%
Minimal compliance	75% or below

The overall score is an average of the audit scores and the rating can only be compliant if all the scores are 85% or above. Weighting is not applied to ICNA audit scores.

The Environmental Cleanliness audits carried out by Trust staff measure the standard of cleanliness within a sample of rooms on a ward and these have tended to concentrate on ward/clinical areas whilst the Environment Section of the ICNA tool also includes utility rooms and domestic stores.

The following are some of the main differences between the two audit tools:-

- The ICNA tool assesses the cleanliness and maintenance of equipment such as lockers, chairs and tables whereas the Cleanliness Matters Toolkit measures cleanliness.

- The Cleanliness Matters Toolkit concentrates more so on the fabric of the building and includes entrances/exits, doors, light fittings, radiators and external grounds whereas these are not included in the ICNA tool.

- Patient equipment including commodes, drip stands etc, drug trolleys and patient wash bowls are included in the Cleanliness Matters Toolkit whereas in the ICNA tool they are included under Management of Patient Equipment Section rather than the Environment Section.

- The ICNA tool picks up on decontamination from a segregation point of view however the Cleanliness Matters Toolkit is only concerned with the cleanliness of the sinks and not the purpose of the sinks.

- The ICNA tool requests evidence of an effective pre-planned programme for curtain changes. This is not measured under the Cleanliness Matters Toolkit.

- The INCA tool assesses cleaning equipment (colour coding, storage of mops and buckets). These areas are not covered under the Environmental Cleanliness audits however Support Services will be implementing practice audits which will pick up on these issues.

- The Environmental Cleanliness audits cover the cleanliness of the kitchen whereas the ICNA tool section on kitchens is divided into Ward and Departmental and is similar to a kitchen inspection as it considers the operations within the kitchen, eg temperature recordings.

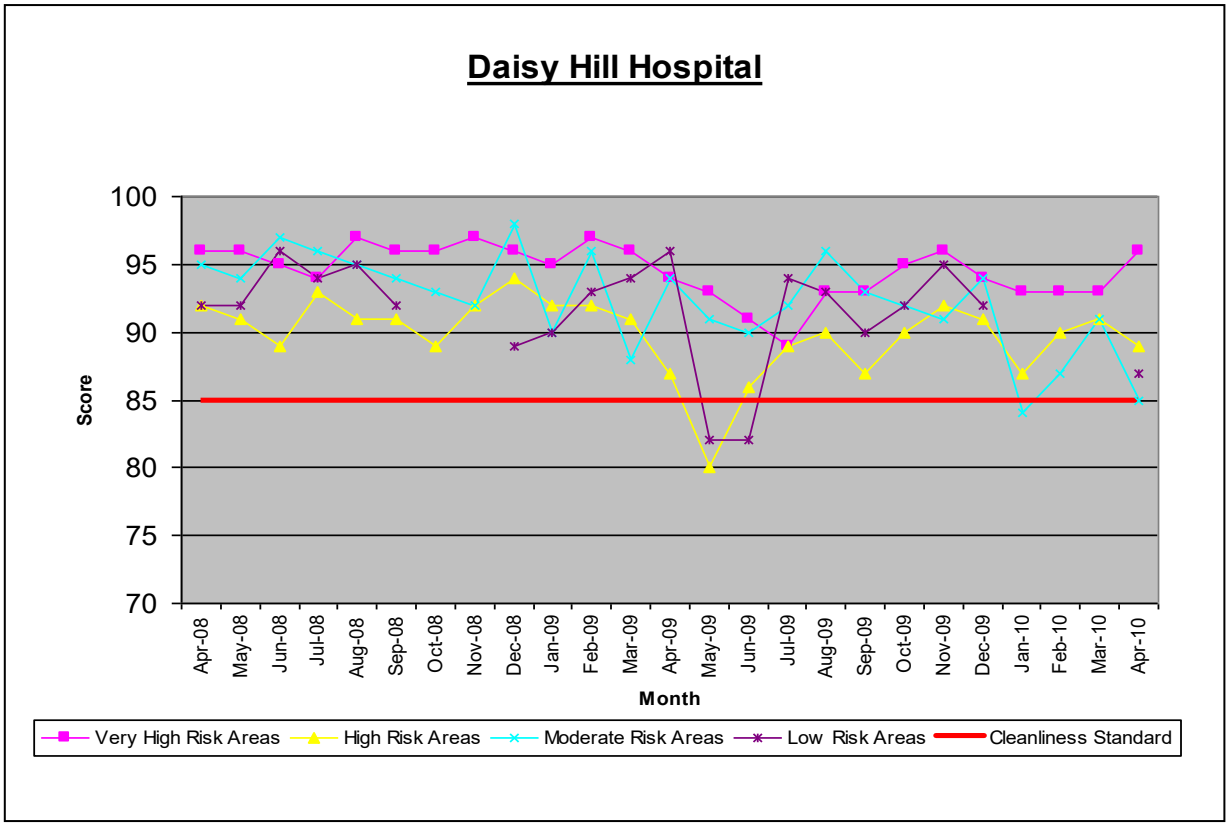
The DHSSPSNI hosted a workshop in 2009 to consider the various audit tools used in HSC settings and a Steering Group has been established to review the Cleanliness Matters Toolkit with a view to harmonising with other tools such as the ICNA tool. Workstreams have been set up to take forward work on developing a common approach to audit, standard definitions and cleaning plans, and training for staff involved in the audit process.

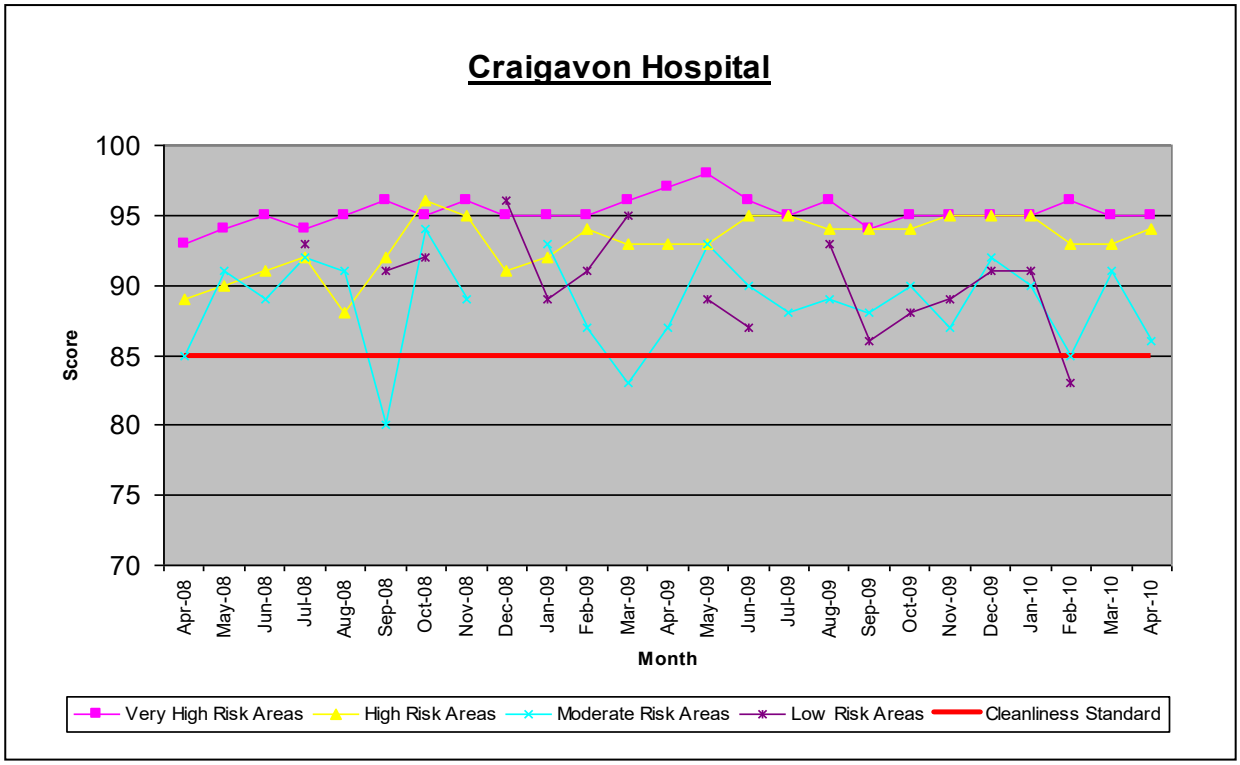
2. Departmental Audit Results - Summary of Overall Weighted Scores using the Cleanliness Matters Toolkit

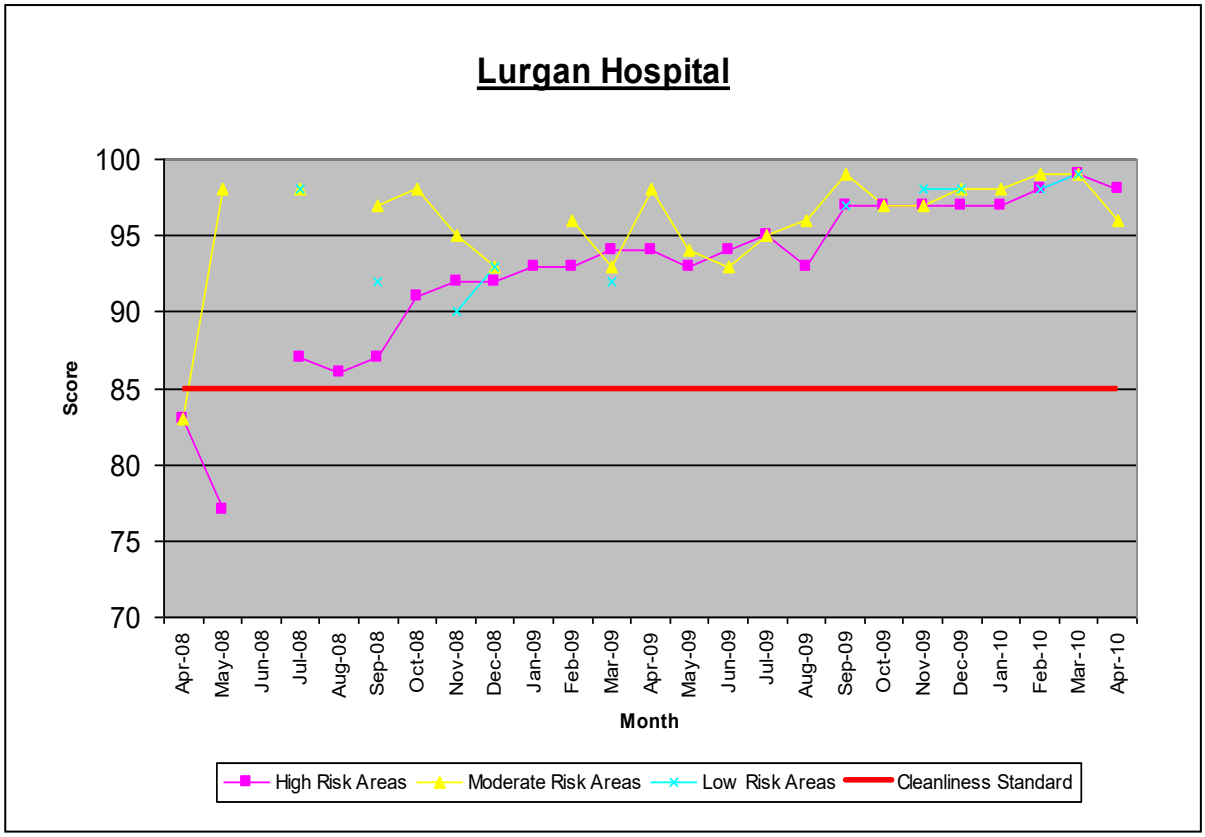
Hospital	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10
St Luke's	85	93	88	86	88	84	90	94	90	85	91	93	90	93	90	91	94	91	90	95	90	86	95	94	95
South Tyrone	85	89	89	86	86	90	87	90	90	89	89	92	89	93	90	90	90	90	89	91	92	93	93	94	92
Longstone	85	89	91	89	87	92	91	88	94	93	92	93	91	89	90	90	88	94	90	84	93	92	87	93	89
Mullinure	93	90	90	91	94	95	91	94	93	95	94	96	95	95	96	91	84	85	88	96	95	96	98		
CAH	90	92	92	93	91	91	95	94	94	93	93	92	93	94	93	93	93	92	93	92	94	93	91	93	92
Lurgan	83	85		92	86	91	94	93	93	93	94	93	96	93	93	95	94	98	97	97	97	98	98	99	97
DHH	94	93	94	94	95	94	92	94	95	93	95	93	92	87	88	90	93	91	93	93	93	89	90	92	91
Bluestone						86	84	89	95	91	95	93	95	95	92	90	95	92	91	92	92	94	91	90	97
Average	88	90	91	90	90	90	91	92	93	92	93	93	93	92	92	91	91	92	91	93	93	93	93	94	93

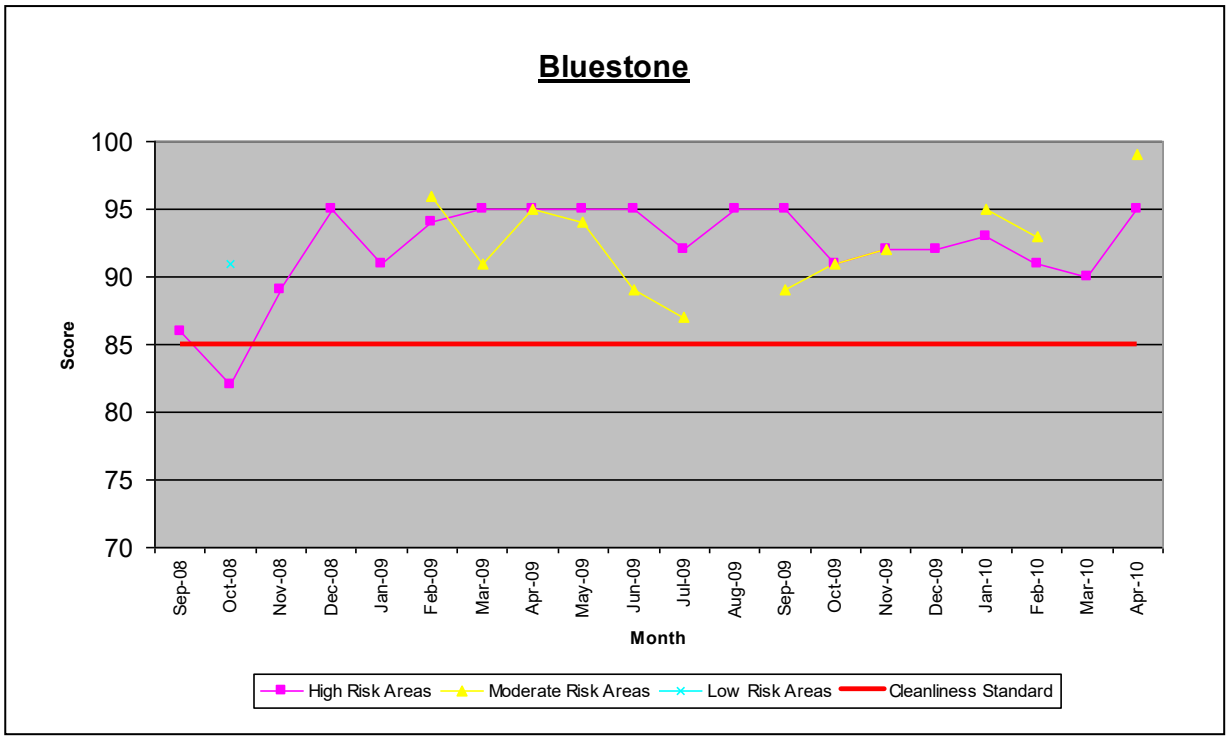
The scores reflect the overall weighted score for each hospital taking into account all risk categories ie very high, high, moderate and low risk category areas.

3. Departmental Audit Results - Breakdown of Scores for each Hospital

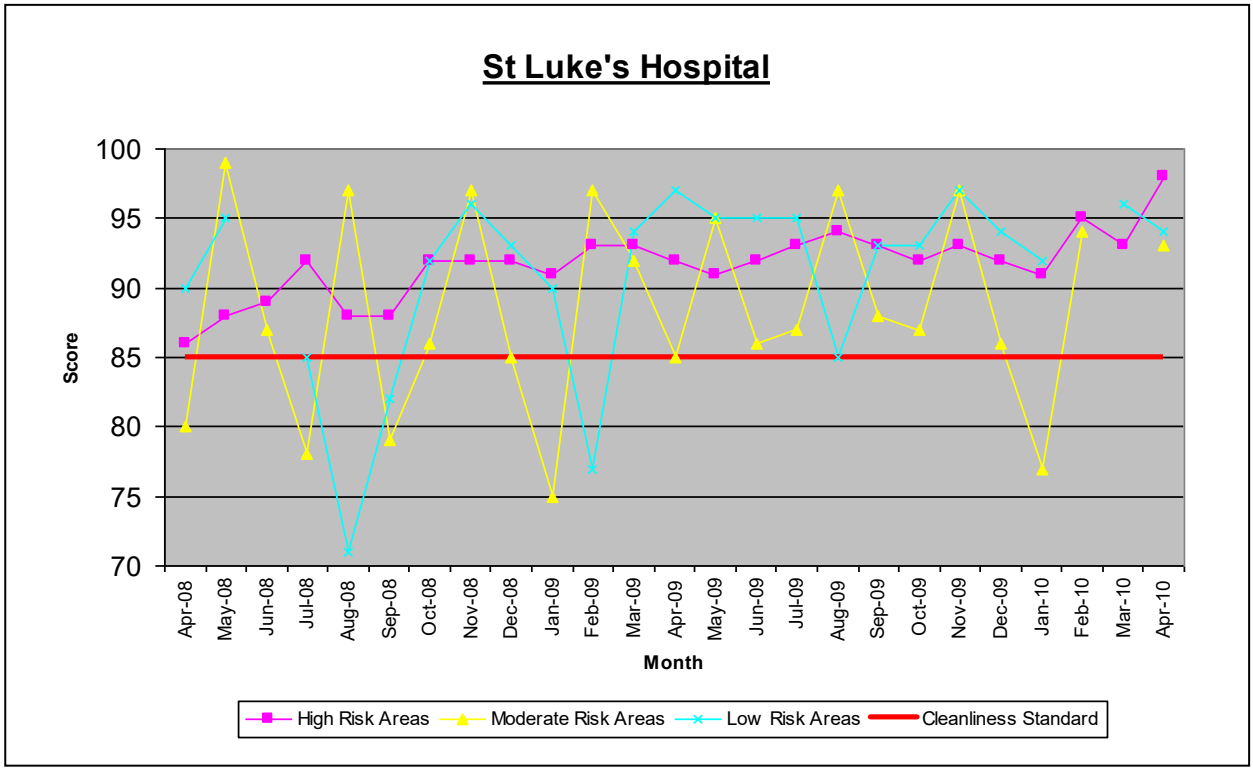


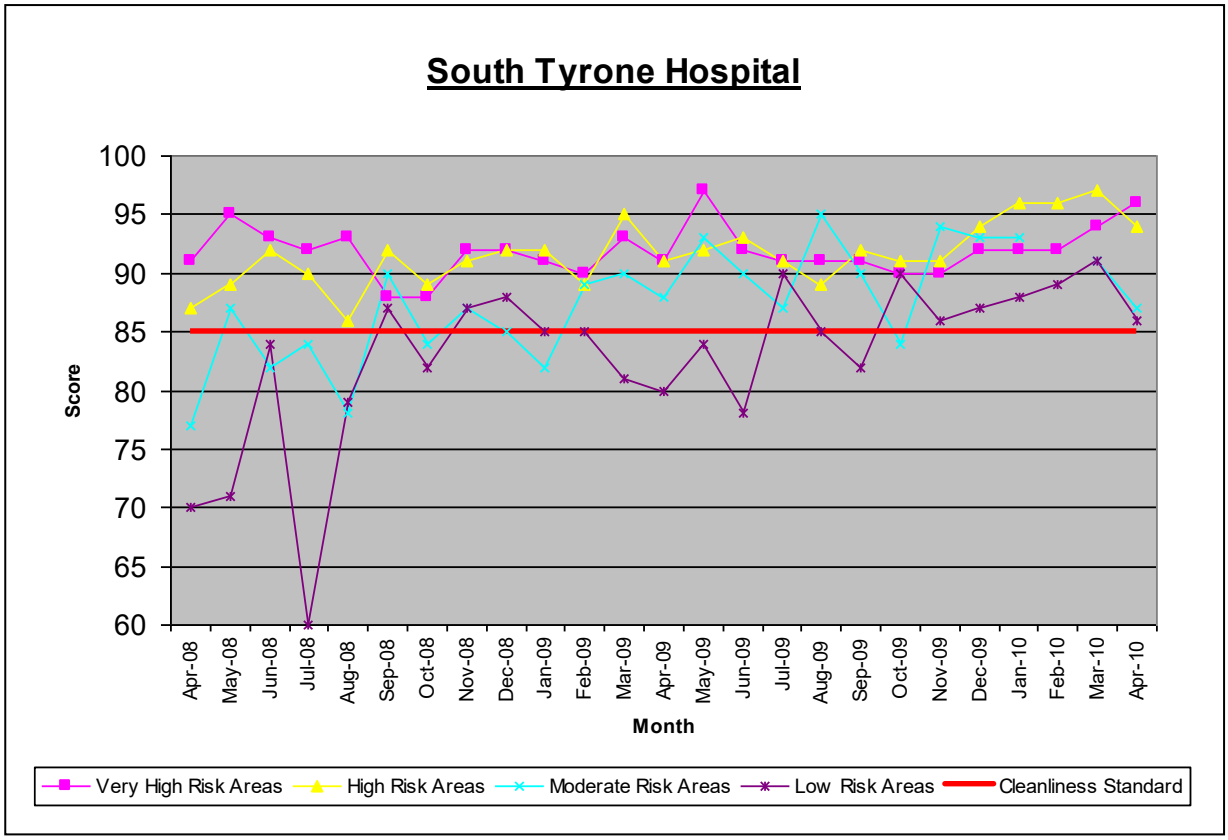






Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.





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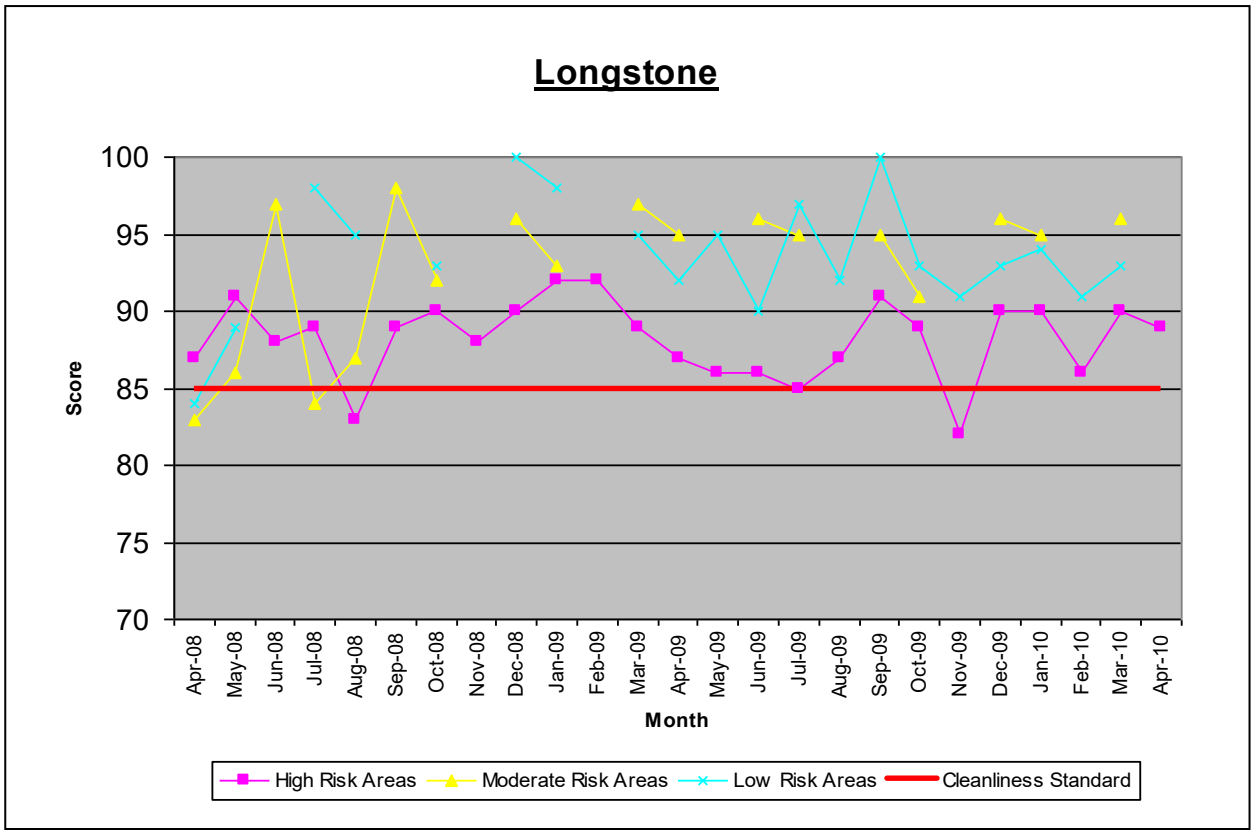
Longstone
100
95
90
85
80
75
70
Score
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
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Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
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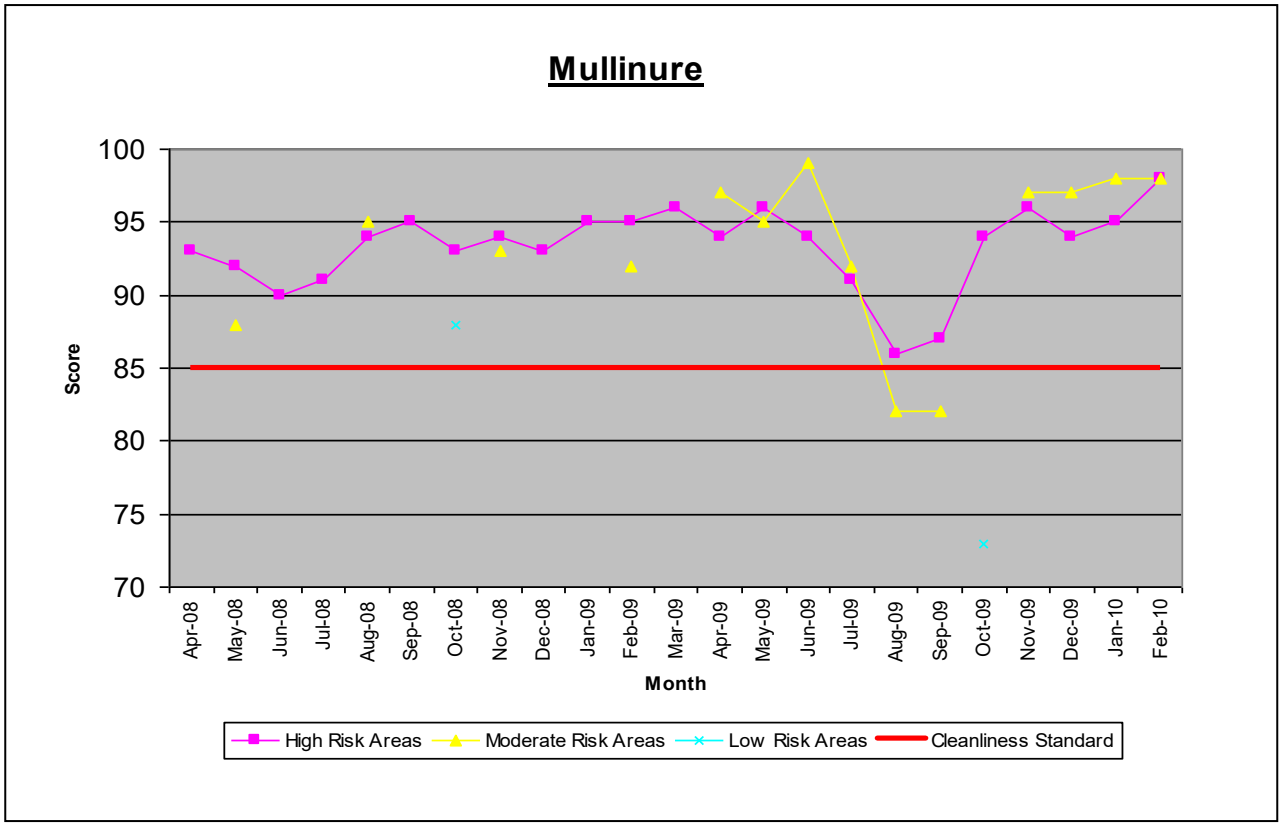
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
Month
High Risk Areas
Moderate Risk Areas
Low Risk Areas
Cleanliness Standard


Mullinure
100
95
90
85
80
75
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Score
Apr-08
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Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Month
High Risk Areas
Moderate Risk Areas
Low Risk Areas
Cleanliness Standard

4. ICNA Audit Results

197 Managerial Audits have been undertaken between May 2009 and March 2010 using the ICNA toolkit. The following table shows the overall range of compliance.

Audit of Infection Control Standards		
Level of Compliance	**Score Range**	**No. of Scores which fall into this range**
Compliant	85% or above	57
Partial compliance	81 to 84%	18
Partial compliance	76 to 80%	24
Minimum compliance	66 to 75%	48
Minimum compliance	51 to 65%	30
Minimum compliance	50% or less	20
Total No. of Audits carried out		**197**

Level of Compliance	
Compliant	85% or above
Partial compliance	76 to 84%
Minimal compliance	75% or below

Summary of minimum compliance scores

In terms of the minimum compliance scores within the range 66-75% these scores contains some areas within wards at St Luke's Hospital in respect of safe handling of sharps, and disposal of Linen; some kitchen and environment areas within Craigavon Hospital and Daisy Hill Hospital.

For those areas that scored 51-65% this category contains some ward kitchens in CAH and some environmental scores in X-Ray at CAH.

For those areas that scored 50% or less:

- a Ward Kitchen at CAH, and some environment scores in Occupational Therapy and Physiotherapy at CAH.
- Waste Management at Day Procedure Unit at DHH,
- the environment and waste management in Cherryvilla at Longstone
- the environment on A Floor at South Tyrone Hospital and some wards in St Luke's Hospital.

5. **Exception Report**

This exception report includes items which are outstanding from Action Plans developed following either internal Environmental Cleanliness or RQIA Unannounced Inspections. These items relate mainly to the fabric of the buildings. Cleaning issues and small repairs which have been addressed have not been reflected in this report.

Facility	Dept	Work Required	Update April 2010
CAH	Areas including Elms, Maples, Laundry, Cedars & Stores	General Refurbishment	
CAH	Transport	Painting	
CAH	Lifts	Refurbishment	
CAH	A&E	Rolling programme for repainting needs to be established. Wheelchairs to be checked for damage to upholstery and repaired or replaced.	All areas have been painted to date. Wheel chairs not completed.
CAH	Outpatients	ENT needs refurbished and redecorated. Refurbishment of dirty utility	Outstanding has been put on the environmental cleanliness priority works list.
CAH	Wards	Refurbishment of ward kitchen.	Outstanding has been put on the environmental cleanliness priority works list
DHH	A&E	Provide patient bathroom or shower area. Refurbishment of domestic store, toilet beside domestic store and dirty utility. Macerator or washer disinfector required in the department. Scrub sink in resus is required. Repainting of walls in Fracture Waiting Area.	Refurbishment of DHH A&E included in Capital Priorities submission to DHSSPS. Interim work also in planning for 10/11.
DHH	Wards	Some repairing and floor replacement	
DHH	Changing Areas	Refurbishment of changing rooms.	
Longstone	Donard, Mourne,	Some painting required & some flooring in some areas needs	

	Sperrin, Cedarwood	replaced.	
South Tyrone	Various floors	Some ceiling tiles needs to be replaced, some painting required.	
South Tyrone	Ambulance Control	Painting required and changing areas require refurbishment	
St Lukes	Various Wards & Villas	Some painting & ceiling tiles replacement, flooring in some areas needs replaced.	

General Comments from RQIA

- National Colour Coding has been implemented with the exception of some items which are not available as stock items. Posters displaying colour coding information are being developed and will be displayed in domestic stores.
- There are a lot of water taps throughout the wards and departments which do not comply with HTM64 as they are not sensor taps.
- System to be established to ensure that mattresses are checked on beds and couches to ensure that they are not damaged or stained.
- Cleaning schedules for wards and departments to be updated and agreed arrangements to be put in place for their display in the wards and departments.
- Infection Control Training for staff to be provided on a rolling basis.
- Storage of bedpans at ward level to be agreed and suitable racks provided in all sluice/dirty utility rooms.
- Sharps and waste management training to be provided to staff.
- Toilet rolls and paper hand towels to be made available in dispensers. Trials of hand towels have taken place and the new contract is due to commence 1/5/2010. It had been originally scheduled to start 1/12/2009 but the date was extended.

Southern Health and Social Care Trust

Southern Health & Social Care Trust

Report on Risk Management, Complaints, Litigation and Patient Client Safety

Senior Management Team Governance Meeting 28th April 2010

CONTENTS

Appendices

1.0 INTRODUCTION

This report provides a summary analysis of activity and trends associated with clinical and social care governance/patient and client safety in the Southern Trust for the period October 2009 to December 2009.

The content of this report reflects the requirements of the Governance Committee Reporting Framework, and the format of the report is as follows:

- Section 2 – Complaints Update.
- Section 3 – Update on Patient/Client Safety Programme
- Section 4 – Risk Management
- Section 5 – Adverse Incidents
- Section 6 – Proposed Changes in Governance Arrangements
- Section 7 – Effectiveness and Evaluation Report
- Section 8 – Litigation
- Section 9 – Research Governance

2.0 COMPLAINTS UPDATE

2.1 Number of Complaints September to December (Q3)

The Trust seeks to resolve concerns raised at a local level in keeping with the Complaints procedures post April 2009. A monthly report is provided to each Director on the numbers and details of complaints or issues resolved locally. The activity of the Patient Support Officer within the acute directorate is not included in this report.

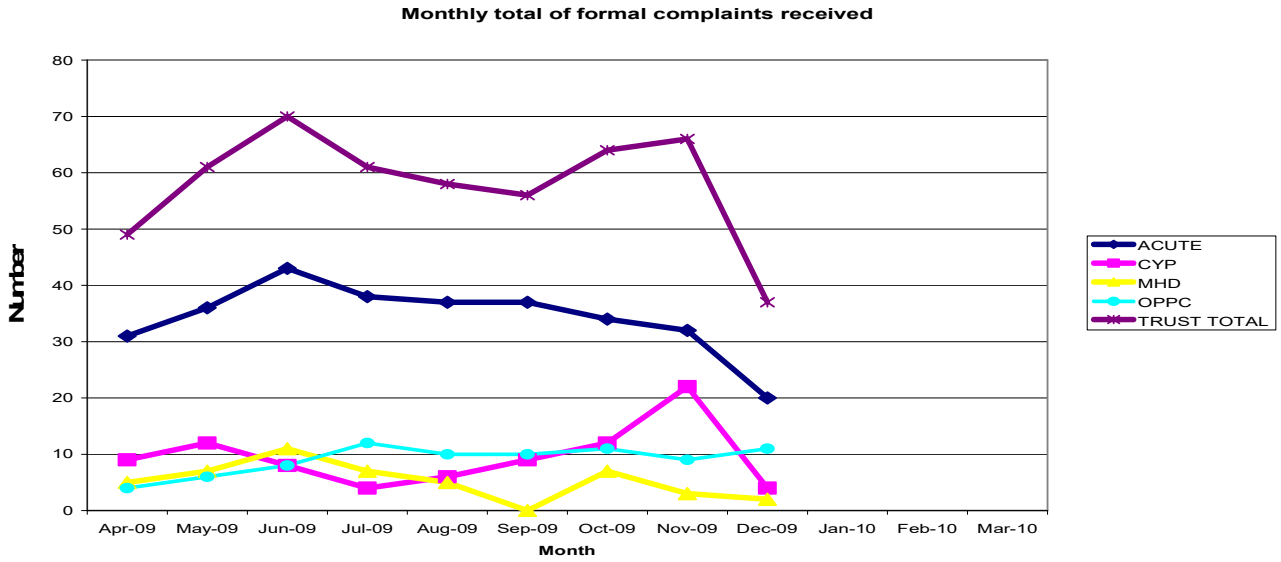
Table 1 – Number of Formal Complaints by Directorate October 2009 to end December 2009

Number of Formal Complaints Received	ACUTE	CYP	MHD	OPPC	TRUST TOTAL
October 2009	34	12	3	8	57
November 2009	32	22	3	9	66
December 2009	20	4	3	13	40
Total	**86**	**38**	**9**	**30**	**163**

2.2 Trust Complaint Response Rates

Tables 2 and 3 illustrate the Trusts performance in responding to complaints.

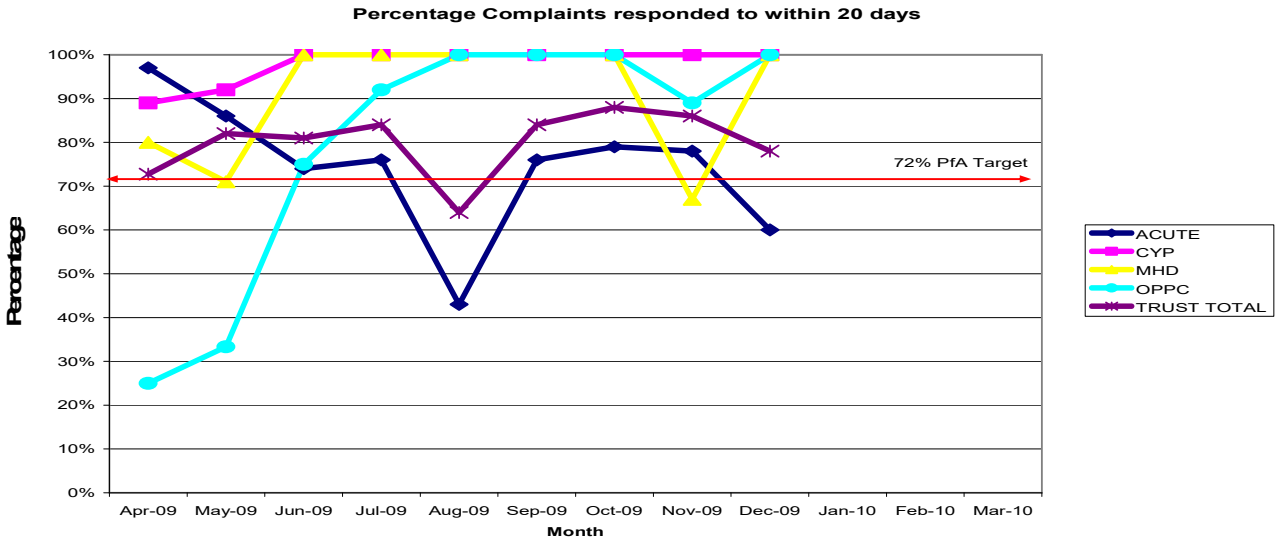
Table 2 – Number of Formal Complaints by Directorate April 2009 to end December 2009



2.2 Trust Complaint Response Rates

The Trust aims to resolve all complaints at the local resolution stage, within the timescale stipulated in the DHSSPS guidance. The current DHSSPS target for local resolution of complaints is *72% of complaints resolved within 20 working days*. The Southern Trust's response rate for the period October 2009 to end December 2009 was 81%.

Table 3 – Percentage of Formal Complaints Responded to within 20 day target



2.3 Feedback on commendations and Issues arising from complaints

Commendations

The Trust continues to receive commendations, gifts and endowments in order to acknowledge the support staff have given. The Trust uses these gifts to make tangible improvements to patient care. Information on gifts and endowments is included in the gifts and endowment report from the Board Secretary. Commendations continue to be collated in statistical format with a random sample of comments from patients and clients being used in this report and for the patient and client experience sub committee of the Board. During Q3 a total of 827 commendations were received.

Issues arising from complaints

At the time of writing this report there are a number of complex complaints within Q3 which have required in-depth analysis and on one occasion advice was sought from external experts. These include:

Acute
October 2009. Complaint regarding the standard of clinical care prior to the death of a patient. The investigation internal root cause analysis of this complaint augmented by findings of the external expert concluded that there were failings by the Trust. An action plan has been drawn up and is currently being implemented by the Director of Acute Services.

20 complaints relate to the quality of treatment and care provided.
19 complaints relate to staff attitude and behaviour. (four complaints listed both staff attitude and behaviour and quality of care as complaint issues)
12 complaints relate to out patient services, (time at clinic 4, cancelled clinic not notified 1, waiting for an appointment 3, and no review appointment received 4)
4 complaints relate to dissatisfaction with professional assessment of need
4 complaints relate to dissatisfaction with communication of information.

Whilst there are no emerging trends regarding specific staff groups or wards and departments, there is considerable work being undertaken within the acute directorate to address individual complaints regarding staff attitude and behaviour and to ensure lessons are learned.

Lower Level Issues

There are small numbers of complaints relating to discharge arrangements, waiting times for outpatient appointments and within out patient clinics, review appointments and communication of information.

Reopened and informal complaints

During Q3 there were 42 informal complaints that did not progress to formal complaints. (These complaints are as intensive in seeking appropriate answers and responding to the complainant)

CYP

No Major issues

Lower level issues

9 complaints relate to staff attitude and behaviour all relate to staff involved in child care cases custody issues etc. This type of complaint is commonplace in these circumstances
7 complaints relate to the decisions taken regarding referral to social work or children in care by parents of children
4 complaints relate to the quality of care provided by Paediatric wards and community clinical services
2 complaints were children order complaints.

Reopened and informal complaints

During Q3 there were 33 informal complaints that did not progress to formal complaints. (These complaints are as intensive in seeking appropriate answers and responding to the complainant)

MHLD

No Major issues

Lower level issues

4 complaints relate to mental health services with patients requesting a referral to another psychiatrist. This is a common area of complaint within mental health services.
2 complaints were from MLAs regarding the direct payment scheme and the costs associated with care management packages.

Reopened and informal complaints

During Q3 there were 10 informal complaints that did not progress to formal complaints. (These complaints are as intensive in seeking appropriate answers and responding to the complainant)

OPPC

No Major issues

Lower level issues

7 complaints relate to the out of hours GP services. Complaints range from the lack of cleanliness of the department on a particular night to the attitude and behaviour of staff.

A number of complaints relate to the reduction in provision of community services, the failure to meet the Trust's agreed criteria for services.

- 4 provision of podiatry services in the community.
- 3 provision of domiciliary care services

There are ongoing issues with the provision of services in line with access criteria and general expectations of services which are beyond the Trusts allocation of resources.

In addition to the above there are an increasing number of requests from MLA's on behalf of their constituents. This is largely relating to the provision of services, financial assessments and appliances and home adaptations.

In all of the above appropriate action was taken by the Trust by provision of an explanation or clarification, including a reassessment of need. In all of the above responses were provided and appropriate actions taken by operational Directorates.

Reopened and informal complaints

During Q3 there were 14 informal complaints that did not progress to formal complaints. (These complaints are as intensive in seeking appropriate answers and responding to the complainant)

2.4 New Complaints Procedure

Progress with the introduction of the new complaints procedure continues. The DHSSPS have provided funding for the complaints manager and administrative support posts until June 2010. At present there are no plans within the Trust to continue with the provision of ongoing training in the absence of funding.

2.5 Reporting Complaints to external bodies

As part of the Trusts reporting responsibilities reports are provided as follows:

Monthly to Health and Social Care Board. Sample report included in appendix one
Quarterly CH08 returns to DHSSPSNI. Q3 report included in appendix two

3 PATIENT/CLIENT SAFETY PROGRAMME

3.1 Patient Safety Interventions 2010

Programme continues with positive outcomes. Continued progress is reported on a monthly basis through the performance monitoring arrangements of the Trust. A comprehensive report on performance until December 2009 was provided in the Report to SMT Governance meeting on the 31 March 2010. (This will be incorporated into the Governance Committee papers for the 11th May 2010)

4.0 RISK MANAGEMENT

4.1 Review of Governance and Risk Management

This is ongoing at present

4.2 Corporate Risk Register

The corporate risk register was updated at the March SMT meeting. It has been agreed that the corporate risk register will be updated through the senior management team and forwarded to the Governance Committee for information. It has been agreed that the corporate risk register will illustrate links between the risk (which is listed) and the Board Assurance Framework. The corporate risk register is included in a separate paper.

4.3 Risk Managers Forum

The Risk Managers Forum has not been meeting since February due to the ongoing review of risk management and governance. This forum provided a unique opportunity for all risk managers across the Trust to discuss key risk issues within their area of responsibility. The risk management forum seeks further direction from the Senior Management Team regarding its role and responsibilities. A Draft Terms of Reference for this group is included in appendix three. (For discussion and approval)

5.0 ADVERSE INCIDENTS

5.1 Quarterly Report on Incidents Reported 01 October 2009 to 31 December 2010 Q3

From 01 October to 31 December 2009 a total of 2186 incidents have been reported. The breakdown of numbers of incidents per Directorate is included in table four. Comparative data for Q2 is also included

Table four: Reported incidents 01 October to 31 December 2009 by directorate

Directorate	Q2 Number	Q3 Number
Acute	901	1028
CYP	252	259
Finance	1	0
HROD	0	2
MHLD	614	597
OPPC	197	277
Perf and Reform	24	21
Medical	0	3
Total	**1989**	**2187**

There has been an 10% increase in the numbers of incidents being reported in Q3

Directors receive a monthly report on the numbers and categories of incidents reported in order that trends are identified and actions can be taken to address high

and moderate level risks as appropriate. These reports are available to Assistant Directors and Associate Medical Directors for further action. There is an ongoing need to ensure that Directorate governance arrangements capture information on actions taken and lessons learned. This is at varying stages of development within each directorate.

5.2 Risk Grading of Incidents

Of the reported incidents table five illustrates the associated risk classification using the Trusts definition of risk regarding the following:

High level of risk to the organisation needing further investigation. These types of incidents are usually reported as serious adverse incidents (SAIs) to the HSCB and DHSSPS. A root cause analysis will be undertaken for incidents in this category.

Moderate level of risk to the organisation. These are investigated at Directorate level with recommendations for improvement being made. A number of these will have a root cause analysis undertaken and a small number will be reported to DHSSPS as SAIs and HSCB as Adverse Incidents (AIs)

Low and Very low level of risk to the organisation are managed within the directorate at a middle management and operational level as appropriate.

Table five shows the numbers of incidents classified by the level of risk to the organisation for Q3. Comparative data for Q2 is also included.

Table five: Reported incidents 01 October to 31 December 2009 by level of risk to the organisation classification.

Classification by Level of Risk	Q2 Number	Q3 Number
High	2	4
Moderate	79	88
Low and very low	1908	2063
Unclassified	0	32
Total	**1989**	**2187**

High level risk incidents included:

Acute Services	1 delay in diagnosis of a cancer that may have had a greater success of treatment if diagnosed earlier
Mental Health and Disability	3 Suspected suicides (routine reporting of SAIs)

5.3 Reporting of Incidents by Consequence

Of the reported incidents table six illustrates the associated consequence classification using the Trusts definition of risk regarding the following:

Catastrophic incident where an Incident leads to one or more deaths. These types of incidents are usually reported as serious adverse incidents (SAIs) to the HSCB, RQIA and DHSSPS.(Depending on the reporting requirements)

Major incident where an Incident leads to Permanent physical / emotional injuries / trauma / harm. A number of these will have a root cause analysis undertaken and a small umber will be reported to DHSSPS as SAIs and HSCB as Adverse Incidents (AIs)

Moderate incident where an Incident leads to Semi permanent physical / emotional injuries / trauma / harm (recovery expected within 1 year). Includes RIDDOR reportable incidents.

Minor incident where an Incident leads to Short-term injury / harm. Emotional distress. (Recovery expected within days / weeks.)

Insignificant incident where an Incident leads to no injury / harm or where no intervention required

Table six shows the numbers of incidents classified by the consequence to the patient/client/member of staff for Q3. Comparative data for Q2 is also included

Table six Reported incidents 01 July to 30 September 2009 by consequence to the patient/client/member of staff classification.

Classification by Consequence	Number	Number
Catastrophic	1	17*
Major	47	59
Moderate	285	325
Minor	1451	1754
Total	**1784**	**2187**

*Incorporates reporting of suicide and reporting of death of children (premature delivery, stillbirth, death of life limited children and cancer related deaths) these are mandatory reporting procedures and are not classified as serious adverse incidents. Further work in ongoing within the medical directorate regarding enhanced reporting in relation to deaths.

The 59 major issues were reviewed and reclassified as follows.
Acute 12, CYP 1. Each of the high level, catastrophic and major issues are notified to the individual director at the time or within directorate reporting arrangements.

Catastrophic and major issues include

Catastrophic CYP	10 relate to inpatient paediatric care 1 relates to social care.
Catastrophic MHD	3 Suicides. 1 serious criminal offence awaiting PSNI action.
Catastrophic Acute (near miss)	Provision of anaesthetic services for IMWH
Major Acute	7 Relate to diagnosis issues.
	2 relate to drug errors
	4 relate to other issues
Major CYP	1 relate to delay in transfer to another hospital

Further clarification is requested by the Medical Director from SMT colleagues on whether or not it is appropriate to share further details of specific incidents at SMT level.

6 LEARNING LESSONS MODEL AND ACTION PLANNING

An update on a proposed learning lessons model and action planning template has been drafted. This has been based on the work undertaken by the National Patient Safety Agency (NPSA) and considers the need to ensure a joined up approach to ensuring an organisation wide approach to learning from internal and external information channels. Ongoing discussion is at directorate level and will be presented to SMT before the model can be agreed. The NPSA model and an example of how the Southern Trusts lessons learned template can be used is in appendix four

7 EFFECTIVENESS AND EVALUATION

The work plan of the Effectiveness and Evaluation department continues to be directed by the corporate needs of the Trust. In addition to the growing corporate requests for analysis and information on key patient and client projects, there is a comprehensive programme of work supporting clinical and social care audit and service improvement. A detailed report on the workplan of the effectiveness and evaluation department was provided in the March SMT Governance report.

The process for audit approval has been updated and is included in appendix five

8 LITIGATION

8.1 Litigation Activity

8.1.1 Professional (Clinical) Negligence and Employer/Public Liability Cases

A detailed report on Q3 activity was provided to the March SMT Governance meeting on the 31 March. (This will be incorporated into the Governance Committee papers for the 11th May 2010)

8.2 Litigation issues

8.2.1 Employer liability claims

A Medical Directorate review of current arrangements for employer liability claims has indicated that there is a gap in current arrangements so that the recovery of sick pay (of employees) has not been secured from insurance companies. There is a lack of focus being given to considering the total costs of litigation being paid out by the Trust against the savings to be made by the Trust in defending cases. From the time of the merger there has been some difficulty in ensuring accidents to staff, patients/clients and the general public (public liability cases) are fully investigated at the time of incident.

At present there is a lack of clarity relating to the investigation of all incidents at a local level. It is important that all incidents are investigated by operational managers at the time of the incident. Information should be reviewed and forwarded to the central reporting unit to be held with the original copy of the IR1 form.

Preparatory work has started in providing Directors with reports on litigation costs and there have been discussions with the Business Services Organisation to examine lessons learned approach to the outcomes of litigation in order that the Trust learns from negligence and employer liability cases.

8.3 Review of Litigation Services

The SMT has requested a review of existing litigation systems and processes. The terms of reference for the review has been agreed. The litigation review will examine how the current services are provided against the recent circular issued by the DHSSPS. (HSC (SQSD) 5/10 Handling Clinical and Social Care Negligence and Personal Injury Claims)

9 RESEARCH GOVERNANCE

A report on research activity was provided in the March SMT Governance report.

HSCB Monthly Report

Enclosed as separate paper

CH08 returns Q3 (October to December 2009

PROVIDER CHARTER MONITORING: TRUST COMPLAINTS **CH8**

Quarter Ending:	30-Dec-09
Contact Name:	
Trust:	Southern Health and Social Care Trust
Tel:	Personal Information redacted by the USI

If you have any queries regarding completion of this form, please contact Hospital Information Branch

Telephone:	Personal Information redacted by USI
Fax:	Personal Information redacted by USI
E-Mail:	Irrelevant information redacted by the USI
Please return to:	Irrelevant information redacted by the USI

Part 1:

PROGRAMME OF CARE OF EACH TRUST COMPLAINT RECEIVED DURING THE QUARTER

POC		**Number**
Acute		86
Maternal & Child Health		1
Family & Child Care (see subdivisions below)		
(i) Complaints under Children Order		9
(ii) Complaints other than under Children Order		27
Elderly Services		2
Mental Health		5
Learning Disability		2
Sensory Impairment & Physical Disability		2
Health Promotion & Disease Prevention		
Primary Health & Adult Community		26
None (No POC Assigned)		
TOTAL COMPLAINT ISSUES		160

NB: The above refers only to complaints received in relevant quarter.

PART 2:

SUBJECT OF EACH TRUST COMPLAINT RECEIVED DURING THE QUARTER

	SUBJECT	NUMBER
1	Access to Premises	1
2	Admission into Hospital, Delay/Cancellation (Inpatients)	2
3	Aids/Adaptations/Appliances	1
4	Appointments, Delay/Cancellation (Outpatient)	11
5	Clinical Diagnosis	1
6	Communication/Information to Patients	7
7	Complaints Handling	
8	Confidentiality	3
9	Consent to Treatment	
10	Contracted Regulated Establishments and Agencies	
11	Other Contracted Services	1
12	Delayed Admission from A&E	
13	Discharge/Transfer Arrangements	4
14	Environmental	1
15	Hotel/Support/Security Services	1
16	Infection Control	1
17	Mortuary & Post-Mortem	
18	Patients' Privacy/Dignity	2
19	Patients' Property/Expenses/Finance	2
20	Patients' Status/Discrimination	
21	Policy/Commercial Decisions	9
22	Professional Assessment of Need	6
23	Records/Records Keeping	2
24	Staff Attitude/Behaviour	41
25	Theatre/Operation/Procedure, Delay/Cancellation	2
26	Transport, Late or Non-arrival/Journey Time	
27	Transport, Suitability of Vehicle/Equipment	1
28	Treatment & Care, Quality	38
29	Treatment & Care, Quantity	5
30	Waiting Lists, Community Services	
31	Waiting Times, Community Services	1
32	Waiting Times, A&E Departments	1
33	Waiting Times, Outpatient Departments	6
34	Children Order Complaints	9
35	Other	1
TOTAL COMPLAINT ISSUES		160

NB The above refers only to complaints received in relevant quarter

Appendix Three

Draft Terms of Reference for Risk Managers Forum

Name of Group	**Risk Managers Forum / Governance Virtual team**	
Membership	**Dr Patrick Loughran**	**Chair**
	Roberta Wilson	Governance Lead Medical Directorate
	Tony Black	Patient Client Liaison Safety and Risk Manager Mental Health and Disability Services
	Jacky Kingsmill	Patient Client Liaison Safety and Risk Manager Childrens and Young Peoples Services
	Beatrice Moonan	Patient Client Liaison Safety and Risk Manager Governance Manager Acute Services
	Nigel McClelland	Risk Management Officer Estates (SABS)
	Mary McIntosh	Professional Governance Lead Social Work
	Fiona Wright	Professional Governance Lead Nursing
	Carmel Harney	Professional Governance Lead AHP
	Jillian Redpath	Pharmacy Governance lead
	Michelle Oliver	Dental Services
	?	Finance /Procurement Department representative
	Ray King	Health and Safety Manager
Duration of group	Ongoing	
Frequency of Meetings	Monthly at least 10 times a year	
Main Purpose of Committee	To support the Medical Director in the discharging of his responsibilities for governance and risk management. To ensure a clear and systematic approach to all aspects of governance and risk management. To bring together a range of stakeholders from different backgrounds to ensure all aspects of governance and risk management are considered and assurances are provided to the Senior Management team and ultimately the Governance Committee and Trust Board.	

Terms of Reference

- Provide advice and support as appropriate to Directorate Risk Management Committees.
- Develop the Corporate Risk Register in line with the Board Assurance Framework.
- Advise the Senior Management team through the Medical Director of key Risk and Governance Issues
- Allocate and Coordinate key projects as they arise to ensure a direct line of communication and accountability exists for each piece of work.
- Monitor performance in key governance and risk areas and report performance to the Trust Senior Management Team.

Minutes/Action points circulation list in addition to membership	Directors, Chief Executive
Anticipated outputs of Group	Provision of a quarterly report to the Senior Management Team on all aspects of Governance and Risk Management
Supported by	Operational Assistant Directors, Heads of Service and Clinical divisions. Associate Medical Directors.
Linkages to other Trust Groups	SMT Governance, AMD Governance, Governance Committee.

Southern Health and Social Care Trust

Southern Health & Social Care Trust

Learning Lessons Model

DRAFT
August 2009

For discussion at Senior Management Team 26th August 2009

CONTENTS

1 Introduction and context

The purpose of this paper is to outline an approach which can be applied to implementing lessons learned and recommendations made from a variety of documents. This includes internal and external reports, guidelines and actions arising from complaints, adverse incidents and risk identification. Learning lessons and implementing changes which improve the quality of care provided to patients and clients assists the Trust with providing assurances to the Trust Board and external bodies.

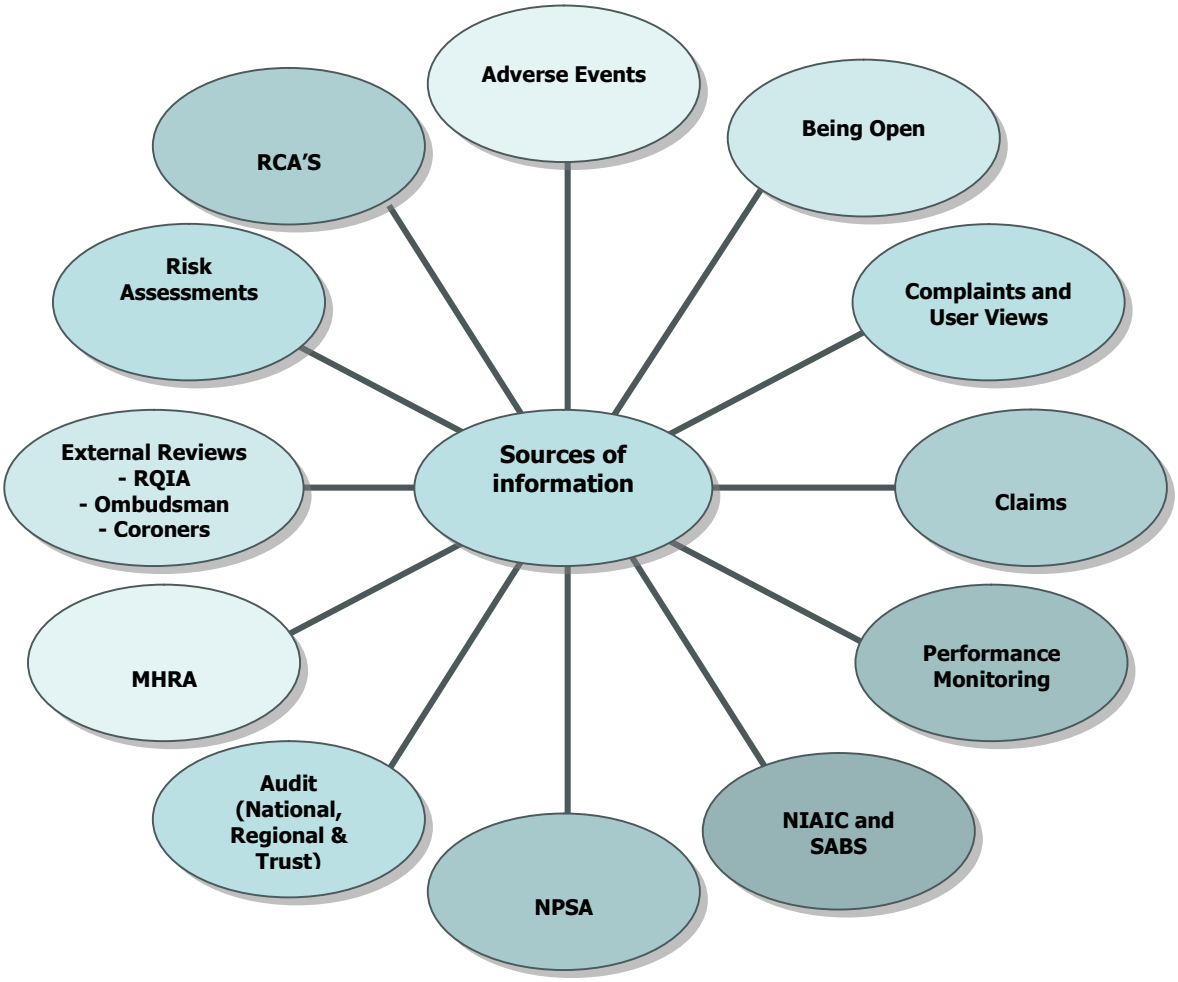
The aim of learning lessons is to adopt a robust approach to providing safe, high quality and effective care (one of the corporate objectives) and to mitigate the risks of future occurrences or actions which have caused harm/have the potential to cause harm to patients/clients.

2 Sources of information for learning lessons

The Southern Trust has many sources of to information which can be used to learn lessons. There is a need to co-ordinate all strands of information and integrate this into an appropriate model and ensure effective communication and associated actions are undertaken.

Illustrated in table one is a map of the information sources which can be utilised to underpin the Trusts approach to learning lessons. The information sources identified will be collated into a template for action in the relevant service area. From this progress with implementation can be measured. Where there are recommendations or actions to be taken that cannot be achieved within the service area consideration needs to be given to developing a risk assessment for consideration within the directorate's governance arenas.

Table one: Sources of information to be considered in the learning lessons template.



3 Action Planning

Those issues which have been identified as appropriate for 'learning lessons' will require an Action Plan. At a minimum action plans should include:

Summary of lessons/recommendations to be implemented.
Identified Lead Director with overall responsibility for coordinating the action plan
Actions required and associated timescales.

A working template for recording lessons learned and recommendations to be actioned is included at the end of this document.

4 Communication and Monitoring

The overall lead Director for the Action Plan is responsible for disseminating same to other directors to whom action(s) have been assigned. The overall lead Director will communicate the necessary actions to other appropriate parties. This may include (though not be limited to) the following:

- Senior/Directorate Management Teams
- Senior Manager, Patient & Client Safety
- Appropriate Directorate Patient/Client Liaison, Safety & Risk Managers
- Professional Governance leads and professional governance fora
- Trust Records Management and Policy Committee
- Effectiveness and Evaluation Manager
- Health and Safety Committee
- Standards and Guidelines Committee
- Individual managers if issue is related to performance of an individual
- Dissemination across the DHSSPS and HPSS as appropriate and in accordance with Departmental guidance.

The above individuals/groups should take forward the actions contained in the action plan and feedback their response to their Director. Individual Directors to whom action(s) have been assigned are responsible for ensuring that progress with the associated Action Plan is reported via the Directorate performance management processes and via Trust Governance Committee/Trust Board as appropriate.

The implementation of the model will be supported by training and awareness disseminated via governance meetings

Appendix five

Audit approval process

The Effectiveness and Evaluation Department provides support to ensure the corporate, clinical, professional and managerial prioritised clinical and social care needs of the organisation are met. This includes a wide range of facilitation for audit activity, support to clinical and managerial processes and provision of information to external bodies. The following outlines the process for approval of audit projects for inclusion in the Effectiveness and Evaluation work plan

Pathway of approval	Supporting information
Audit idea generated agreed/discussed with nominated Consultant and Audit Coordinator|	Questions can this be facilitated within existing resources (junior doctors, Professional governance teams)
Prioritisation by C.D, A.M.D and Ass Director	Consideration of all the audit needs of the division • corporate • clinical • managerial / professional
Agreement and prioritisation all of directorate and professional audit by Director	Only audits approved by the relevant director will be considered as part of the effectiveness and evaluation Work plan (this includes ad hoc and in year additional activity)
Guidance given by Effectiveness and Evaluation unit	Determine what level of facilitation required • advice • chart retrieval only • analysis only • full facilitation
Forward to Medical Directors office for final approval and inclusion in Effectiveness and 'evaluation work plan	Work plan will be agreed by Medical Directors office and Directors informed of reporting process via directorate / governance structures

Outcomes of all audits should be reviewed as part of the Directorate or Divisions governance arrangements with an action plan to implement changes and reaudit where appropriate
All audits undertaken within the Trust should be forwarded to the effectiveness and evaluation unit for central recording and cataloguing.

April 2010

TITLE: RQIA Review of Maternity Services – Intrapartum Care April 2010

In March 2009, RQIA completed a review of intrapartum maternity services in the SHSCT. The RQIA review team assessed the quality and safety of intrapartum care using the ***Safer Childbirth: minimum standards for the organisation and delivery of care in labour***. RQIA brought to the attention of the SHSCT Chief Executive on the 3rd April 2009 a number of concerns including some issues they regarded as serious with respect to staffing levels in obstetrics and anaesthetics in the delivery suites in Daisy Hill Hospital (DHH) and Craigavon Area Hospital (CAH). The Southern Trust have been engaged in ongoing discussions with RHSCB and PHA representatives to highlight the safety and quality issues raised in the initial draft report and the financial implications associated with meeting the RQIA recommendations. This draft report not yet available in the public domain was forwarded to the Trust in March 2010. This paper provides an update on Trust action to address the Trust Specific Recommendations and Recommendations for the Service across Northern Ireland highlighted in this report.

Recommendation	Ref No	Issue	Owner	Action taken	Date completed
Trust Specific Recommendations SHSCT					
The Trust Should develop a specific risk management policy for Obstetrics ensuring that this includes a clearly defined trigger list for incident reporting.	1	Trust Risk Management Policy for Obstetrics to be developed	Dr Martina Hogan, Associate Medical Director	The Trust has a Risk Management Strategy which Obstetrics adheres to. (Management of Adverse Incidents, Complaints, Management of Serious Adverse Incidents) The Trust adopted the RCOG trigger list for incident reporting in Obstetrics. There is a working Risk Management Strategy for obstetrics which facilitates structured review and learning from each clinical incident in obstetrics. A Consultant Obstetrician and Lead Midwife review clinical incidents fortnightly on both CAH & DHH sites. They categorize each incident, identify the action required, the learning points and who is responsible for each action. Dissemination of the learning is provided at the quarterly IMWH Governance/Risk Management Forum, rolling audit meetings and is disseminated to front line staff using ward/department meetings. The monthly IMWH Newsletter is also used to share the learning from clinical incidents or serious adverse incidents.	January 2008 November 2009 November 2009 September 2009 April 2009

The Trust should consider the appointment of a designated risk management midwife to strengthen and build upon existing arrangements and assist in the development of a rolling programme of audit.	2	Appointment of a Designated Risk Management Midwife	Anne McVey, Assistant Director Acute Services, Integrated Maternity & Women's Health	Funding has been secured for the Designated Risk Management Midwife in 09/10 With Commissioner agreement it was decided to deal with one of obstetrics largest risks in relation to CTG training and implementation of the K2 on line training by appointment of a CTG Co-Ordinator. With Commissioner agreement this funding will now be used to appoint the Risk Management Midwife post.	May 2010
The Trust should review provision of anaesthetic cover in the Craigavon and Daisy Hill Hospitals given the nature of the case mix in both units.	3		Ronan Carroll Assistant Director Acute Services, Cancer and Clinical Services Dr Charles McAllister, Clinical Director	1. The Trust has provided options for the Commissioner and NIMDTA in order to address anaesthetic cover in CAH. 2. The Trust is currently recruiting both consultant anaesthetists and specialty doctors for DHH.	

Recommendations for the Service across Northern Ireland					
Standard 1 Organisation and Documentation					
NIMATS should be implemented in all maternity units across Northern Ireland	1	NIMATS is fully implemented in DHH, CAH and Outreach clinics	Siobhan Hanna, Assistant Director Informatics	NIMATS is fully implemented in DHH since March 1993 NIMATS is fully implemented in CAH since 2009 Phase 2 of the Trusts NIMATS Project is exploring the roll out of NIMATS into GP Surgeries/Health Centre's where Trust midwives are located.	Completed Date to be defined
All Trusts should prepare an annual program of audit activity in relation to maternity services and publish an annual report on the audit results which should be disseminated to members of the maternity team	2	Develop a programme in audit activity in relation to Maternity Services. Publish an Annual Audit Report on the audit results and disseminate to members of the Maternity team	Dr Sidhu, Consultant Obstetrician/ Gynaecologist Mr. deCourcy Wheeler, Consultant Obstetrician/ Gynaecologist Ann Quinn, Effectiveness& Evaluation Manager Raymond Haffey, Effectiveness& Evaluation Facilitator	There is a programme of rolling audit, meetings are held monthly engaging staff from both CAH and DHH sites. The priority audits identified for 2009/2010 • Induction of labour comparing practice with NICE Guidelines and this will be presented at the audit meeting in June 2010. • Electronic Fetal Monitoring. This audit has been incorporated into the Patient & Client Safety Work programme and is monitored as part of the Care Bundles project as a regional initiative. • Caesarean Section Surgical Site Infection audit has also been ongoing as part of a regional care bundles project. • A range of other audits have been undertaken by medical , nursing and midwifery staff which meets the training needs of junior doctors and nursing/midwifery staff. Annual Audit Report detailing audits from April 2010 until end of March 2011 will be developed.	March 2011

All Trusts should ensure the harmonisation of policies and guidelines from those used by their legacy trusts and ensure that there are effective mechanisms to disseminate them to staff	3	Harmonisation of policies and guidelines. Effective mechanisms to disseminate policies and guidelines to staff	Dr Martina Hogan, Associate Medical Director	There is a Policy Scrutiny Committee within the Trust. Policies are developed by staff in the IMWH division and are forwarded to this committee for approval. There is a Divisional Multi-Disciplinary Guidelines Group which is harmonising guidelines from the legacy Trusts and devising and updating guidelines as required. Policies and Guidelines are shared electronically with Consultants and Ward Managers/Lead Midwives and Head of Service. Hard copies of policies and guidelines are made available in all wards/departments and placed on the Trust intranet site.	 Ongoing process Ongoing process
All Trusts should review their structures and processes for the reporting and analysis of incidents and near misses in maternity services and ensure there is effective and timely feedback on a multidisciplinary basis	4	Review Structures and processes for reporting and analysis of incidents and near misses in Maternity Services Ensure effective and timely feedback on a multi-disciplinary basis	Anne McVey, Assistant Director Acute Services, Integrated Maternity & Women's Health Dr Martina Hogan, Associate Medical Director	The Integrated Maternity & Women's Health Division has reviewed their structures and processes for the reporting and analysis of incidents and near misses in Maternity. A Consultant Obstetrician and Lead Midwife on each site review 1-2 weekly the incidents reported and develop and implement action plans as required. Serious Adverse Incidents are reported and investigated using RCA methodology. Incidents are placed on the Risk Register and managed as appropriate. The Integrated Maternity & Women's Health Newsletter which is produced monthly highlights key learning from incidents and near misses. Feedback is also provided at the quarterly Divisional Clinical Governance/Risk Management Forum and through presentations at the monthly Rolling Audit meetings.	November 2009
All Trusts should consolidate induction, training and practice in respect of written and electronic record keeping across all disciplines involved in providing maternity services and carry out regular audits of records	5	Consolidate Induction training and practice in respect of electronic record keeping Undertake regular audits of records	Patricia McStay, Head of Midwifery & Gynaecology	The importance of written and electronic record keeping is included in induction programmes. NIMATS has been rolled out across the Trust and training has been provided. NIPACS training provided for medical, midwifery and admin/clerical staff. Midwives records 3 sets of notes are examined for each midwife as part of their annual midwifery supervision.	1st April 2010 Annual basis

Standard 2 Multidisciplinary working					
Each Trust should ensure that the terms of reference of its labour ward forums are clearly defined and that there are mechanisms for user involvement. Where there is more than one labour forum in a particular trust, steps should be taken to ensure regular communication between them.	6	Terms of reference for Labour Ward Forum need to be clearly defined. Consider mechanisms for User Involvement in the Labour Ward Forum.	Dr Martina Hogan, Associate Medical Director	There is one Labour Ward Forum. The Terms of Reference need to be reviewed and consideration given to User Involvement.	March 2008 Mid June 2010
Standard 3 Communication No Recommendations					
Standard 4 Staffing Levels					
The HSC Board and Trusts should consider the adoption of a single assessment tool for midwifery staffing across Northern Ireland and the frequency with which it should be applied	7	Regional Health and Social Care Board to consider the adoption of a single assessment tool for Midwifery staffing.	RHSCB	N/A	N/A

All Trusts should review their senior and junior medical staffing for maternity units in relation to the Safer Childbirth Standards in conjunction with the HSC Board, DHSSPS and NIMDTA	8	The Southern Trust to review their Senior and Junior medical staffing for maternity units in relation to the safer childbirth standards in conjunction with RHSCB, DHSSPS and NIMDTA	Southern Trust RHSCB DHSSPS NIMDTA	Representatives of the Senior Management Team have had ongoing discussions with RHSCB PHA and NIMDTA representatives to highlight the safety and quality issues and the financial implications associated with meeting RQIA recommendations as per Safer Childbirth Standards.	
Standard 5 Leadership					
DHSSPS should develop a specific policy on the development of the role of consultant midwives across Northern Ireland, in line with its policy on the introduction of midwifery led units.	9	Develop a specific policy on the development of the role of Consultant Midwives across Northern Ireland, in line with DHSSPS policy on the introduction of Midwifery Led Units	DHSSPS	N/A	N/A

Standard 6 Core Responsibilities					
All Trusts should aim to have a consultant present for a physical ward round as appropriate and at least twice a day during Saturdays, Sundays and public holidays	10	Consultant Obstetricians to be present for a physical ward round as appropriate and at least twice a day during Saturdays, Sundays and public holidays	Mr Noel Heasley, Clinical Director Mr David Sim, Clinical Lead	Consultant Obstetricians do participate in ward rounds. There is 40hours Consultant presence on Labour Ward on CAH site There was 10 hours Consultant presence in labour ward DHH in March 2009. The appointment of a new Consultant increased Consultant presence in labour ward DHH to 16 hours 18hours Consultant presence on Labour Ward on DHH site by replacing Consultant led satellite clinic with Midwifery led clinic. Plan to increase this to 28 hours through further replacement of all remaining consultant led satellite clinics with midwifery led clinics. The Consultant Medical staffing complement of 6 consultants when implemented will increase Labour Ward cover to 36 hours. Consultants normally visit at least once a day during Saturdays, Sundays and public holidays and more frequently as required There are escalation procedures which govern when a midwife or junior doctor call in a Consultant. Consideration needs to be given to the recommendation of twice a day visits over weekends and public holidays.	November 2008 September 2009 April 2010 June 2010 To be completed by 11th June 2010
Standard 7 Emergencies and Transfers					
All Trusts should have formalised written agreements in place with the NIAS on attendance at emergencies or when transfer is required	11	Formalised written agreements with NIAS on attendance at emergencies or when transfer is required.	Patricia McStay, Head of Midwifery & Gynaecology	There are protocols in place but these are not written protocols. NIAS have been contacted to agree same. Meeting agreed with ambulance service for 2nd June 2010 to develop written agreements.	9th June 2010

Trusts who do not have dedicated 24hr anaesthetic services should review their cover arrangements to ensure that there will be no delay in carrying out an emergency caesarean section	12	No dedicated anesthetic services	Ronan Carroll Assistant Director Acute Services, Cancer and Clinical Services Dr Charles McAllister, Clinical Director	Not achievable at the present time on either site with current staffing levels.	
Standard 8 Training and Education					
All Trusts must work to achieving an appropriate balance between managing rotas and providing protected time for training opportunities, for medical staff	13	Balance managing rotas and providing protected time for training opportunities for medical staff	Mr. Noel Heasley Clinical Director Mr. David Sim Clinical Lead	Medical Staff are released for mandatory and specialized training Dr Hogan to review with Mr Colin Weir, AMD Education and Training, Dr Geoff McCracken and Dr Karen McKinney.	4th June 2010
All Trusts must ensure records of Staffs attendance at mandatory and other training sessions are regularly reviewed and that line managers are made aware of the reasons for non-attendance at mandatory training	14	Ensure records of staff attendance at mandatory and other training sessions are regularly reviewed. Line Managers made aware of the reasons for non attendance at mandatory training	Patricia Mc Stay Head of Midwifery & Gynaecology	The IMWH Division has developed a database to record all training for midwives and mechanisms are in place to review attendance. Details of medical staff who have attended mandatory training is being collated on this database This database is currently being reviewed to facilitate accessibility to the record via a shared network for Ward Managers and other Managers. The Beeches Nursing & Midwifery in Service Education Unit do advise regarding attendances and highlight non attendance.	September 2009 30th June 2010

All Trusts should establish a skills inventory for midwifery staff	15	Establish a Skills Inventory for Midwifery Staff	Patricia Mc Stay Head of Midwifery & Gynaecology	The education and training required by Midwives have been mapped out. This has been used to populate a skills inventory for Midwives. Midwifery skills are monitored as part of Development Review	September 2009 Ongoing process
Standard 9 Environment and Facilities					
The proposed plan for the new maternity unit at the Royal Jubilee Site should be revisited to take account of increased throughput and of the potential for further increases in activity as a consequence of the plans to re-profile maternity services on the Lagan Valley Hospital site, which may impact on referrals to the Belfast Trust	16	N/A	N/A	N/A	N/A

All Trusts should explore further innovative ways to harness the views of service users and to utilise feedback from service users to bring about improvements in the birthing environment	17	Explore innovative ways to harness the views of service users Utilise feedback from service users to bring about improvements in the birthing environment.	Anne McVey Assistant Director Acute Services, Integrated Maternity & Women's Health	Maternity Services Liaison Committee well established in Newry & Mourne Locality and has informed the refurbishment of Delivery Suite DHH. Birthing Pool installed The Delivery Suite in CAH has been refurbished and service users have been involved in choosing the colour scheme and artwork. Birthing Pool installed Staff in conjunction with the Personal and Public Involvement team are developing processes to engage service users to bring service improvements.	1999 September 2008 March 2010 ongoing
Standard 10 Outcomes					
All Trusts should review their information needs for maternity services to ensure that they have systems to provide the data set out in the Safer Childbirth Standards and that this information is effectively shared with staff	18	Review information needs for maternity services to ensure systems to provide the data set out in the Safer Childbirth Standards and that this information is shred with staff.	Dr Gillian Rankin Interim Director of Acute Services	The Integrated Maternity & Women's Health Division has established an Information Group to review the information available from NIMATS, Child Health System and Information Department. The Information Group will ensure that the information required is available and is provided to staff to assist in the population of Maternity Dashboards etc	February 2010 ongoing
The DHSSPS, BSO and trusts should work together to develop the capabilities of the NIMATS and ensure that appropriate information is readily available on clinical outcomes as set out in the Safer Childbirth Standards	19	Develop the capabilities of NIMATS to ensure appropriate information is available on clinical outcomes as set out in the Safer Childbirth Standards	DHSSPS, BSO, Trusts	The Southern Trust has engaged a representative from DIS in the NIMATS Implementation Group to develop the capabilities of NIMATS.	September 2009

Chapter 7 Commentary and Policy Implications					
DHSSPS should consider the development of a strategy for the future development of maternity services in Northern Ireland reflecting increasing birth rate trends, changes in working patterns and developments in obstetric and midwifery practice	20	DHSSPS should consider the development of a strategy for the future development of Maternity Services in Northern Ireland	DHSSPS	The Minister for Health & Social Services announced a Review Of Maternity Services on 9th April 2010 to facilitate the development of a Strategy For Maternity Services in Northern Ireland. Mr Rice, Executive Director of Nursing is a member of the Review Team.	

Southern Health and Social Care Trust

Quality care – for you, with you

PERFORMANCE MANAGEMENT REPORT

Priority for Action
Standards and Targets

And

Key Corporate Performance Indicators

March 2011

Version:	1.0 For TB
Presented to Board of Directors:	21 April 2011
Author of report:	Dawn Livingstone
Presented by:	Paula Clarke

For Information/Approval

Approved by Board of Directors on 21st April 2011

TO: **Board of Directors**

FROM: **Paula Clarke Director of Performance & Reform**

DATE: **21 April 2011**

SUBJECT: **Monthly Performance Management Report**

SUMMARY OF KEY POINTS

Areas of red risk include:

- Fractures (Page 9)
- DRTT – Urgent within 2 days (Page 9)
- Renal: Dialysis via fistula (Page 11)
- Family Support Pathway Assessment (Page 17)
- Day Case Rate (Page 21)
- Unallocated Child Care Cases (Page 26)

WHICH TRUST CORPORATE OBJECTIVE DOES THIS PAPER PROGRESS OR CHALLENGE?			
Provide safe, high quality care.	*P*	Be a great place to work.	
Maximise independence and choice for our patients and clients.	*P*	Make the best use of resources.	*P*
Support people and communities to live healthy lives and improve their health and wellbeing.	*P*	Be a good social partner within our local communities.	

Indicate which of our key strategic objectives are progressed (P) or challenged (C)

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
We will treat people fairly and with respect.	*P*	We will value and give recognition to staff and support their development to improve our care.	
We will be open and honest and act with integrity.	*P*	We will embrace change for the better.	*P*
We will put our patients, clients, carers and community at the heart of what we do.		We will listen and learn.	

Indicate which of Trust values are progressed (P) or challenged (C)

RISKS, CONTROLS AND ASSURANCE	
Risk	Risks discussed at SMT on 16 March 11
Control	P
Assurance	P

(Indicate if: (i) new risk identified or risk is addressed (ii) if this provides/will provide control or assurance)

REVIEWED BY:	Date:
Senior Management Team	Presented to SMT 13 Apr 2011
User Forums / Community Groups whose views have been sought	

CONTENT

1.0 CONTEXT

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance for February against:

- Priority for Action (PfA) 2010/11 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance

New PFA standards and targets for 10/11 have been incorporated into this report.

The format of the report has been changed, to assist in review of the comprehensive range of PfA standards and targets which have been included in priority areas under the Access & Targets sections of the report.

2.0 REPORTING

The PfA standards and targets and KPIs of corporate performance are presented in this performance report within the key domains defined within the performance management framework.

- Access & Targets
- Efficiency
- Clinical and Social Care Quality
- Workforce – detailed reporting via HR & OD Directorate Report
- Finance – will be reported through the Monthly Finance Report

The level of performance will be assessed against 10/11 targets/KPIs, as follows:

	Standard / target achieved
	Standard / target substantially achieved
	Standard partially achieved / limited progress towards achievement of target
	Standard / target not achieved
	Not Assessed

In the 'trend' column, the colour shows the level of performance for the current month against the target whilst the arrow indicates the overall trend relative to the target.

3.0 SUMMARY REPORT

3.1 ACCESS & TARGETS

A summary of the performance against the PfA targets relevant to SHSCT are included in the table below. PfA Supplementary Targets reporting provides a quarterly update on quantitative targets.

PRIORITY AREA 1: IMPROVE THE HEALTH STATUS OF THE POPULATION AND REDUCE HEALTH INEQUALITIES

Early Years Intervention: by March 2011 Trust should ensure that the updated child health promotion programme is fully implemented. The impact of the programme will be measured through the Child Health System and the introduction of a new schedule of visits to be undertaken by Health Visitors

- **Progress/Actions –** The revised regional child health promotion programme is fully implemented. A revised Personal Child Health Record (PCHR) was introduced along with the UK-WHO growth chart In October 2010. The Trust intranet has been updated with further guidance and a Communication Strategy has been developed. However there are a number of constraining factors to full compliance:
  - the new CHS software should be available in April 2011 and following period of testing it will go live and this will enable full recording of the new contacts and relevant public health data. There are pressures in the local Child Health System offices to maintain the contacts on the system. A regional working group is progressing monitoring outcome/reports for the new programme;
  - universal antenatal notification to health visitors being developed from NIMATS to CHS;
  - the workforce capacity to deliver the revised universal programme with home based as opposed to clinic contacts alongside their safeguarding role and other responsibilities.

Bowel Cancer Screening: During 2010/11 Trust should establish on a phased basis a bowel screening programme for those aged 60 – 69 (to include appropriate arrangements for follow up treatment)

- **Progress/Action** –The Trust requires to be accredited by the Joint Advisory Group for Gastroenterology (JAG) in order to proceed with Bowel Screening. Pre-JAG accreditation identified the key constraints relating to
  - capacity – in terms of maintaining access times at 13 weeks (a paper has been submitted to the HSCB with proposals identified to reduce the access time to 13 and subsequently 9 weeks, should this be required);
  - facility – the ability to perform all scopes in one location on CAH site (business case was submitted for an endoscopy area, however interim options have been considered to extend and staff the day surgery unit on the CAH site);
  - leadership – the requirement to have a lead nurse for endoscopy and the Trust is currently recruiting this post.
    In addition the Trust requires to be Hine compliant for decontamination standards and the Trust has submitted a case to the Dept for approval. The Trust is currently working with the Regional Endoscopy Group to standardize protocols and procedures around the screening programme.

Screening for Abdominal Aortic Aneurysm: during 2010/11 Trust to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm

- **Progress/Action** – A Regional Workshop was held in October 2010 to investigate a range of suitable options. Trust awaits feedback on an agreed regional approach. (Guidance has not been implemented in NI as yet).

Emergency Preparedness: By March 2011, all relevant HSC organisations should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness

- **Progress/Actions** –An update to this has been submitted as part of the March 2011 Quarterly PFA Supplementary Target Reporting (Ref Section 3.4). No constraints were identified to meeting the target at that time.

Business Continuity Plans: By March 2011, each HSC organisation should ensure it has a fully tested and operational Business Continuity Plan in place

- **Progress/Actions** – An update to this has been submitted as part of the March 2011 Quarterly PFA Supplementary Target Reporting (Ref Section 3.4). The Trust Business continuity Plan has been updated in line with lessons learned following the adverse weather and flu surge experienced in December.

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
2.1 Anti-TNF: From April 2010 no patient should wait longer than 9 months to commence specialist drug therapies for treatment of severe arthritis **Comment:** Target Achieved														
Mar 10 **0**	**2010/11** **0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Target Achieved
2.2 Elective Access: By March 2011, no patient should wait longer than 9 weeks for a first OP appointment (incs. Non PAS consultant activity), 9 weeks for a diagnostic test (imaging figures only available from NIPACS from Oct onwards), and the majority of IP/DC treated within 13 weeks and no patient waits longer than 36 weeks for treatment; From March 2012 all reviews (outpatients) should be completed within the clinically indicated time. **Comment:** Total waiters >9 wks (OP & Diag), >13 wks (IP/DC) is the trust confirmed position at month end. Figure below i.e. 52 OP and 1 IP/DC is the actual numbers required to be treated to meet 9 and 13 week targets or in excess of backstop arrangements. Target for OP,IP/DC Substantially Achieved. Diagnostic Imaging and Non-imaging with the exception of Neurophysiology were Achieved														
Mar 10	**Mar 11**													
>9wks OP (all specs inc. those with backstop targets agreed)	**0**	**591**	**1633**	**2206**	**4288**	**5560**	**5611**	**6046**	**5681**	**6222**	**5967**	**5726**	**2834**	Substantially Achieved
(No's. waiting												**As at 26 Feb** **1516**	**As at 31 Mar** **52**	Substantially Achieved

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
over 9 weeks or in excess of backstop) **(Ophth, Oral Surg, Rheu, Dermatology, Paed Card)**														
Mar 10 **>9 wks Diag:-** **<u>Imaging</u>** **<u>Non-Imaging</u>** **(No's. waiting over 9 weeks or in excess of backstop) Neuro. Phys. Backstop 52 wks**	**Mar 11** **0**	**n/a** **2**	**n/a** **81**	**n/a** **230**	**n/a** **343**	**n/a** **453**	**n/a** **537**	**239** **610**	**255** **692**	**215** **71**	**184** **87**	**44** **92**	**0** **0**	Target Achieved Target Achieved
Mar 10 **>13 wks IP/DC** **(all specs inc. those with backstop targets agreed)** **(No's. waiting over 13 weeks or in excess of backstop)** **(Backstop Specialies – G. Sur, T&O, Urol, Gastro Scopes, G Surg Scopes, Pain Man, Rheu, Derm, Card)**	**Mar 11** **0**	**445**	**1079**	**1465**	**2012**	**2363**	**2841**	**3027**	**2986**	**3269**	**3289**	**3250** **As at 26 Feb** **94**	**2765** **As at 31 Mar** **4**	Substantially Achieved Substantially Achieved
Backlog Review OP **(incl. Paeds, MH)**		**19451**	**23606**	**24105**	**21967**	**20388**	**20039**	**19845**	**18933**	**19524**	**18591**	**17929**	**17500**	

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
2.3 Diagnostic Reporting: From April 2010 ensure all urgent diagnostic tests reported within 2 days, with 75% routine test being reported within 2 weeks 100% routine tests within 4 weeks.														
March 2010	**2010/11**													
Within 2 Days														
82%Imaging	**100%**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**78%**	**76%**	**81%**	**80%**	**88%**		
63% Non Imaging	**100%**	**51%**	**37%**	**42%**	**41%**	**55%**	**75%**	**64%**	**47%**	**49%**	**74%**	**81%**		⇧
Within 2 wks														
79% Imaging	**75%**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**91%**	**90%**	**92%**	**90%**	**92%**		
88% Non-imaging	**75%**	**91%**	**91%**	**90%**	**89%**	**91%**	**92%**	**91%**	**91%**	**88%**	**93%**	**93%**		⇔
Within 4 wks														
91% Imaging	**100%**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**98%**	**99%**	**98%**	**98%**	**98%**		
94% Non-imaging	**100%**	**94%**	**96%**	**95%**	**92%**	**92%**	**98%**	**95%**	**96%**	**93%**	**97%**	**97%**		⇧
2.4 AHP: From April 2010 no patient waits longer than 9 weeks for treatment. **Comment:** March breaches relate to OT (54) & S&L (27) – target not achieved. Orthoptics service has been re-profiled to 17 wks (2 >9 wks) – backstop achieved														
Mar 10	**2010/11**													
>9wks – 0P (all services inc. those with backstop targets agreed)	**0**	**24**	**93**	**71**	**70**	**85**	**60**	**126**	**102**	**439**	**439**	**388**	**83**	Substantially Achieved
(No's. waiting over 9 weeks or in excess of backstop)											**380**	**364**	**81**	Substantially Achieved
Agreed Backstop: Orthoptics 17 wks											**0**	**0**	**0**	Target Achieved
2.5 Fractures: From April 2010 95%, where clinically appropriate, should wait no longer than 48 hours for IP fracture treatment. **Comments:** Year end cumulative position 81.3% - Target Not Achieved														
April-Mar 10	**2010/11**													
78.4%	**95%**	**67.4%**	**82.9%**	**72.3%**	**82.5%**	**90.7%**	**84.3%**	**72.7%**	**75.5%**	**85.4%**	**84.5%**	**85.7%**	**88%**	Not Achieved

2.6 Cancer: From April 2010 urgent breast referrals seen within 14 days, 98% cancer pts commence treatment within 31 days, 95% of urgent referrals with suspected cancer begin first treatment within 62 days (Source: Web Portal). **Comment:** Performance against 62 day target has been affected by, downtime of regional PET scanner over the summer and the associated backlog, reduction in beds in Thoracic surgery and delays in oncology appointments. *Nb: To allow for the 62 day time lag responses are monitored one month in arrears*

Mar 10	**2010/11**													
14 days - 99%	**98%**	**100%**	**98%**	**98%**	**93%**	**98%**	**99%**	**100%**	**100%**	**100%**	**100%**	**100%**		⇔
31 days - 96%	**95%**	**95%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**99%**		⇩
62 days -100%	**100%**	**100%**	**98%**	**88%**	**100%**	**84%**	**92%**	**92%**	**86%**	**94%**	**94%**	**84%**		⇩

2.7 A&E: 95% of pts attending any A&E Dept. are either treated & discharged home or admitted within 4 hours of arrival. No patient will wait longer than 12 hours **Comment**: Target Partially Achieved on CAH site, Target Achieved on DHH site.

Apr-Mar 10	**2010/11**												
SHSCT 93%	**95%**	**90.1%**	**91.1%**	**91.2%**	**92.6%**	**91.4%**	**90.5%**	**90.5%**	**89.5%**	**86.3%**	**86.2%**	**86.5%**	**89.6%**	Substantially Achieved
CAH 90%	**95%**	**85.3%**	**86%**	**86%**	**88.7%**	**86.5%**	**84.7%**	**84.0%**	**81.9%**	**78.4%**	**77.3%**	**77.1%**	**82.8%**	Partially Achieved
DHH 94.5%	**95%**	**92.5%**	**94.5%**	**94.5%**	**94.7%**	**94.8%**	**95.3%**	**97.1%**	**98.4%**	**95.3%**	**95.7%**	**96.3%**	**95.4%**	Target Achieved
12 hr breach 4	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**5**	**0**	**0**	Substantially Achieved

2.8 Stroke Services: By March 2011 Trusts should ensure 24/7 access to thrombolysis, that high risk TIAs are assessed and treated within 24 hrs and by March 2011 Trusts should work towards door to neede times of 60 minutes for thrombolysis.
Comments: Thrombolysis**:** current service remains Mon – Fri DHH & CAH. All patients deemed suitable for thrombolysis received it within the 60 minute timeframe. Year 3 Stroke Business Case has now been approved, including revenue and capital requirements. Equipment has been ordered to support remote assessment for Thrombolysis. Recruitment is underway for Stroke Specialty for DHH to support delivery of Thrombolysis. Working to establish a 'shadow rota' for Thrombolysis in March 2011 for CAH and DHH. TIA: Currently operating Mon – Fri 2 patients per day. All high risk patients are seen within 24 hours of referral and are assessed at the TIA clinic. At weekends/public holidays within 24 hours on the day referred for assessment and treated within 24 hours or above from A&E. Stroke monitoring commenced in Feb 2011, provisional data has been forwarded to RHSCB for analysis and clarification on definitions; once this has been received figures will be included below.

	2010/11 Admin of Lysis - Within 60 mins – 100%													
	High Risk TIA - Assessed and Treated within 24 Hrs													

2.9 Renal Services: From April 2010 60% of patients should receive dialysis via a fistula														
Mar 10 40%	**2010/11 60%**	**41%**	**40%**	**39%**	**40%**	**43%**	**43%**	**43%**	**42%**	**43%**	**44%**	**44%**	**44%**	Not achieved
2.11 Health Care Associated Infections: In year to March 2011 Trust should secure further reduction of 20% in MRSA and C Difficile infections compared to position in 2009/10														
2009/10 MRSA 15 C Diff 47	**Mar 11 MRSA 14**	**0**	**1**	**2**	**2**	**1**	**0**	**2 Cum 8**	**0 Cum 8**	**2 Cum 10**	**1 Cum 11**	**0 Cum 11**	**0 Cum 11**	Target Achieved
	C Diff 47	**0**	**2**	**0**	**1**	**4**	**1**	**3 Cum 11**	**2 Cum 13**	**4 Cum 17**	**2 Cum 19**	**1 Cum 20**	**1 Cum 21**	Target Achieved

2.12 Hygiene & Cleanliness: from September 2010 Trust should have in place arrangements to routinely review compliance with updated and consolidation regional standards of hygiene and cleanliness. Trust review arrangements should include consideration at Trust Board

- **Progress/Action** – Quarterly update - March update reported in Quarterly PFA supplementary target report (Ref: Section 3.4)

2.13 Mortality: from September 2010, Trusts should put in place arrangements to routinely review standardised mortality rates, over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust Board

- **Progress/Action: COMPLETED** - Processes are well embedded in SHSCT to routinely review mortality rates with reporting via Governance Committee. High level reporting included in Clinical & Social Care Reporting Section 3.3, below
  Trust continues to work with PHA and HSC Board via the Medical Directors to agree how public mortality data will be presented. It is planned to produce a regional report in June 2011 based on last qtr of 2010. Trust Medical Directors have provided extensive feedback on proposed content..

2.14 Trust Quality Initiatives: from April 2010 Trust should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for

- ventilator associated pneumonia
- surgical site infections
- central line infection
- the crash call rate
- the prevention of venous thromboembolism, and
- mental health inpatient care

- **Progress/Action:** Discussions on NI Trust's Safety Priorities for 2011/12 will be held with the HSC Safety Forum in May 2011. The outcome of this work will result in the development of a Business Plan for the HSC Safety Forum for 2011/12, to be submitted to the Safety Forum Steering Group & DHSSPS for approval. Monitoring in place see section 3.3 below.

By July 2010 Trust should submit to PHA for approval and monitoring quality improvement plans to implement WHO Surgical Checklists in 80% of case by March 2011, and in collaboration with the HSC Safety Forum promote initiatives aimed at

o reducing the incident of falls and

- reducing the incident of medication errors

Progress/Action

- Quality improvement plans submitted to the PHA. Monitoring in place - Monthly auditing on Process & Outcome Measures continues with many positive results.

  A version of the WHO Checklist has been implemented in all theatres from December 2010. In March 87 of 93 cases were audited, overall compliance was 93.5% against the 80% target.

2.15 Patient Experience: Following the adoption of the Patient Client Experience standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools, and ensure appropriate reporting and follow up, consistent with the direction from the Public Health Agency.

- **Progress/Action** – Quarterly report for March to be approved by SMT (20th April).
  - Clinical areas where compliance has been tested now includes Acute Surgical, Medical and Gynae wards, Lurgan and South Tyrone Hospitals, Bluestone and Supported Living accommodation for clients with learning disability.
  - New methodologies were tested in Q4 including Observations of Practice and piloting of Learning Disability specific tool.

  An organisational audit of HR practices to support staff was also undertaken, to complement other methodologies of Patient Satisfaction Surveys and triangulation with compliments and complaints.

2.17 Service Frameworks: By March 2011 Action Plans should be in place to ensure the implementation of agreed standards from the Cancer Framework in accordance with guidance to be issued by the Department in October 2010.

- **Progress/Action** – The Cancer Services Framework has just been launched (Feb 2011) by the Minister. The Trust will commence an assessment against the standards to identify an action plan, to be finalised in early 2011/12.

SERVICES PRIORITY AREA 3: INTEGRATED PRIMARY, COMMUNITY AND SECONDARY CARE SERVICES														
Baseline	Target	Monthly Position												Trend
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
3.2 Timely Hospital Discharge From April 2010 90% complex discharges within 48 hours; no complex discharge will take longer than seven days; all other patients should be discharged within six hours **Comment:** NI Average in Jan – Complex 83%, Non-complex 96**%**														
Apr-Mar 10	**2010/11**													
48 Hrs - 96.2%	**90%**	**88%**	**94%**	**95%**	**99%**	**100%**	**97%**	**92%**	**96%**	**92%**	**96%**	**96%**	**95%**	Target Achieved
7 Days - 7	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**2**	**2**	**0**	**1**	**1**	Substantially Achieved
6 Hrs - 97%	**100%**	**96%**	**97%**	**96%**	**96%**	**96%**	**95%**	**96%**	**95%**	**94.4%**	**95.2%**	**95.6%**	**95.6%**	Target Achieved
3.4 Direct Payments By March 2011 number of direct payment cases increases to 1,750 – **Comment**: Year end position – Target Achieved														
Mar 10	**Mar 11**													
495	**339**	**510**	**514**	**518**	**514**	**509**	**520**	**525**	**530**	**523**	**536**	**546**	**556**	Target Achieved

3.3 Unplanned Admissions: By March 2011 50% of unplanned hospital admissions related to exacerbation of severe chronic conditions are reduced.

- **Progress/Action** - Trust submits a return quarterly to PMSID on the numbers who have commenced case management. Processes are now in place by the HF, Diabetes and COPD teams to capture valid information. The Trust has an agreed process to collate information for submission to PMSID.

3.4 Palliative Care: By March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.

- **Progress/Action** – The Trust Project Implementation Structure and membership has been agreed which includes key stakeholders within the Trust, hospice, nursing home sector and voluntary organisations. The steering group, the service modelling and delivery group and education and development subgroup have met. There has been a planning meeting for the systems, processes and datasets subgroup, with the first meeting to be held in April 11. The first meeting of the Trust Raising Awareness and Understanding group will also be held in April 2011.The Regional Palliative Care commissioning group has been established and chaired by Dr Jenny Gingles. A Service Improvement plan has been reviewed and agreed.
  Ongoing educational and development work includes Clinical Buddying programme for Specialist Practitioners; Palliative Care Awareness training and Palliative Care Learning Development Group.

  There is ongoing work within the systems processes and dataset subgroup to scope the information systems capturing information on palliative care, development of community Palliative Care nurse led clinics, implementation of NISAT into revised community palliative care records and practice, and CPI work..

PRIORITY AREA 4: HELP OLDER PEOPLE TO LIVE INDEPENDENTLY														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
4.1 Supporting People at Home: from April 2010 45% of people in care management have their assessed care needs met in a domiciliary setting. **Comment:** Target Achieved														
Mar 10 **45.2%**	**2010/11** **45%**	**46**	**46%**	**46**	**45**	**45**	**45**	**45**	**45**	**45%**	**45%**	**45%**	**45%**	Target Achieved
4.2 Assessment and Treatment of Older People: from April 2010 no older person with continuing care needs will wait - more than 8 weeks for a completed assessment, with the main components of care met within a further 12 weeks. Standard rolled over from 2009/10. **Comment:** Target Achieved														
Mar 10	**2010/11**													
8 wks - 100%	**100%**	**100%**	**100%**	**99%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	Target Achieved
12 wks - 100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	Target Achieved

4.3 Individualised Care Plans: from December 2010 Trust should ensure any patient receiving a new care package at home is provided with a copy of their individual care plan to enable them to understanding the level of care to be provided and who to contact if difficulties arise with care package arrangements.

- **Progress/Action** - The new individualised Care & Treatment Plan is now in use across any new domiciliary Care packages within OPPC & Disability Services. These Plans are patient centered and will provide individuals with information relating to the level of care to be provided and who to contact in the event of any difficulties arising with care package arrangements.

PRIORITY AREA 5: IMPROVE CHILDREN'S HEALTH & WELL-BEING														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
5.1 - Children in Care From April 2010 100% children admitted to **residential care** prior to admission should have had formal assessment & placement matched through Children's Resources Panel. **5.1a** - **Every child taken into care** should have a plan for permanence and timescale agreed within six months and formally agreed at the first six monthly LAC review. **Comment:** From July onwards figures are broken down by Emergency and Planned.														
Mar 10 **Residential Care Only - Assess / Placement 89% (8/9 children)**	**2010/11** **100%**	**50%** (2/4 children)	**0%** (0/3 children)	**-%** (0/0 children)	**100%** (3/3 children)	**100%** (1/1 children)	**100%** (0/0 children)	**100%** (2/2 children)	-% (0/0 children)	**100%** (1/1 children)	**100%** (3/3 children)	**100%** (1/1 children)		⇔
All Children - Permanency Plan - 75% (49/65) **Formal Agment - 67%**	**100% -ALL** **Emergency** **Planned**	**100%** (6/6)	**100%** (10/10)	**100%** (11/11)	**89%** (8/9) **83%** (5/6) **100%** (3/3)	**100%** (5/5) **100%** (1/1) **100%** (4/4)	**100%** (9/9) **100%** (4/4) **100%** (5/5)	**100%** (15/15) **100%** (8/8) **100%** (7/7)	**100%** (2/2) **100%** (2/2) **-%** (0/0)	**100%** (7/7) **100%** (3/3) **100%** (4/4)	**100%** (11/11) **100%** (7/7) **100%** (4/4)	**100%** (8/8) **100%** (2/2) **100%** (6/6)		⇔
5.2 Family Support Interventions (PSA 5.1) By March 2011 provide family support interventions to 3000 children in vulnerable families (Figures shown below each month are cumulative) **Comment:** Target Achieved														
Apr-Mar 10 **403 (cum)**	**Mar 11** **579 (cum)**	**32 + 129 = 161**	**71 + 258= 329**	**98 + 387 = 395**	**124 + 516 =640**	**147 + 645 =792**	**193 + 774 = 967**	**240 + 903 =1143**	**281 + 1032 =1313**	**329 + 1161 =1490**	**382 + 1290 = 1672**	**430 + 1419 = 1849**	**485 + 1548 = 2033**	Target Achieved
5.3 Care Leavers in ETE (PSA 5.2) From April 2010, ensure that at least 70% of care leavers aged 19 are in education, training or employment **Comment:** Please note that figures have been revised from April 2010 due to clarification of definitions from PMSID. Target Substantially Achieved														
Mar 10 **51.5% (17/33)**	**2010/11** **70%**	**64%**	**69%**	**69%**	**78%**	**79%**	**86%**	**81%**	**73%**	**74%**	**73%**	**76%**	**67%**	Substantially achieved
5.4 Care Leavers with Former Foster Carers (PSA 5.3) By March 2011 ensure at least 200 care leavers aged 18+ are living with their former														

PRIORITY AREA 5: IMPROVE CHILDREN'S HEALTH & WELL-BEING														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
foster carers or supported family. **Comment:** All figures have been revised in October to reflect the cumulative monthly position and to include young people over 21 currently in full time education still living with foster carers. Target Achieved														
Mar 10 **27**	**Mar 11** **37 cum.**	**29**	**31**	**31**	**31**	**33**	**35**	**35**	**37**	**38**	**40**	**43**	**43**	Target Achieved
5.5 Looked After Children on the Child Protection Register (PSA 5.4) By March 2011 Trust should ensure that the child protection status of all looked-after children on the current register is reviewed in line with Department guidance issued in April 2010. **Comment:** – Quarterly Update - reported in December Quarterly PFA supplementary target reports.														
Mar 10 **49**	**Mar 11** **47**	**53**	**50**	**48**	**59**	**56**	**60**	**59**	**58**	**45**	**44**	**35**		⇧
5.6 Family Group Conferences During 2010/11 ensure that at least 500 CYP Participate in a FGC (figures shown below each month are cum.)														
2009/10 **130**	**Mar 11** **96 cum.**	**1**	**13**	**20**	**31**	**35**	**51**	**63**	**71**	**78**	**89**	**95**		⇧
5.7 Assessment of Children At Risk and In Need: From April 2010 Child protection (allocation of referrals) – all Child Protection Referrals are allocated within 24 hours of receipt of referral; Child protection (initial assessment) – all child protection referrals are investigated and an initial assessment completed within 10 working days from the date of the original referral being received; Child protection (pathway assessment) – following the completion of the initial assessment, a child protection case conference is held within 15 working days of the original referral being received; Looked after children (initial assessment) – an initial assessment is completed within 10 working days from the date of the child becoming looked after; Family support (family support referral) – 90% of family support referrals are allocated to a social worker within 20 working days for initial assessment; Family support (initial assessment) – all family support referrals are investigated and an initial assessment completed within 10 working days from the date the original referral was allocated to the social worker; Family support (pathway assessment) – on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days. **Comment:**														
Allocation 24 hours	**100%**	**100%**	**97%**	**100%**	**98%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**		⇔
Assessment 10 days	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**		⇔
Case Conf. 15 days	**100%**	**92%**	**95%**	**100%**	**95%**	**100%**	**100%**	**100%**	**100%**	**81%**	**75%**	**96%**		⇧
LAC Assess 10 days	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**		⇔

PRIORITY AREA 5: IMPROVE CHILDREN'S HEALTH & WELL-BEING														
Baseline	Target	Monthly Position												Trend
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
FS Referral 20 days	90%	-	-	-	97%	88%	92%	95%	76%	100%	93%	93%		⇔
FS Investig. 10 days	100%	-	-	-	81%	93%	85%	59%	69%	66%	73%	53%		⇩
FS Pathway 20 days	90%	-	-	-	35%	48%	62%	63%	36%	50%	42%	65%		⇩

PRIORITY AREA 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
6.1 Unplanned Admissions (PSA 6.1) By March 2011 reduce the number of admissions to mental health hospitals by 10% **Comment:** Target Achieved														
2007/08	**Mar 11**													Target Achieved
1196	**90 per month**	**86**	**93**	**85**	**78**	**92**	**76**	**83**	**99**	**85**	**77**	**66**	**80**	
	1080 cum.	**86**	**179**	**264**	**342**	**434**	**510**	**593**	**692**	**777**	**854**	**920**	**1000**	
6.2 Assessment and Treatment (PSA 6.3) From April 2010 ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health, excluding psychological therapies, psychological therapies to sustain 13 week maximum wait. **Comment:** Target Not Achieved														
Mar 10	**2010/11**													Substantially Achieved
0	**0**	**6**	**0**	**0**	**20**	**24**	**9**	**24**	**31**	**49**	**65**	**108**	**1**	
0	**0**	**0**	**0**	**0**	**0**	**1**	**3**	**5**	**5**	**12**	**14**	**21**	**5**	Substantially Achieved
6.4 Learning Disability Resettlement (PSA 6.4) By March 2011 resettle 120 learning disability patients from hospital to appropriate places in community from March 2006 position. Nb: Includes Resettlements commenced **Comment**: Target Ahcieved														
Mar 07	**Mar 11**													Target Achieved
0	**-**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
2008/09	**23**	**22**	**22** **Cum. Position**	**22** **Cum. Position**	**22** **Cum. Position**	**23** **Cum. Position**	**23** **Cum. Position**	**23** **Cum. Position**	**23** **Cum. Position**	**23** Cum. Position	**23** Cum. Position	**23** Cum. Position	**23** Cum. Position	
18														
6.5 Hospital Discharge (includes MH & LD) From April 2010: 75% of admissions discharged < 7days; all other patients being discharged within max 90 days (Number shown is in excess of 90 days). All Mental Health patients discharged from Hospital to receive a follow-up visit within 7 days of discharge. **Comment:** 6 LD patients are currently delayed over 90 days given the difficulties in finding appropriate supported places in the community.														
2009/10	**2010/11**													
99.5%	**75% <7 days**													Target Achieved
	MH	**100%**	**100%**	**100%**	**99%**	**95%**	**99%**	**99%**	**96%**	**98%**	**97.5%**	**96.5%**	**99%**	Target Achieved
	LD	**100%**	**83%**	**100%**	**100%**	**100%**	**100%**	**50%**	**100%**	**100%**	**100%**	**80%**	**100%**	
	Excess of 90 Days													Substantially Achieved
1	**0 - MH**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	Substantially Achieved

PRIORITY AREA 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
91%	**0 - LD (MH follow-up visit) 100%**	**0 77%**	**0 86%**	**0 82%**	**0 83%**	**0 80%**	**0 88%**	**1 87%**	**0 92%**	**0 95%**	**0 85%**	**0 80%**	**0 Update awaited**	⇩
6.7 Respite Learning Disability (PSA 6.7): By March 2011 improve access to learning disability by providing an additional 125 respite packages by March 2011 compared to March 2008 total. **Comment:** Trust has over performed against this target														
2009/10 31 (cum from 08/09)	**2010/11 24**	-	-	-	-	-	-	-	-	**34 cum.**				Target Achieved
6.8 Respite Dementia: By March 2011 provide an additional 1200 dementia respite places by March 2011 compared to March 2008 total. **Comment:** Trust has over performed against this target														
2009/10 1316 (cum from 08/09)	**2010/11 232**	-	-	-	-	-	-	-	-	**1599 cum.**				Target Achieved
6.9 Respite Physical and Sensory Disability (PSA 6.5): During 2010-11improve access to Physical/sensory disability by providing an additional 110 respite packages compared to March 2008. **Comment:**														
2009/10 31 (cum from 08/09)	**2010/11 21**	-	-	-	-	-	-	-	-	**20.6 cum.**				March Update awaited
6.10 Wheelchairs (PSA 6.6) By March 2011 ensure a 13 week maximum waiting time for all wheelchairs including specialist wheelchairs. **Comment:** The target is difficult to achieve within the timescales where clients require postural management systems.														
Mar 10 97%	**Mar 11 100%**	**96%**	**98%**	**98%**	**100%**	**98%**	**71%**	**90%**	**91%**	**74%**	**71%**	**90%**	**91%**	Substantially achieved
6.11 Housing Adaptations (Major Housing Adaptations) From April 2010 all lifts/ceiling track hoists to be installed within 22 week of OT assessment/option appraisal. **(Minor Housing Adaptations)**From April 2010 all minor urgent works to be completed within 10 days - New target. **Comment**: During February the RHSCB are meeting with all the Trusts to review the Housing Adaptations current performance, validate the information returned alongside the data definitions, confirm the expected performance at the end of the year and understand the reasons for any potential problems. Target Substantially Achieved														
Mar 10	**2010/11**													
100%	**100%**	**-**	**60%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	Substantially achieved Substantially achieved

PRIORITY AREA 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
87.2%	**100%**	**100%**	**98%**	**100%**	**100%**	**87%**	**90%**	**100%**	**93%**	**92%**	**97.6%**	**100%**	**100%**	
6.12 Autism From April 2010 ensure that all children wait no longer than 13 weeks for assessment, and a further 13 weeks for commencement of specialist treatment **Comment:** Assessment Target Substantially Achieved; Treatment Target Achieved														
Mar 10	**2010/11**													
Asmnt. >13 -0	**0**	**0**	**0**	**0**	**0**	**5**	**6**	**12**	**11**	**0**	**0**	**4**	**3**	Substantially achieved
Treat. >13 - 0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Target Achieved
6.13 Acquired Brain Injury From April 2010 ensure a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment														
Mar 10	**2010/11**													
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Target Achieved

Note: No target has been set in 10/11 PFA targets in relation to Mental Health Resettlement.

6.3 Card Before You Leave: from April 10, Trust should ensure that all adults and children who self harm and present for assessment at A&E are offered a follow-up appointment with appropriate mental health services within 24 hours.

Progress/Action - The Trust are now offering fixed appointments for all those aged 18yrs and over discharged from A&E with CBYL scheme. The Trust is compliant with the PfA target. The regional group has met to review the monthly return template and have agreed several amendments that will be implemented from April 2011 onward.

6.6 Eating Disorders: Further enhancement of a regional approach to eating disorder services recognising the need for specialist provision, and at least a 10% reduction in extra contractual referrals.

- **Progress/Action** - update to follow.

6.14 Domestic violence: during 2010-11, each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences

- **Progress/Action -** Reported Quarterly – Update in Quarterly PFA Supplementary Target Report (Ref: Section 3.4) - All cases are reviewed in line with Guidance (Protecting Looked After Children) which was issued on the 1 September 2010 by DHSSPS for implementation. The Trust continues to attend 100% of MARACs.

PRIORITY AREA 7: ENSURE FINANCIAL STABILITY AND THE EFFECTIVE USE OF RESOURCES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
7.4 Day Case Rate (PSA 7.2) By March 2011, all Trusts are required to achieve an overall day surgery rate of not less than 75% for the 'basket' of 24 procedures. **Comment:** Monthly figures may change as coding is updated. Work is being progressed to formalise a Trust Action Plan														
Apr 09-Mar 10 Cum. (CHKS) SHSCT - 60.3% Peer 77%	**Mar 11 75% (Source: SHSCT) Source: CHKS**	**58% 75.6%**	**66% 75.9%**	**66% 77.8%**	**60% 75.8%**	**59% 74.0%**	**59% 77%**	**63% 74.2%**	**64% 76.2% (2nd subm.)**	**65% 76.2% (3rd subm.)**	**71%**	**67%**	**62%**	Not Achieved
7.6 Absenteeism (PSA 7.2): Each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.Reflects agreed target reduction to 5.2% as noted in 2009/10 PFA.														
2009/10 5.05% (cum % days lost)	**Mar 11 5.2% (cum. days lost)**	**4.77%**	**4.59%**	**4.57%**	**4.52%**	**4.54%**	**4.59%**	**4.68%**	**4.75%**	**4.83%**	**4.94%**	**4.95%**		⇔
7.8 Cancelled Operations: from April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons. **Comments:** Significant number of cancelled operations in December due to adverse weather conditions.														
Apr 09 – Mar 10 Pre-op N/A Can. Ops	**2%**	**1.1%**	**1.0%**	**0.6%**	**1.4%**	**1.6%**	**0.8%**	**0.7%**	**1.1%**	**3.2%**	**1.4%**			⇔

7.1 Financial Breakeven (PSA 7.1): during 2010-11, the Department and all HSC organisations should live within the resources allocated and achieve in-year financial breakeven and establish a medium and longer-term financially sustainable position.

- **Progress/Actions** – Reported in Monthly Finance Report.

7.2 Efficiency Savings (PSA 7.1): from April 2010, the HSC Board and Trusts should establish effective arrangements to ensure the full delivery of agreed efficiency savings during 2010/11.

- **Progress/Actions** – Reported in Monthly Finance Report.

7.3 Hospital Productivity (PSA 7.2): each Trust should achieve a 3% improvement in hospital productivity, from its 2006/07 base year, for each year over the CSR period.

- **Progress/Actions** – Reported in Monthly Finance Report.

7.5 Pre-Operative Length of Stay (PSA 7.2): Departmental target for March 2011: Trusts will be expected to ensure, by March 2011, an overall admission on the day of surgery rate of not less than 75% for all elective procedures) (excluding day surgery activity and urgent admissions) – target will be monitored regionally. SHSCT working towards implementing local monitoring arrangements.

- **Progress/Action** –Regional monitoring shows, the southern Trust is admitting 85 % of its surgical patients on the morning of their procedure. This has improved from 40% to 85% since July 2009. On a daily basis the number and percentage of patients admitted on the day is monitored and reported to the Head of Service and Assistant Director for Surgery and Elective care. Those admitted on the day before surgery are monitored to ensure that they are admitted in accordance with clinical need. There is also a daily focus in maximising the number of patients who can safely be discharged on the same day of their procedure. For those clinically requiring to stay overnight, a target of 23 hour length of stay is aimed for.

7.9 Staff Health and Wellbeing: all HSC organisations should put in place organisational health and well being strategies including being pro-active in improvement the quality of and speeding up access to occupational health services, and strengthening board accountability for the management of sickness and absence

- **Progress/Action** – Reported in Director of Human Resources Monthly Report.

3.2 EFFICIENCY

This domain includes reporting on key performance indicators on efficiency

- Operational Processes
- Functional Processes
- Service & Budget Agreement

Operational Processes

EFFICIENCY – OPERATIONAL PROCESSES

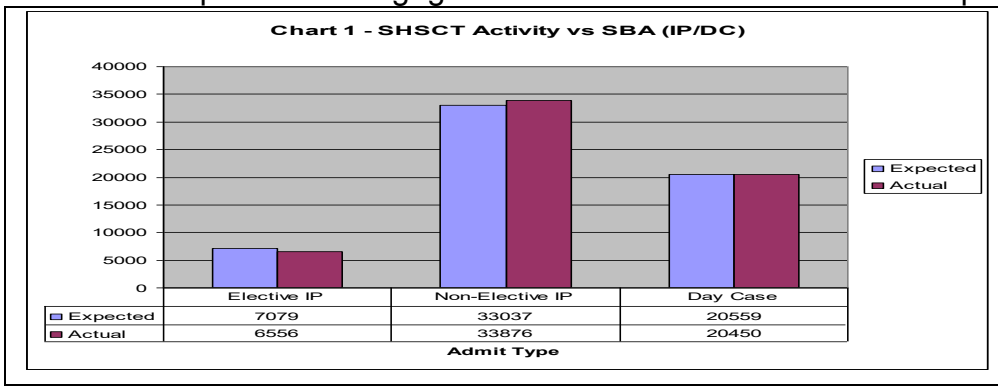
Baseline	Target	Monthly Position												Trend
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Average LOS Episodic Average Length of Stay for Elective and Non Elective Admissions to Hospital. **Comment:**														
2009/10	**TBA**													
Non-elec 5.68		**4.77**	**6.87**	**7.08**	**5.96**	**5.5**	**4.98**	**4.77**	**5.15**	**5.04**	**4.9**	**4.4**		
Elective 1.04		**0.85**	**0.81**	**0.9**	**0.77**	**0.89**	**0.78**	**0.79**	**0.72**	**0.80**	**0.83**	**0.95**		
OP DNA % Patients who 'Did Not Attend' an OP appointment and did not advise the hospital in advance. **Comment:** SHSCT OP DNA rate compares favourably against the peer.														
2008/09 (CHKS)	**(Apr-Mar10)**													
SHSCT – 7.3%	**SHSCT – 6.5%**	**6.3%**	**6.1%**	**6.5%**	**8.2%**	**7.5%**	**7.4%**	**6.9%**	**7.6%**	**10%**	**7.4%**	**6.7%**		
Peer - 8.7%	**Peer - 8.9%**	**9.0%**	**9.0%**	**9.2%**	**9.1%**	**9.0%**	**9.3%**	**8.7%**	**9.1%**	**10.7%**	**9.0%**	**8.3%**		
Partial Booking of OP Appointments % Consultant Led New and Review Appointments partially booked (Excs. Obstetrics); **%** Community led New and Review Appointments partially booked.														
March 08	**Tgt - Sept 08**													
Con. Led														⇩
New - 94.1%	**100%**	**96.6%**	**95.4%**	**95.6%**	**95.1%**	**94.7%**	**95.9%**	**96.4%**	**96.8%**	**96.5%**	**96.4%**	**95.1%**		⇩
Review - 72%		**88%**	**89%**	**88%**	**88%**	**89%**	**90%**	**89%**	**89%**	**87%**	**89%**	**88%**		
Comm. Led														
New - 54.8%		**85.7%**	**86.3%**	**87.7%**	**94%**	**89.4%**	**93.8%**	**90.8%**	**90.6%**	**85.1%**	**90.5%**	**85.5%**		⇩
Review - 4%		**45%**	**45%**	**44%**	**45%**	**41%**	**45.7%**	**45%**	**46%**	**46%**	**52%**	**56%**		⇧
KPI: % Discharges Coded cumulative coding position. **Comment:** Clinical coding Apr-Sept is low as coding resources were focused on 2009/10 backlog.														
March 2008/09	**Target**													
98.4%	**100%**	**39.7%**	**41.0%**	**39.8%**	**56.6%**	**63.6%**	**67.9%**	**73.7%**	**75%**	**73.9%**	**74%**	**76%**	**76%**	Partially Achieved

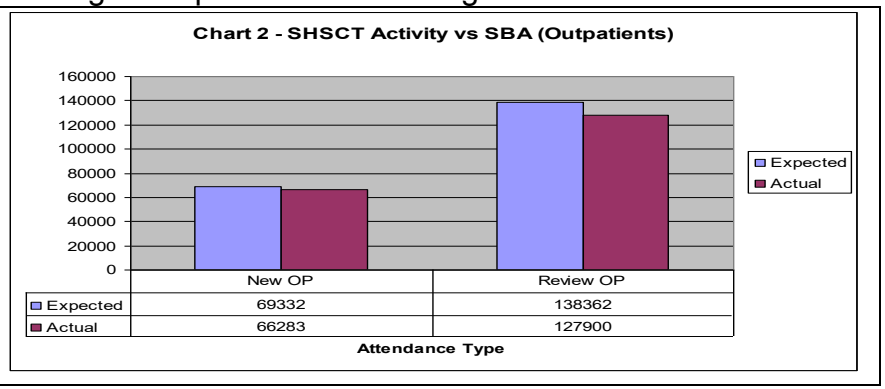
Functional/Support Processes

EFFICIENCY – FUNCTIONAL/SUPPORT PROCESSES														
Baseline	**Target**	**Monthly Position**												**Trend**
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
KPI: Freedom of Information (FOI) % requests responded to within 20 days **Comments:** 23 requests responded to in Jan 2011. 5 responses were overdue (22%).														
SHSCT Baseline 2008 87.5% **(Regional range 50% - 95%)**	**Target 100%**	**78%**	**100%**	**77%**	**86%**	**82%**	**79%**	**79%**	**46%**	**53%**	**73%**	**78%**	**91%**	Partially Achieved
KPI: Complaints 72% of complaints responded to within 20 working days *Nb: To allow for the 20 day time lag this position is being reported a month in arrears*														
March 08 65.6%	**Target 72%**	**73%**	**72%**	**64%**	**66%**	**68%**	**67%**	**70%**	**68%**					⇩
KPI: IT Helpdesk Response Calls received by IT Service Desk resolved on first contact. Measured against the baseline at March 2009 *Nb: Temporary capacity gap in trained staff available is impacting on achievement of this target* **Comment:**														
SHSCT Baseline March 2009 6.61%	**Target 33%**	**18.5%**	**13.3%**	**15.4%**	**17.8%**	**15.3%**	**15.5%**	**7.49%**	**8.30%**	**8.77%**	**17%**	**24.4%**	**30.6%**	Partially Achieved
KPI: Health & Care Number % Population of H+C number on all patient/client information Systems *Nb: Regional comparators are not yet available*														
Dec 08 Baseline 96%	**Internal Target 100%**	**93.00%**	**93.00%**	**93.00%**	**93.00%**	**93.00%**	**93.00%**	**93.00%**	**93%**	**93%**	**93%**	**93%**	**93%**	Substantially Achieved

SERVICE AND BUDGET AGREEMENT (APRIL-FEBRUARY 2011)

This summary report relates to hospital inpatient, day case and consultant-led outpatient activity performance against agreed Service and Budget Agreement (SBA) volumes. The charts provide a summary of performance by admit and attendance type for the cumulative period April – February 2011. Activity excludes any additional in-house sessions undertaken which is outside core funded SBA baselines. The HSCB had indicated in 10/11 that Trusts would be paid for over performance, above 102% of the baseline, at 50% of the relevant SRF/specialty cost. In addition Trusts would be penalised for underperformance, below 98%, of the SBA at the same rate. Trusts have recently been informed that the necessary financial model needed to implement this will not be in place for this financial year. In this shadow year the SHSCT will continue to monitor its performance monthly, against the original intention, in order to focus and work with areas which indicate potential risk in any new model. HSBC have initiated a major regional review of SBA capacity to assess the current funded level of capacity of all acute services and to define what additional activity can be provided if performance increased and what capacity gaps or excesses exist. The outputs will be shared with Trusts in March and a process of engagement will follow to determine the impact and agree implementation arrangements.





Summary of Costed Performance by Admit Type

Table 1 reflects an underperformance equating to £1.6m in financial terms. All variation in performance is currently being reviewed by Divisions.

Table 1

ADMIT TYPE	EXPECTED	ACTIVITY	VARIANCE	% VARIANCE	Costed Variance
Non-elective IPs	33037	33876	+839	2.54%	£269,256.52
Elective IPs	7079	6556	-523	-7.38%	-£763,021.74
Day Cases	20559	20450	-109	-0.53%	£129,835.98
Births	5385	5374	-11	-0.21%	-£22,833.33
New OP	69332	66283	-3,049	-4.40%	-£268,581.73
Review OP	138362	127900	-10,462	-7.56%	-£925,130.45
			Net Gain/Loss		**-£1,580,475**

3.3 CLINICAL AND SOCIAL CARE

This domain includes reporting on qualitative key performance indicators and provides further detail on Patient Safety & HCAI targets:

- Social Care/Children's Services
- Patient & Client Satisfaction
- Patient Safety (Quality Improvement Targets)
- Health Care Associated Infection
- Clinical Indicators

SOCIAL CARE/CHILDREN'S SERVICES

Baseline	Target	Monthly Position												Trend
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Foster Carers Number of foster carers in SHSCT														
Mar 06 **217**	**Mar 10** **275**	**292**	**98**	**296**	**290**	**299**	**303**	**295**	**294**	**296**	**303**	**300**		⇧
Looked After Children Number who received no statutory visit														
Mar 08 **6**	**Target** **0**	**1**	**1**	**1**	**2**	**3**	**3**	**0**	**7**	**3**	**3**	**0**		⇧
Child Protection Registrar Number of children on CPR over 2 years														
QE Mar 09 **7.4% (31/420)**	**Target** **TBA**	**35**	**26**	**22**	**28**	**35**	**37**	**33**	**30**	**33**	**29**	**29**		
Unallocated Child Care Cases Number of unallocated cases														
Apr 08 - 37 **Apr 09 - 119**	**Target** **0**	**218**	**187**	**213**	**231**	**205**	**252**	**206**	**242**	**254**	**201**	**173**	**179**	Not Achieved

Carers Assessments Offered and Completed Target 1: No of Care Assessments offered ***(which includes new and existing cases making in some instances the numerator higher than the demoninator hence a % higher than 100%)*** as a % of Social Work involvement (or integrated teams) opened (current cases only); Target 2: % of assessments accepted as a % of those offered *Nb: Agreement for actual methodology for monitoring is under review*
Comments: Targets below relate to SHSCT locally agreed targets.

		QE June 2010			QE Sep 2010			QE Dec 2010			QE Mar 2011			Year 10'11 to date		
POC	**Target 1**	Assess-ments Offered [completed & declined]	Current Involve-ment Opened	Target 1	Assess-ments Offered [completed & declined]	Current Involve-ment Opened	Target 1	Assess-ments Offered [completed & declined]	Current Involve-ment Opened	Target 1	Assess-ments Offered [completed & declined]	Current Involve-ment Opened	Target 1	Assess-ments Offered [completed & declined]	Current Involve-ment Opened	Target 1
CWD	85%	30	22	136%	34	19	179%	35	29	121%				99	70	141%
CFC	5%	2	1017	0%	7	939	1%	52	893	6%				61	2849	2
Young Carers	-	36	0	-	35	0	-	38	37	103%				109	37	294%
Elderly	30%	212	226	94%	151	225	67%	106	190	56%				469	641	73%
MH	30%	73	292	25%	50	154	32%	24	143	17%				147	589	25%
LD	75%	54	7	771%	50	2	2500%	75	4	1875 %				179	13	1377 %
Phy Dis	85%	81	38	213%	61	23	265%	38	47	81%				180	108	167%

Sen Imp		76	88	86%	88	58	152%	49	59	83%				213	205	104
POC	**Target 2**	Assess-ments Accepted [assessments completed]	Assess-ments Offered [completed & declined]	Target 2	Assess-ments Accepted [assessments completed]	Assess-ments Offered [completed & declined]	Target 2	Assess-ments Accepted [assessments completed]	Assess-ments Offered [complet ed & declined]	Target 2	Assessments Accepted [assessments completed]	Assess-ments Offered [complet ed & declined]	Target 2	Assessments Accepted [assessments completed]	Assess-ments Offered [complet ed & declined]	Target 2
CWD	52%	21	30	70%	34	34	100%	30	35	86%				85	99	86%
CFC	52%	2	2	100%	5	7	71%	8	52	15%				15	61	25%
Young Carers	-	28	36	78%	33	35	94%	32	38	84%				93	109	85%
Elderly	52%	90	212	42%	49	151	32%	24	106	23%				163	469	35%
MH	52%	41	73	56%	27	50	54%	14	24	58%				82	147	56%
LD	52%	29	54	54%	25	50	50%	18	75	24%				72	179	40%
Phy Dis	52%	70	81	86%	53	61	87%	35	38	92%				158	180	88%
Sen Imp		15	76	20%	7	88	8%	6	49	12%				28	213	13%

PATIENT / CLIENT SATISFACTION – Qtr 4 Report to follow

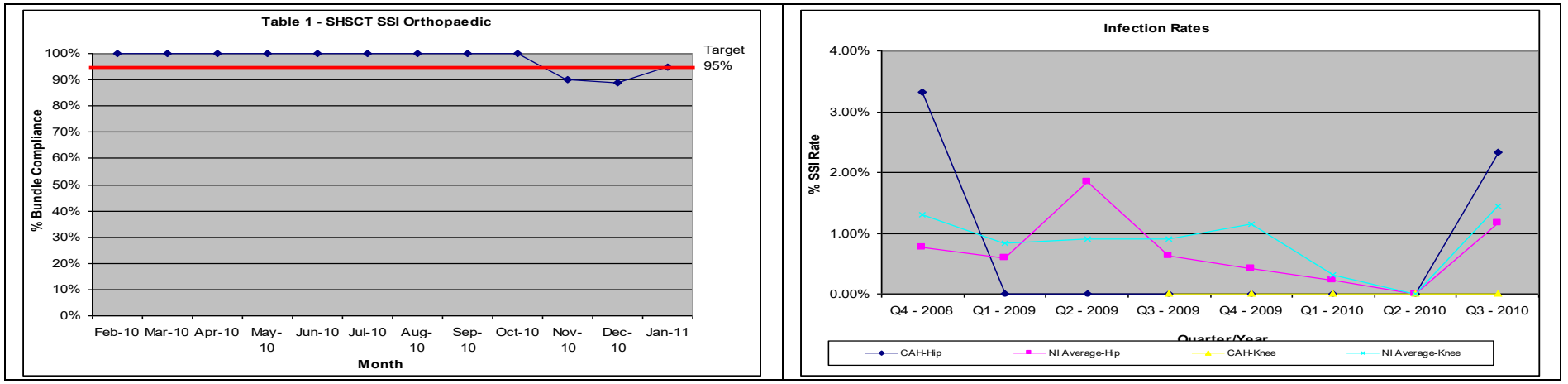
The Trust has now completed phases 1-4, testing the patient satisfaction survey across a number of acute, non-acute and acute mental health wards. The table, below, details the aggregate findings against the 5 standards using the agreed RAG rating (Red <80%, Amber 80-89% and Green >90%). Key performance indicators with lower compliance rates have informed team based multidisciplinary action plans and staff training, as appropriate.

PATIENT SAFETY (QUALITY IMPROVEMENT TARGETS) – update to follow

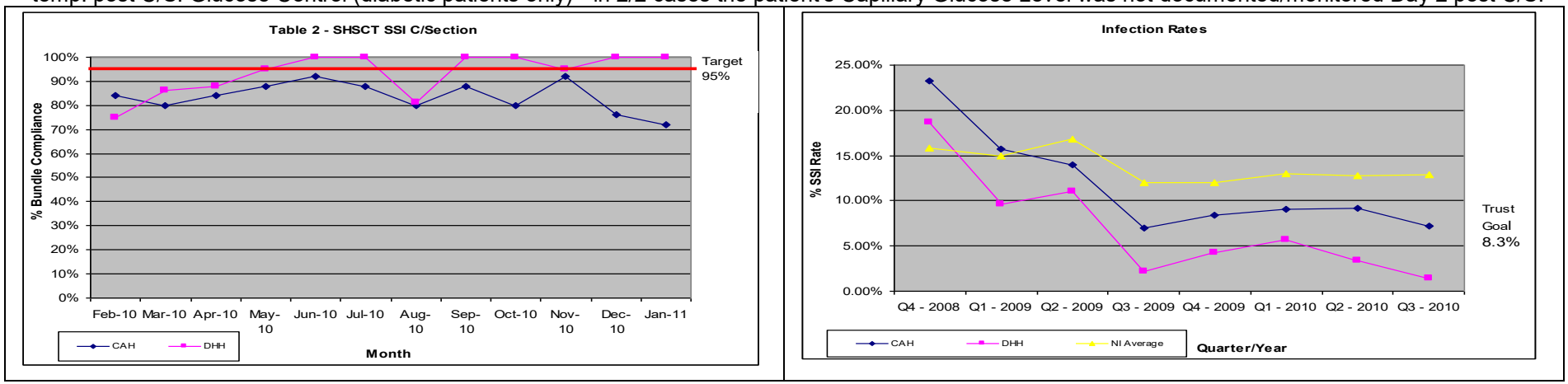
PFA 2.14 – Trust Quality Initiative: PMSID have introduced a new format for QIP reporting.

Surgical Site infections(SSI) Bundle compliance rate -orthopaedics (all elective hips & knees); **SSI rate** (Hips only); **Bundle Compliance rate** -Caesarean Section (audit of 20 cases per month; **SSI Rate** (C-section).

Comment: Overall Bundle Compliance was 95% (19/20 patients audited). Non-compliance element - On 1 occasion the method of hair removal was not documented.



Comment: Non-compliant elements - appropriate hair removal (3/25) - In 1 case the mother had self-shaved prior to her elective C/S & in 2 other cases no method of hair removal was documented, and there was no evidence in the mother's chart that she had received copies of the Trust's Information Leaflets, which address appropriate hair removal. Normothermia in 3/25 cases there was an unacceptable delay in recording & monitoring the mother's temp. post C/S. Glucose Control (diabetic patients only) - in 2/2 cases the patient's Capillary Glucose Level was not documented/monitored Day 2 post C/S.

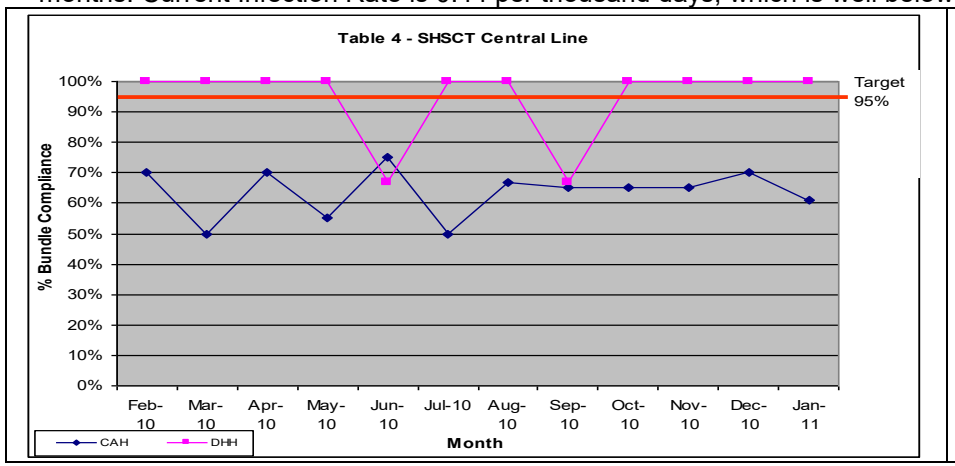


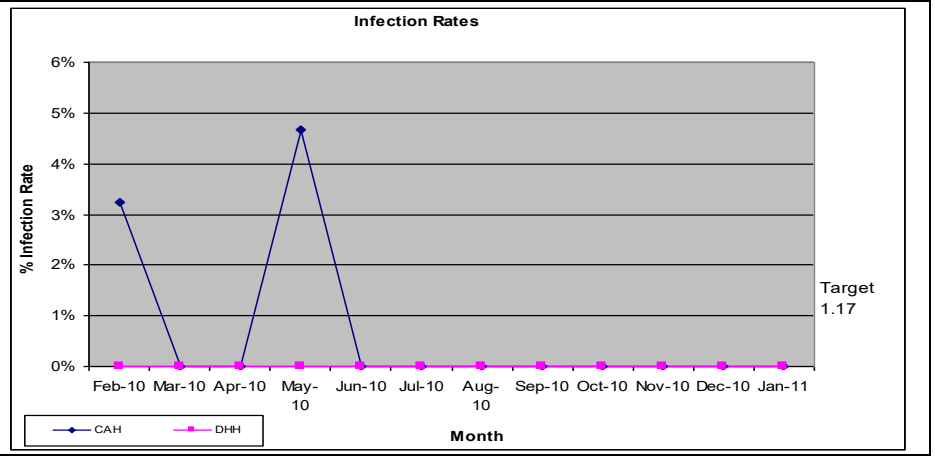
Central Line Infections - Infection Rate per 1000 line days; Compliance with bundle

This target measures the number of central line catheter-related bloodstream infections. Measurement reflects all Central Lines at CAH & DHH and compliance with the care bundle elements. Figures fluctuate month on month.

Targets may be reviewed following approval of QIP.

Comment: DHH 100% compliant. ICU, CAH 88% compliant, Non-compliant element - Daily Review of Line(1/8pts), not being documented as being checked every day. CAH, Excl ICU 40% compliant - Non-compliant elements - Large Drape not used (1/10pts), Subclavian site not used & no contraindication documented (2/10 pts) & Daily Review of Line (4/10pts), not being documented as being checked every day. The Trust has been infection free for the past 8 months. Current Infection Rate is 0.44 per thousand days, which is well below the target for 10/11 of 1.17 per thousand line days.

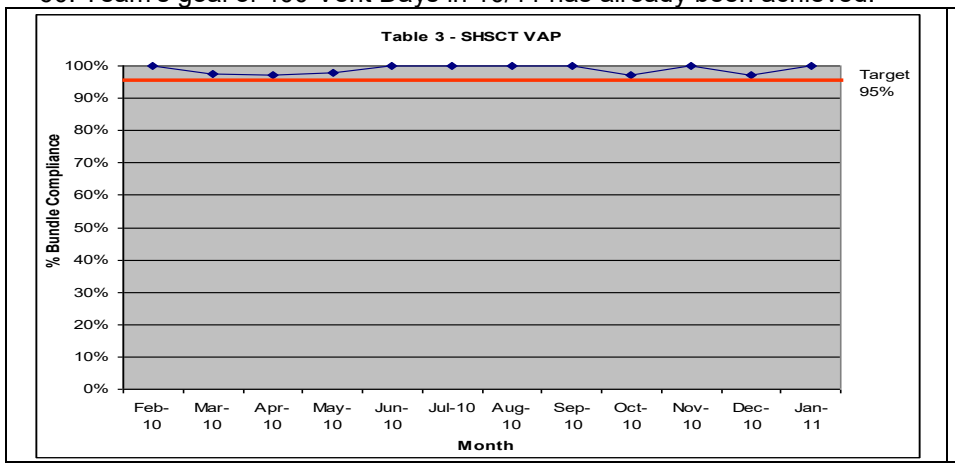


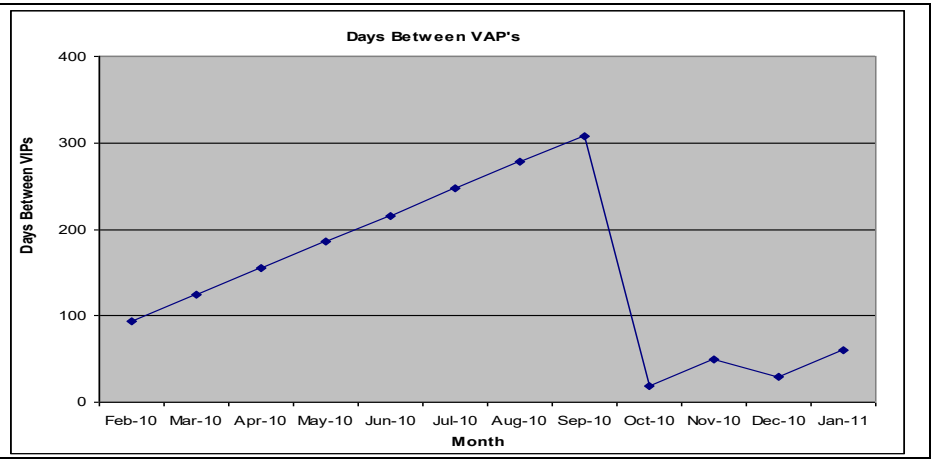


Ventilator Acquired Pneumonia (VAP) - Ventilator days between infections; Compliance with bundle.

This target aims to achieve 95% compliance with all bundle elements in ICU in CAH. Targets may be reviewed following approval of QIP.

Comment: Overall Bundle Compliance 100% (31/31patients audited). Vent Days since last VAP (2nd December 2010) 308. Calendar Days since last VAP 60. Team's goal of 400 Vent Days in 10/11 has already been achieved.

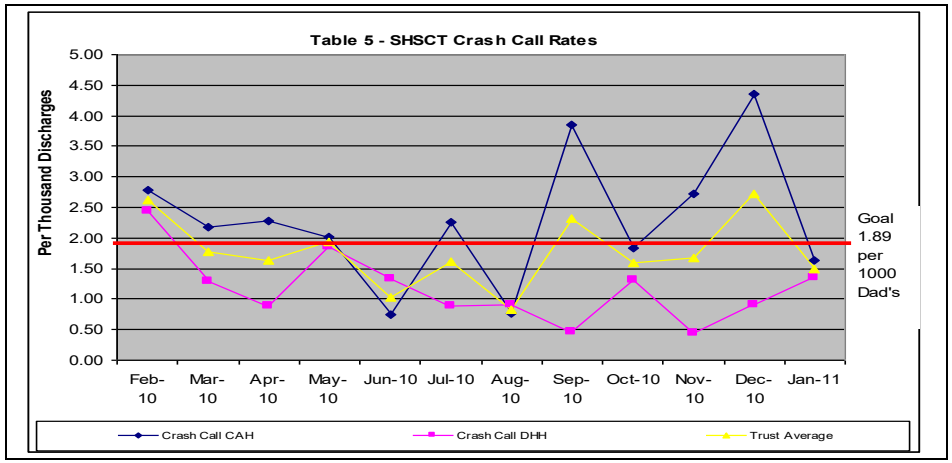




Crash Call Rate -Rate per 1000 deaths/discharges. Monitoring rolled over from 2008/09.

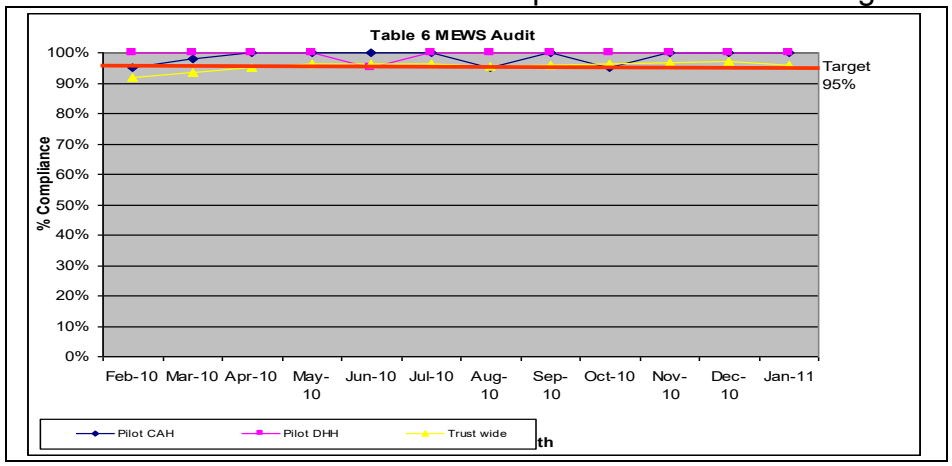
This QIP target is focused on reducing crash calls in A&E, ICU and coronary care. Targets may be reviewed following approval of QIP.

Comment: The Trust's cumulative Crash Call Rate for 10/11 currently stands at 1.69 per thousand deaths/discharges, which is under the Trust Goal of 1.89 per thousand deaths/discharges.



MEWS Modified Early Warning Scoring System- 95% Trust Wide Compliance -

Comment: Trust-wide MEWS compliance was above the goal of 95% for the 9th consecutive month in January 11.



Mental Health Indicators -%compliance with multi-disciplinary review; %compliance with risk assessment; %compliance with patient/carer involvement in TP.

These targets focus on inpatient review, assessment and compliance with patient/carer involvement in treatment planning.

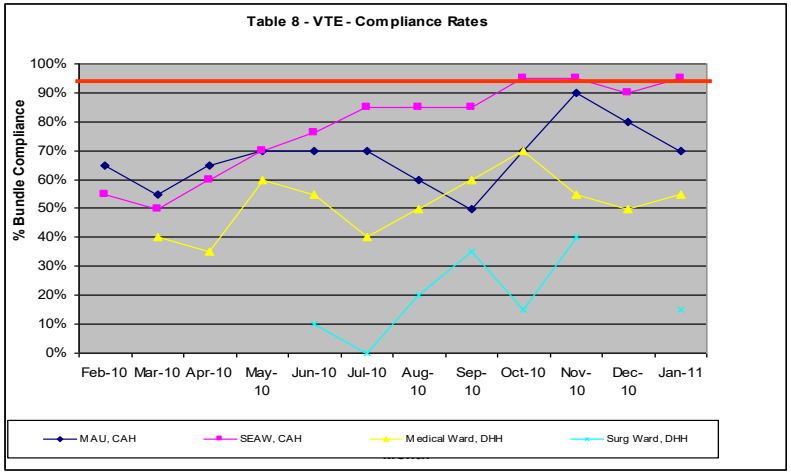
Comment: Mental Health – A Multi-disciplinary review was completed for all 33 patients however not all aspects were fully completed. All patients had a risk assessment with 26/33 patients having all aspects of risk assessment fully completed. All 33 patients had a Care Plan completed.

Mental Health						
Target: To ensure 95% overall Compliance with weekly MDT reviews in each acute admissions unit by March 2011						
Target: To ensure 95% compliance with overall risk assessment in each acute admissions unit by March 2011						
Target: To ensure evidence that 95% of patients are involved in the plan of their care/treatment in each acute admissions unit by March 2011						
Target Area	**Segmentation Area (Area/Wards/Patients to be included)**	**Total Number of Patients/Cases during Month**	**Sample Size**	**% Compliance with Multi-Disciplinary Review**	**% Compliance with Risk Assessments**	**% Compliance with Patient/Carer Involvement in TP**
Southern Trust	Bluestone Unit, CAH & Ward 3, St. Lukes, Armagh	U/K	33	88%	79%	100%

Venous Thromboembolism (VTE)

To ensure 95% compliance with the VTE Risk Assessment and appropriate thromboprophylasis in each of the pilot areas by 31 March 2011.

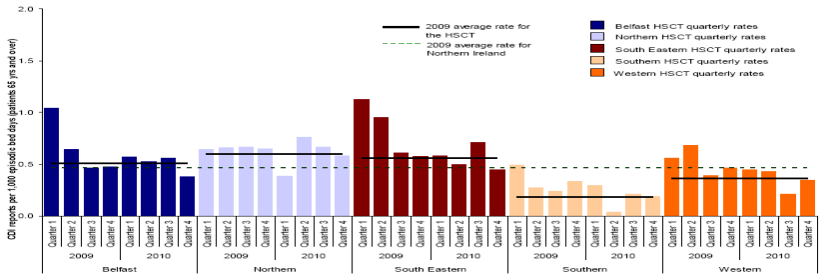
Comment: VTE - Appropriate Prophylaxis - 2 of 4 Pilot Wards achieved goal of 95% compliance or higher, the other 2 narrowly missed the target. Documented Risk Assessment - 1 of 4 Pilot Wards achieved goal in Jan 11 while 1 other scored 75% compliance. The 2 remaining achieved 55% & 15% only.



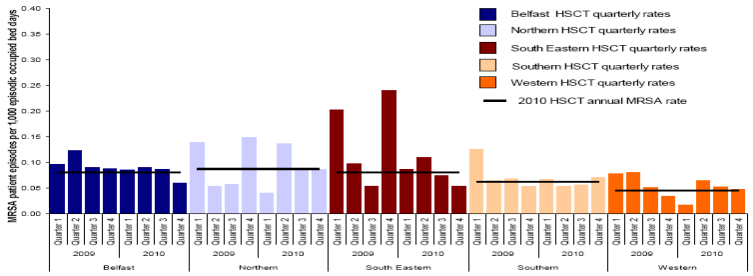
HEALTH CARE ACQUIRED INFECTION

To provide a comprehensive assessment of performance against healthcare associated Infections a multi-dimensional view of performance is required. The following information is monitored by the Trusts Strategic Forum and Clinical Forum in line with the new Trust arrangements for the strategic management of healthcare associated infection. Regional comparative information is collated and validation by the Communicable Disease Surveillance Centre (CDSC) and this information will be included quarterly as available.

CDSCNI *C. difficile* Information

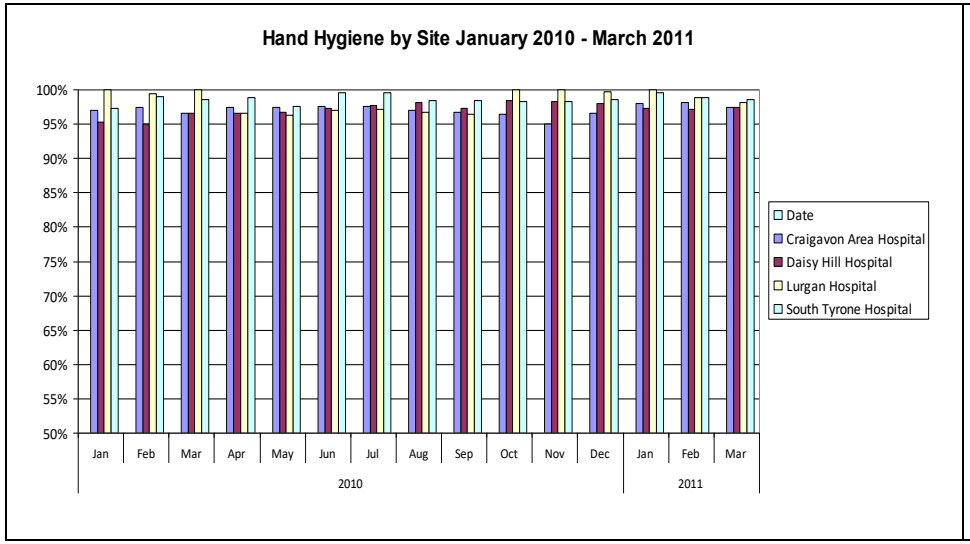


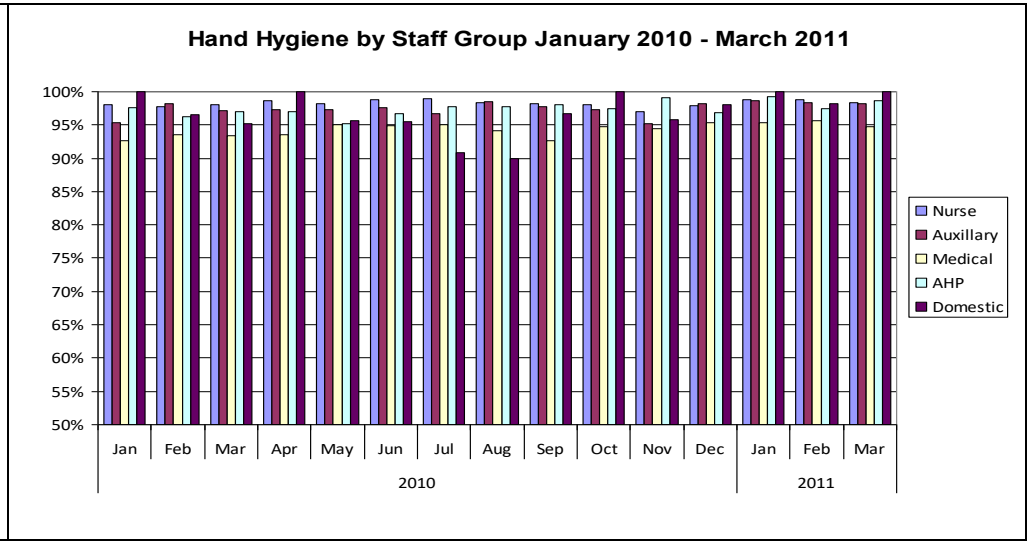
CDSCNI MRSA Information



Hand Hygiene Compliance Audits

Hand hygiene has been well established as one of the key components to reduce healthcare associated infections. The SHSCT's successful launch of the hand hygiene campaign Safe Hands Save Lives has resulted in a substantial increase in hand hygiene compliance across the Trust.





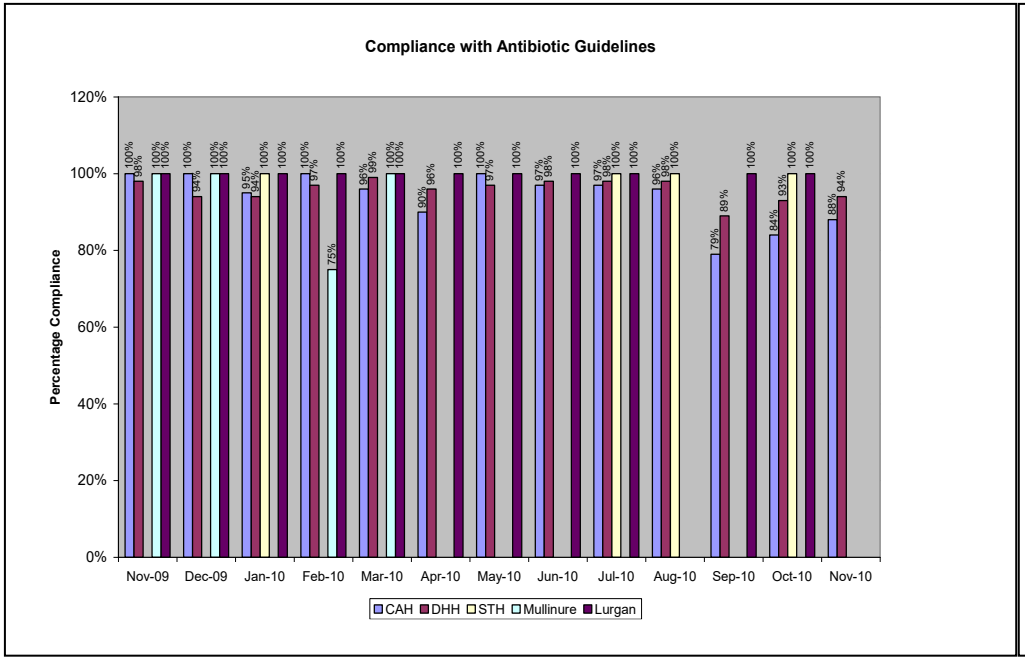
Infection Control Training Statistics January 2009 – March 2011

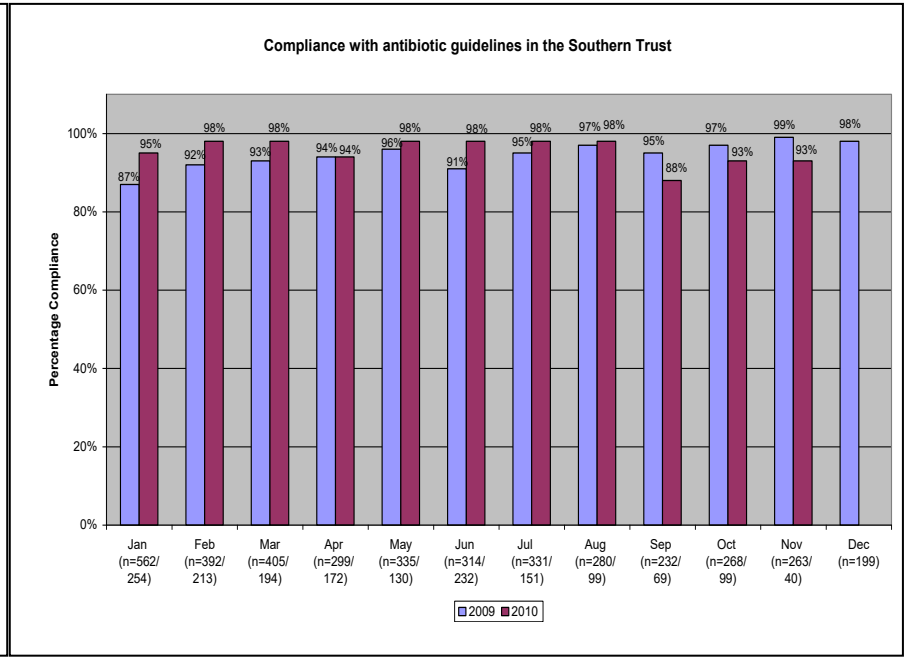
Year	Job Category	Infection Control Training	Peripheral Line Care	Laundry Infection Control Training	Domestic Infection Control Training	Volunteer Infection Control Training	Influenza Training	Peripheral & Central Line Care	Grand Total
2009	Admin	18	0	0	0	0	0	0	18
	AHP	109	0	0	0	0	0	0	109
	Ancillary	5	0	0	0	0	0	0	5
	Aux Nurse	104	0	0	0	0	0	0	104
	Care Assistant	536	0	0	0	0	0	0	536
	Domestic	9	0	0	0	0	0	0	9
	Medical	15	28	0	0	0	0	0	43
	Nurse	403	791	0	0	0	0	0	1194
	Social Worker	33	0	0	0	0	0	0	33
	Technical	16	39	0	0	0	0	0	55
2009 Total		**1248**	**858**	**0**	**0**	**0**	**0**	**0**	**2106**
2010	Admin	40	3	0	0	0	0	0	43
	AHP	157	7	0	0	0	0	0	164
	Ancillary	80	0	44	0	0	0	0	124
	Aux Nurse	70	1	0	0	0	0	0	71
	Care Assistant	451	1	0	0	0	0	0	452
	Domestic	60	0	0	25	0	0	0	85
	Medical	15	133	0	0	0	0	0	148
	Midwife	24	0	0	0	0	0	0	24
	Nurse	492	108	0	0	0	0	0	600
	Social Worker	15	0	0	0	0	0	0	15
	Technical	33	0	0	0	0	0	0	33
	Volunteer	0	0	0	0	17	0	0	17
2010 Total		**1437**	**253**	**44**	**25**	**17**	**0**	**0**	**1776**
2011	AHP	37	0	0	0	0	0	0	37
	Aux Nurse	6	0	0	0	0	0	0	6
	Medical	0	0	0	0	0	0	30	30
	Nurse	78	8	0	0	0	29	0	115
	DCW	24	0	0	0	0	0	0	24
	Auxiliary Nurse	6	0	0	0	0	0	0	6
2011 Total		**151**	**8**	**0**	**0**	**0**	**29**	**30**	**218**
Grand Total		**2836**	**1119**	**44**	**25**	**17**	**29**	**30**	**4100**

Compliance with Antibiotics

There has been a drop in compliance this month as fewer antibiotics were audited. This issue has been raised at the last clinical forum meeting and it is hoped to include F2's to help to increase the numbers again.

Hospital	No. Antibiotics audited												
	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10
CAH	65	91	96	48	52	70	25	100	66	28	14	13	8
DHH	144	68	132	128	112	80	66	86	63	66	46	76	32
STH	0	0	0	0	0	0	0	0	1	5	0	3	0
Mullinure	17	4	4	4	1	-	-	-	-	-	-	-	-
Lurgan	37	36	22	33	29	22	39	46	21	0	9	7	0



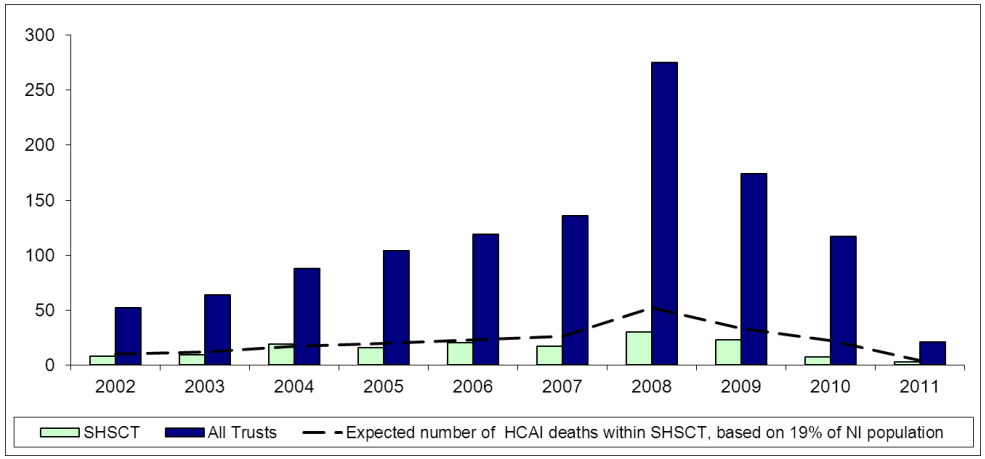


Health Care Acquired Infection – Related Deaths

HCAI death data in the graph shown below has been agreed recently at the HCAI Strategic Forum.

Number of SHSCT deaths where HCAI was mentioned and recorded as the underlying cause of death certificate, 2002 – 2008 (validated)

Jan – Dec 2009[P], Jan – Dec 2010[P] & **1 Jan – 27 Mar 2011** (unvalidated)



[P] – Provisional data pending publication of the Registrar General's Annual Report for 2009 & 2010.

NB SHSCT data excludes deaths in all other places between 2002 – 2008, as this information is aggregated regionally in the Registrar General's Annual Report.

Environmental Cleanliness

KPI Environmental Cleanliness: Cleanliness Matters Strategy indicates that 85% or above is an acceptable level of cleanliness.
Departmental Audit Results (Jan 11) - DHH 94%, STH 97%, CAH 92%. **Target 85%**
Comment: The Trust averaged 96% in March 11 on this weighted score for all risk categories. Detailed report attached in Appendix 1.

CLINICAL INDICATORS

Mortality:

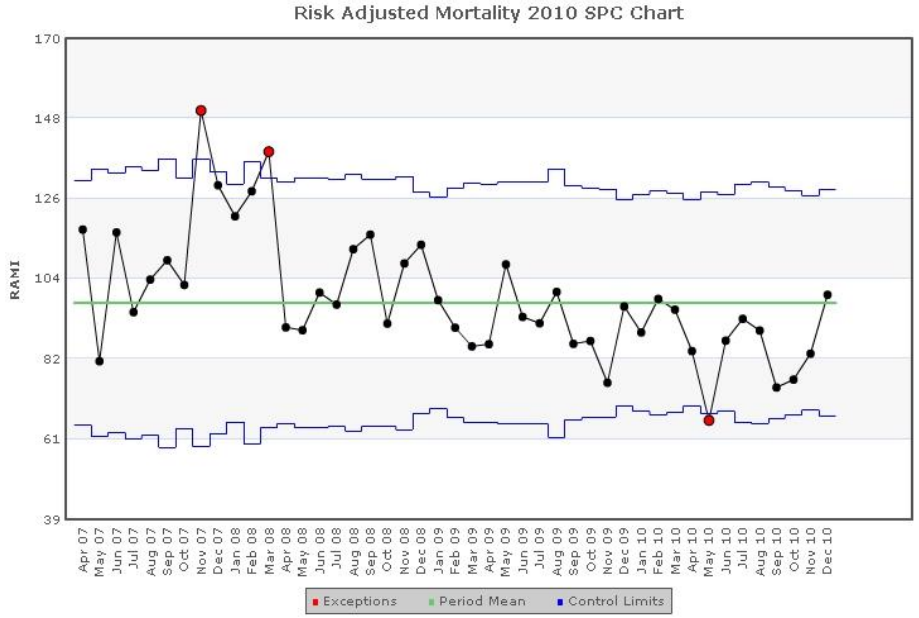
Mortality Report forms part of the Trust's Clinical and Quality Indicator suite.

In line with HSC Board reporting of mortality, SHSCT review the overall Trust RAMI SPC [Statistical process charts] which plot mortality over the time period [April 2007 to December 2010] with upper and lower control limits.

The table has been compiled from data generated by CHKS Limited, an independent organisation which has been engaged by the Trust to provide comparative benchmarking information. Trust data has been extracted from the PAS system. This data is also available to the HSC Board.

CHKS Risk Adjusted Mortality Index [RAMI] uses a method developed by CHKS to compute the risk of death for hospital patients on the basis of 'clinical and hospital characteristic data', widely referred to as casemix.

SHSCT undertake full validation of mortality on a quarterly basis and full details are presented to Governance Committee.



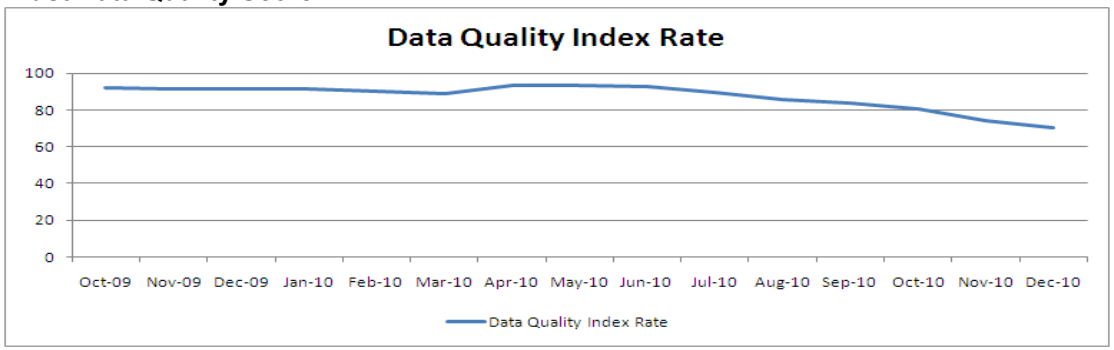
Trigger points for investigation have been agreed regionally:

- Higher than control limit
- Six or more consecutive increases

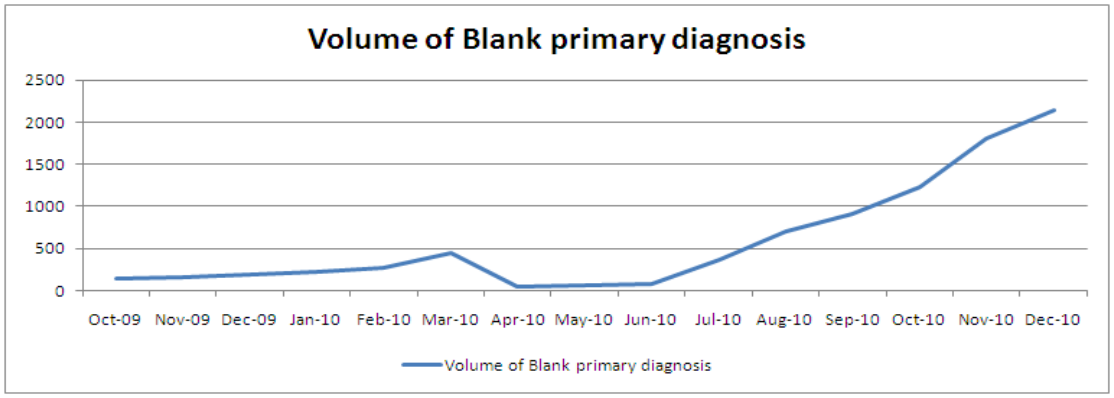
The analysis of any case mix / risk adjusted scoring relies heavily on the accuracy and completeness of the coded data upon which it is based. To this end the SHSCT has adopted the HSC Board coding quality indicators

- Timeliness - Primary standards are that 95% of episodes and day cases are coded within 31 days of discharge and 100% coded within 62 days
- Depth - average no. of diagnoses codes recorded per episode (English NW SHA area average of 3.5)
- Quality (HRG assignment)
- Deaths coded
- Use of Palliative Care code ICD-10 code Z51.5

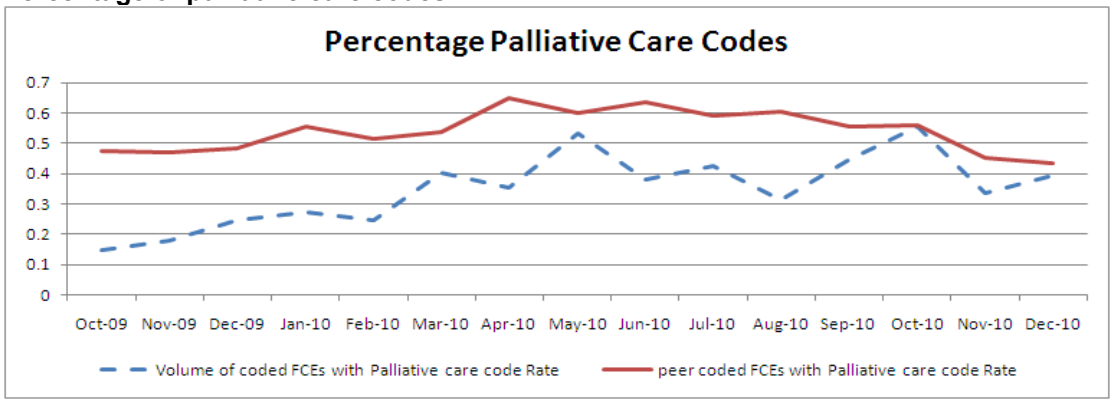
Trust Data Quality Score



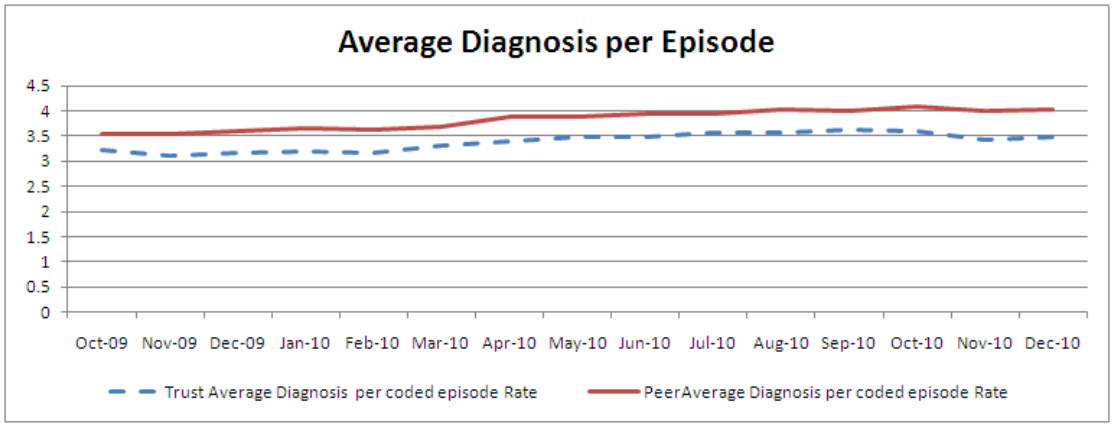
Un-coded (blank diagnosis) volumes



Percentage of palliative care codes



Average diagnosis per episode



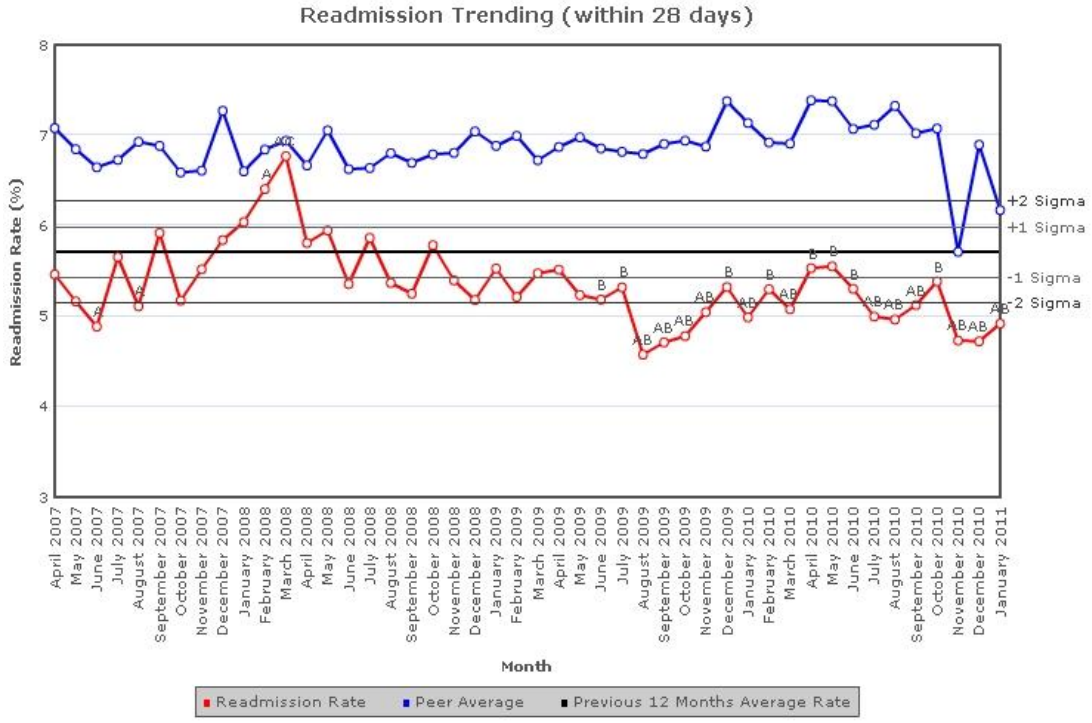
Readmission Rates:

As part of the development of Clinical Indicators the Trust examines readmission rates.

Readmission rates are measured nationally as any patient readmitted to hospital as an emergency within a stated number of days of discharge, usually 28 days. This is not dependent on whether this admission is linked with the initial spell – it is a measure of patients who return and are admitted to the hospital within a relatively short timeframe.

The Trending below indicates Trust overall readmission rates[within 28 days] consistently better than the peer.

A more detailed readmission report is currently being validated and will be presented to Governance Committee in due course.



3.3 Quarterly PfA Supplementary Report

Performance Management for 2010/11

Return Template – QE March 2011

PRIORITY AREA 1: IMPROVE THE HEALTH STATUS OF THE POPULATION AND REDUCE HEALTH INEQUALITIES

Target Area	Responsibility	Update on progress
By March 2011, all relevant HSC organisations should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.	Trusts	QE March 11 Update – see attached proforma. The Acute Hospital major incident plan is still being reviewed and has been tested twice this year through desktop exercises. The Command and Control plan is being reviewed. Emergency Support Centre Managers have attended awareness training and the Armagh and Dungannon team was activated in response to an actual incident in quarter 1. Pandemic plans were revisited as a result of an increase in seasonal flu activity and to ensure adherence to any new guidance issued. The Trust carried out a specific publicity campaign to increase uptake of seasonal flu vaccine within the Trust.
By March 2011, each HSC organisation should ensure it has a fully tested and operational Business Continuity Plan in place.	Trusts	QE March 11 Update The DHSSPSNI has provided the BSI Toolkit to all Trust Emergency Planners to assist with the process of developing business continuity plans.

PRIORITY AREA 2: ENSURE SERVICES ARE SAFE & SUSTAINABLE, ACCESSIBLE & PATIENT-CENTRED

Target Area	Responsibility	Update on progress
From September 2010, each of the five HSC Trusts should put in place arrangements to routinely review compliance with updated and consolidated regional standards of hygiene and cleanliness. Trust review arrangements should include consideration at Trust Board.	Trusts	QE Mar 11 Update The Trust uses the Cleanliness Matters Toolkit (49 elements) issued by the DHSSPS as part of the Environmental Cleanliness Strategy, in order to undertake internal Departmental audits and from May 2009 the Infection Control Nurses Association (ICNA) audit tool has been used to conduct Managerial Audits. All audits and exceptions are reported to senior management team and Trust Board on a weekly and monthly basis. Action plans are developed, implemented and monitored against any deviance from the standard. In Non Acute there are monthly unannounced walkabouts and the proforma for monitoring includes adherence to the cleanliness matters. Managerial Supervision includes discussion on performance in relation to environmental cleanliness.

PRIORITY AREA 3: INTEGRATE PRIMARY, COMMUNITY AND SECONDARY CARE SERVICES

Target Area	Responsibility	Update on progress
By March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.	Trusts	QE March 11 Update Project Implementation Structure and membership has been agreed which includes key stakeholders within the Trust, hospice, nursing home sector and voluntary organisations. There are 4 subgroups, including the raising awareness, systems process and datasets, and Education and Development. The chairs of the raising awareness and understanding and education and development subgroup represent the Trust on the regional groups. A Service Improvement plan has been reviewed and agreed and the work is being taken forward and was detailed in the recent PFA update. A Palliative Care Education and Development of Practice subgroup has been established within the trust, with membership drawn from a wide range of key-stakeholders. The subgroup held its inaugural meeting on 10th Feb, and is currently undertaking a scoping of the palliative care education and training opportunities available to staff in the trust, which will assist the trust to bring forward regional initiatives such as the implementation of the NICaN Competency Framework for Palliative and End of Life Care. On-going work includes Clinical Buddying programme for Specialist Practitioners; Palliative Care Awareness training and Palliative Care Learning Development Group. There is on-going work within the systems processes and dataset subgroup to scope the information systems capturing information on palliative care, development of community Palliative Care nurse led clinics, implementation of NISAT into revised community palliative care records and practice, and CPI work. Both the systems, processes and datasets, and raising awareness and understanding groups will meet in April 2011. The current SIL will be leaving post, and recruitment to this post is being processed

PRIORITY AREA 4: HELP OLDER PEOPLE TO LIVE INDEPENDENTLY

Target Area	Responsibility	Update on progress
From December 2010, the HSC Board and Trusts should ensure any patient receiving a new care package at home is provided with a copy of their individual care plan to enable them to understand the level of care to be provided and who to contact if difficulties arise with care package arrangements.	Trusts	Please provide assurance that this target was achieved by December 2010. The new individualised Care & Treatment Plan is now in use across any new domiciliary Care packages within OPPC.

PRIORITY AREA 5: IMPROVE CHILDREN'S HEALTH AND WELL-BEING

Target Area	Responsibility	Update on progress
By March 2011, the HSC Board and Trusts should ensure that the child protection status of all looked after children on the current register are reviewed in line with Departmental guidance issued in April 2010.	Trusts	QE Mar 11 Update The Trust continues to monitor Looked After Children on the Child Protection Register on a monthly basis. As at 28 February 2011 there were 35 Looked After Children subject to Child Protection procedures (March 11 figures not yet available). This suggests that LAC subject to dual process is reducing and the regional guidelines are being implemented. The Trust will continue to monitor Looked After Children who are subject to Child Protection.
Family Support Interventions - By March 2011, Trusts should also have updated the Regional Information System with details of family support services which they provide.	Trusts	QE Dec 10 Update This Guidance has not been issued to the Trust as RQIA have raised some queries. However the Trust has its own guiding principles to review these cases. The Trust has also contributed information into the regional database on family support services. The Trust has exceeded its target for Family Support Packages. ***QE Mar 11 update awaited***

PRIORITY 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES

Target Area	Responsibility	Update on progress
During 2010-11, each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences held in their area during the year.	Trusts	All cases are reviewed in line with Guidance (Protecting Looked After Children) which was issued on the 1 September 2010 by DHSSPS for implementation. The Trust continues to attend 100% of MARACs.

APPENDIX 1 ENVIRONMENTAL CLEANLINESS REPORT –

Environmental Cleanliness Report

Prepared by: Functional Support Services
5/4/2011

Contents

Section

1. Departmental Audit Results – Summary of Overall Weighted Scores using the Cleanliness Matters Toolkit

Hospital	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
St Luke's	85	93	88	86	88	84	90	94	90	85	91	93	90	93	90	91	94	91	90	95	90	86	95	94	95	96	94	93	94	94	92	94	93	92	93	95
South Tyrone	85	89	89	86	86	90	87	90	90	89	89	92	89	93	90	90	90	90	89	91	92	93	93	94	92	94	96	94	92	95	94	96	97	95	95	97
Longstone	85	89	91	89	87	92	91	88	94	93	92	93	91	89	90	90	88	94	90	84	93	92	87	93	89	88	90	94	90	90	91	93	93		94	94
Mullinure	93	90	90	91	94	95	91	94	93	95	94	96	95	95	96	91	84	85	88	96	95	96	98			97		95	98	97	96	96	97	97	98	97
CAH	90	92	92	93	91	91	95	94	94	93	93	92	93	94	93	93	93	92	93	92	94	93	91	93	92	92	92	94	92	94	92	94	93	93	93	92
Lurgan	83	85		92	86	91	94	93	93	93	94	93	96	93	93	95	94	98	97	97	97	98	98	99	97	98	99	98	99	98	98	99	99	99	99	99
DHH	94	93	94	94	95	94	92	94	95	93	95	93	92	87	88	90	93	91	93	93	93	89	90	92	91	93	92	93	94	94	95	94	93	93	94	94
Bluestone						86	84	89	95	91	95	93	95	95	92	90	95	92	91	92	92	94	91	90	97	97	98	99	96	97	98	97	95	98	98	98
Average	88	90	91	90	90	90	91	92	93	92	93	93	93	92	92	91	91	92	91	93	93	93	93	94	93	94	94	95	94	95	95	95	95	95	96	96

The scores reflect the overall weighted score for each hospital taking into account all risk categories ie very high, high, moderate and low risk category areas.

NB There were no audit scores for Longstone for the month of January 2011. There were audits conducted but due to a problem with the hand held device the scores are unable to be downloaded.

Approved by Board of Directors on 21st April 2011

2. Departmental Audit Results – Scores below 85% in March 2011 for Very High & High Risk Areas

Hospital	Functional Area	Domestic	Nursing	Estates	Overall
Daisy Hill	High Dependency Unit	100	67	100	96
Craigavon	Laundry	66	33	100	70
Craigavon	Pain Clinic (Theatres)	93	75	100	92
Craigavon	MLU	94	67	100	92
Craigavon	1 East	91	72	80	87
Craigavon	Delivery	95	80	89	91
Craigavon	2 West	97	83	96	95
Craigavon	Theatres	85	100	67	83
Daisy Hill	CCU	69	100	100	79
Daisy Hill	A&E	84	100	100	89
Daisy Hill	Acute Medical	94	82	100	94
Craigavon	Delivery	90	79	92	89
Craigavon	Theatres	71	88	69	73

3. Managerial Audit Results (using ICNA Audit Tool)

The following table shows the areas which achieved minimal compliance between January and March 2011.

Hospital	Ward/Dept	Audit	Audit Date	Score
Craigavon	1 North	Environment	02/03/2011	60%
Craigavon	1 North	Departmental Waste	02/03/2011	63%
Craigavon	Mandeville	Handling and Disposal of Linen	17/02/2011	50%
Daisy Hill	Female Medical	Environment	12/01/2011	75%
Daisy Hill	Female Medical	Patient Equipment (General)	12/01/2011	70%

4. Exception Report

This exception report includes items which are outstanding from Action Plans developed following either internal Environmental Cleanliness or RQIA Unannounced Inspections. These items relate mainly to the fabric of the buildings. Cleaning issues and small repairs which have been addressed have not been reflected in this report.

Facility	Dept	Work Required	Update April 2011
CAH	Areas including Elms, Maples, Laundry, Cedars, Stores, Lifts	General Refurbishment	Funding for residential accommodation has been applied for. Other work included on the environmental cleanliness priority works list.
CAH	A&E	Rolling programme for repainting needs to be established. Wheelchairs to be checked for damage to upholstery and repaired or replaced.	All areas have been painted to date. Wheel chairs not completed.
CAH	Outpatients	ENT needs refurbished and redecorated. Refurbishment of dirty utility	Has been placed on the environmental cleanliness priority works list.
CAH	Wards	(1) Refurbishment of ward kitchens is required. A number require repairs to floor and repainting, others require complete floor replacement. (2) Refurbishment of toilets is required on many wards.	Has been placed on the environmental cleanliness priority works list
CAH	Non ward areas on each floor	Refurbishment of toilets.	Has been placed on the environmental cleanliness priority works list
DHH	A&E	Provide patient bathroom or shower area. Refurbishment of domestic store, toilet beside domestic store and dirty utility. Macerator or washer disinfector required in the department. Scrub sink in resus is required. Repainting of walls in Fracture Waiting Area.	Refurbishment of DHH A&E included in Capital Priorities submission to DHSSPS. First phase due to be completed mid May 2011.

Facility	Dept	Work Required	Update April 2011
DHH	Stroke Rehab	Refurbishment of kitchen.	This will be refurbished when the Paeds ward moves to the 6th floor.
DHH	Wards	Some repairing and floor replacement.	Floor repairs have been carried out in Medical/Stroke, Coronary Care Unit, Female Medical, Female Surgical, Male Surgical, High Dependency Unit, Day Procedure Unit, Paeds, entrance/exit to theatre lobby and lift lobbies on 3rd, 4th and 5th levels.
DHH	Changing Areas	Refurbishment of changing rooms.	Has been placed on the environmental cleanliness priority works list.
DHH	Male Medical, Coronary Care and Female Surgical	Increase number of wash hand basins to meet National Guidelines ie one sink per four beds	Costings being obtained.
DHH	Outpatients	Some flooring and sinks need replaced.	Has been placed on the environmental cleanliness priority works list. Sinks have been replaced in 3 consulting rooms.
Longstone	Wards	Some painting required & flooring in some areas needs replaced. Replacement sluice and wash hand basins.	Has been placed on the environmental cleanliness priority works list.
South Tyrone	Various floors	Some ceiling tiles need to be replaced, some painting required. Refurbishment of sluice area.	Has been placed on the environmental cleanliness priority works list.
South Tyrone	Reception	Refurbishment of reception.	Has been placed on the environmental cleanliness priority

			works list.
South Tyrone	Ambulance Control	Painting required and changing areas require refurbishment.	
St Luke's	Various Wards & Villas	Some painting & ceiling tiles replacement, flooring in some areas needs replaced. Replacement sluices and wash hand basins.	Has been placed on the environmental cleanliness priority works list.
St Luke’s	Mortuary	Damp proofing and repainting required.	
St Luke’s	Industrial Therapy Unit	Refurbishment of staff toilet and cleaners store.	

Southern Health and Social Care Trust - Internal Assessment of Year End Performance

(To be agreed by HSCB, therefore may be subject to change)

Version 1 13.04.11

Notes:

End of year performance is being assessed on either Cumulative Position (April '10-March '11) or at Month End March 11

All access time targets are assumed to be achieved at Month End March '11 position

N/A = Not yet available - update to follow

Red Data = Provisional data to be confirmed

Key:

Green	Standard achieved / target achieved
Yellow	Standard substantially achieved / target substantially achieved
Amber	Standard partially achieved / limited progress towards achievement of target
Red	Standard/target not achieved
Grey	Unable to assess performance

	End of Year Assessment of Performance	
PRIORITY AREA 1: IMPROVE THE HEALTH STATUS OF THE POPULATION AND REDUCE INEQUALITIES	**Month End Mar '11**	**Cum Year to Date**
Early Years Intervention - updated child health promotion programme is fully implemented.	Green	
Bowel Cancer Screening: bowel screening programme for those aged 60-69		Grey
Screening for Abdominal Aortic Aneurysm - commence preparatory work for phased introduction of screening arrangeemnts		Grey - Trust awaits feedback on regional approach
Emergency Preparedness - Review, test and update emergency plans		Green
Business Continuity Plans - Fullly tested and operational Business Continuity Plan in place		Green

PRIORITY AREA 2: ENSURE SERVICES ARE SAFE & SUSTAINABLE, ACCESSIBLE AND PATIENT-CENTRED		Month End Mar '11	Cum Year to Date
Healthcare Associated Infection - 20% reduction in MRSA and C diff compared to 09/10	**MRSA (14 target)**		Green - 11
	C diff (47 target)		Green - 21
Anti-TNF – 9 months to commence specialist drug therapies for the treatment of severe arthritis (report on pts waiting >9months)		Green - 0	
Outpatients – 9 weeks by March 2011 (No's. waiting over 9 weeks or in excess of backstop) Agreed Backstop: Dermatology 19 wks Ophthalmology 26 wks Oral Surgery 41 wks Paed. Cardiology 21 Rheumatology 17 wks		Yellow - 52	
Diagnostics – 9 weeks by March 2011 - **Imaging**		Green - 0	
Diagnostics – 9 weeks by March 2011 - Non-imaging (No's. waiting over 9 weeks or in excess of backstop) Agreed Backstop: Neurophysiology 52 wks		Green - 0	
Inpatient/Daycase - 13 weeks by March 2011 (No's. waiting over 13 weeks or in excess of backstop) Agreed Backstop: Cardiology 27 wks Dermatology 19 wks General Surgery 31 wks Pain Man. 36 wks Rheumatology 32 wks Scopes 36 wks T&O 36 wks Urology 36 wks		Yellow - 4 (1 x Gynae, 3 x Urology)	
Diagnostic Reporting (Urgent) – from April 2010, all urgent diagnostic tests within 2 days		N/A	
Diagnostic Reporting (Routine) – from April 2010, 75% of routine tests within two weeks and all within four weeks		N/A	
		N/A	
AHP – 9 weeks from April 2010 (No's. waiting over 9 weeks or in excess of backstop) Agreed Backstop: Orthoptics 17 wks		Yellow - 81 (54 OT, 27 S&L)	
Fractures – from April 2010, 95% within 48 hours		Red - 88%	Red - 501/ 618 81%
Cancer 1 – from April 2010, all urgent breast cancer referrals within 14 days			N/A
Cancer 2 – from April 2010, 98% within 31 days diagnosis to treatment			N/A
Cancer 3 – from April 2010, 95% within 62 days referral to treatment			N/A

Southern

A&E 1 – from April 2010, 95% within 4 hours (by site)	Trust (CAH & DHH only)		Yellow - (94439/ 107987) 87%
	Site		
	Craigavon		Amber - 83%
	Daisy Hill		Green - 95.5%
A&E 2 – from April 2010, no patient to wait longer than 12 hours	Trust (CAH & DHH only)		Yellow - 7
	Site		
	Craigavon		Yellow - 7
	Daisy Hill		Green - 0
Stroke Services - 24/7 access to thrombolysis, high risk TIAs assessed and treated within 24 hrs and by March 2011 door to needle times of 60 minutes for thrombolysis.			Green
Renal Services 1 – from April 2010, 60% of patients to receive dialysis via a fistula		Red - 44%	Red - AVG. 42%
Hygiene & Cleanliness - Routinely review compliance with updated and consolidation regional standards of hygiene and cleanliness.			Green - Quarterly update in supplementary reporting
Mortality - arrangements to routinely review standardised mortality rates			Green
Trust Quality Initiatives: full implementation of the approved QIP			Green
Patient Experience - Extend clinical care areas monitored and increase the range of monitoring tools and ensure appropriate reporting and follow up, consistent with the direction from the PHA			Green
Service Frameworks - action plans should be in place to ensure implementation of agreed standards from the Cancer Framework			Grey - Service Framework launched Feb 2011. Trust Action Plan to be finalised early 2011/12
PRIORITY AREA 3: INTEGRATE PRIMARY, COMMUNITY AND SECONDARY CARE SERVICES		**Month End Mar '11**	**Cum Year to Date**
Hospital Discharges 1 – from April 2010, 90% of complex discharges within 48 hours			Green - 995/1041 - 96%
Hospital Discharges 2 – from April 2010, no complex discharge longer than seven days			Yellow - 8
Hospital Discharges 3 – from April 2010, all non complex discharges within six hours			Green - 26801/28002 - 96%
Direct Payments – 339 direct payment cases			Green - 556
Unplanned Admissions - 50% of unplanned hospital admissions related to exacerbation of severe cronic conditions are reduced.			Grey
Palliative Care - Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.			Green

PRIORITY AREA 4: HELP OLDER PEOPLE LIVE INDEPENDENTLY	Month End Mar '11	Cum Year to Date
Supporting People at Home – 45% of people in care management have assessed care needs met in a domiciliary setting.		Green - 45%
Continuing Care Needs 1 – from April 2010, assessment within 8 weeks		Green - 100%
Continuing Care Needs 2 – from April 2010, delivery of care within 12 weeks		Green - 100%
Individualised Care Plans - Ensure any patient reviecing a new care package at home is provided with a copy of their individual care plan		Green
PRIORITY AREA 5: IMPROVE CHILDREN'S HEALTH AND WELL-BEING	**Month End Mar '11**	**Cum Year to Date**
		N/A
Children In Care - From April 2010, children admitted to care have formal assessment and had their placement matched		N/A
Children In Care – Plan of permanence agreed for every child taken into care within 6 months		N/A
Family Support Interventions - 579 Children to be provided with family support interventions (inc. CSP)		Green - 485 Trust + 1548 CSP = 2033
Care Leavers in Education,Training and Employment - From April 2010, 70% of care leavers are in education, training and employment	Yellow - 67%	Green - AVG. 72%
Care Leavers living with former foster carers - 37 cum. by 31 March 2011		Green - 43
Family Group Conferencing – 96 children to participate in a family group conference		N/A
Assessment of Children at Risk and in Need 1(a) - from April 2010 all Child Protection Referrals must be allocated within 24 hours of receipt		N/A
Assessment of Children at Risk and in Need 1(b) - all Child Protection Initial Assessments must be completed within 10 days		N/A
Assessment of Children at Risk and in Need 1(c)- all Child Protection Case Conferences must be held within 15 days		N/A
Assessment of Children at Risk and in Need 2(a) - all Looked after Children Initial Assessments must be completed within 10 days		N/A
Assessment of Children at Risk and in Need 3(a) - 90% of Family Support Referrals must be allocated within 20 days for initial assessment		N/A
Assessment of Children at Risk and in Need 3(b) - all Family Support Initial Assessments must be completed within 10 days		N/A
Assessment of Children at Risk and in Need 3(c) - 90% of cases requiring a Family Support Pathway Assessment must be allocated within 20 days		N/A
PRIORITY AREA 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES	**Month End Mar '11**	**Cum Year to Date**
Unplanned Admissions – By March 2011, the number of admissions to acute MH hospitals is reduced by 10% (baseline 07/08 - no more than 1080 cum.)		Green - Trust achieved 16% reduction
Assessment and Treatment – from April 2010, 9 weeks from referral to assessment and commencement of treatment (except psychological therapies).	Yellow - 1 (PMHC)	
Assessment and Treatment – from April 2010, 13 weeks from referral to assessment and commencement of treatment for psychological therapies.	Yellow - 5	
Card before you leave - From April 2010 follow-up appointment within 24 hours		Green
Discharge 1 (Dis) – from April 2010, 75% discharged within 7 days		Green - 93%

Discharge 2 (Dis) – from April 2010 no-one longer than 90 days	Green - 0	Yellow - 1
Discharge 1 (MH) – from April 2010, 75% discharged within 7 days		Green - 98%
Discharge 2 (MH) – from April 2010 no-one longer than 90 days	N/A	Yellow - 1
Discharge 3 (MH) – from April 2010 follow up visit within 7 days of discharge		N/A
Respite (LD) – additional 24 respite packages		Green
Respite (Dementia) – additional 232 respite places		Green
Respite (Phys/Sensory Dis) – additional 21 respite packages		N/A
Resettlement (LD) – resettle 23 patients		Green - 23
Specialised Wheelchairs – By March 2011, 13 weeks for all wheelchairs (including specialist)	Yellow - 91%	
Housing Adaptations 1 – From April 2010, 22 weeks for lifts and ceiling track hoists		Yellow
Housing Adaptations 2 – From April 2010, 10 working days for urgent minor housing adaptations		Yellow
Autism 1 – From April 2010, 13 weeks for assessment	Yellow - 3	
Autism 2 – From April 2010, 13 weeks for treatment	Green - 0	
Acquired Brain Injury – From April 2010, 13 weeks to treatment	Green - 0	
Eating Disorders - Further enhancement of a regional approach to eating disorder services recognising the need for specialist provision, and at least a 10% reduction in extra contractual referrals.		N/A
PRIORITY AREA 7: ENSURE FINANCIAL STABILITY AND THE EFFECTIVE USE OF RESOURCES	**Month End Mar '11**	**Cum Year to Date**
Daycase Rates - By March 2011, all Trusts are required to achieve an overall day surgery rate of not less than 75% for the 'basket' of 24 procedures	Red - 62%	
Pre-op Length of Stay - by March 2011, an overall admission on the day or surgery rate of not less than 75%		85% - PMSID to advise
Pre-op Assessment - from April 2010, all surgical patients should have appropriate pre-op assessment		N/A
Cancelled Operations - from April 2010, no more than 2% of operations cancelled for non-clinical reasons		N/A
Financial Breakeven		Ref: Finance Report
Efficiency Savings		Ref: Finance Report
Hospital Productivity		Ref: Finance Report
Absenteeism - each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011		N/A
Staff Health & Wellbeing -		Ref: Director of HR Monthly Report

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: **Date:**	**Trust Board** **28 March 2013**
Title:	**Monthly Performance Management Report**
Lead Director:	**Paula Clarke, Director of Performance and Reform**
Corporate Objective:	• Provide safe high quality care • Maximise independence and choice for our patient and clients • Support people and communities to live healthy lives and to improve their health and wellbeing. • Make best use of resources.
Purpose:	**For Information**
Summary of Key Areas:	***High level context:*** This report reviews performance at the end of February 2013 against the Commissioning Plan standards and targets and provides an assessment of current performance. The report highlights a number of areas of risk predominantly with respect to elective access standards. This month's report includes an update on the Indicators of Performance that are currently reported through to Performance on a monthly basis.
Summary of Key Areas: (continued)	***Key issues/risks for discussion:*** 1. **HCAI** – Continued C Diff levels in February in the context of a zero tolerance approach (additional information on HCAI performance can be found in the Medical Director's Trust Board report). 2. **Elective Access** – Focus remains on achievement of access targets for the end of March 2013 and whilst the majority of specialty areas will achieve the agreed backstop/access targets the Trust has highlighted to HSCB a number of areas across key target areas where it will not achieve the agreed position. These are detailed below Achievement of the access standards monthly is variable across all specialities and the majority of performance risks relate to 2 key, common factors:

- evidence in year of increased demand across a range of a range of specialties particularly for red flag and urgent casemix
- the fact that recurrent investment has not yet been completely agreed nor embedded in our systems to allow teams to routinely achieve the required level of performance. This means that teams are continuing to seek to maintain an additional level of capacity beyond the core and/or source and manage additional capacity in the IS.

The majority of specialty areas expected to breach the agreed backstop/access targets relate to areas where there are defined capacity gaps identified and agreed with the commissioner.

The Trust continues to work with HSCB and SLCG to confirm capacity gaps and agree service models and associated funding to close these gaps. Work also continues within the Trust to reform service provision to be able to provide greater productivity.

Key areas expected to not achieve the agreed backstop/access target at the end of March 2013:

Outpatients

Oral Surgery (Visiting Specialty) with agreed regional capacity gap. Agreed backstop 18 weeks. Trust anticipates non achievement of this position with estimated 90 patients over 18 weeks, with longest wait anticipated at 48 weeks.

Trust failed to achieve the agreed position associated with the unsuitability of the patients, predominantly children, to be managed by the Trusts contracted Independent Sector Providers.

All excess waits are now being transferred to South Eastern Trust who will manage the cohort and seek to ensure a regionally equitable access time for this service which is provided to a number of Trusts.

Cardiology – Agreed capacity gap. Target 9 weeks. Trust anticipates non achievement to this position with estimated 30 patients over 9 weeks, with longest wait anticipated at 18 weeks

Trust will fail to achieve the agreed position associated with lost capacity related to medical staff absence due to sickness.

Urology ICATS – No agreed capacity gap. Target 9 weeks. Trust anticipates non achievement of this position with estimated 59 patients over 9 weeks, with longest wait anticipated at 16 weeks.

Trust will fail to achieve the agreed position associated with lost capacity related to long term medical and specialist nurse staff absence due to sickness and agreed leave.

Inpatients & Daycases

Cardiology – Agreed capacity gap. Agreed backstop 30 weeks. Trust anticipates non achievement of this position with an estimated 140 patients, both general catheterisation laboratory procedures and specialist catheterisation laboratory procedures (EP and ablation), waiting over 30 weeks with the longest waits for specialist procedures anticipated at 58 weeks.

There is a regional capacity issue associated with specialist procedures and work, led by HSCB, has been initiated to seek to address this gap.

The Trust has secured significant additional capacity for catheterisation work, from its own consultant operators and from consultant operators in the Western and Belfast Trusts, however demand continues to exceed capacity.

ENT – Agreed capacity gap. Agreed target 13 weeks. Trust anticipates non achievement of this position with an estimated 29 patients, waiting over 13 weeks with the longest waiters anticipated at 20 weeks.

The Trust will fail to achieve the agreed target due to lost capacity associated with medical staff sickness and more recently compounded by cancellation of elective procedures related to recent bed pressures resultant from increased emergency admissions.

Oral Surgery – Agreed capacity gap. Agreed target 13 weeks. Trust anticipates non achievement of this position with an estimated 45 patients waiting over 13 weeks, with the longest waits anticipated at 30 weeks.

The Trust will fail to achieve the agreed target associated with the unsuitability of the patient casemix; to be managed by the Trusts contracted Independent Sector Providers.

Gynaecology – Agreed capacity gap – Agreed target 13 weeks. Trust anticipates non achievement of this position with an estimated 42 patients waiting over 13 weeks with the longest waiters anticipated at 29 weeks.

The Trust will fail to achieve the agreed target due to inability to secure and maintain the high levels of in-house additionality required to meet the gap and patient choice, not to uptake offers of treatment in capacity secured in the Independent Sector. (RoI)

General Surgery – Agreed capacity gap – Agreed backstop 30 weeks. Trust anticipates non achievement of this position with an estimated 3 patients waiting over 30 weeks with the longest wait at 40 weeks. (All patients waiting over 30 weeks have either had an

	offer of transfer to the Independent Sector or in-house and been subsequently cancelled due to bed pressures) The Trust will fail to achieve the agreed target due to inability to secure and maintain the high levels of in-house additionality required to meet the gap and patient choice, not to uptake offers of treatment in capacity secured in the Independent Sector. (RoI) **Orthopaedic Surgeon** – Agreed capacity gap – Agreed backstop 30 weeks. Trust anticipates non achievement of this position with an estimated 6 patients waiting over 30 weeks with the longest waits straying out to 49 weeks. (Options are still being pursued to improve this position) The Trust will fail to achieve the agreed target due to patient choice, not to uptake offers of treatment in capacity secured in the Independent Sector. (RoI) (All patients waiting over 30 weeks have had an offer of transfer to the Independent Sector) **Diagnostics** **Urodynamics** – No capacity gap – Agreed target 9 weeks. Trust anticipates non achievement of this position with an estimated 170 patients waiting over 9 weeks with the longest wait estimated at 44 weeks. Trust will fail to achieve the agreed position associated with lost capacity related to long term specialist nurse staff absence due to agreed leave coupled with inability to secure additional capacity in the Independent Sector and the prioritisation of available in-house capacity directed towards urological inpatients and daycase waits Backlog clearance will be a priority in 13/14 to return this area to target and maintain a steady state position **Cardiac Investigations** – No capacity gap – Agreed target 9 weeks. Trust anticipates non achievement of this position with an estimated 90 patients waiting over 9 weeks. The Trust is working to improve this position currently and the longest waiting time is to be confirmed. Trust will fail to achieve the agreed position associated with lost capacity related to junior medical staff availability to cover scheduled sessions. Whilst a locum registrar has been sourced the Trust is unable to secure the capacity required to address this backlog as available medical staff capacity has been prioritised to meet IP/DC demands. This is a transient issue and there is no recurrent underlying issues. **Allied Health Professionals** **Paediatric OT** – No agreed capacity gap, however analysis of demand is required as there appears to be an increase in demand

	for this service. Agreed target 9 weeks. Trust anticipates non achievement of this position with an estimated 30 patients waiting over 9 weeks with the longest waiting an estimated 18 weeks. Trust will fail to achieve the agreed target associated with inability to secure the required specialist AHP capacity to clear accrued backlog and to address increasing demand. Recurrent investment was agreed for this area but may not meet any new increase in demand. Directorate are analysing demand to evidence an increase for this service for discussion with HSCB. **Mental Health Specialties** **Psychological Therapies** –Agreed capacity gap, which received recurrent investment in year. Target 13 weeks. The Trust anticipates non achievement of this position with an estimated 150 patients waiting over 13 weeks with longest waits anticipated at 50 weeks. Whilst recurrent investment is now being implemented there has been a significant gap in capacity in year and the Trust has been unable to secure additional capacity to address the increase backlog and access time. Whilst the appointment of these staff will bring the area into balance it will not address the backlog which has steadily built up over the last 18-months. The Trust will seek to secure non-recurrent resources from the HSCB to clear this backlog in 13/14. **Memory/Dementia Services** Consultant Led Services – No agreed capacity gap. Target 9 weeks. Trust anticipates non achievement of this position with estimated 8 patients over 9 weeks, with longest wait anticipated at 17 weeks. Trust failed to achieve the agreed position associated with lost capacity related to medical staff absences due to sickness. This position is temporary and will return to profile in 13/14. MDT service – No agreed capacity gap with commissioner albeit Trust identified under provision in the AHP support to this service. Target 9 weeks. Trust anticipates non achievement of this position with an estimated 8 patients waiting over 9 weeks, with longest wait anticipated at 34 weeks. The Trust has submitted proposals for investment to HSCB and whilst not initially agreed as part of AHP investment there is an agreement for on-going discussions re same and Trust has met with SLCG to progress solutions.

Progress on prioritised recurrent Investments at Specialty level:

Gynaecology - IPT submitted and HSCB have responded to the Trust with offers of investment which the Trust was unable to accept. The Trust and HSCB have met to review areas of non-agreement and agreement in principle has been secured in relation to proposed models and levels of activity. Final agreement is subject to financial assessment of ability to provide the service within the funding allocated which is less that the Trusts submitted costs. The Trust is proceeding with recruitment; trusting issues can be resolved, in parallel.

General Surgery - IPT submitted and HSCB have responded to the Trust with offers of investment which the Trust was unable to accept. The Trust and HSCB have met to review areas of non-agreement and agreement in principle has been secured in relation to proposed model of service provision. Final agreement is subject to finalisation of Outpatient activity levels and financial assessment of ability to provide the service within the funding allocated which is less that the Trusts submitted costs. The Trust has proceeded to appoint one consultant post, trusting issues can be resolved, in parallel.

Orthopaedics – Trust originally submitted high level proposal to the HSCB for a 2 + 2 consultant model however HSCB have met with the Trust and now seek a revised proposal to address the full requirement to repatriate all appropriate southern trust residents requiring trauma and orthopaedic surgery from BHSCT to the Trust. This proposal will require more than 4 consultants and will require a capital investment in infrastructure for both theatre and bed capacity. Trust is progressing development of proposals jointly with SLCG and plan a phased implementation process.

Cardiology – Trust submitted high level paper, HSCB have provided general direction of travel and provided commitment to additional consultant post at SHSCT. HSCB to confirm specific requirements in terms of specialism in keeping with regional decision making and pending this Trust to develop IPT/commence recruitment. As an interim position the Trust continues to increase capacity via use of the modular catheterisation laboratory currently on site.

ENT – Trust submitted high level paper. HSCB have responded to the Trust with funding and activity proposals. The Trust and HSCB have met to review areas of non-agreement and agreement in principle has been secured in relation to proposed models and levels of activity. Final agreement is subject to financial assessment of ability to provide the service within the funding allocated which is less that the Trusts submitted costs.

	3. **Diagnostic Reporting Turnaround Time** – actions to improve reporting of urgent non-imaging diagnostics within 48 hours, specifically within cardiac investigations have been put in place which will improve performance. In imaging, recurrent capacity gaps in reporting capacity remain for which non-recurrent funding support is being provided. Trust seeks to secure recurrent funding to address same. 4. **Emergency Department** – The Trust has experienced significant pressures in ED in March resulting in 17 breaches of the 12 hour standard in month. The impact of the pressures has been felt system wide resulting in general bed pressures and cancellation of elective procedures. Performance generally remains above the regional average currently, including performance against the 12 hour standard. 5. **Cancer 62-Day Pathway** – Whilst the Trust has experienced significant increased demand for cancer (red flag) referrals which has affected performance against the 62-day pathway the regional focus has been on ensuring there are no patients waiting over 85 days. The Trust is maintaining this position and is in a strong regional position The Trust continues to maintain a good performance against the treatment within 31 days from decision to treat. Performance against the 14 day breast cancer target dipped in month but is anticipated to return to its 100% position by the end of March. ***Summary of SMT challenge/discussion*** • Recognition that there will be Regional scrutiny of the elective access position until the access standard close down date of 31 March 2013. • Assurances sought that performance remains a high priority within individual teams. • Agreement that the need to complete discussions on investment decisions with the commissioner will continue to be raised by the Chief Executive and Director of Performance with their counterparts in HSCB/LCG. • Action sought to address long waits as quickly as possible.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERFORMANCE MANAGEMENT REPORT

COMMISSIONING PLAN STANDARDS/TARGETS FOR 2012/2013

INCLUDING INDICATORS OF PERFORMANCE

March 2013 Report for

February 2013 Performance

CONTENT

1.0 CONTEXT

This report forms part of the Trust's Performance Management Framework and sets out a summary of Trust performance for 2012/2013 against:

- Health and Social Care Commissioning Plan Standards/Targets

The HSCB have circulated a range of draft data definitions for Commissioning Plan Standards and Targets, which the Trust has responded to. Once these are regionally agreed monitoring arrangements will be initiated to meet the requirements.

A significant number of Indicators of Performance (IoP) have also been identified in year to complement the Commissioning Plan Standards and Targets. These IoPs whilst not identified as specific targets will be monitored in year to assess broader performance.

Detailed in the attached report are the Indicators of Performance that are currently reported on a monthly basis. The Performance Team are working with the Acute and Community Information Teams to review the remaining indicators to ascertain if routine monthly information is available on these, or if new information reporting requires to be established. HSCB has indicated that they will monitor IoP trends and focus on a defined cluster of indicators each month sequentially. The Trust will mirror this focus when processes are established.

2.0 REPORTING

Qualitative and quantitative updates on performance against the Commissioning Plan Standards/Targets are presented in this performance report under the themes of Ministerial Priority:

- To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention;
- To improve the quality of services and outcomes for patients, clients and carers;
- To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community;
- To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities;
- To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services;

The level of performance on a monthly basis will be assessed as follows:

Green (G)	Standard/target achieved/on track for achievement – Monitor progress to ensure remains on track
Yellow (Y)	Standard/target substantially achieved/on track for substantial achievement – Management actions in place/monitor progress to ensure standard/target remains on track
Amber (A)	Standard partially achieved/limited progress towards achievement of target – Management actions required
Red (R)	Standard/target not achieved/not on track to achieve – Management actions/intervention required
	Not assessed (due to lack of baseline; target; or robust data)

The performance trend will be assessed as follows and represent the typical performance profile for the identified standard/target over the period assessed and will not reflect month on month shifts in performance.

↑	Performance improving
↓	Performance decreasing
⇔	Performance static

3.0 COMMISSIONING PLAN STANDARDS/TARGETS AND ASSOCIATED PERFORMANCE

MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS

CP 5: FRACTURES

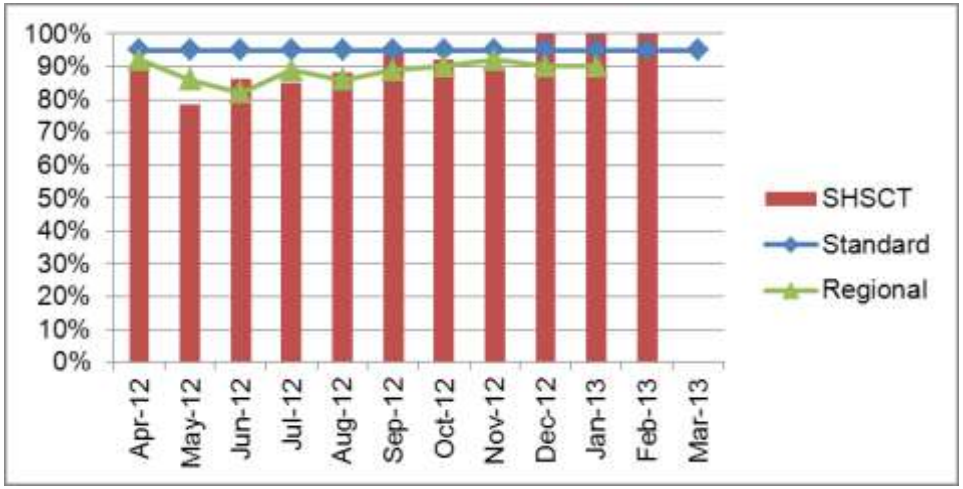
From April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in-patient treatment for hip fractures.

Baseline: 87.5% (cumulative April 2011 – March 2012)
TDP Assessment: Likely to be achieved with some delay/partially achieved

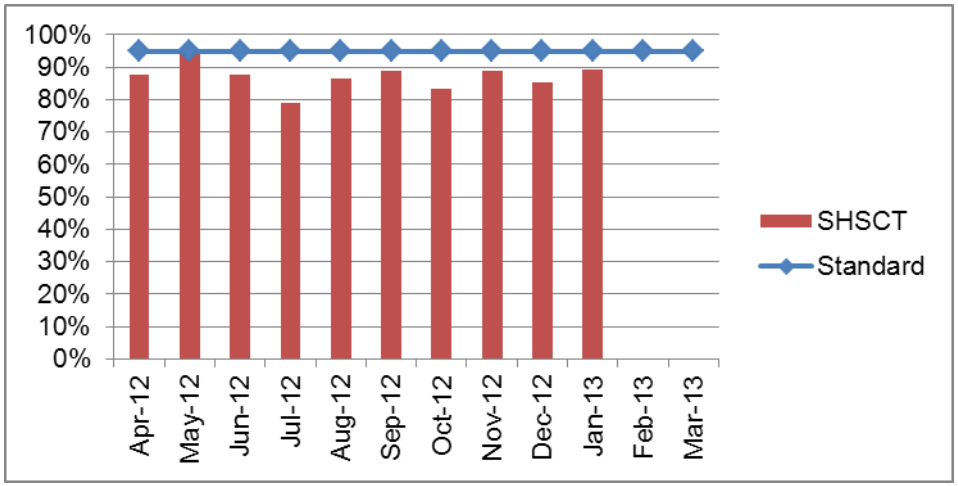
Standard: 95%

Comments: The Trust maintained its 100% performance for Fracture Neck of Femur within 48 hours for a third month, in the context of a maintained high volume of patients for the second month in a row. In February there were 29 patients requiring hip fracture treatment in comparison to 31 in January; 19 in December and November; and 24 in October.

As requested, the Trust has submitted a high level paper to HSCB which identifies the level of capacity deliverable through staged recruitment of additional consultants for Trauma and Orthopaedic Services. The additional capacity has considered both the recurrent elective orthopaedic gap and also the repatriation of Newry & Mourne trauma patients to the Southern Trust. The HSCB has asked the Trust to further develop its proposals.

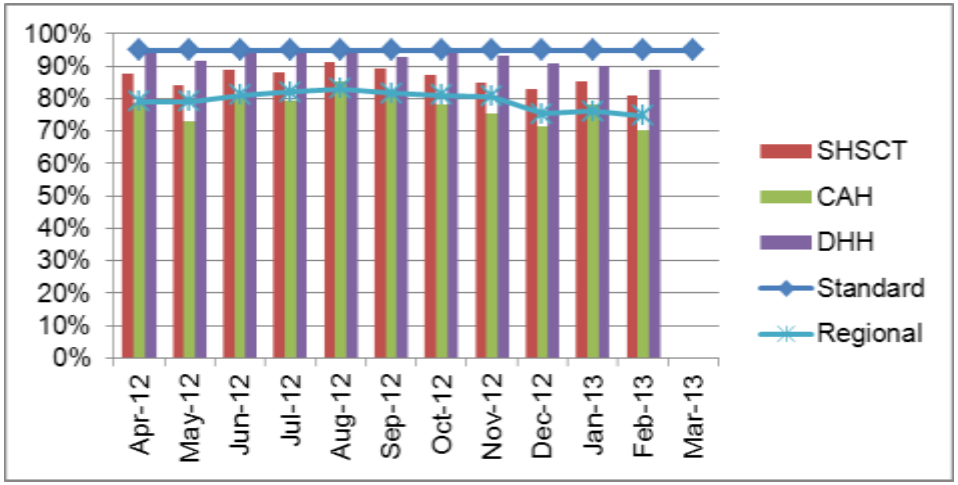


Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	89.5%	78.6%	86.4%	85.2%	88.2%	94.7%	92.3%	89.5%	100%	100%	100% (29 out of 29)		G	↔
Regional	92%	86%	82%	89%	86%	89%	90%	92%	90%	90%	N/A			

CP 6: CANCER CARE SERVICES	
From April 2012, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62-days (from date of referral).	
Baseline: 86.68% (cumulative April 2011 – March 2012) **TDP Assessment:** Likely to be achieved with some delay/partially achieved	**Standard:** 95%
Comments: Reported in arrears to facilitate 62-day reporting period. Performance against the 62-day standard in January has improved in comparison to the December position. The ability to down-grade red flags referrals has only taken effect from the start of December 2012. Factors that continue to impact on performance are as follows: **Internal** • Late updating of routine/urgent outpatient referrals within 48 hours • 1st haematuria OP appointment; flexible cystoscopy and urology surgical capacity • Specialist diagnostic delays eg. CT urogram • 1st outpatient appointment for lung • Breast surgery capacity • Lung pathway due to complex diagnostic testing / repeat bronchoscopies **External** • Lung and upper GI patient delayed accessing regional PET capacity • Access to thoracic surgical assessment and surgery slots • Brachytherapy • 1st outpatient for chemotherapy From April 2012 to February 2013 there have been 32 internal breaches of the 62-standard. The volumes and specialties within are as follows: Breast – 6; ENT – 1; Gynaecology – 3; Haematology – 1; Lung – 4; Upper GI – 1; and Urology 16.	

HSCB have, as an interim standard, stated that no patient by the end of December should be waiting in excess of 85-days. Of note the Trust has sustained this position and did not have any patients waiting in excess of 85-days at the end of January or February.	

Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
87.69%	93.94%	87.88%	78.95%	86.69%	88.89%	83.33%	88.89%	85.37%	89.25% (41.5 out of 46.5)			A	↑

CP 8: ACCIDENT AND EMERGENCY	
From April 2012, 95% of patients attending any Type 1, 2 or 3 A&E Departments are either treated and discharged home, or admitted, within 4 hours of their arrival in the department;	
Baseline: Trust – 86% (Position March 2012) CAH – 75.6% DHH - 94.6% **TDP Assessment:** Likely to be achieved with some delay/partially achieved	**Standard:** 95%
Comments: February (81%) has seen a fall in performance in comparison to January (85.2%). Cumulative performance, from April to 10 March is at 86% seen within 4 hours. Fall in performance in February predominantly relates to CAH with a fall by 7.7%, with a fall of only 1.1% in DHH in comparison to the January position. Whilst Trust performance has fallen in February (81%) both the Trust and DHH performance (88.8%) remained higher than the Regional performance (74.8%). Factors that continue to challenge performance against the 4-hour standard include: • High number of admissions (adult and paediatric); • High acuity of patients; • Availability of beds on the wards; A weekly unscheduled care performance meeting has been established to review wider flow issues and a review of ED performance indicators with potential for external national benchmarking is underway. Through non-recurrent Unscheduled Care HSCB funding Discharge Expeditors have been recruited and have taken up post in January 2013.	

Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	87.6%	84.1%	89%	88%	91.1%	89.1%	87.4%	85%	82.9%	85.2%	81% (2826 out of 3898)		**A**	↓
CAH	78.6%	73.2%	81.1%	79.4%	85.3%	82.5%	78.1%	75.6%	71.3%	78%	70.3% (1236 out of 2097)		**R**	↓
DHH	94.6%	91.5%	95.4%	94.1%	94.4%	92.9%	95.3%	93.1%	90.9%	89.9%	88.8% (875 out of 1086)		**Y**	⇔
Regional	79%	79%	81%	82%	83%	81.6%	81%	80.7%	75.3%	76.1%	74.8%			

CP 8: ACCIDENT AND EMERGENCY

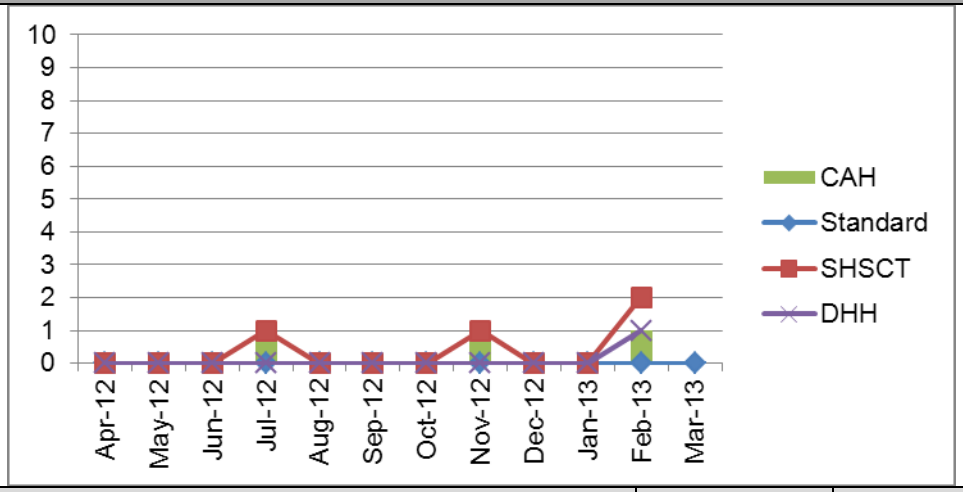
From April 2012, no patient attending any emergency department should wait longer than 12 hours.

Baseline: 10 (cumulative April 2011 – March 2012)
TDP Assessment: Likely to be achieved with some delay/partially achieved

Standard: 0

Comment/Actions: There were 2 breaches of the 12-hour standard in February which continues to reflect a strong position when regionally compared.

The December 2012 DHSSPS Emergency Care Waiting Times Statistics have been issued and the Region has shown an increasing trend in the level of patients waiting in excess of 12-hours for the month of October (301), November (396) and December (570). Of note the Southern Trust had only 1 patient in excess of 12-hours in this period.



Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	0	0	0	1	0	0	0	1	0	0	2		R	↓
CAH	-	-	-	1	-	-	-	1	-	-	1			
DHH	-	-	-	0	-	-	-	0	-	-	1			

CP 9: ELECTIVE CARE – OUT-PATIENTS

From April 2012, at least 50% of patients wait no longer than 9-weeks for their first out-patient appointment with no-one waiting longer than 21-weeks, increasing to 60% by March 2013 and no-one waits longer than 18-weeks.

Baseline: 81.1% (<9-weeks @ 31 March 2012)
327 (>21-weeks @ 31 March 2012)

TDP Assessment: Achievable dependent upon additional funding

Standard: 50% <9-weeks and 0 >21-weeks; rising to
60% <9-weeks and 0 >18-weeks

Comment/Actions:

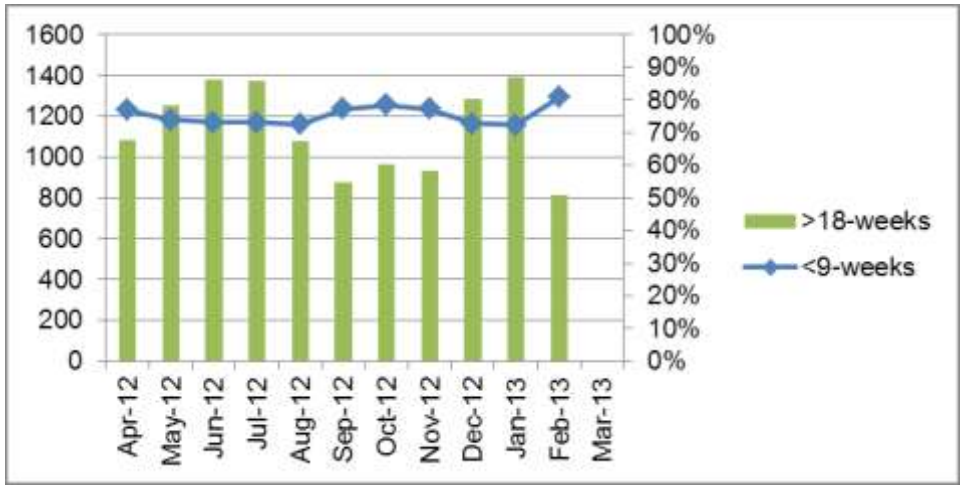
Note: Monitoring now focusing on maximum 18-week access standard.

The percentage of patients waiting less than 9-weeks in February has increased to 80.9% whilst the total number of patients waiting in excess of 18-weeks has decreased to 813 in comparison to 1394 in January.

There are a total of 2437 patients waiting in excess of 9-weeks (2336 consultant-led and 101 ICATS). 459 (278 consultant-led and 181 ICATS) of these relate to specialty areas that require to achieve 9-weeks by March 2013, whilst the remaining 2078 (2058 consultant-led and 20 ICATS) relate to specialty areas where the backstop target has been agreed as a maximum of 18-weeks.

Funding has been approved by HSCB for both in-house additionality and Independent Sector activity to facilitate achievement of a maximum 18-week out-patient standard for all patients, with the majority being seen within 9 weeks. Whilst the majority of patients are now scheduled to meet standards and targets there is risk associated with ensuring delivery of capacity and in any subsequent increases in urgent or red flag demand that would result in the requirement for additional capacity between now and March. Key specialties highlighted to HSCB at risk of not achieving their targets/agreed backstop positions are March include:

- **Oral Surgery** (to achieve 18-weeks) – likely to achieve 48-weeks due to high volume of paediatric patients that cannot be accommodate in-house or in the IS. Trust continues to explore options with South Eastern Trust for the management of these patients; and
- **Urology ICATS** (to achieve 9-weeks) - likely to achieve 16-weeks associated with ongoing staff absences due to sickness in this area.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
<9-weeks	76.9%	73.9%	73.2%	73.2%	72.5%	77.3%	78.5%	77.3%	72.8%	72.4%	80.9%		G	⇔
>18-weeks	1082	1255	1381	1375	1080	875	967	930	1285	1394	813		R	↑

CP 10: ELECTIVE CARE – DIAGNOSTICS

From April 2012, no patient waits longer than 9-weeks for a diagnostic test (13-weeks for a day case endoscopy), and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.

Baseline: Diagnostic Testing – 122 (@ 31 March 2012)
Endoscopy – 0 (@ 31 March 2012)
Imaging DRTT – 88.1% (@ 31 March 2012)
Non-Imaging DRTT – 68.5% (@ 31 March 2012)

TDP Assessment: Achievable dependent upon additional funding

Standard: Diagnostic Testing – 9-weeks
Endoscopy – 13-weeks
DRTT – 2 days

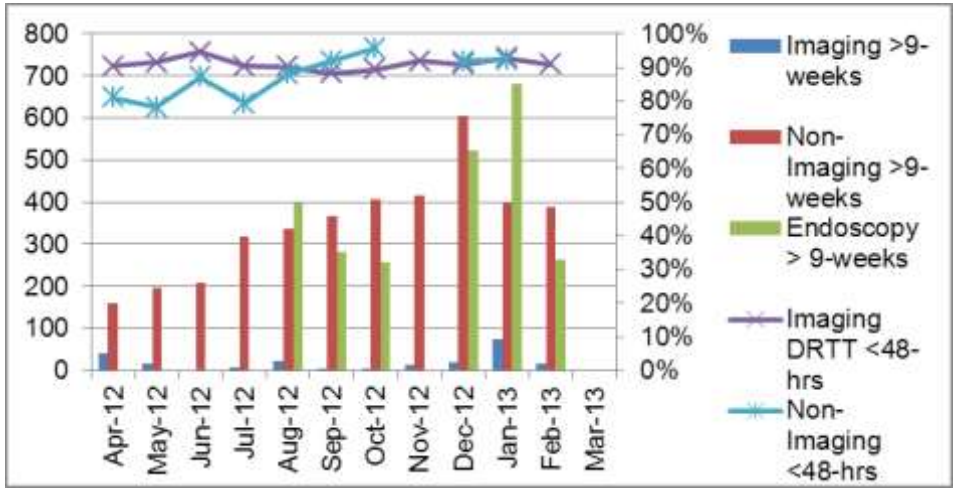
Comment/Actions:

Diagnostic Testing - Waits in excess of 9-weeks have remained relatively static in February with 388 patients waiting in excess of 9-weeks in comparison to 397 at the end of January.

- **Urodynamics** - 181 (47%) of the patients waiting over 9-weeks currently relate to Urodynamics (Urology) for which there has been a significant capacity shortfall. The service was unable to secure additional capacity for this diagnostic in the IS and anticipates a best position of 44-weeks at the end of March. This estimated breach has been highlighted to HSCB.
- **Cardiac Investigations** - 198 (51%) of the patients waiting over 9-weeks relate to Cardiac Investigations for which a non-recurrent bid has been submitted to HSCB in order to return this service to the 9-week access target. Division now estimating 90 patients in excess of 9-weeks at the end of March and are currently estimating a projected access time.

Endoscopy – The Trust continues to be in excess of 9-weeks for endoscopy, with 262 patients waiting in excess of 9-weeks. This is an improved position from the end of January where 680 patients were waiting in excess of 9-weeks. This is predominantly associated with increase in general demand and in particular the volumes of red flag within this and a greater than anticipated conversion rate from the new bowel screening programme.

The Trust has made arrangements for capacity for approximately 1000 additional scope patients this year, via in-house and external independent sector provision, which reflects demand above the commissioned level of service. The Division will continue to work to see achievement of the 9-week position and manage this increased demand.



Diagnostic Reporting – Performance in February has remained relatively static with 91% of urgent examinations reported within 2 days. Within Imaging the challenges in turnaround time for reporting remain within the modalities of MRI and Barium Enema. Performance against the 48-hour standard is affected by the timing of the examinations with timing of examination is based on the clinical need of the patient and not the ability to report within the 48-hour standard. This issue is to be discussed at the HSCB-led Regional Radiology Forum which is due to meet for the first time in April.

Non-Imaging:
Performance in February has remained fairly status. Focus on improving the position in non-imaging reporting has centred on cardiac investigations which accounts for the majority of the volume in this target and in month 116 out of 126 urgent tests were reported within 2 days. The MUSC Division have reviewed contributory factors/constraints and have implemented changes to improve on an interim basis which has resulted in slight improvement. Ability to see a further step change in this performance is reliant upon the resolution of consultant capacity issues in cardiology.

	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Imaging >9-wks	40	16	0	8	22	2	1	14	19	73	16		Y	↑
Non-Imaging >9-wks	159	197	208	317	337	368	408	416	606	397	388		R	⇔
Endos. >9-wks	9-week access standard for Endoscopy from 30 September 2012				396	282	257	337	523	680	262		R	↑
Imaging DRTT Urgents <48-hrs	90.3%	91.5%	94.6%	90.4%	90.2%	88.3%	89.5%	91.9%	90.9%	92.8%	91%		Y	⇔
Non-Imaging DRTT Urgent <48-hrs	81%	78.2%	87.1%	79.3%	88%	91.8%	95.7%	93.5%	91.9%	92.2%	92.1%		Y	⇔

CP 11: ELECTIVE CARE – IN-PATIENTS AND DAY CASES

From April 2012, at least 50% of in-patients and day cases are treated within 13-weeks with no-one waiting longer than 36-weeks, increasing to 60% by March 2013, and no patient waits longer than 30-weeks for treatment.

Baseline: 68.7% (<13-weeks @ 31 March 2012)
28 (>36-weeks @ 31 March 2012)

TDP Assessment: Achievable dependent upon additional funding

Target: 50% <13-weeks and 0 >36-weeks; rising to
60% <13-weeks and 0 >30-weeks

Comment/Actions:

Note – Monitoring now focusing on maximum 30-week access standard.

The percentage of in-patients/day cases, excluding scopes, waiting less than 13-weeks has remained relatively static in February at 59.1% in comparison to 59.3% at the end of January. Total waits, excluding scopes, in excess of 30-weeks have fallen to 574 in comparison to 681 in January.

There is a total of 2949 patients waiting in excess of 13-weeks. 385 of these relate to specialty areas that require to achieve 13-weeks by March 2013, whilst the remaining 2564 to specialty areas where the backstop target has been agreed as a maximum of 30-weeks.

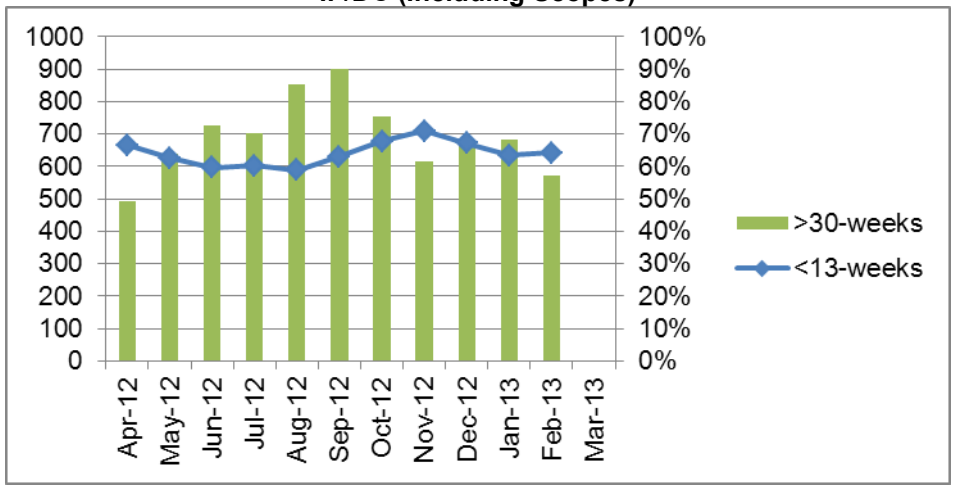
Funding has been approved by HSCB for both in-house additionality and Independent Sector activity to facilitate achievement of a maximum 30-week in-patient/day case standard, with the majority seen within 13-weeks. Areas where backstops are agreed at 30-weeks include Cardiology, General Surgery, Pain Management, Orthopaedics and Urology.

Whilst planning is in place to achieve the access times there is risk associated with the ability to deliver the necessary additional capacity, particularly in the IS as this is dependent upon patient choice. Further risk continues to be associated with any subsequent increases in urgent and red flag demand between now and end of March 2013.

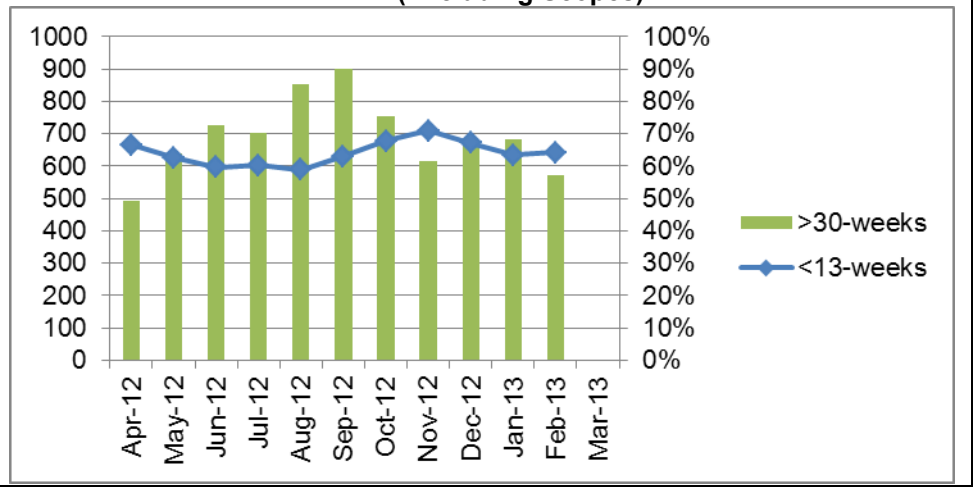
Risks to achievement of the targets/agreed backstops include:

- **Cardiology** (to achieve 30-weeks) - operator capacity remains a challenge and Trust projects 30-weeks for angiography and up to 58-weeks for specialist (EP) cardiology;
- **General Surgery** (to achieve 30-weeks or better) - this is dependent

IP/DC (Including Scopes)



IP/DC (Excluding Scopes)



upon delivery of IS capacity in Republic of Ireland and acceptance of same by patients;

- **Orthopaedics** (to achieve 30-weeks or better weeks) - this is dependent upon delivery of IS capacity in Republic of Ireland and acceptance of same by patients;
- **Gynaecology** (to achieve 13 weeks) - securing additional capacity remains challenging and Division is projecting 25-weeks by March 2013;
- **ENT** (to achieve 13-weeks) – securing additional capacity remains challenging and Division is projecting 23-weeks by March 2013.

	Monthly Position (Including Scopes):												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
<13-weeks	66.6%	62.7%	59.6%	60.3%	58.8%	63.1%	67.8%	70.9%	67.2%	63.5%	64.3%		G	⇔
>30-weeks	494	641	725	703	855	901	756	616	677	681	574		R	↑
	Monthly Position (Excluding Scopes):												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
<13-weeks	62.8%	58%	53.5%	53.9%	52%	56.2%	61.7%	65%	61.9%	59.3%	59.1%		Y	⇔
>30-weeks	490	637	724	703	885	901	756	616	677	681	574		R	↑

CP 12: HOSPITAL RE-ADMISSIONS	
By March 2013, secure a 10% reduction in the number of emergency re-admissions within 30 days.	
Baseline: To be confirmed **TDP Assessment:** To be confirmed	**Target:** 10% reduction
Comment/Actions: The Acute Information Team have begun the development of this report, however, it is anticipated that it will not be ready until the new financial year. Whilst reporting is not in place actions to reduce re-admissions within the Acute Directorate have been reviewed and a number of work streams have been established to reduce inappropriate re-admissions.	

Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

CP 13: HEALTHCARE ACQUIRED INFECTIONS

By March 2013, secure a reduction of 29% in MRSA and Clostridium Difficile infections compared to 2011/2012.

Baseline: MRSA – 10
C Diff – 33

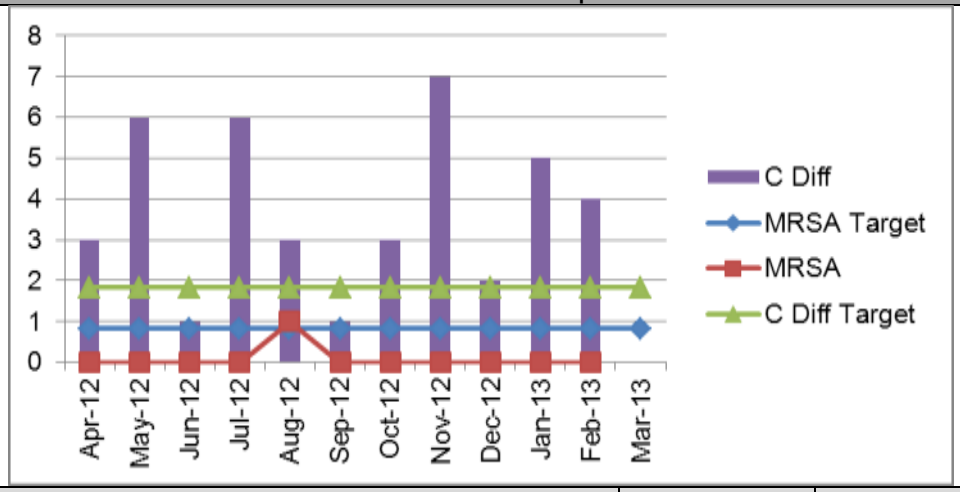
TDP Assessment: Likely to be achieved with some delay/partially achieved

Target: MRSA – 10
MRSA Case Reduction Required – 0
C Diff – 22
C Diff Case Reduction Required – 11

Comment/Actions:
MRSA: No further cases of MRSA have been reported since August.

C Diff – 4 further cases of C Diff have been reported in February. This increases the cumulative level to 41 against cumulative target of 20.13, and therefore, the Trust's C Diff % against the 2012/2013 target, sits at 186% of the year's target level.

Further information on the HCAI rates is provided within the Medical Director's Trust Board Report.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MRSA Actual	0	0	0	0	1	0	0	0	0	0	0 Cum: 1		G	⇔
MRSA Target	0.83	0.83	0.83	0.83	0.83	0.83	0.83	0.83	0.83	0.83	0.83 Cum: 9.13			
C Diff Actual	3	6	1	6	3	1	3	7	2	5	4 Cum: 41		R	↓
C Diff Target	1.83	1.83	1.83	1.83	1.83	1.83	1.83	1.83	1.83	1.83	1.83			

											Cum: 20.13			

CP 14: MEDICINES FORMULARY	
From April 2012, ensure that HSCB achieve 70% concordance with the published Medicines Formulary.	
Baseline: To be confirmed **TDP Assessment:** To be confirmed	**Target:** 70%

Comment/Actions: A baseline figure has not been available as the formulary had not been published. Several chapters of the formulary have now been published on the HSCB website, however, these have caused concerns across the Trusts as they are not user friendly and therefore, are not currently in use by the Trust. HSCB are aware of these concerns and are developing a formulary website that will be user friendly.

Within the Trust the pharmacists are aware of the contents of the formulary and are therefore, trying to ensure that the correct drugs are used. The Director of Pharmacy is also starting to monitor the Trust's drug use levels against the recommendations. The outcomes from this monitoring will be reported in the Trust Board report, when the process has been validated / embedded.

Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

MINISTERIAL PRIORITY: TO DEVELOP MORE INNOVATIVE, ACCESSIBLE AND RESPONSIVE SERVICES; PROMOTING CHOICE AND BY MAKING MORE SERVICES AVAILABLE TO THE COMMUNITY

CP 15: SPECIALIST DRUGS

From April 2012, no patient should wait longer than 9-months commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, decreasing to 3-months by September 2012.

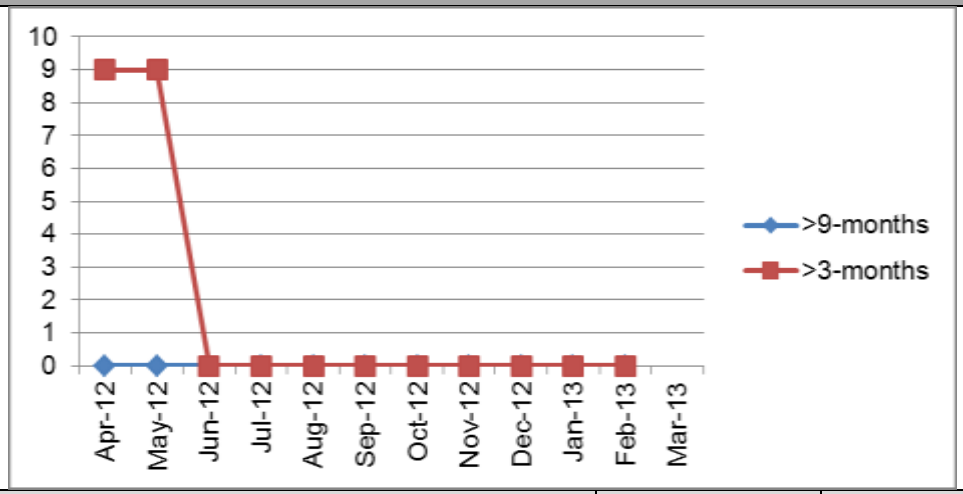
Baseline: 0 (>9-months @ 31 March 2012)
5 (>3-months @ 31 March 2012)

TDP Assessment: Achievable dependent on additional funding

Target: 0 >9-months; changing to
0 >3-months

Comment/Actions: There continues to be no patients waiting more than 9-months for the commencement of NICE approved specialist therapies for rheumatoid arthritis; psoriatic arthritis; or ankylosing spondylitis.

There are currently 0 patients waiting more than 3-months for the commencement of NICE approved specialist therapies for rheumatoid arthritis; psoriatic arthritis; or ankylosing spondylitis.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
>9-months	0	0	0	0	0	0	0	0	0	0	0		G	↔
>3-months	9	9	0	0	0	0	0	0	0	0	0		G	↔

CP 16: SPECIALIST DRUGS

By March 2013, increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis.

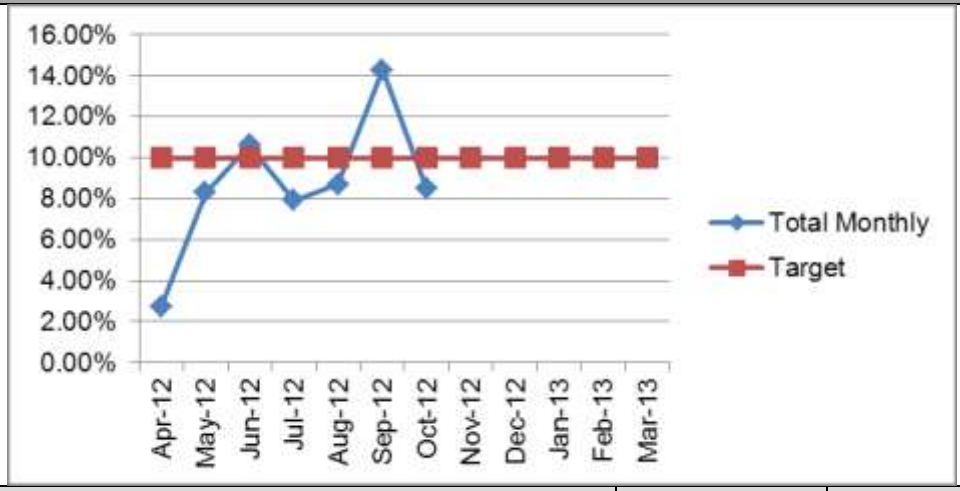
Baseline: To be confirmed
TDP Assessment: The Trust expects to be able to achieve this target

Target: Increase to 10%

Comment/Actions: Please note this information is reported 3-months in arrears.

The Trust has achieved a greater than 10% proportion of patients with confirmed ischaemic stroke having received thrombolysis in June (10.6%) and September (14.3%). Performance across the remaining months varies significantly from 2.7% to 8.7%.

In respect of CAH the target was achieved in 3 out of 7 months; whilst at DHH the target was achieved in 4 out of 7 months.



Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	2.7%	8.3%	10.6%	7.9%	8.7%	14.3%	8.5%						G	↓
Trust Admissions	A 37 T 1	A 36 T 3	A 47 T 5	A 38 T 3	A 46 T 4	A 42 T 6	A 47 T 4							
Trust Cumulative	-	-	-	-	-	-	8.9%							
CAH	5%	4.3%	10%	0%	10%	9.7%	11.8%						G	↑
CAH Admissions	A 20 T 1	A 23 T 1	A 30 T 3	A 23 T 0	A 30 T 3	A 31 T 3	A 34 T 4							
CAH Cumulative	-	-	-	-	-	-	7.9%							

Site	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
DHH	0%	15.4%	11.8%	20%	6.3%	27.3%	0%						G	↓
DHH Admissions	A 17 T 0	A 13 T 2	A 17 T 2	A 15 T 3	A 16 T 1	A 11 T 3	A 13 T 0							
DHH Cumulative	-	-	-	-	-	-	10.8%							

Note: Stroke: A = Stroke Admissions / T = Patients Who Had Thrombolysis Administration

CP 17: ALLIED HEALTH PROFESSIONALS

From April 2012, no patient waits longer than 9-weeks for referral to commencement of AHP treatment.

Baseline: 248 (>9-weeks @ 31 March 2012)
Occupational Therapy – 125
Speech and Language Therapy – 123
Dietetics; Orthoptics; Physiotherapy; and Podiatry – 0

TDP Assessment: Achievable if additional resources agreed

Standard: 0

Comments: The number of waiters in excess of 9-weeks has decreased in February 249 in comparison to 444 in January. The breakdown and longest waiters as follows: Occupational Therapy 166 (24-weeks); Physiotherapy 15 (13-weeks); Dietetics 53 (23-weeks); and Speech and Language Therapy 15 (17-weeks). All AHP service areas, with the exception of Paediatric OT, are projecting achievement of the 9 weeks position at March.

Areas of risk in achievement of targets continue to lie within smaller programme teams and the following areas have been highlighted to HSCB as presenting risk to the target position at March 2013

- **Paediatric OT** (9 weeks) - estimating approximately 30 patients waiting over 9-weeks with the longest waiter at 18-weeks.

The Trust continues to monitor demand in AHP as demand continues to increase; in year referrals for physiotherapy have increased by around 4000.

Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
309	363	417	343	494	262	209	257	275	444	249		R	↓

CP 18: LONG-TERM CONDITIONS

By March 2013, deliver 400,000 Monitored Patient Days (equivalent to approximately 2,200 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract.

Baseline: Monitored Patient Days to be confirmed
178 Patients on Telemonitoring (@ 31 March 2012)

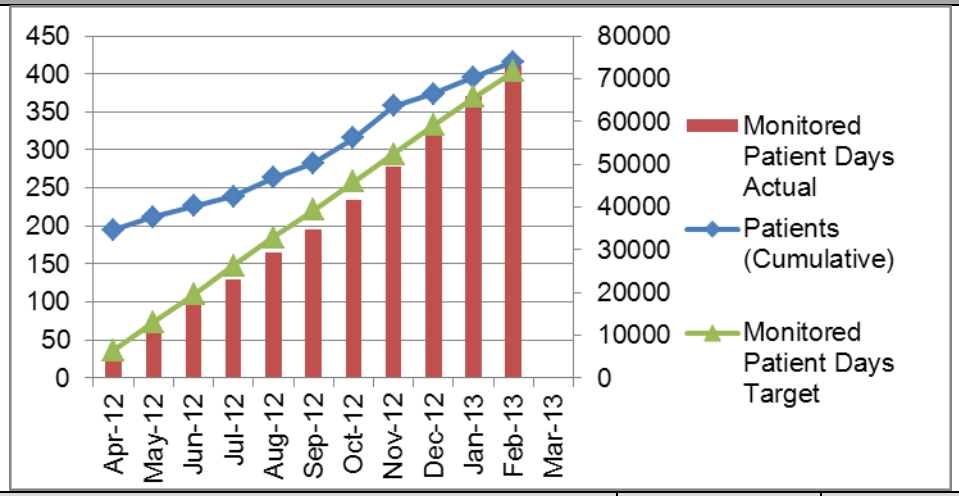
TDP Assessment: To be confirmed

Target: 78,400 monitored patient days

Comment/Actions: The Trust is awaiting confirmation from the Public Health Agency on baseline activity.

At the end of January the Trust is on target for the actual monitored patient days and projected to achieve the target at year end. Regionally only the SHSCT and one other Trust are projected to achieve the in-year target.

At 31 March 2012 there were 178 patients on telemonitoring. Cumulatively at the end of January there were 396 patients on telemonitoring.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Patients (Cumulative)	195	212	226	239	263	283	316	358	374	396	416			
Actual Monitored Patient Days	5400	11302	17066	23088	29260	34797	41757	49296	57700	65835	73188		G	↑
Target Monitored Patient Days	6444	13102	19546	26205	32864	39307	45966	52410	59068	65727	71741	78400		

MINISTERIAL PRIORITY: TO IMPROVE PRODUCTIVITY BY ENSURING EFFECTIVE AND EFFICIENT ALLOCATION AND UTILISATION OF ALL AVAILABLE RESOURCES, IN LINE WITH PRIORITIES

CP 21: UNPLANNED ADMISSIONS

By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long-term conditions

Baseline: 1451 (2010/2011)
TDP Assessment: Achievable depending on Regional action

Target: Reduce by 10%

Comment/Actions: Please note that this information is reported 3-months in arrears. Please note update in October figures.

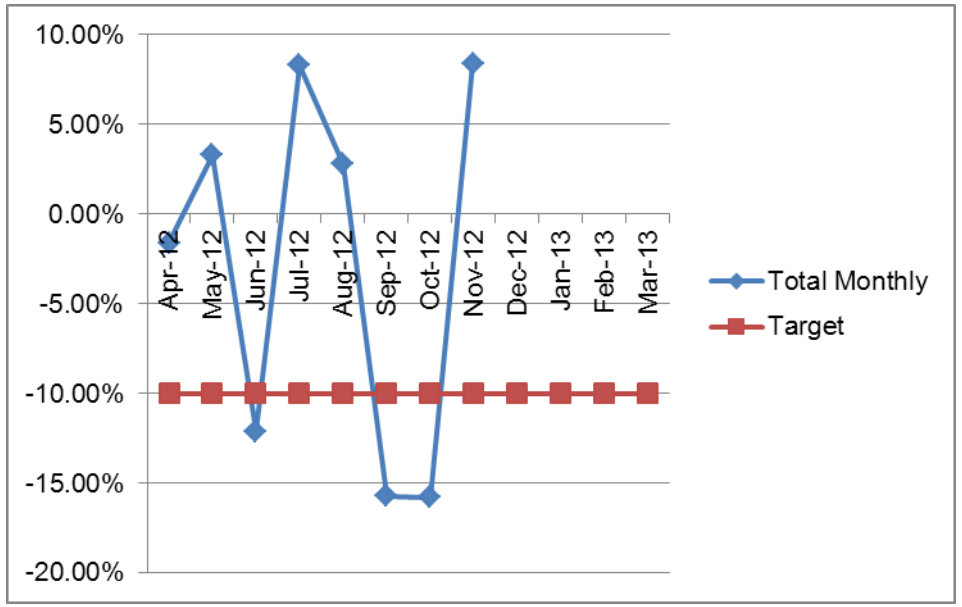
The total* conditions specified within this target are:

- COPD;
- Diabetes;
- Heart Failure; and
- Asthma.

April to November shows that only 1 out of the 4 specified long-term conditions, Heart Failure has achieved a higher reduction than the target of 10%. Cumulative position at November shows a reduction by 20.1%, whilst Asthma still shows a reduction of 6.7% it is not in excess of the target position. COPD and Diabetes continue to show an increase in unplanned admissions, 9.2% and 1.2% respectively.

The baseline admissions for the 4 specified long-term conditions from April to November is listed below with the corresponding in-year activity for 2012/2013:

- Total – Baseline 925 versus In-Year 893;
- COPD – Baseline 426 versus In-Year 465;
- Diabetes – Baseline 82 versus In-Year 83;
- Heart Failure – Baseline 328 versus In-Year 262;
- Asthma – Baseline 89 versus In-Year 83.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Total* Monthly	-1.6%	+3.3%	-12.1%	+8.3%	+2.8%	-15.7%	-15.8%	8.4%					R	↓
Total Admissions*	B 126 A 124	B 118 A 122	B 111 A 99	B 88 A 96	B 109 A 112	B 127 A 107	B 139 A 117	B 107 A 116						
Total* Cumulative	-	-	-	-	-	-	-	-3.5%					A	
COPD	-12.1%	+24.6%	+19.6%	+28.9%	+26.8%	-9.8%	-2.9%	16.4%					R	↓
COPD Admissions	B 58 A 51	B 57 A 71	B 46 A 55	B 38 A 49	B 41 A 52	B 61 A 54	B 70 A 68	B 55 A 64						
COPD Cumulative	-	-	-	-	-	-	-	9.2%					R	
Diabetes	+20%	+7.1%	-33.3%	-14.3%	+40%	-25%	-20%	33.3%					R	↓
Diabetes Admissions	B 8 A 10	B 13 A 14	B 8 A 6	B 8 A 7	B 10 A 14	B 16 A 12	B 10 A 8	B 9 A 12						
Diabetes Cumulative	-	-	-	-	-	-	-	1.2%					R	
Heart Failure	+16.7%	-32.3%	-66.7%	-9.4%	-20.9%	-24.3%	-40.5%	-20%					G	↓
Heart Failure Admissions	B 45 A 54	B 41 A 31	B 50 A 30	B 35 A 32	B 43 A 34	B 37 A 27	B 42 A 25	B 35 A 28						
Heart Failure Cum	-	-	-	-	-	-	-	-20.1%					G	
Asthma	-66.7%	-16.7%	+12.5%	+12.5%	-20%	-7.7%	-5.9%	50%					R	↓
Asthma Admissions	B 15 A 9	B 7 A 6	B 7 A 8	B 7 A 8	B 15 A 12	B 13 A 12	B 17 A 16	B 8 A 12						
Asthma Cumulative	-	-	-	-	-	-	-	-6.7%					Y	

Note: Long-term conditions admissions figures: B = Baseline / A = Actual In-Year

CP 22: UNNECESSARY HOSPITAL STAYS														
By March 2013, reduce the number of excess beddays for the Acute Programme of Care by 5%.														
Baseline: To be confirmed **TDP Assessment:** The Trust expects to be able to achieve this target								**Target:** Reduce by 5%						
Comment/Actions: Clarification remains outstanding, and is again being sought, from HSCB on the data definitions for this target.														
Monthly Position:													**Monthly Assess**	**Trend**
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**			
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A				

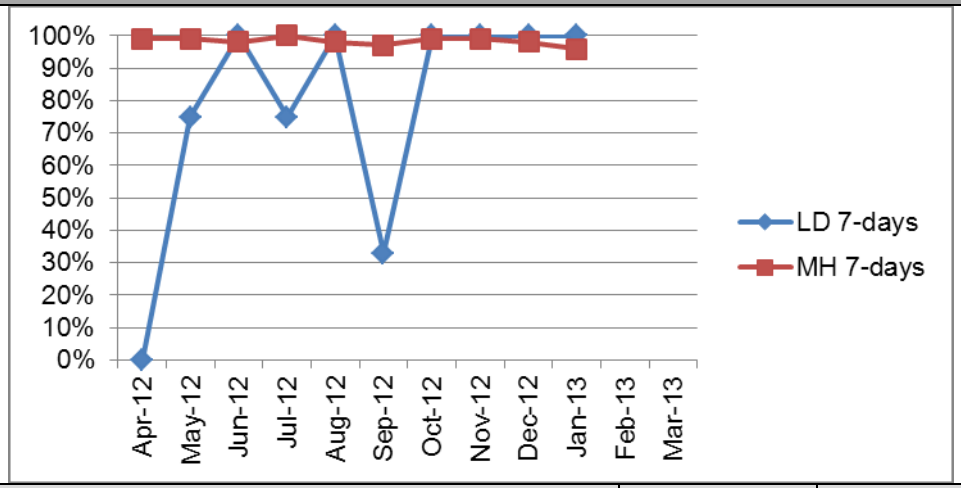
CP 23: PATIENT DISCHARGE

From April 2012, ensure that all learning disability and mental health discharges take place within 7-days of the patient being assessed as medically fit for discharge.

Baseline: LD – (all discharges 7-days)
MH – (all discharges 7-days)
TDP Assessment: To be confirmed

Standard: 100% all discharges 7-days

Comment/Actions: In Learning Disability 4 out of 4 patients were discharged within 7-days, whilst in Mental Health 120 out of 124 were discharged within 7-days.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
LD 7-days	0% (0 out of 1)	75% (3 out of 4)	100% (3 out of 3)	75% (3 out of 4)	100% (1 out of 1)	33% (1 out of 3)	100% (2 out of 2)	100% (5 out of 5)	100% (2 out of 2)	100% (1 out of 1)	100% (4 out of 4)		G	⇔
MH 7-days	99% (126 out of 127)	99% (130 out of 131)	98% (150 out of 153)	100% (135 out of 135)	98% (129 out of 132)	97% (106 out of 109)	99% (133 out of 136)	99% (122 out of 123)	98% (91 out of 93)	96% (110 out of 114)	97% (120 out of 124)		Y	⇔

CP 23: PATIENT DISCHARGE

From April 2012, ensure that all non-complex discharges from an Acute hospital take place within 6 hours; 90% of all complex discharges take place within 48-hours; and that all complex discharges, take place within 7-days.

Baseline: 95.27% – (non-complex 6-hours)
98.14% – (complex 48-hours)
99.79% – (all discharges 7-days – 3 out of 1879)
TDP Assessment: To be confirmed

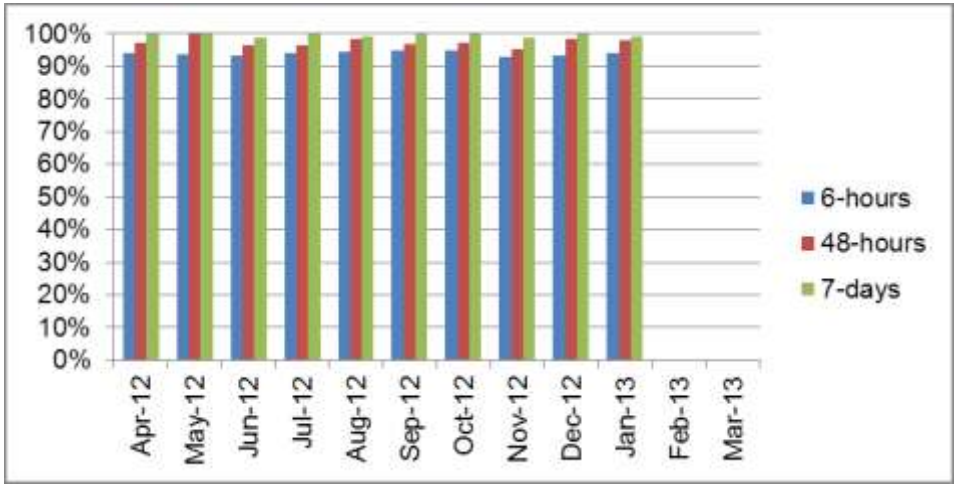
Standard: 100% non-complex 6-hours
90% complex 48-hours
100% all discharges 7-days

Comment/Actions:

Non-Complex Discharges – Performance against the 6-hour discharge standard has remained static in February (94.21%) in comparison to January (94.21%). This equates to 2423 out of 2552 non-complex discharges being completed within 6-hours with 129 out of 2552 not being completed within 6-hours.

This standard is one area of focus that will be monitored weekly by Acute Services Directorate through their newly established standing weekly Unscheduled Care Quality Review meeting.

Complex Discharges – 1 out of 117 complex discharges were not completed within 48-hours with no discharge waiting longer than 7-days.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
6-hrs	93.95%	93.77%	93.38%	94.15%	94.32%	94.86%	94.78%	92.87%	93.18%	94.21%	94.21% (2423 out of 2552)		Y	↑
48-hrs	97.32%	100%	96.50%	96.55%	98.46%	96.94%	97.30%	95.06%	98.29%	97.9%	99.15% (116 out of 117)		G	↔
7-days	100%	100%	98.60%	100%	99.23%	100%	100%	98.77%	100%	99.3%	100% (117 out of 117)		G	↔

MINISTERIAL PRIORITY: TO ENSURE THE MOST VULNERABLE IN OUR SOCIETY, INCLUDING CHILDREN AND ADULTS AT RISK OF HARM, ARE LOOKED AFTER ACROSS ALL OUR SERVICES

CP 24: CHILDREN IN CARE

From April 2012, increase the number of children in care for 12 months or longer with no placement change to 82%

Baseline: To be confirmed **TDP Assessment:** Likely to be achieved with some delay/partially achieved	**Standard:** Increase to 82%

Comment/Actions: The Community Information Team has advised that performance information for this standard will be taken from the AD1 and OC2 annual questionnaires. Therefore, performance information will only be available on an annual basis as opposed to a monthly basis.

Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

CP 25: CHILDREN IN CARE

By March 2013, increase the number of care leavers aged 19 in education, training or employment to 72%.

Baseline: 81% (@ 31 March 2012)
TDP Assessment: Achievable

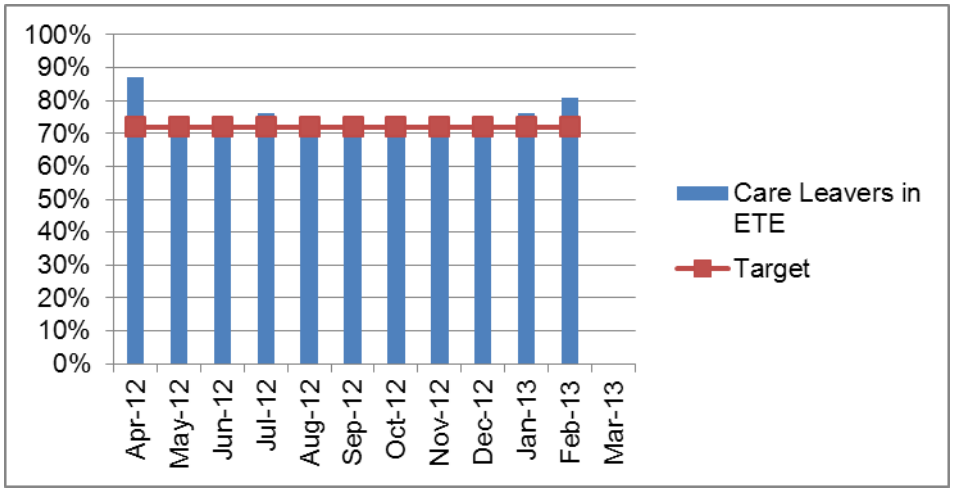
Target: 72%

Comment/Actions: Performance in February is in excess of the target with 81% of care leavers in education, training or employment. This equates to 22 out of 27 care leavers.

Reasons for the trends in this performance are associated with:

- Young people, who despite the teams vigorous efforts, have refused to engage with the 16 Plus Service.
- Young people, who have not engaged in ETE but who have been offered 'Give and Take' and have not attended their various appointments with the employability worker.

Discussions have been held Regionally in respect of not counting those young people who refuse our service. Staff continue to try and engage all these young people in ETE.



Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
87%	75%	73%	76%	74%	74%	72%	74%	71%	76%	81% (22 out of 27)		G	↑

CP 26: CHILDREN IN CARE													
By March 2013, increase the numbers of looked after children placed for adoption within 12-month of the best interest's decision to 60%.													
Baseline: To be confirmed **TDP Assessment:** Achievable							**Standard:** Increase to 60%						
Comment/Actions: The Community Information Team has advised that performance information for this standard will be taken from the AD1 and OC2 annual questionnaires. Therefore, performance information will only be available on an annual basis as opposed to a monthly basis.													
Monthly Position:												**Monthly Assess**	**Trend**
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

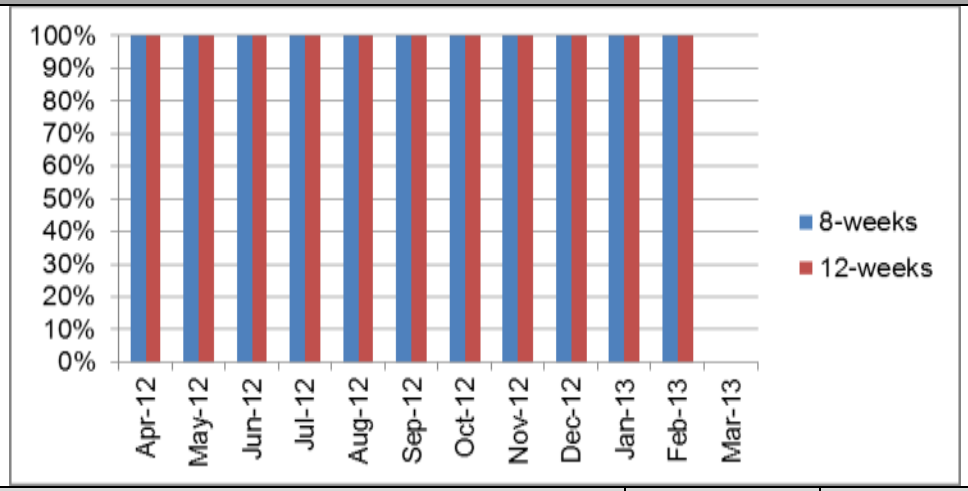
CP 27: COMMUNITY CARE

From April 2012, people with continuing care needs wait no longer than 8-week for assessment to be completed, and have the main components of their care needs met within a further 12-weeks.

Baseline: 100% (8-weeks – cumulative April 2011 – March 2012)
100% (12-weeks – cumulative April 2011 – March 2012)
TDP Assessment: Achievable

Standard: 100% 8-weeks
100% 12-weeks

Comment/Actions: There continues to be no-one waiting >8-weeks or >12-weeks for, respectively, their assessment to be completed or for the components of their care needs to be met.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
8-weeks	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100% (46 out of 46)		G	⇔
12-weeks	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100% (0 out of 0)		G	⇔

CP 28: LEARNING DISABILITY / MENTAL HEALTH

By March 2013, 40% of the remaining long-stay patients in learning disability and psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.

Baseline: Learning Disability – 43
Mental Health – 26

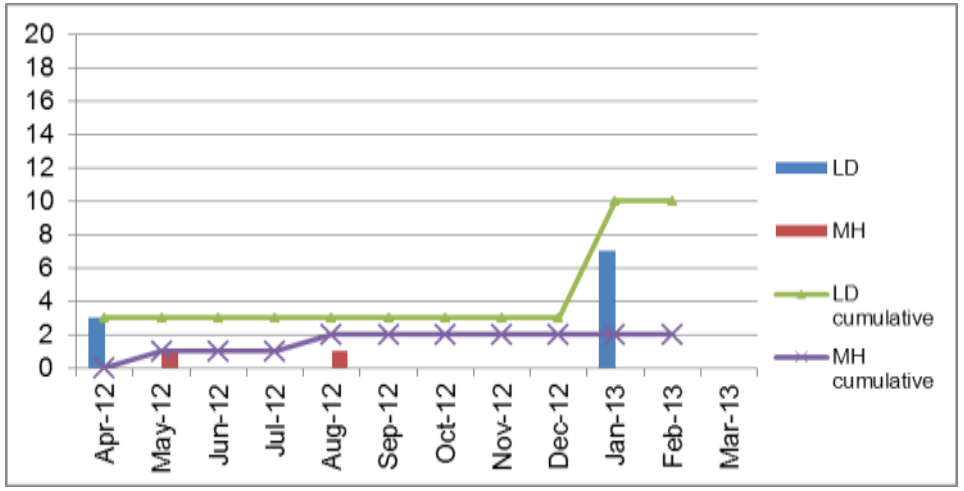
TDP Assessment: Learning Disability – Achievable
Mental Health – Achievable if additional resources agreed

Target: Learning Disability – 12
Mental Health – 17

Comment/Actions:

Mental Health – Resettlement plans for the remaining long stay population in St Luke's remain dependent upon a number of Supported Living schemes that are not going to be available in-year to meet the target. Approval for the schemes has been achieved although they will not be operational in 2012/2013. However, supported housing schemes should be available providing sufficient places to resettle the remaining population by 2015. In the interim the Division is exploring all other potential opportunities for resettlement in year within existing facilities as well new places in the Independent Sector.

Learning Disability – Resettlement plans for learning disability are well advanced in 2012/2013 and are likely to exceed target. January saw the resettlement of 7 clients into the scheme based in Armagh. The Granville scheme is due to open in 2013/2014 and remains on target. The Trust has recently met with the HSCB to review progress towards in-year and long-term targets. The HSCB are now seeking the Trust to profile the resettlement plan over the 3 years, albeit the in-year target will remain.



	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
LD	3	0	0	0	0	0	0	0	0	7	0		G	↑
LD Cumulative	3	3	3	3	3	3	3	3	3	10	10			
MH	0	1	0	0	1	0	0	0	0	0	0		A	↔

MH Cumulative	0	1	1	1	2	2	2	2	2	2	2			

CP 29: MENTAL HEALTH

From April 2012, no patient waits longer than 9-weeks to assess child and adolescent services (CAMHS) or adult mental health (AMH) services, and 13- weeks for psychological therapies (PT) (any age).

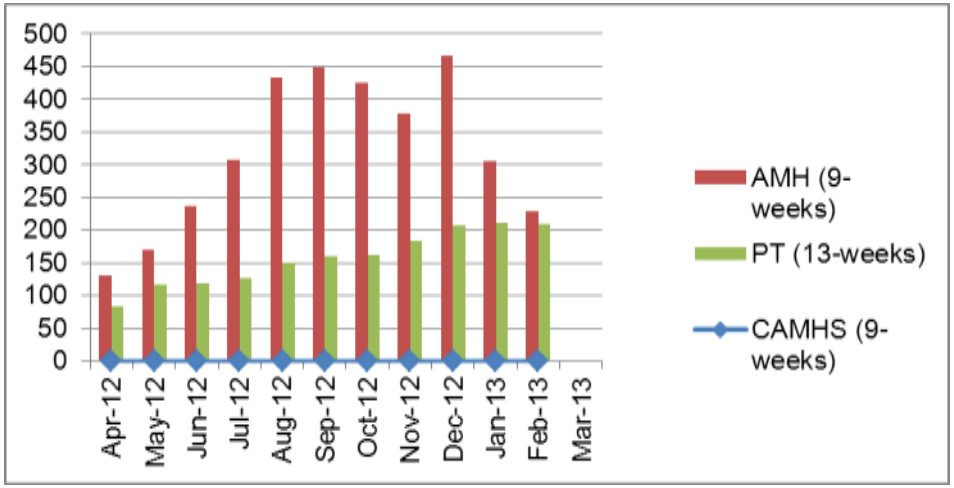
Baseline: CAMHS – 0 (>9-weeks @ 31 March 2012)
Adult Mental Health – 86 (PMHC 11 and Memory 75) (>9-weeks @ 31 March 2012)
Psychological Therapies – 60 (>13-weeks @ 31 March 2012)
TDP Assessment: CAMHS – Achievable
Adult Mental Health and Psychological Therapies – Achievable if additional resources agreed

Standard: 0 >9-weeks – CAMHS and Adult Mental Health
0 >13-weeks – Psychological Therapies

Comment/Actions:

Adult Mental Health Services - The number of patients waiting in excess of 9-weeks has decreased in comparison to the January position. At the end of February 2013 228 patients were waiting in excess of 9-weeks for Adult Mental Health (AMH) with the breakdown as follows: Primary Mental Health Care 133 and Memory 95. The longest waiters for these services are 15-weeks and 61-weeks respectively.

- **Primary Mental Health Care -** A recovery plan has been developed, phasing in as appropriate, the appointment of the new staff along with any additional in-house capacity sourced and the Independent Sector capacity to profile when the service will return to 9-weeks, which is now anticipated to be achieved by the end of March 2013.
- **Memory/Dementia Services** – The total number of patients waiting in excess of 9-weeks has decreased in February (95) in comparison to January (114). The longest waiter, however, has increased to 61-weeks in February. This would indicate inappropriate chronological management practices. These excess waits are predominantly associated with OT capacity pressures. Risk to achievement of target.



Psychological Therapies – At the end of February there was a total of 210 patients waiting in excess of 13-weeks for Psychological Therapies (PT). This is a static position to the end of January. The majority of patients waiting in excess of 13-weeks are waiting for Adult Health ie. Pain Service (200) with 10 patients waiting in excess of 13-weeks within Adult Mental Health. The longest waiter is 56-weeks within Adult Health ie. Pain Service. It should be noted that there are cohorts of long waiting patients and these are not single 'stray' waiters.

The approval and appointment of 2.70 WTE practitioners within Psychological Therapies will assist with the recurrent capacity shortfall within the service. However, it is anticipated that these staff will not commence until February 2013, therefore, this additional capacity will only have a short-term effect on addressing the capacity gap by the end of March 2013. It should be noted that the appointment of these staff will not help address the backlog which has steadily built up over the last 18-months.

A recovery plan requires to be developed, phasing in as appropriate, the appointment of the new staff along with any additional in-house capacity sourced to profile when the service will return to 13-weeks, which is unlikely to be achieved in this financial year.

	Monthly Position:												Monthly Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
CAMHS	0	0	0	0	0	0	0	0	0	0	0		G	↔
AMH Including Memory/ Dementia	131	169	237	307	436	449	425	378	467	305	228		R	↑
PT	84	117	119	126	151	160	162	184	208	211	210		R	↔

MINISTERIAL PRIORITY: TO IMPROVE AND PROTECT HEALTH AND WELL-BEING AND REDUCE INEQUALITIES; THROUGH A FOCUS ON PREVENTION, HEALTH PROMOTION AND EARLIER INTERVENTION

CP 1: BOWEL SCREENING

By March 2013, ensure the Bowel Cancer Screening Programme has invited 50% of men and women aged 60 – 71.

Update Position:	Monthly Assess	Trend
	G	↔

Comment: Bowel screening within the Trust has commenced, with the first patients having been sent FOB kits in January 2012.

- Bowel cancer screening sessions are now being provided – 1.5 sessions weekly.
- The Specialist Screening Practitioner (SSP) sessions are now seeing 8 patients weekly.
- The Trust has seen a higher than predicted conversion rate to endoscopy for the Bowel Screening patients and as a consequence additional lists are being undertaken to keep within the 2 week waiting following SSP assessment. In addition to the higher predicted conversion rate there is a higher than anticipated number of repeat colonoscopies required which is compounding current capacity pressures. Repeat colonoscopies are required due to, for example, histology stating that a polyp is incompletely excised or excision indeterminent; and guidelines say that a repeat procedure is required in 3 months until there is no residual polyp. A short paper has been forwarded to PHA and HSCB to highlight increasing demand which is putting pressure on general scope access targets.
- A new decontamination facility in South Tyrone Hospital is fully commissioned and operational.
- The JAG visit was on the 5 December 2012 and the unit has been accredited.

Detailed below is a breakdown of the Bowel Screening activity from February 2012 – February 2013:

Bowel Screening Pre-Assessment			Bowel Screening							
Pre-Assessed	DNA Pre-Assess	Cancelled Pre-Assess	Colonoscopy	CT Colongraphy	Refused Colonos.	Unfit	DNA	CND	Repeats Undertaken	Cancers Detected
285	3	4	278	10	7	7	4	10	36	23

• The rate of repeat colonoscopies, as demonstrated above, after 1-year is 13%.		

CP 2: AAA SCREENING		
By June 2012, have in place a Northern Ireland wide programme to screen men aged 65 for abdominal aortic aneurysm.		
Update Position:	**Monthly Assess**	**Trend**
Comment: This target is being taken forward on a Regional basis. The Trust has engaged with the Regional Group to provide a local facility for screening.	**N/A**	**N/A**

MINISTERIAL PRIORITY: TO IMPROVE THE DESIGN, DELIVERY AND EVALUATION OF HEALTH AND SOCIAL CARE SERVICES THROUGH INVOLVEMENT OF INDIVIDUALS, COMMUNITIES AND THE INDEPENDENT SECTOR

CP 19: TRANSFORMING YOUR CARE		
By June 2012, produce population plans for implementation following the *Transforming Your Care* report.		
Update Position:	**Monthly Assess**	**Trend**
Comment: The Trust working in partnership with the SLCG through the jointly chaired *Southern Health Economy Population Plan Programme Board* has established local programme management arrangements to bring forward local implementation of the proposals contained within TYC. The Population Plan was submitted to HSCB by June 2012 as required. An updated version of the plan has been posted on the Trust and DHSSPS websites as part of the launch of the regional consultation process which commenced on 9 October 2012.	G	**Achieved**

CP 20: TRANSFORMING YOUR CARE		
During 2012/2013, develop and implement Integrated Care Partnerships in supporting the implementation of *Transforming Your Care*		
Update Position:	**Monthly Assess**	**Trend**
Comment: The Trust working in partnership with the SLCG through the *Southern Health Economy Population Plan Programme Board* has identified the local development of integrated care partnerships as the key transformational change vehicle for driving local service reform in line with the recommendations of TYC. A local ICP project structure has been developed and 9 GP practices are currently engaged in a pilot phase to inform the future for the ICP. These practices are working with secondary care clinicians and service user/voluntary sector representatives to consider how best to risk stratify patients over 65 and ensure they have individual care plans in place across primary and secondary teams to avoid unplanned hospital admissions or attendance at ED where appropriate. A draft care plan and guidance has been prepared for use in the pilot and work is ongoing to identify ICT solutions for risk stratification, implementation of an electronic care plan and the sharing of guidelines and care pathways. The work to inform the CIP is well progressed with 8 multi-disciplinary case conferences having taken place since December 2012 and 42 care plans have been completed by the 8 GP Practices involved in the pilot. An ICP Co-Ordinator was appointed	G	**N/A**

in December 2012 to support GPs and Trust Hospital & Community staff in this process up to 31 March 2013.		

4.0 SPECIFIC ORGANISATIONAL COMMITTMENTS FOR 2012/2013 – GOVERNANCE AND ORGANISATIONAL IMPACT

LEVEL OF CARBON EMISSIONS		
Reduce the level of direct carbon emissions across the Trust estate by 1% on 2011/2012 levels		
Baseline: 28,167 tCO^2 (2010/2011)	**Monthly Assess**	**Trend**
Comment: In 2011/2012 the level of direct carbon emissions was reduced by 2.1% (593 tonnes of CO^2) in comparison with 2010/2011. This allowed the Trust to save on an additional payment of £7,116 as the Trust are charged £12 per tonne under the CRC regulations. The Trust will submit the CRC report to the Northern Ireland Environment Agency by 29 July 2013. From 4 to 8 March the Southern Trust along with the other Health Trusts in Northern Ireland has been promoting Climate Week 2013 and advising staff what they can do to reduce carbon emissions.	G	↑

WATER USAGE		
Reduce the level of water usage across the Trust Estate by 2% on 2011/2012 levels		
Update Position:	**Monthly Assess**	**Trend**
Comment: The Trust has put arrangements in place to record and monitor water usage more closely on major sites. Some of the £300,000 investment by the Carbon Emission Reduction Initiative (CERI) will be used to help monitor water consumption across the Trust. It should be noted there has been pressure on water consumption across the Trust due to increased flushing and sampling for Infection Control purposes and also increase in hand washing practices. This may make achievement of this target difficult. However, patient safety is of utmost importance.	Baseline not yet available to facilitate monitoring against.	

WASTE SENT FOR DISPOSAL		
Reduce the level of waste sent for disposal across the Trust Estate by a further 5% by 2012/2013 compared to 2011/2012 levels		
Baseline (Cardboard Recycling): 23 tonnes of cardboard recycled (Quarter 1 2010/2011)	**Monthly Assess**	**Trend**
Comment: From 1 April 2012 – 28 February 2013 the Trust recycled 176 tonnes of cardboard or 11.87% of domestic waste in comparison to 113 tonnes of cardboard in the same period of 2011/2012. This is an increase of 54%. During this period the total waste tonnage has also decreased by 21 tonnes.	G	↑

PROMPT PAYMENT OF INVOICES
The Trust will aim to achieve at least 95% of all payments in accordance with Departmental guidance on the prompt payment of invoices
Comment: Reported in Monthly Finance Report.

FINANCIAL BREAKEVEN
The Trust will aim to deliver financial breakeven by 31 March 2013 in accordance with Circulars HSC (F) 24/2010 and HSC (F) 25/2010 (and any annual update)
Comment: Reported in Monthly Finance Report.

FORECAST OUTTURN POSITION
The Trust will ensure the accuracy of their forecast outturn position, in particular that: (a) Forecast outturns provided in the October 2012 – December 2012 monitoring returns are within +/- 1.0% of the final outturn position; and (b) Forecast outturns provided in the January 2013 – March 2013 monitoring returns are within +/-0.5% of the final outturn position:
Comment: Reported in Monthly Finance Report.

Southern Health and Social Care Trust

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COMMISSIONING PLAN STANDARDS/TARGETS FOR 2012/2013

INDICATORS OF PERFORMANCE

March 2013 for February 2013 Performance

MINISTERIAL PRIORITY: TO IMPROVE AND PROTECT HEALTH AND WELL-BEING AND REDUCE INEQUALITIES; THROUGH A FOCUS ON PREVENTION, HEALTH PROMOTION AND EARLIER INTERVENTION

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Life Expectancy	**A1.** Average life expectancy for women and men.	*Not applicable to the Trust – Public Health Agency*											
	A2. Life expectancy differential between Northern Ireland average and most disadvantaged areas for women and men.	*Not applicable to the Trust – Public Health Agency*											
	A3. Number of deaths of men aged 65 and over from aortic aneurysm, excluding thoracic aortic aneurysm (AAA).	*Not applicable to the Trust – Public Health Agency*											
	A4. Infant mortality.	*Not applicable to the Trust – Public Health Agency*											
Circulatory Conditions	**A5.** Admissions for Venous Thromboembolism. **Note: 4 VTE Pilot Wards – Information Reported Against Overall Bundle Compliance* ** MAU – Medical Admissions Unit CAH* ** SEAW – Surgical Elective Admissions Ward CAH* ** MM&CCU – Male Medical & Coronary care Unit DHH* ** FS – Female Surgical DHH* *(N/D = Audit Not Done)*	MAU 90% SEAW 95% MM& CCU 80% FS 58%	MAU 80% SEAW 100% MM& CCU 45% FS N/D	MAU 100% SEAW 100% MM& CCU 75% FS N/D	MAU 80% SEAW 100% MM& CCU 95% FS N/D	MAU 55% SEAW 100% MM& CCU 75% FS N/D	MAU 75% SEAW 100% MM& CCU 65% FS 0%	MAU 70% SEAW 100% MM& CCU 80% FS 36%	MAU 55% SEAW 100% MM& CCU N/D FS N/D	MAU 60% SEAW 100% MM& CCU N/D FS 70%	N/A	N/A	

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Standard Death Rates	**A6.** Age Standardise Death Rate (SDR) for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.	*Not applicable to the Trust – Public Health Agency*											
Suicide and Self Harm	**A7.** Suicide rates across Northern Ireland and most deprived areas.	*Not applicable to the Trust – Public Health Agency*											
	A8. Number of A & E presentations due to deliberate self-harm (self-harm/suicide attempt/ideation)	156	137	148	176	138	152	171	168	140	158	141	
Diabetes	**A9.** The prevalence of diabetes.	*Not applicable to the Trust – Public Health Agency*											
Obesity	**A10.** Level of overweight and obesity across the life course (2-10 year olds and 16+).	*Not applicable to the Trust – Public Health Agency*											
Alcohol Consumption	**A11.** Number of alcohol-related admissions to hospital.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against A11											
Smoking	**A12.** Proportion of adults who smoke.	*Not applicable to the Trust – Public Health Agency*											
	A13. Numbers of pregnant women, children and young people and adults from deprived areas (lower quintile) who set a quit date through cessation services.	*Not applicable to the Trust – Public Health Agency*											

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Teenage Pregnancies and Sexual Health	**A14** Rate of births to mothers under 17 years of age (with breakdown by Neighbourhood Renewal Area).	*Not applicable to the Trust – Public Health Agency*											
	A15. Number of new episodes of selected sexually transmitted infections diagnoses made by Genito-urinary Medicine clinics.	Monthly return undertaken by GUM Clinic to Public Health Agency. Head of Performance working with GUM Clinic to extract required data.											
	A16. New HIV diagnoses.	Monthly return undertaken by GUM Clinic to Public Health Agency. Head of Performance working with GUM Clinic to extract required data.											
General Health – Flu	**A17.** Uptake of seasonal flu vaccine by front-line health and social care workers. **Note: Vaccination programme commenced 1 October 2012*	-	-	-	-	-	-	1250	93	10	-	-	

MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS

Area	IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cancer Services	**B1.**	Percentage of patients receiving first definitive treatment within 31-days of a cancer diagnosis (decision to treat). **Note: Reported 1-month in arrears*	100%	100%	100%	95.5%	96.4%	99%	98.4%	99.1%	95.9%	98.3%		
	B2.	Percentage of patients seen within 14-days of an urgent referral for breast cancer.	100%	100%	100%	100%	100%	100%	100%	100%	99.6%	72%	98%	
Attendances at Emergency Departments	**B3.**	Percentage of Category A (life threatening calls) responded to within eight minutes regionally, and in each LCG area.	*Not applicable to the Trust – Northern Ireland Ambulance Service*											
	B4.	Number of new and unplanned attendances at emergency departments Types 1 and 2. **Note: Data currently available only for type 1 & type 3 EDs*	11,296	12,566	11,625	11,605	12,015	11,671	11,815	11,184	11,130	11,116	10,509	
Elective Care	**B5.**	Rate of Review outpatient appointments where the patient did not attend.	8.7%	8.6%	8.9%	9.4%	8.6%	8.3%	8.1%	8.6%	9.5%	9.1%	8%	
	B6.	Rate of new outpatient appointments cancelled by the hospital.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B6											
**Please note revised B7 figures*	**B7.**	Number of GP referrals to consultant-led	6,685	7,574	6,720	6,677	7,201	7,086	8,104	7,479	5,419	N/A	N/A	

Area	IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
		outpatient services*.												
Stroke	**B8.**	Number of patients admitted with stroke.	37	36	47	38	46	42	47					
Patient/Client Experience	**B9.**	Outcomes against the patient client experience standards in the settings agreed for the formal work plan. **Note: Corporate Compliance based on the number of Directorates where the questions were asked – Please note % reported are for December 2009 – September 2012*	Respect 85% and 73% Attitude 89%, 85%, and 89% Communication 84%, 84%, and 87% Privacy & Dignity 67%, 51%, and 73%						N/A					
	B10.	Incidents of pressure ulcers occurring in hospital medical and surgical care settings between 0-300 days.	12 acquired in hospital setting			11 acquired in hospital setting			8 acquired in hospital setting					
	B11.	Number of falls in hospital settings.	347			349			318					
	B12.	Number of hearing aids fitted within 3 months as a percentage of completed waits.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	B13.	Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised).	N/A	N/A	88%	89%	90%	84%	91%	91%	87%	88%	84%	
	B14.	Percentage of patients who have lifts and ceiling track hoists installed within 22 weeks of the OT assessment and options appraisal.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Prescribing	**B15.** Level of attainment of prescribing targets set out in the Regional Board pharmacy efficiency programme.	Information report to be developed to facilitate reporting against B15											
	B16. Level of prescribing of cardiovascular medicines.	Information report to be developed to facilitate reporting against B16											
	B17. Level of prescribing of gastro-intestinal medicines.	Information report to be developed to facilitate reporting against B17											
	B18. Levels of medicines dispensed generically in primary care.	*Not Applicable to Trust – Primary Care*											
Organ Transplants	**B19.** Percentage change in overall transplants.	*Not Applicable to Trust -*											
	B20. Percentage change in transplants following DCD (Donation following Cardiac Death).	*Not Applicable to Trust -*											
Cardiac Catheterisation	**B21.** Percentage increase in access to cardiac catheterisation.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against B21											

MINISTERIAL PRIORITY: TO DEVELOP MORE INNOVATIVE, ACCESSIBLE AND RESPONSIVE SERVICES; PROMOTING CHOICE AND BY MAKING MORE SERVICES AVAILABLE TO THE COMMUNITY

Area	IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Maternity and Young Children ** Please note information requested for babies born in MLU*	**C1.**	Level of activity in maternity and child health programme of care including average length of stay.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against C1											
	C2.	Percentage of babies born by caesarean section and number of babies born* in midwife-led units, either freestanding or alongside.	C-S 32.6% MLU 74	C-S 30.4% MLU 80	C-S 32.9% MLU 60	C-S 33.8% MLU 63	C-S 30.8% MLU 81	C-S 36% MLU 66	C-S 34.2% MLU 76	C-S 31.3% MLU 79	C-S 34.1% MLU 56	C-S 32.4% MLU 65	C-S N/A% MLU 56	
	C3.	Initial incidence of breastfeeding.	Information report to be developed to facilitate reporting against C3											
	C4.	Preschool and school-age children offered the updated Child Health Promotion Programme through percentage uptake at each of the key contacts within the programme offered by health visitors.	Information being sourced to facilitate reporting against C4											
	C5.	Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland.	*Data definitions to be finalised with DHSS&PS / HSCB*											

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	C6. Continued implementation of the first test site of the Family Nurse Partnership programme in Northern Ireland within the fidelity requirements of the programme license.	*Not Applicable to Trust -*											
Pharmacy	**C7.** Number of services delivered by pharmacists in community settings.	*Not Applicable to Trust -*											
	C8. Proportion of people accessing the "Building the Community Pharmacy Partnership" programme residing in the bottom 3 quintiles of wards/Super Output Areas (SOA's) by deprivation.	*Not Applicable to Trust -*											
Specialist Drug Therapies	**C9.** Number of patients waiting longer than 13 weeks to commence NICE recommended therapies for multiple sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.	*Not Applicable to Trust – Belfast Health & Social Care Trust*											

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	C10. Number of patients waiting longer than 9 weeks to commence specialist drug treatment for wet AMD for the first eye, and 6 weeks for the second eye.	*Not Applicable to Trust – Belfast Health & Social Care Trust*											
Long Term Conditions	**C11.** Number of patients benefiting from remote telemonitoring (cumulative).	195	212	226	239	263	283	316	358	374	396	416	

MINISTERIAL PRIORITY: TO IMPROVE THE DESIGN, DELIVERY AND EVALUATION OF HEALTH AND SOCIAL CARE SERVICES THROUGH INVOLVEMENT OF INDIVIDUALS, COMMUNITIES AND THE INDEPENDENT SECTOR

Area	IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Advocacy Services	**D1.**	Level of usage of advocacy services by Looked After Children (monitored by number of contacts made by Looked After Children with advocacy Services).	Information being sourced to facilitate reporting against D1											
	D2.	Level of usage of commissioned advocacy services within each HSC Trust area categorised by model of advocacy.	Information being sourced to facilitate reporting against D2											
Direct Payments	**D3.**	Numbers of direct payment cases.	588	587	567	569	571	582	593	589	610	590	608	

MINISTERIAL PRIORITY: TO IMPROVE THE PRODUCTIVITY BY ENSURING EFFECTIVE AND EFFICIENT ALLOCATION AND UTILISATION OF ALL AVAILABLE RESOURCES IN LINE WITH MINISTERIAL PRIORITIES

Area	IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Efficiency Indicators	**E1.**	Elective average pre-operative stay. **Note: Beddays used by elective admissions not on day of surgery – Reported 3-months in arrears*	120	89	92	85	109	107	117	95				
	E2.	Average length of stay in acute programme of care.	Elect 0.87 Non-Elect 4.78	Elect 0.9 Non-Elect 5.52	Elect 0.97 Non-Elect 7.24	Elect 0.78 Non-Elect 4.66	Elect 0.81 Non-Elect 4.75	Elect 1.02 Non-Elect 4.58	Elect 0.93 Non-Elect 4.92	Elect 0.93 Non-Elect 4.78	Elect 1.01 Non-Elect 5.47	Elect 0.78 Non-Elect 6.21	Elect 1.08 Non-Elect 4.46	
	E3.	Average length of stay for stroke patients within the acute programme of care.	Information available early 2013											
	E4.	Day surgery rate for each of a basket of 24 elective procedures. **Note: Reported 3-months in arrears*	64%	66%	64%	63%	64%	65%	65%	65%				
	E5.	Percentage of operations cancelled for non-clinical reasons.	1%	1%	1.6%	1.5%	1.5%	1.2%	1.2%	0.9%	2.3%	2.1%	2.4%	
	E6.	Percentage of patients admitted electively who have their surgery on the same day as admission. **Note: Reported 3-months in arrears*	89.23 %	88.55 %	87.42 %	86.43 %	89.18 %	88.36 %	87.98 %	87.71 %				

Area	IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	E7.	Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.	Imag. 94.8% Non-Imag. 91.7%	Imag. 95.7% Non-Imag. 95.7%	Imag. 95.9% Non-Imag. 97.2%	Imag. 93.2% Non-Imag. 97.6%	Imag. 93% Non-Imag. 94.2%	Imag. 95.2% Non-Imag 97.7%	Imag. 98.3% Non-Imag 96.6%	Imag. 97.8% Non-Imag 94.3%	Imag. 92.8% Non-Imag 98%	Imag. 93.3% Non-Imag 95.3%	Imag. 94.5% Non-Imag 97.1%	
	E8.	Percentage of routine diagnostic tests reported within 4 weeks of the test being undertaken.	Imag. 99.7% Non-Imag. 95.4%	Imag. 99.7% Non-Imag. 99.2%	Imag. 99.7% Non-Imag. 98.8%	Imag. 100% Non-Imag. 99.2%	Imag. 100% Non-Imag. 96.8%	Imag. 100% Non-Imag. 99.5%	Imag. 100% Non-Imag 98.6%	Imag. 100% Non-Imag 99.8%	Imag. 99.9% Non-Imag 100%	Imag. 99.7% Non-Imag 96.2%	Imag. 99.7% Non-Imag 99.5%	
	E9.	HSC staff absence rates.	Month 4.67% Cum. 4.67%	Month 5.14% Cum. 4.91%	Month 5% Cum. 4.94%	Month 4.81% Cum. 4.91%	Month 5.23% Cum. 4.97%	Month 5.29% Cum. 5.02%	Month 5.38% Cum. 5.08%	Month 5.62% Cum. 5.14%	Month 5.88% Cum. 5.23%	Month 5.79% Cum. 5.92%	N/A	
	E10.	Selected consultant specialty monitoring.	Data definitions to be finalised with DHSS&PS / HSCB to facilitate reporting against E10											
	E11.	Nurse/bed ratios with Normative Staffing Ranges in the use across general and specialist areas to delivery on safety, quality and patient experience outcomes.	Information being sourced to facilitate reporting against E11											
	E12.	Ratio of new to review outpatient appointments scheduled by speciality and Trust. **Note: N:R based on actual activity – not scheduled*	Trust 1:1.96	Trust 1:1.87	Trust 1:1.79	Trust 1:1.65	Trust 1:1.71	Trust 1:1.64	Trust 1:1.77	Trust 1:1.76	Trust 1:1.83	Trust 1:1.77		

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Expenditure	**E13.** Balance of expenditure between community-based and hospital mental health services.	Information being sourced to facilitate reporting against E13											
	E14. Percentage of funding spent on primary and community care.	Information being sourced to facilitate reporting against E14											
	E15. Level of agency staff expenditure.	Information being sourced to facilitate reporting against E15											
	E16. Percentage of funding invested in Public health.	*Not Applicable to Trust – Public Health Agency*											
	E17. Percentage of funding invested in Tackling obesity.	*Not Applicable to Trust – Public Health Agency*											
Pharmacy	**E18.** Prescribing activity by (a) NI Medicines Formulary therapeutic category and (b) corresponding generic rates.	*Not Applicable to Trust – Primary Care*											

MINISTERIAL PRIORITY: TO ENSURE THE MOST VULNERABLE IN OUR SOCIETY, INCLUDING CHILDREN AND ADULTS AT RISK OF HARM, ARE LOOKED AFTER ACROSS ALL OUR SERVICES

Area	IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Children	**F1.** Percentage of all foster care placements that are kinship care placements. **Note: Data reflects kinship foster carers panel and field work approved*	30%	30%	30%	28%	31%	32%	32%	32%	32%	33%	33%	
	F2. Number of residential care leavers in education, training and employment. **Note: Data relates to over 19 years care leavers*	33 out of 38	27 out of 36	27 out of 37	28 out of 37	25 out of 34	25 out of 34	25 out of 36	25 out of 34	25 out of 35	25 out of 33	22 out of 27	
	F3. Numbers of children with an adoption best-interests decision notified to the Regional Adoption Information system (RAIS) within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child.	Information being sourced to facilitate reporting against F3											
	F4. The number of school-age children in care for 12 months or longer who have missed 25 or more school days.	Information being sourced to facilitate reporting against F4											

Area	IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Mental Health Services	**F5.**	Number of children treated in adult mental health wards.	Information being sourced to facilitate reporting against F5											
	F6.	Percentage of young people treated in adult ward.	Information being sourced to facilitate reporting against F6											

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

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 25th October 2012
Title:	Medical Directors Report
Lead Director:	Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	For assurance / information
Summary of key areas:	• Update on Junior Doctor mandatory training • Update on patient safety interventions

TABLE OF CONTENTS

1 Medical Education and Training

1.1 Postgraduate Education

1.1.1 Junior Doctors Induction - Mandatory Training

The Junior Doctors Generic Induction programme was re-launched with the introduction of the new Southern Docs extranet [www.southerndocs.hscni.net] portal for the Junior Doctors online induction commencing August 2012. Generic Induction consists of three distinct phases:-

- **Before you start:** Reading materials available before the Junior Doctor commences employment with the Trust via a password protected website.

- **First Day:** Focused down face to face induction programme

- **First month:** Competency based training and assessment modules to be completed within first month of taking up post.

The Medical Education Team has been pursuing the August 2012 junior doctor cohort to ensure they have attained all the required training competencies. The following competencies were deemed mandatory:

Competency	% Completed	% Desist
Hyponatremia	81.3%	0.5%
Induction	90.6%	0%
Infection Control	90.6%	0%
NEWS	74.6%	0%
NG tube placement	71.8%	2.3%
Patients enrolled in clinical trials	74.2%	0%
Peripheral Line	79.3%	0%
Resuscitation	49.3%	0.9%
RPRB Assessment	69.0%	6.1%
RPRB Competency	70.9%	6.1%
Safe use of Anticoagulants	77.5%	0.9%
Training Tracker	93.9%	0%
Taking Blood Cultures	80.4%	0%

In order to achieve 100% compliance, Associate Medical Directors and Educational Supervisors are to be advised of doctors who have not achieved full compliance for one-to-one follow up.

1.1.2 NIMDTA Deanery Visits – Medicine & Surgery

NIMDTA will be undertaking cyclical visits to Medical and Surgical training units at Craigavon Area Hospital and Daisy Hill Hospital on Thursday 22nd November 2012. Work is underway to collate the necessary pre-visit background information for both sites.

1.1.3 GMC National Trainer Survey 2011

Following the findings of the GMC National Trainer Survey 2011, which highlighted scores below the natiaonal mean for workplace based assessments and feedback to trainees, the Trust has facilitated Clinical and Educational Supervisor Faculty Development workshops at Craigavon Area Hospital and Daisy Hill Hospital. These workshops addressed developments in the Foundation Programme curriculum with regards to workbased placed assessments and workshops on how to effectively deliver feedback to trainees.

1.1.4 GMC National Trainee Survey 2012

Following the publication of results of the GMC National Trainee Survey 2012, which surveyed training for the period 30th April to 15th June 2012, a report has been compiled to highlight any areas where the Southern Trust fell above and below national average scores. From this report, an action plan has been developed to address areas where we need to concentrate our work to bring about improvements to the quality of training.

2 Patient Safety Interventions

2.1 PfA Interventions

The Patient Safety Quality Improvement Plan for 12/13 (attached) was agreed at SMT on Wednesday 29th August 12. The Plan which is based on the draft Commissioning Plan Priorities for 12/13 was forward to the Public Health Agency and will be subject to quarterly monitoring.

2.2 Regional Initiatives & Forthcoming Events

The final venous thromboembolism (VTE) HSC Safety Forum regional Learning Set was held on the 6th September 2012. Although this is the conclusion of the regional initiative the monitoring of the use of the Regional Risk Assessment Tool is subject to a PfA Target in 12/13.

A follow-up to the Global Trigger Tool Training Day in April took place on 9th October 2012. At this event Dr. Kamath & Dr. Adams presented their work on the Pilot of the use of the Global Trigger Tool in Maternity & Gynaecology over the period April 12 → June 12.

A team representing CYP & IMWH will be attending the forthcoming Master Class in Human Factor & Team Skills training on the 12th & 13th November 2012.

The Southern, Western & Northern Trusts will be working collaboratively with the HSC Safety Forum on the normalising childbirth agenda. The initial meeting for Senior Obstetricians & Midwives will be held on the 16th October 12.

The first draft of a Regional Falls Care Bundle, adapted from the Royal College of Physicians Fallsafe Model is currently out for consultation within Trusts. Once agreed the Care Bundle will be piloted on Acute Wards within the Trust over the coming months.

Cooperation & Working Together (CAWT) in partnership with the HSC Safety Forum is running a Patient Safety Training Course over the next 9 months. As well as the Southern & Western Trusts there will be

participants from hospitals in counties, Dublin, Sligo, Louth, Cavan & Donegal. The course will entail 5 group sessions & 5 webinars. As part of this course participants will have to undertake a Quality Improvement Project.

3 Research & Development

3.1 Life Sciences Conference – Cardiology Research – 8 February 2013

A further meeting was held on 4 October 2012 to advance plans for the Conference, the date having been confirmed as Friday, 8 February 2013. The venue will be Craigavon Civic Centre and it is hoped that a 'live link' can be established between the Cardiology Cath Lab at Craigavon Area Hospital and the Civic Centre for the presentation of an interventional cardiology case. A Draft Programme for the Conference was developed with the focus on Cardiology and local businesses. Craigavon Borough Council are proceeding to invite both Minister Foster and Minister Poots to the Conference. Invitations for the Conference will be issued from the Mayor of the Council and the Chair or Chief Executive of the Trust. It is proposed that the Chief Executives of the Council and the Trust will have input at the Conference.

BioBusiness NI, whose Chief Executive was present at the meeting, advised of their involvement in the establishment of a Cardiology Clinical Network, Chaired by Dr Robert Kelly, Cardiologist, Beacon Hospital, Dublin. Dr Kelly will present at the Conference and possibly launch the Network's linkage with Cardiology Research in the Trust on that occasion. Enterprise Ireland has funded the launch of the Network. The linkage to the Clinical Network with a base in the Republic of Ireland should bring opportunities for European Funding applications given that jurisdiction would be considered a separate partner.

Craigavon Borough Council advised an application had been made to Invest NI for the Life Sciences Cluster Programme and offered opportunity to Cardiology Research to input to the outcome, if there was an indication from Invest NI that the application was likely to proceed further.

3.2 Dying Fifteen Years Early – what can Traveller Men and relevant agencies do?

The research was undertaken by Fergal O'Brien, Health and Wellbeing Manager for a Master's degree and was launched on 19 September 2012. It is envisaged that the outcomes of this Study will be widely regarded as very significant research. It is planned that this research will be presented at a future Trust Board Workshop.

4 Emergency Planning

4.1 SHSCT Emergency Management Plan

The SHSCT Emergency Management plan which incorporates major incident and business continuity response has been circulated to Directors for comment and uploaded in draft form to the Trust intranet site. Work is required around information flows during a major incident. When this is complete the plan will be re-circulated internally and to external stakeholders. The plan details the notification and escalation arrangements for the Trust during a major emergency and will be supported by a range of plans: Acute Hospital Major Incident Plans, Pandemic Plans, Emergency Support Centre Plans. The plan will be reviewed on an annual basis. Staff were notified how to access the draft plan through an article in the fortnightly Trust E-Brief and via dissemination of an information leaflet.

4.2 Acute Hospital Major Incident Plan

The draft Acute Hospitals Major Incident Plan has been circulated within the Acute Directorate for comment and posted to the Trust's intranet. Work is still required in relation to the information flows during an acute major incident. When this work is complete, the plan will re-circulated to internal and external stakeholders for comment.

The plan details the operational response to a mass casualty incident or decontamination incident. The plan will be reviewed on a regular basis and at least annually. Staff have been advised how to access the plan.

4.3 Emergency Support Centre Protocols

A regional workshop was held in May 2012 to review the current multi-agency arrangements for establishing and managing Emergency Support Centres. This work stream is being taken forward by a CCG(NI) Sub-Group chaired by OFMDFM, and includes consideration of the statutory position of each of the organisations involved. The outcome of this work will aim to articulate an agreed set of arrangements or protocol setting out the roles and responsibilities of all partner organisations. As there has been no progress in relation to this piece of work, the SHSCT ESC protocols have been reviewed by members of the Southern Responders Group (Council, PSNI, Trust) to ensure they are fit for purpose and to include additional agencies, NIHE, British Red Cross. The revised protocols will be issued to participant agencies of the Southern Responders Group and the ESC managers for comment and will be finalised by the end of October.

4.4 Mass Prophylaxis Centre

The DHSSPSNI has asked all Trusts to develop plans to establish a Mass Prophylaxis Centre within their area. Such a centre would be required for administering prophylaxis to the public if there was an accidental or deliberate release of chemical, biological, radiological or nuclear agents. A multi-disciplinary working group has been established to progress this work. A site has been identified and work progresses to finalise the operational detail.

4.5 Emergency Planning Training Activity

Four members of staff attended a Hospital Major Incident Medical Management and Support course (HMIMMS) in July. The course was facilitated by the Northern Ireland Ambulance Service and was run by Advanced Life Support Group. The course is designed to give hospital staff who would be responsible for managing the response to a major incident.(mass casualty incidents),,the knowledge to plan and train for such a response. The Trust will encourage staff (ED, ICU, patient flow, Assistant Directors) from across the acute sector to attend the course. Further courses are being planned and a waiting list of staff wishing to attend the course is being compiled by NIAS.

4.6 Exercises

A multi-agency desktop exercise involving representatives from a range of agencies including the blue light services,(Northern Ireland Ambulance Service, , Northern Ireland Fire and Rescue Services, Maritime Coastguard Agency, Police Service Northern Ireland), utility services (Northern Ireland Electricity, Northern Ireland Water), Statutory agencies, (Public Health Agency, Health & Social Care Board), voluntary agencies, (British Red Cross) as well as a range of Trust staff, (Emergency Planner, Business Continuity Manager, Social Services and Communications staff). The exercise which was held in September 2012 was based on a flooding incident in the Craigavon area. A debrief report to identify learning arising is being compiled and will be issued to participants.

4.7 Incidents

An Emergency support centre was activated in response to a fire in a pub in Newry in the early hours of 1 October. The incident was stood down by PSNI at approximately 4.45am and residents were not evacuated.

4.8 Audit

An audit of the Trusts processes and equipment for chemical, biological, radiological and nuclear decontamination was carried out by the NIAS on 6th April. The outcomes are awaited.

5 Business Continuity

5.1 Outputs as at 31st October 2012

The following are the expected outcomes at the end of October 2012:

- The draft Trust-wide Business Impact Analysis report will be finalised and will be brought to SMT for approval along with recommendations as to the future management of Business Continuity processes within the Trust.

- A standardised template will be issued to all Heads of Service to assist with the review and/or development of Departmental Business Continuity and Emergency Response Plans in order to ensure compliance with the BS25999 standard. It is intended that these revised plans will be scalable and flexible to provide a response to any major emergency or business disruption.

Southern Health and Social Care Trust

Quality Care - for you, with you

Patient Safety
Quality Improvement Plan
2012/13

INDEX

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
Infection Rates To maintain or reduce the Trust's Q1 2010 C/Section SSI Rate of 8.3% by March 2013		SSI Rate (Quarterly)	SSI Rates: Baseline Q3 2008: CAH: 21.2% DHH: 11.1% TRUST: 18.7% NI: U/K Q1 2012 : CAH: 7.0% DHH: 3.6% TRUST: 5.7% NI: 9.7%	To continue to monitor quarterly infection rates (HISC)	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Leads – Dr. Beverley Adams (CAH) & Mr. David Sim (DHH)
To maintain or reduce the Trust's yearly mean Orthopaedic SSI rate by March 2013		SSI Rate (Quarterly)	SSI Rates: Baseline 08/09: CAH: 0.47% NI: 1.02% 11/12: CAH: 1.17% NI: 0.32% Q1 12: CAH: 3.64% NI: 0.19%	To continue to monitor quarterly infection rates (HISC)	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead – Mr. Brian Mockford

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
To achieve a goal of 500 Vent Days between VAPs during the period April 2012 and March 2013		Vent Days between VAPs	Baseline 08/09: 300 Vent Days between VAPs – achieved twice 11/12: Between 1st April 12 and 5th January 12 a period of 1172 Vent Days between VAPs was achieved Position end of June 12: 224 Vent Days achieved prior to VAP on 27th May 12. Vent Days post VAP 136	To continue to monitor Vent Days between VAPs. Data will be collected monthly & reported quarterly	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead - Dr. Chris Clarke
To achieve a Southern Trust Central Line Infection Rate of 0.50 per 1,000 Line Days by March 2013		Central Line Infection Rate (Monthly)	Baseline 08/09: 1.17 per 1,000 Line Days 11/12: 0 per 1,000 Line Days Position end of June 12: 1.04 per 1,000 Line Days	To continue to monitor monthly infection rates, which will be reported quarterly	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead – Dr. Nizam Damani

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
WHO Surgical Safety Checklist To achieve at least 85% compliance with the WHO Surgical Safety Checklist across all theatres by March 2013	% compliance with checklist completed and signed at all 3 stages i.e. before induction, draping and skin incision and before the patient leaves to operating room and with the checklist being filed in the patient's Medical Records	Monthly audits from Main Theatres, CAH, T&O Theatre, CAH, D.S.U., CAH, Theatres, DHH & Theatres, STH	Baseline January 2012 → March 2011 – 88% 11/12: 97% Position at end of June 12: 99%	Continue to monitor and follow up on compliance To carry out a quality assessment of the checklist in use	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Lead – Mr. Ronan Carroll, Assistant Director, Cancer & Clinical Services

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
Crash Call Rate – Deteriorating Patient (CAH & DHH) To maintain or reduce the Trust 2009/10 Crash Call Rate of 1.89 per 1,000 deaths & discharges by March 13 NB: Excludes Crash Calls in ED, Coronary Care, Cath Lab, ICU & HDU	Monthly measurement of Cardiac Arrest Calls	Monthly Crash Call Rate per 1,000 deaths / discharges at CAH & DHH	Baseline 08/09: 1.89 per 1,000 deaths & discharges 11/12: 1.31 per 1,000 deaths & discharges Position at end of June 12: 1.73 per 1,000 deaths & discharges	NEWS Compliance Continue to review cardiac arrest calls and feed any areas of concern to the Acute Governance Committee, which will oversee the implementation of any local or Trust learning	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Leads – Bernie O'Connor, Resuscitation Officer, CAH & Helen Cullen, Resuscitation Officer, DHH
National Early Warning Score (NEWS) To introduce NEWS on all relevant wards & achieve 95% Overall Bundle Compliance by March 13	-NEWS observation chart with patient identity -Is frequency of monitoring prescribed as indicated on NEWS chart -Was NEWS monitoring frequency adhered to -All vital signs are recorded -Total score is correctly calculated -Was appropriate response followed -All elements performed	Monthly Crash Call Rate per 1,000 deaths / discharges at CAH & DHH	Baseline NEWS Overall Bundle Compliance not available yet	NEWS Chart introduced to all relevant wards August 12 Vast majority of staff undertook NEWS e-learning training module during July 12 NEWS Implementation Group will continue to meet until process fully intergraded Escalation Audit to be introduced in due course	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead – Dr. Charlie McAllister, Associated Medical Director, Cancer & Clinical Services

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
Venous Thromboembolism (VTE) Prophylaxis To improve compliance with the VTE Risk Assessment across all ward areas achieving 95% compliance by Mar 2013 To spread the risk assessment audit from Pilot Wards to all relevant wards by March 2013	% compliance with Risk Assessment	Monthly audits	Baseline 10/11: Pilot Wards: MAU, CAH: 69% SEAW, CAH: 88% Med. Medical, DHH: 59% Surgical Ward, DHH: 20% 11/12: MAU, CAH: 96% SEAW, CAH: 96% Med. Medical, DHH: 77% Surgical Ward, DHH: 36% Position at end of June 12: MAU, CAH: 90% SEAW, CAH: 98% Med. Medical, DHH: 70% Surgical Ward, DHH: 58% (April 12 only)	Introduction of Medical & Surgical Admission Booklets Introduction of Regional VTE Patient Information Leaflet & Poster Spread of auditing compliance in non-Pilot Wards has commenced Update all guidance on the Trust's intranet Use of Regional VTE Screensaver during 12/13 Develop further the mechanism for measuring Outcomes/Root Cause Analysis & feedback to Consultants on patients who develop a PE or DVT within 3 months of an inpatient episode	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead – Dr. Kathryn Boyd

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
HSMR (Standardised Mortality Rate) To monitor monthly HSMR and review all case notes with a high RAMI score.				• Quarterly report to be provided by CHKS • Report subject to validation process • "Red Flag" RAMI scores are reviewed by Senior Clinician • Quarterly report produced for Associate Medical Directors, Senior Management Team, Trust Governance Forums, M& M Forums and Trust • Any coding issues to be logged with Trust Coding Forum	Responsible Directors – Dr. John Simpson, Medical Director / Paula Clarke, Director of Performance & Reform System Leaders – Anne Brennan, Senior Manager, Medical Directorate and Deborah Burns, AD Clinical & Social Care Governance

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
<u>Pressure Ulcers</u> **Process Measure:** To achieve 95% compliance with all elements of the SKIN Care Bundle in 2 Pilot Wards, CAH by March 13 **Outcome Measure:** To achieve a Hospital Acquired Pressure Ulcer Rate of under 2.0 per 1,000 Bed Days on Pilot Wards by Mar 13	% compliance with SKIN Care Bundle on all "at risk" patients: -Surface -Keep Moving -Incontinence -Nutrition	Hospital Acquired Pressure Ulcer Rate per 1,000 Bed Days.	Baseline SKIN Care Bundle Audits on Pilot Wards: 2 North Resp., CAH: May 12: 0% June 12: 71% 4 South Surgery, CAH: May 12: 0% June 12: 11% Hospital Acquired Pressure Ulcer Rates: Baseline (Nov 11 → Mar 12): 2 North Resp., CAH: 0.36 per 1,000 Bed Days Baseline (Dec 11 → Mar 12): 4 South Surgery, CAH: 0.50 per 1,000 Line Days Position at end of June 12: 2 North Resp., CAH: 3.03 per 1,000 Bed Days 4 South Surgery, CAH: 0.35 per 1,000 Bed Days	24 Hour Pressure Ulcer Prevention & Management Plan, which replaces the existing Repositioning Chart, introduced in Pilot Wards for use on all "at risk" patients Safety Cross in use on Pilot Wards Continue to improve compliance with the SKIN Bundle on Pilot Wards Continue to hold Monthly Team Meetings Provide further training on Pilot Wards Development of Pressure Ulcer Patient Safety Dashboard Introduction of Regional Patient Information Leaflet Spread work to an additional 2 Pilot Wards during 12/13	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Leads – Denise McDonagh, TVN/ICN & Anita Heron, TVN

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
Emergency Department To achieve 95% compliance with all elements of the College of Emergency Medicine's Sepsis Bundle in the ED's of CAH & DHH by March 13	% compliance with Sepsis Bundle -Vital signs & blood glucose monitored -High flow O2 commenced -Serum lactate obtained -blood cultures obtained -Fluids administered as per protocol -antibiotics administered as per protocol -Urinary output recorded -Medical Pick up (time of same to be decided Regionally)		Baseline June 12: Overall Bundle Compliance CAH 10% & DHH 0% (Rates subject to change following decision on Bundle Element – Medical Pick up)	Monthly Team Meetings have been established Awareness of this initiative has been raised within the ED's of CAH & DHH Team have reviewed Baseline Data & introduced measures to improve compliance	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead – Mr. Seamus O'Reilly
Stroke	Patients who are deemed suitable for thrombolysis receive first bolus within 60 minutes of arrival at ED		Baseline Oct 10 → Mar 11 64% 11/12 54%	The Stroke Collaborative Team are taking forward this Intervention Data in respect of timeliness of Assessment, CT Scan	

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
			Position at end of June 12: 67%	Bolus & Transfer are reviewed by the ED Team each month	
Ensure that rate of patients who leave before treatment is complete is below 5%, as recommended by the College of Emergency Medicine (March 11) by March 13			Position at end of June 12: 3.6%	The monthly data produced by the Directorate of Performance & Reform was amended to bring the Trust into line with how same was being measured in the other Trusts in NI	
Ensure that the rate of Unscheduled Re-attenders (within 7 days) is below 5%, as recommended by the College of Emergency Medicine (March 11) by March 2013			Position at end of June 12: 5.9% NB: Data is in respect of re-attendances within 30 days as opposed to the 7 day College of Emergency Medicine standard	The current Report will be changed to the 7 day standard recommended by the College of Emergency Medicine once the revised monitoring definitions for 12/13 are issued by the DHSSPS	
Patient/Client Experience	Participate in the Regional Initiative being undertaken by the PHA		Waiting on the Regional initiative being undertaken by the PHA	The Team have agreed to support the forthcoming PHA initiative	

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
Global Trigger Tool (GTT) A Pilot of the Global Trigger Tool is underway			Three Teams will review a random sample of 15 discharges covering the period April 12 → June 12. The 3 areas covered are Gynae, Neo-natal & Obstetrics	When the Pilot has been completed the reviewers will meet & prepare a Report for the Medical & Acute Directors. At this stage a decision will be made on whether there is merit it taking forward this initiative The Team will also participate in the Regional Global Trigger Tool follow-up event in October 12	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead – Dr. Martina Hogan

Aim/ Objective (How much by when)	Measures (to include numeric goals)		Current Position (Baseline + progress to date as at 30 June 12)	Actions/ Interventions	Key Contact (Name and contact details)
	Process	Outcome			
Falls To introduce a Regional Agreed Falls Bundle in Pilot Wards, in an Acute setting, and achieve 95% compliance with same by March 2013 To establish a Baseline of Falls in the selected Pilot Wards and agree a Rate Reduction Aim	Regionally agreed Falls Bundle	Falls rate per 1,000 patient days or % Rate Reduction Aim	Directorate Falls Groups have been working on Falls Reduction for the past 2 years. Initiatives introduced include: • Risk Assessment • Falls Care Plan • Development of information Sheets • Guidance on completion IR1 form • Introduction of Intentional Rounding • Development of post-falls Flow Chart • Introduction of "Falling Star" • Review of data on Falls on Pilot Wards • Trust Post Falls Body established Trust are represented on the Regional Falls Group	Introduction of Regional Agreed Falls Bundle on Pilot Wards Agree mechanism for Real Time Monthly Auditing of Falls Bundle Compliance & Falls Rates on Pilot Wards Development of Patient Safety Falls Dashboard for Pilot Wards Posting of Process & Outcome measures on the Extranet Provide a monthly report on progress to the Acute Governance Committee	Executive Director – Dr. John Simpson, Medical Director Operational Director – Dr. Gillian Rankin, Director of Acute Services Clinical Lead – To be decided

Southern Health and Social Care Trust

Environmental Cleanliness Report

Prepared by: Functional Support Services
8/10/2012

Contents

Section

1. Departmental Audit Results (Cleanliness Matters Toolkit)

The following table shows a summary of the overall weighted scores for each hospital taking into account all risk categories ie very high, high, moderate and low risk category areas.

Hospital	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
St Luke's	90	95	89	93	89	92	91	92	92	92	92	94
South Tyrone	93	95	94	95	92	93	92	93	94	92	93	94
Longstone	85	82	80	90	88	93	83	93	92	91	90	94
Mullinure	93	95	93	96	94	90	92	94	94	95	92	94
CAH	90	90	89	90	91	89	94	93	92	91	94	93
Lurgan	99	94	97	98	99	98	98	98	98	98	98	97
DHH	94	95	95	95	95	94	96	96	96	95	97	95
Bluestone	99	97	99	99	99	98	99	98	98	98	98	98
Average	93	93	92	95	93	93	93	95	95	94	94	95

The following tables show the summary average Departmental Audit scores for community facilities for the quarter ending June 2012.

Moderate Risk Areas	No. of Audits Completed	Overall %	Domestic %	Manager %	Estates %
OPPC Day Centres	3	98	99	100	91
Day Centres/ SECs MHD	9	87	90	83	86
Resource Centres MHD	1	99	100	100	92
MHD Supported Living	6	86	89	92	75
Health Centres/Clinics/ PCC/Com Hosp	17	92	93	94	85
OPPC Residential	5	86	81	97	76
CYP Residential	3	87	93	97	90
MHD Residential	0	-	-	-	-
CYP Children's Centres	1	96	96	90	100
Others	1	86	89	100	67

Low Risk Areas	No. of Audits Completed	Overall %	Domestic %	Manager %	Estates %
Offices	4	92	91	100	93
Community Ambulance Stations	1	95	94	100	96

It is intended to include the Departmental Audit scores for community facilities for the quarter ended September 2012 in the next report to Trust Board.

2. Departmental Audit Results – Scores below 85% in September 2012 for Very High & High Risk Areas

Hospital	Functional Area	Domestic	Nursing/ Manager	Estates	Overall
DHH	Theatres	95	100	80	93
CAH	Emergency CDU	99	82	94	96
DHH	Day Procedure Unit	99	100	84	97
DHH	Male Medical	92	92	83	91
South Tyrone	Minor Injuries Unit	88	100	84	89
CAH	Emergency Majors	92	75	95	90
DHH	Male Surgical	100	100	75	97
South Tyrone	B Floor Left	90	82	89	88
CAH	MAU Backside	80	92	100	85

3. Managerial Audit Results (regional audit tool)

There were 7 Managerial Audits undertaken in 1 area during September 2012 and the results are shown in the table below.

Location	Ward/Dept	Environment %	Patient Linen %	Waste %	Sharps %	Patient Equipment %	Hygiene Factors %	Hygiene Practices %	Average %
CAH	Orthopaedic	97%	100%	100%	100%	100%	100%	100%	100%

Compliant	85% or above
Partial Compliance	76 to 84%
Minimal Compliance	75% or below

4. Exception Report

This exception report includes items which are outstanding from Action Plans developed following either internal Environmental Cleanliness or RQIA Inspections. These items relate mainly to the fabric of the buildings. Cleaning issues and small repairs which have been addressed have not been reflected in this report.

Facility	Dept	Work Required	Update Oct 2012
CAH	Areas including Elms, Maples, Laundry, Cedars, Stores	General Refurbishment	Funding for residential accommodation has been applied for. Other work included on the environmental cleanliness priority works list.
CAH	Lifts / lift lobbies	General Refurbishment	Main passenger lifts are undergoing major upgrade. Walls and ceilings in the lift lobbies to be refurbished. Floors are not included at this stage.
CAH	Emergency Dept	Rolling programme for repainting needs to be established. Wheelchairs to be checked for damage to upholstery and repaired or replaced.	All areas have been painted to date. All wheel chairs are regularly checked and arrangements are in place for repairs.
CAH	ENT Outpatients	ENT OPD needs refurbished and redecorated. Refurbishment of dirty utility.	Has been placed on the environmental cleanliness priority works list.
CAH	Wards	(1) Refurbishment of ward kitchens is required. A number require repairs to floor and repainting, others require complete floor replacement. (2) Refurbishment of toilets is required on many wards.	Has been placed on the environmental cleanliness priority works list
CAH	Non ward areas on each floor	Refurbishment of toilets.	The toilets at the Boardroom, Broadway and Staff Dining Room have been refurbished. Has been placed on the environmental cleanliness priority works list
Longstone	Wards	Some painting required & flooring in some areas needs replaced. Replacement sluice and wash hand basins.	Has been placed on the environmental cleanliness priority works list.
South Tyrone	Various floors	Some ceiling tiles need to be replaced, some painting required. Refurbishment of sluice area.	Has been placed on the environmental cleanliness priority works list.

Facility	Dept	Work Required	Update Oct 2012
South Tyrone	Reception	Refurbishment of reception.	Has been placed on the environmental cleanliness priority works list.
St Luke's	Various Wards & Villas	Some painting & ceiling tiles replacement, flooring in some areas needs replaced. Replacement sluices and wash hand basins.	Has been placed on the environmental cleanliness priority works list.
St Luke's	Mortuary	Damp proofing and repainting required.	
St Luke's	Industrial Therapy Unit	Refurbishment of staff toilet and cleaners store.	
DHH	Emergency Dept	Provide patient bathroom or shower area. Refurbishment of domestic store, toilet beside domestic store and dirty utility. Macerator or washer disinfector required in the department. Repainting of walls in Fracture Waiting Area.	Refurbishment of DHH A&E included in Capital Priorities submission to DHSSPS. First phase completed June 2011. Second phase completed 25th May 2012.
DHH	Stroke Rehab	Refurbishment of kitchen.	This will be refurbished when the Paeds ward moves to the 6th floor.
DHH	Wards	Some repairing and floor replacement.	Floor repairs have been carried out in Medical/Stroke, Coronary Care Unit, Female Medical, Female Surgical, Male Surgical, High Dependency Unit, DPU, Paeds, entrance/ exit to theatre lobby and lift lobbies on 3rd, 4th& 5th levels.
DHH	Changing Areas	Refurbishment of changing rooms in delivery suite	Has been placed on the environmental cleanliness priority works list.
DHH	Male Medical, Coronary Care and Female Surgical	Increase number of wash hand basins to meet National Guidelines ie one sink per four beds	To be raised through the HCAI Clinical Forum.
DHH	Outpatients	Some flooring and sinks need replaced.	Has been placed on the environmental cleanliness priority works list. Sinks have been replaced in 3 consulting rooms. Flooring replaced in toilets and painted.

Stinson, Emma M

From:	Stinson, Emma M
Sent:	18 January 2010 16:40
To:	Carroll, Anita; Carroll, Ronan; Gibson, Simon; McVey, Anne; Stead, Lindsay; Trouton, Heather
Cc:	Burrell, Gail; Lappin, Aideen; McCullough, Elizabeth; Murphy, Jane S
Subject:	*URGENT* Daily Meetings at 9am
Attachments:	Memo to Acute (2).doc; Venues (2).doc

Dear All

Please see attached memo from Dr Rankin. Please cascade through your directorate.

Many thanks

Emma

Emma Stinson
Administrative Assistant to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI

Southern Health and Social Care Trust

Acute Directorate

Memorandum

Our ref:	**MGR/ES**	**Your ref:**	
To:	Acute ADs, Heads of Service, OSLs and Grade 5's with operational role in delivery of elective access standards		
From:	**Dr Gillian Rankin, Interim Director of Acute Services**		
Cc			
Date:	**18th January 2010**		
Subject:	Achievement of Elective Access Standards		

Following internal monitoring meetings held last week to review delivery of March PTLs, it is apparent that we face significant challenges across a wide range of specialties. Current capacity to monitor, identify areas for action, negotiate solutions and ensure all available capacity is maximised across specialties and sites is also challenged given our wide-ranging reform programme which is running in parallel.

I have discussed this position with the acting Chief Executive, and have agreed that increased monitoring and additional capacity is required with immediate effect to reduce risk. Additional capacity has been agreed from Performance and Reform, and I will also be asking a number of people within the Directorate to allocate dedicated time to this task.

From tomorrow (Tuesday), I am establishing a daily 9am meeting which should be attended by all ADs, Heads of Service, OSLs and Grade 5 staff with an operational role in the delivery of elective access standards. The purpose of this meeting is to review the delivery of PTLs, issues requiring resolution, negotiations required with clinical colleagues, etc., and to identify actions to urgently address issues raised. These meetings will be facilitated by Lesley Leeman, and attendance and response on agreed actions should be considered priority above other areas of work.

In addition, Mairead has advised that staff across the Trust should not be attending regional meetings unless agreed as critical with their Director, so I would ask you to review diaries and discuss with me.

I have no doubt of the commitment of staff to ensure that access standards are met where possible, and thank you in anticipation of your co-operation with these arrangements.

The meeting tomorrow will be held in Tutorial Room 1, MEC, CAH and Clanrye House, Meeting Room, DHH.

Thank you

Date	*Time*	*Video-Conferencing venue booked*
19th January	9am – 10am	Tutorial Room 1, MEC, CAH & Clanrye House Meeting Room
20th January	9am – 10am	Communications Room, Admin Floor, CAH & Clanrye House Meeting Room
21st January	9am – 10am	Communications Room, Admin Floor, CAH & Committee Room 2
22nd January	9am – 10am	Tutorial Room 1, MEC, CAH & Committee Room 2
25th January	9am – 10am	Tutorial Room 1, MEC, CAH & Clanrye House Meeting Room
26th January	9am – 10am	Tutorial Room 1, MEC, CAH & Clanrye House Meeting Room
27th January	9am – 10am	Tutorial Room 1, MEC, CAH & Tutorial Room
28th January	9am – 10am	Tutorial Room 1, MEC, CAH & Tutorial Room
29th January	9am – 10am	Tutorial Room 1, MEC, CAH & Committee Room 2
1st February	9am – 10am	Tutorial Room 1, MEC, CAH & Committee Room 2
2nd February	9am – 10am	Tutorial Room 1, MEC, CAH & Clanrye House Meeting Room
3rd February	9am – 10am	Tutorial Room 1, MEC, CAH & Clanrye House Meeting Room
4th February	9am – 10am	Tutorial Room 1, MEC, CAH & Committee Room 2

5th February	9am – 10am	Tutorial Room 1, MEC, CAH & Committee Room 2

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 06 July 2010 15:47
To: Stinson, Emma M
Subject: FW:
Attachments: UROLOGY ICATS.xls; BREAST.xls; CARDIOLOGY.xls; DERMATOLOGY.xls; DERMATOLOGY ICATS.xls; DIABETIC.xls; ENT.xls; GASTRO.xls; GENERAL MEDICINE.xls; GENERAL SURGERY.xls; GYNAE.xls; HAEM TREATMENT.xls; LIPIDS.xls; LOW VISION.xls; NEUROLOGY.xls; OPTHALMOLOGY.xls; ORAL SURGERY.xls; ORTHO ICATS.xls; ORTHODONTICS.xls; ORTHOPAEDICS.xls; PAED NEUROLOGY.xls; PAEDS.xls; PAIN.xls; RESPIRATORY.xls; RESTORATIVE DENTISTRY.xls; RHEUMATOLOGY.xls; THORACIC.xls; UROLOGY.xls

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From: Robinson, Katherine
Sent: Tuesday, July 06, 2010 3:46:54 PM
To: Rankin, Gillian; Reid, Trudy; Corrigan, Martina; Devlin, Louise; O'Rourke, Eileen; Adair, Loraine; McStay, Patricia Sr; McGeough, Mary
Cc: Forde, Helen; Carroll, Anita; Nelson, Amie; Connolly, Connie Auto forwarded by a Rule

Any queries let me know. We have tried to complete this as accurately as possible from April onwards and we now have a greater emphasis on the recording of this by staff.

Regards

Katherine

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[redacted]								

Irrelevant information redacted by the USI

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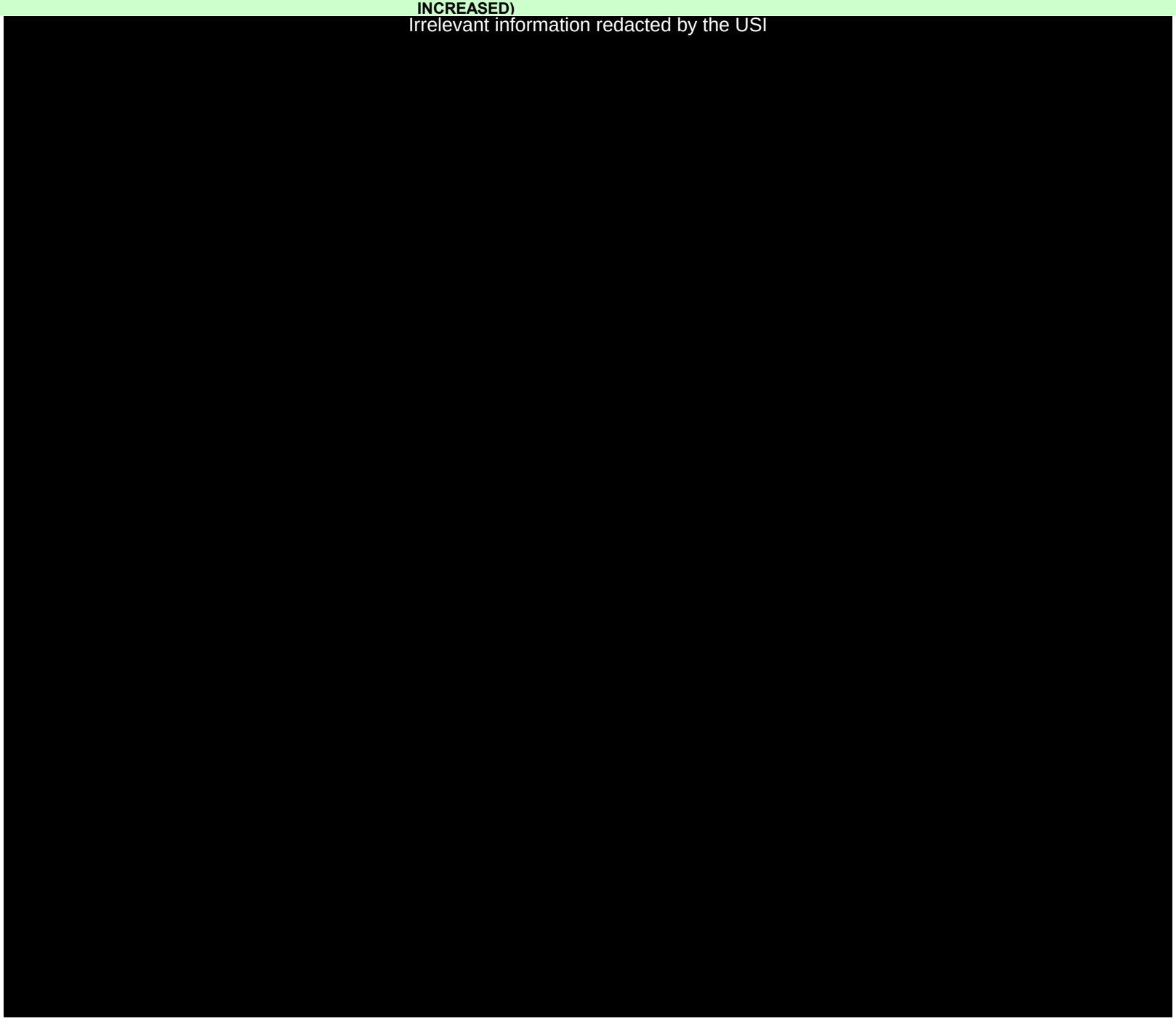

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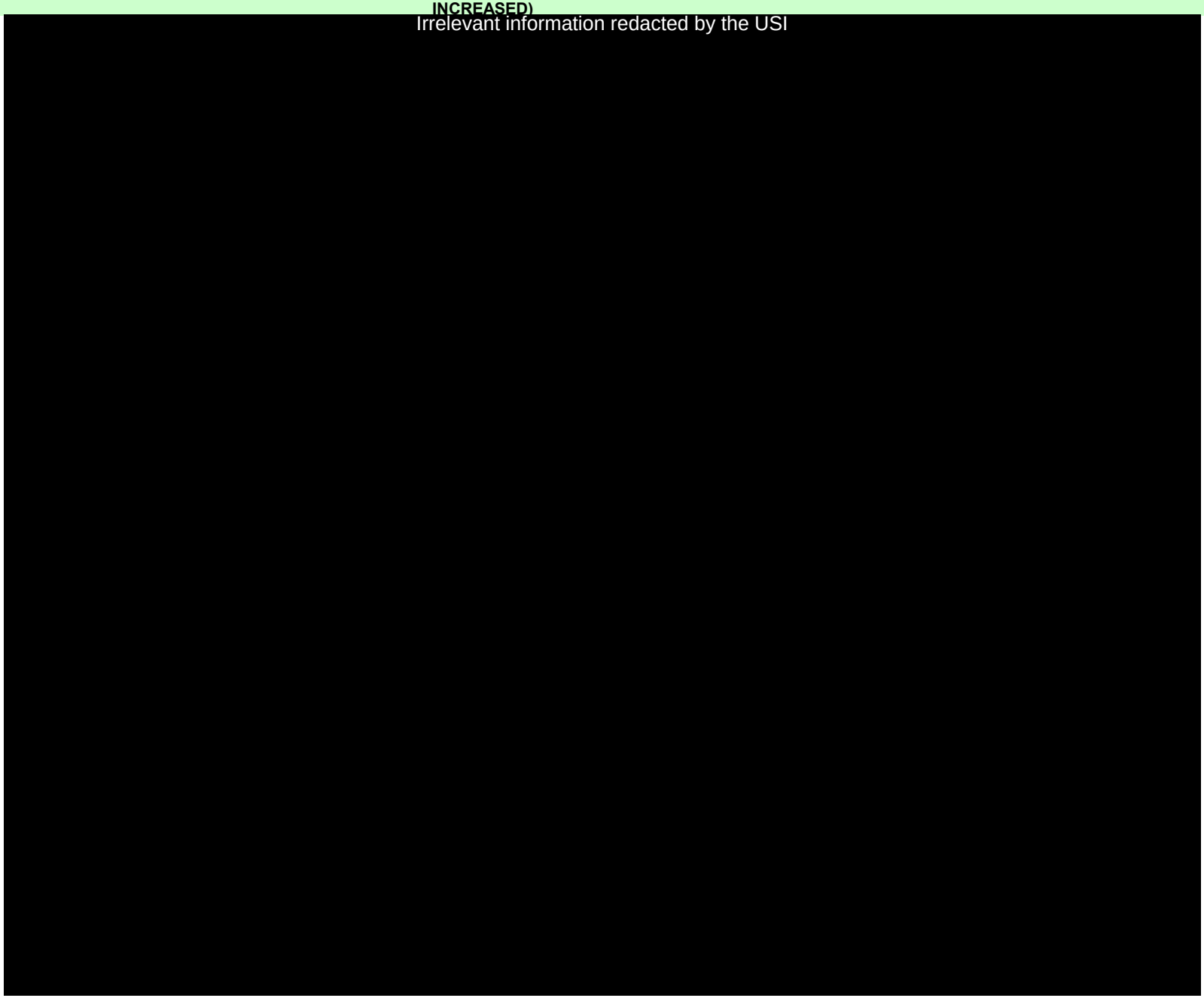

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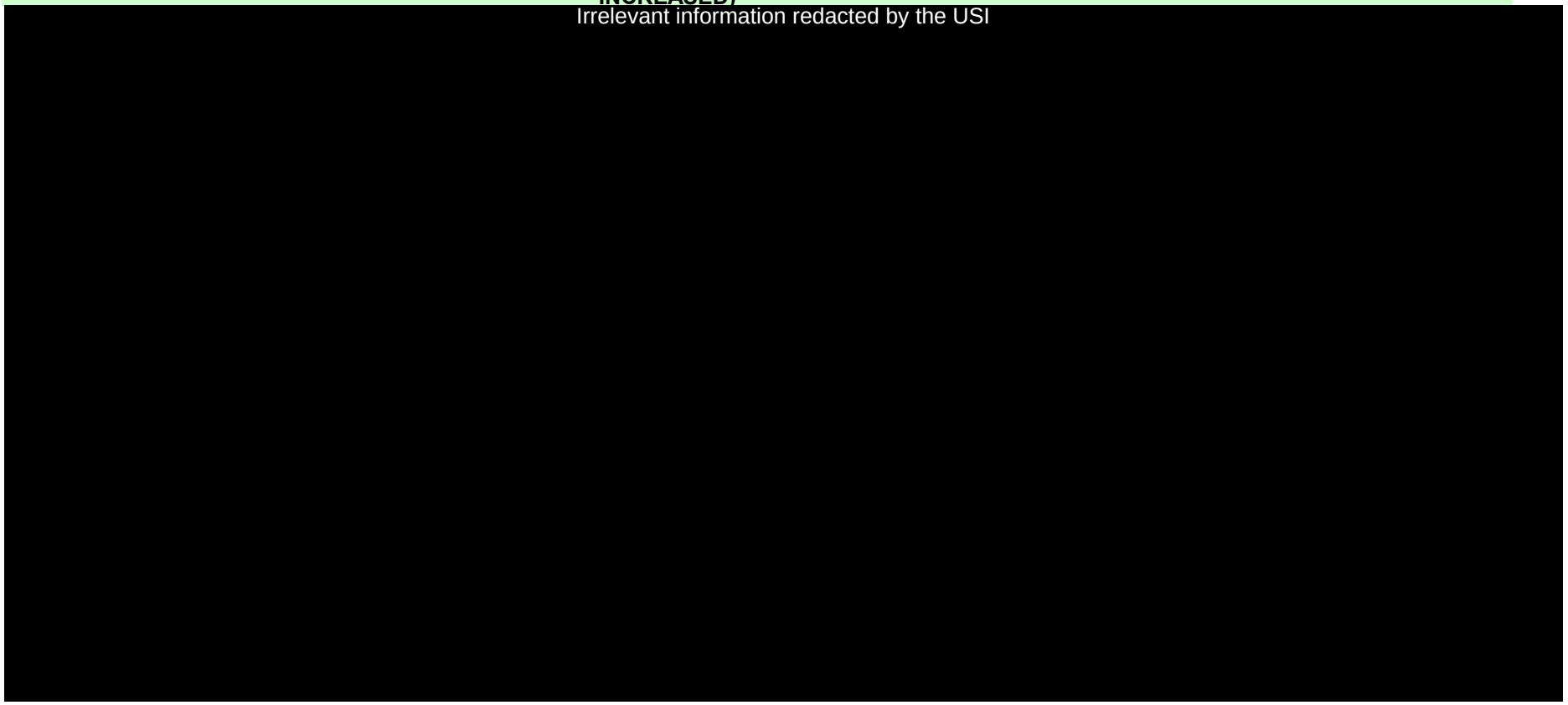

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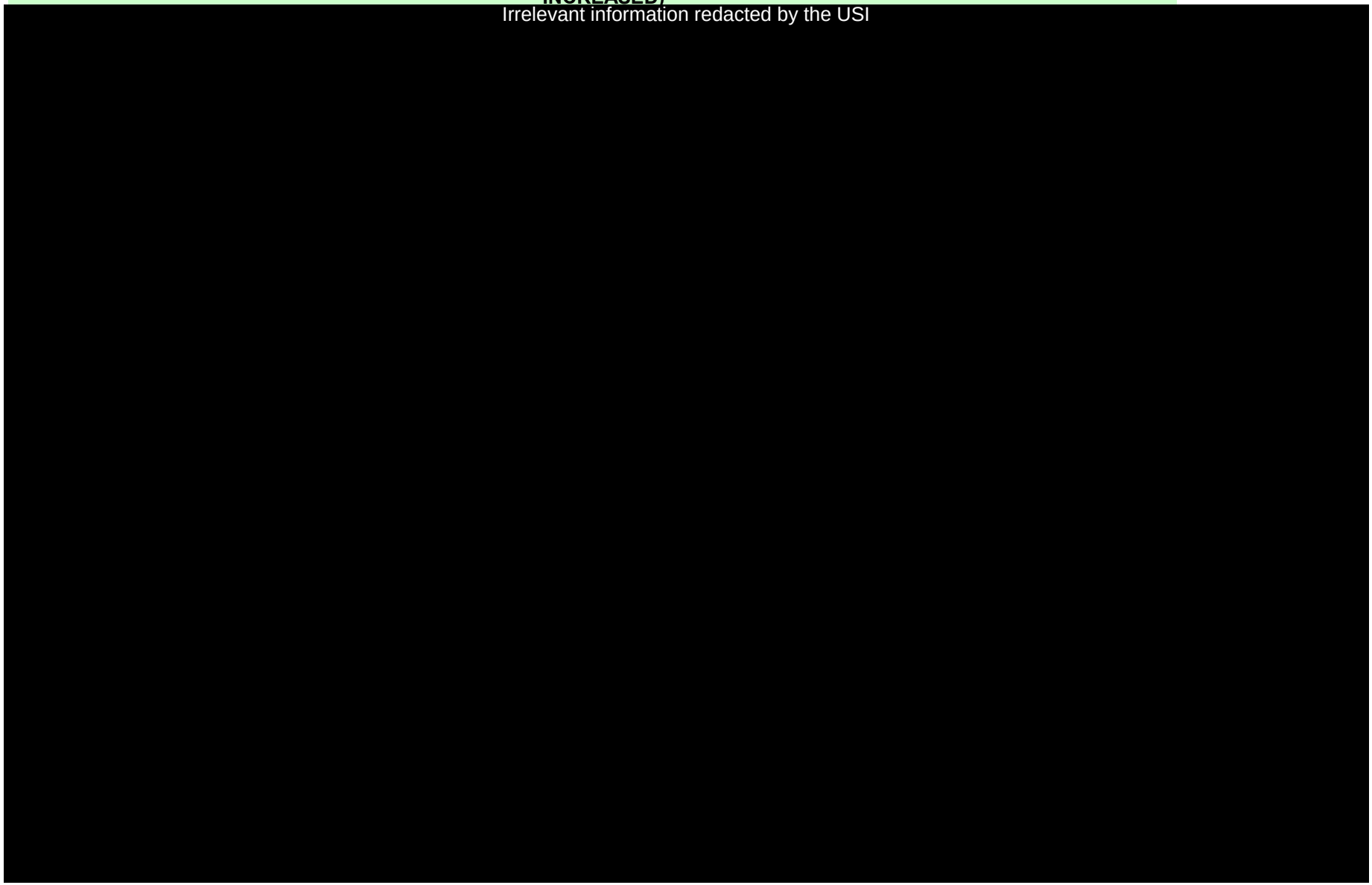

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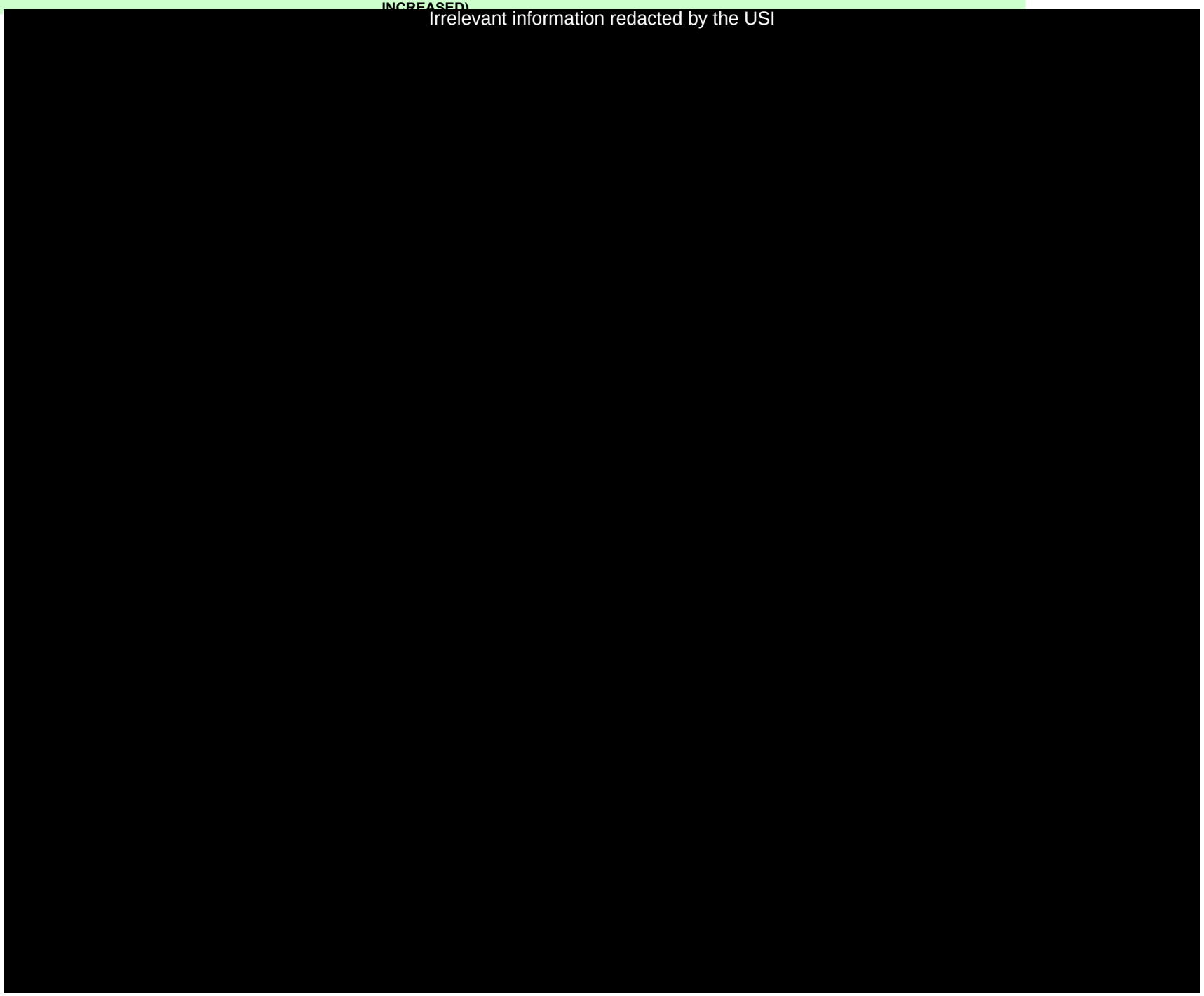

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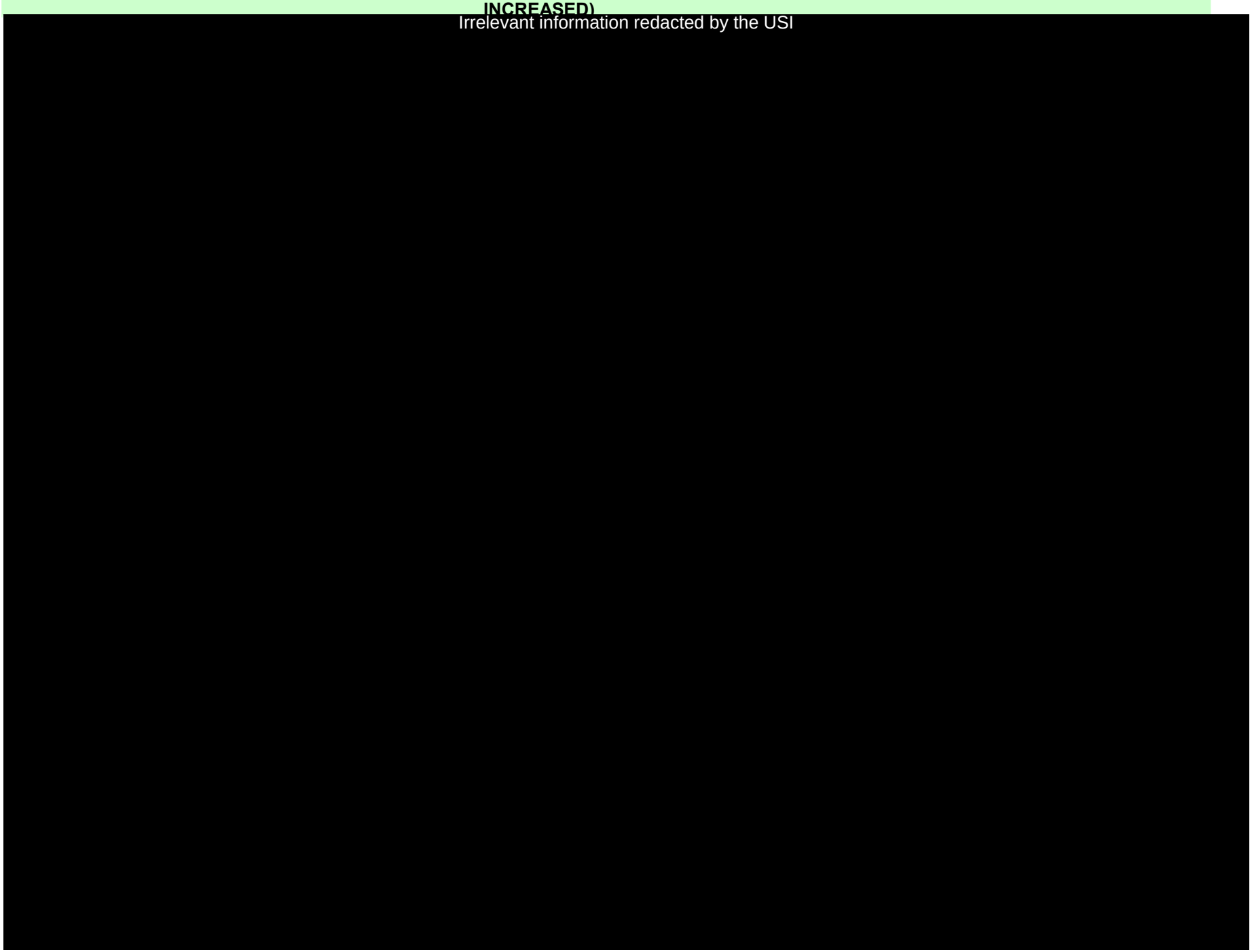

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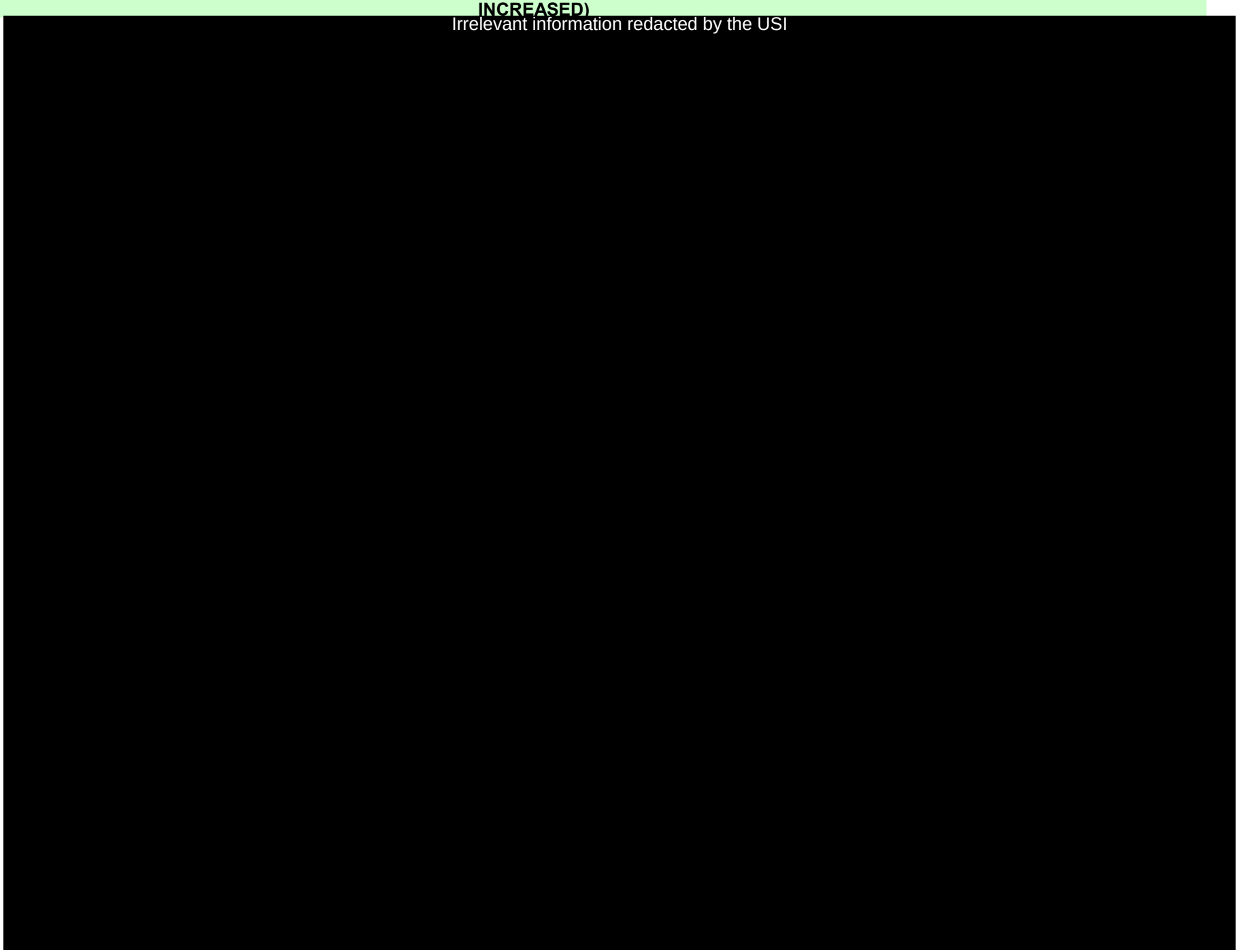

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04/03/10	Mr Young	CAUM4	22/04/10	Reduced	2 Doctors			-12
04/03/10	Mr Young	CURMY	02/04/10	Reduced	2 Doctors	-1	-1	-13
04/03/10	Mr Young	CURMY	09/04/10	Reduced	2 Doctors	-1	-1	-13
04/03/10	Mr Young	CURMY	23/04/10	Reduced	2 Doctors	-1	-1	-13
04/03/10	Mr Young	CURMY	30/04/10	Reduced	REG ONLY	-3	-2	-22
10/03/10	MR AKHTAR	CMA1	12/04/10	Reduced	1 DOCTOR		-1	-5
10/03/10	MR AKHTAR	CMA1	19/04/10	CANCELLED	NO DOCTORS		-3	-8
10/03/10	MR AKHTAR	CMA1	26/04/10	Reduced	1 DOCTOR		-1	-5
10/03/10	MR AKHTAR	SMA2	20/04/10	CANCELLED	NO DOCTORS		-6	-3
10/03/10	MR AKHTAR	SMA2	27/04/10	CANCELLED	NO DOCTORS		-6	-3
07/05/10	MR AKHTAR	SMA2	22/06/10	CANCELLED	NO DOCTORS		-6	-3
07/05/10	Mr Young	CURMY	04/06/10	Reduced	2 Doctors			-15
07/05/10	Mr Young	CURMY	11/06/10	Reduced	2 Doctors	-1		-14
07/05/10	Mr Young	CURMY	25/06/10	Reduced	2 Doctors	-2	-1	-22
07/06/10	MR YOUNG	CURMY	02/07/10	Reduced	2 DOCTORS			-15
07/06/10	Mr Young	CURMY	09/07/10	Reduced	MR YOUNG ONLY	-1	-2	-22
07/06/10	MR YOUNG	CURMY	23/07/10	CANCELLED	NO DOCTORS	-2	-3	-30
07/06/10	MR YOUNG	CURMY	30/07/10	Reduced	2 DOCTORS			-15
07/06/10	MR YOUNG	BURM1	19/07/10	CANCELLED	NO DOCTORS	-1	-4	-26
07/06/10	MR YOUNG	CAUM4	26/07/10	CANCELLED	NO DOCTORS		-7	-22
07/06/10	MR O'BRIEN	CU2	06/07/10	Reduced	2 Doctors			-5
07/06/10	MR O'BRIEN	CU2	13/07/10	Reduced	1 DOCTOR			-15
07/06/10	MR O'BRIEN	CU2	20/07/10	Reduced	2 Doctors			-5
07/06/10	MR O'BRIEN	CU2	27/07/10	Reduced	2 Doctors			-5
07/06/10	MR O'BRIEN	BPU1	05/07/10	REDUCED	2 DOCTORS			-2
07/06/10	MR AKHTAR	SMA2	20/07/10	CANCELLED	MR AKHTAR IN THEATRE		-6	-3
10/06/10	MR AKHTAR	CADDMA	28/06/10		EXTRA CLINIC		10	
10/06/10	MR AKHTAR	CADDMA	05/07/10		EXTRA CLINIC		10	
10/06/10	MR AKHTAR	CADDMA	13/07/10		EXTRA CLINIC		10	
10/06/10	MR AKHTAR	CADDMA	19/07/10		EXTRA CLINIC		10	
10/06/10	MR AKHTAR	CADDMA	26/07/10		EXTRA CLINIC		10	
10/06/10	MR AKHTAR	CADDMA	02/08/10		EXTRA CLINIC		10	
02/07/10	MR O'BRIEN	BPU1	02/08/10	Reduced	2 Doctors		-1	-1
02/07/10	MR O'BRIEN	CU2	03/08/10	Reduced	2 DOCTORS - 20PTS			-5
02/07/10	MR O'BRIEN	CU2	10/08/10	Reduced	2 DOCTORS - 20PTS			-5
02/07/10	MR O'BRIEN	CAU1	09/08/10	Reduced	2 DOCTORS - 18PTS			-2
02/07/10	MR O'BRIEN	CU2	17/08/10	CANCELLED	MR O'BRIEN A/L	-1	-2	-22
02/07/10	MR O'BRIEN	CU2	24/08/10	CANCELLED	MR O'BRIEN A/L	-1	-2	-22
05/07/10	MR O'BRIEN	CU2	31/08/10	Reduced	2 DOCTORS - 20PTS			-5

Southern Health and Social Care Trust

Acute Directorate Performance Meeting

AGENDA

for meeting to be held on Tuesday 13th April 2010, 2.00 pm – 4.00 pm
in the Meeting Room, Trust HQ, CAH with video-conferencing facilities in Tutorial Room, Daisy Hill Hospital

1. Communication Strategy for Acute — Jane McKimm/Paula McKeown
2. CHKS Presentation — Patricia Durkin
3. Elective Care Reform Implementation Plans
4. SABA Performance by division
   - MUSC
   - SEC
   - CCS
   - IMWH
   - FSS
5. Service Business Cases and Implementation Plans — Sandra Waddell
6. PPI Action Plan
7. HWB Action Plan
8. Any Other Business
9. Date of next meeting – Tuesday 11th May at 2.00 pm in the Meeting Room, Trust HQ, CAH with video-conferencing facilities in Tutorial Room, Daisy Hill Hospital

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
1917	13/01/2009	Organisational and workforce development	Laboratory	Laboratory failing Accrediation due to not meeting Working Time Regulations	Recent changes to testing practices for MRSA have led to a significant increase in out-of-hours work without an appropriate re-organisation of working arrangements. Staff have not signed up to any opt-out agreement in relation to out-of-hours working. Facilities for staff to remain on-site during on-call periods have not been reviewed with no overnight accommodation being available, if necessary. This has been highlighted as a critical non compliance during recent Clinical Pathology Accreditation Inspections and could lead to the laboratory failing Accreditation	No control measures in place	Changed on call arrangements giving additional rest time. Bedroom provided. Not meeting working time regulations is covered under Datix Personal	HIGH	DIV
2149	06/02/2009	Safe, High Quality and Effective Care	Laboratory	No mechanism to determine the date and time of receipt of samples in Reception	Recent CPA Inspection highlighted that there is no mechanism to determine the date and time of receipt of samples in Reception. Currently date and time is taken as time of entry on lab system which is incorrect.	Request to be placed with the Trust to purchase six Zebra bar code printers plus software to produce labels realtime by end of February 2009.		MOD	DIV
2148	11/03/2009	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Donor blood for transfusion to patients must be maintained at a temperature of 4 ºC ± 2 ºC.	Donor blood for transfusion to patients must be maintained at a temperature of 4 ºC ± 2 ºC. The temperatures on the three blood bank refrigerators at DHH run between 5.2 ºC and 5.6 ºC. The temperature settings on these refrigerators are at their maximum and therefore can not be adjusted any further. This leaves a very small margin for temperature change before donor blood is deemed 'out of temperature' limits. This could lead to loss of blood stocks, which would have serious implications on the ability of the hospital to provide surgery, receive trauma patients etc. It would also entail a report being sent to SABRE the reporting mechanism for MHRA	An electronic temperature monitoring system has been fitted to the refrigerators that contacts staff if there is a temperature deviation. This provides time for blood to be assigned to an area that is still with the defined temperature limits. All staff involved in blood transfusion have received training in this system.		MOD	HOS
2147	09/04/2009	Safe, High Quality and Effective Care	Cellular Pathology Lab	Complete history of cervical cytology patients is not available at the registration and reporting screens	Complete history of cervical cytology patients is not available at the registration and reporting screens which leads to inefficient and unsafe working practices, potentially putting patients at risk and damaging the reputation of the Trust.	Histories are printed in a batch, sorted and attached to the laboratory request forms. Staff have to be vigilant that the correct history is attached to the appropriate request form.		LOW	HOS
2607	01/05/2009	Provide safe, high quality care	Intensive Care Unit	Safe usage of Silentia Line Screens fixed and portable concertina type screens which folds if not adequately secured with brakes	Potential risk to any staff member/relative who is in close proximity to screens when in use, as screens may fold in or migrate out in concertina type fashion if all brakes not adequately secured in fixed screens. Also if portable screen not adequately closed with elastic binder potential to open out, potentially harming persons. Potential of screens migrating towards persons (i.e. staff/visitors) and causing impact - therefore potential injury if all brakes not properly secured. Portable screens elastic binder too long to adequately secure portable screens are closed	All staff trained/educated in current ergonomic/manual handling trust policy and legislated to comply with ICU based training/education regarding use of silential line screens.	Training provided by Ward Sisters. Written information disseminated to all ICU staff re - securing brakes and use of portable screen with elastic strap attached.	LOW	HOS
2146	28/05/2009	Safe, High Quality and Effective Care	Laboratory	Abbott Saphire haematology analysers are suffering from excessive downtime	The two new Abbott Saphire haematology analysers are suffering from excessive downtime. This has resulted in both analysers being unavailable on a number of occasions and consequently no ability to analyse a full blood count on the Craigavon Site. This has the potential to severely disrupt the management of patients.	Support company has been contacted and have had engineers on site. Samples have been transferred to Daisy Hill Laboratory. Mr T McFarland has been in consultation with Accuscience to complain about the serviceability of the analysers.	Referred to Directorate Risk Register. A third analyser has been provided FOC from the company and this has reduced the workload going through the initial two analysers. As a consequence these analysers now have a reduced downtime and thereby provide a much improved and robust service.	HIGH	DIV
2055	29/05/2009	Safe, High Quality and Effective Care		Malfunction of energy select switch - Philips XL Heart Start M4735A-could result in non-treatment of life threatening arrthymias	The collapsed patient requiring defibrillation for a life threatening arrthymia will be at risk of not delivery of treatment to correct their rhythm. Non-treatment of life threatening arrthymias (patient). Potential for fatalities resulting in potential loss of reputation and litigation for the Trust	1.The affected Philips defibrillators and their location have been identified 2. Communication regarding the identified fault has been distributed Globally to all wards and departments with information received from Cardiac Services as follows on 28/05/09 - Reported non-function of rotary energy switch in affected models may fail and prevent the user from turning the device on, rendering the device un-useable for monitoring and defibrillation therapy 3. Further information required for distribution today is aimed at informing all potential users of contingency plan in event of defibrillator failure: - Ward 1 North Cardiac Resus trolley will have an unaffected device - Cardiac Arrest team will attend arrest calls in CAH with Ward 1 North resuscitation trolley· - The location of the next closest defibrillator in the event of device failure will be given to each ward/dept in event of Ward 1 North trolley in use. - Instruction for all users to 'Contact Technical Services Manager' as soon as possible on occurrence of device failure (Michael Ross ePerson or Stephen Armstrong exPerso) These control measures are considered to be effective during the period of upgrades of all affected Philips defibrillators Cardiac Services have assured 'Free of charge' replacement of affected switches.	To be managed by Facility/Department Team Manager/Leader	VLOW	TEAM
2391	01/06/2009	Provide safe, high quality care	Laboratory	Interruption of electrical supply to Tissue Processor, Immuno BenchMark and LBC Processor	Interruption of electrical supply to Tissue Processor, Immuno BenchMark and LBC Processor can result in the loss of patient tissue samples causing a delay in diagnosis, undiagnosis of disease or condition; loss of prognostic information required for the treatment of patients. The increased volume of throughput in the Immuno BenchMark now means that the machine is operational for 7-8 hours per day plus overnight runs.	Requested Estates Services to cost EPS for the tissue processor and BenchMark.	Dedicated power supply to the tissue processors and the BenchMark with 3 portable UPS. Contacted Estates Services to provide a dedicated telephone line for the antodialler. Installation of autodialler to cost £450. Non-stock requisition 2582710 + statement of need submitted 12.10.09	VLOW	HOS
2072	10/06/2009	Effective organisational governance	Macmillan Suite - Mandeville Unit	Peer review	Peer review - regional process of peer review of Multidisciplinary meetings.Risk to MDMs where lack of some core members and limited audit support.Loss of reputation for the Trust.	None		MOD	DIV
2071	10/06/2009	Safe, High Quality and Effective CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Cancer review	Cancer Review - delays in patients being reviewed within the allocated timeframe, resulting in advances in disease and/or more comprehensive treatment required	Cancer teams monitor and raise review delays with relevant assistant director and medical director. Clinical incidents reported to ensure learning.	26.11.13 Continues to be reviewed. Delays prostate clinic referrals from Belfast.	MOD	HOS
2067	10/06/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Increasing activity across all clinics and treatment areas	Increasing activity across all clinics and treatment areas compounded by increased sickness and maternity leave resulting in delays for patients receiving treatment.	Waiting list created in an attempt to manage the additional activity. Use all available resources effectively - ie relocate blood tranfusion to hospice and MDU		MOD	HOS
2066	10/06/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Anaphylaxis	Pre anaphylaxis/ full anaphylaxis during treatment. No resident medical staff at unit level. Resulting in the potential for major/catastrophic incident. Loss of reputation. Litigation.	Staff receive training regarding the management of anaphylaxis and follow Trust policy.		LOW	HOS

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2068	10/06/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Management pathway for ill patients presenting at Mandeville Unit	Health and Safety of patients and staff due to increase in clinical activity and the increase in number of unwell patients who require to be managed at unit level and require admission resulting in the potential for a major/catastrophic incident.	Monitor clinical activity on a daily basis. Inform AD/ lead clinician when activity levels exceed capacity.		MOD	HOS
2069	10/06/2009	Accessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Reduction in Admin Staff	Reduction in Administration staff and increase in number of outpatient patient clinics and increase in number of patients attending for treatments leading to lack of staff to cover reception, prepare clinics, ensure all notes and results are available for clinics. Risk that insufficient or inadequate information is available for decision making, patients miss appointments as not booked onto systems. Increased waiting times for patients due to delays with charts, x-rays and results.	Activity monitored on a weekly basis, inform Assistant Director when levels exceed capacity. Ensure efficient use of staff		MOD	HOS
2070	10/06/2009	Safe, High Quality and Effective CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Infection control	Infection Control - cross contamination from body fluids, MRSA, C Diff, etc. Inadequate sluice facilities due to changes in treatment regimes and sicker patients in the treatment area. Resulting in the potential for splash injuries and cross contamination from contaminated cytoxic waste/infected waste	Personal protective equipment. Vaccination programme from Occupational Health. Hand hygiene audits in operation, staff training ongoing.	24.3.11 No change require bedpan issue to be escalated.	LOW	HOS
2466	25/06/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Audiology Dept	Design and location of existing audiology department	Current accommodation is unsuitable as it does not meet the minimum British Society of Audiology (BSA) or BS EN ISO 8253-1 standards. Ambient noise levels in accommodation grossly exceed the maximum level of 35 dB (A). These standards have been further compromised by the upgrade of X-Ray's CT Scanner which has increased noise levels in Audiology Room 1 & 2, and the refurbishment of the coffee bar in Daisy Hill has added to noise levels in the temporary untreated paediatric VRA room. Ambient noise levels in the Audiology department are currently between 44 - 67 dB (A). Staff are routinely placed at risk from musculoskeletal problems due to space restraints in a number of rooms. Audiology office/repair room is too small and highly congested. Drill used for modification of ear moulds is housed in enclosed Dental suite store which does not have suitable ventilation and is non-compliant with Abrasive Wheels Regulations which in turns raises health and safety and COSHH issues. Test Room (Audiology Room 2) - the test booth within this room cannot be relocated and is not DDA compliant, if a wheelchair patient arrives staff are required to assist the patient into the booth. Staff are also required to sit at the workstation in this room for at least 30 mins during the test process in cramped conditions. In an effort to avoid possible litigation and to improve clinical care by whatever means possible staff have increased workload from additional tests needed for verification of diagnostic assessment for ENT, Visual Reinforcement Audiometry (VRA) and GP direct access clinics. Current staffing levels do not reflect demand on service and these additionalities further stretch an already compromised service. In summary department staffing levels and accommodation are unfit for purpose	Additional tests are carried out on patient(s). Local procedures in place for testing patients which includes number of tests, rotation of staff, limitation on number of persons in a test room.	30.6.11 - ongoing. 02.05.12 Progress with Estates. Costing approved. Waiting for work to commence. Arrange for ergonomic assessment to be conducted on staff involvement during VRA testing 01.03.11 Immediate review/refurbishment of the current layout of the dept to take into account the demands of the service and minimum BSA standards Arrange for staff to attend manual handling training Carry out/review generic manual handling risk assessment Provision of corner cupboard on wall to accommodate storage and relocation of equipment in test room Turn larger cupboard at ground floor level to make best use of space. 30/6/11 Risk still present, however review of services and accommodation has highlighted issues and a new Audiology and ENT department has been allocated in the refurbishment of old Gynae/maternity Outpatients DHH which is due for completion March 2012. 02.05.12 Progress with estates costing approved. Waiting for work to begin. A Davidson. 25.07.09 Review the current layout of the department (to include ENT accommodation) to take into account the demands of the service and minimum BSA standards DSE Assessment required on workstation in test room 2	HIGH	HOS
2175	17/08/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governanceOrganisational and workforce developmentBest use of resources	Macmillan Suite - Mandeville Unit	Staffing levels	Critical level of staffing due to sickness and annual leave (approximately 45% staff available for duty). Resulting in potential for major/catastrophic incident, litigation and loss of reputation to the Trust.	Staff have been doing additional hours, bank staff requested, but limited availability relevant to specialist area. Re-organisation of work load to reduce risk where possible. Agency staff requested to provide some support, again limited availability. Some patients have been temporarily redirected to Newry Hospice		HIGH	HOS
2523	31/08/2009	Safe, High Quality and Effective CareAccessible and Responsive CareBest use of resources	Occupational Therapy Department	Delay in recruiting to OT vacancies (permanent & maternity leave cover) has the potential to compromise the safety and quality	Current vacancies - Band 5 - Acute Medicine. Upcoming Vacancies: Band 6 - Oncology & Palliative Care Team (Maternity Leave-unavailable Nov 09 onward) Band 6 - Surgical (New Maternity) Band 7 - Team Leader Surgery (Maternity Leave - Unavailable Oct 09 onward) These vacancies will have a severe impact on the continued delivery of services. - Increased workload for remaining OT staff to ensure D/C targets met within CAH - Patients having to wait longer to have OT assessments / treatment increasing the risk for potential delayed discharges. Any vacancies in current staffing compliment are inadequate to meet the changing needs that are occurring due to increased outpatient and inpatient activity combined with the current reconfiguration of acute services. See attached 2006 - 2008 Acute Pressures. Referral Trends from acute medical wards. Excel spreadsheet indicating vacancies & Areas affected. Client - Physical / Functional and equipment needs of patients may not be met for discharge from CAH - Reduced quality of service to patients / families - Failure to meet trust standards / best practice guidance / College of OT Professional Standards. Staff - Increased work stress for staff - Increased time spent trying to prioritise caseload reducing patient contact - Reputation of service - Exposure of staff to abuse. Organisation - Poor Publicity. - Loss of functional assessment for signposting towards	1.Staff undertaking additional duties. 2.Staff focusing on D/C targets to maintain patient flow - compromising the quality of intervention. 3.Staff have clear guidelines re documentation. 4.Additional training to be arranged to cover specific areas (compounded by annual leave and sick leave) 5.Revision of Referral & Prioritization Criteria.		HIGH	DIV
2374	01/10/2009	Safe, High Quality and Effective Care	Trustwide	Failure to comply with current decontamination testing standards for bedpan washers	Bed pan washers within the trust are not currently being tested to HTM2030 standards resulting in possible infection control risk to patients .	Limited range of testing provided quarterly by service contractor		MOD	HOS

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2709	19/11/2009	Provide safe, high quality careBe a great place to work	Physiotherapy	Unable to provide safe, high quality and effective care. Threat to staff safety & wellbeing.	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - No temporary or permanent recruitment into vacant posts.Reduced staffing levels - 1 WTE Band 6 Physiotherapy Rotational Post (Mat leave from 12.11.10), 1 WTE Band 6 Physiotherapy Rotational Post (S/L planned major surgery 11.11.10), 1 WTE Band 6 Physiotherapy Rotational Post (S/L from 27.9.10 - planned surgery 7.12.10), 1 WTE band 6 Physiotherapy Rotational Post (JS - Personal Information from rotation onto acute 1.11.10), 1 WTE Band 6 Physiotherapy Rotational Post (career bread from July 2010) backfill by band 5 temporary post). 1 WTE Band 3 Physiotherapy Assistant Personal Information redacted by the USI. These vacancies present increased risk of staff becoming further fatigued, stressed and physically unwell due to lack of replacement staff. Unable to provide timely physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with Acute Head of AHPs and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc	Discussions initiated at HR review of AHP recruitment working group Vacancies for Band 5 & 6's funded posts - no additional resource required. Potential financial resources may be available from Swine flu training budget/Acute Physiotherapy. E Requisition activated on system. Historic funding confirmed by Management Accounts Feb 10.	HIGH	DIV
2524	19/11/2009	Safe, High Quality and Effective CareEffective user and community engagement and partnership	Wards	Unable to provide safe, high quality and effective physiotherapy care.	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - No temporary or permanent recruitment into vacant posts. Reduced staffing levels - 1 WTE Band 5 rotational post vacant from April 2009. No backfill. 1 WTE Band 6 rotational post vacant (career break) from June 2009. No backfill. Sickness absence levels increased week beginning 16/11/09 2 WTE Band 6's 1 WTE Band 3 Personal 1 WTE Band 8a and 1 WTE Band 6 Personal Information redacted by the USI Increased risk of staff becoming further fatigued, stressed and physically unwell. Unable to provide timely physiotherapy service to Inpatients resulting in poorer outcomes Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc		HIGH	DIV
2395	02/12/2009	Provide safe, high quality careMake the best use of resources	Trustwide	Equipment replacement	Potential for mis-diagnosis of patients due to poor images from old equipment which has not been replaced. Non adherence to NICE guidelines on replacement of equipment. Spare parts now sparce and difficult to source. Resulting in potential litigation and loss of reputation to Trust.	Regular down time with equipment - engineers service and repair regularily.	09.06.10 - approval for replacement CT in DHH. Implementation group set up with a view for completion Oct 2010. Screening room business case went to DHSSPS but no response as yet	HIGH	HOS
2638	08/12/2009	Provide safe, high quality care	Occupational Therapy Department	Quality of Outpatient Occupational Therapy Service for Trauma & Orthopaedics with Current Staffing Provision	Background to T&O Service: We are currently piloting an outpatient hand therapy service as a response to the demand for it by the new Trauma & Orthopaedic service. Staffing to address outpatient need was not included in the initial staffing bid. We are currently delivering this service using a rota so all staff have inpatient and outpatient contact to ensure there is an available skills mix. This workload includes assessment and treatment of new and review patients and one therapist to attend one weekly hand clinic session for wound care, "there and then" splinting, receipt of referrals and case discussion with the consultant. Urgent and non-urgent ad hoc referrals are made from other fracture/ orthopaedic clinics from Monday to Friday. The British Society of Hand Surgeons (2007) recommends that there are six WTE hand therapists for a population of 500,000. Our current staffing (based on the Capacity and Demand October 2008) has 1.5 WTE staff dedicated to delivering hand therapy, leaving a deficit of 2.23 WTE (or 1.73 WTE when Rheumatology staffing included). Prior to the opening of the T&O service there was no hand therapy service in the Southern Trust with patients from this Trust being traditionally seen in the Belfast Trust. Capacity and Demand showed in 2008 that the OT service was working at full capacity. Outpatient referrals have almost doubled since then Examples of Risk: 1. Safe, high quality and effective care. Quantity of treatment sessions offered is impeded by inpatient activity, staff attending meetings, staff on sick, annual and study leave Limited time for clinicians to create a learning environment and for service development (e.g. audit, journal club, research, protocol development) Service withdrawal or scaling down required if staff member off on leave (e.g. annual leave, sick leave, maternity leave) with direct impact on PFA targets Shared clinical space within the OT therapy room has no curtains therefore no patient privacy No wash hand basin in clinical area. Patients attend requiring re-dressing of wounds therefore risk of infection 2. Accessible and responsive care. Service users have difficulty accessing service to report CNAs, with queries, or to rearrange appointments etc due to no clerical support. This results in service user frustration and poor use of clinical time Limited time for adequate stock control, cleaning and maintenance of rehab devices. This is due to: Under provision of hand therapists Wide stretch of service demands (outpatients, ward activity, pre-operative assessment and home visits) with existing staff numbers which is not sustainable as the service grows or if any staff were to go on long-term sick leave 3. No clerical support - booking outpatients, cancellations, DNAs, telephone queries, Mesals, statistic collation, photocopying and letter typing (e.g. case reports, onward referrals). All of these are currently undertaken by clinical staff which is activity not built into the capacity and demand for the OT service in T&O 4. Unsuitable clinical space - await appropriate hand hygiene facilities and curtains for privacy and dignity 1. Client - Poor treatment outcomes for service user resulting in disability and dissatisfaction 2. Staff - Poor reputation of service, profession and individual professional registration could be affected 3. Organisation - Potential for litigation, poor reputation and limited service development	1. T&O Capacity and Demand document completed in October 2008 with Performance and Reform with one year review in October 2009 2. Introduction of capping monthly referrals from January 2010 to align with quantity of referrals identified as full capacity in October 2009. This will mean patients will be at more risk but staff will be protected in terms of registration/ acceptable workload etc. 3. Staff rota introduced for inpatient and outpatient to streamline service demands 4. Monthly Outpatient Group Supervision/ In-service commenced in June 2009 5. Senior and Clinical Lead OT are members of the College of Occupational Therapists Specialist Section in Trauma and Orthopaedics (the Clinical Lead OT is the NI representative for this group) 6. Senior and Clinical Lead OTs are members of the British Association of Hand Therapists and intend to work towards accreditation 7. Acute managers informed of work requests for OT outpatients (Pending)	Analysis completed (Sept 2009) Bid forwarded in April 2009 for additional two theatre lists. Bid forwarded in June 2009 for 6th Consultant. Bid forwarded for deficit of staff October 2009 To commence Daniel has 3 BAHT points and Emma has 1. Daniel and Emma attended accredited course in November 2009 (await points from this)	LOW	TEAM
2420	14/12/2009		Macmillan Suite - Mandeville Unit	Administration of supportive blood transfusions.	Delays with administration of supportive blood transfusions resulting in delays of chemotherapy treatment and increased patient symptoms.	Waiting list created in an attempt to manage the patients, potential to use Hospice and day unit, however this has not been able to accommodate patients in the numbers or time frames required.		MOD	HOS

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2504	08/02/2010	Provide safe, high quality care	Cellular Pathology Lab	Body Fridge/freezers may fail or doors left unsecured causing permanent deterioration of the human tissue stored within	The Body Fridge or freezers may fail or be left with the doors unsecured so that the temperature of the human tissue stored within may rise causing permanent deterioration impacting on subsequent autopsy investigations. The greatest risk is on the DHH site as it is not permanently staffed and the body fridge has no alarm. Autopsy investigations may be compromised. Autopsy process may be compromised which may have implications for friends and relatives of the deceased and learning opportunities for medical and nursing staff may be lost which may impact on the future diagnosis and treatment of patients.	The alarm system for both the body fridge and the freezers in CAH is audible within the mortuary when staff are on site which allows staff to react to any of these system failures. Staff are only on the DHH site to release bodies and the mortuary is not permanently manned. There is an audible alarm on the freezer in DHH mortuary but not the body fridge. Body Fridge/Freezer alarms. These alarm systems on the body fridge (CAH) and freezers (CAH/DHH) do not alert staff when they are not on site in the mortuary.		LOW	DIV
2503	08/02/2010	Provide safe, high quality care	Cellular Pathology Lab	Temperature of the store falls well below the reagent manufacturers recommended storage temperature of 15 -25 degrees C.	In Winter the temperature of the store falls well below the reagent manufacturers recommended storage temperature range 15-25ºC. Temperature recorded for December '09 ranged from 9 to -9ºC. The storage of reagents outside the recommended temperature range may adversely affect the performance of any tests or procedures performed using these reagents. Inaccurate test results as a consequence of poor storage conditions of reagents may put patients at risk. The poor storage conditions of chemicals may adversely impact on the accreditation status of the Cellular Pathology Laboratory.	Reagents are brought into the laboratory and allowed to come up to room temperature before use. Deterioration of reagents caused by storage at low temperatures may not be reversed by simply elevating the reagent temperature before use.	Work on flammable store ie a thermostatically controlled radiator and a ceiling, was completed on 30.3.11	MOD	HOS
2505	11/02/2010	Be a great place to work	Cellular Pathology Lab	Use of defective chairs in Dissection Area of the Cellular Pathology Lab	During a routine inspection of the chairs in CAH Laboratory on the 5/03/09, 5 chairs in use in the Dissection Area of the Cellular Pathology Laboratory were condemned and withdrawn from service by the Estate Services Department's Operations Manager, Colin Spiers. These chairs were returned to service as the risk to staff from performing dissections without chairs was deemed greater than the risk of using chairs which were condemned. These chairs were regarded as unsuitable or defective and therefore if staff were to sustain an injury as result of there use this may leave the Trust liable to litigation.	A non-stock requisition 2460482 for 5 chairs was completed and authorized by the Head of Laboratory Services along with a 'Statement of Need' on the 21/7/09. Forwarded and signed by Kate Corley the Locality Support Services Manager on the 7/08/09. Forwarded to Anita Carroll Assistant Director of Acute Services, Functional Support Services. Returned to Kate Corley with a query and passed back to Anita Carroll on the 9/1/10. Forwarded to the Director of Finance for authorisation who returned it to Cellular Pathology Lead to get the signature of Ronan Carroll, Assistant Director of Acute Services. Passed to Ronan Carroll, Assistant Director of Acute Services signed forwarded for authorisation to Dr G Rankin Interim Director of Acute Services. Rejected by Dr Rankin and returned to Ronan Carroll with the suggestion that it should be held over until the new financial year, then returned to Dr Rankin for authorisation.	Chairs were delivered on 10/08/2010	LOW	DIV
2639	11/02/2010	Provide safe, high quality care	Physiotherapy	Potential for misuse of physiotherapy equipment by patients	Risk of injury to patient, staff, or other patients through the misuse of physiotherapy equipment resulting in short term, semi-permanent or permanent physical injury. Risk to Trust reputation through increased likely hood of complaints/ litigation As part of physiotherapy treatment items of equipment may be loaned or issued to patients for use at ward level or at home. There is a risk that equipment may be misused by patients with potential to cause harm or serious injury to themselves, staff or other patients.	Physiotherapy staff assess patient's physical need for equipment Physiotherapy staff give patient instructions on use of equipment		LOW	HOS
2721	11/02/2010	Provide safe, high quality care	Physiotherapy	Potential for misuse of physiotherapy equipment by patients	As part of physiotherapy treatment items of equipment may be loaned or issued to patients for use at ward level or at home. There is a risk that equipment may be misused by patients with potential to cause harm or serious injury to themselves, staff or other patients. Risk of injury to patient, staff, or other patients through the misuse of physiotherapy equipment resulting in short term, semi-permanent or permanent physical injury. Risk to Trust reputation through increased likely hood of complaints/ litigation	Physiotherapy staff assess patient's physical need for equipment. Physiotherapy staff give patient instructions on use of equipment	19 11 12 policy in place where patients given written instructions and ward staff advised when ward patient loaned equipment	LOW	TEAM
2502	18/02/2010	Provide safe, high quality care	Cellular Pathology Lab	Ulster Anaesthetics unable to offer a full perventative maintenance contract for Shandon Gemini Staining Machine	Over 120,000 slides are stained on this staining machine per annum. The machine a Shandon Gemini, Serial No. 0022E9911, Asset No.45721, purchase date Sept 2002, purchase cost £12,500. This machine is manufactured by Thermo Scientific (Shandon) and serviced by Vector (Ulster Anaesthetics). Ulster Anaesthetics have informed me that next year they will not offer a full preventative maintenance contract as Thermo Scientific will no longer hold spare parts for this machine. If this machine fails all staining will have to be performed manually which equates with 0.5WTE BMS Band 6. This will reduce cervical screening output by 7,800 smears per year which equates with an 11 week backlog (if the machine is not replaced within 12 months). The NHSCSP turnaround target for cervical smears is 2 weeks from the smear is taken to the patient receives a result. The NHSCSP cervical smear turnaround target of 2 weeks will not be met. The diagnosis and treatment of cervical disease will be delayed. This will result in loss of reputation and possible litigation for the Trust.	None. Translating lost output in terms of cervical screening helps quantify the problem but does not manage the problem. Managing a cervical screening backlog via the on-call system reduces the level of commitment of these staff to existing on-call commitments and the annual cost is almost twice that of a new machine. Machine was delivered.			HOS
2716	01/03/2010	Provide safe, high quality careMake the best use of resources	Occupational Therapy Department	Delay in recruiting to OT vacancies (maternity leave cover) - potential to compromise safety & quality of patient care	Delay in recruiting to OT vacancies (maternity leave cover) has the potential to compromise the safety and quality of patient care, the accessibility and responsiveness of our services and is not maximising the resource available. Current vacancies -Band 6 - Oncology & Palliative Care Team Personal Information Band 7 - Team Leader Surgery Personal Information Band 6 - Surgery Personal Information redacted by the USI . These vacancies will have a severe impact on the continued delivery of services.Increased workload for remaining OT staff to ensure D/C targets met within CAH.Patients having to wait longer to have OT assessments / treatment increasing the risk for potential delayed discharges. Any vacancies in current staffing compliment are inadequate to meet the changing needs that are occurring due to increased outpatient and inpatient activity combined with the current reconfiguration of acute services. Client: Physical / Functional and equipment needs of patients may not be met for discharge from CAH. Reduced quality of service to patients / families. Failure to meet trust standards / best practice guidance / College of OT Professional StandardsStaff. Increased work stress for staff. Increased time spent trying to prioritise caseload reducing patient contact. Reputation of service. Exposure of staff to abuse. Organisation: Poor Publicity. Loss of functional assessment for signposting towards appropriate community services. Poor performance against best practice.	1. Staff undertaking additional duties 2. Staff focusing on D/C targets to maintain patient flow - compromising the quality of intervention 3. Staff have clear guidelines re documentation 4. Additional training to be arranged to cover specific areas (compounded by annual leave and sick leave) 5. Revision of Referral & Prioritization Criteria.	Ongoing. Formal Risk Assessment for inpatient and outpatient services OT Team Leader attends daily flow meeting to ensure responsive accessible services. No OT Delays identified. All Staff working to an agreed Discharge plan. Monitored & Accountable. More effective than weekly MD meetings. (Nb. As of 08/02/10, unable to attend these now on surgical wards due to limited staffing) Delegated Referrals prioritised on a daily basis. Referral prioritisation template introduced to Surgical Wards on 08/02/10 will be maintained during period of reduced staffing. The template identifies High Risk patients referred to OT (e.g. living alone, confused and for discharge home) and ensures that this patients are seen in terms of such risks. This is based on a system used in the RVH acute OT setting. It will help minimise patient risk but it does not resolve issue potential unmet DOH targets. Revised criteria in place Waiting release of posts by acute scrutiny	MOD	HOS
2599	01/03/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Intensive Care Unit	Significant fire safety deficiencies in ICU CAH that require to be rectified to reduce the fire risk to an acceptable level.	Significant fire safety deficiencies in ICU CAH that require to be rectified to reduce the fire risk to an acceptable level.			LOW	HOS

2719	01/03/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Potential physical harm to patients & staff in relation to manual handling/therapeutic handling practice.	Potential physical harm to patients and staff in relation to manual handling / therapeutic handling practice. Potential for short term, semi-permanent or permanent physical (in the first instance) injuries to patient and staff. Includes RIDDOR reportable incidents. Risk of litigation, complaints and reputation of the Trust. Increased risk of further injuries to staff secondary to post vacancies.	Provision of mandatory manual handling training to all staff. Staff complete regular risk assessments - generic & patient specific. Follow departmental manual handling guidelines including use of formal safe systems of work. Provision of appropriate manual handling equipment and provision of training in safe usage. Adequate and regular breaks.	9.11.16 no further update. 6 May 2015 Only 50% of staff with up to date training in place 27 11 13 no manual handling training currently available to physiotherapy staff 19 11 12 regular review of compliance with manual handling training regulations, awareness of trust policies and compliance with risk assessment processes	MOD	TEAM
2642	01/03/2010	Provide safe, high quality care	Physiotherapy	Potential physical harm to patients and staff in relation to manual handling / therapeutic handling practice.	Potential for short term, semi-permanent or permanent physical (in the first instance) injuries to patient and staff. Includes RIDDOR reportable incidents. Risk of litigation, complaints and reputation of the Trust. Increased risk of further injuries to staff secondary to post vacancies. Potential physical harm to patients and staff in relation to manual handling / therapeutic handling practice	Provision of mandatory manual handling training to all staff Staff complete regular risk assessments - generic & patient specific Follow departmental manual handling guidelines including use of formal safe systems of work Provision of appropriate manual handling equipment and provision of training in safe usage. Adequate and regular breaks.		MOD	TEAM
2708	01/03/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Unable to provide safe & effective high quality care to patients due to the replacement of vacant posts with lower grades	Unable to provide safe & effective high quality care to patients due to the replacement of vacant posts with lower grades of inexperienced staff. Decreased pool of senior staff to provide adequate supervision of lower grades. Changes in the optimum skill mix within the Inpatient Physiotherapy team has resulted in an increased number of less experienced, lower grade temporary staff working within the service. This could potentially lead to poorer treatment outcomes especially in the more demanding and complex patient. Potential of increased stress on junior staff required to carry a more complex caseload. Potential increase stress on senior staff - increase in inductions, supervision of junior staff, ensuring competencies met etc. High turnover of staff increases workload in these areas. Other professional responsibilities e.g. CPD, learning & development are neglected as a consequence of the shift in supervisory role. Current replacement of staff with lower grade in Physiotherapy Department CAH. 1 wte Band 6 Career Break from 16/7/10 replaced with Temporary Band 5 from 4/10/10. Inexperienced lower grades of physiotherapy staff will not have an advanced level of skill and experience required- there is the potential for poorer quality treatments and poorer outcomes for some patients with more complex problems. Increased risk of complaints and litigation against the Trust. Loss of professional credibility. Increased need for supervision and training due to increased staff turnover, recruitment & retention. Inability to meet professional standards - eg record keeping, informed consent. Potential for staff absences due to increased stress.	Adherence with SHSCT AHP Supervision Policy as able. Induction programme and assessment of core skills / competencies in place within dept. Inservice training as time allows.	Ongoing All recruitment held at scrutiny.	LOW	TEAM
2718	01/03/2010	Maximise independence and choice for patients and clients	Physiotherapy	Lack of informed consent	Patients undergoing assessment or treatment to which they have not given valid consent. This is applicable to patients who are deemed to have full capacity. Risk of complaints, litigation and damage to Trust reputation. Psychological impact / harm to patient.	Adhere to SHSCT / Physiotherapy & CSP guidance on consent. Ongoing induction of staff re consent policies. Availability and completion of appropriate written SHSCT consent forms for invasive / high risk procedures e.g. Nasopharangeal / tracheal suctioning, vaginal / rectal internal examination, cardiac exercise tolerance testing, cervical manipulations, acupuncture. Written informed consent gained prior to assessment or treatment by a physiotherapy student / undergraduate. Availability of patient information leaflets / written information to assist in the decision making process.	19 11 12 consent polices and procedures covered in staff induction period	MOD	TEAM
2720	01/03/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Risk of potential harm/ serious injury to patient or staff due to electrical shock or equipment failure or therapist error.	Potential of harm to patient or therapist due to electric shock, equipment failure or therapist error when using electrical modalities e.g. Curapulse, Ultrasound, TENS. Electrocution of patients or staff. Equipment failure resulting in physical harm. Therapist error resulting in physical harm to patient. Risk of complaints & litigation. Risk to Trust reputation.	Outside contractors maintain / service equipment as per servicing contract. Electrical checks carried out annually by Trust. SOP's in place for all high risk equipment. Adhere to SHSCT equipment management guidelines. Ongoing induction & competency training for all staff using equipment.	19 11 12 Team lead monitors competency and training for all rotational staff. Regular update training in place for less frequently used pieces of equipment and user manuals and SOPs available	LOW	TEAM
2710	01/03/2010	Provide safe, high quality care	Physiotherapy	Delay in receiving prompt and appropriate attention following cardiac arrest	Patient, visitor or staff member may experience cardiac / respiratory arrest - potential for delay in receiving prompt and appropriate attention. Potential for serious injury or death. Loss of reputation of Trust. Increased risk of complaints and litigation.	Adhere to Physiotherapy Dept cardiac arrest policy/procedure. Availability of basic resuscitation equipment within Physiotherapy Dept Access to CPR trolley within main Outpatients Dept. Staff to be aware of location of closest CPR trolley. To attend BLS CPR training / update at least annually. Resuscitation Council guidelines flowchart on display in gym. Staffing levels optimum to ensure can position patient and call for help etc	19 11 12 regular monitoring of staff attendance at yearly CPR training	LOW	TEAM
2515	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	2008 & 2009 Clinical Notes stored in Clinical space	2008 and 2009 Clinical notes stored in clinical space. Unable to utilise clinical space thus affecting client care. If clinical notes (8 cages) remain in clinical space staff and patients are vulnerable to injury due to restricted space for manual handling. Only option is to store cages in OT Corridor however this restricts fire exits and patients quality data protection control.			MOD	DIV
2517	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	Lack of curtains in Hand Therapy Room and Rehab Room	No curtains in Hand Therapy Room and Rehab Room - No patient dignity - limited confidentiality	Risk Assessment Tem informed. Estates have been aware of this issue for 1 year.		LOW	DIV
2518	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	No wash hand basin in Hand Therapy Room	No wash hand basin in Hand Therapy Room. Patients attend with open wounds, no safe suitable washing facility for patient or staff. Risk of infection into open wounds.	Infection Control were informed in 2009 and advised the need for hand basin. Estates have been aware of this issue for 1 year.	19.02.14 Still no running water available 27 11 13 Wash hand basin now in situ but there is no running water available. October 2010 Costings for new sink with lever taps, provided by K Toner Estates 1/10/10 £1200 (senors taps £2500 but lever taps acceptable)	MOD	HOS
2516	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	Carpet throughout OT Department not suitable due to infection Control issues	Carpet throughout OT Department clinical areas not suitable due to infection Control issues	Infection Control Team aware of this and advise this is not satisfactory	24.02.14 No further progress with this request Minor works form completed July 2011	LOW	HOS
2726	12/03/2010	Be a great place to workProvide safe, high quality care	Nutrition & Dietetics	Vulnerability of worker due to working alone	Risk to employee: Being left alone at end of clinics. Visiting patient's with mental health problems/history of aggression. Travelling to and from remote areas with loss of mobile contact. Unaware of who is in the patients house and the frame of mind that patient or relatives/carer is in Potential religious discrimination Exposure of employees to additional health and safety risk while working alone. Risk to employee: Physical/psychological harm. Potential for litigation and complaint. Vulnerable to accusations e.g. physical harm/social/theft.	The dietetic department have developed a lone working policy. Communication systems have been set up to ensure that dietetic department are aware of staff whereabouts at all times with expected time of return to work. List of dietetic contacts for next of kin should member of staff not return home. Staff training on lone working policy/ management of violence and aggression/ MAPPA. Reporting of incidents. Communication system set up between referrer and dietetic department to ensure that 'at risk' patients are identified. Monitor working arrangements are feedback to head of Dietetic service.		LOW	TEAM

2722	23/04/2010	Provide safe, high quality care	Orthoptic Clinic	Funded posts reduced by 50%. Current capacity reduced to levels where a safe and effective service is no longer possible	Orthoptic Clinic review patient slots converted into new patient assessments to ensure compliance with the Trust's 9 week target. eg. New patient assessments have been increased from 4 to an average of 8 per clinical session (10 patients in total per clinical session). Review patient slots converted into new patient assessments to ensure compliance with the Trust's 9 week target. eg. New patient assessments have been increased from 4 to an average of 8 per clinical session (10 patients in total per clinical session). The increased paperwork generated by each new patient is resulting staff working through lunch breaks and working late to deal with the increase. Increased sickness absence/reduced staff health and well being/reduced staff morale. There are currently some 2000 review patients who cannot be allocated appointments when scheduled -increasing at a rate of 200 per month. Children with reduced visual acuity are not receiving adequate review of home treatment plans. The monitoring of compliance and effectiveness of treatment is not occurring in a timely and appropriate manner. Clinical time is being wasted due to non-compliance and parents abandoning treatment. Long term damage to vision and treatment continuing unnecessarily may result without appropriate reviews. Pre and post operative assessments and appropriate referral to Ophthalmology are increasingly difficult to manage. The complex needs of many adult patients require close supervision- and changes in eye conditions may indicate a systemic change requiring referral to Ophthalmology. Again these patients are not being seen in a timely and appropriate manner increasing the risk of harm to this client group. Continued lack of capacity to carry out Health visitor/School Nurse training if left unchecked will seriously compromise the quality of new case referrals into the Department. Potential for loss of reputation and litigation for the Trust.	No control measures currently. An action plan cannot be formulated until staffing levels improve	24.07.12 Additional Saturday clinics to address review backlog. Vacancies recruited and due to take up post Autumn 2012. 23 05 11 Bid for additional staff in next quarter completed re tackling review backlog. Paper to be written.	HIGH	HOS
2723	23/04/2010	Provide safe, high quality careBe a great place to work	Orthoptic Clinic	Reduced staffing levels have reduced the capacity to maintain & sustain AHP governance, workforce development & training	Current situation - Funded posts have been reduced by 30%. Current capacity has been reduced to levels where a safe and effective services is no longer possible. Review patient slots converted into new patient assessments to ensure compliance with the Trust's 9 week target. E.g. New patient assessments have been increased from 4 to an average of 8 per clinical session (10 patients in total per clinical session). The increased paperwork generated by each new patient is resulting staff working through lunch breaks and working late to deal with the increase. Increased sickness absence/reduced staff health and well being/reduced staff morale. There are currently some 2000 review patients who cannot be allocated appointments when scheduled -increasing at a rate of approximately 200 patients per month. Potential harm Re-Children. Children with reduced visual acuity are not receiving adequate review of home treatment plans hence visual problems may be over or under corrected. The monitoring of compliance and effectiveness of treatment is not occurring in a timely and appropriate manner. Clinical time is being wasted due to non-compliance and parents abandoning treatment. Long term damage to vision and treatment continuing unnecessarily may result without appropriate reviews. Pre and post operative assessments and appropriate referral to Ophthalmology are increasingly difficult to manage. Potential harm Re-Adults. The complex needs of many adult patients require close supervision and changes in eye conditions may indicate a systemic change requiring referral to Ophthalmology. Again these patients are not being seen in a timely and appropriate manner increasing the risk of harm to this client group. Continued lack of capacity to carry out Health visitor/School Nurse training if left unchecked will seriously compromise the quality of new case referrals into the Department. Potential for loss of reputation and litigation for the Trust.	E requisitions have been commenced for replacement staff, however in January 2010 the recruitment process was stopped just before interviews occurred.	24.07.12 Band 5/6 post now agreed as permenant. Director agreed to 1 wte temporary band 5/6 post until Head of Service post is filled. HOS post not agreed at meeting and A-D to join meeting on 4 June with chair of British & Irish Orthoptics society to discuss options for HOS post. 24.07.12 HOS post consolidated 01.01.11. Post passed by corporate scrutiny 26/5/10 for action by HR 27/5/10	HIGH	HOS
2596	27/04/2010	Provide safe, high quality careMake the best use of resourcesMaximise independence and choice for patients and clients	Orthoptic Clinic	Staffing levels in Orthoptic Services - current situation = funded posts being reduced by 50 %	Review patient slots converted into new patient assessments to ensure compliance with targets. There are currently some 1800 review patients who cannot be allocated appointments when scheduled -increasing at a rate of 200 per month. All members of staff are currently unable to fulfil the Trust's requirements in terms of supervision and mandatory training nor requirements in terms of CPD. This poses a serious risk in terms of staff being able to stay registered with the HPC if this continues. e.g. Children referred with squint or lazy eye will not receive review of home programme hence effectiveness of patching and retraining of lazy eye muscles cannot be monitored resulting in long term damage to vision. There is currently no capacity to carry out Health visitor/School Nurse training which if left unchecked will seriously compromise the quality of new case referrals into the Department..Potential for loss of reputation and litigation for the Trust.	No control measures currently		MOD	HOS
2597	27/04/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Staff Vacancies - Unable to provide safe, high quality and effective care.	Unable to provide timely physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc	19.02.14 Reviewed with C McIl and staffing levels now improved 27 11 13 Vacant Band 6 funded post in recruitment cycle - staff due to commence 01 01 14. 2wte B7, 1.6wte B6, 1wte B5 maternity leaves with 1wte B5 backfill, 1wte B6 due to commence 01 03 14	MOD	HOS
2711	28/04/2010	Provide safe, high quality careBe a great place to work	Occupational Therapy Department	Redeployed Band 6 O.T Post from DHH Stroke Team covering long term sick leave on rehabilitation ward	Increased workload for remaining O.T staff to ensure D/C targets met within DHH. Patients having to wait for longer to have O.T assessments/ Rx increasing risk for potential delayed discharges. Patients not receiving the indicated quantity and quality of inpatient rehabilitation treatment programme specific to their needs. Delayed discharge due to reduced intensity of rehabilitation and extended duration of inpatient stay to receive adequate rehabilitation to facilitate safe discharge. Reduced liaison with family /caregiver and therefore impaired information sharing. Current staffing on stroke completing additional duties to attempt to meet targets and comply with guidelines and Professional Standards of Practice. All staff focusing on D/C targets from acute medical and surgical wards - compromising the quality of care provided to rehab/stroke/brain injury/complex patients. §Physical / functional and equipment needs of patients may not be met for D/C from DHH and patients at risk of permanent physical / psychological / cognitive impairment.§Reduced quality and quantity of service to patients/ families. Failure to meet College of O.T. Professional Standards / HPC Standards of Proficiency. Failure to meet National Guidelines - RCP / NICE. Reduced ability to deliver on service targets. Risk of service complaints / increased time spent on dealing with complaints. Risk of litigation. Negative impact on staff morale. Increased risk of reduced health of staff - work related stress / fatigue with increased risk of absenteeism. Significant unmet need impacting on service delivery.	Staff following clear guidelines re: documentation. Additional training to be arranged to cover specific areas (compounded by A/L and S/L issues)			TEAM
2712	28/04/2010	Provide safe, high quality care	Occupational Therapy Department	Lack of funding available for provision of small aids/assistive devices for inpatients DHH	Equitable services across the Southern Trust in relation to the provision of small aids e.g. feeding cups / leglifters/ dressing aids / devices to help hand function. Rehabilitation process and quality of care compromised resulting in the loss of patient independence. Additional support services recommended on discharge from DHH as a result of the small aids not being made available. Potential for delay in discharge if awaiting support services / need for Enhanced Intermediate Care Services on discharge. Patient at risk of further complications whilst remaining in hospital waiting on support services. Equipment needs of patients not met for discharge. Reduced quality service for patients. Excessive commissioning of care / support services. Risk of family / caregiver / patient complaints due to inequity across SHSCT. Risk of litigation. Negative impact on staff morale.	Proposal for patients to purchase own small aids / assistive devices from variety of local suppliers across southern area. Additional care / support services recommended on discharge from hospital.	19 11 12 Transforming community equipment work undertaken by Cynthia Cranston will direct this process which will be implemented across SHSCT	VLOW	TEAM
2713	28/04/2010	Provide safe, high quality care	Occupational Therapy Department	Damaged Roho (Pressure Relieving) Cushions	Unable to complete a full postural / pressure relieving assessment using a Roho pressure relieving system. Patients unable to avail of appropriate OT Assessment / Intervention. Limitations on OT intervention without appropriate pressure relieving equipment being available. Impacts upon patients progress with rehabilitation. Reduced quality of service. Compromises the patients comfort / necessary pressure relief in suitable seating system. Equipment needs not being met whilst in DHH. Increased risk for potential delayed discharge due to necessary equipment not being made available	Liaising with Community O.T colleagues to ascertain whether cushions can be sought from OPPC / Community Stores across SHSCT. Liaising with Tissue Viability Team regarding the management of pressure sores when specialised Roho cushions are not available. Unmet need to be recorded with OT Documentation. Ongoing efforts to repair 3 - 4 Roho cushion	19 11 12 pressure relieving cushions in line with those available in community used for patient assessment and treatment in acute	VLOW	TEAM

2704	30/04/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Unable to provide safe, high quality and effective care to T&O Inpatients. Threat to staff safety & wellbeing	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - No temporary or permanent recruitment into vacant posts.Reduced staffing levels. Vacant Posts include 1 WTE Band 3 Physiotherapy Assistant Rotational Post (Mat Leave from Jan 2010), 1 WTE Band 7 Physiotherapy Post (Mat leave from June 2010). These vacancies equate to 25% of the T&O physiotherapy staffing, therefore directly affecting service provision and also ability to maintain the 7 day service within this area. Vacancies present Increased risk of remaining staff becoming further fatigued, stressed and physically unwell due to lack of replacement staff. Unable to provide timely, effective physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver on service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale, unacceptable professional caseloads and casemix raising governance issues around competency, scope of practice experience. Capacity and demand issues which will impact on patient care, outcomes and defective discharges. Stress / fatigue of staff increased with an increased risk of absenteeism. Reduced ability to meet professional standards. Skill development and CPD etc will be impacted on as not able to release staff which will compromise patient care and effective service delivery. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc		MOD	DIV
2706	01/05/2010	Be a great place to workProvide safe, high quality care	Physiotherapy	Potential for staff to experience violence or aggression from visitors, patients or other staff	Potential physical & psychological injury to staff as a result of verbal or physical abuse from visitors, patients or other staff. May result in short term, semi permanent, or permanent injury including physical, emotional trauma or harm. Staff at risk of physical or psychological injury as a result of aggression or violence. Loss of staff ability to work. Loss of earnings. Risk of complaints and litigation.	Avoidance of confrontational situations. Risk assessment of potentially dangerous situations. Ensure avoid lone working in potentially dangerous situations. Completion of training needs analysis for MAPA training. Attendance at MAPA Level 2 training / level 3 for Bluestone physiotherapy staff. Report all incidents & completion of appropriate documentation. Adherence to zero tolerance policy	19 11 12 continue to nominate staff for MAPA training	LOW	TEAM
2707	01/05/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Environmental failures e.g. poor flooring, lack of ventilation, inadequate storage facilities, resulting in harm to patients, st	Potential harm to staff, patients, visitors as a result of an environmental failure - EG. Slip, trip or fall as a consequence of faulty flooring; Inappropriate storage of equipment / lack of storage; lack of designated office space etc. Potential serious physical harm to an individual as a result of environmental failures. Risk to Trust reputation. Risk of complaints & litigation.	Regular Health & Safety checks at departmental level. Comply with regular Trust environmental audits and act upon recommendations. Reporting of any concerns, failure or faults to Estates, Support Services or Infection control. Follow SHSCT guideline on equipment management. Communication & education of staff	19 11 12 monitoring and feedback processes in place	LOW	TEAM
2705	01/05/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Potential physical harm to patients & staff due to the risk of transmission of infectious diseases	Potential infection of staff when dealing with TB infected respiratory patients, also exposure to HIV, hepatitis and other transmissible diseases / infections / viruses eg. Norovirus, clostridium difficile. Risk of staff becoming infected with TB, HIV and hepatitis infections etc resulting in potentially serious illness. Risk of transmission of infection to patients or other staff members. Possible psychological effects. Loss of staff ability to work. Loss of earnings. Possibility of complaints or litigation.	Nominated infection control link person to attend regular training, meetings and feedback to staff. Document risk clearly on patient records. Availability of PPE. Regular training & updates for all staff. Staff advised on SHSCT infection control policies. Follow SOP's for high risk pieces of equipment eg ultrasonic nebuliser, IPPB	19 11 12 monitoring of staff attendance at infection control training and regular discussions with infection control staff re individual situations as they arise	LOW	TEAM
2608	10/05/2010	Be a great place to work	Intensive Care Unit	Ergonomic risk to staff	Staff at increased ergonomic risk when transporting ICU supplies from metal cages to storage areas. At times loads are heavy at top of cages posing risk when staff are attempting to transfer them. High risk of back/neck injury.	All staff trained/educated in current ergonomic/manual handling policies, issues and legislation.	Attend annual mandatory training Store Manager assures that heavy loads are placed on lower part of cage, lighter loads are placed on top and cages should never be piled too high.	LOW	TEAM
2641	18/05/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Occupational Therapy Department	Delay in recruiting to OT vacancies has potential to seriously compromise the safety & quality of patient care.	Delay in recruiting to OT vacancies has the potential to seriously compromise the safety and quality of patient care, the accessibility and responsiveness of services and is not maximising the resource available to contribute to overall system efficiency. Patients having to wait longer to have OT assessments / treatment increasing the risk for potential delayed discharges. Physical / Functional and equipment needs of patients may not be met for discharge from CAH.. Increased time spent trying to prioritise caseload reducing patient contact and service management time. Reputation of service. Exposure of staff to abuse. Loss of functional assessment for signposting towards appropriate community services. Poor performance against best practice.	Staff undertaking additional duties. Staff focusing on D/C targets to maintain patient flow - seriously compromising the quality of intervention - . Staff have clear guidelines re documentation - but increasingly falling behind. Revision of Referral & Prioritisation Criteria carried out.	Ongoing. Formal Risk Assessment for inpatient and outpatient services OT Team Leader attends daily flow meeting to ensure responsive accessible services. No OT Delays identified All Staff working to an agreed Discharge plan. Monitored & Accountable More effective than weekly MD meetings.(Nb. As of 08/02/10, unable to attend these now on surgical wards due to limited staffing) Revised Criteria in place. Referral process standardised. Training of medical and nursing staff re referral/acceptance occurred in 2010/11. Waiting release of posts by acute scrutiny 19 11 12 temporary and permanent recruitment underway, process slow and gaps in staffing will remain until all posts are filled. Team leads have agreed process for minimising impact of vacancies across the 3 teams 24.07.12 Following review of AHP services, permanent posts filled. If post not backfilled as per proposal - withdraw service from Ward 2 South Medical from 1.2.11 due to continued risk of HARM.	LOW	HOS
2637	18/05/2010	Provide safe, high quality care	Physiotherapy	Risk of potential harm/ serious injury to patient or staff due to electrical shock or equipment failure or therapist error.	Electrocution of patients or staff. Equipment failure resulting in physical harm. Therapist error resulting in physical harm to patient. Potential of harm to patient or therapist due to electric shock, equipment failure or therapist error when using electrical modalities E.g. Curapulse, Ultrasound, TENS Risk of complaints & litigation. Risk to Trust reputation.	Outside contractors maintain / service equipment as per servicing contract Electrical checks carried out annually by Trust SOP's in place for all high risk equipment Adhere to SHSCT equipment management guidelines Ongoing induction & competency training for all staff using equipment.		LOW	HOS

2645	18/05/2010	Provide safe, high quality care	Nutrition & Dietetics	Lack of standardised, good quality, timely information being received from referral agents to Dietetic Services	Lack of standardised, good quality, timely information being received from referral agents (hospital, AHP, Health & Social Care professionals) to Dietetic Services has the potential to compromise patient care. The communication process between hospital and community teams are not clearly defined or easily understood and delivered on. Clear referral processes are not agreed for all teams when patients are being referred/transfer-Currently there are different referral criteria within the same service in different localities Existing processes have not been communicated effectively in some cases A inability of staff to be able to access appropriate referral documentation A failure of staff to adhere to agreed referral process The Specialist Services are often not receiving all of the information on time required to provide safe and effective care Failure of staff receiving the referral to pick it up on time Deterioration in patient condition through loss of opportunity for intervention or treatment, which may result in: Injury or potential harm to patient Increased stress for patient and carers Re-admission to hospital Damage to relationship and reputation of the professional/service and the Trust Potential for litigation and complaint Increased cost to Trust The likelihood of distress to staff due to lack of timely information, damage to interpersonal relationships, loss of professional integrity.	Return inappropriate/incomplete referral to the referral agent Introduction of MUST for wards to ensure appropriate		LOW	TEAM
2646	18/05/2010	Provide safe, high quality care	Nutrition & Dietetics	The risk of Dietitians not delivering safe & effective, evidence based care to patients/clients	The risk of Dietitians not delivering safe and effective, evidence based care to patients / clients due to lack of protected time for learning and development, and local / regional networking. The demands of clinical caseload / workload can result in practitioners not accessing protected time for learning, development and networking. There is a risk that the Dietitian may not be suitably informed to provide the best evidence based care. The patient may not receive the best evidence based care. The professional may not be able to fulfil the commitments of the enhanced role of the Dietitian; which includes education of other health care professionals, development and implementation of policies and practice guidelines, service development and promotion. Local and regional networks will not be established / utilised leading to inequality of service provision. If Dietitians do not have access to / avail of education and local and regional networking appropriately the patient may not receive consistently high standards of care which could result in poor condition management, increased rate of complications, inappropriate hospital admissions and delayed discharges. Patients and carers could receive inconsistent treatment /advice / information / education leading to poor health outcomes, undue stress and damage to relationships (patient / professional and inter-professional. Staff morale can be adversely affected leading to frustration and stress. Other healthcare professionals may not have the opportunity to be updated on evidence based practice. Increased cost to the trust through inappropriate treatment . The trust may be exposed to complaint / litigation.	Professional registration and regulation Professional requirement for documented reflection on learning Access to Regional and National Guidelines Access to Local, Regional and National Specialist Interest Groups. Southern Health and Social Care Trust Policy on Clinical Governance which includes Clinical Supervision and Knowledge and Skills Framework Peer Supervision Groups Access to continued education		LOW	TEAM
2640	24/05/2010	Maximise independence and choice for patients and clients	Physiotherapy	Lack of informed consent.	Risk of complaints, litigation and damage to Trust reputation. Psychological impact / harm to patient. Patients undergoing assessment or treatment to which they have not given valid consent. This is applicable to patients who are deemed to have full capacity.	Adhere to SHSCT / Physiotherapy & CSP guidance on consent. Ongoing induction of staff re consent policies. Availability and completion of appropriate written SHSCT consent forms for invasive / high risk procedures E.g. Nasopharangeal / tracheal suctioning, vaginal / rectal internal examination, cardiac exercise tolerance testing, cervical manipulations, acupuncture. Written informed consent gained prior to assessment or treatment by a physiotherapy student / undergraduate. Availability of patient information leaflets / written information to assist in the decision making process.		MOD	HOS
2643	25/05/2010	Provide safe, high quality careMake the best use of resources	Physiotherapy	Physio record storage DHH	Lack of space for storage of health records. Lack of clerical resources to provide adequate storage of physiotherapy cards for current patients. Lack of staff to deal with backlog of cards Failure to meet standards, Trust and CSP for the storage of records. -Breach of confidentiality with records being kept in treatment areas, gym, hydro rest room and hydro changing room -Failure to trace cards for medicolegal dept, DLA reports and the Compensation agency -Failure to access cards for therapist use with their patients. -Lack of clerical support for nearside admin staff to fulfil the duties of their post. -The increasing number of staff who use the space within Daisy Hill physiotherapy service from OPPC, Acute, C&YP and Phys Dis Directorates. -Increasing volume of patient activity within the Physio dept in DHH. -Lack of space in the Physio dept for storage of current records. -Lack of external space for storage of older records. -Lack of clerical support to deal with the disposal of records in a timely fashion. Failure to comply with standards have a negative impact on staff health due to distress due to loss of integrity and damage to interpersonal relationships. Damage to relationship and reputation of the physiotherapy service and Southern Trust. Potential Increased cost to Trust due to potential for litigation and complaints.	A room has recently been redesigned to accommodate the current year discharges which can accommodate 1 to 2 tears discharged cards but there is no staff to actually do it.		HIGH	DIV
2649	28/05/2010	Provide safe, high quality care	Microbiology Lab	Increase in room temperature in the main microbiology laboratory has caused equipment failure for the Gene Xpert PCR machine	Increase in room temperature in the main microbiology laboratory has caused equipment failure for the Gene Xpert PCR machine which detects MRSA, Clostridium difficile and multi resistant tuberculosis. These dangerous organisms if uncontrolled will pose a serious infection control risk. In addition the BacT Alert Blood Culture Analyser which is used to diagnose septicaemia has overheated and if there were to be a period of extended hot weather it will fail rendering us unable to diagnose potentially life threatening infections in patients.	Closing down equipment and placing oscillating fans where appropriate.	21.6.11 - Air conditioning has been provided	HIGH	HOS
2680	14/06/2010	Provide safe, high quality careMake the best use of resources	Theatres	Wormald bipolar forceps with suction for uncontrolled Nasal Bleeding	Theatres are doing increasing amounts of Endonasal sinus surgery for Chr Rhino sinusitis, Nasal Polyposis and Excis of benign or "intermediate" Nasal tumours. Surgeons are currently experiencing problems securing haemostasis on some sphenopalatine arteries with "difficulty" anatomies. Sphenopalatines vessels can contract into sphenopalatines foramen - ultimately bleeding in a very inaccessible area behind the max sinus. If this happens patient might have to be operated through cheek out the back of max sinus and the int. maxillary aa clipped. In a bleeding patient this is a 2 hour procedure.	Currently use sphenopalatines clippers but had "case" recently where this instrument could not access the vessel and haemostasis took approximately 1 1/2 hours with many manoeuvres. Current control measures work most of the time but recent case highlighted that some anatomies are not suitable for this approach. (Willing to discuss further at any time).		MOD	TEAM
2714	22/06/2010	Provide safe, high quality careBe a great place to work	Occupational Therapy Department	Unsuitable trolleys in A&E Department	Task - making transfer of patient from trolley to porters chair difficult. Individual - Risk for staff injuring themselves during transfer of patient. Load - Risk for patient being injured during transfer. Environment - Trolleys very high - do not lower to adequate height. Difficulty moving trolley. Risk to patient of injury. Risk to staff of injury. Failure to meet SHSCT Standards and not adhering to SHSCT Policy and Procedures in relation to safe moving and handling techniques.	Ensure risk assessment for safe moving and handling techniques is completed in advance. Ensure all risks are documented and communicated to staff working directly with the patient. SHSCT Moving and Handling Training Team informed of concerns. Ensure a 3rd member of staff is available to assist with transfer of patients if risks identified.	19 11 12 manual handling team have reviewed equipment (trolleys and transfer equipment) in ED departments	VLOW	TEAM
2724	24/06/2010	Provide safe, high quality careMake the best use of resources	Bio-chemistry Lab	Problems with ROCHE Analysers	Problems with ROCHE analysers. There have been an excessive number of faults with the ROCHE analysers in Biochemistry both in Craigavon and Daisy Hill over the past few months. This has caused a delay in the reporting of results, at times with an increased risk of erroneous results being produced which has the potential to impact the patient.	Performing preventative maintenance as per manufacturers instructions. All analyser faults are immediately reported to ROCHE diagnostics fault desk for engineering response. Extra vigilance is required when releasing results.	The frequency of call outs has reduced.	LOW	HOS

2717	24/06/2010	Provide safe, high quality care	Occupational Therapy Department	Quality of Outpatient Occupational Therapy Service for Trauma & Orthopaedics with Current Staffing Provision	Pilot of outpatient hand therapy service Staffing to address outpatient need was not included in the initial staffing bid. Urgent and non-urgent ad hoc referrals are made from other fracture/ orthopaedic clinics from Monday to Friday Difficulty maintaining responsiveness to in patient and out patient requirements	1. T&O Capacity and Demand undertaken. 2. Staff rotations introduced for inpatient and outpatient to streamline service inputs 3. Acute managers informed of work requests for OT outpatients	Analysis completed (Sept 2009) 27 11 13 Bid submitted for additional staffing under increased numbers of T&O consultants - awaiting outcome from commissioner 19 11 12 Bid submitted for end of year monies to deal with workload created by T&O use of Independent sector. and request for review of need for permanent additional funding 2009- Bid forwarded in April 2009 for additional two theatre lists. Bid forwarded in June 2009 for 6th Consultant. Bid forwarded for deficit of staff October 2009 To commence Daniel has 3 BAHT points and Emma has 1. Daniel and Emma attended accredited course in November 2009 (await points from this)	MOD	TEAM
2725	28/06/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Physiotherapy	Lack of space/clerical resources to provide adequate storage of physiotherapy cards for current patients	Lack of space for storage of health records. Lack of clerical resources to provide adequate storage of physiotherapy cards for current patients. Lack of staff to deal with backlog of cards. Failure to meet standards, Trust and CSP for the storage of records. Breach of confidentiality with records being kept in treatment areas, gym, hydro rest room and hydro changing room. Failure to trace cards for medicolegal dept, DLA reports and the Compensation agency. Failure to access cards for therapist use with their patients. Lack of clerical support for nearside admin staff to fulfil the duties of their post. The increasing number of staff who use the space within Daisy Hill physiotherapy service from OPPC, Acute, C&YP and Phys Dis Directorates. Increasing volume of patient activity within the Physio dept in DHH. Lack of space in the Physio dept for storage of current records. Lack of external space for storage of older records. Lack of clerical support to deal with the disposal of records in a timely fashion. Failure to comply with standards has a negative impact on staff health due to distress due to loss of integrity and damage to interpersonal relationships. Damage to relationship and reputation of the physiotherapy service and Southern Trust. Potential increased cost to Trust due to potential for litigation and complaints.	A room has recently been redesigned to accommodate the current year discharges which can accommodate 1 to 2 years discharged cards but there is no staff to actually do it.	Team Leads to co-ordinate if staff are put in place 19 11 12 filing of records almost complete	HIGH	HOS
2727	28/06/2010	Provide safe, high quality care	Nutrition & Dietetics	Lack of standardised/good quality/timely info received from referral agents (hosp, AHP, H&SC professionals - Dietetic Services	Lack of standardised, good quality, timely information being received from referral agents (hospital, AHP, Health & Social Care professionals) to Dietetic Services has the potential to compromise patient care. The communication process between hospital and community teams are not clearly defined or easily understood and delivered on: Clear referral processes are not agreed for all teams when patients are being referred/transfer. Currently there are different referral criteria within the same service in different localities. Existing processes have not been communicated effectively in some cases. A inability of staff to be able to access appropriate referral documentation. A failure of staff to adhere to agreed referral process. The Specialist Services are often not receiving all of the information on time required to provide safe and effective care. Failure of staff receiving the referral to pick it up on time. Deterioration in patient condition through loss of opportunity for intervention or treatment, which may result in: Injury or potential harm to patient. Increased stress for patient and carers. Re-admission to hospital. Damage to relationship and reputation of the professional/service and the Trust. Potential for litigation and complaint. Increased cost to Trust. The likelihood of distress to staff due to lack of timely information, damage to interpersonal relationships, loss of professional integrity. Exposure of staff to abuse.	Return inappropriate/incomplete referral to the referral agent. Introduction of MUST for wards to ensure appropriate		MOD	TEAM
2728	28/06/2010	Provide safe, high quality care	Nutrition & Dietetics	Risk of Dietitians not delivering safe & effective care to patients due to lack of protected time for learning & development	The risk of Dietitians not delivering safe and effective, evidence based care to patients / clients due to lack of protected time for learning and development, and local / regional networking. The demands of clinical caseload / workload can result in practitioners not accessing protected time for learning, development and networking. There is a risk that the Dietitian may not be suitably informed to provide the best evidence based care. The patient may not receive the best evidence based care. The professional may not be able to fulfil the commitments of the enhanced role of the Dietitian; which includes education of other health care professionals, development and implementation of policies and practice guidelines, service development and promotion. Local and regional networks will not be established / utilised leading to inequality of service provision. If Dietitians do not have access to / avail of education and local and regional networking appropriately the patient may not receive consistently high standards of care which could result in poor condition management, increased rate of complications, inappropriate hospital admissions and delayed discharges. Patients and carers could receive inconsistent treatment /advice / information / education leading to poor health outcomes, undue stress and damage to relationships (patient / professional and inter-professional). Staff morale can be adversely affected leading to frustration and stress. Other healthcare professionals may not have the opportunity to be updated on evidence based practice. Increased cost to the Trust through inappropriate treatment. The Trust may be exposed to complaint / litigation	Professional registration and regulation. Professional requirement for documented reflection on learning. Access to Regional and National Guidelines. Access to Local, Regional and National Specialist Interest Groups. Southern Health and Social Care Trust Policy on Clinical Governance which includes Clinical Supervision and Knowledge and Skills Framework. Peer Supervision Groups. Access to continued education.		MOD	TEAM
2747	22/07/2010	Provide safe, high quality careBe a great place to work	MRI Craigavon Area Hospital	Risk to patients and staff unsing the MRI compatible wheelchair	Risk of injury/fall to patients and staff when transferring or transporting with the MRI compatible wheelchair. Wheelchair is poor design but only 2 prototypes available, brakes insufficient and lever constantly works loose so screws fall off. Safe working load is only 113kg (18st). Due to proximity of wheel rim to arm rest fingers may be trapped. No sideways transfer possible as wheelguard and wheel stick up. Sling seat. Potential of serious injury/harm to both patients and staff. This may result in litigation or staff shortages as a result of back problems. Only MRI compatible wheelchair may enter scanner room. As a result of strong magnetic environment normal manual handling aids are not permissible. Patients are frequently more that 18 st in weight	Manual handling performed on a yearly basis in the MRI Department to reflect the unique problems associated with the area.		MOD	HOS
2748	29/07/2010	Provide safe, high quality careMaximise independence and choice for patients and clients	Occupational Therapy Department	No neurological spinting service post discharge from hospital - Assessment/ provision and review	Clients at risk of developing contractures, pain and increased tone if not assessed for and prescribed with a theraplastic splint if the need indicated. Risk to client - Pain / permanent injury - boney changes / lack of function / Risk to care giver - Increased demands for management of upper limb positioning self care / pain and discomfort of client. Risk to organisation - Failure to met national standards and guidelines of good practice. Significant unmet need impacting on service delivery. Reduced ability to deliver on service targets. Risk of litigation and loss of reputation. Risk of service complaints / increased time dealing with complaints.	Referrals currently returned to source GP / COT with letter of explanation regarding gap in service. Currently 'good will' service to selected clients to however no review service for same List of unmet need recorded and provided to operational and professional lead. Review of policy / guidelines for evidence base and maintain good practice. Liaise directly with line manager operational and professional to identify business case to met gap in service and unmet need.	19 11 12 OT post has been employed across SHSCT to provide assessment and provision of neuro splinting (Based Portadown HC)	MOD	TEAM
2749	29/07/2010	Provide safe, high quality careMaximise independence and choice for patients and clients	Occupational Therapy Department	Damaged specialised seating systems Inappropriate use of specialised seating systems	Patients with complex needs are at risk of not having postural/pressure relieving needs fully met. Patients unable to avail of appropriate OT assessment and intervention. Moving and Handling risks to patients and staff due to damaged/broken seating systems. Patients likely to be increasing dependent/spend longer times in bed delaying rehabilitation. Increased risk of postural changes and risk of deformity. Loss of sitting balance from long periods of bedrest. Increased respiratory complications from lack of appropriate seating to seat patients in. Increased incidence of pressure damage from patients being seated in seating systems with damaged pressure relief. Inappropriate use of seating systems for 'restraint' has potential harm to health and well being of patients and staff, also causes damage to the chairs	Monthly check and record of available chairs for safe use on ward. Broken chairs taken out of use. Monitoring of correct use at ward level. Liaison with AHP Lead re: chair repairs. Forward NSR to relevant manufacturers.		MOD	TEAM
2779	31/08/2010	Provide safe, high quality careBe a great place to work	X-Ray Dept	Risk of fall and potential serious harm to patients and staff	Sink in toilet area is not large enough when patient/staff/others are washing their hands and water is spilling over onto floor resulting in risk of fall and potential serious harm. Potential for litigation and loss of reputation for the Trust.	Regular mopping by domestic services. Paper towels available in the toilet for patients and staff to place on floor when floor gets wet. Patients and staff do not always dry the floor when it becomes wet.	02.05.12 Sink replaced	MOD	HOS

2787	09/09/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsBe a great place to workMake the best use of resources	Radiology, Daisy Hill Hosptial	New CT scanning service - initial limited service	Inappropriate staffing levels leading to compromise for patient safety, care and staff safety. This results in increased clinical incidents, increased numbers of falls, sick leave with decreased staff morale, staff unable to get breaks, Breach of terms and condtions of employment, poor documentation, unable to maintain Trust policies and guidelines (e.g. Manual handling). Requires education and training of staff in a short time frame leading to the potential for harm or death. Potential for misdiagnosis and re-scanning of patient resulting in over radiation going against IRMER guidelines. Potential for litigation and loss of reputation for the trust. Provision for Radiographer Cranial CT reporting will not be possible during the time of staff training therefore leading to increased waiting times and ineffective use of radiographer skills and resources.	Core team - education and training required. Application specialist onsite for initial 5 days, deemed insufficient by other sites who have undergone the same process of installation, implementation and provision of service. Rotas to be revised to facilitate training - knock on effect on staffing levels in the Radiology Department . Currently staffing levels are One dedicated CT radiographer and One general radiographer Control measures considered but discounted and why: Staff already trained in other sites to work alongside DHH staff throughout interim period (Daily and on-call) Potential to reduce lists to facilitate staff training (patients to be scanned at alternative site to ensure no breachers and compliance with Waiting List Initiative. Staffing levels to be comparable with other sites within the trust to ensure the provision of a safe, high quality CT service (four staff members - two dedicated CT radiographers, one general radiographer and one helper).		HIGH	DIV
2786	09/09/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeing	Neurophysiology Dept	Risk of adverse outcome from withdrawal of additional capacity for neurophysiology service	1.Delayed diagnosis of disorders that are potentially disabling if diagnosis or treatment is delayed - including entrapment neuropathy especially ulner nerve entrapment, inflammatory neuropathies, inflammatory myopathies, and reduction in quality of life for people with suspected carpal tunnel syndrome. 2.Misdiagnosis - if treatment proceeds on an empiric basis there is a risk of correct treatment being given (with risk) in a patient with an incorrect diagnosis 3.Prognosis - Motor Neuron Disease is an incurable disorder but can only be diagnosed following EMG/NCS test. It is not possible to give patient this devastating and important advice without knowledge of tests results. 4.Loss of reputation of SHSCT - the waiting list for this test will rise exponentially, and this is likely to lead to adverse publicity, and loss of confidence in SHSCT services. Delayed diagnosis, reduced quality of life, incorrect treatment or inappropriate treatment, use of corticosteroids with accurate diagnosis, inability to manage MND according to Standard Practice, delays in diagnosis of acute illness such as Guillain Barre Syndrome, Loss of SHSCT reputation.	Urgent referrals have been forwarded to Belfast Trust. Await guidance on routine referrals.	1/3/12 - TO BE CLOSED. Regional waiting list for neruophysiology 28.10.11 Letter from Dr Rankin has been sent to all Consultant Referrers. 2/9/11 - A brief NCS options paper has been submitted to Belfast Trust for consideration. Await outcome. Reviewed 27.5.11 - Belfast Trust are now accepting all our NCS patients. The referrers have been contacted by the Director of Acute Services explaining the situation - no new referrals are coming into the Trust. Urgent referrals have been forwarded to Belfast Trust. Ongoing communication with Belfast Trust to create a central waiting list and service for Southern Trust patients	MOD	DIV
2788	15/09/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsBe a great place to workMake the best use of resources	Radiology, Craigavon Area Hospital	X-ray of immobile patients-Trauma and Orthopaedics	Manual Handling risk. Potential injury to patients during stationary grid placement and positioning-which is essential to radiographic examination. Potential of significant harm to new prosthesis with risk of further surgical correction requirements as a direct result of manual handling manoeuvres. Extreme likelihood of back injuries to staff performing examination- due to the manual handling manoeuvres necessary. Potential of litigation from patient and staff member injured. Patient injury as a direct result of stationary grid placement and positioning- essential to pelvic/abdominal/spinal examinations-risk of injury to patient: -opening of surgical wound site by necessary positioning movements; -injury to skin with sharp edges of grid cassette -bruising during positioning; -displacement of prosthesis-likelihood of surgical correction requirement. Radiographer injury-the physical manual requirements are such that extreme stress is placed upon radiographer's back and shoulders and abdominal strains/risk to severed fingertips (grid-placement) as a direct result of lack/inability of patient cooperation -all with potential for absences due to sickness. All the risks are substantially increased with: -patient size -staff availability (particularly on-call) -and the quality of the patient's bed mattress-inflation/firmness variability.	Trust Manual handling annual updates provided to all staff members. Staff awarene Control measures considered but discounted and why: Presently inadequate as too many variables beyond staff control-significant risk to all involved in these examinations. -patient co-operation post surgery- -patient dimensions- -mattress firmness -additional staff availability to promote adequate manual handling techniques -time constraints All of the above measures are negated should the patient arrive to the x-ray department on a dedicated x-ray trolley with grid tray. Patient's inability to cooperate no longer an issue as they are not required to move during the examination. Patient dimensions are no longer an issue as staff no longer have to perform stationary grid placements and positioning. Mattress firmness-no longer an issue-dedicated trolley-adequate and constant firmness Additional staff-no longer an issue as one radiographer can safely perform examination Time constraints-no longer an issue as radiographic examination carried out more quickly and safely.			HOS
2789	28/09/2010	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Patient not being informed of the risks and benefits of transfusion (if condition permits).	Patient not being informed of the risks and benefits of transfusion (if condition permits). Leading to the patient not receiving adequate information regarding the risks and benefits of blood transfusion. Patient may be unaware of the consequences of transfusion e.g. if a patient is a blood donor they will be removed from the donor panel; patient may develop an adverse reaction to the blood transfusion and may be unaware of the symptoms to report to clinical staff.	Staff involved in the request or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA "Right Patient, Right Blood" initiative. Staff must adhere to the SHSCT Blood Transfusion Policy and all blood components must be prescribed on the Integrated Blood Component and Prescription chart and all appropriate sections completed. Patients must be provided with the appropriate blood transfusion leaflet and these must be readily available at ward level. Bi-annual self inspection of the provision of leaflets to patients performed.		VLOW	TEAM
2790	28/09/2010	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Risk to patient when total fluid volume of blood component transfused is not recorded on the patient's intake and output chart	Risk to patient when the total fluid volume of blood components transfused is not being recorded on the patient's intake and output chart. Potential for patient to develop fluid overload. Potential harm to patient which may result in morbidity or mortality.	The Integrated Blood Component Prescription and Transfusion record is used for the prescription of all blood components throughout the SHSCT. The prescription sheet clearly documents that the total fluid volume must be recorded on the intake and output chart. Self inspection audits of the documentation process are undertaken on a quarterly basis to assess compliance of this requirement. Education sessions include the use of the Integrated Blood Component and Prescription record and the need to ensure that the total volume is recorded on intake and output chart.		VLOW	TEAM

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
2884	19/01/2011	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	Macmillan Suite - Mandeville Unit	Staff stress	Dealing with young patients and family with complex needs. Staff sickness levels increase. Deterioration in staff health and well being. Breakdown in communication within team. Dealing with complex patients - end of life. Dealing with prolonged sickness and staff shortages. Increase workload in team. Effects on generic team dealing with lung and gynae patients if staff off who deal specifically with this group of palliative patients. Increased sickness levels. Breakdown in service provision for patients and their families.	All managers to identify stress issues in staff. Advanced communication training. Identify stressors and ways of alleviating these. Use 'Managing Stress in the Workplace' policy. Clinical supervision, appraisals. Monitor generic/specialist teams.		MOD	HOS
2886	20/01/2011	Provide safe, high quality careMake the best use of resources	Macmillan Suite - Mandeville Unit	Independent Nurse Prescribing.	The patient prescribed a drug they are allergic to: Prescribing the wrong dosage of drug. Inappropriate prescribing.	All nurses who prescribe drugs must have completed their nurse prescribing course. Are registered with NMC as a nurse prescriber and on trust register as independent prescriber and on job description.			HOS
2887	20/01/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	Information in boxes on floor.	Staff injury. Staff falling over boxes - nurses, cleaning staff.	Shelves to remove information literature off floor. All staff to ensure free access to office and keep office tidy. Division of desks to ensure staff are not stretching over desks to reach shelves.			HOS
2885	20/01/2011	Provide safe, high quality careBe a great place to workMake the best use of resources	Macmillan Suite - Mandeville Unit	Using computer for prolonged periods.D.S.E user	Eye Damage Repetitive strain injury Postural problems Staff using computer may need individual assessment to identify DSE users .work desk and work chair assessment	2 members of staff using computers for prolonged periods Complete display screen record form for managers.		VLOW	HOS
2900	01/02/2011	Safe, High Quality and Effective Care	Physiotherapy	Lack of designated accommodation for acute physiotherapy staff in physio Department.	Lack of designated accommodation for acute physiotherapy staff in physio Department. Lack of access for acute staff to use currently designated room during hydrotherapy to maintain patient records in compliance with Corporate and Professional standards of care. Risk of cross infection to hydrotherapy patients from acute ward staff. Current location is dual function i.e. hydrotherapy changing area for patients and duty room for ward physiotherapy staff. - Infection Control staff have reported this is unacceptable. Risk of Infection with staff using shared corridor for other uses ie, photocopier, ice machine, stationery which are in that same area. Risk of compromising dignity of children and adults with complex disabilities and staff dignity. Patient confidentiality will be compromised. Poorly designed and inadequate number of work stations for clinical staff to carry out their indirect patient duties and complete record keeping and IT duties could result in poor ergonomics and cause harm to staff. Inadequate storage space for clinical records - currently being stored in clinical areas (hydrotherapy changing room, gym area). Risk of fire from inadequate record storage areas whereby records are stored in the gym, stationary store & patient changing areas. Difficulty in maintaining cleanliness due to high volume of staff can risk falling short of Environmental cleanliness standards. Risk of complaints from staff and service users. Risk of cross infection due to ward staff frequently accessing clinical area for patients. Potential for complaints due to lack of privacy due to patients needing to dress in office environment. Potential for musculoskeletal injury to staff members due to cramped working conditions for all staff. Potential for injury to patients in cramped conditions. Potential for breaches of confidentially which can lead to complaints. Potential for litigation. Potential for RIDDOR incidents.	1.Hydrotherapy pool has not been in use for over 2 years 2.Notice on door advising when patients are changing - ward staff do not enter 3.Overshoes used to decrease risk of contamination 4.Portable screens used to define area 5.Maximise use of storage for records and patient related stock and non-stock 6.Regular change of position of staff. 7.Compliance with manual handling training requirements for all staff 8.Regular cleaning and compliance with cleanliness audits 9.Ensure all health and safety legislation is adhered to. 10.Ensure adequate record keeping for all patients Above control measures (1-4) have now been discounted by Infection Control who advise they pose too high a risk to patient safety for the situation to continue when hydrotherapy is resumed.	27 11 13 awaiting shelving and cabinets and PC's to be fully installed Minor works form brought to attention of AD 12.01.11 [redacted] Personal Information 19 11 12 AD and HOS continue to investigate options for relocation of acute physiotherapy staff 25 01 11 Risk assessment forwarded to Acute AHP HOS	LOW	HOS
2912	09/02/2011	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Macmillan Suite - Mandeville Unit	Working to maximum capacity as a single worker and co-ordinating clinical trials which involve drugs with high risk side effects	Research Nurse unavailable due to other work commitments/ being at another clinic/ study leave/ Annual leave/Sick. Patients presenting to clinics/MDM's need to be screened within the timeframes of the study or they will become ineligible. Concerns about the protocol not being followed in the research nurse's absence. The research nurse attends clinics when patients are being assessed. There are often protocol specific investigations which need to be carried out. If there is no research nurse present, it is likely that these may not be done, resulting in protocol deviations. The clinical research nurse is responsible for data management and patient follow up in the Southern Trust, this is the essential gathering and dissemination of results and endpoints, which needs to be done in a timely fashion. This is very difficult as a lone worker working to maximum capacity. Patient not being screened and therefore being denied access to a clinical trial. Protocol deviations due to assessments/investigations being omitted. Dose adjustments/ side effects not being managed according to clinical trial protocol. Serious adverse events not being reported within 24 Hours as required by ICH GCP. Adverse events not being reported on Case report forms. Risk that a nurse/doctor trying to cover for research nurse could give incorrect patient information or misinterpret the protocol. Risk of Failing a MHRA trust inspection Risk of litigation to the trust/loss of reputation, due to patients care being managed within a clinical trials and a research nurse being absent.	Many Mandeville unit staff nurses have attended ICH GCP training. SOP's and guidelines are being written to guide staff in the research nurses absence. Link nurses have been appointed for specific clinical trials. Staff in the Mandeville unit are advised to contact Head of service and/or NI Cancer Trials Unit for further assistance. Copy of all protocols kept at unit/Ward level. Regular teaching for the ward/s, Mandeville unit, A&E and MAU (including DHH) is ongoing. Teaching and close liaison with the oncology nurse specialist and the A&E/MAU departments. Regular feedback with manager and raising as a concern at steering and committee meetings.	20.03.12 Second nurse appointed on a temporary basis for two years. Risk reduced. A job description and advertisement is being prepared to fill this post	LOW	HOS
3168	25/02/2011	Provide safe, high quality careBe a great place to work	X-Ray Dept	Risk of patients and staff tripping over loose carpet tiles outside the cubicles in Room 2 of Lurgan X-Ray	In room 2 in Lurgan there are loose carpet tiles causing an uneven surface. Staff whilst escorting patients from x-ray cubicles could trip and fall. Also patients themselves could trip and fall while leaving the cubicle for x-ray examination. Additionally, cleaners and maintenance staff could also be at risk of falling if working in the x-ray room. - Potential for persons to trip and fall causing harm to themselves - Possibility of legislation due to injury - Injuries could range from extremity injuries to more serious head and facial injuries. e.g. fractures/lacerations - Loss of reputation to Trust	Staff awareness of potential risk and verbal warning to patients, Carpet tiles have been repositioned to safest possible layout.		VLOW	HOS
3172	03/03/2011	Provide safe, high quality careBe a great place to work	X-Ray Dept	Temperature Levels withing the Xray Department in Lurgan Hospital	Temperature levels within the x-ray department in Lurgan Hospital are unbearably hot as the heating cannot be turned down or off. As a result the temperature within the department probably exceeds the normal range which is 16 - 24 degrees Cent. This is due to the heat aminating from the electrical equipment, the structure of the building and the fact that the radiators cannot be turned down or off. Staff and patients have the potential to become fatigued, dizzy, nauseous and faint due to loss of water and salt. This hot, dry air can increase the risk of eye and throat infections. In extreme cases this could lead to litigation should someone faint or collapse and injure themselves leading to loss of reputation to the Trust. The Trust is failing to meet their obligations.	Use of fans (minimal value). Opening windows (minimal value)		MOD	HOS

3174	04/03/2011	Provide safe, high quality care	Audiology Dept	Risk of misdiagnosis during testing as a result of failure to meet the minimum room standards	Risk of misdiagnosis during testing as a result of failure to meet the minimum room standards. Current accommodation is unsuitable as it does not meet the minimum British Society of Audiology (BSA) standards. There are a number of test rooms which are generally ok for testing. However one test room is not a soundproof test room. It has been sound treated but noise can be heard coming from the corridor, ie. footsteps, doors closing, conversations. Another room is used for tests with not separate observation room, which is recommended within audiology standards to alleviate noise levels and distraction. The Paediatric room cannot be used for diagnostic testing as it is only a sound treated room. Calibration tests were carried out in May 2009 which were ok but staff feel that does not give a true reflection due to the time of day the calibration was carried out.	Room is not to be used for diagnostic tests. It can only be used as a hearing aid fitting/repair room.	Estates have issued a quote for a replacement room and this has been forwarded to Head of Service. The test room has been downgraded to a Hearing Aid fitting room. The result is that all patients for diagnostic tests have to be seen in the one remaining test room. Delays at ENT clinics occur daily. Complaint received by ENT Consultant.	HIGH	HOS
2918	25/03/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	Fire Safety	If a fire occurs there is the potential for harm/death of both patients, relatives and staff. Risks identified following a recent fire audit to include Cavity barrier / wall faults, smoke seals, fire escape signs, fire action notices, fire alarm maintenance, nominated and deputy fire officers and training, evacuation plan and drills, waste bins and housekeeping.	An action plan has been drafted in conjunction with fire officers and estates. Work is on-going to address the department issues for the unit staff, waste etc. however some areas within estates are outstanding as will require significant costs.		MOD	HOS
2986	28/03/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	A confined working space and difficulty hearing intravenous pump alarms, in the chemotherapy preparation area has resulted in a	The Mandeville unit capacity increased which resulted in a treatment area expansion. Unfortunately the chemotherapy preparation area remained unchanged and is currently not fit for purpose. This has resulted in the actions and subsequent risks outlined above. In the event of a fire the door will not close independently. This increases the risk to patients, visitors and staff and may lead to the death of one or more persons. This action also breaches the legislation outlined in the SHSCT Fire Policy (page,13) If the door is closed there is a real risk of needle stick injury to staff working in a confined space. This breaches the health and safety at work regulations. If the door is closed staff are unable to safely monitor and respond to intravenous pump alarms. This compromises patient safety.	In the event of a fire staff have been advised to close the door. A Fire COSHH cabinet has been ordered for a store room awaiting renovation. This room has a fire door which when completed will have a keypad lock insitu. This will reduce the risks in the current preparation area.	26.11.13 Minor works approved for improvements	HIGH	HOS
2987	28/03/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	The patients kitchen door which is a designated fire door is continually propped open when domestic staff are in service.	In the event of a fire there is risk to patients, visitors and staff which may lead to the death of one or more persons. Domestic staff are at risk of injury from hot beverages while attempting to open the door while carrying trays or if the door is opened in on them while carrying a tray. There are several electrical appliances in this room. Hot water geezer, rotation toaster (previously caught fire) microwave, dishwasher, Electrical beverage serving trolley. This increases the risk. In the event of a fire the door will not close independently. This increases the risk to patients, visitors and staff and may lead to the death of one or more persons. This action also breaches the legislation outlined in the SHSCT Fire Policy (page,13) The door has no viewing panel which renders domestic staff at risk if the door is opened inward while they are carrying hot beverages on trays. (This is a continual process throughout the day and not confined to meal time) Domestic staff are also at risk trying to open and close the door while balancing trays with hot beverages.	Domestic staff have been advised to keep the fire door shut and to use the trolley beside the door to place trays while opening the door. The door must not be kept open throughout service. However they report that this is unworkable and the door continues to be propped open. The door is shut only when domestic staff are not on duty.		HIGH	HOS
2942	07/04/2011	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Urology cancer pathway delays (also on SEC Divisional Risk Register ID 2943)	Patients on haematuria and prostate cancer pathways. Delays in first appointments, investigations and treatments. Patients with cancer being delayed in diagnostics and treatment pathways. Patients may be late diagnosed and have further advanced disease leading to poorer outcome. This may mean that a patient changes from potentially curative to palliative during the waiting period.	Identification of patients at risk ongoing. Detailing of capacity and demand ongoing to identify needed capacity and resources.	28/2/13 - As previous ongoing urology risks. 31/1/13 - Risk remains same within urology - haematuria 1st OP on both sites and 1 urologist has handed in their notice. 7/1/13 - As below, new consultants have started, however 1 has handed in their notice for post in the Belfast Trust. 23/11/12 - risks continue within Urology whole way through pathway. Additional flexi lists have been agreed and continued daily escalations. 1/11/12 - 2nd new urology consultant commenced today. ongoing urology risks remain high. 26/9/12 - Risks remain as previous 30/8/12 - Urology continues to remain high risk. However, new urology consultants commenced. Risk will decrease over next few months. Regional risks in PET, surgery, oncology 1st apointment continues. 30/7/12 - Urology remains high risk of breaching cancer pathway. New urology consultants commencing in next few weeks, risk should decrease over time. 22/6/12 - Urology remains high risk of breaching cancer pathway 25/5/12 - unchanged, risks continue 24/4/12 - continued cancer risks as below. 1 consultant urology post vacant - high risk to targets. 26/3/12- Continued cancer risks in urology, lung due to lack of capacity for 1st appointments & complex diagnostic pathways, Risk in gynae due to lack of capacity for theatre 1st definitive. impact of inability to downgrade and continuing regional capacity/operational issues for ENT. Regional risks due to capacity issues in PET, thoracic & plastic surgery. HoS to submit cancer access non-recurrent bids for 12/13. Ongoing escalations to HoS and ADs. 29/2/12 - Continued cancer risks in urology, lung and gynae due to lack of capacity for 1st appointments, complex diagnostic pathways, impact of inability to downgrade and continuing regional capacity/operational issues. Ongoing escalations to HoS and ADs. New prostate service changes commenced 26/9/11	MOD	DIV
2944	11/04/2011	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Patients may receive a 'out of temp' Blood Component due to it not been appropiately packaged/accompanied by documentation	The Transfer of Blood Components that are not appropriately packaged or accompanied by documentation, necessary to ensure that the Trust is in accordance with the requirements of the Blood Safety and Quality Regulations (2005). Patients may receive a blood component that has been transfused 'out of temperature' control which may potentially lead to major morbidity and mortality. The Trust will be in breach of the BSQR requirement of 'unambiguous traceability' of all blood components.	Staff involved in the requesting of blood components must have attended relevant education sessions in accordance with the 'Right Patient. Right Blood' initiative, and be aware of the necessity to communication with blood bank staff if blood components are required to be transferred. The Blood Transfusion Policy (2010) must be adhered if blood in relation to the transfer of blood components. The Integrated Blood Component Chart includes advice for staff in the event that transfer may be required. Audit of the blood transfusion process in relation to transfer non-conformances (6 monthly).		VLOW	TEAM
2969	22/04/2011	Provide safe, high quality careBe a great place to work	General Pathology Lab	Inadequate numbers of MLA and Admin staff to ensure appropriate turnaround of laboratory tests.	Inadequate numbers of MLA and Admin staff to ensure appropriate turnaround of laboratory tests. Also imminent retirements will leave the Biochemistry department with inadequate numbers of management staff.	Work is being prioritised to ensure that the most urgent samples are dealt with. E Requisition raised for replacement staff, paper forwarded to Assistant Director, letter forwarded to Director.		MOD	HOS

2977	10/05/2011	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Trust fails to meet performance standard due to administrative pressure on the cancer coordinators tracking of cancer patients	Trust fails to meet performance standard due to administrative pressure on the cancer coordinators tracking of cancer patients on the pathway. Patient is delayed in diagnostics and treatment for cancer - 95% for patients on the 62 day pathway and 98% for patients on the 31 day pathway. Patients referred with suspected cancer are delayed on their cancer pathway due to lack of resources/ capacity to see in the time frame required within the cancer pathway. Delays experienced during coordinators bank holidays and annual leave throughout the year as no backfill available. In addition there has been an increase in the number of red flag referrals, and an increase in the number of Multi disciplinary meetings in operation (both local and regional). Key areas most at risk - urology, lung, Upper GI, gynae, skin, but all pathways under pressure. Patient delays leads to a poorer outcome for the patient's overall survival, or ability to have the optimum treatment for their cancer, and breach of targets.	A system for identifying suspected cancer patients in in use (red flag labeling). A tracking team are in place to monitor patients and identify patients at risk. Weekly meetings take place with the service administrator and coordinators to highlight risks. An escalation process is in place to expedite patients, where possible, to catch up time in the pathway.	29.2.12 CLOSE and place onto HoS Risk 28.10.11 Cancer admin risk paper has been amended and to be forwarded to Dr Rankin. 2.9.11 - Paper complete and to be forwarded to Dr Rankin for consideration. 12.8.11 - A paper is in draft detailing the requirement for additional support. Escalation processes continue.	HIGH	DIV
2978	10/05/2011	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Trust fails to meet performance standard. Patient is delayed in diagnostics and treatment for cancer	Trust fails to meet performance standard. Patient is delayed in diagnostics and treatment for cancer - 95% for patients on the 62 day pathway and 98% for patients on the 31 day pathway. Patients referred with suspected cancer are delayed on their cancer pathway due to lack of resources/ capacity to see in the time frame required within the cancer pathway. Further delays experienced due to bank holidays and annual leave in April 2011. In addition there has been an increase in the number of red flag referrals. Key areas most at risk - urology, lung, Upper GI, gynae, but all pathways under pressure. Patient delays leads to a poorer outcome for the patient's overall survival, or ability to have the optimum treatment for their cancer.	A system for identifying suspected cancer patients in in use (red flag labeling). A tracking team are in place to monitor patients and identify patients at risk. An escalation process is in place to expedite patients, where possible, to catch up time in the pathway.	26.11.13 Patients continue to experience delays for PET scan - risk of breach	HIGH	HOS
2980	13/05/2011	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Use of one plasma thawing device at both CAH and DHH blood bank laboratories limits the availability of FFP	Use of one plasma thawing device at both CAH and DHH blood bank laboratories limits the availability of FFP to 4 units every half hour i.e. maximum of 8 units per hour. This was considered inadequate at a meeting with Dr B Adams anaesthetist on 8/4/2011 for the management of massive blood loss patients in obstetrics	There is one plasma thawer available for use at each laboratory site. These require a minimum of 30mins to thaw FFP and have a maximum load of 4 units. An additional plasma thaw was purchased for CAH and DHH labs		HIGH	HOS
3003	16/06/2011	Provide safe, high quality careBe a great place to work	Cellular Pathology Lab	Inadequate storage space for blocks and slides in Cellular Pathology	Inadequate storage space for blocks and slides in Cellular Pathology. Blocks are currently stored in the corridor, highly combustible material - fire risk.	No Control Measures possible.	22.11.11 James Heaney reports that additional shelving has been erected in the Cellpath Slide/Block Store which provides an additional years storage.	MOD	HOS
3167	08/07/2011	Provide safe, high quality care	X-Ray Dept	Risk of patients falling whilst being x-rayed for erect knee examinations in the X-ray room of Lurgan Hospital	- Potential for persons to fall causing harm to themselves - Possibility of litigation due to injury - Injuries could range from extremity injuries to more serious head and facial injuries. e.g. fractures/lacerations - Loss of reputation to Trust. In the x-ray room of Lurgan Hospital the x-ray tube does not extend low enough to the floor, meaning patients for knee examinations are required to climb two steps in order to have the examination. Additionally the patient is expected to turn around on the top (narrow) step to achieve the required anatomic position. Due to the design and ergonomics of the equipment available there is the potential for a patient to fall from a height or receive a twisting injury	Staff awareness of potential risk and verbal warning to patients. If patient is not physically able to cooperate with positioning then alternative imaging technique can be used and reason stated on RIS. Use of another member of staff to assist during positioning.		VLOW	HOS
3171	19/07/2011	Provide safe, high quality careMaximise independence and choice for patients and clientsMake the best use of resourcesBe a great place to workBe a good social partner within our local communities	X-Ray Dept	Risk of non replacement of Radiographers in CAH, Lurgan, PHC and Banbridge	Within CAH, Banbridge, Portadown HC and Lurgan X-ray departments there is a potential risk to the quality and delivery of patient care and service. For example less time available to provide a high standard of care to the patient, increased waiting times for x-ray examinations, lack of choice for patient appointments and potentially lists could be cancelled because of the reduced staffing levels within the departments. Service delivery will potentially be adversely affected as targets are not being met. Staffs health and wellbeing will be affected as workload and demands on staff increase, leading to decrease in staff morale, increase in stress levels and increase in absenteeism and sickness. Best use of equipment will be affected due to lack of staffing to operate the equipment e.g CT/MRI scanner. If a high quality of service is not provided local communities lose confidence in the service provider. There is a potential risk of injury to both client and staff due to lack of resources available for safe moving and handling of patients from chair/bed to x-ray couch and back again leading to potential clinical incidents, litigation and loss of reputation for the Trust. Potential risk of staff developing musculoskeletal injuries if they are constantly exposed to increased workloads with less time to rest and recover between examinations. Due to the increased pressure of work on the staff there is a high risk of mistakes occurring leading to misdiagnosis or increase of dose of patient due to either incorrect area x-rayed or incorrect ID check of patient leading to loss of reputation to the Trust and potential for clinical incidents and litigation. Non clinical duties eg: QA, H&S general housekeeping, records etc will suffer as staff struggle to meet the demands of patient service delivery. Potentially there may be an increase in the number of complaints from both the service users and patients leading to loss of reputation for the Trust.	Restricted choice of staff requests for leave. Staff are rotated at short notice to cover service demands. Restriction on number of staff released for mandatory training. Staff working late to meet service demand.		LOW	HOS
3023	10/08/2011	Be a great place to work	Blood Transfusion Lab (Blood Bank)	Current Blood Bank estate is unlikely to pass MHRA Inspection	Current Blood Bank estate is unlikely to pass MHRA Inspection. Flooring is a health and safety hazard.	None possible.		HIGH	HOS
3263	01/09/2011		Radiology, Craigavon Area Hospital	Mobile Image Intensifier in T&O theatres constatntly breaking down causing disruptions to theatr lists	Unable to carry out imaging in theatre due to consistent breakdown of both MII's alternatively and in unison. This is detrimental to the patient's treatment and care as surgical operations are hampered and unable to be completed while patient is under anaesthesia causes lengthier anaesthetic times and surgical complications and may result in the cancellation of the operations, lengthier stays in T&O wards causes undue stress to the radiographers, theatre staff as Consultants are very dissatisfied with the service as it impacts on the theatre lists and work load. Potential Manual handling risk to radiographers who struggle to manoeuvre the machines c arm and monitor from one theatre to the next, through very narrow exits. Manoeuvring to remote sites for engineers access	Regular servicing Staff awareness of contingency measures Rapid call out of engineers QA on MII'S regularly		MOD	HOS

3034	26/09/2011		Macmillan Suite - Mandeville Unit	Working at height, confined space, lack of fridge and lockable storage space for take home meds in the preparation room	Some of the equipment used on a regular basis is stored at a high level. This requires the use of a stepping stool. The current stepping stool has no additional safety measures such as hand rails to steady ones gait. Staff small in stature have to stand on their tip toes adding the additional risk of loosing their balance or missing their footing. The room is too small for purpose adding further risk of accidental bumping of staff when working at this height. The clinical fridges are too small for purpose and located in a confined space making access. In addition the inside fridge opens toward staff resulting in them having to lean over it to access the contents within. The process of entering the fridges results in bending, stooping and twisting on a regular basis to reach chemotherapy and other supplies. Manual handling training to reduce the risk of personal injury cannot be fully implemented. The clinical fridges are too small for current capacity. This results in the overstocking of chemotherapy infusion bags and syringes with the potential risk of damage and spillage. In addition, in the search for an individual's chemotherapy, the fridge is opened on a regular basis; chemotherapy removed and replaced, which may result in it not being stored at the required temperature. The lockable storage for take home medications is insufficient for the current Tuesday and Friday regimes resulting in drugs being squeezed into a confined space or stored in a chemo box needing constant supervision until space is available. Intravenous chemotherapy and oral take home medications can be in the same drawer and should be stored separately. Hot and cold packs are required on a regular basis as part of some patient's care. Cold packs are kept in the fridge and easily maintained at the correct temperature however, hot packs have to be heated in hot water to reach the required temperature which is a slow process, as we currently have insufficient space to store a clinical microwave safely. The preparation of chemotherapy requires staff to set up a trolley, using all four areas of the preparation room. Staff are using needles, breaking ampoules, handling chemotherapy and trying to maintain sterile fields in a confined working space with the following potential risks: "Contaminating the sterile fields as staff brush past. "Needle- stick or ampoule injury as staff brush past to reach supplies. "The aforementioned bending, stooping twisting and working at height to obtain supplies. "Slower preparation processes as staff wait in turn to access supplies. "Staff being interrupted during their drug checking process to accommodate staff needing past with the potential of a drug error. "Staff in particularly busy periods, are having to partially set up their trolleys outside the preparation room waiting to gain access as others finish. chemo has to be checked off at the patients side with the potential risk of raising their anxiety levels.	All unnecessary supplies have already been removed from the room in an attempt to gain space but with an increase in unit capacity, the space remains inadequate for current operations. Less frequently used equipment is stored at the higher level to reduce the risks of working at height.	30/7/12 - new fridge has been delivered - take off divisional register 22/6/12 - as below, no change 25/5/12 - on minor works list, awaiting approval 24/4/12 - Email received from Alan Metcalfe on the 23/4/12 stating that outstanding minor works will be issued to Directors next week for reviewing and priorisation. once finance have confirmed the budget Estates will be able to make arrangements for funded and approved requests. 26/3/12 - fridge is in the process of being ordered, has been authorised. 1/3/12 - still with minor works for costing, to chase up. 20.09.11 Sister Nowak to contact Estates to obtain a costing for an extension into the adjoining store room.? if this will gain the amount of space required. Explore other options such as expanding out.	MOD	DIV
3060	03/11/2011		Occupational Therapy Department	Redeployed Band 6 O.T Post from DHH Stroke Team covering long term sick leave on rehabilitation ward.	Increased workload for remaining O.T staff to ensure D/C targets met within DHH. Patients having to wait for longer to have O.T assessments/ Rx increasing risk for potential delayed discharges. Patients not receiving the indicated quantity and quality of inpatient rehabilitation treatment programme specific to their needs. Delayed discharge due to reduced intensity of rehabilitation and extended duration of inpatient stay to receive adequate rehabilitation to facilitate safe discharge. Reduced liaison with family /caregiver and therefore impaired information sharing. Harm - Physical / functional and equipment needs of patients may not be met for D/C from DHH and patients at risk of permanent physical / psychological / cognitive impairment. Reduced quality and quantity of service to patients/ families Failure to meet College of O.T. Professional Standards / HPC Standards of Proficiency Failure to meet National Guidelines - RCP / NICE Reduced ability to deliver on service targets. Risk of service complaints / increased time spent on dealing with complaints. Risk of litigation. Negative impact on staff morale. Increased risk of reduced health of staff - work related stress / fatigue with increased risk of absenteeism. Significant unmet need impacting on service delivery.	Redeployed Band 6 O.T staff member from Acute Stroke Team (level 6) to cover long term sick leave on rehabilitation ward (level 6). Current staffing on stroke completing additional duties to attempt to meet targets and comply with guidelines and Professional Standards of Practice All staff focusing on D/C targets from acute medical and surgical wards - compromising the quality of care provided to rehab/stroke/brain injury/complex patients. Staff following clear guidelines re: documentation Additional training to be arranged to cover specific areas (compounded by A/L and S/L issues)	29 11 11 staff member returned to work 03 11 11 Consider temporary replacement of band 6 OT post (with band 5 OT) [redacted]		HOS
3061	03/11/2011	Safe, High Quality and Effective Care	Occupational Therapy Department	No Wash Hand Basin in OT Treatment / Clinical Area & Long chain on wc replacement	Staff / patients at risk of infection / ill health due to no WHB being available in OT Treatment / clinical area. Against all Infection Control policies / procedures and potentially placing staff, patients and families at risk of harm. Non Compliance with SHSCT Corporate objectives - ensuring a safe and clean environment for patients and staff alike.	Alternative sink is used in neighbouring toilet area for hand washing before / after clinical care. Alco-rub / Hand gel pumps placed within each treatment room. All staff briefed with SHSCT Policies and procedures and conversant with Infection Control Audits / Action Plans. All staff trained in infection prevention and Control procedures for SHSCT. Review at staff supervision sessions / appraisals. Departmental Audits carried out monthly and safe systems in place for OT Department.	19 11 12 minor works forms submitted and work costed 2011 Source adequate funding to install suitable hand washing facilities in OT Treatment area. Replace current toilet facility with anti - ligature flushing device.		TEAM
3059	02/12/2011		Physiotherapy	Unable to provide safe, high quality and effective care.	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - "No temporary or permanent recruitment into vacant posts. "Reduced staffing levels - Vacant Posts include- 1 WTE Band 7Clinical Specialist Physiotherapist (Mat Leave from 9/10/11) 1 WTE Band 6 Physiotherapy Rotational Post (S/L from14/11/11 commences Mat Leave 19/12/11 0.5 WTE Band 7Clinical Specialist Post (Vacant 31/10/11) 0.6 WTE Band 3 Physiotherapy Assistant (Career break from 16/11/11 for 3 years) 0.6 WTE Band 3 Physiotherapy Assistant (S/L from 30/11/11 ?? long term) "From 5/12/11 2.0 WTE Band 5 Physiotherapy Rotational posts are replaced with inexperienced temporary band 5 physiotherapists with another 1.0 WTE permanent Band 5 Physiotherapist being replaced December 2011with another temporary inexperienced Band 5 physiotherapist. These temporary Band 5 Physiotherapists have little or no previous experience & therefore very limited knowledge & skills. These staff require induction, training, modified caseloads, frequent formal & informal teaching & supervision from senior staff on a daily basis. These vacancies present increased risk of staff becoming further fatigued, stressed and physically unwell due to lack of replacement staff & use of 3 WTE temporary band 5 staff to facilitate OPPC targets Unable to provide timely physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc	29.2.12 CLOSE from divisional to go to HoS Risk register. Vacancies for Band 5 & 6's funded posts - no additional resource required. Potential financial resources may be available from Swine flu training budget / Acute Physiotherapy.	MOD	DIV

3054	08/12/2011		General Pathology Lab	Security	The laboratories on the Craigavon site are located at the back of the hospital site, adjacent to the perimeter road, behind the theatre block.There are lone workers at night in the laboratories. The labs receive specimens from the hospital on a 24/7 basis. The two main methods of specimen delivery are by the chute system or by porters bringing the samples to the labs. Blood products can arrive by taxi at any time of night. Patients attending the andrology service require to be admitted to the laboratory along with occasional visitors such as other clinical staff or supplier representatives. Delivery of goods to the labs takes place on a daily basis. The door locks ore operated by entering a code on a keypad. This code was maintained until recently on a laptop used only for this purpose. The system is approx 10 years old and the laptop has now failed. We are unable to update an security setting on the system. Previous software updates to the system were expensive and the system is incompatible with fob systems used throughout the site. The new reception has a fob controlled lock. Security here is breached because laboratory staff do not have fobs to access the lock and porters fobs have not been activated to operate the lock.	Existing doors are locked but code cannot be updated. Meeting taking place Friday 9 December 2011 to discuss training and documentation for staff accessing laboratory. Security policy exits.	23/4/12 - Fobs have been purchased and are currently being activated for main lab reception. The automated locks on the other 2 doors are not fob operated and did not fail open - locks to be replaced. NOW RETURN TO HOS AS OF TODAY 26/4/12 27/3/12 Estates has been contacted. Awaiting update 29.2.12 - minor works has been complete with Estates. Brian to chase up costings w/c 5.3.12.	HIGH	DIV

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3062	05/01/2012		Occupational Therapy Department	No OT Splinting Service within DHH or N/M	Clients at risk of developing contractures, pain and increased tone if not assessed for and prescribed with a thermoplastic splint / or other as per clinical need. Risk to client - Pain / permanent injury - boney changes / lack of function. Risk to care giver - Increased demands for management of upper limb positioning self care / pain and discomfort of client. Risk to organisation - Failure to met national standards and guidelines of good practice including those for British Association of Hand Therapists and Royal College of Surgeons Significant unmet clinical need impacting on service delivery. Reduced ability to deliver on service targets. Risk of litigation and loss of reputation Risk of service complaints / increased time dealing with complaints	Referrals currently returned to source GP / COT with letter of explanation regarding gap in OT Service provision. Occasional patients referred from Renal Unit / A&E are seen by an appropriately skilled OT however at the cost of Acute inpatient time. List of unmet need recorded and discussed at regular supervision sessions. Review of policy / guidelines for evidence base and maintain good practice. Liaise diectly with line manager operational and professional to identify business case to met gap in service and unmet need.	19 11 12 repeat of DATIXPerso , being closed off Nov 2011 0.5 wte Band 6/7 OT to be employed within SHCST to provide assessment / provision and review of all neuro splinting trust wide. Splintage Materials / Adequate resources provided.		HOS
3170	19/01/2012	Provide safe, high quality careBe a great place to work	X-Ray Dept	Door handles in Portadown Health Centre considered too low for staff and patients	Door handles in Portadown Health Centre x-ray Department are measuring 800mm from the floor which is felt too low for patients and staff. Particularly for staff who may be opening and closing these doors to facilitate the treatment of approximately 30 patients per day. This would equate to the radiographer/sonographer using the low door handles upwards of 100 times per day. This is due to the patient's care pathway involving the radiographer/sonographer opening the cubicle door for the patient on entering and leaving and opening the x-ray room door on entrance/exit for each patient. Potential harm to patients and staff member's backs and shoulders from continually stooping and pulling the low door handles.	Staff awareness. Removal of closure mechanism on some doors to make the lighter to use.		LOW	HOS
3074	30/01/2012		Occupational Therapy Department	Expecting mothers - Carry out assessment of the H&S risks	(1)Carry out an assessment of any activity that may be harmful to new and/ or expectant mothers. (2)Carry out a risk assessment specific to the employee based on the initial assessment and any medical advice their doctor has provided. Outline the potential for harm: (Consider injury to client, staff, litigation, etc) (1)Short or long term injury to member of staff (2)Staff absence/ sick leave due to injury. (3)Possible litigation case re: injury.	(1)Ensure awareness, implementation and monitoring overall health and safety at work policy. (2)Ensure provision of adequate information/ instruction/ training and supervision for health and safety and wellbeing of staff (3)Develop safe methods of manual handling based on risk assessment which will reduce the risk of injury.	19 11 12 implementation of Trust Risk assessment for expectant mothers 2010 Arrange Manual Handling Training. Promote staff awareness of H&S at work policy. Arrange risk assessment training.	LOW	HOS
3137	01/03/2012		Physiotherapy OPD	Potential risk to patient & staff safety and wellbeing as result of hazardous environmental condition within dept.	Hazardous clinical environment with the potential to cause harm to patients , staff & visitors Risk to Trust reputation through increased likelihood of complaints/ litigation. On-going issue with hydrotherapy pool leaking and causing damage to adjacent wall and flooring in T&O gym. Initial investigation of problem carried out by Estates dept and temporary boarding up of wall. Water damage to clinical area remains evident and initial problem still not resolved. Concerns with safety of clinical area with regards to infection control issues and also regarding the close proximity of electrics to the water leak. Potential for further significant damage / harm if problem continues.	Reporting of issue to Estates dept for further investigation. Contact with Infection Control Team - seeking clarification Patient cubicles closed off and staff informed not to use.	19 11 12 Hydro pool wall - pool cover removed and to be monitored by estates. Wall looks dry, plaster board in place and painted 24 07 12 Remedial work completed and area functional again. 01.03.12 Close liaison with Estates dept to ensure resolution of initial problem and completion of any remedial works to return clinical area to usable state.	MOD	HOS
3169	13/04/2012	Provide safe, high quality care	X-Ray Dept	Risk of injury to operator, patients, staff, visitors and clients while operating the MobileArt (GE) x-ray unit	When operating the MobileArt (GE) x-ray machine there are a number of contributory factors that could potentially cause the operator to collide with patients, staff, visitors, clients, trolleys, beds, doors and walls etc leading to the risk of injury to the operator, patients, staff, visitors and clients. These injuries could range from minor injuries to major injuries. The potential consequences for the Trust are: - 1. Long term sickness and absenteeism of the staff member involved impacting on the quality and delivery of service provided and on the service needs. 2. Litigation could ensue from personal injuries from patients, staff, visitors and clients leading to the loss of reputation of the Trust. 3. Furthermore collision with an inanimate object could lead to damage of Trust property. When operating the MobileArt (GE) x-ray unit there are contributory factors that could potentially put the operator, patients, staff, visitors and clients at risk from injury. They include: - 1. Electrical risks when plugging and unplugging the MobileArt (GE) x-ray machine. 2. A blind spot on the machine when driving it due to its design. This makes it difficult to see the general public, patients, clients and other members of staff who may walk in front of the machine. This risk is increased around busy times, for example,visiting times when more people are about the wards and corridors 3. Risk of small children not being noticed by operator when driving the machine. This risk is increased around busy times, for example,visiting times when corridors and wards are busy. 4. Risk of uneven flooring and surfaces on Trust premises e.g. if using the lifts to access wards, the lift may not stop at the correct level. 5. Risk of damage to x-ray machine and doors on entering the wards because of the design of the entrance doors (they tend to close too quickly). Furthermore this could potentially cause injury to the operator as they have to negotiate the x-ray machine through the doors before they close. This may lead to the operator going through the doors awkwardly due to twisting/overreaching to hold the doors open and drive the machine simultaneously. 6. On the wards there may be inadequate space around the patient's bed because of drip stands, night stands and other medical equipment reducing the ease of movement and adjustment of the machine due to the restricted operating space. This could potentially lead to damage of the x-ray machine or other medical equipment and injury to the operator from a manual handling perspective . 7. Risk of injury to operator whilst driving the machine if they have to brake suddenly to avoid colliding with patients, staff, visitors, clients or inanimate objects for example doors/walls.	Staff awareness of the possible consequences of the restricted view from the blind spot on the x-ray machine . -Training of staff on how to use the machine at the Induction stage (updates as necessary). -Importance of reporting faults and incidents applicable to the machine as soon as possible. -Importance of then disseminating this information at the monthly staff meetings to all the relevant staff regarding the faults that have occurred. -Staff awareness regarding NOT driving the machine at full power in busy public areas and at busy times. -Regular servicing to ensure the x-ray machine is in good working order and safe to use. -Staff familiarising themselves with the workings of the machine on a regular basis (CPD). -Records of staff competencies in using the machine signed and kept up-to-date. -Staff must give consideration to others around them when driving the x-ray machine in public areas at all times.	Engineer Terry Headley gave assurance that the MobileArt is sate to use. Full service of machine is due on August 2012. Phone Colin Spiers in Estates Re-iteration of justifying portable x-rays. Ensuring that only x-rays that justify the need for portable x-rays are performed. Otherwise the patient comes to the department. On agenda for staff meeting 19.4.12	LOW	HOS
3164	22/06/2012	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Facilitation of treatment over 3 days - no medical cover available on Monday and Friday for oncology patients	No oncology medical cover available (Named Doctor required as a point of contact in an emergency), so unable to provide treatment on Monday and Friday as chemotherapy treatment can cause numerous complications/emergencies that need urgent medical attention. Treatments continuing Tuesday to Thursday covered by consultant oncologist, this has potential to delay other outpatient appointments. Number of treatments able to be delivered is restricted by number pharmacy able to make up in the time period. In order to ensure patients receive prompt treatment we have had to facilitate all Oncology treatment on Tuesday, Wednesday and Thursday. This has impacted on the activity within the Unit and will cause delays in administration of treatments and also overcrowding of the environment , this puts patients and staff at risk. Potential for harm a)If patients are treated without medical cover they are at risk of deterioration from complications/emergencies such as hypersensitives or anaphylaxis b) Demand outweighs capacity causing patients to wait longer. Space constraints within the environment. c)patient fails to commence treatment within target timeframe	At present we have stopped administering chemotherapy on Monday and Friday. All Oncology patients are treated on Tuesday, Wednesday and Thursday. Allocation of staff has been adjusted to meet the demand. Patient Group Directions are currently being developed. Ongoing training for BLS, Alert and Anaphylaxis	22/3/13 To come off the Divisional Risk as per HOS 28/2/13 - as previous. 31/1/13 Currently there is no patients delayed for chemotherapy. Mondays and Fridays are being utilised for supportive treatments. 7.1.13 Staff grade will be commencing March 2013. No patients waiting to commence chemotherapy. 23/11/12 - risk continues. Staff Grade commences Jan 12, Acute Oncology Consultant interviews last week in November 12. 1/11/12 - risks continues. Staff Grade has been interviewed, offer made and will start in January 2012. Acute oncology consultant post interviews in November 12. 30/8/12 - risk continues; as no Medical cover on a Monday and Friday. 2 medical posts have been advertised and closed. 5 applicants for each. Waiting times for commencement of colorectal chemotherapy 4-5 weeks. 30/7/12 - still continues to be a risk. Cancer HoS to discuss further with Mary Burke, Action AD for MUSC Discussed but not agreed. Ongoing meetings with medical staff i.e. ED, Medical Directorate (with Dr Rankin) Awaiting response from the surgical team	MOD	HOS

3190	03/09/2012		Day Surgery Unit	Roof on Day Surgery Unit CAH is regularly leaking	Roof on Day Surgery Unit CAH is regularly leaking thereby compromising the safety of the clinical environment for patients and staff.	All problems are reported immediately to Estates Department to have them repaired as a matter of urgency.	. 22/3/13 There was a pre-start meeting last week and Estates have confirmed that the work will commence April 2013. 28/2/13 - to be complete by end March 2013. 7/1/13 - on estates works programme to be completed by 31/3/13. 23/11/12 - awaiting on Estates to give start date. 2/11/12 - funding has been approved. 2/11/12 - funding has been approved. 26/9/12 - no further update, still waiting on approval of funding. 30.08.12 Full roof repair for the Day Surgery Unit is currently on Estates list of required work. This has been reprioritised by them as very urgent , currently awaiting approval of funding for same.	LOW	DIV
3261	07/09/2012		Radiology, Craigavon Area Hospital	Risk to radiographers finishing twilight shift (12am) and walking to the car park alone across the hospital site	Radiographers having to walk to remote parts of the hospital to access their cars after finishing the twilight shift at 12am. They feel nervous and vulnerable and fear risk of physical or verbal attack. Also risk of slip, trips and falls especially in winter months when paths and roads may not be gritted. This increases their stress levels after a busy shift	None		MOD	HOS
3257	11/10/2012		Radiology, South Tyrone Hospital	Cold Clean Drinking Water required for STH X-Ray	There is no drinking water supply within the scanning suite for patients. The department uses approximately fourteen litres of water per day for patients to drink prior to scanning. Patients discomfort at having to drink up to 2 litres of luke warm water.	Drinking water can be transferred from the theatre suite, but there is no cool area to store the water. There is a risk of water spillage and a risk of injury to staff during transport of water. Also impact on theatre staff due to interruptions from radiography staff.			HOS
3260	15/10/2012		Radiology, Craigavon Area Hospital	Risk of injury to patients and staff when using Kodax portable machine in ED xray	Due to the design of this machine the radiographers view is restricted and there is lack of speed control (too fast) and appears unsteady and easily tipped. These factors increase the risk of collision and injury to patients and staff. Alsomanual handling risks to staff whilst pulling machine back as it drives too fast	Staff Awareness Machine not used	12.06.13 Kathy Doherty to source a buyer	VLOW	HOS
3244	15/10/2012	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	HEIG Decontamination of flexible endoscopes follow up audit	Follow up audit to the 2010 decontamination audit, there are areas still outstanding from the initial audit report which need to be progressed and which will require development of business cases and agreement from SMT on way forward.	Operationally all actions have been complete and progressed to date. Other areas have been highlighted which require to be actioned.	12.02.14 Responsibility for decontamination has been moved from theatre to CSSD. 22/3/13 Moved from Div to HOS RR as per AD instructions. 28/2/13 - Heads of Service working through money transfer. 31/1/13 - Transfer has been agreed 7/1/13 - Paper has been completed for transfer of responsibility for the theatre decontamination in CAH to become that of CSSD and has been sent to Dr Rankin for consideration. Adjustable sinks have been ordered. 23/11/12 - No further developments. 2/11/12 - Action plan has been identified with requirements and has been forwarded to Dr Rankin. Taking actions forward. 26.09.12 Action plan has been formulated and a working group to be developed.	LOW	HOS
3258	06/11/2012		Radiology, Craigavon Area Hospital	Bulky Nursing Equipment stored in Darkroom CAH	Equipment is obstructing the main thoroughfare to the cleaners store and the Safe Q. It is also making it difficult for Radiography staff to access x-ray films when required.	None			HOS
3262	08/11/2012		Radiology, Craigavon Area Hospital	Temperature within the xray processing area and rooms 3,4 and 5 are higher than the normal ranges which is 16-25 oC	Within these areas the temperature regularly goes above the acceptable range due to the heat eminating from the electrical equipment and the structure of the building. Staff have the potential to become fatigued, dizzy and faint due to loss of water and salt. This hot dry air can cause risk of eye and throat infections for staff Patients who are having rays performed in rooms 3,4 and 5 are complaining about the heat and stuffiness and some feel quite unwell as a result	Ensure staff and patients have access to chilled water Use of fans in rooms Opening windows in rooms		MOD	HOS
3264	08/11/2012		Radiology, Craigavon Area Hospital	Risk of injury to staff due to items being stored on very high shelves in the nurses store room in CAH	Items are being stored on the top shelves in the nurses store in X-ray CAH to maximise space. However these shelves are too high and staff are unable to reach items unless they stand on the foot stool provided. This is a one step stool and staff still have to stretch to reach the top shelves even with the step. This has the potential for the staff to get hurt by either falling or over stretching to reach the items. The items on the top shelves are insecurely placed due to lack of space and they have the potential of toppling down on top of the staff and this could potentially lead to injury also	Staff awareness Manual Handling Mandatory Training One step foot stool provided		LOW	HOS
3265	08/11/2012		Radiology, Craigavon Area Hospital	Risk of injury when entering and exiting radiology department CAH through the automatic doors	The automatic disabled doors in and out of Radiology CAH can be opened manually or automatically. However these doors may close prematurely or too quickly . This has the potential to cause a collision by the doors hitting the user unexpectedly and causing injury to the upper limb	Staff awareness		LOW	HOS
3271	17/11/2012		Radiology, Craigavon Area Hospital	Risk of injury from needle stick injuries within the radiology department CAH	After I.V. injection staff may sustain a needle stick injury from a used needle. Staff may become infected with patient's blood leading to risk of potential infection to staff.	Staff awareness/training. Wear gloves during procedure Do not resheath needle Occupational health access if required Hand washing posters and facilities ready available Sharps flow chart posters displayed in the appropriate rooms		MOD	HOS
3272	17/11/2012		Radiology, Craigavon Area Hospital	Risk of injury to operator whilst driving one of the mobile xray units to the wards and back to perform portable radiography	Whilst driving the xray mobile unit to and from the wards there is a risk of injury to the operator from crashing the machine into an innate object Operator could experience muscular and ligament damage and injury to upper limbs and neck due to the impact and fractures in some cases. There is also a risk of colliding with members of public, staff and patients and this could potentially lead to injury of both parties involved	Staff awareness and training of operating machines at induction stage Staff familiarise themselves with the workings of the machine regularly (CPD) Records of staff competencies in using the machines signed and kept up to date		MOD	HOS
3270	17/11/2012		Radiology, Craigavon Area Hospital	Lack of space within the nurses storage room in the radiology department CAH	Bulky nursing equipment is often stored in this small store with restricted space. This obstructs the main thoroughfare for staff to access the stock that is stored on the shelves. As a result there is a risk of injury to staff from either moving the heavy equipment to access the shelves or bumping into the edges of the equipment if it is not moved out of the way	None		VLOW	HOS
3273	17/11/2012		Radiology, Craigavon Area Hospital	Risk of Injury to operator, clients, patients and visitors whilst driving the MobileArt (GE) xray unit within the Trust premises	When driving the MobileArt to and from the ward there is a risk of injury to the operator, patients, staff, visitors and clients: - 1. Due to the restricted view when driving the MobileArt X-ray unit (caused by the design of the tube arm) 2. Due to restricted operating space caused by members of the public, visitors, patients and other staff during busy times 3. Due to braking suddenly to avoid colliding with members of the public, patients, visitors, other members of staff and doors/walls Operator, patients and members of the public could potentially experience injuries ranging from muscular and ligament damage to fractures in some extreme cases. Litigation could ensue from personal injuries leading to loss of reputation to the Trust.	Staff awareness of the possible consequences of the restricted view -Training of staff at the Induction stage (updates as necessary) -Importance of reporting faults and incidents applicable to the machine as soon as possible -Staff awareness regarding driving the machine on full power in busy public areas -Regular servicing to ensure the machine is in good working order and safe to use -Staff familiarising themselves with the workings of the machine regularly (CPD) -Records of staff competencies in using the machine signed and kept up-to-date -Consideration to be given to others around them when driving the machines in public		LOW	HOS

3274	19/11/2012		Radiology, Craigavon Area Hospital	Manual handling risk to staff when operating the ultrasound couch in room8	Ultrasound couch in Room 8 is used for many different ultrasound examinations and on a daily basis the couch needs to be moved to accommodate the patient, radiologist and radiographer to carry out the examination efficiently and effectively. For example for specialised procedures e.g. joint injections, to make room for bed patients from the ward and to allow the room to be cleaned at the start and end of day. This is where the problems lie as the brakes on the couch do not work properly making the couch difficult to move and lock into position especially for radiographers and Radiographer assistants who are pregnant The couch is also inclined to tip easily especially with the weight of the patient on it as the couch is very unstable Couch's head tilting movement is broken and this poses particular problems when scanning certain patients e.g. those who cannot lie flat Dr Aaron Milligan has expressed grave concerns with regards to the use of this couch in terms of 1.the Manual Handling issues that it presents in its current state 2. Dr Milligan is particularly concerned for the pregnant staff using the couch on a daily and frequent basis 3.Patient welfare as the couch is unsteady and there is the potential for it to tip	Staff awareness Yearly Manual Handling Training and updates Staff, in particular pregnant staff, recognising Their limitations and asking for help when required Maintenance for the Trust have already checked out the couch. Nothing they can do. However they suggested ordering part for head tilt mechanism		VLOW	HOS
3276	20/11/2012		Radiology, Craigavon Area Hospital	Safe lateral transfer of Patients for emergency CT examinations during Out-Of-Hours from trolley/bed to CT Table	Currently during out-of-hours there is only one CT Radiographer available to assist in the lateral transfer of patients from trolley/beds to the CT scanner table. This has led to lateral transfers being performed with only two staff members (CT radiographer and staff member from Ward). Despite this being in breach of Departmental Safe systems of Work (which were devised in conjunction with the Trust's Manual Handling Co-ordinator) it is still being performed as to wait for additional members of staff to assist leads to an unacceptable delay in the treatment of the patient. CT radiographers are very concerned for the safety of themselves and the patients. Risk to patient of injury, musculoskeletal exacerbation from falling or damage to patient's skin and joints and increase of pain.	All staff have attended Manual Handling training, including the use of manual handling aids. Safe Systems of Work. Staff awareness. Repeated requests for additional staff from wards to accompany patients. Control measures considered but discounted: Safe Systems of Work for lateral transfer (four man task) Hoist - not compatible with CT Table Use of On-Call Radiographers based in Emergency Department to assist - due to high workload and demand these Radiographers are not available to assist out-of-hours.		MOD	HOS
3275	20/11/2012		Radiology, Craigavon Area Hospital	Lack of space within the nurses storage room in the Radiology Department, CAH	Bulky nursing equipment is often stored in this small store with restricted space. This obstructs the main thorough fare for staff to access stock items on the shelves. As a result there is a risk of injury to staff from either moving the heavy equipment to access shelves or bumping into the edges of the equipment if it is not moved out of the way. Alternative area to store the heavy equipment i.e. Dark room, CAH, during working hours	Staff Awareness		VLOW	HOS
3277	20/11/2012		Radiology, Craigavon Area Hospital	AMBULATORY EEG MONITORING TO CAPTURE CLINICAL EVENTS	ELECTRODES Accidental ligature risk INJURY TO PATIENT DUE TO CLINICAL RISK Physical injury (patient) Damage to EEG equipment	Binding/grouping all electrode leads together Attach bound leads to patient clothing at shoulder level/ strap of headbox holder at back. Headbox to remain attached to body at all times Presence of parent/carer for duration of test to regularly observe Presence of parent/carer for duration of test Regular observation by parent/carer Ensure if child bed/cot sides in situ and raised			HOS
3279	20/11/2012		Radiology, Craigavon Area Hospital	AMBULATORY EEG MONITORING TO CAPTURE CLINICAL EVENTS part2	EEG EQUIPMENT Malfunction of Equipment ALLERGIC REACTION Allergic reaction to consumables	Annual electrical safety check by XLtek Patient asked via letter to inform Clinical Physiologist of any known allergies			HOS
3296	18/12/2012	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	South Tyrone Hospital, Day Procedure Unit 1 & 2	High level of noise from ventilation in DPU 1&2 STH. Noise assessment for theatres undertaken, Results are above the acceptable level in both Theatres and requires funding and action to reduce the noise to an acceptable level and achieve the standard required for the ventilation system.	Staff are alternated so that they are not in this environment every day. One surgeon at his request has been facilitated to alternate his endoscopy list between DPU1 and DPU 2 as he felt the noise level was higher in one Theatre than the other.	8/12/14 - noise level has been fixed / reduced. TAKE OFF RISK REGISTERED 12.02.14 Situation remains the same. 29/1/14 A budget cost for the above works of £374K has been recently forwarded by design consultants (initially you have approved £100K from your budget) and unfortunately we cannot procure these works this financial year. These works will be added to the capital works list for next year and will be subject to prioritisation/ funding approval with other works on this list. 26.11.13 Money through so noise will be rectified by Mar 14. 8/10/13 - DHH new endoscopy decontamination is currently being commissioned and should be operational from early Nov 13. 2/8/13 Discussed at Theatre User Meeting 1/8/13. Issue re information from Estates and being followed up as a matter of urgency. 3/5/13 Mary discussed with C Maguire. Cecil to get company to go to STH to discuss further with Marti. Mary has asked for a costing and programme of works, length of works. 22/3/13 Cecil Maguire has provided a quote of £100k. A design team to be set up and included in the capital works for 13/14. 28/2/13 - has been forwarded to Cecil Maguire to provide a full cost and programme of works. Following a filter change in the ventilation system the noise levels have increased further in these 2 theatres. 31/1/13 - No further update. Estates taking forward 7.1.13 - Noise assessment report has been received and costs has been forwarded for consideration re ventilation. To be added to 13/14 Capital wishlist. 10.12.12 - Noise assessment has been undertaken. To obtain case to bring ventilation up to the require standard - Minor works form completed - estimates obtained £100k -	MOD	DIV

3297	20/12/2012		X-Ray Dept	Risk of patients and staff colliding with door in Portadown Health Centre x-ray department as no suitable mechanism for holding	Potential for persons to collide with door causing injury to themselves - Possibility of litigation due to injury - Injuries could range from extremity injuries to more serious head and facial injuries. For example fractures/lacerations - Loss of reputation to Trust In Portadown Health centre the heavy leaded door into the X-ray room has an automatic closure device fitted which can only be prevented from operating through use of a metal wedge device. This device has been prone to slipping allowing the door to close at an unpredictable rate and a member of staff has injured their head colliding with the edge of the door. The metal wedge presents a trip hazard when not in use. This could also lead to injuries to staff and patients on entering/exiting the x-ray room.	Staff awareness of potential risk and verbal warning to patients. Use of metal door wedge		MOD	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3303	15/01/2013	Safe, High Quality and Effective Care	Laboratory	Southern Trust Labs On-call	Risk of failure of on-call rota due to staff indicating their intention not to continue unless changes are made Failure of the out of hours system in any of the disciplines that operate a 24/7 system would have serious consequences for patient care.	Management is negotiating changes to ensure rota continues, and management are also undertaking individual interviews with staff to ascertain how pressures can be alleviated	5/1/16 - Funding for 4 posts received and staff have been appointed. Workforce plan for 24/7 indicated required 12.28 wte, with everyone committed to a 24/7 contract. The IPT and associated funding was sufficient for 4 BMS's only. DHH out of hours at risk due to sickness absence in haematology blood bank. Meeting to be arranged with senior clinicians to discuss a plan for contingencies in the event of transfusion not being available on site. 15/9/15 - Recruitment has been complete, however, no funding has been released. Brian Magee has contacted Sarah Buckley, Network Manager and will be discussed at the next Regional Pathology Meeting. 30/4/15 - IPT complete and non-recurrent funding secured for 2014/15. Promise from commissioner for funding for 2015/16. Recruitment underway. 8/12/14 - Commissioner has requested an IPT offering non-recurrent funding to assist with the provision of 24-hour services. IPT to be submitted by the 24/12/14 12/5/14 - Ongoing meetings with Management and Staff side continue in order to provide a sustainable OOH service. Last meeting held Tue 15/4/14. 12.02.14 To date 2 posts have been filled 01.01.14 All promotions to be filled where possible be expression of interest. 26/11/13 - HoS/CD/AD/Director/SMT have all met and agreed a plan for best way forward.	MOD	DIV
3305	16/01/2013		Radiology, Craigavon Area Hospital	Risk of injury to staff members whilst using Display Screen Equipment due to the design of the workbench in the Ultrasound room	The workbench in Ultrasound Room 14 of main X-ray Department is unsuitable for the prolonged use of Display Screen Equipment necessary for the Ultrasound Service. Users are frequently having to stretch and twist to use the equipment on a daily basis. This could lead to musculoskeletal injuries and an increase in sickness and absenteeism.	Staff awareness. DSE recommendations regarding safe use and rest periods	Requisition to estates January 2013	MOD	HOS
3316	31/01/2013		Radiology, Craigavon Area Hospital	Radiographers and Radiography Assistants pushing patient trollies in and out of Emergency Department X-ray rooms on their own	1. Risk of musculoskeletal injuries to Radiographers and Radiography Assistants when pushing and pulling heavy and bulky patient trolleys in and out of x-ray rooms with no assistance. 2.Risk of injury from collisions to patients on trolleys and other service users due to lack of control when being manoeuvred by a single member of staff	1.Staff awareness 2.Mandatory Manual Handling training	12.06.13 Staff Awareness ongoing	MOD	HOS
3367	15/02/2013		Radiology, Craigavon Area Hospital	The tiles on the floor between rooms 1 and 2 in the x-ray department CAH are lifting at the edges	1. The tiles in the area between rooms 1 and 2 in the x-ray department CAH are starting to lift at the edges causing an uneven surface and this has the potential to cause injury of strains sprains and fractures to anyone using this area due to trips and falls. This includes patients and radiography and nursing staff and domestic cleaners and maintenance personnel 2. The tiles that are lifting present a risk from an infection control perspective as dirt can get trapped under the uplifted tiles making this difficult to clean properly.	Staff awareness	12.06.13 Follow up requisition Feb 13 Requisition went in	MOD	HOS
3368	15/02/2013		X-Ray Dept	Maintaining and 'prepping' the processor in Lurgan Hospital to copy x-ray films for medico legal purposes	1. Appropriately two years ago the chemical mixer for the 1200 Fuji FPM processor broke down and could not be fixed. As a temporary measure two rectangular shallow tanks were put in the place of the mixer one for developer and one for fixer. These tanks were placed on the floor as there was no available bench space. They were strategically placed length ways under the bench to prevent cross contamination of the chemicals. As a result of this: - a. The tanks protrude out beyond the benches making them a high risk for people to trip over the tanks especially when the activity of copying is carried out under safe light conditions. There is also a risk of spillage of the chemicals if someone did trip over them and this would become a COSHH issue (COSHH risk assessment to accompany this risk assessment). Cleaners could also knock into the chemical tanks and cause spillage of the chemicals b. Due to the confined working space there is a risk of injury to the radiography assistant when bending down to either replenish or agitate the chemicals in the tanks placed under the bench from striking their shoulders or head of either the bench or the edge of the copying machine that is sitting on the bench above the tanks and this also protrudes over the edge of the bench. c. When cleaning the rollers in the processor the radiography assistant has to stand on a stool to reach into the processor which is set on a plinth. She then removes a rack of rollers (that are dripping and awkward to carry) steps off stool and carries the rollers to the sink. The task is repeated 4 times and this increases the risk of trips and falls from stepping down from a height 2. Due to the position of the tanks that are not placed at the correct working level due to restricted bench space but are placed on the floor under the bench the radiography assistant on a daily basis has to stoop and bend down to agitate the chemicals in the tanks and this could lead to musculoskeletal and back problems. Also to replenish the chemicals on a weekly basis the radiography assistant has to carry 5L bottles of chemicals Developer and Fixer from the store to the chemical tanks. Then she has to bend and kneel with the 5L bottles and pour first the developer into the appropriate tank. She then has to stand up from kneeling position fill the bottle with 5 L of water bend and kneel to pour water into the tank. She repeats this activity 2 more times. The task is repeated for the fixer. This is a repetitive task involving heavy lifting, stooping and bending and this could potentially lead to back injury	Staff awareness Annual Manual Handling Training available to all staff All floor surfaces are in reasonable condition - no uneven surfaces Reasonable housekeeping standards		MOD	HOS

3452	12/06/2013		Radiology, Craigavon Area Hospital	New automatic doors fitted in the new x-ray room (Room 12) are not operating properly and hence they are a safety and radiation	There are new double doors fitted in Room 12 within the Emergency department. The larger door is opened using a push pad. "The smaller door does not open with the push pad and is fitted with a fire closure device. For trolley access to this room this door needs to be opened and remain open to permit trolleys to enter and exit. This door is lead lined and very heavy and is a manual handling issue because to open this door radiography staff working within the Emergency X-ray Department have to pull the door open on a repetitive basis. "The larger door is automatic but opens too wide and stays open too long and this presents a series of issues 1.Patients trying to help with the closure of the door have a risk of injury as the door is very heavy 2.For children's examinations speed is necessary for diagnostic images so radiography staff are forcing the door to close quickly and this could potentially lead to risk of injury to staff member 3.Reduction in privacy to patients in the room 4.The infra- red is not sensitive to all patients and doors could close prematurely on the patients causing injury to the patient The changing room cubicle door within X-ray room 12 is very heavy as it is lead lined, making it difficult to open. Effort is required to pull and push the door open by patients and radiography staff and this could lead to the risk of injury There is a radiation risk associated with the doors as the larger door can be opened from the outside using the push pad. There is a chance that the door could be opened unnecessarily this way whilst a patient is being x-rayed in the room and this has radiation implications and also privacy implications	Staff Training on correct use of doors Staff awareness regarding the doors		MOD	HOS
3455	04/07/2013			OT Cover Stroke Team DHH	Patients not recieveing the required quantity and quality of inpatient rehab, with delays in assessment and discharge. Resulting in failure to meet RCP and NICE guidelines, professional standards, reduced quality of service, increase risk of complaints and litigation, unmet need.	Staff undertaking additional duties, focus on discharge targets and documentation			HOS
3456	04/07/2013	Provide safe, high quality care	Physiotherapy OPD	Lack of space for safe and confidential storage of patient records	100 Boxes of old physio records on cages in clinical area. Potential risks, breach of confidentiality, damage due to fire or flood, visible injury to staff or patients. T&O physiotherapy gym	Have requested transfer to off site storage from Head of Informatics	Dec 16 Situation remains unchanged. 6 May 2015 This continues to be a problem. Filing being held in Physio Treatment area.	LOW	HOS
3457	09/07/2013		Radiology, Craigavon Area Hospital	Temperature Levels within the old PACS/Senior Radiographer Office are higher than the normal range	In the old PACs Office in Craigavon Area Hospital X- ray Department there is a potential for the temperature to go above the acceptable range due to the heat eminating from the electrical equipment, lack of ventilation and the structure of the building. Staff have the potential to become fatigued, dizzy, nauseated and faint due to loss of water and salt. This hot, dry air can increase the risk of eye and throat infections. In extreme cases this could lead to litigation should someone faint or collapse and injure themselves leading to loss of reputation to the Trust. The Trust are failing to meet their obligations. The high temperatures could cause staff fatique, dizziness and fainting when they have to work under these conditions and this may lead to an increase of sickness and absenteeism. It also causes tiredness and loss of concentration which may lead to increase risk of accidents. There are a number of staff (n=4) performing general duties in this area who are experiencing headaches and fatigue after spending a day working in these conditions. When these staff work in other well ventilated areas within x-ray they do not experince these symptoms. Windows are not available to open	Ensuring staff have access to chilled water. Use of fans (minimal benefit). Opening doors (minimal benefit). Portable air conditioning unit (minimal benefit).		MOD	HOS
3458	09/07/2013		Radiology, Craigavon Area Hospital	Temperature Levels within Site Lead Radiographer'sOffice in CAH is higher than the normal range	In the site leads office in Craigavon Area Hospital X- ray Department there is a potential for the temperature to go above the acceptable range due to the heat eminating from the electrical equipment, lack of ventilation and the structure of the building. Staff have the potential to become fatigued, dizzy, nauseated and faint due to loss of water and salt. This hot, dry air can increase the risk of eye and throat infections. In extreme cases this could lead to litigation should someone faint or collapse and injure themselves leading to loss of reputation to the Trust. The Trust are failing to meet their obligations. The high temperatures could cause staff fatique, dizziness and fainting when they have to work under these conditions and this may lead to an increase of sickness and absenteeism. It also causes tiredness and loss of concentration which may lead to increase risk of accidents. There is generally one radiographer working in this office on a daily basis but other staff who perfom general duties in this area are also experiencing headaches and fatigue after spending time working in these conditions. When these staff work in other well ventilated areas within x-ray they do not experince these symptoms. Windows are not available to open.	Ensuring staff have access to chilled water. Use of fans (minimal benefit). Opening doors (minimal benefit).		MOD	HOS
3471	12/08/2013		Radiology, Craigavon Area Hospital	Within the CT department radiography staff are consistently working under staffed and this is detrimental to their health and we	1.Radiography staff are consistently working in an environment that is under staffed. Within the CT Department there should be a minimum of 3 radiographers. Hence there is frequently a deficit of 1 to 2 CT radiographers available to cope with the work load and provide a quality, effective and efficient service in a timely manner. Radiographers are working under immense pressure and stress to get work done each day. They are physically and mentally exhausted and this has the potential to reduce the quality of service that needs to be provided and also there is a potential for mistakes to be made as radiographers are being stretched to cover all the areas and meet the demands put on them 2.Within the CT department there is a potential risk to the quality and delivery of patient care and service. For example less time available to provide a high standard of care to the patient, increased waiting times for CT examinations, lack of choice for patient appointments and potentially lists could be cancelled because of the reduced staffing levels within the departments 3.Sevice delivery will potentially be adversely affected as targets are not being met. 4.If a high quality of service is not provided local communities lose confidence in the service provider. 5.There is a potential risk of injury both for client and staff due to lack of resources available for safe moving and handling of patients from chair/bed to CT scanner and back again leading to potential clinical incidents, litigation and loss of reputation for the Trust 6.Best use of equipment will be affected due to lack of staffing to operate the equipment for example CT/MRI scanner 7.Due to the increased pressure of work on the staff there is a high risk of mistakes occurring leading to misdiagnosis, incorrect ID check or incorrect contrast agent being loaded into the pump. Alternatively air may not be removed prior to injection of the patient leading to loss of reputation to the Trust and potential for clinical incidents and litigation.	Restricted choice for staff requests for leave. Staff are rotated at short notice to cover service demands. Restriction on number of staff released for mandatory training. Staff working late to meet service demand.		HIGH	HOS

3472	12/08/2013		Radiology, Craigavon Area Hospital	Within the x-ray department radiography staff are consistently working under staffed and this is detrimental to their health and	Radiography staff are consistently working in an environment that is under staffed. Within the general x-ray area there should be a minimum of 2 radiographers /room and there are 5 rooms to be covered. Hence a minimum of 10 radiographers are required per day within the general area to cope with the work load and provide a quality, effective and efficient service in a timely manner. Most days in the general area there are a maximum of 5 radiographers to cover all the 5 rooms, theatre and portables. Radiographers are working under immense pressure and stress to get work done each day. They are physically and mentally exhausted and this has the potential to reduce the quality of service that needs to be provided and also there is a potential for mistakes to be made as radiographers are being stretched to cover all the areas and meet the demands put on them Within the X-ray department there is a potential risk to the quality and delivery of patient care and service. For example less time available to provide a high standard of care to the patient, increased waiting times for x-ray examinations, lack of choice for patient appointments and potentially lists could be cancelled because of the reduced staffing levels within the departments Service delivery will potentially be adversely affected as targets are not being met. If a high quality of service is not provided local communities lose confidence in the service provider. There is a potential risk of injury both for client and staff due to lack of resources available for safe moving and handling of patients from chair/bed to x-ray couch and back again leading to potential clinical incidents, litigation and loss of reputation for the Trust Due to the increased pressure of work on the staff there is a high risk of mistakes occurring leading to misdiagnosis or increase of dose to patient due to either incorrect area x-rayed or incorrect ID check of patient leading to loss of reputation to the Trust and potential for clinical incidents and litigation. Non clinical duties e.g.; QA, H&S general house keeping,records etc. will suffer as staff struggle to meet the demands of patient service delivery. Potentially there may be an increase in the number of complaints from both the service users and patients leading to loss of reputation for the Trust	Restricted choice for staff requests for leave. Staff are rotated at short notice to cover service demands. Restriction on number of staff released for mandatory training. Staff working late to meet service demand.		HIGH	HOS
3473	12/08/2013		Radiology, Craigavon Area Hospital	Ergonomic lay out of the work station used by Radiologists, Ultrasonographers and Radiographic Helpers in Ultra sound Room 14 i	As staff are required to be at the workstation for longer periods of time in this room, the current workstation is unsuitable due to the cupboards below the work surface. This workstation does not meet the minimum requirements as detailed in the Trust DSE Procedure. It also fails to achieve the following dimensions for the work desk/surface as outlined in BS EN ISO 9241-5:1999 as follows: Floor to top clearance 705mm - 735mm Floor to thigh clearance min 650mm Kneehole depthmin 600mm Kneehole widthmin 600mm Desk Depth600mm PLUS depth of monitor (if you have a monitor mounted to frame which also holds the hard drive, you need to allow for this depth) Consideration should also be given to any trunking that is currently fixed to the wall and I would therefore recommend for desk depth 600mm + depth of monitor + depth of trunking There are cupboards placed above the work station and these present several Health and Safety issues: - 1.One of the cupboards has a broken hinge and there is a risk of this falling off and injuring some one 2. To access items in these cupboards requires staff to stretch to lift items out of cupboard. This has the potential for staff to sustain an injury by excessive stretching or being struck by falling items. 3. Due to lack of storage space items are being stored on the top of the cupboards. For staff to access these items requires them to climb and this could potentially lead to trips and falls from a height resulting in injury to staff member Staff are required to stand in an uncomfortable position at the workstation due to the design and height of the workstation bench for short periods of time (approx 10-15 mins) and frequently throughout the day as they need to type up their reports after each patient. Furthermore the monitor is too low for comfortable viewing	Staff awareness of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at DSE self assessments have been completed by all ultrasonographers to identify individual problems. Staff awareness Manual Handling training on a yearly basis Manual Handling Training on a yearly basis Staff awareness and reference of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at.		HIGH	HOS
3474	12/08/2013		Radiology, Craigavon Area Hospital	Ergonomic lay out of the work station used by Radiologists, Ultrasonographers and Radiographic Helpers in Ultra sound Rooms 7 &	Due to the design of the ultrasound rooms there is space constraint issues involving the position of the monitors. Staff are required to stand in an uncomfortable position at the workstation due to the design and height of the workstation bench for short periods of time (approx 10-15 mins) and frequently throughout the day as they need to type up their reports after each patient. In room 7 there is a lack of suitable electrical sockets that restricts the even further the positioning of the monitor. In room 7 there is an adaptor that all the plugs feed into making this a high fire risk The monitors in both rooms are too low for staff to view at a comfortable viewing height	Staff awareness of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at Liaised with Maynard Collins the fire officer for the Trust. He has identified this as a high fire risk and removed the adapter immediately and replaced it with an extension cable in the interim. Manual Handling Training on a yearly basis Staff awareness and reference of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at DSE self assessments have been completed by all Ultrasonographers to identify individual problems.		HIGH	HOS
3481	28/08/2013		Radiology, Craigavon Area Hospital	No disabled toilet alarm available in the toilet in Nuclear Medicine, CAH	There is no alarm available in the patient's toilet in Nuclear medicine, CAH. This has a significant impact on the welfare of the patient should they take unwell whilst in the toilet as they have no way at present to raise an alarm in the event of such an emergency. As radiographers we have a duty of care towards our patients and strive at all times to meet the Trust's vision and objectives which are to provide a high quality, efficient and effective service to our patients.	None		MOD	HOS
3482	28/08/2013		Radiology, Craigavon Area Hospital	No alarm available in the Public/disabled toilet in the X-ray Department, CAH	There is no alarm available in the Public/disabled toilet in the X-ray Department, CAH. This has a significant impact on the welfare of the patient should they take unwell whilst in the toilet as they have no way at present to raise an alarm in the event of such an emergency. As radiographers we have a duty of care towards our patients and strive at all times to meet the Trust's vision and objectives which are to provide a high quality, efficient and effective service to our patients.	None		MOD	HOS

3483	28/08/2013		Radiology, Craigavon Area Hospital	New automatic doors fitted in the new x-ray room 12 are not operating properly and hence they are a safety and radiation risk	There have been new double doors fitted in Room 12 within the Emergency department. The larger door is supposed to open using a push pad. "The smaller door does not open with the push pad and is fitted with a fire closure device. For trolley access to this room this door needs to be opened and remain open to permit trolleys to enter and exit. This door is lead lined and very heavy and is a manual handling issue because to open this door radiography staff working within the Emergency X-ray Department have to pull the door open on a repetitive basis. "The automatic large door does not work properly and radiography staff are having to open and close this door manually. Again this door is lead lined and heavy and is a manual handling issue because to open this door radiography staff working within the Emergency X-ray Department have to pull the door open on a repetitive basis and to close it they have to forcibly push the door closed repeatedly "Although the larger door requires force to open it, once it reaches a certain point it opens too wide and this presents a series of issues 1.Patients trying to help with the closure of the door have a risk of injury as the door is very heavy 2.For children's examinations speed is necessary for diagnostic images so radiography staff are forcing the door to close quickly and this could potentially lead to risk of injury to staff member 3.Reduction in privacy to patients in the room especially when nursing staff come in during an examination 4.The infra- red is not sensitive to all patients and doors could close prematurely on the patients causing injury to the patient The large door does not close properly and this is a radiation risk to internal and external service users. Again to close the door properly requires force repeatedly	Staff awareness regarding the doors Automatic closure device has been disabled and signs on doors to make staff aware		LOW	HOS
3488	18/09/2013		Trustwide	Orthoptics - refraction service - BHSCT staffing	Belfast Trust repeatedly requested to provide backfill for maternity leave. Approx 50% of all sessions being provided.	a)New patient referral criteria to refraction service updated and fully implemented. 20% of new patients were removed from the waiting list and this measure has ensured that the new patient backlog has no grown significantly despite 33% reduction in service provided b)Review patients are automatically discharged from the Refraction Service on discharge from Orthoptics. c)Refraction sessions now comprise 50% new patients (was previously 30%)	8.11.16 Backfill issues remain with approx deficit of 40 to 50% of clinics per month. Partical booking implemented and this has improved the DNA rate reducing from 25% to 8% currently. 23 06 15: D2D differently project implementing Partial Booking approved and currently on hold pending replacement of admin support. 19 02 14 additional clinics provided by BHSCT on Saturdays	MOD	DIV
3490	19/09/2013		Trustwide	Orthoptic Visual Fields	Patients are required to have visual field testing in order to aid diagnosis and monitoring of sight -threatening conditions. Patients with Glaucoma who form the greatest proportion of the visual field population, require lifelong monitoring of their condition. A subtle change in their visual field can indicate a need for a change in their treatment plan. Loss of visual field as a result of Glaucoma is irreversible and permanent. Loss of vision will result in a patient being unable to live independently thus placing a greater burden on Trust resources. Current situation - a) Full implementation of NICE Guidelines re Glaucoma/Visual field monitoring b) One additional Ophthalmology Consultant post c) Since 2010/11 there has been a significant increase in referrals YearNumber of referralsReferrals per month% increase in referral rate from 2010/11 2010/1164854 2011/128647233% 2012/138887437% 2013/141536 (Projected 12 month total from figures from April-July 2013 - 509)128137% 2010/11 0.2 WTE equivalent could meet the demand 2011/12 & 2012/13 Additionality was funded to meet additional referrals. Further increase in 2013/14 referrals needs urgent attention as this is above capacity and no Additionality will be funded 34% of all Visual Field referrals are deemed urgent ie to be seen within 6 weeks No funding for Band 3 Visual Field Technician in Business Case for New Consultant Ophthalmologist	a)Orthoptic resources being diverted from core activity to meet the visual field demand resulting in an increase in the Orthoptic Review waiting list. There is also a significant risk to the Orthoptic New patient PTL. b)All activity is closely monitored and following discussion with Trust Consultant Ophthalmologists, the increase in demand for visual field testing is likely to be sustained at the current level in the long term. However, in reality the demand is likely to grow with the predicted increase in the aging demographic. New patient letters are triaged for visual field testing prior to the Ophthalmology consultation leading to a swifter diagnosis, treatment and management of the condition. Testing prior to the Consultant appointment can also lead to earlier discharge in some situations	19.02.14 No further update. Orthoptic resources being diverted from core activity to meet the visual field demand resulting in an increase in the Orthoptic Review waiting list. There is also a significant risk to the Orthoptic New patient PTL. All activity is closely monitored and following discussion with Trust Consultant Ophthalmologists, the increase in demand for visual field testing is likely to be sustained at the current level in the long term. However, in reality the demand is likely to grow with the predicted increase in the aging demographic. New patient letters are triaged for visual field testing prior to the Ophthalmology consultation leading to a swifter diagnosis, treatment and management of the condition. Testing prior to the Consultant appointment can also lead to earlier discharge in some situations	VLOW	HOS
3489	19/09/2013		Trustwide	Orthoptics Refraction	The majority of children attending the Orthoptic Department will require referral to the Refraction (Optician) Service for further assessment prior to the commencement of Orthoptic treatment. Orthoptists cannot commence treatment until full refractive adaptation has taken place. This is a process which takes place up to 20 weeks beyond the glasses being prescribed. An 8 month delay in attending the Refraction Service is putting children's vision at risk of permanent loss. There is also a significant risk of other eye conditions such as cataract and retinal problems not being detected in a timely manner. SLA with Belfast Trust put in place 01/04/04 to provide 1.0 WTE Band 6 Optometrist to provide 6 clinical sessions for Southern Trust. The other 4 sessions were to be carried out in RVH as follows 2 clinical sessions plus 2 sessions for admin, audit & teaching. This SLA was set up for Craigavon & Banbridge and Armagh & Dungannon legacy Trusts. A separate SLA was set up for Newry & Mourne legacy Trust - the nature of this SLA is unknown. There was concern raised prior to September 2012 re-length of waits for new and review refraction appointments. Loss of 0.2 WTE (33%) November 2012 due to maternity leave. Belfast Trust repeatedly requested to provide backfill for maternity leave. To date (08/08/13) 58 sessions lost as a result of maternity leave. To date (08/08/13) 4 backfill sessions provided by Belfast Trust New patient Backlog:- DateNo. of PatientsLength of wait September 121645 months July 133268 months Review Patient Backlog -as at end of July 13 - 159 patients Total No. New & Review waiting = 485 +20% DNA= 582 No. of sessions required to clear backlog = 73 All children attending P1 are offered a vision test by the Orthoptic-led School Nurse Vision Screening programme of which 50% will require refraction. It is anticipated that the new backlog will increase once the School Nurse Programme recommences in the new academic year. Sessions required per month to cope with current demand = 0.75 WTE This does not allow for special schools provision - currently unmet need or changes in Southern trust demography.	a)New patient referral criteria to refraction service updated and fully implemented. 20% of new patients were removed from the waiting list and this measure has ensured that the new patient backlog has no grown significantly despite 33% reduction in service provided b)Review patients are automatically discharged from the Refraction Service on discharge from Orthoptics. c)Refraction sessions now comprise 50% new patients (was previously 30%)		MOD	HOS

3497	01/10/2013	Provide safe, high quality care	Trustwide	Lack of Occupational Therapy and Physiotherapy provision to Trauma and Orthopaedics.	-Limited weekend cover for post-operative trauma and orthopaedic lists. -Delay in provision of Outpatient Occupational therapy and Physiotherapy.	Escalated to Cancer and Clinical Services	12/5/14 - Recruitment in progress in order for service to commence August 2014. RETURN TO HOS RR 12.02.14 Situation remains. 01/10/13: Awaiting update from same	VLOW	DIV

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
1916	ACUTE	13/01/2009	Safe, High Quality and Effective Care	Laboratory failing Accrediation due to External Clinical Waste Bins being kept in a unsecure location	External Clinical Waste bins are kept in an insecure location. This has been highlighted as a critical non compliance during recent Clinical Pathology Accreditation Inspections and could lead to the laboratory failing Accreditation.	Where possible bins are locked using a key but often locks are faulty.	11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed. Letter sent to Mr A Metcalfe requesting that the waste bins be secured. Referred to Directorate Risk Register 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW
1922	ACUTE	19/01/2009	Safe, High Quality and Effective CareEffective organisational governanceBest use of resourcesFinancial viability, reform, and control of costs	Oral surgery instrumentation used in CAH OPD is not currently decontaminated in line with DHSSPS March 2008 recommendations	Risk of cross contamination to patients due to ineffective decontamination of dental instrumentation. Risk of non compliance with Regional Decontamination strategy.	Currently using 'Little sister' bench top sterilizers to decontaminate instrumentation. Bench top sterilises are tested daily by the users and quarterly by Estates in house staff and external contractors.	Update 27.5.11 - Significant instruments have been purchased. However the full order has not been received. Further orders have been processed but there is still a delay in supply. continue to check delivery 25.3.11 - Waiting delivery of new instruments which will improve access to decontamination. Will review any residual gap after delivery. 05.05.10 - Business case to be with SMT by 26.05,10 Business case to be submitted by 31.03.09 for transfer of local decontamination to a centralised facility.	HIGH
1931	ACUTE	23/01/2009	Safe, High Quality and Effective Care	Risk to health & safety of patients in ENT, OPD with ongoing extra clinics	Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demands. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients. Risk to organisation through litigation; adverse publicity/ complaints; loss of reputation; breach of Hine Review Recommendations. Inequality of care for patients - Friday (clean scopes), Saturday (wiped and sheathed scopes).	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations)	"Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist plug for scope cabinets. Awaiting the sourcing of stainless steel cabinets to facilitate transport of scopes to sites and departments. Paper being prepared for SMT regarding the permanent appointment of CSSD staff that will provide enhanced access to scope cleaning (to be complete by 31 July 2010). Aiming to have new scopes in circulation by 31 August 2010. The risks highlighted in this assessment are applicable to clinics which will be held on 24 July 2010 and 31 July 2010." Reviewed 19/5/11- Decontamination cabinet installed in DHH. DHH theatre staff awaiting validated decontamination specification from CAH OPD. Decontamination meetings ongoing with ATICS, SEC and S McLaughlin. CC 310W will fund cleaning in theatres on the CAH site for scopes in CAH until dedicated staff appointed. Pamela Mulholland to confirm access to AER and C Moorcroft to confirm support for additional time for cleaning. Theatre staff in DHH will clean during night shift. R Carroll to ensure Nursing support is released to allow for decontamination. 4 Scopes to be released to ACH/ 12 Scopes to DHH/4 BBPC and 10 Scopes CAH. Transport arrangements need to be secured for cross-site delivery Target date for Resolution: 3 June 2011 Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist plug for scope cabinets. Awaiting the sourcing of	MOD
2150	ACUTE	13/08/2009	Safe, High Quality and Effective Care	Inadequate immuno cyto chemistry staining facilities	Inadequate immuno cyto chemistry staining facilities to ensure the rapid turnaround of urgent histological samples, including red flagged samples.	No control measures. System is operated to full capacity, delays are frequent.	New system of work implemented which has led to a marked reduction in the throughput of immuno slides. The benchmark is no longer a limiting factor with regard to the turnaround time of immuno cytochemistry	MOD

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2421	ACUTE	13/10/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Lack of manual handling training for staff	Staff unable to attend MH Training due to limited places being available to cover the whole Trust. Mandatory requirement not met. Injury to staff/patients. Potential litigation for Trust. Potential damage to Trust reputation.	Use of Hoist/slide sheets/repositioning charts/training for Avant Guard beds. Past MH Training. Raised at Nursing governance meetings on an ongoing basis.	25.09.13 ongoing issue which is on Governance agenda lead nurses to scope how many staff trained and how many outstanding and forward to ELD for for action. 29.11.12 - Reviewed by AD. Ongoing issues which are being kept on the agenda. 19.10.12 - Training now organised weekly at ward level in medical wards. 25.09.12 - Ward Sisters still experiencing difficulty in securing places for ward based staff. Mrs Carroll liaising with ELD re provision of locally based training. 28.02.12 - Heads of service to scope how many staff have been trained, how many need trained and consider how this could take place. 23.01.12 - position remains unchanged. 01.10.11 Reviewed 27.09.11 by MB, EM, PS, KC, & SB - minimal backfill available but same not sufficient to allow staff out for any form of training. Escalated to Michael McConville and Anne Ross on 20.09.11. 17.05.10 - Risk reviewed by E O'R, LA and BM.	MOD
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	18/08/2021- no change core mandatory training monitoring monthly but Face to Face training still an issue due to social distancing and reduced staff numbers per session. 01/06/2021- provisions have been made to allow staff to do training in their own time and to receive overtime payment to do so. 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	MOD
2394	ACUTE	02/12/2009	Provide safe, high quality careMake the best use of resources	The Orthopaedic ICATs are still being sent to Independent sector for MRI scan due to demand outstripping capacity in SHSCT.	Financial risk for the Trust.	None	Write business case for additional MRI scanner and all associated costs 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW
2396	ACUTE	02/12/2009	Provide safe, high quality care	Plain film x-ray reporting by Radiologists	"Plain film x-ray reporting by Radiologists is currently 60% resulting the general wards CAH and A+E CAH not being reported by a radiologist. Potential for mis-diagnosis leading to non-treatment of life threatening conditions. Potential litigation and loss of reputation for the Trust"	Referring consultant looks at the x-ray and writes report in patients notes. The introduction of PACS will increase to throughput of the plain film reporting but will not completely remove the risk.	6.5.11 - The contract has been awarded and the directorate is working with the IS company to get the IT connected. We plan to have the pilot testing complete by next week (fri 3th June). It is expected to scan between 500-1000 per month.There is a daily 19 day escalation plan, which is working well. The tender should be up and running by end of June 2011. 09.06.10 - Plain film reporting backlog in CAH was complete 31.03.10 - 3000 plain films in total. New backlog still exists. Briefing/options papers submitted to Director for discussion at SMT 09.06.10. (RC)	HIGH
2893	ACUTE	04/12/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	RQIA review maternity services - In DHH four out of seven nights there is no middle grade (Registrar) Obstetric cover	Four out of seven nights in DHH only has SHO cover on site Safe care to mothers and babies may be compromised on these four nights	Consultant on call id contactable by telephone and will respond by attending/giving advice as required. Middle grade locums are used.	10 June 2013 Changes again to the middle grade rota is incomplete and weekends are being covered by internal locums. 14-01-13 despite recruitment to all of these posts, there is still a vacant post from April 2013 caused by a resignation. 28.05.12 There is only 1 mid grade vacancy in DHH. All shifts covered by locums known to the service. Efforts to recruit staff continue. 31.8.11- 1 specialty doctor has been appointed	MOD

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2514	ACUTE	09/03/2010	Provide safe, high quality careMake the best use of resources	Vacant admin post in the Social Work department DHH as of April 2010	No admin worker for the Social Work department DHH resulting in 1. Band 6 Social Workers completing admin tasks competing with their social work role and responsibilities 2. Issue with the completion of delegated statutory functions eg child care and vulnerablae adults on to SOSCARE and COMCARE 3. No admin worker to populate COMCARE 4. No admin worker to type RIT supervision records 5. No admin worker to provide a reception service to the department. 6 Backlog of filing and processing of record Potential for harm: 1. SOSCARE not populated resulting in incomplete computerised records and failure to comply with Regional Child Protection Policy and procedures. 2. Community and hospital professionals have an incomplete case history resulting in communication failures. 3. Delayed discharges 4. Potential for complaint against the Trust 5. Potential for Litigation against the Trust 6. Professional standards not met.	1. e requisition completed for maternity cover 25.09.009 2. Admin post discussed at Corporate scrutiny 3. Staff advised of the need to separate recording for child care and vulnerable adults admin currently prioritising this work	09.03.10 - no progress to date 18.08.10 - A temp admin worker commenced in DHH, at the end of July 2010, so the stated risk is no longer valid.	VLOW
2589	ACUTE	14/04/2010	Provide safe, high quality careMake the best use of resources	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50%	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50% resulting in 1. A significant impact on the delivery pf patient care 2.Reduced cover across all shifts of duty 3.Increased workload for all other medical and nursing staff 4. Increased need for locum cover - expensive and potentially higher risk to patients 5.Loss of reputation for the Trust 6. Potential risk of litigation.	None at present		HIGH
2598	ACUTE	15/04/2010	Provide safe, high quality careMake the best use of resources	Failure to identify cardiac structures and abnormalities due to sub-optimal echo images	Due to mis-diagnosis, patient could die; incorrect medication given;reputation of Trust; litigation. Potential to breach waiting times for the Trust.	At present, 33% of echoes are being repeated. Clinical physiologist/ Consultant Cardiologist identifies obvious malfunction scans. Potential for 2 month delay for patients to have repeat scan performed. Audit	12.5.11 - E-mail from B Conway: Yes, this is all sorted and can be removed. 28.3.11 - Due to received the replacement Echo machine in CAH on Tuesday 29th March 2011. 03.02.10 - risk reviewed - Echo machine ordered.	HIGH
2620	ACUTE	17/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsMake the best use of resources	Insufficient capacity and resources to manage patients waiting for a review appointment in MUSC	Potential of harm to the patient secondary to not having timely management of condition and/or disease- possible progression of disease/worsening status of condition. Risk of harm to patient by unmanaged progression or monitoring of condition in a timely manner secondary to SHSCT not having sustained capacity to provide review appointments, within the appointed time. Risk of harm to Medical and Nursing staff as addressing the patients needing review are all done as 'extra sessions'. Potential for exhaustion and escalation of sick leave. There has been inadequate Nursing resources recruited to support the increase work load. Risk of escalation of clinical risks as the Trust is under strict financial constraints, and does not have an obvious form of funding for this risk. Potential harm to patient family secondary to anxiety of not having a timely review Potential of litigation against staff and Trust due to not providing treatment in a timely manner Potential of harm to reputation of Trust due to potential lack of adequate patient management	E O'R and LA are tasked to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. Monthly update on review backlog to give current position Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. All core clinic template capacity utilised as far as practical. Heads of Service are meeting with Relevant Consultants and conveying current position on a monthly basis Control measures considered but discounted and why (where appropriate): Arranging additional clinics to target primarily Review Backlog patients- not feasible in current financial situation Reduce the current number of new patients within Outpatient template, to increase the capacity of review patients- not feasible, as performance targets will then be breached. Recruit additional Medical staff to address shortfall in capacity- not feasible in current financial situation. . : .		HIGH
2629	ACUTE	24/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Delays in treatments, discharges and transfers due to inadequate ambulance service DHH, MSW, FSW, HDU, Gynae	Poor outcome for patient if ambulance not available for patient to be transferred. Delays in discharges leading to poor bed flow and elective lists to be cancelled. Patients from A +E admitted to ward due to no ambulance cannot be discharged. Patients missing appointments due to lack of ambulance service. Patient may develop surgical complication due to delay in treatment. Risk of litigation to trust. Increase of complaints and loss of confidence in organisation. Death of a patient. Delay in patient flow resulting in theatre cancellation	Early booking of ambulance as patients needs. Infection risk MRSA. Assess patient re chair, stretcher. Family involvement if safe for patient. Use of voluntary drivers. Use of blue light - not appropriate use of service.		HIGH
2730	ACUTE	30/06/2010	Make the best use of resourcesBe a good social partner within our local communitiesProvide safe, high quality care	The Body Fridge in DHH Mortuary unavailable for use from the 26/5/10.	Bodies may be released to undertakers which have not been stored in optimal conditions and therefore the process of decomposition may be accelerated. James Details	Bodies to be stored in the Chapel of Rest as this room is slightly cooler than other rooms in the mortuary. This is a temporary arrangement while work on the body fridges continues. The Chapel of Rest does not provide the optimal temperature required to stabilize or slow deterioration of the body. Bodies are to be released to the undertaker as quickly as possible. On Friday 25th June arrangement put in place to transfer bodies to CAH, if the undertaker cannot be contacted to organise a quick release the bodies are transferred to CAH Mortuary.	Authorisation from Ronan Carroll (Assistant Director of Acute Services) for Brian to arrange with Cecil Renshaw (Estate Services DHH) to install a portable air conditioning unit in the Chapel of Rest Dr G Rankin (Director of Acute Services) has identified funding (23/6/10). Brian Magee awaiting confirmation that he can proceed with the procurement and installation of body fridges.	HIGH

2818	ACUTE	25/11/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Unable to provide maximum Outpatient capacity safely due to level of sick leave & lack of availability of staff in Outpatients	Unsatisfactory level of staff with appropriate training. There are staff who have been redeployed, or working via Nurse Bank that do not have access to appropriate supervision secondary to staffing levels. Staff are unable to attend mandatory training due to staff shortages. Risk of staff sickness and absence continuing to escalate due to the level of stress of working in current conditions, further decreasing Outpatient capacity. Increased risk of staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. Contributing factor is the replacement staff have limited or no Outpatient experience. Potential to directly impact staff attending mandatory training updates. This places the public, staff and the Trust to increase risk of not having access to up to date training/information and validation which may result in harm to patients and staff. Increased risk to staff and patient safety secondary to not being able to provide adequate supervision to redeployed staff, and non registered staff due to low staffing allocation. Potential of reduction in Outpatient capacity resulting in extension of waiting times for patient. Increased waiting time has potential to harm and contribute to advancing of clinical disease and/or condition. Potential to further extend waiting time for patients on the Review Backlog waiting list. Increased waiting time has potential to a harm and contribute to advancing of clinical disease and/or condition. Potential for staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. This also has an impact on the level of appropriate supervision is dictated and expected for staff who have been redeployed to Outpatients or who are allocated through Nurse Bank. Potential for staff sickness and absence to escalate secondary to working with limited nursing support. This can have significant financial harm to the Trust as well as on skill level. Contributing factor is Nurse Bank is not able to fill entire requests and Manager may have hours of notice that a shift cannot be filled. Absence of validated update training risks patient and staff safety and increase risk of harm to the patient, staff, negative publicity and litigation to the Trust. Potential harm to Trust's reputation in relation to the breaching of Outpatient waiting time targets.	Band 7 and Band 6 Managers are providing direct patient care. Band 6 staff have been taken out of the POA results room to provide patient care in Outpatients. Band 5 and Band 2 staff requested to backfill shifts. Bank staff have provided 3 block bookings (2x B5 1x B2). Staff have 'doubled up' on clinics where possible (one staff to work between 2 clinics). Pre Op questionnaires have been given to patients to release Band 5 staff to work in clinics. Specialties have been approached to relocate to alternative accommodation due to lack of staff. Near patient testing devices to be purchased to decrease the demand for staff. All staff on sick leave are being actively managed and have been referred to OHD and HR.		MOD

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2916	ACUTE	10/01/2011	Provide safe, high quality careMake the best use of resources	ASR Monohip ; hip implant Recall	Patient that have received this hip implant are at risk of ; Pain, Immobility, Surrounding tissue breakdown. Higher incidence of Revision surgery within 5 years. Litigation against Trust Patients at risk that have received The Monohip, 208 patients in SHSCT.	Being addressed regionally, patients in SHSCT and Belfast Trust. Implant recall by manufactures " DePuy ", Patients reviewed yearly by a revision orthopaedic surgeon and treatment determined as necessary. Cobalt and Chromium blood ion tests. MRI scan. Plain X Rays.	23.01.12 - All patients have been recalled and reviewed with appropriate interventions carried out if required. Patients are now in the yearly review cycle and will remain there up until 5 years as recommended per medical alert. 10.11.11 There are 148 patients in total on the SHSCT ASR database. These patients have all been assessed, had a plain x-ray, MRI and cobalt and chromium ion levels tested and all have had a first consultation with a SHSCT Orthopaedic Consultant. To date 28 patients have undergone revision surgery. It was considered that all patients should have an annual review after their first consultation however a number of patients are being closely monitored eg a follow up review in 3 months as their ion levels were borderline. Review clinics are being organised on an ongoing basis to see patients who require close monitoring within their clinically required timescales. SHSCT is continuing to liaise with BHSCT with respect to 13 BHSCT patients who had their ASR implant done by the SHSCT surgeon but who are BHSCT patients. These patients have had their tests done and checked by the BHSCT practitioner to ensure they are not high risk patients however they have not had a consultation with an Orthopaedic Surgeon. It is planned that BHSCT surgeons will see these patients. 01.10.11 All patients have had a first apt with the Consultant and are being reviewed at the required intervals. Any patients being listed for revision of surgery are being completed timely. Meetings continue fortnightly. Update 27.5.11; 181 patients allocated to SHSCT to see and treat. To date 21 pts have had revision surgery. 5 pts are listed for revision surgery; 1 pt RIP; 113 pts have been reviewed; 5pts have refused a review. This leaves 36 pts still for review. Clinics are arranged for these 36 pts. A review process will require to be put in place for these patients. Admin Support will be required. HSC Management of ASR Recall Regional Meetings continue to be held weekly.	MOD
2915	ACUTE	07/03/2011	Be a great place to work	Staff member suffering from Chiari Malformation requires a saddle chair to prevent the axacerbation of symptoms	A member of staff suffering from the condition Chiari Malformation requires a saddle chair to prevent the exacerbation of symptoms whilst working in the various sections in the Cellular Pathology Laboratory.	Restricted range of duties - The member of staff does not cut routine tissue sections using a microtome as intense prolonged use of a microtome causes fatigue, discomfort and eventually pain. Frequent change of task with micro/mini breaks to prevent fatigue.	21.6.11 - Saddle chair provided. Saddle chair supplier sourced(Fred Storey, 5 High St, Comber, Tele. 91870033/23) and a 4 week trial of a saddle chair organised and trial commenced on the 14/10/10. Risk assessment placed on the laboratory's Q-pulse document control system on the 2/12/10 with a review date on the 1/2/11. Received and signed by the Assistant Director of Acute Services on the 3/12/10. CPL awaiting a copy of the risk assessment.	MOD
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW
2991	ACUTE	26/05/2011	Provide safe, high quality care	Cancer performance risk	Decrease in cancer performance from previous years. 10/11 = 85% for 62 day pathway. Highest risk is urology cancer pathways.	Escalation policy and action plans drafted. Meeting with urology teams. Working towards 1-stop clinics.	See Risk 2942	MOD

2993	ACUTE	26/05/2011	Provide safe, high quality careBe a great place to work	Gaps in Medical Staffing. Daisy Hill Hospital	Gaps at junior and middle grade level in Medicine in DHH Hospital impacting on numbers of doctors on duty particularly during the out of hours period. Due to the gaps on occasions one junior doctor may be left covering medicine in Daisy Hill Hospital - increased clinical risk and potential for adverse events leading to patient harm.	A locum middle grade recruited in January 2011 to address immediate pressures. Assistance given from Renal Medical Staffing complement for two evenings per week. Ad-hoc locum shifts as and when required to address remaining gaps. However, despite these actions other gaps may remain. In the medium to longer term there is a plan for an additional junior doctor to be provided via NIMDTA however recurrent funding is required for this post.	29.09.22 - Risk Reviewed. Improved allocation of SpR from NIMDTA in August. Also stroke specialty doctor commenced Sept 2011. Risk downgraded to Moderate	LOW
3002	ACUTE	13/06/2011	Provide safe, high quality careBe a great place to work	Extremely high level of maternity leave in CAH pharmacists	Extremely high level of maternity leave in CAH pharmacists from summer 2011 (15/36). Current recruitment for maternity leave cover is 2 for 1 - 5 junior pharmacists recruited as cover but only 2 have taken up post so will be 9 pharmacists short during period June to Sep 2011 and 7 short from Sep - Dec 2011. Unable to provide clinical cover for wards and no leave cover at all for other clinical pharmacists. Risk of serious medication incidents not being detected on wards before they reach the patient. Risk will increase in August with intake of newly qualified doctors. High work load of remaining pharmacists wild put them at risk of making an error themselves when dispensing/ checking.	Initially remaining pharmacists allocated to highest risk wards and some temporary junior pharmacists recruited as cover. March 2012 three pharmacists on mat leave.	Feb 12 - Currently 6 staff off work, two to return within 4 weeks, remaining 3 by end of March 2012.	LOW
3019	ACUTE	07/07/2011	Provide safe, high quality careBe a great place to work	Fire	Risk of Fire throughout the Acute Directorate	Evacuation plan implemented for every ward and department. Embedded procedure of simulated drills twice yearly throughout all wards, once in hours and once out of hours. Acute fire committee and reps currently in place for all divisions. All wards have fire files. Checks carried out in basement areas. Estates ensure fire alarm and detection, escape lighting, first aid fire fighting equipment, suppression systems, plant, equipment and other installations are checked, tested and maintained in accordance with good maintenance practice. Regular fire safety checks are being carried out in Residential accommodation on the CAH and DHH sites and records are maintained. Nominated Officers and Deputy Nominated Officers have been identified for all wards and depts on each site. A number of fire risk assessments have been undertaken and actioned to reduce risk. Waste Management Policy and Procedures are in place and subject to monitoring. Smoke Free Policy is in place. Soft furnishings and textiles are purchased through BOS PaLS so comply to standards of fire retardancy. Fire Safety training programme is in place for all staff and fire safety training records are held centrally and reports are issued to Heads of Service. Arson Policy is in place.	18.12.13 Need to have a further desktop	LOW
3020	ACUTE	18/07/2011	Provide safe, high quality careBe a great place to work	Management of Sex Offenders when accessing hospital services	Potential for sexual, emotional and psychological abuse. Those at risk: other patients, staff and members of the general public. Issues with the management of those convicted sex offenders who are known and not known to Hospital Services. Concerns re unplanned access to Hospital Services. No formal mechanism within the Hospitals to share information gained through LAPPP. Potential for litigation and damage of Trust reputation. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	Trust representative at PPANI. Convicted sex offenders referenced through the Soscare system. No formal mechanism within the Hospitals to share information gained through LAPP. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	07.10.13 - Draft Protocol tabled at the Procedures Committee and document accepted - minor additions required. Document to be shared with Regional Emergency Social Work Service. Draft Protocol allows information provided at the LAPPP meetings to be shared with Acute services. The focus is on registered category 2 & 3 sex offenders. Draft protocol completed January 2013. Document equality screened.	MOD
3028	ACUTE	26/08/2011		Staff shortages are adversely impacting on the quality of the Cellular Pathology Service	By 24 august 2011 3 BMS staff were off on long term sick or maternity leave. This equates to 18% of the WTE BMS staffing in Cellular Pathology. A further member of staff whose husband took a stroke on 19 August 2011 has the potential to be off, when included with existing staff off this equates to 23% of the WTE BMS staffing in Cellular Pathology. Coupled with annual leave commitments over the remaining August into October 11 period this reflects a reduction in WTE BMS staffing of 38%. the situation should improve after mid October 2011 with the WTE BMS staffing shortage due to maternity and long term sick falling to 12%.	All part-time BMS and MLA staff were asked if they would consider increasing their hours. One MLA has increased their hours from 0.6 WTE to 0.9 WTE effective from the 24 August 2011 to 30 November 2011.	One has increased their hours from 0.6 WTE to 0.9WTE effective from 24 August 2011 to 30 November 2011. 22.11.11 Temporary arrangements are now in place in the lead up to the accreditation visit. These arrangements include:-1 An increase in part time working hours for a member of staff. 2 An increase in overtime for key staff. 3 The transfer of a maximum of 150 cervical cytology tests per week for a six week period to the Western Trust for processing and reporting. On Monday 22 August 2011 the gynae cytology backlog was 400 smears. On Friday 26 August 2011 the gynae cytology backlog was 700 smears. An increase of 40% in 4 days. The gynae screening backlog will continue to be monitored. If the backlog reaches 1000 smears arrangements may have to be made to have it sent to another laboratory for screening and reporting.	MOD
3026	ACUTE	02/09/2011	Safe, High Quality and Effective Care	Mixed Sex Accommodation	Mixed Sex accommodation can have a significant impact on maintaining privacy and dignity to patients whilst in hospital. In the following areas emergency treatment will take priority over segregation: coronary care, intensive care, A&E, theatre and recovery wards, medical assessment unit. Those at risk are patients requiring admission to CAH/DHH and patients requiring admission to specialist units.	SHSCT Policy on the admission of patients to a mixed sex ward. Acute Services Directorate Escalation Procedure. Safeguarding Vulnerable Adults Procedure. Patient Support Services. Clear signage on toilet and washing facilities.		
3057	ACUTE	28/12/2011		Arrangements for the transfer of acutely ill patients between acute sites in the SHSCT and to acute sites in other Trusts	This risk has been highlighted due to impact on medical cover when patients are transferred out of hours from Daisy Hill Hospital, however we are now also aware that we do not yet have sufficient robust information in relation to the number, nature and times of transfers in the acute system	1. A Proforma has been issued for completion when transfers arise in our system. Completed Proforma are being submitted to Amie Nelson for collation and analysis 2.On DHH site, efforts are being made to schedule a 3rd SHO to be on duty OOH in the event that one of the doctors need to transfer with a patient. Consultant on-call must be contacted about any transfers OOHs, with a decision taken on who should transfer with the patient and what support is required from the consultant during this time. Work is also underway to put a sustainable OOH rota arrangement in place in the medium term. 3.Meeting has been arranged by Director of Acute for early January 2012 to review out of hours cover in both CAH and DHH in the context of a regional review of H@N	25.09.13 lead nurses to scope number of acutely ill patients transferred between sites/other trusts within past year both in hours and OOH and highlight who accompanied these patients 29.11.12 - Arrangements in place to facilitate transfer of patients between sites.	MOD

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3064	ACUTE	09/01/2012		Faulty Lifts in DHH outside labour ward	Lifts outside Delivery Suite which service the maternity ward, frequently breaking down. Health and Safety Issue for transferring mothers in labour or in an emergency situation.	Plan in place for Estates works to commence early 2012. Currently using second lift. Exploration of possible use of Evacuation Chairs.	29-08-12 one lift replaced and one refurbished. No further issues. 28.05.12 Fire evacuation chairs now purchased. Parts for 2nd lift currently being replaced. 26.04.12 Work completed on back lift.	MOD
3165	ACUTE	22/06/2012	Provide safe, high quality care	Inadequate Speech and Language Therapist	Inadequate Speech & Language Therapist. Stroke patients waiting up to 3 days to be seen by Speech and Language Therapist. No Speech and Language Therapist allocated to MAU resulting in inappropriate management of patients care/treatment.	Staff trained in swallow assessment	25.09.13 - 80% staff in stroke ward CAH and XX% stroke ward DHH now trained in swallow awareness. Ongoing training for other ward areas.	HIGH
3166	ACUTE	25/06/2012	Provide safe, high quality care	Urology Access Waiting Times	Urology access waiting times have increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.	This is currently being addressed via approval to go to Independent Sector and the appointment of new consultants.	3/3/15 - TO BE TAKEN AS PER AD CCS/ATICS 10.12.14 - Cancer targets are being met, i.e., 31 and 62 day pathway. While red flag and urgent appointment times are being met this is utilising all outpatient capacity leaving routine patients with longer waiting times. A new service model is being trialled which may improve the totality of waiting times in the long term. Inpatient/Day Case waiting times for routine patients remain challengin with the focus on treating cancer patients within the standards. 12.5.14 - with respect to the urology performance against the 62-day cancer target, there are 21 patients over 62+days of which 11 pts waiting over 85+days. With respect to haematuria 1st appointment now sitting at D16 which is an improvement on the previous positions due to a combination of drop in demand and extra capacity on a Saturday. 12.02.14 Urology waiting times are extended throughout the Province due to demand and capacity issues. The HSCB have commissioned a further Regional review of Urology Services . The SHSCT will partake in this Regional review. In the meantime, Team South will focus its resources on meeting the cancer waiting times within this specialty	MOD
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains unchanged. 06/08/2019 - Ongoing increase in red flag referrals across multiple tumour sites continues, leading to	HIGH

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3304	ACUTE	16/01/2013	Provide safe, high quality care	Lone Workers in X-Ray after 12 midnight	Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period.	Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting.	14.11.17 Awaiting update from J Robinson 5.12.16 The lock down system is being installed W/C 12 Dec 16. 13.9.16 Situation continues to be monitored	MOD
3393	ACUTE	22/04/2013	Provide safe, high quality care	Biochemistry CPA Accreditation	Laboratory has lost its biochemistry accreditation status and is now a non-accredited laboratory	The Lab continues to perform adequately in its external quality assurance and internal quality control.	13.9.16 All findings have been cleared with inspectors. We are awaiting formal confirmation of accreditation status. this may take up to 6 months. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 6/1/16 - Inspection to take place 1st week in April 16. 27/11/15 - Pre-inspection took place on the 8/10/15. The Inspectors advised that Biochemistry is ready for the formal inspection subject to a few minor non-conformances being addressed. Formal inspection is expected in April 2016. 8/9/15 Labs - Pre-inspection visit confirmed for 8th Oct 2015 for Biochemistry. The biochemistry team continue to progress with meeting the ISO Standards. Meetings with Dr Hall and the Senior Biochemistry team continues. 3/3/15 - Labs contacted UKAS in January 2015 to check on progress with application, and was advised it had been passed to the scheduler. Still no indication of an inspection date yet. Staffing levels - benchmarking to be undertaken. Anticipated total additionality is 11 staff, no funding identified.	LOW
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH and the inability to off load patients from Ambulance due to overcrowding.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow. HALO role and ongoing monitoring	20/09/2021- ongoing, risk exacerbated by Covid- bed pressures sustained for long periods. Non commissioned beds have been opened. Surgical beds converted to medical beds. 09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams. Funding needs secured for medical gases for ambulance receiving area. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing escalation plan. 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	HIGH
3515	ACUTE	14/11/2013	Provide safe, high quality care	Ineffective Cardiac Monitoring System in certain Wards/Departments in CAH and DHH	The current cardiac monitoring system is old and unable to monitor patients in various wards/departments in the hospital site given their physical location. Monitoring is not available for certain patients and patients then may be required to move to 1 North for monitoring unnecessarily.	Appropriate selection of patients for monitoring.	14.11.17 Waiting on decision to start work with the potential of relocating coronary care beds to the HDU in DHH. 1.12.16 No further update. 13.9.16 In relation to CAH telemetry, this has now been fully implemented in the main acute wards, cathlab, and delivery suite.DHH,is awaiting funding allocation. 27.05.16 - Work in CAH will be completed with 3 months time. Costing obtained in respect of DHH work and added to Capital Estates list for consideration. 1/3/16 Now in place residual witing being carried out. 14.07.15 - Replacement system purchased and installed. Estates undertaking wiring to ensure all acute areas are covered.	LOW

3526	ACUTE	17/12/2013	Safe, High Quality and Effective Care	Non-compliant bedpan washer disinfectors	Infection control risk to patients due to inadequate disinfection of bedpans throughout wards and departments in the Trust.	Daily testing of bedpan washer disinfectors completed by ward staff. Limited quarterly and annual testing carried out by contractor. Estates plan to provide a fully compliant quarterly and annual testing service early 2014. IPC has advised staff to carry out a visual check for cleanliness of all bedpans before use.	04/11/14 New bedpan washer disinfectors now installed. 23.4.14 Fifty new bedpan washer disinfectors received end of March 2014. Replacement programme underway according to IPC risk - to be completed by August 2014. Estates now providing a fully compliant quarterly and annual testing service. 12.02.14 Informed that order now placed 5.2.14 Contract awarded 18.12.13 Funding has been secured for the replacement of bedpan washer disinfectors. 5.11.13 pre tender meeting with Pals - tender open 8-11-13 and closes on 20-12-13 Tendering currently in progress to be finalised by end of March 2014. 28.3.14 Trust received 50 new bedpan washer disinfectors. A phased replacement programme has been agreed with IPC according to level of IPC risk and is due for completion by September 2014. October 2014 - 45 new bedpan washer disinfectors have been installed and commissioned leaving 5 spares for future new developments / replacements.	LOW

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1932	23/01/2009	Safe, High Quality and Effective Care	ENT Clinic, Surgical Outpatients	Patient Flow difficulties with ongoing additional ENT OPD clinics for NEW patients.	Patient flow for these clinics are in breach of RCOS Guidelines - 3 patients x 15 minutes x 3 Doctors. This clinic has booked 4 patients x 15 minutes x 3 Doctors. - Risk of increase in complaints - Risk of patients walking out of clinic not seen and used to rebook them - Risk of miss diagnosis/loss of comprehensive assessment as time slots are limited - Inequality of care for these patients attending these extra clinics. RCOS Recommendation - 1 patient x 15 minutes (new patient clinic) therefore 3 patients x 15 minutes with 3 Doctor sessions. These clinics are booked on 4 patients x 15 minutes with 3 Doctors	Patient flow - Additional Nursing and Clerical Staff deployed to manage clinic - no additional Medics Request to reduce clinic size to 60 and create 1 additional clinic (x3 in total) rejected by management due to time constraints (PTL breach)	Referred to Directorate Risk Register	LOW	DIV
1933	23/01/2009	Safe, High Quality and Effective Care	ENT Clinic, Surgical Outpatients	Environmental space to hold patients and families during ongoing additional ENT OPD clinics for NEW patients	These clinics are booked on 4 patients x 15 minutes with 3 Doctors. Environmental space to hold patients and family (Saturday Clinic) (8.45am start to 1.45pm finish) 11 seats available with potential to have 16 patients and relatives waiting at any one time. - Increased risk of complaints - Risk of patients walking out of clinic not being seen and need to rebook them - Risk of overcrowding	Environmental space - Overspill patients will be seated in ENT sub waiting area outside examination rooms and staff will manage this. - Families will be requested to remain in main OPD Waiting Area		LOW	HOS
2082	09/04/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Trustwide	Inability to meet or maintain AHP access targets for ENT/Voice service	Risk of harm to patient as no access to appropriate SLT service. Unable to provide support for ENT consultants re patient management in hospital outpatient dept's in C/B and A/D. Trust unable to achieve or maintain access targets so breaching will be inevitable Ineffective clinical management of patients Increase in staff stress, pressure and reduced morale Health and well being of SLT staff	Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success. Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success. Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success.		HIGH	DIV
2463	24/04/2009	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingBe a good social partner within our local communities	Trustwide	Preparedness for Pandemic Flu, specifically a H1N1 current pandemic	Ability to sustain services should there be an outbreak of pandemic flu.	SHSCT H1N1 Plans remain in place Regular SMT/Silver and Bronze Team meetings ongoing at Directorate level Daily monitoring in place - hospitalized patients, attendances at A&E, GP OOHs, MIUs Representation at regional Trust Liaison Group meetings with regional professional fora Vaccination plan submitted for HPA approval Business cases for funding submitted to various work streams Ward 3 (Isolation Ward) operationally ready Vaccination plans have assumed that primary care will cover the six month to five year age group. However, recent information suggests that secondary care may be asked to provide this service. This is likely to create a capacity problem if existing services are to be maintained.		MOD	DIV
2085	09/07/2009	Provide safe, high quality careBe a great place to work	Fracture Clinic	Health & Safety of patients, staff and visitors who attend the Fracture Clinic	Health & Safety of patients, staff and visitors could be compromised due to no waiting room for Fracture Clinic as follows:- 1. No seats for patients. Standing with plasters insitu, risk of fall. 2. Narrow corridor - patients sitting with leg plasters on - leg extended. Risk of fall and further injury. 3. Patients waiting in main thoroughfare for A&E - Rushing through with sick patients. Delay of transfer and risk of injury to patients and relatives. 4. Patients in wheelchairs - no room. Risk of injury.	Maintain patient's safety until relocation of fracture clinic.	28.09.12 - Fracture clinic relocated. 01.08.12 - Works nearing completion. Plan to move into new location by end August 2012. Review in 1 month. 19.06.12 - Refurbishment programme progressing well. Due for completion July 2012. Review in 1 month. 17.04.12 - refurbishment programme commenced. Works ongoing and due to be completed May 2012. 23.01.12 - A new location and facilities have been sourced for the fracture clinic. A refurbishment programme is due to commence in February 2012 with completion due in May 2012. 10.11.11 Additional seating now in place on back corridor to A&E, plans for new fracture clinic now in progress. 01.10.11 Awaiting feedback from fire dept regarding the placement of additional seating.	MOD	DIV
2314	14/09/2009	Provide safe, high quality care	Trustwide	Risk of Hyponatraemia	Risk of hyponatraemia when administering IV fluids to children aged 14 - 16 years when cared for on adult wards. Risk of loss of Trust reputation and loss of confidence in the organisation Risk of litigation to the Trust.	All Solution 18 removed from wards and any attempt to order Solution 18 is alerted to Director of Pharmacy. Trained and competent paediatric medical staff available on CAH + DHH site 24/7 to provide support in relation to prescribing, monitoring and reviewing IV fluid therapy. DHSSPS wall charts are displayed in all adult and paediatric areas where children and young people aged 1 month to 16 years may be treated.	17.04.12 - Approximately 80% of SEC staff trained with follow up sessions arranged for May 2012. 23.01.12 - ongoing within Governance Team with good uptake from SEC. 01.10.11 Competency framework has now been commenced for target wards. All staff undergoing refresher training. SEC attained 98.1% of all staff trained. Ongoing audit to capture under 18 yr olds to ensure all cared for appropriately.	LOW	DIV
2499	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Inappropriate staffing levels for dependency of patients in Trauma Ward	Inappropriate staffing levels leads to compromise in patient safety/care and staff safety. This results in increased clinical incidents, increased number of falls, staff unable to get breaks, potential for decreased staff morale, increased staff sickness levels, breach of Terms and Conditions for employment, poor documentation, not able to maintain NMC Guidelines. Potential for increased complaints and litigation.	Bank staff - unreliable bank staff or bank staff not available to cover shifts. Additional hours for permanent staff. Clinical Lead and Lead Nurse informed re risk.	08.06.10 - temporary staff now made permanent and risk closed.	MOD	DIV
2500	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Moving of Night Staff from Trauma Ward to support other wards	Unsafe staffing levels left on ward for type and dependency of patients. Staff unable to get tea breaks, increased stress, decreased patient care and in the event of an emergency inadequate staffing support.	Adverse incident forms completed. Bed Flow Manager informed re safety issues. Clinical Lead/Lead Nurse informed.		MOD	DIV
2501	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Isolation of the Trauma Ward	Trauma ward has no adjoining ward therefore no medical/nursing support from other close by wards. Isolated staff especially on night duty and lack of support for staff in the event of an emergency.	Staff awareness of teams available.	01.10.11 Ward has access to relevant teams where required for assistance in complex situations.	LOW	DIV
2390	11/11/2009	Safe, High Quality and Effective Care	Orthapaedic Ward CAH	Due to the Isolation of Orthopaedic Ward ensure adequate staffing levels at all times to maintain health and safety of patients.	Due to isolation of orthopaedic ward and Elective Admission Ward especially on night duty inadequate staffing levels when staff are moved to deal with emergency for example on 17-11-09 patient had a respiratory arrest cardiac team called staff felt there was a delay in the arrival of team some members of the team were unsure where Orthopaedics was located. Staff did not get their break. On 19-11-09 Staff nurse and auxiliary off sick nurse bank had no cover day staff had to stay until 2230 for a nurse to cover the shift from 4 south the auxiliary was then moved to 4 south which left only 2 nurses this was unsafe as a patient went into atrial fibrillation and SBAR call was made for medical assistance. Staff were not relieved for breaks and therefore did not get their breaks. Clinical incident forms are being completed on a regular occurrence with no effect. Isolated staff especially on night duty. Lack of support for staff in event of emergency. Potential re-occurrence of incident previously occurred. Decreased no's of staff allowing for inadequate patient ratio to occur as staff are moved by bed manager	Completion of adverse incident forms. Highlighted re concerns to nurse lead and head of Trauma and Orthopaedics and bed manager that staff should not be moved from wards as there is no adjoining ward for support. No dependency levels tool carried out in the hospital as per nurse lead. Ward manager to ensure as far as possible that ward is safely covered. In circumstances where this is not possible, report to Nurse Manager in hours/ Site manager out of hours to assist in getting assistance from other areas within division, or to commence protocol to get bank / agency staff.		MOD	DIV

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2415	11/11/2009	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Orthapaedic Ward CAH	Patient cancellations due to inadequate information given to patients in pre-op assessment	Patients cancelled due to not being informed to stop medication eg aspirin or if patient is still on oral contraceptive pill. Patients condition may have changed and may require further investigations eg echo which was not carried out at pre-op assessment. Patient not seen face to face by consultant at pre-op on day of admission consultant decides patient not to have surgery. Pre-op assessment bloods out of date. Patients not having their operation have to have their operation re-scheduled and become upset. Trust Waiting list has to be altered to other people are cancelled to facilitate the cancelled patients. Complaints will increase. Patients taken time off work to come into hospital for their operation. Risk of litigation. Loss of reputation. Extra work for nursing staff on the wards and secretarial staff.	Clinical incident forms completed. Consultants clinical lead and nurse lead aware of situation. Pre-op Manager aware. Protocols to be in place re medication advise. Pre-op staff sent to Musgrave Park pre-op assessment in orthopaedics for developing the service in Craigavon. Pre-op meetings action plans never followed up as problem continues.	24.02.10 - actions on going	LOW	DIV
2416	11/11/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Orthapaedic Ward CAH	Patient safety and staff safety - Moving of night staff to support other wards.	Unsafe staffing levels left on ward for type and dependency of patients. Staff unable to get breaks. Decreased patient care. In event of emergency inadequate staffing support.	Clinical incident forms completed. Bed Flow Manager informed re safety of patients. Clinical Lead and Nurse Lead informed.		LOW	DIV
2424	14/12/2009	Provide safe, high quality care	Outpatients Dept	Infection Control risks due to lack of decontamination facilities, non compliant taps and sinks in the blood room.	High volumes of patients, public and staff working within/accessing General Outpatients are at increased risk of infection secondary to the non compliant taps, sinks and damaged flooring in department and toilets. Risk of infection to patients, public and staff due to poor provision for hand washing and decontamination. Risk of infection due to broken/damaged flooring and/or units around sinks. Risk of loss of reputation secondary to non-compliance with RQIA recommendations. Risk of infection to patients, staff secondary to decontamination of ENT scopes being done in the same room as patients being assessed.	Daily cleaning of department. Patients are taken to other areas for assessment where possible to separate from Endoscopy decontamination.	19.06.12 - Refurbishment programme of Ramone building for additional facilities and upgrade of current area is near completion. Plan to review in 1 month. 26.03.12 - Will be addressed via outpatient works in early Summer 2012. 23.01.12 - Outstanding working remain on hold until current renovations and proposals complete. 19 May 2011 Decontamination Room complete, sink tops in Rooms 4/5/6/7 have been replaced. Awaiting the replacement of flooring in toilets, and taps/sink in blood room. Estates contacted again 19/05/11 by DHH OPD manager. Awaiting response. Continued risk.	LOW	DIV
2425	14/12/2009	Provide safe, high quality care	Pre-Operative Assessment Clinic	Lack of Anesthetic and Cardiology resources for validating Pre-Op ECG's in a timely manner	Patients are at risk of cancellation of surgery secondary to a cardiac condition not being managed or detected. The Trust is at risk of Litigation if it is shown that a patient has been seen within Surgery and Elective care, with a cardiac condition which was evident from pre op ECG, but not detected or managed due to lack of access to adequately trained staff. There is no adequately trained resource within the Pre Operative Assessment Service to interpret and sign off pre op ECG's which are done as per NICE guidelines. A duty of care to have these ECG's reviewed in a timely manner, is not being met. Risk that designated POA Anaesthetist may not have all potential cardiac issues escalated to them due to the lack of expertise and skill at Band 5 and 6. Risks of patient not getting a Anaesthetic chart ECG/review Financial risk to Trust due to the high volume of charts being sent to Anaesthetist for ECG interpretation and not anaesthetic assessment. Potential harm include patients leaving the department with a undiagnosed Cardiac condition which could progress to a significant cardiac event. The lack of timely review results in ongoing risks around the patient's surgery being postponed or cancelled- potential harm due to delay in treatment. In the event that the patient has a abnormality that needs treatment or management theatre may be cancelled at very short notice. End result being theatre underutilisation. Significant financial harm to the Trust will be incurred in this event.	If Nursing staff see abnormal (as per ECG machine print out) on ECG on tracing, the ECG should be escalated to the Band 6 nurses who then highlight it to either Anaesthetist/ OPD Manager or ECG staff. Designated POA Anaesthetist reviews the charts/ECG's of patients who have been escalated to the Anaesthetist.	Reviewed 6.12.10 - Lorraine Adair meeting with D Lilburn to progress. Awaiting outcome in conjunction with direction from B Conway. Risk remains unchanged. Risk Assessment has been updated 22/10/10 to refine issues. Barry Conway, Lorraine Adair, Diane Lilburn and Connie Connolly met on Monday 11th October 2010. Proposal for Dr Rankin to be prepared by Barry Conway and Heather Trouton for consideration. 16.04.10 - The requirement of ECG screening is being reviewed by Mrs Connie Connolly and Dr Neville Rutherford-Jones. There has been no Cardiology resource identified within Medicine and Unscheduled Care. The Staff doing ECG;s at present are dependant on the individual sites. Any ECG's deemed 'abnormal' are been shown to the ECG department, and or Cardiology clinicians only if available. If no availability, or POA is being done out of hours, relevant ECG's may be seen when appropriate staff available. ECG's are being done during face to face as appropriate. ECG;s are not routinely reviewed until F2F or anaesthetic chart review or on day of surgery. Risk reviewed 24.02.10 - additional actions/controls put in place - On going discussions with Anaesthetics to provide safe and effective cover for pre op clinics. 09.11.11 Meeting to be arranged with Anaes, Cardiology, Pre-op Asses to discuss further management, currently all major abnormal ECGs are being referred to A&E as an interm. 01.10.11 Awaiting further progress report.	MOD	DIV

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2512	08/03/2010	Be a great place to workMake the best use of resourcesBe a good social partner within our local communities	Fracture Clinic	Fracture Clinic stock going missing Department shared by A&E	Patients not receiving appropriate treatment. Risk of complaints. Disharmony between departments. Risk of stock going low for patients. Patients having to go without appliances. Rise in complaints. Inaccurate budget control. Cannot order in bulk due to lack of storage space.	Stock control book. Staff training on staff control. Discussions with A&E Line Manager. Discussions with Fracture clinic Line Manager. Continue stock control. Communicate with A&E staff. Fracture Clinic to monitor stock daily. Educate A&E staff. Lock Fracture clinic at the end of the day. To have ownership.		LOW	HOS
2520	15/03/2010	Make the best use of resources	1 Surgical EAW	Drugs in Treatment Room [Ward closed at night & weekend]	Room locked but unit not locked. No alarm on Controlled Drug Cupboard - Potential for theft of medication and controlled drugs while ward is unoccupied	Locking preparation room door . Controlled drug & ward keys given to Dermatology Monday to Thursday , Porters safe Friday to Monday am .	Security work has been completed ' - risk closed 08.06.10	MOD	DIV
2522	15/03/2010	Provide safe, high quality careMaximise independence and choice for patients and clients	4 North Surgical	Poor toilet and shower facilities on 4 North	Increase in infection rates. Poor environment to recover post operatively. Not enough male / female facilities. Shower male side, door allows water to leak through. Showers need general upgrading. Hand rails need to upgraded on all toilets.	Environmental audit. Complaints about facilities from patients expressing poor satisfaction.		MOD	DIV
2519	15/03/2010	Provide safe, high quality care	1 Surgical EAW	Distance from theatre to EAW for post-op patients	Risk to patients - condition could deteriorate on way back due to distance. Potential for emergency situation to arise whilst patient is not in a clinical environment, post surgery & anaesthetic	Staff take emergency pack with ambubag , airway & facemask with them to recovery ward .		LOW	HOS
2521	15/03/2010	Be a great place to workMake the best use of resources	1 Surgical EAW	Double Doors outside Dermatology have no automatic button	Potential manual handling risk - Potential manual handling risk to staff whilst trying to get door open and bad through	Staff open manually	Estates have been contacted-await further response	LOW	HOS
2745	22/03/2010	Provide safe, high quality care	Outpatients Dept	Mis-timing of pre operative assessment investigations- extension of patient pathway to 17 weeks in T/O and Urology	Due to the extension of the patient pathway for Urology and T/O patients to 17 weeks, current pre operative assessment validity dates of 13 weeks, will no longer provide accurate pre op assessment. Risks are around having to facilitate patients coming back to the POA service for screening once the TCI date has been issued. Due to limited Band 5 availability for screening there is a risk that there will insufficient time to manage any pre op issues that may arise. Risk that POA clerical staff do not have the resources to ensure the patients pass through assessment twice at a time allowing for any management issues. Risk that patients having screening done too close to TCI, will have to be cancelled at short notice due to not having enough time to resolve any clinical issues. POA then has no capacity to assess patients who may have been selected to backfill at short notice. Risk of inefficient utilisation of bed and theatre capacity if there are persistent day of surgery cancellations due to inappropriate or inadequate screening. Potential harm to patients if surgical procedure is cancelled Financial harm to SHSCT due to poor theatre and bed utilisation secondary to delayed pre op screening. Potential for financial harm if pre op screening is out of date and has to be repeated. Potential for financial harm if patients are being admitted to ward prior to surgery if pre op investigations are incomplete.	Band 5 Nurses in POA to cease preliminary screening in T/O & Urology when patients are added to IPWL immediately. POA clerical team chronologically inviting patients who are listed within the next month, to attend for repeat screening. (done on receipt of theatre lists)PCR testing being done for T/O patients if surgery is within 3 days	Reviewed 3/12/10 - Issue is still valid for Urology (52 weeks) T/O 32 weeks, General Surgery 20 weeks. Awaiting cutting plans within specialties. Currently undertaking review of patient flow through POA and will be creating HSQ by appointment if needed according to Specialty waiting times. Continued pressure on POA capacity due to the additionality being generated secondary to cutting plans and PTL compliance. Reviewed 21/7/10 - Change in processes made to reinstate screening at initial HSQ - this is to ensure suitability for short notice admissions. Reviewed 14/5/10 - Preliminary meeting held with Band 6 working in POA on 13/4/10, will be meeting again to work on establishing and agreeing timeline of investigations for T/O and Urology patients. Ward Managers have been requested to release all NVQ candidates to the Infection To be reviewed/updated again 14/5/10. Reviewed 3/12/10 - NVQ training complete. Reviewed 21/7/10 - Meeting Susan Boyce 5.8.10 re NVQ verification. Remains a persistent risk. Reviewed 14/5/10. Prevention training this month and Carmel Markey has agreed to teach and assess MRSA swabbing. To be reviewed/updated again.	LOW	DIV
2546	24/03/2010	Provide safe, high quality careBe a great place to workMake the best use of resources		Risk of fire when oxygen cylinders are stored with other consumables	Fire risk from oxygen cylinders being stored along side stationary and electrical equipment. Resulting in major fire, loss of life, litigation. Oxygen should be stored in appropriate fire proof cupboards.	Oxygen cylinders are stored on metal stands attached to the wall. Staff vigilance.	17.04.12 - Medical gas group has re-established and issue being addressed as part of that group. 23.01.12 - An agreed stock has been established for all wards in SEC - suitable storage and signage. Works ongoing.	LOW	TEAM
2591	15/04/2010	Provide safe, high quality careBest use of resources	Opthamology Clinic	Unable to identify patients at risk of glaucoma from within the back log of review patients	Unable to identify patients at risk of glaucoma from within the back log of review patients - Risk of patients eyesight deteriorating or losing completely resulting in : 1. Patients not receiving a high quality service. 2. Targets breeched. 3 large manpower expenditure to review the backlog.	Initiate an action plan to address the backlog of out patients that require a review and identify those that have a risk of glaucoma.	Backlog review completed	MOD	DIV
2592	15/04/2010		Trauma Ward	5.19 WTE Registered staff on maternity leave at the same time	Patients receiving a poorer quality service, less safe 5.19 WTE Registered staff on maternity leave at the same time. Audits reflecting clinical indicators at risk of dipping , MEWS, Hygiene etc. Sick levels increasing. Unsafe service, reduced quality of service delivered. Poor morale. Expenditure due to bank and agency.	3 temporary registered staff In situ, however staff off are predominantly experienced staff, therefore ward short of experienced senior cover.	17.04.12 - All E reqs processed and all vacancies and maternity leaves filled as allowed. Issue closed. 23.01.12 - All vacant posts are in the process of being filled. 4 members of staff from the Bank Permanent Staff are dedicated to Trauma due to the high volume of maternity leave. 10.11.11 New staff in recruitment process and vacancies will be filled in Dec 2011. 01.10.11 Additional block bookings have been put in place and rotation program implemented from Orthopaedics and Trauma co-ordinators are undergoing further training.	LOW	DIV
2593	15/04/2010		4 North Surgical	Cesation of Band 2 staff trained and currently doing clinical observations under the delegation of registered staff	In wards 4 north, 4 south, 3 south, Band 2 staff that have been trained and currently doing clinical observations under the delegation of registered staff having to stop, therefore a large increase in the number of clinical observations for registered staff to carry out, resulting in risk of observations not being timely. Risk of patients condition changing / deteriorating without recognition Patients not getting clinical observations in a timely manner if band 2s stop their current practice. No data available to identify that patients received less than optimum care when band 2s do clinical observations under delegation of registered nurse	Training carried in legacy trust for band 2 doing clinical observations. Requirement for band 2s to have clinical observation module in NVQ level 3 before being able to do clinical observations. This training not in place at present.			HOS

2743	16/04/2010	Provide safe, high quality careBe a great place to work	Outpatients Dept	Staff Shortages due to implementation of POA without Backfill of Band 5 staff & ACH OPD provide 2.18 wte nursing support for MIU	Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards. Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards.	Outpatient Managers keeping current training records for all staff, while making priority for designated mandatory training. Allocation for training done according to type of training and date of last attendance when capacity allows. Consideration given to KSF and professional requirements first. Staff asked to do training during extra hours if no alternative available. Lead Nurse has escalated the staffing deficit/ Minor Injuries Unit to Finance, the AD for Surgery and Elective Care and Head of Out of Hours Service	6/12/10- Finance has extracted the MIU SIP out of the staffing allocation and funding from OPD. Review of funding to be done in relation to staff in January 2011 by H Trouton and Dr G Rankin. All risks remain outstanding and unchanged. 21 July 2010- staffing constraints have been highlighted to the AD for SEC and the Interim Director for Acute Services. Awaiting financial summary of overall Outpatient financial position. Review 31 August 2010. 6/12/10- Finance has extracted the MIU SIP out of the staffing allocation and funding from OPD. Review of funding to be done in relation to staff in January 2011 by H Trouton and Dr G Rankin. All risks remain outstanding and unchanged. 21 July 2010- staffing constraints have been highlighted to the AD for SEC and the Interim Director for Acute Services. Awaiting financial summary of overall Outpatient financial position. Review 31 August 2010.	LOW	DIV
2636	20/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Patients for surgery having cancellations due to inadequate information and preparation via pre-operative assessment clinic.	Patients for surgery having cancellations due to inadequate information and preparation via pre-operative assessment clinic. Trust waiting list has to be altered so other people are cancelled to facilitate the cancelled patients. Wastage of theatre time and staff. Resource implications for the Trust. Complaints will increase. Extra work for ward staff and secretaries. Patients taking time off work to come to hospital for their surgery. Risk of litigation, loss of reputation. Patients cancelled due to not being informed to stop taking medications, such as anti-coagulants or insulin, or patient has not taken essential medications which should have been taken. Patients condition may have changed and may require further investigations eg: ECG, echo, which was not carried out at pre-op assessment. Patient not seen face-to-face at pre-admission clinic by a nurse (so patient effectively doing their own assessment) and on day of surgery consultant decides patient is not for surgery. Pre-op assessment bloods out of date, especially Group and Hold, and need to be repeated on day of surgery. Patient pre-assessed in CAH and documentation did not arrive at ward level.	Incident forms to be completed. Communicate with nurse in pre-admission clinic. Inform lead nurse		HIGH	DIV
2624	27/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Trustwide	Risk to health and safety of patients and staff in all SEC wards in CAH and DHH due to inadequate environment.	Increased risk of falls. Increased risk of injury to staff due to inadequate storage. Risk of infection due to inadequate sinks in wards and storage of hoists in bathrooms. Risk of theft of staff property. Increased risk of complaints, risk of litigation, loss of reputation to Trust. Risk of falls due to floors sealed with tape to cover cracks in floor covering. Uneven floor surface also providing a risk of falls. Inadequate number of sinks per bed ratio in main wards - should be 1 sink per 4 beds - presently 1 sink per 6 beds. Inadequate storage for stationary and equipment, eg: hoist being stored in main bathroom as there is no room for it anywhere else in the ward (FSW + MSW). Inadequate changing facilities for staff and inadequate number of handbags lockers for staff.	Environmental audits. Maintaining low stock levels. Endeavour to adhere to current infection control policy. Inform Estates.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2624 - expand to SEC as a problem across the division'.	MOD	DIV
2635	27/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Female Surgical Ward DHH	Lack of staff training DHH, MSW, FSW, HDU, Gynae	Risk of staff not being updated due to lack of resources to facilitate staff to go to training and multiple training schedules at Trust level. Staff will not meet mandatory requirements for registration as specified by their professional regulatory body. Mandatory requirements unable to be facilitated. Risk of harm to patient if staff not adequately trained to provide high quality, safe, effective care. Increased risk of complaints, loss of reputation to Trust. Increased risk of HAI's. Risk of litigation. Low morale, increased sickness level, high staff turnover Staff will be unable to provide a high quality, safe, effective care to patients if not updated adequately. If staff at training, safe staffing levels may not be achievable at ward level. Most training takes place at Beeches CAH, which means at least 2 extra hours for travelling to and from DHH, which in turn reduces the amount of staff we can release from the ward.	Plan off duty rotas to facilitate training. Assess ward dependencies to ensure adequate staffing levels and facilitate training on the day of training as to whether staff can be released for training. Ward Manager to prioritise training needs. Controls discounted - Request more training in Daisy Hill Hospital. Beeches Education Centre not always able to provide training in DHH.		MOD	DIV
2631	29/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Female Surgical Ward DHH	Risk of delay in treatment for patients with fractures awaiting a bed or further management in the regional centre in Belfast.	Poor outcome for the patient. Delay in treatment. Potential for developing complications of bed rest eg: pressure sores, thrombosis, infection. Potential for increased complaints, litigation for the Trust. Patients may develop complications of bed rest and of having a fracture eg: fat embolism, thrombosis, infection. Delays in surgery may mean death or poor fracture healing. Bed flow may be impaired which will have an effect on elective lists and may result in theatre cancellations and breach of PFA targets. Loss of confidence in the Organisation.	Close liaison with Bed Manager who in turn communicates with regional centre. Control measure discounted - Patients should be admitted directly from A+E to RVH. Ensure CT scans and X-Rays are sent to RVH # Clinic or wherever designated, and signed for on receipt to ensure timely treatment. Communication with medical staff in regional centre at least daily when awaiting transfer.	01/10/13:An agreement has been reached that all N+M patients will transfer to RVH for treatment. During out of hours they will wait in DHH and then transfer directly the next morning to RVH. 29/03/13: Current position remains; continued utilisation of CAH Trauma Ward 01.02.13 - Optimum utilisation of CAH Trauma Ward continues in conjunction with RVH. 07.01.13 - Processes in place continue to work well. No escalations of delays in treatment for patients received. 29.11.12 - Current position remains. Case currently going to board and if approved and consultant appointed, fracture patients will come to CAH therefore minimising risk. Timescale uncertain. 28.09.12 - No change on review. 19.06.12 - Processes in place continue to work well with optimum utilisation of CAH Trauma Ward encouraged in conjunction with RVH as required. Plan to review in 2 months. 17.04.12 - Current position remains. 23.01.12 - Processes in place are working well. 10.11.11 Improvements noted in access to Belfast. 01.10.11 Awaiting feedback from patient flow team. Update 27.5.11- Dr Loughran has received correspondence from Dr Tony Stevens RVH re issue: - New rota hoped to improve response - Monitor success of new rota CAH taking patients requiring surgery subject to bed availability to facilitate prompt treatment	LOW	DIV

2628	04/05/2010			Delay in diagnosis, treatment, transfer and discharge of patients due to loss of X-Rays, CT, MRI results	DHH Female Surgical,/Gynae, Male Surgical/ HDU - Delay in diagnosis, treatment, transfer and discharge of patients due to loss of X-Rays, CT, MRI results # Clinic RVH. Delay in diagnosis and treatment - poor outcome for patient - permanent injury, death. Patient may develop complications of bed rest, hospital acquired infection, fat embolus, DVT, PE, pressure damage to skin. Patients treatment delay causing further complication of condition. Risk of complaints, litigation, confidence loss in service. Bad reputation for surgical wards. Delay in patient flow, resulting in theatre cancellations. Delay in discharge, theatre cancellation , breach of PEA targets.	Documentation available from surgical ward / A + E to be signed by RVH staff when X-Rays delivered. Good communication by nursing staff. Bed manager to communicate with # Clinic with daily or more regular updates.		VLOW	DIV
2632	04/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Patients are at risk of not receiving prescribed drugs at prescribed times, due to 2 nurses to admin and check drugs IV.	Poor outcome for patient, delay in treatment. Potential for deterioration of condition. Increase of clinical incidents, complaints. Patients will not receive prescribed treatment in timely fashion. Bed flow may be impaired - delay in patient discharged, therefore elective lists may be postponed. Nurse could be disciplined for not adhering to guidelines. Litigation for the Trust, loss of confidence in Organisation.	Encourage use of IV antibiotics in community. 2 Staff on duty at all times to check drugs, risk of not being available for administer of drugs due to patient dependency and bed occupancy. Monitor medication errors and adverse incidents. Controls discounted - Dr to give IV drugs. Daily IV antibiotic ward round.		LOW	HOS
2633	10/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	Female Surgical Ward DHH	Safety of staff property due to inadequate supply of handbag lockers at ward level.DHH, FSW, MSW, Gynae, HDU	Risk of staff property being stolen. Risk of litigation. Risk of loss of Trust reputation. Staff safety at risk if personal details stolen with handbags. Staff are at risk of distress and safety at risk if personal details stolen with handbags.	Handbags in unlocked cupboards.		LOW	HOS
2625	10/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	High Dependency Unit DHH	Patients at risk due to inadequate staff cover at meal times	Poor outcome to patient. Possible death of patient. Extreme stress for staff. Increased sick leave, low morale. Increase in clinical incidents, increase in complaints. Risk of litigation, loss of Trust reputation, risk of increase in HAI's. Nurse could be at risk of losing her pin no. In the High Dependency Unit there are two staff nurses to cover for 5 ill patients. There is no provision made in the nursing establishment for meal break cover, lunch breaks; staff nurse caring for 5 ill patients. There is a risk of patients not receiving prescribed care, or of patients no receiving adequate pain relief due to only 1 staff nurse. Risk assessments for moving and handling cannot be adhered to due to only 1 nurse I unit. If patients condition suddenly deteriorates one staff nurse may not be able to deal with all five high dependency patients.	When possible, cover given by Male Surgical ward but due to maternity leaves, study leave, sick leave, posts not replaced. This is not adequate. Emergency call bell in HDU. Control measure discounted - Extra staff in HDU establishment. Inadequate funding for same.		LOW	TEAM
2739	19/05/2010	Make the best use of resources	Pre-Operative Assessment Clinic	Increase in Day of Surgery Cancellations due to inappropriate/inadequate pre op screening. This is secondary to insufficient cle	Due to the reduction in Clerical Support, the POA clerical team are at risk at not being able to monitor the listing of T/O patients and monitor MRSA screening/status. The patient is at risk of having the procedure delayed or cancelled if not enough time has been given to screen and treat any infection pre operatively. Potential impact on theatre scheduling (surgery being postponed or cancelled at short notice) and theatre capacity)y (day of surgery cancellations) if patients aren't selected for screening in a timely manner. Patient harm - delay or cancellation of procedure has potential the length of time patient is exposed to illness/discomfort. Patient could potentially have financial loss due to time taken from work, along with disruption to domestic circumstance. Financial harm to Trust: substantial financial consequence for Trust secondary to loss of theatre capacity, loss of ward capacity and potential to breach waiting time targets. Harm to resources within the Trust - Day of Surgery cancellations potentially causes additional strain on ward staff due to patient distress and need for reorganisation of surgery. This has the potential for the patient to be exposed to additional screening secondary to delay.	Redistribution of workload within POA Clerical Team. Band 4 officer to monitor the T/O chart processing. S Glenny to provide monthly lists of patients due for selection- Band 4 to then monitor the timely arranging of patient attendance. Scheduling Team to populate Theatre lists a month in advance. POA Band 6 Nurses to highlight patients for screening/rescreening once TCI known.	May 28 2010. Escalate to S Glenny/H Trouton if controls are inadequate.	LOW	DIV
2634	20/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Injury to a patient following a fall DHH, MSW, FSW, Gynae, HDU	Client may have a fracture or head injury or laceration due to a fall. Complaints will increase, risk of litigation. Delayed discharge. Patients who are confused, under the influence of drugs or alcohol, elderly, unsteady on their feet, head injuries may be at risk of falling. This risk may be increased if the staff / patient dependency ratio is not at an adequate level. Patient may need transfer to another hospital. Could develop hospital acquired complications. Risk of death.	Monitor slips, trips and falls. Manual handling risk assessment carried out on admission. Individual patient handling assessment carried out on all patients on admission eg: cot sided, history of fall, use of aids etc. Keep bed at low level, mattress on floor, appropriate chair. Ensure call bell for each patient is within patients reach. Remove environmental risks. Contol measures discounted - Getting family to sit with patients and reviewing staffing levels and getting extra staff to sit with patient. Often family not available. Often unable to get bank staff.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2634 please remove ' - risk closed 08.06.10	LOW	DIV
2742	22/05/2010	Provide safe, high quality care	Outpatients Dept	Risk to health & safety of patients in ENT due to no access to decontamination equipment on weekends	No access to decontamination equipment on weekends. Additional Clinic Saturday May 22 2010. Cross contamination to patients. Risk to organisation through: litigation; adverse publicity/ complaints;loss of reputation; breach of Hine Review. Recommendations. Inequality of care for patients; Friday (clean scopes); Saturday (wiped and sheathed scopes). Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demand. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients.	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations). Arrange for all scopes on other OPD sites to be transported to CAH for the additional clinic. This would mean that the satellite sites would not have access to their scopes for clinics on Monday with a risk of not having them decontaminated for Tuesday. Irrespective if all scopes were recalled, there would not be sufficient numbers to support a clinic of 80 new patients.	23.01.12 - Requisition away for customisation of transfer boxes and same should be resolved by 29 February 2012. Seeking funding to provide decontamination of new scopes. Contribution to Decontamination staff- ? .2 Wte Band 2	VLOW	HOS

2626	24/05/2010	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMaximise independence and choice for patients and clientsBe a great place to workMake the best use of resources	Female Surgical Ward DHH	Staffing levels in Female Surgical/Gynae, Male Surgical/ HDU	Health and Safety of patients and staff could be compromised if staffing falls below safe levels for dependency and high bed occupancy due to staff absence and reduced staffing as a result of bed closures at the weekend. Patients may be at risk of not receiving adequate, safe, high quality and timely care. Risk of increase in accidents, medications not given on time, poor documentation or lack of documentation / not according to NMC code for record keeping. Staff may be placed under stress if staffing levels fall below recommendations for patient dependency / bed occupancy. Patient may be at risk of receiving inadequate care. Adequate maintenance of the ward environment may be compromised if staffing falls below acceptable levels. Increase in complaints. Increased staff sick leave. Risk of increased length of stay due to HAI's. Lower staff morale. Risk o litigation. Risk of loss of reputation.	Monitor staff sickness and absenteeism. Monitor clinical incidents. Monitor complaints. Attend white-board meetings x3 times / week to monitor patient length of stay. Feedback to nurse managers if requesting bank or extra hours. Monitor environmental cleanliness by audits.		LOW	DIV
2627	24/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Delays in repair of equipment eg: sluice master in FSW, MSW, HDU, Gynae DHH	Delays in repair of equipment eg: sluice master. Increase of infection. Risk of injury to patient and staff from equipment. Equipment eg sluice master not repaired when faulty may cause spread of infection due to body fluids being stored in clinical waste bags. This is high risk for staff and patient including portering staff. Risk of complaints, litigation and bad publicity.	Use equipment as per guidelines. Inform maintenance as soon as equipment faulty. Ensure infection control procedure applies as per policy.		MOD	HOS
2647	26/05/2010	Provide safe, high quality care	4 South Surgical	Short term storage of large quantaties of oxygen cylinders at ward level on 27th May 2010	Large quantity of oxygen cylinders at ward level due to the mains oxygen supply being unavailable for a period of time on 27th May 2010, thus potential risk of running out of oxygen and hazard from large quantity of stored oxygen in an unprotected area Risk of litigation if staff harmed due to amount of cylinders stored as area cluttered, and cylinders very heavy Risk of poor quality service if oxygen runs out Risk of injury from oxygen cylinder Risk of fire as no dedicated O2 storage area is available at ward level	Estimation of extra oxygen required obtained and at ward level All cylinders on O2 trolley Porters and Pharmacy informed of the loss of mains O2 Management informed	08.06.10 - work complete and risk closed	MOD	DIV
2681	15/06/2010	Provide safe, high quality careMake the best use of resources	Outpatients Dept	Shortage of (Paediatric) Band 5 Nursing staff due to the implementation of Pre Operative Assessment without backfill of Band 5 s	Potential harm to patients due to not having regular support of Band 5 Paediatric trained Staff Nurse. Potential harm to the reputation of the SHSCT if this issue is highlighted as part or RQIA feedback. Potential for litigation if it is found that a patient received sub standard care due to lack of access to Paediatric trained Staff Nurse. Failure to comply with Child Protection Policy and Procedure. Staff supporting the Paediatric service in Outpatients are at risk of not having sufficient skill and supervision to undertake the assessment of care of patients 16 and under Trust at risk of complaint and litigation. Staff at risk of not meeting SHSCT Child Protection Standards. Children at risk of harm by potential action or inaction by Adult trained nurses/health care assistants Patients and families have to reattend Inpatient services to have Paediatric specific investigations done. (this as a direct result of insufficient specialist skills within General Outpatients.) Increased risk of exposure to HAI and impact on ward staffing resources.	Awaiting the commencement of year long Secondment to Paediatric training for S/N J Doogan Health Care Assistants and Nursing Auxiliaries allocated to support Paediatric clinic with Band 7 Paeds Trained Department Manager on site. Band 5 staff nurses allocated to Paeds clinic when staffing levels allow. Control measures considered but discounted: Increase Band 5 Staff Nursing allocation-Unable to secure funding for POA backfill due to financial constraints Band 7 OPD Manager, covers Child Protection support-Band 7 Paeds trained Department Manager currently on sick leave Band 5 Paeds Nurse allocated to Paeds OPD- The one Band 5 Paeds trained staff nurse is current on Band 6 secondment in POA.	25 June 2010- Meeting held with Mrs Geraldine Maguire, Mrs Grace Hamilton, Mrs Heather Trouton and Mrs Connie Connolly regarding the transfer of funding from General OPD to the Paediatric Directorate. It was agreed that funds equivalent to 1.0 Wte at one Band 5 and 1.0 Wte at one Band 2, would be transferred from OPD to Paeds. Email request regarding this change was sent to Mrs Carol Cassells. It was agreed that current custom and practice would continue until the Paeds Directorate was able to recruit staff accordingly. 3 June 2010. Meeting held with Grace Hamilton and Bernie McGibbon. Actions: Connie Connolly to amend and escalate Risk Assessment to Heather Trouton/Beatrice Moonan. Done 3/06/10. Connie Connolly to approach Dean Faloon in Finance and Dr Mike Smith regarding information regarding funding for Paeds OPD. Consideration was given to OPD funding being transferred to Paediatric Directorate. Connie Connolly to escalate proposed transfer of funding from OPD to Paeds to H Trouton. Connie Connolly to discuss the commissioning position for Paediatric training in 2010/11 with Heather Trouton. 14 June 2010 -Meeting with Bernie McGibbon, Dawn Connolly and Connie Connolly Due to chronic shortage of Band 5 Paediatric trained Staff Nurses, these actions have been agreed. Actions: Paediatric Outpatients children who require the application of EMLA crème with have to attend 3 North to have EMLA crème applied in advance of having blood taken. Memo to be circulated 15 June 2010 To await outcome of meeting with Mrs Maguire and Mrs Trouton regarding the transfer of funding for Nursing support from General Outpatients to Paediatric Services. 6.12.10 - Paediatric funding transferred to CYP in July 2010. October 2010 - staff rotating from Paediatric ward initially for induction, with a view of supporting the complete service by November 2010. 6/12/10- CYP managing the Paediatric Outpatient clinics in CAH/ ACH and BBPC. No longer a risk to OPD	LOW	DIV

2746	21/07/2010	Provide safe, high quality care	Outpatients Dept	Risk of contamination while using Welch Allen sigmoidoscopes (rigid or flexible) with Welch Allen light source etc.	Risk of contamination has been identified while using Welch Allen sigmoidoscopes (rigid or flexible) with Welch Allen light source, reusable eye pieces, reusable bellows with the disposable proctoscope & disposable filter. There is a risk of cross contamination from the equipment to the patient if the bellows are reusable. Currently in Outpatients staff would not have access to sufficient numbers of reusable eye pieces, to replace the eye piece with every examination. There are only 9 sets of bellows across the Trust and the MDA health alert stipulates that the eye piece, filter and bellows are changed with every examination. The Trust currently has disposable proctoscopes and filters in use. Risk of cross contamination between patient and sigmoidoscope equipment. (the reusable bellow has the potential to cross contaminate the reusable eye pieces irrespective of the disposable filter)Potential harm to patient if secondary infection is contracted. Could potentially delay or change management Risk of litigation to SHSCT secondary to patient infection.	Urgently seek the view of the Assistant Director regarding the financial implications of remaining partially compliant with manufacturer's advice. Collate financial estimates for changing to a Single Use system or enhancing stock of current equipment. Manually cleaning bellow in between examinations, while awaiting investment. Not feasible given the number examinations done and the timing between patients. Cannot insist on the changing of eye pieces or bellows until financial resources are released.	6.12.10 - Requisition has been placed to purchase 6 light sources to support the new disposable system. To be supplied by 31.3.11. Integration of new single use MDA compliant system to be in place by 31.3.11. 6.12.10 - Requisition has been placed to purchase 6 light sources to support the new disposable system. To be supplied by 31.3.11. Integration of new single use MDA compliant system to be in place by 31.3.11.	MOD	DIV
2740	27/07/2010	Provide safe, high quality careMake the best use of resources	Pre-Operative Assessment Clinic	Staff Shortages due to sick leave within Band 6 POA nurses providing Face to Face Assessment	Due to chronic staff shortages, there is not enough capacity on the two above mentioned sites for Face to Face assessment to be done in a timely manner. This results in an insufficient number of pre op fit patients available for listing for elective procedure. Risk of Day of surgery cancellations and decreased theatre utilisation due to patients being suspended or cancelled at late notice. Due to lack of capacity, there is limited provision for any patients being booked at late notice due to cancellation, or red flag/urgent status. Potential harm to patients following cancellation of surgery due to untimely or no pre operative assessment. Potential financial harm due to inappropriate theatre utilisation- not enough patients pre op fit. Potential to harm to reputation of SHSCT due to potential breech of waiting times	Patients having surgery in the next 4 weeks are given priority for Face to Face assessment. POA clerical staff allocate appointments in chronological order of TCI dates. All Band 6 POA staff have staffed additional clinics during time which was usually allocated for the reviewing of investigative results. Close monitoring of sickness and absence/referrals to Occupational Health.		MOD	DIV
2741	27/07/2010	Provide safe, high quality care	Outpatients Dept	No provision for Bariatric patient- patients over 25 stone in weight	No bariatric examination couches available on the above mentioned sites. Unable to provided Outpatient service to patients over 25 stone at these sites. Potential to breech waiting time targets as patient may not be able to be seen close to their home or by the relevant specialty. Risk of injury to patient and staff if furniture is not fit to provide support for patient weighing over 25 stone. Risk of inadequate examination due to limitations of non bariatric furniture. Potential harm to patient if the patient cannot be seen on the above mentioned sites, due to lack of appropriate examination couches- potential for increase in severity of disease/illness. Potential for delay in Outpatient appointment if living near one of these site. Potential harm to both patient and staff if patient was seen on inappropriate furniture- potential for inadequate examination due to limitation of furniture. Potential discomfort and embarrassment to patient if department not prepared to meet patient need.	Medical records will book any know bariatric patient to the Daisy Hill site.	6.12.10 - All General Outpatients Departments now have one Bariatric couch and one Bariatric chair in the waiting room. Remove from Register - no longer a risk. 6.12.10 - All General Outpatients Departments now have one Bariatric couch and one Bariatric chair in the waiting room. Remove from Register - no longer a risk. Caroline Doyle in Finance has asked that Helen OHare was contacted regarding updating the status of all E&G accounts. Email sent 15/04/10.	LOW	DIV
2744	27/07/2010	Be a great place to workProvide safe, high quality care	Outpatients Dept	Staff Shortages due to the implementation of Pre Operative Assessment without Backfill of Band 5 staff	Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards. Potential harm to patients and staff due to not being able to be updated with mandatory and in service training. Potential harm to the reputation of the SHSCT if this issue is highlighted as part or RQIA feedback. Potential to delay progression through KSF framework , secondary to lack of attendance re agreed training needs. Potential for litigation if it is found that a patient received sub standard care due to lack of access to training.	Outpatient Managers keeping current training records for all staff, while making priority for designated mandatory training. Allocation for training done according to type of training and date of last attendance when capacity allows. Consideration given to KSF and professional requirements first. Staff asked to do training during extra hours if no alternative available	6/12/10 - Current position remains unchanged and will potentially deteriorate in January due to Maternity leave(22/10/10). Block bookings have been utilised where possible with Nurse Bank at Band 5 (1.0 Wte) and Band 2 1.44 Wte). This was arranged following Meeting with H Walker, H Trouton and C McGoldrick. All staff on long term sickness are under occupational health review. Difficulty in staffing additional clinics Trust Wide. 21 July 2010 Awaiting Financial Summary to illustrate the overall Outpatient status. AD for SEC and Interim Director of Acute Services aware of staffing issues. Nurse Bank being utilised to cover gaps. Review August 31 2010	VLOW	DIV
2820	25/11/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	3 South Surgical	Significant WTE staff levels less than agreed compliment due to sick leave, maternity leave and vacancies.	Patients receiving poor quality care. Clinical Audits reflecting reduction in standards. Staff sick leave increasing. Poor moral, staff feeling over worked. Increase in complaints. Risk to reputation of Trust . Due to reduction in ward compliment of staff, along side normal activity there is a risk that systems and processes will breakdown. Staff, patients and Trust reputation at risk. Escalation in level of sick leave. Training opportunities not able to attend due to ward shortage of staff Mentoring of students compromised.	Bank staff to back fill as bank system and financial climate will allow. Encourage staff to be flexible with off duty rota. Control measures considered but discounted and why: Temporary staff appointed, not feasible due to the current recruitment challenges and the time scale involved.		HIGH	DIV
2821	26/11/2010	Provide safe, high quality care	Outpatients Dept	Risk to health & safety of patients in ENT attending additional clinics on November 20 2010	No access to decontamination equipment on weekends. Additional Clinic Saturday May 29 2010. Cross contamination to patients. Risk to organisation through: litigation, adverse publicity/complaints,loss of reputation, breach of Hine Review Recommendations. Inequality of care for patients - Friday (clean scopes), Saturday (wiped and sheathed scopes). Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demand. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients.	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations)	Seeking funding to provide decontamination of new scopes	MOD	DIV
2824	07/12/2010	Provide safe, high quality careBe a great place to work	Outpatients Dept	Risk of inadequate staffing levels due to long term sick leave resulting in poor or inadequate nursing care and chaperoning	Staff and patients are at risk of error, poor quality care, insufficient chaperoning. Trust is at risk of not meeting SABA levels, secondary to not having enough staff to support additional clinics. Risk of inadequate staffing levels due to long term sick leave resulting in poor or inadequate nursing care and chaperoning. Risk of decreased efficiency and capacity in Outpatient clinics secondary to low staffing levels. Risk of loss of reputation due to increased waiting times and increase risk of error due to increased workload of remaining staff. Potential for a further increase in sick leave due to high demand on remaining staff. Potential for increased complaints due to lack of staffing and staff workload. Extensive Long Term Sick Leave at Bands 5,3 and 2.Band 5 SIP 11.80 Wte 6.75 Wte staff on sick leave, secondment, acting up. Band 3 SIP 7.59 Wte. 3.63 Wte staff on sick leave. Band 2 SIP 2.19 Wte. 1.26 Wte staff on sick or maternity leave. Sickness Rate approx 49% - not withstanding annual leave and mandatory training and casual sick leave. Maternity Leave at Band 6 to be filled by . 90 Wte Band 5	Staff work extra hours when possible Band 5 1.1 Wte Bank block booking. Band 2 1.44 Wte Bank block booking. Staff working between multiple services, instead of single service. CTP has taken over support for Paeds OPD Rheumatology clinics are in DCC in CAH. Requisition has been approved for 2 POC testing for Coagulation Clinic (will release 2 staff)Staff from other Outpatients support when possible		LOW	DIV
2823	07/12/2010	Provide safe, high quality care	ENT Clinic, Surgical Outpatients	Non Compliance with RQIA Environmental Cleanliness Audit 14/09/10	Health and Safety Risks to all patients attending ENT OutpatientsHealth and Safety Risks to all staff working within ENT Outpatients due to poor conditions of environment. Trust is Corporately at risk of loss of reputation if not compliant with RQIA recommendations. Infection control risk due to the type of flooring. Infection control risk due to lack of facilities to do initial decontamination of equipment. Risk of loss of reputation if not compliant with RQIA recommendations. Infection control risk due to poor condition of flooring in public toilets in ENT Department. Risk of patient injury due to inadequate space to conduct phlebotomy.	Carpet is cleaned daily. Blood room is kept uncluttered. Toilets cleaned daily. ENT scopes are taken to CSSD for all cleaning (increasing processing time)	11/11/11 No progress with minor works, duplicate request sent to provide costs for all repair work. Remains a risk 14.11.11 Note link with Risk 2989	MOD	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
2898	01/02/2011	Provide safe, high quality care	Outpatients Dept	No screens surrounding the examination couches in the Consultation rooms	Staff are unable to secure privacy and dignity of patient without adequate resources. Patient does not have any dignity or privacy to change for an examination. Potential for litigation to Trust secondary to inadequate changing facilities and potential for violation of patient privacy during an examination/consultation.	Clinician leaves the room to allow patient for privacy Changing cubicles are in use, and patients then walk in front of waiting are in hospital gown	23.01.12 - Screens have been ordered, awaiting delivery. 11/11/11 J McCaghey has been contacted and measurements have been taken. No cost estimate as yet. 10.11.11 Screens ordered from Jan 2011, awaiting delivery of same to progress with J Austin.	LOW	DIV
2899	01/02/2011	Provide safe, high quality careBe a great place to work	Outpatients Dept	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose ro	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose room. Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	25.10.11 Reviewed and closed by Connie Connolly	MOD	HOS
2943	07/04/2011	Provide safe, high quality careMake the best use of resources	Urology Clinic	Urology cancer pathway delays (also on CCS Divisional Risk Register ID 2942)	Patients on haematuria and prostate cancer pathways. Delays in first appointments, investigations and treatments. Patients with cancer being delayed in diagnostics and treatment pathways. Patients may be late diagnosed and have further advanced disease leading to poorer outcome. This may mean that a patient changes from potentially curative to palliative during the waiting period.	Identification of patients at risk ongoing. Detailing of capacity and demand ongoing to identify needed capacity and resources. Further reconfiguring of services required to support the change required in the service to reduce delays. Further resources required to support the volume of work within both cancer and non cancer urology work.	23.01.12 - one stop prostrate clinic is fully operational, hence no delays at present. See Risk 2942 10.11.11 We will update figures early December 2011 01.10.11 One stop prostate clinic commences 1 October 2011 and One stop Haematuria clinic commences 6 October 2011.	LOW	DIV
2968	21/04/2011	Provide safe, high quality care	4 South Surgical	Risk to staff and patients of the spread of HCAI due to condemned Bedpan Washer Ward 4 South	Condemned Bedpan Washer Ward 4 South. Risk of the spread of Health Care associated Infections [HCAI] to staff and patients. The Bedpan washer is broken and has been condemned on the Male side sluice room of Ward 4 South. This poses significant risk to the patient and the staff re: the spread of HCAI.	At present staff are using the Bedpan Washer on the Female side of the ward to decontaminate bedpans and urinals	A visit is taking place to another facility to view an HTM compliant bedpan washer in April 2011. As an interim measure a temporary Bedpan washer is being installed week commencing 13th June 2011	MOD	DIV
2990	19/05/2011	Provide safe, high quality care	Outpatients Dept	No hand washing facility in clinical Outpatient consultation rooms Room 63 and room adjacent	This risk assessment is being measured on the basis that currently these clinical rooms are being used by Speech and Language only. This specialty by its nature is non-invasive and does not traditionally create a high decontamination risks. If these rooms were to be allocated in the future to other specialties, the risk to the Trust would be substantially higher.** Staff and patients do not have access to any hand washing facilities in the clinical consultation room. Risk to Health and Safety- Risk of infection, cross infection and hospital acquired infection to patients. Risk to Health and Safety Risk of infection and cross infection to staff utilising this clinical area. Environment will not have access to timely cleaning as there is no water or washing/cleaning facilities available. Risk to Health and Safety - infection to staff, and patients. Risk of Litigation, secondary to hospital acquired infection. Risk of Loss of Reputation to Trust with hospital acquired infection rate. Risk of non compliance with RQIA recommendations	Cleansing wipes and alcohol jells are used in between patients and to wipe equipment Equipment cleansed at the end of clinics with soap and water from other clinical area.		LOW	DIV
2989	19/05/2011	Provide safe, high quality care	Outpatients Dept	Inappropriate flooring Consultation rooms not compliant with Health and Safety/Infection Control	Carpet flooring will need replaced with a washable surface. Risk of infection/injury to staff, patients and Clinicians. Risk of litigation to Trust secondary to Hospital Acquired Infection Unable to achieve waiting time targets regarding Outpatient Capacity. Risk of financial penalty for not meeting Outpatient Capacity and Demand.	Daily cleaning of carpet by domestic staff.	11/11/11 No progress with minor works, duplicate request sent to provide costs for all repair work Remains a risk. 14.11.11 Note link with Risk 2823	MOD	HOS
2998	31/05/2011	Provide safe, high quality care	Outpatients Dept	Unable to safely store sterile ENT equipment	Patients will not have access to a sterile nasopharyngeal scope, and appointment for examination will have to be rescheduled. This will directly result in a delay in diagnoses and an increased review backlog. Patients will not have timely access to sterile ENT nasopharyngeal scoped during ENT consultation. Patient at risk of delayed diagnoses. Risk of Hospital Acquired Infection. Risk of Litigation. Risk of Loss of Reputation secondary to RQIA non compliance. Risk of Loss of Reputation secondary to increased Review Backlog	Staff are currently supporting the Outpatient clinic and decontaminating equipment.		HIGH	DIV
3006	21/06/2011	Provide safe, high quality careBe a great place to work		Environmental works at 4 North, 4 South & 3 South wards pose threat to management of HCAI;compliance with fire and disability	Outstanding Environmental works at 4 North, 4 South and 3 South wards pose threat to management of HCAI;compliance with fire and disability regulations. Each of the wards have the following areas which need a minor works programme to include: Toilet facilities upgraded; Bathroom / shower facilities upgraded; Installation of sinks in bays; Painting and plastering; Various Ceiling tiles replaced; Nurses station to be upgraded; The facilitation of a waste room in 4N; Floor tiles.	All reasonable measures are in place at present; cleaning schedules; decluttering; good housekeeping practices.	01.08.12 - Programmed of works completed in 4 North and 4 South. Awaiting funding to commence 3 south. 19.06.12 - Programme of works completed 4 south, programme of works near completion 4 North, awaiting funding to commence 3 south. 17.04.12 - Programme of works has commenced in Wards 4 North and 4 South. 3 South no date as yet - awaiting funding. 23.01.12 - Funding has been approved and refurbishment programme commencing February 2012. 10.11.11 Funding has now been allocated and a workable program for dates is being progressed. 01.10.11 Awaiting costing from Estates for refurbishment have walked the wards. Awaiting feedback. Review July 2011	MOD	DIV
3027	08/09/2011	Safe, High Quality and Effective Care	Pre-Operative Assessment Clinic	PRE OP BAND 6 STAFFING	Patients are at risk of not receiving timely Pre-Operative Assessment by Band 6 POA Nurses Staff are at risk of overlooking patient management issues secondary to dramatic increase in workload Patients are at risk of delay in immediate pre-operative management re medicines management secondary to decrease in workforce. Decreased capacity to Pre Operatively assess patients 6 weeks in advance of surgery Increased risk of day of surgery cancellation or late cancellation secondary to insufficient pre-operative assessment Potential risk for theatre under-utilisation Potential for unnecessary use of staff resource on ward/unit due to unnecessary admission Potential for delay in patient treatment, patient distress, and disruption to patient work/home arrangements Potential for litigation to Trust re potential for delay in patient recovery due to insufficient pre-operative preparation	Patients with dates for admission have been made immediate priority All patients with dates for admission, needing Warfarin management, has been delegated to POA Project Leader Clinic templates have been adjusted to only include patients with dates for admission, and additional time has been allocated for processing results and managing queries Clinical Sister in CAH OPD has been supporting the Band 5/6 triage issues, and has been managing same All long term staff are being actively managed via Occupational Health Temporary replacement of Band 6 Sister has been provided with immediate effect .73 Wte All associated specialties and staff have been notified of temporary staffing issue	25.10.11 Reviewed and closed by Connie Connolly. 01.10.11 Situation should be resolved when full staffing in place by November 2011.	MOD	TEAM
3048	23/11/2011		Outpatients Dept	Portable suction within CAH ENT OPD now obsolete, and no longer fit for purpose	Patients are at risk of not receiving high quality examination secondary to poor visibility for the Clinician. Potential for increase in waiting times for patients secondary to the extended period of time being needed for examination-may result in delay in diagnoses. Clinician at risk of overlooking clinical finding due to poor visibility. Patient at risk of auditory damage if suction control is inadequate during examination. Potential for inconclusive examination secondary to poor visibility during examination. Potential for patient harm secondary to inadequate suction-may result in needing additional treatment.	Patient examinations have been prolonged to allow for inadequate suction.	22.11.11 Direct Nursing support during every examination during ENT Clinics.	MOD	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3069	23/01/2012	Safe, High Quality and Effective Care	Trustwide	Wards and Departments not meeting their mandatory requirements for Right Patient Right Blood training.	Risk of no staff or minimal staff at ward level who can competently erect and monitor a blood transfusion. Risk of harm to patient and loss of Trust reputation as well as confidence.	Close liaison with the Haemovigilance Practitioner. Additional inhouse training has been commissioned. Staff have been issued with desist notices if relevant. Patient Flow team are aware of issues and how to manage same if situation arises out of hours.	01/10/13: Situation improving; focus remains at ward level and the Training matrix is monitored closely. 29.03.13: Training matrix is monitored very closely; focus remains at ward level to ensure training is booked in advance of expiry dates. 01.03.13 - Focus remains at ward level to ensure training is booked in advance; position is improving. 01.02.13 - All mechanisms remain in place to monitor position. 07.01.13 - Processes and monitoring mechanisms remain in place. 29.11.12 - SEC position improved. Monitoring mechanisms in place to avoid recurrence.	LOW	DIV
3071	23/01/2012	Safe, High Quality and Effective Care	Trustwide	Risk of Point of Care Testing at Ward Level	Risk of staff not competent in use of machine and machine not maintained properly. Potentially inaccurate readings resulting in potential harm to patients, increased complaints and litigation.	Close liaison with laboratory staff, particularly Consultant Chemical Pathologist. Discussed with all Ward Sister to cascade to all staff the importance of quality control/cleaning/competency of users.	01/10/13: continue to monitor progress and address any issues that are identified by Laboratories. 29/03/13: continue to await roll out to all wards and departments 01.03.13 - Position remains unchanged. 01.02.13 - Continue to await roll out to all wards and department. 07.01.13 - All wards sisters in SEC have had awareness training. Pilot ongoing in CEAW, awaiting roll out of training via labs staff. 29.11.12 - In service training ongoing. Awareness increased and await outcome of pilot. 28.09.12 - A pilot in conjunction with the Laboratories is commencing at ward level to identify and address issues. 19.06.12 - Staff aware of responsibilities - ongoing work in relation to equipment and point of care testing at ward level. Plan to review in 2 months. 17.04.12 - All wards issued with folders in SEC containing list of all equipment and staff responsibilities. Ward Sisters to continue to reinforce same. 23.01.12 - discussed with all Ward Sisters to cascade to all staff the importance of quality control/cleaning/competency of users.	LOW	DIV
3184	17/08/2012		Fracture Clinic	Fracture Clinic Referral Waiting Times	Due to capacity problems the Fracture Clinic waiting times have the potential to increase significantly for new and review appointments.	Additional clinics are being organised where capacity allows and assistance being sought from other specialities/departments.	29.11.12 - Clinics up to date. 28.09.12 - Up to date at week ending 8 October 2012. However numbers have risen again. Assistance being sought for additional clinics.	HIGH	HOS
3193	06/09/2012		Trauma Ward	Isolation of Trauma and Orthopaedic Wards	Due to the location of the Trauma and Orthopaedic Ward especially in the Out of Hours Period this can result in isolation for staff and patients.	Staffing levels are always maintained at a safe level to ensure safe standards of care at all times; Handover of sick / ill patients forwarded to Patient Flow Team twice daily; Staff have access to a Site Manager and Clinical Co-Ordinator in the Out of hours Period; Staff have access to all grades of Medical Cover via the bleep and escalation policy.	28.09.12 - All measures are in place at all times to ensure safety of staff and patients - review on a 3 monthly basis.	MOD	HOS
3200	17/09/2012			Wards and Departments not meeting their mandatory requirements for Right Patient Right Blood training.	Risk of no staff or minimal staff at ward level who can competently erect and monitor a blood transfusion. Risk of delay and harm to patient; risk of loss of reputation of Trust.	Additional training sessions for theory in particular have been requested; awaiting assistance from Haemovigilance Practitioner and HSC Education Centre. Staff have been issued with desist notices if relevant. All Sisters are aware that staff may have to transfer to other wards / departments to assist. Patient Flow Team are also aware.			DIV
3208	27/09/2012		3 South CESU	Infection control risks due to poor shower and toilet facilities on Ward 3 South.	Threat to management of HCAI. Compliance with fire and disability regulations.	All reasonable measures are in place at present, cleaning schedules, decluttering and good housekeeping practices.	29/03/13: Meetings have taken place with Contractors regarding other Minor works programme and work will commence within two weeks. 01.03.13 - Minor works scheme commencing March 2013 to upgrade treatment rooms in the first instance. A project team has been established to plan for a full refurbishment of 3 South and the other areas 4North and 4 South; working progress. 01.02.13 - Programme of works to commence prior to March 2013. 07.01.13 - Await start date for approved programme of works. 29.11.12 - funding has been approved and refurbishment to commence in January 2013. 28.09.12 - bid for funding has been completed - awaiting update.	MOD	DIV
3209	27/09/2012		Outpatients Dept	Urology project cannot proceed without the decant of OPD blood room	Urology project will not be completed by 31 March 2013. Urology will not receive new accommodation. Risk of loss of capital funding due to project not commencing on time.	None.	01/10/13: works programme has commenced; awaiting completion 29.11.12 - works programme commenced November 2012. 28.09.12 - completion of estates minor works for rooms 16 and 17 to be adapted to accommodate decant.	VLOW	DIV

3210	27/09/2012		Outpatients Dept	Unable to provide full traceability and decontaminatino of Naso Pharyngeal scopes in SHSCT ENT and General OPD.	Risk of infection/injury to staff, patients and Clinicians Risk of litigation to Trust secondary to Hospital Acquired Infection and inability to trace scopes to patients. Unable to achieve waiting time targets regarding Outpatient Capacity- patient may need additional appointment for examination. Risk of financial penalty for not meeting Outpatient Capacity and Demand. Risk of RQIA non-compliance relating to the timing and decontamination of ENT Scopes and litigation Patients may not have access to decontaminated scope during assessment. Risk of litigation to Trust as scope decontamination process does not facilitate traceability	Scopes are cleaned by a variety of staff in CAH and STH without traceability. Insufficient staffing in CSSD for timely decontamination.	03.04.13: Funding has now been approved and recruitment is imminent. Re-training re Drying cabinet is commencing 8 April. 15 scopes awaiting asset tagging. 07.01.13 - Funding has been approved for ATICS to appoint Decontamination support. Retraining re dying cabinet has been arranged. SOP to be finalised 11 Jan 13 re OPD processes. Process to be implemented w/c 4 February 2013 29.11.12 - Standard operating procedures due to be completed by end November 2012. 28.09.12 - Meeting to take place with CSSD Manager and software company re needs and cost of compliance.	MOD	DIV
3211	27/09/2012		Outpatients Dept	CAH OPD environment in poor condition.	CAH OPD environment in poor condition- walls need painting/flaking paint needs removed and holes filled. Water stained ceiling tiles in examination rooms need replaced. Carpeted flooring which is worn and stained. Window blind fitting are worn and cannot be repaired- light is not being excluded. Non- compliance with Infection Control and Estates standards. Poor performance against RQIA standards-cleanliness inspections. Loss of reputation in relation to on-compliance Domestic services can no longer clean the aged and damaged surfaces. Risk of infection due to broken and flaking wall surfaces. Risk of infection due to stained/damaged ceiling tiles due to repeated water leaks. Risk of infection due to repeatedly stained carpet which can no longer be rejuvenated.	Regular and repeated cleaning by domestic services.	7 August 2013 Series of 8 emails since 4/11/12 to C Spiers re placement on the estates schedule. A Metcalfe has advised that the minor works budget is to be reviewed in Sept 2013. A Carroll to petition to have this work included in programme by 2014. this work has been outstanding since 2010 following RQIA inspection. 03.04.13: Works were costed and funding declined in March 2013. For consideration of works schedule for 2013/14. 07.01.13 - Series of 4 emails since 4 November 2012 to C Spiers re placement on the estates schedule. No reply as yet. This work has been outstanding since 2010 following RQIA inspection 29.11.12 - Re-requisitioned in September 2012, awaiting approval for commencement date. 28.09.12 - Submit minor works request with risk assessment to AD and Director of Acute Services. 03.09.12 ENT OPD works identified as priority for 2012/13 funding via HCAI Pgs10/11	VLOW	HOS
3299	31/12/2012		Anaesthetics, Theatres & Intensive Care Services	CAH Main Theatre Staffing Risk	Due to increase in sick leave/maternity leave within Main Theatres CAH, this has led to being unable to provide additionally with consequence risk to ENT and Urology access targets.	Avenues explored 1. Cross site working of all staff difficulties, can be stabilised through redeployment of staff nurse from Female Surgical to DPU. 2. Extra hours offered to all staff Trustwide -email to be re-circulated to al ward sisters. 3. Increased hours for parttime staff working within Trust across all sites. 4. Contacted staff on secondment. 5. Contacted staff on Maternity Leave for keeping in touch days. 6. Bank-unfortunately unable to provided the necessary number of requests. 7. Block bookings requested - staff starting who are only out of University and will be under 24 week preceptorship. 8. Staff moved from other areas to fill core sessions in CAH. 9. Excalated to line management.	28/3/19 to be closed and amalgamated with risk 3802. 4.10.18 Unsuccessful recruitment drive. Continue with cross site working bank, agency and inhouse additionality to cover gaps. 8.8.18 Interviewing 5 x Band 5 late Aug 18. After Belfast Telegraph recruitment ad. Use of agency and ODP staff in the departments. 12.6.8 Unchanged. Recruited only 1 theatre nurse from nursing recruitment fair. Presently trying to secure agency staff. 10.4.18, 28.02.18 Remains unchanged. 7.11.17 monthly staffing meeting with lead nurses identifying e-reqs established. Weekly theatre rota meetings ongoing to ensure cross site working. Bank and agency staff still employed to cover core sessions 30/5/17 - Theatre staff rota meeting offers cross site working. Bank, agency and additionality continue to cover core sessions. E-req has been completed for all vacant posts	LOW	HOS

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3300	07/01/2013	Safe, High Quality and Effective Care		Transfer or Patients to Independent Sector	There is a risk to the patients in terms of extended waiting times associated with the treatment and care with IS providers. There is associated risk of reputation to the Trust with the transfer of patients to IS Provider , there is a risk to the IS Team being able to deal with the volumes in the expected timeframes, financial risk to the Trust if Providers breach contract.	To minimise the risk we have set up regular governance meetings with the Providers, have robust contracts in place and monitoring of activity and performance by the IS team against these contracts.	12.5.16 - Funding for IS up to end of March 16, any pts left out in the IS are 'paused' awaiting further funding from HSCB. If the patients extend in house waiting times, to be brought back. 23.02.16 - Funding provided by HSCB for some surgical specialties , however the IS , while initially accepting volumes have had difficulty delivering the capacity originally offered. Senior management and HSCB aware of risks - HSCB provided funding for endoscopy patients to be treated by IS to reduce waiting times. Due to the downturn of the IS in December 2014, there is an ongoing risk that they may not be able to deliver the volumes required. Continue to have bi weekly meetings with ISP regarding contracts.		DIV
3377	21/03/2013		Outpatients Dept	Lack of Clinical Space to assess Ophthalmology patients and store new visual fields analyser and JAG laser.	Patients are at risk of delay in assessment and provision of care. Risk of cost of recalibration of new equipment due to inadequate storage space. Risk of litigation to the Trust in relation to delayed treatment.	Equipment currently unpacked on fallow floor in CAH - unable to use.	01.03.13 - close entry way behind reception desk in STH OPD. Create door way adjacent to clinical room 9. Discussions ongoing.	HIGH	DIV
3496	01/10/2013		Trustwide	Wards and Departments are not meeting mandatory requirements for Hyponatraemia Training due to unavailability of training dates.	Risk of having no staff, at ward level that can competently erect and monitor IV Fluids. Particularly in the 14-16year old age group. Risk of harm to patient and staff.	Close liaison with assistant director of Nursing Workforce development and training to secure additional dates from CEC.	01/10/13: Some dates have been organised awaiting confirmation of more. All ward sisters encouraged to prioritise.		DIV
3498	01/10/2013		Fracture Clinic	Fracture Clinic Referral waiting Times and waiting times for Fracture Theatre	Fracture Clinic referral times have increased significantly for new and review appointments. Risk of harm, to patients by unmanaged monitoring of condition in a timely manner. Potential of litigation and reputation, of Trust due to potential lack of adequate patient management.	Additional clinics are being organised where capacity allows and assistance being sought.	01/10/13: Increased provision of fracture clinics. Paper to HSCB highlighting the risk and requirement for additional funding to staff demand. Demand highlighted in IPT for expansion of T/O service within SHSCT.	MOD	HOS

Southern Health and Social Care Trust

Quality care – for you, with you

PERFORMANCE MANAGEMENT REPORT

Priority for Action
Standards and Targets

And

Key Corporate Performance Indicators

December 2009

Version	1.0 TB
Presented to Board of Directors	28/01/10
Author of report:	Dawn Livingstone
Presented by:	Paula Clarke

For information/approval

TO: **Board of Directors**

FROM: **Paula Clarke Acting Director of Performance & Reform**

DATE: **28 January 2010**

SUBJECT: **Monthly Performance Management Report**

PURPOSE

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance for Dec against:

- Priority for Action (PfA) 2009/10 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance

The report will highlight areas of risk for management action

SUMMARY OF KEY POINTS

Indicators highlighted as 'Red' status

- PFA: IP/DC, Outpatient & Diagnostic Access Target – Page 11
- PFA: Fractures – Page 12
- PFA: Renal dialysis via fistula – Page 16
- KPI: Unallocated Child Care Cases – Page 24

RECOMMENDATIONS

- The Trust is seeking to address in year and recurrent inpatient, daycase and outpatient capacity gaps and has made a number of bids to the HSCB to secure funding for the necessary investments. Formal decisions in respect of urology services will be subject to the outcome of the public consultation process on the Regional Review of Urology Services, due to end January 2010. In addition the Trust has highlighted risks to RHSCB regarding visiting /outreach consultant services for regional resolution.
- The Trust has been unable to re-instate a former visiting service from the Belfast Trust which undertook fistula work for dialysis services. Medical staff from the Trusts vascular team have now been trained to undertake fistula creation. High number of dialysis patients refuse to have a fistula inserted or, if the fistula failed, to have it redone. Further work is being commenced to fully understand the issues and how they could be addressed.
- Management actions taken to mitigate risk of unallocated child care cases and strengthen the system are detailed in additional reporting (Page 47)
- Management actions are being formulated by the Acute Directorate to address sustainability of performance against the fracture target.

WHICH TRUST CORPORATE OBJECTIVE DOES THIS PAPER PROGRESS OR CHALLENGE?			
Provide safe, high quality care.	*P*	Be a great place to work.	
Maximise independence and choice for our patients and clients.	*P*	Make the best use of resources.	*P*
Support people and communities to live healthy lives and improve their health and wellbeing.	*P*	Be a good social partner within our local communities.	

(Indicate which of our key strategic objectives are progressed (P) or challenged (C))

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
We will treat people fairly and with respect.	*P*	We will value and give recognition to staff and support their development to improve our care.	
We will be open and honest and act with integrity.	*P*	We will embrace change for the better.	*P*
We will put our patients, clients, carers and community at the heart of what we do.		We will listen and learn.	

(Indicate which of Trust values are progressed (P) or challenged (C)

RISKS, CONTROLS AND ASSURANCE	
Risk	Risks discussed at SMT on 20 Jan 10, management actions noted.
Control	P
Assurance	P

(Indicate if: (i) new risk identified or risk is addressed (ii) if this provides/will provide control or assurance)

REVIEWED BY:	Date
Senior Management Team	Date 20/01/10
User forums/Community groups whose views have been sought	
	Date

CONTENT

CONTEXT

This report forms part of the Trusts performance management framework and sets out a summary of Trust performance for December against:

- Priority for Action (PfA) 2009/10 Standards and Targets and
- Key Performance Indicators (KPIs) of corporate performance

The quarterly supplementary report on PFA targets, which are less intensively monitored, is attached for quarter ending 31 December 2000, see Appendix I.

Trust performance against the Service and Budget Agreement (SBA) 2009/10 agreed baseline volumes is attached for the period April-December 09, see Appendix III. **[REPORT TO BE TABLED AT TRUST BOARD MEETING]**

2. REPORTING

The PfA standards and targets and KPIs of corporate performance are presented in this performance report within the key domains defined within the performance management framework.

- Efficiency of Care Delivery
- Access & Targets
- Clinical and Social Care Quality
- Workforce – detailed reporting via HR & OD Directorate Report
- Finance – will be reported through the Monthly Finance Report

The level of performance will be assessed against each target/KPI as follows:

Assessed Level of Performance	
Target achieved/achievable or on track for achievement - No current risk	
Target partially achieved/achievable - Minimal Risk, management actions required to minimise risk	
Target not achieved/achievable - Risk, management actions required	
Performance not yet assessed	

Variation in performance from the previous month's position is indicated by the arrows: ⇔⇩⇧

Improvement towards the target indicated by: ⇧

Worsening performance from the target indicated by: ⇩

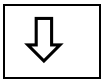
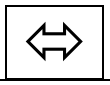
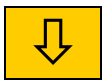
No significant change in performance indicated by: ⇔

3 SUMMARY REPORT

3.1 DOMAIN: EFFICIENCY

Target/Indicator	Baseline	Target	Actual		Comments
PFA Diagnostic Reporting From April 2009 -all urgent tests reported within 2 days -75% of routine within 2 weeks -100% of routine within 4 weeks (Target rolled over from 2008/09)	**Sept 08** **(Imaging & Non-Imaging)** **26%** **77.9%** **89.3%**	**Apr 09** **100%** **75%** **100%**	**Dec 09** **86%** **(Imaging)** **48%** **(Non-imaging)** **84%** **(Imaging)** **92%** **(Non-imaging)** **92%** **(Imaging)** **97%** **(Non-imaging)**	⇧ ⇧ ⇧	Progress has been made in respect of performance against this target since monitoring began in Sept 08. Some risk with the ability to achieve this target recurrently prior to implementation of NIPACS (estimated implementation commencement within SHSCT - March 10).
PFA 4.4 Timely Hospital Discharge From April 2009, -90% complex discharges within 48 hours -no. complex discharge will take longer than seven days -all other patients should be discharged within six hours Target rolled over from 2008/09	**Mar 08** **98.6%** **0** **96.3%**	**Mar 10** **90%** **0** **100%**	**Dec 09** **93%** **(71/76)** **NI Ave: 86%** **0** **96.1%** **(2385/2481)** **NI Ave:96%**	⇩ ⇔ ⇔	The Trust continues to sustain the target for complex discharges and perform well against the regional average. 'Simple' discharges comparable with the regional average.

PFA Priority Area 6- Mental Health Hospital Discharge By March 2009, - 75% of admissions discharged < 7days -all other patients discharges being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09	**Sept 08** **96%** **0**	**Mar 09** **75%** **0**	**Dec 09** **100%** **(127/127)** **0**	⇧ ⇔	
PSA 6.1 Mental Health Unplanned Admissions -By March 2010; reduce the number of admissions to mental health hospitals by 5% Target rolled over from 2008/09	**Mar 08** **1196** **Annual Admissions**	**Mar 10** **1136** **Ave Monthly admissions should not exceed 95**	**Dec 09** **77** **Projected admissions extrapolated to 1075 at year end**	⇧	
PFA Priority Area 7 Learning Dis: Hospital Discharge By March 2010, - 75% of admissions discharged < 7days -all other patients discharged being discharged within max 90 days. (Number shown is in excess of 90 days) Target rolled over from 2008/09 (This monitoring	**Nov 07 – Mar 08** **cumulative** **66%** **0**	**Mar 10** **75%** **0**	**Dec 09** **75%** **(3/4)** **0**	⇩ ⇔	At the end of Dec there were 6 current inpatients deemed medically fit not yet discharged. All six are waiting over 90 days. Delays are associated with complexity of requirements with specific difficulties in identifying

excludes current inpatients) - all patients discharged to receive continuing care plan to receive visit within 7 days	**Baseline to be established**		**Monitoring not in place**		appropriate community resettlement places for these individuals.
KPI ALOS Episodic Average Length of Stay for Elective and Non Elective Admissions to Hospital	**Process Average 2008/09** **5.5 Non-elective** **1.16 Elective**	**To be agreed**	**Dec 09** **4.66 Non-elective** **1.09 Elective**	 	The average LoS for elective episodes in Dec is below the process average of 08/09.
KPI: OP DNA % patients who 'Did not attend' an OP appointment and did not advise the hospital in advance. PMSID have indicated a potential target for this area may be set, initial considerations are 5% for new patients and 8% for review patients.	**Process Average 2008/09** **7.5%** **5.6%** **7.5%**	**Benchmark** **8.6%** **(English National Average)**	**Dec 09** **10.2% Total** **(Trust Avg. Apr-Dec 9.6%)** **8.2% New patients** **11% Review patients**		
PFA -Day Case Rate By March 2011, all Trusts are required to achieve an overall day surgery rate of not less than 75% for the 'basket' of 24 procedures	**Baseline SHSCT 2007/08** **55.6%** **2008/09 (Basket of 24)** **59.5%**	**Target March 11** **75%**	**April-Nov 09** **Cumulative** **63.3%** **(coding level 82.2% therefore % subject to change)**		The Trust submitted its local day surgery improvement plan in May as required. Actions are now being progressed. (Detailed reporting by procedure

					included in Appendix II)
KPI : % Discharges Coded -cumulative coding position	**March 2008/09** **- 98.4%**	**Target** **100%**	**April – 6 Dec 09** **80.5%**	⇩	Performance decreased in December 2009 due to annual leave and high levels of sickness in the coding department
KPI Freedom of Information (FOI) % requests responded to within 20 days	**SHSCT Baseline 2008** **87.5%** **(Regional range 50% - 95%)**	**Target** **100%**	**Nov 09** **57%** **(8/14 requests – responded to within 20 day limit)**	⇩	To allow for the 20 day time lag this position is being report a month in arrears.
KPI Staff Access to Intranet Number of staff as a percentage of the total Trust staffing complement, who have access to the Trust Intranet	**SHSCT Baseline March 2009** **55.72%**	**Internal Target** **55%**	**Dec 09** **69.9%**	⇔	This target has been achieved.
KPI IT Helpdesk response Calls received by IT Service Desk resolved on first contact. This will be measured against the baseline at March 2009	**SHSCT Baseline March 2009** **6.61%**	**Target** **33%**	**Dec 09** **20.7%**	⇩	Temporary capacity gap in trained staff available is impacting on achievement of this target.

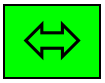
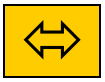
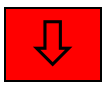
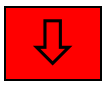
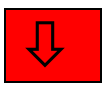
KPI Partial Booking of OP Appointments **%** Consultant led New and Review Appointments partially booked (Excs. Obstetrics) **%** Community led New and Review Appointments partially booked	**March 08** **94.1% (New)** **72% (Review)** **54.8% (New)** **4% (Review)**	**Target Sept 08** **100%**	**Dec 09** **96.5% (New)** **88% (Review)** **84.5% (New)** **42% (Review)**	⇔	Appointments for all hospital sites within SHSCT have now been consolidated into the new centralized appointments booking centre.
KPI – Complaints 72% of complaints responded to within 20 working days	**March 08** **65.6%**	**Target** **72%**	**Nov 09** **86%** **(57/66)**	⇧	To allow for the 20 day time lag this position is being report a month in arrears.

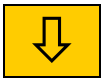
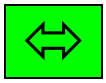
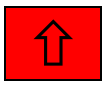
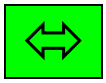
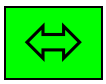
New targets for which monitoring arrangements have yet to be established

PFA 4.1 Unplanned Admissions
By March 2010 50% of unplanned hospital admissions related to exacerbation of severe chronic conditions are reduced.

SHSCT submit a return monthly to PMSID on the numbers who have commenced case management. A workshop was held on early Jan to collection and recording processes and the Trust is now awaiting feedback on definitions and peer comparison.

3.2 DOMAIN: ACCESS & TARGETS

Target/Indicator	Baseline	Target	Actual		Comments
PFA 3.1: Waiting Time Arthritis Drug Therapies By March 2010, no patients should wait longer than 9 months to commence specialist drug therapies for treatment of severe arthritis, By March 2011 – 21 weeks Target increased from 2008/09	**Mar 09 for 9 month position** **n/a** **Mar 08 for 21 week position** 18	**Mar 10** **0** **Mar 11** 0	**Dec 09** **0** **Dec 09** 11 (patient s waiting over 21 weeks)	 	The 9 month target has been achieved. The trust is now working towards the achievement of the 21 week target.
PFA 3.2 IP/DC, OP & Diagnostic Access Targets By March 2010, no patient will wait longer than -9 weeks for a first OP appointment, -9 weeks for a diagnostic test, and -13 weeks for IP/DC treatment Standard rolled over from 2008/09 The 9/9/13 week 08/09 target must be sustained month on month in 2009/10.	**Mar 08 (No. of patients waiting)** **OP: 1624** **Diag: 188** **IP/DC: 1614**	**Mar 10** **OP: 0** **Diag: 0** **IP/DC: 0**	**31 Dec 09** **OP 92 breaches** **Diag: 8 breaches** **IP/DC: 115 breaches**	  	92 Outpatients breached - 1 ENT 1 General Medicine, 39 Oral Surgery, 1 Thoracic Surgery, 34 Orthopaedic, 16 Urology. 8 Diagnostics breached - All Urodynamics. 115 Inpatient/ Daycases breached - 35 T&O, 80 Urology. See additional reporting.

PFA AHP Access By March 2010 -no patients should waiter longer than 9 weeks from referral to commencement of AHP treatment. -the 13 week target achieved in March 09 should be sustained Target increased from 2008/09	**Mar 09** **322** **0**	**Mar 10** **0** **0**	**4 Jan 10** **733** **0**	 	The 13 week position has been sustained. All areas are working to achieve a 9 week position by the end of February.
PFA Fractures -By March 2010, 95% of patients will wait no longer than 48 hours for inpatient fracture treatment. - no patient should wait longer than 7 days for treatment Target rolled over from 2008/09	**Mar 09** **75.6%** **0**	**Mar 09** **95%** **0**	**Dec 09** **75%** **(36/48)** **NI Ave 75%** **0**		Trust performance increased again in December.
PFA Cancer By March 2009, - 98% of cancer patients will commence treatment within 31 days and -95% of patients urgently referred with suspected cancer will begin treatment within 62 days -all urgent GP referrals for breast cancer are seen in 14 days and Target rolled over from 2008/09	**Mar 08** **99%** **96%** **100%**	**Mar 09** **98%** **95%** **100%**	**Dec 09** **Position As at Nov 09** **100%** **(83/83)** **95%** **(32/34)** **100%**	  	Due to the 31 and 62 day time lag these targets are reported retrospectively.

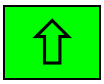
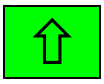
PFA A&E Access From April 2009, 95% of patients treated & discharged or admitted within 4 hrs Standard rolled over from 2008/09	**Mar 08** **SHSCT 95.2%** **CAH 92.9%** **DHH 97.1%**	**Mar 09** **SHSCT 95%** **CAH 95%** **DHH 95%**	**Dec 09** **SHSCT 91%** **CAH 86.6%** **DHH 95%**	⇩ ⇩ ⇩	The drop in performance on the CAH site is largely due to high bed occupancy and patients awaiting admission. The Trusts 4 hr Project Team are meeting fortnightly to review issues impacting on performance
PFA 4.2 Care of Older People From April 2009, -no older person with continuing care needs will wait more than eight weeks for a completed assessment, -with the main components of care met within a further 12 weeks Standard rolled over from 2008/09	**Mar 08** **99.2%** **100%**	**Mar 09** **100%** **100%**	**Dec 09** **100%** **100%**	⇔ ⇔	The Trust continues to sustain this target.
PSA 5.3 Care leavers By March 2010, ensure that at least 70% of care leavers aged 19 are in education, training or employment Revised target	**Mar 09** **36** **Care leavers** **33 (92%)** **In ETE**	**Mar 10** **-** **46**	**Dec 09** **35** **Care leavers** **20 (57%)** **In ETE**	⇔	

PSA 5.4: Care leavers By March 2010 increase to 175 the number of care leavers aged 18-20 living with their former foster carers or supported family Revised target	**Mar 09** **27** **(End of Month position)**	**Mar 10** **33**	**Dec 09** **31** **(29 in Nov)**	⇧	
PSA 6.3 M Health Assessment and Treatment By March 2010 -ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health, excluding psychological therapies, Target increased from 2008/09 -pyschological therapies to sustain 13 week maximum wait Target rolled over from 2008/09	**Mar 09** **26** **Mar 08** **94**	**Mar 10** **0** **0**	**2 Jan 09** **62** **(No. on PTL over 9 weeks)** **0**	⇧ ⇔	The division have a cutting plan in place to meet the 9 week target by the end of January 2010. This target position is being sustained.
PSA 7.3 Specialised Wheelchairs By March 2010 - ensure an 18 week maximum waiting time for 90% of all wheelchairs New target	**31 Jul 09** **90%**	**Mar 10** **90%**	**Dec 09** **92%** **(10/130 waiting over 18 weeks)**	⇔	
PFA – Autism By March 2010 -ensure that all children wait no longer than 13 weeks for	**31 Jul 09** **0**	**Mar 10** **0**	**31 Dec 09** **0**	⇔	This target has been achieved

assessment, and - a further 13 weeks for commencement of specialist treatment New target	**0**	**0**	**0**	⇔	
PFA – Acquired Brain Injury By March 2010, -ensure a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment New target	**31 Jul 09** **0**	**Target Mar 10** **0**	**31 Dec 09** **0**	⇔	This target has been achieved.
PFA 7–Housing Adaptations (Major Housing Adaptations) By March 2010 -all lifts/ceiling track hoists to be installed within 22 week of OT assessment/ option appraisal **(Minor Housing Adaptations)** By March 2010 - all minor urgent works to be completed within 10 days - New target	**31 Oct 09** **92.3%**	**Target Mar 10** **100%**	**31 Dec 09** **73.3% (4/15 >22 weeks)**	⇩	Formal regional monitoring of this new target by HSCB commenced will commence in January for M/E December 09

3.3 DOMAIN: CLINICAL AND SOCIAL CARE QUALITY

Target/Indicator	Baseline	Target	Actual		Comments
PFA - HCAI In the year to, by March 2010, ensure a -35% reduction in the number of hospital patients with staphylococcus aureus (MSSA) bloodstream infections (including MRSA), and a -35% reduction in cases of clostridium difficile infections compared to 2007/08 Target increased	**2007/08** **MRSA 14** Episodes **MSSA 46** Episodes **C Diff 134** Episodes	**Mar 10** **MRSA 9** Episodes (Ave <1 p/mt) **MSSA 30** Episodes (Ave 2 p/mt) **C Diff 87** Episodes (Ave 7 p/mt)	**Dec 09** **MRSA/ 0** Episode (11 episodes cumulatively Apr–Dec) **MSSA 2** (33 episodes cumulatively Apr-Dec) **C Diff 1** Episodes (36 episodes cumulatively Apr-Dec)	⇧ ⇧ ⇧	Additional reporting on Healthcare Associated Infection is included in section 4.0.
PSA 3.6 Renal By March 2010, -at least 60% of patients should receive dialysis via a fistula Target increased	**Mar 09** **36.8%**	**Mar 10** **60%**	**Dec 09** **36%** **(38/105)**	⇧	This target continues to be at risk.
PFA 4.1 Community Care By March 2010 -45% of people in care management have their assessed care needs met in a domiciliary setting. Target increased	**Mar 08** **43.7%**	**Mar 10** **45%**	**Dec 09** **45.9%** **(1750 people)**	⇧	This target has been achieved.

PFA 4 – Direct Payments By March 2010, -number of direct payment cases increases to 1,250 Target increased	**Mar 09** **361**	**Mar 10** **241 (SHSCT target)**	**Dec 09** **471**		This target is achieved. The number of direct payments continues to increase month on month.
PFA Family Group Conferences During 2009/10 -ensure that at least 500 cyp whose assessed need is on levels 1,2 or 3 of the Hardiker model have participated in a FGC. Target rolled over from 2008/09	**2008/09** **58**	**Mar 10** **96** **(Ave 8 per month)**	**Dec 09** **18** **(87 Apr -Nov)**		This target has been achieved with 105 children seen to date (April-Dec).

PSA 5.2 Family support interventions By March 2010 -provide family support interventions to 2000 children in vulnerable families each yearNew Target	**Oct 08 – March 09** **153** **306** **Extrapolated for full year**	**Mar 10** **384** **(Ave 32 per month)**	**Dec 09** **313** **(cumulative position)** **(Ave 35 per month)** **(Nov Cumulative 272)**	⇧	This target extrapolated to full year is on track.
PFA 5.3 - Foster Carers By March 2010, - increase foster carers by 300 (NI target) from the March 2006 total	**Mar 06** **217**	**Mar 10** **275**	**Dec 09** **290**	⇩	This target has been met. The number of Foster Carers fluctuates month on month, showing decreases over the last two months.
PSA 5.1 - Children in Care By March 10 90% of children admitted to residential care prior to admission should -have had formal assessment & placement matched through Children's Resources Panel -Every child taken into care should have a	**Baseline Q1 09** **67%** **Baseline not available**	**Target Mar 10** **90%**	**Dec 09** **60%** **(3/5 child)** **(Q1 average position Apr-June 67%)** **(Q2 average position July-Sept 57%)** **Monitoring not available**	⇩	This target position is subject to variation due to the small number of children involved, therefore a Quarterly average position will be referenced. Cumulative performance April-Dec = 68% (17/25)

plan for permanence and timescale agreed within six months New Target					
PSA 6.2 M Health Resettlement By March 2010, -resettle 60 patients from hospital to appropriate community places from March 2006 position. Target Rolled over from 2008/09	**2006/07** **0** **2007/08** **6** **2008/09** **14** **Cumulative Position**	**Mar 10** **12** **(cumulatively - achieved in 2008/09)**	**Apr - Dec 09** **5 (includes resettlements commenced)** **19 Cumulative Position**	⇧	PMSID reporting is now in-year (09/10) and not cumulative performance. Trust achieved target in 2008/09.
PSA 7.1 Learning Disability Resettlement By March 2010 -resettle 90 learning disability patients from hospital to appropriate places in community from March 2006 position. Target rolled over from 2008/09	**Mar 07** **0** **2008/09** **18** **Cumulative Position**	**Mar 10** **17**	**Apr- Dec 09** **4 (includes resettlements commenced)** **22 Cumulative Position**	⇔	PMSID reporting is now focused on in-year resettlement and not cumulatively.

Surgical Site infections(SSI) Bundle compliance rate -orthopaedics (all elective hips & knees **SSI rate** (Hips only) **Bundle Compliance rate** -Caesarean Section (audit of 20 cases per month **SSI Rate** (C-section) Monitoring rolled over from 2008/09	**Oct 08** **15%** **Q2 2008** **0%** **CAH** **5%** **DHH** **5.26%** **Q2 2008** **CAH** **9.2%** **DHH** **19.2%**	**Mar 09** **95%** **-** **95%** **95%** **25% reduction on Q4 2008 SSI Rate** (as of Feb 09) – **Target 14.21%** (NI Average 14.5%)	**Dec 09** **78.57%** **Q3 2009** **0%** (NI Ave: 0.90%) **88%** **79.17%** **Q3 2009** **CAH** **7.2%** **DHH** **1.4%** (NI Ave: 11.2%)	⇩ ⇔ ⇧ ⇧ ⇧ ⇧	The NI Safety Forum is seeking to standardise how all Trusts measure the Bundle Elements. This may have an impact on overall Bundle Compliance in the months ahead until any new practices are embedded successfully. SSI Infection rates, available as a quarterly position, are now included in reporting.
Central Line Infections -Infection Rate per 1000 line days **-Compliance with bundle** Monitoring rolled over from 2008/09	**Oct 08** **CAH** **3%** **DHH** **3%** **CAH** **30%** **DHH** **0%**	**1.17%** **1.17%** **95%** **95%**	**Dec 09** **0** **0** **60%** **50%**	⇔ ⇔ ⇩ ⇩	This quality improvement target measures the number of central line catheter-related bloodstream infections Measurement reflects all Central Lines at CAH & DHH and compliance with the care bundle elements.
Ventilator	**Oct 08**	**Mar 10**	**Dec 09**		This QIP aims