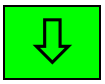
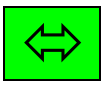
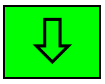
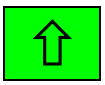
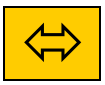
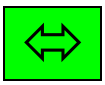
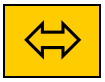
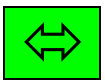
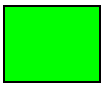
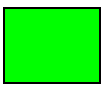
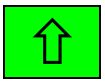
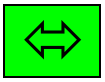
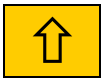
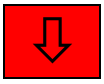
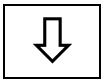
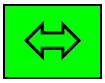
Acquired Pneumonia (VAP) - Ventilator days between infections - Compliance with bundle Monitoring rolled over from 2008/09	**517** **100%**	**300** **95%**	**179** **(Cum days between infections 558)** **100%**	 	to achieve 95% compliance with all bundle elements in ICU in CAH. The Trust has previously met the regional target of 300 Vent Days between infections in 09/10 (558 days free of infections).
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	**Dec 09** **CAH 3.33 per 1000** **DHH 1.33 per 1000** **(NI Range 0 – 7.5)**	 	This QIP target is focused on reducing crash calls in A&E, ICU and coronary care. CAH is experiencing a similar peak to last year.
MEWS Modified Early Warning Scoring System	**Sept 09** **CAH 94.44%** **DHH 100%** **Trust Ave 85.79%**	**Mar 10** **95%**	**Dec 09** **CAH 91%** **(59/65)** **DHH 89%** **(31/35)** **Trust Ave 89.99%** **Non-Acute Sites 90%** **(27/30)**	  	MEWS is the modified early warning scoring system which is a tool to support clinical staff assess patient progress via recording of key observational data to aid decision making This was piloted in two wards and has

					been rolled out Trust wide in September 2009. The Trust will strive to meet the 95% target.
Mental Health Indicators -%compliance with multi-disciplinary review -%compliance with risk assessment -%compliance with patient/carer involvement in TP	**Oct 08** **CAH 79%** **SLH 67%** **CAH 63%** **SLH 17%** **CAH 88%** **SLH 100%**	**Mar 09** **100%** **100%** **100%**	**Dec 09** **CAH 100%** **SLH 100%** **CAH 83%** **SLH 80%** **CAH 100%** **SLH 100%**	  	These QIP 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
KPI - Crude Mortality Rate Deaths as a percentage of total hospital deaths and discharges	**Peer Average** **2007/08 1.98%** **2008/09 1.92%** **Apr – Aug 09 1.72%**	**Target**	**SHSCT** **2007/08 1.22%** **2008/09 1.18%** **Apr – Nov 09** **1.11%**		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.
KPI – Re-admission rate Discharges from the Trust that are re-admitted to the Trust again within 28 days	**Peer Average 2007/08 6.5%** **2008/09 6.7%** **Apr-Aug**	**Target**	**SHSCT** **2007/08 5.3%** **2008/09 5.4%** **Apr –**		The re-admission rate provided shows the Trust average against a peer group of District General Hospitals. This

as a percentage of total discharges	**09** **5.8%**		**Nov 09** **4.6%**		has been extracted from the 'CHKS' benchmarking tool. See additional reporting.
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%**	**Dec 09** **DHH** **93%** **STH** **92%** **CAH** **94%**		The Trust averaged 93% on this weighted score for all risk categories. Additional reported included.
KPI – Looked After children Number who received no visit	**Mar 08** **6**	**Target** **0**	**Dec 09** **0**		

KPI – Child Protection Registrar Number of children on CPR over 2 years	**QE Mar 09** **7.4%** **(31/420)**	**Target** **To be established**	**Dec 09** **7.6%** **(34/449)**		Target to be defined further to enable establishment of this monthly monitoring.
KPI – Unallocated Child Care Cases	**Apr 08** **37** **Apr 09** **119**	**Target** **0**	**Dec 09** **91** **(64 in Sept)**		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%**	**Dec 09** **80%**		Trust average year to date is 81% Regional comparators are not yet available.
Priority 5 (Target 7) PFA – Assessment of Children at Risk From April 2009 -all Child protection referrals should be allocated within 24 hours of receipt By March 2010, -90% of family support referrals should be allocated to a social worker within 20 days for initial assessment -post assessment 90% of cases		**Mar 10** **100%** **90%** **(initial assessment)** **90%** **(post assessment)**	**Dec 10** **100%** **(28/28)** **91 %** **(160/175)** **TBC**		Newly established targets – definitions are currently being refined – performance against target to be confirmed for some aspects of target.

requiring family support pathway assessment allocated within further 20 working days with :initial assessment completed within 10 days & :pathway assessment completed within 20 days		**10 days** **(initial)** **20 days** **(pathway)**	**TBC** **TBC**	☐ ☐	

New targets for which monitoring arrangements have yet to be 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

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%**	**Nov 09** **5.21%**	⇔	

4.0 Analysis, Additional information and Exception reporting by Domain

4.1 Access & Targets

- IP/DC/OP
- Fracture
- Renal

Appendix I - Quarterly PFA Supplementary Report
Appendix II - Daycase rates by Procedure
Appendix III - SBA Report **[to SMT 27th Jan 10] TO BE TABLED AT TB**

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
    - o Unallocated Child Care Cases
- Re-admission Rates with Peer comparison
- Mortality Rates with Peer comparison

Appendix IV (Environmental Cleanliness Report)

4.1 Access & Targets

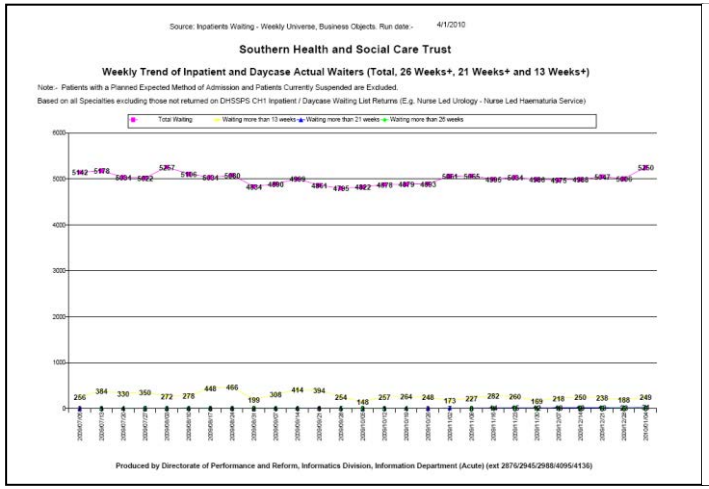
Elective access targets: The Table below shows the month end waiting list position for Inpatient, Day Case, Outpatient Services and Diagnostics.

Inpatients and Daycases (IP/DC) / Outpatients	Waiting List		Waiting List		% Variance	
	WL at 31/03/09		WL at 31/12/09			
	Inpatients and Day Cases	Outpatients	Inpatients and Day Cases	Outpatients	Inpatients and Day Cases	Outpatients
Total Waiting	4,711	11,026	4,912	10,243	4.3%	-7.1%
IP/DC waiting 13 weeks+	0	-	115	-	-	-
OP waiting 9 weeks+	-	3	-	92	-	2966.7%

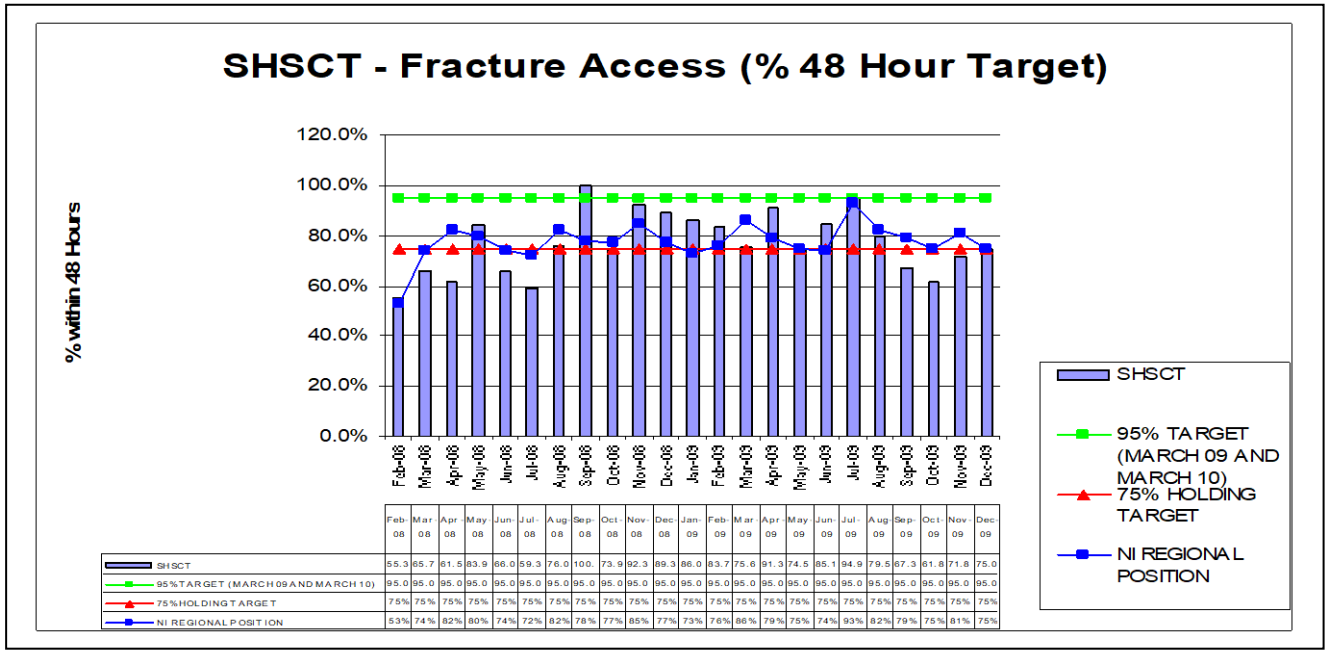
Notes

OP Waiting 9 weeks+ at 31/03/09 excludes outpatient specialties recorded manually (i.e. Adjustments for Community Paediatrics not on PAS, CAHMs and Autism)

Diagnostics	Imaging			Physiological Measurement		
	WL at 31/03/09	WL at 31/12/09		WL at 31/03/09	WL at 31/12/09	
Total Waiting	4,027	3,669	-8.9%	1,238	1,219	-1.5%
Number waiting 13 weeks +	0	0	-	4	0	-
Number waiting 9 weeks +	0	0	-	4	8	100.0%

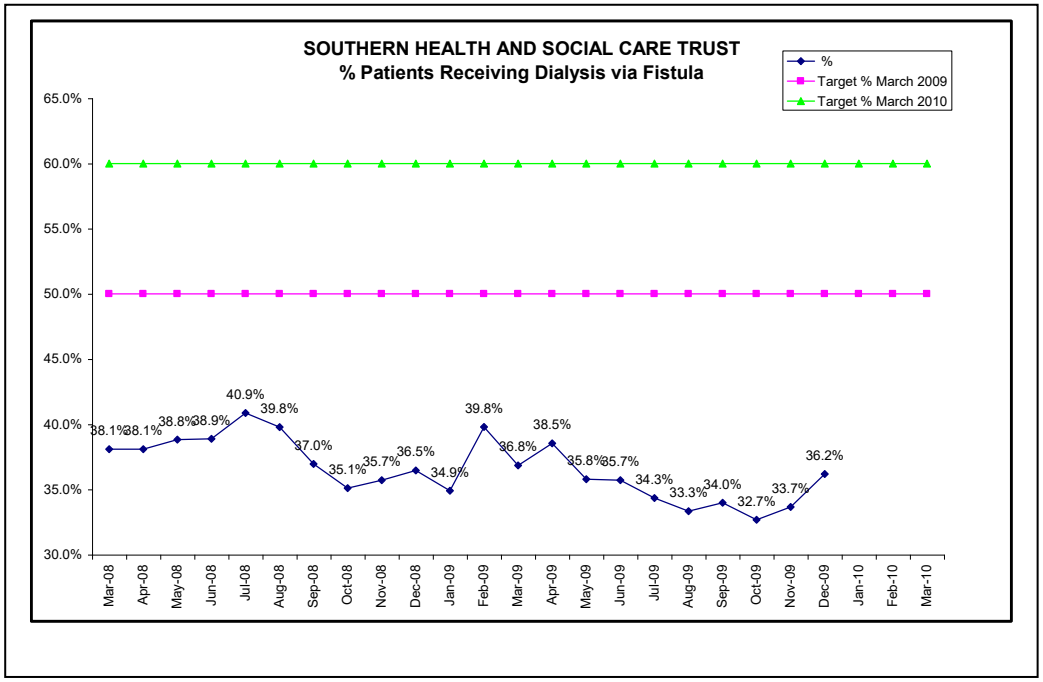


Fractures: Until recurrent investment is secured for a 6 consultant model that enables weekend fracture lists to be delivered 52 weeks of the year, this target remains at risk. A business case has been submitted and is under discussion with the commissioner. In the interim analysis is underway to review demand for routine, urgent and sub specialist work.



	Feb-08	Mar-08	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
SHSCT	55.3	65.7	61.5	83.9	66.0	59.3	76.0	100.	73.9	92.3	89.3	86.0	83.7	75.6	91.3	74.5	85.1	94.9	79.5	67.3	61.8	71.8	75.0
95%TARGET (MARCH 09 AND MARCH 10)	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0
75%HOLDING TARGET	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
NI REGIONAL POSITION	53%	74%	82%	80%	74%	72%	82%	78%	77%	85%	77%	73%	76%	86%	79%	75%	74%	93%	82%	79%	75%	81%	75%

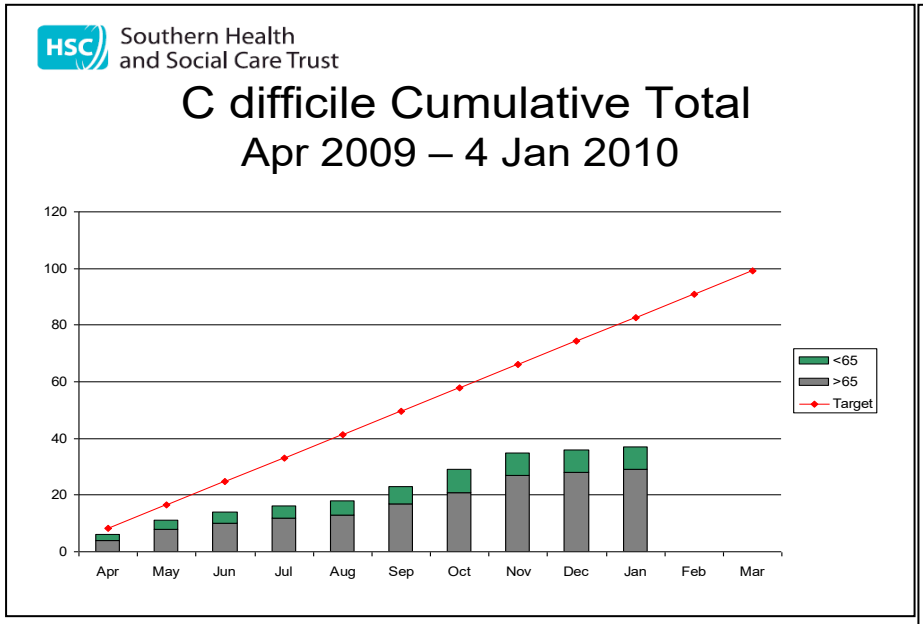
Renal – dialysis via fistula: This target is unlikely to be achieved in year due to the withdrawal of the visiting service from BHSCT. Local surgeons have been trained to undertaken this procedure. The ability to achieve the target is reliant on the uptake of the current patient cohort.



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.



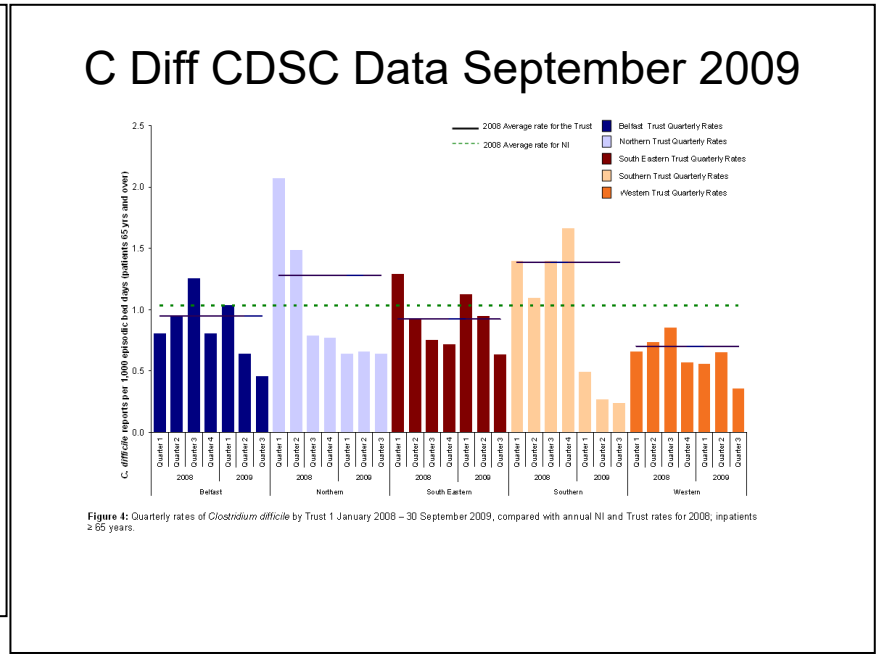
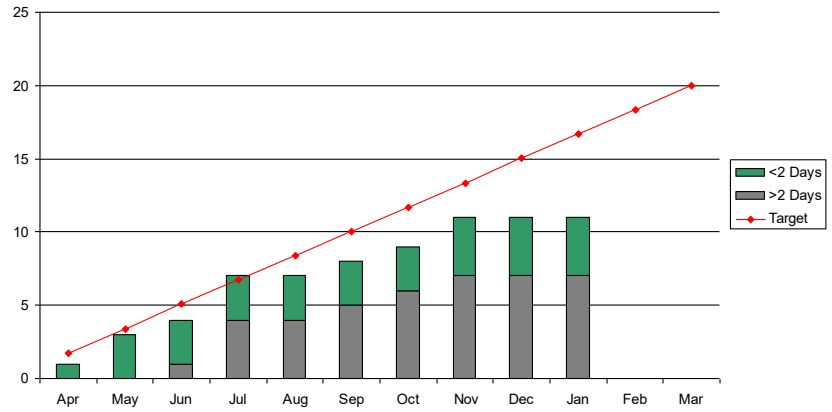


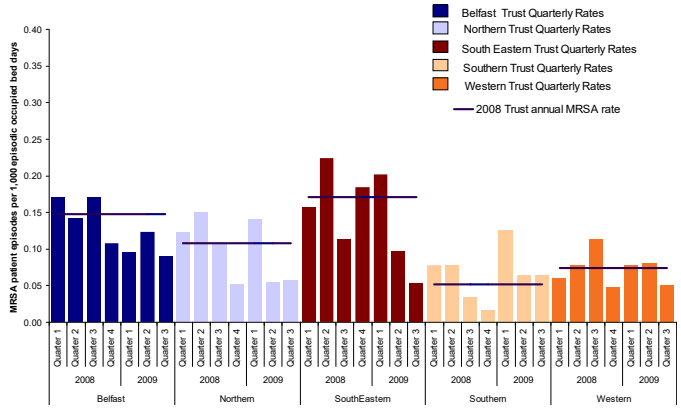
Figure 4: Quarterly rates of *Clostridium difficile* by Trust 1 January 2008 – 30 September 2009, compared with annual NI and Trust rates for 2008; inpatients ≥ 65 years.

Southern Health and Social Care Trust

MRSA Cumulative Total
Apr 2009 – 4 Jan 2010

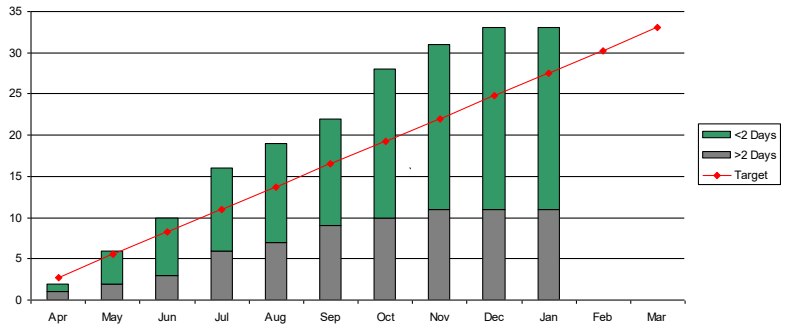


MRSA CDSC Data September 2009



Southern Health and Social Care Trust

MSSA Cumulative Total
Apr 2009 – 4 Jan 2010



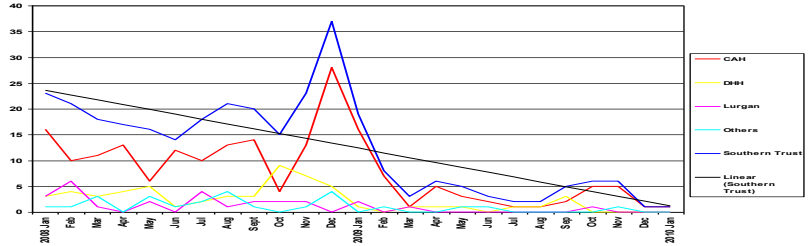
6

C Diff Analysis

Southern Health and Social Care Trust

C difficile

Jan 2008 – 4 January 2010



1

Southern Health and Social Care Trust

Last Case of C diff

As of 4th January 2010

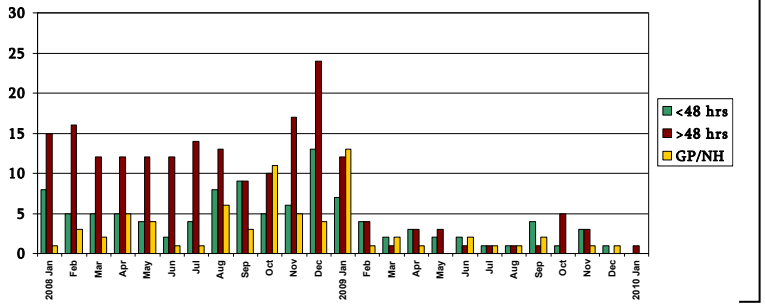
Hospital	Last Date	Days
CAH	02/01/2010	2
DHH	25/09/2009	101
LGH	22/10/2009	74
STH	06/11/2009	59
MUL	30/06/2009	188
SLH	22/05/2009	227

7

Southern Health and Social Care Trust

New cases of C diff

Jan 2008 – 4 January 2010

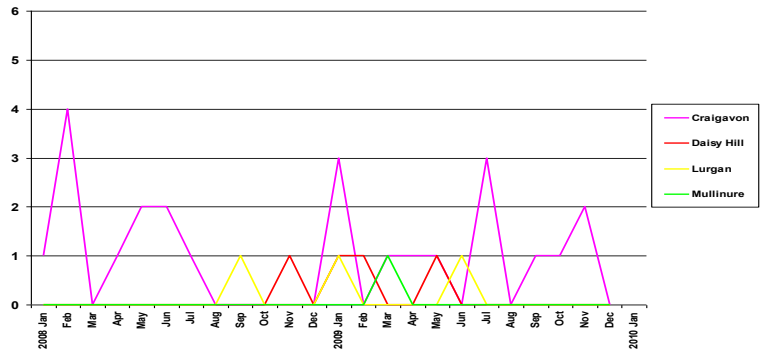


6

MRSA Analysis

Southern Health and Social Care Trust

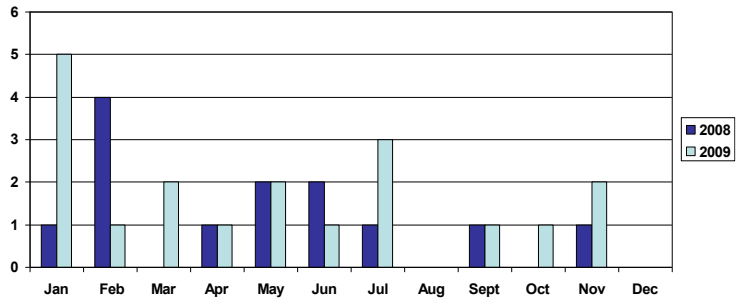
MRSA
Jan 2008 – 4 Jan 2010



1

Southern Health and Social Care Trust

New cases of MRSA
Jan 2008 – 4 Jan 2010

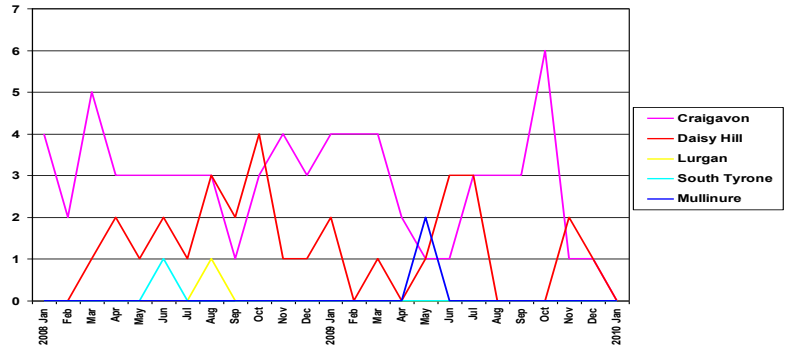


3

MSSA Analysis

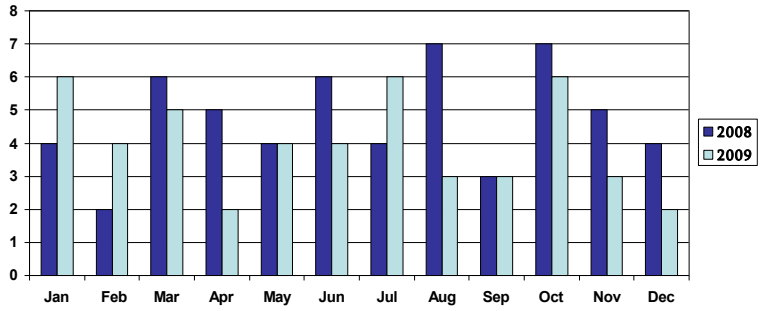
Southern Health and Social Care Trust

MSSA
Jan 2008 – 4 Jan 2010



Southern Health and Social Care Trust

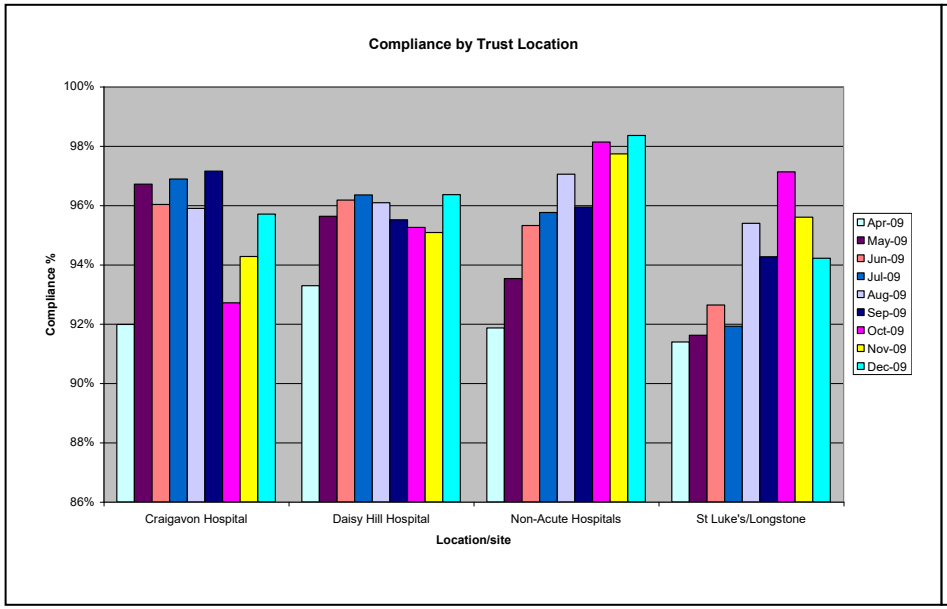
New cases of MSSA
Jan 2008 – Dec 2009

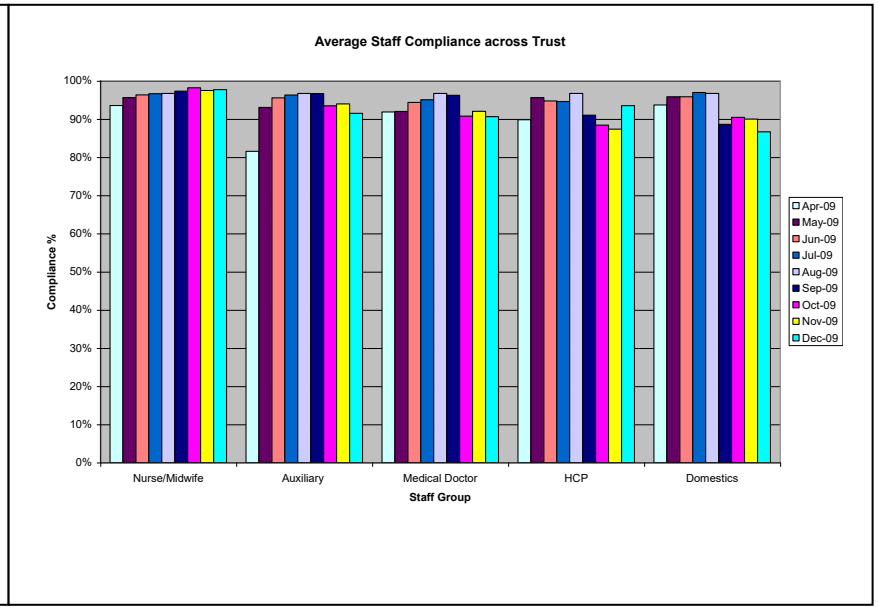


3

Hand Hygiene Compliance Audits

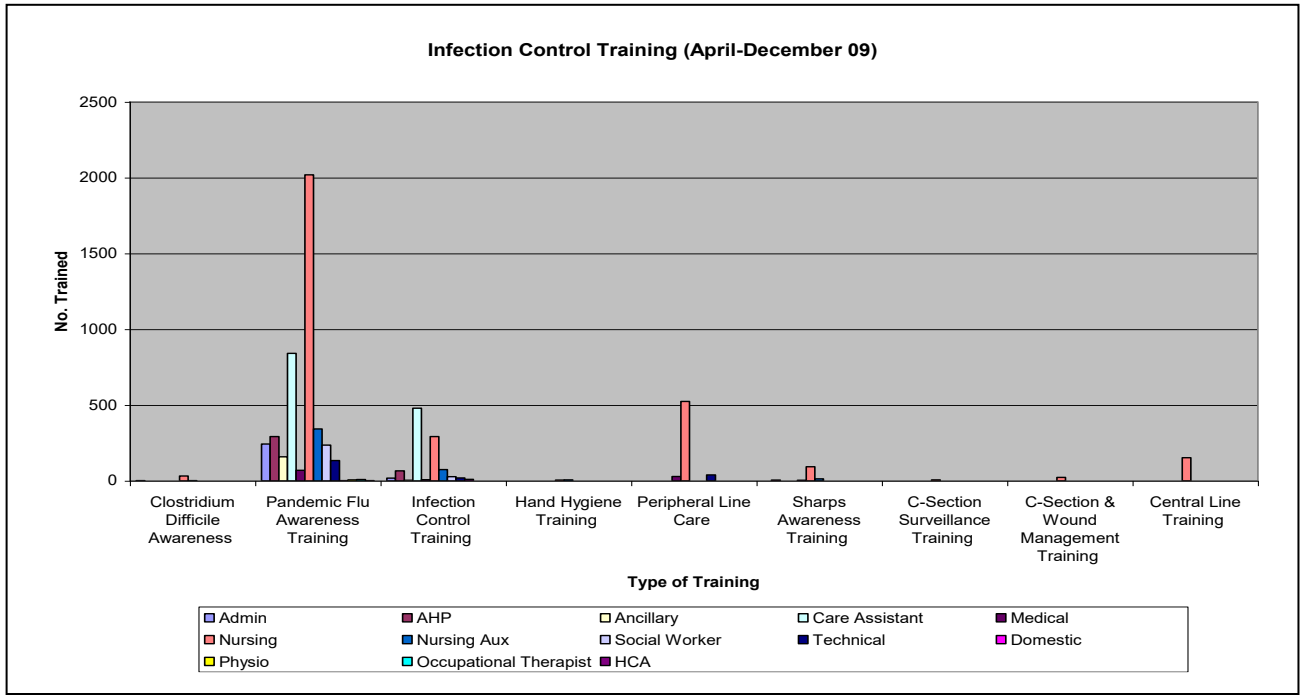
Hand hygiene has been well established as one of the key components to reduce healthcare associated infections. In December 2008, the SHSCT successfully launched the hand hygiene campaign Safe Hands Save Lives which has resulted in a substantial increase in hand hygiene compliance across the Trust.





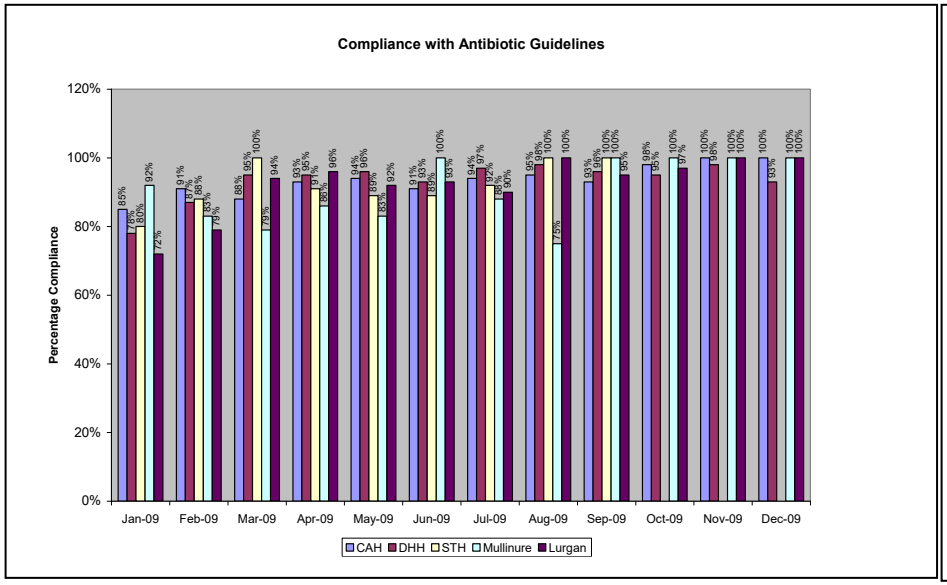
Infection Control Training (April – Dec 2009)

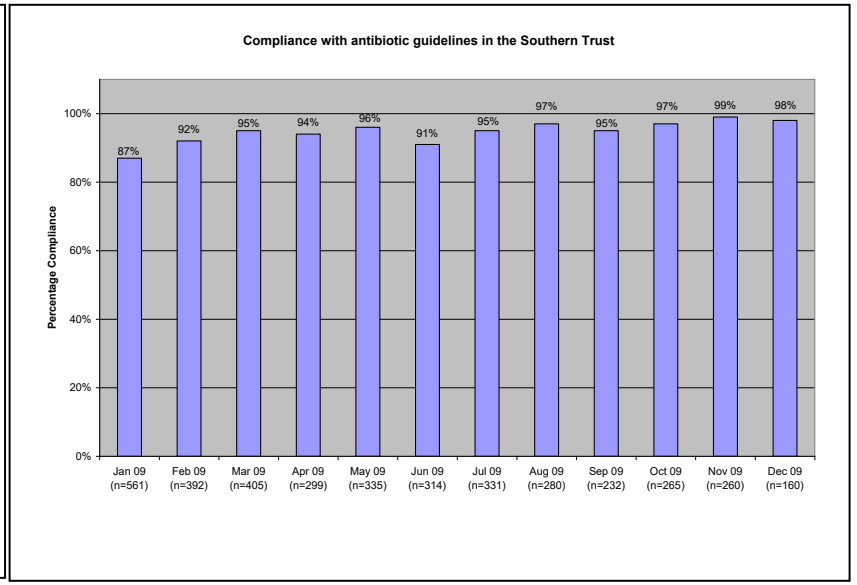
Course Title	Admin	AHP	Ancillary	Care Assistant	Medical	Nursing	Nursing Aux	Social Worker	Technical	Domestic	Physio	Occupational Therapist	HCA	Grand Total
Clostridium Difficile Awareness	1	0	0	0	0	32	1	0	0	0	0	0	0	34
Pandemic Flu Awareness Training	242	291	158	841	69	2019	342	235	134	1	6	8	1	4347
Infection Control Training	18	65	3	479	7	291	74	27	19	9	0	0	0	992
Hand Hygiene Training	0	0	0	0	0	5	6	0	0	0	0	0	0	11
Peripheral Line Care	0	0	0	0	28	524	0	0	39	0	0	0	0	591
Sharps Awareness Training	0	5	0	0	3	92	13	0	0	0	0	0	0	113
C-Section Surveillance Training	0	0	0	0	0	6	0	0	0	0	0	0	0	6
C-Section & Wound Management Training	0	0	0	0	0	22	0	0	0	0	0	0	0	22
Central Line Training	0	0	0	0	0	152	0	0	0	0	0	0	0	152
Grand Total	261	361	161	1320	108	3153	436	262	192	10	6	8	1	6279



Compliance with Antibiotics

Hospital	No. Antibiotics audited											
	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
CAH	361	191	246	147	134	134	157	138	87	106	62	62
DHH	129	98	86	106	154	140	135	104	113	120	143	60
STH	10	25	25	11	9	9	12	7	3	0	0	0
Mullinure	25	12	14	14	12	4	8	4	7	4	17	4
Lurgan	47	38	34	25	26	28	20	16	22	35	37	34





Health Care Acquired Infection – Related Deaths

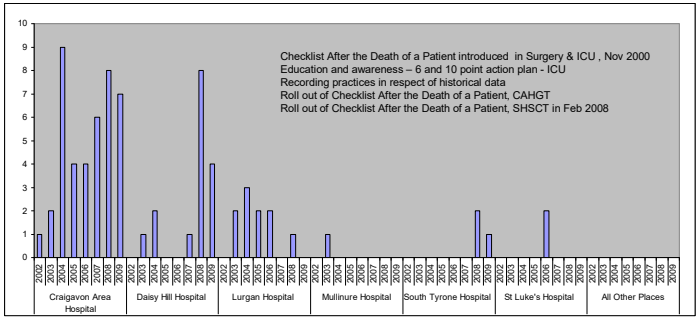
Monitoring of HCAI deaths SHSCT, is now based on the date the death is registered and is fully aligned with the Central Services Agency / NI Stats & Research Agency reporting.

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

Number of SHSCT deaths with *Clostridium Difficile* mentioned and recorded as the underlying cause on death certificate, 2002 – 2008 (validated)

January – December 2009[P] (unvalidated)

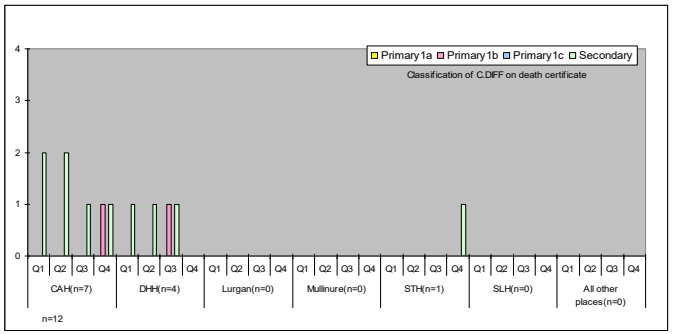


[P] – Provisional data pending publication of the Registrar General's Annual Report for 2009

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)



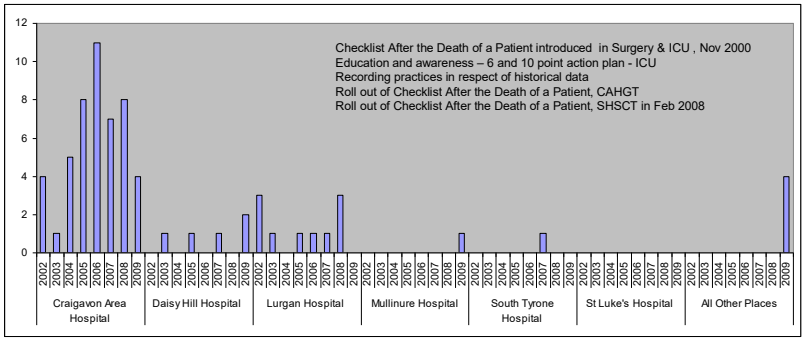
P – Provisional data pending publication of the Registrar General's Annual Report for 2009
Source: NI Stats & Research Agency and Central Services Agency combined weekly submission of HCAI death related data

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, as demonstrated in the following graph.

MRSA – Annual trend by hospital site and breakdown by Quarter for 2009

Number of SHSCT deaths with MRSA mentioned and recorded as the underlying cause of death certificate, 2002 – 2008 (validated)

January – December 2009[P] (unvalidated)

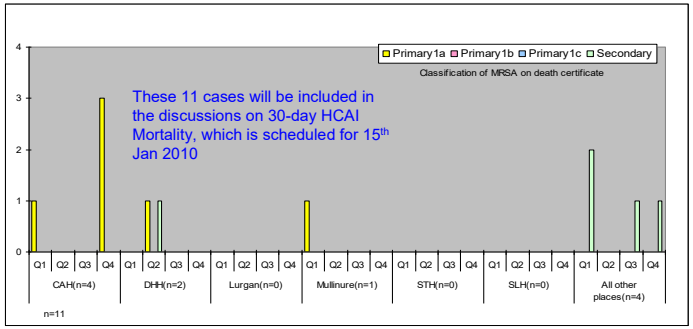


[P] – Provisional data pending publication of the Registrar General's Annual Report for 2009

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)

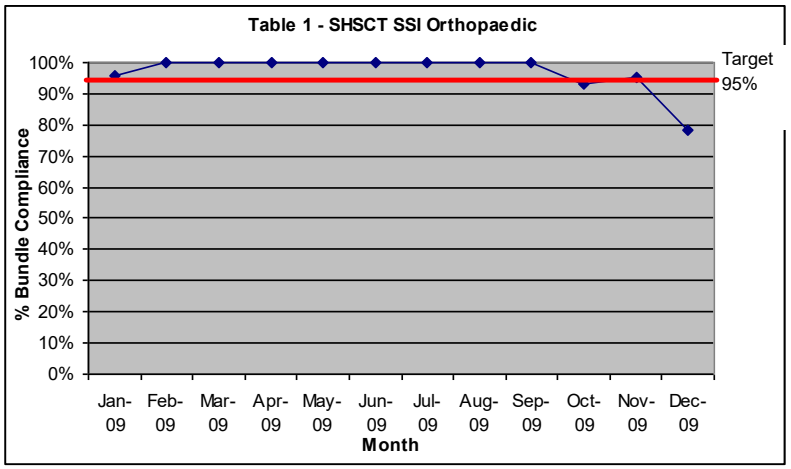


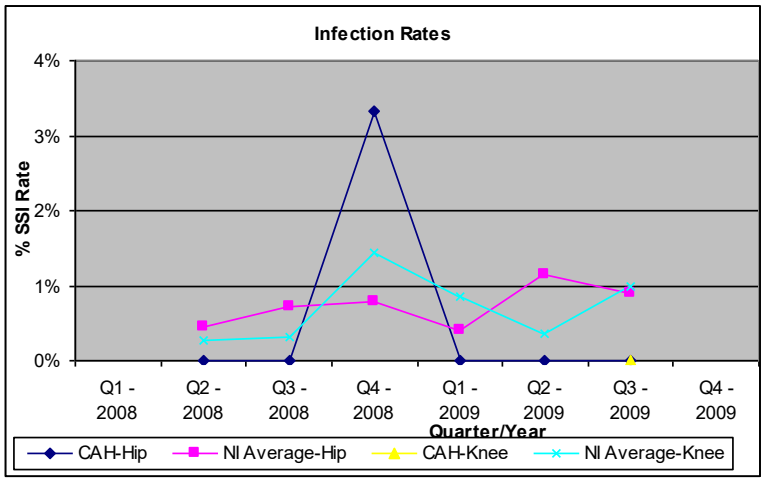
This dataset is provisional pending publication of the Registrar General's Annual Report for 2009

11 MRSA related deaths in SHSCT in 2008 & 2009.

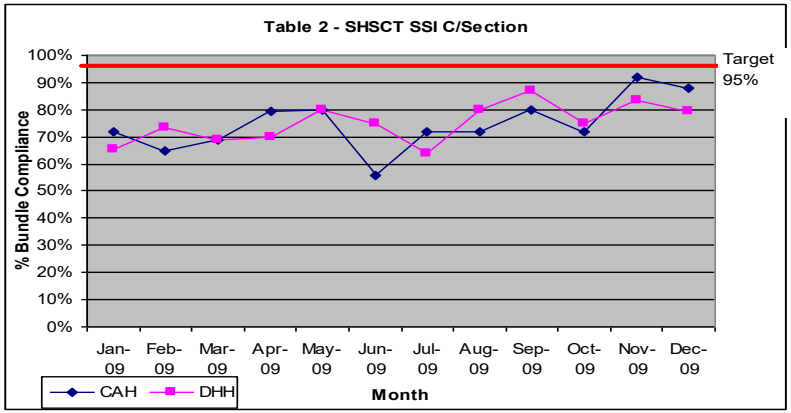
In this update, there has been no additional cases where MRSA was recorded as a cause of death on the death certificate.

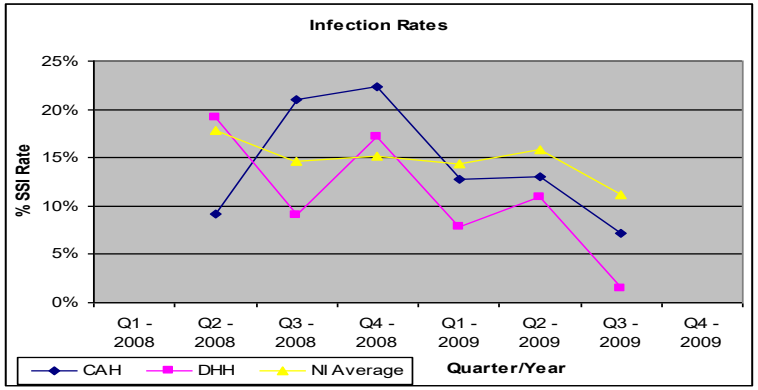
QUALITY IMPROVEMENT TARGETS (Patient Care Indicators)





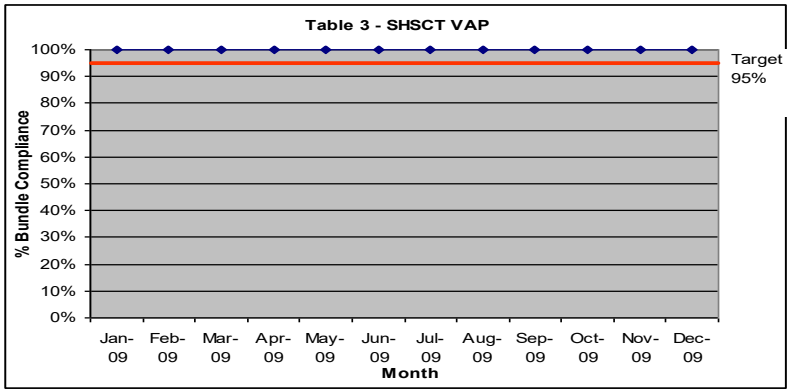
Non-compliant element - Normothermia Control 3/14 patient's first temperature in Recovery was under 35.5°C. CAH Q3, 2009 SSI Infection Rates for both Hip & Knee remain at 0%. NI Average for Hip is 0.9% & Knee is 1.0%

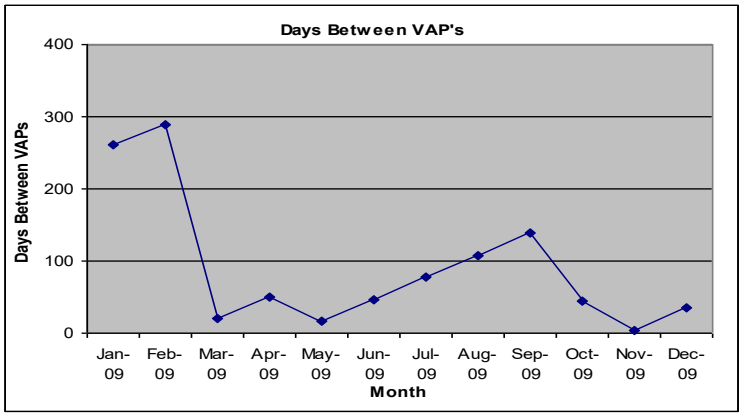




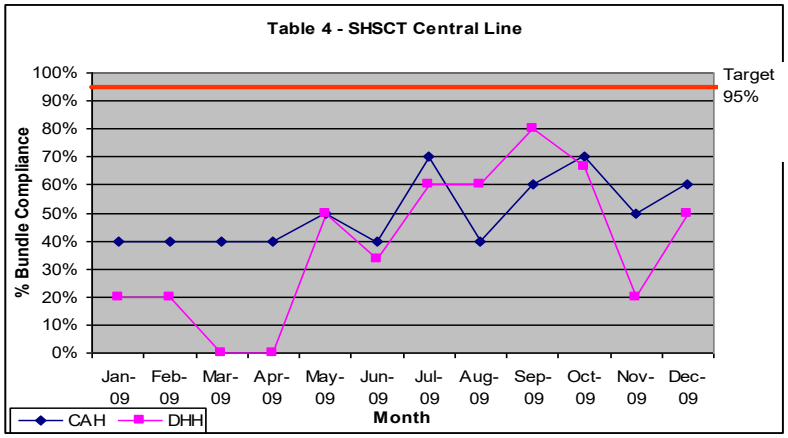
CAH - Overall Bundle Compliance Rate dipped slightly to 88%. DHH - Rate also dipped to 79% as 4 patients 1st temp in Recovery was under 35.5°C. Issues with the room temp in Recovery and with the thermometers currently been used to monitor patient's temp have been identified and actions taken to address same. Q3 2009 SSI Rates show a marked decrease on both sites and are now considerably below Trust goal & the NI Average.

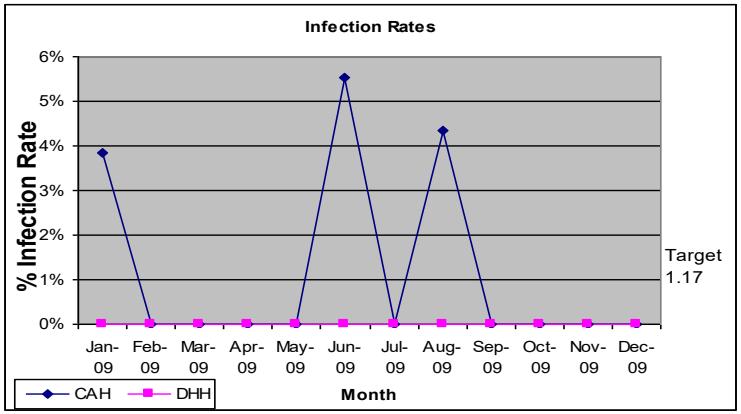
Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.



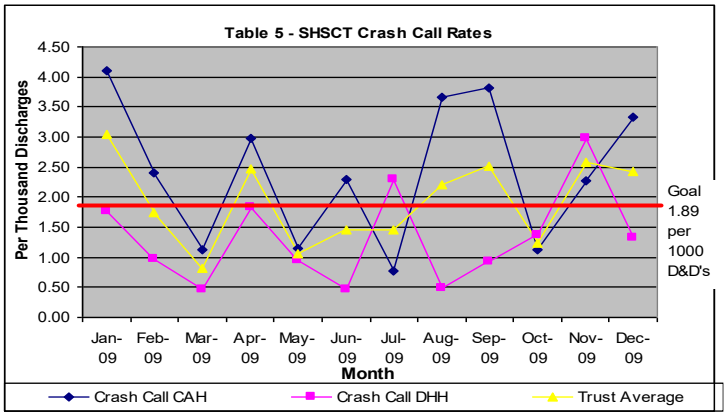


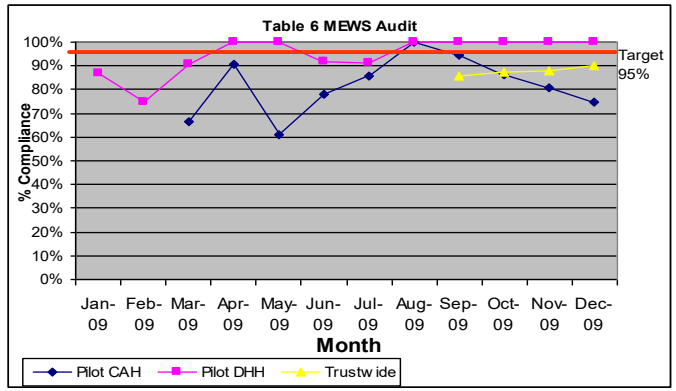
VAP Bundle Compliance Rate remains at 100% (18th consecutive month). It has been 35 days (179 Vent Days) since the last VAP. Trust target of 300 Vent Days between VAP's in 09/10 has already been achieved.



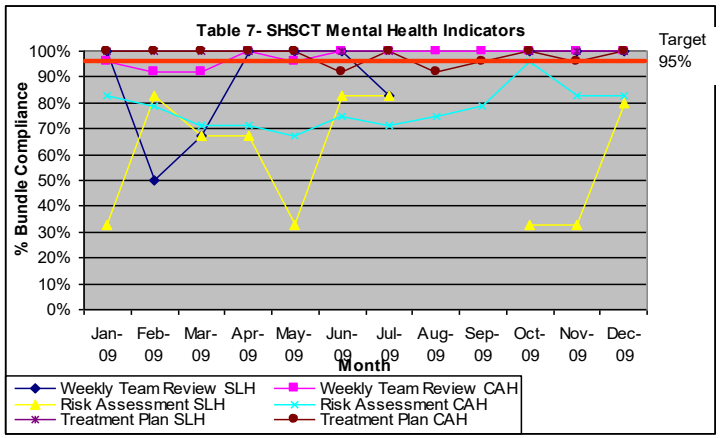


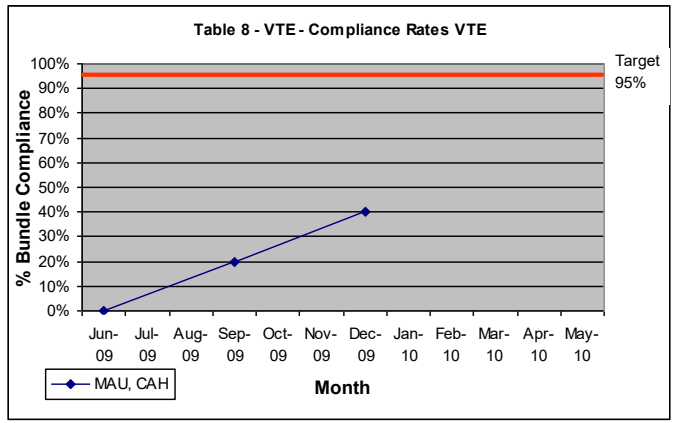
Overall Bundle Compliance at CAH increased from 50% to 60% & from 20% to 50% at DHH. A 6 week initiative to improve compliance with the Daily Review of the Central Line at CAH ended at Christmas and saw compliance increase from 38% to 94%. A further audit will commence in Feb 2010. ICU has been Infection Free for 15 mths & the Trust for the past 4 mths. Infection Rate Apr- Dec 09 is 1.00 per 1,000 Line Days under goal of 1.17 09/10





The Crash Call Rate at CAH has increased over the past 2 months, with the result that the Trust Rate is above our goal of 1.89 per 1,000 deaths/discharges. A similar rise was experienced last winter. The Trustwide MEWS Audit has been completed. The findings of this work are being considered by the MEWS Governance Group who will be making recommendations to SMT on the way forward in due course.

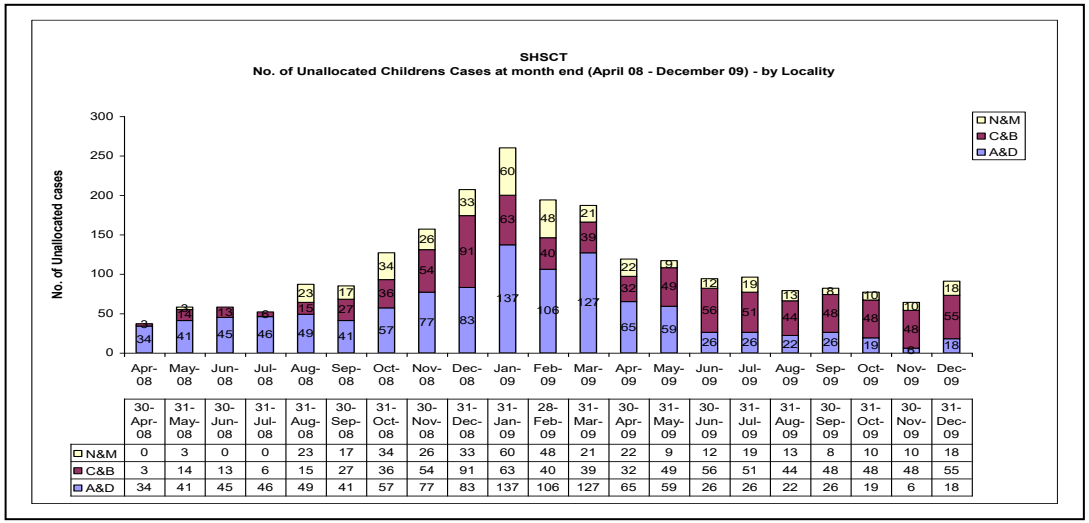




Mental Health - A Risk Ax was done for all 34pts on adm. Three were not signed by a Nurse & Doctor on admission, while three were not signed, as appropriate, during the inpatient episode. The overall Compliance Rate was 82%, an increase from the previous months score of 70%. VTE - Appropriate use of Enoxaparin 85% & new Risk Assessment 45% giving Overall Bundle Compliance Rate of 40%, an increase from Baseline of 0%

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
N&M	0	3	0	0	23	17	34	26	33	60	48	21	22	9	12	19	13	8	10	10	18
C&B	3	14	13	6	15	27	36	54	91	63	40	39	32	49	56	51	44	48	48	48	55
A&D	34	41	45	46	49	41	57	77	83	137	106	127	65	59	26	26	22	26	19	6	18

Action taken to mitigate risks and strengthen our system:

a) There are no unallocated child protection cases

b) Heads of Service and Team Managers monitor and review unallocated cases and prioritise these for allocation.

c) The majority of unallocated cases sit within the Family Support teams. These should begin to reduce over the next 3 months with the recruitment of additional social workers into the Family Support Service. However there has been an increase in unallocated cases during the month of December due to sick leave. In response to this Gateway staff have agreed to work additional hours during January 2010 to reduce unallocated cases.

d) The implementation of the fourth Gateway team has kept unallocated cases at the front door of the Service to a minimum. It will also allow the Gateway Service to complete short term pieces of work (4 - 8 weeks) which will ease pressure on the Family Support Service.

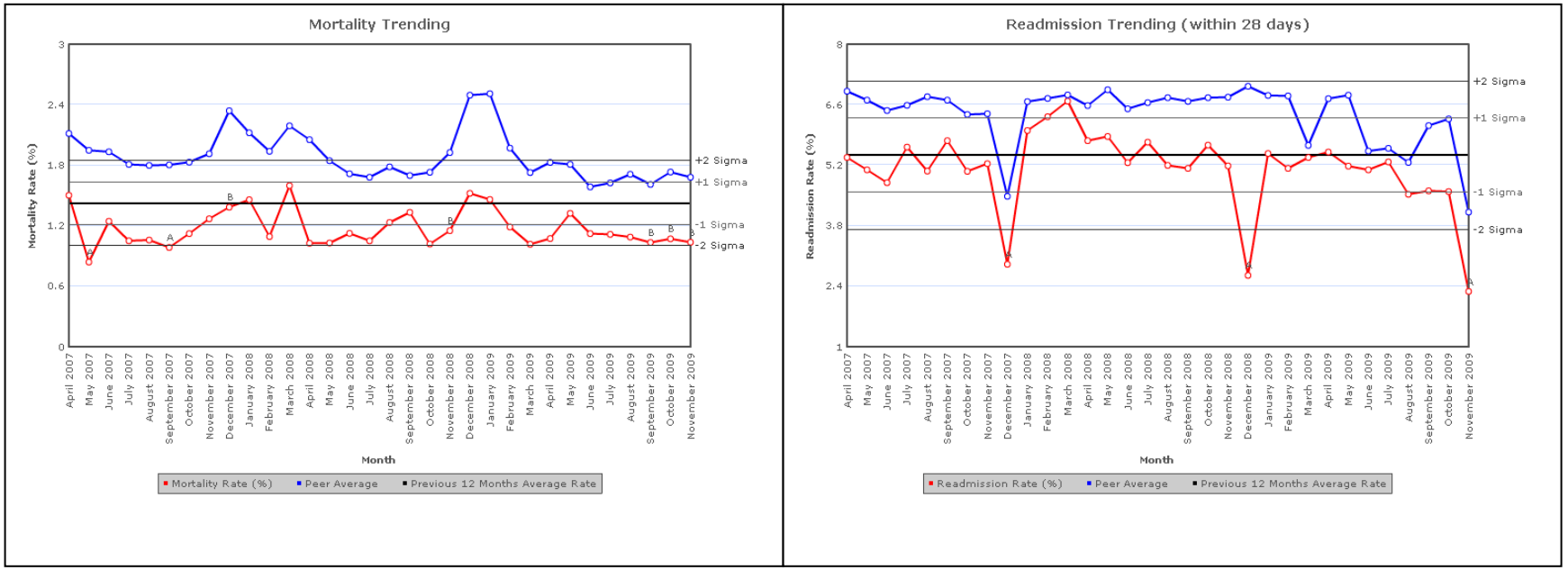
e) Heads of Service meet monthly with Human Resources to plan recruitment, review temporary and permanent waiting lists and address any delays in the recruitment and selection process.

f) The waiting list for temporary and permanent Social Worker posts has been exhausted and interviews to create new waiting lists for Gateway and Family Support will take place during the first week of February 2010.

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 over the last two years (April 07 – Nov 09).
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 over the last two years (April 07 – Nov 09)



Appendix I – Quarterly PFA Supplementary Report

Southern Health and Social Care Trust

Performance Management for 2009/10

'Supplementary PFA Targets'

Return Template – QE December 2009

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	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	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	Currently thrombolysis is administered in the community by nurse led cardiac ambulance from CAH. DHH paramedics bring patients to the hospital if thrombolysis is required. 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. Practice in relation to this area will be discussed at the next Regional Cardiac Network Meeting In February 2010.
By March 2011, increase critical care capacity by two beds, or by the outreach equivalent compared to the position in March 2008.	Trusts	To achieve this priority investment is required. The Trust is in the process of writing a business case to address the requirement to improve our critical care capacity across both Acute hospital sites. This will include the development of the critical care outreach service for both sites and the procurement of the RP7 Robot for the DHH site specifically. The Commissioner has indicated its support in principle and will provide a formal response once the proposal has been received. Acute services are committed to delivering this increased capacity through the areas identified above and the Trust is confident that these services will become operational in April 2010.

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.	Trusts	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.

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	For the first 6 months, March to September 2009, the Southern Trust's Mental Health Referral and Booking Centre has triaged and booked 2513 appointments for patients referred to the Primary Mental Health Care Service. The Trust continues to utilise PAS as the IT booking system for Primary Mental Health Care referrals which has supported the monitoring of the 13 week access target. The Trust commenced its cutting plan in September 2009 in preparation for the move to 9 weeks by March 2010 and has successfully achieved the 10 week PTL for December moving to the 9 week PTL in January 2010. As part of the development of a stepped care model of service delivery the Trust reviewed its Mental Health management structures, which now reflect 3 service areas, Acute, Recovery and Support, and Primary Mental Health Care. Three Heads of Service have been appointed, 8 Service Coordinators and 2 Team Leaders for the PMHC Service. 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.
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	Domestic Violence Partnership: Target has been achieved. The action plan has been submitted to the Regional Strategic Group for Domestic Violence, DHSSPS. MARAC training has now been completed and it is anticipated that Conferences will commence in Jan 10.

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

		FY2009/10 (April - November)		
Anal Fissure	CAH	16	0	100.0%
	DHH	4	0	100.0%
	STH	5	0	100.0%
Arthroscopy	CAH	83	49	62.9%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Bunion Operations	CAH	0	2	0.0%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Carpal Tunnel Decompression	CAH	70	3	95.9%
	DHH	34	8	81.0%
	STH	62	0	100.0%
Circumcision	CAH	30	26	53.6%
	DHH	15	2	88.2%
	STH	17	0	100.0%

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	207	82	71.6%
	DHH	150	16	90.4%
	STH	114	0	100.0%
D&C/ Hysteroscopy exc IS		471	98	82.8%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Excision of Breast Lump	CAH	14	8	63.6%
	DHH	10	0	100.0%
	STH	8	0	100.0%
Excision of Breast Lump exc IS		32	8	80.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Excision of Dupuytrens Contracture	CAH	3	2	60.0%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Excision of Dupuytrens Contracture exc IS		3	2	60.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Excision of Ganglion	CAH	8	2	80.0%
	DHH	0	0	#DIV/0!
	STH	22	0	100.0%
Excision of Ganglion exc IS		30	2	93.8%

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	261	0	100.0%
Extraction of Cataract exc IS		261	0	100.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Haemorrhoidectomy	CAH	7	5	58.3%
	DHH	0	3	0.0%
	STH	2	2	50.0%

Haemorrhoidectomy exc IS		9	10	47.4%

Hydrocele	CAH	5	1	83.3%
	DHH	0	9	0.0%
	STH	2	0	100.0%

Inguinal Hernia	CAH	39	58	40.2%
	DHH	6	66	8.3%
	STH	31	0	100.0%

Laparoscopic Cholecystectomy	CAH	15	101	12.9%
	DHH	0	84	0.0%
	STH	0	0	#DIV/0!

Laparoscopy	CAH	154	70	68.8%
	DHH	51	25	67.1%
	STH	32	0	100.0%

Myringotomy/ Grommets	CAH	102	23	81.6%
	DHH	57	0	100.0%
	STH	34	0	100.0%

Operation on Bat Ears	CAH	0	10	0.0%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Orchidopexy	CAH	3	3	50.0%
	DHH	5	1	83.3%
	STH	1	0	100.0%
Orchidopexy exc IS		9	4	69.2%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Reduction of Nasal Fracture	CAH	58	20	74.4%
	DHH	14	0	100.0%
	STH	8	0	100.0%
Reduc of Nasal Fracture exc IS		80	20	80.0%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Removal of Metalware	CAH	2	19	9.5%
	DHH	0	0	#DIV/0!
	STH	0	0	#DIV/0!
Removal of Metalware exc IS		2	19	9.5%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Sub Mucous Resection	CAH	5	68	6.8%
	DHH	32	1	97.0%
	STH	20	0	100.0%
Sub Mucous exc IS		57	69	45.2%

*** Note - Manual Adjustment made in August - 1 Patient 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	1	270	0.4%
	DHH	75	2	97.4%
	STH	0	0	#DIV/0!
Tonsillectomy exc IS		76	272	21.8%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
TURP	CAH	1	44	2.2%
	DHH	13	5	72.2%
	STH	1	1	50.0%

TURP exc IS	15	50	23.1%

PROCEDURE	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
Varicose Veins	CAH	17	23	42.5%
	DHH	0	3	0.0%
	STH	3	0	100.0%
Varicose Veins exc IS		20	26	43.5%

TRUST TOTAL	SITE	DAY CASES	ELEC ADMIS	% DAY CASE RATE
TRUST TOTAL	CAH	840	889	48.6%
	DHH	466	225	67.4%
	STH	623	3	99.5%
TRUST TOTAL Exc IS		1929	1117	63.3%

Appendix III – SBA Report [to SMT 27th Jan 10] TO BE TABLED AT TB

Appendix IV – Environmental Cleanliness Report

Environmental Cleanliness Report

Prepared by: Functional Support Services
12.1.2010

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 and Managerial Audits. The results from Departmental Audits in hospitals across the Trust are included in section 3 of this report.

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 Audits are used to validate a sample of Departmental Audit scores and Managerial Audit results over a period of months are required to provide sufficient figures for comparative purposes. Managerial Audit results measured against the ICNA audit tool are included in section 4 of 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 to date these have tended to concentrate on ward 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 has implemented practice audits which 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.

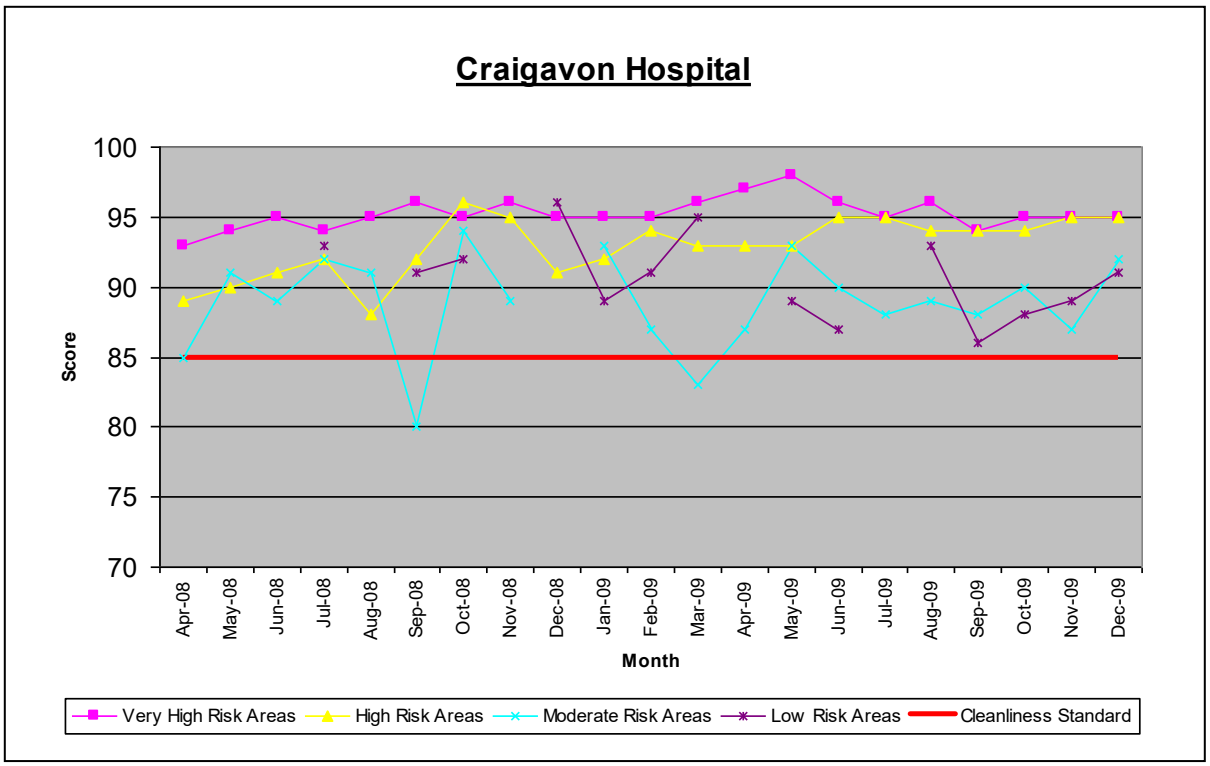
The DHSSPSNI hosted a workshop in 2009 to consider the various audit tools used in HSC settings and a Steering Group has been established to review the Cleanliness Matters Toolkit with a view to harmonising with other tools such as the ICNA tool. Workstreams have been set up to take forward work on developing a common approach to audit, standard definitions and cleaning plans, and training for staff involved in the audit process. The deadline for the revised strategy is likely to be extended to August 2010.

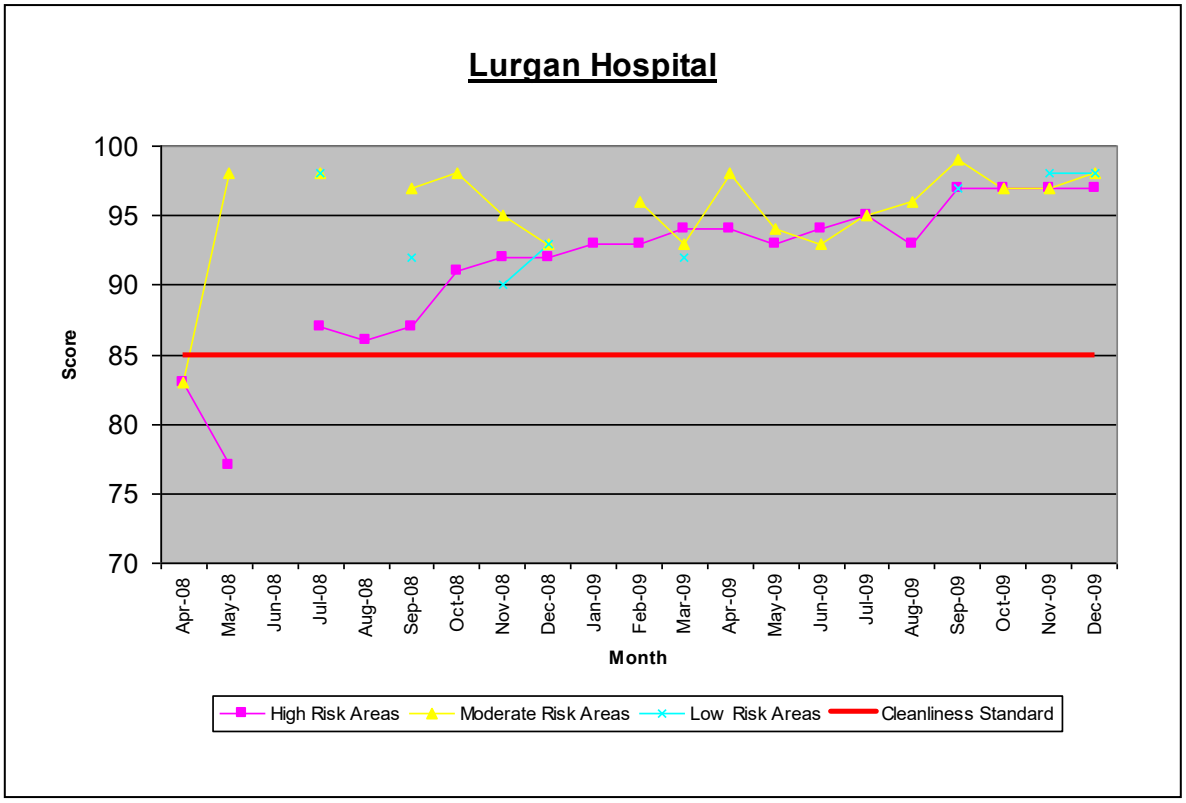
2. Departmental Audit Results - Summary of Overall Weighted Scores using the Cleanliness Matters Toolkit

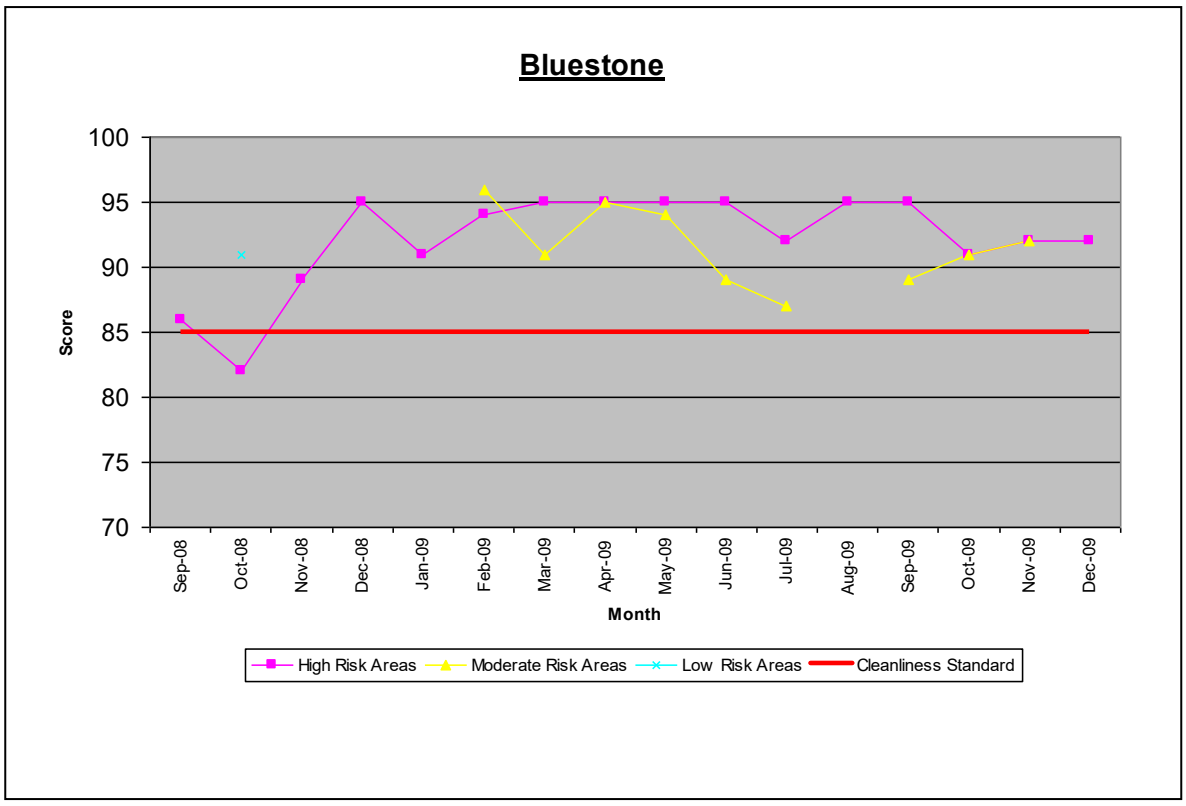
Hospital	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
St Luke's	85	93	88	86	88	84	90	94	90	85	91	93	90	93	90	91	94	91	90	95	90			
South Tyrone	85	89	89	86	86	90	87	90	90	89	89	92	89	93	90	90	90	90	89	91	92			
Longstone	85	89	91	89	87	92	91	88	94	93	92	93	91	89	90	90	88	94	90	84	93			
Mullinure	93	90	90	91	94	95	91	94	93	95	94	96	95	95	96	91	84	85	88	96	95			
CAH	90	92	92	93	91	91	95	94	94	93	93	92	93	94	93	93	93	92	93	92	94			
Lurgan	83	85		92	86	91	94	93	93	93	94	93	96	93	93	95	94	98	97	97	97			
DHH	94	93	94	94	95	94	92	94	95	93	95	93	92	87	88	90	93	91	93	93	93			
Bluestone						86	84	89	95	91	95	93	95	95	92	90	95	92	91	92	92			
Average	88	90	91	90	90	90	91	92	93	92	93	93	93	92	92	91	91	92	91	93	93			

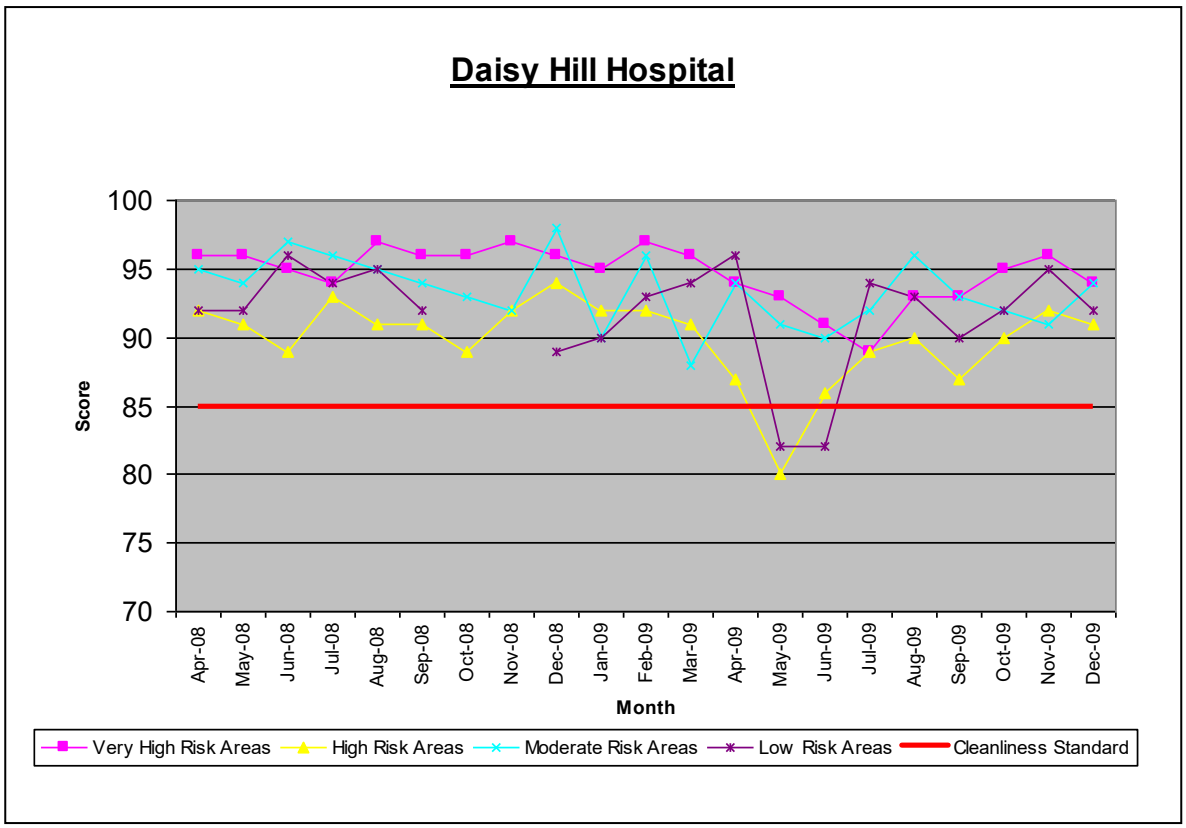
The scores reflect the overall weighted score for each hospital taking into account all risk categories ie very high, high, moderate and low risk category areas.

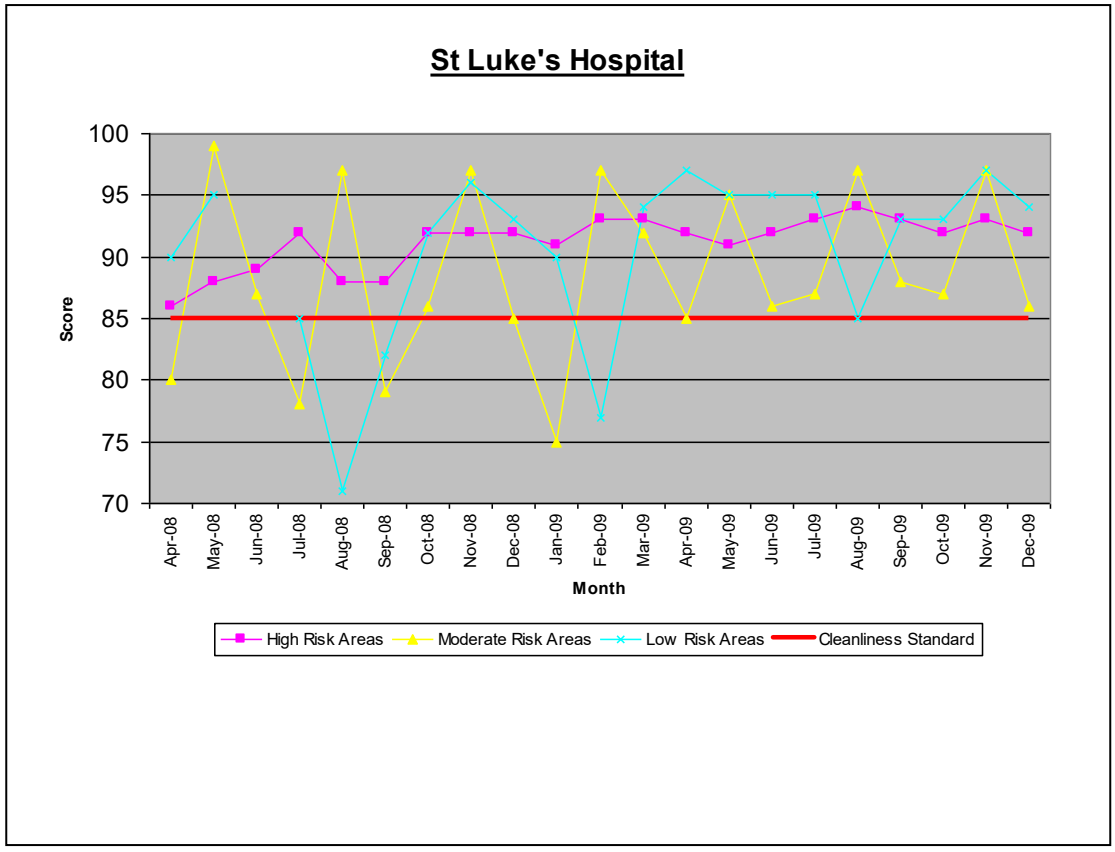
3. Departmental Audit Results - Breakdown of Scores for each Hospital

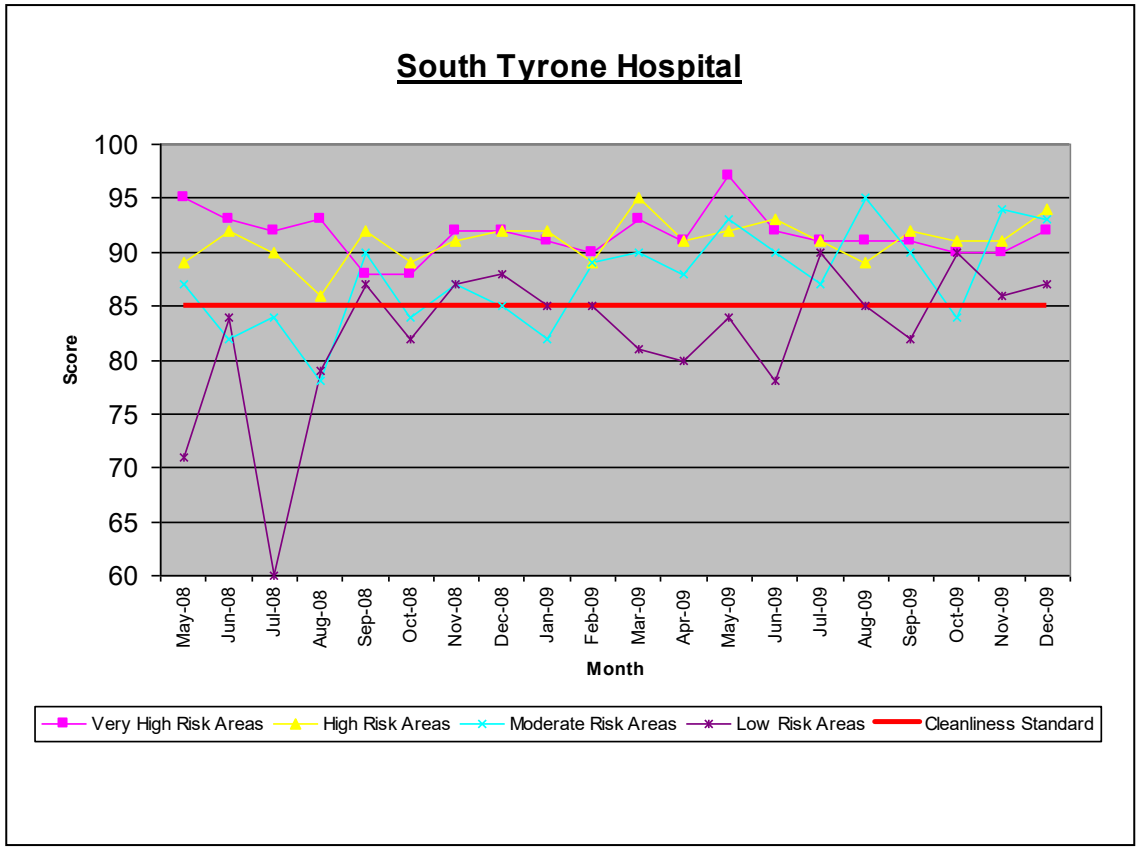


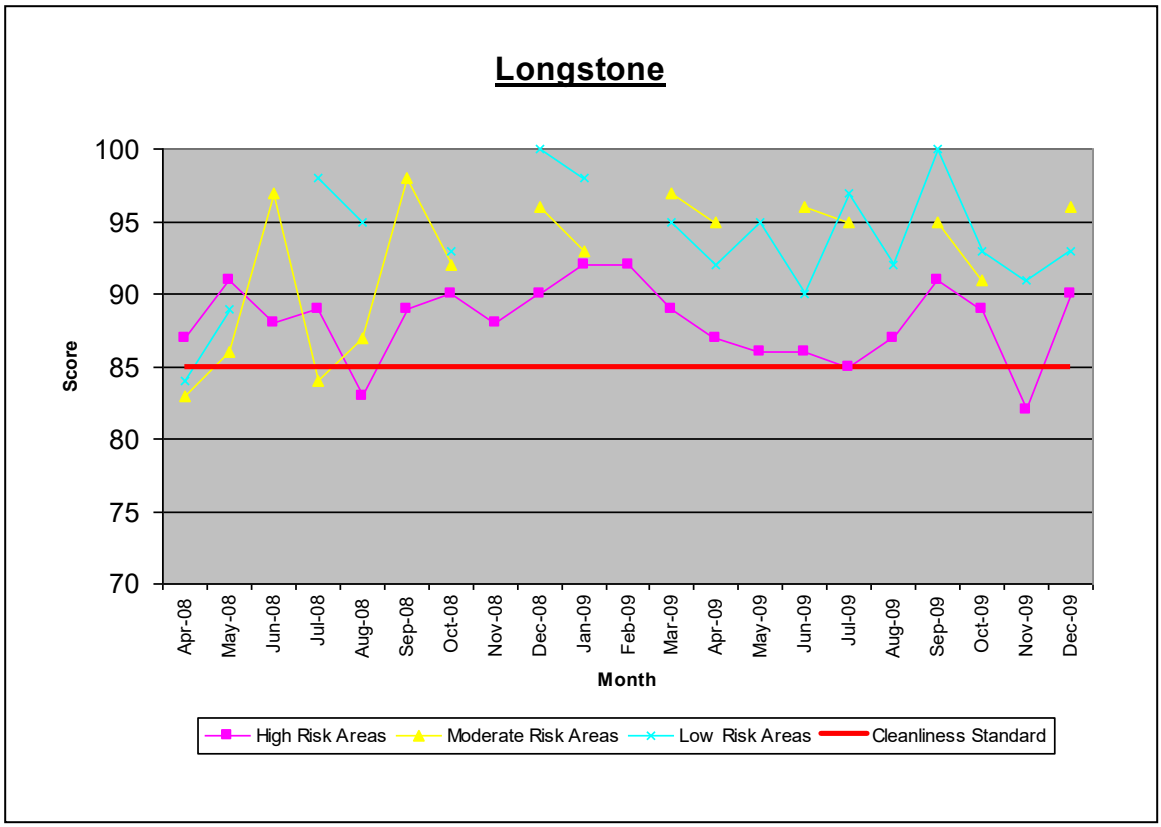


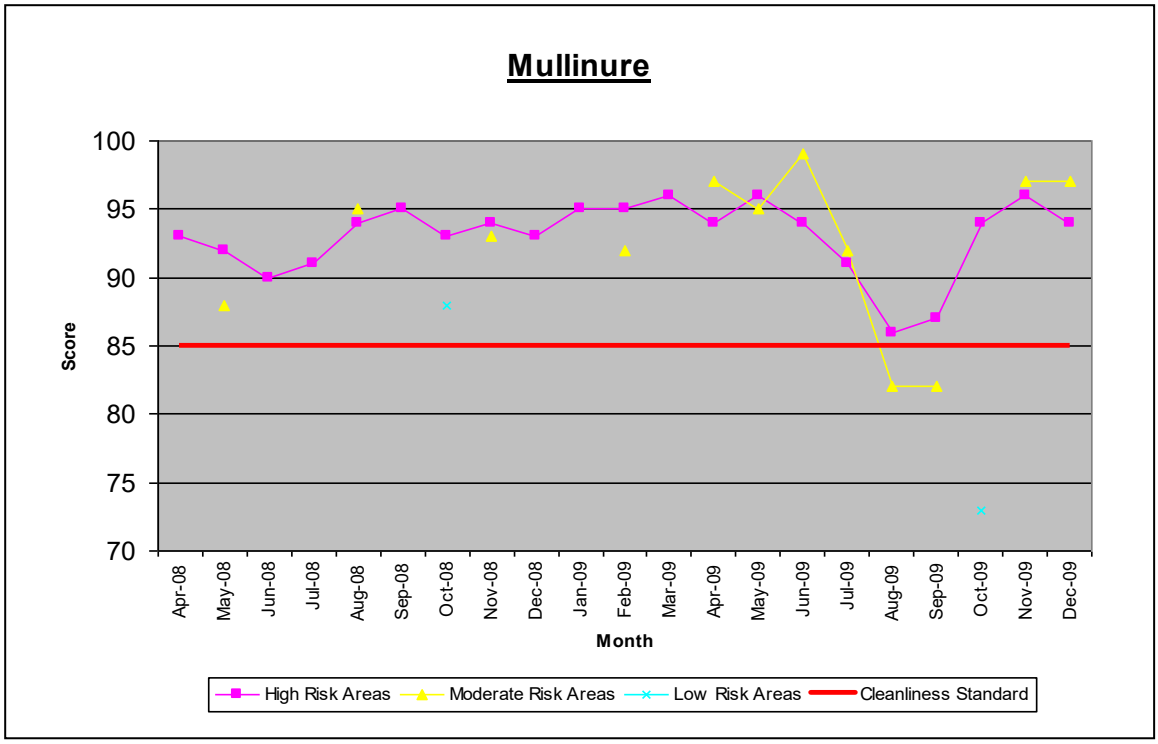





St Luke's Hospital
100
95
90
85
80
75
70
Score
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Month
High Risk Areas
Moderate Risk Areas
Low Risk Areas
Cleanliness Standard


South Tyrone Hospital
100
95
90
85
80
75
70
65
60
Score
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
Month
Very High Risk Areas
High Risk Areas
Moderate Risk Areas
Low Risk Areas
Cleanliness Standard





Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

4. ICNA Audit Results

143 audits have been undertaken in hospitals across the Trust from May 2009 using the ICNA toolkit. There has been a marked increase in the number of audits conducted in recent months to try and bridge the gap between the Environmental Cleanliness audit scores and RQIA audit scores.

The following table shows the results for each audit, ie the scores have not been averaged to give the overall percentage score.

Hospital	Ward/Dept	Audit	Audit Date	Score	Assessment
Craigavon	1 East	Environment	16/06/2009	87%	Compliant
Craigavon	2 South	Environment	08/12/2009	86%	Compliant
Craigavon	4 South	Kitchen	21/08/2009	93%	Compliant
Craigavon	4 South	Departmental Waste	21/08/2009	89%	Compliant
Craigavon	A&E	Departmental Waste	29/09/2009	86%	Compliant
Craigavon	ICU	Environment	17/06/2009	86%	Compliant
Craigavon	Physiotherapy	Patient Equipment (Specialist)	09/09/2009	87%	Compliant
Daisy Hill	Coronary Care	Patient Equipment (General)	28/10/2009	90%	Compliant
Daisy Hill	Female Medical	Departmental Waste	08/07/2009	85%	Compliant
Daisy Hill	High Dependency	Environment	28/10/2009	85%	Compliant
Daisy Hill	High Dependency	Patient Equipment (General)	28/10/2009	86%	Compliant
Daisy Hill	Male Medical	Patient Equipment (General)	08/07/2009	96%	Compliant
Daisy Hill	Male Medical	Departmental Waste	08/07/2009	85%	Compliant
Longstone	Cherryvilla	Personal Protective Equipment	03/08/2009	100%	Compliant
Longstone	Cherryvilla	Safe Handling and Disposal of Sharps	01/12/2009	94%	Compliant
Longstone	Clover	Personal Protective Equipment	30/07/2009	100%	Compliant
Longstone	Donard	Personal Protective Equipment	01/08/2009	100%	Compliant
Longstone	IATU	Personal Protective Equipment	30/07/2009	100%	Compliant
Longstone	Mourne	Personal Protective Equipment	01/08/2009	100%	Compliant
Longstone	Sperrin	Personal Protective Equipment	01/08/2009	100%	Compliant
Lurgan	Day Hosp	Environment	30/09/2009	94%	Compliant
Lurgan	Ward 4	Environment	30/09/2009	89%	Compliant
Mullinure	Ward 1	Personal Protective Equipment	30/07/2009	94%	Compliant
South Tyrone	A Floor	Personal Protective Equipment	30/07/2009	100%	Compliant
South Tyrone	Loane House 2	Personal Protective Equipment	30/07/2009	100%	Compliant
St Lukes	Addiction Unit	Personal Protective Equipment	29/07/2009	95%	Compliant
St Lukes	Villa 1	Personal Protective Equipment	06/08/2009	89%	Compliant
St Lukes	Villa 2	Personal Protective Equipment	30/07/2009	100%	Compliant
St Lukes	Villa 3	Personal Protective Equipment	04/08/2009	90%	Compliant
St Lukes	Ward 2	Personal Protective Equipment	30/07/2009	100%	Compliant
St Lukes	Ward 3	Personal Protective Equipment	13/08/2009	94%	Compliant

St Lukes	Ward 5	Hand Hygiene	02/06/2009	86%	Compliant
St Lukes	Ward 5	Personal Protective Equipment	02/06/2009	100%	Compliant
St Lukes	Ward 5	Personal Protective Equipment	29/07/2009	94%	Compliant
St Lukes	Ward 5	Patient Equipment (General)	29/09/2009	88%	Compliant
Craigavon	1 East	Kitchen	16/06/2009	71%	Minimal Compliance
Craigavon	1 North	Environment	16/06/2009	70%	Minimal Compliance
Craigavon	1 North	Kitchen	16/06/2009	43%	Minimal Compliance
Craigavon	1 North	Environment	09/09/2009	60%	Minimal Compliance
Craigavon	1 North	Kitchen	09/09/2009	67%	Minimal Compliance
Craigavon	1 North	Patient Equipment (General)	09/09/2009	74%	Minimal Compliance
Craigavon	1 North	Departmental Waste	09/09/2009	74%	Minimal Compliance
Craigavon	1 South	Environment	16/06/2009	74%	Minimal Compliance
Craigavon	1 South	Kitchen	16/06/2009	59%	Minimal Compliance
Craigavon	2 North	Environment	08/12/2009	57%	Minimal Compliance
Craigavon	2 North	Environment	08/12/2009	75%	Minimal Compliance
Craigavon	2 North	Handling and Disposal of Linen	08/12/2009	56%	Minimal Compliance
Craigavon	2 North	Departmental Waste	08/12/2009	74%	Minimal Compliance
Craigavon	2 South	Environment	08/12/2009	69%	Minimal Compliance
Craigavon	2 South	Handling and Disposal of Linen	08/12/2009	67%	Minimal Compliance
Craigavon	4 South	Environment	21/08/2009	67%	Minimal Compliance
Craigavon	4 South	Patient Equipment (General)	21/08/2009	71%	Minimal Compliance
Craigavon	A&E	Environment	29/09/2009	73%	Minimal Compliance
Craigavon	A&E	Environment	29/09/2009	61%	Minimal Compliance
Craigavon	A&E	Handling and Disposal of Linen	29/09/2009	67%	Minimal Compliance
Craigavon	ICU	Kitchen	17/06/2009	70%	Minimal Compliance
Craigavon	MAU	Environment	16/06/2009	73%	Minimal Compliance
Craigavon	OT	Environment	29/09/2009	43%	Minimal Compliance
Craigavon	Physiotherapy	Environment	09/09/2009	43%	Minimal Compliance
Craigavon	Physiotherapy	Environment	09/09/2009	29%	Minimal Compliance
Craigavon	X-ray	Environment	24/06/2009	63%	Minimal Compliance
Craigavon	X-ray	Environment	24/06/2009	60%	Minimal Compliance
Daisy Hill	Coronary Care	Environment	28/10/2009	70%	Minimal Compliance
Daisy Hill	Coronary Care	Departmental Waste	28/10/2009	74%	Minimal Compliance
Daisy Hill	Coronary Care	Kitchen	28/10/2009	72%	Minimal Compliance
Daisy Hill	Day Procedure	Environment	08/07/2009	71%	Minimal Compliance
Daisy Hill	Day Procedure	Kitchen	08/07/2009	71%	Minimal Compliance
Daisy Hill	Day Procedure	Patient Equipment (General)	08/07/2009	69%	Minimal Compliance
Daisy Hill	Day Procedure	Departmental Waste	08/07/2009	50%	Minimal Compliance
Daisy Hill	Female Medical	Kitchen	08/07/2009	65%	Minimal Compliance
Daisy Hill	Male Medical	Kitchen	08/07/2009	65%	Minimal Compliance
Daisy Hill	Male Medical	Handling and Disposal of Linen	08/07/2009	66%	Minimal Compliance
Daisy Hill	Male Surgical	Environment	27/05/2009	65%	Minimal Compliance
Daisy Hill	Medical/Stroke	Environment	27/05/2009	53%	Minimal Compliance
Daisy Hill	Paediatrics	Environment	24/06/2009	73%	Minimal Compliance
Daisy Hill	Paediatrics	Kitchen	24/06/2009	72%	Minimal Compliance
Daisy Hill	Paediatrics	Environment	24/06/2009	73%	Minimal Compliance
Daisy Hill	Paediatrics	Kitchen	24/06/2009	72%	Minimal Compliance
Daisy Hill	Rehab	Environment	24/06/2009	69%	Minimal Compliance
Daisy Hill	Rehab	Kitchen	24/06/2009	72%	Minimal Compliance
Daisy Hill	Rehab	Patient Equipment (General)	24/06/2009	60%	Minimal Compliance
Longstone	Cherryvilla	Environment	01/12/2009	32%	Minimal Compliance

Longstone	Cherryvilla	Handling and Disposal of Linen	01/12/2009	50%	Minimal Compliance
Longstone	Cherryvilla	Patient Equipment (General)	01/12/2009	65%	Minimal Compliance
Longstone	Cherryvilla	Kitchen	01/12/2009	70%	Minimal Compliance
Longstone	Donard	Environment	22/09/2009	52%	Minimal Compliance
Longstone	Donard	Handling and Disposal of Linen	22/09/2009	57%	Minimal Compliance
Longstone	Donard	Patient Equipment (General)	22/09/2009	60%	Minimal Compliance
Longstone	Donard	Kitchen	22/09/2009	65%	Minimal Compliance
Longstone	Mourne	Environment	22/09/2009	66%	Minimal Compliance
Longstone	Mourne	Kitchen	22/09/2009	63%	Minimal Compliance
Longstone	Mourne	Handling and Disposal of Linen	22/09/2009	50%	Minimal Compliance
Longstone	Mourne	Patient Equipment (General)	22/09/2009	48%	Minimal Compliance
South Tyrone	A Floor	Environment	04/06/2009	46%	Minimal Compliance
South Tyrone	Loane House 2	Environment	09/06/2009	52%	Minimal Compliance
South Tyrone	Loane House 2	Kitchen	09/06/2009	58%	Minimal Compliance
South Tyrone	Out Patients	Environment	04/06/2009	71%	Minimal Compliance
St Lukes	Villa 2	Kitchen	06/10/2009	61%	Minimal Compliance
St Lukes	Villa 2	Handling and Disposal of Linen	06/10/2009	31%	Minimal Compliance
St Lukes	Villa 2	Safe Handling and Disposal of Sharps	06/10/2009	75%	Minimal Compliance
St Lukes	Villa 2	Patient Equipment (General)	06/10/2009	47%	Minimal Compliance
St Lukes	Villa 2	Environment	06/10/2009	41%	Minimal Compliance
St Lukes	Ward 2	Departmental Waste	30/06/2009	72%	Minimal Compliance
St Lukes	Ward 2	Safe Handling and Disposal of Sharps	30/06/2009	67%	Minimal Compliance
St Lukes	Ward 2	Patient Equipment (General)	30/06/2009	67%	Minimal Compliance
St Lukes	Ward 2	Environment	30/06/2009	45%	Minimal Compliance
St Lukes	Ward 2	Handling and Disposal of Linen	30/06/2009	73%	Minimal Compliance
St Lukes	Ward 3	Handling and Disposal of Linen	02/07/2009	63%	Minimal Compliance
St Lukes	Ward 3	Safe Handling and Disposal of Sharps	02/07/2009	74%	Minimal Compliance
St Lukes	Ward 3	Patient Equipment (General)	02/07/2009	33%	Minimal Compliance
St Lukes	Ward 5	Environment	29/09/2009	69%	Minimal Compliance
St Lukes	Ward 5	Kitchen	29/09/2009	63%	Minimal Compliance
St Lukes	Ward 5	Handling and Disposal of Linen	29/09/2009	62%	Minimal Compliance
Craigavon	1 North	Environment	09/09/2009	76%	Partial Compliance
Craigavon	2 North	Kitchen	08/12/2009	81%	Partial Compliance
Craigavon	2 South	Kitchen	08/12/2009	78%	Partial Compliance
Craigavon	2 South	Patient Equipment (General)	08/12/2009	77%	Partial Compliance
Craigavon	4 South	Environment	21/08/2009	76%	Partial Compliance
Craigavon	A&E	Kitchen	29/09/2009	81%	Partial Compliance
Craigavon	A&E	Patient Equipment (General)	29/09/2009	79%	Partial Compliance
Craigavon	MAU	Environment	16/06/2009	79%	Partial Compliance
Craigavon	MAU	Kitchen	16/06/2009	81%	Partial Compliance
Craigavon	OT	Kitchen	29/09/2009	76%	Partial Compliance
Craigavon	OT	Patient Equipment (Specialist)	29/09/2009	81%	Partial Compliance
Craigavon	X-ray	Environment	24/06/2009	78%	Partial Compliance
Daisy Hill	Female Medical	Environment	08/07/2009	77%	Partial Compliance
Daisy Hill	Female Medical	Patient Equipment (General)	08/07/2009	81%	Partial Compliance
Daisy Hill	Female Medical	Handling and Disposal of Linen	08/07/2009	77%	Partial Compliance

Daisy Hill	High Dependency	Kitchen	28/10/2009	83%	Partial Compliance
Daisy Hill	High Dependency	Departmental Waste	28/10/2009	84%	Partial Compliance
Daisy Hill	Male Medical	Environment	08/07/2009	76%	Partial Compliance
Daisy Hill	Paediatrics	Patient Equipment (General)	24/06/2009	79%	Partial Compliance
Daisy Hill	Paediatrics	Departmental Waste	24/06/2009	80%	Partial Compliance
Daisy Hill	Paediatrics	Patient Equipment (General)	24/06/2009	79%	Partial Compliance
Daisy Hill	Paediatrics	Departmental Waste	24/06/2009	80%	Partial Compliance
Daisy Hill	Rehab	Departmental Waste	24/06/2009	80%	Partial Compliance
Longstone	Cherryvilla	Departmental Waste	01/12/2009	82%	Partial Compliance
Lurgan	Stroke Unit	Environment	30/09/2009	82%	Partial Compliance
Lurgan	Ward 6	Environment	30/09/2009	81%	Partial Compliance
South Tyrone	Loane House 2	Handling and Disposal of Linen	09/06/2009	78%	Partial Compliance
St Lukes	Villa 2	Departmental Waste	06/10/2009	78%	Partial Compliance
St Lukes	Ward 5	Patient Equipment (General)	02/06/2009	77%	Partial Compliance
St Lukes	Ward 5	Safe Handling and Disposal of Sharps	29/09/2009	82%	Partial Compliance

Level of Compliance	
Compliant	85% or above
Partial compliance	76 to 84%
Minimal compliance	75% or below

Audit of Infection Control Standards		
Level of Compliance	**Score Range**	**No. of Scores which fall into this range**
Compliant	85% or above	35
Partial compliance	81 to 84%	11
Partial compliance	76 to 80%	19
Minimum compliance	66 to 75%	29
Minimum compliance	51 to 65%	24
Minimum compliance	50% or less	15
Total No. of Audits carried out		**143**

5. Action Plan

This Action Plan was developed from recommendations following Departmental Audits. The Action Plan is work in progress and when actions are completed they will be removed.

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Jul-09	CAH	High	2 West	82	84	45	96	High and low dusting issues, dirty sink, shower head to be changed and shower chair needs replaced.	Shower heads replaced 2/12/09. Cleaning issues addressed with Domestic.					Jan-10
Dec-09	CAH	Mod	Cath Lab	82	81	50	93	Cleaning issues - low and high dusting and floors.	Cleaning issues addressed with Domestic.					Jan-10
Nov-09	CAH	Mod	Cedars	79	78		82	Low and high dusting issues, walls require repainting.	Cleaning issues addressed with Domestic. Painting referred to Estates to assess and cost.	Repainting				
Sep-09	CAH	Very High	Delivery	84	84	80	84	Major construction work ongoing in the area. Works due to be completed March 2010, in the meantime Support Services working closely with Bus. & Planning and Nursing to try and address problems as best possible.		No further action at present				
Nov-09	CAH	Very High	Delivery	83	85	82	76	Ongoing building works in this area.		No further action at present				
Jul-09	CAH	Very High	Delivery	84	85	76	82	Dusting issues due to ongoing building works. Some estate work to be reported after building work completed.		Awaiting details of further works				

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Aug-09	CAH	Mod	Elms	74	87		11	Painting & floor covering, required in all flats and communal areas. New kitchens required in all flats. Furniture & bedding required	A business case is being prepared to request funding	Refurbishment will be completed pending funding	Support Services			
Nov-09	CAH	Mod	Elms	84	86		79	Painting & floor covering, required in all flats and communal areas. New kitchens required in all flats. Furniture & bedding required	A business case is being prepared to request funding	Refurbishment will be completed pending funding	Support Services			
Jun-09	CAH	Mod	Laundry	83	81	100	90	Cleaning issues - low dusting. Estates issues - area in need of refurbishment. Sanitary areas need refurbished, floors need replaced and painting throughout the area.	Cleaning issues addressed.	Await further comment re audit.				
Jul-09	CAH	Mod	Laundry	72	76		59	Cleaning issues - floors and low dusting. Estates issues - area in need of refurbishment. Sanitary areas need refurbished, floors need replaced and painting throughout the area.	Cleaning issues addressed with Domestic.	Await further comment re audit.				
Sep-09	CAH	Mod	Laundry	74	76		71	Cleaning issues - floors and low dusting. Estates issues - area in need of refurbishment. Sanitary areas need refurbished, floors need replaced and painting throughout the area.	Cleaning issues addressed with Domestic.	Await further comment re audit.				
Oct-09	CAH	Mod	Laundry	84	80		100	Estates issues - area in need of refurbishment. Sanitary areas need refurbished, floors need replaced and painting throughout the area.		Await further comment re audit.				

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Nov-09	CAH	Mod	Lifts, levels	84	91		50	Estates issues - lifts and levels in need of refurbishment. Floors need replaced, sanitary areas need refurbished and painting required.	Referred to Estates to assess and cost.					
Aug-09	CAH	Mod	Maples	83	79		100	Painting & floor covering, required in all flats and communal areas. New kitchens required in all flats. Furniture & bedding required	A business case is being prepared to request funding	Refurbishment will be completed pending funding	Support Services			
Jun-09	CAH	Mod	Stores	60	57	50	71	There are insufficient hours going into this area, poor storage practices are evident and stores area is in need of refurbishment.	Some additional hours have been put into stores and Stores Manager is reviewing storage issues.		Jim Crozier			
Jul-09	CAH	Mod	Stores	80	79		82	There are insufficient hours going into this area, poor storage practices are evident and stores area is in need of refurbishment.	Some additional hours have been put into stores and Stores Manager is reviewing storage issues.		Jim Crozier			
Aug-09	CAH	Mod	Stores	82	82		84	There are insufficient hours going into this area, poor storage practices are evident and stores area is in need of refurbishment.	Some additional hours have been put into stores and Stores Manager is reviewing storage issues.		Jim Crozier			
Sep-09	CAH	Mod	Stores	68	67	67	73	There are insufficient hours going into this area, poor storage practices are evident and stores area is in need of refurbishment.	Some additional hours have been put into stores and Stores Manager is reviewing storage issues.		Jim Crozier			

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Nov-09	CAH	Mod	Stores	79	75		94	There are insufficient hours going into this area, poor storage practices are evident and stores area is in need of refurbishment.	Some additional hours have been put into stores and Stores Manager is reviewing storage issues.		Jim Crozier			
Oct-09	CAH	Low	Transport	74	77		63	High and low dusting. Estates - floors need replaced, painting required.	Cleaning issues addressed with Domestic. Floors and painting referred to Estates to assess and cost.				£1500 including all pre paint repairs.	
Jun-09	Daisy Hill	High	A & E	76	74	75	79	Vents Dusty. Cleaners Store dusty and untidy. Insufficient domestic hours into this area.	Vents cleaned Oct 09. Request has been made to install Mailbox in Cleaners store to create more space. This store is shared space. Additional domestic hours have gone into this area on a temporary basis.					Jan 10
Aug-09	Daisy Hill	High	A & E	70	63	87	74	Vents dusty. Painting required. High and low dust. Build up in corners. Insufficient domestic hours into this area.	'One off' allocation of extra time given to Department at night to address cleaning issues. Vents cleaned October 09. Painting referred to Estates to assess and cost. Additional domestic hours have gone into this area on a temporary basis.					Jan 10

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Jul-09	Daisy Hill	High	A&E	73	69	85	75	Painting required. Vents dusty. Staff room needs deep cleaned. High and low level dusting. Performance issues highlighted and insufficient domestic hours into this area.	Painting issues referred to Estates to assess and cost. Domestic Asst worked additional hrs to gain access to Staff room and to carry out dusting. Vents cleaned October 09. Performance issues addressed with the member of staff. Additional domestic hours have gone into this area on a temporary basis.					Jan 10
Sep-09	Daisy Hill	High	A&E	80	76	93	80	Low level dusting. Build up in corners. Hoover floor in Sister's Office and high and low level dusting. Vents dusty. Bathroom tile cracked, light needs cleaned and new pull cord. Repainting of walls in Fracture Waiting Area and chair needs recovered. Insufficient domestic hours into this area.	Domestic Assistant addressed cleaning issues. Painting issue referred to Estates to assess and cost. Chair removed 16/9/09 for recovering. Vents cleaned in Oct 09. Additional domestic hours have gone into this area on a temporary basis.	Repaint	Contractor		£750 Decant may be necessary	
Jun-09	Daisy Hill	Low	Ambulance Control	78	77	70	85	All areas need repainted. Shower curtain needs replaced. High level dusting. Hallway and Rest Room cluttered.	High level cleaning completed. Shower curtain replaced. Painting issues referred to Estates to assess and cost. Cluttered issues to be addressed by Ambulance Staff.	Repaint	Contractor		£750	

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Sep-09	Daisy Hill	Low	Ambulance Control	84	80	90	90	High and low level dusting. Study Room carpet needs shampooed and walls repainted. Main Entrance sloping roof needs cleaned. Tops of lockers dusty. Walls in ladies WC require to be washed.	Domestic issues addressed. Deep clean completed October 09.	Repaint	Contractor		£750	
Jun-09	Daisy Hill	High	Coronary Care	81	86	75	75	Wall ledges need painted. Dust on high and low surfaces	Domestic Asst addressed cleaning issues. Painting issues referred to Estates to assess and cost.	Repaint	Contractor		£1000 Decant may be required	
Oct-09	Daisy Hill	High	Coronary Care	80	86	70	75	Walls need repainted. Windows smeared. Dust on window ledge. Build-up in corners.	Domestic issues addressed. Window cleaners due this month. Painting referred to Estates to assess and cost.	Repaint	Contractor		£1000 Decant may be required	
Aug-09	Daisy Hill	High	Female Medical	84	84	89	80	Vents dusty. Build up in corners. High and low dust. Shower curtain dirty. Vinyl wall covering coming away from walls in shower areas.	Vents completed – Toilet areas 08/09/09 Wards 10/10/09. Domestic addressed cleaning issues. Shower curtain has been replaced. Wall covering in all shower areas throughout the Hospital referred to Estates to assess and cost.	Repaint	Contractor		£2250 Decant may be necessary	
Sep-09	Daisy Hill	High	Female Medical	74	67	91	76	Low and high level dusting. Build up under soap dispensers. Debris on floors. Glass smeared. Doors need repainted - WC 8056, Sluice Room and walls in Ward 19, 21 and 22. Beds dusty. Performance issues highlighted.	Domestic Assistant addressed cleaning issues. Painting issues referred to Estates to assess and cost. Performance issues addressed with the member of staff.	Repaint	Contractor		£2250 Decant may be necessary	

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Sep-09	Daisy Hill	High	Male Medical	83	78	91	88	Heavy dust on beds. Under sinks dirty. Prep Room, build up in corners. Build up on taps. Outside of bins dirty. Ward 2 - walls need repainted and damp patches on ceiling.	Domestic Assistant addressed cleaning issues. Painting issue referred to Estates to assess and cost. Nursing to address dust on beds.	Repaint	Contractor		£750	
Oct-09	Daisy Hill	High	Male Medical	79	72	86	88	High ledges dusty, floors need scrubbed. Build-up under soap dispenser. Mirror dirty. Walls need repainted.	Domestic issues addressed. Other issues referred to Estates to assess and cost.	Repaint	Contractor		£2500 Decant may be required	
Jun-09	Daisy Hill	High	Male Medical	77	71	95	72	High and Low level dusting, bins dirty, under sinks dirty. Doors and walls need repainted.	Domestic Asst addressed cleaning issues. Painting issues referred to Estates to assess and cost.	Repaint	Contractor		£2500 Decant may be required	
Aug-09	Daisy Hill	High	Male Medical	81	76	86	88	Vents dusty. Low and high surfaces dusty. Walls need painted in Ward 3. Performance issues highlighted.	Domestic Assistant addressed cleaning issues. Vent cleaning completed 09/09/09. Painting issues referred to Estates to assess and cost. Performance issues addressed with the member of staff.	Steam cleaner being purchased to address build up in corners. Repaint.	Contractor		£2500 Decant may be required	
Jun-09	Daisy Hill	High	Male Surgical	80	79	76	88	Painting issues. Parts of floor covering need repaired. Daily cleaning issues, ie glass smeared, bin dirty, debris on floor, dust on cupboard. Wall ledges need repainted.	Domestic Asst addressed cleaning issues. Painting and floor repairs referred to Estates to assess and cost.	Ward Manager liaising with Estates to arrange access to fix floor. Repaint.			£2500 Decant may be required	
Sep-09	Daisy Hill	High	Medical/ Stroke Unit	82	80	79	88	Holes in wall need filled and repainted in Ward 5. High and low level dusting. Floor area needs scrubbed. Dust on medical equipment.	Domestic Assistant addressed cleaning issues. Nursing to address medical equipment. Other issues referred to Estates to assess and	Repaint	Contractor		£750	

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
									cost.					
Jun-09	Longstone	High	Donard	82	77	100	70	Estates issues - damage to walls and doors.	Issues referred to Estates to assess and cost.					
Oct-09	Longstone	High	Donard	83	83	100	78	Painting required in kitchen, day room, side room and store. High and low level dusting required.	Painting referred to Estates to assess and cost. High and low level dusting completed.					
Nov-09	Longstone	High	Donard	83	80	100	84	High/Low level dusting. Painting required.	High/Low level dusting completed. Painting referred to Estates to assess and cost.					
Jun-09	Longstone	High	Mourne	81	80	100	64	Estates issues - damage to walls and doors.	Issues referred to Estates to assess and cost.					Jan-10
Jul-09	Longstone	High	Mourne	78	77	88	69	Painting required for 2 dormitories. Kitchen floor covering to be replaced. High & low level dusting required.	Painting & floor covering referred to Estates to assess and cost. High & low level dusting completed.					Jan-10
Aug-09	Longstone	High	Mourne	83	86	100	65	Painting required for 2 dormitories. Kitchen floor covering to be replaced. High & low level dusting required.	Painting & floor covering referred to Estates to assess and cost. High & low level dusting completed.					Jan-10
Nov-09	Longstone	High	Mourne	59	61	59	56	High and Low Level dusting. Painting programme requested.	High/Low level dusting completed. Painting programme commenced.					Jan-10
Jul-09	Longstone	High	Sperrin	81	89	82	74	Replacement floor covering required for corridor. Refurbishment of ward kitchen required. High & low level dusting required.	Replacement flooring & kitchen refurbishment referred to Estates to assess and cost. High & low level dusting completed.				£7,000	

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Aug-09	Longstone	High	Sperrin	84	80	88	86	Replacement floor covering required for corridor. Refurbishment of ward kitchen required. High & low level dusting required.	Replacement flooring & kitchen refurbishment referred to Estates to assess and cost. High & low level dusting completed.				£7,000	
Dec-09	Longstone	High	Sperrin	84	84	92	82	Replacement floor covering required for corridor. Refurbishment of ward kitchen required. High & low level dusting required.	Replacement flooring & kitchen refurbishment referred to Estates to assess and cost. High & low level dusting completed.				£7,000	
Aug-09	Mullinure	Mod	Dental & Decont.	82	93	100	54	Painting is in progress						Jan-10
Sep-09	Mullinure	Mod	Dental & Decont.	82	93	100	54	Painting ongoing						Jan-10
Oct-09	Mullinure	Low	External Grounds	73		73		Debris around bin enclosure.	Debris removed.					Jan-10
Aug-09	Mullinure	High	M.I.U.& Treatment	82	91	100	57	Painting is in progress						Jan-10
Aug-09	Mullinure	Mod	Physio & O.T.	82	92	95	59	Painting is in progress						Jan-10
Sep-09	Mullinure	Mod	Physio & OT	82	92	95	59	Painting ongoing						Jan-10
Sep-09	South Tyrone	Low	C Floor Admin	81	85	82	74	Removal of clutter. Painting required. Replacement light fittings required. Replacement ceiling tiles required.	De-clutter discussed with appropriate staff. Estates issues referred to Estates to assess and cost.	Painting to commence 25/1/10				
Nov-09	South Tyrone	Low	External Grounds	72	76	60	69	Debris externally.			Estates			
Sep-09	South Tyrone	Low	F Floor Left, Admin	82	86	71	88	High/low level dusting required. Waiting area and toilet walls require painting.	Domestic issues being addressed. Estates issues referred to Estates to assess and cost.				£500	

Month	Hospital	Risk Category	Department	Average Score Below 85 %	Domestic %	Nursing/ Manager %	Estates %	Domestic/ Estates Issues Identified	Action Taken to Address Issues	Action Planned	By Whom	Timescale	Any Cost Implications	Completion Date
Jul-09	South Tyrone	Mod	Hospital Reception	81	81	88	75	Painting issues at entrance, waiting area, toilet & dirty utility-room. Ceiling tiles to be replaced. Toilet floor needs wet scrub. Clean equipment in domestic store.	Painting programme and replacement ceiling tiles referred to Estates to assess and cost. Toilet wet scrubbed. Cleaning equipment damp wiped.				£500	
Oct-09	South Tyrone	Mod	Hospital Reception	75	71	71	87	Walls, doors, entrance, toilet and domestic store require painting. High and low level dusting required. Hard floors require wet scrub.	Painting issues referred to Estates to assess and cost. High and low level dusting completed. Floors wet scrubbed.				£500	
Aug-09	South Tyrone	Low	Medical Records, Corr II	71	67	70	77	Walls require repainting throughout, light fittings require removed for cleaning, medical records 1,2 cluttered, low and high surfaces damp dusting required.	Dusting issues addressed.				£1,500	
Sep-09	South Tyrone	Mod	Out-of-Hours	82	92	100	55	Painting required throughout, radiators require cleaned. High dusting required.	Painting issues referred to Estates to assess and cost.				£1,400	
Dec-09	South Tyrone	Low	SS Training Unit	84	78	100	100	High and low dusting.	Dusting issues addressed.					Jan-10
Oct-09	St Luke's	Mod	Mortuary	82	82	100	79	Painting required. High and low level dusting required.	Painting referred to Estates to assess and cost. High and low level dusting completed.				£5,000	
Oct-09	St Luke's	High	Ward 2	83	82	91	83	High and low level dusting required. Touch up paint work on door frames. Day room curtains require laundering.	High and low level dusting completed Day room curtains removed for laundering. Painting referred to Estates to assess and cost.					Jan-10
Jun-09	St Luke's	Mod	OT	84	83	90	89	Refurbishment of OT not complete	Refurbishment delayed due to leak in roof				£2,000	

6. 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.

Audit	Facility	Dept	Work Required
EC Departmental	CAH	Elms	Refurbishment
EC Departmental	CAH	Maples	Refurbishment
EC Departmental	CAH	Laundry	Refurbishment
EC Departmental	CAH	Stores	Refurbishment. Storage issues to be reviewed.
EC Departmental	CAH	Transport	Painting
EC Departmental	DHH		Walls to be recovered in all shower areas throughout hospital.
EC Departmental	DHH	A&E	Painting
EC Departmental	DHH	Ambulance Control	Painting. Sloping roof to be cleaned.
EC Departmental	DHH	Coronary Care	Painting
EC Departmental	DHH	Female Medical	Painting
EC Departmental	DHH	Male Medical	Painting. Damp patches on ceiling.
EC Departmental	DHH	Male Surgical	Painting. Floor needs repaired.
EC Departmental	DHH	Medical/Stroke	Holes in wall need filled and repainted.
EC Departmental	Longstone	Donard	Painting required and refurbishment of ward kitchen.
EC Departmental	Longstone	Mourne	Kitchen and Bay 10 flooring to be replaced.
EC Departmental	Longstone	Sperrin	Floor covering to be replaced. Refurbishment of ward kitchen.
EC Departmental	Longstone	Cedarwood	Refurbishment of domestic store.
EC Departmental	Longstone	IATU	Refurbishment of staff shower room and patient shower room.
EC Departmental	South Tyrone	C Floor Admin	Ceiling tiles to be replaced.
EC Departmental	South Tyrone	F Floor Admin	Ceiling tiles to be replaced, painting required.
EC Departmental	South Tyrone	Reception	Ceiling tiles to be replaced, painting required.
EC Departmental	South Tyrone	Medical Records Corr II	Painting required throughout.
EC Departmental	South Tyrone	Out-of-Hours	Touch painting in Consulting Room 3.
EC Departmental	St Lukes	Mortuary	Painting

EC Departmental	St Lukes	Ward 2	Touch up paint work on door frames, clean door vents, replacement flooring toilets, night duty station.
EC Departmental	St Lukes	Ward 3	Clean door vents, replacement floor covering clinical room, quiet room and nurses station.
EC Departmental	St Lukes	Villa 2	Painting of day rooms.
EC Departmental	St Lukes	Villa 3	Replacement floor covering in corridor.
EC Departmental	St Lukes	Addiction Unit	Painting to stairway, landing and day room.
EC Departmental	St Lukes	OT	Repair to leaking roof.
RQIA 10/8/09	South Tyrone	Loane House	Locked cupboard required in store.
RQIA 19/2/09	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.
RQIA 19/2/09	DHH	Medical/Stroke	Paintwork touch-up. Repair damage to floors in bays 3 and 4. Temperature recordings are required for patient dishwasher. Ward kitchen to be refurbished.
RQIA 19/2/09	DHH	Male Surgical	Replace floor in ward 3. Refurbishment of dirty utility needed.
RQIA 19/2/09	DHH	Outpatients	Repair walls and repaint. Painting of 2 doors in consulting room 6. Sinks to be repaired/replaced. There is a need to provide a segregation area for waste.
RQIA 9/4/09	DHH	Delivery Suite	Refurbishment of changing rooms.
RQIA 14/10/09	CAH	A&E	Rolling programme for repainting needs to be established. Wheelchairs to be checked for damage to upholstery and repaired or replaced.
RQIA 14/10/09	CAH	Outpatients	ENT needs refurbished and redecorated.
RQIA 7/3/08	CAH	2 South	Refurbishment of ward kitchen.
RQIA 7/3/08	CAH	Outpatients	Refurbishment of dirty utility.

General Comments

- 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 rack 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.

The Trust proposes to implement ICNA action plans across the Trust's hospital settings to provide added assurance to Trust Board and it is intended that these action plans will remain at ward level.

Incorporates changes agreed by SMT Governance on 23rd November

Southern Health & Social Care Trust: Summary of Corporate Risks as at November 2011

No	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2011)	Lead Director	Status
1	Achievement of PfA Access targets and review appointments to secure timely assessment and treatment • A number of inpatient/DC/OP waiting times significantly beyond access standards • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of IRMER with unfunded additional capacity and no regional standard for areas appropriate for IRMER	• Bi-weekly reporting to SMT • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Bids submitted for non-recurring funding on a quarterly basis • Performance meetings with RHSCB • Review backlog plan submitted to RHSCB • OP Review backlog action plan in place and being incrementally implemented. • Bids for additional capacity submitted and secured on a specialty basis • Bi-weekly reporting to SMT	• On-going work with RHSCB to agree capacity gaps and associated funding requirements • Qtr 3 and 4 non-recurring bid for additional resources submitted to HSCB • Business case for Team South Urology now approved (July 2011) • Consultant recruitment proceeding for establishment of local Ophthalmology service • Identification of IS support with HSCB for approval where no IH capacity exists and access times are now extending to almost 52 weeks. IS contracts placed for Orthopaedics, Ophthalmology, Oral Surgery and Scopes. • In house additional capacity utilised where possible within funding allocated Plain Film X Ray • IS and IHA utilised (but unfunded) to maintain reading of non-IRMER plain film X Rays at 28 days • RQIA draft Report Phase 1 Action Plan in progress. Phase 2 visit on 23 August 2011. No report received as yet. OP Review Backlog • RVBL Team established to cleanse lists • Specialist Nurses working with relevant consultants to screen urgent reviews and longest waiters	P&R/ Operational Directors	HIGH

Incorporates changes agreed by SMT Governance on 23rd November

			• Cutting plans being formalised to monitor steady reduction of review backlog waits in association with non-recurrent funding of in-house additional capacity		
2	Achievement of statutory functions/duties: Level of Unallocated Child Care Cases	• Weekly monitoring and review of numbers of unallocated cases and reports to AD • Monthly Priority 5 Report to DHSSPS and HSCB • Monthly reporting to Trust Board • Social work supervision and line management arrangements in place • Fortnightly reporting to the Chief Executive commenced September 2011 • RQIA Review action plans in place and being implemented • Workforce Strategy Group in place	• Participation in regional demand and capacity work (RHSCB leading) • Working regionally with RHSCB and other Trusts to develop 'threshold' standards • The Trust has received recurrent funding from HSCB to address unallocated cases. The Trust has started the recruitment process to establish a Court LAC Team that will deal with interim care proceedings cases, thus increasing the capacity within FIT to allocate Family Support Cases. • Template being developed by HSCB to monitor Trust reductions in unallocated cases.	CYP	HIGH
3	Achievement of statutory functions/duties: Level of OPPC Domiciliary clients Annual Reviews not completed	• Monthly monitoring of reviews undertaken by Head of Service/ADs.	• Domiciliary Care Reviews – exercise underway to scope the number of reviews carried out and those outstanding • An excel spreadsheet is in development that will provide staff with a live register of expected review dates for Residential and Nursing Home clients, as well as for domiciliary care reviews • Social work capacity and demand work underway to identify the long term requirements to manage the review process in a timely fashion	OPPC	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

			• Recruitment of additional temporary social work staff underway to provide additional resources to ensure the Trust reaches compliance with the expected annual review process		
4	Systems of assessment and assurance in relation to quality of Trust services Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• C&SC Governance Review completed and new structures and assurance reports being implemented • Update on implementation to Governance Committee on a quarterly basis • Governance Committee, SMT Governance Group and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to SMT/ Governance Committee • CHKS comparative mortality benchmarking tool - contract in place and information extracted for governance information • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/NED programme of visits in place and feedback to Chief Executive • For SAIs and appropriate level of AIs, investigation/RCA process embedded with reports	• Embedding of new Governance Structures/processes underway • Web-based incident reporting (on Datix) being rolled out – target date for full roll out 1.4.2012 • Review of Specialty M&M system completed. Implementation taking place • Management of Change process in place to minimise risk of this organisational change • Reviewing and revising Incident Policy and SAI Management Policy • Risk Management Policy to be reviewed by 2012 • Clinical and Quality indicator programme of work across Directorates • Director of Nursing report being developed • Medical Director developing proposals for establishment of Patient Safety Forum • Internal Audit of complaints and incidents planned for November 2011	CX	MODERATE

		to Director/SMT Governance to approve recommendations/ actions and ensure shared learning • Governance Committee SMT Governance, Governance Working Body, Divisional and Directorate Governance For a Professional Governance Fora Patient Experience Committee for shared learning			
5	Compliance with Standards and Guidelines • Need for full assessment of Trust position in relation to ALL guidelines issues and endorsed by DHSSPS and RHSCB • Identification where financial and service implications affect compliance and escalation of same to DHSSPS/RHSCB	• Following Governance Review, new system now in place for Clinical Guidelines • SMT Governance (monthly) and Governance Committee • Drugs and Therapeutics Committee (quarterly) • System of logging and monitoring standards and guidelines • SABS system in place for Safety Action Bulletins	• Need to ensure that all standards and guidelines are assessed in relation to compliance • Any received from 1 April 2010 system of assessment of compliance and reporting in place • All NICE guidelines and NPSA guidelines received from 1 January 2009 have been reviewed and any actions required are being taken forward. Any received prior to this date have not yet been reviewed as to level of compliance due to capacity and on-going demand – action underway to scope risk • Compliance report completed for Standards and Guidelines from 2010 • Review of SABS process map to ensure effective dissemination and management of Safety Action Bulletins	CX	**MODERATE**

Incorporates changes agreed by SMT Governance on 23rd November

6	Lack of compliance with RQIA recommendations in relation to the management of medicines management in domiciliary care	Risk management includes • Training programme for domiciliary care staff in place • Trust Medicines Management policy • Review of operational procedures • Induction training for new Dom Care Supervisors	• Issues with achievability of compliance have been raised with HSCB • Working Group in place • Operational guidance for domiciliary care staff to be finalised • Workshop arranged with IS providers to share best practice • Trust representatives on regional group	OPPC/DoN	HIGH
7	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• MES prioritised investment plan agreed by Trust Board and shared with DHSSPS • Recent capital allocations have addressed highest priority risks and this process is on-going CRL also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform MES investment • Recommendations from RQIA hygiene inspection reports prioritised for CRL/Minor works where no other funding source available • £3,753k MES funding secured for 11/12 • Business case approved and 11/12 phased funding for CAH T1-4 secured • Business cases in development to address significant MES infrastructure issues requiring investment > £500k • Structural engineer reports commissioned for sites at higher risk to inform action plan	P&R	HIGH
8	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within MES - £600K allocated for 2010/11 & £1.3m for 2011/12	• Additional staff being recruited (at risk) to implement highest priorities on action plan including Fire risk assessments and fire audits • Staff training on-going • Fire Safety Action Plan in place and to be monitored quarterly • New methods for delivering mandatory fire training agreed and to be implemented and tested 2011/12	P&R	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

			• Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out		
9	High Voltage capacity limit on electrical supply to CAH • Identified under MES scheme • Possible limit to expansion of service provision on the CAH site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand	• Developing schemes with NIE on options for provision of increased supply capacity • Investigating funding streams with SOC to be submitted to HEIG November 2011	P&R	HIGH
10	HCAI	• Increased level of C.difficile April/May 11 picked up through monitoring systems • Action Plan in place • Dedicated ward opened • Action Plan for C Diff Public Inquiry Recommendations agreed and being implemented • Tailored package of actions to deal with Norovirus outbreak • Major focus on staff training • IV Peripheral Line project rolled out in August 2011	• Action plan being implemented and reported to SMT • Monitoring indicating that levels back to normal	Medical Director	MODERATE
11	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers	• Development of key interfaces underway • Intensive training programme for Investigation and Designated officers is underway • Workshops scheduled for the Autumn to roll out the Procedural Guidance • Taking forward the implementation of the Soscare Vulnerable Adults module to address our information	CYP	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

		• Report to Trust Board as part of Statutory Functions Reporting	requirements • Application to research department to examine decision making and thresholds within Adult Safeguarding has been successful. This research will now commence • Work ongoing with Community Information Department to agree a safeguarding dashboard report for presentation at directorate and SMT Governance meetings		
12	ID1971 Potential for harm to patients/clients/staff/visitors as LD/MH clients released from prison into the community including those on probation	• On-going liaison with PBNI and PPS • CX wrote to DHSSPSNI and NIO 10/9/09 to outline concern • Monthly review at MH/LD Governance meeting • Individual client specific control measures	• Meeting with Director Prison Health on 7/1/11 and a range of actions agreed • Trust currently reviewing recommendations from MoD case to identify any actions required • Risk summary being updated for sharing with NI courts & tribunals service with covering letter	MH&D	MODERATE
13	Implementation of new regional on-call arrangements. Risks in relation to disruption to services in the 'out of hours' period as a result of staff withdrawing from on-call rotas from 1.10.2011 due to the reduction in on-call payments. The following services are provided by staff who will experience the biggest reductions in on-call payments: • Social Work out of hours service • Pharmacy emergency duty • Radiography out of hours service	• Meetings with Directorates and HR are currently taking place to consider alternative ways of working for example, partial / full shifts, extended days, recruitment of staff to waiting lists where this is possible and appropriate in order to ensure cover can be provided during the out of hours period from October onwards. • JNCF standing agenda item for discussion with Trade Union colleagues • Director of Social Work & HR collated OOH Social Work information.	• Contingency arrangements are currently being explored. • SMT approved Project Structure for delivery of on-call implementation with Trade Union representation. • Involvement in regional discussions across Trusts to share experience / learning	CYP/ HR&OD	**MODERATE**

Incorporates changes agreed by SMT Governance on 23rd November

	• Laboratory out of hours service	• Director of Social Work & HR have issued letter to all co-ordinators. • Out Of Hours Project Team established in the Trust • Director involved in regional group chaired by Director of HSCB to review developments • Current Arrangements to remain in place until 2012			
14	Development of robust Business Continuity Planning arrangements	• Business Continuity Plans were developed in most Directorates in preparation for pandemic in 2009. • Performance management arrangements in place between PHA/HSCB and SH&SCT • Further development of plans for severe weather • Stock take undertaken • Engagement of Consultant	• Project Manager to be recruited to embed business continuity planning within the organization. • Business impact analysis and review of existing plans to be undertaken • To be reviewed monthly by Medical Director • To be reviewed monthly by SMT		**MODERATE**
15	Day of Industrial Action – 30th November 2011: - Failure to have in place contingency staffing arrangements - Delayed urgent appointments/procedures as a result of appointments having to be cancelled	• Ongoing discussions with Trade Union representatives locally • Ongoing regional discussions and principles agreed for strike action on 30.11.11	• Joint Management/Trade Union communiqué issued requesting that all Trade Union members notify their line manager as to whether they intend to take strike action • Impact on services following discussions with Trade Unions agreed re minimum staffing levels • For all services, where possible, appointments are not booked for 30.11.11 • Meetings with Management and Trade Union representatives scheduled to monitor ongoing impact of industrial action		**MODERATE**

Incorporates changes agreed by SMT Governance on 23rd November

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
16	Fully embedded appraisal system – lack of evidence of compliance	• Succession Planning - established and on-going • Evaluation • Governance – new arrangements in place and ongoing • KSF policy and monitoring system in place • Consultant appraisal policy and monitoring system in place	• KSF – Currently implementing • Supervision – combining staff supervision/KSF and PDP by September 2011 • Mandatory Training		**MODERATE**
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
17	Achievement of financial balance in 2011/12 • In year • Recurring	• Financial Plan in place and agreed by Trust Board • BCBV Project structure • Contingency Plan for 2011/12 in place • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Month 6 position analysed and on target for year end break even (N/R) • Month 6 monitoring of recurrent plan showing satisfactory progress	DoF/ All	MODERATE
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to CoPE coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Request for review of role/terms of reference of newly formed Social Care Procurement Unit to Regional Social Care Procurement Group and Regional Procurement Board	• Action plans in place to address weaknesses identified in IA reports with updates to SMT and Audit Committee • interim arrangements for improved support to monitoring and workplan for review of contracts documentation agreed to improve robustness of social care contract management &	DoPI/DoF/All	MODERATE

Incorporates changes agreed by SMT Governance on 23rd November

		• Interim approach for social care procurement agreed by SMT in absence of CoPE support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by COPE • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT	monitoring • Scoping exercise to commence to establish central database for all Trust contracts and recommend best way forward for contracts management arrangements. Recruitment of temporary staff to complete scoping exercise underway with appointments to be in place by December 2011. • Project Manager appointed October 2011 and due to commence in December 2011 • Trust has responded to draft recommendations of J. Allen Review of Procurement and awaits final recommendations of Procurement Policy		
19	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 12-18 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of 26-30 staff to oversee the implementation	• The Trust has established an implementation structure • Engagement in regional process	• The Trust requires a clearly documented and communicated HR strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases		HIGH

Incorporates changes agreed by SMT Governance on 23rd November

Changes to Corporate Risk Register since September 2011 - date

Date	Decision taken at	Changes to Corporate Risk Register
28th September 2011	**SMT Governance**	Remove Corporate Risk 14 '**Decontamination of dental instruments and podiatry instruments'** from Corporate Risk Register Agreed addition of '**Implementation of Business Systems Transformation Programme'** to Corporate Risk Register. Risk assessments in relation to i) 'Lack of Business Continuity Plans' and ii) 'Industrial Action' to be considered at next SMT Governance meeting.
2nd November 2011	**SMT Governance**	Remove Corporate Risk 2 '**Alternative provision for clients placed in Southern Cross Care Homes'** from Corporate Risk Register Agreed addition of '**Business Continuity Plans' and 'High Voltage Infrastructure**' to Corporate Risk Register. Risk assessment in relation to Industrial Action to be considered at next SMT Governance meeting
9th November 2011	**SMT**	Agreed addition of '**Proposed Industrial Action on 30th November 2011**' to Corporate Risk Register
23rd November 2011	**SMT Governance**	Downgrade Corporate Risk 4 '**Systems of assessment and assurance in relation to quality of Trust services'** from high to moderate risk Remove Corporate Risk 13 '**Full compliance with RQIA Maternity Review recommendations'** and Corporate Risk 14 '**Implementation of RQIA recommendations from 'Independent Review of Reporting Arrangements for Radiological Investigations Phase 1'** from Corporate Risk Register

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

4th December 2012

Summary of Corporate Risks as at November 2012

There are 18 Corporate Risks (6 high level and 12 moderate level) as agreed by the Senior Management Team on 28th November 2012

HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since April 2012
1. Ongoing achievement of PfA access targets and review appointments	1	HIGH	Unchanged
2. Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	HIGH	⇧
- Care Management processes	1	HIGH	New risk added on 31.10.12
3. Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
4. RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	1	HIGH	Unchanged
5. High Voltage capacity limit on electrical supply to Craigavon Area Hospital	1	HIGH	Unchanged
6. Implementation of Business Systems Transformation Programme	5	HIGH	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
7. Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
8. Compliance with Standards and Guidelines	1	MODERATE	Unchanged
9. Fire Safety	1	MODERATE	Unchanged
10. Asbestos – legal compliance with legislation	1	MODERATE	New risk added on 4.7.12
11. HCAI – risk to achievement of PfA target	1	MODERATE	Unchanged
12. Risk of harm to patients from water borne pathogens	1	MODERATE	New risk added on 2.5.12
13. Protection of Vulnerable Adults – inconsistencies in practice and Issues with interagency working	1	MODERATE	Unchanged

MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since April 2012
14. Implementation of new regional on-call arrangements	**1**	**MODERATE**	Unchanged
15. Robust Business Continuity Planning	**1**	**MODERATE**	Unchanged
16. Fully Embedded Appraisal system	**4**	**MODERATE**	Unchanged
17. Financial Balance – risk in 2012/13 that the Trust will not achieve financial balance in year and not meet requirement for £11m cash release	**5**	**MODERATE**	Unchanged
18. Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Note – Red font indicates the changes that have been made to the Register since September 2012

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at October 2012

No	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (November 2012)	Lead Director	Status
1	Achievement of Priority for Action access targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times significantly beyond access standards (Acute and Mental Health areas) • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations • A number of patients waiting beyond Allied Health Professions access target	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Bids submitted for non-recurring funding on a quarterly basis • Performance meetings with Health and Social Care Board • Review backlog plan submitted to Health and Social Care Board • Outpatients Review backlog action plan in place and being incrementally implemented. • Bids for additional capacity submitted and secured on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. A number of Investment Proposal Templates (IPTs) submitted and others to be developed after notification of Commissioner intent to proceed. Offers now made by Health and Social Care Board for General Surgery, Gynaecology and AHP investment. • Quarter 3 and Quarter 4 bids for non recurrent funding submitted to Health and Social Care Board for all specialties with gaps with requirement to maintain access at March 2012 position by March 2013. Capacity increased both in-house and in Independent Sector. • Independent Sector contracts re-let for 2012/13 include mobile MRI capacity, Ophthalmology, Oral Surgery, Orthopaedics and Urology • Business case for Team South Urology approved (July 2011). 3 Urologists will be in post from November 2012. • Consultant recruitment for local Ophthalmology service successful with the lead post appointed. Out to recruitment for second Consultant post. In discussion with Co-operation and Working Together (CAWT) and Dublin North East. Future potential for small volume of long waits to flow to Dublin North East.	Performance and Reform/ Operational Directors	HIGH

			• In house additional capacity utilised where possible within funding allocated • Risks to maintaining March 2012 access position, including agreed backstops, highlighted at fortnightly Elective Performance meetings with Health and Social Care Board. Plain Film X Ray • Independent Sector and In-house additionality utilised (but unfunded) to maintain reading of non-Ionizing Radiation Medical Exposure Regulations plain film X Rays at 28 days • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received, but no regional action yet. Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially, the number of routine waits has shown an increasing trend in 2012 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets. • Of the total waits, 66% of those waiting have only been waiting from 1 April 2012. • The longest waits remain in Urology and Ophthalmology • Work continues to cleanse lists and Specialist Nurses are working with		

			relevant consultants to screen urgent reviews and longest waiters • Cutting plans formalised to monitor steady reduction of review backlog waits in association with non-recurrent funding of in-house additional capacity • Trust anticipates a rolling backlog in reviews until recurrent demand /capacity gaps have been addressed.		
2	Achievement of statutory functions/duties: Care Management Processes. Risk includes: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed. • The Trust should have robust care management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Audit of Care Management on-going within Mental Health & Disability Services. Stage 1 re reviews completed. Stages 2 and 3 re processes and quality of reviews ongoing	• Domiciliary Care Reviews – exercise underway to scope the number of reviews carried out and those outstanding. 67% of all reviews completed at end of September 2012. 33% have been waiting longer than a year to have their reviews carried out • A Cutting Plan is being agreed to recover the backlog in Annual Reviews. • Development of an excel workbook in place for 100% of clients to provide staff with a live register of review dates for Residential and Nursing Home clients, as well as for domiciliary care reviews. • Social work capacity and demand work paper has been presented and additional capacity has been identified and all staff have commencement dates. Further capacity and demand work has been undertaken in the Memory Services and is in final draft. • Additional temporary social work staff remain in post to ensure the Trust reaches compliance with the expected annual review process. The outcome of the capacity and demand work will inform future staffing levels.	Older People and Primary Care	**HIGH**

			• Permanent Placement Team in process of establishment. This team will be established during the 2012/13 period. The service model will be developed to carry out reviews for all clients in Nursing/Residential Homes and contract reviews etc. • Older People & Primary Care Services/Mental Health and Disability Services/ /Contracts and Finance are to conduct a Review of Care Management processes which will include roles & responsibilities (internally & externally) . Membership from RQIA has been requested for this working group. • A letter will be issued to all care management staff reminding them of the requirements relating to care management including assessments, monitoring and taking action proportionate to assessed levels of risk. The letter will request that staff ensure that they continue vigilance in monitoring residents' expenditure in Residential /Nursing Home and Supported Living, pending the outcome of the cross Directorate review and implementation of recommendations. • Adult Safeguarding Team to consider further targeted vulnerable adults training for those staff in care management and involved in annual reviews.		

3	Systems of assessment and assurance in relation to quality of Trust services	• Clinical and Social Care Governance Review completed and new structures and assurance reports being implemented • Update on implementation to Governance Committee on a quarterly basis • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chief Executive • Serious Adverse Incident/Adverse Incident reporting system in place	• New Governance structures/processes embedded • Web-based incident reporting (on Datix) rolled out across the Trust • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy • Risk Management Policy to be reviewed by October 2012 • Clinical and Quality indicator programme of work across Directorates • Executive Director of Nursing report to Trust Board in November 2012 showing performance against Nursing Quality Indicators (NFIs) • Executive Director of Nursing report on Allied Health Professions Quality Indicators to Governance Committee in December 2012 • Internal Audit of complaints completed and a satisfactory level of assurance achieved • Internal Audit of incidents completed and a satisfactory level of assurance achieved • Governance Working Body in place and meeting regularly. Priority strategic areas agreed and work underway	Chief Executive	MODERATE

	Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body on 20th January 2012 and being taken forward for organisational learning. Governance Committee updated on progress in September 2012. • National Early Warning System (NEWS) implemented on 1st August 2012 in adult in-patient settings within Acute and Older People and Primary Care. Progress report on implementation to Trust Board on 30th August 2012 • Reviewing and revising Incident Policy and Serious Adverse Incidents Management Policy		
4	Compliance with Standards and Guidelines (S&G) • Due to the volume/ complexity of new S&G being issued to the Trust by external agencies, it is a challenge for the Trust to also monitor and review the compliance status of those S&G that have already met full compliance in order to ensure that this is maintained. Since 1st January 2012, a total of 172 new standards and guidelines have been regionally endorsed from a range of different external agencies. . The Trust register now indicates a total of 350 standards have been issued since 01/04/2012.	• Establishment of six monthly performance/accountability reports for standards and guidelines. • Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance statements • Standard item for discussion at the Directorate Governance meetings with submission of relevant reports • For those that are 'pharmacy' related a compliance report is also presented by the Trust's Medicines Governance Pharmacist to the Operational Directors and members of the Drug and Therapeutics Committee on a quarterly basis.	• The SABS process map to ensure effective dissemination and management of Safety Action Bulletins was presented and agreed at SMT on 10/10/12. These new processes will be implemented with effect from 01/11/2012. • Following the establishment of Standards and Guidelines Risk Assessment and Prioritisation Group in April 2012 a total of 137 newly issued S&G have been reviewed and managed through the new corporate process. • A BSO graduate intern has been appointed to the Patient Safety & Quality service from 08/10/2012 on an initial 6 month placement. The primary function of this post is to identify all standards that have been issued prior to April 2010 and determine a risk	Chief Executive	**MODERATE**

	• There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved • Standards and guidelines that have been regionally endorsed prior to January 2009 have not been reviewed / managed in line within the Trust's new assurance processes and as a consequence the level of compliance / required action has not been identified for each. • Since 5th April 2012, the Patient Safety and Quality Service has continued to carry a Band 5 vacancy and this has significantly impacted on service capacity. This post has been approved in October 2012 and will now be advertised.	Last report presented on 27/09/2012. • Database has been established and there is system of logging and monitoring standards and guidelines • SABS system in place for Safety Action Bulletins	based approach for ensuring that these are effectively implemented within the organisation and that an assurance framework is in place. • As part of the 2012/13 Internal Audit programme the effectiveness of the corporate process for managing Standards and Guidelines is to be audited and reported on • Meetings have been held with the Trust's ITS Programme Management Team to determine how best to integrate the existing standards and guidelines database into the Trust's *Datix* safety module. A work plan has been established to take this work forward over the next 6 months.		

5	Lack of compliance with RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes	Risk management includes • Training programme for domiciliary care staff in place – all staff have received medicines management training by November 2010 • Refresher training underway by Sept 2012 (without competency assessment - OSCE) • Trust Medicines Management policy • Medicines Management Steering Group • Review of operational procedures • Induction training for new Domiciliary Care Supervisors all of whom have now received medicines management training • SH&SCT and RQIA Incident reporting systems in place • Workshop held with Independent Sector Providers • Draft educational and competency framework rolled out to support the delivery and management of training of all Trust domiciliary care workers, day centre and social education centre staff • Risk assessment for transcribing completed • Transcribing procedure developed and implemented • Transcribing training carried out in Day Care, Supported Living and Residential Care	• Issues with achievability of compliance have been raised with the Health and Social Care Board • Trust draft Operational Procedures regarding medicines management for domiciliary care workers to be reviewed following meeting with Director of Older People and Primary Care and Director of Mental Health and Disability Services • Implement interim guidelines for commissioners of domiciliary care services until Trust operational procedures are agreed. Guidance developed, but not yet fully implemented due to Commissioners continuing to work to local/legacy arrangements and a delay in regional workstreams in relation to the production of a pharmacy produced medication administration record. • Trust representatives on regional group. No meeting since 2011. Trust staff to contribute to Health and Social Care Board regional workstreams when they are re-established. • Transcribing competency assessments to be carried out by trained nominated staff for day care, supported living and residential care.	Older People and Primary Care/ Executive Director of Nursing	HIGH

6	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £2.1m Maintaining Existing Services funding secured for 2012/13 • Craigavon Hospital Theatres1-4 in progress and to be completed by November 2012 • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k including c.£2.2m for structural works to tower block at South Tyrone Hospital • Structural engineer reports commissioned for sites at higher risk to inform action plan	Performance and Reform	HIGH
7	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £1.2 million was invested in 2011/12 to improve fire safety by upgrading the fire alarm systems in Craigavon Area Hospital, Rathfriland and Warrenpoint Health Centres, construction of escape bed lifts in Craigavon and Lurgan Hospitals, upgrading fire hydrants at Daisy Hill and	• Additional staff have been recruited to implement highest priorities on action plan including Fire risk assessments and fire audits • Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2012/13 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Initial Firecode funding allocation from Maintaining Existing Services for 2012/13 c. £500k to be directed to next highest priority risks and further funding continues to be sought	Performance and Reform	MODERATE

		Craigavon Hospitals and the construction of a bin store at Craigavon Area Hospital to remove fire loading from the basement	• Update on Fire Safety Action plan to Trust Board in November 2012 as part of Estates Annual Report		
8	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption	• Developing schemes with Northern Ireland Electricity on options for provision of increased supply capacity. • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Peak Lopping is progressing following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 12 for £2.5m spend in year.	Performance and Reform	HIGH
9	Asbestos and compliance with Control of Asbestos (N.I.) 2007 • Risk of exposure to asbestos by being unable to identify existing asbestos across all Trust property and from lack of a unified/single asbestos management plan.	• Estates Services Asbestos Management Group • Asbestos Policy in place • Revised Asbestos Management Procedures in place • Refurbishment and Demolition Surveys performed when significant work is required on any facility older than 2000 • Asbestos Registers in two legacy systems plus one on-line system	• Re-survey Armagh and Dungannon and Craigavon and Banbridge Estate and develop an integrated Trust Asbestos Management Plan for complete Trust Estate. • One year's management inspections integrated into the Trust's existing Asbestos Register.	Performance and Reform	**MODERATE**

10	HCAI • Risk to achievement of Priorities for Action target identified	• Dedicated isolation ward on Craigavon Area Hospital site • Comprehensive isolation policy in place and strictly adhered to • Ongoing mandatory and tailored training • Comprehensive governance structure in place, including bi-monthly Strategic Forum and fortnightly Clinical Forum • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place to deal with trends/prevalent HAIs • Antibiotic stewardship • Root Cause Analysis process in place	• Compliance with DHSSPS Board to Ward assurance • Further development of independent audit functions • Ongoing measurement of compliance against DHSSPS Communiqués including Independent Review of Pseudomonas • Measurement of compliance against NICE - Prevention & Control of HCAI - Quality Improvement Guide on-going. • Revision and re-launch of Trust Root Cause Analysis process for HCAI's	Medical Director	MODERATE
11	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care	• Water safety plan approved by Trust Board • Installing a trial system for copper sliver ionisation of Ramone Building water system • Extension of legionella testing areas • Consideration of opportunities to increase automated water temperature and flow monitoring • Review resources needed to manage water quality systems (Microbiology, IPC and Estate Services) and identify to Department of Health, Social Services and Public Safety as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines.	Director of Performance & Reform/ Medical Director	MODERATE

		• IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens			
12	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers • Report to Trust Board as part of Statutory Functions Reporting • Director of Social Work Report to Trust Board	• Development of key interfaces underway • The majority of staff across directorates now trained in the Soscare Vulnerable Adults module. • All Vulnerable Adults referrals now captured on Soscare with the referrals within the first 4 months of the year to be backdated on the system by 31.3.13. • Adult Safeguarding Dashboard Report became operational in July 2012. Trust wide summary report is sent to the Executive Director of SW and specific divisional/directorate reports sent to HOS and governance leads.	Children and Young People's Services	MODERATE

			• Adult safeguarding research commenced in July 2012. On target for completion date of 31st December 2012. Learning from the research will then be disseminated throughout the Trust. • Trust Adult Safeguarding Policy to Policy and Records Committee in September 2012 for approval. • Delegated Statutory Functions Action Plan to Trust Board in November 2012.		
13	Implementation of new regional on-call arrangements. Risks in relation to disruption to services in the 'out of hours' period as a result of staff withdrawing from on-call rotas from 1.10.2011 due to the reduction in on-call payments. The following services are provided by staff who will experience the biggest reductions in on-call payments: • Social Work out of hours service • Pharmacy emergency duty • Radiography out of hours service • Laboratory out of hours service	• Meetings with Directorates and Human Resources are currently ongoing to consider alternative ways of working for example, partial / full shifts, extended days, recruitment of staff to waiting lists where this is possible and appropriate in order to ensure cover can be provided during the out of hours period. • Joint Negotiating and Consultation Forum (JNCF) standing agenda item for discussion with Trade Union colleagues • Director of Social Work & Human Resources collated Out of Hours Social Work information. • Director of Social Work & Human Resources issued letter to all co-ordinators with regular update meetings with the Co-ordinators. • The Regional Out of Hours Review Group has been established of which Trust	• The Trust has been participating in the Regional group to plan for the new service model. Timelines for action are being met and the DHSSPS have agreed an extension of the current on-call rates until 30.9.12. • Regional Group has met on a number of occasions since January 2012. A regional contingency plan for a period of four months (October 2012 to January 2013) will be required until the new regional service commences on 1st February 2013. • Discussions are currently ongoing with NIPSA and the staff affected regarding the contingency arrangements • Options have been explored for shift systems in Radiography and Laboratory. A shift system is now operational in Radiography in DHH and CAH from 1st October 2012. In relation to Laboratory, discussions are ongoing in relation to seeking agreement in relation to shift system to be introduced once there are sufficient new staff trained, however, in the interim, the on-call circular has been applied to this service from 1st	Children and Young Peoples' Services/ Human Resources	**MODERATE**

		Directors are members. The Project Initiation Document (PID) has been developed and agreed by the Project Board (comprising Executive Directors of Social Work and the Director of HSCB • Collectively Trusts are seeking an extension to the implementation of the proposed new service arrangements • Social Work staff who are willing to continue on the Out of Hours rota beyond 31.03.2012 will receive current on-call payments • Out of Hours Project Team established in the Trust .	October 2012. • Agreement has been reached in Pharmacy in relation to the implementation of the on-call circular and implemented from October 2012. • Previous difficulties in relation to the hyperbaric chamber on-call have been worked through and arrangements are being finalised during September in relation to the implementation of the on-call circular to both nursing and technical staff.		
14	Development of robust Business Continuity Planning arrangements	• Business Continuity Plans were developed in most Directorates in preparation for pandemic in 2009. • Performance management arrangements in place between Public Health Agency/ Health and Social Care Board and Trust • Further development of plans for severe weather • Stock take undertaken • Engagement of Consultant • Business Continuity Management Policy • Progress reports provided on a monthly basis by the Business Continuity Manager to the Medical Director • Updates provided to Senior Management Team via Medical Director's report and Governance Committee	• Temporary Business Continuity Project Manager has been working with Directors and their staff to identify key time critical services • Business Continuity Manager currently working with Directorate staff to undertake departmental level business impact analyses which will assist with the review/update of the existing suite of continuity/contingency plans for each service in line with the BS25999	Medical Director/ Operational Directors	**MODERATE**

CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
15	Fully embedded appraisal system – lack of evidence of compliance	• Succession Planning - established and on-going. Band 7 Programme 'Breaking Through'being finalised • Evaluation • Governance – new arrangements in place and ongoing • Knowledge and Skills Framework (KSF) policy and monitoring system in place • Consultant appraisal policy and monitoring system in place • Mandatory Training	• Personal Development Plans received from over 44% of staff. Directorate aligned Support Staff (from HR)have been meeting with teams and demonstrating the documentation as well as encouraging team leaders to apply the policy fully in their area of responsibility and send the completed PDPs to HR for the record. • Supervision – combining staff supervision/KSF and PDP • E-learning Policy approved by SMT in September 2012 • E-Learning packages for Moving and Handling, Safeguarding, Infection Prevention & Control, Food Safety and COSHH completed. Fire Safety and Waste Management packages almost completed • Basic ICT Skills training roll-out September-December 2012	Human Resources	**MODERATE**
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
16	Achievement of financial balance in 2012/13 to include requirement for £11m cash release • In year • Recurring	• Contingency Plan for 2012/13 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Trust Delivery Plan, including 2012/13 financial plan, approved by Health and Social Care Board in June 2012.	Finance and Procurement/ All	MODERATE

	Financial impact of Transforming Your Care	• Transforming Your Care (TYC) project leads in place in all Directorates to take forward implementation of priority projects in key workstreams. • Trust BCBV project structure supported by shared Trust/ Local Commissioning Group accountability arrangements through Southern Health Economy Population Plan (SHEPP) Programme Board.	• Initial Draft population plan including indicative financial plans for the period to March 2015 submitted on 22nd June 2012. • Financial Plan for 2013/14 and 2014/15 submitted to HSCB on 23rd November 2012.		
17	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Interim arrangements for improved support to monitoring and workplan for review of contracts documentation agreed to improve robustness of social care contract management and monitoring • Project Team in place to undertake scoping exercise to establish central database for all Trust contracts and assess risks associated with current contract management arrangements • Initial reports providing a summary position on procurement status/risk at Directorate level have been issued by scoping team • New guidance on Single Tender Action (STA) processes issued and implemented • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited	Performance and Reform/ Finance/All	MODERATE

			• Trust to bring forward proposals to Regional Social Care Procurement Group to address procurement deficiencies in social care		
18	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 12-18 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of 26-30 staff to oversee the implementation • Disruption to transaction processing/quality of management information/financial forecasting and achievement of financial duties Shared Services	• The Trust has established an implementation structure • Engagement in regional process	• Human Resources strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases • The Trust continues to prepare itself for FPL implementation on December 17, and has not experienced any local or regional difficulties which would result in a project abort or postponement • The Human Resources Payroll, Travel and Subsistence (HRPTS) side continues to face delays and contractual difficulties. It is expected that this side of the implementation will be delayed for up to six months. There will be a knock-on effect on shared service implementation. • Efforts being renewed to secure suitable employment opportunities within the Trust for displaced staff and to maximize the potential for staff to stay with their current function until replacement systems are tried, tested and in place • Assurance to be sought from BSO that all functions will be maintained throughout the period of transition	Human Resources/ Finance	HIGH

Changes to Corporate Risk Register since April 2012 to date

Date	Decision taken at	Changes to Corporate Risk Register
2nd May 2012	**SMT**	Agreed to separate out risk of harm to patients from water borne pathogens from HCAI risk and include on Corporate Risk Register as moderate risk.
4th July 2012	**SMT**	Agreed addition of risk of exposure to asbestos fibres from work activities on or near asbestos containing materials within Trust facilities to Corporate Risk Register as moderate risk. Risk assessment on 'Lack of compliance with RQIA recommendations in relation to the management of medicines management in domiciliary care' discussed. Risk assessment to be reviewed by Trust Medicines Management by Non Nursing Staff in the Community Steering Group on 23rd July 2012 and update to be provided to next SMT.
5th September 2012	**SMT**	Review of risks and updates received for a number of risks. Agreed removal of Corporate Risk No. 2 '**Level of unallocated child care cases'** – will be managed as Directorate risk issue. Agreed to escalate 'Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed' from moderate to high risk.
31st October 2012	**SMT**	Under Corporate Risk No. 2 '**Achievement of statutory duties/functions,** agreed to include additional risk on the robustness of care management processes.
28th November 2012	**SMT**	Review of risks and updates received for a number of risks.

Southern Health and Social Care Trust

Meeting re Urology Service

Tuesday 1 December 2009

Action Notes

Present:
Mrs Mairead McAlinden, Acting Chief Executive
Dr Patrick Loughran, Medical Director
Mr Eamon Mackle, AMD – Surgery & Elective Care
Mrs Paula Clarke, Acting Director of Performance & Reform
Mrs Deborah Burns, Assistant Director of Performance
Mrs Heather Trouton, Acting Assistant Director of Acute Services (S&E Care)
Dr Gillian Rankin, Interim Director of Acute Services

1. Demand & Capacity

Service model not yet agreed, outpatients and day patients not finalised, no confidence that this will be finalised. Theatre lists not currently optimised and recent reduction in number of flexible cystoscopies per list. Recent indication that availability for lists in December 2009 will be reduced.

Action

- Sarah Tedford to be requested to benchmark service with UK recognised centres regarding numbers, casemix, throughput (eg cystoscopies per list). **Action – urgent within 1 week.**

- Team/individual job plans to be drafted – Debbie Burns/Mr Mackle/Zoe Parks, for approval at meeting on 11 December 2009. To be sent to consultants and a meeting to be held within a week with consultants, Mr Mackle, Heather Trouton and Dr Rankin.

2. <u>Quality & Safety</u>

<u>Key Issues</u>:-

1. Evidence-base for current practice of IV antibiotics for up to 7 days repeated regularly requires urgent validation. Current cohort of 38 patients even though this clinical practice appeared to change after commitment given to Dr Loughran at end July 2009.

Action:-

- Dr Loughran to have phone discussion with Mr Mark Fordham to get urgent professional opinion on appropriateness and safety of current practice. Mr Mackle will meet Mr Fordham next week (w/c 7 December 2009) and report to be ready for discussion

- Discuss outcomes at meeting to be arranged for 11 December 2009

- Depending on the outcome of the professional assessment, management actions may be required as follows:-

    - Commissioner to be informed if practice not safe
    - Letter to be issued to relevant consultants regarding requirement to change clinical practice, with clear indication of sanctions if this change were not to happen
    - Professional assessment of full cohort of patients (38)

2. Triage of Referrals
   Undertaken by 1 of the 3 consultants within required timescale. 1 consultant's triage is 3 weeks and he appears to refuse to change to meet current standard of 72 hours.

3. Red Flag Requirements for Cancer Patients
   1 consultant refuses to adopt the regional standard that all potential cancers require a red flag and are tracked separately. This results in patients with potential cancers not being clinically managed within agreed timescales.

4. Chronological Management of Lists for Theatre
   1 consultant keeps patients' details locked in the desk and refuses to make this available. Current breaches of up to 24 weeks which may or may not include urgent patients, while non-urgent vasectomies are booked for 2 weeks after listing.

Actions for Points 2, 3 & 4:-

- Written approach from Dr Gillian Rankin, Interim Director of Acute Services to consultants to require patient lists/details to be made available immediately, in order that all urgent patients can be booked (Debbie Burns to draft). Safe management of patients is a requirement in the consultants' contracts.
- If no compliance, further written correspondence to be drafted on issues of lack of conformance with triage and red flag requirements, clearly setting out the implications of referral to NCAS if appropriate clinical action not taken.

- Dr Loughran, Kieran Donaghy & Dr Rankin to agree relevant correspondence

2. Other Issues

- Dr Loughran to ensure circulation of recently adopted policies to all consultants (SPA, full job planning, WLI)
- Funding base and recruitment process for Clinical Fellows in Urology to be reviewed before proceeding to any further appointments

Stinson, Emma M

From: Trouton, Heather
Sent: 15 April 2010 13:49
To: Rankin, Gillian
Cc: Stinson, Emma M
Subject: review Backlog
Attachments: Outpatient RBL Report for SEC 14th April 2010 SMT.doc

Follow Up Flag: Follow up
Flag Status: Flagged

Gillian

Please see as requested.

We will have the proposed method of management detailed and sent to you as soon as possible

Heather

Heather Trouton
Acting Assistant Director of Acute Services Telephone Personal Information redacted by the USI Mobile Personal Information redacted by USI

Outpatient RBL Report for SEC 14th April 2010

Please see attached for an updated position on SEC current RBL.

General Surgery: Dorothy Sharpe has commenced a review of all Patient Centre letters starting with the oldest (2007, only 56 of which most have appointments in April). She is stratifying those who require urgent review, those who could be discharged due to a clinical indication, those who could be taken of the review BL due to an administrative issue and those who require review but not urgently. This is a governance strategy to ensure all clinical risk patients will be seen as soon as possible. Currently we only have an average of 4 RBL clinics a month due to the additional funding constraints. Dorothy is working in collaboration with Surgeons on this issue. We are also looking at clinic templates as a recurrent solution.

Ophthalmology: January to March additional resource was put into meeting the New Outpatient Appointments, this has exacerbated the RBL issue. We have now made a decision to move the resource into RBL as far as possible, bearing in mind that this is a visiting service.

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 of the review BL due to an administrative issue and those who require review but not urgently. This is a governance 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.

Orthopaedics: There is currently a vacancy of Clinical Outcomes Practitioner . If this post was filled , this person would be able to reduce significantly the Orthopaedic RB. The orthopaedic Surgeons currently manage urgent referrals effectively.

ENT: Nurse Led RBL commencing first of May in DHH. We are currently waiting for information as to how many patients will be seen on a weekly basis to address the 1500 pt backlog. This initiative was utilised very effectively in the past and should be very effective again.

Breast: Well managed by Miss Sloan

In general we are producing a proposed plan for managing the significant backlog within SEC as a whole, but this will require a team approach, focused progress and co operation from our clinical colleagues.

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.

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 30 November 2010 12:55
To: Stinson, Emma M
Subject: FW: UROLOGY PATHWAY MEETING13/1/2011

Follow Up Flag: Follow up
Flag Status: Flagged

From: Trouton, Heather
Sent: Tuesday, November 30, 2010 12:55:23 PM
To: Young, Michael Mr; O'Brien, Aidan; Akhtar, Mehmood
Cc: Corrigan, Martina; Matier, Pauline; Rankin, Gillian
Subject: FW: UROLOGY PATHWAY MEETING13/1/2011
Auto forwarded by a Rule

Dear all

Following our recent discussion re meeting the GP community to discuss 3 - 4 clinical urology pathways and agree same, please be advised that a number of GP's are indeed available to attend a small workshop on the date suggested at the meeting ie Thursday afternoon 13th Jan 2011.

As agreed can you please cancel the MDT on that day and arrange to attend the workshop.

Can I ask that in preparation for the workshop you would work with Pauline and Martina to set out clearly your suggested pathways (as many as possible to fully utilise the session) , have them clearly documented for discussion and amendment where necessary before the 13th Jan.

Thank you very much

Heather

Heather Trouton
Acting Assistant Director of Acute Services
Telephone ext [redacted]
Mobile [redacted]

-----Original Message-----
From: Rankin, Gillian
Sent: 30 November 2010 12:11
To: Trouton, Heather
Cc: Stinson, Emma M
Subject: FW: UROLOGY PATHWAY MEETING13/1/2011

Heather,

Please see below. Can we confirm the date internally with all those who need to be present and we can send papers and agenda closer to the time.

Gillian

Emma please put into my diary although I know I cannot attend

-----Original Message-----
From: Peter Beckett [redacted]
Sent: 30 November 2010 11:58
To: Rankin, Gillian
Subject: UROLOGY PATHWAY MEETING13/1/2011

Gillian,
Brian Dillon,Kilkeel, Sean Digney,Newry ,Sean Wilson,Lurgan and myself are free to attend on 13/1/11.I still have to contact Gerry Millar.I feel this should produce a good representation of GP thinking on the matter of Urology Services.

Peter

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 03 August 2010 18:02
To: Stinson, Emma M
Subject: FW: Review Backlog Checklist
Attachments: Review process plans - actions Aug 10.doc

From: Trouton, Heather
Sent: Tuesday, August 03, 2010 6:02:05 PM
To: Rankin, Gillian
Cc: Conway, Barry; McVey, Anne; Carroll, Ronan; Reid, Trudy; Corrigan, Martina; Devlin, Louise; McStay, Patricia Sr; Glenny, Sharon; Richardson, Phyllis; Forde, Helen; McAreavey, Lisa; McGeough, Mary; Connolly, Connie; Nelson, Amie; O'Rourke, Eileen; Adair, Loraine; Robinson, Katherine
Subject: Review Backlog Checklist
Auto forwarded by a Rule

Gillian

We met this morning as a group with representation form all the clinical Divisions to discuss the attached document.

We all found it very useful and while we are already compliant with a lot of the suggestions, or there are audits/ work in place to provide some of the information, it did provide some new food for thought that we will address.

Barry has indicated in the attached document the actions that we are already doing or will be undertaken. We will add these into each speciality review backlog plan and progress as such.

Hope this is ok

Best regards
Heather

Heather Trouton
Acting Assistant Director of Acute Services Telephone [redacted] Mobile [redacted]

Outpatient Backlog Review – Mainstreaming

To date significant work has been undertaken within the Acute Directorate to manage the governance risk in the outpatient backlog review including review of processes, triaging, classification, fast-tracking and early planning to address recurrent problems.

The areas listed below should provide a framework for self assessment to clearly identify the current position within your specialty area, the key issues to be address and agreed actions which will co-ordinate the many initiatives and work stream already in place to ensuring best practice in clinical pathway, administrative and operational management practice.

The key purpose is to assure management actions of the review cohort and provide a framework for sharing good practice and initiatives that have proven successful within your area with other specialties

Capacity Have you a clear understanding of your Capacity	BASELINE ASSESSMENT	RECCOMMENDATIONS / KEY FINDINGS FROM REVIEW	KEY ACTIONS IDENTIFIED	PROGRESS TO DATE ON KEY ACTIONS
a. Do you understand the variables that affect your capacity i.e. annual / study leave, junior staffing rotas, surgeon of the week, changeover of staff, reduction in current staffing levels b. Are you clear about the frequency of your clinics and the annualised clinic sessions/outputs (reference consultant job planning)	*Prompts for discussion:* • *Have you undertaken a baseline assessment? Please evidence the current status?* • *Have you identified if your review frequency is in balance with your current templates? (reference to job planning information)*		Yes Need to review clinic templates and benchmark against college guidelines. Need to review clinic start and finish times. Also doing OP	

Capacity Have you a clear understanding of your Capacity	BASELINE ASSESSMENT	RECCOMMENDATIONS / KEY FINDINGS FROM REVIEW	KEY ACTIONS IDENTIFIED	PROGRESS TO DATE ON KEY ACTIONS
c. Are there monitoring processes in place to inform you when capacity fluctuates? d. Do you have a range of options identified that will allow you to increase your capacity. Define / understand potential available capacity which can be flexed as required – Specialist Nurse, – ICATS – Medical staff/specialty doctors/Consultant (Reference Consultant Job planning) (Do you flexible job plan sessions available for practitioners/AS/Spec Drs/S Grades)	• *Have you clarified your clearance times for any backlog)* • *Is the current status in balance?* • *If it is in balance, is there potential to reduce review frequency via pathway review?* • *If is not in balance, i.e. more demand than you currently have available capacity for, is there scope to temporarily increase review capacity whilst still meeting the SBA requirements/access target whilst pathway review ongoing?* • *If it is not in balance, more demand than*		utilisation audits – also to include chronic pain, dermatology and fracture clinic Yes This currently happens on an ad-hoc basis. Needs to be more formalised linked to SABA performance. AD / HOS discussion with relevant specialties / consultants	

Capacity Have you a clear understanding of your Capacity	BASELINE ASSESSMENT	RECCOMMENDATIONS / KEY FINDINGS FROM REVIEW	KEY ACTIONS IDENTIFIED	PROGRESS TO DATE ON KEY ACTIONS
e. Do you know what your core capacity will provide – SBA/urgents f. Will your core capacity meet your review frequency demands (not withstanding review backlog) g. How do you monitor clinic outputs – DNA information?	*available capacity, can you temporarily increase available capacity?* • *What job planning option/other practice are available to flex capacity?*		Yes No OP preparing reports for DNA / CNA – split booking centre / direct booking – to be available mid-August. – also includes numbers seen	

Review Demand Have you a clear understanding of your review Demand	BASELINE ASSESSMENT	RECCOMMENDATIONS / KEY FINDINGS FROM REVIEW	KEY ACTIONS IDENTIFIED	PROGRESS TO DATE ON KEY ACTIONS
a. What are your sources of review? - Ward Review (post operative, further investigations, ongoing treatment or management). - OP follow up reviews - Review pending diagnostics - MAU "Hot Clinic" (Admission avoidance), A/E - GP direct /consultant telephone consultations - Private patients - IS flow back - Other b. Are you clear on which of these sources is adding most review demand c. What are the normal flows you expect in each of this areas	*What are the control processes around these?*		Detailed breakdown of the source of reviews is not readily available We need to agree a mechanism for understanding all the review demand – specialty by specialty approach – audit process to be agreed Yes -after we have the audit info..	
Clinic Management Processes Are your processes optimised for your specialty area				
a. Clinic booking rules are clearly defined and staff are confident in management of clinics	*Please evidence your current agreed processes to support pooling of referrals,*		Booking rules - Ok for now	

– Cross site working arrangements, pooling / cross site referrals cancellation & annual leave policy in place and adhered to and managed via Head of Service b. Clinics are fully optimised and all empty slots backfilled optimising capacity c. Booking arrangements – Review of OP partial booking linking in speciality DNA rates – Review clinic templates – Agreed process for flexing clinic template / numbers in place? d. KPIs agreed for OP utilisation - clinics held / not held, clinics backfilled, annualised OP activity	*consultant backfill for annual / study leave, review booking arrangements by speciality i.e. PB or fixed appointment?* *Please evidence the current monitoring and escalation arrangements?*		We are cross site working – vast majority of cases Yes clinics are filled Audit will confirm Connie and Amie to write up the KPIs	

Clinic Utilisation All capacity is fully utilised				
a. There is clear understanding of clinic start/stop times in line with job planning reviews b. Clinic templates reflect this understanding c. Monitoring processes are in place to ensure clinic utilisation and escalation of exceptions – Clinic start / stop times – Arrival times – Annual utilisation	*Please evidence your current OP clinic audit processes in place please include frequency, feedback and evaluation arrangements?*		Audit to confirm Audit to confirm Audit to confirm Escalation processes are in place on ad-hoc basis – needs to be formalised – Connie and Amie	
Identify Optimum Care Pathways				
a. Have you clear agreed clinical guidelines developed for the management of follow-up patients/conditions, eg	*Please evidence current agreed review pathways by speciality?*		Not currently in place Agreed to work through each specialty – picking the larger patients groupings and working through patient pathways HOS to discuss for AMDs / CDs / consultants to agree one of two – starting with those	

			specialties that have a significant review backlog	
• long term conditions follow up (interfacing with community services/nurse specialist/primary care teams)			To be picked up as part of the pathway work	
• Screening reviews • Patient on request reviews – sos fast track access within 6/12 period			Addressed in the clinic templates – urgent slots	
• Red List/Must Sees			Addressed in the clinic templates – urgent slots	
• Post Operative Review – potential reform opportunity stream to telephone review, nurse led review or consultant review.			To be explored	
b. Have Junior medical staff clear guidance on the review arrangement/practices within the specialty. Including criterion/practice/escalation arrangements (decision tree.			Pathway work to be progressed	

algorhythms) **c.** Have you explored all pathway options with clinical teams/have you had any primary care interface **d.** Have you determined who is best placed to see review patients (condition/grouping specific) - Nurse led review, - Practitioners - Spec Dr - consultant only review - primary care teams e. Have you determined frequency of review for specific conditions/groups. Is is possible to establish a threshold beyond which approval must be sought (eg con sign off after 2 reviews)			Yes – Urology / Gynae – to be done for surgery Needs further clarification – spec doctors / Ass Spec / Nurses	
Monitoring Arrangements				

a. DNAs – looking for variation/reasons/site-specialty specific b. Activity c. Attendance outcomes Review frequency (site-clinic specific)	*Please evidence the current monitoring and escalation arrangements?*		Audit being done	
Acute/ Primary Care interface Actions				
a. Are you sure your reviews are all appropriate/ Have you undertaken an audit of review outcomes/frequencies/decision making **b.** Has guidance/feedback been provided to staff who list reviews (demand sources)	*Please evidence the current monitoring and escalation arrangements?*		Yes – in relation to the backlog Underway – taking on board findings from working through review backlog	
Communication				
a. Do you have an established Op team meeting/pathways for sharing learning with other specialty and within specialty teams b. Do you have active clinical engagement in review management			Yes – Tuesday AM meetings Yes	

General notes
Ensure robust information available
Ensure monitoring processes in place.
Be clear about what information you monitor, what your process are for review, what management actions are taken as a result of review

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 15 September 2010 17:18
To: Stinson, Emma M
Subject: FW: feedback on draft Urology pathways

From: Conway, Barry
Sent: Wednesday, September 15, 2010 5:18:21 PM
To: Rankin, Gillian
Cc: O'Reilly, S MR
Subject: feedback on draft Urology pathways Auto forwarded by a Rule

Gillian,

I met with Seamus today to discuss the draft Urology pathways. See comments below:

Diagnosis and Management of Urinary Retention
- This should refer to Acute Urinary retention
- Discharge home arrangements:
o Need to clarify the arrangements for weekends and Bank Holidays
o Point 4 in discharge home section from CAH should also apply to DHH

Renal Colic:
- bullet point 6 under medical assessment
o Non-contrast CT scan - If it is agreed that this investigation is required, this must be arranged by the Urology Team and not A&E staff – if this will be done in A&E by the Urology Team, an agreed timescale must also be met for this – for example, within 1 hour
o Also – need clarification on what happens after 5pm and weekends
- Admit to Urology Ward
o If the criteria are met for admission, there must be no delay in this process
- Referral collection
o We need to clarify what the arrangements are out of hours

If patients are being referred to the Urology Service from the western catchment area, in view of the distance travelled, some patients may need to be admitted to Urology Ward even if they do not fit the criteria for admission as an ambulance may not be available to take the patient home and the patient would not be suitable for CDU

Also need to explore the option of diagnostic being done in the West and review via NIPACS by the Urology Team.

Barry.

Barry Conway
Assistant Director of Acute Services (Acting) - Medicine and Unscheduled Care Southern Health and Social Care Trust

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

Demand Capacity Analysis - MEDICINE

Month FEB/MARCH 13 **Source of Information: Ref & Booking Centre, PAS & PTL**

Date 07/03/2013 **Prepared by: Referral & Booking Centre**

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

ENDOCRINE SPECIALTY

Irrelevant information redacted by the USI

[redacted]

NEUROLOGY SPECIALTY

[redacted]

Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

DERMATOLOGY SPECIALTY

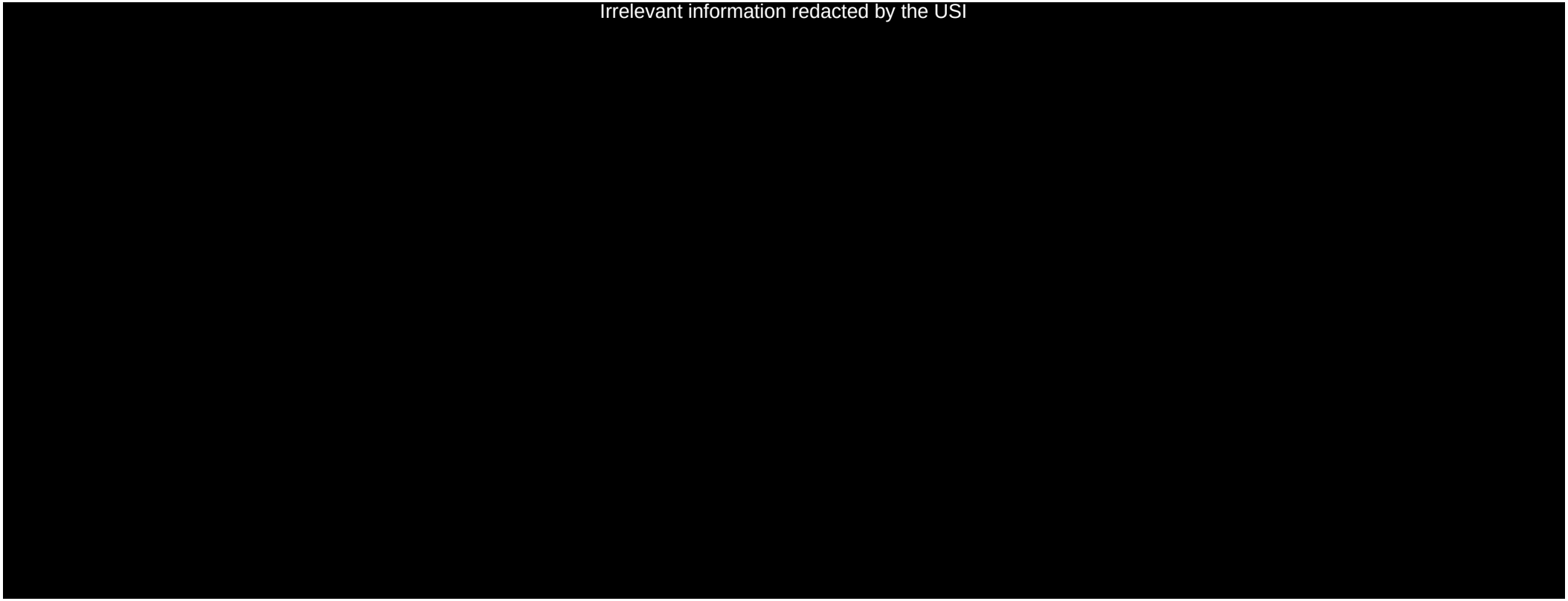
Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Irrelevant information redacted by the USI

[redacted]


Irrelevant information redacted by the USI

RHEUMATOLOGY SPECIALTY

Irrelevant information redacted by the USI

[redacted]

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[redacted]

Demand Capacity Analysis

Month: **Source of Information: Ref & Booking Centre, PAS & PTL**

Date Prepared:5/3/13 Prepared by: Referral & Booking Centre

Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

[redacted]


Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

Orthoptics	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	LGH	PHC	STH	Total	Comments
Irrelevant information redacted by the USI												

Irrelevant information redacted by the USI

All visual field requests are at the consultants request so are always recorded as Reviews

Demand Capacity Analysis - GYNAE

Month: **March 2013**

Source of Information: Ref & Booking Centre, PAS & PTL

Date Prepared: **07 March 2013**

Prepared by: Referral & Booking Centre

Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

URODYNAMICS SPECIALTY

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

[redacted]

Demand Capacity Analysis – SURGERY

Month: **March 2013**

Source of Information: Ref & Booking Centre, PAS & PTL

Date Prepared: **07 March 2013**

Prepared by: Referral & Booking Centre

Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

[redacted]

GENERAL SURGERY SPECIALTY 5/3/13

Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

Triage in DHH is carried out daily and all patients added to one general list

UROLOGY SPECIALTY

UROLOGY	Total on PTL *Needing to be seen*	Capacity	Month	ACH	BBH	CAH	DHH	STH	Total	Comments
	29	84	March			+55			+55	Mr Young -6 *(1 OC Referrals) remainder can be booked to CMA1/APA (? Can OC referrals be booked to CMA1/APA) Mr O'Brien +3 AJ, DCY, APA Prostate -11 (Can these be booked to CMA1/APA)
Total	29	84	March			+55			+55	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS MAR 2013

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Mr O'Brien	Urology	CAH	6(19WKS) 11/10/12 – OC referral	0	95 To be seen in Thorndale 16 (02/2013) To be seen OPD
Mr Young		CAH	4 (12WKS) 13/12/12	2 (6/2/13)	15 (02/2013)
Mr Akhtar		CAH	0	11	59 (02/13)
Mr O'Brien		BBPC	0	0	15 (04/12)UND 18 D/C
Mr O'Brien		ACH	0	0	8 (02/13)
Mr Young		BBPC	0	0	6 (01/13)
Mr Akhtar		STH	0	0	ON CMAUR W/L
Dr Rogers		CAH	0	N/A	N/A
GURO		CAH	5 (19/10/12) AOB OC	N/A	N/A

UROLOGY ICATS	Total on PTL *Needing to be seen*	Capacity	Month	ICGPUNDA	ICGPUPR2	ICSNURSA	ICSNULUP/ ICSNULUP5	Total	Comments
17 weeks	0	13	MAR	+13			OK	+13	LUTS CLINIC SUSPENDED 25.3.13 ?MR HENNESSY AVAIL? CAN WE BRING APRIL PATIENTS FORWARD FOR ANDROLOGY? OR CHANGE TO A REVIEW CLINIC?
TOTAL	0	13	MAR	+13			OK	+13	

OUTSTANDING TRIAGE/NEW URGENTS/URGENT REVIEWS MARCH 2013

CONSULTANT	SPECIALTY	SITE	TRIAGE	NEW URGENT (NU)	URGENT REVIEW (UR)
Dr Rodgers/CURPR2N	Urology Icats	CAH		0	0
Dr Rodgers/Uro-oncology Rev				N/A	0
Nurse L Prostate				5 (30.01.13) 5WKS	N/A
Nurse L Luts				0	0
Andrology				0	0

ORAL SURGERY SPECIALTY – 5/3/13

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

ORTHODONTIC SPECIALTY 5/3/13

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ENT

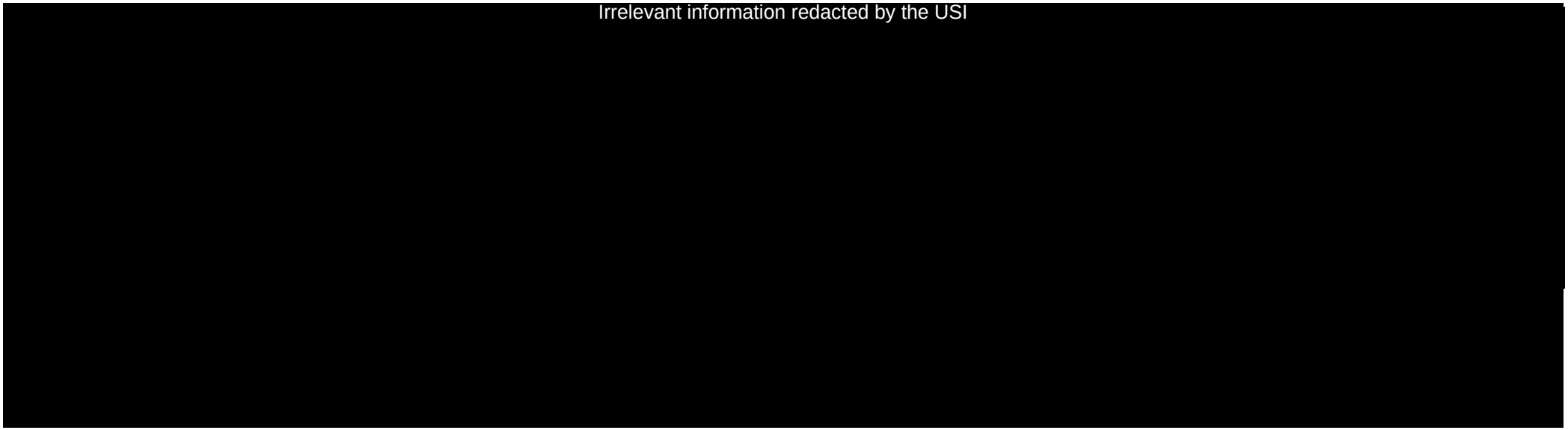
Irrelevant information redacted by the USI

[redacted]

Irrelevant information redacted by the USI

[redacted]

OPTHALMOLOGY SPECIALTY



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Irrelevant information redacted by the USI

Stinson, Emma M

From: Robinson, Katherine [redacted]
Sent: 08 March 2013 16:37
To: Adair, Loraine; Burke, Mary; Carroll, Anita; Carroll, Kay; Carroll, Ronan; Clayton, Wendy; Conway, Barry; Corrigan, Martina; Devlin, Louise; Forde, Helen; Glenny, Sharon; Matier, Pauline; McAreavey, Lisa; McGeough, Mary; McStay, Patricia; McVey, Anne; Murray, Eileen; Nelson, Amie; Rankin, Gillian; Reid, Trudy; Richardson, Phyllis; Trouton, Heather
Subject: DEMAND/CAPACITY/TRIAGE INFO
Attachments: Demand Capacity Analysis - MEDICINE 7 March 2013.doc; Demand Capacity Analysis - wendy 7th March 2013.doc; Demand Capacity Analysis gynae 07 Mar 2013.doc; demand capacity analysis SURGICAL 5 march 2013.doc

Please find attached latest information on demand/capacity to end of March 2013.

Oc referrals still seem to be coming on and returns from the IS, so all of us need to be vigilant with watching the PTLs daily.

If you have any queries please do not hesitate to contact me.

Regards

Katherine

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 24 September 2010 18:39
To: Stinson, Emma M
Subject: FW:
Attachments: Review of CSCG - Governance Committe - FINAL.doc; Medical Profession Regulations NI 2010.pdf

Importance: High

From: McAlinden, Mairead
Sent: Friday, September 24, 2010 6:39:05 PM
To: Loughran, Patrick; Rice, Francis; Rankin, Gillian; Dornan, Brian; Donaghy, Kieran; McVeigh, Angela; McNally, Stephen; Clarke, Paula
Importance: High
Auto forwarded by a Rule

Dear colleagues, a number of you have advised me that there is a high degree of concern within key groups of staff in relation to the Review of Clinical and Social Care Governance.

In order to provide some information to allay concerns and prevent unnecessary speculation, I have decided that the paper approved by Governance Committee should be made available, through you, to your senior staff including your AMDs, with advice that the Senior Management Team are working through a process of translating the principles and recommendations within the document into a detailed consultation paper to be issued by mid-November and that you as Director will be reflecting the views of your staff in this process. It is intended that those directly affected will also be spoken with before the consultation paper is issued.

Hopefully this will ease current concerns.

KIERAN – please also share with Staff Side as discussed, advising of the above process.

Mairead

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Review of Clinical and Social Care Governance

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:

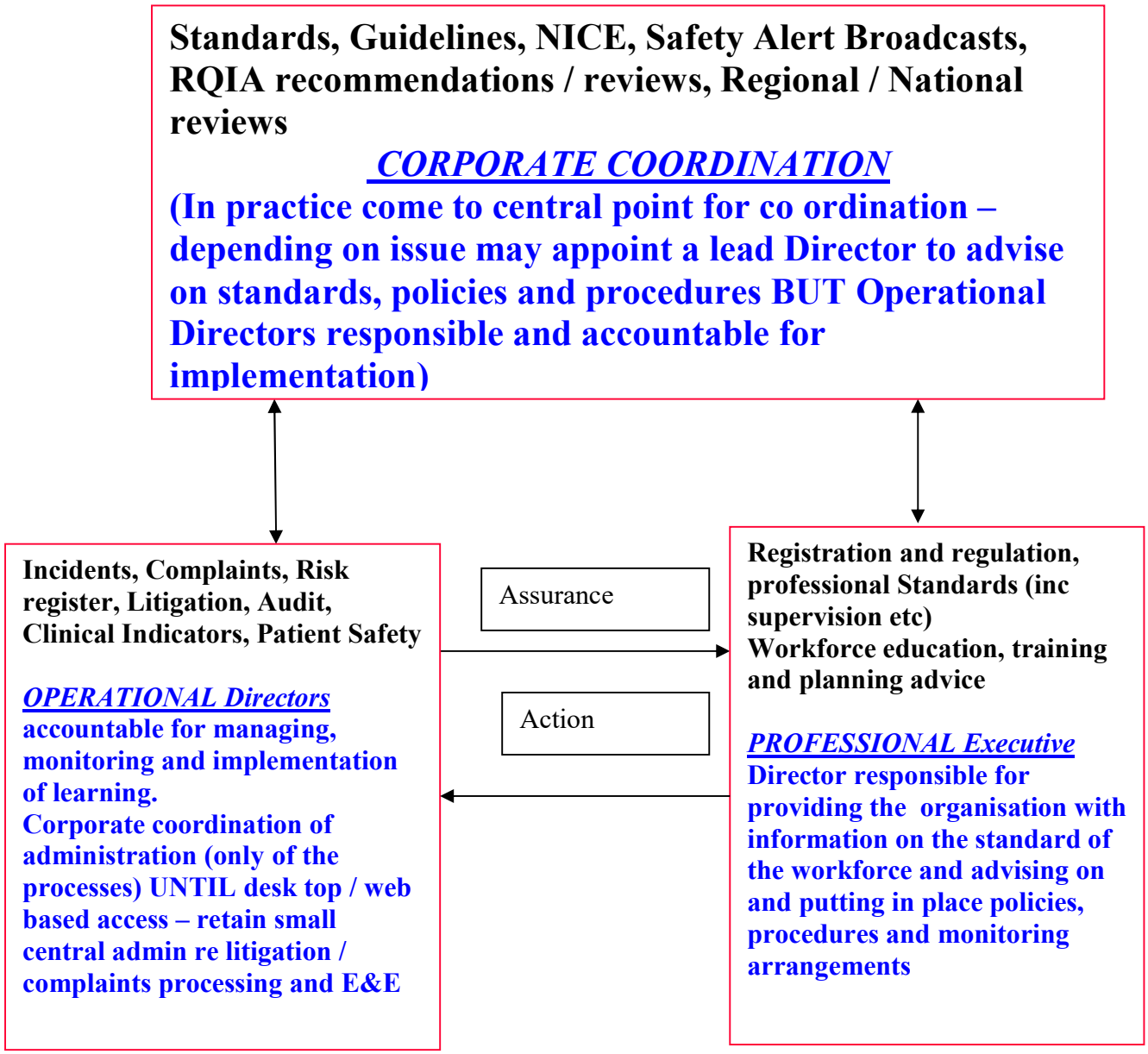
- The components of CSCG are not clearly described within Trust documentation, nor are they fully understood. There is lack of clarity with respect to current roles and accountability for elements of CSCG.

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 are met. 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 in the first instance followed by 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) on the Band 8 scale 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, Dental and HR 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

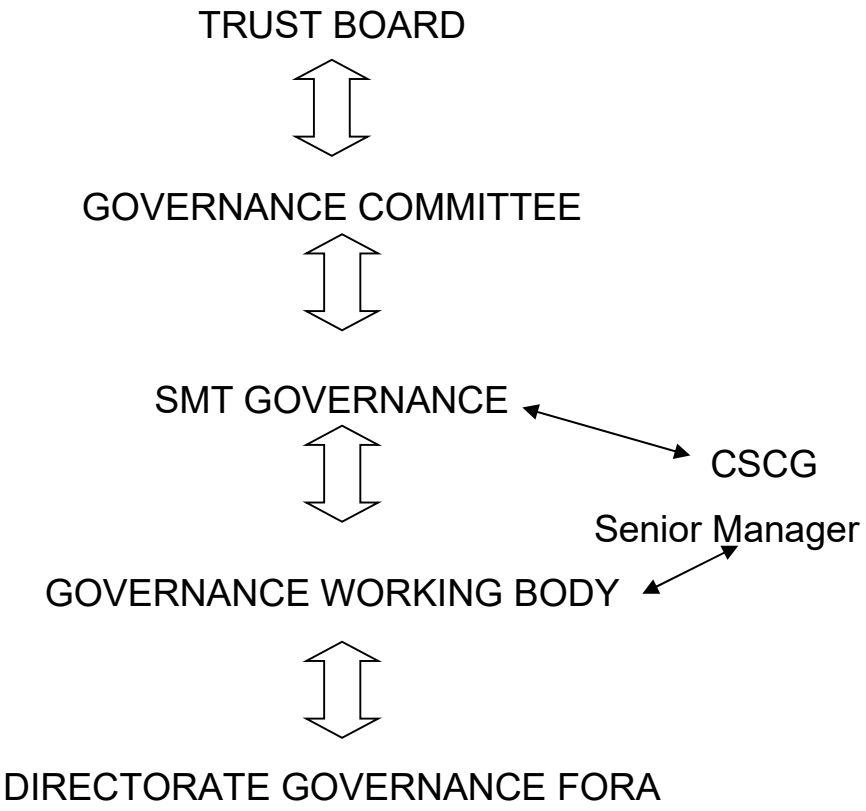
- The links between service directorates, Governance committee and Trust Board require strengthening in relation to organisational intelligence, information, analysis and timeliness.

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 begin this consultation process no later than mid 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

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Tel: Personal Information redacted by the USI
E-mail Personal Information redacted by the 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

The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010

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Stinson, Emma M

From: Stinson, Emma M [redacted]
Sent: 17 February 2011 12:53
To: Boyce, Tracey; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather
Cc: Graham, Michelle; Hamilton, Gail; Murphy, Jane S
Subject: *for info/action* IMPLEMENTATION PLAN CSCG REVIEW 2010
Attachments: IMPLEMENTATION PLAN CSCG REVIEW 2010 2 (3).doc

Follow Up Flag: Follow up
Flag Status: Flagged

Dear All

Please find attached for your information/action.

Emma

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Admin Floor
Craigavon Area Hospital

Tel: [redacted]
Fax:

Email: [redacted]
P Please consider the environment before printing this email

From: Rankin, Gillian
Sent: 14 February 2011 09:29
To: Stinson, Emma M
Subject: FW: IMPLEMENTATION PLAN CSCG REVIEW 2010

From: McAlinden, Mairead
Sent: Monday, February 14, 2011 9:29:10 AM
To: Loughran, Patrick; Donaghy, Kieran; Clarke, Paula; McNally, Stephen; Rankin, Gillian; Rice, Francis; Dornan, Brian; McVeigh, Angela
Cc: Burns, Deborah; Holmes, Jennifer; Judt, Sandra
Subject: IMPLEMENTATION PLAN CSCG REVIEW 2010
Auto forwarded by a Rule

Please find attached the final version of the Implementation Plan for the Trust's Clinical and Social Care Governance Review, now agreed with all Directors.

I would be grateful if you would circulate as appropriate through your line management arrangements and proceed with those actions in the Plan within your areas of responsibility.

I would like to take this opportunity to thank you for your advice, expertise and support for this Review.

Mairead

IMPLEMENTATION PLAN CSCG REVIEW 2010/2011

Action Number	Detail of Action	Action Sponsor	Date of Completion
	REVIEW OF GOVERNANCE CONSULTATION AND IMPLEMENTATION		
1	Issue the main themes brought forward in the consultation process and SMT responses to these. by week ending 4th February.	HR project support, project facilitator & SMT	W/E 4-02-11
2	Issue an implementation plan for the Review of Governance by the week ending 11th February.	HR project support, project facilitator & SMT	W/E 11-02-11
3	Road show with implementation plan to Directorate meetings – and HOS level (for discussion with Directors re approach for each Directorate and staff grouping)	Project Support Facilitator	w/e 25-02-11
	POPULATING OF THE AGREED CSCG STRUCTURE		
4	Advertise the following posts, initially for open competition within the Trust and then to a wider field if necessary: • AD CSCG These posts will proceed to be advertised within the organisation as no affected employees within the Medical Directorate are currently on an equivalent Band. Band 8B Directorate posts	CX office & HR	W/E 4-02-11 W/E 18-02-11

Action Number	Detail of Action	Action Sponsor	Date of Completion
5	Fill the posts listed below within the structure: • Governance Administrative support including the corporate and operational support – 5.6 wte Band 5 posts and 5.6 wte Band 3 • Band 5 and 7 in Acute Directorate for Patient Safety and Quality • Directorate Lead AHP's • Band 7 Governance Training Officer (1 year) • Band 7 AHP Workforce development, education and training officer (1 year) The following process will be applied to fill these posts: • Draw up job specifications and having all new job descriptions desk top banded. • Confirm all existing RPA bandings within the Medical Directorate. • Implement pooling arrangements (see pooling arrangements document) .	HR & Project Facilitator	W/E 18-02-11 w/e 18-02-11 w/e 04-03-11

Action Number	Detail of Action	Action Sponsor	Date of Completion
6	To complete the CSCG structure the realignment of specific staff, listed below, can commence once their direct line management is in post. Preparation for this realignment will commence in advance of this and will include for example revising job descriptions, etc. Staff groupings involved in realignment include: • Band 7 Nurse Governance facilitators – design job descriptions with this group in collaboration with the Operational Directorates and the DON office. Staff will in the first instance self nominate to hours required per Directorate area and any remaining support will be divided between directorates in consultation with staff. • Current central reporting team to the corporate team and the systems manager to Information Systems • Current Effectiveness and Evaluation team	HR, Project Facilitator and Directors	W/E 25-03-11
7	Induction programmes for all levels of staff within the new structure will be developed and implemented as they come into post, including a handover, where appropriate, from those staff within the current structure.	HR & Project Facilitator	Development w/e 18-02-11 Implementation March & April

Action Number	Detail of Action	Action Sponsor	Date of Completion
8	Development of both organisational and Directorate specific work plans for each staff grouping listed below in order to provide measurable key targets for the CSCG framework within the first 6 and 12 months of its implementation: • AD CSCG • Band 8B Directorate CSCG Coordinators • Nurse Governance Facilitators • AHP Directorate Leads • Governance admin support • Effectiveness & Evaluation Team • Central Reporting Team • Band 5 and 7 in Acute Directorate for Patient Safety and Quality • Directorate Lead AHP's • Band 7 Governance Training Officer (1 year) • Band 7 AHP Workforce development, education and training officer (1 year)	AD CSCG, CSCG staff across the Trust and SMT Governance	w/e 20-05-11

Action Number	Detail of Action	Action Sponsor	Date of Completion
	UNDERPINNING SYSTEMS AND PROCESSES - their role, remit and interfaces		
9	Revise the Terms of Reference for SMT Governance to reflect both its organisational leadership function on the CSCG agenda and its assurance function.	Board Secretary in collaboration with SMT Governance & AD CSCG	W/E 25/02/11
10	Design and constitute the CSCG Working Body, including its Term of Reference and interfaces with SMT Governance, Executive Directors and their offices and Operational Directorates. Devise a work plan for the first 6 months of the Working body.	Directors & AD CSCG	W/E 25-03-11
11	Revise and redesign the Executive Directors' fora for Social Work, Nursing, AHP and Medicine, including their Terms of Reference and interfaces with operational Directorates and SMT Governance. Devise work plans in collaboration with the CSCG working body and implementation of the new framework.	Directors, professional governance staff & AD CSCG	W/E 25-03-11

Action Number	Detail of Action	Action Sponsor	Date of Completion
12	Revise and redesign the professional governance sub fora at Directorate level including their terms of reference and interface with Operational Governance fora.	Directors, professional governance staff & AD CSCG	w/e 29-04-11
13	Review and clarify how the Scheme for Delegated Statutory Functions is adequately serviced within the new CSCG framework	Executive Director of Social Work, his offices, Operational Directors & AD CSCG	W/E 25-03-11
14	Review and clarify how the statutory requirements with regard to Vulnerable Adults interfaces with the new framework	Executive Director of Social Work & AD CSCG	W/E 25-03-11
15	Review Operational Directorate Governance Fora across the organisation for best fit within the new framework and uniformity of role, remit and	Directors, AD CSCG &	W/E 25-03-11

	interfaces. This will include how Directorate Governance Coordinators will cover service areas during periods of sickness and leave and how they will interact with AD CSCG	Directorate Coordinators	
16	Review and redesign the Mortality & Morbidity meetings across the organisation	Directors, AMD's &AD CSCG	W/E 25/02/11
17	Revise and standardise the escalation and review mechanism for the organisation's most serious incidents (this will include both those escalated internally and the formal SAI process involving external agencies)	Directors, AMD's & AD CSCG,	W/E 25-03-11
18	Review functional Directorate Governance arrangements across the organisation for best fit within the new framework.	Directors, AD's & AD CSCG	W/E 25/02/11
19	Review and redesign the interface for all Directorates and the Litigation Department within the Trust, using the CSCG working body as a reference point.	Directors, ADs, AMDs, AD CSCG & Litigation	W/E 25-03-11
20	Review and redesign the interface with Northern Ireland Adverse Incident Centre (NIAIC) and the internal Trust processes for dealing with reporting and recommendations received.	Directorates, Medical Devices Liaison Officer, (MDLO) AD	W/E 25-03-11

		CSCG	
21	Review the interface between the Safety Alert Broadcast System and the process for ensuring implementation of Standards and Guidelines – with particular reference to those alert broadcasts relating to user issues	Directorates, MDLO, Patient Safety & Quality and AD CSCG	W/E 25-03-11
22	Review how RIDDOR processes interface with the new framework	AD CSCG, Directorate Governance coordinators	W/E 25-03-11
23	Review and redesign CSCG interfaces with Trust Independent Sector Providers for both acute and community based services	AD CSCG, AD Contracts, Appropriate service AD's	W/E 29-04-11
24	Design and constitute the workforce development and training forum chaired by the Director of HROD, its Terms of Reference, membership, interfaces and work programme	Directors, AD CSCG, Executive function offices	W/E 25-03-11
25	Draw up a framework for standards and quality assurance of the non registered workforce, each section of which has a lead Director as below:	Directors, AD CSCG,	W/E 25-03-11

	Social Care : Exec Director of Social Work Domiciliary care workers: Director of OPPC Admin and clerical staff: Director of HROD Pharmacy, laboratories: Director of Acute Services Ancillary and technical staff: Director of Planning and Performance Nursing and AHP assistants: Director of Nursing	Executive function offices	
	KEY INFORMATION REQUIREMENTS WITHIN THE NEW FRAMEWORK		
26	Develop, design and population of information streams for Assurance reports for the Executive Directors of Nursing, AHP, Social Work and Medicine	Executive Directors, Operational Directors and AD CSCG	W/E 25-03-11
27	Review and revise current information streams available from the current datix management information system to individuals, services and management as an interim step in the progression to web based datix roll out.	AD CSCG, CSCG & Directorate Coordinators	W/E 25-03-11
28	The framework itself will be audited by internal audit 6-8 months post implementation which will include assurances captured within the new framework		W/E 30-03-12

Southern Health and Social Care Trust

INDIVIDUAL PERFORMANCE REVIEW

Name: **Dr Gillian Rankin** **1.4.10 – 31.3.2011**

Year: **10/11**

Southern Health and Social Care Trust

Individual Performance Review

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

1. Key Objectives for the coming period	2. Action Required (who needs to do what, by when for each key objective)	3. Notes on Attainment (for completion by manager prior to major review)	4. Rating 1 - 5 (if applicable) see guidance notes
Provide safe, high quality care	➢ Prompt Diagnosis and Treatment: o Manage services to agreed access standards and within budget ➢ More responsive care: o Implement Trust Opthalmology service. o Implement Team South Urology Service in line with regional review. o Extend T&O and ENT services. ➢ More integrated care: o Through MCN Unscheduled Care seek greater understanding of consultation patterns in A&E and GP OOHs and as a result signpost patients to more appropriate services. o Continue to enhance the networking of Acute services across 3 hospital sites to maximise safety and efficiency.		

	➢ Modernising Care o Optimise admission on day of surgery where clinically appropriate. o Reform care pathways in DHH leading to reduction in beds required – BCBV project. o Ensure 100% pre-operative assessment. o Maximise outpatient procedures. o Maximise day case procedures. o Implement Releasing Time to Care in: - a medical ward in CAH and DHH - a surgical ward in CAH and DHH - ICU CAH - Labour Ward CAH ➢ Improving Patient Safety o Adopt the new Environmental Cleanliness Tool from DHSS. o Implement results of IV line pilot. o Continue to address RQIA Report on Intra Partum Care. ➢ Developing Our Hospitals o Implement with P&R capital developments in DHH to support new service models. o Work with P&R to commence Theatre 1-4 project.		

Southern Health and Social Care Trust

Individual Performance Review

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Maximise independence and choice for patients and charts	➢ Continue implementation of Service Framework: CVS, Respiratory, Stroke, optimising impact of available funding. ➢ Implement Enhanced Recovery across a range of surgical specialties through reform of pre-op, peri-operative and post-operative care in both anaesthetic, surgical and Gynae practice – BCBV project.		

Southern Health and Social Care Trust

Individual Performance Review

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Support people and community to live healthy lives and improve their Health and Wellbeing	➢ Implement Directorate Health and Wellbeing Plan with a range of actions in each Division. ➢ Implement Directorate PPI Action Plan to include: o Roll out of Patient/Client Experience Standards. o Creation of Trust MSLC. o Use of Experience Based Design in the Enhanced Recovery Project. ➢ Implement Patient Advocacy Support Project in DHH.		

Southern Health and Social Care Trust

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Be a great place to work, valuing our people	➢ Fully involve staff themselves in service reviews and developments: ➢ Admin & Clerical ➢ Radiology ➢ Audiology ➢ AHPs ➢ Engage Staffside in service developments and reviews. ➢ Reduce absenteeism rates and improve links to Occupational Health for more prompt access for staff. ➢ Consult on with staff and commence implementation of new nurse shift system across all acute hospitals – BCBV project.		

Southern Health and Social Care Trust

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Make best use of resources	➢ Manage the budget to ensure a breakeven position whilst meeting RPA and CSR requirements. ➢ Increase theatre utilisation rates in all 3 hospital sites – BCBV project ➢ Improve day case rates to improve VFM and meet regional standard. ➢ Improve/reduce LOS in specialties. ➢ Reduce demand for diagnostic and laboratory investigations – BCBV project.		

Southern Health and Social Care Trust

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Be a good social partner within our local community	➢ Promote and evaluate Here to Help scheme and launch in DHH		

We agree that the above objectives are a fair basis on which this work will be planned and reviewed.

Attainment and Rating

7. Individual's Signature	8. Manager's Signature	Date	9. Grandparent's Signature	Date

Date(s) agreed for Interim Review

10. Manager's Overall Rating	11. "Grandparent's" Comments and Signature

Southern Health and Social Care Trust

INDIVIDUAL PERFORMANCE REVIEW

Name:	**Mrs Joy Youart**	**1.4.09 – 30.10.09**
	Dr Gillian Rankin	**1.12.09 – 31.3.10**
Year:	**09/10**	

Updated

Southern Health and Social Care Trust

Individual Performance Review

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Provide safe, high quality care	➢ Implement clear governance structures and processes in Directorate to include AMDs.	➢ Monthly governance meetings with reporting and accountability implemented involving AMDs and ADs and involved support staff. Mechanism cascaded in each division resulting in clearer focus on risks, incidents, complaints and learning processes e.g. RCAs.	
	➢ Achieve regional access standards for emergency and elective access.	➢ A&E achieved over 90% access in 4 hours with 4 12 hour breaches in the year. ➢ All elective access to meet 9/13/17 as agreed with RHSCB achieved through in-house additionality and no access to IS from 1st December 2009.	

Updated

	➢ Develop clear focus on delivery of BCBV projects through addressing quality and safety leading to improved	➢ Surgical bed reconfiguration undertaken at end February to maintain safe care whilst meeting emergency and elective requirements. ➢ Met all cancer access targets despite significant staffing pressures. ➢ NIPACS efficiency savings delivered on 1st April 2010. ➢ CAH and DHH Car Parking Strategies implemented. ➢ DHH Rehabilitation beds reduced by 10. ➢ CAH Reduction of 18 medical beds. ➢ Reduction of 23 surgical beds CAH ➢ Phase I Gynae bed closures in CAH achieved.	

Southern Health and Social Care Trust

Individual Performance Review

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Maximise independence and choice for patients and charts	➢ Continue to implement CVS/RS/Stroke Service Frameworks in conjunction with OPPC Directorate ➢ Increase elective day surgery rates in specialties to meet regional targets	Year 2 actions implemented: ➢ Monday – Friday 9 am – 5 pm Thrombolysis service commenced in CAH and DHH ➢ Telehealth access for consultants on-call to view patient implemented. ➢ Increased availability of NIPPY in CAH and DHH ➢ Rates increased but have not yet demonstrated that regional target is met (partly due to coding issues)	

Updated

Southern Health and Social Care Trust

Individual Performance Review

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Support people and community to live healthy lives and improve their Health and Wellbeing	➢ Complete baseline of activity engaging service users in service development and evaluation; and complete PPI action plan ➢ Complete baseline of Health and Well being activity by service and complete action plan for implementation. ➢ Pilot patient/client experience standards in line with Regional Guidance.	Complete Complete Trust first pilot of patient satisfaction survey completed in 2N Respiratory with excellent results. Action Plan implemented to address key issues raised.	

Updated

Southern Health and Social Care Trust

Individual Performance Review

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Be a great place to work, valuing our people	➢ Lead preparation of project to harmonise nurse shift rotations across Trust. ➢ Ensure engagement and understanding by clinicians of financial and service requirements.	➢ Project Steering Group set-up, refocused and all Directorates engaged. Commence preparation of case for change and options for consideration prior to consultation in 2010/11. ➢ Significant engagement with all consultants in different fora to inform of developments, address issues and encourage performance.	

Updated

Southern Health and Social Care Trust

Individual Performance Review

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Make best use of resources	➢ Manage the budget to reduce over-expenditure and meet CSR requirements. ➢ Ensure delivery of financial in year contingency plan. ➢ Increase utilisation rates of key resources: theatres, inpatient elective beds, outpatients.	➢ Systems and processes implemented to reduce and control use of as and when staff with due regard to safe staffing levels 24/7. Month on Month reduction on expenditure achieved. ➢ Variance in over-expenditure reduced. ➢ Delivered January – March 2010 financial contingency plan as planned. ➢ All elective care brought in house from 1st December 2009 and all targets achieved as agreed with RHSCB. LOS stay reduced for elective surgery and specialties by c1 day.	

Updated

		➢ Commenced scheduling pilot to optimise use of theatre across range of specialties for 3 hospital sites.	

Updated

Southern Health and Social Care Trust

Individual Performance Review

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Be a good social partner within our local community	➢ Promote Here to Help scheme and launch in CAH	➢ Completed – launched in March	

Updated

We agree that the above objectives are a fair basis on which this work will be planned and reviewed.

Attainment and Rating

7. Individual's Signature	8. Manager's Signature	Date	9. Grandparent's Signature	Date

Date(s) agreed for Interim Review

10. Manager's Overall Rating	11. "Grandparent's" Comments and Signature

Updated

Southern Health and Social Care Trust

INDIVIDUAL PERFORMANCE REVIEW

Name: **Dr Gillian Rankin**
Director of Acute Services

Year: **2010/11, 2011/12 as at end February 2012**

Southern Health and Social Care Trust

Individual Performance Review

PERFORMANCE PLAN

This plan should include innovative, maintenance and human resource objectives

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Provide safe, high quality care	➢ Implement and embed the Trust's CSC Governance review ensuring front line staff engagement and clinical leadership.	➢ New systems and processes embedded in all service areas with review of IR1s by front line clinicians. Datix Web almost completely implemented. Constructive clinical engagement in SAI RCA process and refocused M&M processes.	
	➢ Compliance against standards and guidelines.	➢ All Standards & Guidelines received by the Trust for Acute since April 2009 now have compliance measured and actions in process with clinical groups where compliance is not 100%.	
	➢ Access to services • Emergency Department	➢ Performance against 4 hour target has fallen in 11/12. In transition to consultant delivered service and a range of actions are underway. Four 12hour breaches in 11/12.	
	• OP/IP/DC access standards	➢ Access standards will be met by end March except where agreed capacity gaps with Commissioner (Orthopaedics, Ophthalmology, Urology) or increased referrals (Cardiology day cases and Dermatology)	

Southern Health and Social Care Trust

Individual Performance Review

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Provide safe, high quality care	• Endoscopy access • Cancer Performance ➢ Improve safety for patients • VTE • HCAI • RTTC • Organisation of Care	➢ Below 13/52 will be achieved end March from over 30 weeks mid 2011. ➢ Breast at 14 days 100% except July 11 (despite breast surgeon leaving). • 31 day at 99.4% • 62 day performance • 71% April 2011 • 92% December 2011 ➢ Implemented CMO risk assessment and NICE Guidance for VTE prevention for inpatient surgery ➢ Sustained very low levels of C Diff, MRSA and MSSA throughout 2011/12 ➢ Supported 10 wards to undertake RTTC modules with results of freeing nursing time to care ➢ Commenced project across all acute wards to review organisation of care and to engage ward sisters and staff in agreeing a model of care to embed standards and measurements of nursing quality	

Southern Health and Social Care Trust

Individual Performance Review

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Provide safe, high quality care	➢ High Dependency Unit DHH	➢ New HDU combining surgical and medical specialties with new clinical procedures and protocols will open mid-March 2012. Telepresence robot daily ward round to provide advice on assessment and treatment plans by intensivists in place. Agreement with CCaNNI that DHH HDU is now part of the network and necessary processes are being implemented.	
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Southern Health and Social Care Trust

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	➢ Increase day of admission for surgery	➢ Cumulative 11/12 71% with November 2011 at 91%	
	➢ Increase day case rates to 75%	➢ Increased from c60% to cumulative year to date 70.4%	
	➢ Reduce outpatient review backlog to zero March 2012	➢ Backlog of c21,000 patients from 2007 onwards reduced to c9,000 of which 53% waiting 0-2 months, 19% waiting 3-6 months, 13% waiting 6-12 months and 15% waiting over 12 months	
	➢ Meet New:Review outpatient ratio of 1:1.6	➢ Current position is 1:1.7 (NI average 1:2.1)	
	➢ Reduce DNA rate for outpatients	➢ Implemented 'Don't Waste Your Space' campaign and pilot of booking by text message in 4 specialties is in progress. April 2011 9.2% January 2012 8.9%	
	➢ Implement NIPACS	➢ NIPACS implemented from April 2010 with significant savings in admin and goods and services. Continued focus to optimise the benefits of technology for patients and productive use of resources.	
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We agree that the above objectives are a fair basis on which this work will be planned and reviewed.

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7. Individual's Signature	8. Manager's Signature	Date	9. Grandparent's Signature	Date

Date(s) agreed for Interim Review

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Southern Health and Social Care Trust

INDIVIDUAL PERFORMANCE REVIEW

Name: **Dr Gillian Rankin**
Director of Acute Services

Year: **2011/12 as at end August 2012**

Southern Health and Social Care Trust

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Provide safe, high quality care	➢ Implement and embed the Trust's CSC Governance review ensuring front line staff engagement and clinical leadership.	➢ New systems and processes embedded in all service areas with review of IR1s by front line clinicians. Datix Web implemented. Constructive clinical engagement in SAI RCA process embedded and refocused M&M in process.	
	➢ Compliance against standards and guidelines.	➢ All Standards & Guidelines received by the Trust for Acute since April 2009 now have compliance measured and actions in process with clinical groups specifically set up where compliance is not 100%.	
	➢ Access to services • Emergency Department	➢ Performance against 4 hour target has fallen in 11/12. Consultant delivered service implemented from March 2012 and a range of actions are underway. Four 12hour breaches in 11/12.	
	• OP/IP/DC access standards	➢ Access standards met by end March except where agreed capacity gaps with Commissioner (Orthopaedics, Ophthalmology, Urology) or increased referrals (Cardiology day cases and Dermatology)	

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Provide safe, high quality care	• Endoscopy access • Cancer Performance ➢ Improve safety for patients • VTE • HCAI • Releasing Time to Care • Organisation of Care	➢ Achieved 13/52 by end March from over 30 weeks mid 2011 mainly through in-house additionality with some IS. ➢ Breast at 14 days 100% except July 11 (despite breast surgeon leaving). • 31 day at 99.4% • 62 day performance • 71% April 2011 • 92% December 2011 ➢ Implemented CMO risk assessment and NICE Guidance for VTE prevention for inpatient surgery ➢ Sustained very low levels of C Diff, MRSA and MSSA throughout 2011/12. Opened Ramone Ward in June 2011 to isolate patients with CDI. ➢ Supported 10 wards to undertake RTTC modules with results of freeing nursing time to care ➢ Commenced project across all acute wards to review the nursing organisation of care at ward level and to engage ward sisters and staff in agreeing a model of care to embed standards and measurements of nursing quality	

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	➢ MIU South Tyrone	➢ Consultation to reduce opening hours when there is low activity completed with recommendations and a decision taken at Trust Board in March 2012.	

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Kilpatrick Consulting Limited

Project Initiation Document

SBA Capacity Assessment & Modelling

Final Version

NOVEMBER 2ND 2010

Revision history

Please ensure that this page is not included in the final document. Use the document setup tools to delete this page when finalising the document.

Author	Version	Date	Comments
Patricia Kilpatrick	1	25.10.2010	Draft V1 discussion with client
Patricia Kilpatrick	2	29.10.2010	Draft V2 discussion with client
Patricia Kilpatrick	3	02.11.2010	Draft V3 Discussion with client

Contact Details

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Managing Director

Kilpatrick Consulting

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Kilpatrick Consulting

Personal information redacted by USI

Contents

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Figures

1. Introduction

1.1. Project Background

- The HSC Board have engaged Kilpatrick Consulting to undertake a major evaluation and assessment of the current funded capacity of the of all acute services within each Trust and to define what additional activity can be delivered if UK upper quartile performance could be achieved.

- This assignment is designed to facilitate and guide the revision of the HSC Board's Service and Budget Agreements with Trusts in acute specialties for the 2011/12 financial year. The assignment is across five HSC Trusts and is to be completed by 28 February 2011

- Acute services in Northern Ireland are currently provided across five Trusts and numerous sites. In recent years significant funding has been invested to deliver improved access times and reduce waiting lists. Despite this investment Trusts have struggled to maintain waiting lists and maximum waiting times. While the HSC Board, as commissioner, acknowledges that a significant issue for Trusts has been the increase in referrals in each of the last three years, it is not clear if existing capacity within Trusts is being maximised.

- The Board's current Service & Budget Agreement (SBA) with each Trust has a baseline record of capacity using 2005/06 as an indicative year. There is a history as to how baselines were created and modified but from the Board's perspective it is not clear if each SBA fully reflects the true potential of the permanent workforce in each Trust and in each acute specialty. Equally from the Trusts' perspective, there are concerns that existing SBAs may overstate capacity in some specialties.

1.2. Project Aims & Objectives

- To define to what extent the current SBAs fully reflects the true potential of the current service & clinical infrastructure including the permanent workforce in each acute specialty within each Trust.
- To deliver robust outcomes which can be validated against existing UK upper quartile performance levels achieved by similar peer group Trusts, in order to facilitate and guide the revision of the HSC Boards' Service

and Budget Agreements with Trust in acute specialties for the 2011/ 12 financial year.

- To demonstrate through the use of robust benchmarking and comparative analysis against a UK peer group, potential excess capacity where this exists and the additional activity which can be delivered with the current level of consolidated resources
- To highlighting for the HSC, through the use of robust benchmarking and comparative analysis against a UK peer group, any specialties which have capacity shortfalls against the agreed SBAs.
- To train, guide and support commissioning ,service improvement and information staff within the Board, to ensure transferability of learning and key skills required to work independently in delivering this process in future years.
- To train, guide and support commissioning, service improvement and information staff within the Board in developing the required capacity evaluation and measurement skills.
- To engage effectively with Trusts in undertaking the capacity assessment and evaluation process including the collation of information on consultant job plans, the deployment of PAs and the utilisation of other clinical, admin and support staff within the current service infrastructure
- To assess within each specialty & service level to what extent the current model of care maximises capacity using UK best practice to define models.

1.3. The Purpose of the Document

- This document serves as the Project initiation Document (PID) for this work. As such it sets out the principles that will underpin the project, the approach to be taken and key project deliverables. It also provides detail of the resources and timescales required and sets out the project team, controls and risk management arrangements.

1.4. Structure of Document

The remainder of this document is set out as follows:

- Section 2 Outlines the approach & methodology
- Section 3 documents the work-streams used in the delivery
- Section 4 details the reporting and communications
- Section 5 details the assumptions & dependencies
- Section 6 outlines the resources required to deliver the project

- Section7 outlines the project controls and quality management
- Section 8 outlines the project management arrangements including managing risks

2. The Approach

2.1. Overview

- The project methodology combines robust project management with effective skills transfer and successful engagement and delivery. The consultancy team will work closely with the Project Team and with Trusts and other key stakeholders.
- The transfer of skills will take place through a combination of working alongside the project team, providing expertise, guidance and advice in addition to the hands-on training and delivery of the capacity planning and modelling process.
- The programme management requirements of the project will be achieved through a series of engagement meetings with the client to validate and sign off each element of the project based on a set of key milestones outlined in the project plan.

2.2. Key Deliverables

In undertaking the review consultants will be required to secure a range of deliverables including:

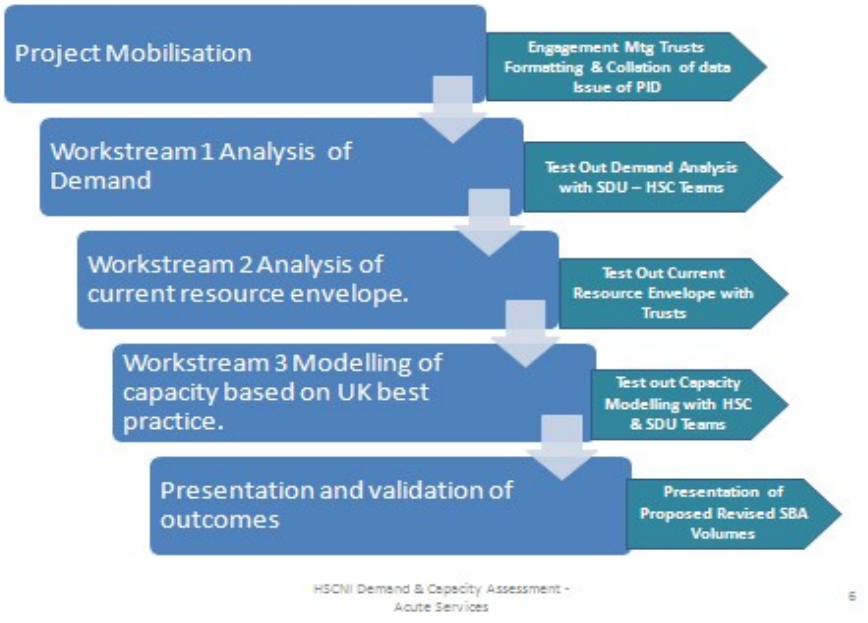
- Robust SBA baselines for all acute specialties in each of the five Trust based on actual capacity.
- Clear and robust of current demand including total referrals to ICATs & post ICATS referral to hospital and current activity by OP, Day Case episode, In-patient episode, operative procedure.
- Clear and robust analysis of current funded resources including medical manpower and clinical infrastructure i.e. clinic sessions, day case sessions , beds , theatre lists etc
- Validation with Trusts of medical staffing including consultant contract PAs per specialty and other key elements of the current funded clinical infrastructure.
- Clearly defined capacity for each specialty within each Trust based on current resources operating at 75th percentile performance level, with best practice models of care based on published evidence where this exists.

- Working closely with HSC and SDU teams providing guidance, advice and support in the development of the in-house capacity planning model to be used year on year as part of the annual SBA review & commissioning process. This model will include best practice capacity assumptions e.g. throughput assumptions – number of new and return patients per orthopaedic clinic session.
- Training for HSC and SDU staff on the model and on the sources and evidence supporting the best practice planning assumptions
- Engagement with the Trust to sign of the current resource envelope within each specialty.
- Clearly defined competencies on capacity planning ensuring effective transferability of learning and key skills underpinning the capacity model

2.3. The Approach Explained

- Our approach `combines robust programme management with effective engagement and delivery. The consultancy team will be on-site to support the Project Team 2 /3 days per week over the 17 week period; this will include project planning, write up and reporting against project milestones. The proposed approach is summarised in the diagram below.

Figure 1: Summary of Proposed Approach



2.4. Project Mobilisation & Establishing the Project Team

- The Project Initiation process is designed to secure agreement and validation of the project plan , the methodology and approach, awareness and understanding of the timescales and the key milestones to be achieved, the time inputs (from all parties) and elapsed time for each project stage.

- As part of the project initiation process we would agree the principles of the communications strategy to be in place whilst the work is being undertaken.

2.5. Outputs

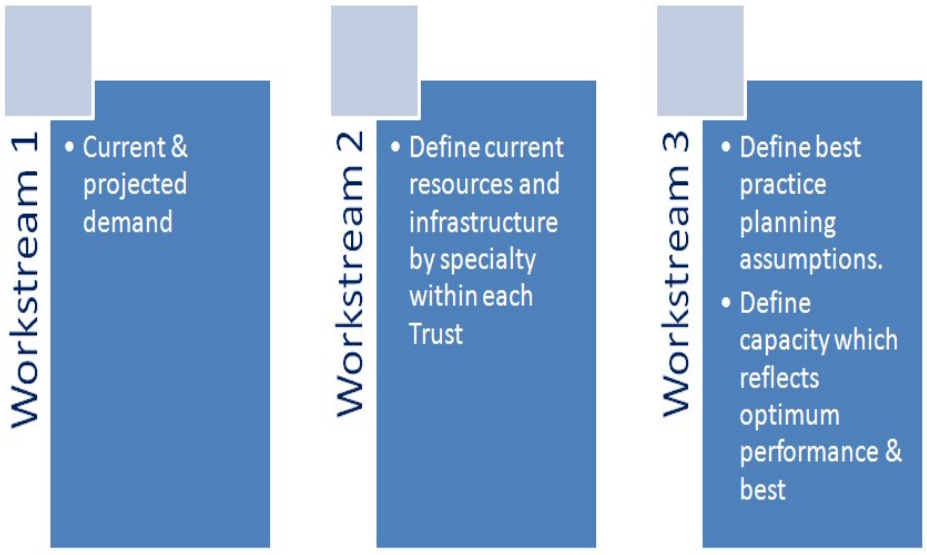
- Agreed methodology, approach and time lines;
- Internal project plan with key accountabilities and deliverables;
- Programme Initiation Document (PID);
- Engagement and communication strategy to manage all aspects of the review;
- Initial meetings with each Trust to secure agreement on the process, the validity of the data, the benchmarking and comparative analysis process, timescales for completion and feedback.

2.6. Establishing the project team

- The project team inputs will reflect the structure and the project methodology. It is proposed that a matrix structure be put in place given the short timescales for the delivery of the project and the complexity and volume of information which has to be collated, analysed, synthesized and modelled to provide the basis for the revised Service & Budget Agreements for 2011/12.

- The main workstreams for the Project Team over the 17 weeks timescale for delivering the work programme are outlined in Figure 2.

Figure 2: Key Workstreams within the Project Team



2.7. Defining the Workstreams within the Project

Workstream 1

- Data collation on current throughput and activity, benchmarking of performance and modelling of capacity based on revised planning assumptions will be led by the LCG Information Officers and undertaken on a Trust basis.

All analysis will be done on the basis of HRGs grouped by specialty; this work will be validated by the Project Reference Group prior to the commencement of the Workstream 1. The structure and staffing for Workstream 1 will provide the project with continuity on information and analysis with each LCG officer working on Trust specific basis and moving to support a specialty based team in Workstream 2 and then bringing the revised planning assumption into a new Trust profile of proposed activity in Workstream 3.

Workstream 2

- Defining & agreeing the current resources within each specialty and service, including consultant PAs and other infrastructure will also be undertaken on a Trust basis. It is proposed that the LCG Managers working with each Trust would be responsible for defining the level of resources currently funded and provided by specialty and service. This information would be based on a defined data set which would include the following: consultant workforce and the utilisation of PA sessions, clinical infrastructure e.g. clinic sessions, day surgery theatres, inpatient beds theatre sessions and other currently funded existing resources required to deliver the service.

Workstream 3

Defining and agreeing the proposed planning assumptions based UK best practice performance and working with the analytical team to complete the modelling of activity and the capacity which can be achieved by optimum utilisation of the currently funded resources**.**

- Workstream 3 which will involve research into defining the best practice planning assumptions by specialty and service in order to define optimum capacity, including models of care and the commissioning of specific high volume care pathways will be completed on the basis of five work streams which are specialty based.

- It is proposed that the 3 Scheduled Care Managers lead on Surgical Specialties and Acute Medical Specialties 1&2 and that the 2 Senior Managers from Regional Acute

services should lead on Regional Services 1&2. The key function of this part of the team is to undertake research and establish for each specialty and service in order to define the best practice capacity planning assumptions which will optimise the throughput and capacity based on the current level of resources. This work will be supported by the project lead for the consultancy providing expertise, knowledge and working with the teams to optimise the use of published information where it exists and to identify leading edge organisations where best practice in a service or specialty has not yet been published.

2.8. Defining best practice performance planning assumptions.

- It is proposed that the clinical specialties be divided into five main areas of work. These are outlined in Figure 3

Figure 3 Specialty Groupings

Group 1 Surgery & Sub Specialties	Group 2 Acute Medicine 1	Group 3 Acute Medicine 2	Group 4 Regional Specialties 1	Group 5 Regional Specialties 2 OBs and Gyn Paediatrics
General Surgery	Cardiology	General Medicine, Diabetes & Endocrinology	Cardiac Surgery	Paediatrics – all specialties
ENT	Gastroenter.	Dermatology	Thoracic Surgery	Obstetrics & Gynaecology
Ophthalmology	Respiratory	Oncology	Thoracic Medicine	GUM
Urology	Rheumatology	Haematology	Neurophysiology	Clinical & Molecular Genetics
Trauma & Orthopaedics	Neurology	Nephrology	Infectious Diseases	Chemical Pathology
Plastics & Burns	Care of the Elderly	Anaesthetics & Pain Management & Palliative Care	Plastics & Burns	Radiology

- In discussion with PMSID areas where there are significant in-year waiting times pressures or specialties & services where work is already ongoing with Trusts will form the basis of the first phase of the programme of work for Workstream 3

- Phase 1 will included the following:

  - Plastic Surgery and Burns
  - Ophthalmology
  - ENT
  - Urology
  - Trauma and Orthopaedics Dermatology
  - General Surgery
  - Cardiology

- Phase 2 will include the following :
  - Gastroenterology
  - Respiratory
  - Rheumatology
  - Neurology
  - Care of the elderly
  - General Medicine
  - Nephrology

- Phase 3 will include the following:
  - Cardiac Surgery
  - Thoracic Surgery
  - Thoracic Medicine
  - Neurophysiology
  - Infectious Diseases
  - Paediatrics
  - Obstetrics & Gynaecology
  - GUM
  - Clinical Molecular Genetics
  - Pathology
  - Radiology

2.9. Project Delivery

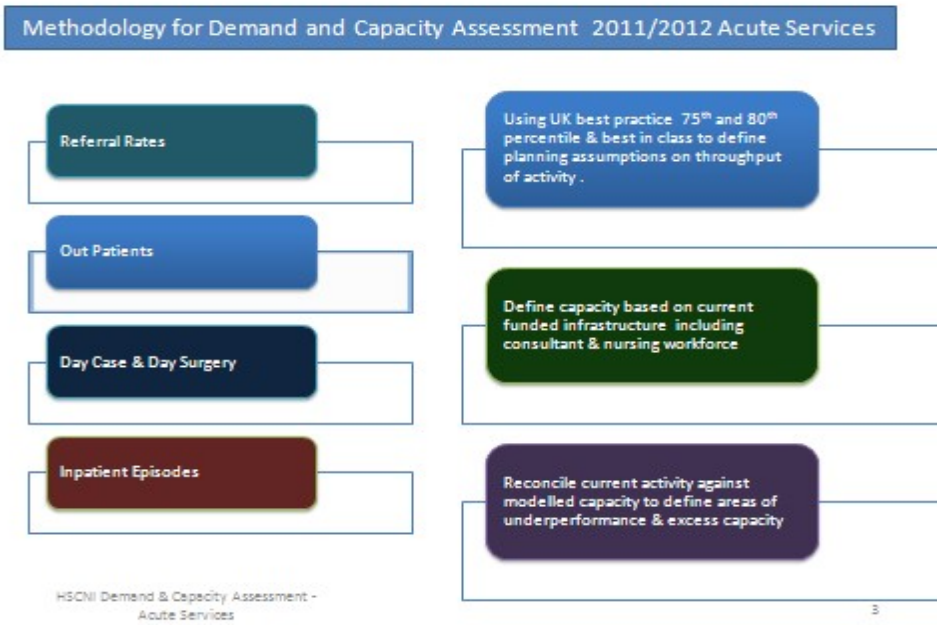
- We propose a phased approach to delivering the assignment as described below.
- We propose to run a number of these phases as parallel work streams as we believe this offers the optimal approach in light of the challenging timescales on the assignment.
- In order to secure effective engagement across the organisation it is proposed that a project initiation meeting take place with each Trust to discuss any specific issues relating to their profile of services, peer comparators, the information required to on medical staffing, and the current level of funded resources within each specialty and service.

3. Section 3 Project Methodology

- The methodology required to deliver the defined outcomes in line with the project timescales will be delivered on the basis of the 3 workstreams as outlined in Section 2. The methodology is outlined in Figure 5.

- Figure 4 demonstrates how the key elements of the project come together to deliver a detailed capacity assessment and those specialties within each Trust which currently have funded excess / under capacity. The methodology is designed to identify current and UK best practice performance and define areas of service improvement including new models of care essential to deliver the planning assumptions on which the SBA for 2011/ 12 will be based.

Figure 4: The Methodology for the Demand & Capacity Assessment



3.1. Workstream 1

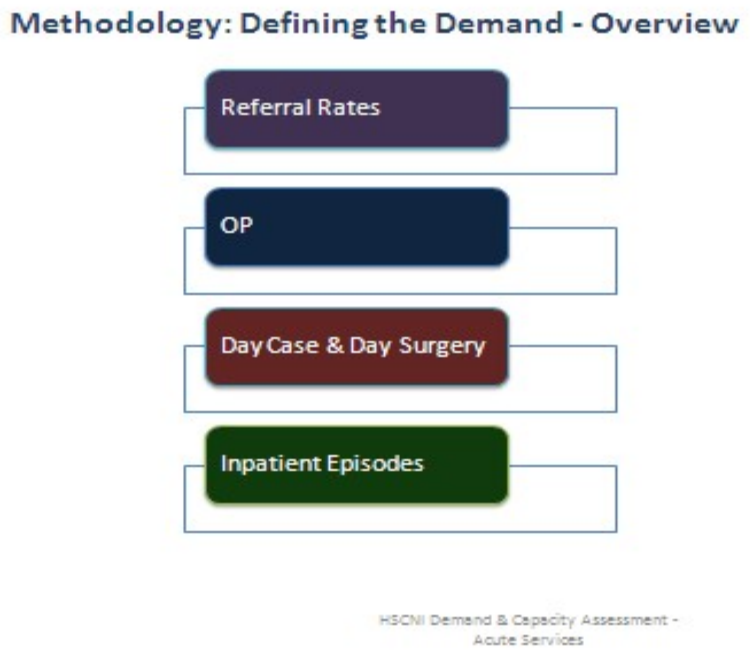
- This Workstream will require significant inputs from Public Health and Finance within the HSC Board.

- This Workstream will deliver the following elements for Out Patients, Day case and day Surgery and Inpatient provision
- Assessment of current demand
- Assessment of performance against a range of standard measurements based on UK best practice

The Outputs of Workstream 1 –Defining the Demand will be as follows:

- A Trust profile which defines the current and projected demand by specialty. The demand analysis will be divided into three areas of work: out patients, day case and day surgery and inpatients.

Figure 5: Methodology Defining the Demand



Outputs for Workstream 1

The outputs of Workstream 1 will include the following key elements of the work programme:

- A clearly defined analysis of current demand by specialty based on appropriate referral rates
- Best practice conversion rates

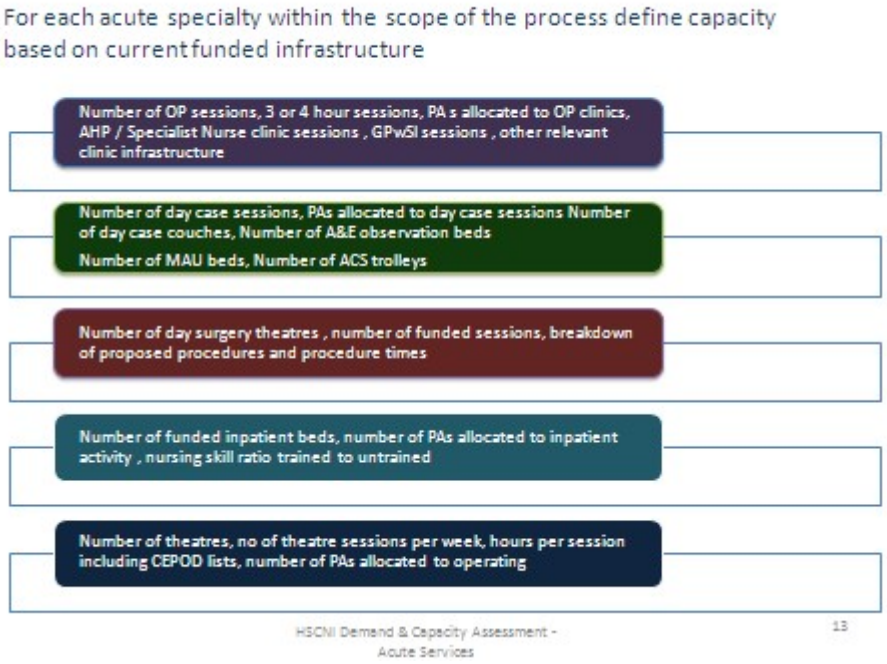
- An increased level of day case and day surgery activity based on best practice published guidance
- Reduced inpatient demand.

3.2. Workstream 2 – Analysis of Current Resource Envelope

- It is proposed that the LCG managers working with each Trust would be responsible for defining the level of resources currently funded and provided by specialty and service.

- The proposed methodology for Workstream 2 is set out in Figure 6

Figure 6 Methodology Defining Current Resources



Outputs for Workstream 2

A detailed breakdown by specialty and by Trust of the current resources and infrastructure which supported the delivered the clinical activity based 2009/2010 data.

- The number of OP sessions and PAs allocated, other clinics delivered by AHPs Nurses or GPs.

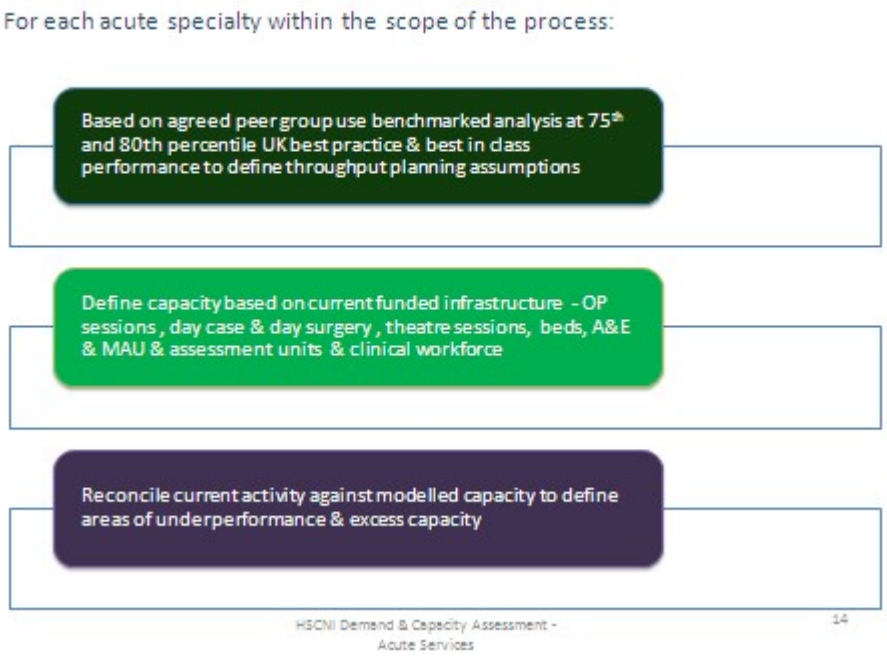
- Day case sessions where day case units exist

- Number of day surgery sessions and PAs allocated
- Number of consultants per specialty
- Number of beds per specialty and type of beds i.e. specialty beds or assessment / step down / rehab beds.
- Nurse staffing / to nursing assistant ratios on inpatient wards

3.3. Workstream 3 -Modelling of Capacity Based on UK Best Practice

- The methodology to deliver the key outputs of Workstream 3 brings together the key planning assumptions based on optimum performance levels which are used to determine the theoretical capacity against the funded resources and infrastructure within each specialty and each Trust.
- The current activity compared with the modelled capacity will be used to define areas of underperformance and those specialties which have excess capacity and the resources to absorb additional activity and meet waiting times targets.
- Figure 11 outlines in detail the methodology to deliver the Workstream 3 target outputs

Figure 7: Workstream 3 Overview of Capacity Modelling



Workstream 3 target outputs

- Outputs will include a detailed capacity modelling process for each area of activity: Out Patients, Day Case and Day Surgery, Inpatient Beds and Operating Theatres to define modelled capacity based on current funded OP infrastructure

4. Section 4 Reporting and Communications

- The Interim Project Reports to be presented to the Director of Commissioning and disseminated through regular scheduled meetings with Local Commissioning Groups and Trusts.
- Interim Reports will be produced at the following key stages:
- End of week 1 the submission of the Project Initiation Document (PID) to the Director of Commissioning, the Project Board and the Trust Project Reference Group.
- End of week 2 reporting to the HSC Director of Commissioning in order to sign off the briefing paper and data collation templates which will enable project teams to identify all current resources within at specialty and Trust level.
- End of week 3 report to LCGs on the completion of the analysis of demand for all elements of acute services for sign off and resolving any outstanding issues prior to the benchmarking activity.
- End of week 8 report to the Director of Commissioning and the Project Board on the total existing infrastructure and resources by specialty & service which are currently funded within each Trust.
- End of week 10 report to the Director of Commissioning, in order to sign off the best practice planning assumptions used in the modelling of optimum capacity.
- End of week 15 presentation of a final draft report to the Director of Commissioning and the Project Board

outlining in detail the level of optimum capacity by specialty that can be realised if Trusts implement the best practice planning assumptions.

- Week 16 & 17 series of presentations to joint meetings of Trusts and LCGs – on the additional capacity by specialty based on existing resources, that can be realised if Trusts implement the best practice planning assumptions.

- At this stage we would also agree a communications strategy with you to establish how best to share the findings of the project with Trusts and Local Commissioning Groups.

5. Assumptions & Dependencies

5.1. Assumptions

To deliver the project within the timescales and resources specified, the following assumptions have been made:

- Tribal will provide project planning and programme management in delivering the outputs of the process, in addition to giving direction, guidance, coaching and support to the HSC & SDU members of the Project Team
- The project team members outlined in the briefing documents, will have sufficient availability to deliver the tasks & requirements outlined in the project plan within the agreed timescales
- Appropriate HSC Board resources will be made available for project governance activities
- Administrative support to support the project team including the organisation of relevant meetings with key stakeholders, feedback workshops and coordinating inputs across each of the 5 Trusts.
- That the relevant datasets including clinical and workforce datasets and other information required assessing and evaluating clinical capacity will be made available in a timely manner.

5.2. Dependencies

The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the process. These are the external influences on the project; things which have to be in place in order to make a success of this investment.

The key project dependencies are:

- Availability of key Trust and other stakeholders for meetings, workshops and interviews
- Availability of relevant clinical activity and workforce data
- Approval by the HSC Board

6. Section 6 Resources

6.1. Project Team

The consultancy team that will support the delivery of the review process comprises the following individuals:

- Pat Kilpatrick - Engagement Director
- Stephanie Searl – Managing Consultant
- Liz Wyndas – Managing Consultant

The HSC Project Team

The HSC project team will comprise a total of 15 senior managers seconded to the HSC SBA Capacity Assessment Project. These are as follows:

- Five Information Managers from each of the LCGs areas
- Five Senior Managers from each LCG area
- Two Senior Managers from Planning & Contracting and from Regional Services
- Three Managers from PMSID

6.2. Expected Inputs

The agreed allocation of inputs from each team member of the Consultancy team is outlined below:

Table 1: Inputs by Team Member and Workstream

Activity		Patricia Kilpatrick	Stephanie Searl	Liz Windas	Total Days
					6
					5

		8	2	4	
	Workstream 3	9	2	3	14
	Presentation & validation of outcomes	6	0	0	6
	Reporting & communications	6	0	0	6
Total Days / Cost		**36**	**7**		**51**

Kilpatrick Consulting anticipate that assistance from the HSC Board will be required to support the team in the following main tasks:

- Provision of baseline data
- Access to detailed workforce information as outlined in the data specification
- Identification of key stakeholders and arrangement of interviews and meetings
- Organisation and co-ordination of workshops and one to one meetings
- Distribution of Project reports and presentation materials.
- Any problems related to these tasks should be communicated to Kilpatrick Consulting at the earliest opportunity.

7. Section 7 Quality Management

7.1. Quality Criteria

- The key project deliverables are set out in section 2 of this PID.
- All project deliverables will go through the standard the Kilpatrick Consulting standard quality control process before being signed off by the Director of Commissioning. Draft materials may be shared during development to expedite the project and provide early feedback

7.2. Project Controls

The approval of this PID will define the scope and approach for the project. Any major variations will be discussed, documented and agreed with the Project Board.

As a minimum, the Project Board should plan to meet in early November to review and sign off agreement on the PID and the project plan. Thereafter key touch points for the Project Board are as follows:

- Agreement and sign off on the analysis of current demand and throughput for each Trust
- The validation and agreement on the current level of funded resources within each Trust
- The validation and agreement with the Project Board or Clinical reference Group on the planning assumptions used in the benchmarking of clinical services
- The submission and agreement on the capacity modelling based on achievement of upper quartile performance

The responsibility for monitoring the project's progress against the agreed programme and making revisions where necessary rests with the Director of Commissioning as the project sponsor. The Engagement Director for Kilpatrick Consulting will confirm adequate completion of the tasks and sign off each Project Workstream.

Any issues relating to Kilpatrick Consulting's provision of the agreed consultancy services should be addressed to the Engagement Director.

7.3. Review and Acceptance

In order to meet project timeframes and milestones, all reasonable efforts will be made to submit documents for validation in good time against the plan and to provide rapid feedback. If required, verbal approval of decisions and actions will be sought to avoid delay to the delivery of the project.

8. Section 8 Project Management Arrangements

8.1. Project Management Structure

Project Board Membership

The Members of the Project Board are as follows:

- Dean Sullivan, HSC Board Director of Commissioning (Chair)
- Louise McMahon, Director of Performance and Service Improvement PMSID
- Senior Medical Officer – The Public Health Agency
- Mary Hind – The Public Health Agency
- Sloan Harper –Director of Integrated Care
- Paul Cummings -Director of Finance HSC Board

The Project Board Chair role will be assumed by the Director of Commissioning for the HSC Board.

Trust Reference Group

The membership of the Trust Reference Group will be as follows:

- Trust representatives X 3
- LCG representatives
- Existing clinical groups will have the opportunity to input and contribute to the Reference Group as appropriate.

8.2. Project Milestones

The project milestones are outlined in the Microsoft project plan attached as appendix to this document.

8.3. Project Risk Factors

The satisfactory completion of the Review Process within the agreed timescales and budget depends on the following main factors:

- Adequate and timely provision by each Trust of clinical data and clinical workforce information;

- Availability of SDU and HSC Commissioning staff to resource the Project Team
- The requisite base level technical and research skills within the Project Team
- Achieving sign off with Trusts on the revised planning assumptions on which the modelled capacity will be based
- Availability of key managerial and clinical management leads to input and actively contribute to the process.

The likelihood of any of these occurring is medium; however the impact could be high, as the rest of the process would be delayed.

These risks can be minimised by providing as much notice as possible when issuing datasets, standardisation of data templates, scheduling meetings, interviews and workshops. Kilpatrick Consulting can confirm the availability and ability of its consultants to carry out the agreed tasks according to the programme set out in this document.

As part of the ongoing risk management process, these risks will be reviewed and discussed further in the report.

Stinson, Emma M

From:	Stinson, Emma M
Sent:	23 April 2010 10:25
To:	Mackle, Eamon; Young, Michael; Brown, Robin; Trouton, Heather; Clarke, Paula; Carroll, Ronan; Walker, Helen; Cassells, Carol; Beth Malloy's email address Joe Lusby's email address
Cc:	Renney, Cathy; McCorry, Monica; Akhtar, Mehmood; Murphy, Jane S; Radcliffe, Sharon; Lappin, Aideen; McNeice, Andrea; Orla Morrow's email address
Subject:	Steering Group Meeting - 13th May 2010
Attachments:	Team South Agenda - 13 May 2010.doc; REGIONAL REVIEW RECOMMENDATIONS.doc; Team South Urology Steering Groups.doc; Review of Urology Services update april 10.doc
Importance:	High

Dear Everyone

The first meeting of the Steering Group to manage the planning and implementation of the Regional Urology Review will take place on Thursday 13th May 2010 starting at 10.00 am in the Board Room, Trust HQ.

I have attached the following documents in preparation:

• Agenda
• Steering Group, Project Team and Clinical Assurance Group Membership • Regional Review recommendations • Southern Trust outline position regarding recommendations

Given that Mr Mark Fordham, the Urology Surgeon engaged to provide clinical leadership to this NI Review, will be with the Trust for the day, I have invited Mr O'Brien and Mr Akhtar to join the Steering Group meeting and subsequent meetings on the day

The Steering Group will commence at 10am and is likely to take most of the morning. The remainder of the day will be used for clinical discussions with Mr Fordham on specific issues in relation to the review and visiting urology facilities in CAH.

I would be grateful for an indication of your availability if my office is not already aware of this.

Regards

Gillian

Dr Gillian Rankin
Interim Director of Acute Services

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Fax:

Email: Personal Information redacted by the USI

AGENDA

TEAM SOUTH UROLOGY STEERING GROUP MEETING ON 13 MAY 2010 AT 10.00 PM IN CRAIGAVON HOSPITAL,

1. **WELCOME AND INTRODUCTIONS**

2. **MINISTERS ENDORSEMENT OF ALL UROLOGY REVIEW RECOMMENDATIONS**

3. **UPDATE ON PROJECT MANAGEMENT ARRANGEMENTS FOR TEAM SOUTH – MEMBERSHIP AND CHAIR**

4. **UPDATE ON PROGRESS WITH RECOMMENDATIONS – IDENTIFICATION OF ANY KEY RISKS AND ACTIONS TO RESOLVE**

5. **IDENTIFY KEY PATIENT PATHWAYS AND PROTOCOLS**

6. **BUSINESS CASE FOR SERVICE EXPANSION**

7. **AGREE NEXT STEPS AND TIMETABLE**

8. **ANY OTHER BUSINESS**

RELEVANT REVIEW RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for

service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5). One local MDT/MDM.*** Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call). One local MDT/MDM plus regional/specialist MDM.*** Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on BCH site.

Table 14 Elements and Arrangements in Three Team Model

*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.

** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

*** MDM reconfiguration has been approved by NICaN Group

Team South Urology Steering Group/Project Board

Dr Gillian Rankin	Interim Director of Acute Services (Chair)
Dr Eamon Mackle	Associate Medical Director – Surgery & Elective Care
Mr Michael Young	Clinical Lead Urologist
Mr Robin Brown	Clinical Director – Surgery & Elective Care
Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care
Mrs Paula Clarke	Acting Assistant Director of Performance & Reform
Mr Ronan Carroll	Assistant Director of Acute Services – Cancer & Clinical Services
Mr Joe Lusby	Deputy Chief Executive, Director of Acute Services, Western Trust
GP Representative	Western Trust
Mrs Helen Walker	Assistant Director – Human Resources
Mrs Carol Cassells	Senior Financial Management Accountant - Acute Services
Ms Beth Malloy	Assistant Director Scheduled Services, PMSID, H&SCB

Project Team

Mrs Heather Trouton	Acting Assistant Director of Acute Services – Surgery & Elective Care (Chair)
Mrs Martina Corrigan	Head of Urology & ENT
Sandra Waddell	Head of Planning – Acute
Project Manager	To be appointed
Heads of Service	As needed
Finance Representative	
HR Representative	

Clinical Assurance Group

Mr Young
Mr O'Brien
Mr Akhtar
Mrs Martina Corrigan
Mrs Shirley Tedford
GP Representative

Health and Social Care Board

REGIONAL REVIEW OF ADULT UROLOGY SERVICES

April 2010

This document makes a total of 26 Recommendations, which are set out in Table 1 below.

Recommendation	Update 15 April 2010
1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial portion of a surgeon's practice (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.	Only the Urologist's in the Southern Trust undertake these urological procedures.
2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team	The Trust will keep this under review as Consultant Surgeons retire and make appropriate plans to transfer the "N" code work to urologists.
3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance. (Section 2 – Introduction and Context, pg 5)	The Trust need to undertake this review and to take into account the service pathways from Primary Care to both Urology and Gynae services. **Action: Group to be set up to take this forward**
4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.	This process was reviewed by the Trust last Summer and is in place.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.	The Trust has a number of representatives that sit and attend meetings for this Group and have been involved in the discussion in respect to the referral guidelines and pathways. The Trust commenced its formal Multi-disciplinary Team meetings on 1 April on Thursday afternoons were suspected and confirmed urological cancer pathways and referrals are discussed.
6. Deployment of New Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.	The Trust will take this into account when preparing job descriptions and job plans.
7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).	The Trust have commenced work on this, for example patients presenting with Urinary Tract Retention. These have been shared with A&E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways.
8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct	The Trust have commenced work on this, for example

transfer and admission to an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).	patients presenting with Urinary Tract Retention. These have been shared with A&E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways
9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week. (Section 3 –Current Service Profile, pg 5).	This recommendation will be actioned as part of the implementation of the review and will include representatives from Urology, A&E and General Surgeons from the those hospitals that do not have a Urology Unit. **Action:- Meeting to be set up to include all as mentioned above to take this forward**
10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home. (Section 3 –Current Service Profile, pg 5).	This recommendation has commenced as from week beginning 5 April the protected Urology Thursday slot will look at each of the ICATS services. 8th April looked at Andrology and it was agreed that this service would be split in two and one part will deal with erectile dysfunction. Today the discussions were concentrating on benign prostatic disease. Notes from these meetings will be available and then discussions and recommendations from these will be implemented.

	Action: these weekly meetings to continue
11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.	The Trust currently adhere to key elements of the Elective Reform Programme, for example, IEAP, pre-op assessment, monitor admission on day of surgery, etc and through weekly dashboard reports etc will be able to evidence. For example the Trust are also looking at methods of operation e.g. TURP to increase day surgery and recognise that some investment is required for equipment to meet these targets and other of the key elements are being taken into consideration for Urology.
12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients. (Section 5 – Performance Measures, pg 6).	This redesign is all part of the protected 'Thursday' meetings and are currently aiming through Thorndale unit to facilitate a single visit for suspected urological cancer patients. we are currently drawing up a timetable at what will be discussed at each of these meetings so as to assist in taking forward these recommendations
13. Trusts should implement the key elements of the elective reform programmed with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.	This is currently on-going as per recommendation 11

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients. (Section 5 – Performance Measures, pg 6).	This point will part of the implementation plan and still needs to be actioned with Consultants. Mr Mark Fordham is visiting the Trust on 13 May and can be included in discussions with the Urologists.
15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery. (Section 5 – Performance Measures, pg 6).	This point will part of the implementation plan and still needs to be actioned with Consultants along with their colleagues in other Trusts
16. Trusts should review their outpatient review practice, design other methods/staff where appropriate and subject to casemix/complexity issues reduce new: review ratios to the level of peer colleagues.	This has partially commenced in the Dr Rodgers, General Practitioner with Specialist Interest (GPWSI) attends Mr Young's weekly CAH outpatient clinic to see reviews. Also Shirley Tedford the Urology Nurse Co-ordinator has started to do chart, letter and results reviews on review patients and then discusses their outcome with the consultants and agrees the best pathway for them.
17. Trust must modernise and redesign outpatient clinic templates and admin/booking processes to ensure their capacity for new and review patients and to prevent backlogs occurring in the future.	The admin/booking processes are in place. As part of the whole review each Urologist will be met to

	discuss their clinic templates and ensure that there is enough capacity for the new and review. This will also depend on the availability of Registrars/Junior Staff to assist at the clinics as there had been a deficit for a while. **Action: On-going**
18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG. (Section 7 – Urological Cancers, pg 6).	This is on-going with representatives of the Trust attending and actioning recommendations from the NICaN group
19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties. (Section 7 – Urological Cancers, pg 6).	There is ongoing discussions taking place regarding this recommendation
20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).(Section 7 – Urological Cancers, pg 6).	There is ongoing discussions taking place regarding this recommendation

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte. (Section 8 – Clinical Workforce Requirements, pg 6).	A business case needs to be prepared for two additional Consultant Urologists for the Southern Trust to include their support and any equipment required in order that they will take into account specialist interests as per Recommendation 6. Work has commenced on team job plans and job descriptions will now have to be drawn up.
22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans. (Section 8 – Clinical Workforce Requirements, pg 6).	Work has commenced on team job plans and job descriptions will now have to be drawn up. Discussions need to take place with Theatres to identify the additional operating sessions and take into account the other sites within the catchment area.
23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010. (Section 8 – Clinical Workforce Requirements, pg 6).	Job plans, job descriptions will have to be developed as part of the implementation plan.

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability. (Section 9 – Service Configuration Model, pg 7).	Agreement that this is part of the implementation plan
25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements. (Section 9 – Service Configuration Model, pg 7).	Not applicable to this Trust
26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served. (Section 9 – Service Configuration Model, pg 7).	Meeting being set up for beginning of May with the Western Trust to begin to work in partnership to discuss the implementation plan.

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 14 May 2010 17:21
To: Stinson, Emma M
Subject: FW: Team South Urology Steering Group
Attachments: image001.jpg; Urology Review.eml

From: Waddell, Sandra
Sent: Friday, May 14, 2010 5:20:32 PM
To: Corrigan, Martina; Trouton, Heather
Cc: Clarke, Paula; Rankin, Gillian
Subject: FW: Team South Urology Steering Group Auto forwarded by a Rule

For information.

Sandra
Sandra Waddell
Head of Acute Planning
Directorate of Performance & Reform
Southern Health & Social Care Trust
1st Floor, The Rowans
Craigavon Area Hospital
Ext [redacted] Direct Line [redacted]
Email: [redacted]
Mobile: [redacted]
Fax: [redacted]

From: Cullen, Caroline [redacted]
Sent: 14 May 2010 16:59
To: Cavanagh, Paul
Cc: Donnelly, Lyn; Waddell, Sandra; Quinn, Martin3
Subject: Team South Urology Steering Group

"This e-mail is covered by the disclaimer found at the end of the message."

Afternoon Paul

I was wondering if we could have a chat about the above. I attended the first meeting of the Steering Group yesterday and Gillian Rankin (Chair) was most anxious to ensure that the appropriate people were involved from both areas.

There was a realization that the Western LCG had not yet been asked to attend and given that I was the SLCG rep I had agreed to approach yourself. Currently the only other Western Rep who

is from the WHSCT is Dan Mc Laughlin, AD Acute Services who is due to officially take up post next Monday.

I have attached some information which will hopefully makes things a little clearer for you regarding the process.

It was agreed at the meeting yesterday that the SHSCT Urologists would visit the Erne on Monday 24th May (provisional arrangements are 10am to 1.30pm) and I think that it would be of use to the WLCG if either yourself or a representative could also attend. They are also trying to get a GP from the West to be involved but as yet have had no success and I think if there was anything that you could do to assist then that would be welcomed.

There is 4 week turnaround for completion of the first draft of the Implementation Plan which has to be submitted to the Board by 11 June. Therefore there is a meeting of the steering group scheduled for 10th June at 2.30. Again it would be useful if there was a rep from the WLCG present at that meeting.

I will be in my office all day Monday if you would like to chat about any of the above.

I look forward to hearing from you

Regards

Caroline Cullen
Senior Contracts Manager
Contracts Department
Tower Hill
ARMAGH
BT61 9DR
Personal Information redacted by the USI
Direct Line: Personal Information redacted by USI

Stinson, Emma M

From: Waddell, Sandra [redacted]
Sent: 14 May 2010 11:35
To: Cullen, Caroline
Subject: Urology Review
Attachments: HM700 - ltr to Trust Dir Acute re Uology Review Implementation.doc

<<HM700 - ltr to Trust Dir Acute re Uology Review Implementation.doc>> Caroline

I have attached a copy of Hugh's recent letter as promised. I will forward the PID when I have incorporated the comments from yesterday's meeting.

Sandra

Sandra Waddell
Head of Acute Planning
Directorate of Performance & Reform
Southern Health & Social Care Trust
1st Floor, The Rowans
Craigavon Area Hospital
Ext [redacted] Direct Line [redacted]
Email: [redacted]
Mobile: [redacted]
Fax: [redacted]

Health and Social Care Board

Performance Management and Service Improvement Directorate

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : Personal Information redacted by USI
Fax : Personal Information redacted by USI
Email: Personal Information redacted by the USI

Trust Directors of Acute Services

Our Ref: HM670
Date: 27 April 2010

Dear Colleagues

REGIONAL UROLOGY REVIEW

As you are aware, the Trust was represented on the Regional Urology Review which was completed in March 2009. The final report was presented to the Department in April 2009 and was endorsed by the Minister on 31 March 2010. I am aware an initial meeting of team East was held on 22 March and team North on the 1 April 2010 and team South is planned for the 13 May 2010.

Now that the Minister has endorsed the recommendations from the Review, it is imperative that the Trusts with lead responsibility for the development of the Business Case/Implementation Plan move quickly to develop the team model and agree the activity to be provided from the additional investment.

The Teams should base their implementation plan on each of the relevant Review recommendations; a full list of the recommendations is included in Appendix 1. I am aware that each of the teams has established project management arrangements to develop and agree the implementation plan for each team. It is also anticipated that these teams will agree the patient pathways, complete a baseline assessment of the current service, their current location and the activity available from the existing service model. The teams should aim to have completed the first draft of the Implementation Plan and submit this to the Board by Friday 11 June 2010.

It is planned that an overarching Implementation Project Board will be established comprising the Chair and Clinical Advisor from each of these project Teams, and key HSCB staff; to oversee the implementation of the Review. The first meeting of the Urology Project Implementation Board will be held on Thursday 1 July 2010 at 2.00pm in the Conference Room, Templeton House. The Project Team chair should send the team nominated representatives to Personal Information redacted by the USI by Friday 7 May 2010. I have asked Beth Malloy, Assistant Director, Scheduled Services, Performance Management and Service Improvement, to chair the Project Implementation Board.

The Review estimated the cost of implementing the recommendations to be £3.5m, of this £637k has already been allocated to Belfast Trust, and the remaining balance of £2.9m is

available. Please see Appendix 2 which has notionally allocated this budget to each of the teams, and it is on this basis the Teams should work collectively across Trusts to develop the Implementation Plans. The plan should also include a proposal for the use of the non-recurrent 'slippage' funding available from the teams share of the recurring £2.9m, this should include what additional in-house sessions will be provide to maintain the waiting times as at 31 March 2010 and to deal with any backlog of patients waiting for urological diagnostic investigations or outpatient review.

As per the details outlined in the Review, the initial assumption regarding the activity associated with each of the additional Consultant appointments is included in Appendix 3. To assist the teams in the further discussion, the figures outlined in the Urology Review have been updated and are attached in Appendix 4.

The Implementation plan, proposed patient pathways and the non-recurrent funding proposal should be sent to Beth Malloy Personal Information redacted by the USI by Friday 11 June 2010.

Yours sincerely

Personal Information redacted by USI

HUGH MULLEN
Director of Performance Management and Service Improvement

Enc

cc Trust Directors of Performance
John Compton
Paul Cummings
Beth Malloy
Michael Bloomfield
Iain Deboys
Lyn Donnelly
Paul Cavanagh
Paul Turley
Bride Harkin

Appendix 1

1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

Section 4 – Capacity, Demand and Activity

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Appendix 2

Estimated Team Costs for the Implementation of Adult Urology Review Recommendations.

	Team South	Team North	Team East	Total	No	Unit Cost	Total
Staffing Costs							
Consultant Urologist – additional wte team allocation	2 wte	1 wte	3 wte	6	6		
Consultant Urologists wte	£208,000	£104,000	£312,000	£624,000		£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	£124,800	£62,400	£187,200	£374,400	3.6	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	£62,400	£31,200	£93,600	£187,200	1.8	£104,000	£187,200
Band 5 Radiographer @ 6 per wte Con Radiologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist	£100,782	£50,391	£151,173	£302,346	10.8	£27,995	£302,346
Band 3 Nursing @ 0.46 wte per Con. Urologist	£17,870	£8,935	£26,805	£53,610	2.7	£19,856	£53,611
Band 7 Specialist Nursing *1	£103,605	£0	£103,605	£207,210	5	£41,442	£207,210
Band 5 Nursing @ 0.64 wte (day surgery)	£5,972	£2,986	£8,958	£17,916	0.64	£27,995	£17,917
Band 4 Personal Secretary @ 0.5 wte per consultant urologists	£23,265	£11,633	£34,897	£69,795	3	£23,265	£69,795

Band 3 Admin support to radiologists at 0.5 wte per Radiologist	6,618	3,309	9,927	£19,854	1	£19,856	£19,856
Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2	£31,438	£0	£28,129	£59,567	3	£19,856	£59,568
Band 4 Medical Records support 0.5 per unit *3	£11,632	£23,265	£23,265	£58,162	2.5	£23,265	£58,162
Band 7 MLSO – Bio-medical Science *4			£41,442	£41,442	1	£41,442	£41,442
Staffing Costs Sub Total	**£797,164**	**£348,510**	**£1,172,174**	**£2,317,848**			**£2,317,853**
Support Costs							
Surgical G&S @ £94,500 per Con. Urologist	189,000	94,500	283,500	£567,000	X 6	£94,500	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	100,000	50,000	150,000	£300,000	X 6	£50,000	£300,000
Radiology G&S per Con. Urologist	5,000	2,500	7,500	£15,000	X 6	£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	64,000	32,000	96,000	£192,000	X 6	£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	40,000	20,000	60,000	£120,000	X 12	£10,000	£120,000
Support Costs Sub Total	**£398,000**	**£199,000**	**£597,000**	**£1,194,000**			
Sub Total	**£1,195,164**	**£547,510**	**£1,769,174**	**£3,511,848**			**£3,511,853**
Less funding in 2008/09			**£637,076**	**£637,076**			**-£637,076**
FINAL TOTAL	**£1,195,164**	**£547,510**	**£1,132,098**	**£2,874,772**			**£2,874,777**

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

	Existing Establishment	Number of consultants with a sub-specialty interest	Additional CNS
Team South	0	2	2
Team North	2	2	0.5
Team East	2	4	2.5

*2 – 0.5 allocated to each Team as per the Specialist Nurse

*3 – 0.5 allocated to each Trust Unit within each Team

*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board

Appendix 3

The exact details of the additional activity associate with the additional Consultant appointments will require agreement with the Board Commissioning teams. As outlined in the Review, it is assumed that the additional activity will be as follows:

Ref: Review Page 40-41
Outpatients: 1176 – 1680 per Consultant
Inpatient and Daycase FCE: 1000 - 1250 per Consultant

Existing 17 Consultants in post
Outpatients 19,992 to 28,560
IP/DC FCEs – 17,000 to 21,250

New 6 Consultant Appointments
Outpatients 7,056 to 10,080
IP/DC FCEs – 6,000 to 7,500

Regional Total
Outpatients 27,048 to 38,640
IP/DC FCEs – 23,000 to 28,750

Please note:
This analysis does not take into account the improvements expected from the introduction and full implementation of the ICATS for urology, as outlined on page 19 of the Review. The additional activity from the CNS has still to be quantified. In addition, the quantification of the service improvements, to be gained from the implementation of the Review recommendations, still to be agreed with the each Trust (for each of the team) and the Board are not included.

Stinson, Emma M

From: Stinson, Emma M [redacted]
Sent: 24 June 2010 09:56
To: 'Beth Malloy'
Cc: [redacted] [redacted]
Subject: FW: Regional Review of Urology Services - Team South Implementation Plan
Attachments: Team South Implementation Plan v0.2.pdf

Dear Beth,

Please see attached Implementation Plan for Team South. Please do not hesitate to contact me if there are any issues which need discussed.

Regards
Gillian

Dr Gillian Rankin
Interim Director of Acute Services

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

Tel: [redacted]
Fax: [redacted]

Email: [redacted]

From: Waddell, Sandra
Sent: 24 June 2010 09:25
To: Stinson, Emma M
Cc: Corrigan, Martina; Trouton, Heather
Subject: Regional Review of Urology Services - Team South Implementation Plan

Emma

I have been speaking to Martina this morning about the implementation plan and have made the minor changes that Dr Rankin requested. Could the attached plan be sent on to Beth Malloy please - [redacted] Dr Rankin may also want to send it to Dr Diane Corrigan at the PHA and Lyn Donnelly or Caroline Cullen at the Southern LCG.

Thank you for your help.

Sandra

Sandra Waddell
Head of Acute Planning
Directorate of Performance & Reform
Southern Health & Social Care Trust
1st Floor, The Rowans
Craigavon Area Hospital

Ext Personal Information redacted by USI Direct Line Personal Information redacted by USI
Email: Personal Information redacted by the USI
Mobile: Personal Information redacted by USI

Stinson, Emma M

From: Stinson, Emma M [redacted]
Sent: 08 July 2010 11:15
To: 'McAlinden, Mairead'
Cc: Wright, Elaine
Subject: Regional Review of Urology Services - Team South Implementation Plan
Attachments: Team South Implementation Plan v0.2.pdf

Dear Mairead

Dr Rankin asked me to forward the Urology Implementation Plan to you which was submitted to LCG/RHSCB.

Many thanks

Emma

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

Tel: [redacted]
Fax: [redacted]

Email: [redacted]

From: Stinson, Emma M
Sent: 24 June 2010 09:56
To: 'Beth Malloy'
Cc: [redacted] [redacted]
Subject: FW: Regional Review of Urology Services - Team South Implementation Plan

Dear Beth,

Please see attached Implementation Plan for Team South. Please do not hesitate to contact me if there are any issues which need discussed.

Regards
Gillian

Dr Gillian Rankin
Interim Director of Acute Services

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

Tel: [redacted]
Fax: [redacted]

Email: [redacted]

Southern Health and Social Care Trust

Regional Review of Urology Services

Team South Implementation Plan

Contents

Tables

Appendices

1. Background

A regional review of (Adult) Urology Services 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. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1.5
LUTS	3
Haematuria	2
Andrology	2.5
General Urology/Uro Oncology	2.5
	14

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	610	474	0	**1084**
	ICATS/Nurse Led New OP	1233	30		**1263**
	Total New OP	1843	504	0	**2347**
	Cons Led Review OP	2391	70	0	**2461**
	ICATS/Nurse Led Rev OP	1594	0	0	**1594**
	Total Review	3985	70	0	**4055**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young[2]	Mr O'Brien	Mr Akhtar[3]	All Core Activity
2009/10	New OP	242	174	193	**609**
	Review OP	964	903	327	**2194**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2] Mr Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.
[3] Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)

3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).

4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers

and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- At what point in the pathway patients should be referred;
- Arrangements for review of the patients.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position with further detail being provided in Appendix 3.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009 for elective and non elective admissions.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

4. Demand for Team South Urology Service

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand. In addition capacity to deal with the current review backlog has not been included. It has been assumed that the Trust's proposal to manage the review backlog (Appendix 2) will be funded separately.

Table 6: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required** [6]
2009/10	Cons Led New OP	610	474	0	87	1171	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	1608
	Total New OP	1843	504	0	187	2534	**2990**
	Cons Led Review OP	2391	70	0		2461	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	1881
	Total Review	3985	70	0		4055	**4785**
	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

Table 7: Weekly Sessions for New Service Model

	Weekly Sessions
Consultant Led OPs	
General	5
Stone Treatment	1
ICATS	
Prostate Assessment	1.5
Prostate Biopsy [1]	1
Prostate Histology [2]	1
LUTS	3
Haematuria	1
Andrology/General Urology/Uro-oncology	5
Urodynamics	1.5
	14
Main Theatres	9
Day Surgery	
GA	3
Flexible Cystoscopy	3
Lithotripsy	2

1) Prostate Assessment and Biopsy will run side by side
2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.
3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.
4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions has to be agreed with the Western Trust.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Banbridge Poly Clinic, Armagh Community Hospital and Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to the availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Approval to Proceed with Implementation from HSCB	July 10
Completion of Job Plans/Descriptions for Consultant Posts	End July 10
Completion of Job Plans/Descriptions for Specialist Nurses	End July 10
Consultant Job Plans to Specialty Advisor	End July 10
Advertisement of Consultant Posts	September 10
Advertisement of Specialist Nurse Posts	September 10
New Consultants and Specialist Nurses in post	February 11

APPENDICES

Appendix 1

Clinicians Name – Mr Young
Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: Consultant

	AM – 4 Hour Session	PM – 4 Hour Session	Other
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	1outpatient clinic per month Banbridge (9 patients per Doctor) 1 outpatient clinic per month Armagh Clinic (9 patients per doctor) CAH STC Clinic (12 – 2pm) STC Cover treatments and Outpatient Clinic (between 9 & 24 patients) Consultant, SPR and Nurses Lithotripter	Day 4 Clinic Thorndale, CAH (between 2-3 patients) No Equipment Specialist Nurse Ultrasound Dynamics (2 patients) Urodynamic machine Specialist Nurses	
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Main Theatre CAH Inpatients (numbers will depend on cases) DSU 1 per month CAH (4-5 patients) See attached equipment list that is used in theatres	Main Theatre CAH Inpatients (numbers will depend on cases) See attached equipment list that is used in theatres	
Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used?	CAH STC Treatments – (day Cases – 4 treatments) - Lithotripter Administration Main Theatre Backfill		

Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	See attached equipment list that is used in theatres		
Thursday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	CAH X-Ray Conference Grand Ward Round Departmental Meeting	MDT	
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	CAH Teaching Administration Lead Clinician Theatre Backfill See attached equipment list that is used in theatres	CAH Outpatient Clinic Cons + SPR 10 patients per doctor No equipment	
Saturday			
Sunday			

Clinicians Name – Mr Aidan O'Brien Consultant Urologist
Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate - Consultant

	AM – 4 Hour Session	**PM – 4 Hour Session**	**Other**
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	1out patient clinic per month Banbridge (9 patients per Doctor) 1 outpatient clinic per month Armagh (9 patients per doctor) Alternative weeks when not in outreach Day 4 (2 patients) or Urodynamics studies (2 patients) Thorndale CAH Urodynamic equipment Consultant & 2 nurses	Day 4 (2 patients) or Urodynamics studies (2 patients) Thorndale CAH Urodynamic equipment Cons + 2 Nurses	Ward Rounds Administration
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Day Surgery x 2 monthly sessions CAH 4 patients Alternative Tuesday's Thorndale Unit Review of Cases	Outpatient Clinic CAH CONS + Register 10 Slots per Clinician	Ward Rounds Administration
Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Main Theatre CAH Inpatients (numbers will depend on cases) See attached equipment list that is used in theatres	Main Theatre CAH Inpatients (numbers will depend on cases) See attached equipment list that is used in theatres	Ward Rounds Administration

Thursday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	CAH X – Ray Meeting - 8.30am Grand Ward Round - 10am Departmental Meeting -12noon	CAH MDM - 2.15pm	Administration
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Day Review or NHS Patients or Private Patients or Backfill Theatre Inpatient See attached equipment list that is used in theatres	Thorndale Urodynamic Studies X 2 patients Consultant and 2 nurses Urodynamic equipment Day 4 Reviews Consultant and specialist nurse	Ward Round
Saturday	Wards / Theatre / Administration		
Sunday	Emergencies only		

Clinicians Name – Mr Akhtar
Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: Consultant

	AM – 4 Hour Session	**PM – 4 Hour Session**	**Other**
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	CAH Ward Round & patient Administration	CAH Outpatient Clinic 12 patients Consultant only No equipment	
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	South Tyrone Hospital 2 sessions per month Day Surgery/Flexis 4 patients/10 patients No Equipment Alternative Tuesdays SPA – CAH	South Tyrone Hospital 1 Session per month Outpatient Clinic 9 Patients per doctor No Equipment	
Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?		CAH SPA Activities]	

Thursday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	CAH Xray Meeting Grand Ward Round Departmental Meeting	CAH MDT – Acting Lead clinician	
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Main Theatre CAH Inpatients (numbers will depend on cases) See attached equipment list that is used in theatres	Main Theatre CAH Inpatients (numbers will depend on cases) See attached equipment list that is used in theatres	
Saturday			
Sunday			

Clinicians Name – Dr Rogers GPSI

Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: GPwSI

	AM – 4 Hour Session	**PM – 4 Hour Session**	**Other**
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	OFF	OFF	
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Thorndale CAH Andrology Clinic Outpatients 8-9 pt's No Equipment	Thorndale CAH Andrology Clinic Outpatients 5-6 pt's No Equipment	
Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Administration Session	Thorndale, CAH General Urology clinic 10 patients Ultrasound	

Thursday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	 Thorndale, CAH Alternative weeks Andrology / Prostate Diagnostic 10 patients Ultrasound	 Administration Session	
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	 Thorndale, CAH Stable Prostrate Cancer Clinic 5pt's No Equipment	 OPD CAH Mr Young backlog Review Clinic 7patients No Equipment	
Saturday			
Sunday			

Clinicians Name – Mr Jerome Marley – Nurse Lecturer

Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: Specialist Nurse

	AM – 4 Hour Session	PM – 4 Hour Session	Other
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	Thorndale Joint Andrology Clinic with DR Rogers Patients 9 No Equipment		
Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	CAH Stone Treatment Centre Lithotripsy Operator 4 Patients Lithotripter		
Thursday			

Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?			
Saturday			
Sunday			

Clinicians Name – Clinical Nurse Specialists Jenny McMahon & Kate O'Neil –
As these services have evolved it has proved most effective to have flexibility across the timetable, therefore sessions can be covered by either nurse, example of this below. Kate works a 5day week – (K), Jenny works a 4 day week (J)

All services below are provided on an out-patient basis within the Thorndale Unit at Craigavon Hospital.
Thorndale Staff (in addition to nurse specialists) The staff nurses provide support to all clinics within the Thorndale Unit, for example prostate biopsy & decontamination, haematuria assessment & venepuncture for all GPwSI clinics
S/N Kate McCreesh 23hrs S/N Dolores Campbell 23hrs
S/N Mairead Leonard 34hrs (17hrs Urodynamics) N/A Marie Briggs 30hrs assist with all clinics

	AM – 4 Hour Session	**PM – 4 Hour Session**	**Other**
Monday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J) Lower urinary tract symptom (LUTS) review clinic 8 patients (K) Prostate assessment clinic 4patients Ultrasound/ Flow meter & bladder scanner	(J) LUTS new clinic 4 patients (K) Prostate histology 4-6 patients (S/N) Ward histology 8 patients Ultrasound / Flow meter	(J/K) mon pm – Ad hoc Consultant clinic for e.g. staging results, urgent referrals
Tuesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J&K) Prostate biopsy 5 patients – L/A and decontamination required Andrology service – (J&K) support from nurse specialist in absence of lecturer practitioner Ultrasound	Andrology service – (K) support GPwSI	Tues pm – Admin (J) All admin. Sessions include for eg. Virtual histology clinic for negative biopsy preparation for diagnostic services & cancer support for patients & ward management duties for Thorndale unit

Wednesday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(K) Prostrate biopsy 4 patients alternate weeks L/A and decontamination required (S/N) Haematuria clinic 4 patients (K) Ad hoc Consultant clinic for eg. Staging results urgent referrals (S/N) ward Histology 6 patients 1-2 clinics per month Ultrasound	Urology clinic – (K) support GPwSI	Jenny off Wednesday
Thursday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J) Prostate assessment clinic 4 patients (red flag) alternate weeks /andrology service – 4 patients alternate weeks Urology review clinic 4 patients support GPwSI Ultrasound	MDM Both nurse specialist attend	(K) Admin Thursday am
Friday Where is the location? What service is provided? Theatre – IP or DC or LA Diagnostic Session What equipment is used? Outpatient – Number/grade of clinicians at clinic Number of slots per clinic?	(J) LUTS new clinic 4 patients (K) Cancer review clinic 4 patients Ultrasound	(S/N) Flexible Cystoscopy list (as part of the Haematuria Service)	Admin session for nurse specialists/ cover for flexible cystoscopy if staff nurse unavailable

Equipment that Consultant Urologist's use in Craigavon Area Hospital Main Theatre

Maquet operating table with appropriate attachments for abdominal x raying and for positioning patients in lithotomy position.

Holmium 100watt laser and consumables eg. Laser fibres 200, 350 and 500, cleaving tools for each fibre and cutting tool for same. Laser safety glasses.

Image intensifier, light weight lead coats and thyroid collars.

Swiss lithoclast Master.

Ultracision

Camera stacking system with recording and insufflator.

Omnitract or a Book Walter retractor

Instrumentation

Flexible cystoscopy

Flexible ureteroscopes

Rigid ureterorenoscopes, sizes 6fg and 8/9 fg

Rigid cystscopes size 21fg 23.5 fg 17 fg

Resectoscopes size 26fg continous.

Bipolar resectoscopes

Stent removing forceps

Bladder biopsy forceps, rigid and flexible

Ureteric grasping forceps and bladder grasping forceps

Internal ureterotomy trays

Mauyer Mayer stone crusher

PCNL trays

0 degree telescopes

Laprascopic instruments for hand assisted nephrectomy

Numerous consumables eg stents, guidewires, uretheral catheters, baskets for removing stones, dilators,giving sets, ellicks evacuator.

Appendix 2

Proposal to Manage Urology Review Backlog

Process to manage the substantial volume of patients involved in Urology - Total = 4037 (2008- 31 May 2010)

- Identify patients who may be at risk and require an urgent review
- Identify patients who require a consultant reassessment in an agreed timeframe
- Cleanse list – ensure that there are no duplicate open requests for same issue.

The Specialty Nurses have agreed to coordinate the process by reviewing patient centre letters and results and collate into the following categories:-

Category 1: Urgent appointment required
Automatically arrange an urgent review appointment

Category 2: Decision required on review management
Lead nurse will meet with consultant to determine a plan for each patient, i.e. either agree review required in a specified time frame or agree an alternative plan.

Category 3: ?Discharge based on clinical results available
Lead nurse to get permission from consultant to discharge and send letter to GP and patient

Category 4: PAS errors/duplication
Lead nurse to get permission from consultant to discharge from PAS

To date there has been a reduction in the waiting list by 6%.

Appendix 3

Regional Benchmarking

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland for:

- New to review ratios;
- Day Case rates;
- Average length of stay for elective and non elective procedures.

New : Review Ratio
1/04/06 - 28/02/10

	2006/07	2007/08	2008/09	2009/10
All Trusts	1.96	2.03	1.79	1.68

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	1.63	2.09	1.77	1.72
Northern Trust	1.97	1.67	1.31	1.75
South Eastern Trust	1.15	1.1	1.15	1.25
Southern Trust	4.04	3.27	3.28	2.09
Western Trust	2.65	2.32	2.49	1.73

Note – the review backlog will have skewed the figures for 2009/10 (perhaps for all Trusts)

Day Case Rates by Trust

April 06 - Feb 10

(Excludes Prim Op M45 and Not coded procedures) (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

		2006/07	2007/08	2008/09	2009/10
All Trusts	Day Cases	3793	3733	4255	3492
	Elective Admissions	3780	3963	4293	3710
	DCs+ElecAdm	7,573	7,696	8,548	7,202
	Daycase Rate	**50.1**	**48.5**	**49.8**	**48.5**

		2006/07	2007/08	2008/09	2009/10
Belfast Trust	Daycases	1737	1584	1896	1615
	Elective Admissions	1938	2092	2015	1873
	Total	**3,675**	**3,676**	**3,911**	**3,488**
	DC Rates	47.3	43.1	48.5	46.3
Northern Trust	Daycases	211	209	241	372
	Elective Admissions	465	430	582	448
	Total	**676**	**639**	**823**	**820**
	DC Rates	31.2	32.7	29.3	45.4
South Eastern Trust	Daycases	930	912	940	751
	Elective Admissions	257	325	369	328
	Total	**1,187**	**1,237**	**1,309**	**1,079**
	DC Rates	78.3	73.7	71.8	69.6
Southern Trust	Daycases	579	576	770	433
	Elective Admissions	742	691	807	650
	Total	**1,321**	**1,267**	**1,577**	**1,083**
	DC Rates	43.8	45.5	48.8	40.0
Western Trust	Daycases	336	452	408	321
	Elective Admissions	378	425	520	411
	Total	**714**	**877**	**928**	**732**
	DC Rates	47.1	51.5	44.0	43.9

Urology - Average LOS (Episode based)

April 06 - Feb 10

Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	3.7	3.5	3.4	2.9

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	3.9	3.5	3.5	3.3
Northern Trust	2.3	2.9	2.4	1.9
South Eastern Trust	3.8	4.0	3.4	3.2
Southern Trust	3.7	4.3	3.9	2.7
Western Trust	3.6	2.9	3.2	2.9

Non Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	4.8	4.7	4.6	4.4

	2006/07	2007/08	2008/09	2009/10
Belfast Trust	5.5	4.9	5.4	5.0
Northern Trust	4.3	5.4	4.9	3.7
South Eastern Trust	3.9	4.4	3.5	3.8
Southern Trust	4.5	4.8	4.6	4.7
Western Trust	3.9	3.8	4.1	3.4

Appendix 4

British Association of Day Surgery (BADS)

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The tables overleaf compare the Trust's performance with the BADS targets for urology. The following notes apply:

- The first table relates to Trust activity for 2009/10. At 2nd June 2010 175 elective finished consultant episodes (FCEs) and 182 day cases were not coded;
- Elective FCEs and day cases have been included (no non elective activity);
- Only activity undertaken by the 3 consultant urologists has been included in the analysis.

British Association of Day Surgery (BADS) Basket of Procedures for Urology
2009/10 SHSCT Data

			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		0%	53%	
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	38%	
3	Removal of prosthesis from ureter	M29.3	100			38%		
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%	
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%	
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		0%	10%	
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	32%	23%
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		0%	10%	
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%	
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%
11	Dilation of outlet of female bladder	M58.2		90	10	100%		
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%	
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%		
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%	
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10				
17	Operations on urethral orifice	M81	90	10		33%	50%	
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%	
19	Excision of lesion of testis	N06.4, N07	90	10				
20	Orchidopexy - bilateral	N08	60	35	5			
21	Orchidopexy	N09	75	20	5	60%	40%	
22	Correction of hydrocoele	N11	90	10		80%	10%	
23	Excision of epididymal lesion	N15	90	10		90%	0%	
24	Operation (s) on varicocoele	N19	90	10		60%	40%	
25	Excision of lesion of penis	N27	50	50		100%		
26	Frenuloplasty of penis	N28.4	90	10		100%		
27	Operations on foreskin - circumcision, divisio of adhesions	N30	90	10		71%	14%	
28	Optical urethrotomy	M76.3	90	10		7%	56%	
29	Laparoscopic nephrectomy	M02.1,M02.5,M02.8, M02.9 (+Y75.2)	5	75	25	0%	11%	0%
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10			
31	Laparoscopic radical prostatectomy	M61.1,M61.2,M61.9 (+Y75.2)		5	90		0%	0%

British Association of Day Surgery (BADS) Basket of Procedures for Urology
2008/09 SHSCT Data

			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	72 HOUR %	DAY CASE %	23 HOUR STAY %	72 HOUR %
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		11%	11%	
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	0%	
3	Removal of prosthesis from ureter	M29.3	100			47%		
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	37%	
5	Other endoscopic procedures on ureter	M27.4-M27.8,M28, M29.1,M29.4, M29.8, M29.9	90	10		12%	24%	
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		8%	8%	
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	10%	35%
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		13%	30%	
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		91%	4%	
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	100%		
11	Dilation of outlet of female bladder	M58.2		90	10			
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		0%	33%	
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%		
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	2%	28%	5%
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10				
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10				
17	Operations on urethral orifice	M81	90	10		86%	14%	

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

			BADS RECOMMENDATION			SHSCT PERFORMANCE		
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	72 HOUR %	DAY CASE %	23 HOUR STAY %	72 HOUR %
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		14%	27%	
19	Excision of lesion of testis	N06.4, N07	90	10		100		
20	Orchidopexy - bilateral	N08	60	35	5	100		
21	Orchidopexy	N09	75	20	5			
22	Correction of hydrocoele	N11	90	10		60%	28%	
23	Excision of epididymal lesion	N15	90	10		75%	13%	
24	Operation (s) on varicocoele	N19	90	10		78%	11%	
25	Excision of lesion of penis	N27	50	50		80%		
26	Frenuloplasty of penis	N28.4	90	10		60%	40	
27	Operations on foreskin - circumcision, division of adhesions	N30	90	10		66%	22%	
28	Optical urethrotomy	M76.3	90	10		22%	25%	
29	Laparoscopic nephrectomy	M02.1,M02.5,M02.8,M02.9 (+Y75.2)	5	75	25	0%	14%	0%
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10			
31	Laparoscopic radical prostatectomy	M61.1,M61.2,M61.9 (+Y75.2)		5	90			

Total increase in daycases in 2008/09 if BADS recommended daycase rates achieved = 215

Updated following meeting on 17 Jun 10 to sign off planning assumptions

Appendix 5

Projected Activity & Sessions v0.1 23 June 10

Table 1 below gives the Board's calculation of the capacity gap, and using the Board's methodology, the projected activity for 'Team South'.

		2009/10 Actual Activity							
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**SBA**	**SHSCT Capacity Gap**	**Team South Capacity Required [6]**
2009/10	Cons Led New OP	610	474	0	87	1171	1014	157	1382
	ICATS/Nurse Led New OP	1233	30		100	1363	990	373	1608
	Total New OP	1843	504	0	187	2534	2004	530	**2990**
	Cons Led Review OP	2391	70	0		2461	3290	-829	2904
	ICATS/Nurse Led Rev OP	1594	0	0		1594	990	604	1881
	Total Review	3985	70	0		4055	4280	-225	**4785**
	Day Case	1502	3	383	47	1935	1239	696	**2283**
	Elective FCE	1199	29	140	28	1396	780	616	**1647**
	Non Elective FCE	629	0	0		629	816	-187	**742**

1) Source is Business Objects
2) Activity has been counted on specialty of clinic
3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog (4037 in June 2010). As shown N:R = 1:2
4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).
5) 18% added for Fermanagh, based on population size relative to SHSCT population
6) SBA for ICATS is 1980 (no split between new and reviews so have just divided equally)

Outpatients

To enable the numbers of clinic sessions to be calculated, Table 2 splits the numbers of new outpatient attendances by clinic, based on the 2009/10 attendances.

Table 2: New Outpatient Attendances

Clinic	Core	IHA	Total	%	Growth	SHSCT Total	Team South [3]
Prostate TRUSA (&B)	248		248	10.6%	20	268	316
LUTS	323		323	13.8%	26	349	412
Andrology/Dr Rodgers gen urology	476	30	506	21.6%	40	546	645
Haematuria	186		186	7.9%	15	201	237
Consultants clinics	374	474	848	36.1%	68	916	1080
Urodynamics (consultants)	236		236	10.1%	19	255	301
	1843	504	**2347**	100.0%	187	2534	**2990**

Stone Treatment new outpatients are being recorded as reviews and are therefore not included in the figures. This means that new outpatients at consultant clinics are under stated by approximately 240 attendances.

Sessions are based on 48 weeks unless otherwise stated.

Prostate Pathway (Revised)

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do digital rectal examination (DRE), take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 69% of patients will require biopsy (218)

316 patients @ 5 per session = 63 sessions per annum = 1.3 assessment sessions per week.

218 cases for biopsy @ 5 per session = 44 sessions per annum. 1 biopsy session per week should therefore suffice (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. It is estimated that 40% of patients who have had biopsy will have positive pathology (using 40% this would be 88 patients. Adding on 10% for those patients with benign pathology who will need to come in for their results gives a figure of 97 patients needing a second appointment. This equates to 2 patients each week (over 48 weeks). These patients are now being seen by a registrar but the consultants want to build time into the new service model to see the patients themselves.

3rd appointment will be discussion of treatment with the estimated 88 patients per annum. The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients

LUTS

412 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 330 reviews.

412 new patients @ 4 per session = 103 sessions

330 reviews @ 8 per session = 42 sessions

103 + 42 = 145 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to Day Surgery Unit to have flexi carried out by a Registrar (Friday flexi sessions).

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

237 new patients @ 5 per session = 48 sessions = **1 per week** (over 48 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

This service will be reviewed over the next 6 months.

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

645 @ 3 news per session = 215 sessions = **5 per week** (over 42 weeks)

Consultant Clinics

Urodynamics patients are included in the consultant clinics (301 new). If these are separated out this leaves 1080 new patients at consultant clinics.

Junior doctors will not be available to support all outpatient sessions. Therefore it has been assumed that on average 1.6 doctors will attend a clinic with 10 patients each, therefore on average 16 at a clinic. Consultants believe that 5 news and 11 reviews is the appropriate number at a clinic for this staffing level. This will give a new to review ratio of 1:2.2.

1080 patients @ 5 news per clinic = 216 sessions = 4.5 per week. 5 sessions (over 48 weeks) will be built in to the service model (to allow some flexibility because of the limited junior doctor support).

Stone Treatment

240 attendances @ 6 news = 40 sessions. 1 session per week will be required.

The new:review rate is approximately 1:1.2. A further session will be required for reviews.

Urodynamics (Revised Model)

Currently carried out on the ward with results reviewed by consultants. These will be moved to Thorndale/Ambulatory Care Unit to be carried out by a Specialist Nurse. Consultants wish to assess the results in their proposed Thorndale session.

301 cases at 5 per all day session = 60 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042. Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will require a second consultant with special interest in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.1 lists (over 48 weeks). As not all cases will be done within the dedicated day case lists, 3 weekly lists will suffice.

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly

and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

APPENDIX 6

Draft Patient Flow and Clinical Pathways

Pathways for Non-Elective Admissions to either Daisy Hill or Erne Hospitals that do not have an acute Urology Unit

Patient presents at Accident and Emergency in either Daisy Hill or Erne Hospitals

Testicular Torsion

Suspected cases of Testicular Torsion should be dealt with by the surgical team

Testicular Infection

Suspected cases of Testicular Infection should be dealt with by the surgical team at the presenting hospital

The patient should have an ultrasound carried out to exclude Testicular Tumour

Patient should then be referred to the Urological Team at Craigavon Area Hospital

Renal Colic

The patient needs to be assessed by the Surgical Team at the presenting hospital

Investigations such as non-contrast CT, IVP/Ultrasound should be undertaken to confirm diagnosis

This combined with the patient's renal function and sepsis status will govern the acuteness of the referral pathway.

Haematuria

Patients admitted with Haematuria/Clot retention that are requiring admission are to be assessed for need of catheter insertion.

Initial investigations of ultrasound and IVP should be undertaken followed by contacting the Craigavon Area Hospital for further advice on referral pathway as there may be a need for transfer or subsequent consultation

Infection – Recurrent Urinary Tract Infection/pyelonephritis

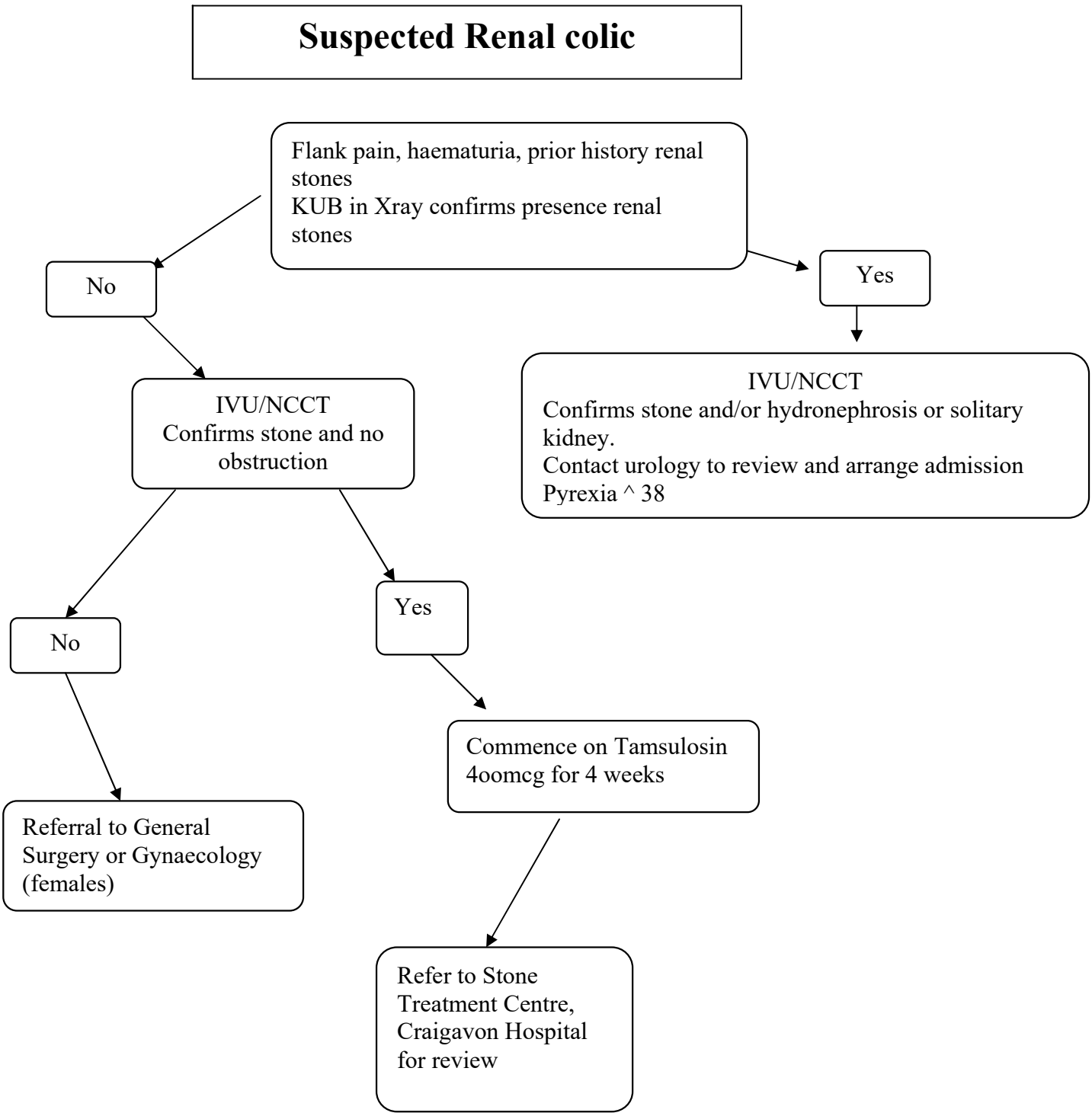
The patient needs to be assessed by the Surgical Team at the presenting hospital.

Catheter Insertion
Current guidelines and a protocol are being drawn-up for insertion of Catheter by the Urological Team at Craigavon Area Hospital and this will be available on all sites

Note: Any entity defined as a Urological Emergency can be referred/discussed with the Urological team at any time for advice/guidance on how best to manage/transfer

If advice is required on any of the above the Urology On call doctor should be contacted via Craigavon Area Hospital Switchboard

Personal Information redacted by the USI



Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Making diagnosis of Urinary Retention in the A&E department

Medical assessment to include
DRE, FBP, U&E, BLOOD SUGAR, PSA

→ PSA done but not impacting on decision

↓

Administer prophylactic antibiotics (clarify)
Pass correct length urethral catheter –
Send a CSU for culture

↓

Catheterisation Successful

Catheterisation Unsuccessful

↓

Contact Urology unit
Admit

Admit to Craigavon Urology unit if

- output greater than 700mls (observe x 2 hours)
- abnormal creatinine
- unfit/elderly
- female patients
- infection suspected
- neurological deficit
- haematuria
- difficult catheterisation

Less than 400ml
Consider alternative diagnosis (UTI) or cause painful abdomen

400-700ml
Patient fit and normal creatinine
Start Alfuzosin 10mg OD

↓

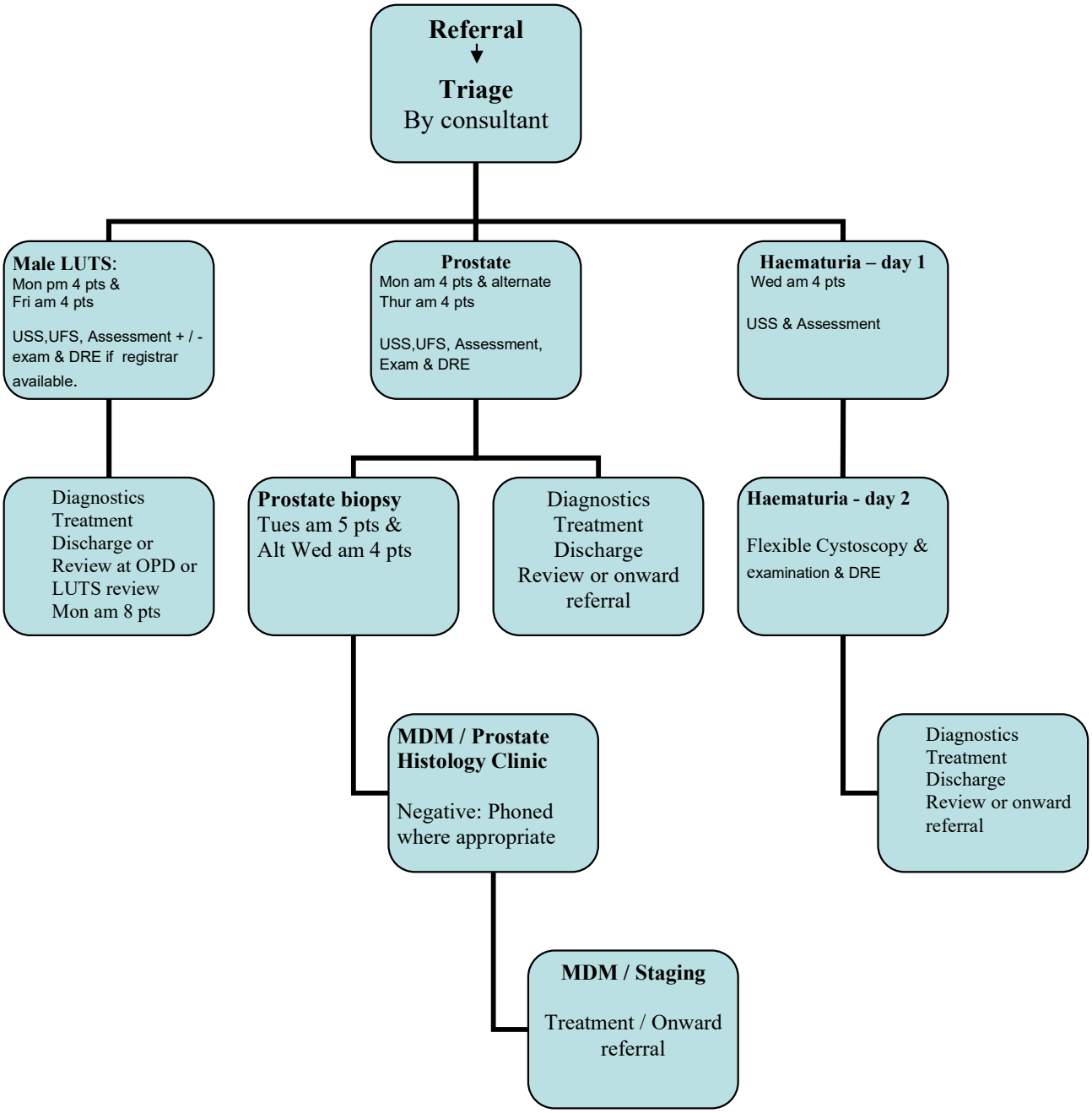
Discharge Home

Refer to Urology Ambulatory Care Centre for TROC and Ultrasound and further evaluation for follow up

An onward referral to Community Continence team if required
Ensure catheter discharge form completed and take home pack is given to patient

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

CRAIGAVON UROLOGY ICATS PATHWAY

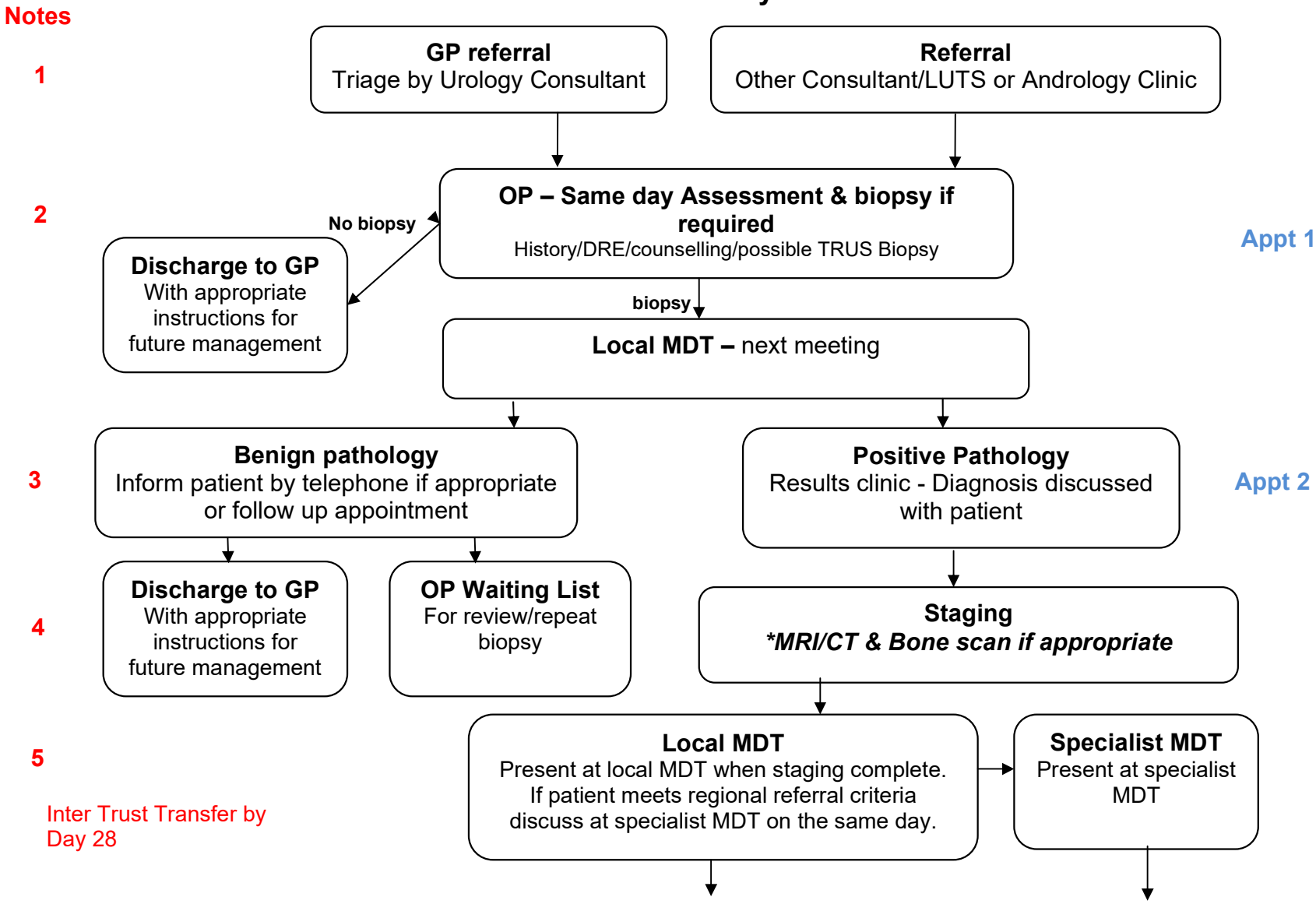


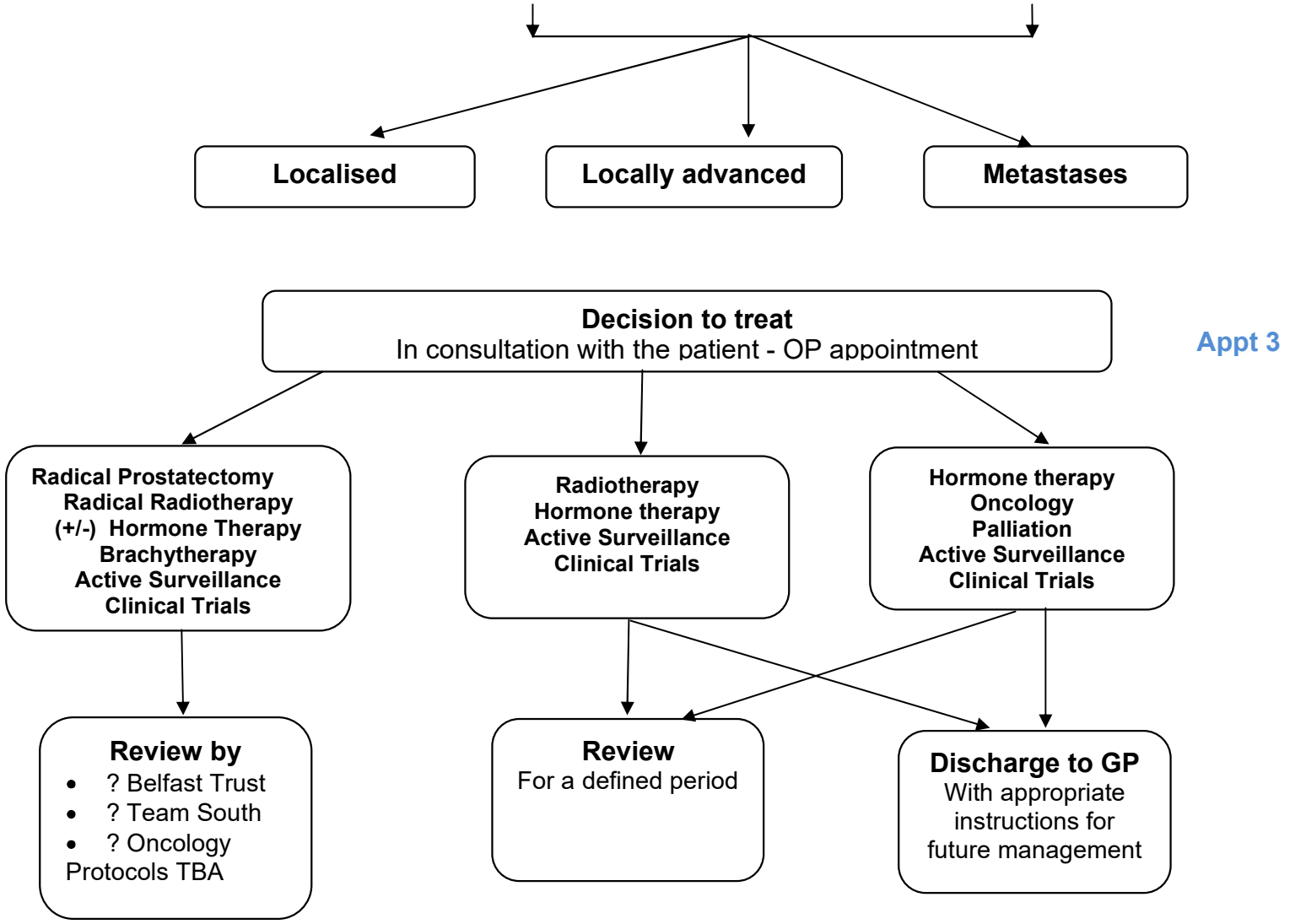
Notes:
USS – ultrasound urinary tracts
UFS – urine flow study
Assessment: Clinical history, urinalysis, Bloods, Urine tests, Symptom history etc

Aim to provide haematuria service in one stop session (resource dependent)
Aim to offer prostate biopsy on day 1 for suitable patients (resource dependent)
Daisy Hill Hospital provide a direct access haematuria service (4 patients weekly)

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Prostate Pathway





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Notes

1. **Referral protocol for GPs** is required. Also an information leaflet for GPs describing what will happen at the OP assessment/biopsy appointment so that they can inform and counsel the patient.
2. **First appointment** – assessment and where clinically indicated a biopsy. Results are normally back from Pathology in 5-10 days.

   Specialist Nurse should assess at this appointment if the patient is suitable to receive the results (if benign) by telephone and should discuss this with the patient.

   Scans should be booked at this point for those patients who have biopsy (to be cancelled if the biopsy is benign). **Note** another PC in Tutorial Room1 with access to NIPACS will be required to facilitate this.

   Only Dr McClure and Mr Akhtar do biopsies at present. One or both of the new consultants will also need to be trained.

   248 new patients attended TRUSA/TRUSB in 2009/10. Factoring in growth in the waiting list and also 18% of SHSCT activity for Fermanagh gives 316 patients @ 4 per session = 79 sessions = 1.7 per week. At 4 patients per clinic this will require **60 sessions** per annum.

   165 patients attended TRUSB in 2009/10 (69% of patients who were assessed). Therefore approximately 30 patients from Fermanagh will require biopsy.
3. **Benign biopsy** – will need to consider management of the outpatient waiting list for patients who need future review or repeat biopsy to ensure they do not get lost in the system.
4. **Staging** – there is a 6 week suspension between biopsy and scanning. The MRI/CT and bone scan can be done on the same day if the MRI/CT is done first. However we need to check if both scans can be booked for the same day to save 2 journeys for the patient (NIPACS issue).

   Reports need to be available within 2 – 5 days (need to be available for the next MDT).
5. **Local/Specialist MDT** – where appropriate inter Trust transfer must be made by day 28 from receipt of referral.
6. The review programme awaiting confirmation of who will review the patients managed by Belfast surgical team and also radiotherapy?

<u>Patients to be discussed at local MDT</u>

All patients with biopsies for suspected cancer (NICE)

All patients diagnosed with prostate cancer (peer review)

(From NICAN Urology Network)

Prostate cancer

Patients with locally advanced or metastatic disease, to be referred for specialist discussion if clinically appropriate. Patients over 85 do not require discussion.

Stinson, Emma M

From:	Stinson, Emma M
Sent:	15 October 2010 16:54
To:	Mackle, Eamon; Akhtar, Mehmood; McCorry, Monica; Young, Michael; Trouton, Heather; Clarke, Paula; Corrigan, Martina; Waddell, Sandra
Cc:	Renney, Cathy; Murphy, Jane S; Dignam, Paulette; Murphy, Jane S; Radcliffe, Sharon
Subject:	Notes of the Urology Review Implementation Board Meeting on 1 October 2010
Attachments:	Urology Meeting Action Points 1 OCT.doc

Dear All

Please see attached for your information.

Emma

Emma Stinson
PA to Dr Gillian Rankin, Director of Acute Services (Interim) Admin Floor Craigavon Area Hospital

Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI

Email: Personal Information redacted by the USI

From: Rankin, Gillian
Sent: 14 October 2010 11:53
To: Stinson, Emma M
Subject: FW: notes of the Urology Review Implementation Board Meeting on 1 October 2010

From: Beth Malloy Beth Malloy's email address
Sent: Thursday, October 14, 2010 11:51:30 AM
To: 'Keane, Patrick'; Colin Mulholland's email address 'Hagan, Chris'; 'Hillick, GeraldineA2'; Seamus.McGoran setrust; Rankin, Gillian; 'Donnelly, Patricia'; Valerie Jackson's email address Margaret O'Hagan's email address 'McCann, Bronagh'; 'Armstrong, Brian'; Diane Keown's email address David McCormick; Corrigan, Diane; 'Hughes, Dermot2'; Trouton, Heather; Paul Downey's email address Brian Best's email address Young, Michael Mr; Hubert Curran; Hall, S DR; 'Fordham Mark (RQ6) RLBUHT'
Cc: 'McNicholl, Catherine'; John Simpson's email address 'Groogan, Sara2'; Clarke, Paula; Martin Sloan's email address Louise McMahon
Subject: notes of the Urology Review Implementation Board Meeting on 1 October 2010
Auto forwarded by a Rule

"This email is covered by the disclaimer found at the end of the message."

Dear all

Please find attached the notes from the Urology Review Implementation Board meeting on the 1 October 2010.

Please do not hesitate to contact me if you have any queries

Please circulate to colleagues

Regards

Beth
Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate
Health and Social Care Board
Templeton House
411 Holywood Road
Belfast
BT4 2LP
Northern Ireland

Mobile Personal Information redacted by USI
Landline Personal Information redacted by USI
Fax Personal Information redacted by USI

Urology Review Project Implementation Board Meeting
1 October 2010

1. Attendees

Present	**Apologies**
Beth Malloy	Margret O'Hagan
Mark Fordham	Catherine McNicholl
David McCormick	
Diane Corrigan	
Hubert Curren	
Chris Hagan	
Patrick Keane	
Dermot Hughes	
Gillian Rankin	
Stephen Hall	
Michael Reilly	
Michael Taylor	
Joe O' Suillivan	
Michael Young	
Brain Armstrong	
Bronagh McCann	
Seamus McGoran	
Diane Keown	
Geoff Hill	

Note: Team North were not represented at the meeting

2. Development of Regional Patient Pathways

It was agreed that regional pathways should be developed to standardise the patient pathway for a range of urological conditions. To support this work, the Board has agreed to fund the appointment of a regional audit lead for a period of 8 weeks, at 2 PAs per week, to co-ordinate the development of regionally agreed pathways (recognising that there will be some local variations based on individual department's facilities). It was agreed that the regional pathways would focus on the following conditions:

- Lower Urinary Tract Symptoms
- Raised PSA
- Haematuria
- Testicular Swelling
- Renal Colic
- Acute Kidney Obstruction
- Acute Urinary Retention

It was noted that a number of patient pathways (eg raised PSA and Haematuria) were already being developed by NICAN Urology Group. It was

agreed that any regional guidelines will need to reflect the recommendations and guidance issued by the NICAN Urology Group.

It was agreed that each Team would forward copies of their local pathways to Beth Malloy so these can be shared with the Teams and the nominated audit lead. Pathways to be forwarded by Monday 4 October

Action: Each Team

Patrick Keane, as the regional BAUS rep, agreed to contact all urology consultants to seek expressions of interest in fulfilling the regional audit lead role. The Expressions of Interest to be sent to Beth Malloy by Monday 11 Oct.

Action: Patrick Keane

It was agreed that the new regional pathways to explain the management of key urological conditions as outlined above would be forwarded to PMSID by 19 November. This would allow their circulation in advance of the meeting on the 30 November 2010.

Action: Chair of each Team

It was agreed these pathways would provide an ideal starting position to develop referral guidelines for General Practice. The referral Guidance would be developed and circulated to general practice for comment with the view to sign off at the regional urology meeting in December 2010. It was agreed that Hubert Curren would act as the GP link regarding this issue.

Action: Hubert Curren

3. Referral Arrangements and Processes for the Management of Radical Pelvic Surgery Patients

It was agreed that each Trust should comply with the regional urology review recommended agreed pathway for the management of radical pelvic surgery patients which had been endorsed by the Minister in March 2010. It was accepted that all malignant radical pelvic surgery patients would be referred to the Belfast Trust via the Urology MDT.

It was also agreed that radical pelvic surgery patients with benign conditions should also be sent to Belfast given that the incidence of this condition is relatively uncommon.

Action: Each Trust to ensure this is actioned for all radical surgery patients

4. Development of Key Performance Indicators

It was agreed that the clinical audit lead will support both the Board and Trusts in developing key performance indicators which could be used to

assess both quantitative and qualitative patient outcomes. These indicators would include a range of performance data including admission on day of surgery, day surgery rates, 31 and 62 day cancer performance, biopsy turnaround times.

5. Submission of revised Plans

It was agreed that each team will submit their updated plans by the 29 Oct. The revised plans should detail the increased clinical throughput and the associated outputs (e.g. development of one stop clinics, expected waiting list position) resulting from the increased investment. It is intended that the updated plans will be endorsed by the HSCB at the meeting on 30 November.

Action: Chair of Each Team

6. Date of Next Meeting

The next meeting is to be held on the 30 November at 2pm in the Conference Room, Templeton House.

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 29 February 2012 08:10
To: Stinson, Emma M
Subject: FW: Consultant Urology Posts x 3

From: Corrigan, Martina
Sent: Wednesday, February 29, 2012 8:09:40 AM
To: [redacted] Young, Michael; O'Brien, Aidan;
[redacted]
Cc: Trouton, Heather; Rankin, Gillian; Mackle, Eamon; Brown, Robin
Subject: Consultant Urology Posts x 3
Auto forwarded by a Rule

Dear all,

I wish to advise that Mr Keane has approved the job descriptions and job plans for the replacement post for Mr Akhtar and the two new consultant posts and that HR are in the process of getting these advertised to appear in the Belfast Telegraph on 6th March and the BMJ on 10th March closing on Thursday 29th March,2012.

Many thanks

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted](Direct Dial)
Mobile: [redacted]
Email: [redacted]

Stinson, Emma M

From:	Stinson, Emma M
Sent:	09 February 2010 15:34
To:	Boyce, Tracey; Carroll, Anita; Carroll, Ronan; Gibson, Simon; McVey, Anne; Stead, Lindsay; Trouton, Heather
Cc:	Burrell, Gail; Lappin, Aideen; McCullough, Elizabeth; Murphy, Jane S
Subject:	*For Action* Clinical Governance and Risk Procedures
Importance:	High

Dear Everyone,

Given the focus on clinical governance processes across the Trust and our recent discussions, I would be grateful if you would now set out your divisional processes to:

• Record IR1s
• Identify SAIs
• Share IR1s/SAIs with clinicians, managers • Identify and record actions and lessons learned • Share information with staff involved, i.e. complete the feedback loop

I would be happy to receive a visual if this is easier.

Please send to my office by 24th February.

Thanks

Gillian

Dr Gillian Rankin
Interim Director of Acute Services

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Fax:

Southern Health and Social Care Trust

Acute Clinical Governance Group Meeting

AGENDA

for meeting to be held on Friday 16th April 2010, 8.00 am – 9.00 am
in the Board Room, Main Building, CAH

1. Purpose of Group

2. Review and Action Plans:
- High Level Risks
- High Rated Incidents

3. RCA Reports in progress

4. RCA Implementation Plans

5. Complaints: Trends and Actions

6. Specific Clinical Governance Issues
- Hyponatraemia

7. Medication Governance Dr Boyce

8. Any Other Business

9. Date of Next Meeting

Southern Health and Social Care Trust

Acute Services Clinical Governance Group

Action Notes

Held on Friday 16th April 2010 at 8.00 am – 9.00 am
in the Board Room, Main Building, CAH

Present:

Dr Rankin, Interim Director of Acute Services (Chair), Mrs Heather Trouton, Acting Assistant Director of Acute Services (SEC), Mr Eamon Mackle, Associate Medical Director (SEC), Mr Barry Conway, Acting Assistant Director of Acute Services (MUSC), Dr Stephen Hall, Associate Medical Director (CCS), Mrs Anne McVey, Assistant Director of Acute Services (IMWH), Dr Philip Murphy, Associate Medical Director (MUSC), Mrs Anita Carroll, Assistant Director of Acute Services (FSS), Dr Martina Hogan, Associate Medical Director of Acute Services (IMWH), Mrs Beatrice Moonan, Risk Manager, Mr Ronan Carroll, Assistant Director of Acute Services (CCS)

Apologies:

Dr Tracey Boyce, Director of Pharmacy, David Cardwell, Patient Liaison Manager (Acute)

1. Purpose of Group

Dr Rankin introduced the meeting outlining the purpose of the group.

The purpose proposed is:

- Acute Senior Clinical and Management staff to receive and review all significant and high rated incidents, risks, RCAs and related governance matters.
- Group to review actions and progress for all significant governance issues in order to assure clear actions and learning across divisions and where necessary to agree joint actions.

2. Review and Action Plans

2.1 High Level Risks

2.1.1 Dr Hall gave a brief report on the lack of reporting of plain films which had been present for some time. A&E films and inpatient films are read by Consultant under protocol and referred as needed to radiologist. Outpatient and GP referred plain films are currently delayed in reporting and an action plan to address is in place. This should be complete by end of April.

The risk is a missed diagnosis which could be significant for the patient.

The Radiology department have committed to formally report on all chest x-rays – this poses a capacity problem which needs quantified in terms of reporting time requirement and will cost financially.

For chest x-ray reporting – to report every chest x-ray in Trust it would take approximately an additional 6-7 reporting sessions per week.

For those x-rays not officially reported on, each AMD must sign up to a protocol to say that the referrer accepts responsibility to report.

Radiology – refreshing above protocols in light of NIPACS implementation.
Action: Dr Hall/Ronan Carroll to produce.
Action: Assistant Directors – Put un-reporting of plain films as a high level risk on Divisional Risk Register.

2.1.2 Chemotherapy in Mandeville Unit – reduced nursing cover due to maternity leave leading to lengthening of time to commence chemotherapy in one area.

Action: Ronan and Barry to discuss nurses who are chemo-competent working in other areas (haem) to support Mandeville to restore chemotherapy start waiting time.

2.1.3 IMWH - CTG recording paper will not last 25 years as the recording fades.

Identified on Risk Register and capital bid in ICT plan for a digital version.

2.2 High Rated Incidents

Clinicians, Ward Managers etc – must have access to IR1s in their Division for learning. Robust feedback loop is required. **Action: Each AD/AMD to agree divisional process.**

3&4 RCAs

List of currently underway RCAs reviewed. No specific issues not already actioned. Robust processes must be in place to share with AMDs and across divisions where this is appropriate.

Guidance of Level 2 investigation vs RCA in discussion with Medical Director.

5. Complaints

The top two are Treatment & Care and Staff Attitude & Behaviour and both of these involve doctors significantly.

Main Areas with most complaints:
- A&E
- Urology Clinic
- Maternity
- Outpatient Department DHH
- Booking Centre

Each AMD requested to look at each of these areas with clinical colleagues and reduce complaints by improving care.

6. Specific Clinical Governance Issues

6.1 Hyponatraemia

There is a draft report from RQIA which has been QA'd, date for publication not yet known.

6.2 Backlog Review

Need clarity on timescales involved in cleansing list.
- Urgents
- Reviews
- Discharges

This requires close Clinical Engagement with each specialty team and each Head of Service has an action plan in progress.

Agreed that until patients on the review backlog for each specialty have been triaged/reviewed this should be a high level risk on each divisional risk register.

6.3 CHKS – Report

- Recognised that further work is needed to assure comparing like for like with peers.
- Refreshed data for quarter October – December 2009 available for discussion in divisions.
- The first report to Trust Board will be on Cardiology Clinical Outcomes. **Action: To be reviewed by Dr Rankin and Dr Murphy prior to Trust Board.**
- Next specialty will be T&O to present to Trust Board.

7. Medication Governance

There will be a report provided by Dr Tracey Boyce at the next meeting.

8. AOB

8.1 Medical negligence information to be requested and reviewed at this meeting.
Action: Dr Rankin to action with Medical Directorate.

8.2 Members can table issues as they have concerns.

8.3 Frequency of Meetings

Monthly pre-summer.

Frequency of meetings post summer will be agreed later.

9. Date of next meeting

Friday 14th May 2010 at 8.00 am in the Board Room, Main Hospital, CAH.
Friday 11th June 2010 at 8.00 am in the Board Room, Main Hospital, CAH.

Stinson, Emma M

From: Stinson, Emma M
Sent: 12 May 2010 15:47
To: Moonan, Beatrice Mrs; Hall, S DR; Hogan, Martina; Mackle, Eamon; Murphy, Philip; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather; Boyce, Tracey; Cardwell, David
Cc: Lindsay, Gail; Beattie, Pauline; Renney, Cathy; Smyth, Elizabeth (Dr P Murphys Secretary); Lappin, Aideen; Graham, Michelle; Burrell, Gail; Murphy, Jane S
Subject: *Agenda and Papers* for Acute Clinical Governance Group Meeting
Attachments: Agenda for Acute Clinical Governance Group 14 5 10.doc; Action Notes Acute Services Clinical Governance Group.doc; Acute Services Accepted Internal RCA 11.05.10 doc.doc; Acute Services Directorate Risk Register as of 11 05 10.xls; MUSC incidents with major - catastrophic consequence 01.01.10 - 31.03.10.xls; SEC incidents with major - catastrophic consequence 01.01.10 - 31.03.10.xls; CCS incidents with major - catastrophic consequence 01.01.10 - 31.03.10.xls; IMWH incidents with major - catastrophic consequence 01.01.10 - 31.03.10.xls; Acute services incidents with major - catastrophic consequence 01.01.10 - 31.03.10.xls; final_RCA Personal information redacted by USI (2).doc; acute summary feb 10.doc; feb 10 directorate report.xls; Complaints awareness Training May 2010.doc; Complaints level 1 Training May 2010.doc

Dear All

Please see attached the agenda and papers for the next Acute Clinical Governance Group meeting scheduled for Friday 14th May 2010 at 8.00 am in the Board Room, Main Building, CAH.

Many thanks

Emma

Apologies – David Cardwell

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Fax:

Email: Personal Information redacted by the USI

Southern Health and Social Care Trust

Acute Clinical Governance Group Meeting

AGENDA

for meeting to be held on Friday 14th May 2010, 8.00 am – 9.00 am
in the Board Room, Main Building, CAH

1. Apologies – Mr David Cardwell

2. Minutes of meeting on 16th April 2010

3. Matters Arising:
- Learning from cases which have gone to litigation

4. Review and Action Plans:
- High Level Risks
- Major Incidents with Catastrophic Consequence

5. RCA Reports in progress
- RCA Datix [redacted] for approval

6. RCA Implementation Plans

7. Complaints: Trends and Actions

8. Specific Clinical Governance Issues
- VTE Patient Safety Dashboard

9. Medication Governance — Dr Boyce

10. Surgery M&M Action Points — Mr Mackle

11. Any Other Business

12. Date of Next Meeting
- Friday 11th June 2010 at 8.00 am in the Board Room, CAH

Southern Health and Social Care Trust

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9. Date of next meeting

Friday 14th May 2010 at 8.00 am in the Board Room, Main Hospital, CAH.
Friday 11th June 2010 at 8.00 am in the Board Room, Main Hospital, CAH.

Acute Services Accepted Internal RCA's action and learning to 14.05.10						
Date	**Division**	**Datix Incident ref number**	**Summary**	**Recommendation, action and learning**	**Lead**	**Update**
28.04.09	MUSC	Personal Information redacted by USI	On 28th April 2009 at 17.10hours patient was administered 80 Units of Insulin sub-cutaenously instead of 8 Units. The error was identified immediately after administration and the appropriate care and treatment was delivered.	**1.Education and training in Insulin prescription for junior medical staff** Regional e-learning induction training on safe prescribing of insulin and prescription writing has been developed and will be introduced from August 2009. Uptake and completion of this training should be monitored to ensure completed. A yearly audit of insulin prescribing, conducted by medical student on SSC in Endocrinology, should continue and the results reviewed by Safe use of insulin group	T Boyce/J Redpath	14.05.10 E-learning module introduced from August 2009 for all prescribers. Training tracker software monitors compliance. Yearly audit of insulin prescribing completed September 2009 – 100% compliance with writing 'units' in full.
				2.Introduction of subcutaneous insulin prescription chart The subcutaneous insulin prescription chart, piloted in CAH and DHH medical wards, was presented to Drugs and Therapeutic Committee. This was approved with one amendment of pre-printing 'units' at each dose section. Funding should be secured for printing the chart and the chart introduced to pilot areas in the first instance and then to other wards in SHSCT.	T Boyce/J Redpath	14.05.10 Agreed chart to be printed via Pharmacy order. Order held until first order from printer received.
				3.Ward pharmacy cover Pharmacy support should be maintained to provide cover to all wards when a pharmacist is on leave. This risk should remain on the pharmacy risk register until suitable cover arrangements are made.	T Boyce/J Redpath	
				4.Communication of findings and lessons learned The RCA team recommend that the report is shared with the Family and Team involved in Care of Mrs McC		

Sept 09	CCS and MUSC	Personal Information redacted by USI	Complex complaint following the death of patient who developed MI whilst awaiting repair of # NOF	**1.There is a need to reinforce the responsibilities of non consultant medical staff (specialty doctors and doctors in training) to effectively prioritise their workload to ensure the appropriate management of all patients within their area(s) of responsibility. (in this case the reporting of a patient with heart problems/chest pain)** a. Included in junior doctor induction with key responsibilities in GMC "Good Medical Practice" highlighted b.Explore use of HaN model for T&O	Associate Medical Directors 1. AMD Education and Training for doctors in training grades 2. Divisional AMDs for specialty doctors	Complete June 2010
				2.In complex cases there is a need for consultant to consultant communication to determine the appropriate plan of care including the agreed sequencing of care of comorbitities (underlying medical problems) and the treatment of fractures Use of case example for discussion on practice at M&M meetings	Associate Medical Directors 1. AMD Education and Training for doctors in training grades 2. Divisional AMDs for specialty doctors	Surgical Completed Medical to be completed
				3.There is a need to reinforce that nursing staff feel confident to contact senior medical staff including consultants when they have concerns regarding the management of a patient. Reaffirm this practice as a key element of MEWS	Assistant Directors Acute and Non Acute Services	Complete

	4.There is a need to reinforce the availability and improve the signposting of the clinical protocols on thrombolytic guidelines to ensure all junior medical staff and medical staff in training is aware of their availability and content both at induction and thereafter. Junior doctors at induction to be made aware of all clinical protocols on Trust Intranet; and at subsequent M&Ms by division	Clinical Lead Cardiology, Associate Medical Directors 1.AMD Education and Training for doctors in training grades 2.Divisional AMDs for specialty doctors	Complete
	5.Specialist Registrar 2 should receive "Right Patient Right Blood" Training	Clinical Lead Trauma	Completed 18.11.09
	6.All relevant medical staff employed by SHSCT who have not yet undertaken 'Right Patient, Right Blood' training and competency assessment will undergo appropriate training If a junior doctor starts in the Trust after induction there is no current procedure to identify this and provide induction or to identify to AMD that they do not have competency training of "Right Patient, Right Blood". Director of Acute Services to discuss with Medical Director	Associate Medical Directors 1. AMD Education and Training for doctors in training grades 2. Divisional AMDs for specialty doctors	June 2010
	7. Specialist Registrar 1 should receive further training on prioritisation of workload and record keeping Specialist Registrar 1 has received additional training and has left the Trust.	Associate Medical Director – Surgery and Elective Care	Complete
	8.There should be further instructions to	Associate Medical	

				all grades of junior doctors to record when they have reviewed test reports, investigations and ECG recordings in the patient's medical records. Recording of relevant test results within clinical records is in line with good practice as defined by the General Medical Councils Standards for Good Recording Keeping. (This should also be included in the Record Keeping audit criteria for medical records) Good practice identified in GMC "Good Medical Practice" regarding record keeping emphasised at junior doctor induction; and the requirement to include signature that test results etc have been reviewed and action taken as needed. The power point presentations given at induction are available to junior doctors subsequently on the intranet	Directors 1. AMD Education and Training for doctors in training grades 2. Divisional AMDs for specialty doctors	Complete
				9.There is a need to reinforce with medical staff the importance of communication with relatives in a timely manner Issue to be discussed at Medical and Surgical M&Ms	Associate Medical Directors 1. AMD Education and Training for doctors in training grades 2. Divisional AMDs for specialty doctors	Complete
16.10.09	MUSC	Personal information redacted by USI	Medication incident resulting in patient collapse.	**1.An escalation protocol should be agreed and written to outline actions for staff to be taken in the event of 'decisions outside of normal practice'**	Mrs L Adair AMD's/CD's	23.03.10: Draft Escalation Protocol drawn up and sent to Dr Boyd, Dr Hull, Alison Porter, Sr Burrows for consultation. 29.04.10 – Escalation protocol now agreed and disseminated to Clinical Staff
				2.All Locum staff should be advised of and adhere to all SHSCT Policies, Procedures and Protocols before commencement of employment.	Associate Medical Directors 1. AMD Education and Training for	

		doctors in training grades 2. Divisional AMDs for specialty doctors	
	3.Human Resources and Medical Administration to be informed of minimum requirements for locum staff.	Associate Medical Directors 1. AMD Education and Training for doctors in training grades 2. Divisional AMDs for specialty doctors	

Acute Services Directorate Risk Register as of 11.05.10

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
2463		Trustwide	24-Apr-2009	Preparedness for Pandemic Flu, specifically a H1N1 current pandemic	Ability to sustain services should there be an outbreak of pandemic flu.	3	5	15	Held on Directorate Register Currently	Planning on going as directives from DHSSPS issues/change. Trust synchronisation workshop being arranged			24.04.09- Risk identified at SMT meeting, to be held on Corporate Risk Register as per discussion. 25.09.09 - reviewed by BM and JY. Planning in place for acute services and working well across directorates. Overall risk rating reduced from high to moderate - deescalated to directorate risk register holding.
2314		Trustwide	14-Sep-2009	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.	2	5	10	Held on Directorate Register Currently				1/11/09 Risk reviewed and risk rating low deescalated to Directorate Risk Register with a view to continue close monitoring.
Irrelevant information redacted by	Cancer and Clinical Services		25-Jun-2009	Irrelevant information redacted by the USI	Irrelevant information redacted by the USI	5	4	20	Held on Directorate Register Currently	Irrelevant information redacted by the USI			28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
Irrelevant information redacted by the USI	Cancer and Clinical Services	Day Procedure Unit CAH	28-Jul-2008	Irrelevant information redacted by the USI		5	5	25	Held on Directorate Register Currently	Irrelevant information redacted by the USI		Risk reviewed by MMcG + BM - risk unchanged - incidents have occurred recently which have left areas in the DPU completely without power during sessions.	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 10.05.10 - Risk reviewed by MMcG + BM - risk unchanged - incidents have occurred recently which have left areas in the DPU completely without power during sessions.
	Cancer and Clinical Services	Day Procedure Unit DHH	28-Jul-2008			5	5	25	Held on Directorate Register Currently			10.05.10 - Risk reviewed by MMcG + BM - risk unchanged	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 10.05.10 - Risk reviewed by MMcG + BM - risk unchanged
	Cancer and Clinical Services	Day Surgery Unit	29-Jul-2008			5	4	20	Held on Directorate Register Currently			Interim papers have been submitted to SMT March 2008. 0.05.10 - Risk reviewed by MMcG + BM risk rating reviewed - drying cabinets have been purchased and commissioned for the storage and use of decontaminated endoscopes up to 70 hours. Risk rating unchanged until replacement of the AER.	01.04.09 - Interim works carried to improve work flow only but level of risk unchanged as HINE recommends - must have segregated clean and dirty work flows. 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 10.05.10 - Risk reviewed by MMcG + BM risk rating reviewed - drying cabinets have been purchased and commissioned for the storage and use of decontaminated endoscopes up to 70 hours. Risk rating unchanged until replacement of the AER.
	Cancer and Clinical Services	Macmillan Suite - Mandeville Unit	17-Aug-2009			4	5	20	Held on Directorate Register Currently				30.09.09 - risk reviewed - no change 26.03.10 - risk reviewed - move to divisional risk register 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
										3 week waiting list for initiation of new chemotherapy treatments has been in operation since June 09 - short term measure only			
Irrelevant information redacted by the USI	Cancer and Clinical Services	Macmillan Suite - Mandeville Unit	4-Aug-2008	Irrelevant information redacted by the USI		5	4	20	Held on Directorate Register Currently	Irrelevant information redacted by the USI			10.06.09 - Vacant haematology staff grade post has resulted in no medical staff cover - risk rating increased and moved to Directorate risk register. 26.03.10 - risk reviewed - no change 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
												10.12.09 - Second staff grade post now also vacant, not able to recruit.	
	Cancer and Clinical Services	MRI Craigavon Area Hospital	2-Dec-2009			5	4	20	Held on Directorate Register Currently			Write business case for additional MRI scanner and all associated costs	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Cancer and Clinical Services	Occupational Therapy Department	31-Aug-20(			5	4	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
			09	Irrelevant information redacted by the USI						Irrelevant information redacted by the USI			
Irrelevant	Cancer and Clinical Services	Physiotherapy	27-Apr-2010			5	4	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
				Irrelevant information redacted by the USI						Irrelevant information redacted by the USI			
Irrelevant information redacted by the USI	Cancer and Clinical Services	Radiology, Craigavon Area Hospital	5-Aug-2008			5	4	20	Held on Directorate Register Currently				risk updated 02.12.09 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Cancer and Clinical Services	THEATRES	28-Jul-2008			5	5	25	Held on Directorate Register Currently			10.05.10 - Risk reviewed by MMcG + BM - risk unchanged.	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 10.05.10 - Risk reviewed by MMcG + BM - risk unchanged
	Cancer and Clinical Services	THEATRES	24-Jul-2008			5	4	20	Held on Directorate Register Currently			10.05.10 - no equipment purchased yet.	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 10.05.10 - risk reviewed by MMcG + BM - no change in risk rating.

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
Irrelevant information redacted by the USI	Cancer and Clinical Services	THEATRES	25-Jul-2008	Irrelevant information redacted by the USI		5	4	20	Held on Directorate Register Currently	Irrelevant information redacted by the USI		Filters in theatres 1&2 changed in Jan 2006. Ducting for theatre 1&2 cleansed in 2005 following terminal cleans and testing by microbiology. Filters in theatres 1&2 changed in Jan 2006. 10.05.10 - Risk reviewed by MMcG + BM risk rating reviewed - no change	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 10.05.10 - Risk reviewed by MMcG + BM risk rating reviewed - no change
	Cancer and Clinical Services	Theatres DHH	28-Jul-2008			5	5	25	Held on Directorate Register Currently			10.05.10 - Risk reviewed by MMcG + BM - risk unchanged	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 10.05.10 - Risk reviewed by MMcG + BM - risk unchanged
	Cancer and Clinical Services	Trustwide	2-Dec-2009			4	5	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Cancer and Clinical Services	Wards	19-Nov-2009			5	4	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
				Irrelevant information redacted by the USI						Irrelevant information redacted by the USI			
Irrelevant	Cancer and Clinical Services	Wards	2-Dec-2009			4	5	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
Irrelevant information redacted by the USI	Functional Support Services		19-Jan-2009	Irrelevant information redacted by the USI		5	4	20	Held on Directorate Register Currently	Irrelevant information redacted by the USI		Business case to be submitted by 31.03.09 for transfer of local decontamination to a centralised facility. 05.05.10 - Business case to be with SMT by 26.05,10	27.04.10 - Whilst this risk does not lie with acute services, S McLoughlin is happy to keep under acute for monitoring purposes. Risk will be resolved when business case is approved. 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM) 04.05.10 - risk discussed at Acute Services directorate governance meeting - option to leave on acute risk register but level of risk to be reduced 05.05.10 - meeting with Sandra Mcloughlin - Sandra will contact Brian Beattie and Michelle Oliver to ensure podiarty and dental risk issues are captured within OPPC and CYP risk register.
	Functional Support Services	Laundry	18-Aug-2008			5	4	20	Held on Directorate Register Currently			Identified as priority under MES.	14.09.09 level of risk reviewed in light of breakdowns of essential equipment over the summer months 27.04.10 - see attached letter from A. Carroll AD 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
												Identified as priority under MES.	

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
										Irrelevant information redacted by the USI		Identified as priority under MES.	
												Identified as priority under MES.	
Irrelevant information redacted by the USI	Integrated Maternity and Women's Health		12-Aug-2008	Irrelevant information redacted by the USI		5	5	25	Held on Directorate Register Currently			Business case has been submitted to DHSSPS, 25/06/08, for extension of 4 delivery rooms to delivery suite, 4 bedded induction area and 4 bedded HDU/recovery area within the delivery suite - awaiting Ministerial approval.	04.01.2010 Risk reviewed - no change in risk rating as additional rooms not completed until March 2010. 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Integrated Maternity and Women's Health	Delivery Suite	12-Aug-2008			4	5	20	Held on Directorate Register Currently			The SHSSB are fully aware of the identified need for similar requirements on the DHH site. Monthly review by Maternity working group.	04.01.2010 - risk reviewed and overall risk rating remains the same but likelihood reduced slightly. 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Integrated Maternity and Women's Health	Delivery Suite	12-Aug-2008			4	5	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

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ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
Irrelevant information redacted by the USI	Integrated Maternity and Women's Health	Trustwide	4-Mar-2010	Irrelevant information redacted by the USI		5	4	20	Held on Directorate Register Currently	Irrelevant information redacted by the USI			04.03.2010 - High risk - needs to be considered for Corporate risk register - Anne Donnelly will pass to A McVey. 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Medicine and Unscheduled Care	1 North Cardiology	15-Apr-2010			4	5	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Medicine and Unscheduled Care	Accident & Emergency	19-Aug-2009			3	5	15	Held on Directorate Register Currently				01/11/09 Risk reviewed, work ongoing as per action plan and risk reduced to Moderate and deescalated to Directorate Risk Register.

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
Irrelevant information redacted by the USI	Medicine and Unschedul ed Care	Acute Social Work Team	9-Mar-2010	Irrelevant information redacted by the USI		5	4	20	Held on Directorate Register Currently	Irrelevant information redacted by the USI		09.03.10 - no progress to date	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Medicine and Unschedul ed Care	Trustwide	14-Apr-2010			4	5	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Medicine and Unschedul ed Care	Trustwide	8-Aug-2008			3	4	12	Held on Directorate Register Currently				21.01.10 - risk reviewed - no change in risk rating- no funding available. 08.03.10 - risk reviewed - no change in risk rating - to be discussed with HOS for supplies re availability and cost for single use consumables. 14.04.10 - risk reviewed - no change.

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ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
Irrelevant information redacted by the USI	Medicine and Unscheduled Care	Trustwide	8-Aug-2008	Irrelevant information redacted by the USI		3	4	12	Held on Directorate Register Currently	Irrelevant information redacted by the USI		21.01.10 - risk reviewed - no change in risk rating as no funding available. 08.03.10 - risk reviewed - no change in risk rating - to be discussed with HOS for supplies re availability and cost for single use consumables. 14.04.10 - risk reviewed - no change.	21.01.10 - risk reviewed - no change in risk rating as no funding available. 08.03.10 - risk reviewed - no change in risk rating - to be discussed with HOS for supplies re availability and cost for single use consumables. 14.04.10 - risk reviewed - no change.
	Surgery and Elective Care	ENT Clinic, Surgical Outpatients	23-Jan-2009			5	4	20	Held on Directorate Register Currently			Referred to Directorate Risk Register	28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Surgery and Elective Care	Orthapaedic Ward CAH	11-Nov-2009			4	5	20	Held on Directorate Register Currently			24.02.10 - actions on going	Risk reviewed 24.02.10 - additional actions/controls put in place 28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
Irrelevant information redacted by the USI	Surgery and Elective Care	Orthapaedic Ward CAH	11-Nov-2009	Irrelevant information redacted by the USI		4	5	20	Held on Directorate Register Currently	Irrelevant information redacted by the USI			28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Surgery and Elective Care	Outpatients Dept	14-Dec-2009			5	4	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
	Surgery and Elective Care	Trauma Ward	10-Nov-2009			5	4	20	Held on Directorate Register Currently				28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
2594	Surgery and Elective Care	Trustwide	16-Apr-2010	Insufficient capacity and resources to manage patients waiting for a review appointment in SEC	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	5	4	20	Held on Directorate Register Currently	RVBL team to work with Consultants to secure backfill for Review Backlog patients, for additional clinics 'out of hours' to minimise risk	Monthly-09/05/10		28.04.10 - Moved to Acute Directorate Risk Register as per Dr Rankin (BM)
										Review backlog team to work on establishing targets and timelines to reduce risk and numbers of patients waiting	Monthly-09/05/10		

ID	Division	Location (exact)	Opened	Title	Description/Potential for Harm	Likelihood (current)	Consequence (current)	Rating (current)	Register Holding	Resources (Action Plan)	Monitoring (Action Plan)	Progress (Action Plan)	Notepad
					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					Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time	Monthly-09/05/10		
										Patients waiting since 2007 have had their Patient Centre letter on PAS downloaded, and appointment given if appropriate	Monthly-09/05/10		

MUSC incidentswith major - catastrophic consequence 01.01.10 - 31.03.10

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	MUC	1 South	Medication	Wrong method of preparation or supply	Personal Information redacted by USI	MAJ4	LIKE4	MODERA
		MUC	Clinical Decisions Unit	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure		MAJ4	POSS3	MODERA
		MUC	Medical Admissions Unit	Diagnosis, failed or delayed	Failure to act on adverse test results or images		MAJ4	POSS3	MODERA
		MUC	Renal Unit Daisy Hill Hospital	Infrastructure or resources (staffing, facilities, environment)	Failure or overload of IT or telecommunicatio ns system		MAJ4	POSS3	MODERA
		MUC	2 North Respiratory	Treatment, procedure	Delay		MAJ4	LIKE4	MODERA

Received from Dr Gillian Rankin on 14/06/22. Annotated by the Urology Services Inquiry.

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	MUC	Accident & Emergency	Consent, Confidentiality or Communication	Communication failure - outside of immediate team	Personal Information redacted by USI	MAJ4	POSS3	MODERA

SEC incidentswith major - catastrophic consequence 01.01.10 - 31.03.10

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	SEC	Opthamology Clinic	Implementation of care or ongoing monitoring/review	Delay or failure to monitor	Personal Information redacted by USI	MAJ4	CERT5	HIGH
		SEC	Thorndale Urology ICATS	Implementation of care or ongoing monitoring/review	Delay or failure to monitor		MAJ4	LIKE4	MODERA
		SEC	ENT Clinic, Surgical Outpatients	Access, Appointment, Admission, Transfer, Discharge	Urgent appointment not available when required		MAJ4	POSS3	MODERA
		SEC	Surgical Clinic, Outpatients Department	Patient Information (records, documents, test results, scans)	Documentation - misfiled		MAJ4	POSS3	MODERA
		SEC	ENT Clinic, Surgical Outpatients	Treatment, procedure	Unsafe / inappropriate clinical environment		MAJ4	CERT5	HIGH
		SEC	Opthamology Clinic	Access, Appointment, Admission, Transfer, Discharge	Failure to follow up		MAJ4	POSS3	MODERA
		SEC	Male Surgical Ward DHH	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure		MAJ4	POSS3	MODERA

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	SEC	Surgical Clinic, Outpatients Department	Implementation of care or ongoing monitoring/review	Failure to follow up	Personal Information redacted by USI	MAJ4	POSS3	MODERA
		SEC	Opthamology Clinic	Access, Appointment, Admission, Transfer, Discharge	Failure to follow up		MAJ4	LIKE4	MODERA
		SEC	Thorndale Urology ICATS	Access, Appointment, Admission, Transfer, Discharge	Failure to follow up		MAJ4	POSS3	MODERA
		SEC	Female Surgical Ward DHH	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure		MAJ4	LIKE4	MODERA

CCS incidentswith major - catastrophic consequence 01.01.10 - 31.03.10

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	CCS	Theatres	Medical device/equipment	Failure of a device or equipment	Personal Information redacted by USI	MAJ4	POSS3	MODERA
		CCS	X-Ray Dept	Clinical assessment (investigations, images and lab tests)	Delay in diagnosis for no specified reason		MAJ4	CERT5	HIGH
		CCS	X-Ray Dept	Treatment, procedure	Unintended injury in the course of an operation or clin task		MAJ4	POSS3	MODERA
		CCS	Theatres	Medication	Wrong drug / medicine		CAT5	POSS3	MODERA
		CCS	Day Surgery Unit	Treatment, procedure	Postponed or cancelled surgery		MAJ4	POSS3	MODERA
		CCS	Recovery Ward	Anaesthesia	Cardiac arrest		MAJ4	POSS3	MODERA

IMWH incidentswith major - catastrophic consequence 01.01.10 - 31.03.10

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	IMWH	Delivery Suite	Infrastructure or resources (staffing, facilities, environment)	Lack of/delayed availability of operating theatre	Personal Information redacted by USI	CAT5	POSS3	MODERA
		IMWH	Delivery Suite	Labour or Delivery	Stillbirth		MAJ4	POSS3	MODERA
		IMWH	Delivery Suite	Labour or Delivery	Simple complication of treatment		MAJ4	POSS3	MODERA
		IMWH	Antenatal Out Patients	Implementation of care or ongoing monitoring/review	Delay or failure to monitor		MAJ4	POSS3	MODERA
		IMWH	Delivery Suite	Labour or Delivery	Delay		MAJ4	LIKE4	MODERA
		IMWH	1 West Gynae	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure		MAJ4	UNLIK2	LOW

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	IMWH	Delivery Suite	Labour or Delivery	Delay	Personal Information redacted by USI	MAJ4	POSS3	MODERA

Acute services incidents with major/catastrophic consequence 01.01.10 - 31.03.10

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	IMWH	Delivery Suite	Infrastructure or resources (staffing, facilities, environment)	Lack of/delayed availability of operating theatre	Personal Information redacted by USI	CAT5	POSS3	MODERA
		CCS	Theatres	Medical device/equipment	Failure of a device or equipment		MAJ4	POSS3	MODERA
		SEC	Opthamology Clinic	Implementation of care or ongoing monitoring/review	Delay or failure to monitor		MAJ4	CERT5	HIGH
		MUC	1 South	Medication	Wrong method of preparation or supply		MAJ4	LIKE4	MODERA
		SEC	Thorndale Urology ICATS	Implementation of care or ongoing monitoring/review	Delay or failure to monitor		MAJ4	LIKE4	MODERA
		MUC	Clinical Decisions Unit	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure		MAJ4	POSS3	MODERA
		CCS	X-Ray Dept	Clinical assessment (investigations, images and lab tests)	Delay in diagnosis for no specified reason		MAJ4	CERT5	HIGH
		IMWH	Delivery Suite	Labour or Delivery	Stillbirth		MAJ4	POSS3	MODERA

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	MUC	Medical Admissions Unit	Diagnosis, failed or delayed	Failure to act on adverse test results or images	Personal Information redacted by USI	MAJ4	POSS3	MODERA
		CCS	X-Ray Dept	Treatment, procedure	Unintended injury in the course of an operation or clin task		MAJ4	POSS3	MODERA
		SEC	ENT Clinic, Surgical Outpatients	Access, Appointment, Admission, Transfer, Discharge	Urgent appointment not available when required		MAJ4	POSS3	MODERA
		SEC	Surgical Clinic, Outpatients Department	Patient Information (records, documents, test results, scans)	Documentation - misfiled		MAJ4	POSS3	MODERA
		SEC	ENT Clinic, Surgical Outpatients	Treatment, procedure	Unsafe / inappropriate clinical environment		MAJ4	CERT5	HIGH
		SEC	Opthamology Clinic	Access, Appointment, Admission, Transfer, Discharge	Failure to follow up		MAJ4	POSS3	MODERA
		SEC	Male Surgical Ward DHH	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure		MAJ4	POSS3	MODERA

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Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	IMWH	Delivery Suite	Labour or Delivery	Simple complication of treatment	Personal Information redacted by USI	MAJ4	POSS3	MODERA
		SEC	Surgical Clinic, Outpatients Department	Implementation of care or ongoing monitoring/review	Failure to follow up		MAJ4	POSS3	MODERA
		IMWH	Antenatal Out Patients	Implementation of care or ongoing monitoring/review	Delay or failure to monitor		MAJ4	POSS3	MODERA
		SEC	Opthamology Clinic	Access, Appointment, Admission, Transfer, Discharge	Failure to follow up		MAJ4	LIKE4	MODERA
		CCS	Theatres	Medication	Wrong drug / medicine		CAT5	POSS3	MODERA
		CCS	Day Surgery Unit	Treatment, procedure	Postponed or cancelled surgery		MAJ4	POSS3	MODERA

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	CCS	Recovery Ward	Anaesthesia	Cardiac arrest	Personal Information redacted by USI	MAJ4	POSS3	MODERA
		SEC	Thorndale Urology ICATS	Access, Appointment, Admission, Transfer, Discharge	Failure to follow up		MAJ4	POSS3	MODERA
		MUC	Renal Unit Daisy Hill Hospital	Infrastructure or resources (staffing, facilities, environment)	Failure or overload of IT or telecommunicatio ns system		MAJ4	POSS3	MODERA
		MUC	2 North Respiratory	Treatment, procedure	Delay		MAJ4	LIKE4	MODERA
		SEC	Female Surgical Ward DHH	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure		MAJ4	LIKE4	MODERA
		IMWH	Delivery Suite	Labour or Delivery	Delay		MAJ4	LIKE4	MODERA
		MUC	Accident & Emergency	Consent, Confidentiality or Communication	Communication failure - outside of immediate team		MAJ4	POSS3	MODERA

Incident date	ID	Division	Location (exact)	Stage of care	Adverse event	Description	Consequence	Likelihood of recurrence	Incident Severity
Personal Information redacted by USI	Personal Information redacted by USI	IMWH	1 West Gynae	Access, Appointment, Admission, Transfer, Discharge	Transfer - delay/failure	Personal Information redacted by USI	MAJ4	UNLIK2	LOW
		IMWH	Delivery Suite	Labour or Delivery	Delay		MAJ4	POSS3	MODERA

Southern Health and Social Care Trust

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Findings of the Root Cause Analysis – Incident Reference [redacted]

Personal Information redacted by USI

Personal Information redacted by USI

11.06.09 – 10.08.09

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Appendix 4 - Theatre specimen book
Appendix 5 - SHSCT mortuary record
Appendix 6 - e-mail from Belfast Trust

1 INTRODUCTION

This report presents the findings of the Root Cause Analysis (RCA) associated with the care of Personal Information redacted by the USI in Daisy Hill Hospital.

This RCA has been commissioned by the Director of Acute Services Southern Health and Social Care Trust (SHSCT).

2 TEAM MEMBERSHIP

The investigation team for this RCA is:

- Mr B Magee Head of Laboratory Service Cancer and Clinical Services SHSCT (Chair)
- Dr G McCusker, Clinical Director of Pathology Services, Designated Individual for HTA Licence for Post Mortem Activity, Consultant Pathologist, SHSCT
- Mrs Anne Coyle SHSCT Bereavement Coordinator
- Mrs B Kelly, Lead Midwife, SHSCT
- Mrs M Delaney Ward Sister Theatres Daisy Hill Hospital (DHH)
- Mrs Beatrice Moonan, Risk Manager, Acute Services SHSCT

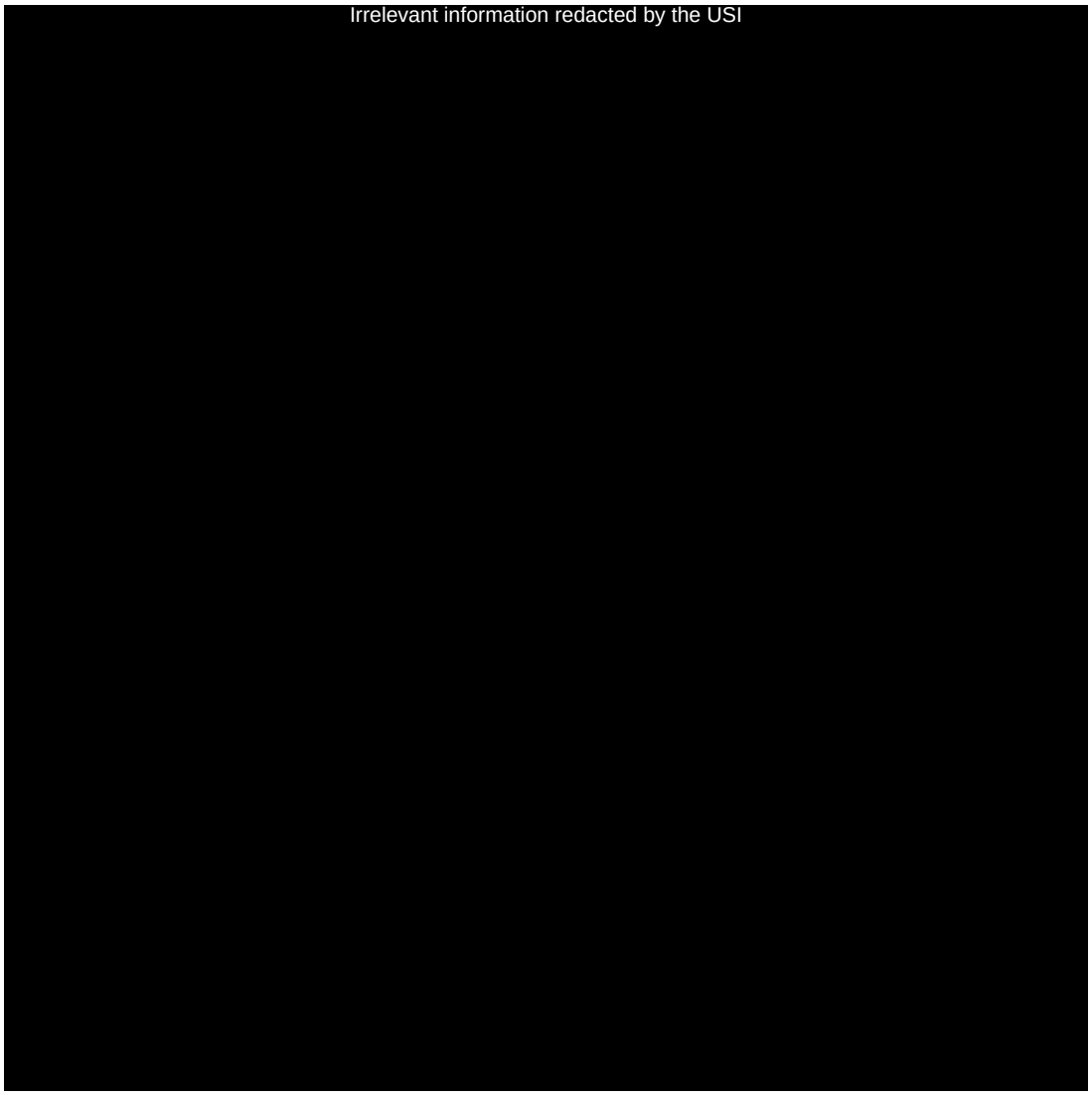
3 TERMS OF REFERENCE OF REVIEW TEAM

The terms of reference for this investigation are:

- To carry out a Root Cause Analysis of the care of Personal Information redacted by the USI using the National Patient Safety Agency RCA methodology.
- To use a multi-disciplinary team approach to the investigation.
- To examine the episode of care of Personal Information redacted by the USI at Daisy Hill Hospital from Personal Information redacted by the USI
- To identify those factors that may have had an influence, or may have contributed to the incident.
- To review the outcome of the investigation agreeing recommendations, actions and lessons learned
- To report the findings and recommendations of the investigation to the Director of Acute Services SHSCT
- To share the finding of the RCA with Personal Information redacted by the USI

4 summary of case

4.1 Description of Events



4.2 Stakeholders Involved

The stakeholders involved in this incident are as follows:

- Consultant 1
- Consultant 2
- Consultant 3
- SHO 1
- SHO 2
- Staff Nurse 1
- Staff Nurse 2
- Staff Nurse 3
- Staff Nurse 4
- Staff Nurse 5

- Mortuary staff member 1

4.3 Chronology of Events

The chronology of events is documented by the timeline at Appendix 1.

4.4 Relevant Past History

Personal Information redacted by the USI. Personal Information redacted by the USI's notes do not indicate any other relevant past medical or obstetric history to this Root Cause Analysis.

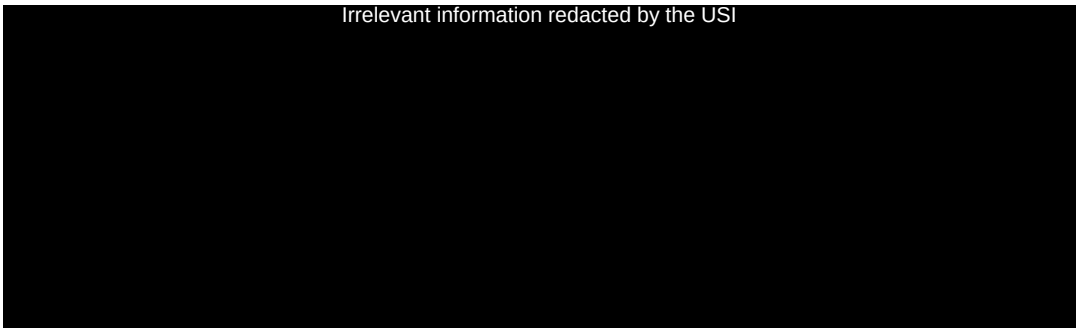
4.5 Outcome, Consequences and Action Taken

The IR1 form was received by the central reporting department on 30.09.09. A Root Cause Analysis into Personal Information redacted by the USI's episode of in patient care was subsequently commissioned by the Director of Acute Services SHSCT.

5 METHODOLOGY FOR INVESTIGATION

This Root Cause Analysis is based on the best practice associated with the National Patient Safety Agency *"Seven Steps to Patient Safety."* The processes associated with this approach are documented in the sub-sections follow.

5.1 Review of Records



5.2 Review of Policies and Procedures

5.3 Carer/User Involvement

6 ANALYSIS

This section of the report summarises the analysis conducted during this Root Cause Analysis.

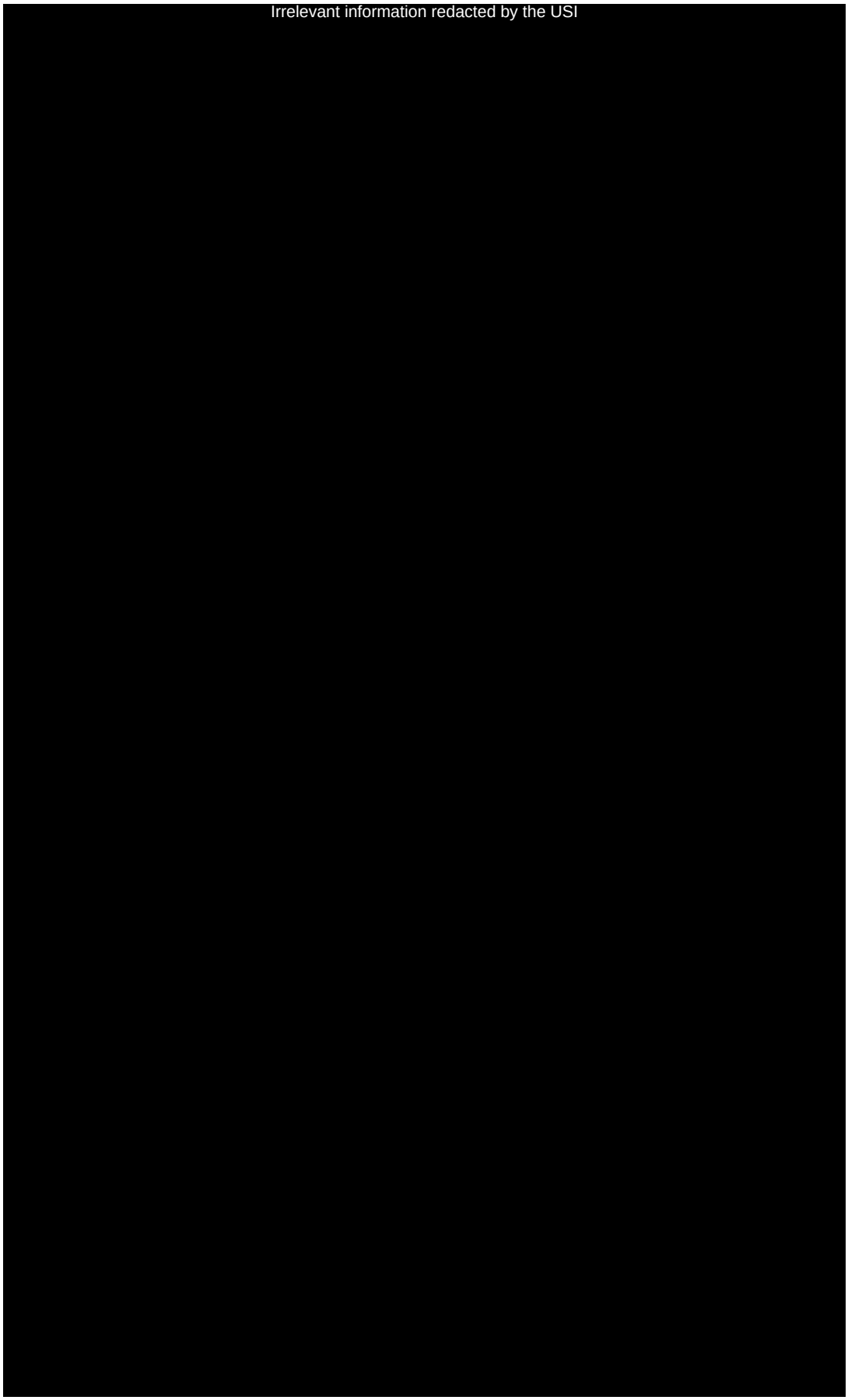
6.1 Admission

Irrelevant information redacted by the USI

6.2 Treatment Daisy Hill Hospital

Irrelevant information redacted by the USI

Irrelevant information redacted by the USI



Irrelevant information redacted by the USI

6.3 Summary of Analysis

Irrelevant information redacted by the USI

6.3.1 Patient Factors – Personal Information redacted by USI

Irrelevant information redacted by the USI

6.3.2 Education and Training

Irrelevant information redacted by the USI

6.3.3 Equipment and Resources

Irrelevant information redacted by the USI

6.3.4 Individual

Irrelevant information redacted by the USI

6.3.5 Working Conditions

Irrelevant information redacted by the USI

6.3.6 Task

Irrelevant information redacted by the USI

6.3.7 Team and Social

Irrelevant information redacted by the USI

6.3.8 Communications

Irrelevant information redacted by the USI

7 Conclusions, recommendations and Learning

The RCA team has highlighted the following shortcomings in the care provided to Personal Information redacted by the USI and has made recommendations for change which should ensure that similar problems in the future do not occur.

7.1 Local Recommendations

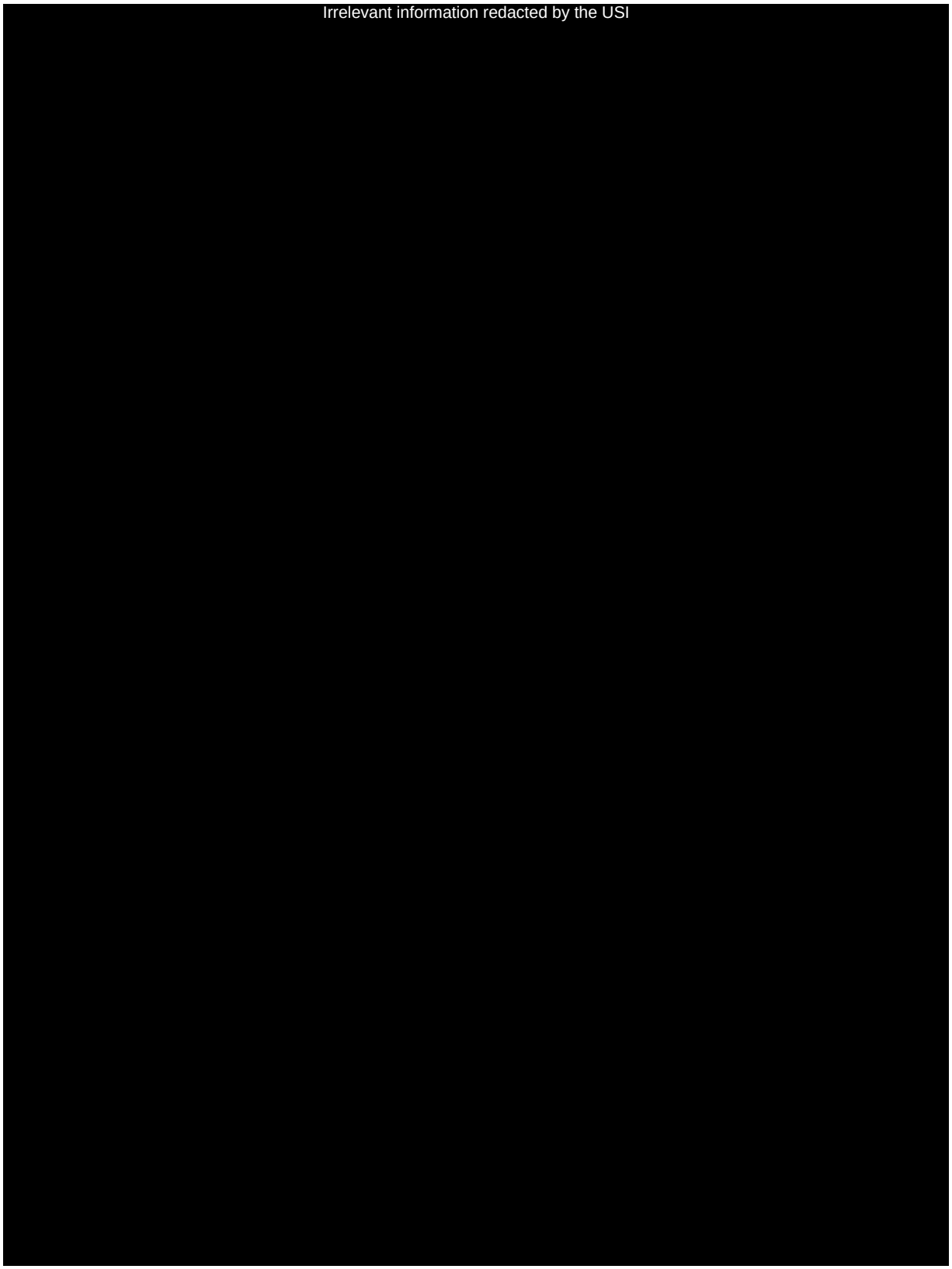
Irrelevant information redacted by the USI

7.2 Regional Recommendations

Irrelevant information redacted by the USI

7.3 Action Planning

Irrelevant information redacted by the USI



DIRECTORATE OF ACUTE SERVICES

Statistical Report on Formal Complaints – February 2010

Purpose of Report

The purpose of this report is to inform the Director and Assistant Directors about the number and nature of formal complaints received within the Directorate in February 2010.

Summary

- The month demonstrates that 34 formal complaints were received, which was a decrease of 2 from the previous month.
- 54% of complaints were responded to within 20 working days.
- 25 complaints pertained to the Craigavon site, 8 to the Daisy Hill Site and the remaining 1 to the South Tyrone Site.
- The complaints broken down by division are as follows:
  - Surgery & Elective Care (12)
  - Medicine and Unscheduled Care (11)
  - Cancer and Clinical Services (7)
  - Functional Support Services (3)
  - Integrated Maternity and Women's Health (1)
- The top three categories of complaint for month were:
  - Treatment and Care Quality (9) [↓4]
  - Communication/Information to Patients (7) [↑4]
  - Staff Attitude/Behaviour (6) [↓2]

Figures in brackets [ ] denotes change from previous month.

- Complaints were attributed to staff grouping as follows:
  - Medical staff (14)
  - No staff directly involved (10)
  - Nursing staff (7)
  - Administrative Staff (4)
  - AHP staff (1)
- The most frequently complained about wards/departments in the period were:
  - Accident and Emergency (4)
  - Theatres (3)
- 10 Complaints were dealt with at the point of service delivery and resolved.
- The Directorate has received notification of 324 positive compliments regarding the services provided.
- Detailed information pertaining to each formal complaint is attached.

Ongoing Independent Reviews

Irrelevant information redacted by the USI **Case**

Final report received by Trust in February 2010. Circulated to staff involved with specific request to staff for the development of an action plan. Director to table agreed action plan at Senior Management Team on 12 May 2010.

Irrelevant information redacted by the USI **Case**

Action plan agreed and circulated throughout the Directorate for updating and direct feedback to Director's Office. Case now being dealt with as a medical negligence issue.

Complaints Training

Complaints training at General Awareness and Level 1 (for managers) is ongoing. Flyers for May 2010 dates attached to this report. With the anticipation that the project will end in June 2010, all staff who require level 1 training should plan to attend as soon as possible.

DIRECTORATE OF ACUTE SERVICES
Report on Formal Complaints - February 2010

Ref	Rcd.	Div.	Site	Ward/Dept	subject	Staff	Description	Grade	Outcome	Action taken	Time	Head of Service
Personal Information redacted by USI	01/02/10	FUNSS	CAH	Booking and Contact Centre	Communication/information to Patients	Admin	Patient unhappy with the length of time it has taken to get an appointment arranged with the Booking and Contact Centre, CAH. Advised that only one member of staff had the code to get into the computer system and states everytime she telephoned this member of staff was always away. When appointment was arranged, she arrived for clinic to be told staff couldn't find her name and she was not seen. Patient would like her name to be put back on to the list for an appointment as this wasn't her mistake.	1-5VLO	Letter detailing appointment system and apology that computerised system was down when she phoned to book a slot.	No Action Plan	12	Helen Forde
	01/02/10	MUC	CAH	EEG OPD	Appointments, Delay/Cancellation (Outpatients)	None	1. MLA who would like clarity of the availability of the EEG Scanning Service at CAH for a constituent and the times it operates and what provision is made for weekend and out of hours service.	1-5VLO	Letter explaining No out of hours EEG service at CAH. 2 Best advice would be to check with Consultant at RVH where the child attends.	No Action plan	6	Lorraine Adair
	02/02/10	SEC	CAH	Surgical Clinic, Outpatients Department	Communication/information to Patients	None	Mother unhappy that her daughter was sent the incorrect information and therefore could not have her operation. Day off school missed and day off work missed.	1-5VLO	Letter of apology that incorrect fasting information was given with the appointment details. Staff member has now been made aware of the error and advised that she is accountable for such actions.	Poor communication to patients prior to medical procedure. Staff member made aware of the error and her accountability for such errors.	34	Trudy Reid
	02/02/10	IMWH	DHH	Delivery Suite DHH	Treatment and Care quality	Doctor	Complainants are unhappy with the behaviour of a member of staff during the delivery of their son. Felt an internal examination was not conducted appropriate and an attempt to turn baby's head raised a number of concerns.	6-11LO	Letter detailing the management of the patient's labour. Explanation of the doctor's attempt to turn the baby to assist in vaginal delivery and apology that this was not fully explained at the time of delivery. Clarification that permission was sought before the procedure was carried out. Clarification that the procedure was stopped when the patient's distress became apparent. Apology given.	1 Improve communication skills. 2 Work in partnership with women. 3 Ensure informed consent clearly obtained. 4 Good documentation	24	Patricia McStay
	03/02/10	MUC	DHH	Accident & Emergency	Treatment and Care quality	Doctor	Complainant is unhappy with the way her daughter was treated when she attended A&E DHH on Friday 22 Jan at 11.30am - attitude of staff and also left waiting for long periods of time even though there was only 1 pt before her.	6-11LO	Letter explaining the course of action initially taken by the the OOH doctor and the instructions delivered by him. Description of the treatment given at A&E and apology that the patient experienced delays in been seen.		18	Barry Conway
	03/02/10	MUC	DHH	Accident & Emergency	Treatment and Care quality	Sister	Complainant is unhappy with the way her daughter was treated when she attended A&E - attitude of staff and also left waiting for long periods of time even though there was only 1 pt before her.	6-11LO	Letter explaining the course of action initially taken by the the OOH doctor and the instructions delivered by him. Description of the treatment given at A&E and apology that the patient experienced delays in been seen.		18	Barry Conway
	08/02/10	CCS	DHH	Theatres	Communication/information to Patients	Doctor	Patient felt that she was not communicated with appropriately during the insertion of an epidural. Also felt that the treatment was "rough" and that the member of staff who was dealing with her was "brusque" in his manner.	6-11LO	Letter detailing care given. Difficulty experienced in administering epidural. Doctor did not feel he was rude. Explanation that the complication experienced is common and was treated correctly. Apology that the experience was not a more positive one.	No Action Plan.	30	Mary McGeough
	08/02/10	CCS	DHH	Theatres	Staff attitude/behaviour	Doctor	Patient felt that she was not communicated with appropriately during the insertion of an epidural. Also felt that the treatment was "rough" and that the member of staff who was dealing with her was "brusque" in his manner.	6-11LO	Letter detailing care given. Difficulty experienced in administering epidural. Doctor did not feel he was rude. Explanation that the complication experienced is common and was treated correctly. Apology that the experience was not a more positive one.	No Action Plan.	30	Mary McGeough
	08/02/10	CCS	DHH	Theatres	Treatment and Care quality	Doctor	Patient felt that she was not communicated with appropriately during the insertion of an epidural. Also felt that the treatment was "rough" and that the member of staff who was dealing with her was "brusque" in his manner.	6-11LO	Letter detailing care given. Difficulty experienced in administering epidural. Doctor did not feel he was rude. Explanation that the complication experienced is common and was treated correctly. Apology that the experience was not a more positive one.	No Action Plan.	30	Mary McGeough
	08/02/10	FUNSS	CAH	Booking and Contact Centre	Communication/information to Patients	Admin	Patient concerned that he was only given 1 weeks notice of an appointment. The same day he received a telephone call to advise his appointment, which was for 2pm, had been changed to 10.45am on the same date. When patient arrived for the appointment he was advised that his name was not on the list of patients to be seen.	1-5VLO	Letter of apology for the conflicting information which the patient received from the booking centre.	Feedback from this has been shared among the team and improvements made to processes to ensure that a recurrence is avoided in the future.	30	Helen Forde
	08/02/10	MUC	CAH	1 North Cardiology	Discharge/transfer arrangements	Sister	Sister of patient discharged expressed concern that he was sent home in a taxi wearing his pyjamas and slippers. Sister stated she and other family members do not drive or own a car and were unable to collect him from hospital and had been told that an ambulance was unavailable. Also advised that her brother had suffered a heart attack and when he arrived home he was freezing cold and feeling very weak. Sister said that the Rehab Team had been told he was being discharged today and therefore had not visited with him last night.	1-5VLO	Letter of apology that the patient was discharged and subsequently transported in an inappropriate manner i.e. in a taxi and inadequate clothing. Also apology that services were not in place for the patient's return home and that no one communicated this to the family.	No Action Plan	20	Lorraine Adair

Ref	Rcd.	Div.	Site	Ward/Dept	subject	Staff	Description	Grade	Outcome	Action taken	Time	Head of Service
Personal Information redacted by USI	09/02/10	CCS	CAH	X-Ray Dept	Records/record keeping	None	Complainant is unhappy with the treatment her husband received - was referred to the Urology Dept after an x-ray revealed he had cancer. Attended the polyclinic in Banbridge where he had a face to face meeting with a Dr from the Urology Dept - Dr had no records available for reference but assured her husband that he would follow it up on return to CAH and would write personally within a wk. Received a letter (24.7.09) stating that the best way forward was to monitor the lump for a period of time and a further CT scan would be arranged in 3 months time. Complainant's husband had a bone scan on 23 July, a DMSA Renal scan on 5 Aug and another CT scan 27 Aug. Nothing further was heard from the Urology Dept - telephoned Oct 09, no appt arranged. Telephoned directly to Urology dept Jan 21- was told that any pt enquiring about review appts had to go back to their GP and get another referral. Complainant says it is very upsetting for her husband to go back on the referral list.	6-11LO	1 Apology for delay in providing and appointment. 2 Apology that a member of staff gave misinformation. 3 Further consultation has now taken place with consultant. 4 Followup CT scan has been arranged and the consultant will discuss with the patient the findings at the next appointment arranged in March 2010.	No Action Plan	19	Alexis Davidson
	09/02/10	SEC	CAH	Urology Clinic	Appointments, Delay/Cancellation (Outpatients)	None	Complainant is unhappy with the treatment her husband received - was referred to the Urology Dept after an x-ray revealed he had cancer. Attended the polyclinic in Banbridge where he had a face to face meeting with a Dr from the Urology Dept - Dr had no records available for reference but assured her husband that he would follow it up on return to CAH and would write personally within a wk. Received a letter (24.7.09) stating that the best way forward was to monitor the lump for a period of time and a further CT scan would be arranged in 3 months time. Complainant's husband had a bone scan on 23 July, a DMSA Renal scan on 5 Aug and another CT scan 27 Aug. Nothing further was heard from the Urology Dept - telephoned Oct 09, no appt arranged. Telephoned directly to Urology dept Jan 21- was told that any pt enquiring about review appts had to go back to their GP and get another referral. Complainant says it is very upsetting for her husband to go back on the referral list.	6-11LO	1 Apology for delay in providing and appointment. 2 Apology that a member of staff gave misinformation. 3 Further consultation has now taken place with consultant. 4 Followup CT scan has been arranged and the consultant will discuss with the patient the findings at the next appointment arranged in March 2010.	No Action Plan	19	Martina Corrigan
	11/02/10	MUC	DHH	Coronary Care Unit	Staff attitude/behaviour	Nurse	Patient who asked for assistance to go to bathroom is upset that after request was made she overheard two nurses talking and one commenting that "she could go on her own" to the bathroom. Patient was made to get out of bed and walk to the bathroom when she was unwell and light headed. Also upset that after she disclosed to a nurse that she had a child with learning disabilities, the same nurse waited around to see the child at visiting and then made a comment that the looked all right to her. In relation to a previous admission 3 weeks previously, patient also upset about the brusque manner of the sister. issue raised with Ward Manager who advised sister would apologise, however to date no apology forthcoming.	1-5VLO	Letter of apology that patient felt attitude of 2 staff members was unacceptable.		19	Lorraine Adair
	11/02/10	SEC	DHH	Female Surgical Ward DHH	Staff attitude/behaviour	Nurse	Patient who asked for assistance to go to bathroom is upset that after request was made she overheard two nurses talking and one commenting that "she could go on her own" to the bathroom. Patient was made to get out of bed and walk to the bathroom when she was unwell and light headed. Also upset that after she disclosed to a nurse that she had a child with learning disabilities, the same nurse waited around to see the child at visiting and then made a comment that the looked all right to her. In relation to a previous admission 3 weeks previously, patient also upset about the brusque manner of the sister. issue raised with Ward Manager who advised sister would apologise, however to date no apology forthcoming.	1-5VLO	Letter of apology that patient felt attitude of 2 staff members was unacceptable.		19	Trudy Reid
	11/02/10	SEC	CAH	4 North Surgical	Environmental	None	post op patient who was being nursed in bay 1, bed 1 unhappy that the ward was busy at night time when patients were trying to sleep and rest. Was also concerned about disruptive patients keeping other patients awake during the night. Patient also had an issue with the fact that visitors appeared to be allowed to stay with certain patients as long as they wished.	1-5VLO	1 Acknowledgement of high activity level on 4 North. 2 Explanation for patient being so close to nursing station when he came out of theatre. 3 Clarification of visiting policy. 4 Apology for the unacceptable noise level from the sister's office.	No action plan.	17	Trudy Reid

Ref	Rcd.	Div.	Site	Ward/Dept	subject	Staff	Description	Grade	Outcome	Action taken	Time	Head of Service
Personal Information redacted by USI	15/02/10	CCS	CAH	MRI Craigavon Area Hospital	Staff attitude/behaviour	Radiographer	Patient unhappy with attitude of operatives in the MRI Dept when he had panic attack in MRI scanner.	1-5VLO	Letter of explanation regarding the level of anxiety the patient experienced prior to and during MRI scan. Radiographer explained that she removed him from the scanner when he became distressed but that enough images were obtained to allow a diagnostic report.	Patient contacted by telephone to clarify his concerns. Staff awareness of good explanation and communication prior to and during scan.	24	Alexis Davidson
	15/02/10	MUC	CAH	Accident & Emergency	Treatment and Care quality	Doctor	Attended A&E on numerous occasions with severe back pain following RTA - attended a private clinic to have an MRI scan which showed a fracture to the vertebrae and a compressed disc - very unhappy that no one in A&E listened to her and felt she should have had the MRI scan when she first attended.	6-11LO	Letter to the complainant explaining treatment for 1. Wrist fracture 2. Back pain - X-Rays examined and fracture was not detected, diagnosis of Sacroiliitis was made and the patient advised that this may take 6-8 weeks to settle. 3. Continued back pain - further lumbar spine x-ray, referral to Physio. Thought to be soft tissue spasm so discharged with analgesia to be reviewed in CDU in 10 days. 4. Patient requested MRI scan but this was felt to be inappropriate at that time but that if pain persisted then she should seek referral for Outpatients MRI from GP. Apology that the fracture was missed but assurance that the subsequent care would not have altered. Consultant did not feel he was dismissive but apology if this appeared to be the case.		29	Barry Conway
	15/02/10	SEC	CAH	Orthopaedic Clinic	Records/record keeping	None	Attended A&E on numerous occasions with severe back pain following RTA - attended a private clinic to have an MRI scan which showed a fracture to the vertebrae and a compressed disc - very unhappy that no one in A&E listened to her and felt she should have had the MRI scan when she first attended.	6-11LO	Letter to the complainant explaining treatment for 1. Wrist fracture 2. Back pain - X-Rays examined and fracture was not detected, diagnosis of Sacroiliitis was made and the patient advised that this may take 6-8 weeks to settle. 3. Continued back pain - further lumbar spine x-ray, referral to Physio. Thought to be soft tissue spasm so discharged with analgesia to be reviewed in CDU in 10 days. 4. Patient requested MRI scan but this was felt to be inappropriate at that time but that if pain persisted then she should seek referral for Outpatients MRI from GP. Apology that the fracture was missed but assurance that the subsequent care would not have altered. Consultant did not feel he was dismissive but apology if this appeared to be the case.		29	Louise Devlin
	15/02/10	SEC	CAH	Orthopaedic Clinic	Admission into hospital (delay cancellation) (inpatients)	None	Patient unhappy that she had to fund a private operation on her knee. She was referred by her GP to the NHS and no appointment has been offered.	6-11LO	Letter detailing the results of examination of patient's knee and hip.		18	Louise Devlin
	16/02/10	SEC	CAH	Orthodontics Clinic	Treatment and Care quality	Doctor	Father unhappy that his 11 year old daughter was being discharged from the Orthodontist Clinic, CAH and his daughter was brought into see the Consultant on her own.	1-5VLO	1 Clarification of extent of patient's over-bite. 2 Consultant can not force treatment of unwilling patient. 3 Assurance that treatment can be administered if patient wishes to pursue in future.	No Action Plan	8	Louise Devlin
	16/02/10	MUC	CAH	Accident & Emergency	Patients' property/expendses/finance	None	Patient was transferred from CAH to Lurgan. Coat went missing at some point. If coat cannot be found complainant wished to claim compensation for a replacement.	1-5VLO	Letter to explain the Trust position on lost property and apology that the lost coat has been discarded in accordance with the practice of discarding such property within 2 weeks.		16	Barry Conway
	16/02/10	CCS	STH	Day Procedure Unit CAH	Appointments, Delay/Cancellation (Outpatients)	Doctor	Complainant is very unhappy that his wife's day procedure case had to be cancelled in STH - had her pre-op assessment in CAH and received a letter to go to STH for her surgery. Ready to have op when told she wasn't suitable for same under local anaesthetic in STH and would have to be re booked for CAH.	1-5VLO	Letter of apology and explanation for decision not to proceed due to BMI. Appointment offered with consultant.	Staff awareness of policy and procedure in relation to day surgery when a patient's BMI is over 40. Appointment at STH should not be offered but at CAH instead.	23	Mary McGeough
	17/02/10	SEC	CAH	Fracture Clinic	Professional Assessment of need	None	Complainant fractured a bone in her foot on 27 March 09 - has been attending the Fracture Clinic. She is unhappy that she is still waiting on 'Exogen' to treat same and if same is not funded by the Board she will have to have her bone broken and reset. Complainant feels that her foot should have been put in plaster from the beginning. She is also worried that she may lose her job with the SHSCT if she is unfit to work.	6-11LO	Letter explaining the delay in availability of Exogen Therapy, which has now been made availabile. Explanation regarding the management of the fracture.		27	Louise Devlin
	17/02/10	SEC	CAH	ENT Clinic, Surgical Outpatients	Treatment and Care quality	Doctor	Patient attending appointment because of a problem with snoring, however patient feels this diagnosis is incorrect. Patient was not prepared for appointment in that he was not expecting other staff to be in attendance, therefore he felt he was unable to ask the questions he wanted to. Also concerned that there was no follow up from a previous MRI examination.	1-5VLO	Letter of apology that patient felt intimidated by students being present during consultation. Clarification that full examination was carried out and that further arranged appointment will give the patient further opportunity to discuss any outstanding concerns.		16	Martina Corrigan
	17/02/10	MUC	CAH	1 North Cardiology	Treatment and Care quality	Sister	Complainant is unhappy with the nursing care her late husband received. In particular dressing on patient's leg was not changed and bed became wet. Patient also found it difficult to summon the assistance of a nurse during the night when he needed help to go to the toilet.	6-11LO			0	Lorraine Adair

Ref	Rcd.	Div.	Site	Ward/Dept	subject	Staff	Description	Grade	Outcome	Action taken	Time	Head of Service
Personal Information redacted by USI	19/02/10	SEC	CAH	4 North Surgical	Communication/information to Patients	Doctor	Complainant unhappy with the lack of information given to the family about patient's diagnosis which led them to being anxious and concerned. Complainant also reports that patient was discharged without any written information or details of follow up care.	6-11LO	Letter of explanation that nursing staff can only give a limited amount of information but that an appointment should have been offered to the family for a meeting with the consultant. Apology that this did not happen. Assurance that no mistake was made during further procedure.	Staff awareness regarding communication to patients and relatives	20	Trudy Reid
	19/02/10	SEC	CAH	4 South Surgical	Communication/information to Patients	Doctor	Complainant unhappy with the lack of information given to the family about patient's diagnosis which led them to being anxious and concerned. Complainant also reports that patient was discharged without any written information or details of follow up care.	6-11LO	Letter of explanation that nursing staff can only give a limited amount of information but that an appointment should have been offered to the family for a meeting with the consultant. Apology that this did not happen. Assurance that no mistake was made during further procedure.	Staff awareness regarding communication to patients and relatives	20	Trudy Reid
	24/02/10	MUC	CAH	Medical Admissions Unit	Staff attitude/behaviour	Doctor	Patient unhappy with the treatment and attitude of a consultant towards him. Allegation that Consultant told patient to sign himself into St Lukes or he would be discharged.	1-5VLO	Letter explaining the advise given to the patient and the treatment offered but declined by the patient. Note made that during any future admissions arrangements would be put in place to have another consultant attending this patient.		20	Eileen O'Rourke
	25/02/10	MUC	CAH	Medical Admissions Unit	Staff attitude/behaviour	Doctor	Patient admitted to hospital unstable and extremely confused with a quick deterioration of condition. Both patient and next of kin felt Consultant was most insensitive and very callous in how she spoke to the family. Next of kin was fully aware that beds in the hospital were at a premium, however felt there was no requirement of the Consultant to advise that there was no medical reason for the patient's admission and that a bed was being taken up unnecessarily.	1-5VLO	Letter detailing 1. The patient's admission, assessment and fitness for discharge. 2. Notes documented that the family was contacted and that they felt the patient was not ready to come home due to hallucinations which the family said she was experiencing but she was denying to staff. 3. Apology for the breakdown in communication in relation to Dr Best's assessment which should have taken place in CAH but instead was in Bluestone. 4. Tests were carried out for urinary tract infection and came back negative.		20	Eileen O'Rourke
	24/02/10	SEC	CAH	Surgical Clinic, Outpatients Department	Communication/information to Patients	Admin	Complainant expressing concern regarding a number of administrative errors made in relation to her need to attend an appointment at the Day Surgery Unit, Craigavon. On arrival for appointment, Dr reviewed a chart in her presence which subsequently turned out to be the wrong chart and belonging to another patient. Complainant distressed that she had been prepared mentally and physically for the procedure and in the end it was not required.	1-5VLO	Ongoing		0	Trudy Reid
	24/02/10	CCS	CAH	Day Procedure Unit CAH	Confidentiality	Doctor	Complainant expressing concern regarding a number of administrative errors made in relation to her need to attend an appointment at the Day Surgery Unit, Craigavon. On arrival for appointment, Dr reviewed a chart in her presence which subsequently turned out to be the wrong chart and belonging to another patient. Complainant distressed that she had been prepared mentally and physically for the procedure and in the end it was not required.	1-5VLO	Ongoing		0	Mary McGeough
	25/02/10	MUC	CAH	Not Applicable	Treatment and Care quality	None	Daughter of patient Personal concerned that during her recent stay in Craigavon Area Hospital, she was moved around 6 different wards. Stated this left her mother confused and that the family found it difficult to get information about her mother's condition and progress.	6-11LO	Letter giving details of the reasons for several moves from ward to ward during the patient's stay in hospital. Apology that this may have caused distress and assurance that the Bed Manager would endeavour to ensure this would be minimised in the future.	1 Numerous transfers thro hospital - Patients should be nursed in appropriate ward settings during admission. 2 Poor documentation re transfer - Good lines of communication 3 No guidelines re selection of patients for transfer - Establish system for identifying patients suitable for transfer.	20	Eileen O'Rourke
	25/02/10	FUNSS	CAH	Portering	Confidentiality	Admin	Wife of patient (now deceased) concerned at inappropriate remarks made by a member of staff regarding her husband's death and illness. Complainant believes that these comments have been passed on around staff via another member of staff who was working in the Ward at the time.	6-11LO	Letter of assurance that, after thorough investigation, no inappropriate information was given out regarding the death of the complainants husband.	No evidence found to substantiate the allegations made.	30	Donal Grimes

Southern Health and Social Care Trust

Quality Care-for you, with you

GENERAL COMPLAINTS AWARENESS TRAINING

MAY 2010

As from 1 April 2009 new Standards for the handling, resolving and learning from HSC Complaints has come into effect.

These sessions are available for

All SHSCT Staff Delivering or Supporting Patient Care

Date	Time	Venue
6/5/10	11am-12.md	Lecture Theatre MEC CAH
7/5/10	9.30- 10.30am 10.45-11.45am	Board Rm Nurses Home DHH
17/5/10	2-3pm	Lecture Theatre MEC CAH
26/5/10	2-3pm 3.15-4.15pm	Iveagh suite Banbridge HSC Centre
28/5/10	9.30- 10.30am 10.45-11.45am	Navan Room St Lukes

Booking Instructions:

Please telephone 028 3861 4182/2696/3873 to book a place. If there is no immediate response, please indicate the session you wish to attend and leave your name, title, directorate, division and contact number on the automated answering service. If you do not receive further contact from us within 48 hours, please assume you have been booked to the session of your choice. Confirmation of booking will not be provided.

In order to register your actual attendance at the session, please ensure you have your staff number available when you attend.

Southern Health and Social Care Trust

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COMPLAINTS LEVEL 1 TRAINING

MAY 2010

New Standards for the handling, resolving and learning from HSC Complaints has come into effect.

Complaints Level 1 sessions are available for

All SHSCT Staff Who Have a Responsibility for Investigating Complaints Related to Delivering or Supporting Patient Care

Date	Time	Venue
6/5/10	2- 4.30pm	Tutorial Rm 2 MEC CAH
10/5/10	10.30-1pm 2.15 - 4.30pm	Tutorial Rm 2 MEC CAH
11/5/10	9.30-12md	Committee Rm 1 DHH
11/5/10	2-4.30pm	Conference Room Banbridge HSC Centre
17/5/10	10.30-1pm	Tutorial Rm 3 MEC CAH
19/5/10	9.30-12md	Callan Room St Lukes
19/5/10	2-4.30pm	Board Room Banvale
25/5/10	9.30-12md	Committee Rm STH
26/5/10	9.30-12md	Committee Rm 1 DHH

Booking Instructions:

Please note that places are limited (**12 per session)** and to secure a place, please telephone 028 3861 4182/2696/3873. If there is no immediate response, please indicate the session you wish to attend and leave your name, title, directorate, division and contact number on the automated answering service. Confirmation of booking will be provided.

In order to register your actual attendance at the session, please ensure you have your staff number available when you attend.

Stinson, Emma M

From: Stinson, Emma M
Sent: 12 May 2010 15:54
To: Moonan, Beatrice Mrs; Hall, S DR; Hogan, M DR; Mackle, Mr E; Murphy, Philip Dr; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather; Boyce, Tracey; Cardwell, David
Cc: Lindsay, Gail; Beattie, Pauline; Renney, Cathy; Smyth, Elizabeth (Dr P Murphys Secretary); Lappin, Aideen; Graham, Michelle; Murphy, Jane S
Subject: *Papers* for Acute Directorate Clinical Governance Meeting
Attachments: PIL moviprep.doc; Prescription Bowel prep.doc; Protocol for bowel cleansing prior to endoscopy.doc; RRR Supporting Information Bowel Preps FINAL.pdf; oral_bowel_cleansing_guidelines.pdf; Rapid Response Report Bowel Preps FINAL[1].pdf; Medication incident report October to December 2009.pdf

Dear All

Please find attached further papers for Friday's Acute Directorate Clinical Governance Meeting.

Many thanks

Emma

Emma Stinson
PA to Dr Gillian Rankin, Interim Director of Acute Services
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by the USI
Fax:

Email: Personal Information redacted by the USI

Southern Health and Social Care Trust

Patient instruction leaflet for Moviprep® Sachets

Please also read the manufacturer's patient information leaflet which is in the Moviprep® Sachet box.

What is Moviprep®

Moviprep® is a bowel cleanser. It is important that your bowel is completely empty prior to your examination, test or procedure.

If you are taking any medicines

If you are on anticoagulation treatment e.g. Warfarin, or if you take insulin, special arrangements may be necessary so please speak to your doctor about this so that you are clear as to what you are to do about these medicines.

If you are on metformin for diabetes this should be taken as normal.

Anti-diarrhoeal preparations should be stopped **three days before** the procedure, for example codeine, loperamide, co-phenotrope, Lomotil®, Imodium®.

Iron supplements should be stopped **seven days before** the procedure, for example Galfer®, ferrous sulphate, ferrous fumerate, Ferrograd®, Pregaday®, Niferex®.

All other medications including steroids should be continued as normal. However on the day of your procedure, you may have to change the time you take your medicines so that they are taken after your procedure is finished. This will depend on the time of your procedure. **Please ask your doctor or pharmacist for further advice on how to manage your medications in relation to your procedure**.

If you are on any other medicines that you buy yourself please let you doctor know about these as well, as this may affect the procedure.

No medicines should be taken for two hours before or during the procedure.

For female patients

You must inform your doctor if you are pregnant, attempting to become pregnant or breastfeeding.

Diarrhoea can make the oral contraceptive pill less effective. Continue taking the pill but use other precautions for the rest of that menstrual cycle. Contact your doctor or pharmacist for further advice.

How to make up a Moviprep® solution

Adults and elderly: A course of treatment consists of two litres of MOVIPREP (Children: Moviprep® is not recommended for use in children below 18 years of age)

Dissolving the sachets

Take one sachet labeled ‘A' and one sachet labeled 'B' and put the powder inside them into a measuring jug. Add water to dissolve the powder and make the solution up to 1 litre with more water. When you have drunk this solution repeat this with the second set of ‘A’ and ‘B’ sachets

If the appointment for your procedure is in the morning:

On the day before your procedure, have your lunch as normal and then that afternoon make up the first litre of Moviprep, as described above.

Over a period of one to two hours, drink the litre of Moviprep® solution.

Make up the second litre of Moviprep® solution and drink it over the next one to two hours.

It is strongly recommended that one litre of clear liquid is also taken while you are drinking the Moviprep solution. This can include water, clear soup, fruit juice without pulp, soft drinks, tea and/or coffee without milk.

Do not eat any food from when you start to drink the Moviprep® solution until after your procedure.

If the appointment for your procedure is in the afternoon:

On the day before your procedure, have your dinner/tea as normal and then that evening make up the first litre of Moviprep, as described above.

Over a period of one to two hours, drink the litre of Moviprep® solution.

It is strongly recommended that one litre of clear liquid is also taken while you are drinking the Moviprep solution. This can include water, clear soup, fruit juice without pulp, soft drinks, tea and/or coffee without milk.

On the morning of the procedure, make up the second litre of Moviprep® solution and drink it over the next one to two hours. You must have finished drinking the Moviprep® solution and any other clear liquids at least two hours before the start of your procedure.

Do not eat any food from when you start to drink the Moviprep® solution until after your procedure.

Other advice

Once the treatment period has started, you are advised to remain within easy reach of a toilet.

If you have **not had any bowel movements** after 6 hours, stop taking the treatment and consult your doctor.

You should not drive or operate machinery for the remainder of the day following your procedure. Please arrange for someone to collect you.

Side effects of Moviprep®

You may experience nausea, tiredness, abdominal bloating, vomiting or cramps. This is usually due to the laxative action of the medication. **The success of your procedure depends on you completing this treatment- please persevere if possible**.

Occasionally, this medication may cause an allergic reaction- please seek immediate medical help if this happens.

SHSCT Bowel preparation prescription

Write clearly and use ballpoint pen

Clinic:……..……

Write or use addressograph

Surname:……

First Names:……..……..

Address:……..……..

……..……..

Hospital number:……..……

Date of Birth:……

Allergies / Medicine sensitivities

No known allergies ☐ (please tick) **or**

Medicines (generic) / allergen (type of reaction)

Procedure planned: ……

***Is the patient on warfarin or any other anticoagulant medicine?** **Yes** **No**

If **Yes**, have the **perioperative guidelines** been followed and the patient been advised accordingly about how to manage their warfarin or other anticoagulant medicine? Yes No

***Is the patient taking any of the following medicines or other medicines that may affect electrolyte levels:**

ACE-inhibitors, Angiotensin-II receptor antagonists, diuretics, NSAIDs, calcium channel blockers, lithium, steroids, digoxin, tricyclic antidepressants, SSRIs, carbamazepine, antipsychotics

****For any patient at risk of **electrolyte disturbance**, consider **U&Es prior to and after treatment****

***Is the patient epileptic or on antipsychotic medicines?** **Yes** **No**

If 'Yes', the **relevant consultant must be **contacted for advice** re maintenance of therapies**

Formatted: Font: 11 pt

please tick relevant box	Bowel preparation required	Dose, Frequency and Route
	Fleet Phospho-soda® Oral solution	Two 45ml doses, diluted and taken orally as per the instruction leaflet
	Moviprep® Oral powder sachets	Two sachets of A and of B to be dissolved and taken orally as per the instruction leaflet
	Picolax® sachets	Two sachets to be dissolved and taken orally as per the instruction leaflet
	Klean – Prep® sachets	Four sachets to be dissolved and taken orally as per the instruction leaflet

Signature_____ Date_____

Name in capitals_____ Designation_____

Please send the completed prescription to the hospital pharmacy department, who will dispense the required preparation and arrange to have it delivered to the patient's home. (Outpatients/ X-ray in South Tyrone should send the prescriptions to the pharmacy in CAH)

For urgent scope appointments, i.e. in less than 10 days, then the patient or their carer should be given the prescription and asked to take it to the closest hospital pharmacy to be dispensed.

Southern Health and Social Care Trust

Protocol for the selection, prescription and supply of bowel cleansing preparations

The following protocol refers to the following list of products, approved bowel cleansing products in the Southern HSC Trust:

- Fleet Phospho-soda® oral solution
- Klean-prep® Sachets
- Moviprep® Sachets
- Picolax® Sachets

The indications, contraindications etc are applicable to all four products unless otherwise stated. The manufacturers SPCs are also available for reference.

Indications

This protocol applies to bowel and colon cleansing in adults prior to clinical procedures e.g. Surgery, X-ray, endoscopy.

Contraindications, cautions and interactions

The NPSA Rapid Response Report: Reducing risk of harm from oral bowel cleansing solutions RRR012 and its associated documents and the Royal Colleges' Consensus Guidelines for the Prescription and Administration of Oral Bowel Cleansing Agents list the following conditions as contra-indications for the use of bowel cleansing products:

- Nausea
- Vomiting
- Abdominal pain
- Allergy/ hypersensitivity to any of the ingredients
- Congestive heart failure
- Impaired renal function
- Ascites
- GI obstruction
- GI ulceration
- Acute appendicitis
- Toxic megacolon
- Perforation
- Ileus
- Disorders of gastric emptying
- Active inflammatory bowel disease
- Pregnancy
- Lactation
- Phenylketonuria (moviprep and kleanprep only)
- G6PD deficiency (moviprep only)

The NPSA report and the Consensus Guidelines recommend that bowel cleansing preparations are used with caution in the following conditions:

- Heart disease
- Acute MI
- Unstable angina
- Risk of/ current electrolyte disturbance
- Elderly
- Colostomy
- Ileostomy
- Salt free diet
- Impaired gag reflex/ at risk of aspiration or regurgitation.
- Epilepsy
- Patient taking any of the following drugs: ACEi, ARBs, diuretics, NSAIDs, calcium channel blockers, lithium, steroids, digoxin, TCADs, SSRIs, carbamazepine or other medications that might affect electrolyte levels. It is recommended that for **any** patient at risk of electrolyte disturbance, **U&Es prior to and after treatment should be considered**.

Interactions with other medicines
Regular oral medications may not be absorbed during treatment. Particular attention should be given to antiepileptics, OCPs etc. Arrangements may be made for patients to receive their oral medications after their procedure- consult patient's doctor and give advice to patient as appropriate.

Any patient who has a listed contraindication/ caution should be referred to their doctor for a decision about going ahead with the use of a bowel cleansing preparation prior to the preparation being prescribed/ dispensed. The outcome of this consultation should be documented in the patient's notes.

Selection of the appropriate bowel cleansing product
It is important that, taking into consideration the patients underlying conditions, their medicines and the procedure required, that the most appropriate bowel cleansing preparation is selected. To aid with this decision the Royal Colleges' Consensus Guidelines have developed an algorithm (Appendix A).

Prescribing
Bowel cleansing preparations are medicines and must be prescribed for individual patients as recommended by the NPSA and the Royal Colleges. A standard Bowel Cleansing prescription for outpatients has been developed for use within the Trust (Appendix B). if the patient is an inpatient at the time of the procedure, the bowel cleansing preparation must be prescribed on the Kardex.

Supply to the patient
Outpatients
Prescriptions for bowel cleansing preparations for should be sent to the Trust Pharmacy to be dispensed. The pharmacy will label the preparations for the patient, include the appropriate patient information and instruction leaflet and post the preparation to the patient. If the patient requires an urgent procedure they or their relative/carer should be asked to take the prescription to the Trust pharmacy to be dispensed. Stocks of bowel cleansing preparations will not be held by individual outpatient clinics or consultant secretaries. Providing a patient with a supply of a bowel cleansing preparations in any

other way is against the NPSA recommendations and is a breach of the Trust Medicines Code.

Inpatients
When a bowel cleansing preparation has been prescribed on a patient's Kardex, the nursing staff should send a requisition, stating the patients name to the pharmacy. The pharmacy will label the preparation with the patient's name and provide the appropriate instruction leaflet to the ward. Stocks of bowel cleansing preparations will not held by individual wards.

NHS
National Patient Safety Agency
National Reporting and Learning Service

Rapid Response Report NPSA/2009/RRR012:
Reducing risk of harm from oral bowel cleansing solutions

February 2009

Supporting Information

Background

Introduction and scope

The NPSA has issued NPSA/2009/RRR012 containing safer practice guidance following reports of death and harm from the inappropriate use of oral bowel cleansing solutions prior to surgery and/or investigative procedures. It covers all age groups, but frail and debilitated elderly patients, children and those with contraindications are particularly at risk from these treatments.

This guidance is relevant to healthcare professionals in all settings involved in the care pathway for the referral and management of patients requiring relevant surgery or investigative procedures or the prescribing, supply or administration of bowel cleansing solutions.

While some scenarios and practices require children to be admitted to hospital to receive bowel cleansing solutions prior to surgery or investigative procedures, some children may be given these medicines to take at home before admission to hospital for the procedure. The NPSA has received a small number of incident reports relating to home administration. None of these reports led to harm on these occasions. However, children are a group particularly at risk of dehydration if fluid balance is not closely monitored.

Organisations should decide on a local dissemination strategy for this Rapid Response Report and supporting information. This should be tailored to local circumstances and arrangements. This might include GPs, consultants (general or other specialist surgeons such as urologists or gynaecologists and also radiologists), junior hospital doctors, community and hospital pharmacists, nurses, pre-admission clinic staff, out patient department nurses, community and bowel specialist nurses, radiographers and administrative managers.

Products involved include:

Picolax®, Citramag®, Fleet Phospho-Soda® ,Klean Prep®, Moviprep®

Additional information in this document:

- **Evidence of harm associated with weak systems for the supply and use of bowel cleansing solutions**
- **Clinical information concerning the use of bowel cleansing solutions. (Please refer to the individual manufacturer's full information for each product)**
- **Suggested compliance checklist (Appendix 1).**

Review of evidence of harm

Evidence of harm associated with weak systems for the supply and use of bowel cleansing solutions

1.1 Reporting & Learning System (RLS) incident data

The NPSA has been notified of one recent death due to faecal peritonitis associated with intestinal obstruction and caecal perforation where a pre-existing clinical condition contra-indicated the use of a bowel cleansing solution. This incident was notified directly from the office of HM Coroner and is not included in the incident data below.

The NPSA conducted a search for medication patient safety incident reports received via the RLS related to bowel cleansing solutions. There were 218 such reports found in the RLS database, as at 06 January 2009.[1] A number of incidents illustrated the lack of supply controls and safety checks in place.

Interpretation of data from the RLS should be undertaken with caution. As with any voluntary reporting system, the data are subject to bias. A proportion of incidents which occur are not reported, and those which are reported may be incomplete having been reported immediately and before the patient outcome is known.

Data have been produced using a text search for specific word or phrases across the descriptive free text fields in the RLS. Free text fields reported are individual to the reporter, and may contain spelling errors, typographical errors or abbreviations which make it difficult to group similar incidents.

Due to the technical challenges inherent in accounting for all the possible variations in describing a given incident, results from this method should be interpreted carefully. In particular, aggregate figures derived using the method above should not be taken as exactly representative of the data on the RLS.

[1] The NRLS was established in November 2003 and all NHS organisations were able to report to the NRLS by 1 January 2005. It is important to note the volume of reports received by the NRLS has increased since inception, and as the NRLS is a voluntary reporting system, the data may not be representative of the rates of incidents across England and Wales. Data are based on the date that incident became available for analysis. All incidents since the inception of the NRLS are included.

The following tables provide a breakdown of incidents reported to the RLS.

Table 1: Incidents involving bowel cleansing solutions by type of medication error

Base: All medication incidents involving bowel cleansing medication in the RLS as at 06 January 2009

Medication Error Category	Number	Per cent
Omitted medicine/ingredient	63	29
Wrong drug/medicine	50	23
Mismatching between patient and medicine	13	6
Wrong/unclear dose or strength/frequency	23	11
Contra-indication to the use of the medicine in relation to drugs or conditions	9	4
Wrong quantity	7	3
Wrong route	6	3
Wrong method of preparation/supply	4	2
Adverse drug reaction (when used as intended)	4	2
Wrong/omitted/passed expiry date	4	2
Wrong/transposed / omitted medicine label	3	1
Wrong/omitted verbal patient directions	1	0
Wrong/omitted patient information leaflet	1	0
Patient allergic to treatment	1	0
Wrong formulation	1	0
Other	25	11
Unknown	2	1
Missing	1	0
Total	**218**	**100**

Table 2: Incidents involving bowel cleansing solutions by stage of medication process

Base: All medication incidents involving bowel cleansing medication in the RLS as at 06 January 2009

Stage of Medication Process	Number	Per cent
Administration/supply of a medicine from a clinical area	122	56
Prescribing	46	21
Preparation of medicines in all locations/dispensing in a pharmacy	29	13
Advice	7	3
Supply or use of over-the-counter (OTC) medicine	3	1
Monitoring/follow-up of medicine use	1	0
Other	9	4
Missing	1	0
Total	**218**	**100**

Table 3: Incidents involving bowel cleansing solutions by degree of harm

Base: All medication incidents involving bowel cleansing medication in the RLS as at 06 January 2009

Degree of Harm	Number	Per cent
No Harm	157	72
Low	46	21
Moderate	14	6
Severe	1	0
Total	**218**	**100**

Table 4: Incidents involving bowel cleansing solutions by location

Base: All medication incidents involving bowel cleansing medication in the RLS as at 06 January 2009

Location	Number	Per cent
General/acute hospital	205	94
Community hospital	5	2
Mental health unit/facility	4	2
Residence/home	2	1
Primary care setting	1	0
Other	1	0
Total	**218**	**100**

It should be noted that while Table 4 should represent the location in which the incident occurred, at times the location may incorrectly be reported as the location in which the incident was identified or reported from. Therefore it may not always represent the location where the initial system failure occurred.

Examples of incident types

Incident 1
Contra-indication for use
A patient was admitted pre-operatively for a morning theatre session.
The patient had been told in pre-assessment clinic that she was to have Picolax. This was confirmed by the pre-assessment nurse. One sachet of Picolax was given. The nurse then checked the notes and saw that the patient should not have received Picolax due to a history of diverticulitis.

Incident 2
Contra-indication for use
A patient telephoned to query the fact he had been sent Picolax and was anxious as he had had a sigmoid colectomy and ileostomy.

Incident 3
Contra-indication for use
Patient admitted for bowel prep for colonoscopy. I gave a verbal instruction for junior staff to give Clean - Prep not Fleet as high risk of renal failure. Despite this (1) Fleet prescribed (2) Fleet dispensed and given to the patient. Patient developed acute renal failure and remains an inpatient (currently inpatient for 12 days).

Incident 4
Wrong dose – procedure re-scheduled
Patient attended for colonoscopy. On admission patient stated he had only taken one sachet of Picolax as supplied, instead of usual 2 supplied . Discussed with endoscopist - patient to be rebooked due to inadequate bowel preparation.

Incident 5
Wrong drug prescribed
Patient given Picolax (twice) without reason. This was the wrong medicine for the planned operation.

Incident 6
Wrong drug and instructions
Wrong letter and preparation sent for a flexible sigmoidoscopy instead of for a gastroscopy procedure. Process being changed so that a nurse checks all bowel preparations prior to being sent out.

Incident 7
Managing administration with dysphagia
Patient has dysphagia and consequently has risk managed feeding (Long term. Puree and Grade 3 thickened fluid.) The patient was drinking Klean Prep, four jugs over 24 hours to prepare bowel for colonoscopy. He had finished 1.5 jugs. Patient was heard by Physio to be very chesty. It was the Physio's impression that the patient had aspirated Klean Prep. The Klean Prep appeared very difficult to thicken with Thick and Easy. Also four jugs is a high volume for a ' Risk Managed Feeding' patient to drink, with the risk of tiring of swallow and aspiration to lungs.

Incident 8
Patient information and management of concurrent clinical conditions and medication
Patient with known Type 2 diabetes on combined triple oral hypoglycaemic agents and warfarin was admitted from home via A+E with mild dehydration and symptomatic hypoglycaemia causing dizziness and unsteadiness. Due for colonoscopy on 8.7.08. Hypoglycaemia related to bowel prep with background of previously tight glycaemia control. Dose of sulphonylurea not reduced prior to admission. Unclear what advice given to patient regarding dose adjustment or whether Endoscopy team aware of previous low HbA1C (below 7% Sept 07). Clearly documented plan to omit warfarin and presence of diabetes identified on Endoscopy sheet but no record of advice given re other drugs. Patient not entirely clear re his own diabetes managment.

Incident 9
Omitted fluids
Pt under going major bowel surgery the following day - bowel preparation given as prescribed however no intra venous fluid replacement given overnight to aid maintenance of electrolyte balance despite ward staff being aware of pre - op bowel preparation regime.

Incident 10
Omitted fluids
Patient was admitted to the ward for bowel preparation prior to investigations. Preparation consisted of Picolax and Kleen-Prep. Investigations were endoscopy and colonoscopy. Frail 85 yr old lady, no IV prescribed despite fasting. Unwell with prep - dizzy and hypotensive, IV therefore introduced.

Incident 11 – Paediatrics (9 year old)
Delayed treatment
Patient who was to undergo colonoscopy was given Picolax at home as prescribed before admission. Patient vomited it out and another dose was given which was also vomited back out. Patient only had one bowel movement and colonoscopy was abandoned. Diagnosis and treatment were delayed.

1.2 Adverse drug reaction data

A review of the Medicines and Healthcare products Regulatory Agency's (MHRA) quantitative data on suspected adverse drug reactions (Drug Analysis Prints, 1963 to 2005) showed a wide range of reported reactions for a variety of bowel cleansing medicines.

Eleven fatal outcomes were reported and associated with the following, cited as potentially single or associated cause. One case was reported for each of the following:

- Small intestine perforation
- Large intestine perforation
- Diverticular perforation
- Intestinal infarction
- Gastro-intestinal obstruction
- Volvulus of bowel
- Peritonitis
- Acute pancreatitis
- Cardiac arrest
- Respiratory failure
- Subarachnoid haemorrhage.

Additionally, there were 44 reports of electrolyte imbalance or dehydration.

The limitations of these data should be noted as further detail and context is not provided.

1.3 Professional body notification

In 2001 the Royal College of Radiologists issued a letter to members and fellows following the collapse of a patient due to hypokalaemia when a bowel cleansing solution was taken concurrently with diuretics. This letter reinforced the need for clinical checks for contra-indications and the provision of information to patients.(1)

1.4 Medical literature

Product information for these preparations cites contra-indications for the use of these types of preparation and side effects which include electrolyte disturbances described as occurring 'less frequently'.(2)

The literature cites many studies comparing and contrasting different types of bowel preparation products and side effects are frequently reported.

In 1997 the British Medical Journal (BMJ) printed two letters reporting serious side effects following home use of these medicines.(3)

The first of these publications described two separate incidents requiring hospitalisation. The first patient was an 85 year old woman who presented with a score on the Glasgow coma scale of 5/15 and a tonic clonic seizure, having drunk some five litres of water with the sodium picosulphate the previous day (patients receive typed instructions saying "drink plenty of clear fluids").

The second patient was admitted the day after bowel preparation with sodium picosulphate. She presented with diarrhoea and vomiting and was fluid depleted. Her score on the

Glasgow coma scale was 6/15 and she had twitching of her lips. On admission her serum sodium concentration was 121 mmol/l, having been 142 mmol/l two months previously.

The second letter describes a clinical team's investigation following a number of cases of hypotension associated with taking bowel preparation medicines. They describe the haemodynamic effects of these products causing changes to heart rate and postural hypotension. Two of the frailest patients required resuscitation prior to surgery.(4)

In 2002 the Australian Adverse Drug Reactions Advisory Committee (ADRAC) published a bulletin advising of 16 reports of adverse drug reactions implicating sodium picosulphate.

Five reports described convulsions associated with hyponatraemia and syncope had been reported with both hyponatraemia and hypokalaemia. There were also single reports of unconsciousness with hyponatraemia, metabolic alkalosis with hypokalaemia and four of syncope and dehydration without documented electrolyte abnormalities. The bulletin advises that low volume sodium phosphate and sodium picosulfate products can cause marked dehydration, hyponatraemia, and other electrolyte abnormalities and associated complications. Infants, the elderly, the frail and those with congestive heart failure or compromised renal function are particularly at risk.(5)

Evidence on effectiveness and practice

2. Clinical information

This is a summary of some of the information contained in manufacturers Specification of Product Characteristics (SPC) for bowel cleansing solutions. The SPC for the individual bowel cleansing preparation should be read before prescribing or use and the risks noted and assessed for the individual patient and associated known and/or suspected clinical condition(s).

2.1 Contra-indications for the use of bowel cleansing solutions

- Use in patients with known or suspected gastrointestinal obstruction or perforation, ileus, gastric retention, acute intestinal or gastric ulceration, toxic colitis or toxic megacolon.
- Severe acute inflammatory disease.
- In patients with severely reduced renal function, accumulation of electolytes contained in the bowel cleansing medicines may occur in plasma e.g. when using Picolax an accumulation of plasma magnesium may occur. Another preparation should be used in such cases.
- Congestive heart failure.
- Difficulty swallowing.
- Reduced levels of consciousness.
- Hypersensitivity to any of the ingredients.

2.2 Special warnings and precautions

- The presence of dehydration should be corrected before use.
- In debilitated fragile patients, patients with poor health, those with clinically significant renal impairment and those at risk of electrolyte imbalance, the physician should consider performing a baseline and post-treatment electrolyte and renal function test.
- Use with caution in patients on drugs that might affect fluid balance e.g. lithium.
- Care should be taken with patients already receiving medicines which may be associated with hypokalaemia (such as diuretics or corticosteroids, or medicines where hypokalaemia is a particular risk i.e. cardiac glycosides).
- The period of bowel cleansing should not exceed 24 hours because longer preparation may increase the risk of water and electrolyte imbalance.
- An inadequate oral intake of water and electrolytes could create clinically significant, deficiencies, particularly in less fit patients. In this regard, the elderly, debilitated individuals and patients at risk of hypokalaemia may need particular attention.
- Caution is also advised when bowel preparations are is used in patients taking non steroidal anti-inflammatory medicines or medicine known to induce Syndrome of Inappropriate Anti-diuretic Hormone Release (SIADH) e.g. tricyclic antidepressants, selective serotonin re-uptake inhibitors, antipsychotic drugs and carbamazepine as these medicines may increase the risk of water retention and/or electrolyte imbalance.
- Bowel cleansing medicine may modify the absorption of regularly prescribed oral medication. The absorption of other orally administered medicines (e.g. anti-epileptics, contraceptives, anti-diabetics, antibiotics) may therefore be modified during the treatment period.
- Care should also be taken in patients who have recently undergone gastrointestinal surgery.
- Specific information concerning the preparation and dose of specific bowel cleansing products for children are available in the manufacturers SPC. Special attention needs to be taken in communication this information to parents and carers and confirming their understanding.

2.3 Overdose

Overdosage with bowel cleansing medicines will lead to profuse diarrhoea. Treatment is by general supportive measures and maintenance of fluid intake.

2.4 Information for patients

- Information provided to patients should be clear and unambiguous and tailored to the needs of the individual patient. The specific administration information needs of high risk groups, for example young and elderly patients, should be catered for. It is unlikely that manufacturer's Patient Information Leaflet (PIL) alone will meet the individual needs of all patients. Suggested areas for inclusion include;
- Oral medication should not be taken within one hour of administration of bowel cleansing preparations as it may be flushed from the gastro-intestinal tract and not absorbed.
- No solid food should be eaten for at least two hours before taking bowel cleansing preparations.

- Diarrhoea is an expected outcome of bowel preparation. Please be sure that you have ready access to a toilet at all times following each dose, before the effects wear off.
- Drink plenty of clear fluid, preferably water, throughout the treatment. An indication of maximum and minimum volumes and type of fluid to be taken should be included and tailored to the patient's needs and condition.
- Side effects include nausea, vomiting, bloating, abdominal pain, anal irritation and sleep disturbance.
- Vomiting and severe diarrhoea can lead to fluid loss (dehydration) with dizziness headache and confusion without proper fluid and salt replacement.
- Allergic reactions including rash, itchy, redness and swelling should be reported.
- Appropriate checks should be put in place to ensure that patients and/or their carers fully understand the information and directions provided for the use of these medicines.

Conclusions and actions for staff

Whilst in the majority of cases the use of bowel cleansing solutions occurs without harm or incident, the NPSA has identified risks and weaknesses in the current system for the supply of bowel cleansing medicines, in particular to vulnerable patients. These weaknesses do not enable the necessary clinical checks to be undertaken and patients are not always receiving sufficient and clear information to assist with safe use.

Staff from the NHS have reported 218 incidents to the RLS and fatalities have been reported via other bodies and agencies.

The Rapid Response Report [NPSA/2009/RRR012] outlines clear actions for the service to minimise risks of using bowel cleansing medicines. This has been issued through the Department of Health's Central Alert System (CAS) in England and directly to organisations in Wales. It applies to all organisations in the NHS and independent sector where bowel cleansing medicines are used.

The deadline date for actions complete is six months after the date of issue. This implementation period takes into account the potential for cross healthcare sector/boundary discussions and agreements to be secured.

In England, compliance with the recommendations should be entered on CAS by CAS liaison officers. To assist organisations in implementing these actions, a checklist is given in Appendix 1 which can be adapted for local use. These actions should help to ensure the safety of patients using bowel cleansing medicines by standardising practice and clarifying roles and responsibilities.

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Appendix: Suggested compliance checklist

Note that actions apply to all organisations where bowel cleansing medicines are used. Primary care trusts and local health boards have responsibilities to ensure that the contents of the Rapid Response Report are communicated to relevant independent contractors, who should be aware of the risks and take the necessary action outlined in this RRR.

No	Recommendation	Action	Compliance Y/N
RRR012/1	A clinical assessment is undertaken by the clinician ordering the surgical or investigative procedure (including GPs using the direct access route) to ensure that there is no contra-indication or special precaution for the use of a bowel cleansing solution.	Review arrangements for the prescribing and supply of bowel cleansing solutions to ensure that roles and responsibilities are clear, agreed and documented, in particular, across healthcare boundaries Update local policy and procedures Date approved by clinical governance group(s)	
RRR012/2	Use of a bowel cleansing solution is authorised by the clinician at the same time as the surgical or investigative procedure is ordered. This may be done by using the same form.	Review arrangements for the prescribing and supply of bowel cleansing solutions to ensure that roles and responsibilities are clear, agreed and documented, in particular, across healthcare boundaries Update local policy and procedures Update investigation request form to enable clinical authorisation of bowel cleansing solution Date approved by clinical governance group(s)	
RRR012/3	The clinician requesting the surgical or investigative procedure, and authorising the use of the bowel cleansing solution, is responsible for ensuring that an explanation on the safe use of the medicine is provided to the patient or carer.	Review arrangements for the prescribing and supply of bowel cleansing solutions to ensure that roles and responsibilities are clear, agreed and documented, in particular, across healthcare boundaries and in relation to information provided to the patient/carer. Ensure that information is available to assist with explaining safe use and taking account of individual patient factors. Update local policy and procedures Date approved by clinical governance group(s)	

RRR012/4	A safe system exists that involves an authorised clinical professional in the supply of the bowel cleansing solution and written information is available for each patient.	Review arrangements for the prescribing and supply of bowel cleansing solutions to ensure that roles and responsibilities are clear, agreed and documented, in particular, across healthcare boundaries Update local policy and procedures Provide written information materials for patients Date approved by clinical governance group(s)	
RRR012/4a	Ensure storage and supply comply with medicines regulations.	Where applicable, review local arrangements for storage (mainly applicable to the acute sector) and ensure that arrangements for supply comply with medicines regulations. Update local policy and procedures Date approved by clinical governance group(s)	
Written information should be made available to patients, carers and healthcare professionals and incorporate the following:			
RRR012/4b	Information is available for the patient, carer or healthcare staff to enable them to assess whether it is still safe to use the bowel cleansing solution just prior to administration (i.e. in case of delay between prescribing and administration during which the patient's condition may have changed/deteriorated)	Update/provide written information for use by the patient/carer at home or healthcare staff enabling an assessment of the patient's condition just prior to use Date approved by clinical governance group(s)	
RRR012/4c	Information concerning the safe preparation and administration of the medicine.	Update/provide written information Date approved by clinical governance group(s)	
RRR012/4d	Contact information to obtain the advice of a clinical professional if needed.	Update/provide written information Date approved by clinical governance group(s)	
Other implementation considerations:			
A	Communication to health care staff about the new arrangements for bowel cleansing solutions	Communication plan Date plan approved by clinical governance group(s)	
B	Evaluation plan – how the organisation will confirm that safer systems for the use of bowel cleansing solutions have been implemented. This will involve; - Checking staff and patient awareness - Audit of procedures in practice - Review of incidents where the safe system has not operated	Evaluation plan Date plan approved by clinical governance group(s) Review date set	

The Association for Coloproctology of Great Britain and Ireland for The Royal College of Surgeons

BRITISH SOCIETY OF GASTROENTEROLOGY ENDOSCOPY

British Society of Gastrointestinal & Abdominal Radiology

Imaging, Intervention and Research in the care of patients with abdominal disease

THE RENAL ASSOCIATION founded 1950

The Royal College of Radiologists

Consensus Guidelines for the Prescription and Administration of Oral Bowel Cleansing Agents

The Association for Coloproctology of Great Britain and Ireland for The Royal College of Surgeons

The British Society of Gasteroenterology

The British Society of Gastrointestinal and Abdominal Radiology

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INTRODUCTION

Oral bowel cleansing preparations are used before colonic surgery, endoscopic and radiological assessment of large and small intestine to minimise faecal contamination. In general, these preparations are safe and well tolerated. However, in February 2009, the National Patient Safety Agency (NPSA) issued a Rapid Response Report alerting healthcare providers to the potential risk of harm associated with the use of oral bowel cleansing preparations.[1] These risks included harm as a result of prescription of bowel preparation to patients in whom there was a definite contraindication (eg, presence of ileostomy; bowel obstruction); renal failure as a result of phosphate nephropathy; complications of hypovolaemia; and electrolyte disturbances including hypokalaemia, hyponatraemia, and hypermagnesaemia. Although there are no reliable estimates of the frequency of each of these complications, it is reasonable to put systems in place to reduce the risk of complications so long as this response is proportionate and does not greatly add to the complexity or cost of investigation.

The NPSA Report instructed Trusts that safeguards should be implemented at a local level to reduce this risk, and specifically required that all Trusts ensure that a clinical assessment of each patient for contraindications and risks occurs; that the use of a bowel cleansing preparation was authorised by a clinician; that an explanation on the safe use of the preparation was provided to the patient; and that a safe system exists for the supply of the preparation for each patient. This guidance has been prepared to help in the first of these recommendations, relating to clinical assessment. We believe that guidelines are necessary because the risk of complications depends on the choice of bowel preparation and on risk factors present in the individual patient, and there has been to date no definitive guidance on which preparation to use for which patients.

The guidelines do not include recommendations on incorporation of prescription of bowel cleansing agents into the request for investigation, nor do they cover the use of oral bowel cleansing agents in children or in pregnancy. While focused on colonic investigation, these guidelines may be also applied to use of bowel cleansing agents for radiological or endoscopic examination of the small bowel, where a reduced dose is typically administered compared to colonic examinations.

Although there are guidelines for bowel preparation prior to colonoscopy already in existence, they do not adequately address the risks identified by the NPSA.[2]

Methodology and Terms of Reference

These recommendations are based on consensus between the authors, each of whom circulated drafts to members of their specialist society. Given the timescale imposed by the NPSA (requiring implementation of the recommendations in the Rapid Response Report by 7 September 2009), we have not performed a systematic review nor adhered in full to the guideline development methodology recommended by the National Institute for Health and Clinical Excellence (NICE). There was no representation from patient groups or from the pharmaceutical industry. The companies that market the products discussed have not been consulted for their views; some of our recommendations go beyond the Summary of Product Characteristics. The evidence for these recommendations has been assessed using the modified GRADE system.[3,4] The modified GRADE system first defines the strength of the recommendations of guideline authors; expert recommendations are graded as 'strong' (Grade 1) or 'weak' (Grade 2) balanced by benefits and risks, burden and cost. Secondly, the quality or level of evidence upon which the recommendation is based is designated as high (Grade A), moderate (Grade B), low (Grade C) or very low (D), depending on study design and consistency of results. Grades of recommendation and quality of evidence may therefore range from 1A to 2D (see Appendix 1).

The NPSA supports these guidelines (Appendix 2) and we hope that NICE will develop guidelines to cover this topic in the near future.

Conflicts of interest

None of the authors have any conflict of interest to declare.

BACKGROUND

Bowel cleansing agents available for use

A number of different oral bowel cleansing agents are currently available in the UK, including:[5]

- **Klean Prep®** (Norgine); polyethylene glycol
- **Moviprep®** (Norgine); polyethylene glycol
- **Fleet Phospho-Soda®** (De Witt); sodium dihydrogen phosphate dehydrate and disodium phosphate dodecahydrate
- **Picolax®** (Ferring); sodium picosulphate and magnesium citrate
- **Citrafleet®** (De Witt); sodium picosulphate and magnesium citrate
- **Citramag®** (Sanochemia); magnesium carbonate and citric acid.

The ideal oral bowel cleansing agent would be convenient to administer, well tolerated, effective in cleansing, with an acceptable side-effect profile. No single agent is ideal in all clinical scenarios, and research into the ideal agent (or combination) continues. The different oral bowel cleansing agents available in the UK are summarised in Appendix 3.

Polyethylene glycols (macrogols) are non-absorbable isosmotic solutions that pass through the bowel without net absorption or secretion. Significant fluid and electrolyte shifts are therefore attenuated. The preparations must be diluted in large volumes of water (up to 4 L) to achieve the desired cathartic effect, and often carry an unpalatable taste (despite flavourings). Compliance is better with divided-dose regimens (for example, the initial 2–3 L on the night prior to the procedure and the remaining 1–2 L the following morning).[6] Not all of the ingested water stays within the gut lumen; absorption of water can therefore lead to water intoxication in predisposed patients. Adequate bowel preparation can be achieved within 12 hours with Moviprep®, which is a significant advantage. Pretreatment with domperidone or metoclopramide to facilitate gastric emptying may be considered.

Conversely, oral sodium phosphate preparations are hyperosmotic and promote colonic evacuation by drawing large volumes of water into the colon (1–1.8 L of water per 45 ml of preparation).[7] They are typically diluted in much smaller volumes of water than the polyethylene glycols (approximately 250 ml). Sodium phosphate preparations have been compared to polyethylene glycols in numerous studies and have generally been found to be safe, equally or more effective, and consistently better tolerated.[8–12] One meta-analysis of eight controlled trials concluded that an ‘adequate’ preparation was equally likely with sodium phosphate or

polyethylene glycol preparations, but that an 'excellent' preparation was more likely with sodium phosphate preparations.[9]

Picosulphate is a prodrug that is metabolised within the bowel lumen to a stimulant that promotes peristalsis. It is often combined with magnesium salts (for example, in Picolax® or Citrafleet®), which act synergistically through their osmotic effects.[13,14] A dose sufficient to provide adequate bowel cleansing is usually diluted in a total of 300 ml of water. Data on efficacy of cleansing are mixed when compared with other agents.[15–20] It remains widely used for bowel preparation for radiological procedures.[21–24]

Preparations of magnesium carbonate with citric acid, such as Citramag®, are osmotic saline agents that require only 200 ml of water as a diluent. Magnesium salts are well tolerated and effective, and have been reported to be used to prepare the bowel in one in every three colonoscopies undertaken in the UK.[25]

Some types of bowel preparation leave a significant amount of watery residue in the gut lumen which is not a problem for endoscopic or surgical procedures. However, this may interfere with mucosal visualization at CT colonography and barium enema and these laxatives are usually avoided for radiological imaging of the colon. Picolax® produces the 'driest' bowel; Citramag® is intermediate; and polyethylene glycol preparations leave the highest amount of watery residue. The choice of agent therefore depends to some extent on which procedure the patient is being prepared for.

Bioavailability of some medications may be affected by bowel cleansing (eg, oral contraceptive pill). There is no evidence relating to bioavailability of immunosuppressive agents. Oral iron should be stopped at least five days before colonoscopy as it forms an adherent residue that interferes with mucosal visualisation.

Diabetic glycaemic control, particularly in patients with type 1 diabetes, can be problematic during the period of dietary restriction, requiring individualised advice from local diabetic specialists. Admission for intravenous glucose and insulin may be required in a small number of cases.

Preparations vary in the requirement for dietary restrictions; most require that a clear liquid or low residue diet should be followed for the 24 hours or longer prior to the procedure, but with Fleet Phospho-Soda® it is only necessary to avoid solid food during the dosing period.

Combinations of different bowel cleansing agents (eg, Picolax® and Klean Prep®, or combinations of senna granules with Citramag®), are used in some centres;[26] these regimens are beyond the scope of these guidelines.

Complications from bowel cleansing agents

When administered correctly, all of the preparations listed have been demonstrated to be safe for use in healthy individuals without significant co-morbidity, and to effect adequate bowel cleansing.[8,27–30] However, as hypertonic solutions, sodium phosphate preparations can cause major fluid and electrolyte shifts, and should generally be considered second line agents that should only be prescribed to patients without other co-morbidities (in particular, these preparations should be avoided in those with chronic kidney disease, congestive cardiac failure, liver failure, hypertension or patients taking renin-angiotensin blockers or diuretics) (Appendix 3).

Current practice for elective procedures is typically for patients to self-medicate oral bowel cleansing agents at home, often received through the post without formal screening of their co-morbidities, medications or hydration state. While the practice of self-medication at home should remain feasible for the majority of patients, it is clear that a screening process is necessary to ensure that patients at risk of harm from oral bowel cleansing agents are identified and prepared appropriately (Appendix 6).

1: Hypovolaemia

Patients receiving oral bowel cleansing agents are at risk of developing the complications of hypovolaemia and intravascular volume depletion – including syncope, myocardial ischaemia and acute kidney injury secondary to acute tubular necrosis. This risk is likely to be greatest with sodium phosphate preparations but also exists with sodium picosulphate; the risk of hypovolaemia is least with polyethylene glycol preparations.

2. Hypokalaemia

Hypokalaemia can occur for two reasons after bowel preparation: increased gastrointestinal loss of secreted potassium complicating the use of hyperosmotic and stimulant preparations, and, with the use sodium phosphate, increased urinary loss as a result of hyperphosphaturia.[31] Co-administration of a carbohydrate-electrolyte solution with sodium phosphate has been reported to reduce the risk of hypokalaemia.[32]

3. Hyponatraemia

The ingestion of large volumes of water, particularly in the context of reduced free water clearance, also predisposes patients to hyponatraemia (a risk that was highlighted specifically in the NPSA Rapid Response Report). Macrogols involve the ingestion of up to 4 L of water, but are designed to be isotonic. The risk of hyponatraemia is probably highest when large volumes of water are ingested (as a result of over-zealous adherence to advice to 'drink plenty of fluids') to offset water loss into the colon caused by oral sodium phosphate and sodium picosulphate preparations,[33] but hyponatraemia has also been reported after use of macrogols.[34]

4. Phosphate nephropathy

Acute phosphate nephropathy is an increasingly reported but under-diagnosed cause of chronic kidney disease,[35,36] which may occur in up to 1 in 1,000 patients who receive sodium phosphate preparations.[35] Oral sodium phosphate preparations provoke a transient mild hyperphosphataemia,[8] which is most profound in elderly subjects.[37] This is rarely associated with untoward events and may reflect the normal reduction in glomerular filtration rate (GFR) with advancing age. For this reason, the recommendations in this document are based on GFR and not on age. However, other factors which promote hyperphosphataemia predispose patients to acute phosphate nephropathy, such as inappropriate phosphate dosing, increased bowel transit time, and a reduced ability to excrete a phosphate load (such as renal impairment).[38] Factors promoting tubular precipitation of calcium phosphate also predispose to acute phosphate nephropathy and include inadequate hydration during phosphate administration, hypertension with arteriosclerosis, and medications including non-steroidal anti-inflammatory drugs, diuretics and renin-angiotensin inhibitors.[36] Heart failure, cirrhosis and advancing age are additional risk factors.[39,40]

Recent concerns over acute phosphate nephropathy are reflected in changes made to the availability of oral sodium phosphate preparations by the United States Food and Drug Administration. These preparations are no longer available as over-the-counter medications for oral bowel cleansing, and those sodium phosphate preparations available as over-the-counter laxatives now carry a Boxed Warning.[41]

5. Hypocalcaemia

Hypocalcaemia is a direct result of hyperphosphataemia and occurs in all patients who receive oral sodium phosphate. Hypoparathyroidism is a risk factor for severe hypocalcaemia in this situation.[31]

6. Hypernatraemia

Hypernatraemia is uncommon, but can occur as a result of the sodium load in oral sodium phosphate preparations in combination with inadequate water intake.[31]

Is a bowel cleansing agent required?

Oral bowel cleansing agents have traditionally been prescribed (predominantly on the basis of observational data and expert opinion) prior to elective colorectal surgery in an effort to reduce the likelihood of surgical complications arising from anastomotic leakage. However, opinion is increasingly divided on the merits of bowel preparation in this context. There is an increasing body of evidence to suggest that bowel preparation is not required for most procedures. Two recent trials are particularly noteworthy. Firstly, in a trial randomising over 1,300 patients, Jung *et al* found no appreciable difference in clinical anastomotic leaks and intra-abdominal abscesses between those patients receiving bowel preparation or no bowel preparation (2.6% vs 4.3%, effect difference 1.7%, 95% CI 0.7–2.7).[42] Similar conclusions were reached by Contant *et al*, who randomised 1,431 patients undergoing elective colorectal surgery to receive an oral bowel cleansing agent (polyethylene glycol or oral sodium phosphate) or no bowel preparation.[43] While the rate of intra-abdominal abscesses was slightly higher in the group not receiving bowel preparation (4.7% vs 2.2%, p=0.02), the general incidence was low. All other endpoints (mortality, length of hospital stay, re-intervention rate) were similar among the two groups.

At present, patients who undergo abdominoperineal excision of the rectum, right hemicolectomy, total proctocolectomy and ileo-anal pouches, are generally not prescribed oral bowel cleansing agents. However, oral bowel cleansing agents are used more widely in patients undergoing anterior resection and left-sided resections. Postoperative rapid recovery programmes are being increasingly employed and usually avoid bowel preparation. In the light of these uncertainties, we recommend that the prescription of oral bowel cleansing agents is discussed with the patient.

In patients requiring bowel investigation, with co-morbidity that may increase the risk of complications from bowel preparation, it is worth considering the role of investigations that require minimal or no formal bowel purgation. CT colonography with faecal tagging is an area of growing clinical interest and research, using iodinated or barium-based contrast to mark faeces in the colon. It is an effective method of diagnosing and excluding colon cancer and other colonic diseases and potentially avoids the complications of bowel preparation. CT colonography is likely to have an increasingly prominent role in the future, particularly if bowel purgation can be avoided.

Gastrografin® is commonly used for small bowel studies (for instance, the investigation of postoperative ileus) and sometimes for CT colonography. It is hyperosmolar and, when used undiluted and/or with high doses, may cause an osmotic diarrhoea. Recommendations on its use are beyond the scope of these guidelines, but clinicians should be aware of the potential risk of causing hypovolaemia.

Finally, these guidelines are intended to reduce the risk of complications from the use of oral bowel cleansing agents, but they do not address *every* situation and are not a substitute for sound clinical judgement.

SUMMARY OF GUIDELINE STATEMENTS

1. Absolute contraindications to the use of oral bowel cleansing agents.

2. The choice of oral bowel cleansing agent.

3. The administration of oral bowel cleansing agents. (3.1–3.6).

4. Relative contraindications: circumstances in which the choice of a particular oral bowel cleansing agent or administration protocol may confer significant benefits.

- 4.1 Chronic kidney disease (4.1.1–4.1.8)
- 4.2 Haemodialysis patients (4.2.1–4.2.2)
- 4.3 Peritoneal dialysis patients (4.3.1–4.3.2)
- 4.4 Renal transplant patients (4.4.1–4.4.2)
- 4.5 Congestive cardiac failure (4.5.1–4.5.2)
- 4.6 Liver cirrhosis and/or ascites (4.6.1)
- 4.7 Patients taking particular medications
  - 4.7.1 Renin-angiotensin blockers
  - 4.7.2 Diuretics
  - 4.7.3 Non-steroidal anti-inflammatory drugs
  - 4.7.4 Medications known to induce the Syndrome of Inappropriate ADH secretion

5. Areas in which further research is needed.

GUIDELINE STATEMENTS

1. The following conditions are absolute contraindications for the use of all oral bowel cleansing preparations:

- Gastrointestinal obstruction or perforation, ileus, or gastric retention
- Acute intestinal or gastric ulceration
- Severe acute inflammatory bowel disease or toxic megacolon
- Reduced levels of consciousness
- Hypersensitivity to any of the ingredients
- Inability to swallow without aspiration (in this situation a nasogastric tube may be used for administration)
- Ileostomy

Grade 1D

2. The choice of oral bowel cleansing agent

Magnesium salt preparations should be avoided in patients with stage 4 and 5 chronic kidney disease (see Appendix 4 for the definition of chronic kidney disease). *Grade 2D*

Sodium picosulphate preparations should be avoided in patients at risk of, or suffering from, hypovolaemia, including those patients taking high-dose diuretics, those with congestive cardiac failure and advanced cirrhosis, and those with chronic kidney disease.

The use of oral sodium phosphate preparations is strongly discouraged in patients with chronic kidney disease, pre-existing electrolyte disturbances, congestive cardiac failure, cirrhosis or with a history of hypertension. *Grade 1C*

The use of oral sodium phosphate preparations in otherwise healthy patients is currently acceptable in cases where sodium picosulphate, magnesium salts and polyethylene glycols are contraindicated or have proven ineffective or intolerable. *Grade 2C*

3. The administration of oral bowel cleansing agents

3.1 The appropriate doses of oral bowel cleansing preparations should not be exceeded. *Grade 1C*

Where sodium phosphate preparations are prescribed, modification of the standard dose (two 45 ml doses 9–12 hrs apart) to a 45 ml dose followed by a 30 ml dose should be considered. *Grade 1C.* The latter regime provides equally effective bowel cleansing but a significantly lower serum phosphate level.[44] Furthermore, increasing the interval between doses to 24 hours reduces the incidence of clinically relevant hyperphosphataemia (>2.1 mmol/L) without compromising efficacy.[45] **Therefore, when administering sodium phosphate preparations, a regime of a 45 ml dose followed by a 30 ml dose 24 hours later should be used.** *Grade 2C*

3.2 The period of bowel cleansing should never exceed 24 hours. *Grade 1C*

To improve both tolerability and efficacy, consideration should be given to splitting the dose of oral bowel cleansing agent over 12 hours when polyethylene glycol preparations are utilised. *Grade 2B*

3.3 Hypovolaemia must be corrected prior to administration of oral bowel cleansing preparations. *Grade 1C*

Patients with co-morbidities indicating a predisposition to hypovolaemia should be assessed prior to commencing administration of oral bowel cleansing agents. Patients at particular risk of hypovolaemia include (but are not limited to) those with chronic or severe diarrhoea, chronic vomiting, dysphagia, those with persistent hyperglycaemia and those taking high-dose diuretics (see Section 4.7.2). Admission to hospital for pre-hydration may be necessary. *Grade 2D*

Where intravenous fluid replacement is undertaken, isotonic fluid (for example, Hartmann's solution) may be preferable.[46] *Grade 2D*

3.4 Hypovolaemia must be prevented during administration of oral bowel cleansing preparations. *Grade 1C*

Patients should receive clear instructions regarding oral fluid intake and these instructions should also be provided in writing. *Grade 1D*

Some patients receiving polyethylene glycol may achieve adequate bowel preparation without consuming the full 4 litres of fluid that are generally suggested.[47] It is reasonable to advise patients to discontinue drinking fluids if their bowel motions become watery and clear. *Grade 2C*

Isotonic electrolyte oral rehydration solutions may be of benefit,[48,49] and should be considered in place of high water intake for patients at risk of hyponatraemia being prescribed sodium picosulphate or sodium phosphate. *Grade 2C*

Admission for intravenous fluid replacement should be considered in all patients who may be unable to maintain adequate oral intake at home (for example, the elderly and those with reduced mobility). *Grade 1C*

3.5 Renal function should be measured (using an estimated GFR from serum creatinine concentration) in all patients in whom the use of oral bowel cleansing agents is considered. *Grade 1C*

3.6 Advice regarding regular medications

Patients should be advised that their regular oral medications should not be taken one hour before or after administration of bowel cleansing preparations due to the possibility of impaired absorption. *Grade 1C*

Patients taking the oral contraceptive pill should be advised to take alternative precautions during the week following the administration of the oral bowel cleansing agent. *Grade 1C*

Patients in whom the possibility of a reduction in the absorption of their regular medications may prove catastrophic (for example, patients taking immunosuppression for transplants) may require admission for the administration of intravenous preparations. *Grade 2D*

Patients with diabetes mellitus receiving treatment with insulin will also require specific advice, which should be agreed locally so as to be consistent with local practice and guidance for management of diabetes mellitus while 'nil by mouth' or on reduced oral intake.

4. The following conditions are relative contraindications for the use of oral bowel cleansing preparations; consideration should be given to the choice and manner of administration of oral bowel cleansing agent in accordance with the recommendations outlined below.

Polyethylene glycol is generally safer than sodium phosphate preparations for patients with electrolyte or fluid imbalances, as may be seen in conditions such as chronic kidney disease, congestive heart failure and liver failure.

Moviprep® requires a smaller total volume of fluid (3 L) to be consumed than Klean Prep® (4 L) and may be preferable in patients in whom the ability to ingest high volumes of fluid causes concern.

4.1 Chronic kidney disease (CKD)

Knowledge of an individual's excretory renal function is an essential consideration when identifying the most appropriate oral bowel cleansing preparation. Pre-existing CKD (sometimes unrecognised) is the single most important factor in the development of acute phosphate nephropathy in patients receiving oral sodium phosphate preparations.

4.1.1 Patients with Stage 3, 4 or 5 CKD (an eGFR less than 60 ml/min/1.73m^2) should not receive oral sodium phosphate preparations. *Grade 1C*

4.1.2 Patients with pre-existing electrolyte imbalances should not receive oral sodium phosphate preparations. *Grade 1C*

4.1.3 For patients with early CKD (Stages 1—3), polyethylene glycols, Picolax® and Citramag® are the preferred oral bowel cleansing agents. *Grade 1C*

4.1.4 In patients with Stage 4 or 5 CKD, who are not receiving dialysis, the use of either polyethylene glycol preparations or Picolax® may be considered. *Grade 2C*

4.1.5 Polyethylene glycol preparations may be preferable in those patients with Stage 4 or 5 CKD, who are not receiving dialysis, and who are expected to be able to tolerate the ingestion of the larger volumes of fluid required with these agents. Moviprep® requires a smaller total volume of fluid (3 L) to be consumed than Klean Prep® (4 L) and may be preferable these patients. *Grade 1D*

4.1.6 In patients with Stage 4 CKD, or patients with Stage 5 CKD who are not receiving dialysis, the use of Picolax® or Citramag® is associated with a small risk of magnesium accumulation and should therefore be reserved for those patients likely to be unable to tolerate the ingestion of the volume of fluid required to administer polyethylene glycol preparations. *Grade 2D*

4.1.7 In patients with Stage 5 CKD, who are not receiving haemodialysis, the use of Picolax® is associated with a small risk of magnesium accumulation and should therefore be reserved for those patients likely to be unable to

tolerate the ingestion of the volume of fluid required to administer polyethylene glycol preparations. *Grade 2D*

4.1.8 Due to the possibility of magnesium accumulation, the use of Citramag® and Citra-Fleet® should be avoided in patients with stage 5 CKD who are not receiving haemodialysis. *Grade 1D*

It should be noted that Klean Prep® is currently the only oral bowel cleansing agent available in the UK not stated to be absolutely or relatively contraindicated in CKD in the summary of product characteristics.

Subgroups of patients with CKD requiring further consideration include the following.

4.2 Patients undergoing chronic haemodialysis

4.2.1 Although acute kidney injury is rarely a concern in these patients, the possibility of intravascular depletion secondary to oral bowel cleansing agents has other implications in patients receiving chronic haemodialysis. Firstly, in those patients dialysing through arteriovenous fistulae or PTFE grafts, a period of intravascular depletion, if it causes hypotension, may risk causing thrombosis of the dialysis access. Secondly, the combination of dialysis (which is itself often associated with significant fluid and electrolyte shifts) and administration of oral bowel cleansing agents, may provoke more profound hypovolaemia than would otherwise occur. Furthermore, the significant oral fluid intake required with polyethylene glycol preparations may provoke fluid overload in anuric patients. For these reasons, each case should be considered on an individual basis, and the timing of dialysis sessions should be tailored to the situation. **Admission to hospital to co-ordinate and oversee dialysis prescription and administration of oral bowel cleansing agents may be necessary for some patients receiving chronic haemodialysis**. *Grade 2D*

4.2.2 Although contraindicated in Stage 4 and 5 CKD in pre-dialysis patients, sodium picosulphate and magnesium salts can be used safely as oral bowel cleansing agents in patients receiving haemodialysis. *Grade 2D*

4.3 Patients undergoing peritoneal dialysis

4.3.1 Peritoneal dialysis is generally associated with less significant fluid shifts than haemodialysis. Admission to hospital for administration of oral bowel cleansing agents is therefore less likely to be necessary for the majority of peritoneal

dialysis patients. However, a small proportion of patients undertaking peritoneal dialysis have a small but important degree of residual native renal function. This must be assessed on an individual basis. Measures to avoid significant fluid shifts and possible intravascular volume depletion are therefore important in this group. **Admission to hospital to oversee administration of oral bowel cleansing agents should be considered in those considered to have important residual renal function.** *Grade 2D*

4.3.2 Patients undertaking peritoneal dialysis should continue to dialyse in the normal way during the administration of the oral bowel cleansing agent. The dialysis fluid should be drained out prior to the procedure for which the bowel preparation has been prescribed.

4.4 Renal transplant recipients

4.4.1 These patients should not receive sodium phosphate preparations unless all the alternative agents are contraindicated. *Grade 1D*

4.4.2 Admission to hospital may be advisable on an individual patient basis when concerns exist over the absorption of immunosuppressants during concomitant administration of oral bowel cleansing agents. *Grade 2D*

4.5 Congestive cardiac failure

Congestive cardiac failure is associated with a reduction in renal blood flow and an associated fall in GFR; the ability of these patients to excrete a phosphate load is therefore reduced, leading to an increased risk of acute phosphate nephropathy. Furthermore, these patients are at particular risk of hyponatraemia caused by the combination of hypovolaemia and high water intake.

4.5.1 Macrogol preparations **are the preferred oral bowel cleansing agents in patients with congestive cardiac failure.** *Grade 2D*

4.5.2 Patients with significant congestive cardiac failure (NYHA Class III or IV, or an Ejection Fraction below 50%) should not receive oral sodium phosphate preparations. *Grade 1C*

Many medications commonly prescribed to treat heart failure require evaluation prior to administration of an oral bowel cleansing agent. For example, where possible, diuretics, angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers should be discontinued in accordance with the guidance below.

4.6 Liver cirrhosis and/or ascites

4.6.1 Cirrhosis has been identified as a possible risk factor for acute phosphate nephropathy. **Polyethylene glycol is the preferred oral bowel cleansing agent for use in patients with liver cirrhosis or ascites.** *Grade 2D*

4.7 Caution is advised in the administration of oral bowel cleansing preparations to patients taking certain medications.

4.7.1 Angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers

An increase in efferent glomerular arteriolar tone is an important physiological response to hypotension and/or volume depletion, enabling the GFR to be maintained. In the presence of angiotensin-converting enzyme inhibition, this compensatory response is ameliorated. Patients established on angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers are prone to deterioration in renal function during periods of hypovolaemia (eg, precipitated by oral bowel cleansing agents).

Furthermore, renin-angiotensin blockers also accentuate bicarbonaturia through inhibition of angiotensin II, enhancing alkalinisation of the urine. This promotes calcium and phosphate precipitation, increasing the risk of acute phosphate nephropathy in the presence of oral sodium phosphate preparations.[50]

Where possible, therefore, **renin-angiotensin blockers should be discontinued on the day of administration of oral bowel cleansing agents and not reinstated until 72 hours after the procedure.** *Grade 2D*

4.7.2 Diuretics

Diuretics may alter electrolyte balance and predispose to intravascular volume depletion. Therefore, as for all patients, **it is advised that a patient's hydration status is assessed prior to administration of oral bowel cleansing preparations in patients taking diuretics.**

Unless there is judged to be a significant risk of pulmonary oedema, **diuretics should be temporarily discontinued on the day of the administration of oral bowel cleansing preparation.** *Grade 1D*

4.7.3 Non-steroidal anti-inflammatory drugs (NSAIDs)

These medications reduce renal perfusion and therefore limit the kidneys' capacity to compensate for reduced renal perfusion through volume depletion. Where possible, therefore, **NSAIDs should be discontinued on the day of administration of oral bowel cleansing preparations and withheld until 72 hours after the procedure.** *Grade 1D*

4.7.4 Medications known to induce the Syndrome of Inappropriate Anti-diuretic Hormone (SIADH) secretion

These medications increase the risk of water retention and/or electrolyte imbalance, and include tricyclic anti-depressants, selective serotonin reuptake inhibitors, many anti-psychotic drugs and carbamazepine. While these medications need not be discontinued, **serum urea and electrolytes should be checked prior to administration of oral bowel cleansing preparations in patients taking these medications.** *Grade 2D*

AREAS REQUIRING FURTHER RESEARCH

1. Should the serum creatinine concentration be re-checked after a patient has received oral sodium phosphate, and when should this be undertaken?

Best practice remains unclear. Identification at a later date of non-progressive chronic kidney disease in a typical patient who has developed acute phosphate nephropathy (an elderly person with hypertension and minimal proteinuria) is unlikely to provide a strong indication for renal biopsy; the link between oral bowel cleansing preparation and renal impairment is less likely to be noticed as time elapses. A decision not to check the serum creatinine concentration following oral sodium phosphate preparations may lead to cases of acute phosphate nephropathy being missed. This may result in the patient receiving further sodium phosphate preparations. The optimal timing of such a blood test has not been established. Furthermore, it is unclear whether it should be undertaken in all patients receiving oral sodium phosphate preparations or simply those at higher risk for acute phosphate nephropathy. A cost–benefit analysis is also required.

2. How safe is the use of oral sodium phosphate preparations in patients without those co-morbidities currently identified as risk factors of acute phosphate nephropathy?

Given the current evidence base,[51–53] and their superior tolerability, the use of oral sodium phosphate preparations as oral bowel cleansing agents in patients without chronic kidney disease, congestive heart failure or liver failure probably remains acceptable. However, further studies are required to ascertain the true safety of sodium phosphate preparations as bowel cleansing preparations for screening investigations (which, by their nature, are often repeated over time) and in patients with very early (Stage 1 or 2) chronic kidney disease.

3. In the presence of predisposing conditions such as heart failure, what is the risk of acute electrolyte disorders with each preparation?

Hyponatraemia appears most likely to occur when predisposed patients drink large volumes of water, causing water intoxication, as a result of over-enthusiastic adherence to advice to drink ‘plenty of water’. Use of macrogols involves ingestion of up to 4 litres of fluid, but this is as an isotonic solution and as such, is designed not to cause electrolyte abnormalities. However, how effective these preparations are at preventing electrolyte disorders requires further study.

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APPENDIX 1: THE MODIFIED GRADE SYSTEM

Grade of Recommendation	Clarity of risk/benefit	Quality of supporting evidence	Implications for clinical practice
1A Strong recommendation. High quality evidence.	Benefits clearly outweigh risk and burdens, or vice versa	Consistent evidence from well performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.	Strong recommendations, can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless there is a clear rationale for an alternative approach.
1B Strong recommendation. Moderate quality evidence.	Benefits clearly outweigh risk and burdens, or vice versa	Evidence from randomized, controlled trials with important limitations (inconsistent results, methods flaws, indirect or imprecise), or very strong evidence of some other research design. Further research may impact on our confidence in the estimate of benefit and risk.	Strong recommendation and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1C Strong recommendation. Low quality evidence.	Benefits appear to outweigh risk and burdens, or vice versa	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain.	Strong recommendation, and applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality.
1D Strong recommendation Very low quality evidence	Benefits appear to outweigh risk and burdens, or vice versa	Evidence limited to case studies	Strong recommendation based mainly on case studies and expert judgement
2A Weak recommendation. High quality evidence.	Benefits closely balanced with risks and burdens	Consistent evidence from well performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.	Weak recommendation, best action may differ depending on circumstances or patients' or societal values
2B Weak recommendation. Moderate quality evidence.	Benefits closely balanced with risks and burdens, some uncertainly in the estimates of benefits, risks and burdens	Evidence from randomized, controlled trials with important limitations (inconsistent results, methods flaws, indirect or imprecise), or strong evidence of some other research design. Further research may change the estimate of benefit and risk.	Weak recommendation, alternative approaches likely to be better for some patients under some circumstances
2C Weak recommendation. Low quality evidence.	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain.	Weak recommendation; other alternatives may be reasonable
2D Weak recommendation Very low quality evidence	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens	Evidence limited to case studies and expert judgement	Very weak recommendation; other alternatives may be equally reasonable.

APPENDIX 2: STATEMENT OF SUPPORT FOR THE GUIDELINES BY THE NPSA

"The NPSA welcomes the helpful guidelines developed by independent clinical experts which provide additional information to help in reducing risks to patients. The NPSA issued a Rapid Response Report in response to the death of a patient with known contra-indications and reports of 218 other incidents relating to oral bowel cleaning preparations. A key recommendation was assessing the risks to patients (such as renal failure or pre-existing bowel conditions) before prescribing these medicines. Given the complexity of these decisions, weighing the evidence on individual preparations and particular risk factors for each patient, these practical clinical guidelines from experts following review of existing evidence and current practice are highly valuable. The NPSA alerted the service to the risks and the need for vigilance - these guidelines provide further detailed information for individual clinicians to make the safest decisions for their patients. We also support the case for further robust review of evidence by NICE on the effectiveness of particular preparations for specific groups of patients and conditions and to address gaps in current guidelines identified by this work."

APPENDIX 3: COMMENTS REGARDING POTENTIAL ADVANTAGES AND COMPLICATIONS OF INDIVIDUAL ORAL BOWEL CLEANSING AGENTS

Oral Bowel Cleansing Agent (OBCA)	Potential **advantages** of this OBCA	**Tolerability** and **ease of use**	Is a **low residue diet** advised prior to dosing?	Are there **complications** specific to this OBCA?*	Are there any **contraindications** specific to this OBCA?+
Picolax® or Citrafleet® (Sodium picosulphate & magnesium citrate)	Produces the lowest watery residue: potentially advantageous for radiological investigation.	Powder is reconstituted with a low volume of water. It then arms on mixing.	Yes	1. Higher risk of hyponatraemia (if excessive water ingestion) than with other OBCAs. 2. Risk of hypermagnesaemia in patients with advanced chronic kidney disease.	It is particularly important that patients with conditions predisposing to **hypovolaemia** are evaluated prior to receiving this OBCA.
Citramag® (magnesium carbonate and citric acid)	Produces a low watery residue (although not as low as Picolax®).	Powder is reconstituted with a low volume of hot water.	Yes.	1. Higher risk of hyponatraemia (if excessive water ingestion) than with other OBCAs. 2. Risk of hypermagnesaemia in patients with advanced chronic kidney disease.	It is particularly important that patients with conditions predisposing to **hypovolaemia** are evaluated prior to receiving this OBCA.
Klean Prep® (polyethylene glycol)	Less likely to cause hypovolaemia.	Powder is reconstituted with a high volume of water (up to 4 litres).	Yes.	*Lowest risk of provoking hypovolaemia and/or hyponatraemia.*	
Moviprep® (polyethylene glycol)	1. Less likely to cause hypovolaemia 2. Bowel preparation can be completed within 12 hrs.	Powder is reconstituted with a moderate volume of water (approx 2 litres).	Yes.	*Lowest risk of provoking hypovolaemia and/or hyponatraemia.*	G6PD deficiency.
Fleet Phosphosoda® (sodium phosphate)	Well tolerated.	A low volume of liquid (45 ml) is mixed with a low volume of water (120 ml).	No. It is sufficient to simply avoid solid food during the dosing period.	1. Acute phosphate nephropathy. 2. Hypocalcaemia resulting from hyper-phosphataemia. 3. Highest risk of hypovolaemia.	Should not be prescribed to patients with: 1. hypovolaemia 2. eGFR <60 ml/min/1.73m^2 3. hepatic cirrhosis 4. cardiac failure 5. hypertension 6. renin-angiotensin blockade … unless *all* other OBCAs are contraindicated.

* It should be remembered that the administration of ALL types of OBCA may be complicated by hypovolaemia and/or electrolyte disturbances (including hypokalaemia, hyponatraemia and hypernatraemia).

+ The following are absolute contraindications to ALL types of OBCA: gastrointestinal obstruction, perforation or ileus; acute intestinal ulceration; severe inflammatory bowel disease; reduced consciousness; hypersensitivity to any of the ingredients; ileostomy.

APPENDIX 4: THE CLASSIFICATION OF CHRONIC KIDNEY DISEASE

The diagnosis of chronic kidney disease (CKD) is based on two parameters. The first is the glomerular filtration rate (GFR). An estimated GFR (eGFR), calculated from the serum creatinine concentration, is commonly employed. To ensure that the impairment in renal function is chronic in nature rather than acute, the GFR should be calculated on two occasions over 90 days apart. The second parameter is the presence of markers of kidney damage, which include abnormalities evident on urinalysis (eg, proteinuria) or radiological investigation.

Stage	**Description**	**GFR mL/min/1.73m^2**
1	Kidney damage evident Normal or elevated GFR	>90
2	Kidney damage evident Mildly reduced GFR	60–89
3A	Moderately reduced GFR +/- documented kidney damage	45–59
3B	Moderately reduced GFR +/- documented kidney damage	44–30
4	Severely reduced GFR +/- documented kidney damage	15–29
5	Kidney failure +/- documented kidney damage	<15 or on dialysis

APPENDIX 5: ORAL BOWEL CLEANSING AGENT PATIENT ADVICE SHEET

The following Patient Advice Sheet is not intended to replace instruction sheets already in existence at a local level. Individual units may wish to use it alongside their existing instruction sheets, or to consider including the information it contains within their existing instruction sheets.

This Patient Advice Sheet provides information that is frequently omitted from the instructions provided by the manufacturers of the oral bowel cleansing agents. It is intended to augment these instructions, not to replace them.

Local contact details should be included on the template to allow patients to raise concerns or uncertainties.

AN ADVICE SHEET FOR PATIENTS WHO HAVE BEEN PRESCRIBED AN ORAL BOWEL CLEANSING AGENT.

You have been prescribed an oral bowel cleansing agent (sometimes also called a 'bowel prep'). Its role is to clear out your bowels. This is important to ensure the safety and effectiveness of the planned procedure. There is a risk of developing dehydration, low blood pressure or kidney problems with this medication. The doctor prescribing the oral bowel cleansing agent will have assessed your risk and identified the most appropriate medication for you. You should also have had a blood test to check your kidney function. A number of oral bowel cleansing agents are available. You should refer to the manufacturer's instructions when taking your preparation. However, the following rules apply in all cases.

The prescribed dose of oral bowel cleansing agent should not be exceeded. The oral bowel cleansing agent should not be taken over a period longer than 24 hours.

Oral bowel cleansing agents predispose to dehydration. You should maintain a good fluid intake whilst taking these medications. If you develop the symptoms of dehydration, and cannot increase your fluid intake, then you should seek medical attention. These symptoms include dizziness or light-headedness (particularly on standing up), thirst, or a reduced urine production.

You should follow any specific advice you have been given with regard to your regular medications. Medications that you may have been asked to temporarily discontinue include:

- ***Antihypertensives*** *(to lower your blood pressure) such as ACE inhibitors like Ramipril®*
- ***Diuretics*** *('water tablets', such as furosemide)*
- ***Non-steroidal anti-inflammatory drugs*** *(a type of pain killer, such as ibuprofen)*
- ***Iron preparations*** *(for anaemia, such as ferrous sulphate)*
- ***Aspirin, dipyridamole, clopidogrel or warfarin*** *(these agents thin your blood out; you may have been asked to discontinue them depending on the nature of the procedure that is planned).*

If you have not received specific advice regarding your regular medications then you should continue to take them as normal. However, you may need to amend the timing as it is preferable to avoid taking them less than one hour either side of any dose of oral bowel cleansing agent.

Patients taking immunosuppression for transplanted organs should seek the advice of their doctor before taking an oral bowel cleansing agent.

Patients taking the oral contraceptive pill should take alternative precautions during the week following taking the oral bowel cleansing agent.

If you experience problems, advice from a healthcare professional is available on (tel no).

ORAL BOWEL CLEANSING AGENT PRESCRIPTION CHECKLIST

This checklist is to be completed by the clinician authorising the oral bowel cleansing agent and should then be filed in the patient's medical records.

NAME ……
HOSPITAL NO. ……
Date of Birth ……

STEP 1: ABSOLUTE CONTRAINDICATIONS

GI Obstruction, ileus or perforation	Y / N
Severe IBD	Y / N
Toxic megacolon	Y / N
Reduced conscious level	Y / N
Hypersensitivity to any ingredients	Y / N
Dysphagia (unless via NGT)	Y / N
Ileostomy	Y / N

If yes to any question, do not continue.

STEP 2: Review the BLOOD RESULTS

Na …….
K …….
eGFR …….

eGFR 30-60 = CKD 3
eGFR 15-29 = CKD 4
eGFR 0-14 = CKD 5

STEP 3: Review MEDICATIONS

ACEi/ARB	Y/N	Safe to stop for 72 hrs?	Y/N
Diuretics	Y/N	Safe to stop for 24 hrs?	Y/N
NSAIDs	Y/N	Safe to stop for 72 hrs?	Y/N

STEP 4: Consider CO-MORBIDITIES & RISK FACTORS

Co-morbidities	Optimal	Acceptable	Avoid
Kidney Disease			
CKD 3	PEG / Picolax / Citramag		OSP
CKD 4	PEG (if fluid status allows)	Picolax / Citramag	OSP
CKD 5	PEG (if fluid status allows)	Picolax	OSP, Citramag
Haemodialysis	Discuss with nephrologist		
Peritoneal dialysis	Discuss with nephrologist		
Renal Transplant	Discuss with nephrologist		
Electrolyte Imbalance	PEG	Picolax / Citramag	OSP
Cardiac Failure	PEG	Picolax / Citramag	OSP
Liver Cirrhosis	PEG	Picolax	OSP
Hypertension	PEG / Picolax / Citramag		OSP

STEP 5: TYPE OF BOWEL PREP ISSUED?

Picolax / Citramag / Klean Prep / Moviprep / Fleet Phospho-soda

STEP 6: INSTRUCTIONS PROVIDED TO THE PATIENT

Verbally Y/N
Leaflet Y/N

STEP 7: OTHER COMMENTS

STEP 8:

SIGNATURE……

KEY **ACEi** Angiotensin converting enzyme inhibitors, **ARB** Angiotensin II Receptor Blockers, **CKD** chronic kidney disease, **OSP** oral sodium phosphate preparations (Fleet Phospho-soda), **PEG** polyethylene glycol (Klean Prep, Moviprep).

NHS
National Patient Safety Agency

Rapid Response Report

NPSA/2009/RRR012

From reporting to learning

19 February 2009

Reducing risk of harm from oral bowel cleansing solutions

Issue

Death and harm from electrolyte abnormalities, dehydration and serious gastro-intestinal problems have been reported following the inappropriate use of oral bowel cleansing solutions (Picolax®, Citramag® , Fleet Phospho-Soda®, Klean Prep®, Moviprep®) prior to surgery and/or investigative procedures. Frail and debilitated elderly patients, children and those with contraindications are particularly at risk from these treatments.

Harm from these medicines result from lack of clarity in relation to who is:
1) authorising the use of these medicines and is therefore clinically responsible for undertaking clinical checks and explaining their safe use to the patient and;
2) authorised to supply these products and is responsible for providing written information about their safe use to the patient or healthcare staff administering these medicines. Currently the supply of these medicines may only involve non-clinical staff (e.g. administrative staff) with inadequate safeguards to ensure safe use.

Evidence of harm

The NPSA has received one report of a death and 218 patient safety incidents involving the use of bowel cleansing solutions up to January 2009. The Medicines and Healthcare products Regulatory Agency (MHRA) has received 11 fatal outcome reports and 44 reports up to 2005. These reports indicate electrolyte imbalance or dehydration due to inappropriate fluid intake or use of these products where there is a clinical contraindication.

For IMMEDIATE ACTION by all NHS sectors and the independent sector where bowel cleansing solutions are used.

Deadline for ACTION COMPLETE is 7 September 2009.

An executive director, nominated by the Chief Executive, working with the lead pharmacist and relevant medical/nursing staff should put arrangements in place to ensure that:

- RRR012/1. A clinical assessment is undertaken by the clinician authorising the surgery or investigative procedure (including GPs using the direct access route) to ensure that there is no contraindication (e.g. clinical condition such as diverticulitis) or risks (e.g. concurrent medication such as diuretics) from the use of a bowel cleansing solution.
- RRR012/2. Use of a bowel cleansing solution is authorised by the clinician at the same time as the surgery or investigative procedure. This may be done by using the same form.
- RRR012/3. The clinician requesting the surgery or procedure and authorising the use of a bowel cleansing solution is responsible for ensuring that an explanation on the safe use of the product is provided to the patient or carer.
- RRR012/4. A safe system exists that involves an authorised clinical professional in the supply of the medicine and written information (including named contact) for each patient. See implementation checklist in supporting information for more details on this.

Further information

Additional information including incident data, clinical information and an implementation checklist to support this Rapid Response Report is available at www.npsa.nhs.uk/rrr. Further queries should be directed to Linda Matthew - Senior Pharmacist, c/o [Irrelevant redacted by the USI] telephone [Personal Information redacted by USI]

The NPSA has informed NHS organisations, independent sector, commissions, regulators and relevant professional bodies.

Southern Health and Social Care Trust

Summary of Medication Incident Reporting

Southern Health and Social Care Trust

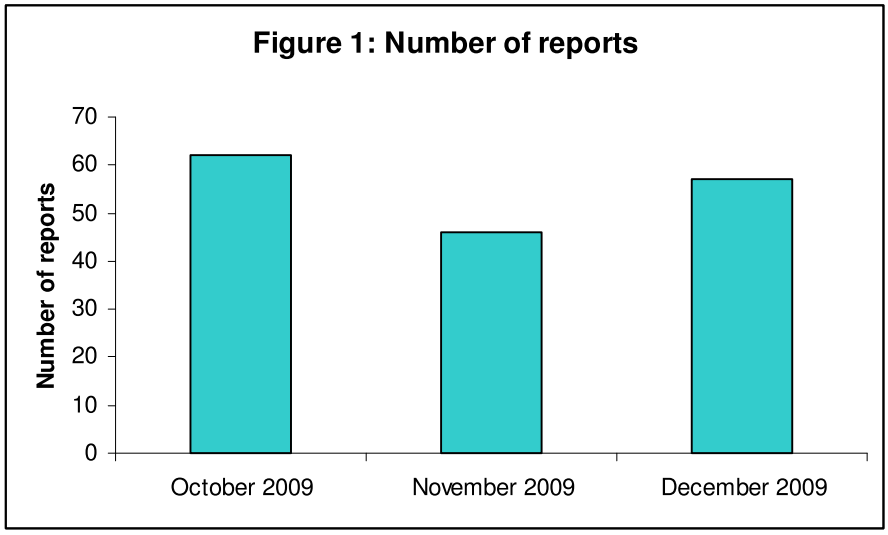
October to December 2009

Jillian Redpath
Medicines Governance Pharmacist

Contents

Reporting levels

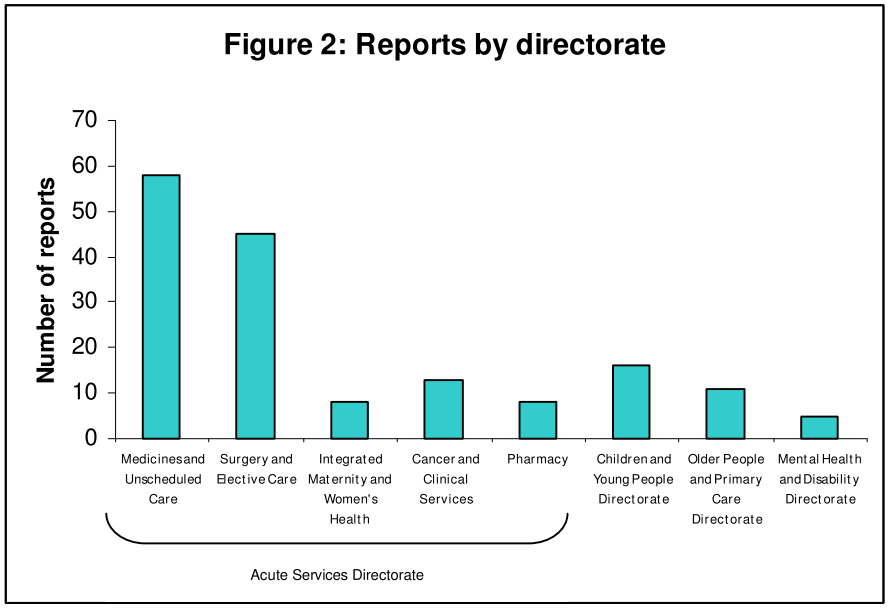
A total of 166 reports were received during the three-month period (Figure 1).



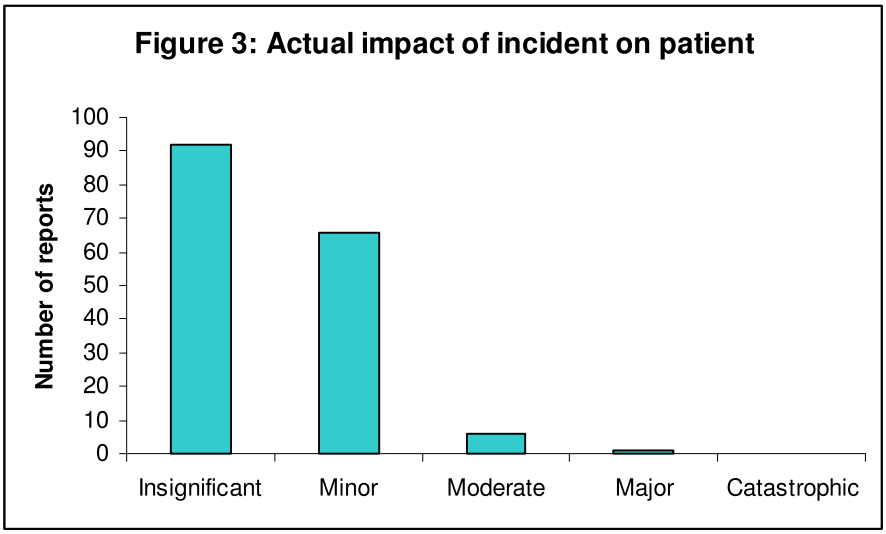
The average number of reports received each month was 55 per month, representing a decrease from 71 per month in the previous quarter.

Origin of reports

Most reports were received from the Acute Services Directorate (Figure 2).



Reported incidents



As can be seen in Figure 3, most reported incidents were of insignificant impact on patients.

Incidents resulting in minor impact on the patient, usually increased monitoring, included:

- Patient drowsy after administration of midazolam 5mg (1ml of 10mg/2ml) instead of prescribed dose of 1mg.
- Patient administered 25mg Oxycontin® instead of prescribed 15mg, dose had been recently changed.
- ECG and WCC checked after administration of another patient's medication that included clozapine.
- FBC and clotting checked after patient's line flushed with heparin 1,000 units/ml instead of intended heparin flushing solution 10 units/ml.
- Patient administered ciprofloxacin diluent for one week without having added ciprofloxacin to diluent to reconstitute.
- Patient not prescribed or administered doses of intravenous gentamicin for three days (over a weekend).
- Patient received three doses of pregabalin 75mg instead of prescribed 25mg dose after wrong strength dispensed.
- Epidural administered at 20ml/hur instead of intended 10ml/hour.
- Following 300mg loading dose of amiodarone, 900mg infusion commenced however rate not changed to new infusion and 900mg administered over 2 hours instead of 23 hours.
- Atropine administered via PICC line instead of subcutaneously.
- Approximately 20% underdose in chemotherapy for first and second cycle due to incorrect body weight used to calculate body surface area and doses.
- Gentamicin administered 12 hours earlier than prescribed.

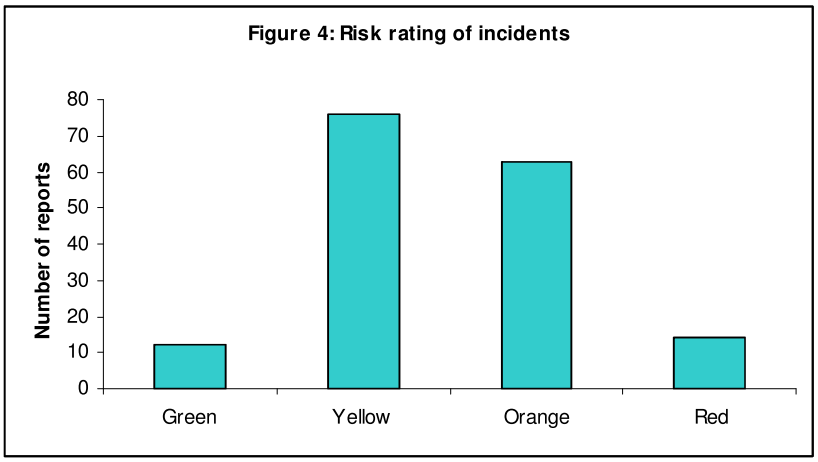
Incidents resulting in moderate impact on the patient included:

- Discharge delayed for 24 hours for monitoring after patient prescribed incorrect doses on admission and received for two days including clonazepam 5mg instead of usual 500 microgram dose and gliclazide MR 30mg od instead of usual 120mg od.
- Cyclizine prescribed for nausea after patient administered part of ampoule of neostigmine/glycopyrrolate instead of glycopyrrolate.
- Intravenous glucose administered in theatre after patient admitted on same day of surgery having taken usual dose on insulin despite fasting for previous 12 hours. Patient stated advised to take usual medication.

One incident resulting in major impact on the patient:

- Prescription and administration of lorazepam 4mg dose after which patient became unresponsive and required flumazenil.

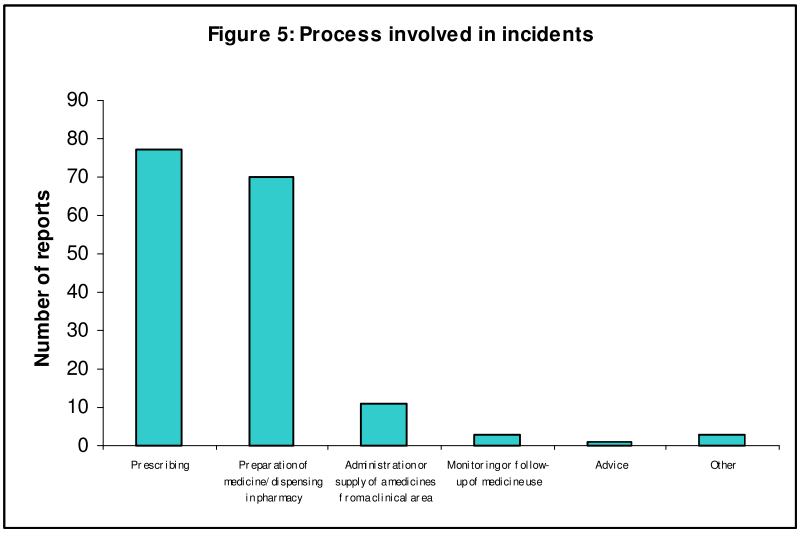
It is important to consider not only the actual impact of an incident upon the individual patient involved but also to assess the potential impact of the incident on a patient if it were to reoccur and the likelihood of reoccurrence. This assists with identifying the areas of highest risk in the use of medicines. The overall risk rating of the reported incidents is shown in Figure 4.



Examples of some other high-risk incidents include:

- Patient prescribed azathioprine 150mg qds instead of 150mg od.
- NKDA recorded in allergy box, patient penicillin allergic.
- Patient prescribed methotrexate 17.5mg once a day instead of 17.5mg once a week.
- Patient on 5 day course of cyclophosphamide and fludarabine, prescribed on discharge prescription to continue indefinitely.
- Patient admitted with increased frequency of seizures, prescribed another patient's medicines and not prescribed usual antiepileptics.

Incidents are categorised on the basis of the process involved: prescribing, preparation of medicines/dispensing in pharmacy, administration or supply of a medicine from a clinical area, monitoring or follow-up of medicine use and other (Figure 5).



Incidents are categorised based on the incident type. The classification system for incident type used in the trust has changed to the Datix system. The most common incident types for each process during the three-month period of reporting in Southern Health and Social Care Trust are shown below.

The latest available Northern Ireland Medication Incident Data is for the period from July to September 2009. The most common incident types for each process during that three-month period are also shown for information.

Southern Health and Social Care Trust (Oct - Dec 09)		Number of incidents	Northern Ireland (Jul – Sept 09)	
Prescribing			Prescribing	
1.	Other medication incident	32	1.	Other medication incident
2.	Dose or strength was wrong or unclear	23	2.	Dose or strength was wrong or unclear
3.	Frequency for taking medication was wrong	13	3.	Wrong drug/medicine
4.	Wrong drug/medicine	4	4.	Frequency for taking medication was wrong
5.	Mismatch between patient and medicine	3	5.	Medication prescribed to which patient had known allergy
Administration			Administration	
1.	Frequency for taking medication was wrong	15	1.	Frequency for taking medication was wrong
2.	Medicine not administered	13	2.	Wrong route for administration of medication
3.	Dose or strength was wrong or unclear	13	3.	Medicine not administered
4.	Wrong drug/medicine	8	4.	Medication incorrectly stored
5.	Mismatch between patient and medicine	5	5.	Patient information leaflet wrong or omitted
Dispensing			Dispensing	
1.	Dose or strength was wrong or unclear	3	1.	Dose or strength was wrong or unclear
2.	Omitted medicine/ingredient	3	2.	Expiry date wrong, omitted or passed
3.	Wrong drug/medicine	2	3.	Medication incorrectly stored
4.	Wrong label	1	4.	Formulation of medication was wrong
5.	Wrong quantity	1	5.	Frequency for taking medication was wrong

Reported incidents have contributed to the following work in progress:

- Review of neostigmine/glycopyrrolate and glycopyrrolate ampoules.
- Review of guidelines for peri-operative management of diabetes.
- Review of procedure for confirming body weight and height for determining body surface area for chemotherapy.
- Addition of warning label to ciprofloxacin suspension as a reminder to reconstitute before administration.