		unit until the staffing issue is resolved	model the unit is short 2 pharmacists for the current workload. At a meeting with HSCB in December they agreed to fund the 2 additional band 7 pharmacists required. The IPT was received in May 2015 and the recruitment process is underway.		
	• The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	• Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	• The first replacement isolator is now fully operational. The second isolator was installed in November 2014. However various problems with the isolators are still to be resolved. BSO PaLS are liaising with the supplier.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
15	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network • Emerging infections (CPE/VHF/ebola)	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly Strategic Forum and monthly Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across	Medical Director	MODERATE

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	• HCAI outbreaks in tertiary services (BHSCT) • Increasing emergence of CPE infections	• HCAI Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	community and acute sites. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence • Enhancement communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Completed Ebola Management Plan • CPE Outbreak/Incident Management • Enhanced HCAI RCA information management system and system developed to further improve meta-analysis of C Difficile cases • Renewed focus on isolation and screening of transferred patients, including planning of negative pressure isolation facilities on CAH site • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
16	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Water Safety Plan • 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 • 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	• Consideration of opportunities to increase automated water temperature and flow monitoring • Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013) • Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013) • £200k MES General Capital funding secured for priority works identified through risk assessments • New sampling regime approved by Trust Board and new monitoring regime now in place with bi-monthly monitoring. This will continue until September 2014 at which point testing will go to quarterly (subject to satisfactory reduction in legionella positives. As at November 2014 this has not happened due to a number of positive Legionella counts being detected as part of the sampling regime. (see note below under Copper Silver Ionisation). • Second Independent Review of Water Management arrangements expected end February 2015.	Director of Human Resources & Organisational Development/ Medical Director	MODERATE

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		is given to designing system that will reduce the likelihood of propagation of water borne pathogens	• New Trust wide contract for the control of water systems to be tendered by PALs (estimated start date of contract – March 2015) • Following installation of Copper-Silver ionisation systems in CAH, a representative team from the Trust Water Safety Group continues to meet weekly to monitor the performance of the system. The initial 12 weeks trial period was extended to 20 weeks (end of August 2015) to ensure sufficient data will have been gathered to enable recommendations to be made regarding the overall water sampling programme for CAH and further application of this technology to other sites including Loane House etc. Early indications are encouraging and preparations are underway for deployment to other sites.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
17	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• The Trust has submitted its application for re-accreditation and is awaiting a new date. A pre-assessment visit is planned for 8th October 2015. This visit will assess the Laboratory's state of readiness for a full UKAS 151189 inspection. • Action Plan updated as progress is made.		**HIGH**

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CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
18	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Consultant Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	**Consultant / Medical Appraisal** The 2013 appraisal round is 100% complete (288 medical staff). Work commenced on the January to December 2014 Appraisal Round at the start of April 2015 as key information became available to issue to medical staff (e.g. CLIP reports, complaints/incidents information). Currently 33% of 315 eligible doctors have completed their 2014 appraisal with the remaining expected to complete by Autumn 2015. **Knowledge and Skills Framework** A KSF steering group continues to meet quarterly. Work is ongoing with individual Directors and Heads of Services to support staff and managers when completing their KSF Documentation, and therefore to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT PDP's are now being recorded on HRPTS as a qualification. As a result of all of the above, there has been an increase in the extent to which KSF is being implemented across the Trust.	Medical Director Director of HR and Organisational Development	**MODERATE**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
19	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in December 2015	• NI Revalidation Programme Board, attended by the Executive Director of Nursing, meets bi-monthly • NI Revalidation Working Group attended by the Trust's Assistant Director Nursing Governance, meets monthly	NMC Revalidation model to be piloted in the Western HSC Trust between January – June 2015. Outcomes of all pilot sites to be considered by NMC in October 2015 and decision made as to whether or not the revalidation model will 'go live' in December 2015 across all 4 UK countries Organisational impact assessment for readiness to be undertaken. Assistant Director Nursing Governance has met with HR to scope out the practicalities of applying KSF/PDP appraisal processes Assistant Director Nursing Governance, along with Directorate Champions, will develop tools and proformas to support evidencing compliance with the core elements and to prepare nurses/midwives for their professional development discussion with their NMC colleague	Executive Director of Nursing	HIGH

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			Each NMC registrant has received a copy of the revised NMC Code in the post and this has been supported by circulation of information and opportunities for open discussion. Assistant Director Nursing Governance has linked with the AND Workforce Development and Training and Clinical Education Centre to scope out planned support programmes		

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
20	• Achievement of financial balance in 2015/16	• Contingency Plan for 2015/16 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	As a result of additional Health and Social Care Board allocations and Departmental approval to a number of additional contingency proposals, the Trust would now expect to breakeven in 2015/16.	Finance and Procurement/ All	**MODERATE**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
21	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Contracts management improvement group established and key actions formed • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided . • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	**GENERAL** • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013) • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements. • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of	Director of Performance and Reform/ Director of Finance and Procurement/ All Directors	**MODERATE**

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			Procurement Policy awaited • New Structures for contract & procurement management being developed as part of Management Review **ESTATES** • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Regional Steering and Working Groups established. Recruitment of PALS team underway. Recruitment of Trust Team being taken forward under newly appointed Head of Service. • Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes <£30k • Estates Works Management Improvement Action Plan (incorporating all IA recommendations) established and 95% implemented during 14/15. Internal Audit undertook a follow-up audit (reported March 2015) and verified that the majority of recommendations had been either partially or fully implemented. Further IA work to be undertaken third quarter of 2015/16.		

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			• Two replacement Estates Officers appointed and volume of works being undertaken balanced against resources to facilitate compliance. **SOCIAL CARE PROCUREMENT** • Regional Procurement Board via Social Care Procurement Group developing approach to social care procurement. No agreed regional way forward for procurement capacity gaps at Trust and COPE level . Issues continue to be raised with DHSSPS and Regional Procurement Board • Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Internal resource diverted to provide procurement support to key mental health directorate projects enabling change • Impact of 2015 Public Contract Regulations on social care procurement assessed and key actions agreed to scope demand and capacity requirements		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
22	Payroll & Travel - HRPTS System & Shared Services • Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer. • Transfer to Payroll Shared Services and maintenance of service delivery	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Progress updates to Audit Committee • 3 weekly performance monitoring meetings between the Trust's Head of Resourcing and Shared Services Centre Head of Recruitment & Selection	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Weekly, Fortnightly and Monthly staff transferred to the Payroll Shared Service Centre.	Finance Director	**MODERATE**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
23	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	• Recruitment process for vacant posts • Business Continuity Plan • Medical Managers with medical responsibility for the service • Call Centre Co-ordinator • Call Manager system • Late availability payment • Flexibility re shift patterns offered • Daily monitoring of rotas and appropriate contingency plans deployed based on resources available	• Advertisement on HSC recruit for sessional GPs closed with 11 applicants. 9 have been interviewed , 1 is pending interview and 1 withdrew. • 2 GPs have come forward in July 2015 seeking employment in GP OoHs • SMT agreed a paper in February 2015 offering payment towards sessional GPs indemnity cover. This ended on 31st March 2015. • The Health & Social Care Board has commenced additional cost pilot from July 2015 to encourage GPs to book additional shifts and this will result in an additional payment.	Older People and Primary Care	

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			• From 13th February 2015, due to sick leave, on occasions there has only been 1 GP to cover the Trustwide service from midnight to 8.00 a.m. There have been further occasions when there has been only 1 GP, however, Nurse Practitioners are providing some cover into the red eye shifts. There is a risk if GP scheduled to work is unable to work leaving no GP cover • Additional salaried shifts were offered to GPs within the service in February 2015. 8 GPs have expressed an interest in 21 shifts amounting to 123 hours in a 4 week rota period. HR processes are being worked through with the aim to commence in June 2015 rota. There has been a further trawl sent to GPs with a list of available salaried shifts, with a return date of 31st July 2015. • Regular updates to HSCB/Integrated Care Department regarding vacant shifts. Escalation to HSCB when GP cover is significantly reduced. • When clinical cover reduced to less than 50% or 1 red eye doctor, early alert sent to HSCB by 2.00 p.m. • A weekly email of vacant shifts is being sent on a Monday to all clinicians. Daily text messages and phone calls to GPs and Nurses in attempts to cover shifts. • Small team of nurses in GP Out of Hours Service working extra		

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			hours, where possible to assist in covering gaps • IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process. Interviews have been completed. Nurse Advisors – 25 are competent and able to work. A further 9 have received telephone triage training and are being shadowed to be deemed competent • As and when bank Nurse Practitioners have been recruited and are working within the service. • Recruitment of 8A service improvement role to the end of April 2015 to review the service model. Report will be presented by end July2015. • Review of workload of clinicians ongoing by Clinical Lead • KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB • Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available. • Locally Enhanced Service pilot commissioned by the Health and Social Care Board ended on 31 March 2015. An evaluation is being undertaken. • Working with other OoH providers to secure additional capacity • The Pharmacy Pilot commenced on 28.2.2015 with 8 Pharmacists recruited to provide cover from 11		

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			a.m. – 4 p.m. Saturday and Sunday and Bank Holidays. Pharmacists have also provided additional cover outside these hours to increase capacity. An evaluation has commenced. • Twice daily operational meetings to review cover and actions required.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
24	Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service	• Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA .	• The Health Visiting workforce position demonstrates that Staff in Post equate to the Funded Staffing Levels. The reality is that there are 16.54 wte unavailable to deliver the service (due to planned and unplanned absence), which equates to 20% of this workforce not available at a given time. This demonstrates a worsening position from that of May 2015 when 14% of the HV workforce was unavailable. This staffing deficit means that all 7 Health Visiting Teams are in step down: **Armagh** currently has a 20% step-down to core service in place; **Dungannon** currently has a 20% step-down to core service in place; **Portadown** currently has a 30% step-down to core service in place; **Lurgan/Brownlow** HV Team	Executive Director of Nursing/ Director of C&YPS	

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			currently has a 20% step-down to core service in place; **Banbridge** HV team has a 20% Step-down in place; **N&M** (Team 1) currently has a 10% step-down to core service in Place; **N&M** (Team 2) has a 20% step-down in place. • There are currently 8 permanent vacancies, 7 maternity leaves and 8 staff on long-term sick leave. • Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&SCT is able to secure through the bank is insufficient to meet the deficit. • Eleven Health Visiting students are currently completing their management placements which releases some of the Practice Teachers time to work into some of the vacant caseloads. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. SHSCT has also articulated the need for additional funding to meet the particular needs of the population within this area. • Sixty-one Health Visiting places were approved regionally for 14/15 and SHSCT is facilitating 11 students. These students will finish		

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			in September 2015. 5 of the permanent vacancies have been offered and accepted by the students, with e-requisitions in progress for the remaining vacancies. We continue to await additional investment agreed with the PHA. This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
25	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds was last reviewed at HHBC Steering group on 7/8/2015. Current controls to remain as agreed by SMT and Trust Board. • Public Prosecution Service has determined no prosecution of the Home Owners regarding one client • RQIA is currently pursuing a prosecution of the Home Owners under Article 42 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA Court date was last held on	Mental Health & Disability	

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		DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel. • Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance	3/7/15. Next Court date is 30/9/15. • Formal Court Order regarding disclosure received by Trust. Information being reviewed by the Trust prior to sending to DLS on 6.9.2015 for presentation to the Court on 16.9.15. • Scoping exercise has been completed should alternative placements be required and will • be revisited • Update Report to Trust Board on 27th August 2015		

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		Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			

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Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee on
8th December 2015

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the Trust's Corporate Objectives as detailed below:-

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.

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OVERVIEW OF CORPORATE RISK REVIEW AS AT 30th NOVEMBER 2015

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	10	12		22

New risks identified by SMT or escalated from Directorate Risk Registers	New Risk No.8 Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital.
Risks removed from the Register	• Risk No. 9 Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health' and retain on MHD Directorate Risk Register. • Risk No.10 Fire Safety – effective management measures are now in place and risk assessments have been substantially progressed. To be managed on Directorate Risk Register • Risk No. 15 Water Safety –effective management measures are now in place and the instances of Legionella detections have been significantly reduced with the installation of the CuAg water treatment system at Craigavon Area Hospital. To be managed on Directorate Risk Register

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	• Risk No. 12 The lack of capacity, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment – Whilst there are still critical vacancies in the Estates structure, their replacement has been approved corporately and resolution rests within Estates.
Merged risks	None
Risks where overall rating has been reduced	Risk No. 12 'High Voltage capacity limit on electrical supply to Craigavon Area Hospital' – downgraded from high to medium risk Risk No.3 'Achievement of Statutory Duties/Functions – 'Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed' – downgraded from high to medium risk Risk No. 6 'Medicines Management compliance in Domiciliary Care' – downgraded from high to medium risk
Risks where overall rating has been increased	None

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Summary of Corporate Risks as at November 2015

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since November 2014
1.	Achievement of Elective Commissioning Plan Standards and Targets	1	HIGH	Unchanged
2.	Out-Patient Reviews and Planned Treatment Backlogs	1	HIGH	Unchanged
7.	Inability to recruit/retain Consultant medical staff for specific specialties	1	HIGH	Unchanged
8.	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	1	HIGH	New risk added on 30.9.2015
9.	Inability to Increasing inability to recruit registered nursing staff	1	HIGH	Unchanged
10.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
12.	Pharmacy Aseptic Suite, CAH	1	HIGH	Unchanged
14.	Accreditation status of Laboratory, Craigavon Area Hospital	1	HIGH	Unchanged
16.	Implementation of NMC's revised revalidation arrangements for Registered Nurses, Midwives and Specialist Community Public Health Nurses	1	HIGH	Unchanged

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20.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	1	HIGH	Unchanged
21.	Health Visiting Service – impact on families due to decreased staffing levels	1	HIGH	Unchanged
22.	Safeguarding of Residents within HH/BC	1	HIGH	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since November 2014
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	MEDIUM	Downgraded from high risk 25.11.2015
4.	Achievement of statutory duties/functions: Robust Case Management processes	1	MEDIUM	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	1	MEDIUM	Unchanged
6.	Medicines Management compliance in domiciliary care	1	MEDIUM	Downgraded from high risk 25.11.2015

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11.	High Voltage capacity limit on electrical supply to Craigavon Hospital	1	MEDIUM	Downgraded from high risk 30.9.2015
13.	HCAI	1	MEDIUM	Unchanged
15.	Fully embedded Appraisal system	1	MEDIUM	Unchanged
17.	Financial Balance – risk in 2015/16 that the Trust will not achieve Financial balance in year	4	MEDIUM	Downgraded from high risk 19.11.14
18.	Management and monitoring of procurement and contracts	5	MEDIUM	Unchanged
19.	HRPTS Payroll,Travel Payments and Shared Services Recruitment	5	MEDIUM	Separated out from BSTP risk on 15.10.14

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Southern Health & Social Care Trust: Summary of Corporate Risks as at November 2015

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No					**Status**
1	**Achievement of Elective Commissioning Plan Standards and Targets** ***a) Waiting times in excess of Commissioning Plan Standards / Targets across***: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients; and • Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • AHP professions	INTERNALMONITORING: 1. ***Fortnightly Operational Performance meetings:*** • Acute Directorate, and • Children & Young Peoples Services Directorate 2. ***Monthly Operational Performance meetings***: • Mental Health & Disability Directorate 3. ***Quarterly Operational Performance meetings:*** • Older Persons and Primary Care Directorate 4. ***Monthly Operational AHP Performance*** - Cross- directorate ***5. Monthly reporting to Senior Management Team and Trust Board*** ***6. Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.***	**Access Times** a) Focus on Service and Budget Agreement (SBA) remains as first priority within Operational Directorates, where robust SBA volumes exist into 2015/16. Delivery of access times will follow SBA delivery on the priority list. Recurrent capacity gaps prioritised with SLCG, in line with early indication of available recurrent funding in 2015/2016 as: - Symptomatic Breast Clinic and - Haematology. IPT was submitted and formal allocation received for recurrent funding for symptomatic breast services (July 2015) b) Non-recurrent allocation received for Diagnostics (including Endoscopy) in 2015/16 • The totality of diagnostic volumes allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity • No allocations received for Out-Patients; In-Patients; or Day Cases.	Performance and Reform and Operational Directors	**HIGH**

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		EXTERNAL MONITORING: 7. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board ACTION PLANNING: 8. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 9. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 10. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	• IS Providers have been given permission to undertake the treatment of the paused patients from 2014/15 in Quarter 1 of 2015/16. • SMT permission granted for additionality in April 2015 to continue to address previously identified risk areas that were funded via non-recurrent allocations in 2014/15. Spend from April to be re-couped from 2015/16 non-recurrent allocations. Further non-recurrent funding made available in November for Independent Sector capacity. The Trust will work to identify what Independent Sector capacity can be put in place to increase capacity for Quarter 4 2015/16. c) Key areas of risk identified within the Acute Services Directorate have been **partially addressed** with non-recurrent funding and part year effect recurrent investments in : • Symptomatic Breast Clinic • CT and • Endoscopy d) Remaining areas of risk highlighted to Health and Social Care Board formally include:- a. Haematology (New OP) b. Urology (OP Review Backlog) c. General Surgery (OP Review Backlog) d. Cardiology (OP Review		

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	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		Backlog) e. Dermatology (OP Review Backlog) f. Trauma (New OP and IP) The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available or as operationally feasible. **Plain Film X Ray** e) A non-recurrent allocation for plain film reporting has been received for Quarter 3 & 4 (2015/2016). This non-recurrent funding is being utilised for Independent Sector (IS) provision. • The original IS provider is now working to full capacity with no further options for additional plain film reporting to be undertaken. • With the lack of internal reporting capacity, the Trust is facing further pressure for plain film reporting. • A further IS contract has been procured and awarded (September 2015) and additional capacity is anticipated in Quarter 4. • An operational plan is being developed, in the first instance, to return chest x-ray plain film reporting to within the 28-day standard.		

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			f) HSCB has provided recurrent funding for the implementation of plain film reporting by radiographers for ED films. g) HSCB has provided recurrent funding for plain film reporting of the remaining in-patient IRMER'ised patients. h) A training programme is in place to increase the scope of Plain Film reporting that is carried out by Radiographers. **AHP Access Times** No non-recurrent funding to address access times has been allocated in 2015/16 as the outcome of the PHA demand and capacity exercise remains outstanding No non-recurrent resources from HSCB were provided in 2014/15 either. The Trust has agreed to retain a level of additionality until the end of August 2015. The Trust, In parallel with the PHA/HSCB review, is undertaking a capacity and demand exercise to calculate available capacity within the AHP professions which will inform future capacity gaps and investment priorities. It is anticipated that this work should be completed in Q3 2015/16. .		

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	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	**Out-Patient Review and Planned Treatment Backlogs** ***Out-Patient Review Waiting List Backlogs in:*** • Acute; • CYPS; • MHD; and • OPPC ***Planned Treatment Backlogs:*** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale*** in Outpatient and AHP services.	Internal and External monitoring controls included as in Corporate Risk 1 above. <u>ACTION PLANNING</u>: • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	a) Outpatient Backlog At 1 November 2015, there were a total of 20,627 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led services only, including Visiting Specialties) as follows: • 44% (9155 people) waiting in excess of 6-months past their clinically indicated timescale; • 15% (3,073) waiting between 3 – 6-months past their clinically indicated timescale; and • 41% (8,398) waiting less than 3-months past their clinically indicated timescale. • The longest waits for Trust services are for Urology and extend back to 2011/12; all patients for 2011/12 and 2012/13 have been validated and those waiting from 2011/12 have all been offered an appointment date. • The longest waits are in the visiting service of Ophthalmology and the Trust is working with the Local Commissioning Group to resolve this. No non-recurrent funding has been received from HSCB in 2015/16 for the out-patient review backlog.		**HIGH**

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			The Acute Services Directorate has identified a number of areas of clinical risk within their review backlog and these were contained within the clinical risk paper to SMT on 29 April 2015. This paper details potential contingency options for discussion and approval in order to minimise the clinical risk associated with this backlog. <u>b) Planned Patient Backlog</u> • As at 2nd November 2015, there are a total of 1,356 patients on the planned treatment backlog. The longest waiting patient dates back to February 2014. • 71% (962) of the planned treatment backlog relates to Endoscopy. The non-recurrent allocation for Endoscopy in Quarter 1 & 2 will only facilitate the maintenance of planned scopes at 8-months past their clinically indicated timescale. Endoscopy, in totality, has been identified as a clinical risk within the clinical risk paper escalated to HSCB in May 15(as referenced in Risk 1 above) and through monthly elective access meetings with HSCB. • In line with JAG accreditation requirements the planned treatment backlog should not exceed 6-months.		

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			c) AHP review backlogs AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
3	Achievement of statutory functions/duties: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Quarterly reporting to Trust Board (from October 2015) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate has undertaken a Domiciliary Care review and has a process in place to implement the recommendations to achieve compliance. Substantial validation is on-going with teams regarding the recording of OPPC reviews as currently two systems are being used. Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. **Care Home Support Team (CHST)** The CHST now has responsibility for the majority of clients, with a remaining 8 clients due to transfer on completion of their reviews.	Older People and Primary Care	**MEDIUM**

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			An assurance process is embedded to ensure all residents in a Care Home with a Failure to Comply Notice in place or Vulnerable Adult investigation ongoing has an up to date review in place. Currently there are no Failure to Comply notices in Care Homes in the SHSCT area **Adult Safeguarding Team** Further targeted vulnerable adults training for those staff in care management and involved in annual reviews. September 2015 Caseload Analysis being led by Social Work Governance Team and supported by the Executive Director of Social Work, has now reported and findings will support changes within teams in respect of how caseloads are allocated and managed.		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust case 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 Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management being planned. • Restructuring process by Heads of Service is in progress within the Disability Division of the Mental Health & Learning Disability Directorate. • Process to be completed within Mental Health and Learning Disability Directorate by December 2015	Mental Health and Disability/Older People and Primary Care	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 2 Lack of agreed indicators/measures of quality to provide assurance across some Trust services 3. Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4 Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings • Web-based incident reporting (on Datix) rolled out across the Trust • Clinical and Social Care Governance Review completed and new structures/processes embedded • Governance Committee and Senior Management Team • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Quality Sub Group • Morbidity and Mortality Group • 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 Chair and Chief Executive	• New I.T. system to capture Standards and Guidelines has not been progressed. The Quality 2020 workstream focusing on Standards & Guidelines has proposed a regional approach to developing an IT system to the Quality 2020 Steering Group. • Q2020 Strategy Regional Workstreams continue to develop and strengthen regional quality indicators for reporting via Trust Quality Report • The Trust has commenced the development and implementation of a Quality Framework. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work • The revisit of Clinical and Social Care Governance has completed with a pilot of the new approach of dashboard assurance reports to Governance Committee on 8.12.2015	Chief Executive	**MEDIUM**

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		• Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services • 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,		

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		Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors			
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
6	Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care	• Trust Medicines Management policy • Review of operational procedures • Incident reporting system in place • Interim procedure on prescribing • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Annual Competency based training re medicines management for domiciliary care workers completed for all staff. • A registered nurse has been seconded in the Newry and Mourne area for a pilot of one year since August 2014, dedicated to progressing medicines review and safer systems. A report has been shared on progress / issues to date. This pilot has now been extended to the Armagh and Dungannon areas with core teams supporting the work in Newry/Mourne areas. • As part of this, single patient medication files are being tested across providers to minimise risk of error. • Following a Regional Medication workshop held by the HSCB, a business case is being developed to secure funding to deliver an interim system which includes a specialist medicines assessment and provision of appropriate solutions for service users who are identified as potentially requiring	Older People and Primary Care/Mental Health and Disability	**MEDIUM**

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			domiciliary care support in the area of medicines management. • Interim funding is required to allow time to fully evaluate and determine the impact of the assessment process on service delivery in the redesigned Medicines Management Pathway. • Project Nurse to review existing service users in other two localities (Armagh & Dungannon and Craigavon & Banbridge) commencing in November 2015 • Audit risk assessments for new service users to ensure compliance with guidelines commencing November 2015		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
7	Inability to recruit/retain Consultant medical staff for specific specialties • Consultant Medical Staff in Dermatology, Emergency Medicine, Orthodontics, T&O, Haematology, Psychiatry Old Age and Radiology • SAS Medical Staff in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	• Recruitment campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Detailed Action Plan is held within the HROD Directorate.	**Dermatology:** There is a recognised UK shortage of consultant posts in Dermatology and therefore a new model to attract GPs has been introduced. From late November 2014, 4 part-time GPs have started in post so this has proved successful. Two retired consultants were engaged to undertake some WLI clinics however this arrangement ceased at the end of June 2015. An application was submitted to the Royal College of Physicians in 2014 for International Medical Graduates (IMGs) under the Medical Training Initiative (MTI) scheme, but was unsuccessful.	Human Resources & Organisational Development/ Medical Director	**HIGH**

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			One local doctor reached her CCT date in July 2015, so would be eligible to apply for a consultant post in the Trust. An IPT is currently being developed. As no funding currently available, the Trust is considering going at risk to recruit another Consultant Dermatologist **T&O:** Two consultants have been appointed to T&O during 2015. One commenced in post at the start of January, however the other was not able to take up post until August. In addition 2 Temporary Specialty Doctors have also been appointed. One transferred from a Clinical fellow post within the Southern Trust and the other started on 3 June 2015. One has since left the Trust, however the other has been appointed to a permanent Specialty Doctor post. This means there are now 9 Consultants and 4 Specialty Doctors in T&O. There are plans to advertise for another permanent Consultant, 2 Clinical Fellows and 3 Temporary Specialty Doctors in T&O. **Emergency Medicine:** A permanent Consultant commenced in Craigavon Area Hospital on 1st May 2015. Two Specialty Doctors were recently interviewed and appointed to ED in DHH, however despite these appointments it still proves very difficult to recruit to Consultant and Specialty Doctor positions within ED The Trust has recently advertised for Consultant and Specialty Doctor posts in DHH. The adverts also featured in the		

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			ROI and stated that enhanced rates of pay and a full relocation package would be considered, however these campaigns were unsuccessful. The situation in Daisy Hill Hospital has worsened considerably following the recent resignation of the Lead Consultant and a full time Specialty Doctor. At consultant level, this will leave one Temporary F/T consultant and one permanent P/T consultant. At SAS (middle grade) level there is one Associate Specialist and two Specialty Doctors – all are full time. The Trust regularly raises the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. The Trust also embarked on a recruitment campaign for middle grade doctors in ED with M3 Creating Connections. This company undertakes medical recruitment project work with Trusts and Health Boards on behalf of doctors.net.uk. There was only one application received, however the candidate subsequently withdrew. The Trust has also met with 'A Team Recruitment regarding a proposal to recruit medical staff from the EU, however it is expected to take at least 6 months to recruit and train suitably qualified doctors via this route.		

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			The Trust has also introduced a Clinical fellowship programme for ED. One appointment has been made – starting in August 2015. **Anaesthetics:** It is planned to develop a training programme with the aim of "growing our own" specialty doctors. A proposal has been drafted and is currently under consideration by the service. **Radiology:** There is a recognized gap in Consultant Radiologist numbers and Clinical Radiology has recently been included in the Government approved shortage occupation list. The Trust has successfully appointed a number of Consultant Radiologists over the past few years; however some of these have left to take up other posts. The position remains unstable. In February 2015, the Trust successfully appointed 4 permanent Consultant Radiologists. One person has since withdrawn, however the other 3 took up post in August 2015.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	
8	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	• Trust Senior Oversight Group • Escalation procedures in place to alert senior management of any changes in rota • In-house training programme • Daily review by Senior Management of night reports and follow up on issues • Daily audit of notes	• Ongoing recruitment of Consultants and Middle Grade Doctors for Emergency Department • Use of locums • Ongoing review of medical rota to ensure senior doctors on duty until midnight • Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a		**HIGH**

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			Registrar • Support provided as required by Paediatric Registrar and Anaesthetic Registrar in the out of hours period. Medical and Surgical Registrar will provide additional support if on duty overnight • Recruitment of senior nursing staff to be on duty 24/7 • Additional ENPs currently being recruited • Associate Medical Director exploring a 16 Consultant model for both Emergency Departments • Resignation of a Consultant effective from 1.2.2016. Action plans in development to seek to address this. • Regular updates to Commissioner and DHSSPS		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
9	Increasing inability to recruit registered nursing staff	• Ward Sister/Charge Nurse management of available staff on a shift by shift basis • Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need • Escalation to Operational Director as required • Open registration for Nurse Bank • E-rostering roll out	• All opportunities to secure permanent staff continue to be progressed • Regular recruitment drives ongoing with the most recent drive for Adult Nursing including Year 2 and Year 3 students. This resulted in 153 job offers on the day with many of the pre-employment checks undertaken. Follow up work is now underway to maintain a relationship with all appointees until their start dates. The most recent drive for MH Nursing is also aimed at including	**Acute Director and Medical Director**	**HIGH**

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			Year 2 and Year 3 students and is ongoing at the time of this update • Introduction of Rotational Programmes within and across Directorates. • Targeted recruitment of current nursing students for bank Band 3 roles ongoing with a view to introducing them to the Southern Trust for their Band 5 career. • Six staff have secured places on the funded Open University Pre-registration Nursing Programme commencing September 2015. A further ten staff were successful at interview. SHSCT has offered these ten deferred places for the OU PRNP commencing September 2016. • A Trust Nursing Workforce Planning Group has been established to seek to address current and future anticipated challenges regarding the demand for and supply of Registered Nurses across all programmes of care. Consideration is now being given to International Recruitment. • A regional Nursing Workforce Planning Group, chaired by Mr F Rice, Executive Director of Nursing, has now completed a scoping exercise at a high level to collate the statistics on vacant posts compared to Funding Staffing and the numbers of staff unavailable for work due to various types of leave.		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
10	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 Specific examples: • Fire Safety Action Plan in place High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • Aging High Pressure Hot Water system (HPHW) at Craigavon Area Hospital has now been replaced with new Low Pressure Hot Water system. • £2.9m secured to complete structural works to tower block at South Tyrone Hospital • Completion of Theatre development CAH	• 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 • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2015/16. Phase 1 of Mechanical Infrastructure complete. • Strategic Outline Case submitted for major redevelopment at CAH site. Work is now being progressed on the main business case for submission in 2015/16. • New negative pressure isolation room at CAH to be completed by November 2015. • Provision of new negative pressure isolation room at DHH awaiting decision on preferred option from Acute Services. Thereafter proposals to be incorporated in Business Case for consideration by SMT/Trust Board.	Director of Human Resources and Organisational Development	**HIGH**

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			The sewage system serving the wards at CAH has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. An extensive replacement programme commenced in August 2015 through a carefully co-ordinated and phased programme of ward decants. Works will be carried out to the most critical areas over the next few months (subject to the availability of decant space v winter pressures). Further works may be necessary after the winter period to complete the programme. A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly reduced should the replacement of CAH proceed.		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	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 • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • 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 have been approved and these projects 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 risk. • Installation of new Combined Heat and Power plant is completed and G59 approval from NIE (to permit parallel generation) in place. Contract for operation and maintenance of plant being finalised with PALS. This will provide additional source of supply for the site. At this point, this risk will be re-assessed and may reduce to moderate risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
12	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: • The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). • Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours. • A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented • Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved	• The queries received in relation to the business case for a new build aseptic suite co-located with the Mandeville Unit have been addressed and the OBC was submitted to the Department on 1.7. 2015. A letter of Commissioner Support received from the HSCB has been submitted. The Trust has identified this as its top priority for capital funding. • Recent deterioration in the fabric of the building is being addressed through an interim plan involving urgent minor works to the aseptic suite. • The Capita Model for chemotherapy/cytotoxic dispensing was applied to the current workload in the unit. This identified a staffing deficit of 3.6wte pharmacists. Using the capacity plan as a model the unit is short 2 pharmacists for the current workload. HSCB agreed to fund	Director of Acute Services	**HIGH**

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	• The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	• Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	the 2 additional band 7 pharmacists required. The IPT was received in May 2015 and the recruitment process is complete. The pharmacists will start in January 2016. • complete		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network • Emerging infections (CPE/VHF/ebola) • HCAI outbreaks in tertiary services (BHSCT)	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence	Medical Director	**MEDIUM**

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	• Increasing emergence of CPE infections	guidelines relating to HCAI	• Enhancement communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Completed Ebola Management Plan • CPE Outbreak/Incident Management • Enhanced HCAI RCA information management system and system developed to further improve meta-analysis of C Difficile cases • Renewed focus on isolation and screening of transferred patients, including planning of negative pressure isolation facilities on CAH site • Joint letter from Medical Director, Executive Director of Nursing and Director of Acute Services issued to staff re Infection Control practice • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Development of a Business Plan to consider Infection Prevention Control (IPC) Nursing Workforce within the Trust		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
14	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• The Trust has submitted its application for re-accreditation and is awaiting a new date. A pre-assessment visit is planned for 8th October 2015. This visit will assess the Laboratory's state of readiness for a full UKAS 151189 inspection. • Action Plan updated as progress is made. • Full inspection advised for April 2016		**HIGH**

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CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
15	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	**Consultant / Medical Appraisal** As at 16/11/15, 93% of 300 eligible doctors have completed their 2014 appraisal. **Knowledge and Skills Framework** A KSF steering group continues to meet quarterly. Work is ongoing with individual Directors and Heads of Services to support staff and managers when completing their KSF Documentation, and therefore to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT PDP's are now being recorded on HRPTS as a qualification. As a result of all of the above, there has been an increase in the extent to which KSF is being implemented across the Trust. Work underway to improve mandatory training levels within the Trust	Medical Director Director of HR and Organisational Development	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
16	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	• NI Revalidation Programme Board, attended by the Executive Director of Nursing, meets bi-monthly • NI Revalidation Working Group attended by the Trust's Assistant Director Nursing Governance, meets monthly • In October 2015 the NMC has agreed its arrangements for the revalidation of nurses and midwives to commence in April 2016	The Trust's Medical Revalidation Team has been extended to support the implementation and progression of Nursing and Midwifery revalidation which is due to commence in April 2016. Extensive work has been undertaken to establish a Nursing and Midwifery Revalidation information management system which holds all (3,023) Trust NMC registrants' PIN, Annual Fee Expiry and Revalidation dates. This information management system is now live and will provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progression of Nursing and Midwifery revalidation. Monthly revalidation reports will be issued to individual nursing / midwifery managers to support local arrangements on the timely revalidation of nurses and midwives for whom they have responsibility. Standard Operating Procedures have been developed to provide timely reports to nursing and midwifery managers and heads of service. Assistant Director Nursing Governance, with Directorate Champions are developing tools and proformas to support nurses and midwives in evidencing compliance with the core revalidation elements and to prepare nurses/midwives for their professional development discussion with their NMC colleague. Assistant Director Nursing Governance has linked with the AD Nursing Workforce Development and Training and Clinical Education Centre to scope out planned support programmes.	Executive Director of Nursing	**HIGH**

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CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
17	• Achievement of financial balance in 2015/16	• Contingency Plan for 2015/16 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	As a result of additional Health and Social Care Board allocations and Departmental approval to a number of additional contingency proposals, the Trust would now expect to breakeven in 2015/16.	Finance and Procurement/ All	**MEDIUM**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Contracts management improvement group established and key actions formed • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided . • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	**GENERAL** • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing	Director of Performance and Reform/ Director of Finance and Procurement/ All Directors	**MEDIUM**

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			(Central monitoring ceased in October 2013) • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements. • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • New Structures for contract & procurement management being developed as part of Management Review **ESTATES** • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Regional Steering and Working Groups established. Recruitment of PALS team underway.		

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			Recruitment of Trust Team being taken forward under newly appointed Head of Service. • Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes <£45k • Estates Works Management Improvement Action Plan (incorporating all IA recommendations) established and 95% implemented during 14/15. Internal Audit undertook a follow-up audit (reported March 2015) and verified that the majority of recommendations had been either partially or fully implemented. Further IA work to be undertaken third quarter of 2015/16. • Two replacement Estates Officers appointed and volume of works being undertaken balanced against resources to facilitate compliance. **SOCIAL CARE PROCUREMENT** • Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement. Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements		

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			• Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. • Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15 enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Impact of 2015 Public Contract Regulations on social care procurement assessed and key actions agreed to scope demand and capacity requirements		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
19	Payroll & Travel - HRPTS System & Shared Services • Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer. • Transfer to Payroll Shared Services and maintenance of service delivery • Recruitment – considerable delays currently being experienced in the recruitment of posts which is impacting on operational services	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Progress updates to Audit Committee • Regular meetings with BSO • Escalation procedure in place by Trust's Head of Resourcing • Weekly monitoring	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Weekly, Fortnightly and Monthly staff transferred to the Payroll Shared Service Centre. • Additional resources identified to support BSO in the delivery of services	Finance Director	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
20	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	• Recruitment process for vacant posts • Business Continuity Plan • Medical Managers with medical responsibility for the service • Call Centre Co-ordinator • Call Manager system • Late availability payment • Flexibility re shift patterns offered • Daily monitoring of rotas and appropriate contingency plans deployed based on resources available	• Regular updates to HSCB/Integrated Care Department regarding vacant shifts. Escalation to HSCB when GP cover is significantly reduced. • When clinical cover reduced to less than 50% or 1 red eye doctor, early alert sent to HSCB by 3.00 p.m. • A weekly email of vacant shifts is being sent on a Monday to all clinicians. Daily text messages and phone calls to GPs and Nurses in attempts to cover shifts. • Small team of nurses in GP Out of Hours Service working extra hours, where possible to assist in covering gaps • IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process. Interviews have been completed. Nurse Advisors – 25 are competent and able to work. A further 9 have received telephone triage training and are being shadowed to be deemed competent • As and when bank Nurse Practitioners have been recruited and are working within the service. • Recruitment of 8A service improvement role to the end of April 2015 to review the service model. Report will be presented by end July2015. • Review of workload of clinicians ongoing by Clinical Lead	Older People and Primary Care	**HIGH**

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			• KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB • Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available. • Working with other OoH providers to secure additional capacity • Twice daily operational meetings to review cover and actions required. • Pharmacy pilot has been extended to end of March 2016 using winter pressures money and covering hours 10.00 a.m. – 8.00 p.m. • Winter pressures plan is being implemented, with enhanced rates and increased capacity • Locally Enhanced Service (LES) implemented on 7th November 2015 until end of March 2016 • Contingency and escalation plan agreed and now being implemented		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
21	Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service	• Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned	• The Health Visiting workforce position demonstrates that Staff in Post equate to the Funded Staffing Levels. The reality is that there are 16.54 wte unavailable to deliver the service (due to planned and unplanned absence), which equates to 20% of this workforce not available at a given time. This demonstrates a worsening position	Executive Director of Nursing/ Director of C&YPS	**HIGH**

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		about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA .	from that of May 2015 when 14% of the HV workforce was unavailable. This staffing deficit means that all 7 Health Visiting Teams are in step down: • There are currently 8 permanent vacancies, 7 maternity leaves and 8 staff on long-term sick leave. • Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&SCT is able to secure through the bank is insufficient to meet the deficit. • Eleven Health Visiting students are currently completing their management placements which releases some of the Practice Teachers time to work into some of the vacant caseloads. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. SHSCT has also articulated the need for additional funding to meet the particular needs of the population within this area. • Sixty-one Health Visiting places were approved regionally for 14/15 and SHSCT is facilitating 11 students. These students will finish in September 2015. 5 of the permanent vacancies have been		

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			offered and accepted by the students, with e-requisitions in progress for the remaining vacancies. We continue to await additional investment agreed with the PHA. This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
22	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board. • Public Prosecution Service has determined no prosecution of the Home Owners regarding one client • RQIA is currently pursuing a prosecution of the Home Owners under Article 42 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. • Formal Court Order regarding disclosure received by Trust. Information requested was provided to DLS for	Mental Health & Disability	**HIGH**

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		• Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel. • Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts".	presentation to the Court on 16.9.2015. • Scoping exercise has been completed should alternative placements be required and will • be revisited • Update Report to Trust Board on 26th November 2015		

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		• Ongoing processes with OCP / RQIA / NMC / HSCB re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			

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Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee
on 4th February 2016

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INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the Trust's Corporate Objectives as detailed below:-

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.

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OVERVIEW OF CORPORATE RISK REVIEW AS AT JANUARY 2016

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	11	12		23

New risks identified by SMT or escalated from Directorate Risk Registers	New Risk No.8 Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital. New Risk No.23 Risk of loss of life and/or serious harm to patient(s), significant interruption to service(s) and limited or no telecommunication within the major hospital sites due to foreseeable unserviceable obsolete telecommunication equipment.
Risks removed from the Register	• Risk No. 9 Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health' and retain on MHD Directorate Risk Register. • Risk No.10 Fire Safety – effective management measures are now in place and risk assessments have been substantially progressed. To be managed on Directorate Risk Register

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	• Risk No. 15 Water Safety –effective management measures are now in place and the instances of Legionella detections have been significantly reduced with the installation of the CuAg water treatment system at Craigavon Area Hospital. To be managed on Directorate Risk Register • Risk No. 12 The lack of capacity, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment – Whilst there are still critical vacancies in the Estates structure, their replacement has been approved corporately and resolution rests within Estates.
Merged risks	None
Risks where overall rating has been reduced	Risk No. 12 'High Voltage capacity limit on electrical supply to Craigavon Area Hospital' – downgraded from high to medium risk Risk No.3 'Achievement of Statutory Duties/Functions – 'Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed' – downgraded from high to medium risk Risk No. 6 'Medicines Management compliance in Domiciliary Care' – downgraded from high to medium risk
Risks where overall rating has been increased	None

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Summary of Corporate Risks as at January 2016

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since November 2014
1.	Achievement of Elective Commissioning Plan Standards and Targets	1	HIGH	Unchanged
2.	Out-Patient Reviews and Planned Treatment Backlogs	1	HIGH	Unchanged
7.	Inability to recruit/retain Consultant medical staff for specific specialties	1	HIGH	Unchanged
8.	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	1	HIGH	New risk added on 30.9.2015
9.	Increasing inability to recruit registered nursing staff	1	HIGH	Unchanged
10.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
12.	Pharmacy Aseptic Suite, CAH	1	HIGH	Unchanged
14.	Accreditation status of Laboratory, Craigavon Area Hospital	1	HIGH	Unchanged
16.	Implementation of NMC's revised revalidation arrangements for Registered Nurses, Midwives and Specialist Community Public Health Nurses	1	HIGH	Unchanged

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20.	GP Out of Hours Service - inability to attract adequate cover for GP shifts	1	HIGH	Unchanged
21.	Health Visiting Service – impact on families due to decreased staffing levels	1	HIGH	Unchanged
22.	Safeguarding of Residents within HH/BC	1	HIGH	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since November 2014
3.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed	1	MEDIUM	Downgraded from high risk 25.11.2015
4.	Achievement of statutory duties/functions: Robust Case Management processes	1	MEDIUM	Unchanged
5.	Systems of assessment and assurance in relation to quality of Trust services	1	MEDIUM	Unchanged

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6.	Medicines Management compliance in domiciliary care	**1**	**MEDIUM**	Downgraded from high risk 25.11.2015
11.	High Voltage capacity limit on electrical supply to Craigavon Hospital	**1**	**MEDIUM**	Downgraded from high risk 30.9.2015
13.	HCAI	**1**	**MEDIUM**	Unchanged
15.	Fully embedded Appraisal system	**1**	**MEDIUM**	Unchanged
17.	Financial Balance – risk in 2015/16 that the Trust will not achieve Financial balance in year	**4**	**MEDIUM**	Downgraded from high risk 19.11.14
18.	Management and monitoring of procurement and contracts	**5**	**MEDIUM**	Unchanged
19.	HRPTS Payroll,Travel Payments and Shared Services Recruitment	**5**	**MEDIUM**	Separated out from BSTP risk on 15.10.14
23.	Risk of loss of life and/or serious harm to patient(s), significant interruption to service(s) and limited or no telecommunication within the major hospital sites due to foreseeable unserviceable obsolete telecommunication equipment.	**1**	**MEDIUM**	New risk added on 27.01.2016

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Southern Health & Social Care Trust: Summary of Corporate Risks as at January 2016

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No					**Status**
1	**Achievement of Elective Commissioning Plan Standards and Targets** ***a) Waiting times in excess of Commissioning Plan Standards / Targets across***: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients; and • Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • AHP professions	INTERNALMONITORING: 1. ***Fortnightly Operational Performance meetings:*** • Acute Directorate, and • Children & Young Peoples Services Directorate 2. ***Monthly Operational Performance meetings***: • Mental Health & Disability Directorate 3. ***Quarterly Operational Performance meetings:*** • Older Persons and Primary Care Directorate 4. ***Monthly Operational AHP Performance*** - Cross- directorate ***5. Monthly reporting to Senior Management Team and Trust Board*** ***6. Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.***	**Access Times** a) Focus on Service and Budget Agreement (SBA) remains as first priority within Operational Directorates, where robust SBA volumes exist into 2015/16. Delivery of access times will follow SBA delivery on the priority list. Recurrent capacity gaps prioritised with SLCG, in line with early indication of available recurrent funding in 2015/2016 as: - Symptomatic Breast Clinic and - Haematology. IPT was submitted and formal allocation received for recurrent funding for symptomatic breast services (July 2015) b) Non-recurrent allocation received for Diagnostics (including Endoscopy) in 2015/16 • The totality of diagnostic volumes allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity • IS Providers have been given permission to undertake the treatment of the paused patients	Performance and Reform and Operational Directors	**HIGH**

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		EXTERNAL MONITORING: 7. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board ACTION PLANNING: 8. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 9. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 10. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	from 2014/15 in Quarter 1 of 2015/16. • SMT permission granted for additionality in April 2015 to continue to address previously identified risk areas that were funded via non-recurrent allocations in 2014/15. Spend from April to be re-couped from 2015/16 non-recurrent allocations. • Further non-recurrent funding for Independent sector capacity was made available in November for specific regionally agreed speciality areas for OP/IP/DC. In response, the Trust has established additional capacity in Q4 2015/16 for pain management, general surgery and orthopaedics. c) Key areas of risk identified within the Acute Services Directorate have been **partially addressed** with non-recurrent funding and part year effect recurrent investments in : • Symptomatic Breast Clinic • CT and • Endoscopy . d) Remaining areas of risk highlighted to Health and Social Care Board formally include:- a. Haematology (New OP) b. Urology (OP Review Backlog)		

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	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		c. General Surgery (OP Review Backlog) d. Cardiology (OP Review Backlog) e. Dermatology (OP Review Backlog) f. Trauma (New OP and IP) The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available or as operationally feasible. **Plain Film X Ray** e) A non-recurrent allocation for plain film reporting has been received for Quarter 3 & 4 (2015/2016). This non-recurrent funding is being utilised for Independent Sector (IS) provision. • The original IS provider is now working to full capacity with no further options for additional plain film reporting to be undertaken. • With the lack of internal reporting capacity, the Trust is facing further pressure for plain film reporting. • A further IS contract has been procured and awarded (September 2015) and additional capacity is anticipated in Quarter 4. • An operational plan is being developed, in the first instance, to		

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			return chest x-ray plain film reporting to within the 28-day standard. f) HSCB has provided recurrent funding for the implementation of plain film reporting by radiographers for ED films. g) HSCB has provided recurrent funding for plain film reporting of the remaining in-patient IRMER'ised patients. h) A training programme is in place to increase the scope of Plain Film reporting that is carried out by Radiographers. i) The Trust is preparing an IPT for recurrent investment in additional reporting radiography staff to increase capacity. The lead in time for training could see implementation of this investment when agreed over the next 4 years. **AHP Access Times** No non-recurrent funding to address access times has been allocated in 2015/16. The Trust has agreed to retain a level of additionality until the end of August 2015. Internal resources continue to be directed as available to increase AHP		

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			capacity, particularly for review activity however, the ability to access staff on short term contracts remains challenging. The outcome of the PHA/HSCB demand and capacity exercise is concluding with areas of investment for 2016-17 identified, pending formal allocation.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
2	**Out-Patient Review and Planned Treatment Backlogs** ***Out-Patient Review Waiting List Backlogs in:*** • Acute; • CYPS; • MHD; and • OPPC ***Planned Treatment Backlogs:*** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale*** in Outpatient and AHP services.	Internal and External monitoring controls included as in Corporate Risk 1 above. ACTION PLANNING: • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	a) Outpatient Backlog The Acute Services Directorate has identified a number of areas of clinical risk within their review backlog and these were contained within the clinical risk paper to SMT on 29 April 2015. This paper details potential contingency options for discussion and approval in order to minimise the clinical risk associated with this backlog. At 1 January 2016, there were a total of 18,065 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led services only, including Visiting Specialties) as follows: • 41% (7407 people) waiting in excess of 6-months past their clinically indicated timescale; • 18% (3251) waiting between 3 – 6-months past their clinically indicated timescale; and • 41% (7407) waiting less than 3-		**HIGH**

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			months past their clinically indicated timescale. • The longest waits for Trust services are for Urology and extend back to 2012/13 all patients for 2012/13 have been validated and those waiting from 2012/13 have all been offered an appointment date. • The longest waits are in the visiting service of Ophthalmology which is provided by the Belfast Trust. The Local Commissioning Group is working with the Trust to resolve this. Note: No non-recurrent funding has been received from HSCB in 2015/16 for the out-patient review backlog. Internal resource continues to be directed to increase capacity for consultant review activity as this becomes available. <u>b) Planned Patient Backlog</u> • As at 31st December 2015, there are a total of 1211 patients on the planned treatment backlog. The longest waiting patient dates back to February 2015. • 52% (1326) of the planned treatment backlog relates to Endoscopy.		

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			• The non-recurrent allocation for Endoscopy in Quarter 1 & 2 will only facilitate the maintenance of planned scopes at 8-months past their clinically indicated timescale. Endoscopy, in totality, has been identified as a clinical risk within the clinical risk paper escalated to HSCB in May 15(as referenced in Risk 1 above) and through monthly elective access meetings with HSCB. • Further non recurrent funding allocated by HSCB in Quarter 3 and 4 for additional capacity. In-house activity has been maximised however limited capacity in the Independent Sector has reduced the level of capacity that can be secured. • In line with JAG accreditation requirements the planned treatment backlog should not exceed 6-months. c) AHP review backlogs • AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. • The Trust will continue to re-direct		

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			internally resources to areas of greatest risk as funding becomes available, however, ability to access staff on short term contracts remains challenging.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
3	Achievement of statutory functions/duties: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Quarterly reporting to Trust Board (from October 2015) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services and follow up of action plan	Older People and Primary Care Directorate have undertaken a Domiciliary Care review and have a process in place to implement the recommendations to achieve compliance. At the June 2015 Delegated Statutory Functions meeting with the HSCB, it was recognised that SHSCT compliance was among the best in the region. **Compliance with Review Target as at 30-12-2015** • Overall % within 12 months for commissioned packages is 78.5% • Overall % within 12 months for Domiciliary Care Packages is 71% • Overall % within 12 months for Nursing Home Packages is 94.3% • Overall % within 12 months for Residential Home Packages is 93% Please note that Banbridge ICT were	Older People and Primary Care	**MEDIUM**

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			unable to provide update for OPPC reviews in December 2015 as PARIS validation due for completion by Week Ending 22 January 2016. Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care. **Adult Safeguarding Team** Further targeted vulnerable adults training for those staff in care management and involved in annual reviews. **Care Home Support Team (CHST)** The CHST now has responsibility for all permanently placed clients. All reviews are completed in a timely way with 96% compliance and the remainder planned. An assurance process is embedded to ensure all residents in a Care Home with a Failure to Comply Notice in place or Vulnerable Adult investigation ongoing has an up to date review in place.		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
4	Achievement of statutory functions/duties: The Trust should have robust case 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 Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management completed. Draft report being considered. • Restructuring process by Heads of Service completed within the Disability Division of the Mental Health & Learning Disability Directorate. • Process has been completed within Mental Health and Learning Disability Directorate and will be by March 2016 in OPPC.	Mental Health and Disability/Older People and Primary Care	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
5	Systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other) 2 Lack of agreed indicators/measures of quality to provide assurance across some Trust services 3. Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues 4 Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings • Web-based incident reporting (on Datix) rolled out across the Trust • Clinical and Social Care Governance Review completed and new structures/processes embedded • Governance Committee and Senior Management Team • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Quality Sub Group • Morbidity and Mortality Group • 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	• New I.T. system to capture Standards and Guidelines has not been progressed. The Quality 2020 workstream focusing on Standards & Guidelines has proposed a regional approach to developing an IT system to the Quality 2020 Steering Group. • Q2020 Strategy Regional Workstreams continue to develop and strengthen regional quality indicators for reporting via Trust Quality Report • The Trust has commenced the development and implementation of a Quality Framework. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work • The revisit of Clinical and Social Care Governance has completed with a pilot of the new approach of dashboard assurance reports to Governance Committee on 8.12.2015 This risk will be fully reassessed and presented at SMT Governance on 2nd March 2016 as agreed at SMT Governance 27th January 2016.	Chief Executive	**MEDIUM**

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		to Chair and Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators • Serious Adverse Incident/Adverse Incident reporting system in place • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy • Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services • 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,		

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		Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning • Complaints assessed/screened for adverse incident review • Litigation process now embedded to ensure early alert to operational Directors			
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
6	Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care	• Trust Medicines Management policy • Review of operational procedures • Incident reporting system in place • Interim procedure on transcribing developed. • Trust Medicines Steering Group • Trust representatives on regional group • Themed Domiciliary Care Forum (IS) focused on safe administration of medication	• Annual Competency based training re medicines management for domiciliary care workers completed for all staff from September to December 2015. • A registered nurse has been seconded to carry out medicines review and safer systems. Completed in Newry/Mourne area. Now commenced in Armagh and Dungannon area. Core teams support the ongoing work in Newry/Mourne areas to prevent regression of project work to date. • A rolling audit will be carried out in N&M area as part of an exit strategy. • The Transcribing procedures have been revised (October 2015) and now include specific guidance for community nurses completing MIS for DCWs. • A Transcribing E learning training programme is available. All	Older People and Primary Care/Mental Health and Disability	**MEDIUM**

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			community nurses who will be required to transcribe to complete this by 01 April 2016. • Risk assessment revised November 2015. • Audit risk assessments for new service users to ensure compliance with guidelines commenced November 2015. • Further training / awareness sessions planned for key workers completing medication assessments. • Single patient medication files are being tested across providers to minimise risk of error. • A regional business case is being developed by HSCBsecure funding to deliver an interim system which includes a specialist medicines assessment and provision of appropriate solutions for service users who are identified as potentially requiring domiciliary care support in the area of medicines management. Statutory domiciliary care agencies recently inspected by RQIA – no requirements identified. Ongoing capacity issues in community nursing teams affecting timely provision of detailed care plans, medication instruction sheets, adherence to procedures etc. There are a range of processes in place for identification and management of		

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			medication risks identified in Trust domiciliary care services which are not available in independent sector providers except through notified incidents.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
7	Inability to recruit/retain Consultant medical staff for specific specialties • Consultant Medical Staff in Dermatology, Emergency Medicine, and Radiology • SAS Medical Staff in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	• Recruitment campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Detailed Action Plan is held within the HROD Directorate.	**Dermatology:** There is a recognised UK shortage of consultant posts in Dermatology and therefore a new model to attract GPs has been introduced. From late November 2014, 4 part-time GPs have started in post so this has proved successful. Two retired consultants were engaged to undertake some WLI clinics and this is continuing until end March 2016. There has also been an increase in expanding nurse led clinics. However there is still a requirement for a new (3rd) consultant post which will be difficult to fill. Part of the difficulty is that trainees do not rotate through our hospital as part of their training so local trainees are more likely to take up posts in Belfast where they are familiar. It has now been agreed that one registrar will rotate through Craigavon on a Thursday which may help somewhat. **Emergency Medicine:** A permanent Consultant commenced in Craigavon Area Hospital on 1st May 2015. Two Specialty Doctors were recently interviewed and appointed to ED in DHH, however despite these	Human Resources & Organisational Development/ Medical Director	**HIGH**

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			appointments it still proves very difficult to recruit to Consultant and Specialty Doctor positions within ED The situation in Daisy Hill Hospital has worsened considerably following the recent resignation of the Lead Consultant and a full time Specialty Doctor. At consultant level, this will leave one Temporary F/T consultant and one permanent P/T consultant. At SAS (middle grade) level there is one Associate Specialist and two Specialty Doctors – all are full time. The Trust has recently advertised for 5 consultants in Emergency Medicine (4 new posts and one replacement). A display advert was compiled and will be advertised as a full page in the BMJ, geo targeting UK, ROI and Western Europe. Also BMJ Banner, Irish Medical Times, NHS Jobs website and Facebook. Closing date 02.02.16. The Trust regularly raises the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. The Trust also embarked on a recruitment campaign for middle grade doctors in ED with M3 Creating Connections. This company undertakes medical recruitment project work with Trusts and Health Boards on behalf of		

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			doctors.net.uk. There was only one application received, however the candidate subsequently withdrew. The Trust has also met with 'A Team Recruitment regarding a proposal to recruit medical staff at SHO level from the EU, however it is expected to take at least 6 months to recruit and train suitably qualified doctors via this route. The Trust has also introduced a Clinical fellowship programme for ED. One appointment has been made and this doctor took up post in August 2015. **Anaesthetics:** It is planned to develop a training programme with the aim of "growing our own" specialty doctors. A proposal has been drafted and is currently under consideration by the service. **Radiology:** There is a recognised gap in Consultant Radiologist numbers and Clinical Radiology has recently been included in the Government approved shortage occupation list. The Trust has successfully appointed a number of Consultant Radiologists over the past few years; however some of these have left to take up other posts. The position remains unstable. In February 2015, the Trust successfully appointed 4 permanent Consultant Radiologists. One person has since withdrawn, however the other 3 took up post in August 2015.		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	
8	Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital	• Trust Senior Oversight Group • Escalation procedures in place to alert senior management of any changes in rota • In-house training programme • Daily review by Senior Management of night reports and follow up on issues • Daily audit of notes	• Ongoing recruitment of Consultants and Middle Grade Doctors for Emergency Department • Use of locums • Ongoing review of medical rota to ensure senior doctors on duty until midnight • Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a Registrar • Support provided as required by Paediatric Registrar and Anaesthetic Registrar in the out of hours period. Medical and Surgical Registrar will provide additional support if on duty overnight • Recruitment of senior nursing staff to be on duty 24/7 • Additional ENPs currently being recruited • Action re medical recruitment covered under detail of risk 7 above • Regular updates to Commissioner and DHSSPS		**HIGH**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
9	Increasing inability to recruit registered nursing staff	• Ward Sister/Charge Nurse management of available staff on a shift by shift basis • Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need • Escalation to Operational Director as required • Open registration for Nurse Bank • Open Recruitment for Adult Band 5 Nurses with interviews scheduled every 2 weeks • E-rostering roll out	• All opportunities to secure permanent staff continue to be progressed • Open Recruitment implemented from 21/12/15 with interviews scheduled every two weeks to ensure ongoing progression of applications received • Regular recruitment days planned alongside ongoing recruitment. An open advertisement with the most recent drive for Adult Nursing including Year 2 and Year 3 students which resulted in 153 job offers on the day with many of the pre-employment checks undertaken. Follow up work is continuing to maintain a relationship with all appointees until their start dates. The most recent drive for MH Nursing is also aimed at including Year 2 and Year 3 students. • Introduction of Rotational Programmes within and across Directorates. • Targeted recruitment of current nursing students for bank Band 3 roles ongoing with a view to introducing them to the Southern Trust for their Band 5 career. • Discussions continue with DHSSPSNI to increase the number of places available on the OU PRNP commencing September 2016. SHSCT has also utilised funding from DHSSPSNI in-year to support	**Executive Director of Nursing; Director of HR; Operational Directors**	**HIGH**

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			thirty-two staff to commence the module K101 in February 2016. • A Trust Nursing Workforce Planning Group has been established to seek to address current and future anticipated challenges regarding the demand for and supply of Registered Nurses across all programmes of care. Consideration is now being given to International Recruitment. • A regional Nursing Workforce Planning Group, chaired by Mr F Rice, Executive Director of Nursing, has now completed a scoping exercise at a high level to collate the statistics on vacant posts compared to Funding Staffing and the numbers of staff unavailable for work due to various types of leave. The report of this group was presented to CNO at CNMAC in December 2015 with 12 key recommendations. 7 of these recommendations relate to recruitment approaches including international recruitment. The Trust has now agreed with other Trusts that two senior Southern Trust staff, take a lead role in progressing international recruitment across the region as well as reviewing the model for recruitment to consider further streamlining of approaches to maximise on the available pool		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
10	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 Specific examples: • Fire Safety Action Plan in place and continuing to progress. • High Voltage capacity limit on supply to Craigavon Area Hospital Identified and remedial project underway. • Aging High Pressure Hot Water system (HPHW) at Craigavon Area Hospital has now been replaced with new Low Pressure Hot Water system. • Structural works to tower block at South Tyrone Hospital complete. • Completion of Theatre development CAH • New negative pressure isolation room at CAH complete.	• 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 • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2015/16/17. Phase 1 of Mechanical Infrastructure complete. • Strategic Outline Case submitted for major redevelopment at CAH site. Work is now being progressed on the main business case for submission in 2015/16. • Provision of new negative pressure isolation room at DHH awaiting decision on preferred option from Acute Services. Thereafter proposals to be incorporated in Business Case for consideration by SMT/Trust Board.	Director of Human Resources and Organisational Development	**HIGH**

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			The sewage system serving the wards at CAH has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. An extensive replacement programme commenced in August 2015 through a carefully co-ordinated and phased programme of ward decants and is progressing well with works being carried out to the most critical areas (subject to the availability of decant space v winter pressures). Further works may be necessary after the winter period to complete the programme. A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly reduced should the replacement of CAH proceed.		

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	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 • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed. • Installation of new Combined Heat and Power plant is complete and G59 approval from NIE (to permit parallel generation) is in place. This will provide increased resilience through an additional source of supply for the site.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • 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 have been approved and these projects 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 risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
12	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues: • The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). • Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours. • A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented • Additional activity will not be accepted by the aseptic unit until the staffing issue	• The queries received in relation to the business case for a new build aseptic suite co-located with the Mandeville Unit have been addressed and the OBC was submitted to the Department on 1.7. 2015. A letter of Commissioner Support received from the HSCB has been submitted. The Trust has identified this as its top priority for capital funding. • Recent deterioration in the fabric of the building is being addressed through an interim plan involving urgent minor works to the aseptic suite. • The Capita Model for chemotherapy/cytotoxic dispensing was applied to the current workload in the unit. This identified a staffing deficit of 3.6wte pharmacists. Using the capacity plan as a model the unit is short 2 pharmacists for the current	Director of Acute Services	**HIGH**

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		is resolved	workload. HSCB agreed to fund the 2 additional band 7 pharmacists required. The IPT was received in May 2015 and the recruitment process is complete. The pharmacists will be in post by the end of February 2016.		
	• The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	• Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	• Complete		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network • Emerging infections (CPE/VHF/ebola)	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • • Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings • Craigavon pressure isolation room now complete • Outbreak /incident management plan in place • Establishment of antimicrobial	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites.	Medical Director	**MEDIUM**

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	• HCAI outbreaks in tertiary services (BHSCT) • Increasing emergence of CPE infections	management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	• Engagement with PHA on Regional Surveillance system funding and procurement to recommence • Enhancement communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Completed Ebola Management Plan • CPE Outbreak/Incident Management in line with regional CPE toolkit • Enhanced HCAI RCA information management system and system developed to further improve meta-analysis of C Difficile cases • Joint letter from Medical Director, Executive Director of Nursing and Director of Acute Services issued to staff re Infection Control practice • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Development of a Business Plan to consider Infection Prevention Control (IPC) Nursing Workforce within the Trust • Electronic C Diff database now developed to develop learning from trends • New early warning criteria developed to identify potential outbreaks earlier • Development of Clinical Antibiotic Stewardship champions to implement new Antibiotic Stewardship Policy		

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14	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• The Trust has submitted its application for re-accreditation and is awaiting a new date. A pre-assessment visit took place on 8th October 2015. • Action Plan updated as progress is made. • Full inspection advised for April 2016	**Director of Acute**	**HIGH**
CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
15	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results	**Consultant / Medical Appraisal** As at 16/11/15, 93% of 300 eligible doctors have completed their 2014 appraisal. **Knowledge and Skills Framework** A KSF steering group continues to meet quarterly. Work is ongoing with individual Directors and Heads of Services to support staff and managers when completing their KSF Documentation, and therefore to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust	Medical Director Director of HR and Organisational Development	**MEDIUM**

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		provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	continue to be presented to SMT PDP's are now being recorded on HRPTS as a qualification. As a result of all of the above, there has been an increase in the extent to which KSF is being implemented across the Trust. Work underway to improve mandatory training levels within the Trust In May 2015 39% of staff completed their PDP. In November 2015 47% of staff completed their PDP.		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
16	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	• NI Revalidation Programme Board, attended by the Executive Director of Nursing, meets bi-monthly • NI Revalidation Working Group attended by the Trust's Assistant Director Nursing Governance, meets monthly • In October 2015 the NMC has agreed its arrangements for the revalidation of nurses and midwives to commence in April 2016	The Trust's Medical Revalidation Team has been extended to support the implementation and progression of Nursing and Midwifery revalidation which is due to commence in April 2016. Extensive work has been undertaken to establish a Nursing and Midwifery Revalidation information management system which holds all (3,023) Trust NMC registrants' PIN, Annual Fee Expiry and Revalidation dates. This information management system is now live and will provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progression of Nursing and Midwifery revalidation. Monthly revalidation reports will be issued to individual nursing / midwifery managers to support local arrangements on the timely revalidation of nurses and midwives for whom they have responsibility. Standard Operating Procedures have been developed to	Executive Director of Nursing	**HIGH**

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			provide timely reports to nursing and midwifery managers and heads of service. Assistant Director Nursing Governance, with Directorate Champions are developing tools and proformas to support nurses and midwives in evidencing compliance with the core revalidation elements and to prepare nurses/midwives for their professional development discussion with their NMC colleague. Assistant Director Nursing Governance has linked with the AD Nursing Workforce Development and Training and Clinical Education Centre to scope out planned support programmes.		

CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
17	• Achievement of financial balance in 2015/16	• Contingency Plan for 2015/16 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	As a result of additional Health and Social Care Board allocations and Departmental approval to a number of additional contingency proposals, the Trust would now not expect to breakeven in 2015/16.	Finance and Procurement/ All	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
18	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Contracts management improvement group established and key actions formed • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided . • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	**GENERAL** • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013) • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements. • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final	Director of Finance and Procurement Director of HROD	**MEDIUM**

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			recommendations of Procurement Policy awaited • New Structures for contract & procurement management being developed as part of Management Review **ESTATES** • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Regional Steering and Working Groups established. Recruitment of PALS team underway. Recruitment of Trust Team being taken forward under newly appointed Head of Service. • Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes <£45k • Estates Works Management Improvement Action Plan (incorporating all IA recommendations) established and 95% implemented during 14/15. Internal Audit undertook a follow-up audit (reported March 2015) and verified that the majority of recommendations had been either partially or fully implemented. Further IA work to be undertaken fourth		

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			quarter of 2015/16. • Two replacement Estates Officers appointed to Estate Development team and volume of works being undertaken balanced against resources to facilitate compliance. **SOCIAL CARE PROCUREMENT** • Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement. Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements • Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. • Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15	Director of Performance and Reform; All Directors	

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			enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Impact of 2015 Public Contract Regulations on social care procurement assessed and key actions agreed to scope demand and capacity requirements		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
19	Payroll & Travel - HRPTS System & Shared Services • Payroll & Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer.	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Progress updates to Audit Committee	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Weekly, Fortnightly and Monthly staff transferred to the Payroll Shared Service Centre.	Finance Director	**MEDIUM**

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	• Transfer to Payroll Shared Services and maintenance of service delivery • Recruitment – considerable delays currently being experienced in the recruitment of posts which is impacting on operational services	• Regular meetings with BSO • Escalation procedure in place by Trust's Head of Resourcing Director of HROD also now meeting with Assistant Director of SSC to escalate concerns and seek engagement for a solutions focused approach. • Weekly monitoring of contract indicators raised with HOS for Issues Log (Reporting unavailable to facilitate actual monitoring of KPI's	• Additional resources identified to support BSO in the delivery of services. The Trust has appointed a Recruitment Liaison officer on a temporary basis for a trial period. This officer reports directly to the Head of Resourcing and is charged with the responsibility of supporting the Recruitment SSC in high volume recruitment areas to provide advice and guidance on progressing pre-employment checks in a timely manner. • Face-to-face meetings being progressed with Directorate HOS teams to provide further guidance and support on managing recruitment activity including advice on escalation arrangements and what the Trust can do to ensure there are no delays caused by Trust actions. • Reporting information still unavailable but requested and highlighted with SSC as a key component to allow monitoring of KPI's.	Director of HROD	

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
20	GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts	• Recruitment process for vacant posts • Business Continuity Plan • Medical Managers with medical responsibility for the service • Call Centre Co-ordinator • Call Manager system • Late availability payment • Flexibility re shift patterns offered • Daily monitoring of rotas and appropriate contingency plans deployed based on resources available	• The Trust has escalated risk to HSCB and DHSSPS, and has had recent joint meetings. • There is a range of actions in place to attract GPs to work in the service. • Ongoing recruitment • Implementation of winter pressure plan to include additional shifts. • The process of over-seas GP recruitment began in December 2015 • HSCB and Trust initiatives to support cost of increased GP indemnity payments. • The HSCB has requested Dalriada Urgent Care to carry out a peer review and report – by end of January 2016. • Early alerts are issued when rate of GP uptake of shifts are less than 50% or when there is less than 2 GP's on duty in the period 12 midnight to 8 am. • Twice daily operational meetings to review medical cover and contingency actions implemented. • Dalriada is providing nurse triage from 8 pm to 8 am daily since December 2015. • Triage and Nurse Practitioners are working within GP Out of Hours Service to assist in covering gaps. • Capacity and demand work is being undertaken by Planning and reform. This commenced in	Older People and Primary Care	**HIGH**

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			December 2015. Review of workload of clinicians ongoing by Clinical Lead. • KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB. • Locally Enhanced Service pilot commissioned by the Health and Social Care Board commenced in November until March 2016 to provide additional medical cover on Saturdays and Sundays. Working with other OOH providers to secure additional capacity. • The Pharmacy Pilot commenced on 28.2.2015 with 8 Pharmacists recruited to provide cover from 11 am – 4 pm Saturday and Sunday and Bank Holidays. Pharmacists have also provided additional cover outside these hours to increase capacity. An evaluation been completed and submitted to HSCB. The pharmacy service will continue until end of March 2016, with additional 5 hours on a Saturday and Sunday as part of the winter pressures plan. • Internal review via independent GP underway to report by end March 2016		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
21	Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in	• Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited	• The Health Visiting workforce position demonstrates that Staff in Post equate to the Funded Staffing Levels inclusive of the investment funding of 8.4wte Band 6 health	Executive Director of Nursing/ Director of C&YPS	**HIGH**

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	the service	supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA .	visitor posts received in September 2015. The additional funding allowed all 11 health visiting students who completed training in September 2015 to secure permanent posts. This has led to some improvement with 10.22 wte unavailable to deliver the service (due to current permanent vacancies and planned and unplanned absence), which equates to 12% deficit in the health visiting workforce. This demonstrates an improved position from that of September 2015 when 20% of the HV workforce was unavailable. This staffing deficit means that 5 of the 7 Health Visiting Teams are in step down: • There are currently 6 permanent vacancies, 3 maternity leaves and 4 staff on long-term sick leave. • Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&SCT is able to secure through the bank is insufficient to meet the deficit. • Ten Health Visiting students are currently training in the Trust but won't complete until September 2016. The internal waiting list has been exhausted and the external waiting list is significantly reduced to HV working in other Trusts who want specific localities. It is unlikely that all our permanent		

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			vacancies will be filled until the next cohort of students qualifies in September 2016. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. • The Trust is progressing on first regional Ecat caseload weighting in February 2016 and this will inform regional normative staffing initiative for health visiting which is been led by the Trust Nursing Workforce Leads and the PHA. • This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).		
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
22	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board and QA by independent "critical friend" review (January 2016) • Public Prosecution Service has	Mental Health & Disability	**HIGH**

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		moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel. • Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any	determined no prosecution of the Home Owners regarding one client • 13.01.16 – RQIA have advised the Trust that their prosecution case against HHBC is now concluded as the Judge granted an application by the defence counsel to stay the proceedings. RQIA also advised that their intention to initiate formal enforcement with HHBC will not proceed. Scoping exercise has been completed and should alternative placements be required will be revisited • Update Report to Trust Board on 28th January 2016 provides further details.		

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		identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
23	Risk of loss of life and/or serious harm to patient(s), significant interruption to	**Hardware:** • The Trust have entered into a	• SMT approved Capital Funding of £342,000 (2015/16) for the provision of a Core Telephony	Director of HROD; Director of Acute	**MEDIUM**

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	service(s) and limited or no telecommunication within the major hospital sites due to foreseeable unserviceable obsolete telecommunication equipment	comprehensive contract (VDCP) with BT to manage the existing network and support the structured replacement of individual legacy systems. The existing Siemens DX switches, which serve telecoms users for approximately 60% of the trust, reach end of supported life in November 2017.At present, in the event of a failure, BT VDCP through Siemens guarantee a repair within 4/8 hours depending on service level agreement. • After November 2017 BT will no longer provide a guaranteed service agreement and it will be “best endeavours” i.e. only if parts can be sourced (used stock of whatever) etc. they’ll try and fix it, if the fault is software related there is unlikely to be a fix. A fault will leave the trust without internal/external communications for a considerable period. These phone systems are well beyond their expected life and desperately need to be replaced.	Platform to provide the centralised telephony foundation and continuity for the existing Avaya Telephony infrastructure deployment. Planned completion end March 2016. • Requirement for additional funding to replace 5 systems on core DX sites including St Lukes, Tower Hill, Craigavon Hospital and Daisy Hill Hospital. [5 systems c£450k each] • Requirement for additional funding to replace 4 systems serving Medium and Small sites (62). [4 systems c£425k each]	Services	

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		System Support: Increased risk of in-cohesive maintenance, system support, due to gaps in out-of-hours provision of cover.			

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Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

August 2016

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INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to one of the four domains contained within the Board Assurance Framework and to the relevant Trust Corporate Objectives as detailed below:-

Four Accountability domains contained within the Board Assurance Framework

- Domain 1 Corporate Control
- Domain 2 Safety and Quality
- Domain 3 Finance
- Domain 4 Operational Performance and Service Improvement

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.

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OVERVIEW OF CORPORATE RISK REVIEW AS AT 31st AUGUST 2016

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	8	5		13

The Corporate Risk Register has been reviewed by SMT on two occasions since the last Governance Committee meeting. Changes include:-

New risks identified by SMT or escalated from Directorate Risk Registers	• Business Services Organisation (BSO) Shared Services Centres – Payroll/Travel & Recruitment (and included in the merged workforce risk detailed below) • Lack of Data Processing Contract with BSO
Risks removed from the Register	• Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation status • Achievement of Statutory Duties/Functions - Level of Residential Home/Nursing Home/Domiciliary Annual Reviews not completed. • Medical Appraisal system

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Merged risks	Following risks have been combined into one workforce resourcing risk:- • BSTP/Recruitment Shared Services • Inability to recruit/retain Consultant medical staff for specific specialties • Inability to secure senior medical staff to provide 24/7 senior cover for Emergency Department in Daisy Hill Hospital • Inability to recruit registered nursing staff • GP Out of Hours Service – inability to attract adequate cover for GP shifts • Health Visiting Service – impact on families due to decreased staffing levels • Reduced ability to provide 24/7 laboratory service at Daisy Hill Hospital due to insufficient Biomedical Scientists • Failure to attract/appoint required staff and delays in recruitment processes in mental health/disability inpatient wards, community teams, supported living and day care facilities • I.T. Department – workforce shortage due to insufficient resources and long term sickness levels. Following risks have been combined into one maintenance and development of Trust Estate risk:- • Insufficient capital to maintain and develop Trust Estate • High Voltage Capacity • Anticipated failure of legacy telecoms infrastructure • Design and fabric of Aseptic Suite, Craigavon Area Hospital • Construction activity on Trust sites leading to increased risk of • significant service disruption • ICT Maintaining Existing Services
Risks where overall rating has been reduced	None
Risks where overall rating has been increased	None

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SUMMARY OF CORPORATE RISKS AS AT AUGUST 2016

DOMAIN 1: CORPORATE CONTROL				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
1	**Revalidation Arrangements –** Implementation of Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016	1 & 4	**HIGH**	**8**
2	**Appraisal –** lack of evidence of compliance with a fully embedded appraisal (KSF) system	1 & 4	**MEDIUM**	**10**
3	**BSO Shared Services:** Payroll/Travel and Recruitment	4&5	**MEDIUM**	**11**
4	**Data Processing –** lack of contract with BSO	1&5	**MEDIUM**	**13**
5	**Infrastructure** – Insufficient capital to maintain and develop Trust Estate (facilities, equipment, ICT Estate etc.) to support service delivery and improvement	1	**HIGH**	**14**

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DOMAIN 2: SAFETY AND QUALITY				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
6	**Workforce Resourcing – Workforce Shortages**	1	**HIGH**	**21**
7	**Achievement of Statutory Duties/Functions –** robust case management processes	1	**MEDIUM**	**30**
8	**Capability of Trust systems of assessment and assurance in relation to quality of Trust services**	1	**MEDIUM**	**31**
9	**Healthcare Acquired Infections (HCAI)**	1	**MEDIUM**	**33**
10	**Safeguarding of residents from risk of potential financial abuse**	1	**HIGH**	**35**

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DOMAIN 3: FINANCE				
Risk No.	**Risk Area/Description**	**Corporate Objective**	**Risk Rating**	**Page**
11	**Achievement of recurrent financial balance**	5	**MEDIUM**	**38**
12	**Management and monitoring of procurement and contracts –** lack of compliance with best practice guidance	5	**MEDIUM**	**38**
DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT				
13	**Achievement of Commissioning Plan Standards and Targets**	1	**HIGH**	**42**

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DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 4 – PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: REVALIDATION ARRANGEMENTS					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
1	Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in April 2016 Organizational processes and registrant support arrangements have been in place since 1st April 2016. On average 53 registrants / month [266, 8%] revalidated in the period April – August inclusive. However, **451** (**15%**) registrants are due to revalidate in the next 2 months (i.e. September or October 2016) - the months most nurses concluded their training.	• SMT agreement that 50% of Nursing Governance Co-Ordinators (NGCOs) hours would be allocated to supporting organisational and registrant readiness for revalidation. • A Professional Revalidation Support Team (an extension of the Medical Revalidation Team) has been established to support organisational arrangements and assurances. • Nursing and Midwifery Revalidation information management system to provide assurance on revalidation status of nurses and midwives in the Trust. • NMC Revalidation Implementation Group, chaired by the Executive Director of Nursing, to support and direct registrants and managers.	The Nursing Governance Co-Ordinators (NGCOs) continue to support directorate managers and registrants in preparing for effective and timely NMC revalidation. The Assistant Director of Nursing Governance and the NGCOs have developed tools and proformas to support nurses and midwives in evidencing compliance with revalidation requirements and in preparing registrants for their reflective discussion and confirmation meetings. The Nursing and Midwifery Revalidation information management system is now live and holds information on over 3,000 NMC registrants' PIN, annual fee and revalidation dates. Standard Operating Procedures have been developed to provide timely reports to nursing and midwifery managers and heads of service. Monthly revalidation reports are issued to individual nursing / midwifery managers to support local arrangements on the timely	**Executive Director of Nursing**	**HIGH**

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	Although the support arrangements have met the needs of smaller numbers / month, the test will be if this significantly larger cohort successfully revalidates in September and October. If successful the risk rating will be reviewed and lowered.		reflective discussion and confirmation meetings for those they have responsibility for. Monthly revalidation reports provide assurance to the Executive Director of Nursing, SMT and Trust Board in relation to the progress on the implementation of the NMC revalidation arrangements. The AD Nursing Governance has worked with the AD Nursing Workforce Development and Training and Clinical Education Centre to agree a planned approach to ongoing support programmes.		

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DOMAIN 1: CORPORATE CONTROL					
LINK TO CORPORATE OBJECTIVES: 1 & 4 - PROVIDING SAFE, HIGH QUALITY CARE & BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
RISK AREA/CONTEXT: FULLY EMBEDDED APPRAISAL SYSTEM					
No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
2	Lack of evidence re compliance of a fully embedded appraisal (KSF) system	There are a variety of mechanisms in place to ensure appraisal takes place:- • Medical Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings • Action Plan in place and reviewed quarterly • Staff Attitude Survey results provide staff view • Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.	<u>Knowledge and Skills Framework</u> Work ongoing with Directors and Heads of Services to support staff and managers when completing their KSF documentation to increase uptake within each Directorate KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT PDPs are now being recorded on HRPTS as a qualification. There has been a slight increase in the extent to which KSF is being implemented across the Trust – 53% as at 31st July 2016, although this is still short of the Internal Audit target of 60% by September 2016. Work is continuing to improve mandatory training levels within the Trust.	**Director of HR and Organisational Development**	**MEDIUM**

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DOMAIN 1: CORPORATE CONTROL

LINK TO CORPORATE OBJECTIVES 4 & 5 - BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE & 5 – MAKING BEST USE OF RESOURCES

RISK AREA/CONTEXT: Shared Services Centres – Payroll / Travel & Recruitment

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
3	**Shared Services** • **Payroll & Travel SSC** – risk to accuracy of payroll as control environment not yet stabilized. Negative media publicity and impact on Trust's reputation as a good employer.	• Customer Forums are in place for monitoring the performance of services in Shared Services Centres • Monthly KPI data shared with the Trust, but this is currently not complete data set • Progress updates to Audit Committee with attendance by BSO, as required • Regional audit of BSO Payroll Shared Services, currently six monthly • Trust participation in a number of grups to provide assistance on progressing improvements in Payroll Shared Services Centre	• Ongoing communication/engagement with Managers as regards timely completion of paperwork • Internal Audit Report – Payroll Shared Services, March 2016 – limited assurance • Internal Audit re-audit September 2016 • Quarterly BSO Assurance Reports circulated to Audit Committee members regarding progress on Internal Audit recommendations • Trust participation in new governance arrangements post BSTP to monitor shared services performance and achievement of benefits realisation	**Finance Director**	**MEDIUM**

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	• **Recruitment Shared Services Centre (RSSC):** The speed of response / time to fill urgent posts poses a risk for front line services. This risk has the potential to increase as Recruitment Shared Services continues to be rolled out to all Trusts – there is a risk that standards will drop and the urgency of Trust services will be lost.	• Continued involvement in regional work / RSSC issues. Assurances to be sought from RSSC Head of Service regarding maintenance of standards and improvement on time to fill urgent positions. Monitoring reports on performance against standards also be provided by RSSC. • Monitoring and ongoing review of all aspects of the pre-employment checks including Occupational Health checks. • Identification of any internal issues, which may be contributing to the timeliness of recruitment exercises.	Regular engagement with RSSC managers to monitor activity and review particular operational issues of concern/shortfalls in service delivery. An issues log is maintained by the Head of Resourcing. There are also regular meetings with RSSSC and Occupational Health to specifically address any blockages and share planning information. Since May 2016, RSSC has been implementing a Recovery Plan in recognition of the level of service not yet being at the desired level and the Trust is working actively and collaboratively in the implementation of this plan. The purpose of this plan is to make improvements in key areas such as shortening the length of time taken to fill posts, improving communications and customer service, enhancing he E-Recruitment system and providing quality management information and KPI monitoring. This will involve the standardization of processes at key stages of the recruitment process, as well as the development of clear operating principles, roles and responsibilities for all stakeholders. A local action plan is also in place to address issues/ delays within the control of the Trust. Communication with Trust managers is ongoing to ensure they fulfil their responsibilities and are supported to do so via training, comprehensive user guides	**Director of Human Resources and Organisational Development**	

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			and access to a local helpdesk. A permanent 'Recruitment Liaison Officer' post is being established and is currently advertised permanently (August 2016).		

DOMAIN 1: CORPORATE CONTROL					
CORPORATE OBJECTIVES: 1 & 5 – PROVIDING SAFE, HIGH QUALITY CARE & MAKING BEST USE OF RESOURCES					
RISK AREA/CONTEXT: Lack of Data Processing Contract with BSO					
Risk No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
4	Lack of 'Data Processing' Contract with BSO as per Information Commissioner (ICO) guidelines. Risk of financial penalties/ fines and adverse publicity in the event of a data loss or breach.	• Trust ICT Security policy • Trust performance in application/ use of HCN re anonymized data	• This Risk requires ongoing monitoring in line with development of electronic and shared systems approaches in HSC. • The Trust has engaged Department of Legal Services (DLS) to assist with development of an appropriate contract. Risk escalated and shared on regional basis via NI Electronic Care Record Information Governance Workstream	**Director of Performance & Reform**	**MEDIUM**

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DOMAIN 1: CORPORATE CONTROL (also linked to Domain 3 Finance and Domain 4: Operational Performance and Service Improvement)					
CORPORATE OBJECTIVE: 1 – PROVIDING SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: INFRASTRUCTURE – Maintenance and development of Trust Estate (facilities, equipment, ICT etc.) to support service delivery and improvement					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
5	Insufficient capital (and associated revenue) funding to maintain and develop Trust Estate (including I.T. Estate) to support service delivery and improvement Specific risks include:- • High Voltage capacity limit on supply to Craigavon Area Hospital • Anticipated failure of legacy Telecommunications infrastructure • Failure of infrastructure within drainage to remove sewage from wards at Craigavon Area Hospital • Design and fabric of Aseptic suite, Craigavon	• 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:-	• On-going prioritisation and bidding process for capital in place • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k • A review of maintaining existing services (for the next 5 years) has been carried out. This review has identified that funding in the region of £119 million is required to address risk areas including: Critical Telecommunications infrastructure; Infection control and Health & Safety issues in patient areas; Medical Gas infrastructure and ventilation system risks; Structural repairs to DHH. This requirement could be significantly	**Director of Human Resources and Organisational Development/ Director of Performance and Reform**	**HIGH**

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	Area Hospital • Construction activity on Trust sites leading to increased risk of significant service disruption • Maintenance and development of existing ICT Estate Each of these risk areas are set out below		reduced should the replacement of CAH proceed. • Work is now being progressed on the main business case for major redevelopment at CAH site. • Prioritisation of highest Estates risks being undertaken to inform allocation of available capital and revenue funding for 2016/17.		

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	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	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 • Peak Lopping installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed. • Installation of new Combined Heat and Power plant is complete and G59 approval from NIE (to permit parallel generation) is in place. This will provide increased resilience through an additional source of supply for the site.	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. • 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 have been approved and these projects 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 risk. • CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion September 2016	Human Resources & Organisational Development	

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	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Anticipated failure of legacy telecoms infrastructure leading to significant service disruption and potential consequential harm to service users. **System Support:** Increased risk of in-cohesive maintenance, system support, due to gaps in out-of-hours provision of cover. Construction of the new Paediatric unit at Craigavon Area Hospital has highlighted an additional resilience risk relating to critical cable routes for telecoms and IT infrastructure	**Hardware:** • The Trust have entered into a comprehensive contract (VDCP) with BT to manage the existing network and support the structured replacement of individual legacy systems. The existing Siemens DX switches, which serve telecoms users for approximately 60% of the Trust, reach end of supported life in November 2017.At present, in the event of a failure, BT VDCP through Siemens guarantee a repair within 4/8 hours depending on service level agreement. • After November 2017, BT will no longer provide a guaranteed service agreement and it will be "best endeavours" i.e. only if parts can be sourced (used stock of whatever) etc. they will try and fix it. If the fault is software related there is unlikely to be a fix. A fault will leave the Trust without internal/external communications for a	• SMT approved Capital Funding of £342,000 (2015/16) for the provision of a Core Telephony Platform to provide the centralised telephony foundation and continuity for the existing Avaya Telephony infrastructure deployment. Planned completion end March 2016. • Requirement for additional funding to replace 5 systems on core DX sites including St Lukes, Tower Hill, Craigavon Hospital and Daisy Hill Hospital. [5 systems c£450k each] • Requirement for additional funding to replace 4 systems serving Medium and Small sites (62). [4 systems c£425k each] • Replacement of Core System and roll-out of Handsets being progressed on a phased basis – £950k revenue funding has been approved to progress this during 2016/17 • Proposals being developed for independent secure cable route to improve resilience .	**Human Resources & Organisational Development**	

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		considerable period. These phone systems are well beyond their expected life and desperately need to be replaced.			

	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding).	• Increased environmental monitoring to check for failures of sterility in the unit • Expiry dates of all products prepared has been reduced to a maximum of 24 hours.	• Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July. The design team have met with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed in mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited.	**Director of Acute Services**	

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	Increased risk of significant service disruption due to high degree of construction activity on Trust sites	• Use of competent 3rd parties- Professional Design Teams & Contractors- competency is part of procurement assessment • Competent staff and comprehensive procedures • Wide stakeholder engagement on all projects • Project specific information- pre-construction information, construction phase plan and Health & Safety File • Use of in-house rules 'Requirements for contractors' in work schemes • Use of work permits for higher risk work processes • Communications team & global email used for wider general & public communications • Annual plan of works	• Recruitment of 'project compliance officer' type of role who would provide a constant presence on work schemes to review Health and Safety, permit compliance, quality, etc. to be progressed in 2016/17 • Longer term planning of work schemes and allocation of funding to spread (on-site) work schemes over the entire year rather than in the 4th quarter which is generally the case. • c£500k funding approved for the creation of additional car parking spaces on the Craigavon Area Hospital site during 2016/17 • On Craigavon Area Hospital site provide an additional site entrance/ exit – design proposals to be developed 2016/17 • Updates to 'Requirements for contractors' document underway	**Director of Human Resources and Organisational Development**	

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	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
	Availability of capital (and associated revenue) funding to maintain and develop existing ICT estate, including server infrastructure, data storage, etc and support to ICT service modernization Specific risks relate to ability to implement planned upgrades / infrastructure as foundation to support developments in ICT innovation and limits these developments within the Trust All ICT resources are Currently targeted at Maintaining existing levels. Specific risks include-: Capacity to expedite/support mobile working roll out which subsequently (impacts on front line service capacity workforce risks below)	• ICT infrastructure requirements in terms of maintaining existing services have been prioritized in the IT Business plan approved by Trust Board and shared with HSCB. • Retention and disposal protocols in place • E-mail Archiving policy and procedure approved by SMT March 16.. • Bids for funding continue to be made to Capital Allocations Group and e-health division of HSCB for access to slippage. IS Technology partners utilised to provide support in line with available NR resources. Prioritisation is being given to maintaining existing services and replacement of existing devices to upgrade them and minimize support requirements. Service requests for more laptops and mobile devices are currently being declined.	• On-going prioritisation and bidding process for capital in place • Policies and procedures in place to manage ICT storage capacity. • A business case is underway to outline the full costs (including staff support) associated with further IT users. • All internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk. A number of vacancies previously held as part of corporate contingency have been released in 16/17 The Trusts technology partner Hewlett Packard is providing temporary non-recruitment staffing to support Trust operational management in 16/17 A business case is being developed to outline full costs (including staff support) associated with further IT users within the Trust. Processes in place to ensure all internal business cases for IT innovation include the recurrent support costs for both infrastructure requirements, licensing and service desk.	**Director of Performance and Reform**	**HIGH**

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DOMAIN 2: SAFETY AND QUALITY

CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE

RISK AREA/CONTEXT: WORKFORCE RESOURCING – WORKFORCE SHORTAGES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
6	**Workforce Resourcing Risk – Workforce shortages** The Trust is facing a number of workforce resourcing risks, including the following key risks: **Medical shortages** • Consultant Medical Staff in Dermatology, Emergency Medicine, Breast Surgery and Radiology • SAS Medical Staff in Anaesthetics, General Surgery, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics	**Key controls to include:** • Ongoing recruitment (including overseas) campaigns • Use of Locum agencies • Risk Assessment highlighting controls/action in place • Trust Senior Oversight Group for ED DHH • Escalation procedures in place to alert senior management of any changes in rota for ED DHH • Daily review by Senior Management of night reports and follow up on issues on ED DHH • Daily audit of notes for ED DHH • Close monitoring of all Breast referral waiting times • Submission of HSCB Unscheduled Care Escalation plan (6th May 2016)	**Dermatology Medical:** A Dermatology trainee is now required to rotate to Craigavon one day per week. This should encourage trainees to apply for Consultant posts in Craigavon. Two retired Consultants continue to undertake some Waiting List Initiatives (WLI) clinics for Dermatology. There has also been an increase in expanding nurse led clinics. However there is still a requirement for a new (3rd) Consultant post which will be difficult to fill. **Emergency Medicine:** The Southern Trust has advertised Consultant ED posts to cover on the Daisy Hill Hospital (DHH) site, but so far have been unsuccessful. 2 Consultants were recently appointed to CAH. There is another advert out closing in August 2016 for Consultant ED CAH (with sessions in DHH) – no applicants to date.	**Human Resources & Organisational Development/ Medical Director/Director of Acute Services**	**HIGH**

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			The Trust is regularly raising the requirement for ED locums with all contracted agencies and other known non-contracted agencies. Apart for occasional ad-hoc cover, it has been very difficult to secure any 'longer term' cover. Ongoing review of ED DHH medical rota to ensure senior doctors are on duty until midnight. Opening of observation area from 22.00 – 08.00 for patients who have no definite diagnosis and have not been assessed or discussed with a Registrar. Recruitment of senior nursing staff to be on duty 24/7. **Breast Service** The Trust has secured the services of a part time Breast radiologist until 31st December in the first instance to support service provision. As an interim measure The Northern, South Eastern and Belfast Trusts are offering additional clinics to see a proportion of Southern Trust red flag referrals to reduce the waiting time for the triple assessment appointment to clinically acceptable levels. Transfers of patients have occurred over recent weeks and we are seeing waiting times falling. A number of our own surgical Breast medics have increased their job plan capacity which now enables them to undertake additional sessions in house , again to increase capacity and reduce		

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			waiting times. The Breast service has met with Dr Gerry Millar to explore options for further GP training on the management of Breast Pain to enable these patients to be appropriately assessed and treated in their own GP surgery and further that we would train a small number of GP's with specialist interest in Breast pain who could assist with specific breast pain clinics working in conjunction with secondary care colleagues to manage this group of patients outside of the triple assessment clinics so increasing capacity for suspect cancer patients. There are further discussions planned and underway with other Trusts regarding the potential for a more sustainable network, providing cross Trust working to enable the provision the required capacity in Symptomatic breast services to meet Southern Trust demand. There are plans by the HSCB to review Breast services from a regional perspective with a view to supporting a sustainable service design to meet the needs of the whole population. This is expected to commence in the Autumn 2016 **<u>Radiology</u>:** The position remains unstable. Four consultant posts were advertised in April 2016 with only one applicant who has since been appointed. The remaining posts will be re-advertised in September 2016		

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		• Business Continuity Plan for GP Out of Hours Service • Medical Managers with medical responsibility for the GP Out of Hours service • On Call Manager system for GP Out of Hours Service • Daily monitoring of GP Out of Hours rotas and appropriate contingency plans deployed based on resources available • Pharmacy Service in place in GPOoHS until March 2017 • Any concerns raised by GPs on the safety of the service will be escalated and addressed by Trust and HSCB. • Contract with Dalriada Out of Hours for additional Nurse Triage 6pm-8am from December 2015.	The Trust engaged with A Team Recruitment regarding the recruitment of medical staff at SHO level from the EU. A total of 10 doctors have now accepted offers – 2 paediatrics, 7 surgery, and 1 ED DHH. It is expected that the doctors will be ready to commence once requirements for GMC registration are processed by end of December 2016. **<u>GP Out of Hours</u>:** • The Trust has escalated the risk to HSCB and DHSSPS, and has had joint meetings. • Action Plan in place including actions from reviews. • The process of over-seas GP recruitment commenced in December 2015. • 2016/17 HSCB and Trust additional costs scheme implemented in June 2016. • Twice daily operational meetings to review medical cover and contingency actions implemented. • Capacity and demand work is ongoing. Review of workload of clinicians is ongoing by Clinical Lead. • HSCB Local Enhanced Service scheme to attract GPs to work in the service circulated to all GPs by HSCB in July 2016. • Rates have been enhanced over July and August due to annual leave	**Director of Older People and Primary Care**	

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			of GPs to secure cover. • KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB. • Urgent KPI response in 20mins, Jan–Mar 84% and Apr–Jun 86% - there is an improvement in the KPI. • Vacant shifts, Jan–Mar 35% and Apr- Jun 26% - there is a reduction in the % vacant shifts.		

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	Nursing shortages • Inability to recruit Registered Nurses across all areas, including Health Visiting Service	• Ward Sister/Charge Nurse management of available staff on a shift by shift basis • Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need • Escalation to Operational Director as required • Open registration for Nurse Bank • Open Recruitment for Adult Band 5 Nurses with interviews scheduled every 2 weeks • E-rostering roll out • International Recruitment • SHSCT staff attend all local university job fairs to promote working in the SH&SCT	**<u>Registered Nurses</u>:** • International recruitment is now progressing on a regional basis.. • EU and non-EU recruitment drives commenced in May 2016 with a recruitment exercise in the Philippines, Italy and Romania (92 posts have been offered for SHSCT from the Philippines to date and 17 posts offered from the campaign in Italy). A further campaign is planned for October. • Rotational Programmes continue to be a unique attraction to working in the SHSCT. Further roll out continues to be explored within and across Directorates, with anticipated interest of approximately 25-30 student nurses for a programme to commence in September 2016. • Department of Health announced increase to adult pre-registration training places by 100 commencing September 2016. Associated work has commenced to further access student placements across the Trust • SH&SCT have worked with OU and Department of Health to maximise funding and been successful to increase significantly the number of places on the OU PRNP commencing September 2016. SH&SCT have 23 staff commencing in September 2016, 7 of these staff are entering stage 2 of the programme with a further 16 commencing stage 1 of the programme. In addition 5 staff have	**Executive Director of Nursing/ Human Resources and Organisational Development**	

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		Health Visiting Service: • Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced; • Utilisation of bank (limited supply) and additional hours of existing health visiting staff; • Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child; • Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases; • Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case. • Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA	been given a deferred place for stage 2 of the programme in 2017 • Collaborative approaches to local recruitment by the 5 HSC Trusts are being taken forward through the Regional Recruitment Working Group **Health Visiting Service:** • Ten Health Visiting students are currently training in the Trust but won't complete until September 2016. External recruitment was progressed and a new waiting list has been developed with 4 candidates and BSO is in the process of offering permanent posts. It is unlikely that all our permanent vacancies will be filled until the next cohort of students qualifies in September 2016. • In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. • The Trust is currently waiting for confirmation from the PHA regarding regional normative staffing range using information from regional Ecat caseload weighting tool. • This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).	**Director of Children and Young People's Services**	

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	Failure to attract/appoint required staff and delays in recruitment processes in mental health/disability inpatient wards, community teams, supported living and day care facilities	• Use of Agency • Cyclical recruitment monitored and reviewed to ensure waiting lists are updated • Creation of the training role with specific interest in disability and mental health	• Additional hours for existing workforce has improved the situation temporarily • Transfer of staff to meet need is becoming increasingly difficult as many services are also stretched due to staffing pressures Introduction of a local transfer policy to assist this process • Undertake recruitment drives for adult practitioners with advertising specific to Mental Health and Disability Directorate – currently ongoing. • Undertake recruitment drives initially within CAMHS, then CAMHS & Adult Mental Health and if no success then externally for specific training posts. • Creation of local banks • Improve linkages with Southern Regional College to facilitate career advice on Health and Social Care related roles and visible presence at open days	**Director of Mental Health and Learning Disability**	

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	Reduced ability to provide 24/7 laboratory service at Daisy Hill Hospital due to insufficient Biomedical Scientists New Regional IT implementations such as NIECR, BSTP and HRPTS have not included recurrent funding for local IT support	• Shadow rota in place from 1st July 2016 • Ongoing training in blood transfusion • Procedures in place in absence of Biomedical Scientist support on site	• The laboratory service is currently training as many Biomedical Scientists as is possible to function on the Daisy Hill Hospital rota. However, training in all aspects of Blood sciences and Blood transfusion takes a significant period of time. • Approval has been given to recruit 4 additional Biomedical Scientists and these are being advertised in September 2016. . The issue has been raised at the Regional Pathology Network Board.	**Director of Acute Services**	

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DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Statutory Functions/Duties					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
7	The Trust should have robust case 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 Case Management process.	• New Trust Case Management Guidance	• Mental Health, Learning/Physical Disability and Older People and Primary Care training completed. • Internal Audit of Case Management completed. Heads of Services tasked with taking forward required actions. • Restructuring process by Heads of Service completed within the Mental Health and Learning Disability Directorate.	**Director of Mental Health and Disability/ Director of Older People and Primary Care**	**MEDIUM**

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No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
8	Capability of Trust systems of assessment and assurance in relation to quality of Trust services Specific risks include:- 1. Monitoring and assurance of implementation/ compliance with Standards and Guidelines 2. Effectiveness of processes in place to review all intelligence from incidents, complaints, litigation and user feedback to highlight areas of risk and safety to drive improvement 3. Effectiveness of processes in place to disseminate and share learning from incidents, complaints and user feedback across the organisation	• Standardised process in place for the dissemination of Standards and Guidelines across the Trust • Web-based incident reporting in place across the Trust • Screening and investigation procedures in place in operational directorates with regards to incidents and complaints • Clinical and Social Care Governance information presented in dashboard format to SMT Governance and Governance Committee using trends over time to highlight risk • Guidelines in place for Directors setting out triggers for presentation of SAIs to SMTand Trust Board • Directorate, Division and Professional Governance Fora in place with reporting arrangements to SMT Governance, Governance Committee and Trust Board • Mortality and Morbidity structure in place across all clinical specialties • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback	• Standards and Guidelines database to be updated to improve tracking of compliance and reporting functionality – September 2016 • Ongoing improvement of processes to disseminate learning across the Trust via - Learning Letters - Safety Alerts - Professional Forums - Mortality and Morbidity meetings - Incident screening processes • Develop corporate system to track compliance and report on RQIA reviews action plans – December 2016 • Develop the use of Clinical and Social Care Governance Audit to provide assurance of compliance and identify risk – September 2016 • Implementation of the Trust's Quality Improvement Framework.	**Medical Director**	**MEDIUM**

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		to Chair and Chief Executive • Executive Director Reports to Trust Board • Continuous Improvement support function to front line staff – capability and capacity building for service improvement • Trust Annual Quality Report • Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy .			

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: HCAI					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
9	• Risk to achievement of HCAI Priorities for Action targets • Risk to patient safety • Lack of automated HCAI surveillance system linked to Trust laboratory system • Lack of appropriate isolation facilities (including negative pressure facilities in Daisy Hill Hospital) within the Trust hospital network • Increasing emergence of infections (CPE/VHF) • HCAI outbreaks in tertiary services • Depletion in IPC Nurse staffing	• Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored IPC training • Manual surveillance systems in place. Independent and self-audit programme • Comprehensive governance structure in place, including bi-monthly HCAI Strategic Forum and monthly HCAI Clinical Forum meetings • Outbreak /incident management plan in place • Establishment of antimicrobial management team to oversee antimicrobial stewardship • HCAI Root Cause Analysis process in place • CDI 'trigger' system in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self and independent audit using the RQIA Augmented Care Audit tools. • Learning outcomes from RCAs being shared with senior and junior medical staff. • Engagement opportunities to be created with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases • Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across community and acute sites – this requires resource. • Engagement with PHA on Regional Surveillance system funding and procurement to recommence • Enhanced communication to front line clinical staff via HCAI e-Alert • Suite of procedures and guidelines to support the prevention, management and control of CPE. • Enhanced HCAI RCA information management system and system developed to further improve meta-	**Medical Director**	**MEDIUM**

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	• Reduction of Microbiological medical workforce from four to two Doctors through loss of a Staff Grade and Special Registrar attachment • High bed occupancy rate and limited isolation resource • Increased Estates new builds and refurbishment reduce number of facilities available	• Close liaison between IPC Team and Patient Flow Team • Close liaison between IPC Team and Estates colleagues	analysis of C Difficile cases • Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA bacteraemia • Electronic C Difficile database is under significant review and a new model is being created in this regard. • Implementation of a CDI 'trigger' system that will act as new early warning criteria to identify potential CDI outbreaks earlier • Development of Clinical Antibiotic Stewardship champions to implement new Antibiotic Stewardship Policy • Seeking funding that will support continuous drive to recruit suitable IPC staff • Appointment of locum Staff Grade and seek funding to secure this as a permanent post		

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DOMAIN 2: SAFETY AND QUALITY					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Safeguarding of residents from risk of potential financial abuse					
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
10	Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse.	• Review of Residents within the Care Management process. Residents' reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel.	• Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds remains in place. Current controls to remain as agreed by SMT and Trust Board and QA by independent "critical friend" review (January 2016) • Updates routinely provided to Trust Board • Trust staff attended a meeting in Arthur Cox offices on 8th July 2016. The home owners did not meet directly with Trust staff but communicated via their solicitor. on 15th July 2016 Arthur Cox wrote to the Trust outlining a proposed way forward regarding day care meals, transport invoices (but not historical transport monies owed as per safeguarding investigations) and clients "A" (mobility car) and "B" (statutory disregard monies owed: £50). No agreement was	**Director of Mental Health and Disability Services**	**HIGH**

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		• Regular advice/support/ direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. • Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA. • Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required. • Contacts with RQIA • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB	reached re additional payments monies owed. Arthur Cox quoted case law and invited the Trust to reconsider its position on suspension of admissions. The Trust responded via its legal advisers on 27th July 2016 advising that the Trust's decision to suspend new admissions remains in place. The Trust legal advisers considered the case law example provided and do not accept its application in this case.		

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		re SAI, Disclosure & Barring Service (DBS) • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices. • New Trust Case Management Guidance and Training Programme completed.			

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DOMAIN 3: FINANCE

LINK TO CORPORATE OBJECTIVE 5: MAKING THE BEST USE OF RESOURCES

No.	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update	Lead Director	Status
11	Achievement of recurrent financial balance	• Contingency Plan in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	• Whilst it is early in the financial year and TDP approval still awaited, the first 4 months outturn would indicate in-year breakeven. It is hoped this can be maintained through a range of non-recurrent measures, including natural slippage on allocations.	**Director of Finance and Procurement and Operational Directors**	**MEDIUM**
No.	**Risk Area and Principal Risks**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
12	Management and monitoring of procurement and contracts – not compliant with best practice guidance Lack of regional formalised guidance/agreed approach for management of social care procurements under threshold value of £589k	• Guidance on Direct Contract Award processes issued and reminder global emails circulated regularly. Follow up training and advice available as required from Head of Purchasing and Supply • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered	**GENERAL** • Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing (Central monitoring ceased in October 2013)	**Director of Finance and Procurement**	**MEDIUM**

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			• Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Trust continues to highlight in Governance Statement the lack of central resource in Trust for contract monitoring • BSO PALs undertake contract monitoring for those regional contracts awarded through them **ESTATES** • Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Recruitment of Phase 1 PALS team complete. Recruitment of Trust Team underway – anticipated completion November 2016 • Measured Term Contract (MTC) in place which mitigates risks to procurement for schemes <£45k • Volume of works being undertaken balanced against resources to facilitate compliance • Actions arising from Internal	**Director of HROD**	

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		• Regional Steering and Working Groups established.	Audit report either complete or in progress. • Recruitment of additional Procurement Officers and 2 x replacement Estate Development Officers to be completed in second quarter of 2016/17. **SOCIAL CARE PROCUREMENT** • Regional Procurement Board via Social Care Procurement Group have agreed approach to social care procurement for overthreshold contracts (c£589k). No approach agreed for allocation of funding under this value. • Internal plan to be developed to secure necessary resources, skill and capacity to take forward a limited number of social care procurements as part of hub and spoke model with Trust staff operating under the influence of the Centre of Procurement Excellence (CoPE) • Capacity sought via HSCB transitional funding in 2014/15 for social care procurement of key projects including (Learning Disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid	**Director of Performance and Reform; All Directors**	

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			approved, however recruitment has been suspended due to financial pressures. • Internal resource diverted to provide procurement support to key mental health directorate projects in 2014/15 enabling change. This capacity has been extended into 2015/16. • Further capacity established in October 2015 to support domiciliary care procurement from redirected internal resources. • Trust proceeding to recruitment of two substantive posts further to agreement with BSO/PALs on job roles		

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DOMAIN 4: OPERATIONAL PERFORMANCE AND SERVICE IMPROVEMENT					
CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE					
RISK AREA/CONTEXT: Achievement of Commissioning Plan Standards and Targets					
No	**Description of Risk**	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
13	***a) Waiting times in excess of Commissioning Plan Standards / Targets across***: • Out-Patients; • Diagnostics (including Endoscopy); • In-Patients and Day Cases (Acute; CYPS; Mental Health; and OPPC areas) • AHP professions	INTERNAL MONITORING: 1. ***Fortnightly Operational Performance meetings:*** • Acute Directorate 2. ***Monthly Operational Performance meetings***: • Mental Health & Disability Directorate • Children and Young People's Services Directorate • Older People and Primary Care Directorate 3. ***Monthly Operational AHP Performance*** - Cross- directorate ***4. Monthly reporting to Senior Management Team and Trust Board*** 5. ***Monthly exception reporting to Operational Directorates In-Year Assurance meetings with Chief Executive.***	**a) Access Times** **Outpatients** - Delivery of Service and Budget Agreement (SBA) volumes (where agreed) remains first priority within Operational Directorates. Prioritisation of Red Flag and urgent assessment/treatment. Delivery of routine patients will follow, based on chronological order. Recurrent capacity 'gaps', which have been agreed with Southern Local Commissioning Group remain in a range of specialty areas affecting routine access times across diagnostics, inpatients/daycases and outpatients. **Diagnostics** - Non-recurrent allocation received for additional Diagnostics imaging and reporting capacity (including Endoscopy) in 2015/16 and 2016/17. The volumes allocated does not address the gaps in all areas but assists with stemming the growth of long waits The additional diagnostic volumes	**Performance and Reform and Operational Directors**	**HIGH**

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		<u>EXTERNAL MONITORING</u>: 6. **Monthly** Elective and Unscheduled Performance meetings with Health and Social Care Board **<u>ACTION PLANNING:</u>** 7. Implementation plans in place to reduce access times, where demand remains static, and additional ***recurrent*** capacity has been invested/ approved via IPT 8. Periodic plans developed aligned to ***non-recurrent*** allocations of available funding for elective access via HSCB 9. Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.	allocated cannot be secured via in-house capacity alone and challenges have been faced securing Independent Sector capacity. The Trust is currently re:-testing market for available capacity (August 2016) Investment was received in 2015/16 to increase capacity in MRI and proposals have been submitted for a 2nd CT mobile (capital & revenue) with expect additional capacity on site in early 2017. **Inpatients/Daycases and Outpatients** - £700k of non-recurrent funding has been made available by Health and Social Care Board (HSCB) for elective areas in Q1/2 in 2016/17. This is insufficient to address the gap and as such the Trust has prioritised this to the following areas:- • Longest outpatients waits beyond clinically indicated timescales; • Outpatients waiting over 26 weeks; • Inpatient and Daycases waiting over 52 weeks; • AHPs The Trust will continue to re-direct any available internal resources to areas of greatest risk as funding becomes available or as operationally feasible (re Workforce capacity) throughout 2016/17		

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	b) Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations		**AHP Access Times-** Additional capacity has been provided in AHP areas (from the £700k) funding where temporary staff can be secured. However, due to the short-term nature, the Trust has faced challenged in securing temporary resource to increase capacity. A regional demand and capacity analysis undertaken by PHA/HSCB concluded with formal gaps in capacity recognized by the commissioner. No specific funding has been provided. The Trust is seeking to prioritise within existing resources and demographic funding to address these gaps in part in 2016/17. Due to accrued backlogs, waits for routine patients will still be in excess of agreed position. Focus remains on urgent cases. **b) Diagnostic Imaging Reporting** Non-recurrent allocation for plain film reporting was received from HSCB in 2015/16 and 201617 for the recognised capacity gap in this area. Increasing demand coupled with manpower issues, is creating a more significant gap. An operational plan is in place to focus capacity on urgent and prioritised areas, including plain film chest x-ray The Trust has sourced additional capacity via two independent sector contracts which are predominantly utilised to support the gap in plain film reporting.		

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			Internal additional reporting capacity has been focused on scanning and reporting CT, non-obstetric ultrasound and MRI examinations. HSCB has provided early recurrent funding for the implementation of plain film reporting by radiographers for ED films to partially address the gap. Trust has submitted proposal for training of radiographers to increase reporting capacity in plain film and non-obstetric ultrasounds. Whilst this has not been funded yet the Trust has agreed to prioritise a number of posts into training to reduce the lag time for implementation.		
	Risk Area and Principal Risks	**Key Controls**	**Action Planned/Progress update**	**Lead Director**	**Status**
	a) Out-Patient Review and Planned Treatment Backlogs ***Out-Patient Review Waiting List Backlogs in:*** • Acute; • CYPS; • MHD; and • OPPC	Internal and External monitoring controls included as in Corporate Risk 1 above. ACTION PLANNING: • Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties • Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting	**a) Outpatient Backlog** At the July position, there were a total of 16,450 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led acute, children's and older peoples services) and 1317 for mental health services. (Visiting Specialties managed by other Trusts are excluded). Longest routine waits extend back to 2013/14. • In 2015/16 Trust diverted internal resources to provide additional capacity for review patients; 5000 additional patients were seen		**HIGH**

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	b*) Planned Patient Backlogs** • Acute only On-going risk with a significant volume of patients waiting ***past their clinically indicated review timescale in Outpatient and AHP services.	list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.	• In 2016/17 some additional review patients were prioritized for additional capacity from the £700k non recurrent allocation; however total volume of those waiting beyond clinically indicated dates has started to increase again. The Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible throughout 2016/17. Operational process are in place to ensure patients requiring clinically urgent review are prioritised. **b) Planned Patient Backlog** As at 1st August 2016, there were a total of 1560 patients on the planned treatment backlog. The longest waiting patient dates back to October 2014 and relates to Urology. 79% (1237) of the planned treatment backlog relates to Endoscopy with the longest substantial wait from January 2015. Non recurrent funding received in 2015/16 and allocated for 2016/17 is insufficient to meet the demand for new and planned repeat endoscopy. Priority is given to red flag, urgent and planned patients initially, then routine waits.		

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			Operational processes have been established to prioritise those planned patients that require urgent review. In line with JAG accreditation requirements, the planned treatment backlog should not exceed 6-months. **c) AHP review backlogs** AHP backlogs for review are not as readily quantifiable. However, available information indicates significant review backlog volumes within Podiatry; Speech & Language Therapy; Dietetics; and Occupational Therapy. The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available however, ability to access staff on short term contracts remains challenging. Short term AHP capacity is prioritized from the £700k of non-recurrent funding made available in Q1/2.		

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ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
710	ACUTE	24/07/2008	Safe, High Quality and Effective Care	Risk of ENT micoscope failure - impact on patient safety and ability to treat	Risk of ENT microscope failure due to age and poor clinical visual quality - impact on patient safety and the ability to treat patients.	Regular maintenance.	10.05.10 - new microscope purchased - risk mitigated and closed.	VLOW	10/05/2010
713	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Only one ENT drill and nerve monitor - no backup	ENT drill an nerve monitor - currently only one of each available; if fault with equipment, no backup and patients unable to be booked for procedure; this is compounded when dual lists are happening simultaneously and equipment required in both theatres.	List coordinated as far as possible to ensure the equipment is not needed at the same time, however this is not always successful.	10.05.10 - risk reviewed by MMcG + BM - new equipment purchased - risk mitigated and closed.	VLOW	10/05/2010
716	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Flexible Ureteroscopes - currently only two available	Flexible Ureteroscopes - currently only two available in the department; very fine scopes with a very limited usage and break down frequently - happens at least every 3 months, usually unable to be repaired, only replaced.	Replaced as required but would need a minimum of two additional scpes to ensure lists not impacted; need to review the current scopes used and change to a different manufacturer, have a service contractt and then likelihood of the scope being repiared would be increased.	10.05.10 - risk reviewed by MMcG + BM - new equipment purchased - risk mitigated and closed.	VLOW	10/05/2010
720	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Only 3 camera stacks for 5 theatres	There are currently 5 theatres in the department and only 3 camera stacks; impacts on lists and is exacerbated when sessions are back filled and similar specialities are operating at the same time; significant number of procedures require use of a camera stack, equipment used by general surgery, urology, ENT, gynae.	None.	10.05.10 - Risk reviewed by MMcG + BM - equipment purchased. Risk mitigated and closed.	VLOW	10/05/2010
724	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Gastroscopes and colonoscopes lack adequate vision	Gastroscopes and Colonoscopes - clinicians have repeatedely highlighted the lack of adequate vision from scopes; risk that lesions will not be detected resulting in missed diagnosis; risk of procedures being cancelled due to lack of appropriate equipment, resulting in Trust not meeting patient access targets.	Scopes sent for repair as required, however when the scope no longer meets the visual need of the clinician due to age etc, the scope is removed from use.	10.05.10 - Risk reviewed by MMcG + BM - equipment purchased. Risk mitigated and closed.	VLOW	10/05/2010
728	ACUTE	25/07/2008	Safe, High Quality and Effective Care	Risk to staff when having to operate 3 different types of scopes and processors	Health and safety risk to staff when having to operate 3 different types of scopes and processors; 1) Olympus scopes and Olympus processor, 2) Pendax non-digital scopes and processor, 3) Digital Pentax scopes and processor; results in 3 times the number of processors being used than what is required to undertake a list; exacerbates number of cables etc. and increases risk of trips, fire hazard etc.	Staff vigilence; staff attempt to minimis risk by making best use of trolleys they have.			01/10/2009
766	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Day Surgery Unit Automatic Endoscope Reprocessor not compliant	Automatic Endoscope Reprocessor (AER) in CAH Day Surgery Unit is not compliant with HTM 2030 and the Hine review recommendations 2004 - no independent channel monitoring, no reverse osmosis water, leading to potential infection control risk to patients; this 2 chamber AER is designed to decontaminate 2 scopes per chamber; the new digital gastroscopes and colonoscopes are too large to allow 2 scops to be adequately decontaminated together in the same chamber, leading to a 50% reduction capacity for endoscopy lists; the 3 hour time limit on the use of scopes following disinfection compounds this even further.	A control measure for water quality only is in place - weekly monitoring of water quality.	Interim papers have been submitted to SMT March 2008. 10.05.10 AER now replaced and compliant with HTM 2030 - risk mitigated and closed	HIGH	10/05/2010
781	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Day Surgery AER has insufficient capacity	The 2 chamber AER in CAH Day Surgery is designed to decontaminate 2 scopes per chambers; the new digital gastroscopes and colonoscopes are too large to allow 2 scopes to be adequately deconaminated together in the same chamber, leading to a 50% reduction capacity for endoscopy lists; the 3 hour time limit on the use of scopes following disinfection compounds this even further; there is an increased risk of cancellation of patients off lists for non-clinical reasons due to reduced capacity; this impacts on the PFA target for elective procedures and the 2% for cancellation for non-clinical reasons; risk to patients - cancellation of endoscopic procedure; cancellation of patients for colonoscopy having taken their bowel preparation; cancellation of patient with undiagnosed symptoms.	None.	10.05.10 - AER has been replaced and this is no longer a risk. Endoscope drying cabinets have been purchased and commissioned which will facilitate the storage and use of decontaminated scopes for up to 70 hours.	VLOW	10/05/2010
767	ACUTE	29/07/2008	Provide safe, high quality care	STH Day Procedure Unit Automatic Endoscope Reprocessor not compliant	Automatic Endoscope Reprocessor (AER) in this area is not compliant with HTM 2030 and the Hine review recommendations 2004; no single shot detergent, no reverse osmosis water, leading to potential infection control risk to patients; the 3 hour time limit on the use of scopes following disinfection compounds this even further.	A control measure for water quality only is in place - weekly monitoring of water quality.	19/12/12 - CLOSED AS PER AD AND HOS the new decontamination Unit is now in operation and the new EWDs are working well. 23/11/12 - it has been verbally agreed by DoH that it has pasted all testing. Just waiting on written confirmation. Once received it will be put into use. 2/11/12 - commissioning test report has been sent to John Singh who is the AED at Health Estates. John has identified some missing information which has been urgently requested from SMC and Puricore to enable the report to be signed off and AERS to be put into use, if all tests are satisfactory 26/9/12 - SMC are currently undertaking the commissioning test of the new ISIS AERs, and these tests should be completed by the 1/10/12. 30/8/12 - unable to complete commissioning as Alpha technologies ltd have ceased trading. At present the Trust is in communication with Puricore re completing the commissioning process for the AERs. 30/7/12 - commissioning tests have to be witnessed by the Authorised Engineer for Decontamination (AED), Health Estates and authorised person for Decontamination arrangements are in place for these to be undertaken. once completed the AER will commence weekly water tests and appropriate results are received the AER will be put into use. 22/6/12 - commissioning of the ISIS/AERs has commenced. the connection requirements to the network has been completed and working well; and the building works are complete. 25/5/12 - snag list has been completed for all outstanding items/areas of concerns to be addressed. we have asked for confirmation of full completion date to be received beginning of next week. IT will be working to ensure that the ISIS/AERs are connected to the network and that the company will then commence commissioning of the AERs 26.4.12 - Email received from Hugh Warner 26/4/12. RO plant has been commissioned and ready for the Isis machines to be connected since 26/3/12. Air handling until to take place 26/3/12. Return to HoS as of 26/4/12 26/3/12 as below. Building works still on target for	HIGH	19/12/2012

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773	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Theatres Endoscope Decontamination room	The interim Endoscope decontamination facilities at CAH theatres do not meet DHSSNI decontamination strategy. There are no transfer lobbies or staff gowning rooms. The process flow is severely compromised by the size of the extremely cramped unit. There is no room for expansion. The workload in the endoscope decontamination facility has increased considerably over the last number of years due to additional theatre and radiology sessions as well as additional clinics in ENT OPD and Thorndale Unit. There is inadequate space for holding the contaminated endoscopes for manual washing prior to the automated process in the endoscope washer disinfectors. This frequently creates a bottleneck and slows down the process flow and turnaround time. The endoscopes and transport trolleys have to be stored in the hospital corridor outside the endoscope decontamination room due to lack of space - increased risk of theft (trolley plus endoscopes). In the event of any prolonged endoscope washer disinfector downtime there would be significant disruption to endoscopic procedures in Theatres, Radiology, ICU or in ENT OPDand Thorndale Unit as there would be insufficient capacity to decontaminate the endoscopes on the Craigavon site. There would also be logistical issues and delays in turnaround times if the endoscopes had to be transported to another Trust site for decontamination ie Daisy Hill or South Tyrone. The endoscope washer disinfectors were installed in 2009 and have a working life of approximately 8 years. The Lancer endoscope washer disinfectors do not have the ability to perform channel patency tests to current DHSS guidance i.e. inability to perform partial blockage of the duodenal channel which is part of the quarterly channel patency testing regime. The EWD manufacturer has confirmed that they will support the FC 2/4 EWD models until 2022 for the electronics and until 2025 for mechanical parts.	Situation being monitored.	12/11/2021 A decontamination meeting is due to take place 19/11/2021 and a further update will be available after this meeting. 15/09/2021- Replacement ISIS EWDs were included in the paper for funding sent earlier this year. Funding still not approved. The procurement process for EWDs can take up to six months and risk remains with the current EWDs not being supported by the manufacturer beyond 2022. 28.06.2021- no update. 16.02.2021- draft paper re funding required has been shared with the Director of Acute Services. 10/08/20 - DOH has set up a regional RDS2 steering group to assess the current provision of decontamination services, identify any shortfalls in compliance with policy and develop a strategy to address any identified gaps. 3.10.19 Replacement EWDs are included on the capital funding list. May 2019 SHSCT provided a summary report to DOH on strategic planning relating to the decontamination of reusable medical devices 24.06.19, 8.8.18, 12.6.18, 7.3.18 Risk remains unchanged 113.9.16 Head of Decontamination Services will work with Acute Planner to explore options for a modular unit adjacent to CAH CSSD to replace the existing the interim arrangement. Given that CSSD will form part of Phase 1 for the CAH Redevelopment, a modular solution will be considered as a further interim arrangement although it will need to address existing concerns. Indicative costs to be detailed in the paper and logged for consideration under capital allocations for 17/18. 23.2.16 Following discussion at Acute senior management team with Head of Acute Planning, the risk will be addressed in the first phase of the redevelopment of the Craigavon site. On this basis it was agreed that nothing further would be done at this stage. 5.1.16 Short paper highlighting the risks shared with Planning Dept and Director of Acute Services	HIGH	
993	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Biochemistry printer is printing incorrectly	Biochemistry printer is printing incorrectly with missing and corrupted data on report forms - intermittent fault; patient at risk through incorrect reports being issued.	Printing has been stopped and wards have been advised to use ward lookup; reported as fault to DIS and waiting resolution.	To be managed by facility/department team manager/leader. 12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed. 12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed.	VLOW	12/05/2010
999	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Building work for the T&O Service has meant no access to the existing laboratory reception	Building work for the T&O Service has meant no access to the existing laboratory reception; porters delivering samples, collecting blood etc. will need to use an alternative route; potential for delay of samples and prolonged turnaround times.	CCTV and alarm to alert reception staff of presence of samples at opposite end of lab is fitted, however access to reception is at the opposite end of the lab.	12.05.10 - risk reviewed by R Carroll and B Magee - risk mitigated and closed.	VLOW	12/05/2010
990	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Currently do not measure bicarbonate as part of the standard U&E profile	Currently do not measure bicarbonate as part of the standard U&E profile; this differs from most other laboratories; likely in NI but is in keeping with the majority laboratories in the UK as evidenced by Keele Benchmark; it is available by request from Medical Staff but only a handful are requested on a monthly basis; a failure to identify serious acid base disturbances may lead to missed or delayed diagnosis; this could result in serious injury or death with the potential of significant medial legal consequences; example is a patiend in DHH who had been admitted with recurrend hypokalaemia over a period of several months.	Education of all all grades of Medical Staff as to the importance of measuring bicarbonate in the clinical cases that merit it; initiate reflex testing of bicarbonate when potassium's as/or chlorides fall outside a certain critical range; to be reviewed after education and Trust response to risk assessment.			18/12/2008
963	ACUTE	06/08/2008	Safe, High Quality and Effective Care	Risk to Radiology staff who have to push and pull ill patients on trolleys without assistance from 5pm to 9am	Risk to Radiology staff who have to push and pull ill patients on trolleys without assistance from 5pm to 9am.	A&E staff are supposed to stay with trolley patients in X-Ray.			02/12/2009
1023	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Disruption caused due to violent/aggressive patients or relatives	Disruption caused due to violent/aggressive patients or relatives - big demand on nursing time causing time spent away from other patients; health and safety and wellbeing of visitors, patients and staff when dealing with/managing violent/aggressive patients; all wards, CAH and DHH.	Staff awareness or proactive approach; availability of security; review staffing levels; medical review of patients by doctor; consultation with Consultant and Bed Manager; training and awareness for staff re Dementia Strategy is ongoing		MOD	19/10/2009
1024	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Health and safety of patients and staff could be compromised if staffing falls below safe levels	Health and safety of patients and staff could be compromised if staffing falls below safe levels when dealing with staff absence, e.g. maternity leave, sick leave; all wards, CAH and DHH.	Reallocation of existing staff to area of greatest need; in the event of further unplanned absences (e.g. sickness) implement the use of additional hours/bank.	25.09.13 - Workforce review carried out September 2013. 01.02.13 - Ongoing review of staffing levels. E-Reqs completed for all vacant posts. Workforce review of MAU and ED being completed. 29.11.12 - Review of funded establishements plus deficits sent to AD. Use of band and redeployment as required. 19.10.12 - Head of Service monitors workforce with Ward Sister. Staff recruited to block bookings. 25.09.12 - Staff levels monitored monthly by HoS and Ward Sisters. HoS and Lead Nurse working closely with Nurse Bank Staff. Ward Staff to work within 25% uplift and if ward has deficit > 25% due to maternity or sick, issue escalated to AD. 18.07.12 - Monthly review of staffing levels, vacancies being recruited to and use of block bank booking.	LOW	12/02/2014
1028	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Inappropriate prescribing and administration of oxygen	Management of oxygen therapy; inappropriate prescribing and administration of oxygen; inappropriateness of administration rate; no medical review; no Acid Blood gas, staff recording of SP02 and respiratory rate; all wards, CAH and DHH.	Audit of prescription and administration at ward level; NMC administration of medicines; record keeping; code of conduct; prescription sheet in place at present.		MOD	19/10/2009
1020	ACUTE	07/08/2008	Safe, High Quality and Effective Care	Health and safety of staff/patients/public due to missing and broken floor tiles in Ward 2 North	Health and safety of staff/patients/public due to missing and broken floor tiles in Ward 2 North.	Risk assessment; caution signs; liaison with maintenance department.	07.09.09 - work complete	LOW	07/09/2009
1041	ACUTE	08/08/2008		Extra patient on ward due to increased workload from waiting time targets	Extra patient on ward due to increased workload from waiting time targets; leading to increased risk in the management of fire, manual handling, lack of privacy and dignity, and CPR.	Staff training in mandatory training issues; provision of screens for extra space; patient allocation according to illness and stability; additional staff for additional workload; Fridays are main issue - working over the limit.	07.09.09 - Eventuality is now rare - risk closed.	MOD	07/09/2009

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1046	ACUTE	08/08/2008	Safe, High Quality and Effective Care	Health and safety of Cardiac Clinical Physiologist due to repetitive strain injury from posture	Health and safety of Cardiac Clinical Physiologist due to repetitive strain injury from posture; potential for back injury.	All staff must attend manual handling training on induction which is regulary updated; rest and counter stretch between patients.	07.09.09 - Ergonomic couches and chairs suitable for echocardiography now in place	LOW	07/09/2009
1079	ACUTE	11/08/2008	Safe, High Quality and Effective Care	Difficulties experienced in getting staff released from wards/departments to attend training (mandatory and otherwise).	Due to manpower issues and availability of training dates, wards and departments not meeting requirements of mandatory yearly training for lifting, manual handling, CPR and fire, right patient right blood, safeguarding and hyponatraemia.	Prioritisation and allocation of staff for training days. Training matrix available at ward level to monitor compliance.	Focus remains at ward level- sisters have been advised to utilise bank hours available to secure training days. Also trying to secure additional in house training days. 29/03/13: Focus remains on securing all available places to improve position 01.03.13 - Focus remains at ward level using the Training Matrix and sourcing and utilising all available training dates to improve position at ward level.	MOD	28/01/2014
1174	ACUTE	14/08/2008	Safe, High Quality and Effective Care	Unsterilised instruments being used on patients to an increasd infection risk	Unsterilised instruments being used on patients to an increasd infection risk; potential for harm - increased infection risk to patients, potential litigation risk to the Trust; Truama and Orthopaedic instrumentation require a 60 minute cycle for effective cycle for effective sterilisation; all other surgical instrumentation require a 40 minutes cycle for effective sterilisation; the 3 sterilisers currently in use are running with the 2 different cycles, 40 minutes and 60 minutes - there is the potential risk that the wrong cycle is initiated for T&O instrumentation resulting in ineffective sterilisation of instruments.	Inform staff; train staff; use of notices; limit the operators who commence T&O cycle.	Capital money has been agreed for the purchase of a steriliser and the associated building works. Capital money has been agreed for the purchase of a steriliser and the associated building works.	HIGH	21/12/2009
1177	ACUTE	14/08/2008	Safe, High Quality and Effective Care	Increased turnaround time for sterilisation leading to lack of available instruments	Increased turnaround time for sterilisation leading to lack of available instruments, cancellation of surgery and Trust not meeting waiting list targets; potential for harm - surgical procedures cancelled leaving patients at risk from untreated conditions and further complications; litigation for the Trust; Trauma and Orthapaedic instrumentation require a 60 minute cycle for effective sterilisation, all other surgical instrumentation require a 40 minute cycle for effective sterilisation; if all sterilisation cycles are extended to 60 minutes this will lead to a loss of 99 cycles over an average working week of day shifts.	None.	Capital money has been agreed for the purchase of a steriliser and the associated building works. Capital money has been agreed for the purchase of a steriliser and the associated building works.	HIGH	21/12/2009
1166	ACUTE	14/08/2008	Safe, High Quality and Effective Care	Clinical pharmacy service reactive as opposed to proactive	Clinical pharmacy service reactive as opposed to proactive; patient may have received a drug before clinical check performed by pharmacist; no clinical pharmacy service out of hours or at weekends.	Some pharmacists attend ward rounds - there at point of prescribing; daily ward visits (Mon-Fri).		LOW	21/08/2008
1266	ACUTE	19/08/2008	Safe, High Quality and Effective Care	Infection control risk to health and safety of patients who are ventilated	Infection control risk to health and safety of patients who are ventilated because there are insufficient quantities of ventilator parts to allow decontamination in SSD.	Staff are currently using the benchtop steriliser in dental room; benchtop steriliser does not meet HTM 2030 requirements.	10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed.	VLOW	10/05/2010
1267	ACUTE	19/08/2008	Safe, High Quality and Effective Care	Infection control risk to patients and staff in Day Surgery Unit - patient chairs are covered in fabric material	Infection control risk to patients and staff in Day Surgery Unit - patient chairs are covered in fabric material and should have a wipeable cover.	None.	10.05.10 - Risk reviewed by MMcG + BM - chairs replaced - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - chairs replaced - risk mitigated and closed.	VLOW	10/05/2010
1874	ACUTE	09/12/2008		Air quality in Andrology laboratory needs to be brought up to the standard required by HFEA.	Air quality in Andrology laboratory needs to be brought up to the standard required by HFEA. A license will be withdrawn if this condition is not met.	None	12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed.	VLOW	12/05/2010
1873	ACUTE	09/12/2008	Be a great place to work	Lack of ergonomic microscope workstations for staff involved in cervical screening in Screening Room 1	Staff are at risk from developing musculoskeletal problems	Staff have ergonomic microscopes and seating. Not possible to have control measures for benching.			16/11/2009
1916	ACUTE	13/01/2009	Safe, High Quality and Effective Care	Laboratory failing Accrediation due to External Clinical Waste Bins being kept in a unsecure location	External Clinical Waste bins are kept in an insecure location. This has been highlighted as a critical non compliance during recent Clinical Pathology Accreditation Inspections and could lead to the laboratory failing Accreditation.	Where possible bins are locked using a key but often locks are faulty.	11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed. Letter sent to Mr A Metcalfe requesting that the waste bins be secured. Referred to Directorate Risk Register 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW	11/05/2010
1922	ACUTE	19/01/2009	Safe, High Quality and Effective CareEffective organisational governanceBest use of resourcesFinancial viability, reform, and control of costs	Oral surgery instrumentation used in CAH OPD is not currently decontaminated in line with DHSSPS March 2008 recommendations	Risk of cross contamination to patients due to ineffective decontamination of dental instrumentation. Risk of non compliance with Regional Decontamination strategy.	Currently using 'Little sister' bench top sterilizers to decontaminate instrumentation. Bench top sterilises are tested daily by the users and quarterly by Estates in house staff and external contractors.	Update 27.5.11 - Significant instruments have been purchased. However the full order has not been received. Further orders have been processed but there is still a delay in supply. continue to check delivery 25.3.11 - Waiting delivery of new instruments which will improve access to decontamination. Will review any residual gap after delivery. 05.05.10 - Business case to be with SMT by 26.05,10 Business case to be submitted by 31.03.09 for transfer of local decontamination to a centralised facility.	HIGH	05/09/2011

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1931	ACUTE	23/01/2009	Safe, High Quality and Effective Care	Risk to health & safety of patients in ENT, OPD with ongoing extra clinics	Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demands. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients. Risk to organisation through litigation; adverse publicity/ complaints; loss of reputation; breach of Hine Review Recommendations. Inequality of care for patients - Friday (clean scopes), Saturday (wiped and sheathed scopes).	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations)	"Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist plug for scope cabinets. Awaiting the sourcing of stainless steel cabinets to facilitate transport of scopes to sites and departments. Paper being prepared for SMT regarding the permanent appointment of CSSD staff that will provide enhanced access to scope cleaning (to be complete by 31 July 2010). Aiming to have new scopes in circulation by 31 August 2010. The risks highlighted in this assessment are applicable to clinics which will be held on 24 July 2010 and 31 July 2010." Reviewed 19/5/11- Decontamination cabinet installed in DHH. DHH theatre staff awaiting validated decontamination specification from CAH OPD. Decontamination meetings ongoing with ATICS, SEC and S McLaughlin. CC 310W will fund cleaning in theatres on the CAH site for scopes in CAH until dedicated staff appointed. Pamela Mulholland to confirm access to AER and C Moorcroft to confirm support for additional time for cleaning. Theatre staff in DHH will clean during night shift. R Carroll to ensure Nursing support is released to allow for decontamination. 4 Scopes to be released to ACH/ 12 Scopes to DHH/4 BBPC and 10 Scopes CAH. Transport arrangements need to be secured for cross-site delivery Target date for Resolution: 3 June 2011 Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist	MOD	27/05/2011
2150	ACUTE	13/08/2009	Safe, High Quality and Effective Care	Inadequate immuno cyto chemistry staining facilities	Inadequate immuno cyto chemistry staining facilities to ensure the rapid turnaround of urgent histological samples, including red flagged samples.	No control measures. System is operated to full capacity, delays are frequent.	New system of work implemented which has led to a marked reduction in the throughput of immuno slides. The benchmark is no longer a limiting factor with regard to the turnaround time of immuno cytochemistry	MOD	09/12/2009
2421	ACUTE	13/10/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Lack of manual handling training for staff	Staff unable to attend MH Training due to limited places being available to cover the whole Trust. Mandatory requirement not met. Injury to staff/patients. Potential litigation for Trust. Potential damage to Trust reputation.	Use of Hoist/slide sheets/repositioning charts/training for Avant Guard beds. Past MH Training. Raised at Nursing governance meetings on an ongoing basis.	25.09.13 ongoing issue which is on Governance agenda lead nurses to scope how many staff trained and how many outstanding and forward to ELD for for action. 29.11.12 - Reviewed by AD. Ongoing issues which are being kept on the agenda. 19.10.12 - Training now organised weekly at ward level in medical wards. 25.09.12 - Ward Sisters still experiencing difficulty in securing places for ward based staff. Mrs Carroll liaising with ELD re provision of locally based training. 28.02.12 - Heads of service to scope how many staff have been trained, how many need trained and consider how this could take place. 23.01.12 - position remains unchanged. 01.10.11 Reviewed 27.09.11 by MB, EM, PS, KC, & SB - minimal backfill available but same not sufficient to allow staff out for any form of training. Escalated to Michael McConville and Anne Ross on 20.09.11. 17.05.10 - Risk reviewed by E O'R, LA and BM.	MOD	22/10/2013
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	19/4/22 . Due to gaps at ward level difficult to release staff to undertake training either Face To face or Virtual e learning. 18/08/2021- no change core mandatory training monitoring monthly but Face to Face training still an issue due to social distancing and reduced staff numbers per session. 01/06/2021- provisions have been made to allow staff to do training in their own time and to receive overtime payment to do so. 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	MOD	
2394	ACUTE	02/12/2009	Provide safe, high quality careMake the best use of resources	The Orthopaedic ICATs are still being sent to Independent sector for MRI scan due to demand outstripping capacity in SHSCT.	Financial risk for the Trust.	None	Write business case for additional MRI scanner and all associated costs 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW	11/05/2010

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2396	ACUTE	02/12/2009	Provide safe, high quality care	Plain film x-ray reporting by Radiologists	"Plain film x-ray reporting by Radiologists is currently 60% resulting the general wards CAH and A+E CAH not being reported by a radiologist. Potential for mis-diagnosis leading to non-treatment of life threatening conditions. Potential litigation and loss of reputation for the Trust"	Referring consultant looks at the x-ray and writes report in patients notes. The introduction of PACS will increase to throughput of the plain film reporting but will not completely remove the risk.	6.5.11 - The contract has been awarded and the directorate is working with the IS company to get the IT connected. We plan to have the pilot testing complete by next week (fri 3th June). It is expected to scan between 500-1000 per month.There is a daily 19 day escalation plan, which is working well. The tender should be up and running by end of June 2011. 09.06.10 - Plain film reporting backlog in CAH was complete 31.03.10 - 3000 plain films in total. New backlog still exists. Briefing/options papers submitted to Director for discussion at SMT 09.06.10. (RC)	HIGH	27/01/2014
2893	ACUTE	04/12/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	RQIA review maternity services - In DHH four out of seven nights there is no middle grade (Registrar) Obstetric cover	Four out of seven nights in DHH only has SHO cover on site Safe care to mothers and babies may be compromised on these four nights	Consultant on call id contactable by telephone and will respond by attending/giving advice as required. Middle grade locums are used.	10 June 2013 Changes again to the middle grade rota is incomplete and weekends are being covered by internal locums. 14-01-13 despite recruitment to all of these posts, there is still a vacant post from April 2013 caused by a resignation. 28.05.12 There is only 1 mid grade vacancy in DHH. All shifts covered by locums known to the service. Efforts to recruit staff continue. 31.8.11- 1 specialty doctor has been appointed	MOD	11/02/2014
2514	ACUTE	09/03/2010	Provide safe, high quality careMake the best use of resources	Vacant admin post in the Social Work department DHH as of April 2010	No admin worker for the Social Work department DHH resulting in 1. Band 6 Social Workers completing admin tasks competing with their social work role and responsibilities 2. Issue with the completion of delegated statutory functions eg child care and vulnerablae adults on to SOSCARE and COMCARE 3. No admin worker to populate COMCARE 4. No admin worker to type RIT supervision records 5. No admin worker to provide a reception service to the department. 6 Backlog of filing and processing of record Potential for harm: 1. SOSCARE not populated resulting in incomplete computerised records and failure to comply with Regional Child Protection Policy and procedures. 2. Community and hospital professionals have an incomplete case history resulting in communication failures. 3. Delayed discharges 4. Potential for complaint against the Trust 5. Potential for Litigation against the Trust 6. Professional standards not met.	1. e requisition completed for maternity cover 25.09.009 2. Admin post discussed at Corporate scrutiny 3. Staff advised of the need to separate recording for child care and vulnerable adults admin currently prioritising this work	09.03.10 - no progress to date 18.08.10 - A temp admin worker commenced in DHH, at the end of July 2010, so the stated risk is no longer valid.	VLOW	18/08/2010
2589	ACUTE	14/04/2010	Provide safe, high quality careMake the best use of resources	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50%	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50% resulting in 1. A significant impact on the delivery pf patient care 2.Reduced cover across all shifts of duty 3.Increased workload for all other medical and nursing staff 4. Increased need for locum cover - expensive and potentially higher risk to patients 5.Loss of reputation for the Trust 6. Potential risk of litigation.	None at present		HIGH	18/08/2010
2598	ACUTE	15/04/2010	Provide safe, high quality careMake the best use of resources	Failure to identify cardiac structures and abnormalities due to sub-optimal echo images	Due to mis-diagnosis, patient could die; incorrect medication given;reputation of Trust; litigation. Potential to breach waiting times for the Trust.	At present, 33% of echoes are being repeated. Clinical physiologist/ Consultant Cardiologist identifies obvious malfunction scans. Potential for 2 month delay for patients to have repeat scan performed. Audit	12.5.11 - E-mail from B Conway: Yes, this is all sorted and can be removed. 28.3.11 - Due to received the replacement Echo machine in CAH on Tuesday 29th March 2011. 03.02.10 - risk reviewed - Echo machine ordered.	HIGH	12/05/2011
2620	ACUTE	17/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsMake the best use of resources	Insufficient capacity and resources to manage patients waiting for a review appointment in MUSC	Potential of harm to the patient secondary to not having timely management of condition and/or disease-possible progression of disease/worsening status of condition. Risk of harm to patient by unmanaged progression or monitoring of condition in a timely manner secondary to SHSCT not having sustained capacity to provide review appointments, within the appointed time. Risk of harm to Medical and Nursing staff as addressing the patients needing review are all done as 'extra sessions'. Potential for exhaustion and escalation of sick leave. There has been inadequate Nursing resources recruited to support the increase work load. Risk of escalation of clinical risks as the Trust is under strict financial constraints, and does not have an obvious form of funding for this risk. Potential harm to patient family secondary to anxiety of not having a timely review Potential of litigation against staff and Trust due to not providing treatment in a timely manner Potential of harm to reputation of Trust due to potential lack of adequate patient management	E O'R and LA are tasked to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. Monthly update on review backlog to give current position Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. All core clinic template capacity utilised as far as practical. Heads of Service are meeting with Relevant Consultants and conveying current position on a monthly basis Control measures considered but discounted and why (where appropriate): Arranging additional clinics to target primarily Review Backlog patients- not feasible in current financial situation Reduce the current number of new patients within Outpatient template, to increase the capacity of review patients- not feasible, as performance targets will then be breached. Recruit additional Medical staff to address shortfall in capacity- not feasible in current financial situation. . : .		HIGH	16/06/2010

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2629	ACUTE	24/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Delays in treatments, discharges and transfers due to inadequate ambulance service DHH, MSW, FSW, HDU, Gynae	Poor outcome for patient if ambulance not available for patient to be transferred. Delays in discharges leading to poor bed flow and elective lists to be cancelled. Patients from A +E admitted to ward due to no ambulance cannot be discharged. Patients missing appointments due to lack of ambulance service. Patient may develop surgical complication due to delay in treatment. Risk of litigation to trust. Increase of complaints and loss of confidence in organisation. Death of a patient. Delay in patient flow resulting in theatre cancellation	Early booking of ambulance as patients needs. Infection risk MRSA. Assess patient re chair, stretcher. Family involvement if safe for patient. Use of voluntary drivers. Use of blue light - not appropriate use of service.		HIGH	24/11/2010
2730	ACUTE	30/06/2010	Make the best use of resourcesBe a good social partner within our local communitiesProvide safe, high quality care	The Body Fridge in DHH Mortuary unavailable for use from the 26/5/10.	Bodies may be released to undertakers which have not been stored in optimal conditions and therefore the process of decomposition may be accelerated. James Details	Bodies to be stored in the Chapel of Rest as this room is slightly cooler than other rooms in the mortuary. This is a temporary arrangement while work on the body fridges continues. The Chapel of Rest does not provide the optimal temperature required to stabilize or slow deterioration of the body. Bodies are to be released to the undertaker as quickly as possible. On Friday 25th June arrangement put in place to transfer bodies to CAH, if the undertaker cannot be contacted to organise a quick release the bodies are transferred to CAH Mortuary.	Authorisation from Ronan Carroll (Assistant Director of Acute Services) for Brian to arrange with Cecil Renshaw (Estate Services DHH) to install a portable air conditioning unit in the Chapel of Rest Dr G Rankin (Director of Acute Services) has identified funding (23/6/10). Brian Magee awaiting confirmation that he can proceed with the procurement and installation of body fridges.	HIGH	01/07/2010
2818	ACUTE	25/11/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Unable to provide maximum Outpatient capacity safely due to level of sick leave & lack of availability of staff in Outpatients	Unsatisfactory level of staff with appropriate training. There are staff who have been redeployed, or working via Nurse Bank that do not have access to appropriate supervision secondary to staffing levels. Staff are unable to attend mandatory training due to staff shortages. Risk of staff sickness and absence continuing to escalate due to the level of stress of working in current conditions, further decreasing Outpatient capacity. Increased risk of staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. Contributing factor is the replacement staff have limited or no Outpatient experience. Potential to directly impact staff attending mandatory training updates. This places the public, staff and the Trust to increase risk of not having access to up to date training/information and validation which may result in harm to patients and staff. Increased risk to staff and patient safety secondary to not being able to provide adequate supervision to redeployed staff, and non registered staff due to low staffing allocation. Potential of reduction in Outpatient capacity resulting in extension of waiting times for patient. Increased waiting time has potential to harm and contribute to advancing of clinical disease and/or condition. Potential to further extend waiting time for patients on the Review Backlog waiting list. Increased waiting time has potential to a harm and contribute to advancing of clinical disease and/or condition. Potential for staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. This also has an impact on the level of appropriate supervision is dictated and expected for staff who have been redeployed to Outpatients or who are allocated through Nurse Bank. Potential for staff sickness and absence to escalate secondary to working with limited nursing support. This can have significant financial harm to the Trust as well as on skill level. Contributing factor is Nurse Bank is not able to fill entire requests and Manager may have hours of notice that a shift cannot be filled. Absence of validated update training risks patient and staff safety and increase risk of harm to the patient, staff, negative publicity and litigation to the Trust. Potential harm to Trust's reputation in relation to the breaching of Outpatient waiting time targets.	Band 7 and Band 6 Managers are providing direct patient care. Band 6 staff have been taken out of the POA results room to provide patient care in Outpatients. Band 5 and Band 2 staff requested to backfill shifts. Bank staff have provided 3 block bookings (2x B5 1x B2). Staff have 'doubled up' on clinics where possible (one staff to work between 2 clinics). Pre Op questionnaires have been given to patients to release Band 5 staff to work in clinics. Specialties have been approached to relocate to alternative accommodation due to lack of staff. Near patient testing devices to be purchased to decrease the demand for staff. All staff on sick leave are being actively managed and have been referred to OHD and HR.		MOD	25/03/2011
2916	ACUTE	10/01/2011	Provide safe, high quality careMake the best use of resources	ASR Monohip ; hip implant Recall	Patient that have received this hip implant are at risk of ; Pain, Immobility, Surrounding tissue breakdown. Higher incidence of Revision surgery within 5 years. Litigation against Trust Patients at risk that have received The Monohip, 208 patients in SHSCT.	Being addressed regionally, patients in SHSCT and Belfast Trust. Implant recall by manufactures " DePuy ", Patients reviewed yearly by a revision orthopaedic surgeon and treatment determined as necessary. Cobalt and Chromium blood ion tests. MRI scan. Plain X Rays.	23.01.12 - All patients have been recalled and reviewed with appropriate interventions carried out if required. Patients are now in the yearly review cycle and will remain there up until 5 years as recommended per medical alert. 10.11.11 There are 148 patients in total on the SHSCT ASR database. These patients have all been assessed, had a plain x-ray, MRI and cobalt and chromium ion levels tested and all have had a first consultation with a SHSCT Orthopaedic Consultant. To date 28 patients have undergone revision surgery. It was considered that all patients should have an annual review after their first consultation however a number of patients are being closely monitored eg a follow up review in 3 months as their ion levels were borderline. Review clinics are being organised on an ongoing basis to see patients who require close monitoring within their clinically required timescales. SHSCT is continuing to liaise with BHSCT with respect to 13 BHSCT patients who had their ASR implant done by the SHSCT surgeon but who are BHSCT patients. These patients have had their tests done and checked by the BHSCT practitioner to ensure they are not high risk patients however they have not had a consultation with an Orthopaedic Surgeon. It is planned that BHSCT surgeons will see these patients. 01.10.11 All patients have had a first apt with the Consultant and are being reviewed at the required intervals. Any patients being listed for revision of surgery are being completed timely. Meetings continue fortnightly. Update 27.5.11; 181 patients allocated to SHSCT to see and treat. To date 21 pts have had revision surgery. 5 pts are listed for revision surgery; 1 pt RIP; 113 pts have been reviewed; 5pts have refused a review. This leaves 36 pts still for review. Clinics are arranged for these 36 pts. A review process will require to be put in place for these patients. Admin Support will be required. HSC Management of ASR Recall Regional Meetings continue to be held weekly.	MOD	23/01/2012

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2915	ACUTE	07/03/2011	Be a great place to work	Staff member suffering from Chiari Malformation requires a saddle chair to prevent the axacerbation of symptoms	A member of staff suffering from the condition Chiari Malformation requires a saddle chair to prevent the exacerbation of symptoms whilst working in the various sections in the Cellular Pathology Laboratory.	Restricted range of duties - The member of staff does not cut routine tissue sections using a microtome as intense prolonged use of a microtome causes fatigue, discomfort and eventually pain. Frequent change of task with micro/mini breaks to prevent fatigue.	21.6.11 - Saddle chair provided. Saddle chair supplier sourced(Fred Storey, 5 High St, Comber, Tele. 91870033/23) and a 4 week trial of a saddle chair organised and trial commenced on the 14/10/10. Risk assessment placed on the laboratory's Q-pulse document control system on the 2/12/10 with a review date on the 1/2/11. Received and signed by the Assistant Director of Acute Services on the 3/12/10. CPL awaiting a copy of the risk assessment.	MOD	21/06/2011
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW	
2991	ACUTE	26/05/2011	Provide safe, high quality care	Cancer performance risk	Decrease in cancer performance from previous years. 10/11 = 85% for 62 day pathway. Highest risk is urology cancer pathways.	Escalation policy and action plans drafted. Meeting with urology teams. Working towards 1-stop clinics.	See Risk 2942	MOD	07/12/2011
2993	ACUTE	26/05/2011	Provide safe, high quality careBe a great place to work	Gaps in Medical Staffing. Daisy Hill Hospital	Gaps at junior and middle grade level in Medicine in DHH Hospital impacting on numbers of doctors on duty particularly during the out of hours period. Due to the gaps on occasions one junior doctor may be left covering medicine in Daisy Hill Hospital - increased clinical risk and potential for adverse events leading to patient harm.	A locum middle grade recruited in January 2011 to address immediate pressures. Assistance given from Renal Medical Staffing complement for two evenings per week. Ad-hoc locum shifts as and when required to address remaining gaps. However, despite these actions other gaps may remain. In the medium to longer term there is a plan for an additional junior doctor to be provided via NIMDTA however recurrent funding is required for this post.	29.09.22 - Risk Reviewed. Improved allocation of SpR from NIMDTA in August. Also stroke specialty doctor commenced Sept 2011. Risk downgraded to Moderate	LOW	01/10/2011
3002	ACUTE	13/06/2011	Provide safe, high quality careBe a great place to work	Extremely high level of maternity leave in CAH pharmacists	Extremely high level of maternity leave in CAH pharmacists from summer 2011 (15/36). Current recruitment for maternity leave cover is 2 for 1 - 5 junior pharmacists recruited as cover but only 2 have taken up post so will be 9 pharmacists short during period June to Sep 2011 and 7 short from Sep - Dec 2011. Unable to provide clinical cover for wards and no leave cover at all for other clinical pharmacists. Risk of serious medication incidents not being detected on wards before they reach the patient. Risk will increase in August with intake of newly qualified doctors. High work load of remaining pharmacists wild put them at risk of making an error themselves when dispensing/ checking.	Initially remaining pharmacists allocated to highest risk wards and some temporary junior pharmacists recruited as cover. March 2012 three pharmacists on mat leave.	Feb 12 - Currently 6 staff off work, two to return within 4 weeks, remaining 3 by end of March 2012.	LOW	10/06/2012
3019	ACUTE	07/07/2011	Provide safe, high quality careBe a great place to work	Fire	Risk of Fire throughout the Acute Directorate	Evacuation plan implemented for every ward and department. Embedded procedure of simulated drills twice yearly throughout all wards, once in hours and once out of hours. Acute fire committee and reps currently in place for all divisions. All wards have fire files. Checks carried out in basement areas. Estates ensure fire alarm and detection, escape lighting, first aid fire fighting equipment, suppression systems, plant, equipment and other installations are checked, tested and maintained in accordance with good maintenance practice. Regular fire safety checks are being carried out in Residential accommodation on the CAH and DHH sites and records are maintained. Nominated Officers and Deputy Nominated Officers have been identified for all wards and depts on each site. A number of fire risk assessments have been undertaken and actioned to reduce risk. Waste Management Policy and Procedures are in place and subject to monitoring. Smoke Free Policy is in place. Soft furnishings and textiles are purchased through BOS PaLS so comply to standards of fire retardancy. Fire Safety training programme is in place for all staff and fire safety training records are held centrally and reports are issued to Heads of Service. Arson Policy is in place.	18.12.13 Need to have a further desktop	LOW	28/01/2014
3020	ACUTE	18/07/2011	Provide safe, high quality careBe a great place to work	Management of Sex Offenders when accessing hospital services	Potential for sexual, emotional and psychological abuse. Those at risk: other patients, staff and members of the general public. Issues with the management of those convicted sex offenders who are known and not known to Hospital Services. Concerns re unplanned access to Hospital Services. No formal mechanism within the Hospitals to share information gained through LAPPP. Potential for litigation and damage of Trust reputation. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	Trust representative at PPANI. Convicted sex offenders referenced through the Soscare system. No formal mechanism within the Hospitals to share information gained through LAPP. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	07.10.13 - Draft Protocol tabled at the Procedures Committee and document accepted - minor additions required. Document to be shared with Regional Emergency Social Work Service. Draft Protocol allows information provided at the LAPPP meetings to be shared with Acute services. The focus is on registered category 2 & 3 sex offenders. Draft protocol completed January 2013. Document equality screened.	MOD	10/02/2014

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3028	ACUTE	26/08/2011		Staff shortages are adversely impacting on the quality of the Cellular Pathology Service	By 24 august 2011 3 BMS staff were off on long term sick or maternity leave. This equates to 18% of the WTE BMS staffing in Cellular Pathology. A further member of staff whose husband took a stroke on 19 August 2011 has the potential to be off, when included with existing staff off this equates to 23% of the WTE BMS staffing in Cellular Pathology. Coupled with annual leave commitments over the remaining August into October 11 period this reflects a reduction in WTE BMS staffing of 38%. the situation should improve after mid October 2011 with the WTE BMS staffing shortage due to maternity and long term sick falling to 12%.	All part-time BMS and MLA staff were asked if they would consider increasing their hours. One MLA has increased their hours from 0.6 WTE to 0.9 WTE effective from the 24 August 2011 to 30 November 2011.	One has increased their hours from 0.6 WTE to 0.9WTE effective from 24 August 2011 to 30 November 2011. 22.11.11 Temporary arrangements are now in place in the lead up to the accreditation visit. These arrangements include:-1 An increase in part time working hours for a member of staff. 2 An increase in overtime for key staff. 3 The transfer of a maximum of 150 cervical cytology tests per week for a six week period to the Western Trust for processing and reporting. On Monday 22 August 2011 the gynae cytology backlog was 400 smears. On Friday 26 August 2011 the gynae cytology backlog was 700 smears. An increase of 40% in 4 days. The gynae screening backlog will continue to be monitored. If the backlog reaches 1000 smears arrangements may have to be made to have it sent to another laboratory for screening and reporting.	MOD	22/11/2011
3026	ACUTE	02/09/2011	Safe, High Quality and Effective Care	Mixed Sex Accommodation	Mixed Sex accommodation can have a significant impact on maintaining privacy and dignity to patients whilst in hospital. In the following areas emergency treatment will take priority over segregation: coronary care, intensive care, A&E, theatre and recovery wards, medical assessment unit. Those at risk are patients requiring admission to CAH/DHH and patients requiring admission to specialist units.	SHSCT Policy on the admission of patients to a mixed sex ward. Acute Services Directorate Escalation Procedure. Safeguarding Vulnerable Adults Procedure. Patient Support Services. Clear signage on toilet and washing facilities.			03/02/2012
3057	ACUTE	28/12/2011		Arrangements for the transfer of acutely ill patients between acute sites in the SHSCT and to acute sites in other Trusts	This risk has been highlighted due to impact on medical cover when patients are transferred out of hours from Daisy Hill Hospital, however we are now also aware that we do not yet have sufficient robust information in relation to the number, nature and times of transfers in the acute system	1. A Proforma has been issued for completion when transfers arise in our system. Completed Proforma are being submitted to Amie Nelson for collation and analysis 2.On DHH site, efforts are being made to schedule a 3rd SHO to be on duty OOH in the event that one of the doctors need to transfer with a patient. Consultant on-call must be contacted about any transfers OOHs, with a decision taken on who should transfer with the patient and what support is required from the consultant during this time. Work is also underway to put a sustainable OOH rota arrangement in place in the medium term. 3.Meeting has been arranged by Director of Acute for early January 2012 to review out of hours cover in both CAH and DHH in the context of a regional review of H@N	25.09.13 lead nurses to scope number of acutely ill patients transferred between sites/other trusts within past year both in hours and OOH and highlight who accompanied these patients 29.11.12 - Arrangements in place to facilitate transfer of patients between sites.	MOD	22/10/2013
3064	ACUTE	09/01/2012		Faulty Lifts in DHH outside labour ward	Lifts outside Delivery Suite which service the maternity ward, frequently breaking down. Health and Safety Issue for transferring mothers in labour or in an emergency situation.	Plan in place for Estates works to commence early 2012. Currently using second lift. Exploration of possible use of Evacuation Chairs.	29-08-12 one lift replaced and one refurbished. No further issues. 28.05.12 Fire evacuation chairs now purchased. Parts for 2nd lift currently being replaced. 26.04.12 Work completed on back lift.	MOD	29/08/2012
3165	ACUTE	22/06/2012	Provide safe, high quality care	Inadequate Speech and Language Therapist	Inadequate Speech & Language Therapist. Stroke patients waiting up to 3 days to be seen by Speech and Language Therapist. No Speech and Language Therapist allocated to MAU resulting in inappropriate management of patients care/treatment.	Staff trained in swallow assessment	25.09.13 - 80% staff in stroke ward CAH and XX% stroke ward DHH now trained in swallow awareness. Ongoing training for other ward areas.	HIGH	22/10/2013
3166	ACUTE	25/06/2012	Provide safe, high quality care	Urology Access Waiting Times	Urology access waiting times have increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.	This is currently being addressed via approval to go to Independent Sector and the appointment of new consultants.	3/3/15 - TO BE TAKEN AS PER AD CCS/ATICS 10.12.14 - Cancer targets are being met, i.e., 31 and 62 day pathway. While red flag and urgent appointment times are being met this is utilising all outpatient capacity leaving routine patients with longer waiting times. A new service model is being trialled which may improve the totality of waiting times in the long term. Inpatient/Day Case waiting times for routine patients remain challengin with the focus on treating cancer patients within the standards. 12.5.14 - with respect to the urology performance against the 62-day cancer target, there are 21 patients over 62+days of which 11 pts waiting over 85+days. With respect to haematuria 1st appointment now sitting at D16 which is an improvement on the previous positions due to a combination of drop in demand and extra capacity on a Saturday. 12.02.14 Urology waiting times are extended throughout the Province due to demand and capacity issues. The HSCB have commissioned a further Regional review of Urology Services . The SHSCT will partake in this Regional review. In the meantime, Team South will focus its resources on meeting the cancer waiting times within this specialty	MOD	03/03/2015

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains unchanged. 06/08/2019 - Ongoing increase in red flag referrals	HIGH	
3304	ACUTE	16/01/2013	Provide safe, high quality care	Lone Workers in X-Ray after 12 midnight	Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period.	Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting.	14.11.17 Awaiting update from J Robinson 5.12.16 The lock down system is being installed W/C 12 Dec 16. 13.9.16 Situation continues to be monitored	MOD	07/08/2019
3393	ACUTE	22/04/2013	Provide safe, high quality care	Biochemistry CPA Accreditation	Laboratory has lost its biochemistry accreditation status and is now a non-accredited laboratory	The Lab continues to perform adequately in its external quality assurance and internal quality control.	13.9.16 All findings have been cleared with inspectors. We are awaiting formal confirmation of accreditation status. this may take up to 6 months. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 6/1/16 - Inspection to take place 1st week in April 16. 27/11/15 - Pre-inspection took place on the 8/10/15. The Inspectors advised that Biochemistry is ready for the formal inspection subject to a few minor non-conformances being addressed. Formal inspection is expected in April 2016. 8/9/15 Labs - Pre-inspection visit confirmed for 8th Oct 2015 for Biochemistry. The biochemistry team continue to progress with meeting the ISO Standards. Meetings with Dr Hall and the Senior Biochemistry team continues. 3/3/15 - Labs contacted UKAS in January 2015 to check on progress with application, and was advised it had been passed to the scheduler. Still no indication of an inspection date yet. Staffing levels - benchmarking to be undertaken. Anticipated total additionality is 11 staff, no funding identified.	LOW	13/10/2016

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH and the inability to off load patients from Ambulance due to overcrowding.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow. HALO role and ongoing monitoring	20/09/2021- ongoing, risk exacerbated by Covid- bed pressures sustained for long periods. Non commissioned beds have been opened. Surgical beds converted to medical beds. 09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams. Funding needs secured for medical gases for ambulance receiving area. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing escalation plan. 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	HIGH	
3515	ACUTE	14/11/2013	Provide safe, high quality care	Ineffective Cardiac Monitoring System in certain Wards/Departments in CAH and DHH	The current cardiac monitoring system is old and unable to monitor patients in various wards/departments in the hospital site given their physical location. Monitoring is not available for certain patients and patients then may be required to move to 1 North for monitoring unnecessarily.	Appropriate selection of patients for monitoring.	14.11.17 Waiting on decision to start work with the potential of relocating coronary care beds to the HDU in DHH. 1.12.16 No further update. 13.9.16 In relation to CAH telemetry, this has now been fully implemented in the main acute wards, cathlab, and delivery suite.DHH,is awaiting funding allocation. 27.05.16 - Work in CAH will be completed with 3 months time. Costing obtained in respect of DHH work and added to Capital Estates list for consideration. 1/3/16 Now in place residual witing being carried out. 14.07.15 - Replacement system purchased and installed. Estates undertaking wiring to ensure all acute areas are covered.	LOW	24/06/2019
3526	ACUTE	17/12/2013	Safe, High Quality and Effective Care	Non-compliant bedpan washer disinfectors	Infection control risk to patients due to inadequate disinfection of bedpans throughout wards and departments in the Trust.	Daily testing of bedpan washer disinfectors completed by ward staff. Limited quarterly and annual testing carried out by contractor. Estates plan to provide a fully compliant quarterly and annual testing service early 2014. IPC has advised staff to carry out a visual check for cleanliness of all bedpans before use.	04/11/14 New bedpan washer disinfectors now installed. 23.4.14 Fifty new bedpan washer disinfectors received end of March 2014. Replacement programme underway according to IPC risk - to be completed by August 2014. Estates now providing a fully compliant quarterly and annual testing service. 12.02.14 Informed that order now placed 5.2.14 Contract awarded 18.12.13 Funding has been secured for the replacement of bedpan washer disinfectors. 5.11.13 pre tender meeting with Pals - tender open 8-11-13 and closes on 20-12-13 Tendering currently in progress to be finalised by end of March 2014. 28.3.14 Trust received 50 new bedpan washer disinfectors. A phased replacement programme has been agreed with IPC according to level of IPC risk and is due for completion by September 2014. October 2014 - 45 new bedpan washer disinfectors have been installed and commissioned leaving 5 spares for future new developments / replacements.	LOW	04/11/2014
3528	ACUTE	05/02/2014	Safe, High Quality and Effective Care	Pharmacy Aseptic Suite	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding) The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	Increased environmental monitoring to check for failures of sterility in the unit Expiry dates of all products prepared has been reduced to a maximum of 24 hours. A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	16.10.17 Unchanged 1.12.16 No further update. 13.9.16 Development Work ongoing 1/3/16 Work commenced for new suite. • Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July 2017. The design team have met throughout August with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed by mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited. two additional pharmacist posts were funded by HSCB to address the staffing deficit that was leading to the capacity plan model showing that the pharmacists are working between 130 and 150% capacity. Both pharmacists took up post in Jan 2017 and the capacity score has been reduced to 94% Capital was identified to replace both isolators and this work was completed by January 2015.	MOD	02/03/2020

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust by DHSSPSNI	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbidity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, loss in confidence / negative publicity Service Capacity As of 30 June 2020 there are 2131 standards and guidelines identified on the Trust's S&G database. Of thes1622 were applicable to Acute Services (78%) Lack of suitable IT Recording System Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . In 2017/18 BSO gave the WHSCT significant funding to support a pilot of a modified Sharepoint system that would in the first instance record and track the implementation of NICE guidelines and Technology Appraisals. The Regional NICE Managers forum acted as the project group and whilst the scope of the project was not embracive of all the types of standards and guidelines endorsed regionally it was at least a starting point. The ultimate vision was that upon completion this system would then be shared across the HSC (including the HSCB/DHSSPNIS) to provide a harmonised / standardised system that would provide effective monitoring and traceability of guidance implementation. Unfortunately this pilot has not yet yielded these desired outcomes and in the interim the SHSCT continues to use an excel spreadsheet whose functionality falls well short of service requirements. Discussions have been undertaken with Mark Toal to seek out other possbile IT solutions - these have included Qlikvue / the new Datix S&G module (which remains in prototype) / Q Pulse. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents were data saving has not occurred due to capacity issues. As a safe guard a system back up is saved on a weekly basis. There is also the added frustration that if any of the directorate governance teams are using the shared excel spreadsheet no-one else can use it. This can impact on staff not being able to carry out their administrative duties on the system at that point in time. This is inefficient and there is a risk of a lack of timely data capture. S&G Backlog S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implementation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an assurance response to the required external agency. It also has the risk of creating 'siloed' implementation	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified Within Acute Services a directorate S&G forum has been established - inaugural meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implementation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implementation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administration processes maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance	24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less 10/08/20 - Risk reviewed and description of risk updated. 02/06/2020 standards still difficult to achieve with limited funding, staffing and equipment 09.03.2020, 5.12.16 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed. Due to ongoing work pressures Phase 1 (01/10/2015 to current date) and Phase 2 of the backlog review (all S&G issued from 01/04/2007 - 30/09/2015) will be undertaken from 01/01/2018 to 31/03/2018 has not been progressed as planned and will continue during 2019/20 workplan. Phase 1 (From 2017 to current date) has been completed. Phase 2 of the backlog (from April 2007 - Sept 2015) remains outstanding.	LOW	
3619	ACUTE	11/11/2014	Safe, High Quality and Effective Care	Water Flooding and Sewage Leaks	Water and effluent leaks into any ward / department on the CAH site. Exposure / illness to raw sewage by patients, visitors or staff. - A foul smell in patient and staff areas make for difficult working conditions. - Contamination of water supply. - Increased rates of infection. - Disruption to patient care or activities in the ward / department. - Damage to equipment and the fabric of the building. - Damage to patient records and breaches under the Data Protection Act if records require to be destroyed. - Bad publicity. - No cleaning service provided in areas if Domestic Services resources require to be re-deployed to assist with clean up. - Additional pressure within Domestic Services may mean a longer response time for terminal cleaning / bed cleaning which could effect bed availability.	Bag it and Bin it posters are displayed in all toilets and have been communicated to all staff via desktop messages. On the poster there is a request for staff to report any slow flushing toilets to Nursing staff. - Posters are displayed in all sluice rooms advising staff not to flush wipes, conti wipes, J cloths and hand towels. - Leak detectors are in place in some areas. - Piping has been replaced in two Health Records libraries in the basement. - In the Health Records libraries the roof tiles have been removed to help see any leaks at an early stage and a large number of charts have been moved and sent to secondary storage in Armagh to avoid them having to be placed on top of the filing bays. - Domestic Services have a process for dealing with flood / sewage incidents. - There is weekly jetting of drains. - Heads of Services were asked to ensure all alcohol wipes were removed from all toilet and bathroom facilities (action from a meeting held 14/05/14). - The Assistant Director of Functional Support Services sent a communications to her AD colleagues in Acute and Heads of Service on 8/10/2014 appealing to all staff not to flush wipes down the toilets and requesting their support in dealing with this problem. - Maintenance staff have spoken to Ward Sisters in Maternity and staff in Maternity are advising patients and staff re the Do's and Don'ts of waste. - There is greater awareness amongst Nursing staff regarding the potential problems and consequently there is better reporting to Estates.	3/3/15 Posters are displayed and all staff communicated with. Leak detectors are in place in some areas. Piping has been replaced in two Health Records libraries in the basement and some roof tiles removed to help see any leaks at an early stage. Large number of charts have been moved and sent to secondary storage in Armagh. Process in place to deal with flood / sewage incidents. Weekly jetting of drains. Heads of Services were asked to ensure all alcohol wipes were removed from all toilet and bathroom facilities. Communication from AD FSS to ADs/HOS on 8/10/2014 remind all staff not to flush wipes down the toilets and requesting their support in dealing with this problem. Work between Maintenance & Maternity staff to advise patients & staff re the Do's and Don'ts of waste. Greater awareness amongst Nursing staff regarding the potential problems and better reporting to Estates.	MOD	14/04/2015
3653	ACUTE	15/04/2015	Provide safe, high quality care	Infection control due to release of sewage into clinical areas	Escape of sewage from sewerage system causing: Infection: Exposure of patients, visitors and staff to increased risk of infection, Contamination of catering/food preparation areas Contamination of drinking water Clinical services - disruption: Closure/cancellation/disruption to clinical services (including due to odour) Patient records damage: May cause damage/loss of patient records Property/infrastructure damage: May cause damage to flooring, ceilings, walls and general building infrastructure Possible damage to electrical systems Possible damage to IT systems Equipment damage: Possible damage to medical devices and equipment Public reputation: Adverse publicity Adverse political interest Legal challenge: Possible breach of Data Protection Act Breach of health and safety legislation (Health & Safety at Work Order) Possible breach of common law duty of care Possible breach of environmental legislation Increase use of resources Addition deep cleaning requiring addition staff and consumables	Information, instruction and training: Use of posters in all sluice rooms Use of splash screen information on computers for staff Senior managers informed of measures required to reduce the incidence of sewage leaks (email from Assistant Director of Clinical Support Services) All clinical staff brief on waste disposal and incident reporting Incident management: Incident reporting systems in place - DatixWeb and Estate Services Help Desk Domestic Services have a process for managing reported sewage incidents Estate Services have waste sewage disposal sub-contractor arrangements in place Proactive measures: Jetting of sewerage system in known areas of frequent blocking Ceiling tiles removed in record stores to aid detection of leaks Automatic leak detection installed in some areas Alcohol wipes removed from all toilet areas Restructuring of record stores (surplus files place in Armagh) Pipe runs replace in two record stores Replacing of old "push-fit" pipe system with welded joint system on a cost benefit basis	1.12.16 No further update. 13.09.16 The drainage issues in the main acute ward block has been mainly resolved in last year's ward works and the risks minimised due to the infrastructure issues(blockages still can occur due to inappropriate items being flushed down the sanitary points) In relation to the maternity block, £250k of funding has been allocated,awaiting business case being approved (possibly at next SMT) to commence with the procurement of the works and implementation on site by March 2017. 7/3/16 South side replaced and north side replaced on ground level. Basement works continuing. 22/7/15 This risk continues to be managed. Approval of 475k Revenue funding by SMT will enable some repairs to sewage system in CAH to be completed this year.	MOD	18/09/2017

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3660	ACUTE	20/04/2015	Provide safe, high quality careMake the best use of resources	Non compliance with testing of decontamination equipment as per DHSSPS guidance	Insufficient resources to carry out the full range of testing on decontamination equipment as per DHSSPSNI guidance.	All high risk decontamination equipment i.e. sterilisers, washer disinfectors, endoscope washer disinfectors will be tested as per DHSSPSNI guidance. Some of the lower risk contamination equipment i.e. bedpan washer disinfectors will be tested 4 monthly rather than 3 monthly as per DHSSPSNI guidance. Interim revised testing schedule approved by the IPC team and AE(D). Interim revised testing schedule will be reviewed annually. Additional revenue funding will be requested if availability of insufficient resources is on-going.	April 2015 Bedpan washer disinfectors will be tested 4 monthly rather that 3 monthly as per DHHSPSNI guidance.	VLOW	09/12/2015
3663	ACUTE	29/04/2015	Provide safe, high quality care	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assesssement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to reitain a modular CT Scanner in DHH.	6/4/22 There has been a further meeting with HSCB to look at the options - there are currently 2 suppliers have submitted bids through PALS procurement. Only one supplier is within original budget. Still awaiting funding stream Dec2021- meeting with HSCB in January 2022. 03/12/2021 - Currently awaiting feedback from DOH regarding the IPT. The provider is querying if the lease will be extended by March 2022 as they have other third parties interested in the unit. 14/09/2021- Medium term plan to build a CT suite in DHH with 2x X-ray machines and one MRI. Finance and Planning have asked the Regional Imaging Board. Clarification has been sought but not yet received. Trust running at risk even without funding March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD	
3689	ACUTE	08/06/2015	Provide safe, high quality care	Delayed reporting of Histopathology samples	Patients are at risk of a delay in the diagnosis and treatment of a variety of conditions as a result of a backlog of histopathology specimens for reporting. this backlog is caused by a reduction in the reporting histopathology capacity. Only consultant histopathologists report these samples. There is currently 1 vacancy and a capacity gap of 2 WTe Histopathologists. he delay could result in a delay in diagnosis and or treatment that would affect the efficacy of treatment and or lead to patient harm.	Some additional reporting sessions are being undertaken by pathologists. All samples are triaged in an effort to ensure that the more urgent or critical samples are processed and reported as a priority. A Locum histopathology has been source and the Trust is attempting to identify a second. The Northern Trust has indicated its willingness to report specimens. Recruitment to the vacancy is being pursued Placed on Directorate Risk register on 8/6/2015 ID: 3689. Placed on Performance risk register Oct 2015.	05/09/2017 Recruitment has been successful with outstanding vacancies being filled in September 2017- the is currently a minimal reporting backlog 1st February 2017 update - we have successfully recruited a permanent pathologist who should start 1st April 2017. we have a locum stating soon. we continue to use vacancy funsing and some elective care (endoscopy) funding to close the gap in capacity 5,.12.16 We continue to have 2 Consultant vacancies we are currently using a number of waiting list sessions from both internal staff and consultants from other Trusts for assistance in core time. Turnaround times are being actively monitored. 13.9.16 Locum Consultant pathologists have been employed since June 2016. The first of these has already left and the second is due to leave at the end of September 2016. In addition another part-time pathologist is leaving for a post in Belfast reducing the establishment by a further 6 P.A.s. There is an active recruitment process and the Trust is actively seeking replacement locum pathologists. 13.06.16 Referral to laboratories outside of Northern Ireland. This has been discounted as the histopathology information would be lost to the regional system. It may have to be considered if the risk does not reduce. Referral to Belfast and or WHSCT. Neither Trust has indicated that they have capacity to take additional samples.	LOW	18/09/2017

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3829	ACUTE	13/09/2016	Safe, High Quality and Effective Care	Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	19/11/21 Update from Lead Nurse SEC- A working group is currently developing a criteria method to help guide the level of supervision required in nursing observations in relation to mental health"Enhanced Care Observation (ECO)". A training component is also being developed for staff prior to the pilot of this tool. There is a corporately led MDT working group who have produced a draft SHSCT point of ligature policy which has been shared for consultation prior to final approval. 20/09/2021- Lead Nurse SEC update- absconding policy used at ward level. Patients identified at risk will be placed in a bedspace as much as possible that provides supervision/visibility. Referral to Psych liaison. Also current working group to establish a "patient at risk" assessment tool which incorporates all levels of risk and care planning. There is also work ongoing regarding access to psych services within Acute. 20/09/2021- Escalated as per trust policy in ED. 18/08/2021- Absconding policy in place and escalated to HOS if incident occurs. Reported via Datix process. 09.03.2021- within ED a risk assessment is carried out if PSNI accompany patient under article 130 a joint risk is completed with nursing team. ED AMU review absconding patients with PSNI and mental health at interface meetings 24.02.2021- still ongoing issue and the staff adhering to policy and datix submitted with review taking taking place for each case. 24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating.	HIGH	
3869	ACUTE	23/01/2017	Safe, High Quality and Effective Care	Limited Speech and Language Therapist Provision	Inability to provide adequate Speech and Language Therapy to acute based patients due to increased volume of referrals of complex patients over previous 10 years - situation escalated by inability to backfill 2 senior staff on maternity leave and complexity of patients requiring SLT assessment. Capacity to provide Dysphagia treatment significantly reduced. Delayed assessment of patients designated nil by mouth so rehabilitation potential reduced. Delayed review of patients on modified diet Delay in discharge as SLT unable to respond to request for assessment and intervention re: swallow management including information re: food/fluid textures to carers. Potential for SAIs. Patients discharged prior to assessment Limited rehabilitation to patients, hence longer length of stay in hospital. Complaints received re: service provision Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Inability to achieve regional PTL waiting time targets	Several requisitions for recruitment of suitably trained staff - unsuccessful Junior locum staff employed but not skilled enough to fully meet caseload demands All core staff offered additional hours Telephone referral system manned by administration staff Triage and prioritisation of referrals Waiting list for in patients Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands Cancellation of VFS clinics which leads to distress of patients and families.	Dec 19 - deficits remain - recruitment to B7 and B6 posts have been unsuccessful. Retention of B5 locum into substantive post and potential to link B5 post to B6 Jan 2020 Jun19 The deficits in this service will now be major as there has been 2 resignations from B7 staff. 21.11.18 New post appointed Apr 18. However, capacity v demand compared with NHS benchmarking identifies approximately 50% deficit re staff required. Also Band 6 gap as member of staff left post. 22.1.18 Situation has deteriorated and continues to be monitored. 14.11.17 Secured SLT for AMU - recruitment in process, Capacity / Demand paper being revised, Prioritisation of demand continues. 6.6.17 Remains limited due to low investment in this service.	MOD	13/08/2020
3922	ACUTE	13/11/2017	Provide safe, high quality care	Lack of funding to ensure compliance with NICE guidelines that have been regional endorsed by the DHSSPSNI.	In April 2017 a Band 5 Governance Officer commenced work within the Acute S&G team as part of a secondment from the Corporate Governance team. This secondment to the Acute S&G forum ended on 31/12/17. The purpose of this audit was to ensure that an assurance framework is in place to comply with the reporting arrangements to the relevant external agencies (such as the HSCB). The outcomes from this audit are now being operationalised and outstanding actions are presented at the Acute S&G forum and Divisional Governance meeting to ensure progression. As part of this work a significant number of NICE guidelines have been identified as having an external barrier impeding implemention. This work has continued and there are now 79 listed NICE guidelines where an E proforma is required. There is a robust system in place to maintain E-proformas being sent to the HSCB as and when required. However due to COVID 19 pandemic from March 2020 / Industrial Action in November and December 2019 there has been a significant increase in the number of E proformas that are now overdue for review. The number is now 25 (32%) - this work will be deferred until October 2020 when it is agreed that the S&G NICE workplan can recommence. A copy of the updated July 2020 E proforma report provides evidence of this work. The work also provides a timely trigger for the compliance position to be reviewed in accordance with stipulated review timescales. In the past the HSCB would have reviewed 'red' status guidelines for all Trusts and for guidelines were all Trust's identified significant barriers these would have been prioritised as part of their annual work plan and there was the possibility of funding being allocated to support implementation at a local level. With effect from 01/04/2017 this is no longer the process, with all Trust' needing to manage all funding requests within existing financial resources. Given the number of competing demands this makes it very difficult to ensure that the S&G constraints are overcome and presenting a risk for the Directorate. As part of the 2020/21 workplan for the Acute S&G team workplan the 'Green Status' report is currently being reviewed to ensure those NICE guidelines that have been identified as either being fully compliant or have an internal action required to achieve full implementation are accurately reported upon.	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. The content of this report is approved by the Director of Acute Services and Director of Performance prior to submission The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified	01/06/2021- link with 3529 as per director 24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less June18 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less	LOW	01/06/2021

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3921	ACUTE	13/11/2017	Provide safe, high quality care	Extra patients on wards	No piped oxygen or suction in extra bedspace, lack of room for manual handling/attendance at cardiac arrest in extra bedspace, lack of privacy and dignity, increased pressure on staffing, increased complaints by service users, extra patient requiring evacuation in event of fire, increased risk of cross infection	All patients to be assessed on ward at time of requirement to place extra patient, so that most mobile patient may go into the extra bedspace, or the patient with no requirement for continous oxygen or suction. portable oxygen/suction is available at ward level for emergency situations. infection control precautions must be kept to the highest standard, continue to isolate high risk patients and all staff to adhere to good IPC practice placement of patients must also take into consideration manual handling needs of the patient and again place most independent patient in extra bed space. in event of cardiac arrest extra bed should be pulled out into corridor and mobile screens etc used to screen patients who require arrest team all efforts should be made to maintain patients privacy dignity for the patient while the extra bed is in use and visiting rules shouls be strictly adhered to i.e 2 visitors per bed. patients should be encouraged to avail of day room etc if appropiate staff to be made aware that extra bed space is put into use only as a last resort and is a decision made by the director for best care option for all patients at the time of bed pressures staff to be aware of the need to explain to patients and their relatives of the reason for the extra bedspace and try to give reassurance that it will be stood down as soon as possible staff to ensure extra patient is on Immix board and patient handover for fire evacuation Where 1 additional patient is noted to pose risks, it needs to be offset against the risks associated with over crowding in ED when recuss, majors and minors are at maximum capacity resulting in delays in assessment of patients, treatment and inability to deal with blue light calls or a major incident	01/06/2021- no longer a risk closed as per director	LOW	01/06/2021
3929	ACUTE	12/12/2017	Provide safe, high quality careMake the best use of resources	Declaratory Orders for patients who lack capacity	Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of liberty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes obo individuals without capacity.	Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievalbe not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision.	30.07.19 There will be partial implementation of Mental Capacity Act NI on 1 October 2019. This may aleviate some of the declarattory orders asTrust Authorisation panels are being set up. 7.3.18 Risk remains unchanged	LOW	
3951	ACUTE	10/04/2018	Provide safe, high quality care	Delays in isolation	Due to lack of side rooms/one to one nursing/lack of bed capacity in the service. Risk of spread of infection. Failure to isolate promptly can lead to outbreaks, close of bays, increased pressure on service. May lead to potential patient harm through the spread of potentially preventable infection or due to a lack of beds.	Trust can emphasise the importance of IPC issues at bed meetings and elsewhere. A recent teaching sessions was arranged to do this amidst the winter pressures. Side rooms are often occupied for reasons other than IPC reasons. IPC reasons for isolation are often of critical importance in that severe harm can be done to other patients and staff by failure to isolate promptly. This is often not the case for other reasons patients are in side rooms and side rooms should be prioritised to maximise patient safety. The Trust should also look to ways to enhance the capacity to isolate a patient when the hospital is full and a patient needs isolated urgently e.g. where a patient could be moved out of a room to facilitate critical IPC isolation.	20/09/2021- all patients who attend ED have Lumira to determine covid status. PCR completed as per protocol. Risk assessments are completed when a high number of beds are closed due to an outbreak vs risks in ED. 01.06.2021- there has been 8.7 million pounds secured from the DOH address nosocomial infections which will allow estates work to progress. This will free up clinical space to accommodate patients. 24.01.21- delays in ascertaining results of swabs and screening and appropriate action delayed based on same and lack of isolation rooms to accommodate this.	HIGH	
3953	ACUTE	10/04/2018	Provide safe, high quality care	Inappropriate antibiotic use (tied to stewardship issues in terms of corporate actions needed)	Inappropriate antibiotic prescribing can lead to a rise in antibiotic resistance which impacts on the safety of the entire public. It can also lead to side effects for individual patients such as Clostridium difficile infection (CDI). The risk of CDI is enhanced where antibiotic treatment is unnecessarily broad spectrum or overly prolonged. Inappropriately narrow spectrum or inadequately long courses of antibiotics can also lead to adverse outcomes for patients including recurrences of infection and death. Inappropriate prescribing most often occurs:- (a) When patients receive antibiotics when they do not have infections - this often occurs whenever a diagnosis is initially unclear and infection is in an initial differential but antibiotics are not stopped whenever the situation becomes clearer. (b) A clear diagnosis is not made e.g. a patient is designated ?LRTI ?UTI - often even when a diagnosis is subsequently made broad spectrum antibiotics are not narrowed as they should be (c) When patients receive prolonged antibiotic courses instead of getting proper source control - all guidelines advise that abscesses or infected collections should be drained promptly if at all possible The patient is at side effects from antibiotics, at risk of acquisition of multi-drug resistant organisms, at risk of Clostridium difficile and potentially death. Other patients and staff are put at risk as bacteria in the hospital environment develop greater resistance, meaning that the number of antibiotics available for future treatments become more restricted. Ultimately bacteria can become panresistant and untreatable. This in turn places greater pressure on side ward capacity in the Trust and risks targets e.g. MRSA target. The Trust has will not be able to meet the upcoming targets for the reduction of broad-spectrum antimicrobial use unless the situation is improved. Staff and the Trust are at risk of litigation and censure from the Coroner and the GMC.	The Trust conducts antimicrobial stewardship rounds to reduce inappropriate antibiotic use. This service however is limited by the inadequate number of microbiologists and antimicrobial pharmacists. The Trust has far fewer microbiologists than neighbouring trusts and the number it is funded for (2) is far short of what the Royal College of Pathologists standards says it requires. The Trust only employs 1 antimicrobial parmacist in comparison to the standard 2 in other Trusts. This means that the stewardship round service is exceptionally vulnerable to leave or illness and at best only is staffed to function two thirds of the year. The service has been severely impacted by the current staffing situation in the Trust. The Trust has only had a single microbiology consultant for over a year and a half. At times there has been no locum cover and there is not capacity to do stewardship rounds when a microbiology is single-handed. Since the Trust's antimicrobial pharmacist was promoted several months ago the Trust has had only had a pharmacist effectively 1 day a week which again had a severe further impact on the antimicrobial stewardship service. Membership of the Trust's Antimicrobial Team Meeting (the main forum for communication for stewardship issues) had waned however the DIPC recently reviewed the membership of the meeting and medical leaders are now expected to attend. This has significantly improved the platform at which stewardship is discussed however the situation of the service as a whole remains critical. The Trust has offered positions to a new antimicrobial pharmacist and a second microbiologist however they have yet to take up posts. A business case is being submitted for expansion of the microbiology and antimicrobial pharmacist services which is critical to address these issues. Medical leads need to be encouraged to take more actions in their areas to emphasise the importance of stewardship. This will be discussed at the next AMT meeting on Tuesday the 27th of March. Lead Nurses and Ward Sisters should be empowered also to encourage nursing staff to challenge prescriptions.	11/08/2020 There is a team of microbiologists and an OPAT team to over see antibiotic prescribing on both sites. No longer a Risk. Removed from Risk Register. Risk added to RR April 2018. Risk added to RR April 2018	HIGH	12/08/2020

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3954	ACUTE	10/04/2018	Provide safe, high quality care	Lack of documentation	Root cause analyses are repeatedly picking up incidences of poor documentation e.g. lack of filling out of Clostridium difficile bundle, lack of documentation that the patient has been informed of a diagnosis of Clostridium difficile, lack of filling out of cannula charts, etc. Lack of documentation can reflect either that something that should have happened has not happened or just that it has not been documented. In the former there is a direct risk to patient safety (e.g. death from Staphylococcus aureus bacteraemia from a cannula that was not inspected properly and removed when it should have been, death from Clostridium difficile due to deterioration not being picked up due to lack of due diligence in the application of the bundle). In the latter there is still danger to the patient as staff subsequently on duty will not be able to see what was done as it is not documented. There is also significant risk to litigation to individual staff and the Trust as without documentation to say that good practice has been carried out there is no proof that it has been done.	Medical and nursing training would emphasise the importance of good documentation. Root cause analyses would emphasise the importance of this. The recurrence of this problem as demonstrated by repeat root cause analyses however would suggest that current control measures are not sufficient. When challenged regarding poor documentation excuses given are usually:- (a) A lack of education/awareness regarding aspect s of care bundles (b) A lack of time to document things due to service pressures Problem (a) could re resolved through additional education to staff through Lead Nurses, Ward Sisters and Clinical Directors to their teams where this is needed. Problem (b) can only be resolved by easing the pressure on nursing and medical staff in general. In general the experience of the IPCT is that nursing documentation is better than medical documentation, especially with regards to documenting when a patient has been informed of their diagnosis.	18/08/2021- RQIA guidelines shared with Cardiology Team following SAI. Audit to be carried out in October 2021. 24.02.2021- improvements have been made but still needs continually monitored	HIGH	
3957	ACUTE	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS	19/4/22. All wards DHH have 3 consultants aligned to them so all patients are seen daily. Need To review middle tier rota to support additional Medical Beds opened on DHH site. Recruitment in progress for substantive consultant posts. 20/09/2021- unable to secure acute physician for DAU. 18/08/2021- COW model in place and patients reviewed daily. New patients discussed at daily handover at 8.30am and also weekend handover at 12.45 on Fridays. 07/06/2021- There are 5 substantive Consultant post in DHH across Med/ Stroke/Respiratory and Gastroenterology. 4 out of 5 contribute to the 1:8 medical rota. The remaining posts are filled by Locum Consultants. there is a 1:12 weekend/bank holiday rota which is supported by colleagues from OPPC. There is now a substantive 1:8 middle tier rota. From August 2021 there will be a full middle tier out of hours rota with no locum's. At weekend/bank holidays there is an additional Consultant, registrar and SHO who work from 09:00-14:00 hours. 24/02/2021- review of medical staffing on DHH site currently taking place. E- Req in system for specialties. 13/05/20. Zoning introduced but issues identified with this system. Audit carried out. Medical rota is sufficient to provide daily senior review. 24.06.19 No change. Zoning introduce needs evaluated. Review workforce available.	MOD	
3958	ACUTE	30/04/2018	Safe, High Quality and Effective Care	EBUS Provision lack of Funding	The risk is that patients requiring this investigations are waiting in access of 13 week Pot for Harm -Delays in patients being diagnosed, commencing treatment and the appropriate way Delays may contribute to patient death.	We have Cardiac investigations teams across both acute Sites Agreed referral process to be used by CI staff at Triage Avail of funding from HSCB for additional clinics.	10/08/20 - can be removed from risk register. 02/06/2020 Initial funding secured from LCG but then it was utilised for other services. So EBUS funding still outstanding 24.06.19 Additional EBUS session secured and we will continue to monitor. 19/11/18 Measure access times monthly and highlight to HSCB via performance team. Review of cardiac investigation demand and capacity by HSCB.	MOD	10/08/2020
4177	ACUTE	20/06/2018	Safe, High Quality and Effective Care	Chiller Faults causing loss of time- MRI	Chillers are required to supply chilled water to the MRI scanner to remove heat produced during scanning and facilitate circulation of liquid helium which maintains the operation of the supercounducting magnet. For the scanner to operate at the highest levels of efficiency, the magnet inside the scanner has to be kept as cool as possible. Any increase in temperature will result if the the chiller is not operating will cause the scanner to no longer operate. This is a safety mechanism for the scanner to prevent boil off the liquid helium "quenching". This is when the wire in the electromagnet stops being superconducting and starts to generate a lot of heat. At this point, any liquid helium around the magnet repeatedly boils off and escapes from the vessel housing the magnet.	Single chiller per scanner with no back up available. Alarm system in place to business management system when chiller is not operating- no communication from switch or estates re this during recent breakdowns. Siemens will test this to check if the system is working.	08/07/2021- recent chiller failure- temporary chiller installed until fault can be replaced. Several days scanning lost while this was ordered and installed. RED FLAG exams delayed due to downtime. 21/11/2020- no change- still awaiting estates action ongoing follow up with estates for progress. 20/06/2018- automatic emergency bypass system needs integrated instead of manual- to be referred to capital department for design team. Additional secondary chiller with associated pipework as a backup- D/W David Thompson needs referred to capital department design team. Discussion with Estates Team and Switch in relation to procedure for notifying estates and MRI if chiller alarm goes off. Alarm system to be tested.	HIGH	

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
3971	ACUTE	28/08/2018	Provide safe, high quality care	Access to cath lab for NSTEMI patients- ST has the highest through put of patients through the Cath Lab in the region.	The ST have highest through put in the region and only have one Cath Lab. If the C Arm breaks down we will not be able to treat Cardiology patients requiring patients to be transferred to another Trust. SHSCT are concerned there is a potential to patient morbidity and mortality due to long waiting list. Standard 18d of Cardio vascular framework that eligible NSTEMI / ACS pts should have Cor Angio +/- PCI within 72 hrs of admission. Angiography within 72 hours improves outcomes for patients. (NICE). MINAP state: The performance of angiography and coronary intervention soon is an important facet of treatment for the majority of patients.	Monitored weekly. Access elective patients. Escalate number of patients waiting for in patient cath procedures daily to AD and Director. There is a Regional Cath Lab implementation group which has been in place since August 2020.	18/08/2021- Have escalated via Elective Performance meeting. Highlighted the impact of high volume of inpatient activity and need for 2nd Cath Lab to address. Meeting held re inpatient plan regarding sharing lists with Belfast and Western Trust. Criteria to be established. Access times monitored monthly. 07/06/2021- The SHSCT has raised with the HSCB the need for decisions re Cath Lab capacity to meet the demand to be made as soon as possible. The Consultant Cardiologist in the SHSCT recommend a second Cath Lab on site. A PID for phase 3 Cath Lab capacity project was finalised in Oct 2020 and it was shared with the interim Director of commissioning in the Board. The process has been delayed due to the impact of Covid. A Clinical Lead is to be appointed to take forward a capacity and demand exercise which will allow a number of different options to be considered. 24/02/2021- working through as part of cardiology network plan but the target is only 33% in 72 hours due to only one cath lab. 5 /11/20 KPI for N STEMI s getting to cath lab within 72 hours has dropped to 35 % from 45% this is impacting on length of stay and bed occupancy at ward level and resulting in patients being admitted to wrong ward 10/08/20 - Regional group has been established PID document agreed. Demand and Capacity for cath lab activity to commence when templates have been distributed to the Trusts. 14/5/2020. Modular Cardiac cath lab was removed in October 2019. Access times for NSTEMIS has dropped to 33% getting to Cath lab within 72 hours . Regionally agreed to establish group to review cath lab activity re access times and demands. 24.06.19 Monitored via MINAP only 50% getting to cath lab despite modular. High volumes of inpatient activity (monitored monthly for each site) Need to secure Funding permanent for modular. Need to reduce elective to facilitate inpatient. 13.08.18 Performance team to liaise with HSCB re funding	HIGH	
4007	ACUTE	28/02/2019	Provide safe, high quality care	Risk that patients receive inappropriate care due to the misuse of point of care testing	Risks arise from the inherent characteristics of the devices themselves and from the interpretation of the results they provide. They can be prone to user errors arising from unfamiliarity with the devices. Patients are at risk of inappropriate treatment as a consequence of inaccurate results. Individuals are sharing passwords/barcodes in contravention of Trust procedures and good governance. Equipment is not being properly maintained which puts equipment at risk of malfunction leaving patients vulnerable. Internal Quality Control review and regular audits have stopped due to a lack of resources. There is a lack of Assurance around temperature control of reagents etc. which has the potential to influence the results. Patients are at risk of receiving an inaccurate test result and receiving inappropriate treatment or not receiving treatment when it is actually required. Patients could come to serious harm / death. Staff are at risk to Trust sanction or Professional body sanction, litigation, dismissal. Trust is at risk of litigation due to improper use of devices. Trust is at risk of litigation due to improper treatment based on inaccurate results or misinterpretation of results.	Training is available on all devices. Quality controls are available. DATIX web is available to report and monitor any incidents. Staff are given unique barcodes to operate Trust equipment where they are deemed competent to do so. It is the responsibility of all staff issuing a POCT device to end users to ensure that the user is adequately trained and competent to use the device.	28/02/2022- Merged with datix 4184 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing policy which will go live in July and will be disseminated to all AD'S and appropriate leads. May 2021 Equipment controller training will re-commence post covid as an online learning via Sharepoint. The powerpoint presentation will be uploaded in the coming weeks and will include a declaration form which will be signed by trainees upon completion. Feb20 Patient safety and quality manager mitigated the risks associated with improper use of Glucometers	LOW	28/02/2022
4009	ACUTE	28/02/2019	Provide safe, high quality care	Delay in the management of oncology patients	Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	Trust currently working closely with colleagues in Belfast Trust to complete a look back exercise to ensure patients have all got a management plan. ongoing review of weekly clinic and outcomes from these.	Dec19 non medical prescribing (NMP) funding has been secured to develop nursing and pharmacy NMP. Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	LOW	02/03/2020

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4010	ACUTE	28/02/2019	Provide safe, high quality care	Delay in the treatment of Cancer Patients due to vacant Oncology Consultant	Due to vacant Acute Oncology Consultant post and reliance on one Specialty Doctor in Oncology there may be times when unwell patients attending mandeville unit will have to be directed to Emergency Department for further assessment and management. Service heavily reliant on Clinical Nurse Specialist support at present.	Trust currently trying actively to recruit into vacant Acute Oncology Consultant post and working closely with colleagues in Belfast Trust to support the oncology service. Trust currently working closely with colleagues in Belfast Trust to complete a look back exercise to ensure patients have all got a management plan. ongoing review of weekly clinic and outcomes from these.	02.03.2020 The medical oncology staffing pressures continue to be a major issue at this point in time. There appears to be no prospect of recruiting into the Consultant Oncology post. The ST is therefore reliant upon visiting Oncology Consultants from Belfast. In recent weeks Belfast HSCT have advised they may have to reduce the number of consultants visiting. Thereby exacerbating the local problem and requiring the risk rating to increase from moderate to high. To address capacity issues working to skill up NMP both nursing and pharmacy. 3/12/19 Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending. Funding has been secured via early workforce bid through Oncology Services Transformation for 0.8WTE Advanced Practitioner Oncology with 0.25 WTE admin support and 1.0 WTE Specialty Doctor for Oncology. Ongoing work to progress recruitment of these posts. Dec19 non medical prescribing (NMP) funding has been secured to develop nursing and pharmacy NMP. Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	HIGH	24/06/2020
4011	ACUTE	28/02/2019	Provide safe, high quality care	Delay in the Management and Review of Haematology Patients	Due to pressures within Haematology service patients requiring review at outpatient Haematology clinic may not be reviewed in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. A senior Consultant is planning to retire at the end of December and due to difficulties in recruiting medical workforce this may further impact the ability to review patients in a timely manner.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner.	June 2020 Nov19 Haematology Consultant workforce is now funded for 5.0WTE however due to 2 senior Consultants retiring earlier this year recruitment is ongoing. There are currently 3.0 WTE in place and following recent interviews for 2 vacant posts, offers were given with one Consultant accepting. This leaves a gap of 1.0 WTE which will be covered by Locum cover. One substantive Consultant has now gone off on sick leave for planned surgery.	MOD	24/06/2020
4005	ACUTE	28/02/2019	Provide safe, high quality careMake the best use of resourcesBe a great place to work	Lack of Availability of Core AHP Staff	Increase volume of complex patients requiring intervention. Increasing demand on services with high patient turnover and additional patients across wards, transition ward, outliers and ED presenters. Staffing across all disciplines below the National average (NHS Benchmarking figures 2017) Gaps in core services with inability/challenge to recruit in timely manner. Lack of backfill for maternity leave. Patients not receiving timely assessment and appropriate level of rehabilitation to maintain patient flow. Patients under nourished, remain nil by mouth for increased length of time due to reduced dysphagia cover especially for stroke patients. Unable to facilitate mobilisation with resulting deterioration in muscle bulk and increased morbidity, lack of facilitation of activities of daily living hence increased dependency and requirement for larger package of care on discharge which will be delayed. Poor SSNAP results Instability of core OT/PT staffing impacts on ability to rollout ward based 7 day working Potential for SAIs. Complaints received re: service provision Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Reduced morale and goodwill among teams - staff retention an issue with posts outside of acute attractive.	Regular contact with BSO re recruitment. Requests to contract and non contract agencies for AHP staff, core staff offered additional hours,		MOD	13/08/2020
4006	ACUTE	28/02/2019	Provide safe, high quality care	Lack of robust arrangements and sufficient resources for the management of equipment and medical devices.	The Trust does not currently have in place suitable and robust arrangements to support the management of medical devices and equipment in accordance with the DHSSPS Controls Assurance Standards and MHRA guidance. Stringent management throughout the lifecycle of medical devices (from procurements to disposal) is essential in minimising the associated risks to both patients and staff. The Trust has a duty of care towards its employees and patients to ensure that they are not put at risk from medical devices which are not managed properly, may be unsafe or unsuitable, are not maintained or whose operation is not understood by the user. There is also a risk that the Trust could be subject to litigation if it can be proved that there were not adequate management systems and resources in place to deal with equipment management.	This risk being managed in the Acute Directorate	March 2020 a Trustwide Equipment and Assessment Manager has been appointed and has taken up post March 2020.	LOW	02/03/2020
4031	ACUTE	28/05/2019	Provide safe, high quality care	BTS National Audits (British Thoracic Society)	Patients are being disadvantaged because we can't take part in good quality national audits. Staff can't show evidence of good quality practice. We are unable to be properly benchmarked against similar organisations.	Ongoing backlog in data provision for national audits	10/08/20 - A process for Audit has been agreed with the respiratory team. Risk can be removed from register. Risk placed on Register for monitoring	MOD	10/08/2020
4039	ACUTE	12/06/2019	Provide safe, high quality careMake the best use of resources	Physiotherapy Staffing Difficulties	Inability to provide adequate Physiotherapy to acute based patients due to increased demand for Physio service in The Blossoms Childrens Services (in particular Paediatric Respiratory requirements. Ongoing recruitment and vacancy difficulties	Delayed assessment of patients. Potential Delay in patient discharge. Potential for complaints Limited rehabilitation to patients, hence longer length of stay in hospital. Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Inability to achieve regional PTL waiting time targets	Jun19 Bid to the Investment Committee for consideration. Requisitions for recruitment of suitably trained staff. All core staff offered additional hours. Triage and prioritisation of referrals. Waiting list for in patients. Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands.	MOD	13/08/2020
4046	ACUTE	05/08/2019	Provide safe, high quality care	Gamma camera Breakdown	The Nuclear Medicine department has 2 gamma cameras. The oldest, which is 20 years old, recently broke down and cannot be repaired as parts are no longer available. The remaining camera is 11 years old. If there is any breakdown with it or there is a service day, there will be no delivery of the service. Delay in patient scans, which may lead to a delay in diagnosis. The majority of the scans that are undertaken in nuclear medicine are for cancer patients. This will lead to Trust breaches in the Cancer Pathway.	Keeping the remaining camera serviced and in good working condition If there was a breakdown of any length of time, the wards would need to be informed, and patients transferred to a different trust as there is no other provision for nuclear medicine scanning in the southern trust. Lists cannot be carried out at the weekend as radiopharmacy does not supply radioisotopes at the weekend.		MOD	03/12/2019

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4049	ACUTE	07/08/2019	Provide safe, high quality care	Due to the staffing situation in Maternity there is an inability to accept Inutero Transfers from other Units for Neonatal Cots	The Trust is currently intermittently unable to accept inutero transfers for neonatal cots from other units. This is due to current maternity staffing level difficulties. Possible harm to mothers and babies who require a neonatal cot due to specific health needs and imminent delivery, therefore requiring transfer to this specialised facility. Potental for undue distress to baby and parents.	Continual monitoring of the staffing situation to make best use of existing resources. Transfer accepted when staffing levels permit.	16/03/2021- Ability to accept inutero transfers remains limited due to staffing and capacity ongoing recruitment continues, increased pressures to accept transfers due to regional neonatal capacity. Will continue to monitor Jun20 continue to monitor Dec19 Specific focus on recruitment - recruitment fayre undertaken and appointments made awaiting registration within next year. Retention of staff also focus within division to retain and recruit staff	MOD	
4060	ACUTE	14/08/2019	Provide safe, high quality careMake the best use of resources	Possible breakdown of aging Ultrasound scanners	Increasing difficulty is sourcing spare parts for ageing and outdated models of Ultrasound equipment currently in use in both CAH and DHH. Possible risk to mothers and babies.	monitor and manage patients through the system.	March 2020 new scanners have been purchased so no longer a risk Dec19 Number of scanners that are breaking down x3 Resuscitaires and ultrasound machines	LOW	02/03/2020
4083	ACUTE	05/02/2020	Provide safe, high quality careMake the best use of resources	Unique barcode access to Glucometer Devices	Use of Glucometer device by members of staff who do not have individual barcode access. This can result in difficulty in identifying the member of staff who carried out blood sugar testing. There is also training required to use this device correctly and escalate any concerns appropriately Correct use of device to ensure the patient details are accurately completed. Diabetic team use the data from this device to identify patients for review on twice weekly ward rounds so if details are incomplete or inaccurate the patient is potentially missed from the ward round. This can be approximately 30 patients across both sites per month.	In the event of an incident occurring there is difficulty identifying the member of staff who carried out testing when barcodes are shared or borrowed. This can be problematic throughout Trust and agency staff are also using these devices. This may cause undue risk to patients. All staff required to use Glucometer require individual barcode for clear identification of all tests carried out.	Feb - Added to Risk Reg	MOD	24/02/2020
4090	ACUTE	09/03/2020	Provide safe, high quality careMake the best use of resourcesImproving Health and Wellbeing	Prescribing of valproate not in line with valproate Pregnancy Prevention (PREVENT) Programme	Valproate is associated with teratogenic risks (congenital malformations, neuro-developmental disorders) in children exposed to valproate during pregnancy. Children exposed to valproate in utero are at increased risk of lower IQ and of risk of developing neurodevelopmental disorders. In 2017 and 2018 the DoH issued a number of circulars in relation to the risks of prescribing valproate in women of childbearing age (HSC (SQSD) 19/17, HSS (MD) 8/2018 and HSS (MD) 27/2018) highlighting new resources to support the safety of girls and women who are being treated with valproate. Among the recommendations to Trusts was the requirement to develop an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care. In addition, all relevant resources are to be embedded in clinical practice for current and future patients, by revising local training, procedures and protocols.	Currently valproate is prescribed to a small number of patients under the care of SHSCT Consultants, all of whom have been made aware of the various DoH circulars and associated recommendations. A number of SHSCT Consultants sit on the Regional Valproate Group, chaired by PHA. The Trust has also recently established a task and finish group to address outstanding risks in relation to the recommendations in the circulars, namely the systemic identification of all girls and women who may be prescribed valproate. The Drugs and Therapeutics Committee also monitors the implementation of the recommendations within the circulars through the Medicines Governance Pharmacist, also a member of the Regional Valproate Group.	9 March 2020 Consultants manage their own registers of girls and women on vaproate.	LOW	
4100	ACUTE	11/08/2020	Provide safe, high quality care	Replacement programme for Radiology Equipment on all Acute Sites	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging.	The equipment plan has been presented at Trust SMT. Unfortuanately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing.	HIGH	09/03/2021
4099	ACUTE	11/08/2020	Provide safe, high quality careMake the best use of resources	Neurophysiology- Due to insufficient staffing levels risk of occasional department closure days	Occasional risk to inpatients as no staff to provide service. There is the occasional inability to provide an inpatients service for EEG. EEGs are an aid to diagnosis. there is no on call/weekend or bank holiday cover	As a rule x2 staff not permitted to have annual leave at the same time however in exceptional circumstances this can occur when staffing levels are insufficient. Change the working pattern for x1 P/T member of staff which will reduce lone working days and therefore reduce risk of closure days	03/12/2021 - A Band 5 MTO commenced in October which alleviates some of the departments staffing pressures. 14/09/2021- Lead has now retired. A new interim lead has been appointed. Continue to train 2 staff- progressing through the 2 year training programme currently. March 2021 - Lead due to retire in August 2021. 1 member of staff has taken a career break for 2 years. Another member of staff will shortly be going off on maternity leave. The remaining member of staff will increase their hours and be assisted by the trainee posts. Staff levels should be 3.22WTE	LOW	
4126	ACUTE	18/11/2020	Provide safe, high quality careMake the best use of resources	Lack of patching- Radiology	could result in the inability to access clinical systems on radiology equipment and server infrastructure. Highlighted by vulnerability scan using Tenable. Loss of essential services.	Patching arrangement need to be formalised. This needs developed within 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching- regional project looking at 3rd part suppliers being led by BSO	ongoing review with IT in relation to this. All 3rd party contracts to be reviewed and amended to include patching- regional project	HIGH	09/03/2021
4127	ACUTE	07/12/2020	Provide safe, high quality careMake the best use of resources	Unsupported windows operating systems	Radiology- the remote host is running Microsoft Windows XP- support for this operating system by Microsoft ended April 2014 leaving risk of ransomware attacks and or hacking.	Targeted staff awareness training, devices to be replaced, upgraded or if not possible must be segregated. It working with Radiology to highlight all devices		HIGH	09/03/2021
4133	ACUTE	29/01/2021		Unable to off load patients from ambulance when ED is overcrowded	Patients at risk due to being unable to offload patients from ambulance to ED due to overcrowding	HALO role and ongoing monitoring	01/06/2021- Risk linked with 3508 as per Melanie and closed 09/03/2021- need to secure funding for medical gases for ambulance receiving area. Daily monitoring and escalation. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing review of escalation plan	MOD	01/06/2021
4142	ACUTE	24/02/2021	Provide safe, high quality careBe a great place to workMake the best use of resources	Recruitment and Retention issues- Trust Wards	Patient safety risk. Identification the deteriorating patients, risk on escalation of same, lack of knowledge of in house processes, potential treatment/management/discharge delays. Increased pressure placed on core team, risk of burn out/work related stress. Potential lack of escalation/risk deteriorating patient not escalated. Potential risk of failed discharge/transfer due to lack of knowledge regarding processes. Risk of non-compliance with appropriate documentation required to manage patients holistic needs.	currently focusing prioritising recruitment to this area. Complete all outstanding e-reqs Internation nurse recruitment Target year 3 nursing students to this area to attract uptake Offer all bank and agency permanent positions Daily review and redeployment of staff to support the skill mix and staff levels with 2 South.	19/4/22. Still ongoing issue with recruitment and retention of Staff. Staffing levels reliant on Bank and Agency to fill gaps at ward level. 20/09/2021- 6 new start band 5 in DHH ED October 2021. 22 New start Band 5 CAH ED October 2021 28.06.2021- ATICS ongoing Band 5 recruitment drive. 8 x band 5 posts from peri-operative work stream. Applications closed 23.06.2021 Action plan completed working collaboratively with the AD from workforce to address this	HIGH	

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4143	ACUTE	11/03/2021	Best use of resourcesProvide safe, high quality care	Replacement programme for Radiology Equipment on all Sites to replace equipment on unsupported operating systems and provide mai	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose. There is equipment currently running on Microsoft Windows XP - the support ended in April 2014 leaving risks of ransomware attacks or hacking..Failure to patch as per schedule could result in the ability to access clinical systems on radiology equipment and server infrastructure. This has been highlighted by Tenable programme and could result in the loss of essential services.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging. Patching arrangement needs to be formalised. This needs developed with 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching - regional project looking at 3rd party suppliers being led by BSO. Targeted staff awareness, devices to be replaced, upgraded or if not possible must be segregated. IT working with Radiology to highlight all devices. "	10/02/2022 -In the financial year 21-22 the following equipment was replaced via Capital Monies: "3 Endoscopes "Technegas "3 General Ultrasound units "2 Breast Ultrasound units "2 Fluoroscopy units Capital priorities for the coming year are: "Funding for a 2nd CT Modular unit at DHH "Second CT scanner CAH "Replacement of 1 MRI scanner CAH "Replacement of DXA scanner and DR room at STH - this is in preparation for a Diagnostic Centre 14/09/2021- 10 year plan drawn up-investment per year shared with Regional Imaging Board- understand that SHSCT needs priority. "The equipment plan has been tabled at Trust SMT. Radiology have also presented to SMT to highlight the issues. This presentation has highlighted specific urgent requirements including breast imaging and fluoroscopy across both sites to include the required ventilation. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. There is ongoing review with IT regarding patching. " ongoing review with IT in relation to patching. All 3rd party contracts to be reviewed and amended to include patching- regional project. "To be amalgamated with 8, 10 and 11. The equipment plan has been presented at Trust SMT. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. "	HIGH	
4155	ACUTE	01/04/2021	Provide safe, high quality careMake the best use of resourcesBe a great place to work	Haematology Outliers	Currently only providing a 6 bedded inpatient side room, augmented care capacity for Haematology patients. All other admitted Haematology patients are cared for throughout both medicine and surgery, without the necessary environment to ensure patient satiety regarding hospital acquired infections. Potential risk could be catastrophic for a haematology inpatient. Haematology patients are immunosuppressed and are amongst one of the most vulnerable client groups within the hospital setting. Ultimately if a patient is exposed to one of the many potential hospital acquired infection this could be life limiting.	Patients that are identified as immunosuppressed must be prioritised for an ensuite side room the estate is limited regarding same and as such we are not always able to accommodate this, patients are then placed in side rooms with shared toileting facilities Haematology Teams keep track of all outlying patients and review same providing clinical plans where necessary. Maximising discharges in Haematology Unit, in order to created capacity for admitted patients.	Action plan completed working collaboratively with the AD from workforce to address same	HIGH	
4157	ACUTE	06/05/2021	Provide safe, high quality careMake the best use of resources	MRI Capacity	MRI inpatient demand has significantly increased with an impact on the capacity for red flag, urgent and routine outpatient examination. There has been a 72% increases in inpatient MRI demand comparing March 20 and March 21. Currently there is no MRI facility available on the Daisy Hill Site and patients have to transfer to CAH for MRI imaging. Increased outpatient waiting list and waiting times. Potential for additional queries regarding inpatients to MRI staff adding additional pressures.	Currently some MRI referrals are being outsourced to the Independent Sector. However due to image quality the more complex outpatient MRI referrals remain in the Southern Trust	6/4/22 The MRI options paper is to be presented to SMT on Tuesday 12th April to seek approval to look at non Trust locations for a modular MRI unit. There is also an ongoing MRI optimisation project being facilitated by Siemens and the initial review of the service has occurred and we are currently awaiting feedback. 14/12/2021- brought to CW to raise with Director re corporate register move. The Department are working with planning on a Business Case for a low field strength MRI Scanner to be located at DHH. The Current MRI scanners located in CAH are due for replacement in 2023 and 2024 which are currently on the equipment replacement plan. The costs of low field MRI scanner for DHH has yet to be finalised	HIGH	
4156	ACUTE	19/08/2021	Provide safe, high quality careMake the best use of resources	Referrer MRI Safety	MRI is potentially hazardous and involves significant risk to patient safety. During the period 2019-2021 there has been an average occurrence (one every 3 weeks) of incidents involving incorrectly completed MRI safety referral information. These incidents have involved referrers stating that patients do not have any potential contraindications to undergo MRI(implants) however it is later identified by MRI Team that implants are in-situ. If these events keep occurring at the current rate there is an increased risk of morbidity and mortality because the source of risk has not been reduced.	The MRI Team screen and check all patients and completed questionnaires to attempt to ensure these errors are captured. E Learning MRI safety for referrers is available on HSC E Learning. Where possible notifications are sent to referrers involved to highlight the error and request that they complete the MRI safety training.	03/12/2021 - A national MR Safety training module is being developed and will be released in 2022. This module will replace the current MR Safety module on ELearning. A trend analysis report has been collated over the past 4 months which has not indicated any reduction in the number of incidents. 14/09/2021- requirement for a 3rd scanner, electrical infrastructure in DHH is an issue- cannot be brought forward. Modular MRI scanner on DHH currently. Cannot be progressed by division. To be discussed with Director of Acute Services t to have this risk moved back onto Directorate register. 16/08/2021- memo has been circulated by the medical director to all medical staff regarding the importance of correct protocol when filling out safety questionnaires for MRI. MD has asked for compliance audit data to be shared with MD and AMD to allow this issue to be addressed. A learning letter was sent out with the memo to be shared at the M&M meetings and Governance Co-coordinators to be raised at directorate governance fora and the AMD and DMD for sharing within teams. Posters to be placed on Trust desktops via Communications team by June 2021 The Department would like Referrer MRI Safety Training to become mandatory for MRI referrers by August 2021	HIGH	

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4176	ACUTE	20/09/2021	Accessible and Responsive CareSafe, High Quality and Effective Care	Covid & Non Covid patients on AGPs being cared for in red Resus	Nosocomial Spread and patients at risk	ED consultants/management/IPC/Micro walkaround CDU identified as resus area for patients receiving AGPs CDU converted to Red Resus as IPC/Micro advice Lumira swabbing commenced in ED to determine Covid status The side room is used were possible to provide some protection for e.g. if one non-covid patient on AGP they will be nursed in side room and vice versa. However still a potential risk that aerosols will mix. When this is not possible patients in an open bay have the same air space which means that they are all in direct contact with one another. Covid positive patients in red resus are transferred to a Covid ward as soon as possible to reduce the risk. Ongoing escalation of red resus at APC meetings. All staff in red PPE. Walk around with Estates.	21/09/2021- Datix to be completed when non-covid/covid patients are nursed in red resus at any one time. Patients transferred out of red resus to appropriate ward when clinical condition permits is ongoing. Estates have confirmed that inability to undertake closing off cubical areas due to the estate structure. March 2020- CDU converted to red resus for patients on AGPs. All staff in red PPE	HIGH	
4184	ACUTE	04/10/2021	Safe, High Quality and Effective CareEffective organisational governance	Misuse of POCT devices and non compliance with clinical governance procedures across the Trust	POCT demand has increased exponentially across the Trust, particularly in response to the Covid pandemic. Mistakes made during the course of POCT analysis and incorrect results acted on by the clinical team can have life-threatening consequences for the patient. The risk is not limited to the POCT team; the risk is applicable to all of the clinical teams across the Trust who are performing POCT and relying on the results to inform patient management. All of the following will cause incorrect results to be produced which, if acted upon, could be fatal for the patient and leave the Trust open to litigation: -Poor sampling technique resulting in poor quality of sample. -Lack of training or knowledge on the part of the operator regarding proper and correct use of the POCT device. -Lack of knowledge or reluctance regarding how to perform internal quality control and calibration (this checks if the machine is producing the correct results). -Inadequate compliance with external quality assurance procedures (this checks that the entire procedure from sampling through to result transmission is working as it should). -Lack of understanding of what will adversely affect results e.g. haemolysis, icterus, lipaemia, incorrect storage temperature for reagents. -Poor cleanliness and maintenance of the device and surrounding area. -Use of incorrect or out of date IQC/calibration or test cassettes. Other risks for the patient -Not using the correct H&C number - result will not transmit to NIECR. -Patient HCN mix up, results going into the wrong patient file. -Staff sharing barcodes - risk of an untrained operator using the device incorrectly. -Lack of POCT team support to deal with issues such as poor IQC/EQA performance and -troubleshooting. -Lack of IT support for issues such as devices losing connectivity. In addition, not all devices are able to connect to the Trust network so there is an increased risk with such devices where the POCT team are unable to adequately monitor their performance. -Users not informing POCT of issues with devices when they arise. Risk of faulty device being used to generate inaccurate results that are acted on by the clinical team. The risks to the user and patient are significantly more substantial than risks associated with performing tests in the main laboratory which is staffed by fully trained laboratory staff. Staff performing POCT have basic training in operating the devices and must adhere fully to the rules set out by the POCT team. Mistakes can have serious, fatal outcomes for the patient if the results produced are incorrect or misinterpreted and subsequently acted upon by the clinical team. Staff not adhering to the rules and standard operating procedures as laid down by the POCT team are open to disciplinary procedures. Mistakes made during the course of POCT analysis can leave the Trust open to litigation from the patient. The POCT team regularly audits aspects of the POCT devices and operators. There are repeated instances of staff sharing barcodes, not using H&C numbers, poor maintenance and cleanliness of equipment, failure to run IQC and EQA, poor sampling technique affecting sample quality, incorrect test cassettes being used,	- Online and/or face to face training available for all devices - training sessions are organised and readily available on request from the POCT team. - POCT staffing - POCT staffing has been extended but staffing levels have fluctuated with staff leaving and being replaced. There is a requirement for a Band 6 BMS to provide support to the POCT Band 7 and robustness across the service, particularly with the continuing increase in demand for POCT across all sites. - SOPs and information are available for all devices on the laboratory website and Sharepoint. - Regular audit of POCT in clinical areas is highlighting problems with regards device maintenance, compliance with IQC/EQA etc, and this information is regularly disseminated to all Heads of Service and Lead Nurses in areas of the Trust that use POCT. The emphasis is on these individuals to enforce the compliance with POCT rules within their teams in order to satisfy clinical governance requirements. - IT support is a constant issue within POCT and causes serious delays in troubleshooting and installation of POCT devices. We are currently recruiting a Band 6 IT person for labs, but they will require proper access and administration rights to IT systems (particularly cyber-security) in order to complete their work. This could be a problem if IT are unwilling to co-operate in this respect. These controls are effective to a certain extent, but non-compliance with POCT regulations within the clinical teams is a critical ongoing issue that is possibly not being taken seriously enough across the Trust. The risk to the patient is significant. Removal of devices from clinical areas where non-compliance with POCT rules has been identified as a serious issue - this will only be as a last resort, particularly in areas such as ED where POCT is essential for patient flow (e.g. Covid testing). However, this leaves the Trust open to litigation in the event of errors. Permanent blocking of users who consistently fail to comply with POCT regulations - this is not feasible in practice, particularly with many clinical areas short staffed. All we can do is ensure the individual's line managers are aware of non-compliance issues, and that they both sign an official form committing to compliance with regulations, and undergo re-training procedures.	17/12/2021- "Update Senior Management (CCS) on developments by Jan 2021 "Create a potential structure to provide further support to the Trust by end of Jan 2021 "Secure additional resource to plug the identified weaknesses in current structure TBA "Seek further investment in POCT Governance structure TBA "Reinforce adherence to protocols through existing governance structures Feb 2021 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing policy which will go live in July and will be	HIGH	
4185	ACUTE	12/10/2021		Risk of not being able to provide a round the clock blood sciences service on both CAH & DHH sites	There is a risk that that the critical provision of Blood Sciences may not be available on one of the main hospital sites. An inability to provide "round-the-clock" cover would compromise the provision of high quality care and in the case of Blood Bank could result in the requirement to close (temporarily) Daisy Hill to emergency admissions. In addition Obstetrics and other specialties, including Theatres would be put at unacceptable risk. Contingency measures that could be brought into operation in Chemistry could compromise patient flow and potentially compromise clinical care. Current contingencies within Haematology / Blood Bank carry even higher risks than Chemistry due to the critical nature of blood bank in particular. The stretching of staff across the 24 hour period and two sites together with the constantly increasing demand for laboratory services is also putting accreditation at risk. Type 1 Emergency Departments and Obstetrics have an absolute requirement for a Blood Bank. If the Blood Bank could not be operated at any stage of a twenty four hour period the Daisy Hill Hospital would not be able to maintain the Emergency Department and patients would need to be directed to other Emergency Departments with potential for delay and significant patient harm or death. It is sobering to reflect that critical hospital services are supported by rotas that are extremely limited and vulnerable to short notice illness with the potential for no available backfill. Unlike nursing agency bank staff are not readily available. In short inability to cover a gap could result in the emergency department having to close and patients on the Daisy Hill site being exposed to significant risk. Therefore the impact could be regarded as a catastrophic. The number of staff available on the Haematology / Blood Bank in the SHSCT is very limited, partly due to the very stringent requirements required to operate autonomously in this discipline. Currently the twenty four hour cycle is covered by too few staff and by utilising substantial overtime. Increased demand on staff has also the potential to increase sickness and stress further compounding the problem. Rotas are effectively so limited that even a few absences could cause one of the rotas to fail. The COVID pandemic has placed significant additional pressures on staff - increased demand and reduced availability of staff. Very tight rotas are highly vulnerable to these issues. Laboratory accreditation (UKAS ISO15189) is at risk where the focus is maintaining a service at the cost of maintaining a rigorous Quality Management System.	"Cross - cover from corresponding site (i.e. CAH cover for DHH) "Cross cover from other departments where relevant and safe "Additional staff in training (two staff due to complete training in the next six months) "Additional support staff through the 24 hour period "Agency support staff These controls have been enabled service provision to continue but they are insufficient to reduce the risk to an acceptable level "Additional Agency Biomedical Scientists - very limited supply (if they can be sourced at all) and likely to be off framework. Introduce additional risk - in terms of competency and experience. "Transferring Blood Bank samples to Craigavon - but there would be an unacceptable delay "Remote release of blood - unacceptable in a Major Haemorrhage scenario "Routinely providing remote Chemistry Biomedical Scientist support from the CAH site with support staff running samples on the DHH site	April 2022-Seek approval to recruit against overtime expenditure. Granted and in progress Discuss contingency with Clinical Leads/ senior staff. - Contingency is limited and has the potential to compromise patient safety Expedite training of B5 Biomedical Scientist. Despite best efforts training is slow due to the obvious constraints and COVID etc limiting further the supply of staff to train and be trained Expedite Chemistry training of Haematology / Blood Bank Biomedical Scientists. Recruit additional Biomedical Scientists and Support Staff. As above but additional staff slowly being recruited - training extremely challenging Discussion with HR around appropriate T&C for working shifts - especially at late notice etc. Procedure to describe the contingency. Completed and has provided some mitigation - however formal sign off from HR pending Plan to ensure return to schedule on all aspects of the Quality Management System. Dependent on above Remote release of results has been introduced where suitable.	HIGH	

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Closed date
4196	ACUTE	16/12/2021	Safe, High Quality and Effective CareEffective organisational governance	Limited implementation and adherence to MCA NI 2016, completion of required STDO and TPA for all patients who lack capacity	Limited Implementation and adherence to the MCA NI 2016 , COMPLETION OF REQUIRED STDO and TPA for all patients whom are deemed to lack capacity in specific decisions .	The DOH training is available to all MDT staff and a live register is maintained of all MDT staff whom can complete the required statutory assessments and documentation , however due to all MDT staff workload capacity and also confidence there is minimal identification of these patients and therefore very low numbers of STDO IN Acute Hospitals .Lead Nurses have been asked to ensure when 1-1 ARE BEING REQUESTED AT WARD LEVELS THESE ARE NOT APPROVED FOR PERSONS WHOM LACK CAPACITY UNLESS A STDO process has commenced .MCA should form part of all daily WBM discussions .The current SOP is not fully implemented as these patients are not being identified early in their journey from ED also. All MDT should agree which staff member / profession is best placed to take forward the MCA process STDO / TPA, this should be shared equally among professions The current STDA are under the management of MHDD Additional bespoke training is available within the SHSCT for any MDT staff group to develop skills and knowledge	18/12/2021- Plan in 2022 that the STDA Team (4.0 wte staff) will come under the operational management of Acute / Non Acute and will suit within HSW management structure's , this will allow more focused work and support to wards , however the challenge will be developing MDT staff to take forward this work as part of their day to day duties	HIGH	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
703	24/07/2008	Safe, High Quality and Effective Care	THEATRES	Second patient requiring emergency caesarean section has to be transferred to main theatre	Second patient requiring emergency caesarean section has to be transferred to main theatre; Delay puts mother and baby at risk.	Maximise speed of transfer.	2nd maternity theatre commissioned April 2008 - old maternity theatre refurbished - minor work to be completed before both available and risk reduced; no additional staff have been provided. 10.05.10 - risk reviewed by MMcG + BM - new maternity theatre has been built, commissioned and is in use as required - there are times when a maternity case may still need to come to main theatre but likelihood is reduced. 5 x 3 = 15 = moderate	MOD	HOS	12/02/2014
712	24/07/2008	Safe, High Quality and Effective Care	Theatres	Risk of ENT laser equipment failure	Risk of ENT equipment failure due to age and equipment parts no longer available - impact on patient and staff safety and the ability to treat patients.	Equipments still inspected and serviced regularly; staff traning on use of laser safely.	2/3/12 - closed equipment received and in use (at HoS) 4.1.12 - equipment ordered Dec 2011. 28.10.11 Approval to purchase replacement laser. 2.9.11 - equipment is on the capital equipment priority list for 2011/12. 10.05.10 - no equipment purchased yet.	HIGH	DIV	03/02/2012
710	24/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk of ENT micoscope failure - impact on patient safety and ability to treat	Risk of ENT microscope failure due to age and poor clinical visual quality - impact on patient safety and the ability to treat patients.	Regular maintenance.	10.05.10 - new microscope purchased - risk mitigated and closed.	VLOW	DIREC	10/05/2010
705	24/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk of emergency theatre being blocked when no ICU bed available while awaiting transfer and/or no regional ICU bed available.	Risk of emergency theatre being blocked when no ICU bed available while awaiting transfer and/or no regional ICU bed available.	All patients in ICU reviewed - potential to move any HDU patients to recovery ward are explored.	3/2/12 - Closed at HoS 4.1.12 - Risk remains the same 28.10.11 Protocol to be developed to manage the situation as described in 7C. 2/9/11 - risk remains the same. 10.05.10 - risk reviewed by MMcG + BM - risk title reworded to reflect 'Risk of emergency theatre being blocked when no ICU bed available while awaiting transfer and/or no regional ICU bed available'. Patient flow to wards from ICU and recovery impacts on the availability of ICU/HDU beds. These delayed discharges have the potential to impact on patient admission and surgery plan.	MOD	DIV	03/02/2012
700	24/07/2008	Safe, High Quality and Effective Care	Theatres	Risk of problems during acute pain treatment when no pain nurse is available	Health and safety of patient who is having acute pain treatment - potential to develop problems e.g. epidural abcess, when no pain nurse is available; health and safety of patient due to localised infection of epidural site when Acute Pain Sister on leave.	Emergency Anaesthetist troubleshoots pain problem as well as covering for patients requiring anaesthesia in emergency theatre - not acceptable as potential for patients to be forgotten about.	Recruitment of 1.30 WTE pain nurses to be taken forward by Mrs McGeough. 1.28 WTE pain nurses have been appointed for additional workload of T&O but no acute pain nurses in DHH included in this.	MOD	HOS	12/02/2014
709	24/07/2008	Provide safe, high quality care	Intensive Care Unit	Risk to health and safety of patients because ICU equipment at end of life expectancy	Risk to health and safety of patients because specialist equipment in ICU is at the end of its life expectancy; risk of sudden failure.	Regular maintenance incurring increased costs.	On medical equipment list - prioritised as urgent with a view to approval to purchase.	MOD	HOS	12/02/2014
707	24/07/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Patient bleeds to death because recombinant factor VIIa subject to financial cap	Patient who could potentially be saved, bleeds to death because recombinant factor VIIa for the year have been subject to financial cap.	Recombinant Factir VIIa only given in consultation with Consultant Haemotologist.		LOW	HOS	12/02/2014
711	24/07/2008	Safe, High Quality and Effective Care	THEATRES	Health and safety of staff when using ENT operating microscope	Health and safety of staff when using ENT operating microscope with a heavy wide base - risk of trip/overbalance of equipment.	2 staff to move equipment; ensure all staff have assistance when moving equipment.		LOW	HOS	12/02/2014
734	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Theatre 5 ventilation system not operating as per Health Estates guidelines	Risk to health and safety of patients and staff during operations because theatre ventilation system is not operating as per Health Estates guidelines in theatre 5.	Minimise access to and from theatres.			HOS	03/12/2009
713	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Only one ENT drill and nerve monitor - no backup	ENT drill an nerve monitor - currently only one of each available; if fault with equipment, no backup and patients unable to be booked for procedure; this is compounded when dual lists are happening simultaneously and equipment required in both theatres.	List coordinated as far as possible to ensure the equipment is not needed at the same time, however this is not always successful.	10.05.10 - risk reviewed by MMcG + BM - new equipment purchased - risk mitigated and closed.	VLOW	DIREC	10/05/2010
716	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Flexible Ureteroscopes - currently only two available	Flexible Ureteroscopes - currently only two available in the department; very fine scopes with a very limited usage and break down frequently - happens at least every 3 months, usually unable to be repaired, only replaced.	Replaced as required but would need a minimum of two additional scpes to ensure lists not impacted; need to review the current scopes used and change to a different manufacturer, have a service contractt and then likelihood of the scope being repiared would be increased.	10.05.10 - risk reviewed by MMcG + BM - new equipment purchased - risk mitigated and closed.	VLOW	DIREC	10/05/2010
718	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Insufficient theatre trays	Insufficient theatre trays in CAH resulting in additional demand on theatre and SSD staff to ensure availability; risk of tray not being available for procedures and surgery being cancelled; prioritisation of theatre requirements has impact on other users; more wear and tear on existing instruments and equipment.	Phone SSD to advise of tray requirements in advance where possible; protocols drafted to ensure availibility of trays.	10.05.10 - Risk reviewed by MMcG + BM - some theatre trays have been purchased. Risk rating reduced to 4 x 3 = 12 = moderate risk.	MOD	HOS	12/02/2014
720	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Only 3 camera stacks for 5 theatres	There are currently 5 theatres in the department and only 3 camera stacks; impacts on lists and is exacerbated when sessions are back filled and similar specialities are operating at the same time; significant number of procedures require use of a camera stack, equipment used by general surgery, urology, ENT, gynae.	None.	10.05.10 - Risk reviewed by MMcG + BM - equipment purchased. Risk mitigated and closed.	VLOW	DIREC	10/05/2010
724	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Gastroscopes and colonoscopes lack adequate vision	Gastroscopes and Colonoscopes - clinicians have repeatedely highlighted the lack of adequate vision from scopes; risk that lesions will not be detected resulting in missed diagnosis; risk of procedures being cancelled due to lack of appropriate equipment, resulting in Trust not meeting patient access targets.	Scopes sent for repair as required, however when the scope no longer meets the visual need of the clinician due to age etc, the scope is removed from use.	10.05.10 - Risk reviewed by MMcG + BM - equipment purchased. Risk mitigated and closed.	VLOW	DIREC	10/05/2010
733	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Theatre ventilation system not operating as per Health Estates guidelines	Risk to health and safety of patients and staff during operations because theatre ventilation system is not operating as per Health Estates guidelines in theatres 1&2, 3&4.	Minimise access to and from theatres.	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	HIGH	HOS	12/02/2014
730	25/07/2008		THEATRES	No service contract for Pentax scopes	Currently no service contract for Pentax scopes within the Trust, only Olympus; reduced number of scopes available, leading to the cancellation of procedures/lists resulting in the Trust's failure to meet patient access targets.	None.	10.05.10 - risk reviewed by MMcG + BM - currently a regional tender for maintenance of Olympus and Pentax scopes which when in place will mitigate this risk.	MOD	DIV	02/09/2011
728	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk to staff when having to operate 3 different types of scopes and processors	Health and safety risk to staff when having to operate 3 different types of scopes and processors; 1) Olympus scopes and Olympus processor, 2) Pendax non-digital scopes and processor, 3) Digital Pentax scopes and processor; results in 3 times the number of processors being used than what is required to undertake a list; exacerbates number of cables etc. and increases risk of trips, fire hazard etc.	Staff vigilence; staff attempt to minimis risk by making best use of trolleys they have.			DIREC	01/10/2009
721	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk of injury to patients or staff when using operating tables > 35 years old	Risk of injury to patients and/or staff when using operating tables which are > 35 years old and no longer supported by the manufacturer; the average life expenctancy of an operating table is 20 years, therefore there is a risk of metal fatigue leading to the collapse of the table when in use.	Tables are serviced by Trust in-house technicians; staff are trained in the use of the operating tables.	28.10.11 Closed. 2/9/11 - Mary McG to ascertain if tables are still in operation	MOD	DIV	28/10/2011

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
732	25/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Agenda for Change annual leave requirements could result in staffing falling below safe levels	Health and safety of patients and staff could be compromised is staffing falls below safe levels when having to meet additional Agenda for Change annual leave requirements.	Reallocation of existing staff to area of greatest need; in the event of further unplanned absences (e.g. sickness) implement the use of additional hours/bank; in conjunction with consultants and nursing staff, discuss the withdrawal of theatre list.		LOW	HOS	12/02/2014
731	25/07/2008	Safe, High Quality and Effective Care	THEATRES	Health and safety of staff when ENT laser in use - exposure to beam	Health and safety of staff when ENT laser in use - exposure to beam; Holium Laser has been purchased for you in Theatre 2 Urology; staff to have training undertaken by supplier before use; all entrances to theatre 3 to ensure consistency within the department during use.	Eye protection available and must be worn by all staff in area when laser is being used; all entrances are kept closed and have recommended signage in place; warning light activated when laser in use; laser protection supervisor has been identified and a locol policy is being finalised requiring all users to be laser traned and to be identified in policy as a user; report issued after each inspection by Medical Physics department which highlights action to be taken.		LOW	HOS	12/02/2014
739	28/07/2008	Safe, High Quality and Effective Care	THEATRES	UPS system in theatres 1-4 not sufficient	Theatres 1-4 currently have only a UPS system installed; this is no longer an acceptable method of providing a backup supply; the existing system of a UPS alone cannot meet the current standard as laid down in the HTM nor meet the British Standard 7671 requirement for disconnection times; any fault on an item of electrical equipment could result in fault current of a magnitude and duration that could cause a fatality to patient or staff.	Equipment is regularly maintained.		LOW	HOS	12/02/2014
741	28/07/2008	Safe, High Quality and Effective Care	THEATRES	Theatre 5 requires UPS/IPS system	Theatre 5 currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure, all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes online.	Battery backup exists on the anaesthetic machine only.			HOS	03/12/2009
746	28/07/2008	Safe, High Quality and Effective Care	Intensive Care Unit	ICU requires UPS/IPS system.	ICU currently does not have any form of backup electrical supply other than the emergency generator at 6 of its bed spaces; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	2/8/13 - all works are complete. Close on Datix 3/5/13 Works starting on 17/5/13, 1 bed space with bed out of use during the 2 week period. Communications complete. 22/3/13 Work to provide UPS at bed spaces has not commenced to date, there is a meeting arranged and work is planned to commence after Easter. 28/2/13 - provisionally scheduled to commence middle of march and agreement secured for closure of 1 ICU bed space for the 2 week period. 31/1/13 - Estates to provide an update regarding the work commencement date 7/1/13 - on estate works programme to be completed 31/3/13 23/11/12 - no further update 2/11/12 - no further update 26/9/12 - no further update 30/8/12 - no further update email sent to Alan Metcalfe 29/8/12 30/7/12 - no further update 26/6/12 - decision still to be made re confirmation of funding 25/5/12 - decision yet to be made regarding the confirmation of funding 24/4/12 - Email received from Alan Metcalfe on the 23/4/12 stating that outstanding minor works will be issued to Directors next week for reviewing and priorisation. once finance have confirmed the budget Estates will be able to make arrangements for funded and approved requests. 26/3/12 - As below no further update 29.2.12 - The UPS equipment has been procured by Estates Department, funding not available at present to install these. It has been agreed that these will be prioritised in funding for the next financial year 12/13. RC has emailed A.Metcalfe re installation date. 3/2/12 - ICU is prioritised as 1st, DSU, CAH then Theatres 3&4. there is an upgrade required for Theatre 5. Theatres 1&2 and REcovery are being done under the new theatres 1-4 scheme. Minor works, going to try and sort the 3 HDU bed spaces in the existing recovery. 4.1.12 - The following system have not been included	LOW	DIV	05/08/2013
748	28/07/2008	Safe, High Quality and Effective Care	Recovery Ward	Recovery ward requires UPS/IPS system	Recovery ward currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	10.05.10 - UPS/IPS have been installed at 10 bed spaces in recovery as part of the contingiency for swine flu - Risk reviewed by MMcG + BM	LOW	HOS	12/02/2014
752	28/07/2008	Safe, High Quality and Effective Care	Theatres DHH	Theatres, endoscopy room and recovery ward in DHH requires UPS/IPS system	Theatres, endoscopy room and recovery room currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	10.05.10 - Risk reviewed by MMcG + BM - risk unchanged 2 Sep 2011 Reviewed at Divisional Governace Forum deescalated to HOS Register	HIGH	DIV	05/09/2011
754	28/07/2008	Safe, High Quality and Effective Care	Day Procedure Unit DHH	DHH Day Procedure Unit requires UPS/IPS system	Day Procedure Unit currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	10.05.10 - Risk reviewed by MMcG + BM - risk unchanged 2 Sep 2011 Reviewed at Divisional Governace Forum deescalated to HOS Register	MOD	HOS	12/02/2014
759	28/07/2008	Safe, High Quality and Effective Care	THEATRES	Automatic endoscope reprocessors (AER) are not compliant	Automatic endoscope reprocessor (AER) in these areas (Main theatres and X-Ray CAH) are not compliant with HTM 2030 and the Hine review recommendations 2004 - AER in main theatre, no independent channel monitoring, no single shot detergent, no print out; Radiology AER, no independent channel monitoring, no single shot detergent, no reverse osmosis water, does have print out but inadequate, leading to potential infection control risk to patients; the 3 hour time limit on the use of scopes following disinfection compounds this.	A control measure for the water quality only is in place - weekly monitoring of water quality.	Interim papers have been submitted to SMT March 2008. 10.05.10 the AER in theatres in CAH has been replaced and is compliant with HTM 2030. The AER in radiology is still currently in use but arrangements are being finalised for removal of this machine - this should be complete by 30.06.10 09.06.10 AER in radiology now removed risk closed	MOD	DIV	09/06/2010
758	28/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk of instrumentation trays not being available for surgical procedures	Risk of instrumentation trays not being available for surgical procedures due to insufficient numbers of trays - e.g. only one of different types of trays in the department (see list with M McGeough).	Single type trays are prioritised with CSSD.	10.05.10 - Risk reviewed by MMcG + BM risk rating reviewed - some trays purchased risk rating reduced to 4 x 3 = 12 moderate 2 Sep 2011 Reviewed at Divisional Governace Forum deescalated to HOS Register	MOD	HOS	12/02/2014
757	28/07/2008	Safe, High Quality and Effective Care	THEATRES	Health and safety of patients and staff could be compromised if staffing falls below safe levels	Health and safety of patients and staff could be compromised if staffing falls below safe levels due to additional sessions without permanent staff in post; length of time to recruit staff to fill vacant posts; availability of staff with suitable skills and experience - all compounded by sickness absence and additional Agenda for Change leave; risk to reputation of Trust and compromise of Trust's financial position if waiting list targets are not met due to inadequate staffing levels.	On a daily basis potentially several of the 5 theatres are working with 1 staff member less; this arrangement is tailored to suit the needs of the lists as far as possible; staff are utilised from Day Surgery CAH and STH where possible.	Some points have been offered though not accepted yet and no start dates. These concerns have been raised with Director of Nursing and Ops team. Currently investigating the feasibility of using an agency which provides theatre nurses as an interim measure.	MOD	HOS	12/02/2014

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
755	28/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk of injury to staff/patients due to unreliable door closers	Risk of injury to staff or patient as doors close unexpectedly during transfer of unconscious patient due to ancient/unreliable self closers; theatres 1&2 need automatic doors.	Staff hold doors open if available.		LOW	HOS	12/02/2014
766	29/07/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	CAH Day Surgery Unit Automatic Endoscope Reprocessor not compliant	Automatic Endoscope Reprocessor (AER) in CAH Day Surgery Unit is not compliant with HTM 2030 and the Hine review recommendations 2004 - no independent channel monitoring, no reverse osmosis water, leading to potential infection control risk to patients; this 2 chamber AER is designed to decontaminate 2 scopes per chamber; the new digital gastroscopes and colonoscopes are too large to allow 2 scops to be adequately decontaminated together in the same chamber, leading to a 50% reduction capacity for endoscopy lists; the 3 hour time limit on the use of scopes following disinfection compounds this even further.	A control measure for water quality only is in place - weekly monitoring of water quality.	Interim papers have been submitted to SMT March 2008. 10.05.10 AER now replaced and compliant with HTM 2030 - risk mitigated and closed	HIGH	DIREC	10/05/2010
781	29/07/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	CAH Day Surgery AER has insufficient capacity	The 2 chamber AER in CAH Day Surgery is designed to decontaminate 2 scopes per chambers; the new digital gastroscopes and colonoscopes are too large to allow 2 scopes to be adequately deconaminated together in the same chamber, leading to a 50% reduction capacity for endoscopy lists; the 3 hour time limit on the use of scopes following disinfection compounds this even further; there is an increased risk of cancellation of patients off lists for non-clinical reasons due to reduced capacity; this impacts on the PFA target for elective procedures and the 2% for cancellation for non-clinical reasons; risk to patients - cancellation of endoscopic procedure; cancellation of patients for colonoscopy having taken their bowel preparation; cancellation of patient with undiagnosed symptoms.	None.	10.05.10 - AER has been replaced and this is no longer a risk. Endoscope drying cabinets have been purchased and commissioned which will facilitate the storage and use of decontaminated scopes for up to 70 hours.	VLOW	DIREC	10/05/2010
790	29/07/2008	Safe, High Quality and Effective Care	THEATRES	AERs out of use due to weekly water quality tests	Weekly water quality tests are undertaken in line with HTM 2030 and the Hine review 2004; when the results of these tests are received there may be recommendations to take all or part of the AERs out of use; this leads to an increased risk of cancellation of patients off lists for non-clinical reasons due to reduced capacity; this impact on the PFA target for elective procedures and the 2% for cancellations for non-clinical reasons; risk to patients - cancellation of endoscopic procedure; cancellation of patients for colonoscopy having taken their bowel preparation; cancellation of patient with undiagnosed symptoms; cancellation of patients who are red flagged for possible cancer; infection control.	Arrangements are in place to obtain weekly water samples; it has been agreed across the SHSCT to use one company - 2030 Labs; results are obtained each Monday and the water quality committee meet to review the results and ensure that appropriate action is taken; Infection Control are advised and interim arrangements are put in place to try to maintain the safety of the decontamination process and the delivery of service to patients to prevent cancellations.		MOD	HOS	12/02/2014
767	29/07/2008	Provide safe, high quality care	Day Surgery Unit	STH Day Procedure Unit Automatic Endoscope Reprocessor not compliant	Automatic Endoscope Reprocessor (AER) in this area is not compliant with HTM 2030 and the Hine review recommendations 2004; no single shot detergent, no reverse osmosis water, leading to potential infection control risk to patients; the 3 hour time limit on the use of scopes following disinfection compounds this even further.	A control measure for water quality only is in place - weekly monitoring of water quality.	19/12/12 - CLOSED AS PER AD AND HOS the new decontamination Unit is now in operation and the new EWDs are working well. 23/11/12 - it has been verbally agreed by DoH that it has pasted all testing. Just waiting on written confirmation. Once received it will be put into use. 2/11/12 - commissioning test report has been sent to John Singh who is the AED at Health Estates. John has identified some missing information which has been urgently requested from SMC and Puricore to enable the report to be signed off and AERS to be put into use, if all tests are satisfactory 26/9/12 - SMC are currently undertaking the commissioning test of the new ISIS AERs, and these tests should be completed by the 1/10/12. 30/8/12 - unable to complete commissioning as Alpha technologies ltd have ceased trading. At present the Trust is in communication with Puricore re completing the commissioning process for the AERs. 30/7/12 - commissioning tests have to be witnessed by the Authorised Engineer for Decontamination (AED), Health Estates and authorised person for Decontamination arrangements are in place for these to be undertaken. once completed the AER will commence weekly water tests and appropriate results are received the AER will be put into use. 22/6/12 - commissioning of the ISIS/AERs has commenced. the connection requirements to the network has been completed and working well; and the building works are complete. 25/5/12 - snag list has been completed for all outstanding items/areas of concerns to be addressed. we have asked for confirmation of full completion date to be received beginning of next week. IT will be working to ensure that the ISIS/AERs are connected to the network and that the company will then commence commissioning of the AERs 26.4.12 - Email received from Hugh Warner 26/4/12. RO plant has been commissioned and ready for the Isis machines to be connected since 26/3/12. Air handling until to take place 26/3/12. Return to HoS as of 26/4/12 26/3/12 as below. Building works still on target for	HIGH	DIREC	19/12/2012
770	29/07/2008	Safe, High Quality and Effective Care	Theatres DHH	DHH Automatic Endoscope Reprocessors not compliant	Automatic Endoscope Reprocessors (AERs) in main theatres and day procedure unit are not compliant with HTM 2030 and the Hine review recommendations 2004; no single shot detergent, leading to potential infection control risk to patients; the 3 hour time limit on the use of scopes following disenfection compounds this even further.	A control measure for water quality only is in place - weekly monitoring of water quality.	4.1.12 - Awaiting on outcome of CAWT building works. 28.10.11 On the capital priority list for 10/11. 2/9/11 - DHH AER is on the capital equipment list and the CAWT proposals to provide additionality sessions on the DHH site and accompanying infrastructure (theatres) will greatly improve compliance. Interim papers have been submitted to SMT March 2008. 10.05.10 - Risk reviewed by MMcG + BM risk rating reviewed - DPU - drying cabinets have been purchased and currently being commissioned for the storage and use of decontaminated endoscopes up to 70 hours. Risk rating reduced to 4 x 3 = 12 moderate.	MOD	DIV	03/02/2012
801	29/07/2008	Safe, High Quality and Effective Care	Recovery Ward	Not enough patient monitors in Recovery Ward	Not enough patient monitors in Recovery Ward.	Need an additional 6 monitors.		MOD	DIV	21/10/2010
792	29/07/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	12.02.14Risk of AERs being used for endoscope decontamination prior to manual self disinfect cycle being undertaken	Risk of AERs being used for endoscope decontamination prior to manual self disinfect cycle being undertaken; potential risk of infection to patients.	Radiology have a record sheet attached to the AER to clearly indicate the date and whether self disinfect cycle has been completed; use of signs; communication to staff outside the department who would use the AER; day surgery - machine used to DSU staff only and all staff should be aware of the need to ensure self disinfect cycle is completed before processing and endoscopes.		LOW	HOS	12/02/2014
794	29/07/2008	Safe, High Quality and Effective Care	Pain Clinic	Risk of over/under infusion of morphine for children	Risk of over/under infusion of morphine for children.	Morphine dosage is administered according to BMI and written procedure; ensure settings are correct and according to the written prescription on drug kardex; IV lines must be clearly and carefully labelled; two persons to check patient armband details against chart and drug kardex		LOW	HOS	12/02/2014

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802	29/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk of patient undergoing incorrect surgery.	Risk of patient undergoing incorrect surgery.	Procedure for checking patients priory to surgery; consent form; checks with patient; identification of site marked on patient as appropriate.		VLOW	TEAM	12/02/2014
793	29/07/2008	Safe, High Quality and Effective Care	Pain Clinic	Patient waiting area lack of wheelchair access	Patient waiting area lack of wheelchair access.	Patients attending clinic are taken through the dental area.	Review quarterly	VLOW	TEAM	12/02/2014
811	30/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk to patient if equipment failure during use	Risk to patient of equipment failure during use.	Equipment checks prior to use documented in patient's noted; staff training in the use of equipment; Trust policy and procedure; department equipment controller; service contracts for equipment; faulty equipment labelled and taken out of use and fault reported; equipment check undertaken following repair before equipment is put back into use.		LOW	HOS	12/02/2014
806	30/07/2008	Safe, High Quality and Effective Care	THEATRES	No Crash Team to respond to Cardiac Arrest, Anaphylaxis	No Crash Team to respond to Cardiac Arrest, Anaphylaxis.	Intermediate life suport training for all registered nurses; CPR training for all nursing auxiliaries; up to 5pm available medical staff respond to emergencies; after 5pm staff dial 999 and request cardiac ambulance from CAH.		VLOW	TEAM	12/02/2014
809	30/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk to staff and patients through Latex allergy	Risk to staff and patients through Latex allergy.	Policy, staff information, education and training; named person in department with responsiblity for latex fee box; patient allergies checked at pre-assessment and on admission.		VLOW	TEAM	12/02/2014
810	30/07/2008	Safe, High Quality and Effective Care		Drug administration errors	Drug administration errors.	Policy, procedures, medicine administraion updates for staff.		VLOW	TEAM	12/02/2014
808	30/07/2008	Safe, High Quality and Effective Care	THEATRES	Risk of patients falling off procedure table used for patiends having procedures for treatment of chronic pain	Risk of patients falling off procedure table used for patients having procedures for treatment of chronic pain; trolley is non-adjustable and too high for patients to get on to unaided.	Currently use a foot stool to facilitate patients getting onto the table and assistance is provided by staff.		VLOW	TEAM	12/02/2014
805	30/07/2008	Safe, High Quality and Effective Care	THEATRES	Retention of foreign bodies; incorrect swab, needle, instrument count	Retention of foreign bodies; incorrect swab, needle, instrument count.	Procedure re checking swabs, needles, instruments etc; swab, needle and instrument check undertaken prior to closure of a cavity and at the end of the procedure; this is documented in the patient's notes and signed by staff undertaking the counts.		VLOW	TEAM	12/02/2014
892	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Health, safety and wellbeing of patients and staff due to absence of oncology medical cover for four treatment sessions	Health, safety and wellbeing of patients and staff due to absence of oncology medical cover for four treatment sessions. 10.06.09 - Vacant haematology staff grade post has resulted in no medical staff cover . 10.12.09 - Second staff grade post now also vacant not able to recruit.	Staff adhere to all policies and guidelines; list prioritised to include lower risk patients; funding secured but post now vacant.	10.12.09 - Second staff grade post now also vacant, not able to recruit.	HIGH	HOS	26/11/2013
891	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Patient receiving cytotocix agents; the potential for life threatening sepsis due to treatment induced neutropenia	Patient receiving cytotocix agents; the potential for life threatening sepsis due to treatment induced neutropenia. No resource to facilitate ongoing audit. Reduction in senior staff due to sick leave resulting in no staff available to provide training at other ward and department level . No resident medical staff at unit level	Patients are educated re recognition and required action of infective complications post treatment; all nursing staff in the unit are educated in the recognition and action required in cases of complicated neutripenia; neutropenicguidelines and antibiotic policy in place; A&E and 2 South Haem staff aware of action required in neutropenic patients with septic symptoms.		MOD	HOS	26/11/2013
843	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Injury to patient when placed/removed from the Lithotomy position	Injury to patient when placed/removed from the Lithotomy position.	Ensure Anaesthetist is informed prior to commencing positioning or changing patient position; ensure that both legs are being moved simultaneously and placed securely in the direct placement leg holders; they are also removed simultaneously from the direct placement leg holders.		LOW	HOS	12/02/2014
889	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Administration of Cytotoxic drugs	Administration of Cytotoxic drugs; potential for exposure to patients and staff of agents which are teratogenic, carcinogenic or mutagenic.	Staff receive education regarding safe handling of cytotoxic agents; staff undertake chemotherapy administration module at QB and mentored practice prior to unsupervised administration; staff wear PPE when handling cytotoxic agents; staff read COSHH risk assessments; clinical incidents reported and followed up.		LOW	HOS	19/10/2010
865	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of staff when moving and handling renal dialysis bags	Risk to health and safety of staff when moving and handling renal dialysis bags (5 litre) being attached to and removed from dialysis machine; staff required to attach bag at low level.	Staff adhere to manual moving procedures; staff attend annual mandatory moving and handling updates.		LOW	HOS	12/02/2014
867	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of staff when moving and handling ventilated patients requiring X-Ray	Risk to health and safety of staff when moving and handling ventilated patients requiring X-Ray; staff are required to support patient and attached equipment during the placing of the X-Ray plate.	Staff adhere to manual moving procedures; staff attend annual mandatory moving and handling updates.		LOW	HOS	12/02/2014
868	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of patients, staff and relatives due to limited bed space and the requirement for essential equipment	Risk to health and safety of patients, staff and relatives due to limited bed space and the requirement for essential equipment e.g. leads, tubing, drains.	Staff are informed of potential to trip or disconnect patient leads/tubing; new staff are trained to deal with essential equipment during induction period; induction programme emphasises the importance of skill development to safely manage equipment.	Ergonomics advisor to be contacted for further advice/guidance. Continuous training for new and existing staff.	LOW	HOS	12/02/2014
854	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk to health and safety of patient if fluid warming cabinet overheats and fluids reach excessive temperatures	Risk to health and safety of patient if fluid warming cabinet overheats and fluids reach excessive temperatures causing internal burns; fluid warming cabinet used daily in theatres.	Staff are reliant on the accuracy of the warming cabinet, however due to age and type of existing equipment this is extremely difficult as temperature gauge is unreliable, so fluid can and does overheat; control measure - staff currently lower the temperature of the heating cabinet by turning off mains supply.	Requisition for this equipment has been processed.	LOW	HOS	12/02/2014
874	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of staff and patients when staffing numbers are lowest and a patient suddenly becomes confused/aggress	Risk to health and safety of staff and patients when staffing numbers are lowest and a patient suddenly becomes confused/aggressive/violent.	Extra staff are required to maintain the health and safety of both patient and staff; difficult and time consuming to get staff who have been relocated outside ICU back to the unit in a timely fashion during such an emergency.		LOW	HOS	12/02/2014
875	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of staff caring for potentially violent/agressive patients in side ward	Risk to health and safety of staff caring for potentially violent/agressive patients in side ward; patient may be ventilated or non ventilated.	Emergency buzzer system to alert medical and security staff is in place; bleep numbers and code for emergency in ICU is also identified and displayed on bleeps; use of bank staff and extra hours to optimise staffing level as activity and acuity of unit intensifies; risk assessment on individual patients as unpredictibility of patient response to critical illness difficult to capture.	2 personal alarms have been supplied.	LOW	HOS	12/02/2014
852	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk of health and safety of patients and staff in the event of a fire outbreak during surgery	Risk of health and safety of patients and staff in the event of a fire outbreak during surgery.	Staff updated in fire prevention/evacuation on an annual basis; evacuation training given on site - specific to theatres.		LOW	HOS	12/02/2014
893	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Risk of Asperigillis infection to immunocompromised patients due to excavation works around the hospital site	Risk of Asperigillis infection to immunocompromised patients due to excavation works around the hospital site.	Macmillan building door s fitted with secure entry mechanism, windows locked; staff and patients advised to internal access points; ongoing monitoring of Aspergillis levels by infection control team.		LOW	HOS	26/11/2013
844	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk of theft of controlled drugs in the departments are not securely locked	Risk of theft of controlled drugs in the departments are not securely locked.	All drug cupboards are locked prior to staff going off duty; all doors to the department are checked by staff going off duty.		LOW	HOS	12/02/2014
845	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk of theft of equipment if the departments are not securely locked	Risk of theft of equipment if the departments are not securely locked.	All doors to the department are checked and locked by staff going off duty.		LOW	HOS	12/02/2014
839	04/08/2008	Safe, High Quality and Effective Care	Theatres	Incorrect packaging and labelling of specimens	Incorrect packaging and labelling of specimens.	Staff training; policy and procedure for labelling and packing specimens; checking procedures and recording of specimens.		LOW	HOS	12/02/2014
841	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk of injury to staff and patients when moving and handling patients, positioning patients in theatre and limb holding	Risk of injury to staff and patients when moving and handling patients, positioning patients in theatre and limb holding.	Staff trained in moving and handling; risk assessments; use of Arjo Maxi slides; use of Phil-E slides; use of hoist if required; QA4 day surgery trolleys reduce need to transfer patients to and from an operating table.		LOW	HOS	12/02/2014
847	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Child protection risk to siblings of children attending for surgical procedure in an adult area	Child protection risk to siblings of children attending for surgical procedure in an adult area.	Information sent to parents however request not always adhered to; if required staff would ring for other relatives to come to the unit and site with siblings.		LOW	HOS	12/02/2014
881	04/08/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	Moving and handling risk to staff when theatre operating table kept on main corridor	Moving and handling risk to staff when theatre operating table kept on main corridor (only used Mon-Fri).	All staff trained in moving and handling; staff who are accompanying patients informed of care to be taken when transferring.	Staff and patients fully informed.	LOW	HOS	12/02/2014

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882	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Delay in Nurse Consultation - resulting in compromised psychological care for patients receiving cancer diagnosis	Delay in Nurse Consultation - resulting in compromised psychological care for patients receiving cancer diagnosis; Glenanne Breast Symptomatic and Screening Clinics.	To use all available resources effectively.			DIV	10/06/2009
883	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Injury to patient following a fall	Injury to patient following a fall.	Risk assessment on admission; observation; lowering bed; appropriate chair; remove environmental risks e.g. surplus equipment; ensure working call bell within reach of patient.			DIV	10/06/2009
885	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Medicines - risk to health and safety of patients due to prescribing error	Medicines - risk to health and safety of patients due to prescribing error.	Policies (NMC); DHSS policy/guidelines (i.e. use and control of); Trust policy; RCN guidelines; guidance on prescribing; clinical incident reporting; all prescriptions reviewed by nursing staff and pharmacy staff.			DIV	10/06/2009
886	04/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Health and wellbeing to patients due to delay in discharge summaries being sent to Community Macmillan Nurses	Health and wellbeing to patients due to delay in discharge summaries being sent to Community Macmillan Nurses in SHSSB.	Discharge summaries are not a priority to the Palliative Secretary due to current workload; Macmillan Nurses currently have to ring the Community Nurse due to delay in information.				10/06/2009
856	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk to health and safety of staff exposed to Gigasept	Risk to health and safety of staff exposed to Gigasept.	Staff fully informed of written policy which is readily accessible in work area; PPE also provided and worn - goggles, gloves, aprons and face masks; a SOP for PPE has been completed.		LOW	HOS	12/02/2014
861	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk to health and safety of staff and patients in the event of an excessive spillage of Gigasept	Risk to health and safety of staff and patients in the event of an excessive spillage of Gigasept in work area.	Staff fully informed of written policy which is readily accessible in work area; PPE also provided and worn; a SOP for PPE has been provided; the above procedure is undertaken however in addition the spillage kit is used.		LOW	HOS	12/02/2014
869	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of staff when placing and removing Duo Mattresses on beds	Risk to health and safety of staff when placing and removing Duo Mattresses on beds (weight and size).	2-3 people are required for this process; staff attend mandatory moving and handling updates.		LOW	HOS	12/02/2014
873	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of staff when moving the critically ill patient using the stretcher hoist	Risk to health and safety of staff when moving the critically ill patient using the stretcher hoist.	2-3 people required for this process; staff adhere to manual moving procedures; staff attend annual mandatory moving and handling updates.		LOW	HOS	12/02/2014
850	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Risk of patients with similar name undergoing incorrect surgery	Risk of patients with similar name undergoing incorrect surgery.	Staff ensure vigilant checking procedure and adherance to policy when admitting patient; further check of patient details undertaken by medical staff prior to commencing surgery.		VLOW	TEAM	12/02/2014
877	04/08/2008	Safe, High Quality and Effective Care	Intensive Care Unit	Risk to health and safety of staff when having to evacuate critically ill patients and associated equipment/machinery etc. in th	Risk to health and safety of staff when having to evacuate critically ill patients and associated equipment/machinery etc. in the event of fire evacuation.	Staff updated in fire prevention/evacuation on an annual basis; evacuation training given on site - specific to ICU.	Link fire person identified within the unit - Sr McGarry.	VLOW	TEAM	12/02/2014
840	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Exposure of staff to radiation - X-Ray equipment failure	Exposure of staff to radiation - x-ray equipment failure.	Regular servicing of equipment; staff wear protective lead aprons; dose meters are worn by staff and these are analysed monthly and a report received in the department; radiation signs placed on theatre doors during use to ward staff before entering.		VLOW	TEAM	12/02/2014
928	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	Screening equipment in room 1 has suboptimal image quality due to the age of the machine	Screening equipment in room 1 has suboptimal image quality due to the age of the machine - 10 years old, resulting in the room not being utilised to maximum capacity, therefore running the risk of not meeting Ministerial targets for diagnostics. Risk of mis- diagnosis when forced to use the equipment.	Unnecessary transfer of patients to STH and Armagh for imaging.	09.06.10 Business case has been submitted to DHSSPS	HIGH	DIV	07/01/2011
897	05/08/2008	Effective organisational governance	Macmillan Suite - Mandeville Unit	Trust's ability to meet Ministerial waiting targets is leading to staff working with different teams	Cancer targets - Potential to breach the Ministerial 31/62 day cancer targets resulting in poor performance for the Trust and delays in the diagnosis and treatment for patients with cancer.	Cancer teams to monitor escalate and raise with relevent AD and Medical Director. Forward assesment and planning in operation		MOD	HOS	26/11/2013
954	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of exposure to developer and fixer chemicals	Risk of exposure to developer and fixer chemicals.	COSSH policy; staff training and education; Occupational Health monitoring of staff; use of PPE; spillage kit.		LOW	HOS	02/05/2012
911	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	No leave cover for Radiologists, resulting in delay in diagnosis/treatment due to cancelling of lists	No leave cover for Radiologists, resulting in delay in diagnosis/treatment due to cancelling of lists - MRI/CT	The Orthopaedic ICATs are still being sent to Independent sector due to demand outstripping capacity in SHSCT.		LOW	HOS	15/10/2012
937	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	No adequate post procedure area for recovery in particular for those patients who attend from outlying hospitals/nursing homes	No adequate post procedure area for recovery in particular for those patients who attend from outlying hospitals/nursing homes.	Patients cared for in corridor prior to transfer back to own ward.		LOW	HOS	15/10/2012
938	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	Delay in reporting of radiodiagnostic procedure due to the shortage of Radiologists and trained Radiographers to meet the demand	Delay in reporting of radiodiagnostic procedure due to the shortage of Radiologists and trained Radiographers to meet the demand.	Films to be sorted within 2 days of being received and placed on radiologists reporting pile.		LOW	HOS	15/10/2012
947	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Unattended patients on trolleys, in chairs or on examination tables	Unattended patients on trolleys, in chairs or on examination tables resulting in falls, harm to patients, legal challenge, loss of reputation.	Request patients are accompanied at all times.		LOW	HOS	02/05/2012
942	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk to patient and staff in the event of a patient collapse due to lack of space in toilet facilities	Risk to patient and staff in the event of a patient collapse due to lack of space in toilet facilities in CAH.	Very limited; patient has to enter toilet in reverse.		LOW	HOS	02/12/2009
952	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	Following X-Ray procedure patient may require to rest 1-3 hours prior to transfer to own/care home	Following X-Ray procedure patient may require to rest 1-3 hours prior to transfer to own/care home; existing trolley not suitable - risk of patient developing pressure sore, falling off trolley; risk of injury to staff when moving and handling patient.	Member of CAH X-Ray staff stays with patient where possible; patient closely observed.		LOW	HOS	15/10/2012
953	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	Non compliance of DHSS "Use and Control of Medicines" - controlled drugs	Non compliance of DHSS "Use and Control of Medicines" - controlled drugs.	In locked cupboard, however not to required standard; retained in cupboard in maint theatres.	One box of 10 ampoules of Fentanyl is now kept in theatre and clearly marked as for use out of hours. A separate drug register is also in place and drug is checked daily by sister.	LOW	HOS	02/12/2009
956	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of patient fall during procedure when screening table is required to be upright	Risk of patient fall during procedure when screening table is required to be upright; CAH, DHH, STH.	Use existing strap and use a second broad strap.		LOW	HOS	02/05/2012
894	05/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Risk to health and safety of patients and staff due to staff not being able to attend mandatory training	Risk to health and safety of patients and staff due to staff not being able to attend mandatory training because of staff shortages and increased clinical activity.	Staff attend training when able to be released from clinical activity; lunchtime sessions arranged where possible.		MOD	HOS	26/11/2013
957	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Health and wellbeing of lone worker at night	Health and wellbeing of lone worker at night; CAH, DHH, STH.	CCTV monitoring; personal alarms; location of panic buttons linked to security; X-Ray relocated in A&E.		LOW	TEAM HOS	02/12/2009
955	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk to critically ill patients from injury from cassette when doing portables	Risk to critically ill patients from injury from cassette when doing portables.	Application of cassette cover.		LOW	TEAM HOS	02/12/2009
959	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Infection control to staff because there is no sluice provision in CAH X-Ray department	Infection control to staff because there is no sluice provision in CAH X-Ray department.	Disposing of body fluids e.g. Ba enema, micturation, cystograms and protgram is by either flushing down toilet or into a clinical waste bag.		LOW	HOS	02/05/2012
945	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of patient injury from falling when transferring from chair to table	Risk of patient injury from falling when transferring from chair to table; risk of patient injury from equipment e.g. tubes.	Observation; assisting the patient; manual handling equipment use; remove environmental risks e.g. susplus equipment; staff attend moving and handling update every 2 years.		LOW	HOS	02/05/2012
949	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of staff injury when moving and handling patients	Risk of staff injury when moving and handling patients.	Staff attend mandatory training in manual handling; use of manual handling equipment.		LOW	HOS	02/05/2012

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950	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Infection control - cross contamination from body fluids, MRSA etc.	Infection control - cross contamination from body fluids, MRSA etc.	Personal protective clothing equipment provided; vaccination programme from Occupational Health Department.		LOW	HOS	02/05/2012
951	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	Health and wellbeing of patients due to the cancellation of lists when staff on leave and no cover available	Health and wellbeing of patients due to the cancellation of lists when staff on leave and no cover available.	All members of staff give 6 weeks advanced notice for leave; Radiologist of the week picks up on any emergency leave list.	Consultant of the week now in place	LOW	HOS	02/12/2009
939	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of overexposure to radiation for foetus	Risk of overexposure to radiation for foetus.	Identification of the patient through a 3 point ID check; clinical history correlates with the examination requested; staff trained in the use of radiation emitting equipment; quality assurance on the equipment; IRMER pregnancy procedures.		LOW	HOS	02/05/2012
935	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of harm to unattended children in the department	Risk of harm to unattended children in the department.	The appointment letter going out to patients asks not to bring young children as there are no staff to look after them in the department.		VLOW	TEAM HOS	02/12/2009
936	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Health, safety and wellbeing of staff when dealing with/managing vilent/aggressive patients/visitors	Health, safety and wellbeing of staff when dealing with/managing violent/aggressive patients/visitors.	Known aggressors will not be X-Rayed if unaccompianed/unsupervised; front line staff; security; personal alarms; CCTV.		VLOW	HOS	02/05/2012
908	05/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Injury to patients - risk of falling when transferring from chair to table	Injury to patients - risk of falling when transferring from chair to table; risk of patient injury form the equipment e.g. tubes.	Observation; assisting the patient; manual handling equipment used; remove environmental risks e.g. surplus equipment.		LOW	HOS	20/03/2012
909	05/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Risk of staff injury when moving and handling patients	Risk of staff injury when moving and handling patients.	Staff attend mandatory training in manual handling; use of manual handling of equipment.		VLOW	HOS	26/11/2013
910	05/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Infection control - cross contamination from body fluids, MRSA etc.	Infection control - cross contamination from body fluids, MRSA etc.	Personal protective equipment; vaccination programme from Occupational Health.		LOW	HOS	03/12/2013
933	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Patient reaction to contract medium	Patient reaction to contract medium.	Thorough check of patient details and corresponding chart information; use of safest contrast medium; check allergy status of patient to administration.		LOW	HOS	02/05/2012
914	05/08/2008	Safe, High Quality and Effective Care	MRI Craigavon Area Hospital	Health, safety and wellbeing of staff when dealing with/managing violent/aggressive patients/visitors	Health, safety and wellbeing of staff when dealing with/managing violent/aggressive patients/visitors.	Known aggressors will not be scanned if unaccompanied/unsupervised.		LOW	HOS	15/10/2012
916	05/08/2008	Safe, High Quality and Effective Care	MRI Craigavon Area Hospital	Risk of injury to patients caused by falls when transferring from chair to table	Risk of injury to patients caused by falls when transferring from chair to table.	Observations; assisting the patient; manual handling equipment use; remove environmental risks e.g. surplus equipment.		LOW	HOS	15/10/2012
918	05/08/2008	Safe, High Quality and Effective Care	MRI Craigavon Area Hospital	Risk of staff injury when moving and handling patients	Risk of staff injury when moving and handling patients.	Staff attend mandatory training in manual handling; use of manual handling equipment.		LOW	HOS	15/10/2012
898	05/08/2008	Safe, High Quality and Effective Care	Macmillan Suite - Mandeville Unit	Dangerous uneven road surfaces at Macmillan Building	Health and safety of patients, visitors and staff at Macmillan Building; dangerous uneven road surfaces due to building work taking place.	Advise and report to Estates Department; advise staff and patients re building and road works.			DIV	10/06/2009
901	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of overexposure to radiation for patients	Risk of overexposure to radiation for patients.	Identification of the patient through a 3 point ID check; clinical history correlates with the examination requested; staff trained in the use of rediation emitting equipment; quality assurance on the equipment.		LOW	HOS	02/05/2012
903	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of overexposure to radiation for foetus	Risk of overexposure to radiation for foetus.	Identification of the patient through a 3 point ID check; clinical history correlates with the examination requested; staff trained in the use of radiation emitting equipment; quality assurance on the equipment.		LOW	HOS	02/05/2012
921	05/08/2008	Safe, High Quality and Effective Care	Radiology, Craigavon Area Hospital	Infection control - cross contamination from body fluids, MRSO etc.	Infection control - cross contamination from body fluids, MRSA etc.	Personal protective equipment; vaccination programme from Occupational Health.		LOW	HOS	15/10/2012
923	05/08/2008	Safe, High Quality and Effective Care	MRI Craigavon Area Hospital	Risk of patient reacting to contrast medium	Risk of patient reacting to contrast medium.	Ascertain known patient allergies; allergy alerts on patient records; refer to Consultant if in doubt; identify reacting medications prior to examination; training from drug companies.		LOW	HOS	15/10/2012
924	05/08/2008	Safe, High Quality and Effective Care	MRI Craigavon Area Hospital	Risk of projectile missile	Risk of projectile missile.	Check all patients for objects.		LOW	HOS	15/10/2012
926	05/08/2008	Safe, High Quality and Effective Care	MRI Craigavon Area Hospital	Risk of fire within the department	Risk of fire within the department.	Regular service of all equipment within the department; fire doors; sprinkler system; break glass boxes; fire fighting equipment; fire training; service contracts for servicing.		LOW	HOS	15/10/2012
929	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of overexposure to radiation for Trust staff and patients	Risk of overexposure to radiation for Trust staff and patients.	Personal protective clothing provided; monitor the number of times a member of staff is required to hold a patient during an exposure; use of safe distance for patients and staff on wards when a portable is required; identification of the patient through a 3 point ID check; clinical history correlates with the examination requested; staff trained in the use of radiation emitting equipment; quality assurance on the equipment.		VLOW	TEAM	02/05/2012
930	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of interventional haematoma in terms of puncturing the skin	Risk of interventional haematoma in terms of puncturing the skin.	Staff are trained to deal with haematoma and apply the interventional procedure; ensure site has stopped bleeding; give information leaflet; give follow up contact number.		VLOW	TEAM	02/05/2012
932	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of burns to patients having Colonic Examination Fluids	Risk of burns to patients having Colonic Examination Fluids.	Check temperature prior to administrating albeit it is manual.		VLOW	TEAM	02/05/2012
905	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of overexposure to radiation to X-Ray staff	Risk of overexposure to radiation to X-Ray staff.	Staff in the department wear radiation monitoring badge and records kept; staff trained in the use of radiation emitting equipment; quality assurance on the equipment.		VLOW	TEAM	02/05/2012
906	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of overexposure to radiation for Trust staff and patients	Risk of overexposure to radiation for Trust staff and patients.	Personal protective clothing provided; monitor the number of times a member of staff is required to hold a patient during an exposure; protective planning of new X-Ray rooms by the RPA and survey prior to use.		VLOW	TEAM	02/05/2012
920	05/08/2008	Safe, High Quality and Effective Care	MRI Craigavon Area Hospital	Risk of surface burns to patients from magnet	Risk of surface burns to patients from magnet.	Patients lie flat and does not cross legs or arms.		VLOW	TEAM	15/10/2012
934	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of overexposure to radiation for X-Ray staff	Risk of overexposure to radiation for X-Ray staff.	Staff in the department wear radiation monitoring badge and records kept; room design, protective screens and clothing; staff trained in the use of radiation emitting equipment; quality assurance on the equipment.		VLOW	TEAM	02/05/2012
958	05/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Health and wellbeing of clients and staff who may be latex sensitive due to exposure to latex	Health and wellbeing of clients and staff who may be latex sensitive due to exposure to latex; CAH; STH; ACH; DHH.	COSHH policy; staff training and education; Occupational Health monitoring of staff; all known latex products have been removed from an identified working environment - all rooms in STH, ultrasound room in ACH and CAH.		VLOW	TEAM	02/05/2012
978	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Filing of films in corridor reduces space and prevents evacuation of bed or chair patients	Filing of films in corridor reduces space and prevents evacuation of bed or chair patients in CAH X-Ray in the event of a fire.	Good housekeeping so that files are not lying on floor; use alternative corridor to evacuate bed and chair patients in the event of a fire.		LOW	HOS	02/05/2012
1000	06/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to patient receiving incorrect blood component due to not having an armband containing minimum patient identifiers	Risk to patient receiving incorrect blood component due to not having an armband containing minimum patient identifiers. This may potentially result in patient receiving incorrect blood/blood component or patient not receiving blood/blood component due to inability of staff to positively identify patient. May potentially lead to major morbidity and mortality.	It is essential that all patients having a blood transfusion should have an identification wristband with the patients second name, first name, gender, date of birth and patient identification number in accordance with the SHSCT Blood Transfusion Policy and the SHSCT Patient Identification Policy and positively identify patients when administering blood components. Audits of patient wristbands will be undertaken when arranged by the TTT.		VLOW	TEAM	18/12/2013

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1001	06/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to patient receiving incorrect blood component	Risk to patient receiving incorrect blood component due to inadequate/illegible positive patient identifiers on blood transfusion prescription chart. Leading to inability to positively identify patient. This may potentially result in patient receiving incorrect blood/blood component or not receiving blood/blood component due to inability of staff to positively identify patient.	It is essential that all patients having a blood transfusion should have the blood component prescribed on an integrated blood component chart with all patient positive patient identifiers documented clearly on this prescription chart. in accordance with the SHSCT Blood Transfusion Policy. Self inspection audits of blood transfusion documentation are undertaken on a quarterly basis. Results are discussed by the TTT, disseminated to SMT and appropriate actions taken.		VLOW	TEAM	18/12/2013
999	06/08/2008	Safe, High Quality and Effective Care	Laboratory	Building work for the T&O Service has meant no access to the existing laboratory reception	Building work for the T&O Service has meant no access to the existing laboratory reception; porters delivering samples, collecting blood etc. will need to use an alternative route; potential for delay of samples and prolonged turnaround times.	CCTV and alarm to alert reception staff of presence of samples at opposite end of lab is fitted, however access to reception is at the opposite end of the lab.	12.05.10 - risk reviewed by R Carroll and B Magee - risk mitigated and closed.	VLOW	DIREC	12/05/2010
1002	06/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to patient safety if blood component has expired	Risk to patient safety if patient receiving blood component that has expired. Patient may receive an expired blood component which may potentially lead to major morbidity and mortality.	It is essential that all patients having a blood transfusion should receive blood components that have not expired and blood components must be checked in accordance with the SHSCT Blood Transfusion Policy. Audits of all incidents related to blood transfusion are undertaken on a bi-annual basis and all trends identified, discussed by the TTT and relevant actions taken.		VLOW	TEAM	18/12/2013
993	06/08/2008	Safe, High Quality and Effective Care	Laboratory	Biochemistry printer is printing incorrectly	Biochemistry printer is printing incorrectly with missing and corrupted data on report forms - intermittent fault; patient at risk through incorrect reports being issued.	Printing has been stopped and wards have been advised to use ward lookup; reported as fault to DIS and waiting resolution.	To be managed by facility/department team manager/leader. 12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed. 12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed.	VLOW	DIREC	12/05/2010
994	06/08/2008	Safe, High Quality and Effective Care	Microbiology Lab	Increasing number of plates in the main lab are being contaminated by Asperigillus of doubtful clinical significance	Increasing number of plates in the main lab are being contaminated by Asperigillus of doubtful clinical significance; this is due to increasing building work in the area leading to aspergillus spors being dispersed; because of the lack of air conditioning the windows are kept open and as a result Aspergillus spores are contaminating agar plates and making interpretation of clinically significant cultures difficult; proposed air testing of NNU could be compromised if Aspergillus is being isolated as a result of lab contamination.	Closing all windows in the lab, which is making working conditions unbearable due to the heat and the lack of ventilation; weekly deep cleaning of incubators, benches and lab environment is performed.		MOD	DIV	23/06/2010
990	06/08/2008	Safe, High Quality and Effective Care	Laboratory	Currently do not measure bicarbonate as part of the standard U&E profile	Currently do not measure bicarbonate as part of the standard U&E profile; this differs from most other laboratories; likely in NI but is in keeping with the majority laboratories in the UK as evidenced by Keele Benchmark; it is available by request from Medical Staff but only a handful are requested on a monthly basis; a failure to identify serious acid base disturbances may lead to missed or delayed diagnosis; this could result in serious injury or death with the potential of significant medial legal consequences; example is a patiend in DHH who had been admitted with recurrend hypokalaemia over a period of several months.	Education of all all grades of Medical Staff as to the importance of measuring bicarbonate in the clinical cases that merit it; initiate reflex testing of bicarbonate when potassium's as/or chlorides fall outside a certain critical range; to be reviewed after education and Trust response to risk assessment.			DIREC	18/12/2008
986	06/08/2008	Safe, High Quality and Effective Care	Cellular Pathology Lab	Backlog of unreported cervical cytology in excess of National 6 week guidance	Backlog of unreported cervical cytology in excess of National 6 week guidance, caused by availability of Consultant Pathologists.	Locum Pathology sessions are purchased.		MOD	DIV	01/07/2010
996	06/08/2008	Safe, High Quality and Effective Care	Laboratory	Lack of adequate storage space	Lack of adequate storage space; corridors cluttered - hazard for fire exits, tripping etc.	None.		MOD	DIV	01/10/2010
960	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Radiology staff are unable to supervise unattended ill patients on trolleys from CAH A&E	Radiology staff are unable to supervise unattended ill patients on trolleys from CAH A&E who have IV infusions; cardiac monitors etc. from 5pm to 9am. Risk to Radiology staff who have to push and pull ill patients on trolleys without assistance from 5pm to 9am.	A&E staff are supposed to stay with trolley patients in X-Ray.		MOD	HOS	02/05/2012
963	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk to Radiology staff who have to push and pull ill patients on trolleys without assistance from 5pm to 9am	Risk to Radiology staff who have to push and pull ill patients on trolleys without assistance from 5pm to 9am.	A&E staff are supposed to stay with trolley patients in X-Ray.			DIREC	02/12/2009
966	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Potential for failure in meeting Ultrasound waiting list targets due to the increase in antenatal scanning in CAH	Potential for failure in meeting Ultrasound waiting list targets due to the increase in antenatal scanning in CAH; the imminent closure of the maternity service in Lagan Valley will also increase the potential risk level.	General Ultrasound lists are being rescheduled on a weekly basis to meet the additional demands of the Antenatal scanning with detriment to all other lists.		MOD	HOS	02/12/2009
982	06/08/2008	Safe, High Quality and Effective Care	Cellular Pathology Lab	Risk of oestrogen receptor analysis not being available for multi-disciplinary team meetings	Risk of oestrogen receptor analysis not being available for multi-disciplinary team meetings; identified at independent review of a complaint against the Trust.	Oestrogen receptors are batched; limited capacity on immuno cyto chemistry analyser.		MOD	DIV	01/07/2010
997	06/08/2008	Safe, High Quality and Effective Care	Laboratory	Lack of adequate reception space	Lack of adequade reception space, failure to meet CPA Accreditation standards and may impact on A&E four hour targets.		22/6/10 - New Reception provided	MOD	DIV	22/06/2010
995	06/08/2008	Safe, High Quality and Effective Care	Laboratory	Failure to comply with working time directives for Biomedical Scientists	Failure to comply with working time directives for Biomedical Scientists.	Compensatory rest given following on-call sessions.		LOW	HOS	26/11/2013
984	06/08/2008	Safe, High Quality and Effective Care	Bio-chemistry Lab	Failure to meet MHRA, CPA and RCPath standard on Point of Care Testing	Failure to meet MHRA, CPA and RCPath standard on Point of Care Testing as it pertains to staff training and competencies, records of test results, sub-optimal External Quality Assurance (EQA) schemes for glucometers, no enrolment in EQA schemes for HbA1c analysers and urinalysis meters; this increases the risk of failure of POCT equipment with erroneous results leading to inappropriate treatment of patients and potential consequence of harm; failure to comply with these regulations will leave the Trust vulnerable to litigation and possible criminal proceedings; in particular children with diabetes have their HbA1c results checked by POCT only and these instruments are not enrolled in EQA schemes; "Acute Hospitals Portfolio" has identified lack of compliance with POCT. Records of test results still do not comply with the guidelines and still increases risk. The urine analysis meters are not on an EQA scheme.	Staff training is ongoing and co-ordinated by Principal Clinical Scientist and the POCT BMS. In liaison with Human Resources, competencies will be checked annually through appraisal and KSF. EQA schemes for glucometers and HbA1c is now in place. A grade 2 Biomedical scientist is running the EQA scheme for glucometers, ICU and A&E instruments; this is performed every 2 months rather than monthly due to time constraints; no other instruments are enrolled in EQA schemes and none of the standards listed above are complied with.		LOW	HOS	04/06/2013
981	06/08/2008	Safe, High Quality and Effective Care	Laboratory	Inability to track units of blood	Inability to track units of blood.	Paper trail in place for tracking blood components; pilot study between Lab and Mandeville Unit complete.			DIV	02/03/2009
974	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk to health and safety of staff due to shortage of filing space in Lurgan Hospital	Risk to health and safety of staff due to shortage of filing space in Lurgan Hospital - films not filed - stored on floor etc.	Destroy films (keep 3 years plus current year).		LOW	HOS	02/05/2012
970	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Health and wellbeing of disabled clients because the department does not meet DDA requirements	Health and wellbeing of disabled clients because the department does not meet DDA requirements.	One toilet area provided for disabled persons.		LOW	HOS	02/05/2012
972	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Risk of fire within the X-Ray department	Risk of fire within the department.	Regular service of all equipment within the department; fire doors; sprinkler system; break glass boxes; fire fighting equipment; fire training.		LOW	TEAM	02/05/2012
973	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	Trailing leads in the Endoscopy room	Trailing leads in the Endoscopy room.	Ensure preventative measures are in place and within health and safety requirements.		LOW	TEAM	02/05/2012
975	06/08/2008	Safe, High Quality and Effective Care	X-Ray Dept	IT breaking down after hours - weekends	IT breaking down after hours - weekends.	Ris go onto Manual paper filing until Ris is fixed during normal working day; CR 24 hour cover is provided by company.		VLOW	TEAM	02/05/2012
1003	06/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Wastage of blood due to blood storage fridge failure	Wastage of blood due to blood storage fridge failure resulting in blood not beng available for patients.	Ensure fridge temperature control alarms are not inappropriately muted; fridge alarm tested out of hours as well as routine hours; SOPs covering temperature control storage, its monitoring and management of the cold chain must be strictly adhered to. Additional temperature monitoring alarms fitted to all blood fridges which measure core and air temperature, with the ability to contact staff via recorded telephone message when a temperature excursion occurs.		VLOW	TEAM	04/06/2013

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1017	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Patient receiving a transfusion of blood component that is inappropriate	Patient receiving a transfusion of blood component that is inappropriate resulting in exposure to the known and the unknown risk to transfusion. Patient may receive an inappropriate transfusion in exposure to the known and unknown risk of transfusion which may lead to major morbidity and mortality.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA 'Right Patient,Right Blood' initiative. All blood components must be prescribed appropriately in accordance with the SHSCT Blood Ordering Schedule and Guidelines for prescription of Red Blood Cells. Audits will be undertaken related to the appropriate use of blood components and the GAIN Guidelines (2009). HTC are currently identifying appropriate data collection forms to ensure that a rolling programme of audit exists.		VLOW	TEAM	18/12/2013
1005	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to patient safety if incorrect blood component collected from blood fridge	Risk to patient safety if incorrect blood component collected from blood fridge leading to the patient receiving an incorrect blood component. Potential harm to patient due to receiving an incorrect blood component may lead to major morbidity and mortality.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA' Right Patient,Right Blood' initiative. The SHSCT Blood Component blood component collection form must always be used to request and collect blood components as outlined in the SHSCT Blood Transfusion Policy. Self-inspection audits are undertaken on a quarterly basis to ensure adherence to policy , results are discussed by the TTT and disseminated to the SMT.		VLOW	TEAM	18/12/2013
1012	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Staff being involved in the blood transfusion process who have not completed the relevant competency assessment in accordance w	Staff being involved in the blood transfusion process who have not completed the relevant competency assessment in accordance with the NPSA Safer Practice Notice(14) 'Right Patient, Right Blood'. Patient may have a pre-transfusion sample taken and/or be administered a blood component by staff who have not been competency assessed in the relevant competencies. lead to major morbidity and mortality.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA Safer Practice Notice (14) 'Right Patient,Right Blood' initiative and records of these assessments must be readily available with in the SHSCT. Self- inspection audits are undertaken on a quarterly basis to ensure that all staff involved in the blood transfusion process are competency assessed. The competency assessment status of staff involved i n errors/ incidents is checked and addressed on an ongoing basis.		VLOW	TEAM	18/12/2013
1013	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Staff not adhering to the SHSCT blood transfusion policy regarding positive patient identification when taking blood samples	Staff not adhering to the SHSCT Blood Transfusion Policy regarding positive patient identification when taking blood samples for group, hold and cross match; leading to the potential to patient receiving incorrect blood component and/or a delay in the patient receiving blood component.	Staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA 'Right Patient,Right Blood' initiative. Staff must adhere to the SHSCT Blood Transfusion and the SHSCT Trust Identification Policy regarding positive patient identification. The blood bank operate a 'zero' tolerance policy regarding sample errors, Sample errors are audited on a monthly basis. Trends identified and the TTT plan to send out quarterly reports to depts as a quality indicator when administration help is secured.		VLOW	TEAM	18/12/2013
1018	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to patient safety to failure of clinical to return the blood component collection form/traceability record to the bood bank	Risk to patient safety to failure of clinical to return the blood component collection form and/or traceability record to the blood bank after transfusion. Patient may received an inappropriate transfusion resulting in exposure to the known and unknown risk of transfusion leading to major morbidity and mortality.	Staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the 'Right Patient,Right Blood' initiative. All blood component collection forms and traceability records must be returned to the blood bank in accordance with the SHSCT Blood Transfusion Policy after transfusion of the blood component. Self- inspection audits are undertaken on a quarterly basis, discussed at TTT and disseminated to SMT.		VLOW	TEAM	18/12/2013
1015	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Clinical staff not aware of how to manage or treat an adverse reaction due to administration of blood component	Risk to patient safety due to clinical staff not being aware of how to manage or treat an adverse reaction due to administration of blood component leading to the patient not receiving the appropriate treatment. Patient may not receive the appropriate treatment in the event of developing an adverse transfusion reaction. Leading to major morbidity and mortality.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the 'Right Patient,Right Blood' initiative. All staff must adhere strictly to the SHSCT Blood Transfusion Policy and all blood components must be prescribed on the Integrated Blood Component and Prescription chart which has a specific section guiding staff on the action to take in the event of an adverse reaction occurring. Education sessions for staff include the recognition and treatment of potential adverse reactions.		VLOW	TEAM	18/12/2013
1014	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to the patient safety due to the failure to communicate special transfusion requirements	Risk to the patient safety due to the failure to communicate special transfusion requirements, this may potentially lead to the patient receiving an incorrect blood component. Leading to major morbidity and mortality.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA 'Right Patient,Right Blood' initiative. Staff must adhere strictly to the SHSCT Blood Transfusion Policy and all blood components must be prescribed on the SHSCT Integrated Blood Component and Prescription chart, which has a facility to document special requirements. Self-inspection audits will be undertaken on a quarterly basis, results discussed by the TTT and disseminated to SMT.		VLOW	TEAM	18/12/2013
1016	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Patient not being informed of the risks & benefits of transfusion due to their clinical condition	Patient not being informed of the risks and benefits of transfusion due to their clinical condition and not being informed of the risks and benefits retrospectively. Leading to the patient not receiving (retrospectively) information regarding the risks and benefits of blood transfusion; this may potentially lead to the patient being unaware of the risks and benefits of transfusion and their right to request alternative treatment; patient may be unaware of the consequences of transfusion, e.g. if a patient is a blood donor they will be removed from the blood donor panel; patient may develop an adverse reaction to the blood transfusion and may be unaware of symptoms to report to clinical staff.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessement in accordance with the 'Right Patient,Right Blood' initiative. All staff must adhere strictly to the SHSCT Blood Transfusion Policy and all blood components must be prescribed on the Integrated Blood Component and Prescription chart and all appropriate sections completed. Provide patients with information regarding the 'risks and benefits' of transfusion retrospectively after the emergency transfusion. Adaptation of the transfusion record will incorporate this.		VLOW	TEAM	18/12/2013
1008	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to patient receiving a blood transfusion out of normal working hours	Increased risk to patient having blood transfusion out of normal working hours, i.e. after 17.00 hours and before 07.30 hours due to inability to adequately observe patient because of decreased staffing levels. Patient may receive a blood component and not be adequately observed by staff which may potentially lead to major morbidity and mortality.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA Safer Practice Notice (14)'Right Patient,Right Blood' initiative. Patients should be transfused during normal working hours and transfusions should only take place 'out of hours', i.e. after 17.00 hours and before 07.30 hours if clinically essential. 'Out of hours' adults to be undertaken bi-annually, results discussed by the TTT and disseminated to SMT.		VLOW	HOS	18/12/2013
1010	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk of patient getting wrong unit of blood due to Registered staff using the compatibility form only as the final bedside check	Risk of patient getting wrong unit of blood due to Registered staff using the traceability record form only as the final bedside check.	All staff involved in the blood transfusion process will receive education at induction and thereafter annually; be competency assessed with relevant competency at induction and 3 yearly thereafter. All staff involved in the administration of blood components will carry out the final bedside check; blood will never be checked remote from the bedside; patients will be involved in the final check and asked to clarify their surname, first name and fate of birth if capable of giving an accurate reliable response. Final check will be validated against patients armband		VLOW	TEAM	18/12/2013

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
1007	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Risk to patient safety if blood is transfused outside of temperature control eg no appropriately packaged when being transferred	Risk to patient safety if blood component that has been transfused when 'out of temperature' control eg not appropriately packaged when being transferred. May lead to major morbidity and	Staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the 'Right Patient,Right Blood' initiative. The Blood Transfusion Blood Component Collection form must always be used to request and collect blood component s and must be completed in accordance with the SHSCT Blood Transfusion Policy. Registered Nurses/Midwives/Medical staff must ensure that all blood component transfusions are commenced within the 30 minute period or returned to the blood bank. Self-inspection audits to be undertaken quarterly.		VLOW	TEAM	18/12/2013
1019	07/08/2008	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Lack of an advanced directive to guide staff when treating patients who are likely to decline a blood transfusion	Risk to the reputation of the Trust because there is no advanced directive to guide staff when treating patients who are likely to decline a blood transfusion. Complaint resulting potential loss of confidence in the organisation. Potential financial claim, potential financial loss to the organisation, potential loss of confidence among staff within the organisation.	All staff involved in the requesting or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA Safer Practice Notice (14)'Right Patient,Right Blood' initiative. A Regional Advance Directive is in the final stages of development and will be readily available to guide staff within the Trust.	Update - the SHSCT transfusion committee is taking forward the implementation of the advanced directive.	VLOW	HOS	18/12/2013
1052	08/08/2008		Emergency Dental Clinic	Risk of moving and handling injury to staff when patient in dentist's chair and floor light being used	Risk of moving and handling injury to staff when patient in dentist's chair and floor light being used.	Staff move cautiously around floor light.	Work ongoing to mount floor light on ceiling.	LOW	HOS	06/06/2017
1059	11/08/2008		EEG Dept	Health and safety of clinical physiologist due to repetitive strain injury during EEG procedure with children	Health and safety of clinical physiologist due to repetitive strain injury during EEG procedure with children; potential for back injury.	All staff must attend manual handling training on induction which is regularly updated; rest and counter stretch between patients; rotation of staff when possible.		LOW	HOS	15/10/2012
1060	11/08/2008	Safe, High Quality and Effective Care	EEG Dept	Health and safety of patients and staff during an EEG if the patient develops a tonic/clonic seizure	Health and safety of patients and staff during an EEG if the patient develops a tonic/clonic seizure.	Alarm bell available.		LOW	HOS	15/10/2012
1061	11/08/2008	Safe, High Quality and Effective Care	EEG Dept	Risk to health and safety due to violent/aggressive/abusive relatives or patients	Risk to health and safety due to violent/aggressive/abusive relatives or patients.	Use of panic button when in department; de-escalation of situation when on phone.		LOW	HOS	15/10/2012
1076	11/08/2008	Safe, High Quality and Effective Care	Stone Treatment Centre	Unnecessary radiation exposure to patients undergoing low dose fluoroscopy radiation	Unnecessary radiation exposure to patients undergoing low dose fluoroscopy radiation when trained ultrasonographers are not available.	All patients are protected with lead aprons; when possible ultrasound treatment is used.		LOW	HOS	03/12/2013
1206	15/08/2008	Safe, High Quality and Effective Care		Infra 2.07, the theatre and delivery suite ventilation at DHH requires to be replaced	Infra 2.07, the theatre and delivery suite ventilation at DHH requires to be replaced; the equipment is now at the end of its useful life; failure of the system would lead to an inability to carry out surgery or admit mothers for delivery at DHH; CAH would not have the capacity to provide contingency in the event of breakdown.		3/2/12 - This work has been complete and theatres tests (microbiology testing). Closed at HOS 4.1.12 - Update to be obtained from Alan Metcalfe 2/9/11 - Ronan Carroll to contact Alan Metcalfe. Identified as priority under MES.	MOD	DIV	03/02/2012
1265	19/08/2008	Safe, High Quality and Effective Care	Recovery Ward	Infection control and health and safety risk to staff and patients in ICU and T&O Recovery Ward due to lack of bedpan washer	Infection control and health and safety risk to staff and patients in ICU and T&O Recovery Ward due to lack of bedpan washer in the dirty utility area in Recovery Ward.	Staff are currently using bedpan washer in ICU and Trauma and Orthopedic Recovery Ward.	4.1.12 - Risk assessment has been undertaken and issues taken into account when disposing of bodily fluids. Sluice in main theatres used and bed pan washer accessed in T&O as interim solution. 28.10.11 Issues will be resolved with the new build. Risk assessment to be undertaken. 10.05.10 - Risk reviewed by MMcG + BM risk rating reduced to 4 x 3 = 12 = moderate risk. 2/9/11 Await refurbishment of CAH Main Theatres. 10.05.10 - Risk reviewed by MMcG + BM risk rating reduced to 4 x 3 = 12 = moderate risk.	MOD	DIV	03/02/2012
1266	19/08/2008	Safe, High Quality and Effective Care	Recovery Ward	Infection control risk to health and safety of patients who are ventilated	Infection control risk to health and safety of patients who are ventilated because there are insufficient quantities of ventilator parts to allow decontamination in SSD.	Staff are currently using the benchtop steriliser in dental room; benchtop steriliser does not meet HTM 2030 requirements.	10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - written protocol in place. All ventilator parts now decontaminated in SSD - risk mitigated and closed.	VLOW	DIREC	10/05/2010
1267	19/08/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	Infection control risk to patients and staff in Day Surgery Unit - patient chairs are covered in fabric material	Infection control risk to patients and staff in Day Surgery Unit - patient chairs are covered in fabric material and should have a wipeable cover.	None.	10.05.10 - Risk reviewed by MMcG + BM - chairs replaced - risk mitigated and closed. 10.05.10 - Risk reviewed by MMcG + BM - chairs replaced - risk mitigated and closed.	VLOW	DIREC	10/05/2010
1263	19/08/2008	Safe, High Quality and Effective Care	Recovery Ward	Vinyl floor covering in Recovery Ward is damaged and in need of replacement; Health and safety risk and infection control risk	Vinyl floor covering in Recovery Ward is damaged and in need of replacement; Health and safety risk and infection control risk.	None.		MOD	HOS	12/02/2014
1264	19/08/2008	Safe, High Quality and Effective Care	Recovery Ward	Privacy and dignity of patients in Recovery Ward is compromised due to no curtain rails and curtains	Privacy and dignity of patients in Recovery Ward is compromised due to no curtain rails and curtains - staff are currently using portable screens which in themselves are a health and safety and infection control risk.	Staff are currently using portable screens which in themselves are a health and safety and infection control risk.		MOD	DIV	01/10/2010
1246	19/08/2008	Safe, High Quality and Effective Care	Trustwide	Failure to carry out decontamination process to latest HTM guidance and Hind report	Failure to carry out decontamination process to latest HTM guidance and Hine report.	Maintaining and testing machines as per current guidance.	Interim measures also identified and cost submitted for approval.	MOD	HOS	12/02/2014
1874	09/12/2008		Laboratory	Air quality in Andrology laboratory needs to be brought up to the standard required by HFEA.	Air quality in Andrology laboratory needs to be brought up to the standard required by HFEA. A license will be withdrawn if this condition is not met.	None	12.05.10 - risk reviewed by R Carroll and B Magee - new printerd purchased - risk mitigated and closed.	VLOW	DIREC	12/05/2010
1873	09/12/2008	Be a great place to work	Laboratory	Lack of ergonomic microscope workstations for staff involved in cervical screening in Screening Room 1	Staff are at risk from developing musculoskeletal problems	Staff have ergonomic microscopes and seating. Not possible to have control measures for benching.			DIREC	16/11/2009
1916	13/01/2009	Safe, High Quality and Effective Care	Laboratory	Laboratory failing Accrediation due to External Clinical Waste Bins being kept in a unsecure location	External Clinical Waste bins are kept in an insecure location. This has been highlighted as a critical non compliance during recent Clinical Pathology Accreditation Inspections and could lead to the laboratory failing Accreditation.	Where possible bins are locked using a key but often locks are faulty.	11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed. Letter sent to Mr A Metcalfe requesting that the waste bins be secured. Referred to Directorate Risk Register 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW	DIREC	11/05/2010

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1917	13/01/2009	Organisational and workforce development	Laboratory	Laboratory failing Accrediation due to not meeting Working Time Regulations	Recent changes to testing practices for MRSA have led to a significant increase in out-of-hours work without an appropriate re-organisation of working arrangements. Staff have not signed up to any opt-out agreement in relation to out-of-hours working. Facilities for staff to remain on-site during on-call periods have not been reviewed with no overnight accommodation being available, if necessary. This has been highlighted as a critical non compliance during recent Clinical Pathology Accreditation Inspections and could lead to the laboratory failing Accreditation	No control measures in place	Changed on call arrangements giving additional rest time. Bedroom provided. Not meeting working time regulations is covered under Datix No 995	HIGH	DIV	18/02/2010
2149	06/02/2009	Safe, High Quality and Effective Care	Laboratory	No mechanism to determine the date and time of receipt of samples in Reception	Recent CPA Inspection highlighted that there is no mechanism to determine the date and time of receipt of samples in Reception. Currently date and time is taken as time of entry on lab system which is incorrect.	Request to be placed with the Trust to purchase six Zebra bar code printers plus software to produce labels realtime by end of February 2009.		MOD	DIV	24/03/2011
2148	11/03/2009	Safe, High Quality and Effective Care	Blood Transfusion Lab (Blood Bank)	Donor blood for transfusion to patients must be maintained at a temperature of 4 ºC ± 2 ºC.	Donor blood for transfusion to patients must be maintained at a temperature of 4 ºC ± 2 ºC. The temperatures on the three blood bank refrigerators at DHH run between 5.2 ºC and 5.6 ºC. The temperature settings on these refrigerators are at their maximum and therefore can not be adjusted any further. This leaves a very small margin for temperature change before donor blood is deemed 'out of temperature' limits. This could lead to loss of blood stocks, which would have serious implications on the ability of the hospital to provide surgery, receive trauma patients etc. It would also entail a report being sent to SABRE the reporting mechanism for MHRA	An electronic temperature monitoring system has been fitted to the refrigerators that contacts staff if there is a temperature deviation. This provides time for blood to be assigned to an area that is still with the defined temperature limits. All staff involved in blood transfusion have received training in this system.		MOD	HOS	04/06/2013
2147	09/04/2009	Safe, High Quality and Effective Care	Cellular Pathology Lab	Complete history of cervical cytology patients is not available at the registration and reporting screens	Complete history of cervical cytology patients is not available at the registration and reporting screens which leads to inefficient and unsafe working practices, potentially putting patients at risk and damaging the reputation of the Trust.	Histories are printed in a batch, sorted and attached to the laboratory request forms. Staff have to be vigilant that the correct history is attached to the appropriate request form.		LOW	HOS	30/11/2010
2607	01/05/2009	Provide safe, high quality care	Intensive Care Unit	Safe usage of Silentia Line Screens fixed and portable concertina type screens which folds if not adequately secured with brakes	Potential risk to any staff member/relative who is in close proximity to screens when in use, as screens may fold in or migrate out in concertina type fashion if all brakes not adequately secured in fixed screens. Also if portable screen not adequately closed with elastic binder potential to open out, potentially harming persons. Potential of screens migrating towards persons (i.e. staff/visitors) and causing impact - therefore potential injury if all brakes not properly secured. Portable screens elastic binder too long to adequately secure portable screens are closed	All staff trained/educated in current ergonomic/manual handling trust policy and legislated to comply with ICU based training/education regarding use of silential line screens.	Training provided by Ward Sisters. Written information disseminated to all ICU staff re - securing brakes and use of portable screen with elastic strap attached.	LOW	HOS	12/02/2014
2146	28/05/2009	Safe, High Quality and Effective Care	Laboratory	Abbott Saphire haematology analysers are suffering from excessive downtime	The two new Abbott Saphire haematology analysers are suffering from excessive downtime. This has resulted in both analysers being unavailable on a number of occasions and consequently no ability to analyse a full blood count on the Craigavon Site. This has the potential to severely disrupt the management of patients.	Support company has been contacted and have had engineers on site. Samples have been transferred to Daisy Hill Laboratory. Mr T McFarland has been in consultation with Accuscience to complain about the serviceability of the analysers.	Referred to Directorate Risk Register. A third analyser has been provided FOC from the company and this has reduced the workload going through the initial two analysers. As a consequence these analysers now have a reduced downtime and thereby provide a much improved and robust service.	HIGH	DIV	22/02/2010
2055	29/05/2009	Safe, High Quality and Effective Care		Malfunction of energy select switch - Philips XL Heart Start M4735A- could result in non-treatment of life threatening arrthymias	The collapsed patient requiring defibrillation for a life threatening arrthymia will be at risk of not delivery of treatment to correct their rhythm. Non-treatment of life threatening arrthymias (patient). Potential for fatalities resulting in potential loss of reputation and litigation for the Trust	1.The affected Philips defibrillators and their location have been identified 2. Communication regarding the identified fault has been distributed Globally to all wards and departments with information received from Cardiac Services as follows on 28/05/09 - Reported non-function of rotary energy switch in affected models may fail and prevent the user from turning the device on, rendering the device un-useable for monitoring and defibrillation therapy 3. Further information required for distribution today is aimed at informing all potential users of contingency plan in event of defibrillator failure: - Ward 1 North Cardiac Resus trolley will have an unaffected device - Cardiac Arrest team will attend arrest calls in CAH with Ward 1 North resuscitation trolley· - The location of the next closest defibrillator in the event of device failure will be given to each ward/dept in event of Ward 1 North trolley in use. - Instruction for all users to 'Contact Technical Services Manager' as soon as possible on occurrence of device failure (Michael Ross ex.3631 or Stephen Armstrong ex.4185) These control measures are considered to be effective during the period of upgrades of all affected Philips defibrillators Cardiac Services have assured 'Free of charge' replacement of affected switches.	To be managed by Facility/Department Team Manager/Leader	VLOW	TEAM	05/08/2009
2391	01/06/2009	Provide safe, high quality care	Laboratory	Interruption of electrical supply to Tissue Processor, Immuno BenchMark and LBC Processor	Interruption of electrical supply to Tissue Processor, Immuno BenchMark and LBC Processor can result in the loss of patient tissue samples causing a delay in diagnosis, undiagnosis of disease or condition; loss of prognostic information required for the treatment of patients. The increased volume of throughput in the Immuno BenchMark now means that the machine is operational for 7-8 hours per day plus overnight runs.	Requested Estates Services to cost EPS for the tissue processor and BenchMark.	Dedicated power supply to the tissue processors and the BenchMark with 3 portable UPS. Contacted Estates Services to provide a dedicated telephone line for the antodialler. Installation of autodialler to cost £450. Non-stock requisition 2582710 + statement of need submitted 12.10.09	VLOW	HOS	16/11/2009

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2057	03/06/2009		THEATRES	Endsocopy decontamination	Infection control risks to the patient by cross contamination. Storage of clean equipment in an area used for decontamination - potential for cross contamination Water test failures- there is an increased risk of the cancellation of procedures Due to the decommissioning of the AER in main theatres there is an increased risk of 1.breakdown of the single AER in Radiology resulting in the cancellation of procedures 2.Reduced capacity leading to a backlog in decontamination 3.Print out only available when both sides complete - leading to potential error in traceability Main theatres CAH Automatic endoscope reprocessor (AER) is not compliant with HTM 2030 and the Hine review recommendations 2004. There is no independent channel monitoring, no single shot detergent, no reverse osmosis water, leading to potential infection control risk to patients; the 3 hour time limit on the use of scopes following disinfection compounds this. Storage of clean equipment in an area used for decontamination - potential for cross contamination. The endoscope decontamination area was a multipurpose room. Main theatres decontamination facilities do not meet the recommendations of the Hine review 2004 - no flows - leading to potential infection control risks to patients by cross contamination of equipment. Radiology CAH - Automatic endoscope reprocessor (AER) is not compliant with HTM 2030 and the Hine review recommendations 2004. There is no independent channel monitoring, no single shot detergent, no reverse osmosis water, it does have print out but this is inadequate, leading to potential infection control risk to patients; the 3 hour time limit on the use of scopes following disinfection compounds this. Storage of clean equipment in an area used for decontamination - potential for cross contamination Radiology decontamination facilities do not meet the recommendations of the Hine review 2004 - no flows - leading to potential infection control risks to patients by cross contamination of equipment. AER in Radiology and Main theatres out of use due to weekly water quality tests - Weekly water quality tests are undertaken in line with HTM 2030 and the Hine review 2004; when the results of these tests are received there may be recommendations to take all or part of the AER out of use; this leads to an increased risk of cancellation of patients off lists for non-clinical reasons due to reduced capacity; this impacts on the PFA target for elective procedures and the 2% for cancellations for non-clinical reasons; risk to patients - cancellation of endoscopic procedure; cancellation of patients for colonoscopy having taken their bowel preparation; cancellation of patient with undiagnosed symptoms; cancellation of patients who are red flagged for possible cancer; infection control Traceability recording of all stages of the decontamination process to the patient was in separate books leading to difficulties in ratifying the information Risk of adverse publicity and litigation for the Trust.	AER and decontamination main theatres decommissioned since Friday 22nd May 2009 Removal of clean items not required for endoscope decontamination from Radiology and Main Theatres.This includes endoscopes which are appropriately stored as per Hine review recommendations in clean areas until the ventilated storage cabinets are commissioned. The multipurpose room in main theatres has been decommissioned. The Trust has built two new interim endoscope decontamination units which have HTM 2030 compliant AERs. There is segregated dirty to clean flows. The Trust has purchased ventilated storage/drying cabinets. Arrangements are in place to obtain weekly water samples; it has been agreed across the SHSCT to use one company - 2030 Labs; results are obtained each Monday and the water quality group review the results and ensure that appropriate action is taken in line with Trust protocol; interim arrangements are put in place to maintain the safety of the decontamination process and the delivery of service to patients to prevent cancellations. Manual traceability records have been reviewed and further enhanced. The Long term business case identifies funding for a computerised traceability system. However the Trust is committed to procuring the electronic traceability system in advance of the long term business case. To reduce risk in radiology a plan is being put in place to provide a dedicated rota of staff for the decontamination area These control measures are adequate in this interim arrangement, however permanent arrangements will be put in place when the funding through business case submitted on the 8th May 08 has been secured. The business case outlines the long term requirements to ensure total compliance with all DHSS standards and guidance		MOD	CORP	01/10/2009
2071	10/06/2009	Safe, High Quality and Effective CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Cancer review	Cancer Review - delays in patients being reviewed within the allocated timeframe, resulting in advances in disease and/or more comprehensive treatment required	Cancer teams monitor and raise review delays with relevant assistant director and medical director. Clinical incidents reported to ensure learning.	26.11.13 Continues to be reviewed. Delays prostate clinic referrals from Belfast.	MOD	HOS	18/02/2014
2067	10/06/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Increasing activity across all clinics and treatment areas	Increasing activity across all clinics and treatment areas compounded by increased sickness and maternity leave resulting in delays for patients receiving treatment.	Waiting list created in an attempt to manage the additional activity. Use all available resources effectively - ie relocate blood tranfusion to hospice and MDU		MOD	HOS	26/11/2013
2066	10/06/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Anaphylaxis	Pre anaphylaxis/ full anaphylaxis during treatment. No resident medical staff at unit level. Resulting in the potential for major/catastrophic incident. Loss of reputation. Litigation.	Staff receive training regarding the management of anaphylaxis and follow Trust policy.		LOW	HOS	26/11/2013
2072	10/06/2009	Effective organisational governance	Macmillan Suite - Mandeville Unit	Peer review	Peer review - regional process of peer review of Multidisciplinary meetings.Risk to MDMs where lack of some core members and limited audit support.Loss of reputation for the Trust.	None		MOD	DIV	07/01/2011
2068	10/06/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Management pathway for ill patients presenting at Mandeville Unit	Health and Safety of patients and staff due to increase in clinical activity and the increase in number of unwell patients who require to be managed at unit level and require admission resulting in the potential for a major/catastrophic incident.	Monitor clinical activity on a daily basis. Inform AD/ lead clinician when activity levels exceed capacity.		MOD	HOS	26/11/2013
2069	10/06/2009	Accessible and Responsive CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Reduction in Admin Staff	Reduction in Administration staff and increase in number of outpatient patient clinics and increase in number of patients attending for treatments leading to lack of staff to cover reception, prepare clinics, ensure all notes and results are available for clinics. Risk that insufficient or inadequate information is available for decision making, patients miss appointments as not booked onto systems. Increased waiting times for patients due to delays with charts, x-rays and results	Activity monitored on a weekly basis, inform Assistant Director when levels exceed capacity. Ensure efficient use of staff		MOD	HOS	26/11/2013
2070	10/06/2009	Safe, High Quality and Effective CareEffective organisational governance	Macmillan Suite - Mandeville Unit	Infection control	Infection Control - cross contamination from body fluids, MRSA, C Diff, etc. Inadequate sluice facilities due to changes in treatment regimes and sicker patients in the treatment area. Resulting in the potential for splash injuries and cross contamination from contaminated cytoxic waste/infected waste	Personal protective equipment. Vaccination programme from Occupational Health. Hand hygiene audits in operation, staff training ongoing.	24.3.11 No change require bedpan issue to be escalated.	LOW	HOS	26/11/2013

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2466	25/06/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Audiology Dept	Design and location of existing audiology department	Current accommodation is unsuitable as it does not meet the minimum British Society of Audiology (BSA) or BS EN ISO 8253-1 standards. Ambient noise levels in accommodation grossly exceed the maximum level of 35 dB (A). These standards have been further compromised by the upgrade of X-Ray's CT Scanner which has increased noise levels in Audiology Room 1 & 2, and the refurbishment of the coffee bar in Daisy Hill has added to noise levels in the temporary untreated paediatric VRA room. Ambient noise levels in the Audiology department are currently between 44 - 67 dB (A). Staff are routinely placed at risk from musculoskeletal problems due to space restraints in a number of rooms. Audiology office/repair room is too small and highly congested. Drill used for modification of ear moulds is housed in enclosed Dental suite store which does not have suitable ventilation and is non-compliant with Abrasive Wheels Regulations which in turns raises health and safety and COSHH issues. Test Room (Audiology Room 2) - the test booth within this room cannot be relocated and is not DDA compliant, if a wheelchair patient arrives staff are required to assist the patient into the booth. Staff are also required to sit at the workstation in this room for at least 30 mins during the test process in cramped conditions. In an effort to avoid possible litigation and to improve clinical care by whatever means possible staff have increased workload from additional tests needed for verification of diagnostic assessment for ENT, Visual Reinforcement Audiometry (VRA) and GP direct access clinics. Current staffing levels do not reflect demand on service and these additionalities further stretch an already compromised service. In summary department staffing levels and accommodation are unfit for purpose	Additional tests are carried out on patient(s). Local procedures in place for testing patients which includes number of tests, rotation of staff, limitation on number of persons in a test room.	30.6.11 - ongoing. 02.05.12 Progress with Estates. Costing approved. Waiting for work to commence. Arrange for ergonomic assessment to be conducted on staff involvement during VRA testing 01.03.11 Immediate review/refurbishment of the current layout of the dept to take into account the demands of the service and minimum BSA standards Arrange for staff to attend manual handling training Carry out/review generic manual handling risk assessment Provision of corner cupboard on wall to accommodate storage and relocation of equipment in test room Turn larger cupboard at ground floor level to make best use of space. 30/6/11 Risk still present, however review of services and accommodation has highlighted issues and a new Audiology and ENT department has been allocated in the refurbishment of old Gynae/maternity Outpatients DHH which is due for completion March 2012. 02.05.12 Progress with estates costing approved. Waiting for work to begin. A Davidson. 25.07.09 Review the current layout of the department (to include ENT accommodation) to take into account the demands of the service and minimum BSA standards DSE Assessment required on workstation in test room 2	HIGH	HOS	15/10/2012
2150	13/08/2009	Safe, High Quality and Effective Care	Laboratory	Inadequate immuno cyto chemistry staining facilities	Inadequate immuno cyto chemistry staining facilities to ensure the rapid turnaround of urgent histological samples, including red flagged samples.	No control measures. System is operated to full capacity, delays are frequent.	New system of work implemented which has led to a marked reduction in the throughput of immuno slides. The benchmark is no longer a limiting factor with regard to the turnaround time of immuno cytochemistry	MOD	DIREC	09/12/2009
2175	17/08/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governanceOrganisational and workforce developmentBest use of resources	Macmillan Suite - Mandeville Unit	Staffing levels	Critical level of staffing due to sickness and annual leave (approximately 45% staff available for duty). Resulting in potential for major/catastrophic incident, litigation and loss of reputation to the Trust.	Staff have been doing additional hours, bank staff requested, but limited availability relevant to specialist area. Re-organisation of work load to reduce risk where possible. Agency staff requested to provide some support, again limited availability. Some patients have been temporarily redirected to Newry Hospice		HIGH	HOS	26/11/2013
2523	31/08/2009	Safe, High Quality and Effective CareAccessible and Responsive CareBest use of resources	Occupational Therapy Department	Delay in recruiting to OT vacancies (permanent & maternity leave cover) has the potential to compromise the safety and quality	Current vacancies - Band 5 - Acute Medicine. Upcoming Vacancies: Band 6 - Oncology & Palliative Care Team (Maternity Leave-unavailable Nov 09 onward) Band 6 - Surgical (New Maternity) Band 7 - Team Leader Surgery (Maternity Leave - Unavailable Oct 09 onward) These vacancies will have a severe impact on the continued delivery of services. - Increased workload for remaining OT staff to ensure D/C targets met within CAH - Patients having to wait longer to have OT assessments / treatment increasing the risk for potential delayed discharges. Any vacancies in current staffing compliment are inadequate to meet the changing needs that are occurring due to increased outpatient and inpatient activity combined with the current reconfiguration of acute services. See attached 2006 - 2008 Acute Pressures. Referral Trends from acute medical wards. Excel spreadsheet indicating vacancies & Areas affected. Client - Physical / Functional and equipment needs of patients may not be met for discharge from CAH - Reduced quality of service to patients / families - Failure to meet trust standards / best practice guidance / College of OT Professional Standards. Staff - Increased work stress for staff - Increased time spent trying to prioritise caseload reducing patient contact - Reputation of service - Exposure of staff to abuse. Organisation - Poor Publicity. - Loss of functional assessment for signposting	1.Staff undertaking additional duties. 2.Staff focusing on D/C targets to maintain patient flow - compromising the quality of intervention. 3.Staff have clear guidelines re documentation. 4.Additional training to be arranged to cover specific areas (compounded by annual leave and sick leave) 5.Revision of Referral & Prioritization Criteria.		HIGH	DIV	25/02/2011
2374	01/10/2009	Safe, High Quality and Effective Care	Trustwide	Failure to comply with current decontamination testing standards for bedpan washers	Bed pan washers within the trust are not currently being tested to HTM2030 standards resulting in possible infection control risk to patients .	Limited range of testing provided quarterly by service contractor		MOD	HOS	12/02/2014
2709	19/11/2009	Provide safe, high quality careBe a great place to work	Physiotherapy	Unable to provide safe, high quality and effective care. Threat to staff safety & wellbeing.	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - No temporary or permanent recruitment into vacant posts.Reduced staffing levels - 1 WTE Band 6 Physiotherapy Rotational Post (Mat leave from 12.11.10), 1 WTE Band 6 Physiotherapy Rotational Post (S/L planned major surgery 11.11.10), 1 WTE Band 6 Physiotherapy Rotational Post (S/L from 27.9.10 - planned surgery 7.12.10), 1 WTE band 6 Physiotherapy Rotational Post (JS - Mat Leave from rotation onto acute 1.11.10), 1 WTE Band 6 Physiotherapy Rotational Post (career bread from July 2010) backfill by band 5 temporary post). 1 WTE Band 3 Physiotherapy Assistant (light duties following long period of sick leave). These vacancies present increased risk of staff becoming further fatigued, stressed and physically unwell due to lack of replacement staff. Unable to provide timely physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with Acute Head of AHPs and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc	Discussions initiated at HR review of AHP recruitment working group Vacancies for Band 5 & 6's funded posts - no additional resource required. Potential financial resources may be available from Swine flu training budget/Acute Physiotherapy. E Requisition activated on system. Historic funding confirmed by Management Accounts Feb 10.	HIGH	DIV	25/02/2011

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2524	19/11/2009	Safe, High Quality and Effective CareEffective user and community engagement and partnership	Wards	Unable to provide safe, high quality and effective physiotherapy care.	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - No temporary or permanent recruitment into vacant posts. Reduced staffing levels - 1 WTE Band 5 rotational post vacant from April 2009. No backfill. 1 WTE Band 6 rotational post vacant (career break) from June 2009. No backfill. Sickness absence levels increased week beginning 16/11/09 2 WTE Band 6's sick leave 1 WTE Band 3 sick leave 1 WTE Band 8a and 1 WTE Band 6 with musculoskeletal pain - currently remaining at work but potential for further injury / sick leave. Increased risk of staff becoming further fatigued, stressed and physically unwell. Unable to provide timely physiotherapy service to Inpatients resulting in poorer outcomes Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc		HIGH	DIV	01/10/2010
2394	02/12/2009	Provide safe, high quality careMake the best use of resources	MRI Craigavon Area Hospital	The Orthopaedic ICATs are still being sent to Independent sector for MRI scan due to demand outstripping capacity in SHSCT.	Financial risk for the Trust.	None	Write business case for additional MRI scanner and all associated costs 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW	DIREC	11/05/2010
2395	02/12/2009	Provide safe, high quality careMake the best use of resources	Trustwide	Equipment replacement	Potential for mis-diagnosis of patients due to poor images from old equipment which has not been replaced. Non adherence to NICE guidelines on replacement of equipment. Spare parts now sparce and difficult to source. Resulting in potential litigation and loss of reputation to Trust.	Regular down time with equipment - engineers service and repair regularily.	09.06.10 - approval for replacement CT in DHH. Implementation group set up with a view for completion Oct 2010. Screening room business case went to DHSSPS but no response as yet	HIGH	HOS	03/12/2013
2396	02/12/2009	Provide safe, high quality care	Wards	Plain film x-ray reporting by Radiologists	"Plain film x-ray reporting by Radiologists is currently 60% resulting the general wards CAH and A+E CAH not being reported by a radiologist. Potential for mis-diagnosis leading to non-treatment of life threatening conditions. Potential litigation and loss of reputation for the Trust"	Referring consultant looks at the x-ray and writes report in patients notes. The introduction of PACS will increase to throughput of the plain film reporting but will not completely remove the risk.	6.5.11 - The contract has been awarded and the directorate is working with the IS company to get the IT connected. We plan to have the pilot testing complete by next week (fri 3th June). It is expected to scan between 500-1000 per month.There is a daily 19 day escalation plan, which is working well. The tender should be up and running by end of June 2011. 09.06.10 - Plain film reporting backlog in CAH was complete 31.03.10 - 3000 plain films in total. New backlog still exists. Briefing/options papers submitted to Director for discussion at SMT 09.06.10. (RC)	HIGH	DIREC	27/01/2014
2638	08/12/2009	Provide safe, high quality care	Occupational Therapy Department	Quality of Outpatient Occupational Therapy Service for Trauma & Orthopaedics with Current Staffing Provision	Background to T&O Service: We are currently piloting an outpatient hand therapy service as a response to the demand for it by the new Trauma & Orthopaedic service. Staffing to address outpatient need was not included in the initial staffing bid. We are currently delivering this service using a rota so all staff have inpatient and outpatient contact to ensure there is an available skills mix. This workload includes assessment and treatment of new and review patients and one therapist to attend one weekly hand clinic session for wound care, "there and then" splinting, receipt of referrals and case discussion with the consultant. Urgent and non-urgent ad hoc referrals are made from other fracture/ orthopaedic clinics from Monday to Friday. The British Society of Hand Surgeons (2007) recommends that there are six WTE hand therapists for a population of 500,000. Our current staffing (based on the Capacity and Demand October 2008) has 1.5 WTE staff dedicated to delivering hand therapy, leaving a deficit of 2.23 WTE (or 1.73 WTE when Rheumatology staffing included). Prior to the opening of the T&O service there was no hand therapy service in the Southern Trust with patients from this Trust being traditionally seen in the Belfast Trust. Capacity and Demand showed in 2008 that the OT service was working at full capacity. Outpatient referrals have almost doubled since then Examples of Risk: 1. Safe, high quality and effective care. Quantity of treatment sessions offered is impeded by inpatient activity, staff attending meetings, staff on sick, annual and study leave Limited time for clinicians to create a learning environment and for service development (e.g. audit, journal club, research, protocol development) Service withdrawal or scaling down required if staff member off on leave (e.g. annual leave, sick leave, maternity leave) with direct impact on PFA targets Shared clinical space within the OT therapy room has no curtains therefore no patient privacy No wash hand basin in clinical area. Patients attend requiring re-dressing of wounds therefore risk of infection 2. Accessible and responsive care. Service users have difficulty accessing service to report CNAs, with queries, or to rearrange appointments etc due to no clerical support. This results in service user frustration and poor use of clinical time Limited time for adequate stock control, cleaning and maintenance of rehab devices. This is due to: Under provision of hand therapists Wide stretch of service demands (outpatients, ward activity, pre-operative assessment and home visits) with existing staff numbers which is not sustainable as the service grows or if any staff were to go on long-term sick leave 3. No clerical support - booking outpatients, cancellations, DNAs, telephone queries, Mesals, statistic collation, photocopying and letter typing (e.g. case reports, onward referrals). All of these are currently undertaken by clinical staff which is activity not built into the capacity and demand for the OT service in T&O 4. Unsuitable clinical space - await appropriate hand hygiene facilities and curtains for privacy and dignity 1. Client - Poor treatment outcomes for service user resulting in disability and dissatisfaction 2. Staff - Poor reputation of service, profession and individual professional registration could be affected	1. T&O Capacity and Demand document completed in October 2008 with Performance and Reform with one year review in October 2009 2. Introduction of capping monthly referrals from January 2010 to align with quantity of referrals identified as full capacity in October 2009. This will mean patients will be at more risk but staff will be protected in terms of registration/ acceptable workload etc. 3. Staff rota introduced for inpatient and outpatient to streamline service demands 4. Monthly Outpatient Group Supervision/ In-service commenced in June 2009 5. Senior and Clinical Lead OT are members of the College of Occupational Therapists Specialist Section in Trauma and Orthopaedics (the Clinical Lead OT is the NI representative for this group) 6. Senior and Clinical Lead OTs are members of the British Association of Hand Therapists and intend to work towards accreditation 7. Acute managers informed of work requests for OT outpatients (Pending)	Analysis completed (Sept 2009) Bid forwarded in April 2009 for additional two theatre lists. Bid forwarded in June 2009 for 6th Consultant. Bid forwarded for deficit of staff October 2009 To commence Daniel has 3 BAHT points and Emma has 1. Daniel and Emma attended accredited course in November 2009 (await points from this)	LOW	TEAM	03/02/2011
2420	14/12/2009		Macmillan Suite - Mandeville Unit	Administration of supportive blood transfusions.	Delays with administration of supportive blood transfusions resulting in delays of chemotherapy treatment and increased patient symptoms.	Waiting list created in an attempt to manage the patients, potential to use Hospice and day unit, however this has not been able to accommodate patients in the numbers or time frames required.		MOD	HOS	26/11/2013

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
2503	08/02/2010	Provide safe, high quality care	Cellular Pathology Lab	Temperature of the store falls well below the reagent manufacturers recommended storage temperature of 15 -25 degrees C.	In Winter the temperature of the store falls well below the reagent manufacturers recommended storage temperature range 15-25ºC. Temperature recorded for December '09 ranged from 9 to -9ºC. The storage of reagents outside the recommended temperature range may adversely affect the performance of any tests or procedures performed using these reagents. Inaccurate test results as a consequence of poor storage conditions of reagents may put patients at risk. The poor storage conditions of chemicals may adversely impact on the accreditation status of the Cellular Pathology Laboratory.	Reagents are brought into the laboratory and allowed to come up to room temperature before use. Deterioration of reagents caused by storage at low temperatures may not be reversed by simply elevating the reagent temperature before use.	Work on flammable store ie a thermostatically controlled radiator and a ceiling, was completed on 30.3.11	MOD	HOS	21/06/2011
2504	08/02/2010	Provide safe, high quality care	Cellular Pathology Lab	Body Fridge/freezers may fail or doors left unsecured causing permanent deterioration of the human tissue stored within	The Body Fridge or freezers may fail or be left with the doors unsecured so that the temperature of the human tissue stored within may rise causing permanent deterioration impacting on subsequent autopsy investigations. The greatest risk is on the DHH site as it is not permanently staffed and the body fridge has no alarm. Autopsy investigations may be compromised. Autopsy process may be compromised which may have implications for friends and relatives of the deceased and learning opportunities for medical and nursing staff may be lost which may impact on the future diagnosis and treatment of patients.	The alarm system for both the body fridge and the freezers in CAH is audible within the mortuary when staff are on site which allows staff to react to any of these system failures. Staff are only on the DHH site to release bodies and the mortuary is not permanently manned. There is an audible alarm on the freezer in DHH mortuary but not the body fridge. Body Fridge/Freezer alarms. These alarm systems on the body fridge (CAH) and freezers (CAH/DHH) do not alert staff when they are not on site in the mortuary.		LOW	DIV	07/01/2011
2639	11/02/2010	Provide safe, high quality care	Physiotherapy	Potential for misuse of physiotherapy equipment by patients	Risk of injury to patient, staff, or other patients through the misuse of physiotherapy equipment resulting in short term, semi-permanent or permanent physical injury. Risk to Trust reputation through increased likely hood of complaints/ litigation As part of physiotherapy treatment items of equipment may be loaned or issued to patients for use at ward level or at home. There is a risk that equipment may be misused by patients with potential to cause harm or serious injury to themselves, staff or other patients.	Physiotherapy staff assess patient's physical need for equipment Physiotherapy staff give patient instructions on use of equipment		LOW	HOS	24/07/2012
2721	11/02/2010	Provide safe, high quality care	Physiotherapy	Potential for misuse of physiotherapy equipment by patients	As part of physiotherapy treatment items of equipment may be loaned or issued to patients for use at ward level or at home. There is a risk that equipment may be misused by patients with potential to cause harm or serious injury to themselves, staff or other patients. Risk of injury to patient, staff, or other patients through the misuse of physiotherapy equipment resulting in short term, semi-permanent or permanent physical injury. Risk to Trust reputation through increased likely hood of complaints/ litigation	Physiotherapy staff assess patient's physical need for equipment. Physiotherapy staff give patient instructions on use of equipment	19 11 12 policy in place where patients given written instructions and ward staff advised when ward patient loaned equipment	LOW	TEAM	19/11/2012
2505	11/02/2010	Be a great place to work	Cellular Pathology Lab	Use of defective chairs in Dissection Area of the Cellular Pathology Lab	During a routine inspection of the chairs in CAH Laboratory on the 5/03/09, 5 chairs in use in the Dissection Area of the Cellular Pathology Laboratory were condemned and withdrawn from service by the Estate Services Department's Operations Manager, Colin Spiers. These chairs were returned to service as the risk to staff from performing dissections without chairs was deemed greater than the risk of using chairs which were condemned. These chairs were regarded as unsuitable or defective and therefore if staff were to sustain an injury as result of there use this may leave the Trust liable to litigation.	A non-stock requisition 2460482 for 5 chairs was completed and authorized by the Head of Laboratory Services along with a 'Statement of Need' on the 21/7/09. Forwarded and signed by Kate Corley the Locality Support Services Manager on the 7/08/09. Forwarded to Anita Carroll Assistant Director of Acute Services, Functional Support Services. Returned to Kate Corley with a query and passed back to Anita Carroll on the 9/1/10. Forwarded to the Director of Finance for authorisation who returned it to Cellular Pathology Lead to get the signature of Ronan Carroll, Assistant Director of Acute Services. Passed to Ronan Carroll, Assistant Director of Acute Services signed forwarded for authorisation to Dr G Rankin Interim Director of Acute Services. Rejected by Dr Rankin and returned to Ronan Carroll with the suggestion that it should be held over until the new financial year, then returned to Dr Rankin for authorisation.	Chairs were delivered on 10/08/2010	LOW	DIV	10/08/2010
2502	18/02/2010	Provide safe, high quality care	Cellular Pathology Lab	Ulster Anaesthetics unable to offer a full perventative maintenance contract for Shandon Gemini Staining Machine	Over 120,000 slides are stained on this staining machine per annum. The machine a Shandon Gemini, Serial No. 0022E9911, Asset No.45721, purchase date Sept 2002, purchase cost £12,500. This machine is manufactured by Thermo Scientific (Shandon) and serviced by Vector (Ulster Anaesthetics). Ulster Anaesthetics have informed me that next year they will not offer a full preventative maintenance contract as Thermo Scientific will no longer hold spare parts for this machine. If this machine fails all staining will have to be performed manually which equates with 0.5WTE BMS Band 6. This will reduce cervical screening output by 7,800 smears per year which equates with an 11 week backlog (if the machine is not replaced within 12 months). The NHSCSP turnaround target for cervical smears is 2 weeks from the smear is taken to the patient receives a result. The NHSCSP cervical smear turnaround target of 2 weeks will not be met. The diagnosis and treatment of cervical disease will be delayed. This will result in loss of reputation and possible litigation for the Trust.	None. Translating lost output in terms of cervical screening helps quantify the problem but does not manage the problem. Managing a cervical screening backlog via the on-call system reduces the level of commitment of these staff to existing on-call commitments and the annual cost is almost twice that of a new machine. Machine was delivered.			HOS	04/09/2012
2716	01/03/2010	Provide safe, high quality careMake the best use of resources	Occupational Therapy Department	Delay in recruiting to OT vacancies (maternity leave cover) - potential to compromise safety & quality of patient care	Delay in recruiting to OT vacancies (maternity leave cover) has the potential to compromise the safety and quality of patient care, the accessibility and responsiveness of our services and is not maximising the resource available. Current vacancies -Band 6 - Oncology & Palliative Care Team (Maternity Leave); Band 7 - Team Leader Surgery (Maternity Leave); Band 6 - Surgery (maternity leave) - maternity leave from 15th March. These vacancies will have a severe impact on the continued delivery of services.Increased workload for remaining OT staff to ensure D/C targets met within CAH.Patients having to wait longer to have OT assessments / treatment increasing the risk for potential delayed discharges. Any vacancies in current staffing compliment are inadequate to meet the changing needs that are occurring due to increased outpatient and inpatient activity combined with the current reconfiguration of acute services. Client: Physical / Functional and equipment needs of patients may not be met for discharge from CAH. Reduced quality of service to patients / families. Failure to meet trust standards / best practice guidance / College of OT Professional StandardsStaff. Increased work stress for staff. Increased time spent trying to prioritise caseload reducing patient contact. Reputation of service. Exposure of staff to abuse. Organisation: Poor Publicity. Loss of functional assessment for signposting towards appropriate community services. Poor performance against best practice.	1. Staff undertaking additional duties 2. Staff focusing on D/C targets to maintain patient flow - compromising the quality of intervention 3. Staff have clear guidelines re documentation 4. Additional training to be arranged to cover specific areas (compounded by annual leave and sick leave) 5. Revision of Referral & Prioritization Criteria.	Ongoing. Formal Risk Assessment for inpatient and outpatient services OT Team Leader attends daily flow meeting to ensure responsive accessible services. No OT Delays identified. All Staff working to an agreed Discharge plan. Monitored & Accountable. More effective than weekly MD meetings. (Nb. As of 08/02/10, unable to attend these now on surgical wards due to limited staffing) Delegated Referrals prioritised on a daily basis. Referral prioritisation template introduced to Surgical Wards on 08/02/10 will be maintained during period of reduced staffing. The template identifies High Risk patients referred to OT (e.g. living alone, confused and for discharge home) and ensures that this patients are seen in terms of such risks. This is based on a system used in the RVH acute OT setting. It will help minimise patient risk but it does not resolve issue potential unmet DOH targets. Revised criteria in place Waiting release of posts by acute scrutiny	MOD	HOS	03/02/2011
2719	01/03/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Potential physical harm to patients & staff in relation to manual handling/therapeutic handling practice.	Potential physical harm to patients and staff in relation to manual handling / therapeutic handling practice. Potential for short term, semi-permanent or permanent physical (in the first instance) injuries to patient and staff. Includes RIDDOR reportable incidents. Risk of litigation, complaints and reputation of the Trust. Increased risk of further injuries to staff secondary to post vacancies.	Provision of mandatory manual handling training to all staff. Staff complete regular risk assessments - generic & patient specific. Follow departmental manual handling guidelines including use of formal safe systems of work. Provision of appropriate manual handling equipment and provision of training in safe usage. Adequate and regular breaks.	9.11.16 no further update. 6 May 2015 Only 50% of staff with up to date training in place 27 11 13 no manual handling training currently available to physiotherapy staff 19 11 12 regular review of compliance with manual handling training regulations, awareness of trust policies and compliance with risk assessment processes	MOD	TEAM	06/06/2017
2642	01/03/2010	Provide safe, high quality care	Physiotherapy	Potential physical harm to patients and staff in relation to manual handling / therapeutic handling practice.	Potential for short term, semi-permanent or permanent physical (in the first instance) injuries to patient and staff. Includes RIDDOR reportable incidents. Risk of litigation, complaints and reputation of the Trust. Increased risk of further injuries to staff secondary to post vacancies. Potential physical harm to patients and staff in relation to manual handling / therapeutic handling practice	Provision of mandatory manual handling training to all staff Staff complete regular risk assessments - generic & patient specific Follow departmental manual handling guidelines including use of formal safe systems of work Provision of appropriate manual handling equipment and provision of training in safe usage. Adequate and regular breaks.		MOD	TEAM	03/02/2011

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2599	01/03/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Intensive Care Unit	Significant fire safety deficiencies in ICU CAH that require to be rectified to reduce the fire risk to an acceptable level.	Significant fire safety deficiencies in ICU CAH that require to be rectified to reduce the fire risk to an acceptable level.			LOW	HOS	12/02/2014
2708	01/03/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Unable to provide safe & effective high quality care to patients due to the replacement of vacant posts with lower grades	Unable to provide safe & effective high quality care to patients due to the replacement of vacant posts with lower grades of inexperienced staff. Decreased pool of senior staff to provide adequate supervision of lower grades. Changes in the optimum skill mix within the Inpatient Physiotherapy team has resulted in an increased number of less experienced, lower grade temporary staff working within the service. This could potentially lead to poorer treatment outcomes especially in the more demanding and complex patient. Potential of increased stress on junior staff required to carry a more complex caseload. Potential increase stress on senior staff - increase in inductions, supervision of junior staff, ensuring competencies met etc. High turnover of staff increases workload in these areas. Other professional responsibilities e.g. CPD, learning & development are neglected as a consequence of the shift in supervisory role. Current replacement of staff with lower grade in Physiotherapy Department CAH. 1 wte Band 6 Career Break from 16/7/10 replaced with Temporary Band 5 from 4/10/10. Inexperienced lower grades of physiotherapy staff will not have an advanced level of skill and experience required- there is the potential for poorer quality treatments and poorer outcomes for some patients with more complex problems. Increased risk of complaints and litigation against the Trust. Loss of professional credibility. Increased need for supervision and training due to increased staff turnover, recruitment & retention. Inability to meet professional standards - eg record keeping, informed consent. Potential for staff absences due to increased stress.	Adherence with SHSCT AHP Supervision Policy as able. Induction programme and assessment of core skills / competencies in place within dept. Inservice training as time allows.	Ongoing All recruitment held at scrutiny.	LOW	TEAM	19/11/2012
2718	01/03/2010	Maximise independence and choice for patients and clients	Physiotherapy	Lack of informed consent	Patients undergoing assessment or treatment to which they have not given valid consent. This is applicable to patients who are deemed to have full capacity. Risk of complaints, litigation and damage to Trust reputation. Psychological impact / harm to patient.	Adhere to SHSCT / Physiotherapy & CSP guidance on consent. Ongoing induction of staff re consent policies. Availability and completion of appropriate written SHSCT consent forms for invasive / high risk procedures e.g. Nasopharangeal / tracheal suctioning, vaginal / rectal internal examination, cardiac exercise tolerance testing, cervical manipulations, acupuncture. Written informed consent gained prior to assessment or treatment by a physiotherapy student / undergraduate. Availability of patient information leaflets / written information to assist in the decision making process.	19 11 12 consent polices and procedures covered in staff induction period	MOD	TEAM	19/11/2012
2720	01/03/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Risk of potential harm/ serious injury to patient or staff due to electrical shock or equipment failure or therapist error.	Potential of harm to patient or therapist due to electric shock, equipment failure or therapist error when using electrical modalities e.g. Curapulse, Ultrasound, TENS. Electrocution of patients or staff. Equipment failure resulting in physical harm. Therapist error resulting in physical harm to patient. Risk of complaints & litigation. Risk to Trust reputation.	Outside contractors maintain / service equipment as per servicing contract. Electrical checks carried out annually by Trust. SOP's in place for all high risk equipment. Adhere to SHSCT equipment management guidelines. Ongoing induction & competency training for all staff using equipment.	19 11 12 Team lead monitors competency and training for all rotational staff. Regular update training in place for less frequently used pieces of equipment and user manuals and SOPs available	LOW	TEAM	19/11/2012
2710	01/03/2010	Provide safe, high quality care	Physiotherapy	Delay in receiving prompt and appropriate attention following cardiac arrest	Patient, visitor or staff member may experience cardiac / respiratory arrest - potential for delay in receiving prompt and appropriate attention. Potential for serious injury or death. Loss of reputation of Trust. Increased risk of complaints and litigation.	Adhere to Physiotherapy Dept cardiac arrest policy/procedure. Availability of basic resuscitation equipment within Physiotherapy Dept Access to CPR trolley within main Outpatients Dept. Staff to be aware of location of closest CPR trolley. To attend BLS CPR training / update at least annually. Resuscitation Council guidelines flowchart on display in gym. Staffing levels optimum to ensure can position patient and call for help etc	19 11 12 regular monitoring of staff attendance at yearly CPR training	LOW	TEAM	19/11/2012
2515	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	2008 & 2009 Clinical Notes stored in Clinical space	2008 and 2009 Clinical notes stored in clinical space. Unable to utilise clinical space thus affecting client care. If clinical notes (8 cages) remain in clinical space staff and patients are vulnerable to injury due to restricted space for manual handling. Only option is to store cages in OT Corridor however this restricts fire exits and patients quality data protection control.			MOD	DIV	01/10/2010
2518	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	No wash hand basin in Hand Therapy Room	No wash hand basin in Hand Therapy Room. Patients attend with open wounds, no safe suitable washing facility for patient or staff. Risk of infection into open wounds.	Infection Control were informed in 2009 and advised the need for hand basin. Estates have been aware of this issue for 1 year.	19.02.14 Still no running water available 27 11 13 Wash hand basin now in situ but there is no running water available. October 2010 Costings for new sink with lever taps, provided by K Toner Estates 1/10/10 £1200 (senors taps £2500 but lever taps acceptable)	MOD	HOS	06/05/2015
2517	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	Lack of curtains in Hand Therapy Room and Rehab Room	No curtains in Hand Therapy Room and Rehab Room - No patient dignity - limited confidentiality	Risk Assessment Tem informed. Estates have been aware of this issue for 1 year.		LOW	DIV	01/10/2010
2516	09/03/2010	Provide safe, high quality care	Occupational Therapy Department	Carpet throughout OT Department not suitable due to infection Control issues	Carpet throughout OT Department clinical areas not suitable due to infection Control issues	Infection Control Team aware of this and advise this is not satisfactory	24.02.14 No further progress with this request Minor works form completed July 2011	LOW	HOS	06/05/2015
2726	12/03/2010	Be a great place to workProvide safe, high quality care	Nutrition & Dietetics	Vulnerability of worker due to working alone	Risk to employee: Being left alone at end of clinics. Visiting patient's with mental health problems/history of aggression. Travelling to and from remote areas with loss of mobile contact. Unaware of who is in the patients house and the frame of mind that patient or relatives/carer is in Potential religious discrimination Exposure of employees to additional health and safety risk while working alone. Risk to employee: Physical/psychological harm. Potential for litigation and complaint. Vulnerable to accusations e.g. physical harm/social/theft.	The dietetic department have developed a lone working policy. Communication systems have been set up to ensure that dietetic department are aware of staff whereabouts at all times with expected time of return to work. List of dietetic contacts for next of kin should member of staff not return home. Staff training on lone working policy/ management of violence and aggression/ MAPPA. Reporting of incidents. Communication system set up between referrer and dietetic department to ensure that 'at risk' patients are identified. Monitor working arrangements are feedback to head of Dietetic service.		LOW	TEAM	27/11/2013
2722	23/04/2010	Provide safe, high quality care	Orthoptic Clinic	Funded posts reduced by 50%. Current capacity reduced to levels where a safe and effective service is no longer possible	Orthoptic Clinic review patient slots converted into new patient assessments to ensure compliance with the Trust's 9 week target. eg. New patient assessments have been increased from 4 to an average of 8 per clinical session (10 patients in total per clinical session). Review patient slots converted into new patient assessments to ensure compliance with the Trust's 9 week target. eg. New patient assessments have been increased from 4 to an average of 8 per clinical session (10 patients in total per clinical session). The increased paperwork generated by each new patient is resulting staff working through lunch breaks and working late to deal with the increase. Increased sickness absence/reduced staff health and well being/reduced staff morale. There are currently some 2000 review patients who cannot be allocated appointments when scheduled -increasing at a rate of 200 per month. Children with reduced visual acuity are not receiving adequate review of home treatment plans. The monitoring of compliance and effectiveness of treatment is not occurring in a timely and appropriate manner. Clinical time is being wasted due to non-compliance and parents abandoning treatment. Long term damage to vision and treatment continuing unnecessarily may result without appropriate reviews. Pre and post operative assessments and appropriate referral to Ophthalmology are increasingly difficult to manage. The complex needs of many adult patients require close supervision- and changes in eye conditions may indicate a systemic change requiring referral to Ophthalmology. Again these patients are not being seen in a timely and appropriate manner increasing the risk of harm to this client group. Continued lack of capacity to carry out Health visitor/School Nurse training if left unchecked will seriously compromise the quality of new case referrals into the Department. Potential for loss of reputation and litigation for the Trust.	No control measures currently. An action plan cannot be formulated until staffing levels improve	24.07.12 Additional Saturday clinics to address review backlog. Vacancies recruited and due to take up post Autumn 2012. 23 05 11 Bid for additional staff in next quarter completed re tackling review backlog. Paper to be written.	HIGH	HOS	15/04/2013

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
2723	23/04/2010	Provide safe, high quality careBe a great place to work	Orthoptic Clinic	Reduced staffing levels have reduced the capacity to maintain & sustain AHP governance, workforce development & training	Current situation - Funded posts have been reduced by 30%. Current capacity has been reduced to levels where a safe and effective services is no longer possible. Review patient slots converted into new patient assessments to ensure compliance with the Trust's 9 week target. E.g. New patient assessments have been increased from 4 to an average of 8 per clinical session (10 patients in total per clinical session). The increased paperwork generated by each new patient is resulting staff working through lunch breaks and working late to deal with the increase. Increased sickness absence/reduced staff health and well being/reduced staff morale. There are currently some 2000 review patients who cannot be allocated appointments when scheduled -increasing at a rate of approximately 200 patients per month. Potential harm Re-Children. Children with reduced visual acuity are not receiving adequate review of home treatment plans hence visual problems may be over or under corrected. The monitoring of compliance and effectiveness of treatment is not occurring in a timely and appropriate manner. Clinical time is being wasted due to non-compliance and parents abandoning treatment. Long term damage to vision and treatment continuing unnecessarily may result without appropriate reviews. Pre and post operative assessments and appropriate referral to Ophthalmology are increasingly difficult to manage. Potential harm Re-Adults. The complex needs of many adult patients require close supervision and changes in eye conditions may indicate a systemic change requiring referral to Ophthalmology. Again these patients are not being seen in a timely and appropriate manner increasing the risk of harm to this client group. Continued lack of capacity to carry out Health visitor/School Nurse training if left unchecked will seriously compromise the quality of new case referrals into the Department. Potential for loss of reputation and litigation for the Trust.	E requisitions have been commenced for replacement staff, however in January 2010 the recruitment process was stopped just before interviews occurred.	24.07.12 Band 5/6 post now agreed as permenant. Director agreed to 1 wte temporary band 5/6 post until Head of Service post is filled. HOS post not agreed at meeting and A-D to join meeting on 4 June with chair of British & Irish Orthoptics society to discuss options for HOS post. 24.07.12 HOS post consolidated 01.01.11. Post passed by corporate scrutiny 26/5/10 for action by HR 27/5/10	HIGH	HOS	27/11/2013
2596	27/04/2010	Provide safe, high quality careMake the best use of resourcesMaximise independence and choice for patients and clients	Orthoptic Clinic	Staffing levels in Orthoptic Services - current situation = funded posts being reduced by 50 %	Review patient slots converted into new patient assessments to ensure compliance with targets. There are currently some 1800 review patients who cannot be allocated appointments when scheduled -increasing at a rate of 200 per month. All members of staff are currently unable to fulfil the Trust's requirements in terms of supervision and mandatory training nor requirements in terms of CPD. This poses a serious risk in terms of staff being able to stay registered with the HPC if this continues. e.g. Children referred with squint or lazy eye will not receive review of home programme hence effectiveness of patching and retraining of lazy eye muscles cannot be monitored resulting in long term damage to vision. There is currently no capacity to carry out Health visitor/School Nurse training which if left unchecked will seriously compromise the quality of new case referrals into the Department..Potential for loss of reputation and litigation for the Trust.	No control measures currently		MOD	HOS	03/02/2011
2597	27/04/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Staff Vacancies - Unable to provide safe, high quality and effective care.	Unable to provide timely physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc	19.02.14 Reviewed with C Mcll and staffing levels now improved 27 11 13 Vacant Band 6 funded post in recruitment cycle - staff due to commence 01 01 14. 2wte B7, 1.6wte B6, 1wte B5 maternity leaves with 1wte B5 backfill, 1wte B6 due to commence 01 03 14	MOD	HOS	06/05/2015
2711	28/04/2010	Provide safe, high quality careBe a great place to work	Occupational Therapy Department	Redeployed Band 6 O.T Post from DHH Stroke Team covering long term sick leave on rehabilitation ward	Increased workload for remaining O.T staff to ensure D/C targets met within DHH. Patients having to wait for longer to have O.T assessments/ Rx increasing risk for potential delayed discharges. Patients not receiving the indicated quantity and quality of inpatient rehabilitation treatment programme specific to their needs. Delayed discharge due to reduced intensity of rehabilitation and extended duration of inpatient stay to receive adequate rehabilitation to facilitate safe discharge. Reduced liaison with family /caregiver and therefore impaired information sharing. Current staffing on stroke completing additional duties to attempt to meet targets and comply with guidelines and Professional Standards of Practice. All staff focusing on D/C targets from acute medical and surgical wards - compromising the quality of care provided to rehab/stroke/brain injury/complex patients. §Physical / functional and equipment needs of patients may not be met for D/C from DHH and patients at risk of permanent physical / psychological / cognitive impairment.§Reduced quality and quantity of service to patients/ families. Failure to meet College of O.T. Professional Standards / HPC Standards of Proficiency. Failure to meet National Guidelines - RCP / NICE. Reduced ability to deliver on service targets. Risk of service complaints / increased time spent on dealing with complaints. Risk of litigation. Negative impact on staff morale. Increased risk of reduced health of staff - work related stress / fatigue with increased risk of absenteeism. Significant unmet need impacting on service delivery.	Staff following clear guidelines re: documentation. Additional training to be arranged to cover specific areas (compounded by A/L and S/L issues)			TEAM	03/02/2011
2712	28/04/2010	Provide safe, high quality care	Occupational Therapy Department	Lack of funding available for provision of small aids/assistive devices for inpatients DHH	Equitable services across the Southern Trust in relation to the provision of small aids e.g. feeding cups / leglifters/ dressing aids / devices to help hand function. Rehabilitation process and quality of care compromised resulting in the loss of patient independence. Additional support services recommended on discharge from DHH as a result of the small aids not being made available. Potential for delay in discharge if awaiting support services / need for Enhanced Intermediate Care Services on discharge. Patient at risk of further complications whilst remaining in hospital waiting on support services. Equipment needs of patients not met for discharge. Reduced quality service for patients. Excessive commissioning of care / support services. Risk of family / caregiver / patient complaints due to inequity across SHSCT. Risk of litigation. Negative impact on staff morale.	Proposal for patients to purchase own small aids / assistive devices from variety of local suppliers across southern area. Additional care / support services recommended on discharge from hospital.	19 11 12 Transforming community equipment work undertaken by Cynthia Cranston will direct this process which will be implemented across SHSCT	VLOW	TEAM	19/11/2012
2713	28/04/2010	Provide safe, high quality care	Occupational Therapy Department	Damaged Roho (Pressure Relieving) Cushions	Unable to complete a full postural / pressure relieving assessment using a Roho pressure relieving system. Patients unable to avail of appropriate OT Assessment / Intervention. Limitations on OT intervention without appropriate pressure relieving equipment being available. Impacts upon patients progress with rehabilitation. Reduced quality of service. Compromises the patients comfort / necessary pressure relief in suitable seating system. Equipment needs not being met whilst in DHH. Increased risk for potential delayed discharge due to necessary equipment not being made available	Liaising with Community O.T colleagues to ascertain whether cushions can be sought from OPPC / Community Stores across SHSCT. Liaising with Tissue Viability Team regarding the management of pressure sores when specialised Roho cushions are not available. Unmet need to be recorded with OT Documentation. Ongoing efforts to repair 3 - 4 Roho cushion	19 11 12 pressure relieving cushions in line with those available in community used for patient assessment and treatment in acute	VLOW	TEAM	27/11/2013
2704	30/04/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Unable to provide safe, high quality and effective care to T&O Inpatients. Threat to staff safety & wellbeing	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - No temporary or permanent recruitment into vacant posts.Reduced staffing levels. Vacant Posts include 1 WTE Band 3 Physiotherapy Assistant Rotational Post (Mat Leave from Jan 2010), 1 WTE Band 7 Physiotherapy Post (Mat leave from June 2010). These vacancies equate to 25% of the T&O physiotherapy staffing, therefore directly affecting service provision and also ability to maintain the 7 day service within this area. Vacancies present Increased risk of remaining staff becoming further fatigued, stressed and physically unwell due to lack of replacement staff. Unable to provide timely, effective physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver on service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale, unacceptable professional caseloads and casemix raising governance issues around competency, scope of practice experience. Capacity and demand issues which will impact on patient care, outcomes and defective discharges. Stress / fatigue of staff increased with an increased risk of absenteeism. Reduced ability to meet professional standards. Skill development and CPD etc will be impacted on as not able to release staff which will compromise patient care and effective service delivery. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc		MOD	DIV	25/02/2011
2706	01/05/2010	Be a great place to workProvide safe, high quality care	Physiotherapy	Potential for staff to experience violence or aggression from visitors, patients or other staff	Potential physical & psychological injury to staff as a result of verbal or physical abuse from visitors, patients or other staff. May result in short term, semi permanent, or permanent injury including physical, emotional trauma or harm. Staff at risk of physical or psychological injury as a result of aggression or violence. Loss of staff ability to work. Loss of earnings. Risk of complaints and litigation.	Avoidance of confrontational situations. Risk assessment of potentially dangerous situations. Ensure avoid lone working in potentially dangerous situations. Completion of training needs analysis for MAPA training. Attendance at MAPA Level 2 training / level 3 for Bluestone physiotherapy staff. Report all incidents & completion of appropriate documentation. Adherence to zero tolerance policy	19 11 12 continue to nominate staff for MAPA training	LOW	TEAM	27/11/2013

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2707	01/05/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Environmental failures e.g. poor flooring, lack of ventilation, inadequate storage facilities, resulting in harm to patients, st	Potential harm to staff, patients, visitors as a result of an environmental failure - EG. Slip, trip or fall as a consequence of faulty flooring; Inappropriate storage of equipment / lack of storage; lack of designated office space etc. Potential serious physical harm to an individual as a result of environmental failures. Risk to Trust reputation. Risk of complaints & litigation.	Regular Health & Safety checks at departmental level. Comply with regular Trust environmental audits and act upon recommendations. Reporting of any concerns, failure or faults to Estates, Support Services or Infection control. Follow SHSCT guideline on equipment management. Communication & education of staff	19 11 12 monitoring and feedback processes in place	LOW	TEAM	19/11/2012
2705	01/05/2010	Provide safe, high quality careBe a great place to work	Physiotherapy	Potential physical harm to patients & staff due to the risk of transmission of infectious diseases	Potential infection of staff when dealing with TB infected respiratory patients, also exposure to HIV, hepatitis and other transmissible diseases / infections / viruses eg. Norovirus, clostridium difficile. Risk of staff becoming infected with TB, HIV and hepatitis infections etc resulting in potentially serious illness. Risk of transmission of infection to patients or other staff members. Possible psychological effects. Loss of staff ability to work. Loss of earnings. Possibility of complaints or litigation.	Nominated infection control link person to attend regular training, meetings and feedback to staff. Document risk clearly on patient records. Availability of PPE. Regular training & updates for all staff. Staff advised on SHSCT infection control policies. Follow SOP's for high risk pieces of equipment eg ultrasonic nebuliser, IPPB	19 11 12 monitoring of staff attendance at infection control training and regular discussions with infection control staff re individual situations as they arise	LOW	TEAM	27/11/2013
2608	10/05/2010	Be a great place to work	Intensive Care Unit	Ergonomic risk to staff	Staff at increased ergonomic risk when transporting ICU supplies from metal cages to storage areas. At times loads are heavy at top of cages posing risk when staff are attempting to transfer them. High risk of back/neck injury.	All staff trained/educated in current ergonomic/manual handling policies, issues and legislation.	Attend annual mandatory training Store Manager assures that heavy loads are placed on lower part of cage, lighter loads are placed on top and cages should never be piled too high.	LOW	TEAM	12/02/2014
2641	18/05/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Occupational Therapy Department	Delay in recruiting to OT vacancies has potential to seriously compromise the safety & quality of patient care.	Delay in recruiting to OT vacancies has the potential to seriously compromise the safety and quality of patient care, the accessibility and responsiveness of services and is not maximising the resource available to contribute to overall system efficiency. Patients having to wait longer to have OT assessments / treatment increasing the risk for potential delayed discharges. Physical / Functional and equipment needs of patients may not be met for discharge from CAH.. Increased time spent trying to prioritise caseload reducing patient contact and service management time. Reputation of service. Exposure of staff to abuse. Loss of functional assessment for signposting towards appropriate community services. Poor performance against best practice.	Staff undertaking additional duties. Staff focusing on D/C targets to maintain patient flow - seriously compromising the quality of intervention . Staff have clear guidelines re documentation - but increasingly falling behind. Revision of Referral & Prioritisation Criteria carried out.	Ongoing. Formal Risk Assessment for inpatient and outpatient services OT Team Leader attends daily flow meeting to ensure responsive accessible services. No OT Delays identified All Staff working to an agreed Discharge plan. Monitored & Accountable More effective than weekly MD meetings.(Nb. As of 08/02/10, unable to attend these now on surgical wards due to limited staffing) Revised Criteria in place. Referral process standardised. Training of medical and nursing staff re referral/acceptance occurred in 2010/11. Waiting release of posts by acute scrutiny 19 11 12 temporary and permanent recruitment underway, process slow and gaps in staffing will remain until all posts are filled. Team leads have agreed process for minimising impact of vacancies across the 3 teams 24.07.12 Following review of AHP services, permanent posts filled. If post not backfilled as per proposal - withdraw service from Ward 2 South Medical from 1.2.11 due to continued risk of HARM.	LOW	HOS	06/05/2015
2637	18/05/2010	Provide safe, high quality care	Physiotherapy	Risk of potential harm/ serious injury to patient or staff due to electrical shock or equipment failure or therapist error.	Electrocution of patients or staff. Equipment failure resulting in physical harm. Therapist error resulting in physical harm to patient. Potential of harm to patient or therapist due to electric shock, equipment failure or therapist error when using electrical modalities E.g. Curapulse, Ultrasound, TENS Risk of complaints & litigation. Risk to Trust reputation.	Outside contractors maintain / service equipment as per servicing contract Electrical checks carried out annually by Trust SOP's in place for all high risk equipment Adhere to SHSCT equipment management guidelines Ongoing induction & competency training for all staff using equipment.		LOW	HOS	03/02/2011
2645	18/05/2010	Provide safe, high quality care	Nutrition & Dietetics	Lack of standardised, good quality, timely information being received from referral agents to Dietetic Services	Lack of standardised, good quality, timely information being received from referral agents (hospital, AHP, Health & Social Care professionals) to Dietetic Services has the potential to compromise patient care. The communication process between hospital and community teams are not clearly defined or easily understood and delivered on. Clear referral processes are not agreed for all teams when patients are being referred/transfer-Currently there are different referral criteria within the same service in different localities Existing processes have not been communicated effectively in some cases A inability of staff to be able to access appropriate referral documentation A failure of staff to adhere to agreed referral process The Specialist Services are often not receiving all of the information on time required to provide safe and effective care Failure of staff receiving the referral to pick it up on time Deterioration in patient condition through loss of opportunity for intervention or treatment, which may result in: Injury or potential harm to patient Increased stress for patient and carers Re-admission to hospital Damage to relationship and reputation of the professional/service and the Trust Potential for litigation and complaint Increased cost to Trust The likelihood of distress to staff due to lack of timely information, damage to interpersonal relationships, loss of professional integrity.	Return inappropriate/incomplete referral to the referral agent Introduction of MUST for wards to ensure appropriate		LOW	TEAM	03/02/2011
2646	18/05/2010	Provide safe, high quality care	Nutrition & Dietetics	The risk of Dietitians not delivering safe & effective, evidence based care to patients/clients	The risk of Dietitians not delivering safe and effective, evidence based care to patients / clients due to lack of protected time for learning and development, and local / regional networking. The demands of clinical caseload / workload can result in practitioners not accessing protected time for learning, development and networking. There is a risk that the Dietitian may not be suitably informed to provide the best evidence based care. The patient may not receive the best evidence based care. The professional may not be able to fulfil the commitments of the enhanced role of the Dietitian; which includes education of other health care professionals, development and implementation of policies and practice guidelines, service development and promotion. Local and regional networks will not be established / utilised leading to inequality of service provision. If Dietitians do not have access to / avail of education and local and regional networking appropriately the patient may not receive consistently high standards of care which could result in poor condition management, increased rate of complications, inappropriate hospital admissions and delayed discharges. Patients and carers could receive inconsistent treatment /advice / information / education leading to poor health outcomes, undue stress and damage to relationships (patient / professional and inter-professional. Staff morale can be adversely affected leading to frustration and stress. Other healthcare professionals may not have the opportunity to be updated on evidence based practice. Increased cost to the trust through inappropriate treatment . The trust may be exposed to complaint / litigation.	Professional registration and regulation Professional requirement for documented reflection on learning Access to Regional and National Guidelines Access to Local, Regional and National Specialist Interest Groups. Southern Health and Social Care Trust Policy on Clinical Governance which includes Clinical Supervision and Knowledge and Skills Framework Peer Supervision Groups Access to continued education		LOW	TEAM	03/02/2011

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2640	24/05/2010	Maximise independence and choice for patients and clients	Physiotherapy	Lack of informed consent.	Risk of complaints, litigation and damage to Trust reputation. Psychological impact / harm to patient. Patients undergoing assessment or treatment to which they have not given valid consent. This is applicable to patients who are deemed to have full capacity.	Adhere to SHSCT / Physiotherapy & CSP guidance on consent. Ongoing induction of staff re consent policies. Availability and completion of appropriate written SHSCT consent forms for invasive / high risk procedures E.g. Nasopharangeal / tracheal suctioning, vaginal / rectal internal examination, cardiac exercise tolerance testing, cervical manipulations, acupuncture. Written informed consent gained prior to assessment or treatment by a physiotherapy student / undergraduate. Availability of patient information leaflets / written information to assist in the decision making process.		MOD	HOS	03/02/2011
2643	25/05/2010	Provide safe, high quality careMake the best use of resources	Physiotherapy	Physio record storage DHH	Lack of space for storage of health records. Lack of clerical resources to provide adequate storage of physiotherapy cards for current patients. Lack of staff to deal with backlog of cards Failure to meet standards, Trust and CSP for the storage of records. -Breach of confidentiality with records being kept in treatment areas, gym, hydro rest room and hydro changing room -Failure to trace cards for medicolegal dept, DLA reports and the Compensation agency -Failure to access cards for therapist use with their patients. -Lack of clerical support for nearside admin staff to fulfil the duties of their post. -The increasing number of staff who use the space within Daisy Hill physiotherapy service from OPPC, Acute, C&YP and Phys Dis Directorates. -Increasing volume of patient activity within the Physio dept in DHH. -Lack of space in the Physio dept for storage of current records. -Lack of external space for storage of older records. -Lack of clerical support to deal with the disposal of records in a timely fashion. Failure to comply with standards have a negative impact on staff health due to distress due to loss of integrity and damage to interpersonal relationships. Damage to relationship and reputation of the physiotherapy service and Southern Trust. Potential Increased cost to Trust due to potential for litigation and	A room has recently been redesigned to accommodate the current year discharges which can accommodate 1 to 2 tears discharged cards but there is no staff to actually do it.		HIGH	DIV	25/02/2011
2649	28/05/2010	Provide safe, high quality care	Microbiology Lab	Increase in room temperature in the main microbiology laboratory has caused equipment failure for the Gene Xpert PCR machine	Increase in room temperature in the main microbiology laboratory has caused equipment failure for the Gene Xpert PCR machine which detects MRSA, Clostridium difficile and multi resistant tuberculosis. These dangerous organisms if uncontrolled will pose a serious infection control risk. In addition the BacT Alert Blood Culture Analyser which is used to diagnose septicaemia has overheated and if there were to be a period of extended hot weather it will fail rendering us unable to diagnose potentially life threatening infections in patients	Closing down equipment and placing oscillating fans where appropriate.	21.6.11 - Air conditioning has been provided	HIGH	HOS	21/06/2011
2680	14/06/2010	Provide safe, high quality careMake the best use of resources	Theatres	Wormald bipolar forceps with suction for uncontrolled Nasal Bleeding	Theatres are doing increasing amounts of Endonasal sinus surgery for Chr Rhino sinusitis, Nasal Polyposis and Excis of benign or "intermediate" Nasal tumours. Surgeons are currently experiencing problems securing haemostasis on some sphenopalatine arteries with "difficulty" anatomies. Sphenopalatines vessels can contract into sphenopalatines foramen - ultimately bleeding in a very inaccessible area behind the max sinus. If this happens patient might have to be operated through cheek out the back of max sinus and the int. maxillary aa clipped. In a bleeding patient this is a 2 hour procedure.	Currently use sphenopalatines clippers but had "case" recently where this instrument could not access the vessel and haemostasis took approximately 1 1/2 hours with many manoeuvres. Current control measures work most of the time but recent case highlighted that some anatomies are not suitable for this approach. (Willing to discuss further at any time).		MOD	TEAM	12/02/2014
2714	22/06/2010	Provide safe, high quality careBe a great place to work	Occupational Therapy Department	Unsuitable trolleys in A&E Department	Task - making transfer of patient from trolley to porters chair difficult. Individual - Risk for staff injuring themselves during transfer of patient. Load - Risk for patient being injured during transfer. Environment - Trolleys very high - do not lower to adequate height. Difficulty moving trolley. Risk to patient of injury. Risk to staff of injury. Failure to meet SHSCT Standards and not adhering to SHSCT Policy and Procedures in relation to safe moving and handling techniques.	Ensure risk assessment for safe moving and handling techniques is completed in advance. Ensure all risks are documented and communicated to staff working directly with the patient. SHSCT Moving and Handling Training Team informed of concerns. Ensure a 3rd member of staff is available to assist with transfer of patients if risks identified.	19 11 12 manual handling team have reviewed equipment (trolleys and transfer equipment) in ED departments	VLOW	TEAM	19/11/2012
2717	24/06/2010	Provide safe, high quality care	Occupational Therapy Department	Quality of Outpatient Occupational Therapy Service for Trauma & Orthopaedics with Current Staffing Provision	Pilot of outpatient hand therapy service Staffing to address outpatient need was not included in the initial staffing bid. Urgent and non-urgent ad hoc referrals are made from other fracture/ orthopaedic clinics from Monday to Friday Difficulty maintaining responsiveness to in patient and out patient requirements	1. T&O Capacity and Demand undertaken. 2. Staff rotations introduced for inpatient and outpatient to streamline service inputs 3. Acute managers informed of work requests for OT outpatients	Analysis completed (Sept 2009) 27 11 13 Bid submitted for additional staffing under increased numbers of T&O consultants - awaiting outcome from commissioner 19 11 12 Bid submitted for end of year monies to deal with workload created by T&O use of Independent sector. and request for review of need for permanent additional funding 2009- Bid forwarded in April 2009 for additional two theatre lists. Bid forwarded in June 2009 for 6th Consultant. Bid forwarded for deficit of staff October 2009 To commence Daniel has 3 BAHT points and Emma has 1. Daniel and Emma attended accredited course in November 2009 (await points from this)	MOD	TEAM	06/05/2015
2724	24/06/2010	Provide safe, high quality careMake the best use of resources	Bio-chemistry Lab	Problems with ROCHE Analysers	Problems with ROCHE analysers. There have been an excessive number of faults with the ROCHE analysers in Biochemistry both in Craigavon and Daisy Hill over the past few months. This has caused a delay in the reporting of results, at times with an increased risk of erroneous results being produced which has the potential to impact the patient.	Performing preventative maintenance as per manufacturers instructions. All analyser faults are immediately reported to ROCHE diagnostics fault desk for engineering response. Extra vigilance is required when releasing results.	The frequency of call outs has reduced.	LOW	HOS	02/08/2012
2725	28/06/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Physiotherapy	Lack of space/clerical resources to provide adequate storage of physiotherapy cards for current patients	Lack of space for storage of health records. Lack of clerical resources to provide adequate storage of physiotherapy cards for current patients. Lack of staff to deal with backlog of cards. Failure to meet standards, Trust and CSP for the storage of records. Breach of confidentiality with records being kept in treatment areas, gym, hydro rest room and hydro changing room. Failure to trace cards for medicolegal dept, DLA reports and the Compensation agency. Failure to access cards for therapist use with their patients. Lack of clerical support for nearside admin staff to fulfil the duties of their post. The increasing number of staff who use the space within Daisy Hill physiotherapy service from OPPC, Acute, C&YP and Phys Dis Directorates. Increasing volume of patient activity within the Physio dept in DHH. Lack of space in the Physio dept for storage of current records. Lack of external space for storage of older records. Lack of clerical support to deal with the disposal of records in a timely fashion. Failure to comply with standards has a negative impact on staff health due to distress due to loss of integrity and damage to interpersonal relationships. Damage to relationship and reputation of the physiotherapy service and Southern Trust. Potential increased cost to Trust due to potential for litigation and complaints.	A room has recently been redesigned to accommodate the current year discharges which can accommodate 1 to 2 years discharged cards but there is no staff to actually do it.	Team Leads to co-ordinate if staff are put in place 19 11 12 filing of records almost complete	HIGH	HOS	27/11/2013
2727	28/06/2010	Provide safe, high quality care	Nutrition & Dietetics	Lack of standardised/good quality/timely info received from referral agents (hosp, AHP, H&SC professionals - Dietetic Services	Lack of standardised, good quality, timely information being received from referral agents (hospital, AHP, Health & Social Care professionals) to Dietetic Services has the potential to compromise patient care. The communication process between hospital and community teams are not clearly defined or easily understood and delivered on: Clear referral processes are not agreed for all teams when patients are being referred/transfer. Currently there are different referral criteria within the same service in different localities. Existing processes have not been communicated effectively in some cases. A inability of staff to be able to access appropriate referral documentation. A failure of staff to adhere to agreed referral process. The Specialist Services are often not receiving all of the information on time required to provide safe and effective care. Failure of staff receiving the referral to pick it up on time. Deterioration in patient condition through loss of opportunity for intervention or treatment, which may result in: Injury or potential harm to patient. Increased stress for patient and carers. Re-admission to hospital. Damage to relationship and reputation of the professional/service and the Trust. Potential for litigation and complaint. Increased cost to Trust. The likelihood of distress to staff due to lack of timely information, damage to interpersonal relationships, loss of professional integrity. Exposure of staff to abuse.	Return inappropriate/incomplete referral to the referral agent. Introduction of MUST for wards to ensure appropriate		MOD	TEAM	27/11/2013

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
2728	28/06/2010	Provide safe, high quality care	Nutrition & Dietetics	Risk of Dietitians not delivering safe & effective care to patients due to lack of protected time for learning & development	The risk of Dietitians not delivering safe and effective, evidence based care to patients / clients due to lack of protected time for learning and development, and local / regional networking. The demands of clinical caseload / workload can result in practitioners not accessing protected time for learning, development and networking. There is a risk that the Dietitian may not be suitably informed to provide the best evidence based care. The patient may not receive the best evidence based care. The professional may not be able to fulfil the commitments of the enhanced role of the Dietitian; which includes education of other health care professionals, development and implementation of policies and practice guidelines, service development and promotion. Local and regional networks will not be established / utilised leading to inequality of service provision. If Dietitians do not have access to / avail of education and local and regional networking appropriately the patient may not receive consistently high standards of care which could result in poor condition management, increased rate of complications, inappropriate hospital admissions and delayed discharges. Patients and carers could receive inconsistent treatment /advice / information / education leading to poor health outcomes, undue stress and damage to relationships (patient / professional and inter-professional). Staff morale can be adversely affected leading to frustration and stress. Other healthcare professionals may not have the opportunity to be updated on evidence based practice. Increased cost to the Trust through inappropriate treatment. The Trust may be exposed to complaint / litigation	Professional registration and regulation. Professional requirement for documented reflection on learning. Access to Regional and National Guidelines. Access to Local, Regional and National Specialist Interest Groups. Southern Health and Social Care Trust Policy on Clinical Governance which includes Clinical Supervision and Knowledge and Skills Framework. Peer Supervision Groups. Access to continued education.		MOD	TEAM	27/11/2013
2730	30/06/2010	Make the best use of resourcesBe a good social partner within our local communitiesProvide safe, high quality care	Cellular Pathology Lab	The Body Fridge in DHH Mortuary unavailable for use from the 26/5/10.	Bodies may be released to undertakers which have not been stored in optimal conditions and therefore the process of decomposition may be accelerated. James Details	Bodies to be stored in the Chapel of Rest as this room is slightly cooler than other rooms in the mortuary. This is a temporary arrangement while work on the body fridges continues. The Chapel of Rest does not provide the optimal temperature required to stabilize or slow deterioration of the body. Bodies are to be released to the undertaker as quickly as possible. On Friday 25th June arrangement put in place to transfer bodies to CAH, if the undertaker cannot be contacted to organise a quick release the bodies are transferred to CAH Mortuary.	Authorisation from Ronan Carroll (Assistant Director of Acute Services) for Brian to arrange with Cecil Renshaw (Estate Services DHH) to install a portable air conditioning unit in the Chapel of Rest Dr G Rankin (Director of Acute Services) has identified funding (23/6/10). Brian Magee awaiting confirmation that he can proceed with the procurement and installation of body fridges.	HIGH	DIREC	01/07/2010
2747	22/07/2010	Provide safe, high quality careBe a great place to work	MRI Craigavon Area Hospital	Risk to patients and staff unsing the MRI compatible wheelchair	Risk of injury/fall to patients and staff when transferring or transporting with the MRI compatible wheelchair. Wheelchair is poor design but only 2 prototypes available, brakes insufficient and lever constantly works loose so screws fall off. Safe working load is only 113kg (18st). Due to proximity of wheel rim to arm rest fingers may be trapped. No sideways transfer possible as wheelguard and wheel stick up. Sling seat. Potential of serious injury/harm to both patients and staff. This may result in litigation or staff shortages as a result of back problems. Only MRI compatible wheelchair may enter scanner room. As a result of strong magnetic environment normal manual handling aids are not permissible. Patients are frequently more that 18 st in weight	Manual handling performed on a yearly basis in the MRI Department to reflect the unique problems associated with the area.		MOD	HOS	03/12/2013
2748	29/07/2010	Provide safe, high quality careMaximise independence and choice for patients and clients	Occupational Therapy Department	No neurological spinting service post discharge from hospital - Assessment/ provision and review	Clients at risk of developing contractures, pain and increased tone if not assessed for and prescribed with a theraplastic splint if the need indicated. Risk to client - Pain / permanent injury - boney changes / lack of function / Risk to care giver - Increased demands for management of upper limb positioning self care / pain and discomfort of client. Risk to organisation - Failure to met national standards and guidelines of good practice. Significant unmet need impacting on service delivery. Reduced ability to deliver on service targets. Risk of litigation and loss of reputation. Risk of service complaints / increased time dealing with complaints.	Referrals currently returned to source GP / COT with letter of explanation regarding gap in service. Currently 'good will' service to selected clients to however no review service for same List of unmet need recorded and provided to operational and professional lead. Review of policy / guidelines for evidence base and maintain good practice. Liaise directly with line manager operational and professional to identify business case to met gap in service and unmet need.	19 11 12 OT post has been employed across SHSCT to provide assessment and provision of neuro splinting (Based Portadown HC)	MOD	TEAM	19/11/2012
2749	29/07/2010	Provide safe, high quality careMaximise independence and choice for patients and clients	Occupational Therapy Department	Damaged specialised seating systems Inappropriate use of specialised seating systems	Patients with complex needs are at risk of not having postural/pressure relieving needs fully met. Patients unable to avail of appropriate OT assessment and intervention. Moving and Handling risks to patients and staff due to damaged/broken seating systems. Patients likely to be increasing dependent/spend longer times in bed delaying rehabilitation. Increased risk of postural changes and risk of deformity. Loss of sitting balance from long periods of bedrest. Increased respiratory complications from lack of appropriate seating to seat patients in. Increased incidence of pressure damage from patients being seated in seating systems with damaged pressure relief. Inappropriate use of seating systems for 'restraint' has potential harm to health and well being of patients and staff, also cause damage to the chairs	Monthly check and record of available chairs for safe use on ward. Broken chairs taken out of use. Monitoring of correct use at ward level. Liaison with AHP Lead re: chair repairs. Forward NSR to relevant manufacturers.		MOD	TEAM	27/11/2013
2779	31/08/2010	Provide safe, high quality careBe a great place to work	X-Ray Dept	Risk of fall and potential serious harm to patients and staff	Sink in toilet area is not large enough when patient/staff/others are washing their hands and water is spilling over onto floor resulting in risk of fall and potential serious harm. Potential for litigation and loss of reputation for the Trust.	Regular mopping by domestic services. Paper towels available in the toilet for patients and staff to place on floor when floor gets wet. Patients and staff do not always dry the floor when it becomes wet.	02.05.12 Sink replaced	MOD	HOS	02/05/2012
2787	09/09/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsBe a great place to workMake the best use of resources	Radiology, Daisy Hill Hosptial	New CT scanning service - initial limited service	Inappropriate staffing levels leading to compromise for patient safety, care and staff safety. This results in increased clinical incidents, increased numbers of falls, sick leave with decreased staff morale, staff unable to get breaks, Breach of terms and condtions of employment, poor documentation, unable to maintain Trust policies and guidelines (e.g. Manual handling). Requires education and training of staff in a short time frame leading to the potential for harm or death. Potential for misdiagnosis and re-scanning of patient resulting in over radiation going against IRMER guidelines. Potential for litigation and loss of reputation for the trust. Provision for Radiographer Cranial CT reporting will not be possible during the time of staff training therefore leading to increased waiting times and ineffective use of radiographer skills and resources.	Core team - education and training required. Application specialist onsite for initial 5 days, deemed insufficient by other sites who have undergone the same process of installation, implementation and provision of service. Rotas to be revised to facilitate training - knock on effect on staffing levels in the Radiology Department . Currently staffing levels are One dedicated CT radiographer and One general radiographer Control measures considered but discounted and why: Staff already trained in other sites to work alongside DHH staff throughout interim period (Daily and on-call) Potential to reduce lists to facilitate staff training (patients to be scanned at alternative site to ensure no breachers and compliance with Waiting List Initiative. Staffing levels to be comparable with other sites within the trust to ensure the provision of a safe, high quality CT service (four staff members - two dedicated CT radiographers, one general radiographer and one helper).		HIGH	DIV	06/01/2011
2786	09/09/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeing	Neurophysiology Dept	Risk of adverse outcome from withdrawal of additional capacity for neurophysiology service	1.Delayed diagnosis of disorders that are potentially disabling if diagnosis or treatment is delayed - including entrapment neuropathy especially ulner nerve entrapment, inflammatory neuropathies, inflammatory myopathies, and reduction in quality of life for people with suspected carpal tunnel syndrome. 2.Misdiagnosis - if treatment proceeds on an empiric basis there is a risk of correct treatment being given (with risk) in a patient with an incorrect diagnosis 3.Prognosis - Motor Neuron Disease is an incurable disorder but can only be diagnosed following EMG/NCS test. It is not possible to give patient this devastating and important advice without knowledge of tests results. 4.Loss of reputation of SHSCT - the waiting list for this test will rise exponentially, and this is likely to lead to adverse publicity, and loss of confidence in SHSCT services. Delayed diagnosis, reduced quality of life, incorrect treatment or inappropriate treatment, use of corticosteroids with accurate diagnosis, inability to manage MND according to Standard Practice, delays in diagnosis of acute illness such as Guillain Barre Syndrome, Loss of SHSCT reputation.	Urgent referrals have been forwarded to Belfast Trust. Await guidance on routine referrals.	1/3/12 - TO BE CLOSED. Regional waiting list for neruophysiology 28.10.11 Letter from Dr Rankin has been sent to all Consultant Referrers. 2/9/11 - A brief NCS options paper has been submitted to Belfast Trust for consideration. Await outcome. Reviewed 27.5.11 - Belfast Trust are now accepting all our NCS patients. The referrers have been contacted by the Director of Acute Services explaining the situation - no new referrals are coming into the Trust. Urgent referrals have been forwarded to Belfast Trust. Ongoing communication with Belfast Trust to create a central waiting list and service for Southern Trust patients	MOD	DIV	01/03/2012

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2788	15/09/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsBe a great place to workMake the best use of resources	Radiology, Craigavon Area Hospital	X-ray of immobile patients-Trauma and Orthopaedics	Manual Handling risk. Potential injury to patients during stationary grid placement and positioning-which is essential to radiographic examination. Potential of significant harm to new prosthesis with risk of further surgical correction requirements as a direct result of manual handling manoeuvres. Extreme likelihood of back injuries to staff performing examination- due to the manual handling manoeuvres necessary. Potential of litigation from patient and staff member injured. Patient injury as a direct result of stationary grid placement and positioning- essential to pelvic/abdominal/spinal examinations-risk of injury to patient: -opening of surgical wound site by necessary positioning movements; -injury to skin with sharp edges of grid cassette -bruising during positioning; -displacement of prosthesis-likelihood of surgical correction requirement. Radiographer injury-the physical manual requirements are such that extreme stress is placed upon radiographer's back and shoulders and abdominal strains/risk to severed fingertips (grid-placement) as a direct result of lack/inability of patient cooperation -all with potential for absences due to sickness. All the risks are substantially increased with: -patient size -staff availability (particularly on-call) -and the quality of the patient's bed mattress-inflation/firmness variability.	Trust Manual handling annual updates provided to all staff members. Staff awarene Control measures considered but discounted and why: Presently inadequate as too many variables beyond staff control-significant risk to all involved in these examinations. -patient co-operation post surgery- -patient dimensions- -mattress firmness -additional staff availability to promote adequate manual handling techniques -time constraints All of the above measures are negated should the patient arrive to the x-ray department on a dedicated x-ray trolley with grid tray. Patient's inability to cooperate no longer an issue as they are not required to move during the examination. Patient dimensions are no longer an issue as staff no longer have to perform stationary grid placements and positioning. Mattress firmness-no longer an issue-dedicated trolley-adequate and constant firmness Additional staff-no longer an issue as one radiographer can safely perform examination Time constraints-no longer an issue as radiographic examination carried out more quickly and safely.			HOS	10/08/2013
2789	28/09/2010	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Patient not being informed of the risks and benefits of transfusion (if condition permits).	Patient not being informed of the risks and benefits of transfusion (if condition permits). Leading to the patient not receiving adequate information regarding the risks and benefits of blood transfusion. Patient may be unaware of the consequences of transfusion e.g. if a patient is a blood donor they will be removed from the donor panel; patient may develop an adverse reaction to the blood transfusion and may be unaware of the symptoms to report to clinical staff.	Staff involved in the request or collection of blood components must have completed the relevant competency assessment in accordance with the NPSA "Right Patient, Right Blood" initiative. Staff must adhere to the SHSCT Blood Transfusion Policy and all blood components must be prescribed on the Integrated Blood Component and Prescription chart and all appropriate sections completed. Patients must be provided with the appropriate blood transfusion leaflet and these must be readily available at ward level. Bi-annual self inspection of the provision of leaflets to patients performed.		VLOW	TEAM	18/12/2013
2790	28/09/2010	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Risk to patient when total fluid volume of blood component transfused is not recorded on the patient's intake and output chart	Risk to patient when the total fluid volume of blood components transfused is not being recorded on the patient's intake and output chart. Potential for patient to develop fluid overload. Potential harm to patient which may result in morbidity or mortality.	The Integrated Blood Component Prescription and Transfusion record is used for the prescription of all blood components throughout the SHSCT. The prescription sheet clearly documents that the total fluid volume must be recorded on the intake and output chart. Self inspection audits of the documentation process are undertaken on a quarterly basis to assess compliance of this requirement. Education sessions include the use of the Integrated Blood Component and Prescription record and the need to ensure that the total volume is recorded on intake and output chart.		VLOW	TEAM	18/12/2013
2884	19/01/2011	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	Macmillan Suite - Mandeville Unit	Staff stress	Dealing with young patients and family with complex needs. Staff sickness levels increase. Deterioration in staff health and well being. Breakdown in communication within team. Dealing with complex patients - end of life. Dealing with prolonged sickness and staff shortages. Increase workload in team. Effects on generic team dealing with lung and gynae patients if staff off who deal specifically with this group of palliative patients. Increased sickness levels. Breakdown in service provision for patients and their families.	All managers to identify stress issues in staff. Advanced communication training. Identify stressors and ways of alleviating these. Use 'Managing Stress in the Workplace' policy. Clinical supervision, appraisals. Monitor generic/specialist teams.		MOD	HOS	26/11/2013
2886	20/01/2011	Provide safe, high quality careMake the best use of resources	Macmillan Suite - Mandeville Unit	Independent Nurse Prescribing.	The patient prescribed a drug they are allergic to: Prescribing the wrong dosage of drug. Inappropriate prescribing.	All nurses who prescribe drugs must have completed their nurse prescribing course. Are registered with NMC as a nurse prescriber and on trust register as independent prescriber and on job description.			HOS	26/11/2013
2887	20/01/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	Information in boxes on floor.	Staff injury. Staff falling over boxes - nurses, cleaning staff.	Shelves to remove information literature off floor. All staff to ensure free access to office and keep office tidy. Division of desks to ensure staff are not stretching over desks to reach shelves.			HOS	20/03/2012
2885	20/01/2011	Provide safe, high quality careBe a great place to workMake the best use of resources	Macmillan Suite - Mandeville Unit	Using computer for prolonged periods.D.S.E user	Eye Damage Repetitive strain injury Postural problems Staff using computer may need individual assessment to identify DSE users .work desk and work chair assessment	2 members of staff using computers for prolonged periods Complete display screen record form for managers.		VLOW	HOS	20/03/2012
2900	01/02/2011	Safe, High Quality and Effective Care	Physiotherapy	Lack of designated accommodation for acute physiotherapy staff in physio Department.	Lack of designated accommodation for acute physiotherapy staff in physio Department. Lack of access for acute staff to use currently designated room during hydrotherapy to maintain patient records in compliance with Corporate and Professional standards of care. Risk of cross infection to hydrotherapy patients from acute ward staff. Current location is dual function i.e. hydrotherapy changing area for patients and duty room for ward physiotherapy staff. - Infection Control staff have reported this is unacceptable. Risk of Infection with staff using shared corridor for other uses ie, photocopier, ice machine, stationery which are in that same area. Risk of compromising dignity of children and adults with complex disabilities and staff dignity. Patient confidentiality will be compromised. Poorly designed and inadequate number of work stations for clinical staff to carry out their indirect patient duties and complete record keeping and IT duties could result in poor ergonomics and cause harm to staff. Inadequate storage space for clinical records - currently being stored in clinical areas (hydrotherapy changing room, gym area). Risk of fire from inadequate record storage areas whereby records are stored in the gym, stationary store & patient changing areas. Difficulty in maintaining cleanliness due to high volume of staff can risk falling short of Environmental cleanliness standards. Risk of complaints from staff and service users. Risk of cross infection due to ward staff frequently accessing clinical area for patients. Potential for complaints due to lack of privacy due to patients needing to dress in office environment. Potential for musculoskeletal injury to staff members due to cramped working conditions for all staff. Potential for injury to patients in cramped conditions. Potential for breaches of confidentially which can lead to complaints. Potential for litigation. Potential for RIDDOR incidents.	1.Hydrotherapy pool has not been in use for over 2 years 2.Notice on door advising when patients are changing - ward staff do not enter 3.Overshoes used to decrease risk of contamination 4.Portable screens used to define area 5.Maximise use of storage for records and patient related stock and non-stock 6.Regular change of position of staff. 7.Compliance with manual handling training requirements for all staff 8.Regular cleaning and compliance with cleanliness audits 9.Ensure all health and safety legislation is adhered to. 10.Ensure adequate record keeping for all patients Above control measures (1-4) have now been discounted by Infection Control who advise they pose too high a risk to patient safety for the situation to continue when hydrotherapy is resumed.	27 11 13 awaiting shelving and cabinets and PC's to be fully installed Minor works form brought to attention of AD 12.01.11 Further email to A-D 25 01 11 re situation by C McIlroy 19 11 12 AD and HOS continue to investigate options for relocation of acute physiotherapy staff 25 01 11 Risk assessment forwarded to Acute AHP HOS	LOW	HOS	06/05/2015

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2912	09/02/2011	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Macmillan Suite - Mandeville Unit	Working to maximum capacity as a single worker and co-ordinating clinical trials which involve drugs with high risk side effects	Research Nurse unavailable due to other work commitments/ being at another clinic/ study leave/ Annual leave/Sick. Patients presenting to clinics/MDM's need to be screened within the timeframes of the study or they will become ineligible. Concerns about the protocol not being followed in the research nurse's absence. The research nurse attends clinics when patients are being assessed. There are often protocol specific investigations which need to be carried out. If there is no research nurse present, it is likely that these may not be done, resulting in protocol deviations. The clinical research nurse is responsible for data management and patient follow up in the Southern Trust, this is the essential gathering and dissemination of results and endpoints, which needs to be done in a timely fashion. This is very difficult as a lone worker working to maximum capacity. Patient not being screened and therefore being denied access to a clinical trial. Protocol deviations due to assessments/investigations being omitted. Dose adjustments/ side effects not being managed according to clinical trial protocol. Serious adverse events not being reported within 24 Hours as required by ICH GCP. Adverse events not being reported on Case report forms. Risk that a nurse/doctor trying to cover for research nurse could give incorrect patient information or misinterpret the protocol. Risk of Failing a MHRA trust inspection Risk of litigation to the trust/loss of reputation, due to patients care being managed within a clinical trials and a research nurse being absent.	Many Mandeville unit staff nurses have attended ICH GCP training. SOP's and guidelines are being written to guide staff in the research nurses absence. Link nurses have been appointed for specific clinical trials. Staff in the Mandeville unit are advised to contact Head of service and/or NI Cancer Trials Unit for further assistance. Copy of all protocols kept at unit/Ward level. Regular teaching for the ward/s, Mandeville unit, A&E and MAU (including DHH) is ongoing. Teaching and close liaison with the oncology nurse specialist and the A&E/MAU departments. Regular feedback with manager and raising as a concern at steering and committee meetings.	20.03.12 Second nurse appointed on a temporary basis for two years. Risk reduced. A job description and advertisement is being prepared to fill this post	LOW	HOS	26/11/2013
3173	25/02/2011	Provide safe, high quality care	Radiology, Craigavon Area Hospital	Temperature levels within the x-ray processing area	Temperature levels within the x-ray processing area are higher than the normal range which is 16 - 24 degrees Cent. In the processing area in CAH X-Ray Department there is a potential for the temperature to go above the acceptable range due to the heat eminating from the electrical equipment and the structure of the building. Staff and patients have the potential to become fatigued, dizzy, nauseous and faint due to loss of water and salt. This hot, dry air can increase the risk of eye and throat infections. In extreme cases this could lead to litigation should someone faint or collapse and injure themselves leading to loss of reputation to the Trust. The Trust is failing to meet their obligations.	Ensuring staff and patients have access to chilled water. The use of a small mobile air cooling system (minimal value). Use of fans (minimal value). Opening windows (Minimal value).		MOD		08/11/2012
3168	25/02/2011	Provide safe, high quality careBe a great place to work	X-Ray Dept	Risk of patients and staff tripping over loose carpet tiles outside the cubicles in Room 2 of Lurgan X-Ray	In room 2 in Lurgan there are loose carpet tiles causing an uneven surface. Staff whilst escorting patients from x-ray cubicles could trip and fall. Also patients themselves could trip and fall while leaving the cubicle for x-ray examination. Additionally, cleaners and maintenance staff could also be at risk of falling if working in the x-ray room. - Potential for persons to trip and fall causing harm to themselves - Possibility of legislation due to injury - Injuries could range from extremity injuries to more serious head and facial injuries. e.g. fractures/lacerations - Loss of reputation to Trust	Staff awareness of potential risk and verbal warning to patients, Carpet tiles have been repositioned to safest possible layout.		VLOW	HOS	17/11/2012
3172	03/03/2011	Provide safe, high quality careBe a great place to work	X-Ray Dept	Temperature Levels withing the Xray Department in Lurgan Hospital	Temperature levels within the x-ray department in Lurgan Hospital are unbearably hot as the heating cannot be turned down or off. As a result the temperature within the department probably exceeds the normal range which is 16 - 24 degrees Cent. This is due to the heat aminating from the electrical equipment, the structure of the building and the fact that the radiators cannot be turned down or off. Staff and patients have the potential to become fatigued, dizzy, nauseous and faint due to loss of water and salt. This hot, dry air can increase the risk of eye and throat infections. In extreme cases this could lead to litigation should someone faint or collapse and injure themselves leading to loss of reputation to the Trust. The Trust is failing to meet their obligations.	Use of fans (minimal value). Opening windows (minimal value)		MOD	HOS	03/12/2013
3174	04/03/2011	Provide safe, high quality care	Audiology Dept	Risk of misdiagnosis during testing as a result of failure to meet the minimum room standards	Risk of misdiagnosis during testing as a result of failure to meet the minimum room standards. Current accommodation is unsuitable as it does not meet the minimum British Society of Audiology (BSA) standards. There are a number of test rooms which are generally ok for testing. However one test room is not a soundproof test room. It has been sound treated but noise can be heard coming from the corridor, ie. footsteps, doors closing, conversations. Another room is used for tests with not separate observation room, which is recommended within audiology standards to alleviate noise levels and distraction. The Paediatric room cannot be used for diagnostic testing as it is only a sound treated room. Calibration tests were carried out in May 2009 which were ok but staff feel that does not give a true reflection due to the time of day the calibration was carried out.	Room is not to be used for diagnostic tests. It can only be used as a hearing aid fitting/repair room.	Estates have issued a quote for a replacement room and this has been forwarded to Head of Service. The test room has been downgraded to a Hearing Aid fitting room. The result is that all patients for diagnostic tests have to be seen in the one remaining test room. Delays at ENT clinics occur daily. Complaint received by ENT Consultant.	HIGH	HOS	03/12/2013
2915	07/03/2011	Be a great place to work	Cellular Pathology Lab	Staff member suffering from Chiari Malformation requires a saddle chair to prevent the axacerbation of symptoms	A member of staff suffering from the condition Chiari Malformation requires a saddle chair to prevent the exacerbation of symptoms whilst working in the various sections in the Cellular Pathology Laboratory.	Restricted range of duties - The member of staff does not cut routine tissue sections using a microtome as intense prolonged use of a microtome causes fatigue, discomfort and eventually pain. Frequent change of task with micro/mini breaks to prevent fatigue.	21.6.11 - Saddle chair provided. Saddle chair supplier sourced(Fred Storey, 5 High St, Comber, Tele. 91870033/23) and a 4 week trial of a saddle chair organised and trial commenced on the 14/10/10. Risk assessment placed on the laboratory's Q-pulse document control system on the 2/12/10 with a review date on the 1/2/11. Received and signed by the Assistant Director of Acute Services on the 3/12/10. CPL awaiting a copy of the risk assessment.	MOD	DIREC	21/06/2011
2918	25/03/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	Fire Safety	If a fire occurs there is the potential for harm/death of both patients, relatives and staff. Risks identified following a recent fire audit to include Cavity barrier / wall faults, smoke seals, fire escape signs, fire action notices, fire alarm maintenance, nominated and deputy fire officers and training, evacuation plan and drills, waste bins and housekeeping.	An action plan has been drafted in conjunction with fire officers and estates. Work is on-going to address the department issues for the unit staff, waste etc. however some areas within estates are outstanding as will require significant costs.		MOD	HOS	26/11/2013
2986	28/03/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	A confined working space and difficulty hearing intravenous pump alarms, in the chemotherapy preparation area has resulted in a	The Mandeville unit capacity increased which resulted in a treatment area expansion. Unfortunately the chemotherapy preparation area remained unchanged and is currently not fit for purpose. This has resulted in the actions and subsequent risks outlined above. In the event of a fire the door will not close independently. This increases the risk to patients, visitors and staff and may lead to the death of one or more persons. This action also breaches the legislation outlined in the SHSCT Fire Policy (page,13) If the door is closed there is a real risk of needle stick injury to staff working in a confined space. This breaches the health and safety at work regulations. If the door is closed staff are unable to safely monitor and respond to intravenous pump alarms. This compromises patient safety.	In the event of a fire staff have been advised to close the door. A Fire COSHH cabinet has been ordered for a store room awaiting renovation. This room has a fire door which when completed will have a keypad lock insitu. This will reduce the risks in the current preparation area.	26.11.13 Minor works approved for improvements	HIGH	HOS	14/11/2017
2987	28/03/2011	Provide safe, high quality careBe a great place to work	Macmillan Suite - Mandeville Unit	The patients kitchen door which is a designated fire door is continually propped open when domestic staff are in service.	In the event of a fire there is risk to patients, visitors and staff which may lead to the death of one or more persons. Domestic staff are at risk of injury from hot beverages while attempting to open the door while carrying trays or if the door is opened in on them while carrying a tray. There are several electrical appliances in this room. Hot water geezer, rotation toaster (previously caught fire) microwave, dishwasher, Electrical beverage serving trolley. This increases the risk. In the event of a fire the door will not close independently. This increases the risk to patients, visitors and staff and may lead to the death of one or more persons. This action also breaches the legislation outlined in the SHSCT Fire Policy (page,13) The door has no viewing panel which renders domestic staff at risk if the door is opened inward while they are carrying hot beverages on trays. (This is a continual process throughout the day and not confined to meal time) Domestic staff are also at risk trying to open and close the door while balancing trays with hot beverages.	Domestic staff have been advised to keep the fire door shut and to use the trolley beside the door to place trays while opening the door. The door must not be kept open throughout service. However they report that this is unworkable and the door continues to be propped open. The door is shut only when domestic staff are not on duty.		HIGH	HOS	26/11/2013

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
2942	07/04/2011	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Urology cancer pathway delays (also on SEC Divisional Risk Register ID 2943)	Patients on haematuria and prostate cancer pathways. Delays in first appointments, investigations and treatments. Patients with cancer being delayed in diagnostics and treatment pathways. Patients may be late diagnosed and have further advanced disease leading to poorer outcome. This may mean that a patient changes from potentially curative to palliative during the waiting period.	Identification of patients at risk ongoing. Detailing of capacity and demand ongoing to identify needed capacity and resources.	28/2/13 - As previous ongoing urology risks. 31/1/13 - Risk remains same within urology - haematuria 1st OP on both sites and 1 urologist has handed in their notice. 7/1/13 - As below, new consultants have started, however 1 has handed in their notice for post in the Belfast Trust. 23/11/12 - risks continue within Urology whole way through pathway. Additional flexi lists have been agreed and continued daily escalations. 1/11/12 - 2nd new urology consultant commenced today. ongoing urology risks remain high. 26/9/12 - Risks remain as previous 30/8/12 - Urology continues to remain high risk. However, new urology consultants commenced. Risk will decrease over next few months. Regional risks in PET, surgery, oncology 1st apointment continues. 30/7/12 - Urology remains high risk of breaching cancer pathway. New urology consultants commencing in next few weeks, risk should decrease over time. 22/6/12 - Urology remains high risk of breaching cancer pathway 25/5/12 - unchanged, risks continue 24/4/12 - continued cancer risks as below. 1 consultant urology post vacant - high risk to targets. 26/3/12- Continued cancer risks in urology, lung due to lack of capacity for 1st appointments & complex diagnostic pathways, Risk in gynae due to lack of capacity for theatre 1st definitive. impact of inability to downgrade and continuing regional capacity/operational issues for ENT. Regional risks due to capacity issues in PET, thoracic & plastic surgery. HoS to submit cancer access non-recurrent bids for 12/13. Ongoing escalations to HoS and ADs. 29/2/12 - Continued cancer risks in urology, lung and gynae due to lack of capacity for 1st appointments, complex diagnostic pathways, impact of inability to downgrade and continuing regional capacity/operational issues. Ongoing escalations to HoS and ADs. New prostate service changes commenced 26/9/11	MOD	DIV	22/04/2013
2944	11/04/2011	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Patients may receive a 'out of temp' Blood Component due to it not been appropiately packaged/accompanied by documentation	The Transfer of Blood Components that are not appropriately packaged or accompanied by documentation, necessary to ensure that the Trust is in accordance with the requirements of the Blood Safety and Quality Regulations (2005). Patients may receive a blood component that has been transfused 'out of temperature' control which may potentially lead to major morbidity and mortality. The Trust will be in breach of the BSQR requirement of 'unambiguous traceability' of all blood components.	Staff involved in the requesting of blood components must have attended relevant education sessions in accordance with the 'Right Patient. Right Blood' initiative, and be aware of the necessity to communication with blood bank staff if blood components are required to be transferred. The Blood Transfusion Policy (2010) must be adhered if blood in relation to the transfer of blood components. The Integrated Blood Component Chart includes advice for staff in the event that transfer may be required. Audit of the blood transfusion process in relation to transfer non-conformances (6 monthly).		VLOW	TEAM	18/12/2013
2969	22/04/2011	Provide safe, high quality careBe a great place to work	General Pathology Lab	Inadequate numbers of MLA and Admin staff to ensure appropriate turnaround of laboratory tests.	Inadequate numbers of MLA and Admin staff to ensure appropriate turnaround of laboratory tests. Also imminent retirements will leave the Biochemistry department with inadequate numbers of management staff.	Work is being prioritised to ensure that the most urgent samples are dealt with. E Requisition raised for replacement staff, paper forwarded to Assistant Director, letter forwarded to Director.		MOD	HOS	02/08/2012
2977	10/05/2011	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Trust fails to meet performance standard due to administrative pressure on the cancer coordinators tracking of cancer patients	Trust fails to meet performance standard due to administrative pressure on the cancer coordinators tracking of cancer patients on the pathway. Patient is delayed in diagnostics and treatment for cancer - 95% for patients on the 62 day pathway and 98% for patients on the 31 day pathway. Patients referred with suspected cancer are delayed on their cancer pathway due to lack of resources/ capacity to see in the time frame required within the cancer pathway. Delays experienced during coordinators bank holidays and annual leave throughout the year as no backfill available. In addition there has been an increase in the number of red flag referrals, and an increase in the number of Multi disciplinary meetings in operation (both local and regional). Key areas most at risk - urology, lung, Upper GI, gynae, skin, but all pathways under pressure. Patient delays leads to a poorer outcome for the patient's overall survival, or ability to have the optimum treatment for their cancer, and breach of targets.	A system for identifying suspected cancer patients in in use (red flag labeling). A tracking team are in place to monitor patients and identify patients at risk. Weekly meetings take place with the service administrator and coordinators to highlight risks. An escalation process is in place to expedite patients, where possible, to catch up time in the pathway.	29.2.12 CLOSE and place onto HoS Risk 28.10.11 Cancer admin risk paper has been amended and to be forwarded to Dr Rankin. 2.9.11 - Paper complete and to be forwarded to Dr Rankin for consideration. 12.8.11 - A paper is in draft detailing the requirement for additional support. Escalation processes continue.	HIGH	DIV	01/03/2012
2978	10/05/2011	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Trust fails to meet performance standard. Patient is delayed in diagnostics and treatment for cancer	Trust fails to meet performance standard. Patient is delayed in diagnostics and treatment for cancer - 95% for patients on the 62 day pathway and 98% for patients on the 31 day pathway. Patients referred with suspected cancer are delayed on their cancer pathway due to lack of resources/ capacity to see in the time frame required within the cancer pathway. Further delays experienced due to bank holidays and annual leave in April 2011. In addition there has been an increase in the number of red flag referrals. Key areas most at risk - urology, lung, Upper GI, gynae, but all pathways under pressure. Patient delays leads to a poorer outcome for the patient's overall survival, or ability to have the optimum treatment for their cancer.	A system for identifying suspected cancer patients in in use (red flag labeling). A tracking team are in place to monitor patients and identify patients at risk. An escalation process is in place to expedite patients, where possible, to catch up time in the pathway.	26.11.13 Patients continue to experience delays for PET scan - risk of breach	HIGH	HOS	14/11/2017
2980	13/05/2011	Provide safe, high quality care	Blood Transfusion Lab (Blood Bank)	Use of one plasma thawing device at both CAH and DHH blood bank laboratories limits the availability of FFP	Use of one plasma thawing device at both CAH and DHH blood bank laboratories limits the availability of FFP to 4 units every half hour i.e. maximum of 8 units per hour. This was considered inadequate at a meeting with Dr B Adams anaesthetist on 8/4/2011 for the management of massive blood loss patients in obstetrics	There is one plasma thawer available for use at each laboratory site. These require a minimum of 30mins to thaw FFP and have a maximum load of 4 units. An additional plasma thaw was purchased for CAH and DHH labs		HIGH	HOS	04/06/2013
2991	26/05/2011	Provide safe, high quality care	Trustwide	Cancer performance risk	Decrease in cancer performance from previous years. 10/11 = 85% for 62 day pathway. Highest risk is urology cancer pathways.	Escalation policy and action plans drafted. Meeting with urology teams. Working towards 1-stop clinics.	See Risk 2942	MOD	DIREC	07/12/2011
3003	16/06/2011	Provide safe, high quality careBe a great place to work	Cellular Pathology Lab	Inadequate storage space for blocks and slides in Cellular Pathology	Inadequate storage space for blocks and slides in Cellular Pathology. Blocks are currently stored in the corridor, highly combustible material - fire risk.	No Control Measures possible.	22.11.11 James Heaney reports that additional shelving has been erected in the Cellpath Slide/Block Store which provides an additional years storage.	MOD	HOS	22/11/2011
3167	08/07/2011	Provide safe, high quality care	X-Ray Dept	Risk of patients falling whilst being x-rayed for erect knee examinations in the X-ray room of Lurgan Hospital	- Potential for persons to fall causing harm to themselves - Possibility of litigation due to injury - Injuries could range from extremity injuries to more serious head and facial injuries. e.g. fractures/lacerations - Loss of reputation to Trust. In the x-ray room of Lurgan Hospital the x-ray tube does not extend low enough to the floor, meaning patients for knee examinations are required to climb two steps in order to have the examination. Additionally the patient is expected to turn around on the top (narrow) step to achieve the required anatomic position. Due to the design and ergonomics of the equipment available there is the potential for a patient to fall from a height or receive a twisting injury	Staff awareness of potential risk and verbal warning to patients. If patient is not physically able to cooperate with positioning then alternative imaging technique can be used and reason stated on RIS. Use of another member of staff to assist during positioning.		VLOW	HOS	17/11/2012

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3171	19/07/2011	Provide safe, high quality careMaximise independence and choice for patients and clientsMake the best use of resourcesBe a great place to workBe a good social partner within our local communities	X-Ray Dept	Risk of non replacement of Radiographers in CAH, Lurgan, PHC and Banbridge	Within CAH, Banbridge, Portadown HC and Lurgan X-ray departments there is a potential risk to the quality and delivery of patient care and service. For example less time available to provide a high standard of care to the patient, increased waiting times for x-ray examinations, lack of choice for patient appointments and potentially lists could be cancelled because of the reduced staffing levels within the departments. Service delivery will potentially be adversely affected as targets are not being met. Staffs health and wellbeing will be affected as workload and demands on staff increase, leading to decrease in staff morale, increase in stress levels and increase in absenteeism and sickness. Best use of equipment will be affected due to lack of staffing to operate the equipment e.g CT/MRI scanner. If a high quality of service is not provided local communities lose confidence in the service provider. There is a potential risk of injury to both client and staff due to lack of resources available for safe moving and handling of patients from chair/bed to x-ray couch and back again leading to potential clinical incidents, litigation and loss of reputation for the Trust. Potential risk of staff developing musculoskeletal injuries if they are constantly exposed to increased workloads with less time to rest and recover between examinations. Due to the increased pressure of work on the staff there is a high risk of mistakes occurring leading to misdiagnosis or increase of dose of patient due to either incorrect area x-rayed or incorrect ID check of patient leading to loss of reputation to the Trust and potential for clinical incidents and litigation. Non clinical duties eg: QA, H&S general housekeeping, records etc will suffer as staff struggle to meet the demands of patient service delivery. Potentially there may be an increase in the number of complaints from both the service users and patients leading to loss of reputation for the Trust.	Restricted choice of staff requests for leave. Staff are rotated at short notice to cover service demands. Restriction on number of staff released for mandatory training. Staff working late to meet service demand.		LOW	HOS	03/12/2013
3018	09/08/2011	Provide safe, high quality care	X-Ray Dept	Implementation of RQIA Recommendations in relation to 'Independent Review of Reporting Arrangements for Radiological Investigati	Implementation of RQIA Recommendations in relation to 'Independent Review of Reporting Arrangements for Radiological Investigations' March 2011	1. Action plan for final RQIA report in progress. 2. Daily Escalation process in place for Plain film reporting 3. Weekly business objects return on: Rolling backlog for all unreported plain film x-rays ie. films that remain unreported 28 days after examination undertaken (in line with DRTT standard for routine examinations 4. fortnightly performance report for SMT 5. Contract with independent provider to report Plain film X-rays	02.05.12 Ongoing as discussed with A Davidson 30.09.11 - 1. Action plan continues to be progressed 2. PF 19 day excalation continues and managed daily. Audit re IRMER compliance paper has been drafted sent to Dr Rankin for approval and presentation to AMD's. 5. Contact has been made with BSO re progressing a long term contract with the IS. Specification used for the 2nd IS contract being reviewed. However, risk is that due to the duration and the cost of the contract there is a legal requirement to proceed to EU tender - this can take up to 6 months.	MOD	CORP	
3023	10/08/2011	Be a great place to work	Blood Transfusion Lab (Blood Bank)	Current Blood Bank estate is unlikely to pass MHRA Inspection	Current Blood Bank estate is unlikely to pass MHRA Inspection. Flooring is a health and safety hazard.	None possible.		HIGH	HOS	02/08/2012
3028	26/08/2011		Cellular Pathology Lab	Staff shortages are adversely impacting on the quality of the Cellular Pathology Service	By 24 august 2011 3 BMS staff were off on long term sick or maternity leave. This equates to 18% of the WTE BMS staffing in Cellular Pathology. A further member of staff whose husband took a stroke on 19 August 2011 has the potential to be off, when included with existing staff off this equates to 23% of the WTE BMS staffing in Cellular Pathology. Coupled with annual leave commitments over the remaining August into October 11 period this reflects a reduction in WTE BMS staffing of 38%. the situation should improve after mid October 2011 with the WTE BMS staffing shortage due to maternity and long term sick falling to 12%.	All part-time BMS and MLA staff were asked if they would consider increasing their hours. One MLA has increased their hours from 0.6 WTE to 0.9 WTE effective from the 24 August 2011 to 30 November 2011.	One has increased their hours from 0.6 WTE to 0.9WTE effective from 24 August 2011 to 30 November 2011. 22.11.11 Temporary arrangements are now in place in the lead up to the accreditation visit. These arrangements include:-1 An increase in part time working hours for a member of staff. 2 An increase in overtime for key staff. 3 The transfer of a maximum of 150 cervical cytology tests per week for a six week period to the Western Trust for processing and reporting. On Monday 22 August 2011 the gynae cytology backlog was 400 smears. On Friday 26 August 2011 the gynae cytology backlog was 700 smears. An increase of 40% in 4 days. The gynae screening backlog will continue to be monitored. If the backlog reaches 1000 smears arrangements may have to be made to have it sent to another laboratory for screening and reporting.	MOD	DIREC	22/11/2011
3263	01/09/2011		Radiology, Craigavon Area Hospital	Mobile Image Intensifier in T&O theatres constatntly breaking down causing disruptions to theatr lists	Unable to carry out imaging in theatre due to consistent breakdown of both MII's alternatively and in unison. This is detrimental to the patient's treatment and care as surgical operations are hampered and unable to be completed while patient is under anaesthesia causes lengthier anaesthetic times and surgical complications and may result in the cancellation of the operations, lengthier stays in T&O wards causes undue stress to the radiographers, theatre staff as Consultants are very dissatisfied with the service as it impacts on the theatre lists and work load. Potential Manual handling risk to radiographers who struggle to manoeuvre the machines c-arm and monitor from one theatre to the next, through very narrow exits. Manoeuvring to remote sites for engineers access	Regular servicing Staff awareness of contingency measures Rapid call out of engineers QA on MII'S regularly		MOD	HOS	12/06/2013
3034	26/09/2011		Macmillan Suite - Mandeville Unit	Working at height, confined space, lack of fridge and lockable storage space for take home meds in the preparation room	Some of the equipment used on a regular basis is stored at a high level. This requires the use of a stepping stool. The current stepping stool has no additional safety measures such as hand rails to steady ones gait. Staff small in stature have to stand on their tip toes adding the additional risk of loosing their balance or missing their footing. The room is too small for purpose adding further risk of accidental bumping of staff when working at this height. The clinical fridges are too small for purpose and located in a confined space making access. In addition the inside fridge opens toward staff resulting in them having to lean over it to access the contents within. The process of entering the fridges results in bending, stooping and twisting on a regular basis to reach chemotherapy and other supplies. Manual handling training to reduce the risk of personal injury cannot be fully implemented. The clinical fridges are too small for current capacity. This results in the overstocking of chemotherapy infusion bags and syringes with the potential risk of damage and spillage. In addition, in the search for an individual's chemotherapy, the fridge is opened on a regular basis; chemotherapy removed and replaced, which may result in it not being stored at the required temperature. The lockable storage for take home medications is insufficient for the current Tuesday and Friday regimes resulting in drugs being squeezed into a confined space or stored in a chemo box needing constant supervision until space is available. Intravenous chemotherapy and oral take home medications can be in the same drawer and should be stored separately. Hot and cold packs are required on a regular basis as part of some patient's care. Cold packs are kept in the fridge and easily maintained at the correct temperature however, hot packs have to be heated in hot water to reach the required temperature which is a slow process, as we currently have insufficient space to store a clinical microwave safely. The preparation of chemotherapy requires staff to set up a trolley, using all four areas of the preparation room. Staff are using needles, breaking ampoules, handling chemotherapy and trying to maintain sterile fields in a confined working space with the following potential risks: "Contaminating the sterile fields as staff brush past. "Needle- stick or ampoule injury as staff brush past to reach supplies. "The aforementioned bending, stooping twisting and working at height to obtain supplies. "Slower preparation processes as staff wait in turn to access supplies. "Staff being interrupted during their drug checking process to accommodate staff needing past with the potential of a drug error. "Staff in particularly busy periods, are having to partially set up their trolleys outside the preparation room waiting to gain access as others finish. chemo has to be checked off at the patients side with the potential risk of raising their anxiety levels.	All unnecessary supplies have already been removed from the room in an attempt to gain space but with an increase in unit capacity, the space remains inadequate for current operations. Less frequently used equipment is stored at the higher level to reduce the risks of working at height.	30/7/12 - new fridge has been delivered - take off divisional register 22/6/12 - as below, no change 25/5/12 - on minor works list, awaiting approval 24/4/12 - Email received from Alan Metcalfe on the 23/4/12 stating that outstanding minor works will be issued to Directors next week for reviewing and priorisation. once finance have confirmed the budget Estates will be able to make arrangements for funded and approved requests. 26/3/12 - fridge is in the process of being ordered, has been authorised. 1/3/12 - still with minor works for costing, to chase up. 20.09.11 Sister Nowak to contact Estates to obtain a costing for an extension into the adjoining store room.? if this will gain the amount of space required. Explore other options such as expanding out.	MOD	DIV	30/07/2012

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3060	03/11/2011		Occupational Therapy Department	Redeployed Band 6 O.T Post from DHH Stroke Team covering long term sick leave on rehabilitation ward.	Increased workload for remaining O.T staff to ensure D/C targets met within DHH. Patients having to wait for longer to have O.T assessments/ Rx increasing risk for potential delayed discharges. Patients not receiving the indicated quantity and quality of inpatient rehabilitation treatment programme specific to their needs. Delayed discharge due to reduced intensity of rehabilitation and extended duration of inpatient stay to receive adequate rehabilitation to facilitate safe discharge. Reduced liaison with family /caregiver and therefore impaired information sharing. Harm - Physical / functional and equipment needs of patients may not be met for D/C from DHH and patients at risk of permanent physical / psychological / cognitive impairment. Reduced quality and quantity of service to patients/ families Failure to meet College of O.T. Professional Standards / HPC Standards of Proficiency Failure to meet National Guidelines - RCP / NICE Reduced ability to deliver on service targets. Risk of service complaints / increased time spent on dealing with complaints. Risk of litigation. Negative impact on staff morale. Increased risk of reduced health of staff - work related stress / fatigue with increased risk of absenteeism. Significant unmet need impacting on service delivery.	Redeployed Band 6 O.T staff member from Acute Stroke Team (level 6) to cover long term sick leave on rehabilitation ward (level 6). Current staffing on stroke completing additional duties to attempt to meet targets and comply with guidelines and Professional Standards of Practice All staff focusing on D/C targets from acute medical and surgical wards - compromising the quality of care provided to rehab/stroke/brain injury/complex patients. Staff following clear guidelines re: documentation Additional training to be arranged to cover specific areas (compounded by A/L and S/L issues)	29 11 11 staff member returned to work 03 11 11 Consider temporary replacement of band 6 OT post (with band 5 OT) if sickness leave is to continue over winter months		HOS	19/11/2012
3061	03/11/2011	Safe, High Quality and Effective Care	Occupational Therapy Department	No Wash Hand Basin in OT Treatment / Clinical Area & Long chain on wc replacement	Staff / patients at risk of infection / ill health due to no WHB being available in OT Treatment / clinical area. Against all Infection Control policies / procedures and potentially placing staff, patients and families at risk of harm. Non Compliance with SHSCT Corporate objectives - ensuring a safe and clean environment for patients and staff alike.	Alternative sink is used in neighbouring toilet area for hand washing before / after clinical care. Alco-rub / Hand gel pumps placed within each treatment room. All staff briefed with SHSCT Policies and procedures and conversant with Infection Control Audits / Action Plans. All staff trained in infection prevention and Control procedures for SHSCT. Review at staff supervision sessions / appraisals. Departmental Audits carried out monthly and safe systems in place for OT Department.	19 11 12 minor works forms submitted and work costed 2011 Source adequate funding to install suitable hand washing facilities in OT Treatment area. Replace current toilet facility with anti - ligature flushing device.		TEAM	15/11/2016
3059	02/12/2011		Physiotherapy	Unable to provide safe, high quality and effective care.	Reduced capacity to deliver on service targets and reduced ability to provide a safe, effective & quality service to patients due to - "No temporary or permanent recruitment into vacant posts. "Reduced staffing levels - Vacant Posts include- 1 WTE Band 7Clinical Specialist Physiotherapist (Mat Leave from 9/10/11) 1 WTE Band 6 Physiotherapy Rotational Post (S/L from14/11/11 commences Mat Leave 19/12/11 0.5 WTE Band 7Clinical Specialist Post (Vacant 31/10/11) 0.6 WTE Band 3 Physiotherapy Assistant (Career break from 16/11/11 for 3 years) 0.6 WTE Band 3 Physiotherapy Assistant (S/L from 30/11/11 ?? long term) "From 5/12/11 2.0 WTE Band 5 Physiotherapy Rotational posts are replaced with inexperienced temporary band 5 physiotherapists with another 1.0 WTE permanent Band 5 Physiotherapist being replaced December 2011with another temporary inexperienced Band 5 physiotherapist. These temporary Band 5 Physiotherapists have little or no previous experience & therefore very limited knowledge & skills. These staff require induction, training, modified caseloads, frequent formal & informal teaching & supervision from senior staff on a daily basis. These vacancies present increased risk of staff becoming further fatigued, stressed and physically unwell due to lack of replacement staff & use of 3 WTE temporary band 5 staff to facilitate OPPC targets Unable to provide timely physiotherapy service to Inpatients resulting in poorer clinical outcomes. Inability to deliver service targets. Risk to Trust reputation - increased likelihood of complaints & litigation. Negative impact on staff morale. Stress / fatigue of staff increased with an increased risk of absenteeism. Limited ability to meet professional standards. Limited ability to meet Trust standards. Staff injury - short term, semi-permanent or permanent physical and emotional injury. Inadequate staffing levels - unable to avail of uninterrupted breaks during working hours. Increase in unpaid hours worked.	Monitoring of individual staff caseloads and appropriate division of labour. Prioritisation of workload as able on a daily basis. Active encouragement for staff to feedback issues. Regular contact with AHP lead and Professional HOS to feedback re ongoing & unresolved issues regarding staffing. Timely completion of recruitment process to ensure permanent recruitment of staff into all vacant posts ASAP. Temporary staff to cover vacant posts due to maternity leave, career breaks, parental leave etc	29.2.12 CLOSE from divisional to go to HoS Risk register. Vacancies for Band 5 & 6's funded posts - no additional resource required. Potential financial resources may be available from Swine flu training budget / Acute Physiotherapy.	MOD	DIV	29/02/2012
3054	08/12/2011		General Pathology Lab	Security	The laboratories on the Craigavon site are located at the back of the hospital site, adjacent to the perimeter road, behind the theatre block.There are lone workers at night in the laboratories. The labs receive specimens from the hospital on a 24/7 basis. The two main methods of specimen delivery are by the chute system or by porters bringing the samples to the labs. Blood products can arrive by taxi at any time of night. Patients attending the andrology service require to be admitted to the laboratory along with occasional visitors such as other clinical staff or supplier representatives. Delivery of goods to the labs takes place on a daily basis. The door locks ore operated by entering a code on a keypad. This code was maintained until recently on a laptop used only for this purpose. The system is approx 10 years old and the laptop has now failed. We are unable to update an security setting on the system. Previous software updates to the system were expensive and the system is incompatible with fob systems used throughout the site. The new reception has a fob controlled lock. Security here is breached because laboratory staff do not have fobs to access the lock and porters fobs have not been activated to operate the lock.	Existing doors are locked but code cannot be updated. Meeting taking place Friday 9 December 2011 to discuss training and documentation for staff accessing laboratory. Security policy exits.	23/4/12 - Fobs have been purchased and are currently being activated for main lab reception. The automated locks on the other 2 doors are not fob operated and did not fail open - locks to be replaced. NOW RETURN TO HOS AS OF TODAY 26/4/12 27/3/12 Estates has been contacted. Awaiting update 29.2.12 - minor works has been complete with Estates. Brian to chase up costings w/c 5.3.12.	HIGH	DIV	25/05/2012
3062	05/01/2012		Occupational Therapy Department	No OT Splinting Service within DHH or N/M	Clients at risk of developing contractures, pain and increased tone if not assessed for and prescribed with a thermoplastic splint / or other as per clinical need. Risk to client - Pain / permanent injury - boney changes / lack of function. Risk to care giver - Increased demands for management of upper limb positioning self care / pain and discomfort of client. Risk to organisation - Failure to met national standards and guidelines of good practice including those for British Association of Hand Therapists and Royal College of Surgeons Significant unmet clinical need impacting on service delivery. Reduced ability to deliver on service targets. Risk of litigation and loss of reputation Risk of service complaints / increased time dealing with complaints	Referrals currently returned to source GP / COT with letter of explanation regarding gap in OT Service provision. Occasional patients referred from Renal Unit / A&E are seen by an appropriately skilled OT however at the cost of Acute inpatient time. List of unmet need recorded and discussed at regular supervision sessions. Review of policy / guidelines for evidence base and maintain good practice. Liaise diectly with line manager operational and professional to identify business case to met gap in service and unmet need.	19 11 12 repeat of DATIX 2748, being closed off Nov 2011 0.5 wte Band 6/7 OT to be employed within SHCST to provide assessment / provision and review of all neuro splinting trust wide. Splintage Materials / Adequate resources provided.		HOS	19/11/2012
3170	19/01/2012	Provide safe, high quality careBe a great place to work	X-Ray Dept	Door handles in Portadown Health Centre considered too low for staff and patients	Door handles in Portadown Health Centre x-ray Department are measuring 800mm from the floor which is felt too low for patients and staff. Particularly for staff who may be opening and closing these doors to facilitate the treatment of approximately 30 patients per day. This would equate to the radiographer/sonographer using the low door handles upwards of 100 times per day. This is due to the patient's care pathway involving the radiographer/sonographer opening the cubicle door for the patient on entering and leaving and opening the x-ray room door on entrance/exit for each patient. Potential harm to patients and staff member's backs and shoulders from continually stooping and pulling the low door handles.	Staff awareness. Removal of closure mechanism on some doors to make the lighter to use.		LOW	HOS	03/12/2013
3074	30/01/2012		Occupational Therapy Department	Expecting mothers - Carry out assessment of the H&S risks	(1)Carry out an assessment of any activity that may be harmful to new and/ or expectant mothers. (2)Carry out a risk assessment specific to the employee based on the initial assessment and any medical advice their doctor has provided. Outline the potential for harm: (Consider injury to client, staff, litigation, etc) (1)Short or long term injury to member of staff (2)Staff absence/ sick leave due to injury. (3)Possible litigation case re: injury.	(1)Ensure awareness, implementation and monitoring overall health and safety at work policy. (2)Ensure provision of adequate information/ instruction/ training and supervision for health and safety and wellbeing of staff (3)Develop safe methods of manual handling based on risk assessment which will reduce the risk of injury.	19 11 12 implementation of Trust Risk assessment for expectant mothers 2010 Arrange Manual Handling Training. Promote staff awareness of H&S at work policy. Arrange risk assessment training.	LOW	HOS	19/11/2012

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
3137	01/03/2012		Physiotherapy OPD	Potential risk to patient & staff safety and wellbeing as result of hazardous environmental condition within dept.	Hazardous clinical environment with the potential to cause harm to patients , staff & visitors Risk to Trust reputation through increased likelihood of complaints/ litigation. On-going issue with hydrotherapy pool leaking and causing damage to adjacent wall and flooring in T&O gym. Initial investigation of problem carried out by Estates dept and temporary boarding up of wall. Water damage to clinical area remains evident and initial problem still not resolved. Concerns with safety of clinical area with regards to infection control issues and also regarding the close proximity of electrics to the water leak. Potential for further significant damage / harm if problem continues.	Reporting of issue to Estates dept for further investigation. Contact with Infection Control Team - seeking clarification Patient cubicles closed off and staff informed not to use.	19 11 12 Hydro pool wall - pool cover removed and to be monitored by estates. Wall looks dry, plaster board in place and painted 24 07 12 Remedial work completed and area functional again. 01.03.12 Close liaison with Estates dept to ensure resolution of initial problem and completion of any remedial works to return clinical area to usable state.	MOD	HOS	19/11/2012
3169	13/04/2012	Provide safe, high quality care	X-Ray Dept	Risk of injury to operator, patients, staff, visitors and clients while operating the MobileArt (GE) x-ray unit	When operating the MobileArt (GE) x-ray machine there are a number of contributory factors that could potentially cause the operator to collide with patients, staff, visitors, clients, trolleys, beds, doors and walls etc leading to the risk of injury to the operator, patients, staff, visitors and clients. These injuries could range from minor injuries to major injuries. The potential consequences for the Trust are: - 1. Long term sickness and absenteeism of the staff member involved impacting on the quality and delivery of service provided and on the service needs. 2. Litigation could ensue from personal injuries from patients, staff, visitors and clients leading to the loss of reputation of the Trust. 3. Furthermore collision with an inanimate object could lead to damage of Trust property. When operating the MobileArt (GE) x-ray unit there are contributory factors that could potentially put the operator, patients, staff, visitors and clients at risk from injury. They include: - 1. Electrical risks when plugging and unplugging the MobileArt (GE) x-ray machine. 2. A blind spot on the machine when driving it due to its design. This makes it difficult to see the general public, patients, clients and other members of staff who may walk in front of the machine. This risk is increased around busy times, for example,visiting times when more people are about the wards and corridors 3. Risk of small children not being noticed by operator when driving the machine. This risk is increased around busy times, for example,visiting times when corridors and wards are busy. 4. Risk of uneven flooring and surfaces on Trust premises e.g. if using the lifts to access wards, the lift may not stop at the correct level. 5. Risk of damage to x-ray machine and doors on entering the wards because of the design of the entrance doors (they tend to close too quickly). Furthermore this could potentially cause injury to the operator as they have to negotiate the x-ray machine through the doors before they close. This may lead to the operator going through the doors awkwardly due to twisting/overreaching to hold the doors open and drive the machine simultaneously. 6. On the wards there may be inadequate space around the patient's bed because of drip stands, night stands and other medical equipment reducing the ease of movement and adjustment of the machine due to the restricted operating space. This could potentially lead to damage of the x-ray machine or other medical equipment and injury to the operator from a manual handling perspective . 7. Risk of injury to operator whilst driving the machine if they have to brake suddenly to avoid colliding with patients, staff, visitors, other inanimate objects, for example,	Staff awareness of the possible consequences of the restricted view from the blind spot on the x-ray machine . -Training of staff on how to use the machine at the Induction stage (updates as necessary). -Importance of reporting faults and incidents applicable to the machine as soon as possible. -Importance of then disseminating this information at the monthly staff meetings to all the relevant staff regarding the faults that have occurred. -Staff awareness regarding NOT driving the machine at full power in busy public areas and at busy times. -Regular servicing to ensure the x-ray machine is in good working order and safe to use. -Staff familiarising themselves with the workings of the machine on a regular basis (CPD). -Records of staff competencies in using the machine signed and kept up-to-date. -Staff must give consideration to others around them when driving the x-ray machine in public areas at all times.	Engineer Terry Headley gave assurance that the MobileArt is sate to use. Full service of machine is due on August 2012. Phone Colin Spiers in Estates Re-iteration of justifying portable x-rays. Ensuring that only x-rays that justify the need for portable x-rays are performed. Otherwise the patient comes to the department. On agenda for staff meeting 19.4.12	LOW	HOS	17/11/2012
3164	22/06/2012	Provide safe, high quality care	Macmillan Suite - Mandeville Unit	Facilitation of treatment over 3 days - no medical cover available on Monday and Friday for oncology patients	No oncology medical cover available (Named Doctor required as a point of contact in an emergency), so unable to provide treatment on Monday and Friday as chemotherapy treatment can cause numerous complications/emergencies that need urgent medical attention. Treatments continuing Tuesday to Thursday covered by consultant oncologist, this has potential to delay other outpatient appointments. Number of treatments able to be delivered is restricted by number pharmacy able to make up in the time period. In order to ensure patients receive prompt treatment we have had to facilitate all Oncology treatment on Tuesday, Wednesday and Thursday. This has impacted on the activity within the Unit and will cause delays in administration of treatments and also overcrowding of the environment , this puts patients and staff at risk. Potential for harm a)If patients are treated without medical cover they are at risk of deterioration from complications/emergencies such as hypersensitives or anaphylaxis b) Demand outweighs capacity causing patients to wait longer. Space constraints within the environment. c)patient fails to commence treatment within target timeframe	At present we have stopped administering chemotherapy on Monday and Friday. All Oncology patients are treated on Tuesday, Wednesday and Thursday. Allocation of staff has been adjusted to meet the demand. Patient Group Directions are currently being developed. Ongoing training for BLS, Alert and Anaphylaxis	22/3/13 To come off the Divisional Risk as per HOS 28/2/13 - as previous. 31/1/13 Currently there is no patients delayed for chemotherapy. Mondays and Fridays are being utilised for supportive treatments. 7.1.13 Staff grade will be commencing March 2013. No patients waiting to commence chemotherapy. 23/11/12 - risk continues. Staff Grade commences Jan 12, Acute Oncology Consultant interviews last week in November 12. 1/11/12 - risks continues. Staff Grade has been interviewed, offer made and will start in January 2012. Acute oncology consultant post interviews in November 12. 30/8/12 - risk continues; as no Medical cover on a Monday and Friday. 2 medical posts have been advertised and closed. 5 applicants for each. Waiting times for commencement of colorectal chemotherapy 4-5 weeks. 30/7/12 - still continues to be a risk. Cancer HoS to discuss further with Mary Burke, Action AD for MUSC Discussed but not agreed. Ongoing meetings with medical staff i.e. ED, Medical Directorate (with Dr Rankin) Awaiting response from the surgical team	MOD	HOS	26/11/2013

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3191	03/09/2012	Safe, High Quality and Effective Care		62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains unchanged. 06/08/2019 - Ongoing increase in red flag referrals	HIGH	DIREC	
3190	03/09/2012		Day Surgery Unit	Roof on Day Surgery Unit CAH is regularly leaking	Roof on Day Surgery Unit CAH is regularly leaking thereby compromising the safety of the clinical environment for patients and staff.	All problems are reported immediately to Estates Department to have them repaired as a matter of urgency.	. 22/3/13 There was a pre-start meeting last week and Estates have confirmed that the work will commence April 2013. 28/2/13 - to be complete by end March 2013. 7/1/13 - on estates works programme to be completed by 31/3/13. 23/11/12 - awaiting on Estates to give start date. 2/11/12 - funding has been approved. 2/11/12 - funding has been approved. 26/9/12 - no further update, still waiting on approval of funding. 30.08.12 Full roof repair for the Day Surgery Unit is currently on Estates list of required work. This has been reprioritised by them as very urgent , currently awaiting approval of funding for same.	LOW	DIV	03/05/2013
3261	07/09/2012		Radiology, Craigavon Area Hospital	Risk to radiographers finishing twilight shift (12am) and walking to the car park alone across the hospital site	Radiographers having to walk to remote parts of the hospital to access their cars after finishing the twilight shift at 12am. They feel nervous and vulnerable and fear risk of physical or verbal attack. Also risk of slip, trips and falls especially in winter months when paths and roads may not be gritted. This increases their stress levels after a busy shift	None		MOD	HOS	03/12/2013
3257	11/10/2012		Radiology, South Tyrone Hospital	Cold Clean Drinking Water required for STH X-Ray	There is no drinking water supply within the scanning suite for patients. The department uses approximately fourteen litres of water per day for patients to drink prior to scanning. Patients discomfort at having to drink up to 2 litres of luke warm water.	Drinking water can be transferred from the theatre suite, but there is no cool area to store the water. There is a risk of water spillage and a risk of injury to staff during transport of water. Also impact on theatre staff due to interruptions from radiography staff.			HOS	17/11/2012
3260	15/10/2012		Radiology, Craigavon Area Hospital	Risk of injury to patients and staff when using Kodax portable machine in ED xray	Due to the design of this machine the radiographers view is restricted and there is lack of speed control (too fast) and appears unsteady and easily tipped. These factors increase the risk of collision and injury to patients and staff. Alsomanual handling risks to staff whilst pulling machine back as it drives too fast	Staff Awareness Machine not used	12.06.13 Kathy Doherty to source a buyer	VLOW	HOS	12/06/2013
3244	15/10/2012	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	HEIG Decontamination of flexible endoscopes follow up audit	Follow up audit to the 2010 decontamination audit, there are areas still outstanding from the initial audit report which need to be progressed and which will require development of business cases and agreement from SMT on way forward.	Operationally all actions have been complete and progressed to date. Other areas have been highlighted which require to be actioned.	12.02.14 Responsibility for decontamination has been moved from theatre to CSSD. 22/3/13 Moved from Div to HOS RR as per AD instructions. 28/2/13 - Heads of Service working through money transfer. 31/1/13 - Transfer has been agreed 7/1/13 - Paper has been completed for transfer of responsibility for the theatre decontamination in CAH to become that of CSSD and has been sent to Dr Rankin for consideration. Adjustable sinks have been ordered. 23/11/12 - No further developments. 2/11/12 - Action plan has been identified with requirements and has been forwarded to Dr Rankin. Taking actions forward. 26.09.12 Action plan has been formulated and a working group to be developed.	LOW	HOS	12/02/2014
3258	06/11/2012		Radiology, Craigavon Area Hospital	Bulky Nursing Equipment stored in Darkroom CAH	Equipment is obstructing the main thoroughfare to the cleaners store and the Safe Q. It is also making it difficult for Radiography staff to access x-ray films when required.	None			HOS	10/08/2013
3262	08/11/2012		Radiology, Craigavon Area Hospital	Temperature within the xray processing area and rooms 3,4 and 5 are higher than the normal ranges which is 16-25 oC	Within these areas the temperature regularly goes above the acceptable range due to the heat eminating from the electrical equipment and the structure of the building. Staff have the potential to become fatigued, dizzy and faint due to loss of water and salt. This hot dry air can cause risk of eye and throat infections for staff Patients who are having rays performed in rooms 3,4 and 5 are complaining about the heat and stuffiness and some feel quite unwell as a result	Ensure staff and patients have access to chilled water Use of fans in rooms Opening windows in rooms		MOD	HOS	12/06/2013
3264	08/11/2012		Radiology, Craigavon Area Hospital	Risk of injury to staff due to items being stored on very high shelves in the nurses store room in CAH	Items are being stored on the top shelves in the nurses store in X-ray CAH to maximise space. However these shelves are too high and staff are unable to reach items unless they stand on the foot stool provided. This is a one step stool and staff still have to stretch to reach the top shelves even with the step. This has the potential for the staff to get hurt by either falling or over stretching to reach the items. The items on the top shelves are insecurely placed due to lack of space and they have the potential of toppling down on top of the staff and this could potentially lead to injury also	Staff awareness Manual Handling Mandatory Training One step foot stool provided		LOW	HOS	12/06/2013

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3265	08/11/2012		Radiology, Craigavon Area Hospital	Risk of injury when entering and exiting radiology department CAH through the automatic doors	The automatic disabled doors in and out of Radiology CAH can be opened manually or automatically. However these doors may close prematurely or too quickly . This has the potential to cause a collision by the doors hitting the user unexpectedly and causing injury to the upper limb	Staff awareness		LOW	HOS	12/06/2013
3271	17/11/2012		Radiology, Craigavon Area Hospital	Risk of injury from needle stick injuries within the radiology department CAH	After I.V. injection staff may sustain a needle stick injury from a used needle. Staff may become infected with patient's blood leading to risk of potential infection to staff.	Staff awareness/training. Wear gloves during procedure Do not resheath needle Occupational health access if required Hand washing posters and facilities ready available Sharps flow chart posters displayed in the appropriate rooms		MOD	HOS	10/08/2013
3272	17/11/2012		Radiology, Craigavon Area Hospital	Risk of injury to operator whilst driving one of the mobile xray units to the wards and back to perform portable radiography	Whilst driving the xray mobile unit to and from the wards there is a risk of injury to the operator from crashing the machine into an innate object Operator could experience muscular and ligament damage and injury to upper limbs and neck due to the impact and fractures in some cases. There is also a risk of colliding with members of public, staff and patients and this could potentially lead to injury of both parties involved	Staff awareness and training of operating machines at induction stage Staff familiarise themselves with the workings of the machine regularly (CPD) Records of staff competencies in using the machines signed and kept up to date		MOD	HOS	17/11/2012
3270	17/11/2012		Radiology, Craigavon Area Hospital	Lack of space within the nurses storage room in the radiology department CAH	Bulky nursing equipment is often stored in this small store with restricted space. This obstructs the main thoroughfare for staff to access the stock that is stored on the shelves. As a result there is a risk of injury to staff from either moving the heavy equipment to access the shelves or bumping into the edges of the equipment if it is not moved out of the way	None		VLOW	HOS	12/06/2013
3273	17/11/2012		Radiology, Craigavon Area Hospital	Risk of Injury to operator, clients, patients and visitors whilst driving the MobileArt (GE) xray unit within the Trust premises	When driving the MobileArt to and from the ward there is a risk of injury to the operator, patients, staff, visitors and clients: - 1. Due to the restricted view when driving the MobileArt X-ray unit (caused by the design of the tube arm) 2. Due to restricted operating space caused by members of the public, visitors, patients and other staff during busy times 3. Due to braking suddenly to avoid colliding with members of the public, patients, visitors, other members of staff and doors/walls Operator, patients and members of the public could potentially experience injuries ranging from muscular and ligament damage to fractures in some extreme cases. Litigation could ensue from personal injuries leading to loss of reputation to the Trust.	Staff awareness of the possible consequences of the restricted view -Training of staff at the Induction stage (updates as necessary) -Importance of reporting faults and incidents applicable to the machine as soon as possible -Staff awareness regarding driving the machine on full power in busy public areas -Regular servicing to ensure the machine is in good working order and safe to use -Staff familiarising themselves with the workings of the machine regularly (CPD) -Records of staff competencies in using the machine signed and kept up-to-date -Consideration to be given to others around them when driving the machines in public		LOW	HOS	12/06/2013
3274	19/11/2012		Radiology, Craigavon Area Hospital	Manual handling risk to staff when operating the ultrasound couch in room8	Ultrasound couch in Room 8 is used for many different ultrasound examinations and on a daily basis the couch needs to be moved to accommodate the patient, radiologist and radiographer to carry out the examination efficiently and effectively. For example for specialised procedures e.g. joint injections, to make room for bed patients from the ward and to allow the room to be cleaned at the start and end of day. This is where the problems lie as the brakes on the couch do not work properly making the couch difficult to move and lock into position especially for radiographers and Radiographer assistants who are pregnant The couch is also inclined to tip easily especially with the weight of the patient on it as the couch is very unstable Couch's head tilting movement is broken and this poses particular problems when scanning certain patients e.g. those who cannot lie flat Dr Aaron Milligan has expressed grave concerns with regards to the use of this couch in terms of 1.the Manual Handling issues that it presents in its current state 2. Dr Milligan is particularly concerned for the pregnant staff using the couch on a daily and frequent basis 3.Patient welfare as the couch is unsteady and there is the potential for it to tip	Staff awareness Yearly Manual Handling Training and updates Staff, in particular pregnant staff, recognising Their limitations and asking for help when required Maintenance for the Trust have already checked out the couch. Nothing they can do. However they suggested ordering part for head tilt mechanism		VLOW	HOS	12/06/2013
3276	20/11/2012		Radiology, Craigavon Area Hospital	Safe lateral transfer of Patients for emergency CT examinations during Out-Of-Hours from trolley/bed to CT Table	Currently during out-of-hours there is only one CT Radiographer available to assist in the lateral transfer of patients from trolley/beds to the CT scanner table. This has led to lateral transfers being performed with only two staff members (CT radiographer and staff member from Ward). Despite this being in breach of Departmental Safe systems of Work (which were devised in conjunction with the Trust's Manual Handling Co-ordinator) it is still being performed as to wait for additional members of staff to assist leads to an unacceptable delay in the treatment of the patient. CT radiographers are very concerned for the safety of themselves and the patients. Risk to patient of injury, musculoskeletal exacerbation from falling or damage to patient's skin and joints and increase of pain.	All staff have attended Manual Handling training, including the use of manual handling aids. Safe Systems of Work. Staff awareness. Repeated requests for additional staff from wards to accompany patients. Control measures considered but discounted: Safe Systems of Work for lateral transfer (four man task) Hoist - not compatible with CT Table Use of On-Call Radiographers based in Emergency Department to assist - due to high workload and demand these Radiographers are not available to assist out-of-hours.		MOD	HOS	03/12/2013
3275	20/11/2012		Radiology, Craigavon Area Hospital	Lack of space within the nurses storage room in the Radiology Department, CAH	Bulky nursing equipment is often stored in this small store with restricted space. This obstructs the main thorough fare for staff to access stock items on the shelves. As a result there is a risk of injury to staff from either moving the heavy equipment to access shelves or bumping into the edges of the equipment if it is not moved out of the way. Alternative area to store the heavy equipment i.e. Dark room, CAH, during working hours	Staff Awareness		VLOW	HOS	12/06/2013
3277	20/11/2012		Radiology, Craigavon Area Hospital	AMBULATORY EEG MONITORING TO CAPTURE CLINICAL EVENTS	ELECTRODES Accidental ligature risk INJURY TO PATIENT DUE TO CLINICAL RISK Physical injury (patient) Damage to EEG equipment	Binding/grouping all electrode leads together Attach bound leads to patient clothing at shoulder level/ strap of headbox holder at back. Headbox to remain attached to body at all times Presence of parent/carer for duration of test to regularly observe Presence of parent/carer for duration of test Regular observation by parent/carer Ensure if child bed/cot sides in situ and raised			HOS	03/12/2013
3279	20/11/2012		Radiology, Craigavon Area Hospital	AMBULATORY EEG MONITORING TO CAPTURE CLINICAL EVENTS part2	EEG EQUIPMENT Malfunction of Equipment ALLERGIC REACTION Allergic reaction to consumables	Annual electrical safety check by XLtek Patient asked via letter to inform Clinical Physiologist of any known allergies			HOS	03/12/2013

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3296	18/12/2012	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	South Tyrone Hospital, Day Procedure Unit 1 & 2	High level of noise from ventilation in DPU 1&2 STH. Noise assessment for theatres undertaken, Results are above the acceptable level in both Theatres and requires funding and action to reduce the noise to an acceptable level and achieve the standard required for the ventilation system.	Staff are alternated so that they are not in this environment every day. One surgeon at his request has been facilitated to alternate his endoscopy list between DPU1 and DPU 2 as he felt the noise level was higher in one Theatre than the other.	8/12/14 - noise level has been fixed / reduced. TAKE OFF RISK REGISTERED 12.02.14 Situation remains the same. 29/1/14 A budget cost for the above works of £374K has been recently forwarded by design consultants (initially you have approved £100K from your budget) and unfortunately we cannot procure these works this financial year. These works will be added to the capital works list for next year and will be subject to prioritisation/ funding approval with other works on this list. 26.11.13 Money through so noise will be rectified by Mar 14. 8/10/13 - DHH new endoscopy decontamination is currently being commissioned and should be operational from early Nov 13. 2/8/13 Discussed at Theatre User Meeting 1/8/13. Issue re information from Estates and being followed up as a matter of urgency. 3/5/13 Mary discussed with C Maguire. Cecil to get company to go to STH to discuss further with Marti. Mary has asked for a costing and programme of works, length of works. 22/3/13 Cecil Maguire has provided a quote of £100k. A design team to be set up and included in the capital works for 13/14. 28/2/13 - has been forwarded to Cecil Maguire to provide a full cost and programme of works. Following a filter change in the ventilation system the noise levels have increased further in these 2 theatres. 31/1/13 - No further update. Estates taking forward 7.1.13 - Noise assessment report has been received and costs has been forwarded for consideration re ventilation. To be added to 13/14 Capital wishlist. 10.12.12 - Noise assessment has been undertaken. To obtain case to bring ventilation up to the require standard - Minor works form completed - estimates obtained £100k -	MOD	DIV	08/12/2014
3297	20/12/2012		X-Ray Dept	Risk of patients and staff colliding with door in Portadown Health Centre x-ray department as no suitable mechanism for holding	Potential for persons to collide with door causing injury to themselves - Possibility of litigation due to injury - Injuries could range from extremity injuries to more serious head and facial injuries. For example fractures/lacerations - Loss of reputation to Trust In Portadown Health centre the heavy leaded door into the X-ray room has an automatic closure device fitted which can only be prevented from operating through use of a metal wedge device. This device has been prone to slipping allowing the door to close at an unpredictable rate and a member of staff has injured their head colliding with the edge of the door. The metal wedge presents a trip hazard when not in use. This could also lead to injuries to staff and patients on entering/exiting the x-ray room.	Staff awareness of potential risk and verbal warning to patients. Use of metal door wedge		MOD	HOS	03/12/2013
3303	15/01/2013	Safe, High Quality and Effective Care	Laboratory	Southern Trust Labs On-call	Risk of failure of on-call rota due to staff indicating their intention not to continue unless changes are made Failure of the out of hours system in any of the disciplines that operate a 24/7 system would have serious consequences for patient care.	Management is negotiating changes to ensure rota continues, and management are also undertaking individual interviews with staff to ascertain how pressures can be alleviated	5/1/16 - Funding for 4 posts received and staff have been appointed. Workforce plan for 24/7 indicated required 12.28 wte, with everyone committed to a 24/7 contract. The IPT and associated funding was sufficient for 4 BMS's only. DHH out of hours at risk due to sickness absence in haematology blood bank. Meeting to be arranged with senior clinicians to discuss a plan for contingencies in the event of transfusion not being available on site. 15/9/15 - Recruitment has been complete, however, no funding has been released. Brian Magee has contacted Sarah Buckley, Network Manager and will be discussed at the next Regional Pathology Meeting. 30/4/15 - IPT complete and non-recurrent funding secured for 2014/15. Promise from commissioner for funding for 2015/16. Recruitment underway. 8/12/14 - Commissioner has requested an IPT offering non-recurrent funding to assist with the provision of 24-hour services. IPT to be submitted by the 24/12/14 12/5/14 - Ongoing meetings with Management and Staff side continue in order to provide a sustainable OOH service. Last meeting held Tue 15/4/14. 12.02.14 To date 2 posts have been filled 01.01.14 All promotions to be filled where possible be expression of interest. 26/11/13 - HoS/CD/AD/Director/SMT have all met and agreed a plan for best way forward.	MOD	DIV	28/06/2016
3305	16/01/2013		Radiology, Craigavon Area Hospital	Risk of injury to staff members whilst using Display Screen Equipment due to the design of the workbench in the Ultrasound room	The workbench in Ultrasound Room 14 of main X-ray Department is unsuitable for the prolonged use of Display Screen Equipment necessary for the Ultrasound Service. Users are frequently having to stretch and twist to use the equipment on a daily basis. This could lead to musculoskeletal injuries and an increase in sickness and absenteeism.	Staff awareness. DSE recommendations regarding safe use and rest periods	Requisition to estates January 2013	MOD	HOS	03/12/2013
3304	16/01/2013	Provide safe, high quality care	Radiology, Craigavon Area Hospital	Lone Workers in X-Ray after 12 midnight	Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period.	Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting.	14.11.17 Awaiting update from J Robinson 5.12.16 The lock down system is being installed W/C 12 Dec 16. 13.9.16 Situation continues to be monitored	MOD	DIREC	07/08/2019
3316	31/01/2013		Radiology, Craigavon Area Hospital	Radiographers and Radiography Assistants pushing patient trollies in and out of Emergency Department X-ray rooms on their own	1. Risk of musculoskeletal injuries to Radiographers and Radiography Assistants when pushing and pulling heavy and bulky patient trolleys in and out of x-ray rooms with no assistance. 2.Risk of injury from collisions to patients on trolleys and other service users due to lack of control when being manoeuvred by a single member of staff	1.Staff awareness 2.Mandatory Manual Handling training	12.06.13 Staff Awareness ongoing	MOD	HOS	10/08/2013

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3367	15/02/2013		Radiology, Craigavon Area Hospital	The tiles on the floor between rooms 1 and 2 in the x-ray department CAH are lifting at the edges	1. The tiles in the area between rooms 1 and 2 in the x-ray department CAH are starting to lift at the edges causing an uneven surface and this has the potential to cause injury of strains sprains and fractures to anyone using this area due to trips and falls. This includes patients and radiography and nursing staff and domestic cleaners and maintenance personnel 2. The tiles that are lifting present a risk from an infection control perspective as dirt can get trapped under the uplifted tiles making this difficult to clean properly.	Staff awareness	12.06.13 Follow up requisition Feb 13 Requisition went in	MOD	HOS	10/08/2013
3368	15/02/2013		X-Ray Dept	Maintaining and 'prepping' the processor in Lurgan Hospital to copy x-ray films for medico legal purposes	1. Appropriately two years ago the chemical mixer for the 1200 Fuji FPM processor broke down and could not be fixed. As a temporary measure two rectangular shallow tanks were put in the place of the mixer one for developer and one for fixer. These tanks were placed on the floor as there was no available bench space. They were strategically placed length ways under the bench to prevent cross contamination of the chemicals. As a result of this: - a. The tanks protrude out beyond the benches making them a high risk for people to trip over the tanks especially when the activity of copying is carried out under safe light conditions. There is also a risk of spillage of the chemicals if someone did trip over them and this would become a COSHH issue (COSHH risk assessment to accompany this risk assessment). Cleaners could also knock into the chemical tanks and cause spillage of the chemicals b. Due to the confined working space there is a risk of injury to the radiography assistant when bending down to either replenish or agitate the chemicals in the tanks placed under the bench from striking their shoulders or head of either the bench or the edge of the copying machine that is sitting on the bench above the tanks and this also protrudes over the edge of the bench. c. When cleaning the rollers in the processor the radiography assistant has to stand on a stool to reach into the processor which is set on a plinth. She then removes a rack of rollers (that are dripping and awkward to carry) steps off stool and carries the rollers to the sink. The task is repeated 4 times and this increases the risk of trips and falls from stepping down from a height 2. Due to the position of the tanks that are not placed at the correct working level due to restricted bench space but are placed on the floor under the bench the radiography assistant on a daily basis has to stoop and bend down to agitate the chemicals in the tanks and this could lead to musculoskeletal and back problems. Also to replenish the chemicals on a weekly basis the radiography assistant has to carry 5L bottles of chemicals Developer and Fixer from the store to the chemical tanks. Then she has to bend and kneel with the 5L bottles and pour first the developer into the appropriate tank. She then has to stand up from kneeling position fill the bottle with 5 L of water bend and kneel to pour water into the tank. She repeats this activity 2 more times. The task is repeated for the fixer. This is a repetitive task involving heavy lifting, stooping and bending and this could potentially lead to back injury	Staff awareness Annual Manual Handling Training available to all staff All floor surfaces are in reasonable condition - no uneven surfaces Reasonable housekeeping standards		MOD	HOS	03/12/2013
3393	22/04/2013	Provide safe, high quality care	Trustwide	Biochemistry CPA Accreditation	Laboratory has lost its biochemistry accreditation status and is now a non-accredited laboratory	The Lab continues to perform adequately in its external quality assurance and internal quality control.	13.9.16 All findings have been cleared with inspectors. We are awaiting formal confirmation of accreditation status. this may take up to 6 months. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 6/1/16 - Inspection to take place 1st week in April 16. 27/11/15 - Pre-inspection took place on the 8/10/15. The Inspectors advised that Biochemistry is ready for the formal inspection subject to a few minor non-conformances being addressed. Formal inspection is expected in April 2016. 8/9/15 Labs - Pre-inspection visit confirmed for 8th Oct 2015 for Biochemistry. The biochemistry team continue to progress with meeting the ISO Standards. Meetings with Dr Hall and the Senior Biochemistry team continues. 3/3/15 - Labs contacted UKAS in January 2015 to check on progress with application, and was advised it had been passed to the scheduler. Still no indication of an inspection date yet. Staffing levels - benchmarking to be undertaken. Anticipated total additionality is 11 staff, no funding identified.	LOW	DIREC	13/10/2016
3452	12/06/2013		Radiology, Craigavon Area Hospital	New automatic doors fitted in the new x-ray room (Room 12) are not operating properly and hence they are a safety and radiation	There are new double doors fitted in Room 12 within the Emergency department. The larger door is opened using a push pad. "The smaller door does not open with the push pad and is fitted with a fire closure device. For trolley access to this room this door needs to be opened and remain open to permit trolleys to enter and exit. This door is lead lined and very heavy and is a manual handling issue because to open this door radiography staff working within the Emergency X-ray Department have to pull the door open on a repetitive basis. "The larger door is automatic but opens too wide and stays open too long and this presents a series of issues 1.Patients trying to help with the closure of the door have a risk of injury as the door is very heavy 2.For children's examinations speed is necessary for diagnostic images so radiography staff are forcing the door to close quickly and this could potentially lead to risk of injury to staff member 3.Reduction in privacy to patients in the room 4.The infra- red is not sensitive to all patients and doors could close prematurely on the patients causing injury to the patient The changing room cubicle door within X-ray room 12 is very heavy as it is lead lined, making it difficult to open. Effort is required to pull and push the door open by patients and radiography staff and this could lead to the risk of injury There is a radiation risk associated with the doors as the larger door can be opened from the outside using the push pad. There is a chance that the door could be opened unnecessarily this way whilst a patient is being x-rayed in the room and this has radiation implications and also privacy implications	Staff Training on correct use of doors Staff awareness regarding the doors		MOD	HOS	03/12/2013
3455	04/07/2013			OT Cover Stroke Team DHH	Patients not recieveing the required quantity and quality of inpatient rehab, with delays in assessment and discharge. Resulting in failure to meet RCP and NICE guidelines, professional standards, reduced quality of service, increase risk of complaints and litigation, unmet need.	Staff undertaking additional duties, focus on discharge targets and documentation			HOS	27/11/2013
3456	04/07/2013	Provide safe, high quality care	Physiotherapy OPD	Lack of space for safe and confidential storage of patient records	100 Boxes of old physio records on cages in clinical area. Potential risks, breach of confidentiality, damage due to fire or flood, visible injury to staff or patients. T&O physiotherapy gym	Have requested transfer to off site storage from Head of Informatics	Dec 16 Situation remains unchanged. 6 May 2015 This continues to be a problem. Filing being held in Physio Treatment area.	LOW	HOS	09/11/2016

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3457	09/07/2013		Radiology, Craigavon Area Hospital	Temperature Levels within the old PACS/Senior Radiographer Office are higher than the normal range	In the old PACs Office in Craigavon Area Hospital X- ray Department there is a potential for the temperature to go above the acceptable range due to the heat eminating from the electrical equipment, lack of ventilation and the structure of the building. Staff have the potential to become fatigued, dizzy, nauseated and faint due to loss of water and salt. This hot, dry air can increase the risk of eye and throat infections. In extreme cases this could lead to litigation should someone faint or collapse and injure themselves leading to loss of reputation to the Trust. The Trust are failing to meet their obligations. The high temperatures could cause staff fatique, dizziness and fainting when they have to work under these conditions and this may lead to an increase of sickness and absenteeism. It also causes tiredness and loss of concentration which may lead to increase risk of accidents. There are a number of staff (n=4) performing general duties in this area who are experiencing headaches and fatigue after spending a day working in these conditions. When these staff work in other well ventilated areas within x-ray they do not experince these symptoms. Windows are not available to open	Ensuring staff have access to chilled water. Use of fans (minimal benefit). Opening doors (minimal benefit). Portable air conditioning unit (minimal benefit).		MOD	HOS	03/12/2013
3458	09/07/2013		Radiology, Craigavon Area Hospital	Temperature Levels within Site Lead Radiographer'sOffice in CAH is higher than the normal range	In the site leads office in Craigavon Area Hospital X- ray Department there is a potential for the temperature to go above the acceptable range due to the heat eminating from the electrical equipment, lack of ventilation and the structure of the building. Staff have the potential to become fatigued, dizzy, nauseated and faint due to loss of water and salt. This hot, dry air can increase the risk of eye and throat infections. In extreme cases this could lead to litigation should someone faint or collapse and injure themselves leading to loss of reputation to the Trust. The Trust are failing to meet their obligations. The high temperatures could cause staff fatique, dizziness and fainting when they have to work under these conditions and this may lead to an increase of sickness and absenteeism. It also causes tiredness and loss of concentration which may lead to increase risk of accidents. There is generally one radiographer working in this office on a daily basis but other staff who perfom general duties in this area are also experiencing headaches and fatigue after spending time working in these conditions. When these staff work in other well ventilated areas within x-ray they do not experince these symptoms. Windows are not available to open.	Ensuring staff have access to chilled water. Use of fans (minimal benefit). Opening doors (minimal benefit).		MOD	HOS	03/12/2013
3471	12/08/2013		Radiology, Craigavon Area Hospital	Within the CT department radiography staff are consistently working under staffed and this is detrimental to their health and we	1.Radiography staff are consistently working in an environment that is under staffed. Within the CT Department there should be a minimum of 3 radiographers. Hence there is frequently a deficit of 1 to 2 CT radiographers available to cope with the work load and provide a quality, effective and efficient service in a timely manner. Radiographers are working under immense pressure and stress to get work done each day. They are physically and mentally exhausted and this has the potential to reduce the quality of service that needs to be provided and also there is a potential for mistakes to be made as radiographers are being stretched to cover all the areas and meet the demands put on them 2.Within the CT department there is a potential risk to the quality and delivery of patient care and service. For example less time available to provide a high standard of care to the patient, increased waiting times for CT examinations, lack of choice for patient appointments and potentially lists could be cancelled because of the reduced staffing levels within the departments 3.Sevice delivery will potentially be adversely affected as targets are not being met. 4.If a high quality of service is not provided local communities lose confidence in the service provider. 5.There is a potential risk of injury both for client and staff due to lack of resources available for safe moving and handling of patients from chair/bed to CT scanner and back again leading to potential clinical incidents, litigation and loss of reputation for the Trust 6.Best use of equipment will be affected due to lack of staffing to operate the equipment for example CT/MRI scanner 7.Due to the increased pressure of work on the staff there is a high risk of mistakes occurring leading to misdiagnosis, incorrect ID check or incorrect contrast agent being loaded into the pump. Alternatively air may not be removed prior to injection of the patient leading to loss of reputation to the Trust and potential for clinical incidents and litigation.	Restricted choice for staff requests for leave. Staff are rotated at short notice to cover service demands. Restriction on number of staff released for mandatory training. Staff working late to meet service demand.		HIGH	HOS	03/12/2013
3472	12/08/2013		Radiology, Craigavon Area Hospital	Within the x-ray department radiography staff are consistently working under staffed and this is detrimental to their health and	Radiography staff are consistently working in an environment that is under staffed. Within the general x-ray area there should be a minimum of 2 radiographers /room and there are 5 rooms to be covered. Hence a minimum of 10 radiographers are required per day within the general area to cope with the work load and provide a quality, effective and efficient service in a timely manner. Most days in the general area there are a maximum of 5 radiographers to cover all the 5 rooms, theatre and portables. Radiographers are working under immense pressure and stress to get work done each day. They are physically and mentally exhausted and this has the potential to reduce the quality of service that needs to be provided and also there is a potential for mistakes to be made as radiographers are being stretched to cover all the areas and meet the demands put on them Within the X-ray department there is a potential risk to the quality and delivery of patient care and service. For example less time available to provide a high standard of care to the patient, increased waiting times for x-ray examinations, lack of choice for patient appointments and potentially lists could be cancelled because of the reduced staffing levels within the departments Service delivery will potentially be adversely affected as targets are not being met. If a high quality of service is not provided local communities lose confidence in the service provider. There is a potential risk of injury both for client and staff due to lack of resources available for safe moving and handling of patients from chair/bed to x-ray couch and back again leading to potential clinical incidents, litigation and loss of reputation for the Trust Due to the increased pressure of work on the staff there is a high risk of mistakes occurring leading to misdiagnosis or increase of dose to patient due to either incorrect area x-rayed or incorrect ID check of patient leading to loss of reputation to the Trust and potential for clinical incidents and litigation. Non clinical duties e.g.; QA, H&S general house keeping,records etc. will suffer as staff struggle to meet the demands of patient service delivery. Potentially there may be an increase in the number of complaints from both the service users and patients leading to loss of reputation for the Trust	Restricted choice for staff requests for leave. Staff are rotated at short notice to cover service demands. Restriction on number of staff released for mandatory training. Staff working late to meet service demand.		HIGH	HOS	03/12/2013

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3473	12/08/2013		Radiology, Craigavon Area Hospital	Ergonomic lay out of the work station used by Radiologists, Ultrasonographers and Radiographic Helpers in Ultra sound Room 14 i	As staff are required to be at the workstation for longer periods of time in this room, the current workstation is unsuitable due to the cupboards below the work surface. This workstation does not meet the minimum requirements as detailed in the Trust DSE Procedure. It also fails to achieve the following dimensions for the work desk/surface as outlined in BS EN ISO 9241-5:1999 as follows: Floor to top clearance 705mm - 735mm Floor to thigh clearance min 650mm Kneehole depthmin 600mm Kneehole widthmin 600mm Desk Depth600mm PLUS depth of monitor (if you have a monitor mounted to frame which also holds the hard drive, you need to allow for this depth) Consideration should also be given to any trunking that is currently fixed to the wall and I would therefore recommend for desk depth 600mm + depth of monitor + depth of trunking There are cupboards placed above the work station and these present several Health and Safety issues: - 1.One of the cupboards has a broken hinge and there is a risk of this falling off and injuring some one 2. To access items in these cupboards requires staff to stretch to lift items out of cupboard. This has the potential for staff to sustain an injury by excessive stretching or being struck by falling items. 3. Due to lack of storage space items are being stored on the top of the cupboards. For staff to access these items requires them to climb and this could potentially lead to trips and falls from a height resulting in injury to staff member Staff are required to stand in an uncomfortable position at the workstation due to the design and height of the workstation bench for short periods of time (approx 10-15 mins) and frequently throughout the day as they need to type up their reports after each patient. Furthermore the monitor is too low for comfortable viewing	Staff awareness of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at DSE self assessments have been completed by all ultrasonographers to identify individual problems. Staff awareness Manual Handling training on a yearly basis Manual Handling Training on a yearly basis Staff awareness and reference of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at.		HIGH	HOS	03/12/2013
3474	12/08/2013		Radiology, Craigavon Area Hospital	Ergonomic lay out of the work station used by Radiologists, Ultrasonographers and Radiographic Helpers in Ultra sound Rooms 7 &	Due to the design of the ultrasound rooms there is space constraint issues involving the position of the monitors. Staff are required to stand in an uncomfortable position at the workstation due to the design and height of the workstation bench for short periods of time (approx 10-15 mins) and frequently throughout the day as they need to type up their reports after each patient. In room 7 there is a lack of suitable electrical sockets that restricts the even further the positioning of the monitor. In room 7 there is an adaptor that all the plugs feed into making this a high fire risk The monitors in both rooms are too low for staff to view at a comfortable viewing height	Staff awareness of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at Liaised with Maynard Collins the fire officer for the Trust. He has identified this as a high fire risk and removed the adapter immediately and replaced it with an extension cable in the interim. Manual Handling Training on a yearly basis Staff awareness and reference of the 12 point ergonomic plan included in the Trusts DSE Procedure (Appendix 2) for guidance on how to properly position your computer and the correct height to be working at DSE self assessments have been completed by all Ultrasonographers to		HIGH	HOS	03/12/2013
3481	28/08/2013		Radiology, Craigavon Area Hospital	No disabled toilet alarm available in the toilet in Nuclear Medicine, CAH	There is no alarm available in the patient's toilet in Nuclear medicine, CAH. This has a significant impact on the welfare of the patient should they take unwell whilst in the toilet as they have no way at present to raise an alarm in the event of such an emergency. As radiographers we have a duty of care towards our patients and strive at all times to meet the Trust's vision and objectives which are to provide a high quality, efficient and effective service to our patients.	None		MOD	HOS	03/12/2013
3482	28/08/2013		Radiology, Craigavon Area Hospital	No alarm available in the Public/disabled toilet in the X-ray Department, CAH	There is no alarm available in the Public/disabled toilet in the X-ray Department, CAH. This has a significant impact on the welfare of the patient should they take unwell whilst in the toilet as they have no way at present to raise an alarm in the event of such an emergency. As radiographers we have a duty of care towards our patients and strive at all times to meet the Trust's vision and objectives which are to provide a high quality, efficient and effective service to our patients.	None		MOD	HOS	03/12/2013
3483	28/08/2013		Radiology, Craigavon Area Hospital	New automatic doors fitted in the new x-ray room 12 are not operating properly and hence they are a safety and radiation risk	There have been new double doors fitted in Room 12 within the Emergency department. The larger door is supposed to open using a push pad. "The smaller door does not open with the push pad and is fitted with a fire closure device. For trolley access to this room this door needs to be opened and remain open to permit trolleys to enter and exit. This door is lead lined and very heavy and is a manual handling issue because to open this door radiography staff working within the Emergency X-ray Department have to pull the door open on a repetitive basis. "The automatic large door does not work properly and radiography staff are having to open and close this door manually. Again this door is lead lined and heavy and is a manual handling issue because to open this door radiography staff working within the Emergency X-ray Department have to pull the door open on a repetitive basis and to close it they have to forcibly push the door closed repeatedly "Although the larger door requires force to open it, once it reaches a certain point it opens too wide and this presents a series of issues 1.Patients trying to help with the closure of the door have a risk of injury as the door is very heavy 2.For children's examinations speed is necessary for diagnostic images so radiography staff are forcing the door to close quickly and this could potentially lead to risk of injury to staff member 3.Reduction in privacy to patients in the room especially when nursing staff come in during an examination 4.The infra- red is not sensitive to all patients and doors could close prematurely on the patients causing injury to the patient The large door does not close properly and this is a radiation risk to internal and external service users. Again to close the door properly requires force repeatedly	Staff awareness regarding the doors Automatic closure device has been disabled and signs on doors to make staff aware		LOW	HOS	03/12/2013
3488	18/09/2013		Trustwide	Orthoptics - refraction service - BHSCT staffing	Belfast Trust repeatedly requested to provide backfill for maternity leave. Approx 50% of all sessions being provided.	a)New patient referral criteria to refraction service updated and fully implemented. 20% of new patients were removed from the waiting list and this measure has ensured that the new patient backlog has no grown significantly despite 33% reduction in service provided b)Review patients are automatically discharged from the Refraction Service on discharge from Orthoptics. c)Refraction sessions now comprise 50% new patients (was previously 30%)	8.11.16 Backfill issues remain with approx deficit of 40 to 50% of clinics per month. Particial booking implemented and this has improved the DNA rate reducing from 25% to 8% currently. 23 06 15: D2D differently project implementing Partial Booking approved and currently on hold pending replacement of admin support. 19 02 14 additional clinics provided by BHSCT on Saturdays	MOD	DIV	09/01/2017

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3490	19/09/2013		Trustwide	Orthoptic Visual Fields	Patients are required to have visual field testing in order to aid diagnosis and monitoring of sight -threatening conditions. Patients with Glaucoma who form the greatest proportion of the visual field population, require lifelong monitoring of their condition. A subtle change in their visual field can indicate a need for a change in their treatment plan. Loss of visual field as a result of Glaucoma is irreversible and permanent. Loss of vision will result in a patient being unable to live independently thus placing a greater burden on Trust resources. Current situation - a) Full implementation of NICE Guidelines re Glaucoma/Visual field monitoring b) One additional Ophthalmology Consultant post c) Since 2010/11 there has been a significant increase in referrals YearNumber of referralsReferrals per month% increase in referral rate from 2010/11 2010/1164854 2011/128647233% 2012/138887437% 2013/141536 (Projected 12 month total from figures from April-July 2013 - 509)128137% 2010/11 0.2 WTE equivalent could meet the demand 2011/12 & 2012/13 Additionality was funded to meet additional referrals. Further increase in 2013/14 referrals needs urgent attention as this is above capacity and no Additionality will be funded 34% of all Visual Field referrals are deemed urgent ie to be seen within 6 weeks No funding for Band 3 Visual Field Technician in Business Case for New Consultant Ophthalmologist	a)Orthoptic resources being diverted from core activity to meet the visual field demand resulting in an increase in the Orthoptic Review waiting list. There is also a significant risk to the Orthoptic New patient PTL. b)All activity is closely monitored and following discussion with Trust Consultant Ophthalmologists, the increase in demand for visual field testing is likely to be sustained at the current level in the long term. However, in reality the demand is likely to grow with the predicted increase in the aging demographic. New patient letters are triaged for visual field testing prior to the Ophthalmology consultation leading to a swifter diagnosis, treatment and management of the condition. Testing prior to the Consultant appointment can also lead to earlier discharge in some situations	19.02.14 No further update. Orthoptic resources being diverted from core activity to meet the visual field demand resulting in an increase in the Orthoptic Review waiting list. There is also a significant risk to the Orthoptic New patient PTL. All activity is closely monitored and following discussion with Trust Consultant Ophthalmologists, the increase in demand for visual field testing is likely to be sustained at the current level in the long term. However, in reality the demand is likely to grow with the predicted increase in the aging demographic. New patient letters are triaged for visual field testing prior to the Ophthalmology consultation leading to a swifter diagnosis, treatment and management of the condition. Testing prior to the Consultant appointment can also lead to earlier discharge in some situations	VLOW	HOS	06/05/2015
3489	19/09/2013		Trustwide	Orthoptics Refraction	The majority of children attending the Orthoptic Department will require referral to the Refraction (Optician) Service for further assessment prior to the commencement of Orthoptic treatment. Orthoptists cannot commence treatment until full refractive adaptation has taken place. This is a process which takes place up to 20 weeks beyond the glasses being prescribed. An 8 month delay in attending the Refraction Service is putting children's vision at risk of permanent loss. There is also a significant risk of other eye conditions such as cataract and retinal problems not being detected in a timely manner. SLA with Belfast Trust put in place 01/04/04 to provide 1.0 WTE Band 6 Optometrist to provide 6 clinical sessions for Southern Trust. The other 4 sessions were to be carried out in RVH as follows 2 clinical sessions plus 2 sessions for admin, audit & teaching. This SLA was set up for Craigavon & Banbridge and Armagh & Dungannon legacy Trusts. A separate SLA was set up for Newry & Mourne legacy Trust - the nature of this SLA is unknown. There was concern raised prior to September 2012 re-length of waits for new and review refraction appointments. Loss of 0.2 WTE (33%) November 2012 due to maternity leave. Belfast Trust repeatedly requested to provide backfill for maternity leave. To date (08/08/13) 58 sessions lost as a result of maternity leave. To date (08/08/13) 4 backfill sessions provided by Belfast Trust New patient Backlog:- DateNo. of PatientsLength of wait September 121645 months July 133268 months Review Patient Backlog -as at end of July 13 - 159 patients Total No. New & Review waiting = 485 +20% DNA= 582 No. of sessions required to clear backlog = 73 All children attending P1 are offered a vision test by the Orthoptic-led School Nurse Vision Screening programme of which 50% will require refraction. It is anticipated that the new backlog will increase once the School Nurse Programme recommences in the new academic year. Sessions required per month to cope with current demand = 0.75 WTE This does not allow for special schools provision - currently unmet need or changes in Southern trust demography.	a)New patient referral criteria to refraction service updated and fully implemented. 20% of new patients were removed from the waiting list and this measure has ensured that the new patient backlog has no grown significantly despite 33% reduction in service provided b)Review patients are automatically discharged from the Refraction Service on discharge from Orthoptics. c)Refraction sessions now comprise 50% new patients (was previously 30%)		MOD	HOS	09/11/2016
3497	01/10/2013	Provide safe, high quality care	Trustwide	Lack of Occupational Therapy and Physiotherapy provision to Trauma and Orthopaedics.	-Limited weekend cover for post-operative trauma and orthopaedic lists. -Delay in provision of Outpatient Occupational therapy and Physiotherapy.	Escalated to Cancer and Clinical Services	12/5/14 - Recruitment in progress in order for service to commence August 2014. RETURN TO HOS RR 12.02.14 Situation remains. 01/10/13: Awaiting update from same	VLOW	DIV	08/12/2014
3537	24/03/2014		Radiology, Craigavon Area Hospital	Patients with a disability who come to the radiology department, CAH for an x-ray have no proper changing facilities at present.	At present within the main radiology department, CAH there are no disabled changing facilities available. As a result patients with a disability who need to change prior to their x-ray examination have to go into the x-ray room to change. They have no privacy in the x-ray to change. The Disability Discrimination Act, 1995 and the Equality Act, 2010 state that the same standard and quality of care must be offered to both able bodied and disabled persons. Unfortunately at present we are not offering disabled patients the same quality service as abled bodied patients an disabled patients are being discriminated against and their basic human rights are not being met To bring us in line with the legislation and to ensure we maintain a good quality service to all patients in main x-ray we need to incorporate disabled changing facilities into our department and this is a good time to ensure this happens as the department is getting new x-ray equipment installed and there is structural work being carried out in each room.	Disabled patients changing in the x-ray rooms Staff to lock doors during changing of patients Staff awareness of the Disability Discrimination Act through audit sessions		MOD	HOS	06/06/2017
3615	08/10/2014		Radiology, Craigavon Area Hospital	Ensuring that the Main x-ray and ED departments in CAH are secure for radiographers working shifts	Risk of unauthorised persons entering main x-ray department between the hours of 20:00 and 08:00. Porters use main x-ray as thoroughfare to access labs this results in the potential for doors in and out of s-ray to be unlocked during the above hours. Radiographers will be having their have breaks during the night in the staff room in main x-ray. Due to the position of the staff room the radiographers are isolated and become lone workers in this area. Due to the location of the x-ray office in ED there is a potential for unauthorised person i.e. patients and relatives to enter as they have direct access to the office once they are in ED.	Yearly MOVA training for staff Staff awareness regarding working safely Personal alarms provided Staff made aware and reminded to read Trust's Lone Worker Policy Buddy system i.e. communicating where the radiographers are at all times during shift		MOD	HOS	14/11/2017
3646	03/03/2015	Provide safe, high quality care	Trustwide	Radiology Service Provision	Vacant consultant radiology posts resulting in the reduction in reporting capacity and radiology examination capacity. Delay in diagnosis.	19.09.16 Escalated to Corporate RR. Approved by Acute Services Director Recruitment has commenced for 4 vacant consultant radiology posts	28.6.16 Loss of further 2 Consultant Radiologists. The service remains at risk due to vacancies. The Trust continues to out source reporting and also organise in house additionality to maintain SBA levels and to keep waiting times within a reasonable duration. Requisition gone to recruitment has attracted i Consultant Radiologist commencing 1 August 2016. 5/1/16 - Compliment of 23 consultants of which 4 vacant and 2 long term absence(1 secondment and 1 other). Back out to recruit the 4 vacancies. One Consultant retirement due end March16. Patients have been transferred to the IS in order to manage waiting times and report examinations.	HIGH	CORP	

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3663	29/04/2015	Provide safe, high quality care	Trustwide	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assesssement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to reitain a modular CT Scanner in DHH.	6/4/22 There has been a further meeting with HSCB to look at the options - there are currently 2 suppliers have submitted bids through PALS procurement. Only one supplier is within original budget. Still awaiting funding stream Dec2021- meeting with HSCB in January 2022. 03/12/2021 - Currently awaiting feedback from DOH regarding the IPT. The provider is querying if the lease will be extended by March 2022 as they have other third parties interested in the unit. 14/09/2021- Medium term plan to build a CT suite in DHH with 2x X-ray machines and one MRI. Finance and Planning have asked the Regional Imaging Board. Clarification has been sought but not yet received. Trust running at risk even without funding March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD	DIREC	
3674	06/05/2015	Provide safe, high quality care	Trustwide	Radiology Service Provision Div	Vacant consultant radiology posts resulting in the reduction in reporting capacity and radiology examination capacity. Delay in diagnosis	Recruitment has commenced for 4 vacant consultant radiology posts (Dr J Hamill, MRI post, 2 new IPT posts) - all offered, but will not commence until minimum of August 2015. However, there is now an additional 3 vacant posts (Dr G Gracey, Dr M McClure, Dr M Fawzy -temp only)	5/1/16 - Compliment of 23 consultants of which 4 vacant and 2 long term absence (1 secondment and 1 other). Back out to recruit the 4 vacancies. One Consultant retirement due end March16. Patients have been transferred to the IS in order to manage waiting times and report examinations. 19/5/15 - 3 of the 4 Radiology Consultant took up post end of Aug/Sept. However, this still leaves 4-vacant posts. Currently out to recruit for Breast and Paediatrics, 2 of the 4 was availability is limited.	HIGH	DIV	28/06/2016
3673	06/05/2015	Provide safe, high quality care	Occupational Therapy Department	Staffing difficulties due to maternity leave	50% replacement of staff during maternity leave. 20% of staff are currently on maternity leave. Potential to seriously compromise the safety and quality of patient care, the accessibility and responsiveness of services and is not maximising the resource available to contribute to overall system efficiency. Patients having to wait longer to have OT assessments / treatment increasing the risk for potential delayed discharges. Physical / Functional and equipment needs of patients may not be met for discharge from hospital. Increased time spent trying to prioritise caseload reducing patient contact and service management time. Reputation of service. Exposure of staff to abuse. Loss of functional assessment for signposting towards appropriate community services. Poor performance against best practice.	Staff undertaking additional duties. Staff focusing on D/C targets to maintain patient flow - seriously compromising the quality of intervention . Staff have clear guidelines re documentation - but increasingly falling behind. Revision of Referral & Prioritisation Criteria carried out.	9.11.16 Continue to process through HRPTS for vacancies	LOW	HOS	06/06/2017
3689	08/06/2015	Provide safe, high quality care	Laboratory	Delayed reporting of Histopathology samples	Patients are at risk of a delay in the diagnosis and treatment of a variety of conditions as a result of a backlog of histopathology specimens for reporting. this backlog is caused by a reduction in the reporting histopathology capacity. Only consultant histopathologists report these samples. There is currently 1 vacancy and a capacity gap of 2 WTe Histopathologists. he delay could result in a delay in diagnosis and or treatment that would affect the efficacy of treatment and or lead to patient harm.	Some additional reporting sessions are being undertaken by pathologists. All samples are triaged in an effort to ensure that the more urgent or critical samples are processed and reported as a priority. A Locum histopathology has been source and the Trust is attempting to identify a second. The Northern Trust has indicated its willingness to report specimens. Recruitment to the vacancy is being pursued Placed on Directorate Risk register on 8/6/2015 ID: 3689. Placed on Performance risk register Oct 2015.	05/09/2017 Recruitment has been successful with outstanding vacancies being filled in September 2017- the is currently a minimal reporting backlog 1st February 2017 update - we have successfully recruited a permanent pathologist who should start 1st April 2017. we have a locum stating soon. we continue to use vacancy funsing and some elective care (endoscopy) funding to close the gap in capacity 5,.12.16 We continue to have 2 Consultant vacancies we are currently using a number of waiting list sessions from both internal staff and consultants from other Trusts for assistance in core time. Turnaround times are being actively monitored. 13.9.16 Locum Consultant pathologists have been employed since June 2016. The first of these has already left and the second is due to leave at the end of September 2016. In addition another part-time pathologist is leaving for a post in Belfast reducing the establishment by a further 6 P.A.s. There is an active recruitment process and the Trust is actively seeking replacement locum pathologists. 13.06.16 Referral to laboratories outside of Northern Ireland. This has been discounted as the histopathology information would be lost to the regional system. It may have to be considered if the risk does not reduce. Referral to Belfast and or WHSCT. Neither Trust has indicated that they have capacity to take additional samples.	LOW	DIREC	18/09/2017

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3728	01/09/2015	Provide safe, high quality care	Trustwide	Serious concerns following June 2015 Cancer Peer Review	Serious concerns for skin, urology and H&N following assessment against the cancer peer review standards. Potential for Harm; The highlighted serious concerns may result in risk to patients who are/should be on the cancer pathway.	Recognised capacity gaps exist, consultation with HSCB ongoing with IPTs submitted where appropriate and participate and await the outcome of the Regional outpatient reform exercise. With regards to CNS's await outcome of the Regional CNS prioritisation project.	22.1.18 No longer serious concerns. Awaiting new Risk Assessment with accurate update. There are now action plans in place for each cancer MDT. 14.11.17 Ongoing process. Working closely with cancer MDT's to ensure compliance against standards 6/6/17 Clinical Nurse Spec workforce expansion on a 5 year period agreed by HSCB. Skin & other CNS under recruitment. 24/10/16 Fiona Reddick to provide an update 6/1/16 - The Urology & skin task/finish groups continue to meet to address peer review issues.	MOD	DIV	16/12/2019
3761	03/02/2016		Radiology, Craigavon Area Hospital	All Patients for CT Scans out of Hours Need to be Accompanied by Either a Nurse or Support Care Worker from the Ward to the CT S	Risk to the welfare of lone CT Radiographer working out of hours shifts in the CT scanning suite. Due to the remote location of the scanner in the hospital and the lack of security within the department there is the potential risk of physical or verbal attack/theft from patient's and relatives leading to increased stress levels for the staff. Staff have a right to expect a safe and secure working environment. At present due to the location of the CT scanner and the departmental structural design no panic buttons are available in either the control room or the scanning room within the CT department leaving the CT radiographers very vulnerable Out of hours lateral transfers of CT patients from their own beds onto the CT scanner is enviable. The departmental policy states that a minimum of 4 people are required for a lateral transfer. Presently there are not always 4 people available for transfer and the CT staff have to source other staff members for assistance. This delays the patient's scan and there for their care, treatment and outcomes Risk to patients health and wellbeing should they become acutely unwell whilst being scanned and require medical attention ASAP. Currently the staff member may have to leave the patient to use the control room's phone in order to make the emergency call for assistance. This delay could be to the detriment of the patient Following a recent incident that occurred out of hours when an unaccompanied patient collapsed out of the wheelchair after becoming unwell on a pregnant radiographer pushing the patient down the corridor to await a porter. The radiographer was left in a very vulnerable position as there was no panic buttons or phones in the vicinity of the incident. The radiographer had to leave the patient to summons help The radiographer was very distressed and upset following the incident and needed medical attention herself in ED. This incident highlights the immediate necessity for ALL patients to be accompanied when attending for CT scans out of hours.	Raising staff Awareness around the lone working issues Staff to read the Trust Lone working Policy and Procedures MAPA training Carry Personal attack screecher alarms worn when working as a lone radiographer Panic buttons on Main X-ray corridor To report any incidence including security breeches i.e violence and aggression as per Trust Management of Adverse Incidents Policy and Procedures Meet with MOVA advisor to review the risk Memo circulated to all Heads of Departments on theDATE to avoid patients arriving unaccompanied out of hours-unfortunately to date this has not been adhered to Staff to read the department lateral transfer policy Development of departmental lateral transfer policy out of hours awaiting to be signed off by Head of Service-Mrs Jeanette Robinson Staff awareness - asked to keep cordless phone near-by - not always practical. Mandatory CPR training	31.03.16 Staff awareness training continuing	MOD	HOS	14/11/2017
3791	12/04/2016	Safe, High Quality and Effective Care		Lack of space for Dietitians to assess and treat patients who attend renal outpatient clinics on renal unit, DHH.	The lack of space within the service area to see patients during outpatient clinics - occurs all day Monday, Tuesday and Wednesday. - Patients are often seen in a corridor risking a breach of confidentiality and portraying an unprofessional image for trust staff - Seeing the patient in the corridor results in blocking of a fire exit - Capacity to relocate / adapt current offices has been exhausted "Possibility for increase complaints from patients who are treated in a corridor "Damage to relationships due to lack of professionalism "Potential breach of confidentiality "Potential damage to the reputation of the Southern Trust. "Lack of space for storage of records has health and safety implications for staff and users of service. There has already been a near miss to a physiotherapy staff member retrieving records. "Negative impact on staff morale	Office space are used to their capacity within renal unit / DHH Issue has been raised with management - capital build is proposed Consent is obtained from patients before seeing them in corridor Chairs are removed from corridor directly after consultation to minimise fire risk	6/6/17 Situation unchanged April 2016 Currently office space used to capacity. Capital build is proposed. Consent obtained from patients while in corridor. Chairs removed from corridor area after each consultation to minimise fire risk.	LOW	HOS	14/11/2017
3847	24/10/2016	Provide safe, high quality care	Trustwide	AHP Capacity Deficit for Acute Oncology Staff	Lack of timely response to Oncology referrals by specialist staff and limited rehabilitation input.	Patients rehabilitation may be compromised.	22.1.18 Still ongoing risk 14.11.17 -Capacity and demand paper being revised, This need remains largely unmet 6.6.17 Regional work still ongoing Dec 16 Working with region to establish any regional developments.	LOW	DIV	
3850	24/10/2016	Safe, High Quality and Effective Care	Trustwide	SLT AMU with control measures	When AMU was planned and made operational, there was no allocation for funding for SLT in that unit. Delay in the patient with swallow problems receiving assessment and intervention by SLT while in the AMU.	Medical staff currently decide on appropriate nutritional support to be provided to the patient and expedite transfer to base ward.	6/6/17 Remains unfunded post - preparing business case Dec 16 C McIlroy to provide update.	LOW	DIV	14/11/2017
3849	24/10/2016	Provide safe, high quality careMake the best use of resources		Lack of Manual Handlng Training for Acute Staff	Risk of staff not being updated due to lack of resources to facilitate staff to go to training and multiple training schedules at Trust level.	Staff attend training when able to be released from other duties; lunchtime sessions arranged where possible.	7.11.17 Manual handling instructors now coming onsite on request but maintaining numbers within timeframes remains difficult. 6/6/17 Remains difficult to access sessions in a timely manner	LOW	DIV	14/11/2017
3848	24/10/2016			Backfill issue Belfast Refraction Service	Risk Assessment to be completed by C McIlroy	Repeat of Risk Number 3488			DIV	24/10/2016
3866	14/01/2017		Reception Area	The waiting room in the x-ray department,Lurgan Hospital needs to be revamped	Patients and staff are complaining regarding the condition of the waiting area in the x-ray department of Lurgan Hospital. It appears unclean, grubby and unhygienic. The carpet is stained and uneven. There is a crack in one of the window panes and the seating is very uncomfortable, torn and stained. There are nails sticking out of the walls were pictures have been removed and the wall paper is peeling off the walls. Pipes under the radiator are broken and the insulation is exposed. It does not give a good first impression of the department and we are not meeting the Trust's values of delivering a safe high quality service to all our service users. There have been numerous written complaints from service user regarding the condition of the waiting room Please see photographs of the waiting room and patient reviews of their experience attached Service users complaining about the seats being very uncomfortable especially for people with back problems -see patient reviews of their experience	Routine, daily house keeping Deep clean performed to try to remove stains from carpet and seats, however this was unsuccessful Patients advised to prevent their children climbing on the chairs An extra chair has been placed in the waiting room as a temporary measure for those with back problems	10/02/2022- works have been completed. 01/06/2021- move to divisional risk register as per director	MOD	DIV	10/02/2022
3869	23/01/2017	Safe, High Quality and Effective Care	Trustwide	Limited Speech and Language Therapist Provision	Inability to provide adequate Speech and Language Therapy to acute based patients due to increased volume of referrals of complex patients over previous 10 years - situation escalated by inability to backfill 2 senior staff on maternity leave and complexity of patients requiring SLT assessment. Capacity to provide Dysphagia treatment significantly reduced. Delayed assessment of patients designated nil by mouth so rehabilitation potential reduced. Delayed review of patients on modified diet Delay in discharge as SLT unable to respond to request for assessment and intervention re: swallow management including information re: food/fluid textures to carers. Potential for SAIs. Patients discharged prior to assessment Limited rehabilitation to patients, hence longer length of stay in hospital. Complaints received re: service provision Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Inability to achieve regional PTL waiting time targets	Several requisitions for recruitment of suitably trained staff - unsuccessful Junior locum staff employed but not skilled enough to fully meet caseload demands All core staff offered additional hours Telephone referral system manned by administration staff Triage and prioritisation of referrals Waiting list for in patients Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands Cancellation of VFS clinics which leads to distress of patients and families.	Dec 19 - deficits remain - recruitment to B7 and B6 posts have been unsuccessful. Retention of B5 locum into substantive post and potential to link B5 post to B6 Jan 2020 Jun19 The deficits in this service will now be major as there has been 2 resignations from B7 staff. 21.11.18 New post appointed Apr 18. However, capacity v demand compared with NHS benchmarking identifies approximately 50% deficit re staff required. Also Band 6 gap as member of staff left post. 22.1.18 Situation has deteriorated and continues to be monitored. 14.11.17 Secured SLT for AMU - recruitment in process, Capacity / Demand paper being revised, Prioritisation of demand continues. 6.6.17 Remains limited due to low investment in this service.	MOD	DIREC	13/08/2020

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3875	21/02/2017	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Trustwide	The transfer of patient data outside the EU.	Due to insufficient availability of Radiology Registrars within the Southern Trust the Radiology Department is unable to provide the service of reporting emergency CT scans for patients between 10.00pm and 9.00am daily. In order to address the problem the The Southern Trust has an arrangement with the Independent Sector provider to report on the CT scans in the out of hours and overnight periods. given that the Ind Sector Supplier is in Australia images have to be transferred electronically and this presents a risk and potential for data loss	The risks have been assessed by BSO Legal Services, Trust Information Governance and IT. Due to the following mitigating factors it is believed this risk is of an acceptable level:-Reputable company with contracts ongoing in NHS England Company has DPA obligations in place and have been co-operative in responding to additional requests for clarification -Lack of alternative re processing of records -Consequences of a data breach (CT scan images) -Likelihood of a data breach -Impact on patient if breach occurred -Reputational damage to Trust if breach occurred - may be low - depending on number of records involved Within the specification the following has been recorded: "3.11 Confidentiality / Intellectual Property Rights. Assurances must be provided to the Trust that data and digital images are secure at all times." Ongoing monitoring of images being sent and reports being returned will also be used to ensure there has been no loss of data.	April 2022 - This practice is still being utilised for reporting, therefore, the risk still remains. March 2021 - this will continue to be a risk as in previous years March 2020 This will continue to be a risk due to the lack of availability of senior radiologists. 21.02.17 Risk added to Acute Risk Register	VLOW	DIV	
3897	14/06/2017	Provide safe, high quality careMake the best use of resourcesBe a great place to work		Insufficient Consultant Radiologists to provide the necessary diagnostic reporting services for SHSST.	Due to insufficient availability of Consultant Radiologists within Northern Ireland and the UK the Southern Trust has been unable to fill the funded posts within Radiology. Therefore the Radiology Department is unable to provide a full responsive reporting service required for inpatient and outpatient examinations ie red flag, urgent and routine examinations. Delay in reporting of routine plain film x-rays has increased due to the rise in demand for inpatient CT and MRI examinations which utilise a significant proportion of Consultant capacity. we have maximised the activity of reporting radiographers and all backlog activity requires reporting by a Consultant Radiologist. Currently 12,000 plain film examinations are waiting for a diagnostic report, 6,299 of these are chest X-rays and of these 2,290 are waiting for reports longer than 28 days. The longest waiters are at 61 days. There is no mechanism for additional in-house activity for plain film reporting. Potential for harm arises due to delayed diagnosis, specifically lung carcinoma, with consequent delay in treatment and poorer prognosis.	Monitoring of waiting lists, prioritisation of Emergency Department, all red flag and urgent examinations. Maximisation of the current IS contracts with 4 ways and RRO, both of which are unable to increase their volumes. Working to procure furthur Independent Sector (IS) providers for routine reporting via PaLs and NHS supply chain. This latter action is required to deal with the backlog and to maintain the performance standard. Through the Managed Clinical Radiology Network we will seek the assistance of other Trusts within the Region with Plain Film reporting.	7.3.18 Risk remains unchanged, still significant gap in cover	MOD	CORP	
3936	03/01/2018	Be a great place to work	Laboratory	Lone Worker in Laboratory	Risk of harm to laboratory staff who may be working on their own to provide a critical service on the Daisy Hill site. There is risk to staff form adverse incidents including potential for sudden illness, accident or intruder with no immediate help at hand.	Out of hours entrances and exits are locked. Staff have access to phones and two-way radios that give the laboratory staff access to portering staff in case of an emergency. Single Pane windows upgraded. Personal Panic alarm system installed. Inner doors replaced / thumb turn removed.	July 2020- As part of the 2019 support staff have been facilitating the Biomedical Scientist over the night time period. Whilst not all nightts have been covered the majority are. Efforts are being made to secure additional resource to ensure all nights have additional staff cover. June 2020 Resource was given for additional staff to be on at night and reduce the "lone-worker" risk. Two staff have been agreed - a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. Nov 19 Risk reviewed and this remains unchanged Aug 19 Resource was given for additional staff to be on at night and reduce the "lone worker" risk. Two staff have been agreed a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. 7.3.18 Risk continues to be monitored	LOW	DIV	08/07/2020
3938	30/01/2018	Safe, High Quality and Effective CareAccessible and Responsive Care	Occupational Therapy Department	Data confidentiality and Information Governance risk	Lack of storage, 3 cages in OT Dept holding 53 boxes 2017 records, held in an area with high level of patients attending. Query confidentiality and Information Governance Risk. Possible breach of confidientiality, staff tripping and litigation.	Formal request has been made to stores to collect the cages as urgent. No other controls in place.	27.02.18 Risk continues to be monitored	HIGH	DIV	21/11/2018
4177	20/06/2018	Safe, High Quality and Effective Care		Chiller Faults causing loss of time- MRI	Chillers are required to supply chilled water to the MRI scanner to remove heat produced during scanning and facilitate circulation of liquid helium which maintains the operation of the supercounducting magnet. For the scanner to operate at the highest levels of efficiency, the magnet inside the scanner has to be kept as cool as possible. Any increase in temperature will result if the the chiller is not operating will cause the scanner to no longer operate. This is a safety mechanism for the scanner to prevent boil off the liquid helium "quenching". This is when the wire in the electromagnet stops being superconducting and starts to generate a lot of heat. At this point, any liquid helium around the magnet repeatedly boils off and escapes from the vessel housing the magnet.	Single chiller per scanner with no back up available. Alarm system in place to business management system when chiller is not operating- no communication from switch or estates re this during recent breakdowns. Siemens will test this to check if the system is working.	08/07/2021- recent chiller failure- temporary chiller installed until fault can be replaced. Several days scanning lost while this was ordered and installed. RED FLAG exams delayed due to downtime. 21/11/2020- no change- still awaiting estates action ongoing follow up with estates for progress. 20/06/2018- automatic emergency bypass system needs integrated instead of manual- to be referred to capital department for design team. Additional secondary chiller with associated pipework as a backup- D/W David Thompson needs referred to capital department design team. Discussion with Estates Team and Switch in relation to procedure for notifying estates and MRI if chiller alarm goes off. Alarm system to be tested.	HIGH	DIREC	

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3981	05/11/2018	Provide safe, high quality care		Administrating Contrast Media within Radiology	The current framework for prescribing, supply and administration of medicines (primarily the prescription of contrast media) within Radiology across the region does not meet current legislative requirements. It is the agreed approach of the Regional Modernising Radiology Clinical Network that this current practice poses a low risk to patients and has developed as normal practice over the past number of decades to meet the ever increasing demand for contrast enhanced examination. All decisions regarding the administration of medicines in Radiology is done under the direction of senior clinical staff following local procedures, protocols and guidelines as delegated by their Clinical Director. Issues with the management of medicines within Radiology has been recognised as a national issue, which has been escalated to NHS England as a risk to Radiology services. As a long term administration of contrast media. Low Risk PGD's are being put in place within the Southern Trust to provide a degree of cover for Radiographers administering contrast media.	Currently radiographers operate under written protocols agreed by the clinical director of Radiology.	27/04/2022 CEC Training: A draft of one section of AHP medicine management training at the last NMP group meeting. CEC aiming for a test version by mid may PGDs: 3 further radiography PGDS currently in draft with pharmacy assisting. An ongoing gap analysis of medicines in use versus PGDs is in place will be performed to monitor this area. 10/03/2022 - Regional AHP medicine running behind schedule, CEC hoping to have a test version of the main module available around April/May time 03/12/2021 - CEC are going to provide a Medicines Management ELearning programme in the new year. Some PGDs are still in the development process however the majority are available for staff. 14/09/2021- training continues to be ongoing. More funding for medications management has been obtained. 03/03/21 Radiographers received medicines management training in 2020, which is a requirement of administering contrast media under a PGD. This training has been added to the a new radiographers internal training matrix. The matrix has been colour coded for individual compliance, the percentage team compliance and arranged so that each team lead has more streamlined oversight of their staff members mandatory training. The most commonly used / higher risk contrast media / PGDs were prioritised for completion first. 7 have been completed and issued. Oral contrast administered on wards for CT scans was issued and requires all nursing staff to meet training requirements. Radiology remains in contact on the review of oral contrast administered on wards via acute standards and guidelines forum. At least 10 more PGDs have been identified. Drafts are in progress with Radiology and pharmacy. 02/06/2020 Process drawn up, agreed and is operational Mar 2020 Draft process has been prepared and further discussion to take place between ward based nursing and medical staff to determine if proposed process is workable. Dec19 A working group including radiology and pharmacy has been established with an initial meeting	MOD	DIV	
3984	19/11/2018	Provide safe, high quality care		Second CT Scanner is now in situ in CAH				LOW	DIV	17/06/2019
3999	04/12/2018	Provide safe, high quality care		Vacant Oncology post impact on service	Due to vacant Acute Oncology Consultant post and long term sickness with Specialty Doctor in Oncology there may be times when unwell patients attending mandeville unit will have to be directed to Emergency Department for further assessment and management. Service reliant on Clinical Nurse Specialist support at present. Patients may not be seen in Mandeville unit. Delay in treatment when presenting unwell	Trust currently actively trying to recruit into vacant Acute Oncology Consultant post and working closely with colleagues in Belfast Trust to support Oncology service.	June 19 - Trust advertised vacant post recently and closed with no applicants. Peer Review visit of the Acute Oncology Service (November 2018) commended the Nurse Led service and recommended that the Trust explore further expansion of this model. Trust liasing with HSCB to identify resource to expand AOS nursing cover to 7 day week in Craigavon and roll out to Daisy Hill Hospital. Speciality Doctor resumed after long term sick leave.	MOD	DIV	07/08/2019
3998	04/12/2018	Provide safe, high quality care		Review Backlog in Haemotology Service	Due to pressures within Haematology service patients requiring review at outpatient Haematology clinic may not be reviewed in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. A senior Consultant is planning to retire at the end of December and due to difficulties in recruiting medical workforce this may further impact the ability to review patients in a timely manner. Patients may not be seen within appropriate review. Delay in diagnosis	staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner.	June 2019 - Two senior Consultants have now retired from the Haematology service and 3 posts were recently advertised. There will be a significant gap to the service over the next few months. Difficulty getting red flag slots at present which is laos impacting on review availability. Reliance on Locum cover at present	MOD	DIV	07/08/2019
4008	28/02/2019	Provide safe, high quality care	MRI Craigavon Area Hospital	SyngoVia imaging software is not covered by service contract.	This software is essential in the reporting of Breast MRI as it is used to produce contrast uptake curves that cannot be produced on the PACS reporting stations. Server breakdown - costly repair as not under contract. Software versions not being updated - missing out on new benefits and uses for example in Prostate diffusion analysis. Data security risk - software out of date - updates not carried out. Info from IT - There is a security flaw with the SQL database server, which is out of support by Microsoft and I will need to approach Siemens. Scurity risk to patient data if not protected by software and security updates Risk of software becoming obsolete and no longer usable if versions no longer supported Risk then of being unable to provide breast MRI service	Risks to be managed on the current NIPACS system and images are being accepted as of diagnostic quality. If not of highest possible quality level.	23.09.2021- to be closed as per DN as the server is no longer in use. 7.8.19 This continued to be monitored and flagged in the region. Solution - to be part of NIPACS replacement BC.	HIGH	DIV	23/09/2021
4009	28/02/2019	Provide safe, high quality care		Delay in the management of oncology patients	Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	Trust currently working closely with colleagues in Belfast Trust to complete a look back exercise to ensure patients have all got a management plan. ongoing review of weekly clinic and outcomes from these.	Dec19 non medical prescribing (NMP) funding has been secured to develop nursing and pharmacy NMP. Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	LOW	DIREC	02/03/2020

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4010	28/02/2019	Provide safe, high quality care		Delay in the treatment of Cancer Patients due to vacant Oncology Consultant	Due to vacant Acute Oncology Consultant post and reliance on one Specialty Doctor in Oncology there may be times when unwell patients attending mandeville unit will have to be directed to Emergency Department for further assessment and management. Service heavily reliant on Clinical Nurse Specialist support at present.	Trust currently trying actively to recruit into vacant Acute Oncology Consultant post and working closely with colleagues in Belfast Trust to support the oncology service. Trust currently working closely with colleagues in Belfast Trust to complete a look back exercise to ensure patients have all got a management plan. ongoing review of weekly clinic and outcomes from these.	02.03.2020 The medical oncology staffing pressures continue to be a major issue at this point in time. There appears to be no prospect of recruiting into the Consultant Oncology post. The ST is therefore reliant upon visiting Oncology Consultants from Belfast. In recent weeks Belfast HSCT have advised they may have to reduce the number of consultants visiting. Thereby exacerbating the local problem and requiring the risk rating to increase from moderate to high. To address capacity issues working to skill up NMP both nursing and pharmacy. 3/12/19 Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending. Funding has been secured via early workforce bid through Oncology Services Transformation for 0.8WTE Advanced Practitioner Oncology with 0.25 WTE admin support and 1.0 WTE Specialty Doctor for Oncology. Ongoing work to progress recruitment of these posts. Dec19 non medical prescribing (NMP) funding has been secured to develop nursing and pharmacy NMP. Due to significant vacancies in Medical Oncology Consultant workforce across the region there is reliance on locum Consultant cover to support Oncology clinics. Breast Oncology clinic have now 2 substantive visiting Consultants from Belfast, 2 substantive visiting Consultants for Colorectal, there is still 1 Lung Consultant Locum attending.	HIGH	DIREC	24/06/2020
4011	28/02/2019	Provide safe, high quality care		Delay in the Management and Review of Haematology Patients	Due to pressures within Haematology service patients requiring review at outpatient Haematology clinic may not be reviewed in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. A senior Consultant is planning to retire at the end of December and due to difficulties in recruiting medical workforce this may further impact the ability to review patients in a timely manner.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner.	June 2020 Nov19 Haematology Consultant workforce is now funded for 5.0WTE however due to 2 senior Consultants retiring earlier this year recruitment is ongoing. There are currently 3.0 WTE in place and following recent interviews for 2 vacant posts, offers were given with one Consultant accepting. This leaves a gap of 1.0 WTE which will be covered by Locum cover. One substantive Consultant has now gone off Personal Information redacted by the USI.	MOD	DIREC	24/06/2020
4007	28/02/2019	Provide safe, high quality care		Risk that patients receive inappropriate care due to the misuse of point of care testing	Risks arise from the inherent characteristics of the devices themselves and from the interpretation of the results they provide. They can be prone to user errors arising from unfamiliarity with the devices. Patients are at risk of inappropriate treatment as a consequence of inaccurate results. Individuals are sharing passwords/barcodes in contravention of Trust procedures and good governance. Equipment is not being properly maintained which puts equipment at risk of malfunction leaving patients vulnerable. Internal Quality Control review and regular audits have stopped due to a lack of resources. There is a lack of Assurance around temperature control of reagents etc. which has the potential to influence the results. Patients are at risk of receiving an inaccurate test result and receiving inappropriate treatment or not receiving treatment when it is actually required. Patients could come to serious harm / death. Staff are at risk to Trust sanction or Professional body sanction, litigation, dismissal. Trust is at risk of litigation due to improper use of devices. Trust is at risk of litigation due to improper treatment based on inaccurate results or misinterpretation of results.	Training is available on all devices. Quality controls are available. DATIX web is available to report and monitor any incidents. Staff are given unique barcodes to operate Trust equipment where they are deemed competent to do so. It is the responsibility of all staff issuing a POCT device to end users to ensure that the user is adequately trained and competent to use the device.	28/02/2022- Merged with datix 4184 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing policy which will go live in July and will be disseminated to all AD'S and appropriate leads. May 2021 Equipment controller training will re-commence post covid as an online learning via Sharepoint. The powerpoint presentation will be uploaded in the coming weeks and will include a declaration form which will be signed by trainees upon completion. Feb20 Patient safety and quality manager mitigated the risks associated with improper use of Glucometers	LOW	DIREC	28/02/2022

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4005	28/02/2019	Provide safe, high quality careMake the best use of resourcesBe a great place to work		Lack of Availability of Core AHP Staff	Increase volume of complex patients requiring intervention. Increasing demand on services with high patient turnover and additional patients across wards, transition ward, outliers and ED presenters. Staffing across all disciplines below the National average (NHS Benchmarking figures 2017) Gaps in core services with inability/challenge to recruit in timely manner. Lack of backfill for maternity leave. Patients not receiving timely assessment and appropriate level of rehabilitation to maintain patient flow. Patients under nourished, remain nil by mouth for increased length of time due to reduced dysphagia cover especially for stroke patients. Unable to facilitate mobilisation with resulting deterioration in muscle bulk and increased morbidity, lack of facilitation of activities of daily living hence increased dependency and requirement for larger package of care on discharge which will be delayed. Poor SSNAP results Instability of core OT/PT staffing impacts on ability to rollout ward based 7 day working Potential for SAIs. Complaints received re: service provision Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Reduced morale and goodwill among teams - staff retention an issue with posts outside of acute attractive.	Regular contact with BSO re recruitment. Requests to contract and non contract agencies for AHP staff, core staff offered additional hours,		MOD	DIREC	13/08/2020
4039	12/06/2019	Provide safe, high quality careMake the best use of resources	Trustwide	Physiotherapy Staffing Difficulties	Inability to provide adequate Physiotherapy to acute based patients due to increased demand for Physio service in The Blossoms Childrens Services (in particular Paediatric Respiratory requirements. Ongoing recruitment and vacancy difficulties	Delayed assessment of patients. Potential Delay in patient discharge. Potential for complaints Limited rehabilitation to patients, hence longer length of stay in hospital. Inability to consistently meet professional standards Health and wellbeing of staff compromised Staff working outside levels of competency and under significant pressure. Inability to achieve regional PTL waiting time targets	Jun19 Bid to the Investment Committee for consideration. Requisitions for recruitment of suitably trained staff. All core staff offered additional hours. Triage and prioritisation of referrals. Waiting list for in patients. Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands.	MOD	DIREC	13/08/2020
4040	12/06/2019	Provide safe, high quality careMake the best use of resources	Trustwide	Inability to provide adequate Occupational Therapy service to patients in acute settings	There is currently a shortfall of Occupational Therapy staff to provide adequate service to acute based patients due to Ongoing recruitment and vacancy difficulties	Delayed assessment of patients. Potential Delay in patient discharge. Potential for complaints. Limited rehabilitation to patients, hence longer length of stay in hospital. Inability to consistently meet professional standards. Health and wellbeing of staff compromised. Staff working outside levels of competency and under significant pressure.	Jun 19 Ongoing recruitment taken forward to fill vacant posts. Requisitions for recruitment of suitably trained staff. All core staff offered additional hours. Triage and prioritisation of referrals. Waiting list for in-patients. Timetable constantly reviewed with staff managed & moved between the 2 sites to attend to priority demands.	MOD	DIV	05/12/2019
4046	05/08/2019	Provide safe, high quality care		Gamma camera Breakdown	The Nuclear Medicine department has 2 gamma cameras. The oldest, which is 20 years old, recently broke down and cannot be repaired as parts are no longer available. The remaining camera is 11 years old. If there is any breakdown with it or there is a service day, there will be no delivery of the service. Delay in patient scans, which may lead to a delay in diagnosis. The majority of the scans that are undertaken in nuclear medicine are for cancer patients. This will lead to Trust breaches in the Cancer Pathway.	Keeping the remaining camera serviced and in good working condition If there was a breakdown of any length of time, the wards would need to be informed, and patients transferred to a different trust as there is no other provision for nuclear medicine scanning in the southern trust. Lists cannot be carried out at the weekend as radiopharmacy does not supply radioisotopes at the weekend.		MOD	DIREC	03/12/2019
4050	07/08/2019	Be a great place to work	Radiology, Daisy Hill Hosptial	Lone Worker in Radiography	Risk of harm to radiography staff who may be working on their own to provide a critical service on the Daisy Hill site. There is risk to staff form adverse incidents including potential for sudden illness, accident or intruder with no immediate help at hand.	Out of hours entrances and exits are locked. Staff have access to phones and two-way radios that give the radiography staff access to portering staff in case of an emergency. Single Pane windows upgraded. Personal Panic alarm system installed. Inner doors replaced / thumb turn removed.	6/4/22 The CT staff in DHH are now on site 24/7. Therefore, there are 2 members of staff in the department. This risk can be removed from the register. 14/09/2021- implementation of new shift rota with 2 Radiographers will be in place by February 2022. March 2021- Locks have been added to all rooms. Swipe access door to be installed between ED and Radiology. Radiology main doors have been replaced and have the option to become a swipe door July 2020- As part of the 2019 support staff have been facilitating the Biomedical Scientist over the night time period. Whilst not all nights have been covered the majority are. Efforts are being made to secure additional resource to ensure all nights have additional staff cover. June 2020 Resource was given for additional staff to be on at night and reduce the "lone-worker" risk. Two staff have been agreed - a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. Nov 19 Risk reviewed and this remains unchanged Aug 19 Resource was given for additional staff to be on at night and reduce the "lone worker" risk. Two staff have been agreed a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. 7.3.18 Risk continues to be monitored	LOW	DIV	

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4079	16/12/2019	Provide safe, high quality care		Concerns highlighted following Peer Review visit of Systemic Anti - Cancer Treatment Service (SACT) November 2019.	no electronic prescribing system for Haematology chemotherapy drugs. Competency assessment for those prescribing first cycle of chemotherapy not in place SACT nursing competencies - some out of date storage of patients notes - confidentiality . SACT meetings did not include both Haematology and Oncology Increased risk of errors when prescribing drugs Inappropriate commencement of chemotherapy for a patient staff training out of date not in line with good practice Risk of breach of confidentiality lack of service development for the whole service	Corrective action plan developed to work through the concerns however regional support is required to implement electronic prescribing system for haematology chemotherapy. Medical competency framework needs to be progressed through NICaN. nursing staff to update competencies explore options for safe storage of patient notes Liaise with colleagues in Belfast trust to ensure job planning of oncologists to attend	08/10/2021- still awaiting regional direction re implementation of electronic prescribing (RISOH)for Haematology. SACT competence remain under continual review. Staff training has been updated. Further funding secured via the regional Onc/haem stabilisation plan develop AOS service with ANP commenced on training course to allow for service development June 2020 Awaiting regional direction re implementation of RISOH within Haematology. Nursing staff all now trained and signed off as competent in the delivery of SACT. Ongoing review to ensure all staff are up to date with competencies. SACT Multi Professional meeting occurs bi monthly with representation from both Oncology and Haematology. Ongoing review and awareness raising of the importance of Information Governance to ensure confidential information is kept secure. Regional Oncology/Haematology stabilisation plan underway with a bid submitted from Southern Trust. Dec19 Regional Support is required. Liaise with Belfast Trust to ensure job planning of oncologists to attend.	MOD	DIV	
4100	11/08/2020	Provide safe, high quality care	Trustwide	Replacement programme for Radiology Equipment on all Acute Sites	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging.	The equipment plan has been presented at Trust SMT. Unfortuanately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing.	HIGH	DIREC	09/03/2021
4099	11/08/2020	Provide safe, high quality careMake the best use of resources		Neurophysiology- Due to insufficient staffing levels risk of occasional department closure days	Occasional risk to inpatients as no staff to provide service. There is the occasional inability to provide an inpatients service for EEG. EEGs are an aid to diagnosis. there is no on call/weekend or bank holiday cover	As a rule x2 staff not permitted to have annual leave at the same time however in exceptional circumstances this can occur when staffing levels are insufficient. Change the working pattern for x1 P/T member of staff which will reduce lone working days and therefore reduce risk of closure days	03/12/2021 - A Band 5 MTO commenced in October which alleviates some of the departments staffing pressures. 14/09/2021- Lead has now retired. A new interim lead has been appointed. Continue to train 2 staff- progressing through the 2 year training programme currently. March 2021 - Lead due to retire in August 2021. 1 member of staff has taken a career break for 2 years. Another member of staff will shortly be going off on maternity leave. The remaining member of staff will increase their hours and be assisted by the trainee posts. Staff levels should be 3.22WTE	LOW	DIREC	
4112	13/08/2020		Trustwide	AHP Staffing Deficit - Acute Services	Core Acute AHP staffing significantly below the National Average (NHS Benchmarking 2017) combined with additional unresourced demand in the system across all areas and workforce issues in particular across Physiotherapy and Speech and language Therapy contribute to risk for the service, staff and patients/service users. This relates in this instance to the core Occupational Therapy, Physiotherapy, Speech and Language therapy and Dietetic teams on CAH site Current unresourced demand in the system: - Additional ICU beds in Recovery - big demand on existing ICU staff both Physiotherapy and Dietetics - no funded resource or cover for ICU from SLT or OT - Higher Acuity patients in 2N - Elective Ward - Transition ward - Additional stroke beds (funded for 10) - Additional medical beds 3S - Non recurrent funding frailty ward - only agency OT support, unable to recruit Physio - ED waits - on average 30 waits in ED - small resource contributing to GLT ED and AMU and struggling to impact on ED numbers/prevention of admission/signposting to AC@H etc - Increased age range and acuity of patients - Patients not receiving timely assessment and appropriate level of rehabilitation to maintain patient flow or actively contribute to timeliness and experience of the patient journey - Patients under nourished, remain nil by mouth for increased length of time due to reduced dysphagia cover. - Unable to facilitate mobilisation with resulting deterioration in muscle bulk and increased morbidity, lack of facilitation of activities of daily living hence increased dependency and requirement for larger package of care on discharge which will be delayed - complex delays - Poor/variable SSNAP results - Instability of core OT/PT staffing impacts on ability to rollout ward based 7 day working - Potential for SAIs - increasing number of same in the system - Complaints received re: service provision - Inability to consistently meet professional standards - Health and wellbeing of staff compromised - Staff working outside levels of competency and under significant pressure. - Reduced morale and goodwill among teams - staff retention an issue with posts outside of acute attractive. High risk of losing staff to other teams which we are seeing evidence of already	Regular contact with BSO re recruitment. Requests to contract and non contract agencies for AHP staff, core staff offered additional hours, Regular review of transfer of staff from DHH especially for stroke and current 2nd ED - challenging within OT/PTdue to gaps secondary to S/L, M/L especially in COVID era and recruitment issues ongoing and as 7 day working being piloted across OT/PT teams DHH, we have utilised cross site working effectively within SLT and dietetic teams as able to meet short term need but this does not address the longterm deficits	20/10/2021- Baseline deficits remain as outlined. Initial IPT was agreed in principle but to be looked at in overall AHP deficit trustwide therefore on hold. Ongoing pressures and a consistent need for redeployment confounded by Covid pressures has allowed the Acute deficit paper to be considered as stand alone - Planning now supporting to develop this further into a prioritised and phased approach with priority for demography funding Stroke staffing deficit now to be taken out separately for a combined stroke paper for regional investment Other bids in progress: - Biologics for Rheumatology - Additional HDU beds - Long Covid Need for investment in oncology services is not included in baseline piece however the baseline deficit is such that it draws on these staff to cover across all other areas. The overall oncology and palliative staffing requires review. Regional audit currently ongoing. Aim for regional or cancer specific investment opportunities to develop this for the patient group As mitigating actions I continue to look to secure additional staff via WFA/Agency/Additional hrs and CRR. 01/06/2021- moved to divisional risk register as per director. 03/03/2121 significantedeployment from across directorates to enable Acute AHP teams to address demand secondary to additional medical beds and Covid impact across ICU and wards. Redeployment ending through March 21 Bids in place via Annex A and NMS workstreams for additional OT/PT input to wards secondary to covid - posts to be filled Awaiting confirmation of funding for Ambulatory models to address patient flow and ED prevention of admission Support from Acute Director for investment paper to be drafted to address the baseline gaps across Acute AHP s a whole - March 21	HIGH	DIV	
4126	18/11/2020	Provide safe, high quality careMake the best use of resources	Trustwide	Lack of patching- Radiology	could result in the inability to access clinical systems on radiology equipment and server infrastructure. Highlighted by vulnerability scan using Tenable. Loss of essential services.	Patching arrangement need to be formalised. This needs developed within 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching- regional project looking at 3rd part suppliers being led by BSO	ongoing review with IT in relation to this. All 3rd party contracts to be reviewed and amended to include patching- regional project	HIGH	DIREC	09/03/2021
4127	07/12/2020	Provide safe, high quality careMake the best use of resources	Trustwide	Unsupported windows operating systems	Radiology- the remote host is running Microsoft Windows XP- support for this operating system by Microsoft ended April 2014 leaving risk of ransomware attacks and or hacking.	Targeted staff awareness training, devices to be replaced, upgraded or if not possible must be segregated. It working with Radiology to highlight all devices		HIGH	DIREC	09/03/2021

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4141	10/03/2021		Trustwide	Acute AHP Accommodation	Pre-covid space was a challenge within Acute AHP departments especially in relation to equipment storage. IPC recommendations in line with COVID 19 has had a significant impact on Acute AHP accommodation in both Acute sites: Physiotherapy CAH - department is shared space with outpatient MSK services (OPPC) to facilitate doffing the Gym including the Acute T&O gym has been out of use and with outpatient services downturning/stopping Acute staff were able to branch out into outpatient space to facilitate safe distancing in the department. This also required a significant decant of physiotherapy equipment to various storage areas around the Acute site. With the Doffing move to basement the gym will be reinstated as will all equipment and as MSK outpatient Physiotherapy services resume Acute staff will be displaced yet again and there is no solution to ensure safe distancing among this clinical team going forward. Team need to be onsite and responsive to the acute clinical need at ward level to ensure patient flow and improved patient outcomes. No Gym or Hydrotherapy space for rehabilitation of our complex patients. Need IPC guidance re: how this may progress alongside outpatient use T&O Physiotherapy - due to zoning and donning/doffing routes the T&O team were fully displaced and currently are allocated to rooms in outpatient area CAH (dental) temporarily. No access to T&O Gym space for intensive rehab of patients Occupational Therapy/Speech & language Therapy CAH - OT/SLT teams moved 3 times to facilitate Covid 19 - OT are now back in original department area but have had to displace SLT staff to enable social distancing in the department. All equipment also relocated to allow staff to branch out into all available space including the pre-covid assessment rooms. The department sits on main thoroughfare of the acute site therefore has a large volume of staff and patients flowing through it and also has outpatient fertility services alongside it as well as facilitating outpatient T&O and Rheumatology hand therapy Speech & Language Therapy CAH displaced to upstairs in Ramone building with additional space provided on the Admin floor as a temporary solution due to the need to safely distance staff. Long term solution required Physiotherapy DHH - department is shared space with outpatient MSK services (OPPC). To facilitate donning the Gym has been out of use and with outpatient services downturning/stopping some of this area has also been taken up by PPE storage. Acute staff have been able to branch out into outpatient space to facilitate safe distancing in the department as able. This also required a significant decant of physiotherapy equipment to various storage areas around the Acute site. No Gym or Hydrotherapy space for rehabilitation of our complex patients. Need IPC guidance re: how this may progress alongside outpatient use Dietetics DHH - due to IPC guidance for renal unit and need for spacing of doctors/nurses in renal the Dietitians lost the use of their office space and are now decanted to small outpatient dietetic office on ground floor beside the coffee bar. Insufficient space to safe distance so we have had to stagger use. This is now shared space with outpatient virtual assessments Speech & Language Therapy DHH - Office space in DHH is also shared with Community outpatient SLT as office space and used pre-covid as a clinic room for Acute outpatients. Safe social distancing is very challenging and staff are having to stay at ward level for longer periods and utilise ward computers etc to enable reports etc to be completed Departmental space for Acute AHP's is vital: "They are not ward based staff - work across the wards as required/fluid workforce "They need to ensure clinical documentation is maintained for safety and quality of care - impacting on discharge pathways, changes in discharge plans, guidance on safe patient handling and management and	"Estates have walked OT/PT/SLT areas CAH - limited potential to create additional space - plan of works drawn up to maximise areas for safety. Same not actioned as yet and still leaves shortfall of 20+ spaces for staff "Physio Departmental RA completed "Occupational Therapy RA completed "Accommodation for SLT CAH in Ramone building - additional space required as well as outpatient clinic space "Portacabin allocated to OT/PT CAH for storage of essential equipment for patient discharge - temporary however needs to be retained as it is also used as a collection site for relatives for equipment avoiding the main hospital area	20/10/2021- - Agreed plan for the decant of Physiotherapy outpatients to Clover building Armagh. This will release space for inpatient team accomodation in line with IPC precautions and growing team - future proofing. Timescale app 3-4 months for initial decant - CAH SLT team currently located upstairs Ramone and meeting room 2 Admin floor as hotdesk area. They have been added to the list for accomodation in new drop in Admin block. Anita aware of same - Pressures remain on DHH site with outpatient Dietetics and SLT services need ing acute accomodation back to restart service. This has been raised through SAG also - no outcome as yet - stroke rehab space - due to nosocomial monies and Covid ward changes all plans for Rehab space on stroke ward are on hold. With no clinical Physio Gym space available or OT Clinical space left on site patients can no longer receive therapy/rehab intervention off the ward - this has been confounded by covid pressures for staff accomodation and has a significant impact on our high acuity patients such as stroke/head injury/post ICU. 01/06/2021- there is a joint OPPC/Acute paper being developed to move services off site. this should free up accommodation clinic space. 03/03/21 Outpatient OPPC services are set to resume activity onsite with the moving of doffing to basement in CAH - urgent need for additional space for staff PT Estates to review plans to maximise space as urgent across PT/OT Long term accommodation TBA for SLT Longterm storage solutions required	HIGH	DIV	
4143	11/03/2021	Best use of resourcesProvide safe, high quality care		Replacement programme for Radiology Equipment on all Sites to replace equipment on unsupported operating systems and provide mai	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose. There is equipment currently running on Microsoft Windows XP - the support ended in April 2014 leaving risks of ransomware attacks or hacking..Failure to patch as per schedule could result in the ability to access clinical systems on radiology equipment and server infrastructure. This has been highlighted by Tenable programme and could result in the loss of essential services.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging. Patching arrangement needs to be formalised. This needs developed with 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching - regional project looking at 3rd party suppliers being led by BSO. Targeted staff awareness, devices to be replaced, upgraded or if not possible must be segregated. IT working with Radiology to highlight all devices. "	10/02/2022 -In the financial year 21-22 the following equipment was replaced via Capital Monies: "3 Endoscopes "Technegas "3 General Ultrasound units "2 Breast Ultrasound units "2 Fluoroscopy units Capital priorities for the coming year are: "Funding for a 2nd CT Modular unit at DHH "Second CT scanner CAH "Replacement of 1 MRI scanner CAH "Replacement of DXA scanner and DR room at STH - this is in preparation for a Diagnostic Centre 14/09/2021- 10 year plan drawn up-investment per year shared with Regional Imaging Board- understand that SHSCT needs priority. "The equipment plan has been tabled at Trust SMT. Radiology have also presented to SMT to highlight the issues. This presentation has highlighted specific urgent requirements including breast imaging and fluoroscopy across both sites to include the required ventilation. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. There is ongoing review with IT regarding patching. " ongoing review with IT in relation to patching. All 3rd party contracts to be reviewed and amended to include patching- regional project. "To be amalgamated with 8, 10 and 11. The equipment plan has been presented at Trust SMT. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. "	HIGH	DIREC	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
4157	06/05/2021	Provide safe, high quality careMake the best use of resources	Trustwide	MRI Capacity	MRI inpatient demand has significantly increased with an impact on the capacity for red flag, urgent and routine outpatient examination. There has been a 72% increases in inpatient MRI demand comparing March 20 and March 21. Currently there is no MRI facility available on the Daisy Hill Site and patients have to transfer to CAH for MRI imaging. Increased outpatient waiting list and waiting times. Potential for additional queries regarding inpatients to MRI staff adding additional pressures.	Currently some MRI referrals are being outsourced to the Independent Sector. However due to image quality the more complex outpatient MRI referrals remain in the Southern Trust	6/4/22 The MRI options paper is to be presented to SMT on Tuesday 12th April to seek approval to look at non Trust locations for a modular MRI unit. There is also an ongoing MRI optimisation project being facilitated by Siemens and the initial review of the service has occurred and we are currently awaiting feedback. 14/12/2021- brought to CW to raise with Director re corporate register move. The Department are working with planning on a Business Case for a low field strength MRI Scanner to be located at DHH. The Current MRI scanners located in CAH are due for replacement in 2023 and 2024 which are currently on the equipment replacement plan. The costs of low field MRI scanner for DHH has yet to be finalised	HIGH	DIREC	
4158	06/05/2021	Provide safe, high quality careMake the best use of resources	Trustwide	CT Out of Hours Activity	The total increase in Out of Hours Activity across the Trust is 20% compared to March 2019 and March 2021. The majority of the increase is between the hours of 5-10pm which has seen a 60% increase in its demand. Risk on staffing levels as increased pressure may cause undue stress and therefore result in sickness and absence. Additional pressure on Radiologists for reporting	Previously there was on CT Radiographer working during the Out of Hours period however this has now increased to two CT Radiographers without any additional funding. (This is for CAH). There has been an increase in demand in DHH and awe are currently embarking on trying to implement a shift rota rather than on call. Previously there was one CT Radiographer working during the Out of Hours period however this has now increased to two CT Radiographers without any additional funding. (This is for CAH). There has been an increase in demand in DHH and awe are currently embarking on trying to implement a shift rota rather than on call. The increase in CT out of hours activity has greatly increased the workload of the radiology registrars and Consultant Radiologists. The period 5pm to 10pm has become an extension of the core working day and the pressure to provide these reports in a timely manner is challenging for Radiologists	6/4/22 DHH CT staff have now commenced their shift rota 4/4/22, thereby ensuring the staff are working a safer rota and appropriate rest periods in between. The ongoing issue now is the increase in activity which is impacting the radiologists from a reporting capacity and the 5pm to 10pm being seen as an extension of the working day rather than an oncall service. 10/02/2022- DHH CT staff are currently on an interim shift with full implementation of shift from 1st April 2022. CAH have been able to recruit one additional CT member of staff, there is still a vacancy which will be re-advertised in due course The radiologists have the ability to send out to Everlight before 10pm, however, this incurs more cost to the Trust. Review of examinations performed out of hours is required. 03/12/2021 - 2 CT Radiographers have been recruited for DHH CT. Recruitment is underway for CAH CT Radiographers with interviews taking place before Christmas. While these gaps remain the frequency has increased for STH CT radiographers working on the CAH site. Back up to high risk 14/09/2021- Funding has been secured. Recruitment is ongoing. Downgraded to Moderate risk May 2021- Additional funding required for two CT Radiographers working out of hours on CAH Radiologists are keen for additional reporting cover between the hours of 8-10pm In order to facilitate moving to a shift rota in DHH additional funding is required for 4 WTE CT Radiographers.	HIGH	DIV	
4156	19/08/2021	Provide safe, high quality careMake the best use of resources	Trustwide	Referrer MRI Safety	MRI is potentially hazardous and involves significant risk to patient safety. During the period 2019-2021 there has been an average occurrence (one every 3 weeks) of incidents involving incorrectly completed MRI safety referral information. These incidents have involved referrers stating that patients do not have any potential contraindications to undergo MRI(implants) however it is later identified by MRI Team that implants are in-situ. If these events keep occurring at the current rate there is an increased risk of morbidity and mortality because the source of risk has not been reduced.	The MRI Team screen and check all patients and completed questionnaires to attempt to ensure these errors are captured. E Learning MRI safety for referrers is available on HSC E Learning. Where possible notifications are sent to referrers involved to highlight the error and request that they complete the MRI safety training.	03/12/2021 - A national MR Safety training module is being developed and will be released in 2022. This module will replace the current MR Safety module on ELearning. A trend analysis report has been collated over the past 4 months which has not indicated any reduction in the number of incidents. 14/09/2021- requirement for a 3rd scanner, electrical infrastructure in DHH is an issue- cannot be brought forward. Modular MRI scanner on DHH currently. Cannot be progressed by division. To be discussed with Director of Acute Services t to have this risk moved back onto Directorate register. 16/08/2021- memo has been circulated by the medical director to all medical staff regarding the importance of correct protocol when filling out safety questionnaires for MRI. MD has asked for compliance audit data to be shared with MD and AMD to allow this issue to be addressed. A learning letter was sent out with the memo to be shared at the M&M meetings and Governance Co-coordinators to be raised at directorate governance fora and the AMD and DMD for sharing within teams. Posters to be placed on Trust desktops via Communications team by June 2021 The Department would like Referrer MRI Safety Training to become mandatory for MRI referrers by August 2021	HIGH	DIREC	
4172	19/08/2021	Provide safe, high quality care	Trustwide	Delay in Everlight Radiology Reports being available in SHSCT	There is a risk to SHSCT patients due to the potential delay in diagnosis when reports are not available in line with the agreed turnaround time. Everlight Radiology provide Out of Hours reporting cover within. the SHSCT. The delay in the reports being available is highlighted to Everlight by SHSCT staff when issues occur. The report has not been pasted back onto Radiology Information System from their system. This is a manual process which occurs post dictation by the reporting Radiologist. This issues recur every few months and must be addressed to avoid recurrence. Potential for delayed diagnosis and mismanagement until report is available	Both Radiographer and the PACS team to monitor that the report is available in a timely fashion and to contact Everlight as soon as a delay has been recognised. Agreement at Weekly Radiology Meeting to put on the CCS Divisional Risk Register due to the issue of recurrence every few months. Issues to be raised on DATIX so recurrence can be monitored. A solution would be to have a HL7 link between IS providers and Sectra.	Further action must be taken by Everlight Radiology and Sectra to have HL7 link created Future incidents to be closely monitored by SHSCT staff. Everlight to provide an action plan to address the issue. Everlight Radiology & Sectra are to be informed this is on the risk register.	HIGH	DIV	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
4184	04/10/2021	Safe, High Quality and Effective CareEffective organisational governance	Laboratory	Misuse of POCT devices and non compliance with clinical governance procedures across the Trust	POCT demand has increased exponentially across the Trust, particularly in response to the Covid pandemic. Mistakes made during the course of POCT analysis and incorrect results acted on by the clinical team can have life-threatening consequences for the patient. The risk is not limited to the POCT team; the risk is applicable to all of the clinical teams across the Trust who are performing POCT and relying on the results to inform patient management. All of the following will cause incorrect results to be produced which, if acted upon, could be fatal for the patient and leave the Trust open to litigation: -Poor sampling technique resulting in poor quality of sample. -Lack of training or knowledge on the part of the operator regarding proper and correct use of the POCT device. -Lack of knowledge or reluctance regarding how to perform internal quality control and calibration (this checks if the machine is producing the correct results). -Inadequate compliance with external quality assurance procedures (this checks that the entire procedure from sampling through to result transmission is working as it should). -Lack of understanding of what will adversely affect results e.g. haemolysis, icterus, lipaemia, incorrect storage temperature for reagents. -Poor cleanliness and maintenance of the device and surrounding area. -Use of incorrect or out of date IQC/calibration or test cassettes. Other risks for the patient -Not using the correct H&C number - result will not transmit to NIECR. -Patient HCN mix up, results going into the wrong patient file. -Staff sharing barcodes - risk of an untrained operator using the device incorrectly. -Lack of POCT team support to deal with issues such as poor IQC/EQA performance and -troubleshooting. -Lack of IT support for issues such as devices losing connectivity. In addition, not all devices are able to connect to the Trust network so there is an increased risk with such devices where the POCT team are unable to adequately monitor their performance. -Users not informing POCT of issues with devices when they arise. Risk of faulty device being used to generate inaccurate results that are acted on by the clinical team. The risks to the user and patient are significantly more substantial than risks associated with performing tests in the main laboratory which is staffed by fully trained laboratory staff. Staff performing POCT have basic training in operating the devices and must adhere fully to the rules set out by the POCT team. Mistakes can have serious, fatal outcomes for the patient if the results produced are incorrect or misinterpreted and subsequently acted upon by the clinical team. Staff not adhering to the rules and standard operating procedures as laid down by the POCT team are open to disciplinary procedures. Mistakes made during the course of POCT analysis can leave the Trust open to litigation from the patient. The POCT team regularly audits aspects of the POCT devices and operators. There are repeated instances of staff sharing barcodes, not using H&C numbers, poor maintenance and cleanliness of equipment, failure to run IQC and EQA, poor sampling technique affecting sample quality, incorrect test cassettes being used, incorrect reading/interpretation of results. Other issues are staffing levels within the POCT team and the	- Online and/or face to face training available for all devices - training sessions are organised and readily available on request from the POCT team. - POCT staffing - POCT staffing has been extended but staffing levels have fluctuated with staff leaving and being replaced. There is a requirement for a Band 6 BMS to provide support to the POCT Band 7 and robustness across the service, particularly with the continuing increase in demand for POCT across all sites. - SOPs and information are available for all devices on the laboratory website and Sharepoint. - Regular audit of POCT in clinical areas is highlighting problems with regards device maintenance, compliance with IQC/EQA etc, and this information is regularly disseminated to all Heads of Service and Lead Nurses in areas of the Trust that use POCT. The emphasis is on these individuals to enforce the compliance with POCT rules within their teams in order to satisfy clinical governance requirements. - IT support is a constant issue within POCT and causes serious delays in troubleshooting and installation of POCT devices. We are currently recruiting a Band 6 IT person for labs, but they will require proper access and administration rights to IT systems (particularly cyber-security) in order to complete their work. This could be a problem if IT are unwilling to co-operate in this respect. These controls are effective to a certain extent, but non-compliance with POCT regulations within the clinical teams is a critical ongoing issue that is possibly not being taken seriously enough across the Trust. The risk to the patient is significant. Removal of devices from clinical areas where non-compliance with POCT rules has been identified as a serious issue - this will only be as a last resort, particularly in areas such as ED where POCT is essential for patient flow (e.g. Covid testing). However, this leaves the Trust open to litigation in the event of errors. Permanent blocking of users who consistently fail to comply with POCT regulations - this is not feasible in practice, particularly with many clinical areas short staffed. All we can do is ensure the individual's line managers are aware of non-compliance issues, and that they both sign an official form committing to compliance with regulations, and undergo re-training procedures.	17/12/2021- "Update Senior Management (CCS) on developments by Jan 2021 "Create a potential structure to provide further support to the Trust by end of Jan 2021 "Secure additional resource to plug the identified weaknesses in current structure TBA "Seek further investment in POCT Governance structure TBA "Reinforce adherence to protocols through existing governance structures Feb 2021 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing policy which will go live in July and will be disseminated to all AP's and appropriate leads	HIGH	DIREC	
4185	12/10/2021		Laboratory	Risk of not being able to provide a round the clock blood sciences service on both CAH & DHH sites	There is a risk that that the critical provision of Blood Sciences may not be available on one of the main hospital sites. An inability to provide "round-the-clock" cover would compromise the provision of high quality care and in the case of Blood Bank could result in the requirement to close (temporarily) Daisy Hill to emergency admissions. In addition Obstetrics and other specialties, including Theatres would be put at unacceptable risk. Contingency measures that could be brought into operation in Chemistry could compromise patient flow and potentially compromise clinical care. Current contingencies within Haematology / Blood Bank carry even higher risks than Chemistry due to the critical nature of blood bank in particular. The stretching of staff across the 24 hour period and two sites together with the constantly increasing demand for laboratory services is also putting accreditation at risk. Type 1 Emergency Departments and Obstetrics have an absolute requirement for a Blood Bank. If the Blood Bank could not be operated at any stage of a twenty four hour period the Daisy Hill Hospital would not be able to maintain the Emergency Department and patients would need to be directed to other Emergency Departments with potential for delay and significant patient harm or death. It is sobering to reflect that critical hospital services are supported by rotas that are extremely limited and vulnerable to short notice illness with the potential for no available backfill. Unlike nursing agency bank staff are not readily available. In short inability to cover a gap could result in the emergency department having to close and patients on the Daisy Hill site being exposed to significant risk. Therefore the impact could be regarded as a catastrophic. The number of staff available on the Haematology / Blood Bank in the SHSCT is very limited, partly due to the very stringent requirements required to operate autonomously in this discipline. Currently the twenty four hour cycle is covered by too few staff and by utilising substantial overtime. Increased demand on staff has also the potential to increase sickness and stress further compounding the problem. Rotas are effectively so limited that even a few absences could cause one of the rotas to fail. The COVID pandemic has placed significant additional pressures on staff - increased demand and reduced availability of staff. Very tight rotas are highly vulnerable to these issues. Laboratory accreditation (UKAS ISO15189) is at risk where the focus is maintaining a service at the cost of maintaining a rigorous Quality Management System.	"Cross - cover from corresponding site (i.e. CAH cover for DHH) "Cross cover from other departments where relevant and safe "Additional staff in training (two staff due to complete training in the next six months) "Additional support staff through the 24 hour period "Agency support staff These controls have been enabled service provision to continue but they are insufficient to reduce the risk to an acceptable level "Additional Agency Biomedical Scientists - very limited supply (if they can be sourced at all) and likely to be off framework. Introduce additional risk - in terms of competency and experience. "Transferring Blood Bank samples to Craigavon - but there would be an unacceptable delay "Remote release of blood - unacceptable in a Major Haemorrhage scenario "Routinely providing remote Chemistry Biomedical Scientist support from the CAH site with support staff running samples on the DHH site	April 2022-Seek approval to recruit against overtime expenditure. Granted and in progress Discuss contingency with Clinical Leads/ senior staff. - Contingency is limited and has the potential to compromise patient safety Expedite training of B5 Biomedical Scientist. Despite best efforts training is slow due to the obvious constraints and COVID etc limiting further the supply of staff to train and be trained Expedite Chemistry training of Haematology / Blood Bank Biomedical Scientists. Recruit additional Biomedical Scientists and Support Staff. As above but additional staff slowly being recruited - training extremely challenging Discussion with HR around appropriate T&C for working shifts - especially at late notice etc. Procedure to describe the contingency. Completed and has provided some mitigation - however formal sign off from HR pending Plan to ensure return to schedule on all aspects of the Quality Management System. Dependent on above Remote release of results has been introduced where suitable.	HIGH	DIREC	
4207	20/04/2022	Safe, High Quality and Effective Care	Trustwide	Multiple risks associated with non commercial barcode system that is critical to processing large numbers of patient samples	Patient blood samples cannot be processed in the laboratory without being issued with a laboratory barcode. The current software program for printing barcodes was developed "in house" and as such has no contingency back up and is unsupported by Trust I.T. If system falls over the laboratory will not be able to process patient samples in a timely manner or possibly at all. Samples may have to be sent to other Trusts for analysis. This would have severe impact on turnaround times with resulting detrimental impact on patient diagnosis and treatment .	Current practices include SOP that provides guidance to the operation use of equipment. The handling of the software is limited to 1 or 2 lab staff with sufficient programming knowledge but is not supported by local I.T. department. The daily issues occurring related to the software for example duplication of labels being printed has been highlighted to staff who have been asked to increase vigilance when checking labels.	Control measure being considered is the implementation of a commercial barcode printing software (Bartender) used across the region and supported by I.T This software will allow the labs to meet regulatory and compliance standards, increase operational efficiency, consistency, protection and plan business continuity. Not currently possible without funding	HIGH	DIV	

Step by step guide to job planning

17 February 2004

This documentation has jointly been agreed by the BMA(NI), HPSS employers and the DHSSPS and has been issued to all Northern Ireland trusts.

Introduction
This document outlines the suggested steps that could be taken in order to achieve an agreed job plan.

A more detailed description and guidance on job planning can be found in the document 'Consultant Job Planning – Standards of Best Practice' - read more here - which is included with this documentation at Annex 2. That document should be read alongside this one.

What if I work for more than 1 employer?
If a consultant works for more than one employer, one organisation should be identified as the lead employer who will assume responsibility for agreeing the entire job plan.

What should the job plan cover?
It should cover:
• The consultant's main duties and responsibilities
• The scheduling of commitments
• Accountability arrangements – professionally and managerially
• Agreed personal objectives and their relationship with wider service objectives
• The support needed to fulfill the job plan.

What are the principles underpinning the job planning process?
In developing the job plan the following should be borne in mind:
• It should be developed in a spirit of partnership
• It is a prospective agreement setting out duties, responsibilities and objectives for the coming year
• It should cover all aspects of a consultant's professional practice
• It may be modeled on the previous year's plan
• The plan may be wholly or partly team based
• It could include local, regional or national service objectives
• It should include personal objectives
• Resources and support required are agreed and stated
• The process is separate from, but linked to, appraisal.

Who is involved?
Many people can be involved in the job planning process. The three most important are:
· Consultant or team of consultants for part of the process (as each consultant will have their own personal objectives and personal schedule)
· Medical Manager Lead Clinician, Clinical Director or Medical Director
· Chief Executive

Although the job plan is an agreement between the employer and the consultant, in practice the detailed discussion will take place between the consultant and their medical manager, whose responsibility it is to draw up the draft job plan. The Chief Executive's responsibility is to ensure that all consultants have agreed job plans, as well as to sign them off.

Job plan reviews
There should be a job plan review every year. Much of the information required for the job plan review is the same or similar to that required for the appraisal process.

In addition, one outcome of the appraisal process is a personal development plan.
It would seem sensible, therefore, that the two processes should occur as close together in time as possible.

If there is a significant change in any aspect of the job plan during the year it may be necessary to have an interim job plan review.

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The purpose of the review is to:
• Consider what has affected the job plan
• Consider progress against the agreed objectives
• Agree any changes to duties and responsibilities
• Agree a plan for achieving personal objectives
• Agree support needed from the organisation
• Review relationship with private practice

Information needs
The information needed to inform job planning will differ between specialties and even between consultants in the same specialty. It is not possible, therefore, to give a definitive list of what might be required. The different parties to the job planning process also require different sets of information. The following checklist provides suggestions about the sort of information required. The list is by no means exhaustive, nor is every item mentioned necessary.

Information checklists
Consultant:
• Last year's job plan. If this is the first job plan or if either party feels that there might be need for significant change in the current job plan, a sensible diary kept over an appropriate number of weeks. Attached at Annex 1 is the diary card developed by the BMA (NI), DHSS&PS and HPSS employers
• List of main clinical responsibilities for employer
• Workload figures broken down in a meaningful way
• Timetable of private practice commitments
• List and scheduling of any fee paying services
• Teaching commitments
• CPD/CME requirements
• Personal development plan
• List and time commitment of other duties and responsibilities for main employer
• List and time commitment of duties and activities for other organisations such as work for trades unions, GMC, and Royal Colleges
• Clinical audit and clinical governance issues to be addressed
• Support provided by the organisation and support required
• Ideas for improvements to service quality, range or performance
• Thoughts on blockages to efficient service delivery

Medical Manager:
• Quantity and quality targets for the directorate and performance against them by the team and individually in the previous year
• Knowledge of the relevant priorities within the local delivery plan
• Changes in services being required of, or offered by, the directorate
• Clinical audit and clinical governance issues affecting the directorate
• Knowledge of the resource base of the directorate including numbers of staff, changes in skill mix and those services, space and equipment available
• Understanding of current and new initiatives within the directorate or Trust

In addition, the consultant and/or the medical manager may require information from other sources in order to complete the job plan accurately. Such information might include:
• Activities for other employers in the case of joint appointments
• Changes in practices and/or services of other directorates or other providers
• National clinical audit or clinical governance issues
• Changes in the health provision requirements of the local health community
• Information from tertiary centres regarding referrals
• Guidance from the Royal Colleges, particularly regarding workload and changes in clinical practice
• The requirements of medical schools
• The needs of doctors in training
• Feedback from trainees

Before the discussion
If the job planning process is to have meaning and to be helpful to both the consultant and the organisation, some preparatory work is necessary by both parties.

It is very likely that a diary will need to be kept for a period of time to assess accurately the amount of time consultants spend on different activities. Consultants and medical managers will need to agree how long a diary

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needs to be kept, however it is believed that in the greater majority of cases this will be for a 4-week period.

Other information will also need to be collected. In order to give some structure to the process, it is suggested that the consultant, whilst preparing for the job planning discussion, use the pro forma on the pages following the diary. If the job planning discussion takes place immediately after the annual appraisal then much of the information can be shared. As the personal development plan will have been agreed at the appraisal session, it can immediately inform the job planning discussion.

Medical managers and consultants need to agree, at the outset, who should prepare the first draft job plan. Whilst this is the responsibility of the medical manager, by agreement the consultant may undertake this task.

Diary
The following diary has been prepared by the BMA (NI), DHSS&PS and HPSS employers. It has been tailored to reflect the definitions of work and out of hours as set out in the contract.

The purpose of the diary is to help inform the job planning process. Consultants may find it helpful to note down when they are undertaking private practice or other additionally remunerated work, particularly work of this nature that is irregular. If, however, they prefer not to do this, there is no requirement to do so.

Predictable emergency work (e.g. post take ward rounds) should be programmed where possible into the working week and count towards programmed activities. Less predictable emergency work should be handled, as now, through on-call arrangements. For this reason, consultants should distinguish between predictable and unpredictable on-call duties in their diary.

Completing the diary
The diary is double-sided, with one page being completed for each day of the exercise. For each day consultants should put the date at the top of the diary card.

At the end of every day, consultants should assign in the "Work Commitment " box a brief note of his/her duties, and assign the relevant code when convenient. Please remember this is a survey of a consultant's work activities, not their private life.

All activities not related to HPSS or other additionally remunerated work is covered by the single code N2.

Preparing the job plan
There should now be sufficient information for a draft job plan to be prepared. This needs to include the following elements:
• activities, timing, content and where they will happen
• on-call commitments and the work that is generated as a consequence of being on-call
• commitments to the employing organisation that do not occur on a regular, weekly basis
• additional duties for the employing organisation
• commitments to other organisations
• personal objectives
• the support required to undertake the job that is already provided by the organisation
• additional support requested

The job planning meeting
It is essential that both parties allow sufficient, uninterrupted time (perhaps one hour, although more time may be required for first job plans or where significant changes are being proposed). It is also essential that sufficient time has been allowed to prepare for the meeting, that all relevant information has been collated and that a provisional job plan has been drawn up for discussion.

Both parties should make every possible effort to agree job plans. In the rare circumstances where a consultant and employer fail to reach agreement on the content of a job plan, either initially or at a job plan review, they should follow the facilitation and appeal procedures which will be set out in Schedule 4 of the Terms and Conditions. Once the job plan has been agreed, a copy should be sent to the Chief Executive for formal ratification, with a copy being retained by both the consultant and medical manager also.

	Work Commitment	On-Call Y/N	Code	O
7am – 7:30				
7:30 – 8:00				
8:00 – 8:30				
8:30 – 9:00				

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9:00 – 9:30
9:30 – 10:00
10:00 – 10:30
10:30 – 11:00
11:00 – 11:30
11:30 – 12:00
12:00 – 12:30
12:30 – 13:00
13:00 – 13:30
13:30 – 14:00
14:00 – 14:30
14:30 – 15:00
15:00 – 15:30
15:30 – 16:00
16:00 – 16:30
16:30 – 17:00
17:00 – 17:30
17:30 – 18:00
18:00 – 18:30
18:30 – 19:00

Time	Work commitment	On-Call Y/N	Code	C
19:00 – 20:00				
20:00 – 21:00				
21:00 – 22:00				
22:00 – 23:00				
23:00 – 24:00				
24:00 – 1:00				
1:00 – 2:00				
2:00 – 3:00				
3:00 – 4:00				
4:00 – 5:00				
5:00 – 6:00				
6:00 – 7:00				

Direct clinical care - Code C
Emergency attendance:
Predictable on-call - C1x
Unpredictable on-call -C1y
Outpatient or other clinic - C2
Operating session - C3
Ward round - C4
Other patient treatment or relative
Consultation - C5
Telephone advice to hospital - C6
Multi-disciplinary meetings about direct patient care - C7
Investigative, diagnostic or laboratory work - C8
Public Health duties - C9
Travelling time between sites - C10
Patient administration - C11

Additional responsibilities - Code A
Audit lead or clinical governance lead - A2
Clinical Tutor - A3
Medical/clinical directors/ lead clinician - A4
Other additional responsibilities - A5

Non-work activity – Code N
Absent from work
Annual/study leave - N1x
Sickness - N1y

Other (time spent not working) - N2

Other duties – Code D
Trade union duties - D1
AAC external member - D2
NCAA/GMC/CHAI - D3
Work for Royal Colleges - D4
Other - D5

Supporting activities – Code S
Training/Teaching - S1
Continuous Professional Development - S2
Audit/Clinical Governance - S3
Job planning & appraisal -S4
Research - S5
Clinical management - S6

Addition remunerated work – Code P
Private Practice - P1
Category 2 work - P2
Other remunerated work - P3
Background Details
Name
GMC/GDC registration number
Main employer
Other employer(s)

Date of completion of relevant appraisal
Start date of new job plan

Timetable and workload information
List information on current main job that you have collected
(delete those listed not collected)
1 Current job plan
2 List of main clinical responsibilities
3 Workload Figures
4 Diary showing work other than on call
5
6
7
8
9
10
11
12

Information required about your on-call
1 Actual rota frequency (state frequency)
2 Timetable of predictable PAs
3 Diary showing unpredictable on-call work

Information on activities that are supporting professional activities
1
2
3
4
5
6
7
8
9

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List of additional duties and responsibilities for main employer and time commitment

Duty	Time commitment
1	
2	
3	
4	
5	
6	
7	
8	
9	

List of external duties for other organisation, both HPSS and non HPSS, and time commitment

Duty	Time commitment
1	
2	
3	
4	
5	
6	
7	
8	
9	

List of private practice commitments

Type of clinical work	Scheduled Time
1	
2	
3	
4	
5	
6	
7	
8	
9	

List of regular fee-paying services

Type of clinical work	Scheduled time
1	
2	
3	
4	
5	
6	
7	
8	
9	

List of non-regular fee-paying services

Type of clinical work	Frequency
1	
2	
3	
4	
5	
6	
7	
8	
9	

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Objectives
List of the clinical and service objectives for you and your team as you understand them

List of your personal objectives, as agreed in the appraisal process

List of CPD/CME requirements

Clinical audit and clinical governance issues

Ideas for services improvements

What do you feel prevents you from working efficiently? Detail below

What resources do you need to complete your duties and objectives effectively? Detail below
Currently provided

Not currently provided, that you believe are required:

- Feedback
- Equal opportunities
- Privacy policy
- Terms and conditions
- Accessibility
- Help

© British Medical Association 2004

To Be Completed For All Consultant Posts Requiring 10+ PA's To Deliver Current Workload

This pro forma forms part of the audit trail required to demonstrate that a thorough analysis has been carried out before confirming the requirement for additional PA's to the Southern Board / Department. It will also hopefully help you to work through the issues involved.

Name:	M.Young
Directorate:	**Surgery**
Specialty:	**Urology - I understand that this particular assessment is to define the nos of PA's to keep MY existing service at a level to maintain the service (This is a level I personally do not want to be at !) These figures are from my diary card.**

Total no. of PA's in Proposed Prospective Job Plan: ____15.6_____ PA's

Breakdown Of PA's:

Emergency Work

- Predictable: _____**.8**_____ PA's
- Unpredictable: _____**1.08**_____ PA's

Travelling Time: _____**.82**_____ PA's

Theatre Sessions: _____**2.8**_____ PA's

Outpatient Clinics: _____**1.28**_____ PA's

Ward Rounds: _____**2.24**_____ PA's

Other: _____**4.5**_____ PA's

Total Direct Clinical Care: _____**12.69**_____ PA's

Supporting Professional Activities: _____**2.37**_____ PA's
(breakdown where appropriate)

(.56 Additional duties)

How could changes in work pattern improve efficiency?

See Urology Review document

All options considered to reduce PA's To 10:

Please list options and provide details of implications (e.g. if additional staff is an option show grades, numbers e.t.c.)

Outline proposals for longer term reduction to 10 PA's including timescales:

SIGNATURE: _____ **(Clinical Director)**

Week 1 2 3 4 5 6

PROSPECTIVE JOB PLAN

Name: _____M. Young_____

DAY	TIME	DETAILS	LOCATION
MON	9.00 – 1.45 2.00 - 3.00 3.00 – 5.00 5.00 – 6.00	Ward round ESWL Treatment Stone Clinic MDT Pathology Urodynamics Administration Ward Round Pre-op	
TUES	8.00/8.15 9.00 – 5.30/6.00 6.00 to necessary time	Pre-op ward round Theatre Post op ward round	
WED	9.00 – 1.30	Ward Round ESWL Treatment / Cover / Administration	
THUR	8.15 – 1.30 1.30 – 2.00 2.00 – 5.00 +	MDT X-ray conference Grand Ward Round Travel Out Reach Clinic (50%) Out Reach Clinic (Banbridge or Armagh 50%) Admin (other 50%)	
FRI	9.00 – 2.00 2.00 – 5.00 5.00 – 5.30/6.00	SPA activity Teaching. Programme Director – Admin, education CAH Out- patients and directorate work Ward round	

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

21 March 2006

Dear John

Thank you for your letter of today in reference to the new consultant's contract. It would appear that my letter in reply to your original letter of 12 December has been misplaced. This stated that I still did not accept the Trusts offer after Dr Gaston's reassessment and wished to proceed to facilitation. I would like to point out that my objection to the offer mainly related to the SPA allocation, which clearly was shown on my time sheet combined with the entitlement to this activity. It should also be noted that I am the programme director for Urology in Northern Ireland. I am sure the postgraduate dean would encourage that this is included. I had requested the BMA to reply on my behalf but due to certain issues this did not occur. In any case, I therefore wish to take this further.

Yours sincerely

Michael Young

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr MRA Young, Consultant Urologist
SECRETARY: Mrs Michelle McClelland
TELEPHONE: Personal Information redacted by the USI
FAX: Personal Information redacted by the USI
E-MAIL: Personal Information redacted by the USI

11 December 2007

Mr Stephen Hall
Medical Director
CAHGT

Dear Stephen

Thank you for your letter of the 4th December re additional programmed activities. I would like to state that I am not in a position to accept the 12.5 programmed activities on several fronts.

The job plan supplied interestingly is exactly the same as offered to me originally. This being rejected by us and with resolution of our last job contract it would appear from the Trust's perspective that they also had rejected it. The current offer is substantially less than our current offer yet the job we do has not been reduced by the corresponding amount.

Other factors that should be taken into account are the significant increase in pressure to perform in meeting targets. The extra work of ensuring that the ICATS service is covered (namely the review of patients that have fallen outside of the original plans as well as Urodynamic patient reviews – these being just a few examples) I know from correspondence with my colleagues in different Trust's that this offer is less than their offers especially when our workload and on call is substantially higher than theirs. It is however appreciative that the rota has changed slightly. All in all I would regard that a compromised offer be forwarded.

Yours sincerely

Mr MRA Young, MD FRCS (Urol)
Lead Clinician in Urology/mm

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Stinson, Emma M

From: Young, Michael
Sent: 25 August 2022 16:37
To: Stinson, Emma M
Subject: FW: [redacted] **In confidence**

Sensitivity: Confidential

another

From: Haynes, Mark [redacted]
Sent: 03 September 2020 11:11
To: ODonoghue, JohnP [redacted]; Young, Michael [redacted]; Glackin, Anthony [redacted]
Subject: RE: [redacted] **In confidence**
Sensitivity: Confidential

Perhaps we can have a VC after MDM – Michael how would it suit you?

Mark

From: ODonoghue, JohnP
Sent: 03 September 2020 11:01
To: Young, Michael; Glackin, Anthony; Haynes, Mark
Subject: RE: [redacted] **In confidence**
Sensitivity: Confidential

I have had my concerns for some time, initially by the standard of the letters.
Maire had mentioned 2 patients to me which I thought had bizarre management and very worrying.
He recommended furosemide to flush out a ureteric stone and the other patient was the gentleman who was septic and not stented as he couldn't find the stone in the kidney,
J

From: Young, Michael
Sent: 02 September 2020 22:17
To: Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP
Subject: RE: [redacted] **In confidence**
Sensitivity: Confidential

SEE red below

In saying all this I do agree - we can not look over our shoulders to check – have said this for 20 yrs - hence past rotas
There is a lot of territory to cover – there is a role but possibly not for the full package – its an expensive subdivision
The Urology team needs to discuss this and the Trust needs to respect the outcom
-----Original Message-----
From: Glackin, Anthony
Sent: 02 September 2020 16:23
To: Haynes, Mark
Cc: ODonoghue, JohnP; Young, Michael

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Subject: RE: Personal information redacted **In confidence**
Sensitivity: Confidential

Dear All,
I share these concerns and dealt with HCN Personal Information redacted by the USI.
Decision making and written communication in letters from flex cystoscopy letters that I have read is not up to the standard of a day one NHS Consultant Urologist.
By continuing his employment in this role we are placing patients at risk. I do not have the time to cross check on the work of locum Consultants given my current workload.
Additionally, expecting an inexperienced person to take on the backlog review of AOBs caseload will lead to further risks to patient care.

Tony

-----Original Message-----
From: Haynes, Mark
Sent: 02 September 2020 13:45
To: Young, Michael; Glackin, Anthony; ODonoghue, JohnP
Subject: Personal information redacted **In confidence**
Sensitivity: Confidential

I am meeting with Personal Information redacted by today to explore his involvement in some cases that have been brought to my attention;

HCN Personal Information redacted by the USI - haematuria, CTU done before attendance at STH showed ureteric stone. Flexi normal, discharge with no plans for ureteric stones (CT commented on in letter as normal)
Agree. Clearly stated on the report and in the conclusion.
Can John and I point out from today's stone meeting there is a learning point
Conclusion does not always cover ALL the salient points.
The conclusion is not what should be read but the complete text. This can take time.
Radiology need to have a responsibility to document all salient points in conclusion

Significant miss.

HCN Personal Information redacted by the USI - ureteric stone / sepsis, bladder stone and 22m upper ureteric stone on CT. Emergency theatre, no ureteroscopy or stent done as found bladder stone so presumed stone passed (despite CT clearly reporting 2 stones, 1 in bladder, 1 in ureter). Taken for further emergency theatre GA following day for ureteroscopy.
This is a very interesting case . I did not get a handle on this on Monday and thought it strange and was the start of a conversation I was having with Martina, BUT ACTUALLY look at the series as it happened - its actually very interesting. Fully agree stone in bladder and stone in ureter - very straight forward. Conclusion is must see two stones in bladder from the discussion - would everyone document ? Go back and look at xray reports - very important - would not expect this to pass but yet report notes a different possible outcome. Look at the fluoroscopy - do you see a stone ? see size of ureter compared to next day and fluro pic and ? stone. Fully agree 22mm stone passing spontaneously virtually unheard off. Registrars wonder why I only do fluoro with the ureteroscopy. Fabulous case. Advise a CT (I've already booked)
Also bookable list for repeat endoscopy (done)
HCN Personal Information redacted by the USI - bilateral ureteric obstruction, cystoscopy abnormal, unable to stent. No biopsy or EUA. Nephrostomy, repeat GA emergency theatre and TUR done, I attended at end and prompted an EUA which identified VVF.
Not involved - was it complex ?

These 3 cases demonstrate some question in my view, regarding his ability to function at consultant level. There may be factors which explain which I intend to explore today but I have significant concerns.

Do you have any thoughts or comments?

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

YES to be discussed please

Mark

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commit

10 July 2006

STRICTLY PRIVATE & CONFIDENTIAL

Mr M Young
Consultant Urologist
Urology Department
CAH

Michael

Dear Mr ~~Young~~

Further to the discussions which we have had, I now wish to confirm the Trust's intention that you will be offered 5.5PA's in recognition of additional workload over and above the 10 Programmed Activities that constitute your standard contractual duties under the New Consultant Contract. The additional PA's are reflected in the job (copy attached).

In the event of you deciding to transfer to the new contract, the requirement for you to undertake additional PA's will be reviewed annually as part of your job plan review. Termination of the contract for additional PA's is subject to a three month notice period and will have no effect on your main contract of employment. It should be noted that additional programmed activities are not subject to pay protection arrangements.

The Trust is also making you an offer of an ex gratia payment of Personal Information redacted by the USI in recognition of your extra contribution during the period 1998 until inception of the new contract.

Following discussion with your Clinical Director, your on call category has been determined as 'A' with your on call commitment being 1 in 2.

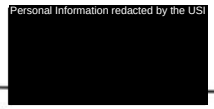
It is important to appreciate that this proposed offer is based on the understanding that the attached job plan schedule is a reflection of the time commitment given as a team member to HPSS work during 2004/05. Your acceptance will be taken as confirmation of this and also of the accuracy of the attached declaration of external duties/private practice which you have been involved in.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: 028 3833 4444

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Since I would like to get this matter finalised, I would be grateful if you would indicate in writing to the Office of the Medical Executive, whether you wish to progress to the next stage on the basis outlined above. In that event, I will make arrangements for Finance to finalise their calculation and for HR to prepare the necessary formal contract documentation. Your final acceptance of the contract will, of course, be subject to confirmation at that stage.

Yours sincerely



Dr I Orr
Medical Director

cc: Mrs M Richardson
Mr L Stead
Mr J W Templeton

Dear

This letter is in relation to the use of the Trust email system for the transfer of information about patients. There are several points I wish to raise.

What is the Trust's position on the transfer of information/correspondence on patients, the recording of same as an official document and the responses of the receiver when email is being used?

Email is indeed a quick, efficient, eco-friendly, user friendly, recordable method of communication. There are however several concerns, one of which is the volume of emails. There are so many emails received with varying level of content importance. Particularly there is the requirement to sift to identify the important emails. Attachments on the email add to the volume of literature to read. There is no time allocation set aside each day in my job plan to read emails, never mind addressing the content. Like other administration, it is fitted in and around other activities – I am sure others would say the same.

However the more important point relates to the information the email contains. It is my understanding that the Trust's logging system does not pick up and record referrals of any kind when primarily / solely sent via an email. If an email is not addressed, accidentally deleted or there is a slow response, then there is a delay or worse still - a complete lack of enactment. Recent communication has focused on a 24hr turn around for Red Flag referrals, 72 hrs for urgent and another time for routine referrals. This relates to the referrals the Trust knows about, however completely misses the referrals which are not passing through the Booking Office.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

In addition to this, it is observed that the RF office are now sending their information via email for triage. It is suggested that all referrals are loaded up via the ECR system in a timely fashion.

When all this is combined with the expectation that radiology and blood reports are assessed on a timely basis, then this does add up to risk. So on two fronts there are distinct issues, firstly the pathway of recording and secondly time allocation to address email content. It is appreciated that some are fastidious and quick in achieving this goal but others like myself find it challenging and the volume seems to be increasing.

Regards

Michael Young MD FRCS(Urol)

Consultant Urologist

Southern Health and Social Care Trust

Directorate of Acute Services
Craigavon Area Hospital

29th June 2021

By Internal Mail and Email

Mr Michael Young
Consultant Urologist
Craigavon Area Hospital

Dear Mr Young

Re: Use of Email for Referrals

Thank you for your letter received 8th March 2021. I appreciate you taking the time to bring these issues to my attention and providing me with the opportunity to respond. For ease I have taken each of your main areas of concern and provided a response as follows:

1 **What is the Trust's position on the transfer of information/correspondence on patients, the recording of same as an official document and the responses of the receiver when email is being used.**

The Trust has an Email policy which is available on the Trust intranet. I have enclosed a copy for your convenience.

2 **There is no time allocation set aside each day in my job plan to read/address emails**

I am aware that you are currently working with your AMD and CD to finalise your job plan and I trust that this issue will be addressed in these discussions.

3 **It is my understanding that the Trust's logging system does not pick up and record referrals of any kind when primarily/solely sent via an email**

There is currently an Administrative and Clerical Standard Operating Procedure in place which has been shared with the Medical Secretaries and is currently under review (copy enclosed). This provides a clear process for Consultant to Consultant referrals and applies to referrals both internally and externally.

4 **The Red Flag office are now sending their information via email for triage**

I have investigated your concerns and have been assured that the Red Flag Referral Team are following the correct process for Red Flags.

I understand from Emma that she has discussed this recently with you and that the bigger issue is that you are receiving referrals from Consultant colleagues which are not going through the correct process and I will address this with the Assistant Directors and Associate Medical Directors to ensure the correct procedure is adhered to when referring patients.

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Another issue you mentioned to Emma was that the Red Flag office had stopped printing off referrals. This was correct for a period of time when we were in surge due to Covid-19, however, I have been advised that the process of printing off referrals and leaving them in to the Thorndale Unit has recommenced.

I hope that this reassures you of the processes in place, but if you require any further information or have other concerns please do not hesitate to contact me again. Emma would be happy to facilitate a meeting should you feel that would be beneficial.

Yours sincerely

Personal Information redacted by the USI

MRS MELANIE McCLEMENTS
Director of Acute Services

cc Mr Ted McNaboe, Clinical Director

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 03 January 2017 14:49
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB

Importance: High

Richard/Simon/Esther
Colin & Martina & I met with the urology consultants this am, at which we shared with them all the events that had been taking place and the decisions that had been taken.
From this meeting we need to answer a few questions

1- What are the ToR for the investigation/review
2- How long would you expect the review to last?
3- What was Mr O Brien advised re the undictated outpatient clinics i.e. can he dictate or has he to cease having anything to do with the outstanding backlog
4- What is the Trust's position on Mr O Brien undertaking private work and in particular using Trust secretarial staff to type private patient work whilst off?
5- What is the Trust position in regard to notes being transported in staff's private car to and from SWAH? Clinics run twice mthly (2nd & 4th wks)

Mr O Brien contacted Martina and advised that the notes which were not on Trust's premises have been left in his office. Martina has checked and this is confirmed, these notes will be transferred to the med exe office asap to be tracked to Martina on PAS and then a refreshed report will be ran to see if there are any more outstanding.

The Team are going to think/discuss and come back to Colin & I on thurs with how they proposed to complete the actions required associated with review.

Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
[redacted]

From: Carroll, Ronan
Sent: 30 December 2016 12:44
To: Gibson, Simon; Corrigan, Martina
Cc: Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey; Weir, Colin
Subject: RE: Confidential - AOB
Importance: High

Simon,
Tks – we will now speak with Mr Young (clinical lead) re the plan & then informing the remaining consultants urologist Tuesday am with Mr Weir as CD
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

From: Gibson, Simon
Sent: 30 December 2016 11:44
To: Corrigan, Martina
Cc: Carroll, Ronan; Gishkori, Esther; Hainey, Lynne; Wright, Richard; Boyce, Tracey
Subject: Confidential - AOB

Dear Martina

The meeting with Mr O'Brien has just concluded. There are a number of operational issues as a consequence:

1. Have discussed a script should anyone ask with Lynne Hainey and we have agreed the following: "Mr O'Brien remains absent from work and this will be kept under review. Staff will be updated when this situation changes"

2. Mr O'Brien is aware that an OH referral is now being made.

3. Mr O'Brien will be delivering charts to your office at 11am on Tuesday. Should you need space, you could use the AMD's office – I will make sure it is clear today.

Ronan – Mr O'Brien was informed that he was being "Immediately excluded" to allow the Trust time to scope the scale of the issues which have been identified in terms of:

- Notes at home
- Untriaged referrals
- Undictated clinics
- Conclusion of SAI
- Any other areas which are identified

As part of your plan, there will need to be a clinical note review of all charts/referral letters returned by Mr O'Brien to assess whether patients have a clinical management plan or require a clinical review with a Urologist. The follow-up meeting with Mr O'Brien will take place in four weeks, so potentially Friday 27th January to discuss the outcome of this scoping exercise, of which the outcome of the clinical note review will be a critical factor. Dr Wright is willing to approve any additional costs incurred for this review to be completed within this timescale.

Happy to discuss if you require any further clarity.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
DHH: Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Corrigan, Martina

From: Young, Michael
Sent: 26 November 2013 12:35
To: Trouton, Heather; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Understand
I will speak

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Despite the fact that patients sitting not triaged from August mean that we have breached the access standard before we even start to look for appointments I am more concerned about the clinical implications for patients who need seen urgently and possibly even needing upgraded to a red flag status.

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

From: Corrigan, Martina
Sent: 26 November 2013 08:02
To: Robinson, Katherine; Glenny, Sharon

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Cc: Trouton, Heather
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: O'Brien, Aidan
Sent: 26 November 2013 02:08
To: Corrigan, Martina
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Martina,
I really am so sorry that I have fallen so behind in triaging.
However, whilst on leave, I have arranged all outstanding letters of referral in chronological order, so that I can passed them to CAO via Monica in that order, beginning tomorrow.
I know that I have fallen behind particularly badly (except for red flag referrals which are up to date) and I do appreciate that this causes many staff inconvenience and frustration, and that all have been patient with me!
I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion,

Aidan

From: Corrigan, Martina
Sent: 24 November 2013 17:28
To: O'Brien, Aidan
Cc: McCorry, Monica; Robinson, Katherine; Glenny, Sharon
Subject: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Importance: High

Dear Aidan,

Please advise, this is holding up picking patients for all clinics as these letters have not been triaged and I know that this will need to be escalated early this week if not resolved.

I would be grateful for your action/update

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Robinson, Katherine
Sent: 21 November 2013 14:31
To: Corrigan, Martina
Subject: FW: MISSING TRIAGE

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Browne, Leanne
Sent: 21 November 2013 14:12
To: McCorry, Monica
Cc: Cunningham, Andrea; Robinson, Katherine
Subject: MISSING TRIAGE

Monica

Here is list of missing triage as requested.

CAH

Personal Information redacted by the USI

CAHB Personal Information

Personal Information redacted by the USI

Personal Information

Pers onal

URO

AOB

ROUTINE

03/09/2013

65

EMAIL TO MONICA/NOLEEN 091013 - AC

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

EMAILED ANDREA 161013 AC

email to sharon 11.11.13

CAH

Personal Information redacted by the USI

CAH Personal Information

Personal Information

Personal Information redacted by the USI

Pers onal

Personal Information redacted by the USI

URO

GURO

ROUTINE

23/08/2013

76

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH

Personal Information redacted by the USI

CAHE Personal Information

Personal Information

Personal Information

Pers onal

Personal Information redacted by the USI

URO

GURO

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

ROUTINE

27/08/2013

72

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH

Personal Information redacted by the USI

CAHE Personal Information

Personal Information

Personal Information redacted by the USI

Pers onal

Personal Information redacted by the USI

URO

GURO

ROUTINE

28/08/2013

71

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH

Personal Information redacted by the USI

CAHE Personal Information

Personal Information

Personal Information

Pers onal

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Personal Information redacted by the USI

Personal Information redacted by the USI

URO

GURO

ROUTINE

28/08/2013

71

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH

Personal Information redacted by the USI

CAH Personal Information

Personal Information

Personal Information

Pers onal

Personal Information

URO

GURO

ROUTINE

29/08/2013

70

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH

Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

CAH Personal Information

Personal Information redacted by the USI

Personal Information

Pers onal

Personal Information redacted by the USI

Personal Information redacted by the USI

URO

GURO

ROUTINE

29/08/2013

70

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH

Personal Information redacted by the USI

CAH Personal Information

Personal Information

Persona l

Pers onal

Personal Information redacted by the USI

URO

GURO

ROUTINE

29/08/2013

70

EMAIL TO MONICA/NOLEEN 091013 - AC

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

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16/10/2013

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email to monica 11.11.13

Leanne

Leanne Browne
Acting Supervisor
Referral & Booking Centre
Ramone Building
Craigavon Area Hospital
T: Personal Information redacted by the USI
E: Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Confidential

Meeting on 17 December 2015
Associate Medical Director's Office – Admin Floor – Craigavon Area Hospital

Present:
Mr Mackle (chair)
Mr Young
Mr O'Brien
Mr Glackin
Mr Haynes
Martina Corrigan

Apologies: Mr O'Donoghue (on annual leave)

Mr Mackle outlined that the purpose of the meeting was to put a plan in place to support Personal Information redacted by the USI and assist him fulfil all aspects of job in a safe supported manner, and to determine his fitness and ability on all aspects of the job but in particular the ability to perform 'open' surgery.

Mr Mackle advised that he had outlined the Team's concerns to Dr Wright the Medical Director and he has asked that a documented plan is put in place in particular with respect to:

a) What training and courses needs to be identified and booked
b) What are the timescales
c) Support for when on call

TG = difficult for provide to cover by team in day to day.
Deficiency in open surgery e.g. injured bladders, injured uterus.

Pers onal Infor: doesn't recognise deficiencies – his perception different from Team (TG)

Surgery is not the only one element
Registrars – decision making on WR
"Lack of decision-making"

Long term. Here and now – how do we manage?

Process of defined training,
Second on call = MY tonight up on ward at 5pm to check patients.

Need to meet with Pers onal Infor and explain training + pro-active about patients.

More international.
Ward rounds to be accompanied by another consultant. (paid ½ PA)

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

6months. Consultants to do a supportive ward round:
Wed PM going to AOB in place.
Alternative Tuesday , AOB/TG.

Courses……..

1. MY to talk- decision making
2. EM to talk- decision making
3. Go to theatres
4. Talk to people
5. Courses

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

MINUTES OF UROLOGY DEPARTMENTAL MEETING
– CAH BOARDROOM 18th April 2013

In Attendance: Mr Young
Mr O'Brien
Mr Pahuja
Mr Glackin
Mr Brown
Jenny McMahon
Martina Corrigan

Minutes of this meeting records the planned reintroduction of a regular urology departmental meeting. We have decided that this should be for one hour between 12.30 and 1.30pm on Thursdays. This would match in well with the planned scheduling rota meeting which already exists. We thought the 12.30 start would be ideal as the ward round often doesn't finish till just after midday. We also decided that this would be a minuted meeting and we would discuss a topic until its completion before moving on to a new area.

The topic chosen to start these meeting was haematuria.

We defined the needs as twofold: firstly to resolve the access haematuria numbers on the books at present and secondly to address this problem in the longer term.

The agenda for this topic included current demand and how to record its volume, how patients were to be triaged to the service, making clear the entry requirements to the service, to re-evaluate what was to be included in the clinic assessment, whether the clinic design should be one, two or three stops and finally to discuss clinic locations.

Mr Brown has commented that national studies have shown that in general the referral to haematuria is one per 10,000 of the population. Therefore estimated that about 450 or so patients would be referred into our service. This would average 36 patients per month. Figures for February and March 2013 were available for our assessment. Noting that in February there were 16 referrals with an additional 4 upgrades and in March there were 41 referrals with 11 upgrades.

It was decided that the triage of letters would still continue to be consultant performed. Theoretically letters received could be as a direct referral as a Red Flag or indeed the consultant may wish to upgrade the letter to a Red Flag. A new arrangement now is that letters referred to Daisy Hill Hospital, with regards to haematuria, were to be triaged by the Craigavon team of consultants. Also the Mandeville Unit Team will now be taking over the booking of these referrals and their tracking. The allocation of patients to the Craigavon and Daisy Hill site will still continue as before and be based on the patient's address. Martina and Jenny were to liaise with the Mandeville Team about this new arrangement.

Discussion was held about the haematuria 'box' on the list of available clinics recorded on the hospital stamp. It is now recorded that a tick in the haematuria box means that all these referral letters are automatically to be regarded as a Red Flag referral (whether or not the words Red Flag or the sticker Red Flag has been attached to the letter).

We commenced discussions with regards to the care pathway. It is recorded that NICE and BAUS have nationally agreed guidelines on referral criteria for patients into this service. Discussion was held on this front as some have had reservations with regard to non-visible (microscopic) haematuria pathways. We will be commencing our next session with further discussion on this particular point but it is recorded that it is the consultants responsibility to triage referral letters to the appropriate clinic as the consultant sees fit for the patient to attend.

The next meeting will be for scheduling on Thursday, 2nd May 2013 and on the 16th May 2013 we will return to the topic of haematuria.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Stinson, Emma M

From: Young, Michael
Sent: 22 August 2022 11:29
To: Stinson, Emma M
Subject: FW: New complaint for investigation - Personal Information redacted by the USI
Attachments: Personal Information redacted by the USI .docx; Personal Information redacted by the USI .docx

upload

From: Corrigan, Martina Personal Information redacted by the USI
Sent: 08 March 2017 15:07
To: Young, Michael Personal Information redacted by the USI ; Haynes, Mark Personal Information redacted by the USI
Subject: FW: New complaint for investigation - Personal Information redacted by the USI

Good afternoon

I am not sure what time Personal Information attended over the weekend, but need to check where either of you contacted about her?

Any other comments on this complaint please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Changed My Number

INTERNAL: EX Personal Information ***if dialling from Avaya phone. If dialling from old phone please dial*** Personal Information redacted by the USI
EXTERNAL : Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 08 March 2017 14:33
To: Corrigan, Martina
Subject: FW: New complaint for investigation - Personal Information redacted by the USI

Martina
Can we get this turned around asap
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

From: Truesdale, Pamela
Sent: 08 March 2017 14:29
To: Hampton, Gareth; Corrigan, Martina
Cc: Stinson, Emma M; Cardwell, David; Carroll, Ronan; Livingston, Laura; McVey, Anne; Burke, Mary; Conlon, Noeleen
Subject: New complaint for investigation - Personal Information redacted by the USI

Please find attached a new complaint for investigation and note that you are required to provide your draft response by **21 March 2017**. The Directorate's recognised template is attached for you to complete.

This should be returned to Irrelevant information redacted by the USI in the first instance. If you have any queries please do not hesitate to contact **David Cardwell.**

I appreciate your assistance with this matter.

Pamela Truesdale
Governance Office, Acute Services
The Maples
Craigavon Area Hospital
68 Lurgan Road
Craigavon
BT63 5QQ

Tel Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

From: Complaints
Sent: 06 March 2017 16:34
To: ClientLiaison, AcutePatient
Subject: Personal Information redacted by the USI - Urology

Personal Information redacted by the USI

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Mobile: Personal Information redacted by the USI

Personal Information redacted by the USI presented at ED over the weekend with an urology problem. ED Staff phoned for an Urologist to attend to Personal Information redacted by the USI, but she alleges that one would not see her, and she was sent home with pain relief.

She said she has been having urological problems for the past 6 week and she is not healing. She said she would like another scan carried out as her "insides just don't feel right". She said she is being refused treatment by the SHSCT as she is currently pursuing a negligence claim about the Trust and her previous treatment.

I would be grateful if you could action this accordingly.

Regards.

Eileen
Corporate Complaints

Complaint Received	7 March 2017
Final Response due	4 April 2017

8 March 2017 **Our Ref:** AS389.16/17 **Your Ref:**

Private & Confidential

Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI

Dear Personal Information redacted by the USI

I refer to your complaint in respect of . Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them.

INSERT RESPONSE:

I hope that you will find this response has addressed the issues that you raised. However, if you are unhappy with any aspect of this response you should contact a member of our Clinical & Social Care Governance Team on 028 3861 2987 or 028 3861 2030 or email: Irrelevant information redacted by the USI within 3 months of the date on this letter so that we can attempt to resolve any outstanding issues.

Should you remain dissatisfied at the end of the complaints process, you can then refer your complaint to the NI Public Services Ombudsman at the following address, "Freepost NIPSO", Freephone: 0800 34 34 24 or email nipso@nipso.org.uk within 6 months of the completion of the Trust's internal complaints process. Further information on the role of the NI Public Services Ombudsman can be found at www.nipso.org.uk. Please note that the Ombudsman will not normally accept your complaint until the complaints process with the Trust has been exhausted.

Yours sincerely

_____

ESTHER GISHKORI (Mrs)
Director of Acute Services

for Mr F Rice, Chief Executive (Interim)

Clinical and Social Care Governance Team
Directorate of Acute Services
Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Telephone: Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

RESPONSE TO COMPLAINT BY Personal Information redacted by the USI **&** Personal Information redacted by the USI

STATEMENT

To my knowledge Personal Information redacted by the USI was admitted under my colleagues care Mr O'Brien. Personal Information redacted by the USI indeed is a long-term patient of mine.

She was admitted with sepsis and due to past information protocol we have asked that Personal Information redacted by the USI attends early before she gets into extremis. From my knowledge she did this on this occasion.

We have an agreed action plan for Personal Information redacted by the USI and her antibiotic regime. This has been agreed within the Trust and with Personal Information redacted by the USI and it is primarily lead by the Microbiology Team.

Personal Information redacted by the USI has extremely difficult intravenous access and indeed for more than a year we have had to rely on intramuscular antibiotic regimes. In fact this regime is particularly tailored for Personal Information redacted by the USI and is generally not a UK sanctioned protocol but is used in the United States. This method and antibiotic choice relates to a combination of Personal Information redacted by the USI 's allergic reaction to antibiotics and lack of easy venous access.

In more recent months we have attempted to get peripheral vein access. This has been via the Ward Doctors. This has been intermittently possible. If access fails we have asked our anaesthetic colleagues for help. It would be reasonable to state that the anaesthetic service is not the primary peripheral line venous access service provider. Prior facility by them has been for central line insertion in the theatre environment but following a previous case conference they have noted that the insertion of central lines is putting her at significant health risk and that future central line insertion is contraindicated.

The anaesthetic service has been kind to help us in our need if this fits in with their emergency workload, i.e., only if they are free to come to the ward to do this. This is my understanding of their care provision. Up to this time the initial management plan is for Personal Information redacted by the USI to have intramuscular antibiotic regime to start with. If there has been a lack of response to this management plan then intravenous lines are attempted. Firstly by ward staff and if not possible to ask for anaesthetic help if available.

I wasn't present at the time of the statement noting 'if he can't insert an IV no one can'. I am not entirely certain that this was a phrase used, it is not the standard communication but even if similar words were conveyed my interpretation of this is that it is trying to alleviate anxiety rather than to create it.

I came on call on the particular Friday mentioned in the correspondence. I observed that Personal Information redacted by the USI maybe wasn't making the progress that she was expecting. She was also asking for all the antibiotics to be given. I had noted that the antibiotic regimes were governed by our Microbiology Team. I did ask if an anaesthetist could attend to insert an IV line if possible. I have checked with the doctors concerned to find if this request had been made

and indeed it was, however the anaesthetic service were extremely busy that day. I was not on call over the weekend but did receive a phone call from our Registrar on the Sunday requesting advice and I had suggested to ask the anaesthetic service again to see if they could attend, which I believe they were able to do on that day. On the Friday I do feel that Personal Information redacted by the USI should have continued on her prior antibiotic regime but I was attending to her request for further antibiotics to be given and knowing the past history I felt that this was a reasonable request but not necessarily imperative to give.

Personal Information redacted by the USI's subsequent clinical pathway after her venous line was inserted was fairly standard for her and she was discharged on the expected date.

The second issue pertains to the prescribing of an antibiotic. (Although not stated the antibiotic is Linezolid). Personal Information redacted by the USI states that the Immunologist in the Royal Victoria Hospital advised that this particular antibiotic should not be prescribed to her. The antibiotic in question has been prescribed to Personal Information redacted by over a number of years with success. We are aware of the side effect profile of this antibiotic and in fact it had been discontinued because of the development of such side effect. The antibiotic in question is generally used as a second line therapy, though sometimes as first line, and has been given on the advice of our local Microbiologist. So due care and attention has been given to the prescribing of this antibiotic. We have had no communication at all from the Royal Victoria Hospital Immunology Team to say that this antibiotic should not be used (*I would appreciate if the subsequent comment is not put in a response to* Personal Information redacted by the USI *but for us to log the report. This is to state that I have had personal verbal communication with the Immunology Team in question and have asked a direct question whether this antibiotic shouldn't be used for treatment of* Personal Information redacted by the USI *and they note that this conversation did not occur in the terms that* Personal Information redacted by the USI *is quoting and that antibiotic choice is for the Trust to define.*) Personal Information redacted by the USI has known about this antibiotic usage in the past and in fact had been discharged home on these tablets previously.

The third comment relates to the flushing of the intravenous line. This is a nursing issue. I have tried to emphasize to the Nursing Team the importance of maintaining these lines and there is a distinct learning point here for the Staff Nurses on the Ward. Although I have emphasized this point it really will take the Ward Manager to address with all staff which will involves day and night staff along with Agency Nurses. It will be especially important to stress to the Agency Staff as they would not be usual members of the team.

With regards to the final point about agreeing to give her an alternative antibiotic, I would note that our antibiotic regime is defined by our Microbiology Team. A specific point brought up during our meeting with Personal Information redacted by the USI and Personal Information redacted by the USI is that Personal Information redacted by the USI asked Personal Information redacted by the USI what antibiotics she wanted. This is not at all the approach to be taken for

treatment. I informed Personal Information redacted by the USI that treatment policy is by Trust Policy rather than by patient's request.

From a learning point perspective the care pathway for Personal Information redacted by the USI is far from straight forward. We do have a treatment path for intramuscular antibiotics to be prescribed first. Careful consideration should be given to the intravenous route as venous access is difficult. It is appreciated that in recent times that this has improved and that specialised peripheral venous lines are now available and seem to work better for Personal Information redacted by the USI and importantly last longer. It is appreciated that the anaesthetic service kindly provides a ward service that is specifically for Personal Information redacted by the USI, this is not standard for other patients but we have tailored a care pathway specifically for her. It is appreciated that the anaesthetic service is busy and when free do attend. A learning point would be handover for the next day if this wasn't possible. This probably would have meant line insertion on the Saturday rather than the Sunday in this particular case. The antibiotic regime will still be governed by the Microbiologists and probably the most important feature of this rather than the line insertion is the timely line flushing by the Nursing Staff and frankly I feel that this is probably the most important learning point in this case. I have addressed this point with the Nursing Staff and will again emphasize it on completion of this complaint episode.

M.Young

Consultant in charge case

Lead Clinician

08/06/2020

Re: Letter of complaint
On: Personal Information redacted by the USI

Response to letter from Personal Information redacted by the USI

Personal Information redacted by the USI has given a detailed account of her care and attendance with her GP and at hospital here in Craigavon Area Hospital at the end of April into early May.

She has given a detailed and fair account. She documents her attendance at her General Practitioner but the question to address is her attendance at Craigavon Area Hospital. Her account in relation to the day that I had seen Personal Information redacted by the USI is indeed a very reasonable account. On enquiry from Personal Information redacted by the we found that he had been hit on the testicle the night before and was having pain at that stage. It did settle a little overnight but was still present from my understanding of the situation but had got worse in the morning. Personal Information redacted by the did allow me to examine the area; *often* Personal Information redacted by the USI *with torsion are extremely reticent to allow examination,* especially if it had been present for a full 24 hours. I do appreciate Personal Information redacted by the USI comments that I had started to examine Personal Information redacted by the but I was able to examine it sufficiently and to be happy with the situation of knowing that both testes were lying at the base of the scrotum. There was no evidence at all of any swelling or erythema other than a small bruise at the base of the scrotum. The point of noting the bruising at the base of the scrotum as opposed to on top of the testicle is that there is a condition of a twisted cyst of morgagni, which is a small cyst at the upper part of the testis, that when twisting can give a blue dot sign similar to a bruise. This was not the case as it was noted at the lower pole of the testis and taking this into account of being hit the previous day, pointed very much towards trauma. If torsion had been present for 24 hours there certainly would be swelling and erythema of the area.

I was fully appreciative of Personal Information redacted by the USI's concern. She did comment on another member of the family having torsion but this was in infancy and therefore a different age span to Personal Information redacted by the USI. I was very mindful of the concern re torsion and this was obviously in the forefront of our examination but at that particular time I did not feel that torsion was present. I did comment to Personal Information redacted by the USI that there was a known condition of intermittent torsion where twisting can occur on an intermittent basis. This was the reason I was informing Personal Information redacted by the USI that if she did notice any swelling, erythema or if the pain got worse certainly to bring Personal Information redacted by the back to hospital.

It is mindful that this period of time was in the midst of the early COVID time and whether an ultrasound scan could be performed. Ultrasound scanning is not a panacea to confirm or exclude torsion. I was aware that Personal Information redacted by the USI was at risk but still taking that into account and further

exposing everybody to the hospital environment, I made a clinical decision that an ultrasound in conjunction with the clinical findings was not best.

I note from the subsequent correspondence that Personal Information redacted by the USI has covering the next several days, noted their examination of Personal Information redacted by the USI's scrotum was undertaken and there was not any further swelling and the testes looked normal. It was only some five days later that there was an obvious acute change and they did observe the swelling and erythema. it was at this stage that they brought Personal Information redacted by the USI to the hospital.

I do appreciate the comments; both Personal Information redacted by the USI did follow up on examining Personal Information redacted by the USI over the subsequent few days as instructed, and they have indeed been particularly attentive, but at the time that I had examined Personal Information redacted by the USI there was not a clinical diagnosis of torsion. Ultrasound is not a definitive test but do appreciate it is an aid. The fact that there was a further five days without change in clinical findings is important.

I do fully sympathise that Personal Information redacted by the USI has lost a testicle and certainly our learning point is to emphasise to clinicians and parents to bring Personal Information redacted by the USI back if they have any further concerns, even indeed if it is a false alarm 'so to speak'.

Mr M R A Young, MD FRCS (Urol)
Consultant Urologist

RE: Personal Information redacted by the USI,
D.O.B. Personal Information redacted by the USI

A clinical report has been requested. The background is that Personal Information redacted by the USI had developed diabetes insipidus following pituitary surgery. She did have a prior suprapubic catheter in but this had been removed because of bypassing. Several years elapsed over which time she had further lower urinary tract investigations. The initial focus was on fluid management as she had a significant ingestion of fluid; this was in terms of litres during the day. This being compatible with her diabetes insipidus despite apparent maximum medication to counteract this. She had urodynamics in July 2014 noting significant detrusor instability contractions even as low as 70mls of fluid infusion. It was recognised at this stage that she did have a prior suprapubic catheter with some success. She was boarded for repeat suprapubic catheter insertion along with bladder wall Botox injection for her detrusor instability. It is noted that Personal Information redacted by the USI has not had any other prior abdominal surgery other than a hysteroscopy. Clinical notes from April 2009 record a cystoscopy and being placed on the waiting list for insertion of a TVT tape. There is however no operative record within the chart or on the ECR system to back that a TVT was actually ever undertaken.

On the 13th October 2015 cystoscopy dysport bladder wall injection and a suprapubic catheter were inserted. Operative findings defined a cystocele, meatal stenosis, a small capacity bladder but normal bladder mucosa. The operative procedure records Hagar dilatation (of the urethra). A cystoscopy was then undertaken. 500 Units of dysport in 20mls of normal saline were injected via 20 sites. A suprapubic Seldinger technique was then used to insert the suprapubic catheter and the 10ml balloon was then inflated. Plans were for a change of suprapubic catheter in the community in three months' time. The operative procedure being recorded has been performed by Mr Tyson and Mr Young. It is at this point that I would like to supplement the information provided. Firstly, that this procedure was jointly performed by two surgeons. Discussion had been held with regards to the precise skin insertion site for the suprapubic. It was recognised that there was a lack of prior abdominal surgery but there had been a prior suprapubic catheter insertion and for this reason with adequate bladder distension that the skin entry site was below the prior suprapubic tract site and with the Seldinger technique the needle was inserted under direct vision below the air bubble that is usually found in the bladder with cystoscopy i.e. placement in the anterior part of the bladder wall rather than the dome. One pass with the needle was used. The standard Seldinger technique was then used. It is appreciated that ultrasound can be used and is recommended to aid suprapubic catheter insertion, this being recommended by the National Patient Safety Agency and by the British Association of

Urological Surgeons however the caveat to this is that ultrasound should be available and that the person using the ultrasound should have adequate training. To date, neither surgeons in this case have routinely used ultrasound for suprapubic catheter insertion prior to this case nor have they been trained in the technique of doing so. They were not aware of the availability of ultrasound in the theatre department. So it was not their usual practice to use ultrasound and it should be emphasised that they were not trained in this technique.

Personal Information redacted by the USI was discharged but was re-admitted five days later requiring a laparotomy which defined a small bowel injury had been created by the suprapubic catheter.

Despite the consideration taken with regards to the prior suprapubic catheter and inserting the new catheter below the prior tract and with adequate bladder distension there obviously has still been adhesions in the retropubic space which is normally extra peritoneal but is evident by the small bowel adhesion; this was not the case. The prior suprapubic tract was initially not thought to be a factor but must now be regarded as prior pelvic intervention and as such consideration could have been given for the suprapubic catheter to be inserted via an open approach in retrospect. I regard this document as an accurate commentary on the events of the case as I remember discussing with the Registrar the specific techniques described above that we had agreed to follow.

Mr M Young
Consultant Urologist

April 2018

Southern Health and Social Care Trust

4 December 2015 **Our Ref:** AS185.15/16 **Your Ref:**

Private & Confidential

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

I refer to your complaint in respect of urology and endocrinology care provided to you at Craigavon Area Hospital and I will respond in this order. I also acknowledge receipt of your most recent letter dated 28 November 2015. Thank you for taking the time to highlight your concerns and for providing me with the opportunity to address them and I hope this response covers the concerns you have raised in both letters.

Urology Care

I have shared your concerns with Mr Young, Consultant Urologist. I understand that unfortunately you have developed an independent pathological lesion separate to your urological status.

Mr Young has summarised his understanding of your clinical picture, however he will not be commenting on the personal comments you have made.

Mr Young has reviewed the Electronic Care Record system. He is aware that the first urological records relate to a period when you were under Mr O'Brien's care. You were having some lower urinary tract symptoms and an ultrasound scan had shown a simple cyst in the left kidney; this was back in December 2007.

It is noted that you had bowel investigations which identified quite significant diverticular disease but a comment by Mr Mackle on 3 October 2011 noted that an updated CT scan had shown an incidental 15mm left renal nodule of uncertain aetiology and you were then to be referred to the urology team. This is in the background of you noting tiredness and weight loss. A nodular right adrenal gland was also noted along with an aortic aneurysm. Mr Mackle referred you for urological assessment noting that a small cyst had been noted before along with a past history of you having a transurethral resection of the prostate (TURP) which is a surgical procedure that involves cutting away a section of the prostate, in 2008 but that there was a new 1.5cm lesion in the left kidney.

In January 2012 you were assessed by the respiratory team noting at that stage you were Personal Information redacted by the USI. Chest x-ray at that stage appeared clear. In addition to this you had a consultation in July 2012 at the falls clinic. Comments were made by Dr Gormley that you had 'a very long history of multiple and at

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times quite vague symptoms, generally feeling tired over the past five years with poor exercise tolerance'. You complained of widespread aches and pains including your lower back and your bowel action was frequent. It was noted that you had a recent CT chest, abdomen and pelvis showing a degree of lung basal bronchiectasis and pleural thickening; the left renal nodule was again noted with the abdominal aortic aneurysm and a nodular right adrenal gland, which was thought to be a small benign adenoma.

In summary, you were noted to have a long history of a multitude of symptoms. Your dementia did not appear to have progressed significantly and this was the conclusion of Dr Gormley.

Mr Young consulted with you in November 2012 noting that your urinary symptoms were unremarkable and well settled from the previous prostatic surgery. The main issue was your small left renal mass. It was discussed that it was 1.5cm in size and this had remained unchanged over the previous year. Mr Young did explain that at this small size it makes it a little indefinite as to its pathology. He did point out that there was a low/some risk of malignancy but even if this was the case the incidence of secondary disease was extremely low. Mr Young noted that our departmental and urological regional general policy for such small renal lesions in your age group would indeed be observational and had organised a scan for a year later. This is as defined per discussions at urology x-ray multi-disciplinary team meeting which asked for a repeat CT scan in June 2013, the report commenting on an unchanged exophytic nodule on the left kidney.

A further scan was undertaken in August 2013 as follow up of a 1.5cm left renal mass. Again the conclusion for this report was that there was no significant change in the indeterminate small enhancing left renal nodule. This was further assessed at x-ray conference in November 2013, which noted an unchanged mass since 2011. This was communicated per letter to Personal Information redacted by the USI your General Practitioner. Mr Young also wrote a follow up letter to Personal Information redacted by the USI with regards to a phone conversation he had had with Personal Information redacted by Personal Information redacted by the USI as she had been ringing on your behalf in relation to your investigations. She noted that you had on-going pain on the left hand side of your body and she was querying if this was due to your cyst. Mr Young informed her again that he was following up your 1.5cm left renal lesion which was of an indeterminate nature; importantly it had not increased in size and that surveillance would continue. The next planned scan was August 2014; this had already been booked. Mr Young did log that you had not been back for urology review for some time but in any case the review appointment was to impart the knowledge of the last scan.

Mr Young did note that there was something new within the adrenal gland and that Dr Ritchie was looking into this in further detail. The on-going pain in your side Mr Young thought was more likely to be arthritic in nature since you had quite significant osteoarthritic changes in your neck. The plan of action was to see you again after your August 2014 scan.

It is noted that in November 2012, you were also assessed by the neurology team for headaches. It is interesting to note that the January 2014 CT of adrenal gland again comments on an unchanged left renal lesion and the left adrenal gland, albeit being slightly bulky, had no discreet mass and again was unchanged from the previous CT scan. A further CT scan, performed in September 2014, showed the left renal lesion to be remaining

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unchanged in size. However now there was a new tiny 5mm exophytic nodule on the lateral aspect of the left lower pole. No comment was passed on the adrenal gland on this scan.

Mr Young then received a letter from Mr Keane, Senior Consultant Urologist in the BCH Urology Unit. He noted that you were 'a little disquieted about the follow up you were having for two tiny lesions in your left kidney'. Mr Keane had agreed that these were 'not at a treatment phase as yet'. He noted that they were not able to offer a surveillance type follow up in Belfast for patients from the Southern Region, hence asking for follow up under my wing. It's not clear how you got under the care of the Belfast City Hospital.

Mr Young consulted with you and your wife on 1 May 2015. He noted the unchanged left renal lesion and informed you of the new small 5mm lesion, as was pointed out by Mr Keane to you. Mr Young did note however that you were having increasing lower urinary tract symptoms, albeit that the ultrasound at that clinic showed you were emptying your bladder. Your main complaint at this consultation was of slow micturitional flow and for this reason Mr Young organised for you to have a flexible cystoscopy to exclude a urethral stricture. You did comment on having left sided pain; this you commented was on movement and would wake you from sleep. Mr Young suspected strongly that this was of a musculoskeletal origin as the previous year's CT scan had excluded any other intra-abdominal problem. Mr Young did however rebook an updated CT scan. This was electively booked for September 2015.

This CT scan again confirmed the unchanged left renal lesion. However the smaller other lesion had increased in size. This was noted at 1.5cm. What was distinctly new was a mass in the left adrenal gland as well as a mass within the right adrenal gland. Further nodules were now present in the left lobe of the liver and in the superior aspect of the stomach. The report concluded that there was a stable appearance to the previously noted left renal lesion, an increase in size of the previously noted small lower pole lesion and now new enhancing adrenal masses bilaterally with abdominal lymphadenopathy. It was suggested that metastatic adrenal deposits was the diagnosis. It was recommended that a CT chest be organised and this was duly arranged. This identified supra and infra diaphraghmatic lymphadenopathy, a left para renal retroperitoneal deposit; the primary tumour was not identifiable. The differential diagnosis was of an occult gastric or colorectal carcinoma or indeed a malignant melanoma. It was felt that a metastatic renal carcinoma was unlikely to be the origins.

On receipt of this information, your case was discussed at the urology MDT on 8 October 2015. The outcome of this discussion was that you had metastatic cancer, as yet of an indeterminate primary, the left renal lesion was stable and follow up was already noted to be arranged with Mr Carey in Belfast. It would be usual practice for patients to be reviewed in person after such a MDT meeting but it was already noted that a review had been arranged in the Belfast City Hospital.

As such therefore, the last contact was at the end of May 2015 with the urology team when a flexible cystoscopy was performed and this was basically normal; no other comment is made on your urinary symptoms at that time.

It should be noted that comment had been specifically made on the late 2014 x-rays having been reviewed at x-ray conference in November 2014 and you being informed of our review of the situation per letter on 13 January 2015.

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Mr Young subsequently observes from the ECR system that you have had a CT guided biopsy of your left adrenal gland on 3 November 2015 and the pathology of this has shown a squamous cell carcinoma which is most likely to have originated from a lung primary.

In summary, you have been followed up with annual x-rays of your renal lesion under the urology wing. This has remained unchanged over this period of time, namely 4 years. It is noted that you have been assessed by other physicians from a variety of sub-specialities, namely general surgery with colorectal interest, respiratory, neurology and general physicians. These specialities have addressed the various components of your history but have not defined a cause for your pain. It is only with the last CT scan that has defined your current condition; this was not evident in any of the previous scans.

In response to your complaint letter, you initially record medical negligence, failure of duty of care and old age discrimination.

In section (1a) you refer to the possible malignant nature of adrenal and kidney lesions and these were to be monitored by yearly CT scans. This indeed was the process undertaken and explained why this course was to be taken – it was not at all certain as to the exact nature of the lesion and the surgical approach had its risks.

When initially seen in 2012 you did not comment on any pain as per the consultation letter. It is agreed that Mr Young's consultation was urologically based and as noted above you have been seen by many consultant physicians and surgeons who had been addressing the symptoms of weight loss, weakness and pain.

Mr Young is unaware of Dr Evans' referral back for a urological review as there is no associated letter on the ECR system.

I accept that there is a substantial backlog in reviews. Clinicians had however been reviewing your x-rays at x-ray conference and indeed Mr Young did have a phone conversation with your wife on a Saturday afternoon in early 2014. In this conversation there was comment on pain in your side. Mr Young did feel that this was more likely arthritic in nature as a small renal lesion measuring 1.5cm would not be associated with causing pain. A planned CT scan was organised for August of that year and this seemed to be acceptable. Again, there was no mention of the other associated symptoms during this phone conversation.

In (1b) reference to the GP informing Mr Young of the severe left kidney pain and severe weight loss; again Mr Young is unaware of this correspondence.

In (1c) again there is reference to 'eighteen months of agonising pain'. Mr Young's understanding is that during this period of time you had been assessed by neurology and by Dr Gormley in the care of the elderly. Mr Young had seen you in the clinic at the beginning of May 2015. At this consultation you were commenting on increasing lower urinary tract symptoms and Mr Young thought it prudent to perform a flexible cystoscopy to exclude a stricture. You were complaining of left sided pain; this was on movement and would wake you from sleep. Mr Young did suspect that this was of a musculoskeletal origin. He pointed out that your previous CT scans had excluded any other intra-abdominal problem but he still wanted the planned updated CT scan to be performed in any case.

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This does reassure me that Mr Young was investigating your complaint despite the previous normal CT scans and the Trust is satisfied that he was investigating you properly. We totally refute the comments in section (1d) of your letter.

In section (1e), your wife booked a private consultation at the Hillsborough Clinic with Mr Young. It is noted from your records that this indeed was booked but the 'patient cancelled as they had spoken with Mr Young'. As noted in the NHS correspondence of January 2014, Mr Young did have a lengthy conversation with your wife and this did cover the topics talked about, namely the surveillance programme for the renal tumour. It was acknowledged that you hadn't been seen for some time but correspondence had been sent two months earlier noting the unchanged renal mass and that any outpatient consultation was to further discuss this point. The pain in your side had been commented upon. Mr Young had suggested that this was more likely arthritic in nature as you had quite significant osteoarthritis changes in your neck and that the previous scans had all been satisfactory. Your wife seemed satisfied that there was a further scan booked for August 2014.

Mr Young takes particular exception to the words used like 'very irate' being mentioned in a phone call as this would be far from Mr Young's approach to talking to anyone. He also does not encourage patients to attend for private consultation having been seen on the NHS; He would rather add them on to an NHS clinic appointment or indeed as noted in this case phone them directly. However it should be noted that Mr Young does not cancel patients' appointments; if they still are wishing a private appointment, then this is their prerogative.

In section (1e) you refer to the urology CT scan only looking at the kidney lesions. Mr Young would like to point out that both the patient's records and the completeness of the x-ray scan are looked at in totality. The complete picture is taken into account. The outcome of x-ray conference are indeed usually sent out to the General Practitioners' if we feel there is something important to put across and this indeed has been the case in your situation, as for example the correspondence of November 2013.

The statements noted in section (1e) relating to the letter of 8 January 2014 written to the General Practitioner noting that the severe left kidney pain you were experiencing was likely to be arthritic, you feel feels relates to the severe spreading cancer. It should be pointed out that the scan later that year, in August 2014, did not confirm any spreading cancer. Therefore this would not have been an issue for the January letter.

In (1f) you note that Mr Young consulted with you in May 2015. You were commenting on your severe left kidney pain and weight loss. You have claimed that Mr Young 'dismissed out of hand without further investigative tests or examination that this was musculoskeletal'. You are failing to record that Mr Young did indeed organise for you to have a further CT scan.

Mr Young cannot comment on your wife's direct contact with the Radiologist; it is noted that the 9 September 2015 CT scan was of 'kidneys with contrast'. In the conclusion part of this report it notes that a red flag CT chest, abdomen & pelvis should be then performed. The Radiologist notes that this should be requested with further urology MDT advised. The CT was indeed requested and this was duly performed on 18 September 2015.

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Endocrinology Care

I have asked Dr McConnell, Clinical Lead for Diabetes and Endocrinology to reply to your concerns on behalf of Dr Ritchie who has since retired and left the Trust.

Dr Ritchie received a request for an appointment with regard to one possible left adrenal adenoma picked up co-incidentally on a Lifescan Screening appointment, received into the Trust on 15 October 2013. Dr McConnell assumes the reference to 2 malfunctioning adrenal lesions are based on your most recent scan.

The details on the referral from the GP at that time were of chest pain, shortness of breath and intermittent palpitations but that you had also been referred to cardiology with regards to these symptoms. Dr Ritchie organised the ultrasound as suggested which a consultant radiologist felt was inappropriate to see the level of detail required and recommended a dedicated non-contrast CT adrenal scan which was subsequently requested.

This again showed the indeterminate 15mm lower pole left renal lesion which you were under urology surveillance for and the left adrenal gland was described as bulky but no discrete mass, unchanged from a previous scan (8 January 2014).

On reviewing the previous scan, reported by a different radiologist this concluded that there was an incidental 10mm diameter nodule however in the right adrenal gland with negative Hounsfield score diagnostic of an adenoma unchanged again from a previous scan (29/6/12), although the adrenal nodule in either the right or left was not referenced in the 2012 scan. The density of ≤10HU has a sensitivity of 96–100% in distinguishing benign from malignant lesions.

A previous CT carried out on 20 November 2011 referenced that the right gland was nodular possibly containing an adenoma but the left gland was unremarkable.

The serial imaging of the adrenal glands would therefore have indicated a stable adrenal adenoma (between 2011 and 2014 over a 3 year period). Dr McConnell has asked an independent radiologist who has not reported any of these scans to relook at the CT's given.

The incidence of adrenal gland incidentalomas was found in a large study from the Mayo clinic to be 3.4% (ranging from 0.2-7% in old age). There is no consensus on the optimal diagnostic approach for hormonal excess in incidental adrenal adenomas. The National Institute for Health (NIH) recommend a hormonal evaluation except when the imaging findings are unequivocal. The unchanging size of the adrenal lesion would have suggested a benign adenoma as evidenced by the negative Hounsfield score.

Benign adenomas can still be hormonally active and possibly the history of palpitations would have warranted screening by 24 hour urinary catecholamines to exclude a phaeochromocytoma, which can present with a normal blood pressure. There was however no mention on the GP letter of weight loss, fatigue, weakness, thirst and low blood pressure as referenced in the complaint, symptoms which would have raised concern for an underlying malignancy. In addition hormonally active lesions of the adrenal gland usually give rise to a high blood pressure (and not a low blood pressure) and facial changes such as seen in Cushings syndrome. Dr McConnell is aware however that you were seen by Dr Gormley in July 2012 and had 24 hour urinary catecholamines and 24 hour urinary cortisol

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tested for and found to be normal. There was no mention of this in Dr Ritchie's hand written comments on the GP referral letter when she advised no endocrine appointment was required but may have given her further information to conclude that this was a hormonally inactive adrenal adenoma and therefore no endocrine evaluation would have been required when requested in 2013 but there is no documentation of this.

In your letter you have stated that Dr Ritchie wrongly addressed her referral about the 15mm left kidney lesion to Mr O'Brien which could have been easily detected had she bothered to read the hospital notes. The reason the original letter was addressed to Mr O'Brien was that in 2007 you were under Mr O'Brien for follow up flexible cystoscopy on Patient Administration System (PAS) and Dr Ritchie's secretary has a handwritten amendment on her letter to Mr O'Brien on 22 January 2014 stating that it had not been sent to Mr O'Brien as she had discovered you were a patient of Mr Young's although the heading had not been altered and so it was actually sent to the appropriate consultant managing your case and who was already following you up for the kidney lesion. It would however not have changed her management of the adrenal lesion and the kidney lesion as she was asking an urologist to assess it anyway.

You have also stated that Dr Ritchie's interpretation of the CT result not showing the adrenal adenoma was incorrect, yet the official report from that time shows that the left adrenal gland was bulky but with no discrete mass (implying an adenoma) which was in fact correct.

There is an allegation that given your increasing symptoms of weight loss, thirst, weakness and low blood pressure that an opinion from an expert endocrinologist could have saved your life by showing the extent of the left and right adrenal cancer before it had time to spread to your stomach area and bone. Unfortunately the most recent scan does not indicate that the adrenal lesions are the primary source of the malignancy but have been most likely metastasized to. Metastatic deposits in adrenals are common but very rarely do they cause hormonal imbalance as a result. Dr McConnell notes the plan to biopsy the adrenal lesions to determine the primary source of the cancer, which is thought to be possible gastric, colonic or skin related and not related to the adrenal and will be crucial in ruling in or out whether the renal or adrenal lesion had indeed any relevance to your most recent situation.

I am aware that you are off the opinion that a CT or MRI or I-123 MIBG scan in January would have saved your life. You had a CT in Jan 2014 which showed the pre-existing nodule in the kidney for which you were under urology review, a bulky adrenal which was felt to be co-incidental and had not changed in 3 years and would not have by the Society of Endocrine Guidelines merited further imaging on the scan result alone. Repeat imaging is only recommended for 2 years for incidental definite adenomas and not for bulky adrenals. With regards to MIBG scanning – this is specifically looking for a phaeochromocytoma, which would only be performed if 24 hour urinary catecholamines were elevated and only following a positive clonidine suppression test in the Regional Endocrine Unit in Belfast. As your sample for cathecholamines were negative under Dr Gormley, there was no indication to perform either a clonidine suppression test or MIBG scan. An MRI is only used to examine adrenal lesions where there is controversy over the Hounsfield score where the lipid content of an adenoma may make an adenoma appear to have a score in the malignant range.

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From reading through your complaint, it would appear that you developed severe left sided pain during 2014 after the scan in January 2014 as organised by Dr Ritchie which was a new symptom from your weight loss and weakness which you had had from 2011 and was not mentioned in the GP referral letter. This possibly should have indicated another diagnosis as neither stable adrenal adenomas nor stable kidney nodules should cause what has been described as agonising pain, and possibly prompted another urgent referral letter to either a general surgeon / physician for another opinion.

Dr Ritchie's letter stated that she thought you were the victim of unnecessary screening, believing that the left kidney lesion and bulky adrenal lesion which was felt to be possibly benign had meant that further investigation would therefore be required and serial follow up CT scans for the kidney lesion. She didn't appear to realise that you were already being followed up for the kidney lesion as she had sent a new referral to urology with regards to this. While Dr McConnell cannot comment on her thought process, the endocrine department does get a significant number of referrals for assessment of adrenal lesions picked up co-incidentally on scans performed for other reasons and it may have been that she felt this was another case, without appreciating that you were already under review for the kidney lesion. In fact, the adrenal lesion was not felt to be significant by radiologists attending the urology MDM and therefore referral to endocrine by urology was not a recommendation by radiology for any of the CT scans dating back to 2011. The risk of an untreated adrenal incidentaloma, qualified as a benign lesion, subsequently developing malignancy appears to be very low <1 out of 1000 from available statistics.

In section 3 of your complaint you comment on the Craigavon Hospital management allowing for a backlog. We (as a Trust) are aware of this being an issue, however your x-rays have been performed as planned and correspondence from the same.

In your conclusion you refer to comments about red flag cancer diagnosis in the letter dated 19 September 2015. It is noted that you did have your x-rays on 9 September 2015 and a repeat scan as requested on 18 September 2015. Your case was discussed at our urology MDT meeting of 8 October 2015. You would have been seen within days of this MDT meeting but it was noted that your care had already been moved to Belfast at the request of your General Practitioner and yourself. There therefore was no requirement to liaise with you as this would have been a duplication of appointments and in any case it appears that you wouldn't have attended as per your letter.

This unfortunately is a very upsetting situation for all concerned.

I do however feel that you are very focused on your renal lesion being the cause of your symptoms; this is not the case. Mr Young has tried to put this across to both you and your wife that small renal lesions do not cause symptoms nor are they associated with spreading cancer. This is also stated in the commentary from the BCH Oncology team.

In your correspondence you use the words – 'severe renal pain'; this was not Mr Young's impression when you attended at the clinic. It is now evident that a completely new lesion has developed in the interim, without any new symptoms being evident. Your symptomatology has remained the same over four years and you have been assessed by several physicians for the same symptoms.

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Finally there has been an apparent misinterpretation about age and therapy. It is put across by you and your wife that clinicians have an age discrimination approach to therapy. Apart from saying that this is far from the Trust's approach to caring for the elderly, it was pointed out on several occasions, that the surgical approach would potentially put you at more risk than treating a lesion of uncertain pathological significance. This was accepted as a management plan by both yourself and the clinician. It is not certain why there has been a change in opinion now. The BCH Oncology team on referral appear to agree.

This whole situation has had an unexpected outcome. The previously noted symptoms and x-ray findings have not had any relation to the current situation, as recorded by MDT on two sites and two specialities.

Unfortunately for you this situation does not look optimistic and my empathy is undoubtedly extended to both you and your wife.

I hope that you will find this response has addressed the issues that you raised. However if you would like to discuss any aspect of this response further so that we may help in resolving any outstanding issues, please do not hesitate to contact a member of the Clinical and Social Care Governance Team on [redacted] or email [redacted] within 3 months of the date on this letter.

Alternatively, if you remain unhappy with the Trust's response and feel that further contact with the Trust will not resolve your complaint, you can refer your complaint to the NI Commissioner for Complaints (the Ombudsman) at the following address: Freepost BEL 1478, Belfast, BT1 6BR or Freephone: 0800 34 34 24 or email ombudsman@ni-ombudsman.org.uk Further information on the role of the NI Ombudsman can be found at www.ni-ombudsman.org.uk

Yours sincerely

[redacted]

MRS ESTHER GISHKORI
Director of Acute Services

for Mrs Paula Clarke, Chief Executive (Interim)

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Notes of Meeting on Thursday 5 July 2012

Tutorial Room 1 Medical Education Centre

Present: **Mr R Brown, Case Investigator / Consultant Surgeon**

Mr M Young, Consultant Urologist

Mrs Zoe Parks, Medical Staffing Manager

Statement made by Mr M Young to Mr R Brown after interview on 5.7.12

This statement was drafted on my behalf by Mr R Brown and I have confirmed its accuracy, having seen it in draft and having been given an opportunity to make corrections or additions. The investigator advised me of the terms of reference of the investigation and asked questions about my experience of Personal Information redacted by the USI during his employment in Craigavon Area Hospital.

Personal Information redacted by the USI started in this Trust at the end of November 2011 as a LAT (Locum appointment for Training). I had been on the interview panel that interviewed him for this post and I can recall that he interviewed very well. He is very knowledgeable about Urology.

During his placement in Craigavon, I am aware he wanted to sit the FEBU exam- the European exit exam. He has passed the first part of the exam (the theory) and wanted to sit the second part of the exam, but he has been turned down as normally this is undertaken in your last year of training and it is not evident he is at that stage in his career. Personal Information redacted by the USI has also not been working on-call from February.

At Outpatient Clinics & on the Ward:

I believe his clinical decisions are reasonable. I am aware he can make a decision, form a management plan and formulate appropriate communication to the GP. Overall I think he may a little slow but this is not necessarily a bad feature. I am not concerned about his decisions in outpatients. On ward rounds, I understand that he is perhaps not quick enough in taking decisions and communicating these to the nurses, leaving them questioning management plans. He seems to have some difficulty in the day to day management of acutely ill patients and the ability to cope in these demanding circumstances.

Haematuria Clinic:

I was aware there may have been some concerns from the nurses in the Haematuria clinic that Personal Information redacted by the USI was bringing more patients back for biopsies than they would have expected or been used to, with other registrars. I therefore went to the clinic one day to see how things were going and observe his practice. I felt his treatment was appropriate and his inspection of the bladder was fine. However his technique using a camera on one female could have been better. It was a bit sore to pass the scope and I would have expected someone with his years of experience in urology to be able to manage this a little better. This is one area where there may be some technical training required, as it wasn't a difficult case. This was my observation on one day, so I am not sure if this is a consistent pattern or if he was just having a 'bad day'. I have also heard that some patients have questioned Personal Information redacted by the USI's

approach during the Haematuria Clinic wondering if he is a doctor. I think this may be related to his lack of confidence in this environment as it is very patient focused, seeing them for the first time.

Operative experience:

I have directly observed him in theatre. He was with me in Theatre last week doing a TURP. I showed him what to do and it was evident after 10 minutes he was performing it well. He virtually completed the operation himself although I completed the resection. My experience of his endoscopic operations has been fine although I am aware there may be some issues with other surgical operations.

I know he operated with Mr O'Brien who has raised concerns. In my opinion he is short in operative experience and is not fully conversant with operative techniques, considering the years he has spent in urology.

Prescription Issues:

I am aware of reports of a few prescription errors but I am not aware of the details of these. I would suggest you speak to the nurses if you wish to investigate this. It was not brought to my attention as the lead consultant in Urology.

Patient complaint on attitude:

I am aware there was a complaint from a patient who overheard Personal Information redacted by the USI telling the nurses to tell the patient to wait, while he returned to the scheduling meeting. I am not aware of the manner in which Personal Information redacted by the USI spoke about the patient but I can confirm the context in which this incident occurred which perhaps the nurses wouldn't have been fully aware. About ½ hour before this encounter, both registrars were told in no uncertain terms that they must attend the scheduling meeting. It would be unusual for the post op patient to come up to the ward to be seen and although they did need to be seen, I believe the nurses were expecting Personal Information redacted by the USI to see him there and then. It is unfortunate that the patient overheard his response however it should be noted the context in which this encounter occurred. .

Organisational & Interpersonal Skills:

The Urology ward is busy, often with competing demands on a doctors' time. I am aware he has difficulty multi-tasking when undertaking the ward round and ensuring the flexible cystoscopies are completed. Personal Information redacted by the USI is slow when undertaking tasks so this makes this multitasking even more difficult for him. I would comment however that this is a challenging task and would be difficult for most doctors. We are aware as a Unit that we do have an issue with how patients are arranged for the flexible cystoscopies and we are looking at ways internally to improve the running of this, so this is not his fault.

Information from nurses informs me that Personal Information redacted by the USI may appear a bit superior to them on the ward – implying he is the doctor and they are the nurse. This annoys them as they don't believe he has the clinical ability to back this up. It would be my view that he may display this behaviour as a confidence issue. He wants to be seen as the doctor but due to his level, he perhaps doesn't appreciate that he has to rely on the nurses to support him also. He is not good at interacting with the secretary to do the paperwork and this management ability could be improved.

He has been through the ARCP with Mr Nambi, the Urology Regional Programme Director in NIMDTA but to date he has not reached the standard to pass this yet. He was excluded from on-call in February but we have placed him back on-call recently on the understanding he presents every case and that he doesn't go to Theatre on his own.

In summary, for this stage in his Urology career and the level of experience portrayed at Interview, this has not been borne out in practice. He is at a lower standard which I believe has been due to a lack of exposure to busy ward attachments. He has come from a Clinical Research Fellow role where his on-call has been undertaken from a distance. He may not have had the exposure to the busy day to day running of a urology unit and his training has lacked that exposure. I would say however that I have seen improvement in him during the six months he has worked here. He has spent more time with Mr O'Brien than myself during this period, so I would suggest you speak to him on his experience of his performance during this time. I believe he is best suit to and capable of a post with a defined singular role per session. He will discuss cases properly and appropriately and in addition with time as well as exposure in a training environment be capable of simple core urology.

I believe that the facts in this statement are true***:***

M Young MD FRCS(Urol) 24/7/12 Correction of Draft
_____ Date: _____
Mr M Young

21st March 2014

Mr Kristan Matuszczak
Investigation Officer
Fitness to Practise Directorate
General Medical Council

Dear MR MATUSZCZAK

Re: Personal Information redacted by the USI

Personal Information redacted by the USI has asked me to supply a reference as he is due to attend a tribunal in the near future. He has informed me about decision making and care pathway issues with regards to this tribunal. I am not in a position to make comment on this. I can however give reference to his employment here in Craigavon Area Hospital. Personal Information redacted by the USI was employed as a Locum middle grade Urologist. Due to the short notice request, I am unable to give precise dates of employment but it was long enough to certainly get a good impression of his clinical and interaction abilities; the employment was certainly in excess of six months.

Personal Information redacted by the USI is certainly very knowledgeable of his area of speciality. I was comfortable with his knowledge base. It was also evident that he had practical experience and plenty of interaction with patients. I felt that he had solid decision making ability however like many middle grade doctors in their decision making as well as variances between clinicians that we all see, there were a few decisions that were at variance but I would emphasise that these were indeed very minor and not worthy of comment. I include this statement as it appears relevant to the tribunal case but as I note I had no reason to alter any of his decision making choices. I am not personally aware of any complaints from patients with regards to his behaviour or clinical decisions and am unaware of any Trust complaints. I have checked with our administration and there are no registered complaints.

I would comment that Personal Information redacted by the USI is what one might call a little head strong and this comes across in his personality but again, I feel that this is a variant of normal but could cause a personality clash for some. Again, I would note this is more amongst his peer group than having any effect on his doctor/patient relationship. I do see that Personal Information redacted by the USI's future career will probably pursue a middle grade posting and therefore to be supervised.

Yours sincerely,

Mr M RA Young, MD FRCS (Urol)
Consultant Urologist and Lead Clinician

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr MRA Young, Consultant Urologist
SECRETARY: Miss Paulette Dignam
TELEPHONE: [redacted]
FAX: [redacted]
E-MAIL: [redacted]

26th January 2013

RE: REPORT ON INCIDENT INVOLVING [redacted], [redacted] AND FOLLOW UP ACTION FROM SAME EVENT.

MARTINA CORRIGAN
HEAD OF SERVICE (UROLOGY & ENT)
ADMIN FLOOR
CRAIGAVON AREA HOSPTIAL

Dear MARTINA

I am writing to you as Departmental Service Administrator with reference to an incident on [redacted]. It was brought to my attention at [redacted], while in the Thorndale Unit, that [redacted] had left the building with the intention of not returning for clinical duties that afternoon. Earlier that morning, I had a conversation with [redacted] with regards to a change in planned clinical activities that afternoon; the change of plan related to the fact that several of the urology team were off sick and clinical duties had to be changed. Of the duties to be covered, [redacted] agreed to undertake the haematuria clinic in the Thorndale Unit that afternoon. There appeared to be no problem with this arrangement.

When attending a meeting in the Thorndale Unit at lunchtime, I was informed that there was a change in plan and that the haematuria clinic was to be switched from one room to another within the Thorndale Unit. This, I am told, related to an infection control risk. It is not clear why [redacted] took exception to the senior nurses' decision to switch rooms. The verbal exchange between [redacted] and the senior nurse [redacted] did not portray to me a clear reasoning from what nurse [redacted] told me about the conversation. In any case, he left the building; the temperament was such that it was not clear whether he was going to return.

At this point, I decided to leave the situation until it was clear whether he would return and as such, while I was in my office with Malcolm Clegg, Senior HR Officer, that I took the opportunity to ring Personal Information redacted by the USI on his mobile phone. An adequate reason for not being at his clinical station for duties that afternoon was not given and in fact I found that when I asked where he was at 2:10pm he informed me that he was at home. It should be noted that at this stage Personal Information redacted by the USI had not informed me as his Line Manger that he would not be attending his clinical duties that afternoon nor had he made an arrangement for others to cover his activity. Mr Clegg overheard the full conversation to be had with Personal Information redacted by the USI. I terminated the conversation with Personal Information redacted by the USI noting that I would speak to him the following day. On completion of this phone conversation Mr Clegg and myself noted this rather unusual state of affairs and in fact neither of us had come across this situation before and we both concluded that it was completely unacceptable. Mr Clegg and myself then had a conversation with regards to his subsequent clinical activities for the Trust, being somewhat concerned about this bizarre reaction. Mr Clegg was to find out about his employment position.

On further investigation we find that although Personal Information redacted by the USI had been offered a clinical post as a speciality doctor, he had not signed his contract as we were awaiting references from previous employment, which would have governed his position on the pay scale. He had been enquiring specifically about this particular point and I understand both from the Trust's perspective and Personal Information redacted by the USI himself that contracts had not been exchanged because both parties were uncertain about this exact point.

On Personal Information redacted by the USI, I understand that Personal Information redacted by the USI attended the ward as part of his previously arranged rota allocation to perform a ward round and associated duties. I personally was not on Trust duties that morning but did return at lunchtime. However during the morning I had contacted Mr Pahuja, Consultant Urologist, to whom Personal Information redacted by the USI was due to help for an afternoon theatre list. I informed Mr Pahuja that I felt it prudent and indeed requested him to perform all the duties for the theatre list himself to include the consenting of patients and the undertaking of the theatre list. I had asked that Personal Information redacted by the USI not to undertake any of these duties. The reason for this was I was uncertain whether he was capable of doing so in light of the previous day's events. I would like to note that I was unaware that he had been assigned ward duties in the morning; this also would have been halted. There had been the expectation that he would have spoken to me before proceeding further. As it was, he had obviously spoken to Mr Pahuja, who had informed him of the afternoon's plans and at this point Personal Information redacted by the USI had phoned me. An ultimatum was given to me that he was going to go home again if not allowed to undertake the theatre list in the afternoon. At this point, I stopped Personal Information redacted by the USI's conversation and informed him that he was not to be giving me an ultimatum and that I would meet him in my office in fifteen minutes.

When I arrived at my office, Personal Information redacted by the USI was already sitting in a seat. I asked him if it was his normal practice to enter an office of a senior member of staff without the senior member already being in the room. At this point he said that on this occasion he took the liberty. I then had a clear consultation with Personal Information redacted by the USI informing him that the activities of the day before were completely unacceptable, that he had left patients at risk, had not informed me as his Line Manger, had not arranged cover and that after an opportunity to explain himself that from the fact that he offered no reason that I was left in no other position other than to terminate his contract with our department. He appeared to accept this as there was no further rebut and we shook hands and he left the room. Just prior to this meeting I had phoned you to define the Trust's position. I was informed that he had not signed any contract for his speciality doctor post and that he was still under the remit of the Locum Agency. It was therefore in our power to terminate contract as this was on a sessional basis in any case. The meeting with Malcolm Clegg the day before would have held the same conclusion that this behaviour was unacceptable to the level of dismissal.

I, as Lead Clinician, have informed my fellow colleagues in the department of this action and I have obtained unanimous agreement. I also had discussed my thoughts with my senior colleague, Mr O'Brien prior to the consultation. I feel this is a fair and accurate record of the course of events. I have asked for a copy to be sent to Robin Brown for his information as Urology Surgical Directorate Lead as well as to Malcolm Clegg, Human Resources.

Yours sincerely,

Mr M RA Young, MD FRCS (Urol)
Consultant Urologist

cc MR ROBIN BROWN
CONSULTANT SURGEON
DAISY HILL HOSPITAL
5 HOSPITAL ROAD
NEWRY
BT35 8DR

cc MR MALCOLM CLEGG
SENIOR HR OFFICER
TRUST HEADQUARTERS
CRAIGAVON AREA HOSPITAL

Urology Department Governance Meeting 22nd October 2015 Minutes

Attendees
Mr O'Brien, Mr Young, Mr Glackin (Chair), Mr Suresh, Mr Haynes, Mr O'Donoghue, Mrs McMahon, Mrs Corrigan, Mr Tyson, Mr Mukhtar and Ms Martin

1. Minutes of last meeting 16 June 2015 and matters arising
   19082015 Minutes.docx
   Confirmed as an accurate reflection of the meeting.

2. Update on Registrar Audits Received
   a. Partial nephrectomy – All partial nephrectomies undertaken from 2010 onwards to be reviewed by Jenny Martin. Work ongoing.
      To be presented at December 2015meeting.
   b. Outcome of invasive transitional cell carcinoma from 2000 – 2010. This is a pathology based audit to identify all outcomes of such patients. Mr Mukhtar to liaise with Mr O'Brien on this topic. Work ongoing.
      To be presented at February 2016 meeting.
   c. Audit of hand over quality – Mr Tyson. Work commenced.
      To consider using IMMIX NOTE.

3. Mr Glackin Nephrectomy cases
   6 cases presented. One specific point of technique relating to occlusion of renal vein(s) during partial nephrectomy emphasised. No other criticisms or learning to be shared.

4. Morbidity & Mortality
   a. Personal Information redacted by the USI Mr Haynes
      Agreement to use ultrasound guidance when placing an SPC. Consider use of open cystostomy when placing an SPC in patients who have had previous pelvic procedures.
   b. Personal Information redacted by the USI Mr O'Donoghue
      Appropriate and timely management. Inevitable death. No specific learning points identified.
   c. Personal Information redacted by the USI Mr Suresh
      Appropriate and timely management. The group question what criteria are applied to mark a case as a potentially avoidable admission to ITU.
      Action:This case will be forwarded for discussion at the Surgical and Anaesthetic meeting because it demonstrates interface working between specialties.
   d. Personal Information redacted by the USI Mr O'Brien
      This was a very challenging case from the perspective of the patient and family dynamic. Care involved several members of the Urology team over a period of several weeks. The management was appropriate and timely. This patients disease was aggressive and death was inevitable. The medical cause of death certificate noted non-muscle invasive bladder cancer. This was incorrect, it should have stated metastatic bladder cancer.
      Action: Mr O'Brien to advise the Coroner's Office.

e. Personal Information redacted by the USi Mr Haynes
Inevitable death form metastatic prostate cancer. Holistic care provided.

5. Audit of UTI post flexible cystoscopy in the Thorndale Unit.
Mrs McMahon presented an audit of 68 cases, there were no identifiable cases of UTI post procedure. The issue of non-sterile handling of flexible ureteroscopes was raised. This needs further discussion between Theatres, Urologists, HOS for Urology and Infection Control.
Action: Mrs Corrigan to convene meeting with interested parties at the Urology Departmental meeting.

6. Complaints & Compliments
None discussed
7. Learning from SAI's
None discussed
8. Any other Business : Other issues relating to Clinical Governance.
It was agreed by the Urology Consultants and Mrs Corrigan, HOS for Urology, that when an emergency urology patient transfer from another hospital required a bed in CAH this patient would take precedence over elective urology admissions.

Mitomycin C administration: Not discussed
SPC training dates TBA and circulated by Mr Young

9. Date for future meetings

Wednesday	18th	November	2015	1:45pm – 5:00pm	*Lecture Theatre, MEC*	*Clanrye House*
Friday	11th	December	2015	2:00pm – 5:00pm		*TDU*

Thursday	21st	January	2016	1.45 – 5.00pm	*Speciality specific*	*Lecture Theatre, MEC* Seminar Room 1 &2 &Tutorial Room 4	*Boardroom Tutorial Room (2.30-5pm)*
Tuesday	23rd	February	2016	1.45 – 5.00pm	*Combined*	*Lecture Theatre, MEC* Seminar Room 1 &2	*Boardroom*

MINUTES FROM UROLOGY DEPARTMENTAL GOVERNANCE MEETING

19th AUGUST 2015

In attendance: Mr O'Donoghue, Chair, Mr Young, Minutes, Mr Haynes, Mr O'Brien, Dr Martin, Mr Tyson, Mr Mukhtar, Sister O'Neill & Martina Corrigan.

Apologies: Mr Glackin, Mr Suresh (holiday leave).

1. **HAND OVER** – This is proving an on-going issue; it is still recorded that this should be in person and in writing. It is recognised that the clinical governance committee are awaiting to report on this however in the interim our Registrar's will attend the surgical hand over in the morning at 8:40am. This will be the interim measure until it is defined what exactly will be the on-going arrangement. It is also appreciated that there is a hand over in the evening.

2. **LOCUM WORK** – It's not exactly clear when Locum's are commencing their shift time. There is an appreciation that they are working in other Trusts prior to commencing work for us in the evening. A more realistic start time may be recommended. Outcome is for Martina Corrigan to audit start time.

3. Where a patient is an inpatient and a urology consult is requested we are recommending that as much as possible from a urology investigative point of view should be performed as an inpatient rather than bringing the patient back as an outpatient.

4. The daytime Registrar cover of the urology unit was discussed with regards to the change noted in July where all day cover for a full week had been instigated; Dr Martin felt that there was good continuity of care. We are currently trialling the consistency of a single Registrar covering the morning sessions from Monday to Friday for two months. In October we will again trial the all day Monday to Friday approach.

5. There has been an adoption of one bleep only for the on-call urology Registrar i.e. the bleep is handed between Registrars' as opposed to switchboard etc. having to look at a rota for each session.

6. There are on-going training issues with regards to Immax (now called - Note). The M&M form data needs to be completed by the individual consultant and then at the audit meeting this will be completed by the audit members led by the chairman.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

7. The Trust audit on fifty inpatients has had a poor uptake to date. It was hoped that 'google-doc' could be used but this has not been possible due to Trust computer blocking systems. Martina Corrigan will be addressing this with the IT Department but we have suggested that if this is not immediately correctable that a paper version would be undertaken. Plan to start 01st September 2015.

8. The stent register process is on-going. Mr Haynes has liaised with BAUS central office. Update for next meeting.

9. Audits for the incoming year:

    1. Partial nephrectomy – All partial nephrectomies undertaken from 2010 onwards to be reviewed by Jenny Martin.

    2. Outcome of invasive transitional cell carcinoma from 2000 – 2010. This is a pathology based audit to identify all outcomes of such patients. Mr Mukhtar to liaise with Mr O'Brien on this topic.

    3. Audit of hand over quality – Mr Tyson.

    4. On-line catheterisation teaching questionnaire for FY1's.
    These audits are in addition to the index control audit of TURBT and TURP.

10. Dr McAllister's comment on VTE prophylaxis was noted. The outcomes for each ward are recorded. Discussion on this topic did record that for 3 South the VTE risk assessment was only at 55%. Discussion also noted that our ward was a mix of ENT and urology. This led to a discussion around whether Clexane should be given to patients where bleeding is at risk, namely haematuria, TURBT and prostate surgery. It was concluded that all patients will be given the appropriate Clexane and TED stockings unless there is a specific default from same recommended by the consultant in charge. A focus at the daily ward round on the drug kardex is to be instigated.

11. **COMPLAINTS** – There is a general trend of complaints with regards to waiting times for outpatients and inpatients. No specific complaint with learning point has been recorded.

12. **CLINIC TIMES** – It is recorded that the afternoon clinics are overrunning often finishing well after 5:00pm and sometimes at 6:30pm. The afternoon clinics start at 1:30pm. The booking times towards the end of the clinic are to be readdressed by Martina Corrigan. It is recommended that last patient appointments should be at 4:00pm; this is to be trialled, actioned by Martina Corrigan.

13. No mortalities are recorded this month.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

14. **MORBIDITY** – Case of bilateral flexible ureteroscopy with resultant acute renal failure from obstruction. The case presented with bilateral diagnostic flexible ureteroscopy with passage of urine for 48 hours post-procedure which then progressed to acute onset of anuria. Renal function blood tests then defined increasing creatinine. An ultrasound scan did not show any hydronephrosis. Patient then developed pain. Nephrology input requested as unusual presentation of obstruction. Proceeded with bilateral stent insertion; this resolved the renal function.

    Outcome learning points:

    1. Treat bilateral ureteroscopy with utmost respect with insertion of ureteric catheters or stenting.

    2. A lack of hydronephrosis does not necessarily exclude obstruction – clinical judgement to take precedence.

15. **NEXT MEETING** – General hospital audit on 15th September 2015.
    (post- script = this date is same as Regional Audit in the Ulster Hospital)

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Re : Personal Information redacted by the USI Urology cover

June 2016

Dear Medical Director

Although you will be aware of this issue, I write to keep you up to date of meetings and progress in relation to urology emergency cover for our colleague Personal Information redacted by the USI. Due to circumstances arising last autumn, it was felt that additional senior cover was required in the event that emergency 'open' urological procedures would be needed. Mr Mackle has discussed this with you already but further clarification was to be defined.

The consultants in the department have had two meetings with Mr Mackle, (Dec15 and in March 16) to discuss arrangements. All consultants have been present at either or both the meetings. Two areas of cover were deemed necessary to cover. These were for emergency theatre cover for open urological procedures and day time supervision of ward work.

A rota was to be put in place so that these two areas where covered. Although it was clear what cover emergency theatre meant, it was up to each consultant to provide daytime cover as they felt to be required. Some consultants felt uneasy about too high a profile cover but they were there for advice. Support, cover and mentorship were in essence the backbone of our approach. Mr Young and Mr Mackle had separate meetings with Personal Information redacted by the USI to outline and reaffirm the needs and expectations for progress. These included surgical skills training courses and attend other consultants theatre lists where appropriate.

Personal Information redacted by the USI has fully engaged with the process. He has recognised the areas that require attention and has added additional ideas for training opportunities. He has recognised that the patients under his 'wing' of on-call are his responsibility yet other consultants are available for consultation. During the last six months he has appropriately availed of this facility.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

There has been a formalized evening rota arrangement for cover within the department for the past six months. Formalized daytime joint consultant ward rounds have been conducted but on a more ad hoc basis, but to an adequate level to assess the situation. A Multi-disciplinary feedback questionnaire is planned to be completed and collated within the Team (not linked to the 360 feedback) – M Corrigan will be organising and collating responses. This will be used as constructive feedback for Personal Information redacted by. Mr Mackle regarded that the cover arrangement for second on-call would be remunerated by a ½ PA.

A further meeting was to be held over the summer to assess progress and the next step. This will be planned soon but it is clearly evident that distinct progress has been made from comments made from senior colleagues.

M Young

Lead Clinician Urology

Southern Health and Social Care Trust

Occupational Health Department

PRIVATE AND CONFIDENTIAL

Mr M Young
Consultant Urologist
Ward 2 South
Craigavon Area Hospital

23 December 2009 **Our Ref:** AB/cm

Dear Mr Young

Re: Personal Information redacted by the USI
Personal Information redacted by the USI
Date of birth: Personal Information redacted by the USI
Directorate: Personal Information redacted by the USI

Background

Many thanks for referring this Personal Information redacted by the USI (sessions) who was seen by myself on 15 December 2009. I understand that whilst currently at work, Personal Information redacted by the USI has recently experiences some further difficulties in respect of his Obsessive Compulsive Disorder (OCD) for which he continues to receive specialist support.

Current fitness for work

Personal Information redacted by the USI is currently fit.

Outlook

Personal Information redacted by the USI' OCD is of a remitting and relapsing nature. It is hoped however that with the commencement of recent treatment and the provision of further treatment which should hopefully commence early in the New Year, the condition will stabilise. I would emphasize however that currently, Personal Information redacted by the USI remains well and in my view, fit to practise.

Disability

It is possible due to the nature of Personal Information redacted by the USI' condition, he may be viewed as being disabled under current legislation. The final decision in this regard can however only be taken by an employment tribunal.

Workplace adjustments

I cannot identify any workplace adjustments which are clinically indicated.

Contd/

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Southern Health and Social Care Trust

Personal Information redacted by the USI

Follow-up / Recommendations

In order to provide continuing support to Personal Information redacted by the USI and to monitor his progress, I will arrange to review him again myself in three months' time. Naturally should there be any concerns with regard to Personal Information redacted by the USI' wellbeing prior to then I would be happy to bring that appointment forward.

Please confirm with Personal Information redacted by the USI that a sickness review appointment has been arranged for **Tuesday 16 March 2010 at 9.00 am.**

Yours sincerely

Proof read but not signed by

Dr Alan J Black MRCP (UK) MFOM FFOMI
Senior Consultant, Occupational Health

Cc Ms P Hughes, Employee Engagement & Relations Department, Hill Building, St Luke's Site, Loughgall Road, Armagh
Ms Zoe Parks, Medical Staffing Manager, CAH

Occupational Health Department
The Maples, 68 Lurgan Road, Portadown, BT63 5QQ Tel: Personal Information redacted by the USI E-mail: Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Craigavon Area Hospital Group Trust
68 Lurgan Road, Portadown, Co. Armagh, BT63 5QQ

Urology Department
Tel; Personal Information redacted by the USI
Fax No; Personal Information redacted by the USI
E-Mail; Irrelevant information redacted by the USI

Consultant Urologist
Mr MRA Young, MD FRCS (Urol)

Consultant's Secretary
Mrs Michelle McClelland

---

2 February 2004

Mr I Stirling
Clinical Director of Surgery
CAHGT

Dear Ivan

Just prior to Christmas Mr Herron approached me with regards to urological equipment. The Department of Health apparently has extra resources. I informed him of our needs however I believe this is now back in the hands of the Trust to prioritize needs. As previously discussed there is a list of equipment needs. This was emphasized at our recent surgical directorate meeting for risk assessment.

-- Our equipment needs focus on updating our endoscopes.
-- Flexible Ureterorenoscope
The Trust has never replaced the scope we previously had. An important issue relates to the fact that this scope has a shelf life of 30-50 cases. Provision has to be made for re-purchase. The lack of scope is contributing to our long waiters.
-- An additional rigid ureteroscope is required as more often than not one of our existing scopes has to be returned to the manufacturers for repair. This restricts the number of cases of ureteroscopies on the list and has in the past resulted in patients requiring to be cancelled from the emergency list due to lack of scope.
-- Our TURP resectoscope sheath and working element are a liability.
-- For some four years now I have requested a holmium laser
The advantages of this machine focus on its versatility and safety over existing methods and these are clearly outlined in previous business cases. Purchase could for instance be via partial payment combined with leasing.

These undoubtedly are the major issues at present for us. We would have many other requests but the equipment noted above is required before we can move on.

Yours sincerely

Mr MRA Young
Lead Clinician in Urology

Cc Mr D Herron
Director of Business and Planning
CAHGT

Dear Eamon

Below is a job spec. for the new urology SHO post with its on-call being as part of the urology registrar rota. I would be grateful if you could take it forward with the college.

Daily Record	Activity First SHO	Activity New SHO
Monday AM	Ward Round Multidisciplinary Ward Team meeting	Stone Treatment and Clinic
Monday PM	Histopath MDT Admin	Histopath. MDT and Ward Round
Tuesday AM	Ward Round / Theatre (alternate weeks)	Theatre / Ward Round (alternate weeks)
Tuesday PM	Urology Out-Patients	Theatre
Wednesday AM	Theatre	Admin
Wednesday PM	Theatre	Ward Round
Thursday AM	Radiology MDT and Grand Round	Radiology MDT and Grand Round
Thursday PM	Admin / discharge comments / emergency cover / evening round	Outpatient Clinic
Friday AM	Ward Round Ward attender therapies	Theatre
Friday PM	Urology Outpatients	Theatre / Outpatients (alternate weeks)

This is the defined job spec. when both SHOs are present. There may be a need for some cross cover when the opposite number is on a specific part of the general surgical rota and therefore not available to the urology service. Do we have to go into this aspect in greater detail??

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Corrigan, Martina

From: Corrigan, Martina
Sent: 24 February 2014 07:45
To: Burns, Deborah; Mackle, Eamon; Young, Michael
Subject: RE: Yesterday

Thanks Debbie,

Michael can we have a chat about how we will manage this operationally with you and the rest of the team?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Burns, Deborah
Sent: 21 February 2014 19:13
To: Mackle, Eamon; Young, Michael; Corrigan, Martina
Subject: Yesterday

I had a very helpful meeting with Mr O'Brien yesterday (Martina also attended). Mr O'Brien has agreed to not triage new referrals (with exception of those named to himself). He is also to think about if any additional admin support would assist him.

Michael I know this may place an additional burden on the rest of the team but appreciate you accommodating

Thanks for your help with this situation D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Corrigan, Martina

From: Corrigan, Martina
Sent: 18 February 2014 10:55
To: Young, Michael
Subject: RE: Urology - untriaged letters

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Young, Michael
Sent: 18 February 2014 10:49
To: Corrigan, Martina
Subject: RE: Urology - untriaged letters

Monica is off on a Monday so was going to give her them at lunchtime as see would need to sort some of them out MY

From: Corrigan, Martina
Sent: 18 February 2014 10:47
To: Young, Michael; Personal Information redacted by the USI
Subject: FW: Urology - untriaged letters

Hi Michael

The booking centre have received none of the referrals that either you or Aidan done. Do you know where these are and I can chase?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Robinson, Katherine
Sent: 18 February 2014 09:41
To: Corrigan, Martina; Carroll, Anita
Subject: FW: Urology - untriaged letters

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Browne, Leanne
Sent: 18 February 2014 09:32
To: Robinson, Katherine
Subject: RE: Urology - untriaged letters

No referrals yet

From: Robinson, Katherine
Sent: 17 February 2014 13:13
To: Browne, Leanne
Subject: FW: Urology - untriaged letters

Keep me posted on this

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 17 February 2014 13:12
To: Carroll, Anita
Cc: Robinson, Katherine; Trouton, Heather; Lappin, Aideen
Subject: RE: Urology - untriaged letters

Anita

There has been a lot of discussions about this. Mr Young confirmed with Debbie and I yesterday that Mr O'Brien had confirmed that as of last Friday PM all of October and November were complete and was due to be left with booking centre by Monica on Friday PM. Mr O'Brien was to do up until 26 December over the weekend and would leave into the booking Centre this evening. Mr Young has completed Mr O'Brien's triage from 27 December up until last Friday 14 February and this should also be with the booking centre this evening.

I have asked Katherine to update me once they receive or if they don't receive these triage letters.

I will keep you informed

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust

Telephone: Personal Information redacted by the USI (Direct Dial)

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

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

From: Carroll, Anita
Sent: 17 February 2014 11:58
To: Corrigan, Martina
Cc: Robinson, Katherine; Trouton, Heather; Lappin, Aideen
Subject: Urology - untriaged letters

Martina

Have you any updates from the Consultants?

Anita

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

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

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Urology Departmental Meetings Autumn 2018

12-15 Seminar Room 2

DATE	TOPIC
4 Oct	
11 Oct	Xmas cover
18 Oct	
25 Oct	
1 Nov	Dec Scheduling
8 Nov	
22 Nov	
29 Nov	
3 Dec	AWAY DAY
6 Dec	
13	

- Urologist of the Week
- Triage
- First Out Patient Consultation Waiting Times
- Development of care pathways (bladder cancer, LUTS/BOO)
- Outreach clinics
- Specialty Doctor Clinics
- Consultant Job Planning
- Annual Leave
- Care of Benign Urology Patient
- Cancer MDT
- Theatre allocation and usage
- Waiting List Management
- Winter pressure planning
- Technology & Equipment

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

OCT 4th

1/ Weekend ward round recognition – have to ?

unpredictable / predictable

Discussion - conclusion is for a Saturday 3 hr duration of predictable work, based on work pattern observed by all Consultants in the Unit.

This is however not an agreement for elective planned work of any kind on a Saturday morning.

2/ Sign off of job plans.

Has everyone agreed?

3/ triage

Time to perform – we are not entirely sure of the duration spent over the week. Times given were only given as a prediction but not actually timesheet assessed.

Six hours appears to be the current allocation

Assessment to be undertaken of actual time

OCT 11th

WARD CARE

Concern expressed at level of nursing care – distinct failure of orders and observations being carried out.

Stability of staff and emphasis of enacting on orders = how can this be ensured and obtained?

Consultants are expressing deep concern.

Meeting with management and senior nursing required.

Suggesting that an excess of variety of patient types is a distinct problem.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

WINTER PRESSURE

What is Trust plans ?

Suggestions

– ring fence elective ward

- Day cases on T4
- Can some of our pt be sent out on WLI

Trust needs to be informed of the extent of our waiting list problem.

It is suggested that we meet with Trust Management to express concerns. A request will be made to the Chief Executive - long waiting list and winter crisis.

Recognised the Mr Haynes has raised this already and as a dept we wish to take this forward

MY to do letter on this in view of dept plans - to mitigated risk.

18th OCT

Cns pathway for turbt for the dept as a whole Mr Glackin

Should this approach be used for stented pt and catheterized pts ie give a date prior to discharged

Registrars to inform consultant of all referrals.

Communicate this cohort of patients to the Trust especially with winter crisis approaching and that this toto of patients will be addressed despite red flag or not

Paeds meeting 4th Dec who is going? John has been volunteered

Xmas

Stents and flex scope

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Stinson, Emma M

From: Young, Michael
Sent: 05 August 2022 17:32
To: Stinson, Emma M
Subject: FW: Retirement of Mr Aidan O'Brien - Consultant Urologist

To enclose in the folder please
MY

From: Young, Michael [redacted]
Sent: 22 June 2020 10:02
To: alan.bailie@[redacted] Connolly, David [redacted] ; 'Brian.Duggan@[redacted] Abogunrin, Funsho (Funsho.Abogunrin[redacted] Gray, Sam ([redacted] chris hagan [redacted] <chrishagan@[redacted] Keane, John ([redacted] McKnight, John ([redacted] alex.macleod@[redacted] Mulholland, Colin [redacted] <[redacted] OKane, Hugh ([redacted] <[redacted] OSullivan, Joe [redacted] <[redacted] ajay pahuja [redacted] Karen Randhawa ([redacted] 'trevor.thompson@[redacted] <[redacted] Travers Kathy [redacted] <[redacted] tyson@[redacted] Woolsey Siobhan (niecr) ([redacted] AL[redacted]
Subject: FW: Retirement of Mr Aidan O'Brien - Consultant Urologist

Dear Colleague,

I write to inform you that Mr Aidan O'Brien is due to retire at the end of this month after 28 years' service. Aidan was appointed as the first Consultant Urologist in Craigavon Area Hospital on the 2nd of July 1992. He has overseen the growth of the Urology services in the Southern Health Board from its inception.

It is usual to celebrate such an event, but we are currently in trialling and uncertain times. Social distancing advice and event restrictions continue. Unfortunately these features hamper a formal presentation at this time. However we still wish to mark the occasion in some form.

If you wish to send a personal message or card, then this can be forwarded to the Thorndale Unit by the 30th June 2020. We will then amalgamate these for one presentation.

If you would wish to contribute towards a gift, which we intend to present at a later less restrictive time, this donation can be sent to Noleen Elliott, Mr O'Brien's Secretary, Thorndale Unit Craigavon Area Hospital **by the 30th of June 2020**.

Michael Young
Consultant Urologist

And
Noleen Elliott

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Secretary to Mr O'Brien
e-mail address: Personal Information redacted by the USI

First draft as an idea:

Dear Colleagues,

I write to inform you that Mr Aidan O'Brien is due to retire at the end of this month after 28 years' service. Aidan was appointed as the first Consultant Urologist in Craigavon Area Hospital on the 2nd of July 1992. He has overseen the growth of the Urology services in this Health Board from its inception.

It is usual to celebrate such an event, but we are currently in trialling and uncertain times. Social distancing advice and event restrictions continue. Unfortunately these features hamper a formal presentation at this time. However we still wish to mark the occasion in some form.

If you would wish to contribute towards a gift, which we intend to present at a later less restrictive time, this donation can be sent to Noleen Elliott, Mr O'Brien's Secretary, Thorndale Unit Craigavon Area Hospital. If you wish to send an individual message by e-mail or card, then this can be facilitated via the Thorndale Urology Unit in Craigavon Hospital. We would then amalgamate these for one presentation.

Michael Young
Consultant Urologist

And

Noleen Elliott
Secretary to Mr O'Brien
e-mail address: Personal Information redacted by the USI

First draft as an idea:

Dear Colleagues.
I write to inform you all that Mr Aidan O'Brien is due to retire at the end of this month.
Aidan was appointed as the first Consultant Urologist in Craigavon Area Hospital 28 years ago.
He has overseen the growth of the Urology services in this Health Board from its inception.
It is usual to celebrate such events but we are in trialling and uncertain times currently. Social distancing advice and event restrictions continue.
Unfortunately these features hamper a gathering at this time.
However we still wish to mark the occasion in some form.
If you wish to send an individual message or sign a collective large card, then this can be facilitated via the Thorndale Urology Unit in Craigavon Hospital.
We would wish to amalgamate these for one presentation at the end of June.
In addition if you would wish to contribute towards a gift, which we intend to present at a later less restrictive time, this donation can be sent to Noleen Elliott, Mr O'Brien's Secretary, Thorndale Unit Craigavon Area Hospital.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Michael Young
Consultant Urologist

And

Noleen Elliott
Secretary to Mr O'Brien

From: Corrigan, Martina
Sent: 04 June 2020 14:32
To: Young, Michael; Elliott, Noleen
Subject: Retirement of Mr Aidan O'Brien - Consultant Urologist

As discussed – please see below:

Dear colleague

Mr Aidan O'Brien, Consultant Urologist for the Southern Trust will be retiring from the Trust at the end of June 2020 after 30 years of much dedicated service as a Consultant Urologist

Throughout his career Aidan has made an outstanding contribution to health and social care

Aidan will be greatly missed by his numerous colleagues and friends.

We would take this opportunity to invite anyone who would like to contribute to Aidan's retirement gift to please forward your donation to Noleen Elliott, Thorndale Unit, Craigavon Area Hospital by F**riday 19 June 2020**

Due to the current social distancing we are unable to have the traditional 'get together' for a presentation so we are inviting staff to email a farewell message to Aidan [redacted]
Personal Information redacted by the USI

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Team South Urology Care Pathway = Vision for future delivery

Pathway event	Patient	GP management	Referral process	hospital assessment	ongoing Review process	Treatment process
Issue	Empowerment	lack of adequate first line assessment of patients	excess referral and demand Referral threshold	inadequate capacity inadequate responivness	excessive time to review appropriativeness of r/v	long waiting list theatre capacity
New Concept	to take ownership of their care more	Provide a Computerized patient assessment Prompt to urology assessment and first line management which also act as areferral document	Only method of referral accepted is via Electronic Referral with mandatory completion of defined data sets before it can be sent	Complete change in clinic design = 1/ Rapid access clinic 2/ Clinical assessment clinic 3/ specialist clinic 4/ review clinic (*explain separately*)		
		improved GP education via Trust website	Define a Red Flag specific referral form	Urology Coordinator for day to day patient flow		
		Key questions to be addressed before referral Improved access for GPs to radiological investigation before referral	Specialist input before Referral eg Continence Advisor assessment prior to referral	Encourage GP to be part of the in-house urology assessment unit on a sessional basis		
					CNS follow up oncology clinics post discharge telephone consult	Emergency slot on theatre list
Efficiency	Remove vasectomy reversal for NHS			To assess Holistic and preadmission needs at first attendance before listing for surgery Consultant of the Week	CNS stone follow up clinc	Weekly assessment meeting to schedule cases
				monthly scheduling of work commitments = commitment to adaptable sessonal allocation to direct clinical care sessions		Backfill
				pre-assessment at initial consult		
Risk	empowerment not suitable for all patients	All GPs engaging	ongoing known increase in referral rates	uncertainty of clinic volume		
			IT keeping up with our needs	Outreach activity - parity of service delivery		
Explanation	**Rapid Access clinic** Emergency referrals from E.D	**Clinical Assessment Clinic** All-commers clinic on stop assessment principle - less rigid clinic design. To incorporate consult with assessments like TRUS biopsy, flexible cystoscopy and outstanding laboratory and radiological investigations + preadmission assessment	**Specialist Clinic** urodynamic	**Review** face to face		
	Telephone clinic for GP queries Virtual clinic of referrals deamed suitable for phone consult		oncology	Virtual clinic		
			stone	outreach		
	Acute followup for discharged patients post op			CNS		

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

The Vision for Urology Services in the SHSCT

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Background…

- Healthcare Demand > Healthcare capacity
- Year on year demand increases
  - Demographics
  - Increasing incidence / detection of disease
  - New treatments
- CAH Urology;
  - 1586 New outpatient referrals awaiting appointments.
    - 1250 waiting > 9 weeks
    - 880 waiting > 15 weeks
  - 973 patients listed for Inpatients or daycase procedures.
    - Longest waiter 76 weeks
  - 3385 patients awaiting follow-up appointments.
  - Demand increases (new referrals) approximately 10% per year.

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Background…

- 1586 New outpatient referrals awaiting appointments.
  - 1250 waiting > 9 weeks
  - 880 waiting > 15 weeks
- 973 patients listed for Inpatients or daycase procedures.
  - Longest waiter 76 weeks
- 3385 patients awaiting follow-up appointments.
- Demand increases (new referrals) approximately 10% per year.

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Aim

- Sustainable service
  - Efficient models of care
  - Maximise available capacity
  - Acceptable, equitable waiting times
  - Planning for increased demand
- Identify resource required to deliver this service
- Identify risks which will threaten successful delivery

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Workstreams;

- Demand Management
  - Increase urological investigation and management in primary care
  - Reduce referral to secondary care
- Service Delivery
  - Maximise efficiency of consultant input
  - Minimise requirements for multiple visits to see the consultant
- Capacity management / planning
  - Plan to deliver the required capacity
  - Pro-active capacity management

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Demand Management

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Demand Management;

- Key aspect in delivering a sustainable service
  - Initial Investigation / Management
  - Referral criteria
  - Passive / Mandated
- Electronic referral
  - Current electronic process designed with ease of use for the referrer as primary aim.
  - No mandated requirement for clinical information.
- Resultant consultant time required to triage referrals, with often limited clinical information.
  - Primary goal of current triage process is prioritisation.
- Predicting impact difficult
  - Small sample (48) routine referrals 50% could have had further investigations and primary care management prior to referral
  - Impact on Urgent / Red flag referrals likely to be less
- Access to advice
- GPs want diagnosis and plan and find promised but not delivered FU frustrating

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Service Delivery

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Elective Service

- Do all patients need to be seen in OP?
  - Vasectomy patients placed directly on waiting list.
  - Female LUTS patients (after management as per demand management) listed directly for urodynamics.
- What can be done before the OP visit?
  - Radiological and Biochemical tests done and available at the OP visit
- What can be done at the time of the OP visit?
  - Flexible cystoscopy
  - TRUS
- Operating theatre capacity
- Follow-up
  - Who?
  - How?

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Pre-hospital

- Referral based upon Primary care guidance (see demand management)
- Triage
  - Specific referrals listed directly
  - Check investigations available
  - Arrange required pre hospital investigations
  - Nurse specialist input with consultant input where required

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Elective Service - outpatients visit

- Based upon the Guys model
  - Single new outpatient clinic.
  - Consultant delivered service.
  - Urological diagnostics available at time of visit (flexible cystoscopy, TRUS).
  - Tried and Tested – published and recreated at other centres
- Initial pre-admission assessment
  - Current waiting lists includes patients who will ultimately be deemed unfit for surgery.
  - Identification of patients who require additional anaesthetic investigation before placing on waiting list.
  - Holistic needs assessment (avoid losing capacity).

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Elective Service - Operating Theatre capacity

- Maximise Day case provision
- Theatre efficiency
  - Focus on turnaround times
- Pooled waiting list for common urological procedures (eg circumcision, TURBT)
- Off site operating
  - Daisy Hill, SWAH
  - Theatre equipment
  - Junior dr support
  - Out of Hours cover

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Elective Service - Follow-up

- Minimise Follow-up appointments
  - Letters with results and plans
  - Specific primary care instructions for ongoing management and advice regarding when to refer back
  - Telephone follow-up after non-cancer elective surgery
  - Nurse led follow-up where appropriate
  - NICAN guidance

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Acute Service

- Consultant of the week.
- Consultant led morning ward rounds Mon-Fri.
- Acute clinic – A&E referrals plus non-elective GP referrals which didn't require admission from previous 24 hours.
- Planned emergency theatre time.
- GP telephone advice and triage of referrals where required.
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations to review results and make further plans).

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Capacity Planning

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Capacity planning and Management

- Current Demand
  - Elective and Acute
  - New and Follow-up
  - Outpatients and Inpatients / day cases
- Capacity planning
  - Based upon proposed service models
  - Current demand at 80% upper confidence limit
  - 20% estimate demand reduction for new referrals
  - Annual increased demand estimated at 10%
  - Planned service capacity set at expected demand year 3 to allow backlog reduction year 1 and 2.
  - Staffing requirements to deliver required capacity

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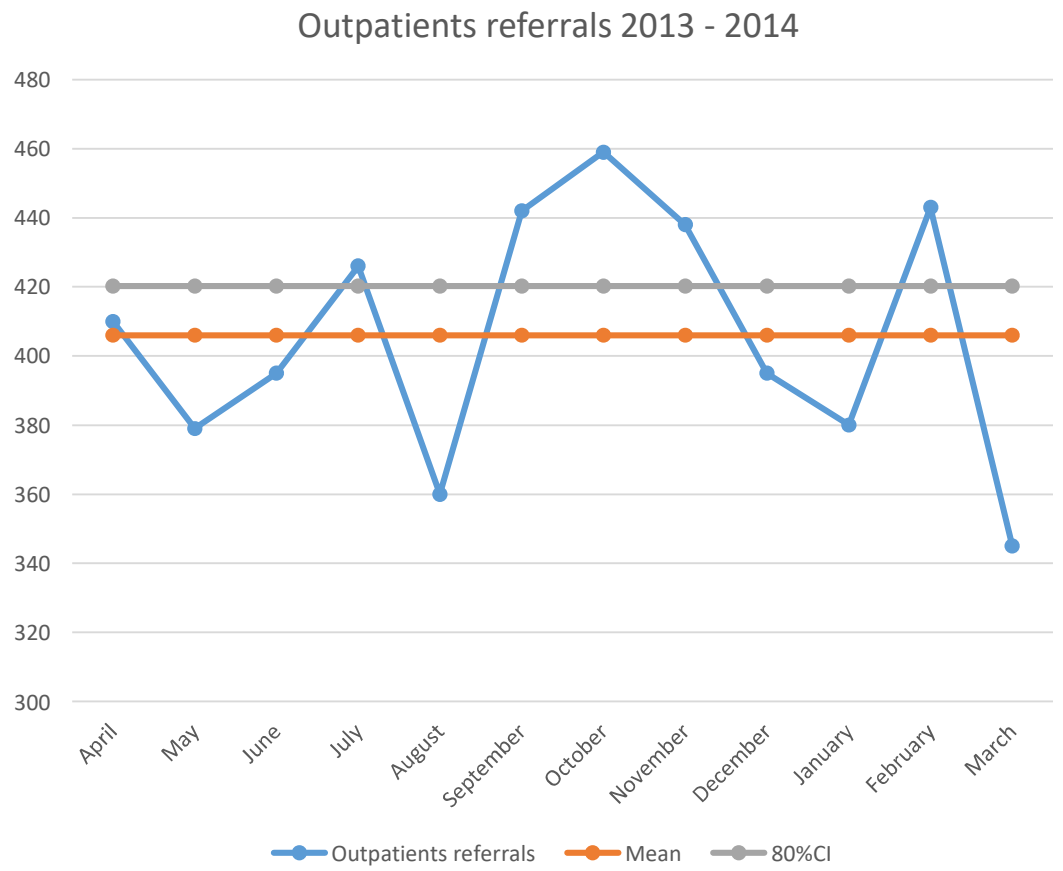
New Outpatients

- 2013-2014
  - Total 4872
  - Mean 406 per month
  - 80% confidence level 420 per month
- Capacity plan 407 referrals per month
- A proportion will be managed via the Acute clinic
  - Estimated at 5 / day, 5 days per week, 50 weeks per year (not bank holidays)
- Total 3634 new appointment capacity per year
- Modelled at 41 weeks requires 202 clinics per year (5 per week)



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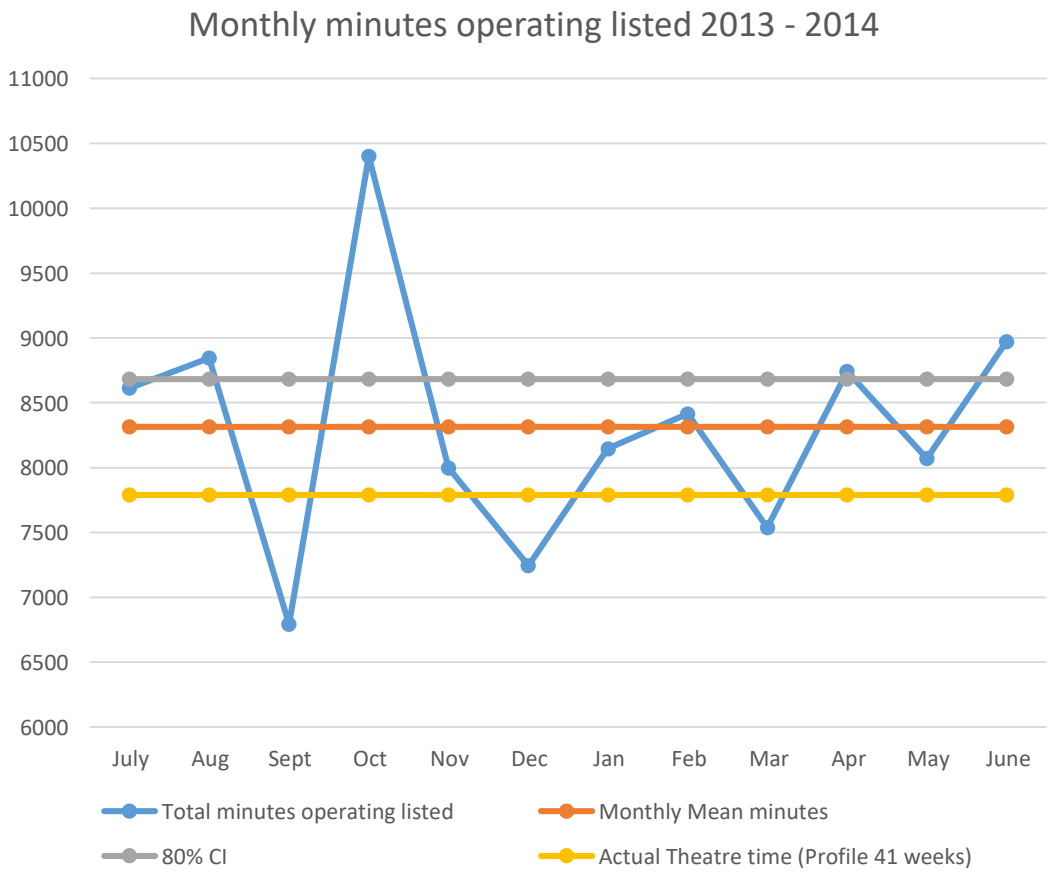
Operating Theatre Capacity

- Projected Capacity requirement Year 3 10506 minutes per month (2101 hours).
- Weekly list requirements profiled at 41 weeks 13 lists per week.
- Increased capacity is in inpatient theatres (12 per week required).
  - Increase in current capacity already in progress.
- This projected demand does not include demand created from the unseen referrals
  - Anticipated that efficiency measures will create capacity for this demand.
  - Benchmarking against English trust suggests this will create the equivalent of a further 4.8 hours per week operating
  - The benchmark trust has been through a number of cycles of work to reach this point and it is anticipated it will take significant time to reach this point.



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Flexible cystoscopy / TRUS / Urodynamics

- Flexible cystoscopy
  - Demand estimated at 1 list per week (8 patients)
  - Outside of general new clinic this capacity will be provided in a consultant led, CNS delivered service.
- TRUS
  - Radiology consultant provided service @2 lists per month anticipated to meet demand for those patients who do not have biopsy at 1st clinic visit.
- Urodynamics
  - Weekly demand 4-6 patients per week.
  - Consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered).
- ESWL
  - 444 treatments per year required @ 3 per half day session (148 sessions)
  - Delivered as at present (nurse / radiographer with consultant input).
- Capacity and demand for these services will require close monitoring and adjustment over the course of the first months of delivery of the new service.

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Off Site Services

- No proposed change in services currently provided off site
- Majority of new patients will be seen at CAH in general new clinic, some may be seen at off site sessions where on triage it is determined appropriate (not anticipated to require additional visit to CAH for diagnostic procedure eg TRUS / Flexible cystoscopy).
- Current profile 2.6 consultant sessions / week profiled to 41 weeks.

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Follow-up Outpatients

- 3274 OP follow-up appointments last 12 months
- Number awaiting a follow-up appointment grew over the same period from 1665 to 3385
- Demand over the last 12 months was 4994.
- Added Follow-up requirements of those new referrals received but not seen (based on 30% FU rate) in the last 12 months 494.
- Total current Follow-up demand is 5488.
- Delivery planned 50:50, CNS:Consultant in consultant led service.
- Projected 7.6 sessions per week (CAH and off site clinics)

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Staffing Requirements

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Staffing – Nursing / Administrative

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

- Some currently funded but unfilled
- Training requirements

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

Staffing Requirements - Medical

- Currently funded;
  - Consultants = 54.9 PA / week
  - Staff grade posts = 3 WTE (vacant, clinical fellow interviews mid Sept)
  - GPwSI = 7 PA / week
- Proposed model requirements;
  - 80.25 consultant PA's per week
  - 6 Consultants @ 13.4 PA's
  - 7 Consultants @ 11.4 PA's

Session	Consultant Hours per session (including admin time)	Weekly sessions required	Weekly Hours	Weekly PA's
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	12.2	57.9	14.5
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

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Work to date

- Electronic referral
  - Meetings held, Long term aspirations of the electronic referral gateway are in line with our aspirations (but long term).
  - Short / medium term will rely on education, feedback and triage.
- Primary care guidance / engagement commenced.
- Advice functionality of electronic referral gateway being turned on for Urology Southern Trust.
- Consultant of the week system starting September 2014.
- Initial trial of ‘Guys model’ to be run Sept / Oct.

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The Future

- Avoid crisis management
  - Quality management
    - Waiting time indicators
    - Trigger points
- Rigid vs responsive delivery models.

- Close working between Board and CAH Urology to avoid crises.

Received from Michael Young on 01/09/22. Annotated by Urology Services Inquiry

From: Clayton, Wendy
Sent: 17 October 2018 15:11
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 FINAL.

See below dictation report. There are approx 82 charts in the office on level 2. Do you need me to try and find out how long they have been there?

UROLOGY	**Backlog - Number of charts with oldest date in brackets**								
Consultant	**Discharges awaiting Dictation**	**Discharges to be typed**	**Clinic letters to be dictated**	**oldest date of clinic letters to be dictated**	**Clinic letters to be typed**	**oldest date**	**Results to be dictated**	**Results to be typed**	**Filing**
Mr Jakob					18	25.09.18	30	0	3 files
Mr Glackin	5	6	7	06/06/2018 (1 letter)	11	26.09.18	29	5	1.5 files
Mr Haynes	0	0	19	26.09.18	0		55	0	115 sheets
Mr O'Brien	17	0	91	15.06.18	0				6 files
Mr O'Donoghue					15	26.09.18	12	0	2 files
Mr Young	12	0	0	0	2	27.09.18	35	0	2.5 files
Sub Speciality Totals	**34**	**6**	**117**		**46**		**161**	**5**	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
745	28/07/2008	Safe, High Quality and Effective Care	Dental Room CAH	Dental room requires UPS/IPS system	The dental room currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery back up exists on the anaesthetic machine only.	7.11.17 Take off no Dental surgery undertaken on CAH site. 6.6.17 Moved to SEC (ATICS) following meeting with HT 10.05.10 - risk reviewed by MMcG + BM - risk reduced to 5 x 3 = 15 = moderate 2 Sep 2011 Reviewed at Divisional Governace Forum deescalated to HOS Register	MOD	HOS	07/11/2017
750	28/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	STH Theatres and Day Procedure Unit requires UPS/IPS syste,	Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	12/11/2021- no change 20/09/2021- UPS/IPS need an injection of £200k. Estates are costing. 29/06/2021- less than 50% of the required installation has been completed. I have liaised with estates to advise of the next priorities if a phased approach for installation of further UPS/IPS is being considered when funding becomes available. I have listed the areas below detailing completed works in Green and the work that remains outstanding in red: Theatre 1 pendants Completed Theatre 2 pendants Completed Recovery area main theatre 6 bed spaces and defib plug Not completed DPU recovery 6 bed spaces and defib plug in reception Not completed DPU 1 procedure room pendants Not completed DPU 2 procedure room pendants Not completed DPU Decontamination unit (2 drying cabinets completed and 2 endoscope washers not completed) 15/02/2021- covid remains a priority for estates no change to risk 11/12/2020 - still with estates, priority to covid 20/10/2020 - no change and remains with estates. Priority being given to covid 10/8/2020 - no change, remains a risk. Helena to e-mail Estates re plan to address IPS/UPS. 18.09.19 No change	HIGH	HOS	
799	29/07/2008	Safe, High Quality and Effective Care	Recovery Ward	Risk to health and safety of ventilated patients if required to be nursed in recovery ward	Risk to health and safety of ventilated patients if required to be nursed in recovery ward in the event of an intensive care bed not being available; recovery nursing staff are not trained as ICU nurses.	Patients are ventilated in theatre; cancel theatre list; staff from ICU are brought across to help if available; junior medical staff are only available 9am to 5pm leaving out of hours cover very difficult; explore the availability of ICU bed in another hospital.	28.02.18 Remains the same. 7.11.17- escalation policy in operation. To remain on risk register as pateitns continue to be ventilated in theatre. 30/5/17 - escalation policy in draft in accordance with CCaNNI 28.02.18 Remains the same. 7.11.17- escalation policy in operation. To remain on risk register as pateitns continue to be ventilated in theatre. 30/5/17 - escalation policy in draft in accordance with CCaNNI	LOW	HOS	10/04/2018
795	29/07/2008	Safe, High Quality and Effective Care	Pain Clinic	Risk of bolus of morphine being administered when PCA morphine running with concurrent infusions.	Risk of bolus of morphine being administered when PCA morphine running with concurrent infusions.	Patient must have dedicated IV line or non return valve IV connector.	28.02.17, 7.11.17, & 30.5.17 Risk remains unchanged	LOW	HOS	10/04/2018
797	29/07/2008	Safe, High Quality and Effective Care	Pain Clinic	Risk of tampering with PCA and epidural pump settings	Risk of tampering with PCA and epidural pump settings.	A single lock should be placed on each pump prior to commencement on each new patient.	28.02.18, 7.11.17 & 30.05.17 Risk remains unchanged	LOW	HOS	10/04/2018
879	04/08/2008	Safe, High Quality and Effective Care	Day Procedure Unit CAH	Moving and handling risk to staff when having to move equipment around the department due to inadequate storage space	Moving and handling risk to staff when having to move equipment around the department due to inadequate storage space; equipment (hoist/microscope) being stored in changing facility.	All staff trained in moving and handling; all staff aware of where equipment is stored; staff are informed of position of equipment and of precautions to be taken when in this area.	06.02.19 - To be amalgamated with risk 3727 as per Helena Murray. 1.10.18, 8.8.18 Remains an issue and to remain on RR. 12.06.18 Storage space continues to be an issue. 10.4.18, 28.02.18, 6.11.17 & 30.05.17 Risk remains unchanged 2.02.14 Storage space continues to be an issue. Currently seeking approval under capital works scheme for the provision of additional storage facility in DSU.	LOW	HOS	28/02/2019
846	04/08/2008	Safe, High Quality and Effective Care	THEATRES	Diathermy hazards - risk of burns to patients	Diathermy hazards - risk of burns to patients.	Training/education of staff; check patient's position to ensure they are not in contact with metal; proper application of diathermy pad.	28.02.18, 7.11.17 unchanged 30/5/17 - continuous training and new staff inducted to equipment training. Competencies signed and records kept.	VLOW	TEAM	10/04/2018
1054	08/08/2008	Safe, High Quality and Effective Care	Reception Area	Health and safety of wheelchair users is compromised due as front doors are not suitable	Health and safety of wheelchair users is compromised due as front doors are not suitable.	Staff vigilance; staff assistance.	10.12.07 Update - a side door has been reconfigured for wheelchair users as an interim measure until funding released for all work to be completed.	LOW	HOS	05/09/2011
1053	08/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Children/adult patients in the same area during clinic	Children/adult patients in the same area during clinic which is against the Child Order Act 1995 and the National Framework Document.	Patients/guardian accompany children to clinics; staff vigilance; staff aware of risk; clinical incident reporting.	23.01.12 - no further actions undertaken.	VLOW	TEAM	22/10/2013
1063	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Decontamination of resuable instruments in benchtop sterilizer does not meet the standards specified in HTM 2030	Decontamination of resuable instruments in benchtop sterilizer does not meet the standards specified in HTM 2030.	Testing of sterilizer daily, weekly, quarterly, annually.		MOD	DIV	25/03/2010
1068	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Health and safety of patients and staff is compromised due to inadequate clinical and waiting areas in OPD	Health and safety of patients and staff is compromised due to inadequate clinical and waiting areas in OPD; inappropriate seating placed in corridors restricting access.	Main waiting area and patients waiting in corridors outside consulting room.		MOD	DIV	25/03/2010
1055	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Windows opening out more than recommended	Windows opening out more than recommended.	Staff vigilant; staff awareness.	No work planned for financial reasons.	MOD	DIV	21/09/2011

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
1077	11/08/2008	Safe, High Quality and Effective Care		Health and wellbeing of patients when high dependency patients are being managed within the general surgical ward area	Health and wellbeing of patients when high dependency patients are being managed within the general surgical ward area.	Reprioritisation of workload; ongoing training for management of high dependency patients; input of pain management nurse; twilight nurses.	24.02.10 risk reviewed - additional action/controls in place. Ward manager to monitor the dependency level of patients on a daily basis, if escalated beyond the safe staffing level to escalate to Nurse Manager/HOS/Patient Flow Manager. High dependency patient monitors being ordered for 4 North / 4 South - 24.2.10 08.06.10 - monitors now in place in 4 North and 4 south - risk closed. 24.02.10 risk reviewed - additional action/controls in place. - Ward manager to monitor the dependency level of patients on a daily basis, if escalated beyond the safe staffing level to escalate to Nurse Manager/HOS/Patient Flow Manager. High dependency patient monitors being ordered for 4 North / 4 South - 24.2.10 08.06.10 monitors now in situ in 4 North and 4 south - risk closed.	MOD	DIV	08/06/2010
1083	11/08/2008	Safe, High Quality and Effective Care		Health and safety of patients and staff could be compromised if staffing falls below safe levels when dealing with staff absence	Health and safety of patients and staff could be compromised if staffing falls below safe levels when dealing with staff absence, e.g. maternity leave, sick leave and delays in recruitment process for vacancies; all wards, CAH and DHH.	Reallocation of existing staff to area of greatest need; in the event of further unplanned absences (e.g. sickness) implement the use of additional hours/bank; in conjunction with consultants and nursing staff discuss the posibility of closing the ward to admissions.	24.02.10 - Escalate through lead nurse, HOS, AD etc re problems . If ward manager is unable to cover wd with available staff; ensure bank forms are filled in and signed in a timely manner 24.02.10 - Escalate through lead nurse, HOS, AD etc re problems . If ward manager is unable to cover wd with available staff; ensure bank forms are filled in and signed in a timely manner 24.02.10 - Escalate through lead nurse, HOS, AD etc re problems . If ward manager is unable to cover wd with available staff; ensure bank forms are filled in and signed in a timely manner	MOD	DIV	05/09/2011
1078	11/08/2008			Health, safety and wellbeing of patients and staff when dealing with/managing violent/aggressive patients	Health, safety and wellbeing of patients and staff when dealing with/managing violent/aggressive patients; wards, CAH and DHH.	Staff awareness of proactive approach; availability of security; guidelines for alcohol withdrawal for inpatients; review staffing levels; medical review of patients by doctor; consultation with Consultant and Bed Manager; liaison RMN in post; personal safety in the workplace training available for all staff; violent and aggressive behaviour towards staff post incident procedure in place; policy and procedure on the management of aggression and use of restraint; transfer to suitable environment/appropriate unit when medical condition stabilised.	01.10.11 Additional/controls in place 24.02.10 - risk reviewed - additional action/controls in place. Good communication from admitting area re status of patient. Ensure medications are administered as per drug kardex/protocol, and effectiveness recorded. Staff trained in MAPA. Call security/police without delay when necessary.	MOD	HOS	23/01/2012
1080	11/08/2008	Safe, High Quality and Effective Care		Risk of spread of infection due to inadequate facilities	Risk of spread of infection due to inadequate facilities, e.g. lack of sidewards/bed space near sinks; all wards, CAH and DHH.	Endeavor to adhere to current Infection Control Policy; use of alcohol gel is in place; training sessions in place for hand hygiene and control for C Diff; ward sisters charter in place.	24.02.10 risk reviewed - additional action/controls in place. - Programme of replacing and upgrading basins in patient areas on going 24.02.10 risk reviewed - additional action/controls in place.	LOW	HOS	05/09/2011
1056	11/08/2008	Safe, High Quality and Effective Care	Banbridge Area	Health and safety of wheelchair users compromised due to entrance ramp to front door being too steep	Health and safety of wheelchair users compromised due to entrance ramp to front door being too steep and not suitable for wheelchair users.	Staff vigilant and provide assistance.	Update - a side door has been reconfigured for wheelchair users as an interim measure until funding released for all work to be completed.	MOD	HOS	05/09/2011
1058	11/08/2008	Safe, High Quality and Effective Care	Banbridge Area	Health and safety of disabled users is compromised due to invalid toilet	Health and safety of disabled users is compromised due to invalid toilet - not in central position in room; too close to wall, not suitable.	Nursing staff provide patient assistance.	Estates staff visited site. Update - funding not released for work to be completed.	MOD	HOS	21/09/2011
1075	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Risk to staff and patients in OPD when liquid nitrogen is stored or used	Risk to staff and patients in OPD when liquid nitrogen is stored or used.	Follow pharmaceutical guidance and Trust policies. Ensure that Liquid Nitrogen is stored as per hospital policy. Report any deviation and address appropriately. Report any faults or fixture failings to Estates immediately.	24.02.10 - risk rated additional action/controls in place. Ensure that Liquid Nitrogen is stored as per hospital policy. Report any deviation and address appropriately. Report any faults or fixture failings to Estates immediately. 24.02.10 - risk rated additional action/controls in place. Ensure that Liquid Nitrogen is stored as per hospital policy. Report any deviation and address appropriately. Report any faults or fixture failings to Estates immediately.	VLOW	HOS	21/09/2011
1069	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Risk to patient if equipment fails during use	Risk to patient if equipment fails during use.	Policies, procedures, protocols; education and training; regular maintenance; service contract; report faults. 24.02.10- Ensure all equipment is checked routinely.	24.02.10 risk reviewed - additional action/controls in place -Ensure all equipment is checked routinely 24.02.10 risk reviewed - additional action/controls in place -Ensure all equipment is checked routinely	LOW	HOS	05/09/2011
1081	11/08/2008	Safe, High Quality and Effective Care		Health, safety and wellbeing of patients due to misinterpretation/misunderstanding of inappropriate use of abbreviations	Health, safety and wellbeing of patients due to misinterpretation/misunderstanding of inappropriate use of abbreviations by health care team; all wards, CAH and DHH.	Vigilance of nursing staff; PSI documentation project ongoing; awareness of use of abbreviations highlighted as part of project. Update abbreviations commonly used in surgery & circulate.Ensure proper use of English Language is adhered to when completing any documentation.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2635 and 1079 are the same essentially - this should be termed to cover SEC' Piece of work being progressed by Heather Ellis to co ordinate these training needs. 24.02.10 Escalate through HOS/AD to leads in Statutory/Mandatory training that additional sessions are required to meet the needs of service. 24.02.10 risk reviewed - additional action/controls in place - Update abbreviations commonly used in surgery & circulate. Ensure proper use of English Language is adhered to when completing any documentation.	LOW	HOS	23/01/2012

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1057	11/08/2008	Safe, High Quality and Effective Care	Reception Area	Fingers could be trapped in spring loaded swing doors	Health and safety of patients, visitors and staff - fingers could be trapped in spring loaded swing doors; double front doors; inner doors.	Wating room door kepy opened by stopper; staff vigilant. Ensure staff have adequate training in MAPA & follow protocol re same	24.02.10 risk reviewed - additional action/controls in place -Ensure appropriate signage is prominently displayed advising of same. 10/12/2007 - Update - a side door has been reconfigured for wheelchair users as an interim measure until funding released for all work to be completed.	LOW	HOS	21/09/2011
1064	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Extended waiting times for patients due to specific clinics over-running	Extended waiting times for patients due to specific clinics over-running.	Patients adequately appointed; partial booking being introduced to all clinics.	24.02.10 risk reviewed - additional action/controls in place -Escalate to HOS so same can be addressed . 24.02.10 risk reviewed - additional action/controls in place -Escalate to HOS so same can be addressed .	LOW	HOS	05/09/2011
1066	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Unhealthy environment for staff and patients	Unhealthy environment for staff and patients; rooms too hot in summer - no circulation of fresh air, temperature more than 22°C/72°F; rooms too cold in winter - temperature less than 22°C/72°F.	Summer time - use of fans/ineffective skylights; winter time - requests to Estates to increase heating levels.		LOW	HOS	24/03/2010
1067	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Manual doors to OPD entrance could cause entrapment to patients	Manual doors to OPD entrance could cause entrapment to patients.	Doors left open during daytime to facilitate patients.	24.02.10 risk reviewed - additional action/controls in place -Ensure signs are prominently displayed advising of risk of same	LOW	HOS	05/09/2011
1072	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Poor access to Outpatients Department for wheelchair users and mothers with pushchairs	Poor access to Outpatients Department for wheelchair users and mothers with pushchairs.	Middle door left open to allow access.	24.02.10 risk reviewed - additional action/controls in place 24.02.10 risk reviewed - additional action/controls in place	LOW	HOS	05/09/2011
1065	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Continued inappropriate placement of charts on floor by doctors	Continued inappropriate placement of charts on floor by doctors leading to manual handling risk to staff who have to lift charts off the floor.	Trolleys provided for doctors to leave charts on; notices displayed; verbal communication to doctors; built into doctors' induction.		LOW	TEAM	24/03/2010
1073	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Lack of site security - injury to staff or patients	Lack of site security - injury to staff or patients.	Last member of staff to leave department locks doors; porters check all outer doors every evening Mon-Fri. 24.02.10 - Ensure all staff are trained in MAPA.		VLOW	TEAM	21/09/2011
1074	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Fire in OPD - risk to patients, staff and building	Fire in OPD - risk to patients, staff and building; fire evacuation after 9pm, limited staff on site to assist elderly frail.	Nominated fire officer; deputy nominated office on duty has fire training - yearly fire seminar.		VLOW	TEAM	05/09/2011
1071	11/08/2008	Safe, High Quality and Effective Care	Outpatients Dept	Risk to staff and patients through latex allergy	Risk to staff and patients through latex allergy.	Policy in place in department; latex free box in MIU; staff can avail of training and education.	24.02.10 risk reviewed - additional action/controls in place. Ensure latex free gloves/equipment etc are readily available in all wards /depts	VLOW	TEAM	21/09/2011
1082	11/08/2008	Safe, High Quality and Effective Care	3 South CESU	Health and safety of all staff who may be exposed to due to chemotherapy agents while working with urology/surgical patients	Health and safety of all staff who may be exposed to due to chemotherapy agents while working with urology/surgical patients	Procedures in place for the management of administration of agents. Ensure all staff working with chemo agents have adequate training /qualifications	23.01.12 - All approrpriat estaff have training and controls are in place. 01.10.11 Awaiting progress 4.02.10 risk reviewed - additional action/controls in place	VLOW	TEAM	23/01/2012
1062	11/08/2008		Outpatients Dept	Loss of child in Outpatients Department	Loss of child in Outpatients Department.	Staff awareness and vigilance; guidelines drawn up for staff/parents/guardians; secure Paeds Unit with controlled access operational from December 2005.		VLOW	TEAM	24/03/2010
1070	11/08/2008	Safe, High Quality and Effective Care	Trustwide	Risk of wrong patient being seen at clinic	2 or 3 patients with the same name; risk of wrong patient being seen at clinic.	Name and address checked on arrival, receptionists inform nursing staff re duplicate names; nursing staff check name, address when calling patient. 24.02.10 -Ensure patients notes are adequately labelled informing staff at clinic of same.[Alert sticker]	19.06.06 This remains a low risk, there have been no incidents. 24.02.10 risk reviewed - additional action/controls in place - Ensure patients notes are adequately labeled informing staff at clinic of same.[Alert sticker]	VLOW	TEAM	05/09/2011
1084	12/08/2008	Safe, High Quality and Effective Care		Health and Safety of patients and staff could be compromised due to lack of weekend ward clerk cover on surgical wards	Health and Safety of patients and staff could be compromised due to lack of weekend ward clerk cover on surgical wards.	None.		LOW	HOS	24/03/2010
1085	12/08/2008	Safe, High Quality and Effective Care		Health and safety of patients and staff could be compromised if clerical staffing falls below safe levels	Health and safety of patients and staff could be compromised if clerical staffing falls below safe levels when dealing with staff absence, e.g. maternity leave, sick leave and delays in the recuitment process for vacancies; all wards, CAH.	No bank staff available; additional hours used when available; re-allocation of staff to areas of greatest need.	24.02.10 risk reviewed - additional action/controls in place - Escalate through OSLs if Clerical staff are off on sick leave, A/L leave.	LOW	HOS	05/09/2011
1086	12/08/2008	Safe, High Quality and Effective Care		Health and safety of patients, visitors and staff due to adequate storage space for equipment/stock	Health and safety of patients, visitors and staff due to adequate storage space for equipment/ stock; all wards, CAH.	Maximum use of existing facilities with continuous risk assessment.	24.02.10 risk reviewed - additional action/controls in place - Issues to be addressed through the Productive Ward project 24.02.10 risk reviewed - additional action/controls in place - Issues to be addressed through the Productive Ward project	LOW	HOS	05/09/2011
1087	12/08/2008	Safe, High Quality and Effective Care		Infection control risk + Slips/trips/falls for patients, relatives and staff due to loose and missing floor tiles	Infection control risk + Slips/trips/falls for patients, relatives and staff due to loose and missing floor tiles.	Estates Department informed; all wards, CAH. 24.02.10 - Ensure missing floor tiles are reported to maintenance for immediate repair	24.02.10 risk reviewed - additional action/controls in place - Ensure missing floor tiles are reported to maintenance for immediate repair	LOW	HOS	05/09/2011
1205	15/08/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards	Trust facilities for the cleaning, decontamination and storage of endoscopes do not comply with standards recommended in the Hine Review, increasing the risk of infection transmission.	STH have new fully compliant decontamination facility which is JAG accredited. DHH same opened Jan 2014. CAH day surgery has been refurbished with AERS and drying cabinets and is awaiting the installation of new sinks.Interim decontamination facilities for main theatres, Xray and ENT services are in place. Management of this service has been taken over by CSSD staff. Minor works upgrade to the endoscopy theatre and storage facilities is taking place to comply with JAG.	18.09.19 combine with risk 733 on the Directorate RR 26.06.19, 28/3/19, 06/02/2019 - No change. 1.10.18, 8.8.18, 12.06.18, 10.4.18, 28/02/2018, 6.11.17 & 30.05.17 Remains unchanged. All areas compliant with Hine recommendations now. To remain on Risk Register as not achieving JAG accreditation.	LOW	HOS	18/09/2019
1896	19/12/2008		Outpatients Dept	Unable to achieve the sterilisation of ENT flexible scopes between each patient as per policy due to lack of equipment/resources	Flexible ENT Scopes in accordance to policy must be sterilised between use. Due to the invasive nature of the use of this equipment patients are at risk of cross infection if this is not carried out. DHH has no ENT flexible scope. In order to adhere to new protocol/policy, would be required to purchase 5 more at a cost of £25,000 approx. Patient are at risk of cross infection if scopes are not sterilised and Trust is at risk of litigation and lose of reputation. (ENT flexible scope does not have an internal channel. It is a camera only. The user cannot take biopsies, suction or blow using this equipment.)	DHH has been using disposable sheaths for 8 years on removal of sheath, scope is cleaned with alcohol wipes and left to dry. 1 Box of sheaths contains 50 and costs £500 lasts for approx 1 month. (SMcL) (head of Sterile Services) states sheaths must no longer be used as there is no evidence of adequate research into their effectiveness of cross infection protection.		MOD	DIV	19/05/2011
1900	19/12/2008		ENT Clinic, Surgical Outpatients	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes need to be decontaminated between each patient and	Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case)The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Craigavon Area Outpatients has 7 Nasophyngeal flexible scopes in use, with 2 scopes currently away for repair. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 10 ENT sessions per week, with an average of 5 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (50 patients per week on average)Patients are at risk of cross infection as there is only one scope available to examine all patients.	Craigavon Outpatients has been using Storz disposable sheaths to cover its scopes if there is insufficient time to decontaminate the scope as per policy. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT		MOD	DIV	19/05/2011

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
1901	19/12/2008		Banbridge Area	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes need to be decontaminated between each patient.	Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case) The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Banbridge Outpatients has 1 Nasophyngeal flexible scope in use. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 1 ENT sessions per week, with an average of 3 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (3 patients per week on average) Patients are at risk of cross infection as there is only one scope available to examine all patients.	Banbridge Poly Clinic has been using Storz disposable sheaths to cover its scope as there is only one scope on site. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT.		MOD	DIV	19/05/2011
1902	19/12/2008		Outpatients Dept	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes need to be decontaminated between each patient	Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case) The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Armagh Community Outpatients has 1 Nasophyngeal flexible scope in use. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 1 ENT sessions per week, with an average of 5 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (5 patients per week on average) Patients are at risk of cross infection as there is only one scope available to examine all patients.	Armagh Community Hospital has been using Storz disposable sheaths to cover its scope as there is only one scope on site. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT.		MOD	DIV	19/05/2011
1903	19/12/2008		ENT Clinic, Surgical Outpatients	Unable to adhere to SHSCT Decontamination Policy	Unable to adhere to SHSCT Decontamination Policy which stipulates endoscopes (flexible nasopharyngeal endoscopes) need to be decontaminated between each patient and after 3 hours of inactivity. This lack of adherence is secondary to due to the insufficient numbers of scopes within the department. There is also the additional risk of cross infection as all current decontamination equipment within SHSCT do not completely comply with HTM2030 Due to the contact with the mucous membrane surrounding the nasopharynx, patients are at risk of cross infection with the scopes not be decontaminated as per trust policy. (between each case)The Trust is at risk of litigation and loss of reputation if it was proven that the lack of scopes was a contributing factor in a Hospital Acquired Infection/Illness. Daisy Hill Outpatients has one Nasophyngeal flexible scope. The nature of a flexible Nasopharyngeal scope is that has no internal channel. The scope does not have the facility to take any biopsies,or use any type of suction. It is used as a camera only This site has 6 ENT sessions per week, with an average of 5 patients per session needing an examination with a Flexible Nasopharyngeal Scope. (30 patients per week on average)Patients are at risk of cross infection as there is only one scope available to examine all patients.	Daisy Hill Hospital has been using Storz disposable sheaths to cover its scope during each examination. Staff have received training from Storz regarding the application and removal of the sheaths. Scope is sent for decontamination at the end of each day that there is ENT. The manufacturer cannot provide robust scientific evidence that sheaths provide 100% protection against CJD in particular. For this reason (SMcL) Head of Decontamination SHSCT, has not considered sheathing a viable option or substitution for following the Trust's Decontamination Policy.		MOD	DIV	19/05/2011
1932	23/01/2009	Safe, High Quality and Effective Care	ENT Clinic, Surgical Outpatients	Patient Flow difficulties with ongoing additional ENT OPD clinics for NEW patients.	Patient flow for these clinics are in breach of RCOS Guidelines - 3 patients x 15 minutes x 3 Doctors. This clinic has booked 4 patients x 15 minutes x 3 Doctors. - Risk of increase in complaints - Risk of patients walking out of clinic not seen and used to rebook them - Risk of miss diagnosis/loss of comprehensive assessment as time slots are limited - Inequality of care for these patients attending these extra clinics. RCOS Recommendation - 1 patient x 15 minutes (new patient clinic) therefore 3 patients x 15 minutes with 3 Doctor sessions. These clinics are booked on 4 patients x 15 minutes with 3 Doctors.	Patient flow - Additional Nursing and Clerical Staff deployed to manage clinic - no additional Medics Request to reduce clinic size to 60 and create 1 additional clinic (x3 in total) rejected by management due to time constraints (PTL breach)	Referred to Directorate Risk Register	LOW	DIV	19/07/2010
1933	23/01/2009	Safe, High Quality and Effective Care	ENT Clinic, Surgical Outpatients	Environmental space to hold patients and families during ongoing additional ENT OPD clinics for NEW patients	These clinics are booked on 4 patients x 15 minutes with 3 Doctors. Environmental space to hold patients and family (Saturday Clinic) (8.45am start to 1.45pm finish) 11 seats available with potential to have 16 patients and relatives waiting at any one time. - Increased risk of complaints - Risk of patients walking out of clinic not being seen and need to rebook them - Risk of overcrowding	Environmental space - Overspill patients will be seated in ENT sub waiting area outside examination rooms and staff will manage this. - Families will be requested to remain in main OPD Waiting Area		LOW	HOS	21/09/2011
2082	09/04/2009	Safe, High Quality and Effective CareAccessible and Responsive CareEffective organisational governance	Trustwide	Inability to meet or maintain AHP access targets for ENT/Voice service	Risk of harm to patient as no access to appropriate SLT service. Unable to provide support for ENT consultants re patient management in hospital outpatient dept's in C/B and A/D. Trust unable to achieve or maintain access targets so breaching will be inevitable Ineffective clinical management of patients Increase in staff stress, pressure and reduced morale Health and well being of SLT staff	Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success. Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success. Current SLT in post until 30 04 09 AHP ACCESS FUNDING ceased 30th 03.09 Requests to acute for ongoing funding have been made but without success.		HIGH	DIV	25/03/2010
2463	24/04/2009	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingBe a good social partner within our local communities	Trustwide	Preparedness for Pandemic Flu, specifically a H1N1 current pandemic	Ability to sustain services should there be an outbreak of pandemic flu.	SHSCT H1N1 Plans remain in place Regular SMT/Silver and Bronze Team meetings ongoing at Directorate level Daily monitoring in place - hospitalized patients, attendances at A&E, GP OOHs, MIUs Representation at regional Trust Liaison Group meetings with regional professional fora Vaccination plan submitted for HPA approval Business cases for funding submitted to various work streams Ward 3 (Isolation Ward) operationally ready Vaccination plans have assumed that primary care will cover the six month to five year age group. However, recent information suggests that secondary care may be asked to provide this service. This is likely to create a capacity problem if existing services are to be maintained.		MOD	DIV	17/10/2013
2085	09/07/2009	Provide safe, high quality careBe a great place to work	Fracture Clinic	Health & Safety of patients, staff and visitors who attend the Fracture Clinic	Health & Safety of patients, staff and visitors could be compromised due to no waiting room for Fracture Clinic as follows:- 1. No seats for patients. Standing with plasters insitu, risk of fall. 2. Narrow corridor - patients sitting with leg plasters on - leg extended. Risk of fall and further injury. 3. Patients waiting in main thoroughfare for A&E - Rushing through with sick patients. Delay of transfer and risk of injury to patients and relatives. 4. Patients in wheelchairs - no room. Risk of injury.	Maintain patient's safety until relocation of fracture clinic.	28.09.12 - Fracture clinic relocated. 01.08.12 - Works nearing completion. Plan to move into new location by end August 2012. Review in 1 month. 19.06.12 - Refurbishment programme progressing well. Due for completion July 2012. Review in 1 month. 17.04.12 - refurbishment programme commenced. Works ongoing and due to be completed May 2012. 23.01.12 - A new location and facilities have been sourced for the fracture clinic. A refurbishment programme is due to commence in February 2012 with completion due in May 2012. 10.11.11 Additional seating now in place on back corridor to A&E, plans for new fracture clinic now in progress. 01.10.11 Awaiting feedback from fire dept regarding the placement of additional seating.	MOD	DIV	28/09/2012

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
2314	14/09/2009	Provide safe, high quality care	Trustwide	Risk of Hyponatraemia	Risk of hyponatraemia when administering IV fluids to children aged 14 - 16 years when cared for on adult wards. Risk of loss of Trust reputation and loss of confidence in the organisation Risk of litigation to the Trust.	All Solution 18 removed from wards and any attempt to order Solution 18 is alerted to Director of Pharmacy. Trained and competent paediatric medical staff available on CAH + DHH site 24/7 to provide support in relation to prescribing, monitoring and reviewing IV fluid therapy. DHSSPS wall charts are displayed in all adult and paediatric areas where children and young people aged 1 month to 16 years may be treated.	17.04.12 - Approximately 80% of SEC staff trained with follow up sessions arranged for May 2012. 23.01.12 - ongoing within Governance Team with good uptake from SEC. 01.10.11 Competency framework has now been commenced for target wards. All staff undergoing refresher training. SEC attained 98.1% of all staff trained. Ongoing audit to capture under 18 yr olds to ensure all cared for appropriately.	LOW	DIV	17/10/2013
2501	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Isolation of the Trauma Ward	Trauma ward has no adjoining ward therefore no medical/nursing support from other close by wards. Isolated staff especially on night duty and lack of support for staff in the event of an emergency.	Staff awareness of teams available.	01.10.11 Ward has access to relevant teams where required for assistance in complex situations.	LOW	DIV	23/01/2012
2500	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Moving of Night Staff from Trauma Ward to support other wards	Unsafe staffing levels left on ward for type and dependency of patients. Staff unable to get tea breaks, increased stress, decreased patient care and in the event of an emergency inadequate staffing support.	Adverse incident forms completed. Bed Flow Manager informed re safety issues. Clinical Lead/Lead Nurse informed.		MOD	DIV	05/09/2011
2499	10/11/2009	Provide safe, high quality careBe a great place to work	Trauma Ward	Inappropriate staffing levels for dependency of patients in Trauma Ward	Inappropriate staffing levels leads to compromise in patient safety/care and staff safety. This results in increased clinical incidents, increased number of falls, staff unable to get breaks, potential for decreased staff morale, increased staff sickness levels, breach of Terms and Conditions for employment, poor documentation, not able to maintain NMC Guidelines. Potential for increased complaints and litigation.	Bank staff - unreliable bank staff or bank staff not available to cover shifts. Additional hours for permanent staff. Clinical Lead and Lead Nurse informed re risk.	08.06.10 - temporary staff now made permanent and risk closed.	MOD	DIV	08/06/2010
2390	11/11/2009	Safe, High Quality and Effective Care	Orthapaedic Ward CAH	Due to the Isolation of Orthopaedic Ward ensure adequate staffing levels at all times to maintain health and safety of patients.	Due to isolation of orthopaedic ward and Elective Admission Ward especially on night duty inadequate staffing levels when staff are moved to deal with emergency for example on 17-11-09 patient had a respiratory arrest cardiac team called staff felt there was a delay in the arrival of team some members of the team were unsure where Orthopaedics was located. Staff did not get their break. On 19-11-09 Staff nurse and auxiliary off sick nurse bank had no cover day staff had to stay until 2230 for a nurse to cover the shift from 4 south the auxiliary was then moved to 4 south which left only 2 nurses this was unsafe as a patient went into atrial fibrillation and SBAR call was made for medical assistance. Staff were not relieved for breaks and therefore did not get their breaks. Clinical incident forms are being completed on a regular occurrence with no effect. Isolated staff especially on night duty. Lack of support for staff in event of emergency. Potential re-occurrence of incident previously occurred. Decreased no's of staff allowing for inadequate	Completion of adverse incident forms. Highlighted re concerns to nurse lead and head of Trauma and Orthopaedics and bed manager that staff should not be moved from wards as there is no adjoining ward for support. No dependency levels tool carried out in the hospital as per nurse lead. Ward manager to ensure as far as possible that ward is safely covered. In circumstances where this is not possible, report to Nurse Manager in hours/ Site manager out of hours to assist in getting assistance from other areas within division, or to commence protocol to get bank / agency staff.		MOD	DIV	05/09/2011
2415	11/11/2009	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Orthapaedic Ward CAH	Patient cancellations due to inadequate information given to patients in pre-op assessment	Patients cancelled due to not being informed to stop medication eg aspirin or if patient is still on oral contraceptive pill. Patients condition may have changed and may require further investigations eg echo which was not carried out at pre-op assessment. Patient not seen face to face by consultant at pre-op on day of admission consultant decides patient not to have surgery. Pre-op assessment bloods out of date. Patients not having their operation have to have their operation re-scheduled and become upset. Trust Waiting list has to be altered to other people are cancelled to facilitate the cancelled patients. Complaints will increase. Patients taken time off work to come into hospital for their operation. Risk of litigation. Loss of reputation. Extra work for nursing staff on the wards and secretarial staff.	Clinical incident forms completed. Consultants clinical lead and nurse lead aware of situation. Pre-op Manager aware. Protocols to be in place re medication advise. Pre-op staff sent to Musgrave Park pre-op assessment in orthopaedics for developing the service in Craigavon. Pre-op meetings action plans never followed up as problem continues.	24.02.10 - actions on going	LOW	DIV	05/09/2011
2416	11/11/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Orthapaedic Ward CAH	Patient safety and staff safety - Moving of night staff to support other wards.	Unsafe staffing levels left on ward for type and dependency of patients. Staff unable to get breaks. Decreased patient care. In event of emergency inadequate staffing support.	Clinical incident forms completed. Bed Flow Manager informed re safety of patients. Clinical Lead and Nurse Lead informed.		LOW	DIV	05/09/2011
2425	14/12/2009	Provide safe, high quality care	Pre-Operative Assessment Clinic	Lack of Anesthetic and Cardiology resources for validating Pre-Op ECG's in a timely manner	Patients are at risk of cancellation of surgery secondary to a cardiac condition not being managed or detected. The Trust is at risk of Litigation if it is shown that a patient has been seen within Surgery and Elective care, with a cardiac condition which was evident from pre op ECG, but not detected or managed due to lack of access to adequately trained staff. There is no adequately trained resource within the Pre Operative Assessment Service to interpret and sign off pre op ECG's which are done as per NICE guidelines. A duty of care to have these ECG's reviewed in a timely manner, is not being met. Risk that designated POA Anaesthetist may not have all potential cardiac issues escalated to them due to the lack of expertise and skill at Band 5 and 6. Risks of patient not getting a Anaesthetic chart ECG/review Financial risk to Trust due to the high volume of charts being sent to Anaesthetist for ECG interpretation and not anaesthetic assessment. Potential harm include patients leaving the department with a undiagnosed Cardiac condition which could progress to a significant cardiac event. The lack of timely review results in ongoing risks around the patient's surgery being postponed or cancelled- potential harm due to delay in treatment. In the event that the patient has a abnormality that needs treatment or management theatre may be cancelled at very short notice. End result being theatre underutilisation. Significant financial harm to the Trust will be incurred in this event.	If Nursing staff see abnormal (as per ECG machine print out) on ECG on tracing, the ECG should be escalated to the Band 6 nurses who then highlight it to either Anaesthetist/ OPD Manager or ECG staff. Designated POA Anaesthetist reviews the charts/ECG's of patients who have been escalated to the Anaesthetist.	Reviewed 6.12.10 - Lorraine Adair meeting with D Lilburn to progress. Awaiting outcome in conjunction with direction from B Conway. Risk remains unchanged. Risk Assessment has been updated 22/10/10 to refine issues. Barry Conway, Lorraine Adair, Diane Lilburn and Connie Connolly met on Monday 11th October 2010. Proposal for Dr Rankin to be prepared by Barry Conway and Heather Trouton for consideration. 16.04.10 - The requirement of ECG screening is being reviewed by Mrs Connie Connolly and Dr Neville Rutherford-Jones. There has been no Cardiology resource identified within Medicine and Unscheduled Care. The Staff doing ECG;s at present are dependant on the individual sites. Any ECG's deemed 'abnormal' are been shown to the ECG department, and or Cardiology clinicians only if available. If no availability, or POA is being done out of hours, relevant ECG's may be seen when appropriate staff available. ECG's are being done during face to face as appropriate. ECG;s are not routinely reviewed until F2F or anaesthetic chart review or on day of surgery. Risk reviewed 24.02.10 - additional actions/controls put in place - On going discussions with Anaesthetics to provide safe and effective cover for pre op clinics. 09.11.11 Meeting to be arranged with Anaes, Cardiology, Pre-op Asses to discuss further management, currently all major abnormal ECGs are being referred to A&E as an interm. 01.10.11 Awaiting further progress report.	MOD	DIV	23/01/2011

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2424	14/12/2009	Provide safe, high quality care	Outpatients Dept	Infection Control risks due to lack of decontamination facilities, non compliant taps and sinks in the blood room.	High volumes of patients, public and staff working within/accessing General Outpatients are at increased risk of infection secondary to the non compliant taps, sinks and damaged flooring in department and toilets. Risk of infection to patients, public and staff due to poor provision for hand washing and decontamination. Risk of infection due to broken/damaged flooring and/or units around sinks. Risk of loss of reputation secondary to non-compliance with RQIA recommendations. Risk of infection to patients, staff secondary to decontamination of ENT scopes being done in the same room as patients being assessed.	Daily cleaning of department. Patients are taken to other areas for assessment where possible to separate from Endoscopy decontamination.	19.06.12 - Refurbishment programme of Ramone building for additional facilities and upgrade of current area is near completion. Plan to review in 1 month. 26.03.12 - Will be addressed via outpatient works in early Summer 2012. 23.01.12 - Outstanding working remain on hold until current renovations and proposals complete. 19 May 2011 Decontamination Room complete, sink tops in Rooms 4/5/6/7 have been replaced. Awaiting the replacement of flooring in toilets, and taps/sink in blood room. Estates contacted again 19/05/11 by DHH OPD manager. Awaiting response. Continued risk.	LOW	DIV	29/11/2012
2512	08/03/2010	Be a great place to workMake the best use of resourcesBe a good social partner within our local communities	Fracture Clinic	Fracture Clinic stock going missing Department shared by A&E	Patients not receiving appropriate treatment. Risk of complaints. Disharmony between departments. Risk of stock going low for patients. Patients having to go without appliances. Rise in complaints. Inaccurate budget control. Cannot order in bulk due to lack of storage space.	Stock control book. Staff training on staff control. Discussions with A&E Line Manager. Discussions with Fracture clinic Line Manager. Continue stock control. Communicate with A&E staff. Fracture Clinic to monitor stock daily. Educate A&E staff. Lock Fracture clinic at the end of the day. To have ownership.		LOW	HOS	05/09/2011
2520	15/03/2010	Make the best use of resources	1 Surgical EAW	Drugs in Treatment Room [Ward closed at night & weekend]	Room locked but unit not locked. No alarm on Controlled Drug Cupboard - Potential for theft of medication and controlled drugs while ward is unoccupied	Locking preparation room door . Controlled drug & ward keys given to Dermatology Monday to Thursday , Porters safe Friday to Monday am .	Security work has been completed ' - risk closed 08.06.10	MOD	DIV	08/06/2010
2522	15/03/2010	Provide safe, high quality careMaximise independence and choice for patients and clients	4 North Surgical	Poor toilet and shower facilities on 4 North	Increase in infection rates. Poor environment to recover post operatively. Not enough male / female facilities. Shower male side, door allows water to leak through. Showers need general upgrading. Hand rails need to upgraded on all toilets.	Environmental audit. Complaints about facilities from patients expressing poor satisfaction.		MOD	DIV	01/10/2011
2519	15/03/2010	Provide safe, high quality care	1 Surgical EAW	Distance from theatre to EAW for post-op patients	Risk to patients - condition could deteriorate on way back due to distance. Potential for emergency situation to arise whilst patient is not in a clinical environment, post surgery & anaesthetic	Staff take emergency pack with ambubag , airway & facemask with them to recovery ward .		LOW	HOS	05/09/2011
2521	15/03/2010	Be a great place to workMake the best use of resources	1 Surgical EAW	Double Doors outside Dermatology have no automatic button	Potential manual handling risk - Potential manual handling risk to staff whilst trying to get door open and bad through	Staff open manually	Estates have been contacted-await further response	LOW	HOS	05/09/2011
2745	22/03/2010	Provide safe, high quality care	Outpatients Dept	Mis-timing of pre operative assessment investigations- extension of patient pathway to 17 weeks in T/O and Urology	Due to the extension of the patient pathway for Urology and T/O patients to 17 weeks, current pre operative assessment validity dates of 13 weeks, will no longer provide accurate pre op assessment. Risks are around having to facilitate patients coming back to the POA service for screening once the TCI date has been issued. Due to limited Band 5 availability for screening there is a risk that there will insufficient time to manage any pre op issues that may arise. Risk that POA clerical staff do not have the resources to ensure the patients pass through assessment twice at a time allowing for any management issues. Risk that patients having screening done too close to TCI, will have to be cancelled at short notice due to not having enough time to resolve any clinical issues. POA then has no capacity to assess patients who may have been selected to backfill at short notice. Risk of inefficient utilisation of bed and theatre capacity if there are persistent day of surgery cancellations due to inappropriate or inadequate screening. Potential harm to patients if surgical procedure is cancelled Financial harm to SHSCT due to poor theatre and bed utilisation secondary to delayed pre op screening. Potential for financial harm if pre op screening is out of date and has to be repeated. Potential for financial harm if patients are being admitted to ward prior to surgery if pre op investigations are incomplete.	Band 5 Nurses in POA to cease preliminary screening in T/O & Urology when patients are added to IPWL immediately. POA clerical team chronologically inviting patients who are listed within the next month, to attend for repeat screening. (done on receipt of theatre lists)PCR testing being done for T/O patients if surgery is within 3 days	Reviewed 3/12/10 - Issue is still valid for Urology (52 weeks) T/O 32 weeks, General Surgery 20 weeks. Awaiting cutting plans within specialties. Currently undertaking review of patient flow through POA and will be creating HSQ by appointment if needed according to Specialty waiting times. Continued pressure on POA capacity due to the additionality being generated secondary to cutting plans and PTL compliance. Reviewed 21/7/10 - Change in processes made to reinstate screening at initial HSQ - this is to ensure suitability for short notice admissions. Reviewed 14/5/10 - Preliminary meeting held with Band 6 working in POA on 13/4/10, will be meeting again to work on establishing and agreeing timeline of investigations for T/O and Urology patients. Ward Managers have been requested to release all NVQ candidates to the Infection To be reviewed/updated again 14/5/10. Reviewed 3/12/10 - NVQ training complete. Reviewed 21/7/10 - Meeting Susan Boyce 5.8.10 re NVQ verification. Remains a persistent risk. Reviewed 14/5/10. Prevention training this month and Carmel Markey has agreed to teach and assess MRSA swabbing. To be reviewed/updated again.	LOW	DIV	19/05/2011
2546	24/03/2010	Provide safe, high quality careBe a great place to workMake the best use of resources		Risk of fire when oxygen cylinders are stored with other consumables	Fire risk from oxygen cylinders being stored along side stationary and electrical equipment. Resulting in major fire, loss of life, litigation. Oxygen should be stored in appropriate fire proof cupboards.	Oxygen cylinders are stored on metal stands attached to the wall. Staff vigilance.	17.04.12 - Medical gas group has re-established and issue being addressed as part of that group. 23.01.12 - An agreed stock has been established for all wards in SEC - suitable storage and signage. Works ongoing.	LOW	TEAM	10/12/2014
2591	15/04/2010	Provide safe, high quality careBest use of resources	Opthamology Clinic	Unable to identify patients at risk of glaucoma from within the back log of review patients	Unable to identify patients at risk of glaucoma from within the back log of review patients - Risk of patients eyesight deteriorating or losing completely resulting in : 1. Patients not receiving a high quality service. 2. Targets breeched. 3 large manpower expenditure to review the backlog.	Initiate an action plan to address the backlog of out patients that require a review and identify those that have a risk of glaucoma.	Backlog review completed	MOD	DIV	21/09/2011
2592	15/04/2010		Trauma Ward	5.19 WTE Registered staff on maternity leave at the same time	Patients receiving a poorer quality service, less safe 5.19 WTE Registered staff on maternity leave at the same time. Audits reflecting clinical indicators at risk of dipping , MEWS, Hygiene etc. Sick levels increasing. Unsafe service, reduced quality of service delivered. Poor morale. Expenditure due to bank and agency.	3 temporary registered staff In situ, however staff off are predominantly experienced staff, therefore ward short of experienced senior cover.	17.04.12 - All E reqs processed and all vacancies and maternity leaves filled as allowed. Issue closed. 23.01.12 - All vacant posts are in the process of being filled. 4 members of staff from the Bank Permanent Staff are dedicated to Trauma due to the high volume of maternity leave. 10.11.11 New staff in recruitment process and vacancies will be filled in Dec 2011. 01.10.11 Additional block bookings have been put in place and rotation program implemented from Orthopaedics and Trauma co-ordinators are undergoing further training.	LOW	DIV	17/04/2012

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2593	15/04/2010		4 North Surgical	Cesation of Band 2 staff trained and currently doing clinical observations under the delegation of registered staff	In wards 4 north, 4 south, 3 south, Band 2 staff that have been trained and currently doing clinical observations under the delegation of registered staff having to stop, therefore a large increase in the number of clinical observations for registered staff to carry out, resulting in risk of observations not being timely. Risk of patients condition changing / deteriorating without recognition Patients not getting clinical observations in a timely manner if band 2s stop their current practice. No data available to identify that patients received less than optimum care when band 2s do clinical observations under delegation of registered nurse	Training carried in legacy trust for band 2 doing clinical observations. Requirement for band 2s to have clinical observation module in NVQ level 3 before being able to do clinical observations. This training not in place at present.			HOS	05/09/2011
2743	16/04/2010	Provide safe, high quality careBe a great place to work	Outpatients Dept	Staff Shortages due to implementation of POA without Backfill of Band 5 staff & ACH OPD provide 2.18 wte nursing support for MIU	Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards. Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards.	Outpatient Managers keeping current training records for all staff, while making priority for designated mandatory training. Allocation for training done according to type of training and date of last attendance when capacity allows. Consideration given to KSF and professional requirements first. Staff asked to do training during extra hours if no alternative available. Lead Nurse has escalated the staffing deficit/ Minor Injuries Unit to Finance, the AD for Surgery and Elective Care and Head of Out of Hours Service	6/12/10- Finance has extracted the MIU SIP out of the staffing allocation and funding from OPD. Review of funding to be done in relation to staff in January 2011 by H Trouton and Dr G Rankin. All risks remain outstanding and unchanged. 21 July 2010- staffing constraints have been highlighted to the AD for SEC and the Interim Director for Acute Services. Awaiting financial summary of overall Outpatient financial position. Review 31 August 2010. 6/12/10- Finance has extracted the MIU SIP out of the staffing allocation and funding from OPD. Review of funding to be done in relation to staff in January 2011 by H Trouton and Dr G Rankin. All risks remain outstanding and unchanged. 21 July 2010- staffing constraints have been highlighted to the AD for SEC and the Interim Director for Acute Services. Awaiting financial summary of overall Outpatient financial position. Review 31 August 2010.	LOW	DIV	19/05/2011
2636	20/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Patients for surgery having cancellations due to inadequate information and preparation via pre-operative assessment clinic.	Patients for surgery having cancellations due to inadequate information and preparation via pre-operative assessment clinic. Trust waiting list has to be altered so other people are cancelled to facilitate the cancelled patients. Wastage of theatre time and staff. Resource implications for the Trust. Complaints will increase. Extra work for ward staff and secretaries. Patients taking time off work to come to hospital for their surgery. Risk of litigation, loss of reputation. Patients cancelled due to not being informed to stop taking medications, such as anti-coagulants or insulin, or patient has not taken essential medications which should have been taken. Patients condition may have changed and may require further investigations eg: ECG, echo, which was not carried out at pre-op assessment. Patient not seen face-to-face at pre-admission clinic by a nurse (so patient effectively doing their own assessment) and on day of surgery consultant decides patient is not for surgery. Pre-op assessment bloods out of date, especially Group and Hold, and need to be repeated on day of surgery. Patient pre-assessed in CAH and documentation did not arrive at ward level.	Incident forms to be completed. Communicate with nurse in pre-admission clinic. Inform lead nurse		HIGH	DIV	05/09/2011
2635	27/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Female Surgical Ward DHH	Lack of staff training DHH, MSW, FSW, HDU, Gynae	Risk of staff not being updated due to lack of resources to facilitate staff to go to training and multiple training schedules at Trust level. Staff will not meet mandatory requirements for registration as specified by their professional regulatory body. Mandatory requirements unable to be facilitated. Risk of harm to patient if staff not adequately trained to provide high quality, safe, effective care. Increased risk of complaints, loss of reputation to Trust. Increased risk of HAI's. Risk of litigation. Low morale, increased sickness level, high staff turnover Staff will be unable to provide a high quality, safe, effective care to patients if not updated adequately. If staff at training, safe staffing levels may not be achievable at ward level. Most training takes place at Beeches CAH, which means at least 2 extra hours for travelling to and from DHH, which in turn reduces the amount of staff we can release from the ward.	Plan off duty rotas to facilitate training. Assess ward dependencies to ensure adequate staffing levels and facilitate training on the day of training as to whether staff can be released for training. Ward Manager to prioritise training needs. Controls discounted - Request more training in Daisy Hill Hospital. Beeches Education Centre not always able to provide training in DHH.		MOD	DIV	08/06/2010
2624	27/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Trustwide	Risk to health and safety of patients and staff in all SEC wards in CAH and DHH due to inadequate environment.	Increased risk of falls. Increased risk of injury to staff due to inadequate storage. Risk of infection due to inadequate sinks in wards and storage of hoists in bathrooms. Risk of theft of staff property. Increased risk of complaints, risk of litigation, loss of reputation to Trust. Risk of falls due to floors sealed with tape to cover cracks in floor covering. Uneven floor surface also providing a risk of falls. Inadequate number of sinks per bed ratio in main wards - should be 1 sink per 4 beds - presently 1 sink per 6 beds. Inadequate storage for stationary and equipment, eg: hoist being stored in main bathroom as there is no room for it anywhere else in the ward (FSW + MSW). Inadequate changing facilities for staff and inadequate number of handbags lockers for staff.	Environmental audits. Maintaining low stock levels. Endeavour to adhere to current infection control policy. Inform Estates.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2624 - expand to SEC as a problem across the division'.	MOD	DIV	05/09/2011

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
2631	29/04/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Female Surgical Ward DHH	Risk of delay in treatment for patients with fractures awaiting a bed or further management in the regional centre in Belfast.	Poor outcome for the patient. Delay in treatment. Potential for developing complications of bed rest eg: pressure sores, thrombosis, infection. Potential for increased complaints, litigation for the Trust. Patients may develop complications of bed rest and of having a fracture eg: fat embolism, thrombosis, infection. Delays in surgery may mean death or poor fracture healing. Bed flow may be impaired which will have an effect on elective lists and may result in theatre cancellations and breach of PFA targets. Loss of confidence in the Organisation.	Close liaison with Bed Manager who in turn communicates with regional centre. Control measure discounted - Patients should be admitted directly from A+E to RVH. Ensure CT scans and X-Rays are sent to RVH # Clinic or wherever designated, and signed for on receipt to ensure timely treatment. Communication with medical staff in regional centre at least daily when awaiting transfer.	01/10/13:An agreement has been reached that all N+M patients will transfer to RVH for treatment. During out of hours they will wait in DHH and then transfer directly the next morning to RVH. 29/03/13: Current position remains; continued utilisation of CAH Trauma Ward 01.02.13 - Optimum utilisation of CAH Trauma Ward continues in conjunction with RVH. 07.01.13 - Processes in place continue to work well. No escalations of delays in treatment for patients received. 29.11.12 - Current position remains. Case currently going to board and if approved and consultant appointed, fracture patients will come to CAH therefore minimising risk. Timescale uncertain. 28.09.12 - No change on review. 19.06.12 - Processes in place continue to work well with optimum utilisation of CAH Trauma Ward encouraged in conjunction with RVH as required. Plan to review in 2 months. 17.04.12 - Current position remains. 23.01.12 - Processes in place are working well. 10.11.11 Improvements noted in access to Belfast. 01.10.11 Awaiting feedback from patient flow team. Update 27.5.11- Dr Loughran has received correspondence from Dr Tony Stevens RVH re issue: - New rota hoped to improve response - Monitor success of new rota CAH taking patients requiring surgery subject to bed availability to facilitate prompt treatment	LOW	DIV	01/10/2013
2628	04/05/2010			Delay in diagnosis, treatment, transfer and discharge of patients due to loss of X-Rays, CT, MRI results	DHH Female Surgical,/Gynae, Male Surgical/ HDU - Delay in diagnosis, treatment, transfer and discharge of patients due to loss of X-Rays, CT, MRI results # Clinic RVH. Delay in diagnosis and treatment - poor outcome for patient - permanent injury, death. Patient may develop complications of bed rest, hospital acquired infection, fat embolus, DVT, PE, pressure damage to skin. Patients treatment delay causing further complication of condition. Risk of complaints, litigation, confidence loss in service. Bad reputation for surgical wards. Delay in patient flow, resulting in theatre cancellations. Delay in discharge, theatre cancellation , breach of PFA targets	Documentation available from surgical ward / A + E to be signed by RVH staff when X-Rays delivered. Good communication by nursing staff. Bed manager to communicate with # Clinic with daily or more regular updates.		VLOW	DIV	05/09/2011
2632	04/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Patients are at risk of not receiving prescribed drugs at prescribed times, due to 2 nurses to admin and check drugs IV.	Poor outcome for patient, delay in treatment. Potential for deterioration of condition. Increase of clinical incidents, complaints. Patients will not receive prescribed treatment in timely fashion. Bed flow may be impaired - delay in patient discharged, therefore elective lists may be postponed. Nurse could be disciplined for not adhering to guidelines. Litigation for the Trust, loss of confidence in Organisation.	Encourage use of IV antibiotics in community. 2 Staff on duty at all times to check drugs, risk of not being available for administer of drugs due to patient dependency and bed occupancy. Monitor medication errors and adverse incidents. Controls discounted - Dr to give IV drugs. Daily IV antibiotic ward round.		LOW	HOS	23/01/2012
2633	10/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	Female Surgical Ward DHH	Safety of staff property due to inadequate supply of handbag lockers at ward level.DHH, FSW, MSW, Gynae, HDU	Risk of staff property being stolen. Risk of litigation. Risk of loss of Trust reputation. Staff safety at risk if personal details stolen with handbags. Staff are at risk of distress and safety at risk if personal details stolen with handbags.	Handbags in unlocked cupboards.		LOW	HOS	23/01/2012
2625	10/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingBe a great place to workMake the best use of	High Dependency Unit DHH	Patients at risk due to inadequate staff cover at meal times	Poor outcome to patient. Possible death of patient. Extreme stress for staff. Increased sick leave, low morale. Increase in clinical incidents, increase in complaints. Risk of litigation, loss of Trust reputation, risk of increase in HAI's. Nurse could be at risk of losing her pin no. In the High Dependency Unit there are two staff nurses to cover for 5 ill patients. There is no provision made in the nursing establishment for meal break cover, lunch breaks; staff nurse caring for 5 ill patients. There is a risk of patients not receiving prescribed care, or of patients no receiving adequate pain relief due to only 1 staff nurse. Risk assessments for moving and handling cannot be adhered to due to only 1 nurse I unit. If patients condition suddenly deteriorates one staff nurse may not be able to deal with all five high dependency patients.	When possible, cover given by Male Surgical ward but due to maternity leaves, study leave, sick leave, posts not replaced. This is not adequate. Emergency call bell in HDU. Control measure discounted - Extra staff in HDU establishment. Inadequate funding for same.		LOW	TEAM	04/04/2012
2739	19/05/2010	Make the best use of resources	Pre-Operative Assessment Clinic	Increase in Day of Surgery Cancellations due to inappropriate/inadequate pre op screening. This is secondary to insufficient cle	Due to the reduction in Clerical Support, the POA clerical team are at risk at not being able to monitor the listing of T/O patients and monitor MRSA screening/status. The patient is at risk of having the procedure delayed or cancelled if not enough time has been given to screen and treat any infection pre operatively. Potential impact on theatre scheduling (surgery being postponed or cancelled at short notice) and theatre capacity)y (day of surgery cancellations) if patients aren't selected for screening in a timely manner. Patient harm - delay or cancellation of procedure has potential the length of time patient is exposed to illness/discomfort. Patient could potentially have financial loss due to time taken from work, along with disruption to domestic circumstance. Financial harm to Trust: substantial financial consequence for Trust secondary to loss of theatre capacity, loss of ward capacity and potential to breach waiting time targets. Harm to resources within the Trust - Day of Surgery cancellations potentially causes additional strain on ward staff due to patient distress and need for reorganisation of surgery. This has the potential for the patient to be exposed to additional screening secondary to delay.	Redistribution of workload within POA Clerical Team. Band 4 officer to monitor the T/O chart processing. S Glenny to provide monthly lists of patients due for selection- Band 4 to then monitor the timely arranging of patient attendance. Scheduling Team to populate Theatre lists a month in advance. POA Band 6 Nurses to highlight patients for screening/rescreening once TCI known.	May 28 2010. Escalate to S Glenny/H Trouton if controls are inadequate.	LOW	DIV	19/05/2011

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2634	20/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Injury to a patient following a fall DHH, MSW, FSW, Gynae, HDU	Client may have a fracture or head injury or laceration due to a fall. Complaints will increase, risk of litigation. Delayed discharge. Patients who are confused, under the influence of drugs or alcohol, elderly, unsteady on their feet, head injuries may be at risk of falling. This risk may be increased if the staff / patient dependency ratio is not at an adequate level. Patient may need transfer to another hospital. Could develop hospital acquired complications. Risk of death.	Monitor slips, trips and falls. Manual handling risk assessment carried out on admission. Individual patient handling assessment carried out on all patients on admission eg: cot sided, history of fall, use of aids etc. Keep bed at low level, mattress on floor, appropriate chair. Ensure call bell for each patient is within patients reach. Remove environmental risks. Contol measures discounted - Getting family to sit with patients and reviewing staffing levels and getting extra staff to sit with patient. Often family not available. Often unable to get bank staff.	07.06.10 - email from K McGoldrick - 'Beatrice as a follow up to a meeting with Heather, Connie and myself last week would you please look at these entries to 27/05/10, SEC risk register 2634 please remove ' - risk closed 08.06.10	LOW	DIV	08/06/2010
2742	22/05/2010	Provide safe, high quality care	Outpatients Dept	Risk to health & safety of patients in ENT due to no access to decontamination equipment on weekends	No access to decontamination equipment on weekends. Additional Clinic Saturday May 22 2010. Cross contamination to patients. Risk to organisation through: litigation; adverse publicity/ complaints;loss of reputation; breach of Hine Review. Recommendations. Inequality of care for patients; Friday (clean scopes); Saturday (wiped and sheathed scopes). Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demand. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients.	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations). Arrange for all scopes on other OPD sites to be transported to CAH for the additional clinic. This would mean that the satellite sites would not have access to their scopes for clinics on Monday with a risk of not having them decontaminated for Tuesday. Irrespective if all scopes were recalled, there would not be sufficient numbers to support a clinic of 80 new patients	23.01.12 - Requisition away for customisation of transfer boxes and same should be resolved by 29 February 2012. Seeking funding to provide decontamination of new scopes. Contribution to Decontamination staff- ? .2 Wte Band 2	VLOW	HOS	17/09/2013
2626	24/05/2010	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMaximise independence and choice for patients and clientsBe a great place to workMake the best use of resources	Female Surgical Ward DHH	Staffing levels in Female Surgical/Gynae, Male Surgical/ HDU	Health and Safety of patients and staff could be compromised if staffing falls below safe levels for dependency and high bed occupancy due to staff absence and reduced staffing as a result of bed closures at the weekend. Patients may be at risk of not receiving adequate, safe, high quality and timely care. Risk of increase in accidents, medications not given on time, poor documentation or lack of documentation / not according to NMC code for record keeping. Staff may be placed under stress if staffing levels fall below recommendations for patient dependency / bed occupancy. Patient may be at risk of receiving inadequate care. Adequate maintenance of the ward environment may be compromised if staffing falls below acceptable levels. Increase in complaints. Increased staff sick leave. Risk of increased length of stay due to HAI's. Lower staff morale. Risk o litigation. Risk of loss of reputation.	Monitor staff sickness and absenteeism. Monitor clinical incidents. Monitor complaints. Attend white-board meetings x3 times / week to monitor patient length of stay. Feedback to nurse managers if requesting bank or extra hours. Monitor environmental cleanliness by audits.		LOW	DIV	08/06/2010
2627	24/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Female Surgical Ward DHH	Delays in repair of equipment eg: sluice master in FSW, MSW, HDU, Gynae DHH	Delays in repair of equipment eg: sluice master. Increase of infection. Risk of injury to patient and staff from equipment. Equipment eg sluice master not repaired when faulty may cause spread of infection due to body fluids being stored in clinical waste bags. This is high risk for staff and patient including portering staff. Risk of complaints, litigation and bad publicity.	Use equipment as per guidelines. Inform maintenance as soon as equipment faulty. Ensure infection control procedure applies as per policy.		MOD	HOS	23/01/2012
2647	26/05/2010	Provide safe, high quality care	4 South Surgical	Short term storage of large quantaties of oxygen cylinders at ward level on 27th May 2010	Large quantity of oxygen cylinders at ward level due to the mains oxygen supply being unavailable for a period of time on 27th May 2010, thus potential risk of running out of oxygen and hazard from large quantity of stored oxygen in an unprotected area Risk of litigation if staff harmed due to amount of cylinders stored as area cluttered, and cylinders very heavy Risk of poor quality service if oxygen runs out Risk of injury from oxygen cylinder Risk of fire as no dedicated O2 storage area is available at ward level	Estimation of extra oxygen required obtained and at ward level All cylinders on O2 trolley Porters and Pharmacy informed of the loss of mains O2 Management informed	08.06.10 - work complete and risk closed	MOD	DIV	08/06/2010

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2681	15/06/2010	Provide safe, high quality careMake the best use of resources	Outpatients Dept	Shortage of (Paediatric) Band 5 Nursing staff due to the implementation of Pre Operative Assessment without backfill of Band 5 s	Potential harm to patients due to not having regular support of Band 5 Paediatric trained Staff Nurse. Potential harm to the reputation of the SHSCT if this issue is highlighted as part or RQIA feedback. Potential for litigation if it is found that a patient received sub standard care due to lack of access to Paediatric trained Staff Nurse. Failure to comply with Child Protection Policy and Procedure. Staff supporting the Paediatric service in Outpatients are at risk of not having sufficient skill and supervision to undertake the assessment of care of patients 16 and under Trust at risk of complaint and litigation. Staff at risk of not meeting SHSCT Child Protection Standards. Children at risk of harm by potential action or inaction by Adult trained nurses/health care assistants Patients and families have to reattend Inpatient services to have Paediatric specific investigations done. (this as a direct result of insufficient specialist skills within General Outpatients.) Increased risk of exposure to HAI and impact on ward staffing resources.	Awaiting the commencement of year long Secondment to Paediatric training for S/N J Doogan Health Care Assistants and Nursing Auxiliaries allocated to support Paediatric clinic with Band 7 Paeds Trained Department Manager on site. Band 5 staff nurses allocated to Paeds clinic when staffing levels allow. Control measures considered but discounted: Increase Band 5 Staff Nursing allocation-Unable to secure funding for POA backfill due to financial constraints Band 7 OPD Manager, covers Child Protection support-Band 7 Paeds trained Department Manager currently on sick leave Band 5 Paeds Nurse allocated to Paeds OPD- The one Band 5 Paeds trained staff nurse is current on Band 6 secondment in POA.	25 June 2010- Meeting held with Mrs Geraldine Maguire, Mrs Grace Hamilton, Mrs Heather Trouton and Mrs Connie Connolly regarding the transfer of funding from General OPD to the Paediatric Directorate. It was agreed that funds equivalent to 1.0 Wte at one Band 5 and 1.0 Wte at one Band 2, would be transferred from OPD to Paeds. Email request regarding this change was sent to Mrs Carol Cassells. It was agreed that current custom and practice would continue until the Paeds Directorate was able to recruit staff accordingly. 3 June 2010. Meeting held with Grace Hamilton and Bernie McGibbon. Actions: Connie Connolly to amend and escalate Risk Assessment to Heather Trouton/Beatrice Moonan. Done 3/06/10. Connie Connolly to approach Dean Faloon in Finance and Dr Mike Smith regarding information regarding funding for Paeds OPD. Consideration was given to OPD funding being transferred to Paediatric Directorate. Connie Connolly to escalate proposed transfer of funding from OPD to Paeds to H Trouton. Connie Connolly to discuss the commissioning position for Paediatric training in 2010/11 with Heather Trouton. 14 June 2010 -Meeting with Bernie McGibbon, Dawn Connolly and Connie Connolly Due to chronic shortage of Band 5 Paediatric trained Staff Nurses, these actions have been agreed. Actions: Paediatric Outpatients children who require the application of EMLA crème with have to attend 3 North to have EMLA crème applied in advance of having blood taken. Memo to be circulated 15 June 2010 To await outcome of meeting with Mrs Maguire and Mrs Trouton regarding the transfer of funding for Nursing support from General Outpatients to Paediatric Services. 6.12.10 - Paediatric funding transferred to CYP in July 2010. October 2010 - staff rotating from Paediatric ward initially for induction, with a view of supporting the complete service by November 2010. 6/12/10- CYP managing the Paediatric Outpatient	LOW	DIV	06/12/2010
2746	21/07/2010	Provide safe, high quality care	Outpatients Dept	Risk of contamination while using Welch Allen sigmoidoscopes (rigid or flexible) with Welch Allen light source etc.	Risk of contamination has been identified while using Welch Allen sigmoidoscopes (rigid or flexible) with Welch Allen light source, reusable eye pieces, reusable bellows with the disposable proctoscope & disposable filter. There is a risk of cross contamination from the equipment to the patient if the bellows are reusable. Currently in Outpatients staff would not have access to sufficient numbers of reusable eye pieces, to replace the eye piece with every examination. There are only 9 sets of bellows across the Trust and the MDA health alert stipulates that the eye piece, filter and bellows are changed with every examination. The Trust currently has disposable proctoscopes and filters in use. Risk of cross contamination between patient and sigmoidoscope equipment. (the reusable bellow has the potential to cross contaminate the reusable eye pieces irrespective of the disposable filter)Potential harm to patient if secondary infection is contracted. Could potentially delay or change management Risk of litigation	Urgently seek the view of the Assistant Director regarding the financial implications of remaining partially compliant with manufacturer's advice. Collate financial estimates for changing to a Single Use system or enhancing stock of current equipment. Manually cleaning bellow in between examinations, while awaiting investment. Not feasible given the number examinations done and the timing between patients. Cannot insist on the changing of eye pieces or bellows until financial resources are released.	6.12.10 - Requisition has been placed to purchase 6 light sources to support the new disposable system. To be supplied by 31.3.11. Integration of new single use MDA compliant system to be in place by 31.3.11. 6.12.10 - Requisition has been placed to purchase 6 light sources to support the new disposable system. To be supplied by 31.3.11. Integration of new single use MDA compliant system to be in place by 31.3.11.	MOD	DIV	19/05/2011
2740	27/07/2010	Provide safe, high quality careMake the best use of resources	Pre-Operative Assessment Clinic	Staff Shortages due to sick leave within Band 6 POA nurses providing Face to Face Assessment	Due to chronic staff shortages, there is not enough capacity on the two above mentioned sites for Face to Face assessment to be done in a timely manner. This results in an insufficient number of pre op fit patients available for listing for elective procedure. Risk of Day of surgery cancellations and decreased theatre utilisation due to patients being suspended or cancelled at late notice. Due to lack of capacity, there is limited provision for any patients being booked at late notice due to cancellation, or red flag/urgent status. Potential harm to patients following cancellation of surgery due to untimely or no pre operative assessment. Potential financial harm due to inappropriate theatre utilisation- not enough patients pre op fit. Potential to harm to reputation of SHSCT due to potential breech of waiting times	Patients having surgery in the next 4 weeks are given priority for Face to Face assessment. POA clerical staff allocate appointments in chronological order of TCI dates. All Band 6 POA staff have staffed additional clinics during time which was usually allocated for the reviewing of investigative results. Close monitoring of sickness and absence/referrals to Occupational Health.		MOD	DIV	17/08/2010
2744	27/07/2010	Be a great place to workProvide safe, high quality care	Outpatients Dept	Staff Shortages due to the implementation of Pre Operative Assessment without Backfill of Band 5 staff	Due to chronic staff shortages, staff are unable to be release to attend in service and mandatory training. Risk of not being able to fulfil professional development requirements. Risk of staff providing patient care to potentially out of date standards. Potential harm to patients and staff due to not being able to be updated with mandatory and in service training. Potential harm to the reputation of the SHSCT if this issue is highlighted as part or RQIA feedback. Potential to delay progression through KSF framework , secondary to lack of attendance re agreed training needs. Potential for litigation if it is found that a patient received sub standard care due to lack of access to training.	Outpatient Managers keeping current training records for all staff, while making priority for designated mandatory training. Allocation for training done according to type of training and date of last attendance when capacity allows. Consideration given to KSF and professional requirements first. Staff asked to do training during extra hours if no alternative available	6/12/10 - Current position remains unchanged and will potentially deteriorate in January due to Maternity leave(22/10/10). Block bookings have been utilised where possible with Nurse Bank at Band 5 (1.0 Wte) and Band 2 1.44 Wte). This was arranged following Meeting with H Walker, H Trouton and C McGoldrick. All staff on long term sickness are under occupational health review. Difficulty in staffing additional clinics Trust Wide. 21 July 2010 Awaiting Financial Summary to illustrate the overall Outpatient status. AD for SEC and Interim Director of Acute Services aware of staffing issues. Nurse Bank being utilised to cover gaps. Review August 31 2010	VLOW	DIV	19/05/2011
2741	27/07/2010	Provide safe, high quality care	Outpatients Dept	No provision for Bariatric patient- patients over 25 stone in weight	No bariatric examination couches available on the above mentioned sites. Unable to provided Outpatient service to patients over 25 stone at these sites. Potential to breech waiting time targets as patient may not be able to be seen close to their home or by the relevant specialty. Risk of injury to patient and staff if furniture is not fit to provide support for patient weighing over 25 stone. Risk of inadequate examination due to limitations of non bariatric furniture. Potential harm to patient if the patient cannot be seen on the above mentioned sites, due to lack of appropriate examination couches- potential for increase in severity of disease/illness. Potential for delay in Outpatient appointment if living near one of these site. Potential harm to both patient and staff if patient was seen on inappropriate furniture- potential for inadequate examination due to limitation of furniture. Potential discomfort and embarrassment to patient if department not prepared to meet patient need.	Medical records will book any know bariatric patient to the Daisy Hill site.	6.12.10 - All General Outpatients Departments now have one Bariatric couch and one Bariatric chair in the waiting room. Remove from Register - no longer a risk. 6.12.10 - All General Outpatients Departments now have one Bariatric couch and one Bariatric chair in the waiting room. Remove from Register - no longer a risk. Caroline Doyle in Finance has asked that Helen OHare was contacted regarding updating the status of all E&G accounts. Email sent 15/04/10.	LOW	DIV	06/12/2010
2820	25/11/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	3 South Surgical	Significant WTE staff levels less than agreed compliment due to sick leave, maternity leave and vacancies.	Patients receiving poor quality care. Clinical Audits reflecting reduction in standards. Staff sick leave increasing. Poor moral, staff feeling over worked. Increase in complaints. Risk to reputation of Trust . Due to reduction in ward compliment of staff, along side normal activity there is a risk that systems and processes will breakdown. Staff, patients and Trust reputation at risk. Escalation in level of sick leave. Training opportunities not able to attend due to ward shortage of staff Mentoring of students compromised.	Bank staff to back fill as bank system and financial climate will allow. Encourage staff to be flexible with off duty rota. Control measures considered but discounted and why: Temporary staff appointed, not feasible due to the current recruitment challenges and the time scale involved.		HIGH	DIV	05/09/2011

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2821	26/11/2010	Provide safe, high quality care	Outpatients Dept	Risk to health & safety of patients in ENT attending additional clinics on November 20 2010	No access to decontamination equipment on weekends. Additional Clinic Saturday May 29 2010. Cross contamination to patients. Risk to organisation through: litigation, adverse publicity/complaints,loss of reputation, breach of Hine Review Recommendations. Inequality of care for patients - Friday (clean scopes), Saturday (wiped and sheathed scopes). Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demand. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients.	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations)	Seeking funding to provide decontamination of new scopes	MOD	DIV	19/05/2011
2824	07/12/2010	Provide safe, high quality careBe a great place to work	Outpatients Dept	Risk of inadequate staffing levels due to long term sick leave resulting in poor or inadequate nursing care and chaperoning	Staff and patients are at risk of error, poor quality care, insufficient chaperoning. Trust is at risk of not meeting SABA levels, secondary to not having enough staff to support additional clinics. Risk of inadequate staffing levels due to long term sick leave resulting in poor or inadequate nursing care and chaperoning. Risk of decreased efficiency and capacity in Outpatient clinics secondary to low staffing levels. Risk of loss of reputation due to increased waiting times and increase risk of error due to increased workload of remaining staff. Potential for a further increase in sick leave due to high demand on remaining staff. Potential for increased complaints due to lack of staffing and staff workload. Extensive Long Term Sick Leave at Bands 5,3 and 2.Band 5 SIP 11.80 Wte 6.75 Wte staff on sick leave, secondment, acting up. Band 3 SIP 7.59 Wte. 3.63 Wte staff on sick leave. Band 2 SIP 2.19 Wte. 1.26 Wte staff on sick or maternity leave. Sickness Rate approx 49% - not withstanding annual leave and mandatory training and casual sick leave. Maternity Leave at Band 6 to be filled by . 90 Wte Band 5	Staff work extra hours when possible Band 5 1.1 Wte Bank block booking. Band 2 1.44 Wte Bank block booking. Staff working between multiple services, instead of single service. CTP has taken over support for Paeds OPD Rheumatology clinics are in DCC in CAH. Requisition has been approved for 2 POC testing for Coagulation Clinic (will release 2 staff)Staff from other Outpatients support when possible		LOW	DIV	19/05/2011
2823	07/12/2010	Provide safe, high quality care	ENT Clinic, Surgical Outpatients	Non Compliance with RQIA Environmental Cleanliness Audit 14/09/10	Health and Safety Risks to all patients attending ENT OutpatientsHealth and Safety Risks to all staff working within ENT Outpatients due to poor conditions of environment. Trust is Corporately at risk of loss of reputation if not compliant with RQIA recommendations. Infection control risk due to the type of flooring. Infection control risk due to lack of facilities to do initial decontamination of equipment. Risk of loss of reputation if not compliant with RQIA recommendations. Infection control risk due to poor condition of flooring in public toilets in ENT Department. Risk of patient injury due to inadequate space to conduct phlebotomy.	Carpet is cleaned daily. Blood room is kept uncluttered. Toilets cleaned daily. ENT scopes are taken to CSSD for all cleaning (increasing processing time)	11/11/11 No progress with minor works, duplicate request sent to provide costs for all repair work. Remains a risk 14.11.11 Note link with Risk 2989	MOD	HOS	17/10/2013
2898	01/02/2011	Provide safe, high quality care	Outpatients Dept	No screens surrounding the examination couches in the Consultation rooms	Staff are unable to secure privacy and dignity of patient without adequate resources. Patient does not have any dignity or privacy to change for an examination. Potential for litigation to Trust secondary to inadequate changing facilities and potential for violation of patient privacy during an examination/consultation.	Clinician leaves the room to allow patient for privacy Changing cubicles are in use, and patients then walk in front of waiting are in hospital gown	23.01.12 - Screens have been ordered, awaiting delivery. 11/11/11 J McCaghey has been contacted and measurements have been taken. No cost estimate as yet. 10.11.11 Screens ordered from Jan 2011, awaiting delivery of same to progress with J Austin.	LOW	DIV	27/03/2012
2899	01/02/2011	Provide safe, high quality careBe a great place to work	Outpatients Dept	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose ro	Non compliance with Infection Control and Health and Safety Standards in relation to patients, staff using this multi purpose room. Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	Potential harm to patients and staff of hospital acquired infection. Potential of litigation to the Trust secondary to Hospital Acquired Infection.	25.10.11 Reviewed and closed by Connie Connolly	MOD	HOS	23/01/2012
2943	07/04/2011	Provide safe, high quality careMake the best use of resources	Urology Clinic	Urology cancer pathway delays (also on CCS Divisional Risk Register ID 2942)	Patients on haematuria and prostate cancer pathways. Delays in first appointments, investigations and treatments. Patients with cancer being delayed in diagnostics and treatment pathways. Patients may be late diagnosed and have further advanced disease leading to poorer outcome. This may mean that a patient changes from potentially curative to palliative during the waiting period.	Identification of patients at risk ongoing. Detailing of capacity and demand ongoing to identify needed capacity and resources. Further reconfiguring of services required to support the change required in the service to reduce delays. Further resources required to support the volume of work within both cancer and non cancer urology work.	23.01.12 - one stop prostrate clinic is fully operational, hence no delays at present. See Risk 2942 10.11.11 We will update figures early December 2011 01.10.11 One stop prostate clinic commences 1 October 2011 and One stop Haematuria clinic commence 6 October 2011	LOW	DIV	23/01/2012
2968	21/04/2011	Provide safe, high quality care	4 South Surgical	Risk to staff and patients of the spread of HCAI due to condemned Bedpan Washer Ward 4 South	Condemned Bedpan Washer Ward 4 South. Risk of the spread of Health Care associated Infections [HCAI] to staff and patients. The Bedpan washer is broken and has been condemned on the Male side sluice room of Ward 4 South. This poses significant risk to the patient and the staff re: the spread of HCAI.	At present staff are using the Bedpan Washer on the Female side of the ward to decontaminate bedpans and urinals	A visit is taking place to another facility to view an HTM compliant bedpan washer in April 2011. As an interim measure a temporary Bedpan washer is being installed week commencing 13th June 2011	MOD	DIV	05/09/2011
2990	19/05/2011	Provide safe, high quality care	Outpatients Dept	No hand washing facility in clinical Outpatient consultation rooms Room 63 and room adjacent	This risk assessment is being measured on the basis that currently these clinical rooms are being used by Speech and Language only. This specialty by its nature is non-invasive and does not traditionally create a high decontamination risks. If these rooms were to be allocated in the future to other specialties, the risk to the Trust would be substantially higher.** Staff and patients do not have access to any hand washing facilities in the clinical consultation room. Risk to Health and Safety- Risk of infection, cross infection and hospital acquired infection to patients. Risk to Health and Safety Risk of infection and cross infection to staff utilising this clinical area. Environment will not have access to timely cleaning as there is no water or washing/cleaning facilities available. Risk to Health and Safety - infection to staff, and patients. Risk of Litigation, secondary to hospital acquired infection. Risk of Loss of Reputation to Trust with hospital acquired infection rate. Risk of non compliance with RQIA	Cleansing wipes and alcohol jells are used in between patients and to wipe equipment Equipment cleansed at the end of clinics with soap and water from other clinical area.		LOW	DIV	23/01/2012
2989	19/05/2011	Provide safe, high quality care	Outpatients Dept	Inappropriate flooring Consultation rooms not compliant with Health and Safety/Infection Control	Carpet flooring will need replaced with a washable surface. Risk of infection/injury to staff, patients and Clinicians. Risk of litigation to Trust secondary to Hospital Acquired Infection Unable to achieve waiting time targets regarding Outpatient Capacity. Risk of financial penalty for not meeting Outpatient Capacity and Demand.	Daily cleaning of carpet by domestic staff.	11/11/11 No progress with minor works, duplicate request sent to provide costs for all repair work Remains a risk. 14.11.11 Note link with Risk 2823	MOD	HOS	23/01/2012
2998	31/05/2011	Provide safe, high quality care	Outpatients Dept	Unable to safely store sterile ENT equipment	Patients will not have access to a sterile nasopharyngeal scope, and appointment for examination will have to be rescheduled. This will directly result in a delay in diagnoses and an increased review backlog. Patients will not have timely access to sterile ENT nasopharyngeal scoped during ENT consultation. Patient at risk of delayed diagnoses. Risk of Hospital Acquired Infection. Risk of Litigation. Risk of Loss of Reputation secondary to RQIA non compliance. Risk of Loss of Reputation secondary to increased Review Backlog	Staff are currently supporting the Outpatient clinic and decontaminating equipment.		HIGH	DIV	05/09/2011
3006	21/06/2011	Provide safe, high quality careBe a great place to work		Environmental works at 4 North, 4 South & 3 South wards pose threat to management of HCAI;compliance with fire and disability	Outstanding Environmental works at 4 North, 4 South and 3 South wards pose threat to management of HCAI;compliance with fire and disability regulations. Each of the wards have the following areas which need a minor works programme to include: Toilet facilities upgraded; Bathroom / shower facilities upgraded; Installation of sinks in bays; Painting and plastering; Various Ceiling tiles replaced; Nurses station to be upgraded; The facilitation of a waste room in 4N; Floor tiles.	All reasonable measures are in place at present; cleaning schedules; decluttering; good housekeeping practices.	01.08.12 - Programmed of works completed in 4 North and 4 South. Awaiting funding to commence 3 south. 19.06.12 - Programme of works completed 4 south, programme of works near completion 4 North, awaiting funding to commence 3 south. 17.04.12 - Programme of works has commenced in Wards 4 North and 4 South. 3 South no date as yet - awaiting funding. 23.01.12 - Funding has been approved and refurbishment programme commencing February 2012. 10.11.11 Funding has now been allocated and a workable program for dates is being progressed. 01.10.11 Awaiting costing from Estates for refurbishment have walked the wards. Awaiting feedback. Review July 2011	MOD	DIV	28/09/2012

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3027	08/09/2011	Safe, High Quality and Effective Care	Pre-Operative Assessment Clinic	PRE OP BAND 6 STAFFING	Patients are at risk of not receiving timely Pre-Operative Assessment by Band 6 POA Nurses Staff are at risk of overlooking patient management issues secondary to dramatic increase in workload Patients are at risk of delay in immediate pre-operative management re medicines management secondary to decrease in workforce. Decreased capacity to Pre Operatively assess patients 6 weeks in advance of surgery Increased risk of day of surgery cancellation or late cancellation secondary to insufficient pre-operative assessment Potential risk for theatre under-utilisation Potential for unnecessary use of staff resource on ward/unit due to unnecessary admission Potential for delay in patient treatment, patient distress, and disruption to patient work/home arrangements Potential for litigation to Trust re potential for delay in patient recovery due to insufficient pre-operative preparation	Patients with dates for admission have been made immediate priority All patients with dates for admission, needing Warfarin management, has been delegated to POA Project Leader Clinic templates have been adjusted to only include patients with dates for admission, and additional time has been allocated for processing results and managing queries Clinical Sister in CAH OPD has been supporting the Band 5/6 triage issues, and has been managing same All long term staff are being actively managed via Occupational Health Temporary replacement of Band 6 Sister has been provided with immediate effect .73 Wte All associated specialties and staff have been notified of temporary staffing issue	25.10.11 Reviewed and closed by Connie Connolly. 01.10.11 Situation should be resolved when full staffing in place by November 2011.	MOD	TEAM	23/01/2012
3048	23/11/2011		Outpatients Dept	Portable suction within CAH ENT OPD now obsolete, and no longer fit for purpose	Patients are at risk of not receiving high quality examination secondary to poor visibility for the Clinician. Potential for increase in waiting times for patients secondary to the extended period of time being needed for examination-may result in delay in diagnoses. Clinician at risk of overlooking clinical finding due to poor visibility. Patient at risk of auditory damage if suction control is inadequate during examination. Potential for inconclusive examination secondary to poor visibility during examination. Potential for patient harm secondary to inadequate suction-may result in needing additional treatment.	Patient examinations have been prolonged to allow for inadequate suction.	22.11.11 Direct Nursing support during every examination during ENT Clinics.	MOD	HOS	18/09/2013
3069	23/01/2012	Safe, High Quality and Effective Care	Trustwide	Wards and Departments not meeting their mandatory requirements for Right Patient Right Blood training.	Risk of no staff or minimal staff at ward level who can competently erect and monitor a blood transfusion. Risk of harm to patient and loss of Trust reputation as well as confidence.	Close liaison with the Haemovigilance Practitioner. Additional inhouse training has been commissioned. Staff have been issued with desist notices if relevant. Patient Flow team are aware of issues and how to manage same if situation arises out of hours.	01/10/13: Situation improving; focus remains at ward level and the Training matrix is monitored closely. 29.03.13: Training matrix is monitored very closely; focus remains at ward level to ensure training is booked in advance of expiry dates. 01.03.13 - Focus remains at ward level to ensure training is booked in advance; position is improving. 01.02.13 - All mechanisms remain in place to monitor position. 07.01.13 - Processes and monitoring mechanisms remain in place. 29.11.12 - SEC position improved. Monitoring mechanisms in place to avoid recurrence.	LOW	DIV	17/10/2013
3071	23/01/2012	Safe, High Quality and Effective Care	Trustwide	Risk of Point of Care Testing at Ward Level	Risk of staff not competent in use of machine and machine not maintained properly. Potentially inaccurate readings resulting in potential harm to patients, increased complaints and litigation.	Close liaison with laboratory staff, particularly Consultant Chemical Pathologist. Discussed with all Ward Sister to cascade to all staff the importance of quality control/cleaning/competency of users.	01/10/13: continue to monitor progress and address any issues that are identified by Laboratories. 29/03/13: continue to await roll out to all wards and departments 01.03.13 - Position remains unchanged. 01.02.13 - Continue to await roll out to all wards and department. 07.01.13 - All wards sisters in SEC have had awareness training. Pilot ongoing in CEAW, awaiting roll out of training via labs staff. 29.11.12 - In service training ongoing. Awareness increased and await outcome of pilot. 28.09.12 - A pilot in conjunction with the Laboratories is commencing at ward level to identify and address issues. 19.06.12 - Staff aware of responsibilities - ongoing work in relation to equipment and point of care testing at ward level. Plan to review in 2 months. 17.04.12 - All wards issued with folders in SEC containing list of all equipment and staff responsibilities. Ward Sisters to continue to reinforce same. 23.01.12 - discussed with all Ward Sisters to cascade to all staff the importance of quality control/cleaning/competency of users.	LOW	DIV	17/10/2013
3184	17/08/2012		Fracture Clinic	Fracture Clinic Referral Waiting Times	Due to capacity problems the Fracture Clinic waiting times have the potential to increase significantly for new and review appointments.	Additional clinics are being organised where capacity allows and assistance being sought from other specialities/departments.	29.11.12 - Clinics up to date. 28.09.12 - Up to date at week ending 8 October 2012. However numbers have risen again. Assistance being sought for additional clinics.	HIGH	HOS	17/10/2013
3193	06/09/2012		Trauma Ward	Isolation of Trauma and Orthopaedic Wards	Due to the location of the Trauma and Orthopaedic Ward especially in the Out of Hours Period this can result in isolation for staff and patients.	Staffing levels are always maintained at a safe level to ensure safe standards of care at all times; Handover of sick / ill patients forwarded to Patient Flow Team twice daily; Staff have access to a Site Manager and Clinical Co-Ordinator in the Out of hours Period; Staff have access to all grades of Medical Cover via the bleep and escalation policy.	28.09.12 - All measures are in place at all times to ensure safety of staff and patients - review on a 3 monthly basis.	MOD	HOS	17/10/2013
3200	17/09/2012			Wards and Departments not meeting their mandatory requirements for Right Patient Right Blood training.	Risk of no staff or minimal staff at ward level who can competently erect and monitor a blood transfusion. Risk of delay and harm to patient; risk of loss of reputation of Trust.	Additional training sessions for theory in particular have been requested; awaiting assistance from Haemovigilance Practitioner and HSC Education Centre. Staff have been issued with desist notices if relevant. All Sisters are aware that staff may have to transfer to other wards / departments to assist. Patient Flow Team are also aware.			DIV	28/09/2012
3208	27/09/2012		3 South CESU	Infection control risks due to poor shower and toilet facilities on Ward 3 South.	Threat to management of HCAI. Compliance with fire and disability regulations.	All reasonable measures are in place at present, cleaning schedules, decluttering and good housekeeping practices.	29/03/13: Meetings have taken place with Contractors regarding other Minor works programme and work will commence within two weeks. 01.03.13 - Minor works scheme commencing March 2013 to upgrade treatment rooms in the first instance. A project team has been established to plan for a full refurbishment of 3 South and the other areas 4North and 4 South; working progress. 01.02.13 - Programme of works to commence prior to March 2013. 07.01.13 - Await start date for approved programme of works. 29.11.12 - funding has been approved and refurbishment to commence in January 2013. 28.09.12 - bid for funding has been completed - awaiting update.	MOD	DIV	17/10/2013

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3210	27/09/2012		Outpatients Dept	Unable to provide full traceability and decontaminatino of Naso Pharyngeal scopes in SHSCT ENT and General OPD.	Risk of infection/injury to staff, patients and Clinicians Risk of litigation to Trust secondary to Hospital Acquired Infection and inability to trace scopes to patients. Unable to achieve waiting time targets regarding Outpatient Capacity- patient may need additional appointment for examination. Risk of financial penalty for not meeting Outpatient Capacity and Demand. Risk of RQIA non-compliance relating to the timing and decontamination of ENT Scopes and litigation Patients may not have access to decontaminated scope during assessment. Risk of litigation to Trust as scope decontamination process does not facilitate traceability	Scopes are cleaned by a variety of staff in CAH and STH without traceability. Insufficient staffing in CSSD for timely decontamination.	03.04.13: Funding has now been approved and recruitment is imminent. Re-training re Drying cabinet is commencing 8 April. 15 scopes awaiting asset tagging. 07.01.13 - Funding has been approved for ATICS to appoint Decontamination support. Retraining re dying cabinet has been arranged. SOP to be finalised 11 Jan 13 re OPD processes. Process to be implemented w/c 4 February 2013 29.11.12 - Standard operating procedures due to be completed by end November 2012. 28.09.12 - Meeting to take place with CSSD Manager and software company re needs and cost of compliance.	MOD	DIV	17/10/2013
3209	27/09/2012		Outpatients Dept	Urology project cannot proceed without the decant of OPD blood room	Urology project will not be completed by 31 March 2013. Urology will not receive new accommodation. Risk of loss of capital funding due to project not commencing on time.	None.	01/10/13: works programme has commenced; awaiting completion 29.11.12 - works programme commenced November 2012. 28.09.12 - completion of estates minor works for rooms 16 and 17 to be adapted to accommodate decant.	VLOW	DIV	07/01/2013
3211	27/09/2012		Outpatients Dept	CAH OPD environment in poor condition.	CAH OPD environment in poor condition- walls need painting/flaking paint needs removed and holes filled. Water stained ceiling tiles in examination rooms need replaced. Carpeted flooring which is worn and stained. Window blind fitting are worn and cannot be repaired- light is not being excluded. Non- compliance with Infection Control and Estates standards. Poor performance against RQIA standards-cleanliness inspections. Loss of reputation in relation to on-compliance Domestic services can no longer clean the aged and damaged surfaces. Risk of infection due to broken and flaking wall surfaces. Risk of infection due to stained/damaged ceiling tiles due to repeated water leaks. Risk of infection due to repeatedly stained carpet which can no longer be rejuvenated.	Regular and repeated cleaning by domestic services.	7 August 2013 Series of 8 emails since 4/11/12 to C Spiers re placement on the estates schedule. A Metcalfe has advised that the minor works budget is to be reviewed in Sept 2013. A Carroll to petition to have this work included in programme by 2014. this work has been outstanding since 2010 following RQIA inspection. 03.04.13: Works were costed and funding declined in March 2013. For consideration of works schedule for 2013/14. 07.01.13 - Series of 4 emails since 4 November 2012 to C Spiers re placement on the estates schedule. No reply as yet. This work has been outstanding since 2010 following RQIA inspection 29.11.12 - Re-requisitioned in September 2012, awaiting approval for commencement date. 28.09.12 - Submit minor works request with risk assessment to AD and Director of Acute Services. 03.09.12 ENT OPD works identified as priority for 2012/13 funding via HCAI Pgs10/11	VLOW	HOS	22/10/2013
3299	31/12/2012		Anaesthetics, Theatres & Intensive Care Services	CAH Main Theatre Staffing Risk	Due to increase in sick leave/maternity leave within Main Theatres CAH, this has led to being unable to provide additionally with consequence risk to ENT and Urology access targets.	Avenues explored 1. Cross site working of all staff difficulties, can be stabilised through redeployment of staff nurse from Female Surgical to DPU. 2. Extra hours offered to all staff Trustwide -email to be re-circulated to al ward sisters. 3. Increased hours for parttime staff working within Trust across all sites. 4. Contacted staff on secondment. 5. Contacted staff on Maternity Leave for keeping in touch days. 6. Bank-unfortunately unable to provided the necessary number of requests. 7. Block bookings requested - staff starting who are only out of University and will be under 24 week preceptorship. 8. Staff moved from other areas to fill core sessions in CAH. 9. Excalated to line management.	28/3/19 to be closed and amalgamated with risk 3802. 4.10.18 Unsuccessful recruitment drive. Continue with cross site working bank, agency and inhouse additionality to cover gaps. 8.8.18 Interviewing 5 x Band 5 late Aug 18. After Belfast Telegraph recruitment ad. Use of agency and ODP staff in the departments. 12.6.8 Unchanged. Recruited only 1 theatre nurse from nursing recruitment fair. Presently trying to secure agency staff. 10.4.18, 28.02.18 Remains unchanged. 7.11.17 monthly staffing meeting with lead nurses identifying e-reqs established. Weekly theatre rota meetings ongoing to ensure cross site working. Bank and agency staff still employed to cover core sessions 30/5/17 - Theatre staff rota meeting offers cross site working. Bank, agency and additionality continue to cover core sessions. E-req has been completed for all vacant posts	LOW	HOS	28/03/2019
3300	07/01/2013	Safe, High Quality and Effective Care		Transfer or Patients to Independent Sector	There is a risk to the patients in terms of extended waiting times associated with the treatment and care with IS providers. There is associated risk of reputation to the Trust with the transfer of patients to IS Provider , there is a risk to the IS Team being able to deal with the volumes in the expected timeframes, financial risk to the Trust if Providers breach contract.	To minimise the risk we have set up regular governance meetings with the Providers, have robust contracts in place and monitoring of activity and performance by the IS team against these contracts.	12.5.16 - Funding for IS up to end of March 16, any pts left out in the IS are 'paused' awaiting further funding from HSCB. If the patients extend in house waiting times, to be brought back. 23.02.16 - Funding provided by HSCB for some surgical specialties , however the IS , while initially accepting volumes have had difficulty delivering the capacity originally offered. Senior management and HSCB aware of risks - HSCB provided funding for endoscopy patients to be treated by IS to reduce waiting times. Due to the downturn of the IS in December 2014, there is an ongoing risk that they may not be able to deliver the volumes required. Continue to have bi weekly meetings with ISP regarding contracts.		DIV	25/07/2016
3377	21/03/2013		Outpatients Dept	Lack of Clinical Space to assess Ophthalmology patients and store new visual fields analyser and JAG laser.	Patients are at risk of delay in assessment and provision of care. Risk of cost of recalibration of new equipment due to inadequate storage space. Risk of litigation to the Trust in relation to delayed treatment.	Equipment currently unpacked on fallow floor in CAH - unable to use.	01.03.13 - close entry way behind reception desk in STH OPD. Create door way adjacent to clinical room 9. Discussions ongoing.	HIGH	DIV	08/10/2013
3466	29/07/2013		Outpatients Dept	Lack of clinical space to assess opthalmology patients and store new visual fields analyser and JAG laser.	Delay in outpatient treatment and access for patients needing opthalmology assessment. Risk of litigation to Trust in relation to delayed treatment/assessment. Risk of damage to new equipment without adequate storage facilities.	Equipment currently unpacked on fallow floor in CAH. Unable to use.	01.03.13 - Close entry behind reception desk in STH OPD reception area to create doorway adjacent to clinical room 9.	LOW		18/09/2013
3496	01/10/2013		Trustwide	Wards and Departments are not meeting mandatory requirements for Hyponatraemia Training due to unavailability of training dates.	Risk of having no staff, at ward level that can competently erect and monitor IV Fluids. Particularly in the 14-16year old age group. Risk of harm to patient and staff.	Close liaison with assistant director of Nursing Workforce development and training to secure additional dates from CEC.	01/10/13: Some dates have been organised awaiting confirmation of more. All ward sisters encouraged to prioritise.		DIV	17/10/2013
3498	01/10/2013		Fracture Clinic	Fracture Clinic Referral waiting Times and waiting times for Fracture Theatre	Fracture Clinic referral times have increased significantly for new and review appointments. Risk of harm, to patients by unmanaged monitoring of condition in a timely manner. Potential of litigation and reputation, of Trust due to potential lack of adequate patient management.	Additional clinics are being organised where capacity allows and assistance being sought.	01/10/13: Increased provision of fracture clinics. Paper to HSCB highlighting the risk and requirement for additional funding to staff demand. Demand highlighted in IPT for expansion of T/O service within SHSCT.	MOD	HOS	10/12/2014

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3690	08/06/2015			Increased waiting time for New out-patients and Elective Surgery	Surgery & Elective Care: Breast Surgery, General Surgery, Endoscopy, ENT, Urology, Orthopaedics Urgent Out-Patients: Waiting times have been growing across the specialties, in some cases exceeding clinically accepted waiting times for urgent appointments. Current urgent waiting times for new out-patients are: General Surgery - 21 weeks, ENT - 28 weeks, Urology - 30 weeks, Orthopaedics - 43 weeks Current urgent waiting times for elective surgery are: Breast Surgery - 33 weeks, General Surgery - 54 weeks, Endoscopy - 12 weeks, ENT - 13 weeks, Urology - 87 weeks, Orthopaedics - 56 weeks Delay in treatment plan and diagnosis. Increased waiting time for Routine patients may result on patients being reprioritised as urgent putting increased pressure on existing capacity and bottle-necking available urgent slots	Monitoring measures are being put in place to ensure that patients triaged/categorised as urgent are being seen within the clinically accepted waiting time. Patients exceeding this waiting time will be escalated to management and clinical teams for further advice. Active plans to reduce urgent waits within specialties are on-going Increasing urgent waiting times have been escalated to HSCB and they are aware of limited control due to demand vs capacity mismatch.		LOW	DIV	24/09/2015
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	19/11/2021- no change 28/06/2021- remains unchanged no funding. 15/02/2021- remains unchanged still no capital funding 11/12/2020 - remains unchanged 20/10/2020 - remains unchanged, no capital funding identified. 10/8/2020 - Still no capital funding, risk remains the same. 18.09.19 Still no capital funding risk remains the same 18/6/19 - still no capital funding identified, risk remains the same. 28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same.	MOD	DIV	
3726	01/09/2015	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	Registered nurses assisting during operative procedures	It has come to light that currently there are registered nurses assisted during operative procedures who have not completed nationally recognised training and this role has never been agreed or approved by the Trust. Risk of potential injury to the patient, risk to staff member in undertaking duties out with their role and job description as registered practitioners.	It has been discussed with Interim Director of Acute Services we cannot cease the practice immediately as this would impact adversely on operating lists, thereby resulting in patient cancellations. In order to reduce the risk we have stopped nurses undertaking assisting duties that would be considered a surgical in nature ie tapping on a chisel in ENT and uterine manipulation for gynae patients not having a hysterectomy. The need has been identified for surgical first assistant role, currently the Trust is working to secure funding for these roles. We are also looking at a dual role for a scrub practitioner for very minor cases only. An interim holding position has been discussed and agreed with gynae, with regards to the duties that the nursing staff can undertake until surgical first assistants are in post.	08/04/2019 - closed following further review by SEC. 6/2/19 - as below MOVE to departmental RR 20/11/18 - ongoing risk, MOVE TO Departmental ATICS risk register. Job plan is being finalised for possible advertisement in the near year. Discussion to take place with Mr Carroll re progression banding. 4/10/18 Ongoing keep on RR until recruited. 8.8.18 Research completed meeting arranged to discuss findings with BK and plan to move forward with recruitment. 10.4.18 Ongoing research 28.02.18 Risk remains the same 7.11.17 Funding to be transferred from SEC to ATICS. To research posts before recruitment commenced. 30/5/17 - Money identified for 2 x surgical practitioners. For follow up and recruitment once processes agreed 7.3.17 Unchanged	HIGH	HOS	08/04/2019
3734	24/09/2015	Accessible and Responsive Care		At intervals, the Trust does not have the capacity to meet the demands of the outpatient and inpatient trauma and orthopaedic se	Poor patient outcomes.	Discussions ongoing with HSCB regarding additional resources. Additional outpatient clinic and theatre lists organised where possible.	12.5.16 - Ongoing 'at risk' additional fracture sessions being undertaking from April 16 onwards to meet demand. Additional funding received for orthopaedic IP long waiters to reduce waiting time, Orthopaedic NOP and ROP. In process of securing dates. 23.02.16 - Additional clinics and operating lists organised to meet trauma demand as required to meet patient safety standards. HSCB aware of capacity gap. Work ongoing with ED to implement elements of the Glasgow model to meet demand.	MOD	DIV	26/07/2016
3745	30/11/2015	Safe, High Quality and Effective Care	High Dependency Unit DHH	NIV Equipment in DHH HDU is becomming difficult to repairr and 2 of the 4 have recently been condemned.	Risk of being unable to provide non invasive ventilation to patients who require this, adversely affecting patient outcome, e.g., morbidity and mortality.	New NIV 60 ordered on 26 November 2015 and request for additional capital funding requested for further machines. Request sent to finance for approval to lease new equipment until receipt of new order.	29.11.16 New NIV equipment has been replaced. CAH have ordered more, they are both elf contained. 23/10/16 - As below, still outstanding. RC to advise if actioned. 05.08.16 - Still outstanding. Ronan Carroll to advise if actioned. 26/5/16 - Need to communicate with the appropriate staff that this medical device needs to be standardised between both sites. Ronan Carroll to action. 23.02.16 - NIV equipment ordered and will be delivered before 31st March 2016.	MOD	DIV	29/11/2016
3746	30/11/2015	Safe, High Quality and Effective Care	3 South ENT	Paediatric Patients treated in 3 South ENT treatment room - cannot guarantee nurses with up to date paediatric training.	Limited paediatric trained staff includes - paediatric trained nurse may not be with patient in the treatment room - clinical outcomes if patient needs specific paediatric nursing care including resuscitation - poor patient experience and safeguarding issues.	Meeting held with Paediatric Head of Service to discuss issues on 27 November to scope the problem. Data has been requested. Further meetings planned with the aim to have a paediatric nurse with paediatric patients or inform paediatric ward of admissions.	10/8/2020 - take off RR, paeds go to Blossom Unit and 18.09.19 part of rapid access clinic when this moves will resolve the issue 26.06.19, 28/3/19 06/02/19- no change.	LOW	DIV	12/08/2020

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3766	24/02/2016	Make the best use of resources		Despite refurbishment of ward areas this financial year, due to winter pressures all work was not completed	Increased risk of infection due to poor bed spacing / inadequate side room availability and inadequate storage. Increased moving and handling risks.	Some wards have had significant refurbishment with plans for further work in the summer of 2016. Significant minor works request in place and mail box requested for some areas.	20/10/2020 - Level 4 refurb is completed. Take off RR 10/8/20 - covid gave the opportunity for maintenance on the 4th floor. 4S works completed, in progress of refurbing 4N. Keep on until all works complete. 18.09.19 Risk remains the same 28/3/19 - 4th floor works remain on the minor works and continued risk with buzzer and oxygen needing placed. 6/2/19 - risk remains that same, no change 20/11/18 - As per below. 4th floor works has never been commenced. In particular buzzer and oxygen require to be replaced. 1/10/18 Risk remains same. 4th floor works has never been commenced. In particular buzzer and oxygen require to be replaced. 8.8.18 Risk remains same. 12/6/18 4th floor still outstanding. 10/4/18 - 4th floor still outstanding. 28/2/18 - No change 30.5.17 No change 7/3/17 - work goings on a phased basis in conjunction with Estates	MOD	DIV	20/10/2020
3764	24/02/2016	Best use of resources		Unexpected vacancies in the scheduling team	Delays in the scheduling of patients for the operational lists in T&O, Gynae, ophthalmology, cardiology and endoscopy. Potential for inefficient use of lists and a higher than average CNA / DNA rate.	Temporary reallocation of duties within the team. Temporary recruitment of bank staff to fill vacancy. Internal permanent recruitment commenced.	27.05.16 - Full compliment of staff now in post. Risk closed. 23.02.16 - New risk.	LOW	DIV	27/05/2016
3772	29/02/2016	Provide safe, high quality care	Trustwide	Use of Hypodermic Needles (not safer sharps) for breast biopsies	Breast biopsies at breast clinic, unsuitable for safer sharps use. The design of the safer sharp interferes with this procedure and patient safety may be compromised. Sharps injuries create potential exposure to hazardous substances as defined in the COSHH Regulations. Cannot comply with Health & Safety (sharp instruments in health care) Regulations (NI) 2013. Non catalogue hypodermic needles to be used.	All staff directly involved to have completed e-learning for sharps awareness. Added to risk register. Key staff to be informed of decision to use original hypodermic needles. Raise awareness of trust policies and procedures in relation to blood, bodily fluids, Health & Safety at work, adverse incident procedure, safe use and disposal of sharps policy. Ensure all staff suitably trained. Staff follow sharps injury flowchart. Practice of re-sheathing needles prohibited. Sharps boxes are readily available in all rooms.	28/3/19 - closed as per Wendy Clayton. 3.10.18 Hypodermic needles currently being used. Safer sharps not adequate for use during FNA procedures. All steps required to minimise risk are in place (as per previous column) Reminder will be given to all Breast Screening staff at next staff meeting. 8.8.18 No update from J Robinson following escalations. 12/6/18 - WC has emailed J Robinson for update, waiting on response before closing. 10.4.18, 28.2.18, 6.6.17 & 24.10.16 J Robinson and F Reddick to provide update or close. 28/2/18 When the newer needles were introduced both radiologists trialled and both found that they were unable to obtain the detail for optimum needle visualisation during FNA, Biopsy procedures.	LOW	DIV	28/02/2019
3802	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Nurse Recruitment for Adult and Paed theatres	Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available.	We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions.	19/11/2021- no further update. 20/09/2021- Rolling nurse recruitment for Band 6 for paeds theatre is at advert. No paediatric surgery at present due to surge- redeployment of staff to ICU. 28/06/2021- Jan/Feb 2021x8 band 5 staff nurses recruited through peri-operative workstream. June 2021 band 5 applications closed, approx 8 band 5 have been recruited. Waiting on checks and start dates. Delivering of care x 1 Band 7 and 10 x Band 6's funding secured. ATICS going out to advertisement (3x CEPs Band 7- 1 funded and 2 at risk). 15/02/2021- regional peri operative recruitment drive closing date 05/02/2021, awaiting confirmation of applicants and interviews to be processed. ATICS remain with larger number of vacant adult and paediatric theatre nursing posts. 11/12/2020 - request through E&G for a commissioned paediatric nursing course for 21/22. Regional recruitment plans ongoing. HOS ATICS remains on group 20/10/2020 - regional recruitment plans ongoing. HOS ATICS sits on the group. 10/8/2020 - Since the covid-19 pandemic Paediatric theatre presently being used for outpatient ENT AGPs. No paediatric surgery currently on the DHH site. Only 2 paediatric nurses Band 6 at present, out for recruitment with BSO. Continues as risk. Continuing with recruitment drives for adult theatre nursing staff. Vacancies still remain. For retention Band 5 uplift to Band 6 successfully completed. 3/9/19 - only 3 paed nurses at present (1 is 16 hours only). Further nursing gap highlighted to AD and Director - paper attached 18/6/19 - Unfortunately continued high level of vacancies in ATICS. Theatre nursing paper has been submitted to the Acute Director. Continue to run main theatres in CAH and DHH at 30% reduction. Risk remains high. 28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019.	MOD	DIV	

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3804	27/05/2016	Safe, High Quality and Effective Care	Outpatients Dept	Pre Op Assessment	Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service	Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes.	20/09/2021- Pre-op staffing currently matches the requirements for urgent bookable. Recruitment required. Will update as necessary. 28/06/2021- remains unchanged will discuss way forward with AD. 15/02/2021- remains unchanged. 11/12/2020 - remains unchanged. Internal audit completed and addressing recommendations 2010/2020 - remains unchanged 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 18/9/19 - Lead nurse is interviewing this week for new pre-op nursing staff. Pre-op is one of the projects submitted under demography monies. 18/6/19 - Ongoing works pressures continue in pre-op due to demand. Group met to progress pre-op paper however planners will be not support without confirmed funding stream. To remain on RR. 28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff. 6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6	MOD	DIV	
3805	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Theatre nursing staff being redeployed during OOH to cover wards, in particularly DHH	Putting at risk the ability to provide an emergency service to theatre and hospital in general	For wards / departments to staff their own areas	28/3/19 - closed as per discussion at SEC Divisional meeting. 6/2/19 - consider removing from directorate RR, discuss with AD. 28/11/18 - Can this be removed as there is a process to follow 1/10/18 Remains unchanged. Due to hospital pressures to remain safe theatre nurses still redeployed during OOH when required. 8.8.18 Remains unchanged. Due to hospital pressures to remain safe theatre nurses still deployed when during OOH when required. 12/6/18 Theatre nursing being redeployed during OOH still occurs on all sites, ongoing risk. 10.4.18 Unchanged 28/2/18 - redeployment is still an issue on both sites 7.11.17 - redeployment of theatre staff at night continues, especially on the DHH site at present 30/5/17 - Action plan still to be developed and agreed. Theatre staff still are redeployed at night 7/3/17 - ADs have met with staff side, action plan to be developed and agreed. Future meeting to be arranged	MOD	DIV	09/04/2019
3800	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Anaesthetic cover for maternity services	We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards.	A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover.	19/11/2021- no change 20/09/2021- no change 28/06/2021- no change 15/02/2021- risk remains the same 11/12/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 20/10/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 10/8/2020 - no further update. Risk continues. 18.09.19 - HOS & LN's have met and are meeting again in the next month to go through figures for the nursing requirement 18/6/19 - meeting was held between gynae and ATICs, business case to be progressed. To be kept on RR 28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion. 6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres	MOD	DIV	

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3801	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	JAG Accreditation	Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same.	JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation.	12/11/2021 No ATICS business meeting interface 15/09/2021- unchanged. 28/06/2021- unchanged. 15/02/2021- priority given to covid pandemic. Significantly reduced capacity available on all day surgery sites. 11/12/2020 - remains the same, priority being given to covid pandemic 20/10/2020 - Due to covid pandemic remains unchanged, currently going into 2nd surge 10/8/2020 - Dr P Murphy is the Interim Endoscopy lead. Endoscopy waiting times continue to be an issue in achieving JAG accreditation. 18.09.19 Require a led for JAG 28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR. 6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting.	MOD	HOS	
3803	27/05/2016	Safe, High Quality and Effective Care	Recovery Ward	Post op Surgical Pts in the Recovery Ward	Regularly there are patients kept over night in the recovery ward due to ongoing bed pressures within the Trust. However, this increases the risk within the recovery area due to having post op surgical pts, HDU patients (med or surg), adults male, female and children are all mixed within the area. There are post op pts being fed while pts are still being brought out from theatre intubated and pts that come round from anaesthetic can also be nauseated. Unable to get patients out in a timely manner to the wards the following day which impacts on patients being able to get out of theatres to recovery, which in turn impacts on the operating time available if patients have to be recovered in the Theatre.	ATICs try to ensure as far as possible that a limited number of patients are kept post op in the recovery ward. This is not always adhered to.	06/07/2021- remove from risk register 28/06/2021- recovery continues to work over 3 areas managing covid and non-covid ICU/HDU patients as well as 2-3 urgent bookable list Mon-Fri and emergency/trauma lists. ICU 1 available for AGP recovery when required. 15/02/2021- currently in 3rd surge. recovery continues to work over 3 areas managing covid and non-covid ICU/HDU patients, as well as 1 urgent bookable list Mon-Fri and emergency/ trauma lists. 11/12/2020 - remains unchanged. Recovery are working over 3 areas to accommodate covid pandemic, which is challenging on recovery manpower. 20/10/2020 - remains challenging 2nd surge expected, recovery staffing ICU2, Hub (Urgent bookable elective) and main recovery. Staffing identified daily at communication Hub meetings between ICU, recovery and theatres 10/8/2020 - challenges in recovery due covid-19 pandemic and requirement to segregate patients. Top end of recover for 'red' AGP patients, anaesthetic hub for urgent bookable patients, main recovery for 2 x HDU, emergency and trauma however all at reduced bed capacity due to social distancing. Issue still continues with over night patients and managed locally. 18.09.19 No change it has become the mai stream of covering Mon-Thurs extra 4th nurse, with more often requiring 4th nurse on a Friday. 28/3/19 - due to continued bed pressures, recovery cstsaff with 3rd nurse Tues, Wed and Thursday nights, increasing to 4th nurse when required. Some patients continue to be kept in recovery post op which limits their enhanced recovery on the wards. 6/2/19 - continue to staff with 3rd nurse on Tues, Wed, and Thursday on night duty to cope with capacity. increased to 4th nurse dependent on bed pressures.	MOD	HOS	06/07/2021
3826	19/08/2016	Safe, High Quality and Effective Care		Demand of fracture referrals outweighs fracture capacity.	Fracture patients at risk of late diagnosis and treatment.	The Trust has given permission for "at risk" fracture clinics, however, this still does not meet demand.	10/8/2020 Fracture MSK Hub up and running from June 2019. Take off RR. 17/06/2019 Fracture MSK Hub commenced in CAH on 17/6/19. The principle of the hub is to redirect ED fracture referrals to the right pathway eg physio, OT, face to face, back to ED or discharge. (Keep on RR to see outcome of the Hub before downgrading to department) 28/3/19 - current fracture patient outweighs capacity. 11th T&O consultant part funded which include 1 fracture clinic per week. Q1 2019/20 additionality approved by SMT for fractures new and review 6/2/19 - as below, no change	HIGH	DIV	10/08/2020

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3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	12/11/21 Refurbishment in DHH for fracture clinic will not take place within financial year 2021/2022. Await confirmation of funding for 2022/2023. 08/09/2021- accommodation for refurb not available as yet. 28/06/2021- remains a risk. Investigating refurbishing Phase 1 OPD in DHH for fracture clinic. Plans developed at a cost of £60k. Waiting to here if funding is to be approved before commencing work. 15/02/2021- remains a risk. Due to the Covid 19 pandemic DHH fracture clinics remain in CAH however still risk due to no social distancing. One DHH clinic has moved to an evening clinic from November 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH 10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics. 18.09.19 Remain on Register until capital allocation 24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk	HIGH	DIV	
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	19/11/21 ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessions in DHH 16/09/2021- OSL update- continues to monitor backlog. Due to Covid 19 pressures there are reduced theatre sessions and therefore the focus is on red flag. 08/09/2021- Due to the increase in Covid ICU patients, theatres have decreased sessions down to 3 all day urgent bookable in CAH and one AM session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL continues to monitor planned IPDC backlog. Theatres sessions has increased with DHH restarting 14/06/2021 with 15 theatre sessions. Only RF and urgent at present. Validating top 10 longest waiters each month. 15/02/2021- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to Covid. Currently one 1 urgent bookable list per day Mond to Friday. clinically urgent and priority 2 patients being scheduled. The Trust is currently facing the 3rd surge. No urgent bookable in DHH. 11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH 20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue 10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV	

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4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Endoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	19/11/21 Currently only clinical urgent and red flag priority 2 patients are being scheduled for endoscopy. Planned backlog continues to increase as no planned patients are being booked. Validation of planned endoscopy patients is still ongoing. Endoscopy capacity has decreased due to Covid 19 pressures, the redeployment of theatre based workforce continues to impact on capacity within South Tyrone Hospital (STH). The day clinical centre was redeployed to STH day procedure admission ward during the pandemic which still remains in day procedure. This was a 14 bedded ward historically used to run two endoscopy lists 5 days a week simultaneously. Until they return to CAH it is not possible for STH to return to a 19 planned endoscopy list per week. 16/09/2021- Planned endoscopy backlog validation is still in progress 28/06/2021- planned endoscopy backlog is currently being validated by the Gastro and General Surgical Team. 15/02/2021- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. as no planned endoscopy patients are being scheduled. Validation of planned endoscopy patients has commenced. 20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qfit test then prioritised for their colon. Still working on IS contract 10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional	HIGH	DIV	
3880	07/03/2017	Provide safe, high quality care	Trustwide	Patients requiring review at Breast Family History Clinic	Patients requiring review at Breast Family History Clinic not being seen in a timely manner due to review backlog therefore risk that patients may have delay in diagnosis. Patients may not be seen within appropriate review.	Staff have been offered the opportunity to undertake additional sessions to ensure that the waiting time for patients to be seen is reduced and patients are seen in a timely manner . Plan to recruit and additional admin person to book yearly mammograms as a rolling programme.	28/06/2021- remove as per HOS. 11/12/2020 - Downgrade to departmental Risk register please 20/10/2020 - remains unchanged 10/8/2020 - downgrade as per below, all review patients have been risk stratified. 18.09.19 downgraded to departmental 28/3/19 - no update. 6/2/19 - downgrade to departmental risk	VLOW	TEAM	28/06/2021
3900	27/06/2017	Provide safe, high quality care		Breast Fail Safe Band 4.	Breast Fail Safe (Band 4) needs to be recruited within the Trust. Risk to SDA & Breast family history patients not receiving following up mammogram	BOXI report for SDA patients is currently being run once a month. Patients being checked if mammogram request has been entered.	28/2/18 - Recruitment successful and successful applicants commence beginning of April 18. 7.11.17 - recruitment for Breast fail safe with BSO at present, however on hold due to possible redeployment 6.10.17 Failsafe post has now been passed by SMT and with BSO for recruitment June 2017, Ronan to discuss with Esther re recruitment at Risk for B4 Breast Failsafe.	MOD	DIV	10/04/2018
3905	26/07/2017	Provide safe, high quality careMake the best use of resources	4 North Surgical	Oxygen and Suction not central in bay	Patient who is furthest away from O2 and suction ie at entrance of bay. Due to tubing etc being long - implication are that there is a ligature risk and suffocation risk. Call bell system is also at risk of failing due to age and poor condition.	As per email dated 8 July 2017 there are no plans to replace bed heads in 4 North/4 South in the immediate future.	28/3/19 - close and amalgamate with 3766. 1.10.18 High risk remain the same, replacement required in 4N for buzzers and oxygen/suction. 8.8.18, 12/06/18 Situation remains the same. 10/4/18, 28/2/18 - no costs at present, to email Estates. Due to ongoing bed pressures unable to close a bay. 26/7/17 Estates need to provide cost, delayed due to winter pressures 15/16	LOW	DIV	28/02/2019
3920	13/11/2017	Provide safe, high quality care	Intensive Care Unit	ICU Consultant Workforce	Potential for inability to cover the department with appropriate staff for ICU	Advertisement to replace 2 ICU consultants and also 2 general anaesthetic consultants.	18/6/19 - new ICU anaesthetists has commenced ?? further update from HMM. 28/3/19 - no change, still waiting start date and vacancies out for re-advertisement. 6/2/19 - 1 consultant anaesthetist recruited awaiting start date. Other vacancies out for re-advertisement. 20/11/18 - Out to advertisement, awaiting outcome of interviews1.10.18 - With medical staffing for recruitment. 8.8.18 Still awaiting start date. 12/6/18 Consultant anaesthetists has been appointed awaiting start date. 10/4/18 - 1 further consultant anaesthetists retirement. Going out for advertisement again closing date Tuesday 17/4/18. 28/2/18 - 4 consultant anaesthetists have been appointment, waiting checks and commencement date. 7/11/17 - in progress, interviewing in the next few weeks and backfilling with Locums at present.	HIGH	DIV	08/07/2019

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3930	12/12/2017	Provide safe, high quality careMake the best use of resources	Anaesthetics, Theatres & Intensive Care Services	Discontinuation of guaranteed Service for Drager Oxylog Ventilators	Maintenance Company can no longer guarantee support the Drager Oxylog Ventilator for items that may be required for repair/service. There are no spare machines available to STH.	None in place	20/10/2020 - purchased successfully, however they are being used for covid. Take off risk register 10/8/2020 - Due to covid-19 extra ventilators were purchased. HMM to confirm number of ventilators, remain on RR until confirmed 18.09.19 4 last year and new capital from 19/20 to replace another 4 18/6/19 - Ongoing risk as still 6 machines to be replaced, these are are on the equipment capital list however no confirmed funding 28/3/19 - 3 machines arrived, training and implementation plan ongoing. anaesthetic machines programme to remain. 6/2/19 - 3 machines procured for CAH. Will be delivered pre-31/3/19. Rolling replacement programme in place to procure remaining 9 machines	MOD	DIV	20/10/2020
3962	09/05/2018			The flooring in Theatre 4, CAH has a hole in it. The Siemens Image Intensifier wheel keeps getting stuck in this hole. To date a	The flooring in theatre 4 has a small hole in it. Unfortunately, it is in the vicinity that the radiographers park the Image Intensifier prior to starting a screening case. Recently the machine was parked here and unbeknown to the radiographer one of the wheel of the intensifier had been parked on the hole. When the Radiographer went to move the machine into position at the start of the screening case she found the machine every difficult to move laterally. To move the machine it took a lot of stretching, straining and pulling and unnecessary force. The radiographer eventually moved the machine out of the hole but in the process hurt her back. There is a manual handling and health and safety risk that need addressed immediately. If not dealt with it will increase staffs stress levels and effect their welfare and could leave the Trust open to litigation. Staff have a right to expect a safe and secure working environment.	"Raising Staff Awareness regarding the flooring in theatre 4 to help manage the risk. -Actioned 8/4/18 Round Robin e-mail to be sent to all staff with photos of the area in question. "Staff to attend yearly mandatory manual handling training-Actioned-on going. Incident reported on Datix-Actioned IR1 completed 27/4/18 Siemen's Engineer to be called to check out the intensifier as it seemed very stiff and difficult to move. Machine was out of action until checked - Actioned-Engineer checked out machine on 4.5.18. and the machine was ok'd to work by engineer and put back into action. Lead Radiographers to Liaise with theatre sister regarding the incident---Actioned 4.5.18 Theatre Sister to liaise with Urologists regarding the positioning of the machine-Actioned-Urologists happy that radiographers work to the right of the patient to avoid the area in question (3/5/18) Theatre sister to put up safety awareness signs regarding the flooring and the image intensifier machine-Actioned 4.5.18 Flooring to be fixed-Theatre sister to contact Estates to find out when flooring to be replaced-Actioned 2.5.18-Estates have assured the sister that the floor will be replaced May/June 18 Flooring temporarily mended with a metal covering-Actioned 1/5/18-however there is a "lip" on this that is difficult to push machine over especially laterally. Radiographer advised to go for medical assessment.	28/06/2021- all works completed	VLOW	DIV	28/06/2021
3972	28/08/2018	Provide safe, high quality care	Anaesthetics, Theatres & Intensive Care Services	Inexperience of CT1 for General Anaesthetics in Theatres/OOH/Weekends	ATICS cannot guarantee access for c sections due to CT1 inexperience. Potential for harm to women and babies	On-call Consultants will come into the Trust when c sections is required.	28/3/19 - continued risk. To remain on risk register. 6/2/19 - discussed with Dr Scullion and ATICS Business meeting and remains on Directorate RR 20/11/18 - Dr Scullion to review, keep on Directorate risk 1.10.18 Unchanged, review in November 2018. 7.8.18 Dr Scullion, AMD e-mailed all anaesthetists re CT1 inexperience issue and controls. Competencies of CT1's to be completed in 3 months, revalidate.	HIGH	DIV	26/06/2019
3992	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Rostering of 3 level 2 skilled/competent staff per shift not achieved	Reduction of beds available for level 2 patients due to reduced availability of competent staff during induction period. Risk of inappropriate placement of level 2 patients in HDU and risk to staff members in undertaking duties pre completion of induction period due to current to training of pre reg nurses to provide care to 2 level 2 patients	Discussed with HOS/AD and Director of Acute Services and SMT plan to recruit trained staff from agency as block booking to fill gaps in roster with suitable skills in level 2 care	18.09.19 HDU beds are now agreed 8 beds and the B7 & B6 are now permanently in post as per pathfinder. 18/6/19 - Doctors - Recruited 2 additional Consultant Anaesthetists, waiting on references and checks to be completed. Commencing Sept 19. Nurses, recruited B6 however she has left so back out for recruitment. Closing date today 29/5/19, interviews 8/6/19 Pharmacy, new post has started. A&C, Band 4 ICNARC is with BSO for recruitment, training to be completed following recruitment. To remain on the RR until transferred to ATICs 28/3/19 - recruitment challenges continue for DHH HDU, to remain under general surgery. Pathfinder group continue to meet regularly to work through possible solutions. 6/2/19 - discussions ongoing re HDU in DHH recruitment. Pathfinder meetings continue regularly. Recruitment challenges continue. 20/11/18 - pathfinder recruitment for DPU DHH ongoing. Risk assessment being completed	HIGH	DIV	18/09/2019
3994	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Change in the concertation of phenylephrine from a 10ml ampule containing (10mg in 1 ml)to (1mg in 10mls) November 2017	The change of strength to 1mg/10 ml vials of phenylephrine is fine for short term use ie., a few hours waiting for a central line to be placed. The difficulty is the delivery of phenylephrine for longer than a few hours this tends to arise when patients are not deemed stable for a central line or where a decision has been made not to go down a more invasive route.	Discussion with pharmacy/anaesthetic staff & medical staff re-introducing high dose phenylephrine. The plan is to hold in pharmacy in a segregated area; it will only be issued to HDU and it will be the only strength that HDU stock. The remainder of the hospital will use the low strength and follow the Trust protocols, and once transferred to HDU, staff will use an HDU protocol. Protocol to be review by medical, pharmacy and nursing staff. Pharmacy staff to liaise with procurement about getting the high strength product back in and appropriately set up within the pharmacy system.	18.09.19 phenylephrime HDU protocol reviewed by Dr Harty and re-issued by for HDU 11.03.19- No update. 12/10/18 MD. A McC & JH to discuss protocol and disseminate to staff nursing and medical staff regarding change over date when established AMcC to discuss with procurement	HIGH	DIV	18/09/2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
3993	19/11/2018	Provide safe, high quality care	High Dependency Unit DHH	Agency nursing staff not trained to SHSCT protocols	Agency staff from block booking with appropriate qualifications in level 2 may not complete procedures as per SHSCT processes's. Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports. Agency staff fulling gaps in roster without skills for level and may not complete procedures as per SHSCT processw.with appropriate qualifications in level 2 may not complete procedures as per SHSCT processess Potential for risk to patient safety and potential for staff who may not follow procedures as per SHSCT process which could influence results potential for low performance reports.	Discussed with HOS/AD agency staff can be issued with codes for e-learning gap until completed and time to roster to complete need to have suitable trained staff with level 2 care priority to manage deteriorating patients. Roster reviewed to have suitable trained staff with level 2 care on roster /priority to manage deteriotating patients.	20/09/2021- update from HOS/Lead Nurse for HDU- this risk is from 2018 and was requested to be removed from the risk register 2021. 28/06/2021- ATICs continue to use agency staff, vetted and monitored. Induction and training provided on site. 15/02/2021- gaps remain filled by agency nursing staff. Induction/training is provided on site 11/12/2020 - Ongoing reliance in block booking and agency staff to fill nursing gaps throughout ATICS/SEC. Require period of induction and training 20/10/2020 - below comment not relevant Ongoing reliance in block booking and agency staff to fill nursing gaps throughout ATICS/SEC 07/09/2020- The old scanner was replaced and modular now in place. Funding sorted until March 22021 but a plan needs to be implemented from April 2021 onwards 18/6/19 - on going reliance in block booking and agency staff to fill nursing gaps. Continues to be a risk throughout ATICS/SEC 28/3/19 - BB agency to complete e-learning and practice audit, ongoing review required. 6/2/19 as below, no further update	HIGH	HOS	20/09/2021
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL update SEC, New regional guidance has been approved for Outpatient admin validation this will be for ENT, Urology and Trauma and Orthopaedics. From April 19 admin validation has been ongoing, new regional technical guidance has been approved and will commence Jan 2022 and the validation team admin support will increase, recruitment in progress.Capacity reduced due to Covid 19 social distancing guidance which is decreasing the number of booked clinics. IPC guidance is continually reviewed and updated. 160921 OSL update- Within outpatients admin validation is ongoing within the following areas: ENT, BFH and orthopaedics. OSL progressing decision with IPC if clinic sizes can be increased. 08/09/2021 - Currently only red flag and some urgent patients are being booked however demand is still greater than capacity. Redeployment of DSU and Theatre staff to ICU for surgery reduces theatre capacity on CAH, STH and DHH sites. Six urgent bookable sessions in CAH, fourteen trauma sessions and five urgent bookable sessions in DHH with cancellation of day surgery and endoscopy. 28/06/2021- OSL and HOS continue to monitor longest waiters. Currently due to social distancing reduced numbers continue and only red flag and urgent patients being booked. Agreed to contact IPC to see if we can increase numbers at clinics. Admin validation to commence. 15/02/2021New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 3rd surge at present. All outpatients cancelled again and outpatient staff redeployed. 0/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding	Closed date
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL and HOS continue to monitor outpatient stragglers >52 weeks. we are currently booking P2 priority patients due to Covid 19 patients. 16/09/21 OSL update- OSL and HOS continue to monitor top ten longest waiters for inpatient/day case. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL and HOS continue to monitor. Top 10 longest waiters to be validated on a monthly basis. Theatres sessions have increased with DHH restarting 14.06.2021 with 15 theatre sessions. Only priority 2 elective surgery on CAH site. 15/02/2021- New outpatient long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Still only RF and urgent patients being scheduled. Surge 3 all outpatients have been cancelled and staff redeployed to support the Wards 11/12/2020 - New outpatients long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Only RF and urgent patients being scheduled. Outpatient accommodation increased slightly from 14/12/2020 but not to full capacity. To continue with reduced numbers due to social distancing 20/10/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic. 10/8/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients	HIGH	DIV	
4095	02/06/2020	Provide safe, high quality careBe a great place to work	Trustwide	Mishandling of Patient handover resulting in an Information Governance breach	There is a risk that the handover with patients details could be mislaid anywhere on site or in the community. Patient detail not being managed in a confidential manner thereby reveling the patient's private business and exposing the Trust to a breach in public confidence.	All disciplines of staff have been informed of the recent breaches in Information Governance and the consequence of same. All wards and departments have bins with clearly visible signage indicating they are for the disposal of the confidential handover prior to the end of their shift Regular reminders at patient safety briefings to adhere to Trust governance protocols Representative in Acute have met and agreed the content on the handovers. Incident and meeting note shared with OPPC, Peads and MH directorates.	12/11/20212 An Information Governance audit has taken place and results are pending to ascertain compliance with non identifiable patient from handovers.To await report to ascertain compliance to inform if this risk should remain on register. 20/09/2021- AD to confirm is this can be removed from risk register 28/06/2021- Additional confidential waste bins at doffing, exits and signs were erected re disposing confidential waste appropriately. 24/02/2021- continuously monitored 02/06/2020 Staff regularly reminded of necessity to adhere to Trust governance protocols.	LOW	DIV	
4131	03/12/2020	Safe, High Quality and Effective Care	Trustwide	Reduction in elective capacity due to covid restrictions-Urology ENT, Gen Surgery, Gynae and Orthopaedics	With the Covid-19 pandemic SEC ability to accommodate commissioned levels of activity is not being achieved resulting in increases in waiting times and volumes of patients on the elective and planned waiting list. As a result of increased waiting times and reduced capacity consequently patients may come to harm, increased levels of pain and discomfort and reduced quality of life	Mon-Friday 1x all day Urgent bookable on both sites CAH and DHH Due to limited elective capacity consultants clinically prioritise patients for surgery using the FSSA royal college guidelines, priority to cancer patients. Regional cancer rest meeting working towards equalising waiting times across the province. In house additionally from January 2021 on DHH site Endoscopy- weekend additional sessions in LV	12/11/2021ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessionsin DHH. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. THis will result in ongoing backlog in planned and surveillance surgical patients. Only priority 2 for CAH and DHH sites. 28/06/2021- DHH recommenced elective theatres x 15 sessions on the 07/06/2021. CAH elective sessions continue with reduced theatres- currently 2-3 urgent bookable per staff however this is staff dependent. Agency staff have taken leave July/August 21. 9/6/2021 the ongoing workforce issues will affect our ability to provide core operating sessions. Primarily for in patient theatres. The action in respect to recruitment is in place. advertisements are going out in June and 9 new registered nurses are due to commence work between June and Sept for CAH in patient theatres. we are currently working with the nurse bank and agency to attract theatres nurses and Dps from agency across mainland UK. 15/02/2021- ICU remains open to 16 patients, surge staff from day surgery and theatres/recovery remain in-situ. Currently in surge 3 03/12/2020- full de-escalation of CCaNNi critical care surge plan- this is currently medium surge and difficult to predict. Commencement of in house additionally from Jan 2021 for endoscopy and surgical specialties and the January sessions are currently being agreed. Increase urgent bookable theatre sessions	HIGH	DIV	

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APPENDIX 6

Revised November 2016 (Version 1.1)

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

Organisation's Unique Case Identifier: 69120

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier: S11471

Service User Details: (*complete where relevant*)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 22 May 2020

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1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient (Personal Infor), discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Personal Infor – Personal Information redacted by the USI male was referred to Urology Outpatients on [redacted] August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on [redacted] January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on [redacted] February 2016 (D153). On day 166, Personal Infor was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Personal Inform – Personal Information redacted by the USI male was referred to Urology Outpatients on [redacted] June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review, the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Personal Inform – Personal Information redacted by the USI male was referred to Urology Outpatients on [redacted] July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, Personal Inform was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Personal Informat – Personal Information redacted by the USI male referred to Urology following an episode of haematuria on [redacted] July 2016. The referral was marked Routine by the GP. The letter was not triaged and Personal Informa was placed on a routine waiting list on [redacted] September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. Personal Informa was reviewed at OPD on [redacted] January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. Personal Informa has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

Personal Inform – Personal Information redacted by the USI male was referred to Urology Outpatients on [redacted] Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, Personal Inform had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in

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obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely

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manner.

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser - Chair

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients "Personal Infor", "Personal Informa", "Personal Inform", "Personal Inform" and "Personal Inform", in the period after referral to the SHSCT Urology service using

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3.0 SAI REVIEW TERMS OF REFERENCE

National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to "Personal Infor", "Personal Informa", "Personal Inform", "Personal Inform" and "Personal Inform" that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

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5.0 DESCRIPTION OF INCIDENT/CASE

The DHSSPSNI **Service Framework for cancer prevention, treatment and care** (Standard 13) of 2011 indicates, "*All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed*".

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland

NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - *Referral guidelines for suspected cancer,* published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, "*triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation".*

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP's.

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5.0 DESCRIPTION OF INCIDENT/CASE

NICaN Urology Cancer Clinical Guideline (2016)

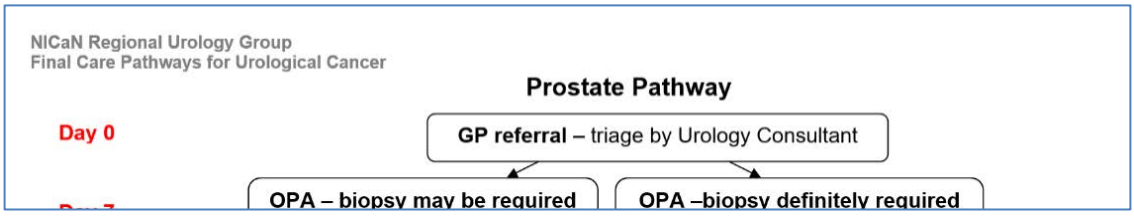
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer. This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.



5.3 Triage of GP referrals – SHSCT

The process of Urology triage in CAH is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12. In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; and this varied between consultants and specialities. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

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5.0 DESCRIPTION OF INCIDENT/CASE

Interview with Associate Medical Director (AMD1)

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

Interview with Director of Acute Services (DAS2)

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Cons 1 was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He had the longest backlog and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate

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5.0 DESCRIPTION OF INCIDENT/CASE

patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".

5.4 Index case

In 2016, the SHSC Trust investigated (RCA ID 52720), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Persona l Informat. Persona l Informat was a patient who had had Ca Colon (2010), breast carcinoma (2013) and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Persona l Informat's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Persona l Informat's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration.*"

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5.0 DESCRIPTION OF INCIDENT/CASE

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Persona l Informat. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate

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5.0 DESCRIPTION OF INCIDENT/CASE

management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

5.5 Look back exercise #2

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

This (RCS 69120) Review Team reviewed the clinical notes from these 4 patients and following discussion, under the Urological guidance of AMD1, detailed the clinical course and made the following conclusions.

Personal Inform 03/06/2016 - Personal Information redacted by the USI male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
09/08/2016 - added to W/L Urgent.
27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.
05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 10-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Personal Inform 28/07/2016 - Personal Information redacted by the USI male referred to Urology Outpatients by GP for assessment and advice, concerning elevated PSA.
The referral was marked Urgent by the GP.

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The referral was not triaged on receipt.
30/09/2016 - added to W/L Urgent.
18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.
20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.
11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 9-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Personal Information 28/07/2016 - Personal Information redacted by the USI male referred to Urology by GP following an episode of haematuria.
The referral was marked Routine by the GP.
The letter was not triaged.
30/09/2016 - Personal Information was placed on a Routine waiting list.
19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.
31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.
22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.
Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018.

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. Cancer March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology 50 (2006) 1176–1182.*

Personal Information 08/09/2016 - Personal Information redacted by the USI male was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
27/01/2017 – further GP letter – please upgrade to R/F.
30/01/2017 - as part of the internal review #2, upgraded to R/F.

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5.0 DESCRIPTION OF INCIDENT/CASE

06/02/2017 - seen in clinic on day 152.
11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.

Conclusions

Resultant 8-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is not clinically significant.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Personal Information. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

Personal Information 30/08/2015 - Personal Information redacted by the USI male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Routine by the GP.
The referral was not triaged on receipt.
29/01/2016 2nd GP referral marked as Suspected Cancer – Red flag; Personal Information was added to W/L R/F following this referral.
As part of the internal look back #2, the referral was noted.
Personal Information had already received an appointment and was seen in clinic on day 153. Therefore, 1st GP referral was incorrect; the 2nd was a correct GP referral.
11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is felt that the delay is unlikely to be clinically significant.

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7.0 CONCLUSIONS

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

"Very significant". Very high up the list in terms of importance".
"It is fundamental people are seen in the appropriate time".
"Very important" ... "Important for the patient".
"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".

Cons1 replied,

"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 (Personal Informa) there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

7.1 Referral letters did not have the clinical priority accurately assigned by the GP.

Contributory factors

Task Factors (policy and guidelines)
The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

Task Factors (decision aids)
The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately

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involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net, work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

NICE NG12
The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

7.2 Referral letters were not triaged following receipt by the hospital.

Contributory factor

Task Factors (policy and guidelines)

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The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first*'.

The Principles for booking Cancer Pathway patients states,

> "Clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

Review of Adult Urology Services in Northern Ireland

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related*

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(and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process."

Contributory factor

Staff factor

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....*yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated, '*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline

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standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

Contributory factor

Work load/scheduling

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

Contributory factor

Organisational

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These

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attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

Escalation within Organisation
At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed,

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they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

8.0 LESSONS LEARNED

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged,

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and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

10. From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

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9.0 RECOMMENDATIONS AND ACTION PLANNING

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

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9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Mrs Melanie McClements Interim Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

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

Reporting Organisation SAI Ref Number:	69120	HSCB Ref Number:	S11471

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	✓	
	Comment: 5 ***If multiple service users are involved please indicate the number involved**				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	✓	**NO**		
	If **YES**, insert **date informed**:19.2.18				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

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

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

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	✓
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			✓

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SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

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

SECTION 2							
INFORMING THE CORONERS OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	**22.5.2020**

[1] *Service User or their nominated representative*

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