Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016 at www.hscboard.hscni.net [27]

[27] HSCB Loc. Cit Section 4

3.0 Stage 2 Identifying and tracing service users at risk

One of the most important stages of the Lookback Review Process is the accurate identification and tracing of the service user cohort who have been identified as being affected by the triggering event. The HSC organisation is responsible for the identification and tracing of the affected service users must allocate appropriate resources to ensure that this is undertaken.

In the context of the Lookback Review process, this Stage involves the review of care/ processes against explicit standards and criteria to identify those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria. [28]

3.1 Role of the Steering Group –Terms of Reference and Action Planning

The Steering Group should continue to ensure the management of immediate safety issues and care for those harmed or potentially harmed by the triggering event.

The Steering Group is responsible for ensuring the identification and tracing of the cohort of service users to be included in the service user lookback and recall phases of the Lookback Review Process. The Steering Group will need a clear definition of which service users should be recalled/ offered further tests/assessments, what they should be recalled for, how test/assessment outcomes will be categorised and how each category will be managed/followed-up (Sections 3.2 – 3.4 and Appendix 3).

The Steering Group should review their Terms of Reference and Group membership at this stage and consider if additional membership from the service area/support services and from service users advocacy services are required for either the Steering Group or the Operational Group/ Lookback Review Management Team if applicable (see Section 2.3). The extent and complexity of the Lookback Review Process will determine the resources and responses required.

The Steering Group should also review the Lookback Review Action plan (Section 2.5). As required, expert advice or linkages may be also made with resources such as relevant Professional Bodies and Faculties (e.g. Royal Colleges) to assist with this stage of the Lookback Review.

[28] HSE. *Op.Cit*. Section 7.7 Page 17

The Steering Group should also consider the service user recall methodology for the next stage and further develop the Communication Plan (including the formation of Helplines/Information Lines and use of the organisation's web page to provide general information and Frequently Asked Questions and responses Section 4.4).

The Steering Group will need to meet on a regular basis to ensure that they receive situation reports (SITREPS) and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared with internal stakeholders (Executive Team/Senior Management Team and Board) and external stakeholders i.e. HSCB, PHA and DoH.

3.2 Establish the Service User Database

The HSC organisation will need to develop a service user database to collate the details of the service users that have been identified for inclusion in the service review/ audit stage of the Process. It is important to consider the output from the service user notification database at the outset. The list of service users will be needed to:

- Generate letters to service users;
- Check if service users at risk have made contact;
- Keep track of who requires further review/testing;
- Record who has had results;
- At the end of the Lookback Review Process to generate information on numbers of service users identified, further assessed and their outcomes.

The database needs to be updated, by administrative staff, on a regular, and at some stages at least on a daily basis. This will ensure the information held is the most up to date and reliable.

The database may already exist on one of the organisations Information Technology (IT) systems. In some circumstances (for example service users who have not been reviewed for a period of time), it may be necessary to check the service user details with the General Register Office for NI to identify if any of these service users have since deceased.[29] Information Technology staff are essential members of the sub

[29] General Register Office for Northern Ireland @ www.gov.uk.

team to assist in accessing existing databases/establishing databases. Specific data variables, will be determined by the nature of the triggering event and the audit methodology to be applied. If a database of service user details does not already exist then a suggested core dataset for service users at risk has been outlined in Appendix 2.

The Steering Group should give special consideration in the Lookback Review Action Plan as to whether or not the cases of deceased persons meet the inclusion criteria, how their records should be handled and how best to communicate with their relatives.[30]

3.3 Establish the Process for the Identification of Affected Service Users[31]

The Steering Group should establish and record clear processes for the identification of the service users/ staff to be included in the Recall Stage. This will include the development/ agreement of the:

- Audit criteria (criteria as to what will be considered within acceptable practice limits, minor or major discrepancy, the clinical significance of these discrepancies, and actions to be taken in each category, guided by national and international best practice, faculty requirements etc.);
- Scope of Audit (including timeframes and definition of records to be reviewed);
- Audit Methodology;
- Audit Tool;
- Instructions to ensure consistent recording of audit results;
- Instructions for analysis of audit data;
- Procedures for ensuring the validity and reliability of the audit to ensure that all auditors interpret and apply audit criteria in the same way;
- Process for the submission of audit outcomes to the Steering Group.

The HSC organisation should take account of extant guidance in relation to maintaining service user confidentiality.[32] [33] [34] The audit of service user's healthcare

[30] HSE. *Op.Cit.* Section 7.7.4, page 18.
[31] Ibid. Section 7.7.3 Page 17
[32] EU Data Protection Regulation (GDPR) 25 May 2018 @ https://eugdpr.org
[33] Data Protection Act 2018 @ www.legislation.gov.uk .
[34] DoH 'Code of Practice for protecting the confidentiality of service user information' 31 January 2012 @ www.health,n-i.gov.uk

records should be undertaken by the healthcare team who would ordinarily have the right to access the service user's healthcare records as part of the delivery of health and social care. However, if the audit team is extended to include healthcare personnel who would not have a right to access the service user's healthcare records, and consent has not been provided by the service user for these personnel to access their records, then these records must be sufficiently anonymised, such that an individual is not identifiable to those undertaking the audit.[35]

3.4 Undertaking the Audit

The Steering Group will commission the audit of the healthcare records of the affected service users as identified in Stage 1 (risk assessment). The audit methodology and tools will have been defined by the Steering Group (see Section 3.3).

The audit will involve clinical staff with the necessary skill and knowledge of the specialty involved. However, depending on the nature, extent and complexity of the Lookback Review the HSC organisation may need to commission relevant experts to undertake the audit or service review.

Again, depending on the nature of the Lookback Review the team may initially be required to screen the service users' notes/x- rays/test results etc. to establish if they are in the affected cohort. A system for the initial identification of the service users including flow charts, service review proformas and service user notification letters are contained in Appendix 3. These are examples only and are provided as reference material and should be adapted by the HSC organisation for the specific health and social care trigger event on a case by case basis.

Following initial screening and identification of service users affected, further assessment may be required.

The service user database will be used to document the service users/ staff who are included and excluded following each stage of the Lookback Review Process (see Section 3.2 above). In general, it will be used to track persons affected and to record actions, interventions and outcomes.

[35]HSE. *Op.cit*. Section 7.7.3.

Upon completion of the audit, the service review team will provide the Steering Group with the results of the audit which will inform the Steering Group of the persons affected to be included in the Recall Stage.

4.0 Stage 3 Service User Recall

4.1 Planning the Recall

Following completion of Stage 2, the Steering Group will move to the third stage, the Service User Recall Stage. The Steering Group and Operational Group should ensure that their Terms of Reference include the following; purpose of Recall, scope, method and timeframe.

The Steering Group will also establish the Recall Team(s) which will consist of experts in the subject area/ discipline which is the covered by the Lookback Review Process.

The Steering Group must agree with the Recall Team(s) a realistic work-plan with timelines that reflect the urgency and complexity of the Lookback Review Process.

The Steering Group will have to consider the following which will form the basis of the Operation Group/Lookback Review Management Team work-plan:

- Identify venue for the conduct of the Recall stage;
- Secure administrative support;
- Establish an appointment system including DNA management;
- Secure clinical and other specialist support e.g. laboratory/x-ray etc.;
- Arrange transportation of samples and results;
- Manage arrangements for assisting service users affected to attend the Recall Stage (for example car parking, site maps, signage/ 'meet and greet' arrangements, public transport, taxis, meals);
- Agree a system for recording of results;
- Ensure that counselling and welfare services are available to service users and to staff;
- Agree the communication and service user support arrangements (see Section 4.3);
- Consider the arrangements for overtime/out-of- hours working for staff.

Ideally, a liaison person/team should be appointed to oversee the seamless conduct of each attendance a service user has as part of the Recall stage, whether they are

clinic appointments or repeat tests/x-rays etc. Responsibilities would include; providing a point of contact, follow-up of DNAs , quality assurance of the Process (correct letter to correct person) and checking that the service user affected are referred into the 'system' for subsequent follow-up.[36]

Depending on the extent, nature and complexity of the Process, the Steering Group will have to meet on (at least) a daily basis to ensure they receive SITREPS and continue to have an accurate oversight of the Lookback Review at this Stage (see Section 3.1).

4.2 Service User Communication and Support

One of the most important areas of managing any Lookback Review Process is the communication with all the affected service users. When communicating it is equally important to be able to say who is not affected. The timing of any communication is critical and every effort should be made to notify the entire group simultaneously. The method of doing this will be dictated by the numbers of service users involved (see Section 4.3). Service user notification must be co-ordinated with public announcements made by the organisation. In an ideal situation service users should be contacted before a media announcement is made. However, this is not always possible given the nature/scale of some Lookback Review Processes or if there is a breach in confidentiality at an earlier stage. Where applicable, the Steering Group should identify any service user representative bodies/third sector and brief them.

The Steering Group should agree key messages to ensure consistent and accurate information to provide confidence in the process. The Steering Group should consider the person(s) best suited to communicating bad news with affected service users, their families and/or carers. A spokesperson, should be identified to act as the organisation's spokesperson and be available for interview by the media etc. Media training should be provided on a case to case basis (see also Section 4.6).

The following should be included in the service user communication and support plan:

- access to professional interpreters as required;
- a designated point of contact for service users, their families and/or carers;

[36] *Ibid.* Section 7.8.2 Page 22.

- regular and ongoing information updates provided to service users and families and/or carers;
- affected service users offered a written apology by the health service organisation;
- establishment of a Helpline/Information Line/website to ask questions and to obtain information (see Section 4.5 and Appendix 4 for practical guidance);
- affected service users who need additional consultation have these appointments expedited to allay any anxieties or concern that they may have.

Communication and support of families should include:

- identifying immediate and ongoing management needs of service users, their families and/or carer;
- ensuring that service users understand the processes for ongoing management and have written advice/fact sheets concerning this;
- ensuring that relevant fact sheets containing information on the lookback review are published on the health service inter/intranet website;
- ensuring adequate resources are in place to provide the level of service required;
- provide counselling and welfare services;
- initial communication should be direct, either face-to-face or via telephone, where the service user must be given the opportunity to ask questions.

4.3 Service User Notification by Letter

Depending on the extent of the Lookback Review Process notification may be by a letter sent to the service users affected by the issue. As above, the timing of service user notification must be carefully choreographed with any public announcement made by the organisation. If the Process has affected small numbers of service users organisations may wish to consider alternative forms of direct communication e.g. telephone calls in first instance which should be supplemented by a follow-up letter containing the pertinent information. A sample of letters has been provided in Appendix 3 for reference/guidance.

The service user letter should be signed by the Chief Executive or a Director of the HSC organisation. Service user letters should be sent by first class post in an envelope marked “Private and Confidential -To be opened by addressee only” and “If undelivered return to...(*the relevant Trust*)...”

Letters to the service user should include the following if appropriate:

- Unique service user identifier number;
- Service user information leaflet/ fact sheet;
- The website/freephone helpline number(s) and hours of opening;
- Location map with details of public transport routes;
- Free access to parking facilities;
- Arrangements for reimbursement of travelling expenses.

It can be helpful to include a reply slip with a pre-paid envelope to confirm that service users have received the letter. Alternatively, the organisation may consider using a recorded delivery service or hand delivering the letters if number are manageable.

Depending on the individual Lookback Review Process the HSC organisation may need to identify any service users under 16 and/or other vulnerable groups to write to their parent/guardian/ representative.

The Steering Group should plan for how service users who do not respond to an invitation and/or ‘lost to follow-up should be managed. The Steering Group should ensure that ‘every reasonable effort’ is made to contact all service users at risk for example by telephone or through General Practitioners. It is accepted that service users may have moved out of the region or abroad.

4.4 Public Announcement of the Recall Stage

The Steering Group will determine the timing of the Public Announcement of the Recall Stage of the Lookback Review Process. Communications management throughout the Lookback Review Process should be guided by the principles of ‘Being Open’[37] balanced with the need to provide reassurance and avoid unnecessary concern.

Recall Stage will be announced to the public by the relevant HSC organisation lead Director in line with the Communication Plan (Section 4.2 and 4.6). As stated in

[37] DoH ‘Saying sorry – when things go wrong’. January 2020.

Section 4.3, it is vital that the Steering Group strive to ensure that the Lookback Review Process is not publicly announced until all of the persons affected have been notified and a clear public message can be given regarding the extent of the cohort and those that are not affected. This is not always possible, as breaches of confidentiality may occur and therefore the Communication Plan should be prepared for this eventuality at all times.

When it is determined that communication with the public is required it should not be announced until all of the service users affected have been notified. As above it is recognised that this is not always possible. Key principles of public announcements include:

- Being open with information as it arises from the Lookback Review Process;
- Ongoing liaison with the media throughout the Lookback Review Process;
- Preliminary notification being made public where a situation requires additional time for the discovery of accurate information to be provided to service users and the wider public.

It essential that the findings in relation to the Lookback Review Process should not be released into the public domain until the Process is complete, all the findings are known and all affected service users are informed of the implications of the findings for them.[38]

4.5 Setting up a Service User Helpline/ Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of enquiries from service users, their families and the general public. It is recommended that site-specific helplines are considered for persons affected and a more general information line for the wider public. Consideration should also be given to providing information on the Trust's website for example Frequently Asked Questions (FAQs) and responses. Planning at this stage is vital to ensure that public confidence in the service is not further eroded. Guidance on setting up a service user helpline/information line are contained in Appendix 4.

[38] HSE *Op Cit* Page 20

4.6 Communication with the Media

Adverse incidents, especially those involving a service user lookback generate intense media attention. Regardless of the nature or intensity of media inquiries, information given to them should never exceed that which has been shared with the service users affected.[39]

The Steering Group should consider developing a 'media pack' (see below). The Head of Communications/Communications Manager should take a lead on developing this strategy. Depending on the extent, nature and complexity of the Lookback Review Process the Head of Communications/Communications Manager will liaise with the DoH Communications branch to seek advice on the communication strategy for the media and general public.

As part of the Communications Plan for dealing with the media, the Steering Group should:

- nominate a spokesperson for public and media communications;
- minimise the delay in response to the public and the media
- develop a media pack which should contain;
    - key messages
    - frequently asked questions (FAQs) and answers
    - draft media statements for each phase of the review process.

Media statements in relation to the issue, should be accurate and not add to the anxiety of the service users and their families/carers. Media statements should not be released prior to notification of the Lookback Review Process (see Sections 4.3 and 4.4). In the circumstances where a media statement is released it should state that a Lookback Review Process is being carried out, and immediately limit the area of concern to time period, region and service area within which the Process is being conducted. It should detail the numbers of persons affected being included in the

[39] *Ibid.* Section 7.11.2 Page 26

recall stage of the process and the expected timeframe for the completion of the recall stage, if known.[40]

The media statement should note that all service users affected have been contacted (and method of contact) and that a Helpline/Information line/website has been established, giving the opening time(s) of the line and the contact details. The FAQs can be provided to the media as well as any additional briefing information such as an information leaflet.

All media statements and briefing notes should be ratified by the Steering Group.

4.7 Staff Communication and Support

While the public will need to be reassured that every effort is being made to conduct a full and thorough review, it is essential that the involved healthcare workers are protected and supported during this time. They need to be kept fully informed at all times during the exercise. Support from a peer and counselling should be offered by the employer. This is particularly important during the early stages of the lookback review process when there will be intense media interest. One point of contact, such as the Director of Human Resources should be identified to lead on this aspect throughout the process. In the case of an individual(s) being managed under the HSC organisation's capability/performance management/disciplinary procedures then the relevant HR policies should apply. These parallel processes are not included in the scope of this guidance (see Section 1.3).[41]

A communication and support plan should be devised for staff. This should include communication and support for:

- All staff who are managing the lookback process;
- All staff working in the area of concern;
- All other staff that may be affected.

[40] *Ibid*. Page 27.
[41] DoH Policy for Implementing a Lookback Review Process Section 4.

5.0 Stage 4 Closing, Evaluating and Reporting on the Lookback Review Process

A Lookback Review Process Guideline Checklist has been included in Appendix 5. The Checklist is a memory aid only and must be used in conjunction with the guidelines.[42]

The Steering Group are responsible for formally closing the Lookback Review Process when all service users affected have been reviewed and the care of service users requiring further treatment and care management have been transferred to the appropriate service and all the service users have been written to with the outcome of the review.

At the end of any Look Back process it is the responsibility of the Lead Director/Chair of the Steering Group to evaluate the management of the Lookback Review to assess the efficiency and effectiveness of the process and to identify any lessons learned from the process. Key measures should be assessed and strategies for further improvement should be implemented and reported to the Chief Executive as required.

The findings should be included in a Look Back Review Report. The content will be unique to each Lookback Review Process. The report should be shared with all relevant internal and external stakeholders. This report should be used to form the basis of the Serious Adverse Incident Report (Section 2.10) to facilitate the dissemination of learning across the HSC as a whole.

For the purposes of a report on a Lookback Review Process the report should contain the following information:

- Introduction including:
  - Details of Terms of Reference(s) (include Terms of Reference(s) in the
  - Appendices section of the report)
  - Composition and roles of the Safety Incident Management Team
  - Composition and roles of the Audit Team
  - Composition and roles of the Recall Team
- Methodology applied to the Look-back Review Process including:
  - Methodology applied to preliminary review/Risk Assessment

[42] HSE. *Ibid*. Appendix 8.

- Clear audit methodology for the Audit Stage including:
  - Audit Criteria
  - Scope of Audit
  - Audit Methodology
  - Audit Tool
- Procedures for ensuring the validity and reliability of the Audit stage to ensure that all auditors interpret and apply audit criteria in the same way.
- Recall Stage methodology
- Communications Plan
- Information and Help Line Plan
- Plans for follow up for persons affected following both the Audit and Recall Stage

- Results/ Findings of Stage 1 Preliminary Findings/Risk Assessment;
- Results/ Findings of Stage 2 service review/ audit;
- Results/ Findings of the Recall stage;
- Actions taken to date to address findings;
- Learning and further recommended actions to address findings.

Peer review publication of issues relating to the Lookback Review Process, for instance; the development of an audit tool, logistics and communication with service users/families and staff may be of benefit and should be encouraged.[43]

[43] HSE. *Op. Cit*. Section 7.10.

Glossary

Term	Definition
Adverse Incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Audit	In the context of the lookback review process, audit involves the review of care/processes against explicit standards and criteria to identity those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria.
Clinical Review	A re-examination of a medical and or clinical process/es which has delivered results that were not to the expected quality standard.
Cohort	A group of people who share a common characteristic or experience within a defined period (e.g., are currently living, are exposed to a drug or vaccine or pollutant, or undergo a certain medical procedure) i.e. a sub-group selected by a predetermined criteria.
Contributory factor	A circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.
Database	The ability to record information for retrieval at a later date. In this instance it may be on paper if the numbers involved are small. If the numbers are large, ITC equipment and competent administration staff may be required.
Harm	1 **Harm to a person**: Any physical or psychological injury or damage to the health of a person, including both temporary and permanent damage.

	2 **Harm to a thing**: Damage to a thing may include damage to facilities or systems; for example environmental, financial data protection breach, etc.
Hazard	A circumstance, agent or action with the potential to cause harm.
Lookback Review	A re-examination of a process(es) which has delivered results that were not to the expected quality standards.
Proforma	A page on which data is recorded. The page has predefined prompts and questions which require completing.
Quality Assurance	A check performed and recorded that a certain function has been completed. Negative outcomes must be reported and actioned.
Recall	An act or instance of officially recalling someone or something. In the context of the Lookback Review Process, the recall will involve the examination of the service user and/ or the review all relevant records in line with the Terms of Reference and will identify any deviations from required standards of care. Appropriate corrective actions will be identified as appropriate.
Risk	The chance of something happening that will impact on objectives.
Risk Assessment	A careful examination of what could cause harm to people, to enable precautions to be taken to prevent injury or ill-health.
Serious Adverse Incident	In the context of a Lookback Review Process an SAI is any event or circumstance that meet the specific criteria laid out within the HSCB Procedure for the Reporting and Follow up of SAIs 2016 at www.hscboard.hscni.net.

Service Review Team/expert advisory group	A specially selected group of individuals, competent in the required field of expertise, to perform the Lookback Review Process
Service User	Members of the public who use, or potentially use, health and social care services as patients, carers, parents and guardians. This also includes organisations and communities that represent the interests of people who use health and social care services.
Triggering Event	The initial concern(s) or adverse incident which lead to the HSC organisation considering the initiation of the Lookback Review Process.

Appendices

Template for Risk Assessment

Appendix 1

Information about the event or concern that has given rise to the need to consider a lookback review process (include information in relation to any actual harm that has been caused as a result of this issue)**:**

Information about the potential extent of the issue (include information about the number of people, number of HSC organisations that might be adversely affected by the issue)**:**

Information about the potential outcomes of the issue (include information about the potential consequences of the issue e.g. missed diagnosis / missed return appointments / harm from contaminated equipment):

Information about the risk level of the issue (include information about the severity of harm that might occur in the people adversely affected by the issue). Use the Regional Risk Matrix (Section 2.7) to evaluate the risk.

Please tick one:

Extreme	
High	
Medium	
Low	

Additional Details:

Information about the potential cohort of service users affected (number, gender, age range):

Details of Immediate Action Required

Recommendations to Steering Group regarding Stage 2 Lookback Review (include recommendations for the Terms of Reference for the Lookback Review including recommended inclusion and exclusion criteria; and for scoping audit(s) of service users that might fall within the inclusion criteria):

Details of personnel who undertook the Risk Assessment:

Name	Title

Date of Risk Assessment :

Establishing the Service User Database – Core Dataset Appendix 2

The data below is a minimum dataset, it is however subject to change depending on the individual situation. Ideally the use of an existing HSC organisation database(s) is preferred.

- Unique identifier number;
- Surname;
- Forename;
- Title;
- Date of birth;
- Sex;
- Address line one (House name, number and road name);
- Address line two (Town);
- Address line three (County);
- Postcode.

- GP name;
- GP address line one;
- GP address line two;
- GP address line three;
- Postcode.

- Named consultant;
- Date of appointment/procedure1;
- Date of appointment/procedure 2;
- Date of appointment/procedure 3;
- Procedure one description;
- Procedure two description;
- Procedure three description.

- Reviewer 1 description;
- Reviewer 2 description;
- Data entered by – identification;
- Data updated 1 by – identification;

- Data updated 2 by – identification;
- Data updated 3 – identification.

Appendix 3

Initial Identification of Service Users involved in the Service Review/ Audit Stage

See Flow Chart - Process for advising that all service users who may have been affected (Appendix 3.1 Section 1)

See Flow Chart - Process for advising all service users known to be the affected cohort (Appendix 3.1 Section 2)

The retrieval of notes/x-rays/test results must be co-ordinated with the support from Medical Records staff.

A Service Review Proforma (Appendix 3.2) is attached to each set of notes.

The service user database needs to be updated after completion of this Proforma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Service Review Proforma should be transferred from the front of the notes and filed into the service users' records.

Conducting Further Assessment (Notes/X-rays/Test Results etc.)

A Notes/X-ray/Test Results Review Proforma (Appendix 3.3) is attached to the front of each set of service user notes.

The service review team will undertake a further detailed audit of the notes to review the outcomes of previous assessment/scans/tests.

The service review team will then decide if previous outcomes/diagnosis were accurate.

The Proforma will be completed by the Service Review Team.

- A green or red sticker is placed on the pro forma. The **green** sticker identifies a positive outcome and that no further follow up is required - Letter D is sent to service user.

- A **red** sticker identifies a negative outcome that requires a further assessment – Letter E is sent to service user.

The service user database needs to be updated after completion of this pro forma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Notes Review Pro forma should be removed from the front of the notes and filed into the healthcare record.

Conducting Further Assessment (Clinical)

A Clinical Review Pro Forma (Appendix 3.4) is attached to the front of each set of healthcare record.

The service review team will undertake a clinical examination/test/scan etc. as appropriate to determine a positive or negative outcome. One must bear in mind that timescales for test/scan results may differ depending on individual situations.

The pro forma is then completed by the Service Review Team. A **green** or **red** sticker is placed on the pro forma.

- The **green** sticker identifies a positive outcome and that no further follow up is required - Letter F is sent to service user.

- A **red** sticker identifies a negative outcome that requires further treatment which should be managed within normal clinical arrangements – Letter G is sent to service user.

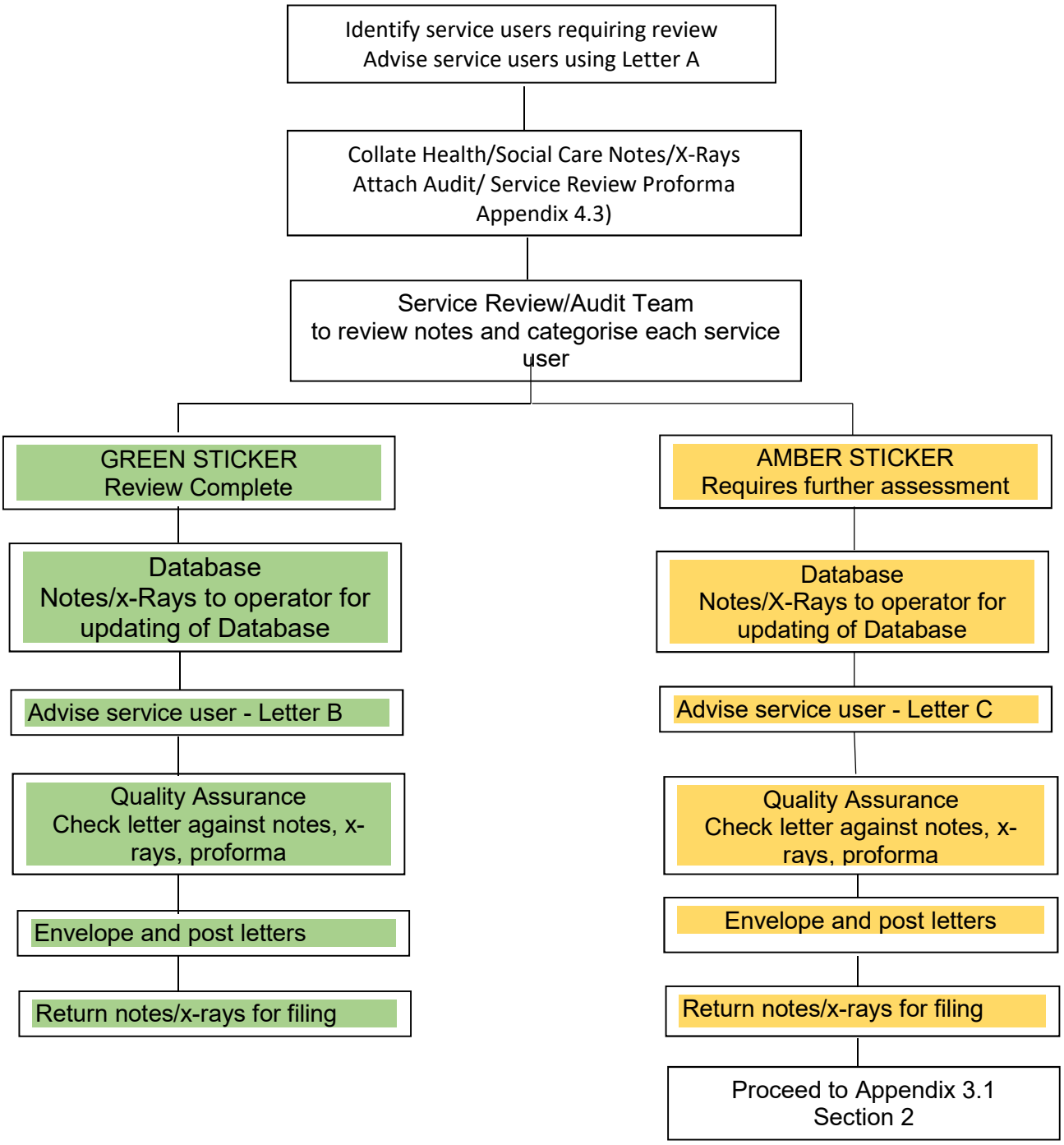
The service user database needs to be updated after completion of this proforma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Clinical Review Pro Forma should be transferred from the front of the notes.

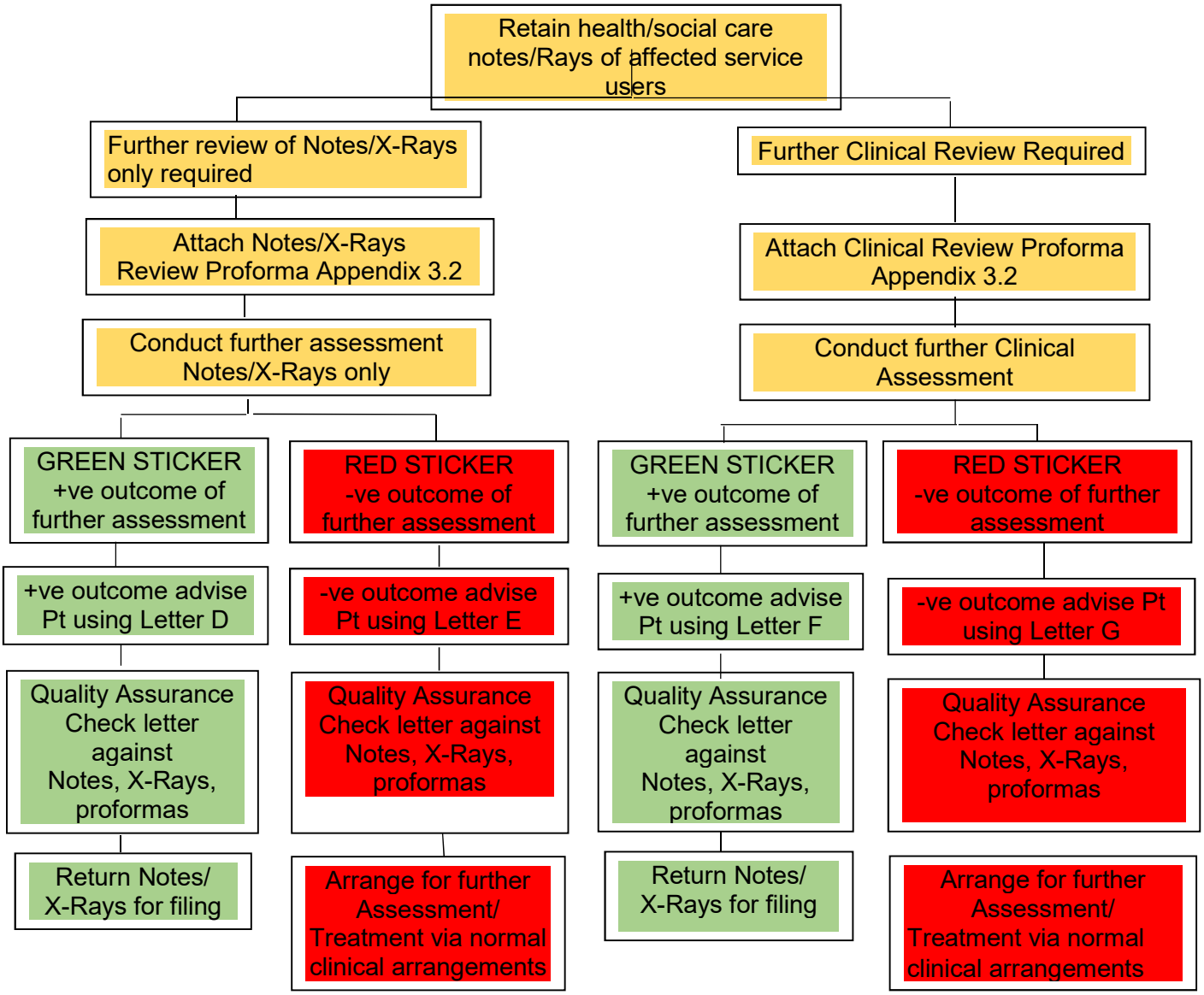
- If it has a **green** sticker attached: file into service user notes.
- If it has a **red** sticker attached: return service user notes and pro forma to admin support for processing within normal clinical arrangements.

Appendix 3.1 (Section 1) Advising service users who may be in the affected service user cohort



Appendix 3.1 (Section 2)

Process for Advising Service users known to be in the affected cohort.



Appendix 3.2 Service Review Proforma

SERVICE USER DETAILS (ATTACH LABEL)

CASENOTES REVIEWED ☐

X-RAYS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐

(Give details)

DATE OF APPOINTMENT/SCAN/EXAMINATION REVIEWED ☐

REVIEWER 1

Signature & date

REVIEWER 2

Signature & date

GREEN STICKER – REVIEW COMPLETE

AMBER STICKER – FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

Appendix 3.3 NOTES/X RAY REVIEW PROFORMA

SERVICE USER DETAILS (ATTACH LABEL)

ADDITIONAL INFORMATION

CASENOTES REVIEWED ☐

X-RAYS/SCANS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐

ADDITIONAL TESTS/SCANS/X-RAYS REQUIRED ☐

CLINICAL REVIEW REQUIRED ☐

REVIEWER 1

Signature & date

REVIEWER 2

Signature & date

GREEN STICKER – REVIEW COMPLETED

RED STICKER – FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

Appendix 3.4 CLINICAL REVIEW PROFORMA

DETAILS (ATTACH LABEL)

	OUTCOME +VE	-VE
CLINICAL EXAMINATION	☐	☐
TEST	☐	☐
SCAN/X-RAY	☐	☐
BIOPSY	☐	☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED
(Give details)

	YES	NO
FURTHER FOLLOW REQUIRED: PROCESS INTO NORMAL CLINICAL ARRANGEMENTS	☐	☐

CONSULTANTS SIGNATURE: _____DATE:_____

GREEN STICKER – REVIEW COMPLETED

AMBER STICKER – FOLLOW UP REQUIRED
PROCESS INTO NORMAL CLINICAL ARRANGEMENTS

RED STICKER - FOLLOW UP REQUIRED
REQUIRED URGENT REFERRAL

DATABASE UPDATED ☐ (Signature & date) _____

ADMIN QA CHECK ☐ (Signature & date) _____

LETTER SENT ☐ (Signature & date) _____

Appendix 3.5 DRAFT LETTERS

Although there will be one “master” letter, you will need to generate several variants from it for different circumstances e.g. when the service user is a child.

The following are provided for suggested content only.

LETTER A: Advising of a Lookback Review Process

LETTER B: No further follow up required

LETTER C (version 1): Further follow up is required – Notes only

LETTER C (version 2): Further follow up is required – Clinical

LETTER D: Positive outcome of further assessment – Notes only

LETTER E: Negative outcome of further assessment –Notes only

LETTER F: Positive outcome of further assessment – Clinical

LETTER G: Negative outcome of further assessment – Clinical

LETTER H: Letter to General Practitioner to advise them that the service user(s) are being included in the Recall Phase of Lookback Review Process

LETTER A: Advising of a service review/lookback review process

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear < Title>

<***Title of Lookback Review Process***>

It has come to the attention of <*HSC organisation*> that < *a healthcare worker/system*> has <brief outline of the incident>.

We have decided as a precautionary measure to review each of the cases with which this <*healthcare worker/system*> has been involved since <*date range*>.

Your case will be included in this review, which will be a substantial process <*involving…..*>. We have initiated a Service Review Process and will endeavour to deal with this as timely as possible.

I wanted to inform you directly about this rather than letting you hear it through another source and I believe it is important that you are kept fully informed of the review process. We will write to you immediately after your case has been reviewed to advise you whether or not it will be necessary for you to have <*a follow up appointment/test*>.

If in the interim you have any queries, a special telephone helpline has been set up on <*freephone/Tel:xxxxxxxx*> so that you can discuss any concerns. It is staffed from <*date and time to date and time*>. This line is completely confidential and operated by professional staff who are trained to answer your questions.

Although there are a large number of call handlers, there will be times of peak activity and there may be occasions where you may not get through. In this event I would ask you to please call again at another time.

<*Enclosed is a factsheet with more detailed information, which you may find helpful*>.

Please have your letter when you call the helpline, as you will be asked to quote the unique reference number from the top of the page.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER B: No further follow up required

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <*HSC Organisation*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx / using the protocol*> and I am pleased to inform you that your <*case notes/assessment/test*> has now been reviewed and that **no further follow up is required.**

I fully appreciate that this has been a worrying time for you and I apologise for any upset this may have caused. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER C (version 1): Further follow up is required – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <HSC Organisation> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <*clinician/consultant*> has advised that **further follow up is required.** I must emphasise that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for <*name and grade of person*> to <*review notes/assessment*> and we will contact you again as soon as this is complete.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER C (version 2): Further follow up is required – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

We had previously written to advise you that <*HSC Organisation*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <clinician/consultant> has advised that **further follow up is required.** I must emphasise that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for you to be seen in <*where*> on <*date & time of appointment*>.

Our service review team will be available at this appointment to discuss the clinical aspects of your case. I have enclosed directions to <*xxxxxxx*> and information on parking arrangements.

If you are unable to attend this appointment please contact <*Tel xxxxxx*> to allow us to reorganise this for you.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER D: Positive outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

I am pleased to advise you that your case has been reviewed by <*name and grade of person*> and we would wish to reassure you that <*he/she*> is satisfied with the quality of your original <*assessment/investigation/test*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER E: Negative outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

Your case has been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that the quality of your original <*assessment/investigation/test*> was unsatisfactory.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER F: Positive outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are pleased to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **NEGATIVE**. This indicates that you have not been exposed to <*infection/illness*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER G: Negative outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **POSITIVE**. This indicates that you have been exposed to <*infection/illness*>.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of HSC Trust)

Letter H: Letter to General Practitioner (informing them of the inclusion of their patient(s) in the Recall Phase of the Lookback Review Process)

Service user name & address

Dear <*Doctor Name*>

<Title of Lookback Review Process>

<*Service Name*> recently reviewed <*Procedure*> undertaken at the hospital in <*Date(s)/Year(s*)>. This review was part of a quality assurance process as we were not satisfied with the quality of a number of <*Procedure(s)*> carried out. As a precautionary measure our medical advisors have recommended that a number of service users who attended for <*Procedure*> are offered a <*Specialty*> outpatients appointment.

Our records show that your patient <*Name*> previously attended <*name of location*> for <*name of procedure*>. We have written to your patient to advise them that their file was reviewed as part of this process and to offer them an outpatient appointment.

If you have any queries about this letter, please contact <*Name person and contact details*>.

Yours Faithfully

(Chief Executive/Director of HSC Organisation)

Appendix 4 Setting up a Service User Helpline or Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of calls from service users, their families and the general public. It is recommended that site specific helplines are considered for persons affected and a more general information line for the wider public.

The following points should be considered by the Steering Group:

- An individual, such as a senior manager should be identified to coordinate and implement the Telephone Help Line;
- A meeting needs to be convened with a small number of individuals, with the necessary knowledge of the speciality, to establish the necessary systems to support the helpline/information line. It may be that Lead and Specialist Nurses are ideally placed to assist at this crucial stage of planning;
- Information Technology staff are essential members of this team to assist in establishing databases and the necessary technology. A senior member of staff from the Telephone Exchange is invaluable at this stage in planning.

Identification of Venue for Helpline/Information Line

- Ideally the Helpline should not be isolated from the main hub of the organisation. Staff need to be able to access others to seek advice while the Helpline is operational. However, it does need to allow confidential conversations to take place and requires a dedicated space.
- Cabling to allow sufficient telephones is required. Once the media report on the issue is in the public domain then there is likely to be an influx of calls.
- Free phone telephone numbers need to be agreed with Telephone Exchange staff or relevant department.
- It is advisable to have a failsafe system to capture additional calls if the telephone lines become blocked with calls. This may involve agreeing with the Telephone Exchange staff to take details from those callers who are unable to get through quickly and ensure one of the Helpline staff return the call within an acceptable timeframe.

- Once the number of Helpline stations are agreed, personal computers are required for each to facilitate easy access to service user information. IT staff will assist in accessing the necessary cabling and hardware.

Briefing Paper for Helpline Staff

- It is important that those manning the Helpline should be trained and briefed. They should be provided with training and background information on the circumstances surrounding the Look Back exercise.
- Files should be prepared and updated daily with the initial press release and briefing notes on the subject (see Key Messages below).

Production of Algorithms

- Staff manning the Helpline will find it useful to have simple algorithms which assist in giving accurate information to callers. It may be that the caller has no reason to be alarmed when they are informed they are not within the affected group of service users.

Production of Key Messages

- Helpline staff need to be confident in the messages they are giving to callers. To assist this “key messages” should be agreed with the clinical teams and these are read to callers in response to specific questions. Helpline staff must not deviate from these messages.
- Some anxious callers will ring on many occasions and it is vital that if they speak to different Helpline staff they are being given a consistent message.
- Key messages will change as the review progresses. These then require to be updated in the individual files for Helpline staff.

Production of Proforma

- As each call is received it is important to maintain a record. A proforma should be designed to capture the relevant information. It should not be so detailed that the caller feels annoyed, however there needs to be sufficient to ascertain if follow up action is required.
- If the Helpline staff believe that follow up is required then a system needs to be agreed to segregate proformas, perhaps by identifying follow up calls with a red

dot. By the following day these need to have been actively followed up, probably by clinical staff in the speciality being reviewed.

- For completeness and post Look Back audit purposes a database of Helpline calls might be helpful.

Production of Rotas

- The Helpline opening times need to be agreed at the outset so that rotas can be produced. However as stated earlier the extent to which the matter is covered in the media will largely dictate when the calls might be made and some flexibility might be required. There is a strong correlation between media reports and number of calls made.
- In the early stages it will be essential to have staff with good communication skills. Staff will need to be released very quickly from their "normal" duties to assist with this work. There may need to be back filling of these posts to release these staff to assist.
- While staff should not be asked to work more than 6 hours at any one time on the Helpline, it is recognised that in the first few days resources may be stretched. On occasion some normal hospital business may need to be suspended temporarily. Overtime and out-of-hours arrangements should be considered and agreed through the Human Resources Department prior to the commencement of the Helpline.
- Ideally if new staff are coming onto the rota there should always be one member of staff who is familiar with the system and can advise others and co-ordinate overall. As far as possible the help lines should be staffed by experienced people with an understanding of the governance and duty of care responsibilities. Briefing on this area is helpful to understand the corporate responsibility.

Staff Briefing

- Briefing of staff, particularly in the early stages of the exercise is vital. A leader needs to be identified to take this role. This would normally be an Executive Director.

- Staff need to feel they are being listened to during the exercise. If they believe that the system could be improved they should have that opportunity to discuss their views at a daily staff briefing session.
- Catering arrangements should be in place for staff who assist in this work. Regular coffee breaks should be accommodated.

Appendix 5 Lookback Review Process Guideline – Process Checklist Template

	Look-back Review Process **The purpose of the check-list is to act as an aide memoir to managers and staff to assist them to ensure compliance with the HSE Look-back Review Process Guidelines.** **The check-list must always be used in conjunction with the Lookback Review Process Guidelines. References to the relevant sections of the Guideline have been included in the check-list.**	**You should refer to the relevant Guideline Section(s) for guidance on each stage of the process.**	**Tick as appropriate**		
1	**Stage 1: Scoping the extent, nature and complexity of the Lookback Review**	**Section**	**Yes**	**No**	**N/A**
1.1	Chief Executive notified that a Lookback Review Process may be required	**2.1**			
1.2	Chief Executive or nominated Director has established a Steering Group and Terms of Reference were agreed	**2.2 – 2.4**			
1.3	The Risk Assessment was commissioned by the Steering Group	**2.7**			
1.4	Using the information obtained from the Risk Assessment, the Steering Group made a decision to progress to the Service Review/ Audit and Recall stages of the Lookback Review Process	**2.7 – 2.8**			
1.5	The Chair of the Steering Group has notified the relevant bodies (DoH, HSCB, PHA) of the decision to progress with the Lookback Review Process	**2.9 – 2.10**			
2	**Stage 2: Identifying and Tracing Service Users at Risk**	**Section**	**Yes**	**No**	**N/A**
2.1	The Steering Group agreed the Scope and the Terms of Reference of the Service Review/ Audit and Recall stages of the Lookback Review Process	**3.1**			
2.2	The Steering Group developed a Lookback Review Action/Work Plan to inform the Audit and Recall Stages of the Lookback Review Process	**3 .1 – 3.2**			
2.3	A database was established to collate and track the information gathered by the Lookback Review Process	**3.2 – 3.3**			
2.4	The Service Review/ Audit was undertaken by nominated team or experts commissioned by the Steering Group	**3.4**			
2.5	The Service Review/Audit identified persons affected to be included in the Recall stage	**3.4**			
2.6	The Helpline/ Information Line was established by the Steering Group	**4.2 , 4.5 & Appendix 4**			

3	Stage 3: Recall Stage	Section	Yes	No	N/A
3.1	The Recall stage was announced by the relevant Director	**4.3 – 4.4**			
3.2	The Recall stage was announced after persons affected had been informed of their inclusion in the Recall stage of the Lookback Review Process	**4.4**			
3.3	The Recall Team(s) implemented the Recall stage as per the Steering Group Action Plan	**4.1**			
3.4	The Recall Team identified actions to be taken to address any deviations from required standards of care	**4.1**			
3.5	The Recall Team implemented actions and/ or communicated required actions to the Steering Group	**4.1**			
3.6	The Steering Group undertook an evaluation of the Lookback Review Process and developed an anonymised report with recommendations and learning	**5**			
3.7	The Chair of the Steering Group submitted the anonymised report to Chief Executive and relevant external bodies	**5**			

Policy for Implementing a Lookback Review Process

Final draft

Contents

This policy should be read in conjunction with the Regional Guidance for Implementing a Lookback Review Process.

This policy, and the accompanying Regional Guidance, replaces HSS (SQSD) 18/2007 issued by the Office of the Chief Medical Officer on 8 March 2007.

Lookback Review Policy

1.0 Introduction

A Lookback Review Process is implemented as a matter of urgency where a number of people have potentially been exposed to a specific hazard, in order to identify if any of those exposed have been harmed and to identify the necessary steps to ameliorate the harm as well as to prevent further potential occurrences of harm.[1]

A Lookback Review is a process consisting of four stages;

- immediate action including a preliminary investigation and risk assessment to establish the extent, nature and complexity of the issue(s),
- the identification of the service user cohort to identify those potentially affected,
- the recall of affected service users and finally
- closing and evaluating the Lookback Review Process and the provision of a report including any recommendations for improvement.

The decision that a Lookback Review is required, often occurs after a service user, staff member or third party such as a supplier has reported concerns about the death or harm to a service user, or the potential for death or harm, the performance or health of healthcare staff, the systems and processes applied, or the equipment used.

The triggers for consideration of a Lookback Review may include, but are not limited to the following:

- Equipment found to be faulty or contaminated and there is the potential that people may have been placed at risk of harm;
- Concern about missed, delayed or incorrect diagnoses related to diagnostic services such as screening, radiology or pathology services;
- Concerns about incorrect procedures being followed or evidence of non-compliance with extant guidance;
- Concerns raised regarding the competence of practitioner(s) or outdated practices;

[1] Health Service Executive (HSE) 'Guideline for the Implementation of a Look-back Review Process in the HSE', HSE National Incident Management and Learning Team, 2015. Section 1 page 4.

- A service review or audit of practice shows that the results delivered by either a service or an individual were not in line with best practice standards and there is a concern that there was potential harm caused to a cohort of service users as a result;
- Identification of a staff member who carries a transmissible infection such as Hepatitis B and who has been involved in exposure-prone procedures which have placed service user at risk; or as
- A result of the findings from a preceding Serious Adverse Incident review, or thematic review by the Regulation Quality and Improvement Authority.

This Policy, should be read in conjunction with the 'Regional Guidance for the Implementation of a Lookback Review Process' which documents the steps, including the service user and staff support and communication plans that are to be undertaken by Health and Social Care (HSC) organisations when a Lookback Review Process is initiated. HSC organisations should develop their own local policies and procedures, consistent with this Regional Policy and related Guidance, to address any potential Lookback Review Processes.

As the triggers for considering a Lookback Review process may also constitute a Serious Adverse Incident (SAI) and/or an Early Alert, the Policy should also be read in conjunction with the Health and Social Care Board (HSCB) SAI Regional Guidance [2] and Department of Health (DoH) Early Alert Guidance.[3]

The circumstances may also require the HSC organisation to notify other statutory bodies such as the Coroners Service for Northern Ireland, the Police Service for Northern Ireland and/or the Health and Safety Executive for Northern Ireland. In that regard, all existing statutory or mandatory reporting obligations, will continue to operate in tandem with this Regional Policy.

2.0 Purpose

The purpose of this policy and regional guidance is to ensure a consistent, coordinated and timely approach for the notification and management of

[2] HSCB 'Procedure for the Reporting and Follow up of Serious Adverse Incident'. November 2016.
[3] DoH 'Early Alert System' Reference HSC (SQSD) 5/19.

potentially/affected service users carried out in line with the principles of openness and candour, [4] [5] [6] whilst taking account of the requirements of service user confidentiality and Data Protection. [7] [8]

3.0 Objectives

The objectives of this policy are to:

1. Assist HSC organisations adopt a risk-based approach and ensure the timely management of appropriate and relevant care for affected groups of service users.

2. Establish a standard approach to notification of service users, families/carers, healthcare managers and the public of adverse incidents involving potential injury, loss or other harm to groups of service users.

3. Ensure that communication with, and support for, all affected and potentially affected service users, their families and/or carers and also staff occurs as soon as reasonably practicable, and in as open a manner as possible.

4. Ensure that the HSC organisation adopts appropriate support mechanisms for the health and well-being of staff involved.

5. Ensure that communication with the Department of Health (DoH), the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and the public occurs in a consistent and timely manner.

6. Ensure that HSC organisations' services have established and consistent processes in place when a Lookback Review is undertaken, that also maintain the business continuity of existing services and public confidence;[9]

[4] In his Inquiry into Hyponatraemia Related Deaths (IHRD), Judge O'Hara made recommendations concerning openness and candour. This included a recommendation for the legal duty of candour for HSC organisations and staff, as well as support and protections to enable staff to fulfil that duty. Work is underway to introduce the necessary legislation and policies to implement these recommendations.
[5] DoH 'Being Open – Saying sorry when things go wrong'. January 2020.
[6] National Patient Safety Agency (NPSA) 'Being open – communicating patient safety incidents with patients and their carers'. September 2005. Archived on 18 February 2009 at webarchive.nationalarchives.gov.uk.
[7] European Union (EU) 'General Data Protection Regulations (GDPR)'. 25 May 2018 at https://eugdpr.org.
[8] Data Protection Act 2018 at www.legislation.gov.uk
[9] South Australia Health ' Lookback Review Policy Directive', Safety & Quality, System Performance & Service Delivery, July 2016. Section 1 page 4.

7. Ensure that HSC organisations appropriately reflect upon the issues which prompted the Review and any learning from the outcomes of a Lookback Review within their systems of governance.

4.0 Scope

This policy and related guidance applies to all HSC organisations. The purpose of the policy and guidance is to provide a person-centred risk-based approach to the management of a Lookback Review and support to any service users and their families/carers who may have been exposed to harm, and to identify the necessary steps to ameliorate that harm. The scope of the policy and related guidance also includes providing information and support to those not directly exposed to the harm in question i.e. concerned members of the public.

Whilst the outcomes of a Lookback Review may inform other processes e.g. Serious Adverse Incident reviews or a Coroner's Inquest, this is not the primary purpose of a Lookback Review Process.

Section 1 identifies some typical examples of the concerns which may lead to a Lookback Review Process being initiated. Where those concerns relate to the health, capacity or performance of practitioner(s) this may trigger a parallel process of investigation and/or performance management. This lies outside the scope of this guidance.

5.0 Roles and Responsibilities

5.1 The Chief Executive is responsible for:

- Commissioning the Lookback Review Process and establishing a Steering Group to oversee the implementation of the Lookback Review in line with extant policy, procedure and guidelines. This will usually be delegated to an Executive Director/Service Director who will act as Chair of the Steering Group (see below);
- Ensuring that effective Lookback Review Processes are implemented, when required, in line with extant policies, procedures and guidelines and that adequate resources are allocated to facilitate effective Lookback Review Processes;

- Reporting the rationale for the implementation of a Lookback Review Process to the DoH, HSCB and PHA as appropriate and as per extant guidance; [10] [11]
- Ensuring that the Lookback Review process is conducted with openness and transparency; and
- Providing service users, families and/or carers with a meaningful apology, where appropriate;
- Communicating the findings of the Lookback Review Process to the HSC organisation's Board and to the DoH, HSCB and PHA as appropriate and as per extant guidance. [12] [13]

5.2 The Oversight Group/Steering Group is responsible for:

- Overseeing the service review/ risk assessment process to identify the scope of the issue and inform the decision to progress to the service review/audit and recall stages of the Lookback Review Process as required;
- Deciding on the requirement for progression to Stage 2 Identifying and Tracing the Service User's at risk and Stage 3 Service User Recall;
- Communicating the need for the service review/audit and recall stages of the Lookback Review Process through the organisation's governance structures/Assurance Framework to the Board of Directors and external stakeholders (including DoH);[14]
- Developing the Scope and Terms of Reference for each element of the Lookback Review Process;
- Overseeing operational management of all aspects of the Lookback Review Process;
- Developing a Lookback Review Action/ Work Plan which outlines the methodologies to be implemented in relation to the Audit and the Recall stages of the Lookback Review Process;
- Ensuring that arrangements are in place to capture and report information on the outcome of the Lookback Review Process;

[10] DoH. (SQSD) 5/19. *Op.cit.*
[11] HSCB. November 2016. *Op.cit.*
[12] DoH. *Op.cit.*
[13] HSCB *Op.cit*
[14] DoH. HSCB. *Loc. Cit.*

- Ensuring that the impact on ‘business as usual’ for all service users is assessed and reported on;
- Ensuring that service managers implement contingency plans for service continuity where necessary, including providing for additional health care demands which may arise as a consequence of the Lookback Review Process, this should include service users not included in the ‘at risk’ cohort who also may be affected by the impact on services as a result of the Lookback Review Process;
- Ensuring that arrangements are in place to provide support to both service users and staff e.g. counselling and welfare services;
- Ensuring that service managers allocate the necessary resources to implement the Lookback Review Process and to meet associated demands;
- Ensuring communication at the appropriate time and implementation of recommended actions arising from the Lookback Review Process.

5.3 The Operational Group/Lookback Review Management Team are responsible for:

- Supporting the Steering Group in the implementation of the Steering Group Lookback Review Action/Work plan (see above);
- Putting in place arrangements to capture and report information on the progress of the Lookback Review Process;
- Implementing contingency plans for service continuity including implementing plans for referral pathways, rapid access clinics, diagnostic or pathology services;
- Providing support to both service users and staff e.g. counselling and welfare services;
- Providing the operational arrangements to support the communication plan, at the appropriate time with the implementation of actions arising from the Steering Group’s Action plan to meet Stage 2 and Stage 3 of the Lookback Review Process.

5.4 The HSC Organisation Board of Directors is responsible for:

- Ensuring appropriate oversight of the Lookback Review and that this is reflected within the organisation's system of governance e.g. risk register;
- Satisfying itself that the Lookback Review Process is being undertaken in line with extant policy;
- Satisfying itself that the Lookback Review Process has been appropriately resourced in terms of funding, people with relevant expertise, access to expert advice and support, IT and any other infrastructure required;
- Satisfying itself that the impact of the Lookback review process on 'Business as Usual' is assessed, monitored and reported on with mitigating measures in place where possible;
- Satisfy itself that required actions identified by the Lookback Review Process are implemented;
- Providing challenge, management advice/guidance and support to the Lookback Review Commissioning Director and the Lookback Review Steering Group as required.

5.5 The Public Health Agency is responsible for;

- Providing advice/guidance and support to the Lookback Review Steering Group as required;
- Dissemination of information and notification to the wider health services of the adverse incident or concern as required;
- Assisting the HSC organisation with the Lookback Review Process Action Plan and Communication Plan as required.

5.6 The Health and Social Care Board is responsible for;

- Providing advice/guidance and support to the Lookback Review Steering Group as required;
- Dissemination of information and notification to the wider health services of the adverse incident or concern as required;
- Assisting the HSC organisation with the Lookback Review Process Action Plan and Communication Plan as required;

- Monitoring compliance with the HSCB 'Procedure for the Reporting and Follow-up of Serious Adverse Incidents';
- Assisting with the dissemination of learning from the Lookback Review Process.

5.7 The Department of Health is responsible for;

- Ensuring that the HSC reporting organisation complies with the Policy Directive;
- Providing advice and information to the Minister.
- Assisting the HSC organisation with the development and management of communication strategies to the wider health service.

6.0 Legislative and Regional Guidelines

- Health and Safety at Work (NI) Order 1978;
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000;
- Freedom of Information Act 2000;
- EU Data Protection Regulation (GDPR) 25 May 2018;
- Data Protection Act 2018;
- Department of Health 'Code of Practice for protecting the confidentiality of service user information' 31 January 2012;
- HSCB Procedure for the Reporting and Follow-up of Serious Adverse Incidents 2016;
- Department of Health Early Alert System HSC (SQSD) 5/19;
- Department of Health 'Being Open – Saying sorry when things go wrong'. January 2020.

Dr Maura Briscoe
Director Mental Health & Disability Policy

Department of
Health, Social Ser
and Public Safety
www.dhsspsni.gov.uk
AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poibl
MÄNNYSTRIE O
Poustie, Resydènter Heisi
an Fowk Siccar

To:
Chief Executive of HSC Trusts
Chief Executive of HSC Board (for cascade to GPs and other relevant practitioners)
Chief Executive of PHA
Chief Executive of RQIA (for cascade to private hospitals, clinics and other relevant establishments and agencies)
Chief Executive of PCC
British Medical Association (NI)
Royal College of Nursing (NI)
Royal College of Psychiatry (NI)
British Association of Social Workers (NI)
College of Occupational Therapists (NI)

Castle Buildings
Belfast BT4 3SQ
Tel: (Irrelevant redacted by the USI
Fax: (
Email: maura.briscoe Personal information redacted by USI

Your Ref:

Our Ref: HSC/MHDP – MHU 1 /10 - **revised**

Date: 14 October 2010

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance

Purpose

1. The purpose of this circular is to provide interim guidance on the principles to be applied by those involved in taking decisions about an individual's care or treatment that may result in the deprivation of that individual's liberty. The guidance is issued pursuant to the European Court of Human Rights (ECtHR) judgement in 2004 in the "Bournewood" case (see Annexe 1) and is therefore an important element in the protection of Human Rights of patients as required under the European Convention of Human Rights. The guidance is intended as an interim solution based on the current legislative framework, the Mental Health (Northern Ireland) Order 1986 (the Order) and best practice, pending the introduction of new mental capacity legislation in Northern Ireland.

2. The guidance is intended for use by staff working in hospital and/or community care settings across all HSC organisations and relevant independent sector organisations where an individual may be subject to deprivation of their liberty.

A copy of this circular has been placed on the Department's website (www.dhsspsni.gov.uk).

3. This guidance revokes and replaces Circular Letter HSC/MHDP – MHU 1/10: DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance, issued by the Department on 1 March 2010.

The Case

4. Attached (annexe 1) is a summary of the Bournewood judgement which involved HL, a man who had autism and learning disabilities who was admitted to Bournewood Hospital for treatment. HL eventually took proceedings to the ECHR against the UK government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirement of Article 5(4) of the ECHR. The summary conclusions of the ECHR are important and are attached.

Deprivation of Liberty

5. The European Court found that HL had been deprived of his liberty within the meaning of Article 5(1) of the Convention. It is important to note that the judgement does not concern the treatment of incapacitated patients generally. It was only concerned with the question of deprivation of liberty of an incapacitated person.

6. The European Court's judgement does not, therefore, mean that incapacitated patients admitted to hospital or to care homes are automatically deprived of their liberty, even if staff would prevent them leaving unescorted for their own safety.

7. There must be particular factors which provide the "degree" and "intensity" to render the situation one of deprivation of liberty. The factors might relate for example, to the type of care being provided, its duration, its effects and the ways in which admission came about.

8. In this case, the European Court said that:

> "the key factor in this present case [is] that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements".

and, noting that HL had been resident with his carers for over three years the Court went on to say that

> " the clear intention of Dr M and the other relevant health care professionals [was] to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from hospital to the care of Mr and Mrs E as and when professionals considered it appropriate (paragraph 91).

9. Accordingly the Court found that "the concrete situation was that the applicant was under continuous supervision and control and was not free to leave" (paragraph 91).

10. The Court attached particular importance to the fact that HL had a settled home with his paid carers to which he was prevented from returning and that his contact with those carers was (to some extent) restricted by the staff of the hospital. The court did not consider the issue of whether the ward was “locked” or “lockable” to be determinative.

Lack of Procedural Safeguards

11. The European Court did not find that HL’s rights had been breached simply because he was admitted to hospital on the basis of common law doctrine of necessity (i.e. in his “best interests”), rather than under specific statutory provisions (e.g. the Mental Health Order).

12. However, the Court did find that the absence of procedural safeguards surrounding his admission failed to protect him against “arbitrary deprivation of liberty on grounds of necessity and, consequently, (failed) to comply with the essential purpose of article 5(1) of the Conventions”.

13. In this latter respect, the European Court was clearly influenced by the “lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted” when contrasted with “the extensive network of safeguards applicable to psychiatric committals covered by the (Mental Health Act 1983). Paragraph 120 is of relevance.

14. The European Court also said:

> “the nomination of a representative of a patient who could make certain objections and applications on his/her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities” (paragraph 120)
>
> By which it presumably had in mind the role of the nearest relative under current mental health legislation.

15. Above all, although it did not question their good faith, the Court seems to have been concerned that the hospital’s health care professionals were able to assume “full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit” (paragraph 21).

16. The Court did not say that HL should have been formally detained under the Mental Health Act. Nor, in the Department’s view, does the judgement mean that procedural safeguards for people in HL’s position must be identical to those patients detained under the current mental health legislation. However, it is accepted that to avoid further violations of Article 5(1), new procedural safeguards are required for patients who are not formally detained, but who are, in effect, deprived of their liberty in the best interests under common law doctrine.

Breach of Article 5(4)

17. The European Court also found a violation of his rights under Article 5(4) of the convention.

Next Steps

The following paragraphs outline the next steps to be taken by DHSSPS, HSC organisations and relevant independent sector organisations.

Proposals for new procedural safeguards

18. The Department will bring forward new safeguards in law via the proposed Mental Capacity (Health, Welfare and Finance) Bill.

Interim steps that might be taken by HSC bodies and relevant independent sector organisations.

19. Until these safeguards are established in law, the effect of the Bournewood Judgement is that it would be unlawful for an HSC body (without the prior authorisation of the High Court) to arrange or provide care or treatment for an incapacitated patient in a way that amounted to deprivation of liberty within the meaning of Article 5 of the Convention unless the patient were detained under the Mental Health (NI) Order 1986.

20. Nonetheless, the HSC will need to continue to provide care and treatment for incapacitated patients, and it is important that neither the safety of those patients nor the quality of the care they receive is jeopardised during the interim period, both for their good, and, it follows, the care and protection of other patients.

21. Pending the development of new safeguards described above, HSC bodies will want to consider what steps they can take in the short-term to protect incapacitated people against the risk of arbitrary deprivation of liberty and minimise the risk of successful legal challenges.

22. The Department suggests that HSC bodies and relevant independent sector organisations will want to ensure they have systems in place so that when making arrangements to provide care to an incapacitated person which involves a restriction on the liberty of that person, consideration is given as to whether what they are proposing amounts in practice to a deprivation of that person's liberty within the meaning of Article 5 of the Convention, taking into account the range of factors identified by the Court set as described above and also contained within (a) to (f) in the Bournewood Judgement attached. The same question will need to be asked when reviewing the circumstances of those people who they have already placed who may, in practice, be deprived of their liberty.

23. If patients are considered to be deprived of their liberty (or at risk of it), consideration should always be given to alternatives to ensure that they get adequate care but which falls short of deprivation of liberty. In particular, HSC bodies and independent sector organisations will want wherever possible, to avoid situations in which professionals may be said to take "full and effective control" over patients care and liberty.

24. Elements of good practice which are likely to assist in this, and in avoiding the risk of legal challenge, may include:

- ensuring that decisions are taken (and reviewed) in a structured way, which includes safeguards against arbitrary deprivation of liberty. There should, for example, be a proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed, and that decisions should be taken on the basis of proper medical advice by a person properly qualified to make the judgement.

- effective, documented care planning and record keeping for such patients, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare and safety.

- ensuring that alternatives to admission to hospital or residential care are considered and that any restrictions placed on the patient while in hospital or residential care should be kept to the minimum necessary in all the circumstances of their case.

- ensuring appropriate information is given to patients themselves and to family, friends and carers. This would include information about the purpose and reasons for the patient's admission, proposals to review the care plan and the outcome of such reviews and the way in which they can challenge decisions (e.g. through the relevant complaints procedure). The involvement of local advocacy services, where these are available, should be encouraged to support patients and their families, friends and carers.

- taking proper steps to help patients retain contact with family, friends and carers, with proper consideration given to the views of these people. If, exceptionally, there are good clinical reasons why that is not in the patient's best interests, those reasons should be properly documented and explained to the people they affect.

- ensuring both the assessment of capacity and the care plan are kept under review. It may be helpful to include an independent element in the review. Depending on the circumstances, this might be achieved by involvement of social work or community health staff, or by seeking a second medical (or other appropriate clinical) opinion either from within the HSC Body/independent organisation, or elsewhere. Such a second opinion will be particularly important where family members, carers or friends do not agree with the organisation's decisions. But, even where there is no dispute, an organisation must ensure its decision making stands up to scrutiny.

25. If it is concluded that there is no way of providing appropriate care which does not amount to deprivation of liberty, then consideration will have to be given to using the formal powers of detention in the Mental Health (NI) Order 1986. However it is important to remember that:

- nothing in the judgement changes the requirements in the Mental Health Order which must be met before patients can be detained. It should not therefore be assumed that all patients who are to be subject to restrictions

which may amount to deprivation of liberty can be detained under the Order. (For example, it would be unlawful to detain patients under the Order if their mental disorder does not warrant detention in hospital, although reception into guardianship under the Order might be appropriate in some cases).

- there are dangers in using the Order simply to be "on the safe side". Although it provides procedural safeguards, the use of the Mental Health Order will not necessarily be welcomed by their family, friends or carers, given the stigma that is often (wrongly) perceived to attach to it. Moreover, a significant increase in the use of the Mental Health Order will inevitably put considerable further pressure on approved social workers, the availability of second opinion appointed doctors (SOADs) and on the operation of the Mental Health Review Tribunal (MHRT).

Action Required

26. I should be grateful if Trust Chief Executives would bring this guidance to the attention of all relevant personnel; ensure the principles it contains are embedded into Trust's procedures; and, confirm to me by **10 December 2010** that this has been done.

Yours sincerely

[SIGNED]

DR MAURA BRISCOE
Director of Mental Health and Disability Policy

Annex 1

The Bournewood Judgement

The Bournewood judgement refers to the European Court of Human Rights' decision in the case of "H.L. v the UK" (published on 5th October 2004).

The case involved H.L, a man who suffered from autism and learning disabilities, who was admitted to Bournewood hospital for treatment under the common law doctrine of necessity. H.L lacked the capacity to consent or object to being admitted and detained for treatment. Although H.L. did meet the criteria for detention under the Mental Health Act 1983 (the 1983 Act) he was not formally detained because he was compliant and did not resist admission and was, therefore, admitted as an "informal patient".

This approach was taken in compliance with the Code of Practice drawn up under the 1983 Act. Chapter 2 of that Code specifically provided that, "if at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal. The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient's treatment in accordance with what is in the patient's best interests and is justifiable on the basis of the common law doctrine of necessity".

H.L. applied, by his carers, to the High Court for leave to apply for judicial review of the hospital/Health Trust's decision to admit him, for a writ of habeas corpus and for damages for false imprisonment and assault. The Court held that, although the 1983 Act provided a comprehensive statutory regime for those formally admitted to psychiatric care, section 131(1) of that Act preserved the common law jurisdiction in respect of informal patients. It concluded that H.L. had not been "detained" but had been informally admitted and that the requirements of the common law principle of necessity had been satisfied. The application was therefore refused.

H.L appealed and the Court of Appeal held that he had been detained by the hospital/Trust and that the right to detain a patient for treatment for mental disorder was to be found only in the 1983 Act, which excluded the application of the common law doctrine of necessity. It considered that section 131(1), which preserved the right to admit a patient informally, applied only to a patient who had the capacity to and did consent to his/her admission. The Court of Appeal therefore held that, since H.L. had been admitted for treatment without his consent and without the other formalities required by the 1983 Act, his detention was unlawful.

The hospital/Trust then appealed to the House of Lords, which unanimously allowed the appeal.

H.L. then took proceedings to the ECtHR against the UK Government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that the procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirements of Article 5(4) of the ECHR.

The relevant parts of Article 5 are set out below.

Article 5 - Right to liberty and security

Article 5(1):
Everyone has the right to liberty and security of person. No one shall be deprived of his liberty *save* in the following cases and in accordance with a procedure prescribed by law.

Article 5(1)(e):
The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts or vagrants.

(The case of *Winterwerp v Netherlands* (1979) set out the criteria which must be satisfied in order to lawfully deprive a person of his/her liberty on the basis of unsoundness of mind, namely: the person concerned must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder.)

Article 5(4):
Everyone who is deprived of his/her liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his/her detention shall be decided speedily by a court and his/her release ordered, if the detention is not lawful.

European Court of Human Rights considerations

The ECtHR had to consider whether H.L. had in fact been detained: and, if so, whether that detention was lawful (i.e. whether detaining H.L in his own best interests under the common law doctrine of "necessity" complied with Article 5(1)); and also whether sufficient safeguards existed to comply with Article 5(4).

The ECtHR concluded that:

- H.L. had in fact been detained and, therefore, the right to liberty in Article 5(1) had been engaged.

  The Court considered that the question as to whether there has been a deprivation of liberty or a restriction upon a person's liberty depends on the particular circumstances of the individual case and "account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question". It stated that "the distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance". It considered the facts of HL's case and concluded that he had been detained because he was constantly under supervision, was not free to leave and because "the health care professionals treating and managing him exercised complete and effective control over his care and movements".

- HL's detention under the common law doctrine of necessity in his own best interests was unlawful under the ECHR, as it did not comply with Article 5(1): i.e. it lacked procedural safeguards which are required to protect against the risk of arbitrary deprivation of liberty.

The ECtHR considered the common law under which H.L was detained. It noted particularly "the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" in contrast with the extensive safeguards available to persons who are compulsorily detained under the Mental Health Act 1983. It also noted the lack of the following attributes which would be necessary to ensure compliance with Article 5(1):

a) Formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions;

b) A requirement to fix the exact purpose of admission (e.g. for assessment or for treatment);

c) Limits in terms of time, treatment or care which should attach to the person's admission;

d) Specific provision requiring continuing clinical assessment of the persistence of a disorder warranting detention;

e) A requirement to nominate or appoint a representative of a patient who could make certain objections and applications on his/her behalf; and

f) Arrangements to enable the person (or his/her representative) to have access to a court/body with judicial character to have the lawfulness of the detention and/or any decision relating to deprivation of liberty reviewed and dealt with within a reasonable period of time.

The Court concluded that "this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5(1)".

- HL's detention was also contrary to Article 5(4) because he was unable to take proceedings by which the lawfulness of his detention could have been challenged and decided quickly by a court.

  The ECtHR considered that HL's application for leave to apply for judicial review of the decision to admit and detain, including a writ of habeas corpus, did not provide H.L. with an adequate means to challenge his deprivation of liberty. Therefore, Article 5(4) of the ECHR was breached.

The ECtHR formally held that Articles 5(1) and 5(4) of the ECHR were violated by the UK Government.

Assumptions

- The person is in a place where care and treatment is available
- There has been no refusal by the Trust panel to an application for authorisation
- The Tribunal has not terminated the deprivation of liberty

SCENARIO 1: No application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- Staff take all reasonable steps to put in the additional safeguards of the MCA:
  - formal assessment of capacity; and
  - application to Trust panel.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 2: Application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- An Application has been made to the Trust for Trust panel authorisation.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

TIME LIMITS: There are no time limits to the use of emergency provisions
REQUIREMENTS: There must at all times be a reasonable belief of lack of capacity, best interests, that the DoL is to prevent serious harm and that the DoL is proportionate to the likelihood and seriousness of the harm.

SCENARIO 3: Decision has been made by Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.

authorisation by Trust panel

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 4: Trust panel has made decision to refuse DoL

A DoL cannot take place.

Staff are not protected from liability.

SCENARIO 5: No steps taken by staff to put in safeguards

Staff are not protected from liability.

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Policy position
Mental Capacity Act (Northern Ireland) 2016
Deprivation of Liberty Safeguards

By:
Mental Capacity Unit
Department of Health

Date: 2 June 2021

Address:
Mental Capacity Unit
Room D2.10
Department of Health
Castle Buildings
Stormont
Belfast
BT4 3SQ

Deprivation of liberty and liability
Protection from liability
Emergency provisions

Introduction

1. This is a policy position paper by Mental Capacity Act Unit in the Department of Health. This paper constitutes **official guidance** in respect of the implementation period of the Deprivation of Liberty Safeguards. This guidance must be read in conjunction with the Mental Capacity Act (Northern Ireland) 2016 (the Act), the Mental Capacity (Deprivation of Liberty) (No. 2) Regulations 2019 (the Regulations) and the Code of Practice (the Code).

2. The first phase of the Act was commenced on 2 December 2019 for the purposes of deprivation of liberty (DoL), offences and money and valuables. Research provisions of the Act were commenced on 1 October 2019.

3. At commencement the Department noted that phase 1 of the Act would allow for a 12 month implementation period. Due to pressures relating to the Covid-19 pandemic it was decided to extend the implementation period until 31 May 2021.

4. This policy paper outlines the requirements for authorisation in respect of deprivation of liberty, safeguards and protection from liability and provides guidance in respect of the emergency provisions in the Act.

Deprivation of Liberty

5. European Convention on Human Rights (ECHR), Article 5 provides that:

   Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

6. This ensures that no one can be deprived of liberty unless it has taken place within a legal framework. In judgements from the European Court of Human Rights

(*Bournewood*[1]) and the UK Supreme Court (*Cheshire West*[2]) the Courts have refined the requirements for a deprivation of liberty to note that:

a. The common law defence of necessity is not sufficient to meet the requirement for a procedure prescribed by law.
b. All deprivation of liberty cases must be authorised prior to taking place.
c. The acid test for a deprivation of liberty is the two questions:
    i. Is the person free to leave?
    ii. Is the person under continuous control and supervision?
d. It does not matter if a deprivation of liberty is done for good reasons if it is not authorised; it would still be unlawful.

7. **The effects of the Courts' decisions are that a deprivation of liberty that is not authorised is unlawful**. If a person is carrying out an unlawful deprivation of liberty, that person carries potential civil and criminal liabilities and the corporate entity (such as the HSC Trust, care or nursing home or other) carries civil liabilities.

8. In Northern Ireland the criminal liability in relation to a deprivation of liberty pre-dates the Mental Capacity Act. The criminal offence of false imprisonment applies in circumstances where a person is preventing another person from leaving the place. A consequence from the ECtHR case of *Bournewood* is that the defence of necessity does not apply to false imprisonment where it is planned, pro-longed or part of a care plan. A person preventing someone from leaving in a health and social care setting therefore potentially carries criminal liabilities relating to false imprisonment, unless the deprivation of liberty has been authorised.

9. Prior to the commencement of the Mental Capacity Act the only methods of authorisation in the health and social care system in Northern Ireland were the Mental Health (Northern Ireland) Order 1986 for patients in hospital or a declaratory order in the High Court.

10. The first phase commencement of the Act, through the Deprivation of Liberty Safeguards (DoLS), provides a statutory framework to authorise a DoL in all settings where the Mental Health (Northern Ireland) Order 1986 does not apply. As such the Mental Capacity Act provides protection from the criminal liability of false imprisonment.

Legislative background

11. The functioning of the Act is based on the concept of **protection from liability**, as found in section 9 of the Act. This provides a protection from a liability in relation to a person who is over 16 who lacks capacity to consent to a specific act that would normally require that person's consent.

12. Many acts done in relation to a person that interfere with a person's body are done based on the person's consent. This includes most acts in a health and social care setting. For example:

    a. if a nurse provides the flu vaccination through an injection on a person the nurse requires consent to do so. If no consent is provided the nurse is

[1] *HL v UK* (2004).
[2] *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] MHLO 16.

potentially committing the criminal offence of assault and the tort of trespass to the person.

b. if a care assistant helps a person dress in the morning and touches the person, without consent potentially the criminal offence of assault has been committed and the tort of trespass to the person.
c. if a surgeon operates on a person, consent is required. If no consent is provided the surgeon potentially commits the offence of wounding and trespass to the person.
d. if a support worker prevents a service user from leaving a building the support worker potentially commits the offence and tort of false imprisonment.

13. Valid consent negates the liability, as the act is consented to. If a person lacks capacity to consent, the act can be carried out if it is deemed necessary, by relying on the common law defence of necessity. This defence allows an act to be carried out because it is necessary even though it would normally be unlawful.[3]

14. The Mental Capacity Act, through the protection from liability, codifies the common law defence of necessity. That means if a person (D) does an act in relation to a person who is 16 or over and lacks capacity (P), **D is protected from liability if the safeguards and additional safeguards of the Act are adhered to**.

15. The first phase commencement, with the go live date on 2 December 2019, relates to acts that amount to deprivation of liberty and research, with deprivation of liberty the focus on this policy paper. In relation to DoL the protection from liability relates to care arrangements amounting to deprivation of liberty.

Safeguards and additional safeguards

16. The protection from liability as found in the Act for the purpose of an act that is a detention amounting to a deprivation of liberty can be relied upon if two safeguards and four additional safeguards are met.[4]

17. The safeguards are:

a. Reasonable belief of lack of capacity; and
b. Reasonable belief of bests interests.

18. The additional safeguards are:

a. Formal assessment of capacity;
b. Prevention of serious harm condition (POSH);
c. Consultation with nominated person (NP); and
d. Authorisation[5].

[3] Please note as a result of jurisprudence in the European Court on Human Rights and the UK Supreme Court the common law defence of necessity cannot be relied upon when the act is a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights.
[4] In the case of an emergency the additional safeguards of formal assessment of capacity, Nominated Person and authorisation can be delayed to protect P from unnecessary harm.
[5] Short-term detention authorisation or trust panel authorisation.

19. All the safeguards and additional safeguards are of equal importance. If one of the safeguards or additional safeguards are not in place the protection from liability cannot be relied upon (unless the situation is an emergency – see footnote 4).

Power v protection

20. Traditionally statutory provisions in relation to detention and deprivation of liberty have provided powers to act. For example, the powers of detention in the Mental Health (Northern Ireland) Order 1986 provide explicit powers to detain a person. Those powers are vested in the statutory report and forms where the signing of the form provides a power to detain a person.

21. **The Act does not provide powers of detention but a protection from liability.** That means that there are no "traditional" powers of detention and a deprivation of liberty cannot take place simply because there is a form, papers, care plan or similar that notes that a person should be deprived of liberty. The person doing the act (D) must be satisfied that the safeguards and additional safeguards are met at all times (except in an emergency). If ***any*** of the safeguards are not met, or if there is no reasonable belief for D that the criteria for detention are met, a deprivation of liberty cannot occur.

22. When D is considering whether the criteria are met, D can rely on previous work and work of others. That means a formal assessment of capacity forms a good foundation for reasonable belief that P lacks capacity. However, it is important to note that D must have a reasonable belief. If the formal assessment of capacity is obviously incorrect D cannot rely on that information.

Liability

23. **The Act provides a protection from liability for D if the criteria for deprivation of liberty are met and the safeguards and additional safeguards of the Act are fulfilled.** This protection is enshrined in the law and is absolute – if the law is followed correctly.

24. The person needing protection is the person who carried a liability i.e. D. As there are no powers of detention the only person that requires the protection is the person who prevents P from leaving a place.

25. A deprivation of liberty normally carries liabilities as this could amount to a false imprisonment. That means a deprivation of liberty that is done without an authorisation or other approval could amount to criminal behaviour. This is not a consequence of the Mental Capacity Act, but of previous case law in the UK Supreme Court and the European Court of Human Rights, the European Convention on Human Rights and the Human Rights Act 1998. **In the Mental Capacity Act, D is protected against the personal liabilities (both civil and criminal)** that is included by falsely imprisoning a person as long as D has a reasonable belief that the criteria for DoL and the safeguards required under the Act are in place.

26. The safeguards include a reasonable belief of lack of capacity and best interests and the additional safeguards of a formal assessment of capacity, consultation

with the nominated person, prevention of serious harm condition and authorisation.

27. These additional safeguards, including the authorisation, do not provide powers to act or powers to detain a person. Rather it provides the safeguards that D requires to be protected from liability. Therefore carrying out the safeguards by, for example, making the formal assessment of capacity or sitting on a trust authorisation panel, does not constitute acts that create a liability (outside normal duties of care and professional responsibilities). It is part of normal assessments in the health and social care system that provides a basis for the reasonable belief required by D.

28. As noted, a person doing an assessment, writing a report or signing an authorisation has not carried out an act that would normally require P's consent. These people therefore have no liability and therefore have nothing to be protected from.

29. If the Act had been drafted to provide powers of detention, the person signing the authorisation could have been held liable for an unlawful deprivation of liberty based on their signing the authorisation or reports. However, as the Act **does not** provide such powers, and rather is **based on the concept of protection from liability** then there is **no liability** in relation to the assessors, report writers or authorisers. The **liability rests with the person who prevents P from leaving the place**.

30. There are, of course, general responsibilities to carry out professional functions in a professional manner and to act within professional standards. If a professional purposefully or wilfully provides a false assessment, statement, report or authorisation this could, and should, be dealt with in line with normal disciplinary manners. Such wilful acts may also constitute the offence of wilful ill-treatment or neglect of a person deprived of liberty.

Protection from liability of false imprisonment

31. The current position in Northern Ireland in relation to deprivation of liberty is that a lawful authorisation must be in place before a deprivation of liberty. The 2004 European Court of Human Rights case, *Bournewood*, ruled that deprivation of liberty cases needed procedural safeguards so as to ensure a person is not being deprived of their liberty unnecessarily. In 2014, the Supreme Court ruled in Cheshire West that a person was deprived of their liberty if they were under continuous control and supervision and not free to leave.

32. Therefore, if a person believed to lack capacity is unable to leave and under continuous control and supervision, their confinement **must** be authorised. The Mental Capacity Act contains the procedural mechanisms by which a DoL is authorised and provides protection from liability for those depriving a person of their liberty.

33. **The Act provides a statutory framework to protect from this liability**. As such the purpose of the Act is twofold. On the one hand it provides a statutory framework of protections for P; this ensures that P is only deprived of liberty when it is right and just to do so. On the other hand it also provides protection for those

depriving P of liberty (D); so that the health and social care worker who prevents P from leaving has a statutory protection for the act he or she is doing.

Emergency provisions

34. The Act provides that in some circumstances waiting until all the required safeguards are met would create an unacceptable risk of harm to P and thus would risk greater harm to P than the risk of doing the act without the safeguards. It may then be possible to rely on the emergency provisions under the Act. **Chapter 10 of the Code of Practice[6] outlines guidance on the emergency provisions.** The following paragraphs provide advice on how to interpret the emergency provisions during the implementation period.

35. For the protection of liability to apply in relation to DoL there must always be a reasonable belief of lack of capacity and that the care arrangements are in P's best interests, even if the situation is an emergency. If there is not a reasonable belief of lack of capacity and best interests the person doing the act (D) will never be protected from liability.

36. The prevention of serious harm (POSH) condition must also always be met when a DoL is carried out, even when the situation is an emergency.

Definition of emergency[7]

37. Emergency has a specific meaning for the purposes of the Act. For a situation to be an emergency there does not have to be a crisis and the place of the emergency is irrelevant; it may be in an Emergency Department, but it may also be in a care home, in a private house or anywhere else where an act must be done for P.

38. For a situation to be an emergency **two** conditions have to be met:
    a. that D knows that an additional safeguard is not met, or that D does not know whether the safeguard is met; and
    b. waiting until the safeguard is met, or waiting to establish if the safeguard is met, would create an unacceptable risk of harm to P.

Effects of the emergency provisions

39. Circumstances amounting to an emergency may allow one, or more, of the additional safeguards to be delayed to avoid creating an unacceptable risk of harm to P. It is important to note that just because it would create an unacceptable risk of harm to P to wait for one of the safeguards it does not mean that all safeguards can be delayed.

40. For example, DoL requires a formal assessment of capacity, nominated person and authorisation. It may be that not detaining P in circumstances amounting to a DoL while waiting for a trust panel authorisation (who have up to 7 working days to make a decision after receiving the application), would create an unacceptable risk of harm to P but waiting a number of hours while the other safeguards are met

[6] Much of the advice in this guidance is also available in Chapter 10 of the Code of Practice. However, the Code of Practice provides further guidance on emergencies.
[7] The emergency provisions can be found in sections 65 to 67 of the Act.

would not. In such a situation, if all the safeguards were ignored D would not be protected from liability, whereas he or she would be protected if the trust panel authorisation was not yet in place but the formal assessment of capacity and nominated person safeguards were met.

41. Another example of this may be where P is an in-patient in hospital, subject to a short-term detention and is due to be discharged into a care home. It has been determined that it is in P's best interests to be subject to a DoL in the care home. At the time of the discharge it has not been possible to make an application and get trust panel authorisation. If it would be best for P to be discharged from hospital and admitted into the care home it would normally cause an unacceptable risk of harm for P to remain in hospital. The emergency provisions can then be used to ensure that there is no delay in the discharge from hospital.

Reliance on emergency provisions

42. Staff can rely on the emergency provisions in the Act if D knows an additional safeguard is not in place, but waiting to put in place the safeguard would create an unacceptable risk of harm to P. **This provides a protection in law from liabilities, including from criminal sanctions.**

43. D must have reasonable belief of both lack of capacity and best interests, must be satisfied that the POSH condition is met and must take all reasonable steps to put in place:
    a. **a statement of incapacity;**
    b. **a nominated person; and**
    c. **an authorisation.**

44. As noted above the inability to do one or more additional safeguards is not a reason to not do any. It may therefore be possible to do one or two of the three additional safeguards above.

45. **Statement of incapacity in an emergency** – A wide range of professionals can make statements of incapacity. Such persons must also have received relevant training, have experience working with people who lack capacity and must be designated as a person to make capacity assessments by his or her employer. If a person does not meet the requirements he or she cannot do a statement of incapacity, and can rely on the emergency provisions to deprive P of liberty by informing others, including their line manager, that a statement of incapacity is needed, as this would be considered taking all reasonable steps to fulfil the additional safeguard. For further information on statements of capacity/capacity assessments see chapters 5 and 8 of the Code of Practice.

46. **Nominated person in an emergency** – A nominated person is a person either nominated by P (in writing and witnessed), a person on the default list or a person appointed by the Review Tribunal (see chapter 9 in the Code of Practice for further information). Anyone can ensure a nominated person is in place if nominated by P or taken off the default list, but only some people can apply to the Tribunal to have one appointed. If a person does not meet the requirement to apply to the Tribunal he or she can rely on the emergency provisions to deprive P of liberty by informing others, including their line manager, that an application to the Review Tribunal to appoint a nominated person is needed.

47. **Authorisation in an emergency** – An authorisation outside hospital includes an application to a Trust and a decision by a Trust Panel (see the Code of Practice for further information). If a person does not meet the requirement to make a Trust Panel application he or she can rely on the emergency provisions to deprive P of liberty by informing others, including their line manager, that an application for Trust Panel authorisation is needed.

48. There are no time limits for how long the emergency provisions can be relied upon. However, at all times D must take all reasonable steps to put the additional safeguards in place.

49. If D is an employee of another person (E), E can be held liable for any unreasonable delays in putting the additional safeguards in place. However, the liability of E does not affect the liability of D.

Summary of emergency provisions

50. Anyone can rely on the emergency provisions, and be protected from liability as below. **If a person relies on the emergency provisions and takes all necessary steps required, that person is protected from liability.**

51. A one page summary /process map of the emergency provisions is provided at the end.

Offences

52. Section 269 of the Act provides that it is an offence to unlawfully detain a person. From 31 May 2021, this is a new statutory offence under the Act. **However, it has always been an offence in common law to falsely imprison someone.** A similar offence is also currently in force under the Mental Health Order (NI) 1986. Therefore, the Act does not create a new criminal offence.

53. The staff member/carer, unlawfully detaining the person will be guilty of the offence. Senior managers will also be guilty of the offence if it was done with their consent, if they connived with it or if it can be attributed to neglect on their part.

54. However, if a person is relying on the emergency provisions in the Act, the person is protected from liability. That means the person carries no risk in relation to the statutory offences in the Mental Capacity Act or the Mental Health Order or the common law offence of false imprisonment.

55. Health and social care staff can be assured that where they act in compliance with the Act, and where they take the reasonable steps available to them to put in place all relevant safeguards they are **not** at risk of liability.

56. Only where health and social care staff are **intentionally** ignoring the requirements to have a legal authority for a deprivation of liberty; or where the staff member does not consider if the deprivation of liberty is in the best interests and are not attempting to put processes in place, may there be criminal liability. This is to protect patients, residents and others from arbitrary detention when the deprivation of liberty cannot be justified.

Assumptions

- The person is in a place where care and treatment is available
- There has been no refusal by the Trust panel to an application for authorisation
- The Tribunal has not terminated the deprivation of liberty

SCENARIO 1: No application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- Staff take all reasonable steps to put in the additional safeguards of the MCA:
  - formal assessment of capacity; and
  - application to Trust panel.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 2: Application has been made to Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.
- An Application has been made to the Trust for Trust panel authorisation.

emergency provisions

Staff are protected from liability.

DoL can take place without risk of liability.

TIME LIMITS: There are no time limits to the use of emergency provisions
REQUIREMENTS: There must at all times be a reasonable belief of lack of capacity, best interests, that the DoL is to prevent serious harm and that the DoL is proportionate to the likelihood and seriousness of the harm.

SCENARIO 3: Decision has been made by Trust panel.

Action taken by staff:

- Reasonable belief of:
  - lack of capacity; and
  - best interests.
- Reasonable belief that:
  - the DoL is to prevent serious harm; and
  - the DoL is a proportionate to the likelihood and seriousness of that harm.

authorisation by Trust panel

Staff are protected from liability.

DoL can take place without risk of liability.

SCENARIO 4: Trust panel has made decision to refuse DoL

A DoL cannot take place.

Staff are not protected from liability.

SCENARIO 5: No steps taken by staff to put in safeguards

Staff are not protected from liability.

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Southern Health and Social Care Trust

Nosocomial COVID-19 Deaths Mortality Review Process

Version 1

Date: 23rd March 2021

Southern Health and Social Care Trust

Background

1. COVID-19 has been extensively documented as a particularly potent and virulent nosocomial infection that can spread easily in health care settings in part due to the increased susceptibility to infection among patients with co-morbidities and those who are immunocompromised.

2. As a result of the COVID-19 pandemic the Trust has experienced to date (23rd March 2021) 392 patient deaths where COVID-19 was recorded on either Part 1 or 2 of their death certificate.

3. As part a key element of Patient Safety, the Trust operates a Morbidity and Mortality review process that as part of its function reviews and quality assures the care we provided to our patients who die while resident under our care.

4. Given the scale and spread of COVID-19 and the subsequent number of deaths that record COVID-19 as a factor the Trust has developed a stratified review approach that utilises the Public Health Agency algorithm for assigning probability of COVID-19 resulting from nosocomial source, the Royal College of Physicians Structured Judgement Review and the regional Serious Adverse Incident review processes.

Mechanism of Review

The stages of the review process are as follows, a flow chart of actions is attached below

Identification of Patients with COVID-19 as a Cause of Death

5. Patients with COVID-19 recorded on their death certificate are held in electronic form by the MDO Patient Safety team. The Trust COVID-19 'App' allows for the automatic identification of patients according to the Public Health Agency definitions of Indeterminate, Probable and Define hospital onset of COVID-19.

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Information Collation

6. The Post Infection Review form will be initially pre-populated with patient information from electronic records by the MDO support team (Medical Technicians). The IPC team will review the content of the forms for completeness.
7. A Structured Judgement Review will be conducted by one of the Trust trained Medical reviewers, pending the outcome score a second, verification will be required if concerns in care are identified by the first reviewer.

Serious Adverse Incident Process

8. For those cases where the Structured Judgement review outcome indicates potential issues with care, the case will be considered for adverse incident screening and if required enter in to the Serious Adverse Incident review process.

Sharing of Learning from Nosocomial COVID-19 Mortality Reviews

9. Where learning has been identified from either post infection review, Structured Judgement Review or Serious Adverse Incident process this will be shared with Trust Morbidity and Mortality meetings and via other relevant Trust shared learning mechanisms.

Mortality Sign Off by M&M Chairs

10. M&M Chairs will be asked to suspend full sign off of cases either found to be a result of probable or define nosocomial transmission pending completion of the Nosocomial mortality review process.

Timescales for Delivery

11. It is anticipated that based on the number of cases requiring review this process will take approximately 3 months to complete.

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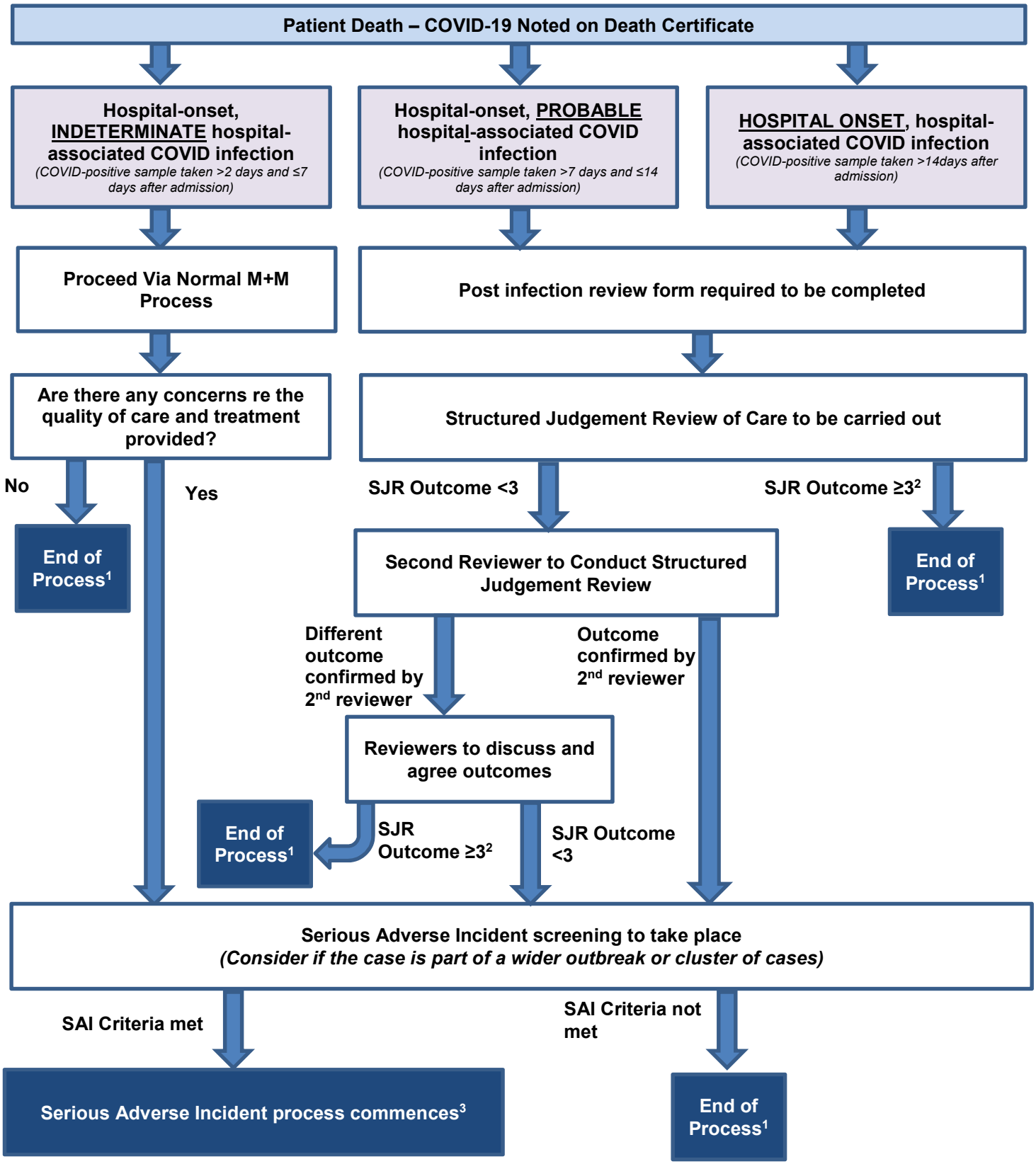
Appendix 1 - Nosocomial COVID-19 Deaths Mortality Review Process



[1]A Generic theme analysis will be conducted for all cases. Any relevant learning shared including via M+M. This will include areas of good practice and any assessment of problems identified.
[2] If there are there any concerns re the quality of care and treatment provided consideration should still given as to whether this reaches the threshold for an SAI?
[3]Any relevant learning shared including via M+M.

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Appendix 2 – Post Infection Review Form

Addressograph	**Confidential** (When completed) **COVID-19 MORTALITY Information (SHSCT)**

Name		**Gender**	**F/M**
HSC			
D.O.B		**AGE**	
Address			
Consultant			
Speciality			
GP			
Hospital of 1st Admission			
ED Admission	**Yes/ No**		
Planned Admission	**Yes/ No**		

DIAGNOSIS

Presenting complaint	

Patient outcome (at point of completing this form) tick appropriate

Fatal		**Non-Fatal**	

Frailty Score (if known)

Charlson co-morbidity score	

CURRENT ADMISSION

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Date of Admission	
Date of death	
No of days between death/ discharge and admission	

If admitted from a long term care facility, name of facility	
Was the facility known to have a COVID-19 outbreak at that time?	

PREVIOUS ADMISSION within 14 days prior to positive test: **YES/NO**
If YES, please give detail test

Place (please note location if known)	Date of Admission	Date of Discharge	Length of stay

MOVEMENT OF PATIENT DURING CURRENT ADMISSION Ward(s): Please list all the wards and bed moves with dates where the patient have been during this admission (including bed spaces)

Hospital and Ward	Bed location (BAY and BED NO)	Single room YES/ NO	Dates	Duration of stay

Total number of bed moves during episode, EXCLUDING ED:	**0**

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How long after covid positive test was patient isolated? (hours)	0

RISK FACTORS

Older age ≥ 70 years			
Cardiovascular Disease			
Chronic Respiratory Disease			
Renal Disease			
Diabetes			
Hypertension			
Cancer			
Chemotherapy or immunosuppressive agents and/or steroid			
Obesity: BMI: ≥ 30			
Smoker			
BAEM			
Other			

TESTING

Covid Type Result: Circle as appropriate	Group 1	Group 2	Other

	Yes	No	N/A

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Was a repeat of negative screen completed within 5-7 days?			
Repeat PCR Test prior to discharge to Care Home (if relevant)			

EXPOSURE HISTORY *before* patient's positive test within 14 days of positive COVID test

Hospital setting

	Yes	No	Not available
Patient admitted via Respiratory ED			
Please note time spent in ED if appropriate			
Did patient have any contacts in previous 14 days prior to positive test with a patient who subsequently tested positive?			

COVID 19 INFORMATION OF DEATH CERTIFICATE

Death Certificate information:	
Place of Death: Please tick out as appropriate	☐ Hospital ☐ in the community within 28 days
Part 1a	
Part 1b	
Part 1c	
Part 2	

Communication with Patient	YES/ NO
Communication with Patient's relative	YES/ NO

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M&M Summary Attached (if appropriate)	Yes

Additional Information and Comments

Root Cause Analysis

Root Cause Analysis			
Contributory Factors		Tick relevant boxes	
1. Communications and team working		6. Policy and protocol	
2. Training, skills and knowledge includes use of appropriate PPE		7. Care pathway: includes failure of appropriate testing	
3. Workload and staffing resources		8. Patient-derived risk factors	
4. Environmental conditions; includes cleaning		9. Treatment-derived risk factors	
5. Equipment and utilisable resources: includes re-use of equipment		10. Failure of isolation	
		11. Visitor factors (e.g. potentially contaminated items brought in by family members).	

Issues identified (provide and explanation of the contributory factors – enter under corresponding section number)	
1	
2	
3	
4	
5	
6	
7	
8	

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9	
10	
11	

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Lessons Learnt / Lapses in care

Action Plans / Changes in practice to prevent further cases

Further comments / Recommendation

Completed by			
Name: (print)		Job Title:	
Signature:		Date:	
Updated			
		Date :	

Additional information:-

Southern Health and Social Care Trust

Medical Directorate

Memorandum

To:	Mr Mark Lee, Director of Mental Health, Disability and Older People – Department of Health, Northern Ireland.
c.c.	
From:	Dr Maria O'Kane, Medical Director
Date:	17th May 2021
Subject:	**Royal College of Psychiatrists – Care Review Tool for Mortality Reviews**

Dear Mr Lee,

I am writing to detail work we are undertaking within the Southern Trust regarding the Royal College of Psychiatrists Care Review Tool for Mortality Reviews that is designed to review the care provided to patients and service users who have died by suicide. The review tool has the potential be used as an alternative review methodology to the existing Serious Adverse Incident process for deaths in mental health services.

As you may be aware, the Royal College of Psychiatrists developed the Care Review Tool through its centre for Quality Improvement. The tool is based on the Structured Judgement Review methodology (SJR), originally developed by the Royal College of Physicians. Please find attached the documentation regarding the Care Review Tool attached.

The SJR method asks reviewers to consider the strengths and weaknesses in the processes of the care and treatment provided to patients. It provides learning from care when it goes right, as well as identifying gaps, problems or difficulties for the patient when care goes wrong. The tool aims to allow Trusts to screen all deaths of patients who have been in contact with Mental Health services which would normally be subject to the SAI process, and help determine areas where good care can be recognised as well as recognise where care can be improved.

Following a RQIA/GAIN report, published in September 2019 entitled "*A Project Examining learning arising from Serious Adverse Incidents involving Suicide, Homicide and Serious*

Self Harm", some recommendations were made with regards to deaths from suicide namely:

Recommendation 3: "Incidents related to suicide should be taken out of the SAI reporting system. Trusts must continue to review suicides, using an appropriate level of review with discretion to escalate as an SAI when the trust deems it necessary to do so. Suicides that occur within an inpatient setting/trust facility must continue to be reported using the SAI reporting and learning system."

Recommendation 4: "A task and finish group should be established, with oversight provided by the Department of Health, to develop a standardised process for trusts to follow, for review of the suicide of an individual known to mental health services, that occurs outside an inpatient setting/trust facility and has not been escalated as an SAI."

With this in mind and in collaboration with the HSCB, the Trust has conducted a retrospective pilot review of 10 cases of deaths by suicides using the SJR method and detailed the outcomes. These cases had previously been subject to an SAI review. The SJR reviews were conducted by Dr John Simpson, Consultant Psychiatrist during March and April 2021.

Dr Simpson has provided a summary report on his findings from this pilot. I have enclosed these with this correspondence. Given the tangible benefits of this approach including the ability to identify learning themes in excess of the SAI process, I would be very interested in meeting to discuss this work in more detail including the potential for developing a further prospective pilot within the Southern Trust.

Yours sincerely

Personal Information redacted by USI

DR MARIA O'KANE
MEDICAL DIRECTOR / INTERIM DIRECTOR OF MENTAL HEALTH AND LEARNING DISABILITY SERVICES

Encs

Annual Professional Review

Job planning & performance pay for consultants

Dr Nick Murphy
Assistant Medical Director – Consultant Workforce

Building healthier lives

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University Hospitals Birmingham
NHS Foundation Trust

Context

- Changes to the consultant contract 2018
  - End of the LCEA system
  - Introduction of “performance pay”
- The merger of the Trusts
  - The development of single systems
- Development of Medic@Work 2

Consultant & employer

Appraisal

Job planning

Building healthier lives

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NHS Foundation Trust

Appraisal

- GMC
  - Assurance not excellence
  - Meeting a benchmark
  - Personal development
    - objectives
  - Revalidation

What does appraisal assess?

Appraisal requires the production of evidence relevant to GMP to support continued practice

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Job Planning – reviewed annually

- Timetable
  - DCC / SPA
  - Pay
- Declarations
  - PP, conflicts of interests
- Trust objectives

The job plan - document

- Timetable of activities
- Summary of total number of PAs of each type in timetable
  - DCC & SPA
- On-call arrangements i.e. supplement category and rota
- List of agreed SMART objectives (both DCC & SPA)
- List of supporting resources necessary to achieve objectives
- Description of additional responsibilities to the wider NHS and profession (including external duties)
- Any arrangements for additional PAs
- Any details of regular private work
- Any agreed arrangements for carrying out regular fee-paying services
- Any special agreements or arrangements regarding the operation/ interpretation of the job plan
- Any agreed annualised activity

DCC PAs

- Work directly relating to the prevention, diagnosis, treatment and on-going management of illness
- Scheduled emergency work and on-call
- Theatre sessions, including pre and post-op follow-up/review
- Out-patient clinics
- Formal ward rounds
- Informal ward rounds (which will be typically less than the duration of a formal ward round)
- Clinical diagnostic work
- Preparation time for MDT
- Clinical admin (dictation, reviewing results/ requests/referrals), request investigations, etc.

SPA PAs

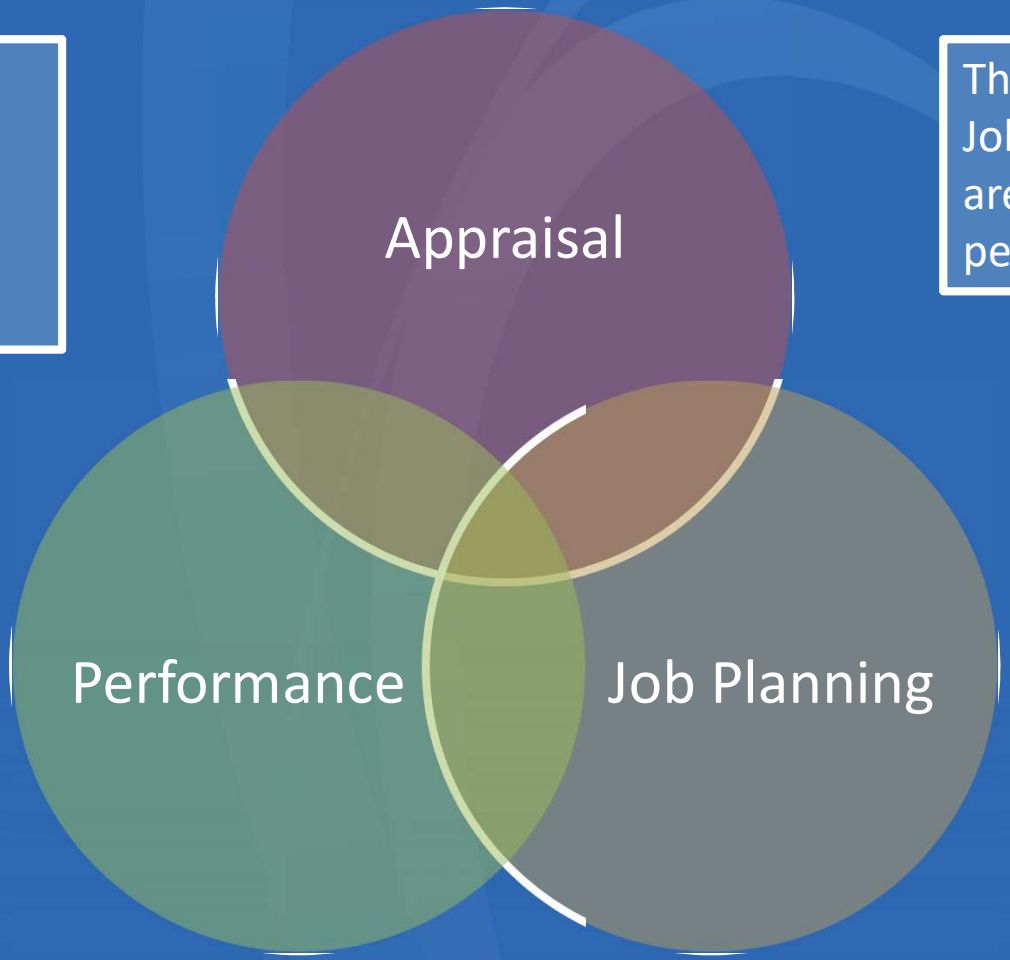
- Maximum of 2.5, unless agreed by DD or MD
- New starters get 2.0 in most specialties
- 1.0 SPA is minimum needed to meet CPD for revalidation
- Additional SPA time should be linked to organisational objectives, such as research, clinical management or medical education roles
- Based on SMART objectives and measurable outcomes
- Flexibility on location – how many hours “off site”?
- Should support the service

What is the annual professional review?

- Annual meeting with your clinical lead
  - Meeting with your employer
- Discuss contribution to Trust & how the consultant is performing & excels
  - How this might influence the job plan
- Combination of performance & job planning
- There is some overlap with appraisal

Appraisal, Job Planning & Performance

The collection of evidence for appraisal can be used to evidence performance



The completion of Job plan objectives are linked to performance

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Annual professional review

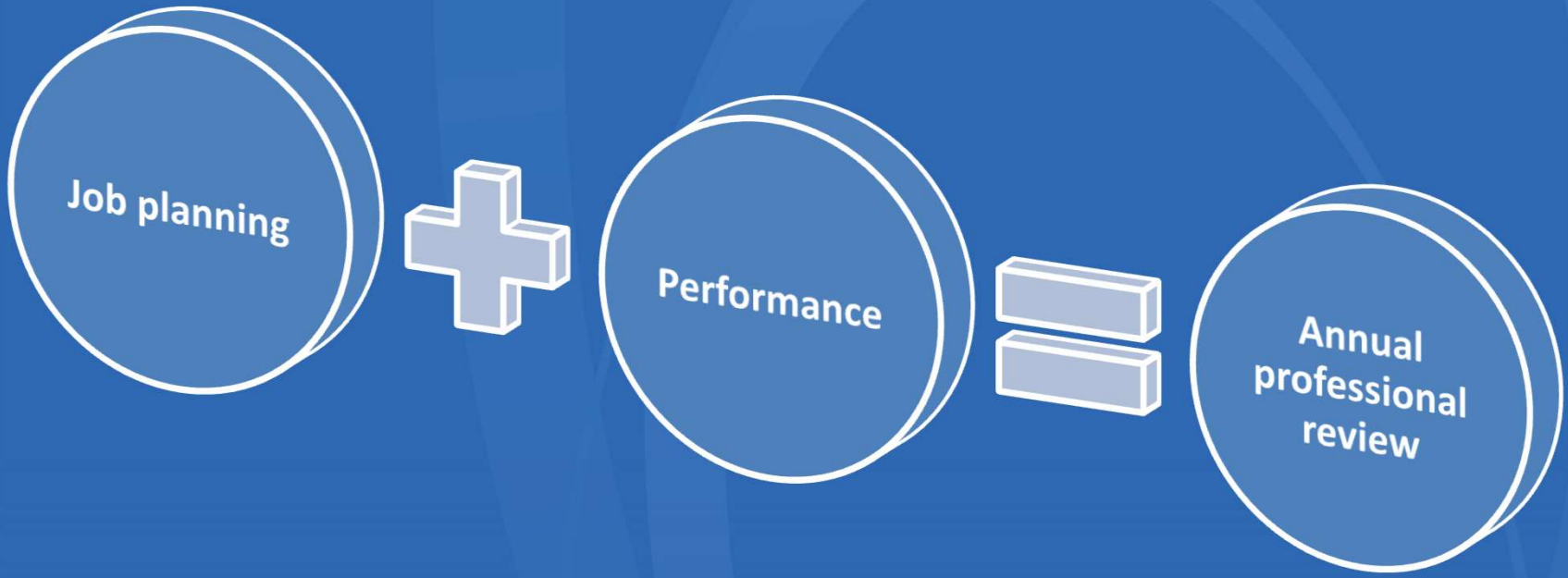

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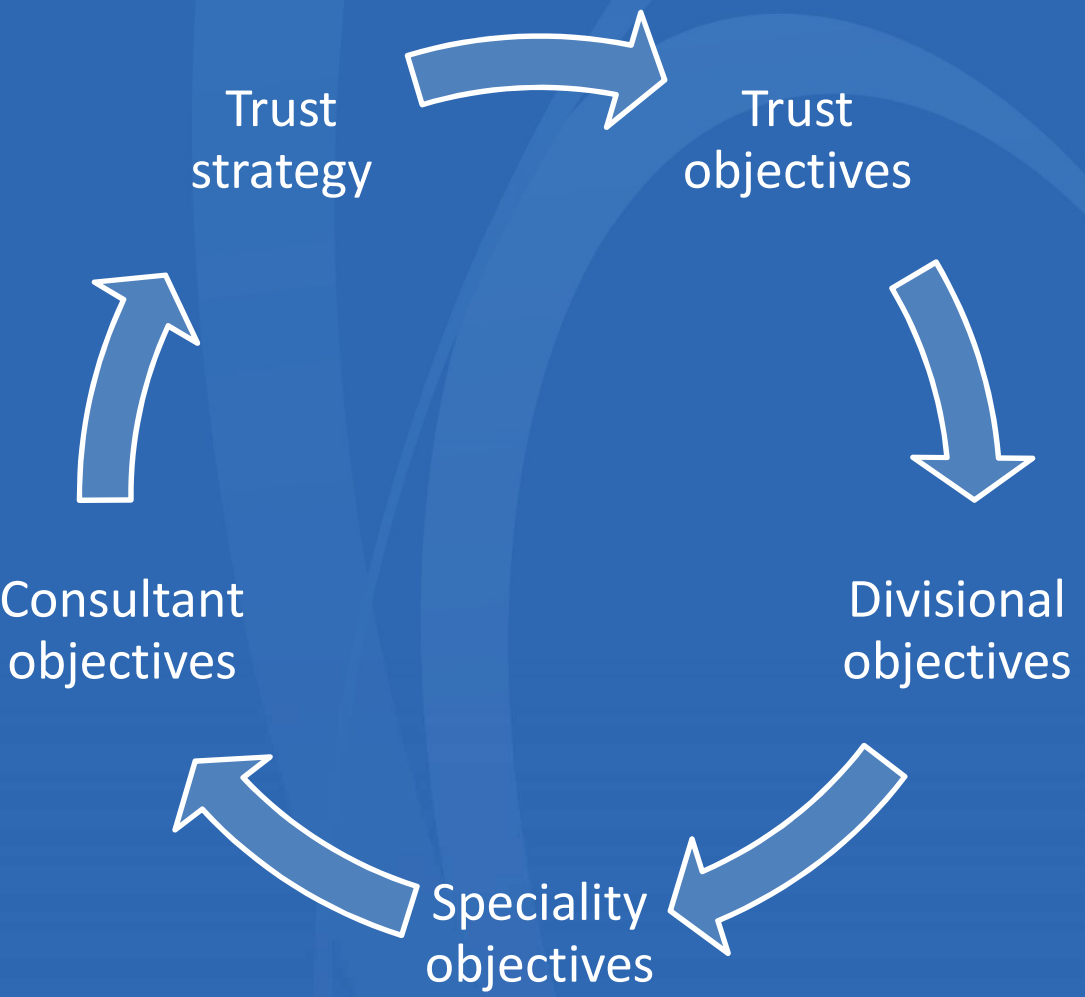
Figure 1: UHB's nine strategic themes from the multi-year strategy

Trust needs to be explicit in what it wants from consultants

- Delivery of the strategy
  - Integration of the Trust sites
  - Transformation of patient care
- Improved patient care & outcomes
- Increased productivity & efficiency
- Delivery of priorities – education & research
- Engage with Trust operational priorities

Annual cycle for delivery of strategy



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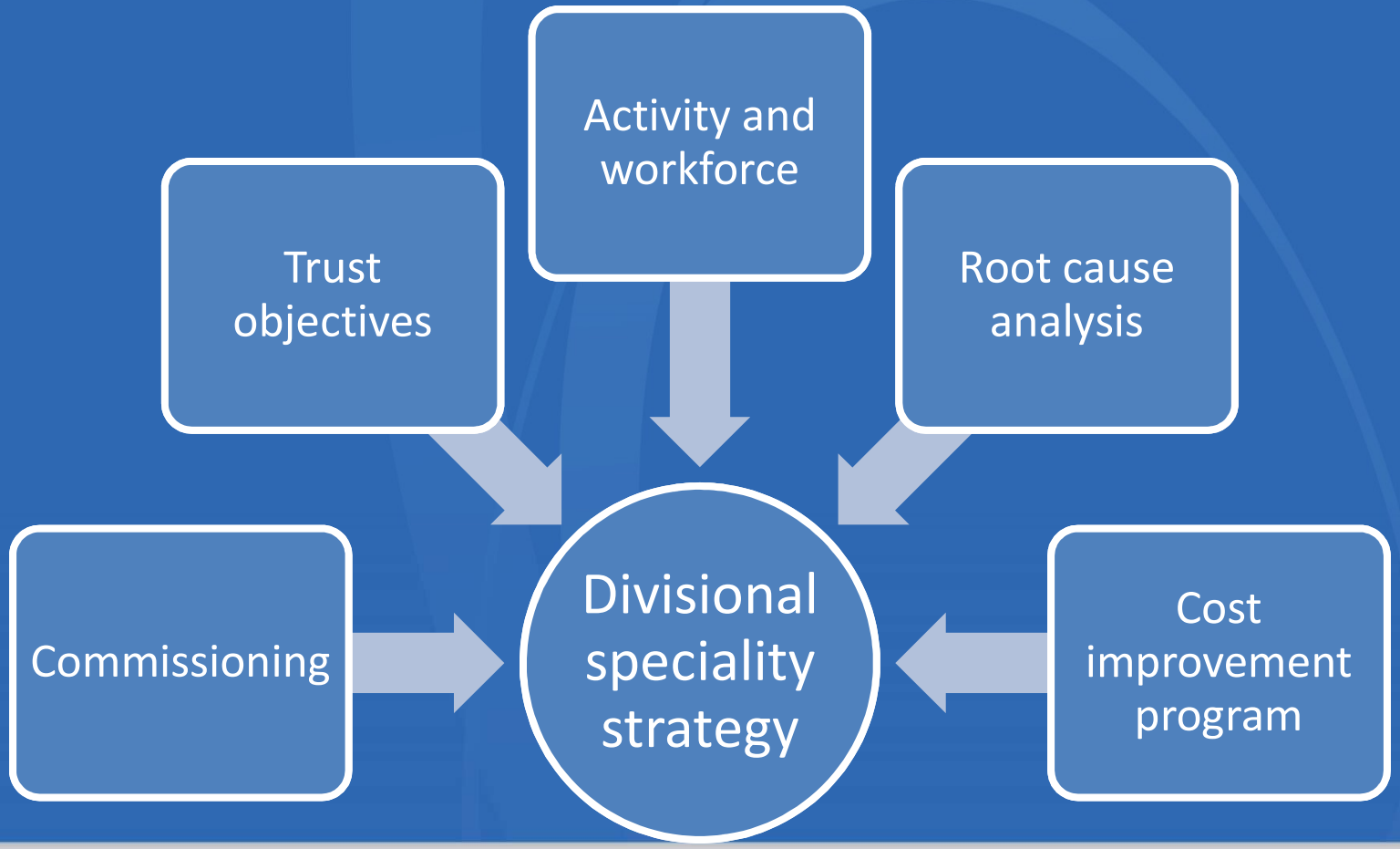
July – September The Divisions plan their priorities for the specialities

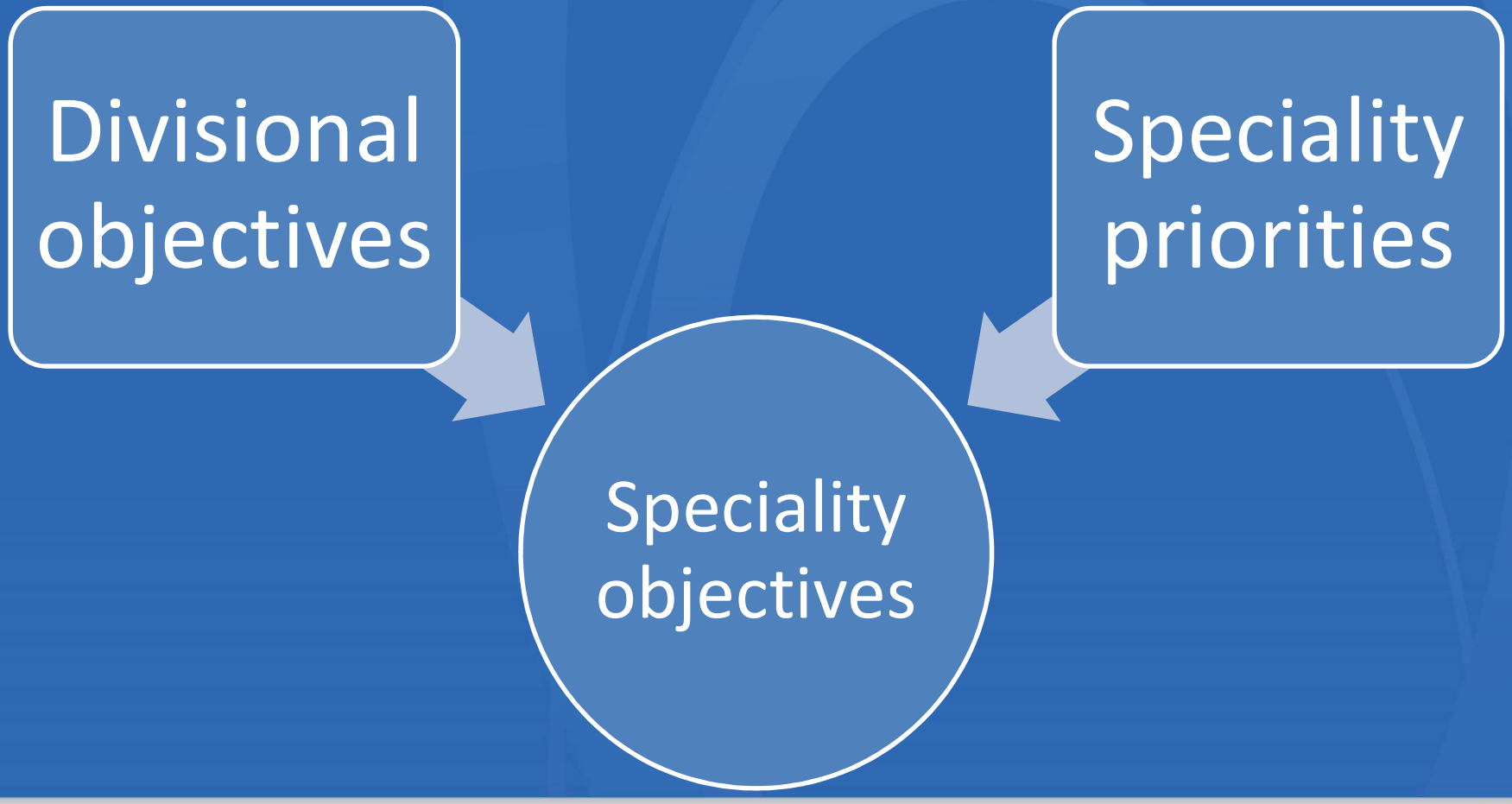


Team Job Planning (DCC & SPA)

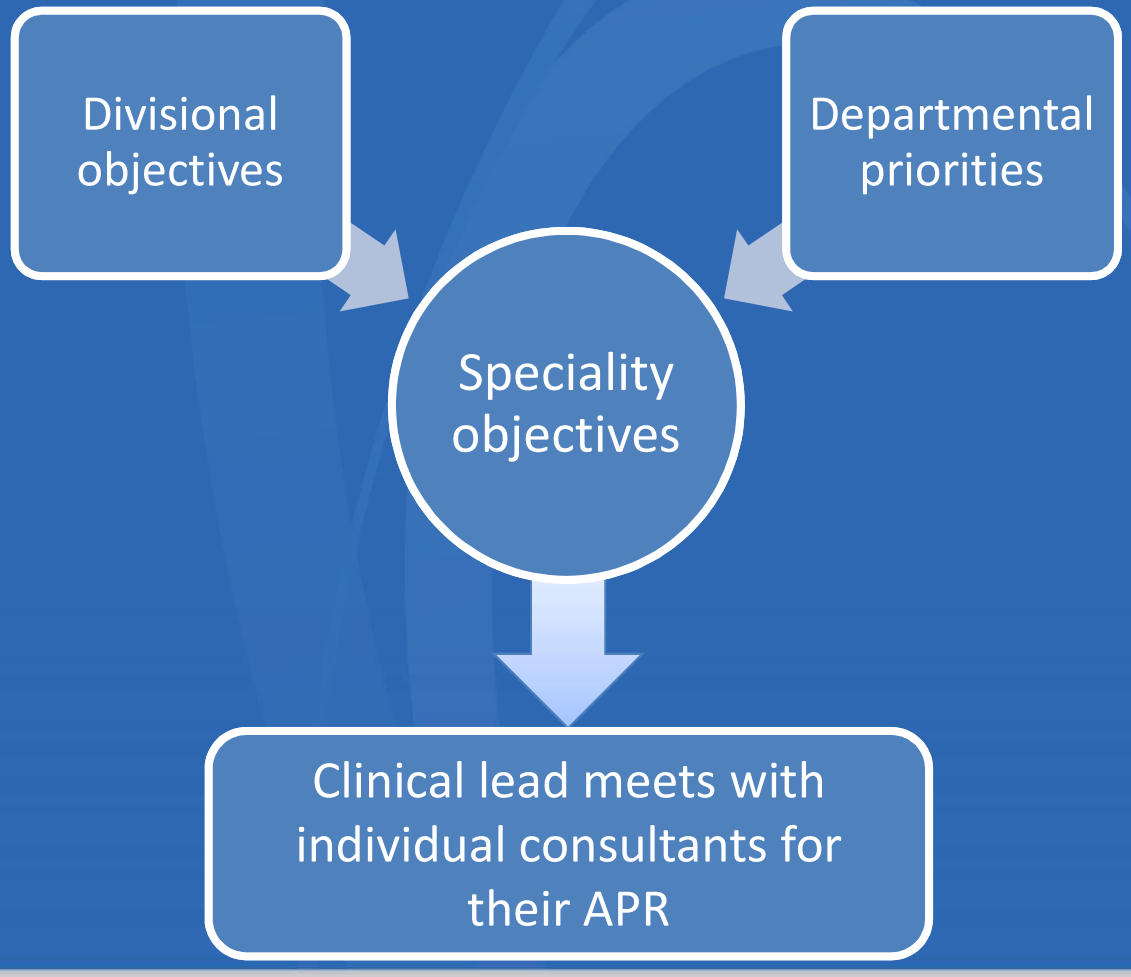
- What DCC activity needs to be delivered, how and when for the department
- What SPA activity do we need to deliver as a team
  - Medical student teaching
  - Educational supervision
  - Audit Lead
  - College Tutor
  - Governance, safety, mortality review
  - Coding
  - Innovation
  - Pathway redesign / transformation
  - Research

July – September, specialities meet and plan their priorities

September – October, divisions and specialities meet and agree objectives for the year



October - December, clinical lead meets with individual consultants



Key questions to consider by the Trust

- What is the present demand?
- What is the capacity?
- What is the pattern of demand?
- What is the actual activity and gap if any?
- What is the future demand?
- What is the quality of the activity?
- What is the patient experience of the activity?
- Can we deliver the service efficiently?
- How do reduce WLIs, outsourcing, temporary spend?
- What are the risks associated with the activity?
- Does payroll tally with job plans?
  - If not where are the discrepancies?

What can effective APR deliver

- Better ward cover
- Uniform cover Monday - Friday
- Daily Consultant rounds
  - Decreased LOS
  - Right care, right place, right time
- Less theatre / OPD cancellation
- Better training
- A research agenda for the specialty
- Better matching of capacity and demand
- Flexible working / annualised type plans where appropriate
- Increased 7 day working – especially in unscheduled care areas
- Reduced WLIs, locums, improved efficiency, better WLB

Practicalities (1)

- Step 1
  - Be knowledgeable of trust objectives and service requirements
  - Read the Trust job planning policy!!!
- Step 2
  - Develop team / service objectives
  - DD meet with the CSL agree what service objectives for the year
  - Discuss how this should be translated into consultant JPs with the team

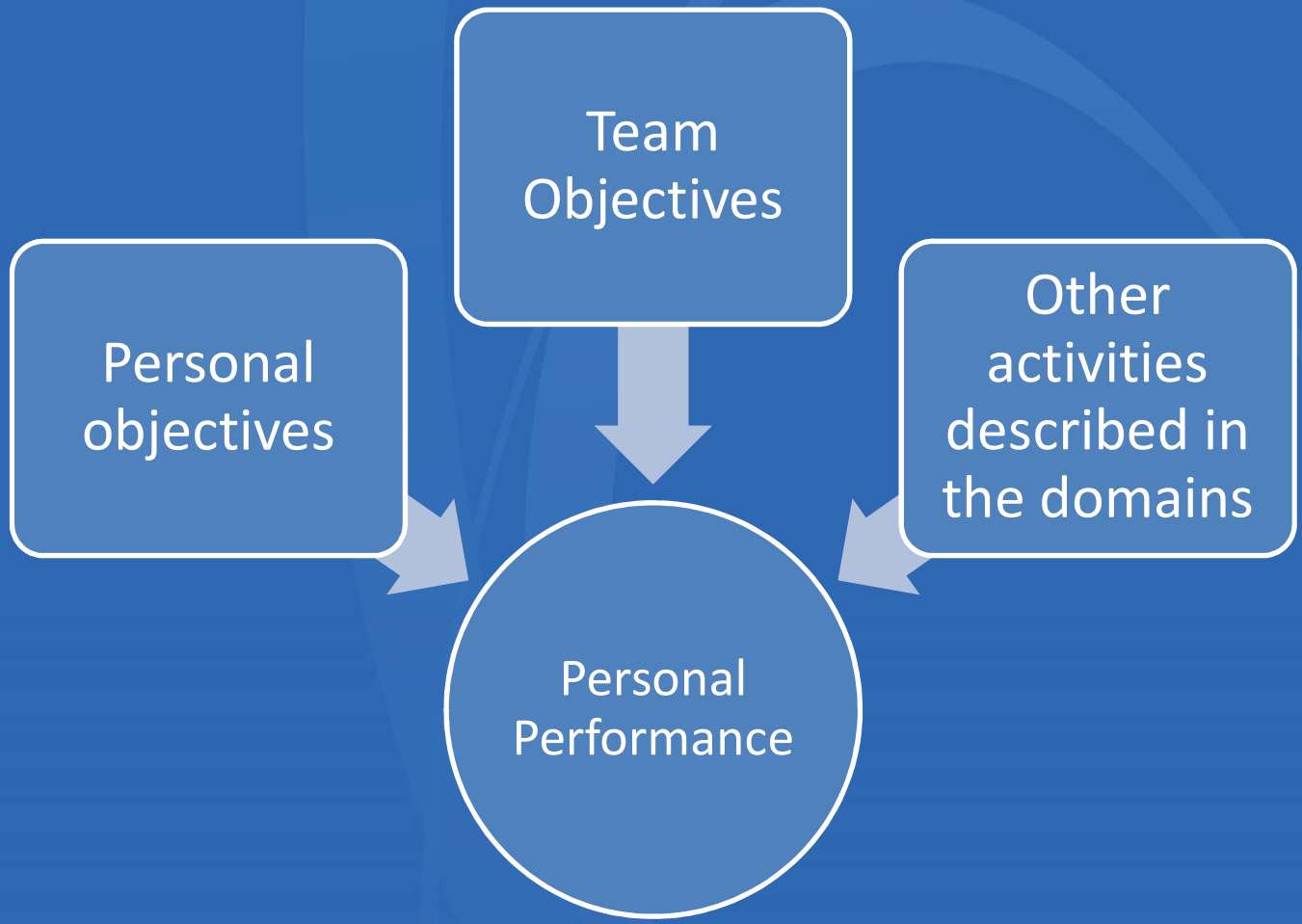
Practicalities (2)

- Step 3
  - Remove duplication in SPAs
  - Ensure all SPA roles are supported by Trust
- Step 4
  - Individual Objectives
  - Individual Job Plans
- Step 5
  - Ensure together individual plans deliver the whole

What's new about the new reward scheme?

- Focused on local priorities
- More local control over detail
- Enable an operational focus to performance as well as clinical
- Series of domains
- Some will be nationally defined
- Some locally defined

Consultant uses a range of evidence to describe how they excel in their role

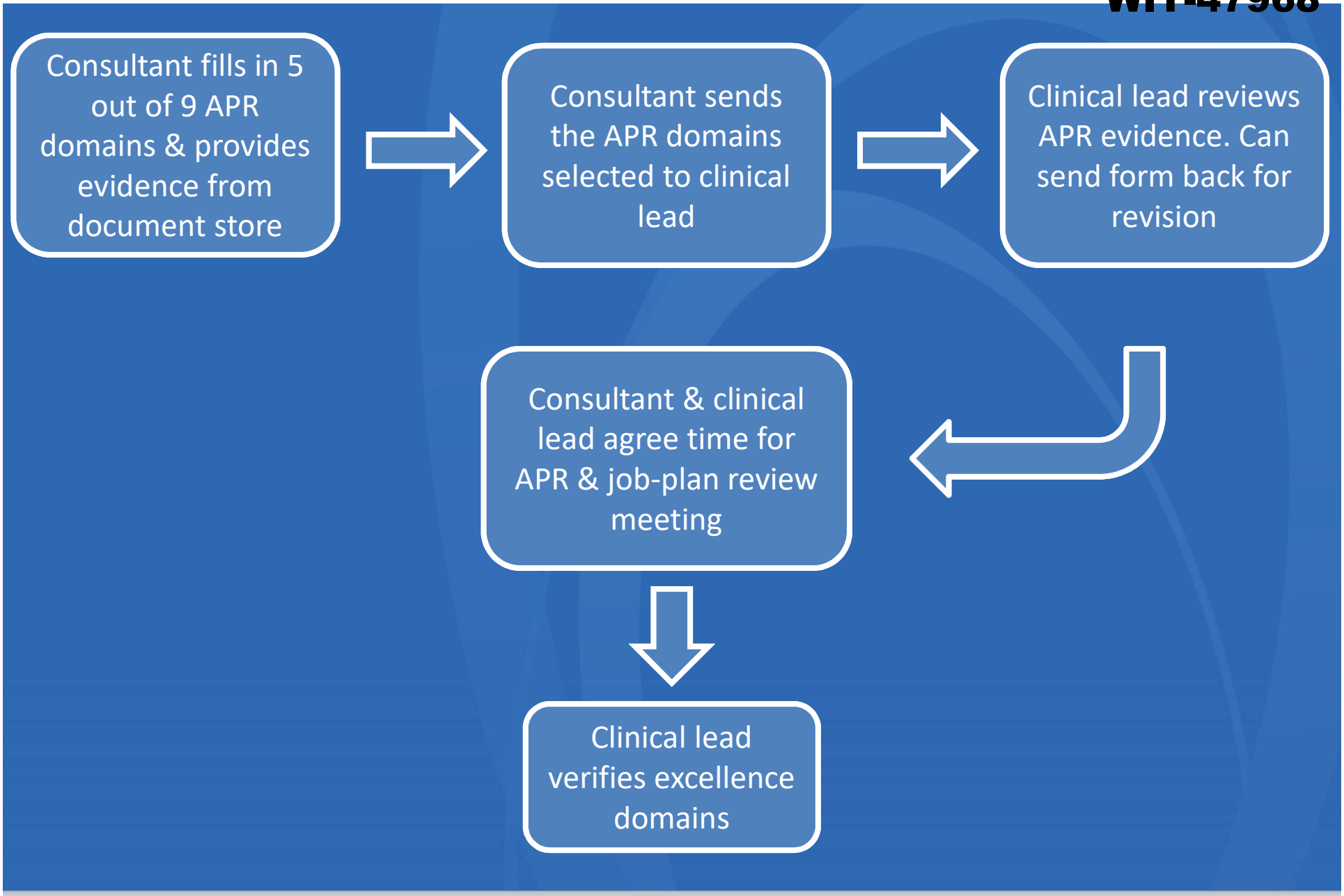


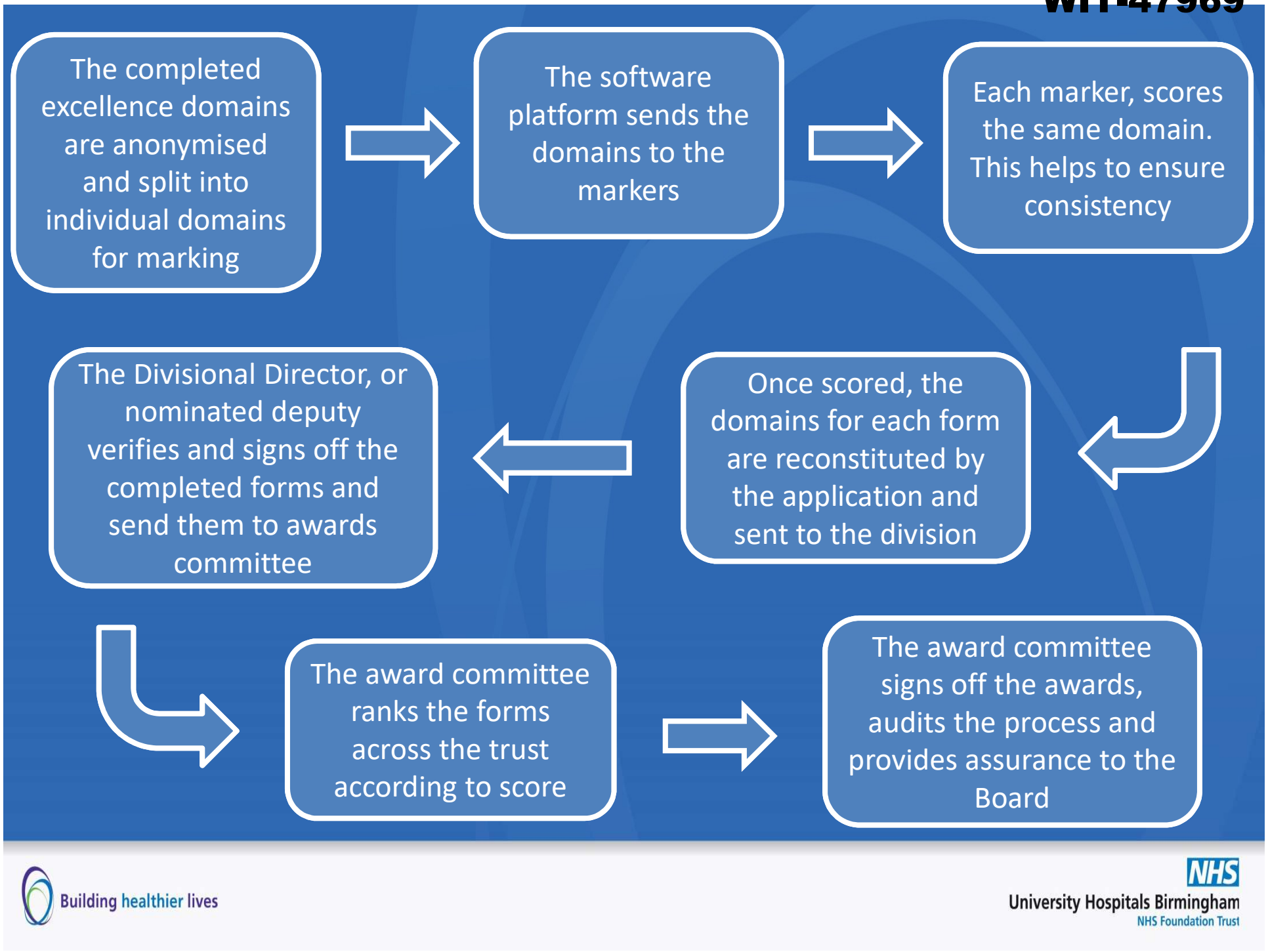
APR meeting

- Set any prospective objectives linked to Trust strategy
- Review last year
- Domain system used to describe and assess objectives & other activities
  - Consistency in approach
  - Enable objective scoring

Possible domains

- Delivering an excellent patient experience
- Ensuring patient safety
- Advancing healthcare through research
- Developing a world-class workforce
- Managing and leading in healthcare
- Education and teaching
- Delivering cost-effective healthcare
- Working across systems and collaborating with other providers
- Improving healthcare through innovation





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MEDICAL REVALIDATION OVERSIGHT GROUP

TERMS OF REFERENCE (20th April 2021)

Purpose

Medical revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practice. A cornerstone of the revalidation process is that doctors participate in annual medical appraisal. On the basis of this and other information available to the Trust Responsible Officer (RO) from local clinical governance systems and additional feedback mechanisms, the RO makes a recommendation to the GMC, normally once every five years, about the doctor's revalidation.

The purpose of the Trust Medical Revalidation Group (the Group) is to provide a forum for Trust Medical Senior Management Team members to consider and inform decision regarding medical revalidation of Trust licensed doctors.

Aim and Objectives

The aim of the Group is to ensure that decisions regarding Medical Revalidation are consistent, robust and quality assured by the relevant Trust Senior Medical Leader. To meet this aim each relevant Associate Medical Director / Divisional Medical Director for doctors under their leadership will:

- Provide assurance that opportunities for reflection, learning and development e.g. significant events and complaints have been adequately discussed and reflected on appropriately at appraisal
- Ensure there is has been a formative approach taken to the doctors appraisal process and there has been an appropriate level of engagement by the doctor
- Ensure outputs are adequate and identify if additional time is required to review a doctor's portfolio before the RO's decision prior to the revalidation recommendation date
- Assure that all summaries from all sources accurately reflect the doctor's work and if the documentation is inadequate, advise the responsible officer allowing for an informed decision to be made regarding a recommendation for revalidation

- Bring to the attention of the RO any additional information that has not been captured in other sources that require the consideration of the RO prior to making a revalidation recommendation.

Membership

Members of the group shall be made up of:

- Medical Director (Chair)
- Deputy Medical Directors
- All operational Associate Medical Directors / Divisional Medical Directors
- Assistant Director – Medical Directors Office

Others may be invited by the Chair to attend all or part of any meeting as and when appropriate and necessary.

Quorum

The quorum necessary for the meeting will be each AMD / DMD or nominated deputy for each operational area.

Members should aim to attend all meetings.

Frequency of Meetings

The Group shall meet via Zoom on a monthly basis.

Group members will receive agenda and papers confidential to their area no less than five working days in advance of the meeting.

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Private Practice / Medico-Legal Structured Reflective Template

Principles agreed by the Academy of Medical Royal Colleges April 2020

Name of doctor: GMC No:

Date reflective template completed: Appraisal Year:

Where have you undertaken your private practice / medico-legal over the last twelve months? (Tick all that are appropriate)

	Y/N	Estimated % of Private Practice
NHS Hospitals	☐	
Independent Clinics	☐	
Home / Domestic Premises	☐	
Virtual Clinics	☐	
Medico-Legal Work	☐	

Job Planning – Is your private practice / medico-legal activity fully declared in your Trust job plan?

Medical Protection / Indemnity Arrangements
Describe your arrangements for medical protection / indemnity regarding your medico-legal / private or independent practice? GMC requires private practitioners to arrange adequate and appropriate insurance or indemnity (even if this work takes place on NHS or HSC body premises). This applies even if the work is in addition to work you do for an NHS or HSC body.

Scope of Practice – Describe the nature of your private practice / medico-legal work (Consider factors including; are you doing a low volume of work of this type? Are you deliberately limiting your scope of practice? Are you returning to this type of work after a prolonged break for some reason?):

Volume worked in the last twelve months – How much private practice / medico-legal work have you undertaken over the last twelve months of practice?

(Is your work evenly spread throughout the year or do you regularly have significant breaks e.g. > 6 weeks? Please describe your annual arrangements. When was the last time you did any work of this type?):

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Experience

What prior experience do you bring to this role? How long have you worked as a qualified doctor in this type of work?

And/or If appropriate, explain how many skills based clinical procedures of this type you have done in the past and how you have kept your skills up to date.

Duration of working in this way and future plans

How long have you been working in your current way, and what are your plans?

- If you do a low volume of work in this role, will you increase, maintain or decrease the volume of your work over the coming year?

And/or

- If you have a limited scope of practice, will you be changing this over the coming year?

And/or

- If you are coming back to work after a prolonged absence, what induction and support will you have / have you already had?

Record Keeping

Please describe how you manage and process private practice / medico-legal records

- As a private practitioner who collects and holds information about patients have you registered as a data controller with the Information Commissioner's Office?

- What processes do you have for responding to a Subject Access Requests? - that is, a request for access to the notes you hold about a patient. The request could be made for a number of different reasons, including clinical negligence claims.

- What processes do you have to meet requirements of General Data Protection Regulation 2018 (GDPR) and Department of Health Code of Practice for Records Management. Although, as a private practitioner, you are working outside the HSC / NHS, and are therefore technically exempt from the Public Records Acts, the GMC guidance in 'Confidentiality' (2009) makes clear that everyone should use the retention schedule and does not distinguish between private and HSC / NHS records.

- If you are planning to end your private practice, as long as you hold information, you will need to be able to fulfil your duties as a data controller under GDPR. Please give details of your arrangements to meet this requirement

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Overlap with other roles
Please describe the overlap between this part of your scope of practice and other roles you may currently have / have recently had. How well does the experience from your other roles help you to maintain your knowledge and skills for this one?

Benchmarking, integration and support
Are you able to compare your scope of practice in this role with that of your peers? For example:
Do you receive organisationally generated data on your activity which compares you to your peers? Do you meet regularly with your peers to discuss your work, e.g. multidisciplinary team meetings? Do you have easy access to support and advice from your peers (either through work or externally)?

Personal approach to risk and governance around your private practice
How do you limit the impact of your private practice / medico-legal on any risk to your patients?

Do you regularly ask for patient feedback that is undertaken by an independent body and can you provide examples/statistics?

What arrangements do you have in place to stay within the boundaries of your competence?

If you move around, what actions do you take to ensure you have access to adequate induction and systems information?

How do you ensure you are informed promptly of complaints and any other patient safety incidents? And, how do you report these to the organisations you work in?

Continuous Professional Development (CPD)
Please describe how your approach to CPD helps to ensure you are up to date for your scope of practice.

Does your CPD give you an ongoing exposure to the breadth of your potential workload such as to mitigate any reduction in experience?

Do you access any other learning through groups or social media discussion forums? Do you rely predominantly on advice from peers on site?

Are you able to confidently access up to date, authoritative factual information about issues relevant to your scope of practice?

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Actions

Going forward are there any further actions you feel may be necessary to ensure you retain your competencies across your scope of practice and support your development?

You may wish to formulate these as ideas for a Personal Development Plan or as actions to take forward with your employers in relation to the governance around your role

Feedback after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

Stinson, Emma M

From: OKane, Maria
Sent: 09 December 2020 11:01
To: Wallace, Stephen
Subject: FW: IPR's

Can we discuss???

From: Gibson, Simon
Sent: 09 December 2020 08:44
To: Reid, Trudy; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

See below

Individual Performance Review

Kind regards

Simon

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

From: Reid, Trudy
Sent: 09 December 2020 08:44
To: Gibson, Simon; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

Simon I have a mental block, what is it?
Trudy

From: Gibson, Simon
Sent: 09 December 2020 08:28
To: OKane, Maria; Wallace, Stephen; Reid, Trudy
Subject: RE: IPR's

P>S – If you don't have one, I'm sure we could all help you put one together as a baseline document

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI (DHH)

From: OKane, Maria
Sent: 09 December 2020 08:26
To: Wallace, Stephen; Reid, Trudy; Gibson, Simon
Subject: FW: IPR's

What are iprs?

From: Devlin, Shane
Sent: 08 December 2020 11:07
To: Beattie, Brian; Magwood, Aldrina; McClements, Melanie; McNeany, Barney; OKane, Maria; O'Neill, Helen; Morgan, Paul; Toal, Vivienne; Trouton, Heather
Cc: Alexander, Ruth; Campbell, Emma; Stinson, Emma M; Gilmore, Sandra; Griffin, Tracy; Mallagh-Cassells, Heather; Livingston, Laura; PADirectorofP&RSHSCT; Willis, Lisa
Subject: IPR's

Dear All

At our next 1:1 meetings we will be discussing IPR's for 2019/20 and 2020/21. Can I ask that you do two things in advance of the meeting.

1. Please review your 2019/20 IPR noting achievements (up until 31st March 2020) and forward to me.
2. Based on 2019/20 IPR produce for 2020/21 a roll forward of those items not achieved in 2019/20. I would then suggest a general statement, which I will prepare, to go into all IPR's with regards to managing the organisation through the COVID-19 pandemic

Given the year of COVID we have had, I think this is a fair approach to IPRs for 2020/21.

We will for 2021/22 have a modified approach and I will discuss this further.

Many thanks, Shane

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability
Candour	1	A statutory duty of candour should now be enacted in Northern Ireland so that: *(i) Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public.* *(ii) Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.* *(iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).* *(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.* *(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.* *(vi)Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.* *(vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.*	Regional update of IHRD Implementation Plan Work stream 1: Duty of Candour Staff views 5.1 Learning Culture Structure and Process Clarity simplicity and Consistency within organisations and Regionally Open Communication accesable systems clear processes Barriers fear of repercussions lack of resources lack of consistancy streamlining required -link to 9 Opinion is sought from staff around various developments, for example Trust response to COVID. Need to continue to encourage staff to be open and give their honest opinion. Re this piece of work site requires permissions to view-this is not in keeping with cultural shift toward inclusion and openness as required by being open. Strict hierarchy remains - consider membership of e.g. Bronze COVID Group. Need to use this opportunity to include a variety of staff patients and service users into this work to show by example that openness is welcomed in Trust. Consider responses in section 5 and 5.5 in particular. Independent advocacy support identified. in place. Regional Duty of Candour Group are looking at options re brining work forward. Working group service users and carers set up to develop guidance as part of framework for openness Introduction of Duty of Candour will require Minisrterial and Executive approval prior to introduction to Assembly No timeframe identified. Trust to work on Culture of openness in meantime	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	Vivienne Toal and Maria O'Kane to link Send instruction + Template to VT	Viviene Toal	Human Resources
Candour	2	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.	Awaiting Regional action. Joint statement re Duty of Candour NMC and BMA reviewed and clearly identifies requirement. HR contacted re job discriptions	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	3	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.	Awaited	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	4	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.	Standard requirement of Professional Codes therefore staff should be aware	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	5	Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.	Most JDs refer to abide by professional code therefore implicit see link to HR base position Meetings to be arranged with VT + Team and pF	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	6	Support and protection should be given to those who properly fulfil their duty of candour.	Will link this with second phase when focus on SAIs as much work done from Donaldson Report onwards	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources
Candour	7	Trusts should monitor compliance and take disciplinary action against breach.	Further Regional work required Regional update December 2019 says recommendation 5+7 will bedelayed until statutory DoC completed	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources

Candour	8	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.	RQIA remit sub-group Department has developed a "principles of Regulation" Policy consultation document out 2020 second stage to look at role and powers and new role from IHRD implemmentation programme Link to recommendation 86 Articles 5 and 35 of RQIA founding legislation offer them leeway to do this already under statutory framework. Update of functions contained in IHRD Update Dec 2019 pg 22	RQIA Led Recommendation Parked at minute	Fill in Template□ Check Regional position with Karen Jeffrey		
Leadership	9	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.	Should be ongoing in SHSCT multiple initiatives across region which Trust taps into some such as Nightengale challenge innovative but curtailed by COVID. As with all leadership inextrpically linked to communication and shared values of Trust. Suggest we scope all internal and external pieces as spring board to further developments. COVID restrictions has required new ways of working which can be built upon to look at leading through innovation and change. Collate Directory of Leadeship activities/opportunities	Directorates to feedback to Director of HROD and SMT	VT will link this to Leadership strategy through SMT Resend Template to Vivienne > all Transfer templates can be filled at one meeting with her (had tried to arrange to no avail) Suggest try to arrange a face to face meeting and merge templates at this	Viviene Toal	Human Resources
Paediatric - clinical	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.	SHSCT version of Regional Policy required 3 appendicies to be completed. Same developed -sign off at meeting. Link to training programme Nurse training considered -will be detailed in Training update.Medical AHP and Pharmacy programmes to be determined- links to be identified and level of training agreed. Re Nursing scoping exercise re wards outside CYP that take 14-16 and 16-18 undertaken for future evidence and clarity (BSO report ID'd discrepancies in wards listed in various documents. Audit of current state re 10-30 in CYP and Acute wards has been piloted _results via audit update. Many aspects will be updated	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Clinical Templates need completed	Bernie McGibbon	Children & Young People
Paediatric - clinical	11	There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.	Transfer information- included in audit and updtaed by BMcG for presentation	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.	Clarity obtained by BMcG again will be presented by her for sign off	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	13	Foundation doctors should not be employed in children's wards.	Compliant	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.	Emails to HR a- litle more teasing out around Nursing(A/L timings rather than complexity) - essentially interview and shortlisting should ID history and requirements. Unreasonable to expect all Nurses to be assessed prior to employment in Acute. Deficits in training can be addressed via Mandatory + specialised additional training. Cross ref with training Matrix Identify aditional Learning Needs through Supervision, appraisal and self reflection. Medical training not explored as yet.	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Needs to stay as wider than IHRD Await response from Joanne Bell's email to Ronan (25 05 21) then update template will need to involve Maria Heather Bernie Acute Rep + ID the lead	Bernie McGibbon	Children & Young People
Paediatric - clinical	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Await response from Joanne Bell's email to Ronan (25 05 21)	Bernie McGibbon	Children & Young People
Paediatric - clinical	16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People

Paediatric - clinical	17	Any change in clinical accountability should be recorded in the notes.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	This needs to be considered by Damian in conjunction with no 29	Bernie McGibbon	Children & Young People
Paediatric - clinical	18	The names of all on-call consultants should be prominently displayed in children's wards.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	20	Children's ward rounds should be led by a consultant and occur every morning and evening.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	21	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.	Included in Audit and possibly covered within BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.	Included in Audit. Also discussed with PCE leads around potential developments	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.	Included in Audit note does not say must be kept says available therefore audit guidance has covered this	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People
Paediatric - clinical	24	All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart	Included in audit -may need guidance following audit of Adult wardsIncluded in audit -may need guidance following audit of Adult wards	Remains on Hyponatraemia agenda. Above leads to process map and bring back to Hyponatraemia Oversight Group	Joanne Bell has undertaken extensive preparatory work. Get updated Template from Joanne	Joanne McConville	Patient Data Safety
Paediatric - clinical	25	All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction the pharmacist should inform the prescribing clinician.	Statement unsafe see response from pharmasist in email and covering draft sign off statement for Oversight Group	Transferred to Dr Tracey Boyce Pharmacy	Paula had sent to Tracey	Tracey Boyce	Pharmacy
Paediatric - clinical	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.	Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Also link this to 17 and 29 from Dr perspective PACE audits should show from Nursing perspective	Bernie McGibbon	Children & Young People
Paediatric - clinical	27	Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care.	The Regional Encompass Contract has been awarded to EPIC. Implementation will be staged and undertaken in one Trust at a time. SET first October 2022 then BT others not decided as yet so we will realistically need to consider prior to this	Parked - Awaits Regional Encompass System	Await response from Mark Toal		
Paediatric - clinical	28	Consideration should be given to recording and/or emailing information and advices provided for the purpose of obtaining informed consent.	The SHSCT has no concerns regarding this recommendation provided the relevant guidance is followed and any procedure for the emailing of personal identifiable information is followed	Remains on Hyponatraemia agenda until update is received from Catherine Weaver, Information Governance	email and response from Catherine Weaver Hof IG. Will now separate this recommendation in 2		
Paediatric - clinical	29	Record keeping should be subject to rigorous, routine and regular audit.	Nursing as per KPS and NOAT audits also current IHRD Baseline Audit Also yearly Medicines audit. Position around Medical notes not determined as yet see Draft statement	Remains on Hyponatraemia agenda until further work is explored in relation to Medical Audits. Dr Gormley to link with Stephen Wallace with the aim of creating a Clinical Audits programme and feedback to Medical Director	email to DG + Stephen Wallace Remember to include 17 + 26 + 28 in conversation	Joanne McConville	Patient Data Safety
Serious Adverse Clinical Incident Reporting	30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.	This is in addition to DATIX and hasn't been explored yet	Remains on Hyponatraemia agenda until definite lead agreed	Check with Viviene Toal	Viviene Toal	Human Resources

Serious Adverse Clinical Incident Reporting	31	Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').	SAI work not undertaken by me- second stage as quite aware of it and that following Dondaldson review required changes are in progress. Good links established to progress. If Oversight Group in agreement initial position can be got through recommendation email question and subsequent sign off of draft position or identification of Actions required and Plan with date for completed Actions/update devised 31-42 inclusive	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Connie and Caroline will have main Lead for these recommendations> Majority transferred to their own work plans. DC Need to go through the Transfer Template with them	Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Reporting	32	Failure to report an SAI should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Hyponatraemia Lead to link with DoH	Viviene Toal	Human Resources
Serious Adverse Clinical Incident Investigation	33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	34	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	35	Failure to co-operate with investigation should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Paula Fearon to complete	Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	36	Trust employees who investigate and accident should not be involved with related Trust preparation for inquest or litigation.		Transferred to Litigation	Check with Viviene Toal and Lynne Hainey	Viviene Toal	Human Resources
Serious Adverse Clinical Incident Investigation	37	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints. (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation. (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress. (iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases. (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports. (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive. (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing. (viii) Family GPs should, with family consent, receive copies of feedback provided. (ix) Families should be formally advised of the lessons learned and the changes effected. (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and	Cross Link with 22; 43-47; 52; 54; 59-60; 62	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37i	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator			

Serious Adverse Clinical Incident Investigation	37ii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37iii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37iv	A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37v	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37vi	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37vii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37viii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (viii) Family GPs should, with family consent, receive copies of feedback provided.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37ix	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ix) Families should be formally advised of the lessons learned and the changes effected.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	37x	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	38	Investigations should be subject to multi-disciplinary peer review.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	39	Investigation teams should reconvene after an agreed period to assess both investigation and response.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	40	Learning and trends identified in SAI investigations should inform programmes of clinical audit.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.		Remains on Hyponatraemia Agenda until a discussion paper is created taking Duty of Candour into consideration. Discussion paper to be drafted by C&SCG, Litigation and Information Governance to be presented to the Hyponatraemia Oversight Group	Caroline should give you this in due course	Connie Connolly	Corporate Governance
Serious Adverse Clinical Incident Investigation	42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance

In the event of a Death related to a Serious Adverse Clinical Incident.	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.	Response Trust Bereavement Lead While Trust procedures include timely notification to the GP following all patients' deaths, I am not aware whether Dr to GP discussion routinely takes place in SAI's. Bereavement information packs are in place across the Trust with the expectation that these are provided to relatives when a person dies. Additional resources are in place within wards and on Sharepoint including information on the Coroner's service when the Coroner is involved. The bereavement team contacts the next of kin following all hospital deaths within 2 weeks of the person's death. The team has limited information on the person's death. The bereavement co-ordinator is willing to provide a bespoke telephone response to families in the case of SAI's should a specific referral process be put in place. Appointment of the Corperate Service User Liaison post will enhance bereavement support to families.	Transferred to Bereavement Coordinator with input from Corporate CSCG Coordinator		Sharon McCloskey	Bereavement
In the event of a Death related to a Serious Adverse Clinical Incident.	44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family.	This is being addressed regionally BY DoH. The Trust Bereavement Co-ordinators have contributed to amending the regional post mortem consent policy/procedure and the post mortem consent forms. A process for securing the second signature is being finalised. This work has been delayed as a consequence of COVID-19.	Transferred to Deputy Medical Director	Meeting with Damian Gormley and Sharon McCluskey		Deputy Medical Director
In the event of a Death related to a Serious Adverse Clinical Incident.	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.	As above-this is being coordinated regionally by DoH	Transferred to Deputy Medical Director with input from Bereavement coordinator	Regional check with Karen		Deputy Medical Director
In the event of a Death related to a Serious Adverse Clinical Incident.	46	Where possible, treating clinicians should attend for clinic-pathological discussions at the time of post-mortem examination and thereafter upon request.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Deputy Medical Director to lead further discussion for decision on transfer to Divisional/Deputy Medical Director	Sharon and Barry Paula check this with Sharon also 44 45 46 47. Damian to discuss with Ahmed? Departmental Medical Director		Medical Director
In the event of a Death related to a Serious Adverse Clinical Incident.	47	In providing post-mortem reports pathologists should be under a duty to: (i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them. (ii) Work in liaison with the clinicians involved. (iii) Provide preliminary and final reports with expedition. (iv) Sign the post-mortem report (v) Forward a copy of the post-mortem report to the family GP.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Remains on Hyponatraemia agenda until Hyponatraemia lead obtains nominated lead	Regional check with Karen	Sharon McCloskey	Bereavement
In the event of a Death related to a Serious Adverse Clinical Incident.	48	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach		Joanne McConville	Patient Data Safety
In the event of a Death related to a Serious Adverse Clinical Incident.	49	Where the care and treatment under review at a mortality meeting involves more than one hospital or Trust, video conferencing facilities should be provided and relevant professionals from all relevant organisations should, in so far as is practicable, engage with the meeting.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach.	Damian is checking if remote link to M+M is possible from all Trusts. Video conferencing should be part of Technology enablement Programme> Digital Work Place (Microsoft Office and Teams. Office 365 Microsoft Team) Contact for this is Stephen Hyland Template to be updated	Joanne McConville	Patient Data Safety
In the event of a Death related to a Serious Adverse Clinical Incident.	50	The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved.	Not explored as yet	Compliant. Litigation to send evidence to Hyponatraemia Lead	Template needs completed	Viviene Toal	Human Resources
In the event of a Death related to a Serious Adverse Clinical Incident.	51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.	Not explored as yet	Transferred to Director HROD	Need meeting with Viviene Toal	Viviene Toal	Human Resources

In the event of a Death related to a Serious Adverse Clinical Incident.	52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Transferred to Director HROD		Viviene Toal	Human Resources
In the event of a Death related to a Serious Adverse Clinical Incident.	53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed	Not explored as yet	Remains on Hyponatraemia agenda. Policies are being drafted regionally, this work has been suspended and will reconvene upon the workstreams meeting again.		Viviene Toal	Human Resources
In the event of a Death related to a Serious Adverse Clinical Incident.	54	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow- up service and facilitated access to family support groups.	Not all families will require professional bereavement counselling. Families require access to bereavement support in a manner that is responsive to their need. The Service User Liaison Officer will enhance bereavement support for families in this situation and a pathway for referral onto	2 Family Liaison Posts Appointed	Link with Family Liason officers and Bereavement coordinator	Sharon McCloskey	Bereavement
Training and Learning	55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources
Training and Learning	56	All Trust Board Members should receive induction training in their statutory duties.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources
Training and Learning	57	Specific clinical training should always accompany the implementation of important clinical guidelines.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recommendation template post collating and addressing findings (post A/L x 2wks) don't anticipate this will be a long piece	Remains on Hyponatraemia agenda.	Link with Caroline Beattie	Caroline Beattie	Acute Governance
Training and Learning	58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and hyponatraemia.	Training re nurses undertaken by short life group Sharon Burnside will update. As part of assurance around this work scoping exercise around current practice, documents, guielines, policies explored discrepancies revealed and addressed. Oversight Group to give clear steer -see accompanying documentation	Transferred to Nursing and Midwifery structure	Further meeting Paula and Dawn C 2nd/3rd> will update you with Transfer Process Map	Dawn Ferguson	Nursing & Midwifery
Training and Learning	59	There should be training in the completion of the post-mortem examination request form.	In place as a requirement of the HTA Licence	Transferred to Bereavement coordinator		Sharon McCloskey	Bereavement
Training and Learning	60	There should be training in the communication of appropriate information and documentation to the Coroner's office.	Training is undertaken by medical colleagues.	Transferred to Medical Directors office	Sharon will send through DoH expectations. Sharon will link Guidance. P will send email to Sharon but leave Template update + Action Plan for S+DC to update so DC gets feel for this	Damian Gormley	Medical Director
Training and Learning	61	Clinicians caring for children should be trained in effective communication with both parents and children.	Not explored in detail as yet but aware some relevant training available	Potential transfer to ELD. Hyponatraemia Lead to confirm with Director HROD	Suggest Meeting with Vivienne	Bernie McGibbon	Children & Young People
Training and Learning	62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death	Link with 22 and relevant SAI pieces	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Connie Connolly	Corporate Governance
Training and Learning	63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.	Some exploratory work undertaken with LN CYP and PCE Leads and Care opinion Link below and with 22	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People
Training and Learning	64	Parents should be involved in the preparation and provision of any such training programme.	Link to 22 and above not formally scoped yet	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People
Training and Learning	65	Training in SAI investigation methods and procedures should be provided to those employed to investigate.	Training is available detail not requested as yet	Transferred to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance
Training and Learning	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	As above	Transferred to Medical Director – Lead HoPS (will need Heather for N+M +AHPs)	Needs processed mapped. See email comment to you 27 05 2021 re R 66 + also Paula to contact Karen	Lisa Houlihan	Patient Safety
Training and Learning	67	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed.	As above but mechanisms are in place through Professional leads and Trust Education channels to address within or without organisation	Transferred to Medical Director – Lead HoPS	Check out Nursing Midwifery + Nursing assistants	Lisa Houlihan	Patient Safety
Training and Learning	68	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining.	Again mechanisims in place but not yet scoped. Post scoping analysis and if necessary Action Plan can be developed to improve this area	Transferred to Corporate CSCG Coordinator	Connie Aisling + Robin Browne looking into re revalidation + learning from experience forum + potential.	Connie Connolly	Corporate Governance

Trust Governance	69	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour (ii) Child Healthcare (iii) Learning from SAI related patient deaths	Unaware-require contact details to check. Ideally this work can present opportunity for sharing of insights and new approaches	Remains on Hyponatraemia agenda until Medical Director and Director CYPS liaise	My understanding is that it is Maria O'Kane and Paul Morgan	Maria O'Kane	Medical Director
Trust Governance	70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.	As per 68. Important to utilise skills of those best placed to undertake this, as wider piece need to standardise format of documents; determine detail that should be captured, clear	Transferred to Board Assurance Manager	Sandra Judt. RE send to her transfer Template to be completed	Sandra Judt	Assurance
Trust Governance	71	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.	Not explored as yet but will link to current audits and current Governance oversight with linked working across Operational, professional and Corporate Directorates - personally feel this is improving	Remains on Hyponatraemia agenda until Hyponatraemia Lead speaks with Board Assurance Manager	This needs to go to the Chair Eileen Mullan via Sandra Judt. This sits with Eileen as the Chair of Trust and the Chair of Governance Committee	Eileen Mullan	Trust Chairperson
Trust Governance	72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.	Not explored as yet	Links with recommendations 1-7. Director HROD to lead	I have Paula McKeown's section agreed in Template and Transferred to Communications but you will need to bring this to Vivienne re the update of rest of Template	Paula McKeown	Communications
Trust Governance	73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.	Links established to HR re this	Transferred to Director HROD		Viviene Toal	Human Resources
Trust Governance	74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.	Nursing JDs checked contained in all viewed. As per 74 re HR	Transferred to Director HROD		Viviene Toal	Human Resources
Trust Governance	75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies.	HR further Regional work required	Transferred to Director HROD		Viviene Toal	Human Resources
Trust Governance	76	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.	Needs further clarity around which clinical standards perhaps Regional lead follow NICE etc.	Remains on Hyponatraemia agenda		Caroline Beattie	Acute Governance
Trust Governance	77	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.	Wide	Remains on Hyponatraemia agenda until position confirmed via Medical Director	Check with Karen		
Trust Governance	78	Implementation of clinical guidelines should be documented and routinely audited.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recomme	Remains on Hyponatraemia agenda	Caroline Beattie Staying as big area with project work ongoing will ultimately come off	Caroline Beattie	Acute Governance
Trust Governance	79	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.	Clarity -define significant changes and ID process and contact at HSCB	Hyponatraemia Lead to contact HSCB for clarity	Check with Karen		
Trust Governance	80	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.	Processes in place and further development of NQI audit support links through Nursing Governance channels. Focus on	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	81	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.	Define immediate. Will be included in 2 phase re SAI recommendations	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths	Review existing policy	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	83	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.	Look back exercise	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance
Trust Governance	84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.	Ongoing requires review of current structures so that recommendations can be implemented where necessary in simple LEAN way. Discuss at Oversight Group or as specific	Hyponatraemia Lead to link with Chair and Chief Executive's office to seek confirmation of ownership	Chair + Chief Executive opinion on this i.e Shane + Eileen		

Department	85	The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person		
Department	86	The Department should expand both the remit and resources of the RQIA in order that it might (i) maintain oversight of the SAI process (ii) be strengthened in its capacity to investigate and review individual cases or groups of cases, and (iii) scrutinise adherence to duty of candour.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person		
Department	87	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	There is pilot at minute SHSCT is engaged in it Damian is our link person. Damian will engage with Department when it starts.		
Department	88	The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel.		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	Template needs completed		
Department	89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Paula to send to Maria for Chief Medical Officer to define		
Department	90	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability. (ii) The identification of specific training requirements necessary for effective implementation.		Remains on Hyponatraemia agenda. Head of Risk and Learning to progress	Check with Karen		
Department	91	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.		Transferred to Corporate CSCG Coordinator	In interim taken as Datix transferred to Connie	Connie Connolly	Corporate Governance
Department	92	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods		
Department	93	The Department should review Trust responses to the findings and recommendations of this Report.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods		
Culture and Litigation	94	The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods		
Culture and Litigation	95	Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.		Remains on Hyponatraemia agenda. Director HROD and Litigation Manager to lead	Link with 53 + 9. Protocol should be updated May 21 should bring clarity. Check with Karen		
Culture and Litigation	96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.		Parked – Awaits the outcome of the public consultation			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Candour	1	A statutory duty of candour should now be enacted in Northern Ireland so that: *i) Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with patients and the public.* *(ii) Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.* *(iii) Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).* *(iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.* *(v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.* *(vi)Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a patient, must inform that patient (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.* *(vii) Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.*	Regional update of IHRD Implementation Plan Work stream 1: Duty of Candour Staff views 5.1 Learning Culture Structure and Process Clarity simplicity and Consistency within organisations and Regionally Open Communication accesable systems clear processes Barriers fear of repercussions lack of resources lack of consistancy streamlining required -link to 9 Opinion is sought from staff around various developments, for example Trust response to COVID. Need to continue to encourage staff to be open and give their honest opinion. Re this piece of work site requires permissions to view- this is not in keeping with cultural shift toward inclusion and openness as required by being open. Strict hierarchy remains - consider membership of e.g. Bronze COVID Group. Need to use this opportunity to include a variety of staff patients and service users into this work to show by example that openness is welcomed in Trust. Consider responses in section 5 and 5.5 in particular. Independent advocacy support identified. in place. Regional Duty of Candour Group are looking at options re brining work forward. Working group service users and carers set up to develop guidance as part of framework for openness Introduction of Duty of Candour will require Minisrterial and Executive approval prior to introduction to Assembly No timeframe identified. Trust to work on Culture of openness in meantime	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until 2 August 2021.	Vivienne Toal and Maria O'Kane to link Send instruction + Template to VT	Viviene Toal	Human Resources			
Candour	2	Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.	Awaiting Regional action. Joint statement re Duty of Candour NMC and BMA reviewed and clearly identifies requirement. HR contacted re job discriptions	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	3	Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.	Awaited	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			

Candour	4	Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.	Standard requirement of Professional Codes therefore staff should be aware	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	5	Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.	Most JDs refer to abide by professional code therefore implicit see link to HR base position Meetings to be arranged with VT + Team and pF	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	6	Support and protection should be given to those who properly fulfil their duty of candour.	Will link this with second phase when focus on SAIs as much work done from Donaldson Report onwards	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Candour	7	Trusts should monitor compliance and take disciplinary action against breach.	Further Regional work required Regional update December 2019 says recommendation 5+7 will bedelayed until statutory DoC completed	A public consultation exercise on the policy proposals developed by the Hyponatraemia Implementation Programme for the statutory Duty of Candour and Being Open in health and social care was launched on 12 April 2021, and will last for sixteen weeks until	2-7 VT, sent previously, re-send	Viviene Toal	Human Resources			
Leadership	9	The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.	Should be ongoing in SHSCT multiple initiatives across region which Trust taps into some such as Nightengale challenge innovative but curtailed by COVID. As with all leadership inextrpically linked to communication and shared values of Trust. Suggest we scope all internal and external pieces as spring board to further developments. COVID restrictions has required new ways of working which can be built upon to look at leading through innovation and change. Collate Directory of Leadeship activities/opportunities	Directorates to feedback to Director of HROD and SMT	VT will link this to Leadership strategy through SMT Resend Template to Vivienne > all Transfer templates can be filled at one meeting with her (had tried to arrange to no avail) Suggest try to arrange a face to face meeting and merge templates at this	Viviene Toal	Human Resources			
Serious Adverse Clinical Incident Reporting	30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.	This is in addition to DATIX and hasn't been explored yet	Remains on Hyponatraemia agenda until definite lead agreed	Check with Viviene Toal	Viviene Toal	Human Resources			

Serious Adverse Clinical Incident Reporting	32	Failure to report an SAI should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Hyponatraemia Lead to link with DoH	Viviene Toal	Human Resources			
Serious Adverse Clinical Incident Investigation	36	Trust employees who investigate and accident should not be involved with related Trust preparation for inquest or litigation.		Transferred to Litigation	Check with Viviene Toal and Lynne Hainey	Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	50	The Health and Social Care ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved.	Not explored as yet	Compliant. Litigation to send evidence to Hyponatraemia Lead	Template needs completed	Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.	Not explored as yet	Transferred to Director HROD	Need meeting with Viviene Toal	Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Transferred to Director HROD		Viviene Toal	Human Resources			
In the event of a Death related to a Serious Adverse Clinical Incident.	53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed.	Not explored as yet	Remains on Hyponatraemia agenda. Policies are being drafted regionally, this work has been suspended and will reconvene upon the workstreams meeting again.		Viviene Toal	Human Resources			
Training and Learning	55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources			
Training and Learning	56	All Trust Board Members should receive induction training in their statutory duties.	Not explored as yet	Transferred to Director HROD	Sandra Judt link to Chair/Non Ex	Viviene Toal	Human Resources			
Trust Governance	73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.	Links established to HR re this	Transferred to Director HROD		Viviene Toal	Human Resources			
Trust Governance	74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.	Nursing JDs checked contained in all viewed. As per 74 re HR	Transferred to Director HROD		Viviene Toal	Human Resources			
Trust Governance	75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies.	HR further Regional work required	Transferred to Director HROD		Viviene Toal	Human Resources			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Paediatric - clinical	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.	SHSCT version of Regional Policy required 3 appendicies to be completed. Same developed -sign off at meeting. Link to training programme Nurse training considered -will be detailed in Training update.Medical AHP and Pharmacy programmes to be determined- links to be identified and level of training agreed. Re Nursing scoping exercise re wards outside CYP that take 14-16 and 16-18 undertaken for future evidence and clarity (BSO report ID'd discrepancies in wards listed in various documents. Audit of current state re 10-30 in CYP and Acute wards has been piloted _results via audit update. Many aspects will be updated	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Clinical Templates need completed	Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	11	There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.	Transfer information- included in audit and updated by BMcG for presentation	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.	Clarity obtained by BMcG again will be presented by her for sign off	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	13	Foundation doctors should not be employed in children's wards.	Compliant	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.	Emails to HR a- litle more teasing out around Nursing(A/L timings rather than complexity) - essentially interview and shortlisting should ID history and requirements. Unreasonable to expect all Nurses to be assessed prior to employment in Acute. Deficits in training can be addressed via Mandatory + specialised additional training. Cross ref with training Matrix Identify aditional Learning Needs through Supervision, appraisal and self reflection. Medical training not explored as yet.	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Needs to stay as wider than IHRD Await response from Joanne Bell's email to Ronan (25 05 21) then update template will need to involve Maria Heather Bernie Acute Rep + ID the lead	Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Await response from Joanne Bell's email to Ronan (25 05 21)	Bernie McGibbon	Children & Young People		Acute	

Paediatric - clinical	16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	17	Any change in clinical accountability should be recorded in the notes.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	This needs to be considered by Damian in conjunction with no 29	Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	18	The names of all on-call consultants should be prominently displayed in children's wards.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	20	Children's ward rounds should be led by a consultant and occur every morning and evening.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	21	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.	Included in Audit and possibly covered within BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.	Included in Audit. Also discussed with PCE leads around potential developments	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.	Included in Audit note does not say must be kept says available therefore audit guidance has covered this	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Bernie McGibbon	Children & Young People		Acute	
Paediatric - clinical	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.	Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Also link this to 17 and 29 from Dr perspective PACE audits should show from Nursing perspective	Bernie McGibbon	Children & Young People		Acute	
Training and Learning	61	Clinicians caring for children should be trained in effective communication with both parents and children.	Not explored in detail as yet but aware some relevant training available	Potential transfer to ELD. Hyponatraemia Lead to confirm with Director HROD	Suggest Meeting with Vivienne	Bernie McGibbon	Children & Young People			
Training and Learning	63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.	Some exploratory work undertaken with LN CYP and PCE Leads and Care opinion Link below and with 22	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People			
Training and Learning	64	Parents should be involved in the preparation and provision of any such training programme.	Link to 22 and above not formally scoped yet	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Bernie McGibbon	Children & Young People			

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Paediatric - clinical	10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings.	SHSCT version of Regional Policy required 3 appendicies to be completed. Same developed -sign off at meeting. Link to training programme Nurse training considered -will be detailed in Training update.Medical AHP and Pharmacy programmes to be determined- links to be identified and level of training agreed. Re Nursing scoping exercise re wards outside CYP that take 14-16 and 16-18 undertaken for future evidence and clarity (BSO report ID'd discrepancies in wards listed in various documents. Audit of current state re 10-30 in CYP and Acute wards has been piloted _results via audit update. Many aspects will be updated	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Clinical Templates need completed	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	11	There should be protocol to specify the information accompanying a patient on transfer from one hospital to another.	Transfer information- included in audit and updtaed by BMcG for presentation	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.	Clarity obtained by BMcG again will be presented by her for sign off	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	13	Foundation doctors should not be employed in children's wards.	Compliant	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	14	The experience and competence of all clinicians caring for children in acute hospital settings should be assessed before employment.	Emails to HR a- litle more teasing out around Nursing(A/L timings rather than complexity) - essentially interview and shortlisting should ID history and requirements. Unreasonable to expect all Nurses to be assessed prior to employment in Acute. Deficits in training can be addressed via Mandatory + specialised additional training. Cross ref with training Matrix Identify aditional Learning Needs through Supervision, appraisal and self reflection. Medical training not explored as yet.	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Needs to stay as wider than IHRD Await response from Joanne Bell's email to Ronan (25 05 21) then update template will need to involve Maria Heather Bernie Acute Rep + ID the lead	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	15	A consultant fixed with responsibility for a child patient upon an unscheduled admission should be informed promptly of that responsibility and kept informed of the patient's condition, to ensure senior clinical involvement and leadership.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Await response from Joanne Bell's email to Ronan (25 05 21)	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	

Paediatric - clinical	17	Any change in clinical accountability should be recorded in the notes.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	This needs to be considered by Damian in conjunction with no 29	Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	18	The names of all on-call consultants should be prominently displayed in children's wards.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	19	To ensure continuity, all children's wards should have an identifiable senior lead nurse with authority to whom all other nurses report. The lead nurse should understand the care plan relating to each patient, be visible to both patients and staff and be available to discuss concerns with parents. Such leadership is necessary to reinforce nursing standards and to audit and enforce compliance. The post should be provided in addition to current staffing levels.	Included in Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	20	Children's ward rounds should be led by a consultant and occur every morning and evening.	Included in Audit and will form part of BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	21	The accountable nurse should, insofar as is possible, attend at every interaction between a doctor and child patient.	Included in Audit and possibly covered within BmG update policy pieces for presentation around recipricol support	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	22	Clinicians should respect parental knowledge and expertise in relation to a child's care needs and incorporate the same into their care plans.	Included in Audit. Also discussed with PCE leads around potential developments	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.	Included in Audit note does not say must be kept says available therefore audit guidance has covered this	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell		Joanne Bell	Acute		Children & Young People	
Paediatric - clinical	26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.	Audit	Transferred to relevant Directorate. Lead for CYPS Bernie McGibbon; Lead for Acute Joanne Bell	Also link this to 17 and 29 from Dr perspective PACE audits should show from Nursing perspective	Joanne Bell	Acute		Children & Young People	

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Training and Learning	57	Specific clinical training should always accompany the implementation of important clinical guidelines.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recommendation template post collating and addressing findings (post A/L x 2wks) don't anticipate this will be a long piece	Remains on Hyponatraemia agenda.	Link with Caroline Beattie	Caroline Beattie	Acute Governance			
Trust Governance	76	Clinical standards of care, such as patients might reasonably expect, should be published and made subject to regular audit.	Needs further clarity around which clinical standards perhaps Regional lead follow NICE etc.	Remains on Hyponatraemia agenda		Caroline Beattie	Acute Governance			
Trust Governance	78	Implementation of clinical guidelines should be documented and routinely audited.	emails sent re our current processes There is no Corporate Governance Meeting re this. Many discussed at Acute Governance and then shared as needs be- I have requested information from relevant staff to provide Trust position and will update Draft recommendations	Remains on Hyponatraemia agenda	Caroline Beattie Staying as big area with project work ongoing will ultimately come off	Caroline Beattie	Acute Governance			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Serious Adverse Clinical Incident Reporting	31	Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').	SAI work not undertaken by me- second stage as quite aware of it and that following Dondaldson review required changes are in progress. Good links established to progress. If Oversight Group in agreement initial position can be got through recommendation email question and subsequent sign off of draft position or identification of Actions required and Plan with date for completed Actions/update devised 31-42 inclusive	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Connie and Caroline will have main Lead for these recommendations> Majority transferred to their own work plans. DC Need to go through the Transfer Template with them	Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	34	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	35	Failure to co-operate with investigation should be a disciplinary offence.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator	Paula Fearon to complete	Connie Connolly	Corporate Governance			

Serious Adverse Clinical Incident Investigation	37	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints. (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation. (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress. (iv) A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases. (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports. (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive. (vii) Families should be afforded the	Cross Link with 22; 43-47; 52; 54; 59-60; 62	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37ii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37iii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37iv	A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			

Serious Adverse Clinical Incident Investigation	37v	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37vi	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37vii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37viii	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (viii) Family GPs should, with family consent, receive copies of feedback provided.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37ix	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (ix) Families should be formally advised of the lessons learned and the changes effected.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	37x	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	38	Investigations should be subject to multi-disciplinary peer review.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	39	Investigation teams should reconvene after an agreed period to assess both investigation and response.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			

Serious Adverse Clinical Incident Investigation	40	Learning and trends identified in SAI investigations should inform programmes of clinical audit.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.		Remains on Hyponatraemia Agenda until a discussion paper is created taking Duty of Candour into consideration. Discussion paper to be drafted by C&SCG, Litigation and Information Governance to be presented to the Hyponatraemia Oversight Group	Caroline should give you this in due course	Connie Connolly	Corporate Governance			
Serious Adverse Clinical Incident Investigation	42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.		Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			
In the event of a Death related to a Serious Adverse Clinical Incident.	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.	Response Trust Bereavement Lead While Trust procedures include timely notification to the GP following all patients' deaths, I am not aware whether Dr to GP discussion routinely takes place in SAI's. Bereavement information packs are in place across the Trust with the expectation that these are provided to relatives when a person dies. Additional resources are in place within wards and on Sharepoint including information on the Coroner's service when the Coroner is involved. The bereavement team contacts the next of kin following all hospital deaths within 2 weeks of the person's death. The team has limited information on the person's death. The bereavement co-ordinator is willing to provide a bespoke telephone response to families in the case of SAI's should a specific referral process be put in place. Appointment of the Corperate Service User Liaison post will enhance bereavement support to families.	Transferred to Bereavement Coordinator with input from Corporate CSCG Coordinator		Connie Connolly	Corporate Governance		Bereavement	
Training and Learning	62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death.	Link with 22 and relevant SAI pieces	Remains on Hyponatraemia Agenda until scoped by Marita Magennis and Bernie McGibbon		Connie Connolly	Corporate Governance			
Training and Learning	65	Training in SAI investigation methods and procedures should be provided to those employed to investigate.	Training is available detail not requested as yet	Transferred to Corporate CSCG Coordinator		Connie Connolly	Corporate Governance			

Training and Learning	68	Information from clinical incident investigations, complaints, performance appraisal, inquests and litigation should be specifically assessed for potential use in training and retraining	Again mechanisims in place but not yet scoped. Post scoping analysis and if necessary Action Plan can be developed to improve this area	Transferred to Corporate CSCG Coordinator	Connie Aisling + Robin Browne looking into re revalidation + learning from experience forum + potential.	Connie Connolly	Corporate Governance			
Trust Governance	80	Trusts should ensure health care data is expertly analysed for patterns of poor performance and issues of patient safety.	Processes in place and further development of NQI audit support links through Nursing Governance channels. Focus on patient safety is increasing. Most likely more than one avenue may be pertinent need to consider further to prevent silos. Need to scope and process map current mechanisims including success in changing outcomes/reducing risk	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Trust Governance	81	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member	Define immediate. Will be included in 2 phase re SAI recommendations	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Trust Governance	82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths	Review existing policy	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Trust Governance	83	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.	Look back exercise	Transferred to AD CSCG	David + Caroline update your template	Caroline Doyle	Corporate Governance			
Department	91	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.		Transferred to Corporate CSCG Coordinator	In interim taken as Datix transferred to Connie	Connie Connolly	Corporate Governance			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
In the event of a Death related to a Serious Adverse Clinical Incident.	44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family.	This is being addressed regionally BY DoH. The Trust Bereavement Co-ordinators have contributed to amending the regional post mortem consent policy/procedure and the post mortem consent forms. A process for securing the second signature is being finalised. This work has been delayed as a consequence of COVID-19.	Transferred to Deputy Medical Director	Meeting with Damian Gormley and Sharon McCluskey		Deputy Medical Director		Bereavement	
In the event of a Death related to a Serious Adverse Clinical Incident	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.	As above-this is being coordinated regionally	Transferred to Deputy Medical Director with input from Bereavement coordinator	Regional check with Karen		Deputy Medical Director		Bereavement	
In the event of a Death related to a Serious Adverse Clinical Incident	46	Where possible, treating clinicians should attend for clinic-pathological discussions at the time of post-mortem examination and thereafter upon request.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Deputy Medical Director to lead further discussion for decision on transfer to Divisional/Deputy Medical Director	Sharon and Barry Paula check this with Sharon also 44 45 46 47. Damian to discuss with Ahmed? Departmental Medical Director		Medical Director			
Training and Learning	60	There should be training in the communication of appropriate information and documentation to the Coroner's office.	Training is undertaken by medical colleagues.	Transferred to Medical Directors office	Sharon will send through DoH expectations. Sharon will link Guidance. P will send email to Sharon but leave Template update + Action Plan for S+DC to update so DC gets feel for this	Damian Gormley	Medical Director			
Trust Governance	69	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour (ii) Child Healthcare (iii) Learning from SAI related patient deaths	Unaware-require contact details to check. Ideally this work can present opportunity for sharing of insights and new approaches	Remains on Hyponatraemia agenda until Medical Director and Director CYPS liaise	My understanding is that it is Maria O'Kane and Paul Morgan	Maria O'Kane	Medical Director		Child & Family Services	

Trust Governance	69	Trusts should appoint and train Executive Directors with specific responsibility for: (i) Issues of Candour (ii) Child Healthcare (iii) Learning from SAI related patient deaths	Unaware-require contact details to check. Ideally this work can present opportunity for sharing of insights and new approaches	Remains on Hyponatraemia agenda until Medical Director and Director CYPS liaise	My understanding is that it is Maria O'Kane and Paul Morgan	Paul Morgan	Child & Family Services		Medical Director	

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Directorate Applicability	RAG
Training and Learning	58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and hyponatraemia.	Training re nurses undertaken by short life group Sharon Burnside will update. As part of assurance around this work scoping exercise around current practice, documents, guielines, policies explored discrepancies revealed and addressed. Oversight Group to give clear steer - see accompanying documentation	Transferred to Nursing and Midwifery structure	Further meeting Paula and Dawn C 2nd/3rd> will update you with Transfer Process Map	Dawn Ferguson	Nursing & Midwifery			
Training and Learning	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	Training is available detail not requested as yet	Transferred to Medical Director – Lead HoPS (will need Heather for N+M +AHPs)	Needs processed mapped. See email comment to you 27 05 2021 re R 66 + also Paula to contact Karen	Heather Trouton	Nursing & Midwifery		Patient Safety	

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
In the event of a Death related to a Serious Adverse Clinical Incident.	43	A deceased's family GP should be notified promptly as to the circumstances of death to enable support to be offered in bereavement.	Response Trust Bereavement Lead While Trust procedures include timely notification to the GP following all patients' deaths, I am not aware whether Dr to GP discussion routinely takes place in SAI's. Bereavement information packs are in place across the Trust with the expectation that these are provided to relatives when a person dies. Additional resources are in place within wards and on Sharepoint including information on the Coroner's service when the Coroner is involved. The bereavement team contacts the next of kin following all hospital deaths within 2 weeks of the person's death. The team has limited information on the person's death. The bereavement co-ordinator is willing to provide a bespoke telephone response to families in the case of SAI's should a specific referral process be put in place. Appointment of the Corperate Service User Liaison post will enhance bereavement support to families.	Transferred to Bereavement Coordinator with input from Corporate CSCG Coordinator		Sharon McCloskey	Bereavement		Corporate Governance	
In the event of a Death related to a Serious Adverse Clinical Incident.	44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors acting with the written and informed consent of the family.	This is being addressed regionally BY DoH. The Trust Bereavement Co-ordinators have contributed to amending the regional post mortem consent policy/procedure and the post mortem consent forms. A process for securing the second signature is being finalised. This work has been delayed as a consequence of COVID-19.	Transferred to Deputy Medical Director	Meeting with Damian Gormley and Sharon McCluskey	Sharon McCloskey	Bereavement		Deputy Medical Diector	
In the event of a Death related to a Serious Adverse Clinical Incident.	45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.	As above-this is being coordinated regionally by DoH	Transferred to Deputy Medical Director with input from Bereavement coordinator	Regional check with Karen	Sharon McCloskey	Bereavement		Deputy Medical Diector	
In the event of a Death related to a Serious Adverse Clinical Incident.	47	In providing post-mortem reports pathologists should be under a duty to: (i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them. (ii) Work in liaison with the clinicians involved. (iii) Provide preliminary and final reports with expedition. (iv) Sign the post-mortem report (v) Forward a copy of the post-mortem report to the family GP.	Anticipate that this is also being addressed regionally by DoH (link person in DoH is Sharon Wright)	Remains on Hyponatraemia agenda until Hyponatraemia lead obtains nominated lead	Regional check with Karen	Sharon McCloskey	Bereavement			

In the event of a Death related to a Serious Adverse Clinical Incident.	54	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow- up service and facilitated access to family support groups.	Not all families will require professional bereavement counselling. Families require access to bereavement support in a manner that is responsive to their need. The Service User Liaison Officer will enhance bereavement support for families in this situation and a pathway for referral onto additional services can be developed but is not currently formalised. Bereavement guidance in Covid-19 is anticipated in the coming months from DoH and it will include a tiered response pathway which will be applicable in these situations.	2 Family Liaison Posts Appointed	Link with Family Liason officers and Bereavement coordinator	Sharon McCloskey	Bereavement			
Training and Learning	59	There should be training in the completion of the post-mortem examination request form.	In place as a requirement of the HTA Licence	Transferred to Bereavement coordinator		Sharon McCloskey	Bereavement			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Trust Governance	72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director	Not explored as yet	Links with recommendations 1-7. Director HROD to lead	I have Paula McKeown's section agreed in Template and Transferred to Communications but you will need to bring this to Vivienne re the update of rest of Template	Paula McKeown	Communications			

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Paediatric - clinical	25	All instances of drug prescription and administration should be entered into the main clinical notes and paediatric pharmacists should monitor, query and, if necessary, correct prescriptions. In the event of correction the pharmacist should inform the prescribing clinician.	Statement unsafe see response from pharmasist in email and covering draft sign off statement for Oversight Group	Transferred to Dr Tracey Boyce Pharmacy	Paula had sent to Tracey	Tracey Boyce	Pharmacy			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Trust Governance	71	All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.	Not explored as yet but will link to current audits and current Governance oversight with linked working across Operational, professional and Corporate Directorates - personally feel this is improving	Remains on Hyponatraemia agenda until Hyponatraemia Lead speaks with Board Assurance Manager	This needs to go to the Chair Eileen Mullan via Sandra Judt. This sits with Eileen as the Chair of Trust and the Chair of Governance Committee	Eileen Mullan	Trust Chairperson			

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Trust Governance	70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.	As per 68. Important to utilise skills of those best placed to undertake this, as wider piece need to standardise format of documents; determine detail that should be captured, clear succinct and meaningful records that can be easily opened and understood by all- reflects Duty of Candour. Again as wider piece consider considerable skills of our libraians re proof reading cataloguing and possibly ghost writing on bigger poliy pieces. ToR standardised and simplified	Transferred to Board Assurance Manager	Sandra Judt. RE send to her transfer Template to be completed	Sandra Judt	Assurance			

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Paediatric - clinical	24	All blood test results should state clearly when the sample was taken, when the test was performed and when the results were communicated and in addition serum sodium results should be recorded on the Fluid Balance Chart.	Included in audit -may need guidance following audit of Adult wardsIncluded in audit -may need guidance following audit of Adult wards	Remains on Hyponatraemia agenda. Above leads to process map and bring back to Hyponatraemia Oversight Group	Joanne Bell has undertaken extensive preparatory work. Get updated Template from Joanne	Joanne McConville	Patient Data Safety			
Paediatric - clinical	29	Record keeping should be subject to rigorous, routine and regular audit.	Nursing as per KPS and NOAT audits also current IHRD Baseline Audit Also yearly Medicines audit. Position around Medical notes not determined as yet see Draft statement	Remains on Hyponatraemia agenda until further work is explored in relation to Medical Audits. Dr Gormley to link with Stephen Wallace with the aim of creating a Clinical Audits programme and feedback to Medical Director	email to DG + Stephen Wallace Remember to include 17 + 26 + 28 in conversation	Joanne McConville	Patient Data Safety			
In the event of a Death related to a Serious Adverse Clinical Incident.	48	The proceedings of mortality meetings should be digitally recorded, the recording securely archived and an annual audit made of proceedings and procedures.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach.		Joanne McConville	Patient Data Safety			
In the event of a Death related to a Serious Adverse Clinical Incident.	49	Where the care and treatment under review at a mortality meeting involves more than one hospital or Trust, video conferencing facilities should be provided and relevant professionals from all relevant organisations should, in so far as is practicable, engage with the meeting.	Not explored as yet	Remains on Hyponatraemia Agenda. Head of Patient Safety (HoPS) will have overall responsibility but will require input from all Directorates. HoPS to link with Deputy Medical Director as well as the M&M oversight group to develop a consistent approach.	Damian is checking if remote link to M+M is possible from all Trusts. Video conferencing should be part of Technology enablement Programme> Digital Work Place (Microsoft Office and Teams. Office 365 Microsoft Team) Contact for this is Stephen Hyland Template to be updated	Joanne McConville	Patient Data Safety			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Training and Learning	66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.	As above	Transferred to Medical Director – Lead HoPS (will need Heather for N+M +AHPs)	Needs processed mapped. See email comment to you 27 05 2021 re R 66 + also Paula to contact Karen	Lisa Houlihan	Patient Safety		Nursing & Midwifery	
Training and Learning	67	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed.	As above but mechanisms are in place through Professional leads and Trust Education channels to address within or without organisation	Transferred to Medical Director – Lead HoPS	Check out Nursing Midwifery + Nursing assistants	Lisa Houlihan	Patient Safety			

Theme	No.	Recommendation	Trust Position August 2020	Trust Position April 2021	Action Required	Lead Officer	Directorate Applicability	Date of Completion	Shared with Directorate	RAG
Candour	8	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.	RQIA remit sub-group Department has developed a "principles of Regulation" Policy consultation document out 2020 second stage to look at role and powers and new role from IHRD implemmentation programme Link to recommendation 86 Articles 5 and 35 of RQIA founding legislation offer them leeway to do this already under statutory framework. Update of functions contained in IHRD Update Dec 2019 pg 22	RQIA Led Recommendation Parked at minute	Fill in Template□ Check Regional position with Karen Jeffrey					
Paediatric - clinical	27	Electronic patient information systems should be developed to enable records of observation and intervention to become immediately accessible to all involved in care.	The Regional Encompass Contract has been awarded to EPIC. Implementation will be staged and undertaken in one Trust at a time. SET first October 2022 then BT others not decided as yet so we will realistically need to consider prior to this	Parked - Awaits Regional Encompass System	Await response from Mark Toal					
Paediatric - clinical	28	Consideration should be given to recording and/or emailing information and advices provided for the purpose of obtaining informed consent	The SHSCT has no concerns regarding this recommendation provided the relevant guidance is followed and any procedure for the emailing of personal identifiable information is followed	Remains on Hyponatraemia agenda until update is received from Catherine Weaver, Information Governance	email and response from Catherine Weaver Hof IG. Will now separate this recommendation in 2					
Serious Adverse Clinical Incident Investigation	37i	Trusts should seek to maximise the involvement of families in SAI investigations and in particular: (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints	Cross link with 22	Transferred to Clinical and Social Care Governance – to Corporate CSCG Coordinator						
Trust Governance	77	Trusts should appoint a compliance officer to ensure compliance with protocol and direction.	Wide	Remains on Hyponatraemia agenda until position confirmed via Medical Director	Check with Karen					
Trust Governance	79	Trusts should bring significant changes in clinical practice to the attention of the HSCB with expedition.	Clarity -define significant changes and ID process and contact at HSCB	Hyponatraemia Lead to contact HSCB for clarity	Check with Karen					
Trust Governance	84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.	Ongoing requires review of current structures so that recommendations can be implemented where necessary in simple LEAN way. Discuss at Oversight Group or as specific way forward meeting.	Hyponatraemia Lead to link with Chair and Chief Executive's office to seek confirmation of ownership	Chair + Chief Executive opinion on this i.e Shane + Eileen					
Department	85	The Department should appoint a Deputy Chief Medical Officer with specific responsibility for children's healthcare.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person					

Department	86	The Department should expand both the remit and resources of the RQIA in order that it might (i) maintain oversight of the SAI process (ii) be strengthened in its capacity to investigate and review individual cases or groups of cases, and (iii) scrutinise adherence to duty of candour.		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Email Karen + Maria as to who is nominated person					
Department	87	The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	There is pilot at minute SHSCT is engaged in it Damian is our link person. Damian will engage with Department when it starts.					
Department	88	The Department should engage with other interested statutory organisations to review the merits of introducing a Child Death Overview Panel		Remains on Hyponatraemia agenda. Deputy Medical Director to progress	Template needs completed					
Department	89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department		Further clarity required from CMO. Hyponatraemia Lead to contact Medical Director. Medical Director to write to CMO	Paula to send to Maria for Chief Medical Officer to define					
Department	90	The Department should develop protocol for the dissemination and implementation of important clinical guidance, to include: (i) The naming of specific individuals fixed with responsibility for implementation and audit to ensure accountability. (ii) The identification of specific training requirements necessary for effective implementation.		Remains on Hyponatraemia agenda. Head of Risk and Learning to progress	Check with Karen					
Department	92	The Department should review healthcare standards in light of the findings and recommendations of this report and make such changes as are necessary.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods					
Department	93	The Department should review Trust responses to the findings and recommendations of this Report.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods					

Culture and Litigation	94	The interests of patient safety must prevail over the interests engaged in clinical negligence litigation. Such litigation can become an obstacle to openness. A government committee should examine whether clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.		Remains on Hyponatraemia agenda. Hyponatraemia Lead to link with Medical Director, Deputy Medical Director, AD CSCG and Head if Risk and Learning	Paddy Woods					
Culture and Litigation	95	Given that the public is entitled to expect appropriate transparency from a publically funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.		Remains on Hyponatraemia agenda. Director HROD and Litigation Manager to lead	Link with 53 + 9. Protocol should be updated May 21 should bring clarity. Check with Karen					
Culture and Litigation	96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.		Parked – Awaits the outcome of the public consultation						

To: **IHRD Programme Members**

Date: **28 May 2021**

From: **Andrew Dawson**
Director of Quality, Safety and Improvement

IHRD Programme – Update

Dear All

I hope you are well.

The Department's last communication to you was from my predecessor, Donna Ruddy, on 3 November 2020, advising you of some changes to the programme structure and to provide you with an update on the work of the programme. I would just like to take this opportunity to provide an update on the current situation.

Donna has returned to her previous post and I trust you will join me in sending Donna sincere thanks for all of her work and dedication. Donna has reverted to her role as Head of Quality, Regulation and Improvement Branch, and I have taken on the role of IHRD Programme Director. I am looking forward to working with you.

While the suspension of workstream meetings meant that much of the work was paused, some work was able to continue in the background.

Some key pieces of work which have continued include work relating to the Statutory Duty of Candour, guidance on Being Open, the HSC Arm's-Length Body (ALB) Board Member Handbook and the Statement of Rights relating to Serious Adverse Incidents (SAI).

The Programme's Duty of Candour Workstream has taken on board evidence and feedback from stakeholders, and developed policy proposals for formal public consultation. The consultation launched on 12 April 2021 and will run for 16 weeks,

closing on 2 August 2021. Events have been held for HSC Trust oversight groups and Boards to raise awareness of the consultation and to provide an opportunity for a Q&A with Quintin Oliver, Chair of the Duty of Candour Workstream. Further events are being held throughout the consultation period with stakeholders and service users. For more information, please see:

https://consultations.nidirect.gov.uk/doh-1/duty-of-candour

Work is underway to develop guidance on Being Open for individuals, staff and organisations.

The HSC Board Member Handbook is now published on the Department's website. This can be viewed at HSC Board member Handbook | Department of Health (health-ni.gov.uk).

An IME service is currently in operation reviewing a percentage of deaths in 3 Trusts (NHSCT, SHSCT and WHSCT) with Belfast joining the prototype on 1 June. This prototype has already helped to identify some of the issues and action has already been undertaken in order to resolve these. The learning from this prototype will help us develop firm proposals for a statutory system. When final proposals are developed these will require full consultation and Executive approval as well as the introduction of legislation. It is extremely unlikely this could be achieved within the current mandate.

An SAI workstream meeting has been planned for 11 June 2021 with the objective of getting a final sign off for the Statement of Rights. The statement will be passed to HSC organisations for implementation. The remaining SAI Workstream actions will be implemented in the coming months. This work will be taken forward in conjunction with wider changes on the SAI policy overseen by the Department's SAI policy lead and the forthcoming RQIA review on SAIs report.

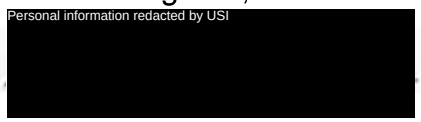
The IHRD Implementation team is now working to identify those recommendations that they can expedite over the next 3 – 6 months working closely with departmental

staff, taking into account the Department's Business Continuity arrangements and the need to address competing priorities.

As the pressure on the system eases, it is my intention to re-engage with the Chairs, Service Users & Carers and the Workstream members and I will be arranging introductory meetings during June and July. I look forward to meeting you all.

I hope you find this update helpful and that you all continue to keep well and stay safe.

With kind regards,



Andrew Dawson
Director of Quality, Safety & Improvement

Health and Social Care Board

Public Health Agency

12-22 Linenhall Street
Belfast BT2 8BS

Tel: 0300 555 0115 / 0300 555 0114

Shane Devlin
Chief Executive
Southern Health and Social Care Trust

BY EMAIL

3 June 2021

Dear Shane

Serious Adverse Incident involving the family of Personal information redacted by USI **– Ref** Personal information redacted by USI

I refer to the above SAI and the request from the family, via the Patient Client Council, to meet with representatives from the HSCB and PHA. The letter (attached), requesting the above, was shared with SHSCT colleagues at a recent SAI Improvement meeting held on 19 May 2021.

At the meeting, Dr O'Kane informed us that this review was nearing completion. We advised the DRO within the HSCB/PHA had not yet approved the Terms of Reference or panel membership, as further information had been requested from the Trust, to allow the DRO to make an informed decision if the SAI should be escalated to a level 3. Given the Trust had initially written to the DRO to request this advice, we were surprised to learn a level 2 review was nearing completion.

We have since met with Personal information redacted by USI on 24 May 2021 to discuss their concerns and, in particular, the application of the SAI process. It was evident, throughout the duration of our meeting, that the sequence of events that led to their mother's death, as well as their involvement to date in the SAI process has been extremely distressing. They also made their discontentment with the current Terms of Reference and panel membership very clear, in particular the Chair, who they do consider to be independent to the Trust.

In light of the above and based on the information the HSCB/PHA have received to date, we would request a level 3 review is now undertaken for this SAI and led by a fully independent panel that will ensure robust engagement with the family throughout the duration of the review.

Yours sincerely

Lisa McWilliams
Director of Strategic Performance
Health and Social Care Board

Rodney Morton
Director of Nursing, Midwifery & AHP's
Public Health Agency

Enc. Letter from PCC

Cc: Gary Wilson - Patient Client Council
Patricia Kingsnorth - Southern Trust
Caroline Doyle - Southern Trust

Phase	Action
Phase 1	• Patient Safety Data and Improvement Manager, Band 8a **Being Recruited** • Senior Manager Risk & Learning, Band 8b **Complete** • Datix Manager Band 6 **Being Recruited** • Patient Safety Strategy Manager, Band 7 **Being Recruited** • Project Manager Band 7 **Being Recruited**
Phase 2	• Corporate Clinical Audit Manager, Band 7 • CSCG Training Officer Band 7 • Morbidity and Mortality Manager Band 6 • Directorate Clinical audit and patient safety posts Band 5
Phase 3	• Datix Admin, Band 4 • Risk and Learning Admin Support Band 4 • Training admin Support Band 4 • Business Partner posts Band 5

REPORT SUMMARY SHEET

Meeting: Date:	Senior Management Team 8th June 2021
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information

Overview:

Provide SMT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance

Key Issues / Risks for SMT Consideration:

-

-Outcome of SMT Discussion:

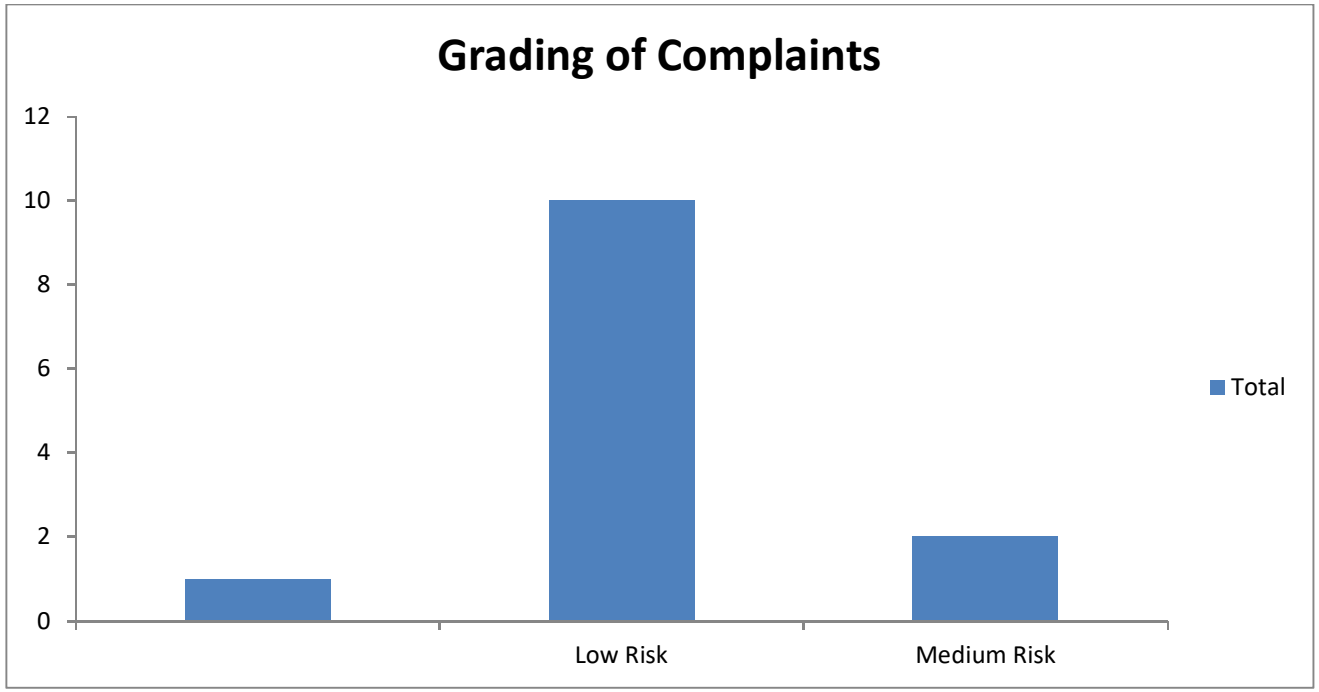
Summary of Weekly Governance Activity 24.05.2021 - 30.05.2021

	DIRECTORATE				
	ACUTE Number	MHLD Number	CYP Number	OPPC Number	TOTAL Number
New SAI's Notification's	0	0	0	0	0
SAI Reports submitted to HSCB	1	0	0	2	3
Ongoing SAI's*	26	40	6	6	78
High Risk Complaints	0	0	0	0	0
NIPSO Case Accepted for Investigation	0	0	0	0	0
NIPSO Draft/Final Reports Received	0	0	0	0	0
Early Alerts	0	2	0	3	5

*Below highlights the change in ongoing SAI figures from 81 last week to 78 this week:

Ongoing SAIs reported last week – 23/05/2021		81
Add New SAI notifications:		0
		81
Less SAI reports submitted:	Acute	1
	CYPS	2
Ongoing SAIs reported week ended 30/05/2021		78

Grading of Formal Complaints Received 24.05.2021 – 30.05.2021



*Grading not available for one complaint at time of report.

ACUTE DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

1. **Status of SAI's -** Summary of the status of SAI's between 24.05.2021 - 30.05.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

More than 26 weeks	Less than 26 weeks	Within Timescales	Total
6	13	7	26

2. **SAI Reports**

Datix ID	Incident Date	SAI Description	Recommendations
Personal Information redacted by	24/07/2020	On the 18 July 2020 a patient was admitted to Daisy Hill Hospital (DHH) Male Medical Ward following a collapse outside in the street. The patient was treated for aspiration pneumonia, alcohol withdrawal and rib fractures. The patient's condition deteriorated on the Ward requiring increasing oxygen requirements and was transferred to High Dependency Unit for AIRVO management. On the 24th July 2020 the patient's condition deteriorated further and subsequently required intubation and ventilation.	All nursing staff should be adequately trained in the use of the NEWS tool and be aware that they can agree trigger points with medical teams. This issue will be placed on the agenda of the Senior Nursing and Midwifery Governance Forum within 3 months of the publication of this report. All nursing staff will be reminded of the requirement to follow the recognised escalation process should they have ongoing clinical concerns about the medical management of a patient. This should be carried out within 3 months by the Executive Directorate of Nursing. The Trust should ensure it has arrangements in place for the safe and effective handover of patients, during the out of hours period, so therefore a complete review of the hospital at night process should be undertaken to include details of how patients are added to the report, how outcomes are listed and how discussions are noted and kept for future reference. This should be led by the Assistant Director of Acute Services with responsibility for Patient Flow within 6 months of the publication of this report.

3. Catastrophic Incidents

Datix ID	Incident Date	Description
Personal Information	Personal Information redacted by the USI	Death of Child in ED

Discussion at meeting	Action
Dr O'Kane and Patricia discussed the SJR model. Dr O'Kane is going to raise this with the Regional Medical Directors 28/05/2021 then link in with Dr Gormley on his return from leave.	No specific actions for this meeting.

4. Intertrust Incident

Personal Information

Patient transferred from other hospital for direct admission. Hospital failed to carry out covid swab pre admission, give inadequate pain relief, this resulted in delay on admission theatre.

5. Never Events

None

6. Issues escalated by Corporate or Directorate office at meeting

26/5/2021 Personal Information - Ruptured tumour following discharge.

MENTAL HEALTH AND DISABILITY DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

5. Status of SAI's

Summary of the status of SAI's between 24.05.2021 - 30.05.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3 – No timescale	Total
19	17	2	2	40

6. Early Alerts

28/05/2021 – 2 x Inquest Hearings

7. Never Events

None

8. **Issues escalated by Corporate or Directorate office at meeting**

Incidents related to staffing shortages

A) Organisational – Service Disruptions inc Human Resources – Human resources availability – Insufficient number of staff breaks down by Healthcare and non-professional

B) Staff – Exposure to Hazard – Workplace Stressor/Demands – Staffing Levels

Discussion at meeting	Action
Work is progressing in relation to the issues raised at the Serious Concerns meeting with the RQIA regarding Granville. Work progressing with the Quality Improvement team. Meetings ongoing to discuss the actions.	No specific actions
There is a meeting 20/05/2021 to discuss the MCA between MH Directors, DoH and the HSCB.	No specific actions.

CHILDREN AND YOUNG PEOPLE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

9. Status of SAI's

Summary of the status of SAI's between 24.05.2021 - 30.05.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

Less than 26 weeks	More than 26 weeks	Within Timescales	Total
4	2	-	6

10. SAI Reports

Datix ID	Incident Date	SAI Description	Recommendations
Personal Information redacted by the USI	Personal Information redacted by the USI	On Personal Information redacted by the USI the Southern H&SC Trust were advised that a young person, XX, Personal Information old female tragically died in a road traffic accident on Personal Information redacted by the USI. The PSNI are investigating circumstances of accident. XX was on the Child Protection Register under the categories potential sexual and emotional abuse. XX was in receipt of services from Family Intervention Service (co-ordination of child protection plan) Child and Adolescent Mental Health Service, NSPCC and Adolescent project.	N/A
Personal Information redacted by the USI	Personal Information redacted by the USI	Sudden unexpected death of XX in the community on Personal Information redacted by the USI. XX was a Looked After Child and subject to a Care Order. XX had been in a long term foster placement from Personal Information redacted by the USI until his untimely death. The PSNI had issued a missing person appeal via social media on [redacted] as XX had failed to return to his foster home at the agreed time of 18.30 hours on Personal Information redacted by the USI. This was noted to be out of character of XX. Regional Emergency Social Work Services were informed. A CMR notification to SBNI will be progressed.	The review team did not identify any recommendations.

11. Never Events

None

12. Issues escalated by Corporate or Directorate office at meeting.

None

OLDER PEOPLE AND PRIMARY CARE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings - 9am – 10am)

13.Status of SAI's

Summary of the status of SAI's between 24.05.2021 - 30.05.2021

Any reports received after Friday will not be reflected in the numbers below until the following week

More Than 26 weeks	Within Timescale	Less Than 26 Weeks	Total
3	2	1	6

14. Early Alert

26/05/2021 – Personal Information redacted by the USI Care Home

27/05/2021 – Whistleblow statement at STH

28/05/2021 – GP OOH

15. Never Events

None

16. Actions from Previous Week

Discussion at meeting	**Action**

Review of Covid deaths in Care Homes. Connie advised that at the Regional Governance meeting held this week, the Trust was advised there had been a letter sent to confirm if the Incident meets the criteria of SAI then an SAI is to be raised. Ambiguity remains in relation to the Governance Framework around all of these incidents.	Letter received and the ambiguity still remains. Stephen Wallace, Damian Gormley and Trudy Reid to discuss the review of the Covid deaths in Care Homes in more detail. Update 20/05/2021 – This was discussed at the meeting with the PHA 19/05/2021 and the position remains unclear. Further discussions regarding other HCAI and if they would then meet the criteria for SAI.
The group discussed the Shared Learning templates for Falls incidents.	Dr Gormley to link with Nicole and Colum Robinson and feedback to Heather and Dr O'Kane. Update 20/05/2021 – Heather Trouton confirmed the Falls Group is being reinstated from the beginning of June. Lisa Houlihan is linking with the PHA to strengthen the process re the submission of Learning templates from Moderate and above falls. The audit that was carried out did not provide assurance that this process is robust. It was agreed that all Incidents reported as a Hospital or Community Fall will be reported at this meeting. Further discussions between Carmel Harney and Heather Trouton how this fits in with the wider discussions around Enhanced Care Home Network. Claire to link with Monica McAllister regarding the reinstatement of the Independent Sector Governance meeting.

LITIGATION

17. New Clinical negligence

New clinical negligence claims: 24.05.2021 – 28.05.2021

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description
Personal Information redacted by the USI	ACUTE	MUC	Unknown	TBC	28.05.2021	28.05.2021	Writ Lodged with the High Court. No details relating to the claim. Awaiting further and better particulars

18. Clinical Negligence Claims Listed for Hearing in June 2021

Ref	Directorate	Division	Incident type	Incident date	Claim date	Opened date	Description	Update
Personal Information redacted by the USI	ACUTE	MUC	Fail/Delay treatment	14/01/2015	20/11/2015	04/12/2015	It is alleged that there was a failure in ED to diagnose tendon damage to hand **Trial listed for 1 June 2021**	Court Case commenced on 1st June and is delayed until 24th June 2021.

19. Vaginal Mesh Cases

The Trust has 17 open cases where the allegations relate to vaginal mesh. One case is listed for trial on 6 December 2021 (for 4 days). Since last week, one of the cases below has lodged proceedings formally with the Court.

Stage	Number of Mesh Cases
Letter of Claim	0
Discovery	4
Investigation	8
Proceedings Issued	4
Trial date Set	1

20. Urology Cases - no update from previous week – one case that was pre-proceedings has now lodged a Writ with the High Court.

Due to the announcement by the Minister for Health that a public inquiry is to be carried out in relation to the work of a Urology Consultant who was employed in the Trust, it is anticipated that there will be an increase in related medico-legal requests and litigation cases. New Claims received had been added to this section. This has been reviewed to include any older claims (that remain open) where it is known that the Urology Consultant in question has been involved in the care of the patients. There are a total of 7 open cases identified at present which involve the above Consultant. Since last week, one of the below cases has lodged proceedings formally with the Court.

Stage	Number of Urology Cases
Letter of Claim	0
Discovery	3
Investigation	1
Proceedings Issued	2
Trial date Set	1

A trial for one of the above claims is listed to take place on Irrelevant redacted by the USI

21. Coroner's Inquiries and Inquests

- The following are new Coroners Inquiries received 24.05.2021 – 28.05.2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Description
Personal Information redacted by the USI	ACUTE	MUC	Accident	Personal Information redacted by the USI	28/05/2021	The Coroner directed a Post Mortem and the Pathologist's *preliminary* finding is: Subarachnoid and Subdural Haemorrhage with Cerebral Oedema and associated with Fracture of Skull

- The following Inquest Hearing is scheduled in June 2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description	Governance Process
Personal Information redacted	MHD	MHS	Self-harm	Personal Information redacted by the USI	08/02/2018	9-10 June 2021	The deceased died of suspected suicide (hanging) on Personal Information redacted by the USI following discharge from CAH	SEA Report

- The following preliminary Inquest Hearings are scheduled in June 2021

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description	Governance Process
Personal Information redacted by the USI	MHD	MHS	Homicide	Personal Information redacted by the USI	05/07/2018	03/06/2021	This relates to the homicide of an elderly couple in their home by an individual known to mental health services	SAI
Personal Information redacted by the USI	MHD	MHS	Self-harm	Personal Information redacted by the USI	30/07/2019	23/06/2021	The deceased was a patient known to Mental Health Services who completed death by suicide (hanging)	SAI
Personal Information redacted by the USI	CYP	SOCIAL	Self-harm	Personal Information redacted by the USI	04/07/2019	24/06/2021	The deceased was known to the Trust's Gateway Service and died of suspected suicide	SEA
Personal Information redacted by the USI	OPPC	Older People		Personal Information redacted by the USI	21/01/2019	28/06/2021	The deceased was a resident in a nursing home, who was admitted to hospital after a fall	Falls proforma. No SAI
Personal Information redacted by the USI	ACUTE	IMWH	Maternal Death	Personal Information redacted by the USI	09/03/2018	30/06/2021	PM Report records cause of death as post-partum haemorrhage following emergency c-section in association with lacerations of uterus, uterine atony, breech position of the foetus and premature rupture of membranes	SAI

22. Judicial Reviews & pre-action correspondence re Judicial Reviews

Further report to be provided by DLS at end of June 2021

23. Number of Subject Access Requests exceeding timeframe for completion.

The Medico-Legal Team are unable to comply with the General Data Protection Regulations (GDPR) 2018 in respect of responding to Subject Access Requests within the statutory time-frames. This had been due to the sheer volume of requests and a lack of staffing to cope with the demand. The Governance Committee have been advised of the ongoing back-log; it has been brought to the attention of the Trust's SIRO and placed on the HROD Risk Register. An application was made to the Strategic Investment Committee for additional funding for staff. This was considered by the Strategic Investment Committee on 27th July 2020. Approval has since been provided and the recruitment process is under-way, however there have been delays, and further unexpected absences within the team which is impacting on the ability to deal with requests.

Discussion took place with Deputy Director of HR re structures and this is now being reviewed to ensure further resources, as required are allocated to this area of work to address the significant back-log, some of which are outstanding for a significant period of time. Members of the current team have worked additional hours to try and reduce the back-log as much as possible. This has helped reduce the back-log but it still remains significant and further work will continue within the team, however the issue still remains about available resources outside of the Medico-Legal Team for review of records, consideration of redaction (where appropriate), task of redaction and consent to release.

There is currently a back-log of 269 requests that are in excess of 90 days across the following areas:-

Directorate	Acute Services	C&YP	MH&D	OPPC	HROD	TOTAL
Number of Outstanding Requests	207	24	32	6	0	269
New requests opened 24.05.2021:28.05.2021	50	1	2	0	1	53

As above, the back-log has Decreased from the previous week, due to additional hours being undertaken by team members as a short-term measure whilst further resources are sources. As outlined previously, the reasons for back-log include (in addition to the staffing and volume issues) - difficulties accessing notes and records, and issues relating to redaction and consent to release.

MEDICATION INCIDENTS

24. Medication Incidents between 10.05.2021 – 16.05.2021

25. Link to SharePoint site regarding RQIA Notifications/Alerts

http://sharepoint/pr/perfimp/scc/_layouts/15/WopiFrame.aspx?sourcedoc=/pr/perfimp/scc/RQIA%20Notifications%20and%20Alerts/Alert%20Notice%20Board.xlsx&action=default

New adult safeguarding activity week beginning 17.05.2021 – 23.05.2021 by Directorate

Adult Safeguarding Activity 24.05.21 – 30.05.21	Trustwide	MHD	OPPC	Acute	CYP
1.0 No of new adult safeguarding referrals (APP1 sec 1)	40	22	6	11	0
2.0 No of new adult safeguarding referrals meeting threshold for Adult Protection Gateway team (APP1 Sec 2)	16	8	3	4	
3.1 No of new referral assessed as Adult in Need of Protection by APGT (APP1 Sec 3)	4	3	0	1	0
3.2 No of new referrals managed as adult at risk of harm (APP1 Sec 2/3)	16	12	3	1	0
3.3 No of new referrals with NFA under Adult Safeguarding (APP1 Sec 2/3)	11	2	2	6	0
Referrals by category of allegation					
▪ Physical	22	15	1	6	0
▪ Psychological	7	4	2	1	0
▪ Sexual	2	1	0	0	0
▪ Financial	1	0	1	0	0

▪ Neglect	8	2	2	4	0
▪ Institutional	0	0	0	0	0
▪ Exploitation	0	0	0	0	0
No of adult protection cases open on PARIS system * **REF STATUS** *	158	79	67	11	1

**3 referrals pending assessment at section 2 by delegated appointed person (1 acute: 2 MHD)
6 referrals pending assessment at section 3 by APGT (2 acute: 1 OPPC: 3 MHD)

Current Adult Protection Investigations where there are interfaces with other processes					
	SAI	**Complaint**	**Coroner**	**Litigation**	**Potential High Profile Protection Cases**
MHD	2				1
OPPC	2	1	1		1
Acute		2			

- 1 Ongoing SAI in MHD where adult protection investigation was undertaken. SAI on hold pending JP investigation. PSNI investigation ongoing. Review Strategy scheduled 3rd June
- 1 SAI in MHD ongoing. APP investigation closed.
- 1 SAI on hold OPPC - Ongoing Joint Protocol – awaiting PPS decision – Personal Information care Home
- 1 SAI OPPC – relates to JP case common assault in Personal Information care home. Case in court Personal Information
- 1 OPPC - APP case being prepared for PPS re theft by staff member – Personal Information redacted by the USI PNH. Internal Audit finalising report.
- 1 ongoing complaint in OPPC where adult protection investigation has been closed. Review of ASG file requested by HoS for completeness
- 2 adult protection investigations in Acute where there has also been a complaint.
- 1 adult protection investigation ongoing in Acute related to pressure care.

- Personal Information redacted by the USI Care Home – ongoing support being provided by SHSCT to address wider care and governance issues. Reviewed monthly. Individual adult protection JP case – staff member pleaded guilty to common assault. Awaiting presentenced report. Due back in court Personal Informati for sentencing. Individual likely to be referred by Judge to DBS.
- Large scale investigation in OPPC – number of patients involved with HR interface. Joint Protocol Investigation. Early alert completed.

INFORMATION GOVERNANCE

26. Number of Subject Access Requests exceeding timeframe for completion.

Directorate	ACUTE	OPPC	MHD	CYPS	FINANCE	P&R	HROD	CX
Number of outstanding Requests	9	-	9	25	-	-	-	-

These relate to Subject Access Requests which have not been completed within the legislative timescale (legal timeframe 30 days or 90 days for complex requests). These delays are in relation to the demands on Services to carry out redactions of these notes etc. In some cases there are requests which were made in 2019 and have not been progressed.

27. Data Breaches reported to the ICO

Directorate	ACUTE	OPPC	MH&D	CYPS	FINANCE	P&R	HROD	CX
Breaches	1	-	-	-	-	-	-	-

There have been one data breaches reported to the ICO in this period in relation to inappropriate access to a Patient record by a member of staff. In this period the Trust received 4 complaints from the Information Commissioners Office, One in relation to a data breach and three in relation to the time taken to respond to Subject Access Requests, these three relation to Children's Social Care records. One of these complaints is now closed and the Trust is working with the Requestor to deliver copies of their records.

NEW STANDARDS AND GUIDELINES RECEIVED AND ASSURANCES DUE OR SUBMITTED

28. Responses Sent.

Title of Correspondence	Full Implementation Date for S&G	Directorates applicability	Assurance Response
Foreign Body Aspiration During Intubation, Advanced Airway Management or Ventilation	01/06/2021 Submitted: 28/05/2021	Acute Services, MHD, CYPS	20210528_SHSCT Assurance Response

29. Responses that are due to be submitted to an external agency within the next 8 weeks (up until 31/07/2021)

Title of Correspondence	Category	Full Implementation Date for S&G	Directorates applicability	Clinical Lead
Insulin Pump Starts in Children	Safety and Quality Reminder of Best Practice Guidance	17/06/2021	CYPS	Joan McMahon
NICE Positive assurance template	HSCB Positive Assurance response for NICE Clinical Guidelines & Technology Appraisals	30/06/2021	Acute Services, CYPS, MHD, OPPC	All Directorate Governance Leads
Combination anti-platelet therapy for patients who have had a coronary stent	Safety and Quality Learning Letter	21/07/2021	Acute	Dr Aiden Cullen Dr Mark Feenan Dr Artur Mlodzianowski

30. Responses that are overdue for submission

Title of Correspondence	Full Implementation Date for S&G	Directorates applicability	Clinical Lead
Assurance Required in relation to HSC (SQSD) Deterioration Due to Rapid Offload of Pleural Effusion Fluid from Chest Drains	01/06/2021	Acute Services, CYPS	Dr A John / Mrs Kay Carroll Respiratory Consultant
Investigation and Management of Pulmonary Nodules	15/04/2021 HSCB have granted extension until 31 July 2021	Acute Services	MDT working group led by Dr Yousuf
Incidents Relating To Significant or Unexpected Radiological Findings	15/04/2021 Awaiting response from HSCB regarding extension date	Acute Services	MDT working group led by Dr Yousuf

31. Newly Issued S&G received by SHSCT from date of last Corporate Governance meeting

Title of Correspondence	Date of Issue External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
Update to Heavy menstrual bleeding assessment and management	24/05/2021	NG 88	NICE Clinical Guideline Update	N/A	24/08/2021

32. Regional PIVFAIT Audits

CAH CYP	4/4 = 100%
DHH CYP	No cases with IVF
ACUTE	3 cases this week, 1 case from previous to be reviewed, returns awaited - Total to review = 4. Follow on work from the Hyponatraemia oversight group: Cross check being undertaken on 14-15 year olds on adult ward, (Admissions April 2020 to January 2021)– 44 episodes identified, with 26 episodes not included in ward returns. Exercise to retrieve these charts for assurance re if IVF was given. 2 additional cases with IVF given identified at this time. 3 episiodes remain to be cross checked and IMWH are following up.

Discussion at meeting	Action
Dr O'Kane discussed the work that Laure Martin has been doing in relation to Greatix.	Marita to link with Laure in relation to PIVFAIT. Caroline Doyle and Dr O'Kane to discuss Corporate plans in relation to Greatix.

33. PPE Report

PPE Report.xlsx

34. AOB

Discussion at meeting	Action
Jilly asked for an update in relation to Clinical Guidelines being uploaded.	Joanne McConville confirmed that the team are progressing with this. Caroline Beattie will feedback in relation to this.

	Update 13052021: Caroline confirmed that all Guidelines on the old site have now been transferred to the new site. Jilly asked for Caroline to confirm how many new guidelines or amended guidelines are waiting to be uploaded. Update 20/05/2021: 32 New/Amended guidelines are still to be uploaded to the system. Update 27/05/2021 Caroline Beattie and Joanne confirmed BSO are planning too 'switch on' the new site today 27/05/2021.
Patricia raised the concern of the amount of queries received from MLAs regarding service users seeking reimbursement for private treatment.	LPP Information redacted by the USI
Dr O'Kane further updated the group on the meeting with the PHA. It was a comprehensive meeting with a lot covered. Discussions were had in relation to the use of SJR rather than SAI. There was a further emphasis on extracting learning.	Dr O'Kane asked Caroline to submit any of the requests to the HSCB and to consider how learning is being extracted from meetings similar to this.

Attendees:

Apologies: Lynne Hainey

Southern Health and Social Care Trust

Chief Executive – Medical Director
1-1 Meeting
8th June 2021

	Item	Attachment
1	**Urology Update SAIs** • GMC have requested copy of 9 sets of patient notes from most recent SAI. A review meeting for AOB suspension is due this month, it is expected that the exclusion will be extended. • Dermot Hughes has confirmed that the 11 overarching SAI report recommendations meet the requirements found in the 9 individual reports, this makes for a total of 11 recommendations for the Trust to complete. • Apology letters drafted, pending finalisation – dates to be finalised • DoH Considering legislative powers to ask RQIA to intervene re private patients and AOB	20210527_LtrApology2.doc 20210521_LtrApology1.doc Summary of Patients under the care of AO
2	**ED SAI** • ED SAI is concluding, communications with staff member and family to progress	
3	**Urology Public Inquiry** • Lookback Guidance – DoH have agreed this requires discussion at the UAG. DoH not opposed to Trust operating outside of this in the circumstances however will seek assurance that alternative arrangements are safe. HSCB meeting to take place this week to discuss further. Lookback guidance due to be launched end of June. **Resourcing** • Fiona Davidson (8B) will be working 2 days per week overseeing work to deliver on the recommendations. This may increase to 3 days from July.	Regional Guidance for Implementing a Lc Policy for Implementing a Lookb
4	**Mental Health and Learning Disability** • Mental Capacity Act update from Tomas Adell • Update on regional MHLD challenges	DoLs circular - Oct 2010.pdf MCA DoLS - emergency provisions MCA DoLS - policy paper deprivation of l
5	**Infection Prevention and Control** • Role of the DIPC – potential for this to be a nurse lead. Consideration of banding of this post	Director of Infection Prevention and Contr

6	**Nosocomial COVID-19 Mortality** • Process agreed and endorsed by regional group as the basis for all reviews. MDO team are currently gathering data to support this process. DoH sign off expected on process in next few weeks	Nosocomial COVID-19 Deaths Mo
7	**Structured Judgement Reviews / SAI Chairs** • Meeting proposed with Mark Lee DoH to discuss SJR for MHLD SAI • Meeting took place with Andrew Dawson to discuss SJR approach, DoH to consider further • Fourth SAI Chair available, 2 Pas required • RQIA review suggests Suicide removed from automatically being in SAI process	Memo - Structured Judgement Review -
8	**HCAT Model** • Meeting with Andrew Dawson agreed a regional pilot of HCAT with a view to using HCAT in place of CH8 coding. Regional group to be established in coming weeks	
9	**Medical Leadership Proposal** • Phase 1 posts have been circulated: CYPS, Older Persons, IMWH, Surgery and Emergency Medicine closing 18th June • Phase 2 posts, Medicine, Cancer Clinical MHLD and Anaesthetics to progress in coming weeks following 1-1 conversations • Identification of 3rd Deputy Medical Director post – Professional Governance / Appraisal and Revalidation	
10	**Appraisal, Revalidation and Annual Management Reviews for Doctors** • Update on monthly DMD Revalidation Oversight Group has been established to inform revalidation recommendations. • Update on the discussion with UHB further meeting planned for April – PowerPoint of UHB model attached. • Appraisal Private Practice Structured Reflective Template developed – Trust to pilot for the region Appraisal Structured Reflective Template regarding Private Practice based on the principles agreed by the Academy of Medical Royal Colleges document (April 2020). The template covers a range of private practice areas including: ○ Job Planning ○ Medical Protection / Indemnity Arrangements ○ Scope of Practice Volume of Work ○ Experience ○ Duration of working in this way / future plans ○ Record Keeping ○ Overlap with other roles ○ Benchmarking, integration and support ○ Personal approach to risk and governance	Annual professional review for consultant Medical Revalidation Oversight Group ToR Private Practice Structured Reflective

	around your private practice ○ Continuous Professional Development (CPD) Consideration of requiring a proportionate amount of patient feedback should come from private practice sources.	
11	**Trust Paying Patients Guidance** Trust is conducting a review of paying patient policy and guidance. Change of status forms will be electronic and all relevant information required must be filled out to submit. This removes the manual keying in for all involved, and allows a variety of reports to be run. As part of QA, a report will be run quarterly and a sampling of Change of Status forms sent to medical records to check waiting lists to ensure that patients are entering at the correct point. Reports will be consultant specific and highlight issues and patterns such as patients frequently changing status within a short time frame. Division reports will be possible to see the pattern in each area. Undertaking to pay will be generated automatically. Plan to remove the MD as approver for change of status forms in place of Clinical Director / AMD DivMD	
12	**Individual Performance Review** • Shane to discuss what will be required for IPR re Medical Director	FW IPR's.msg
13	**Hyponatraemia** • Hyponatraemia 8B commenced last week – updated workplan attached	IHRD Rec. Database 07.06.21.xlsx Memo to IHRD Programme Members
14	**Crowe SAI** • Update - meeting this week. PPT being prepared for discussion with HSCB on approval times for ToR and discussion of communications re SAI discussions	20210603 Letter to [redacted]
15	**Compliance re Surgical Rota**	
16	**MDO Risk Register**	
17	**COVID-19 Level 3 SAI Update** • SAI on course for 30 June completion	
18	**Obs and Gynae** • Weekly meeting continuing, next meeting now 4 weeks. Progress being made on safety indicators. SAI for never events being progressed. Chair Aidan Armstrong approached to lead SAI. Further calls with O&G experts being progressed to develop increased safety measures. Request for regional	

	Maternity network drafted	
19	**CSCG Staffing Proposal Update** • AD CSCG post – extension / permanent • Two posts are commencing recruitment this month – 8a Patient Safety and 7 Patient Safety Strategy Lead • Connie retiring in July, 8B replacement post being advertised • Proposal for ringing CSCG under corporate leadership in development paused	Phase Plan.docx
20	**Unscheduled Care Centre Governance** • Clinical Governance for the UCC will sit with ED.	
21	**Weekly Governance Report** • 24.05.2021 Report	Weekly Governance Report 24.05.2021 -

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

PERFORMANCE COMMITTEE

DATE: Thursday, 17th October 2019
TIME: 2.00 p.m. – 4.00 p.m.
VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM	DIRECTOR	Purpose
2.00 – 2.20 p.m.	1.	Welcome and introductions Apologies: • Mrs V. Toal, Director of Human Resources and Organisational Development *(Mrs Siobhan Hynds, Deputy Director of Human Resources deputising)*	Mrs S. Rooney	
	2.	Declaration of Interests	Mrs S. Rooney	
	3.	Performance Committee – introduction, purpose and remit	Mrs S. Rooney	Information
2.20 – 2.50 p.m.	4.	Chief Executive's Accountability arrangements and Performance Management Framework	Mr S. Devlin/ Mrs A. Magwood	Information
2.50 – 3.30 p.m.	5.	Proposed performance reporting to the Committee a) Internal Assurance b) External Assurance c) Executive Director of Nursing, Midwifery and AHPs	 Mrs A. Magwood Mrs A. Magwood Mrs H. Trouton	 Discussion " " " "
3.30 – 3.40 p.m.	6.	Draft Terms of Reference	Mrs S. Rooney	Approval
3.40 – 3.50 p.m.	7.	Proposed reporting to Trust Board	Mrs S. Rooney	Approval
3.50 – 3.55 p.m.	8.	Future meeting dates	Mrs S. Rooney	Approval
3.55 – 4.00 p.m.	9.	Any other Business		

The next meeting of the Performance Committee will take place on Monday, 9th December 2019 at 9.30 a.m., in the Boardroom, Trust Headquarters.

Southern Health and Social Care Trust
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PERFORMANCE COMMITTEE

DATE: Monday, 9th December 2019
TIME: 9.30 a.m. – 12.30 p.m.
VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Ms G. Donaghy, Non-Executive Director* • *Mr P. Morgan, Director of Children and Young People's Service (Ms Francesca Leyden deputising)*	Mrs S. Rooney	
	2.	Declaration of Interests	Mrs S. Rooney	
	3.	Minutes of previous meeting held on 17th October 2019	Mrs S. Rooney	Approval
	4.	Matters arising from previous meeting	Mrs S. Rooney	Information
9.40 – 10.00 a.m.	5.	Performance Management Framework	Mr S. Devlin/ Mrs A. Magwood	Information
10.00 – 11.30 a.m.	6.	Performance Reporting a) Internal Assurance i) Integrated Performance Report • Unscheduled Care - performance and issues to include Executive Director Professional issues (*Mrs M McClements, Mr B McNeany and Mr B Beattie attending* • Elective Care - performance and issues to include Executive Director Professional issues (*Mrs M McClements attending)* ii) Executive Director of Nursing, Midwifery and AHPs Report iii) HCAI Report iv) Corporate Performance Scorecard b) External Assurance i) Sentinel Stroke National Audit Programme results - *Mrs M McClements attending* ii) Summary Briefing of Outcome of Acute Bed Modelling Exercise commissioned via Utilisation Management Unit (Health Innovation Manchester)	Mrs A. Magwood Mrs H. Trouton Dr M. O'Kane Mrs A. Magwood Mrs A. Magwood	Assurance Assurance Assurance Approval Assurance Assurance

TIME		ITEM	PRESENTER	Purpose
11.30 – 11.50 a.m.		**Coffee break**		
11.50 – 12.05 p.m.	7.	Draft Committee Work Programme 2020	Mrs S. Rooney	Approval
12.05 – 12.15 p.m.	8.	Draft Terms of Reference	Mrs S. Rooney	Approval
12.15 – 12.30 p.m.	9.	Any other Business		

The next meeting of the Performance Committee will take place on Thursday, 19th March 2020 at 9.30 a.m., in the Boardroom, Trust HQ.

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

PERFORMANCE COMMITTEE

DATE: Thursday, 19th March 2020
TIME: 9.30 a.m. – 12.45 p.m.
VENUE: Boardroom, Trust Headquarters, Craigavon

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: *Mrs R Brownlee, Trust Chair*	Mrs S. Rooney	
	2.	Declaration of Interests	Mrs S. Rooney	
	3.	Minutes of previous meeting held on 9th December 2019	Mrs S. Rooney	Approval
	4.	Matters arising from previous meeting	Mrs S. Rooney	Information
		Performance Reporting - Internal Assurance		
9.40 – 10.00 a.m.	5.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.00 – 10.40 a.m.	6.	Integrated Performance Report i) Children's Services – performance, issues and actions to include Executive Director Professional issues	Mr P. Morgan	Assurance
10.40 – 11.10 a.m.		ii) Cancer Services – performance, issues and actions to include Executive Director Professional issues	Mrs M McClements	Assurance
11.10 – 11.30 a.m. Coffee break				
11.30 – 11.40 a.m.	7.	Unallocated Childcare Cases Report	Mr P. Morgan	Assurance
11.40 – 11.55 a.m.	8.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
11.55 - 12.10 p.m.	9.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr M. O'Kane	Assurance
		Performance Reporting - External Assurance		
12.10 – 12.25 p.m.	10.	Cancer Services – Peer Review	Mrs M McClements	Assurance
12.25 – 12.40 p.m.	11.	Children and Young People's Services – Regional Performance	Mr P. Morgan	Assurance
12.40 – 12.45 p.m.	12.	Any other Business		

The next meeting of the Performance Committee will take place on Thursday, 21st May 2020 at 9.30 a.m., in the Boardroom, Trust HQ.

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

VIRTUAL PERFORMANCE COMMITTEE

DATE: Thursday, 21st May 2020
TIME: 12 noon – 2.45 p.m.
VENUE: Boardroom, Trust Headquarters, Craigavon Hospital

AGENDA

TIME		ITEM	DIRECTOR	Purpose
12. noon – 12.10 p.m.	1.	Welcome and apologies:	Mrs S. Rooney	
	2.	Declaration of Interests	Mrs S. Rooney	
	3.	Chair's Business • Feedback from Committee meeting on 19th March 2020: o Committee Chair report o Feedback questions and answers	Mrs S. Rooney	Information Assurance
Performance Reporting - Internal Assurance				
12.10 – 12.30 p.m.	4.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
12.30 – 1.10 p.m.	5.	Integrated Performance Report i) Mental Health – performance, issues and actions to include Executive Director Professional issues Comfort Break 1.10 p.m. – 1.25 p.m.	Mr B. McNeany	Assurance
1.25 – 1.55 p.m.		ii) Infection Prevention and Control – performance, issues and actions to include Executive Director Professional issues	Dr M O'Kane	Assurance
1.55 – 2.10 p.m.	6.	Unallocated Childcare Cases Report	Mr P. Morgan	Assurance
2.10 – 2.30 p.m.	7.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
Performance Reporting - External Assurance				
2.30 – 2.40 p.m.	8.	Mental Health Benchmarking Report	Mr B. McNeany	Assurance
2.40 – 2.45 p.m.	9.	Any other Business		

The next meeting of the Performance Committee will take place on Thursday, 3rd September 2020 at 9.30 a.m., in the Boardroom, Trust HQ.

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 3rd September 2020
TIME: 9.30 a.m. - 12.45 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 21st May 2020	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.00 a.m.	6.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.00 – 10.15 a.m.	7.	Corporate Re-Build Plan	Mr S. Devlin/ Mrs A. Magwood	Information
10.15– 10.30 a.m.	8.	Year End Performance Report	Mrs A. Magwood	Approval
10.30 – 11.15 a.m.	9.	Integrated Performance Report PRESENTATION: Support to Carers and Adult Community Services – performance, issues and actions to include Executive Director Professional issues	Mr B. Beattie Mr P. Morgan Mr B. McNeany	Assurance
Coffee Break				
11.30 – 11.45 a.m.	10.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr. M O'Kane	Assurance
11.45 – 12.00 noon	11.	Unallocated Childcare Cases Report	Mr P. Morgan	Assurance
12.00 – 12.15 p.m.	12.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
Performance Reporting - External Assurance				
12.15 – 12.30 p.m.	13.	NHS Benchmarking Report - Management of Frailty in Acute Setting	Mrs M. McClements	Assurance
12.30 – 12.45 p.m.	14.	Terms of Reference	Mrs P. Leeson	Approval
	15.	Committee Work Plan 2021	Mrs P. Leeson	Approval
	16.	Meeting Dates for 2021	Mrs P. Leeson	Approval
	17.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 3rd December 2020 at 9.30 a.m.

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 3rd December 2020
TIME: 9.30 a.m. – 12.45 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Mr P. Morgan, Director of Children and Young People's Services (David Douglas and Colm McCafferty, Assistant Directors deputising)* • *Mrs H Trouton, Executive Director of Nursing, Midwifery and AHPs (Dawn Ferguson, Assistant Director Nursing Education and Workforce deputising)*	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 3rd September 2020	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.00 a.m.	6.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.00 – 10.20 a.m.	7.	Corporate Re-Build Plan Summary	Mr S. Devlin/ Mrs A. Magwood	Information
10.20 – 11.10 a.m.	8.	Integrated Performance Report PRESENTATION: Disability Services	Mr B. McNeany	Assurance
COFFEE BREAK				
11.30 – 11.45 a.m.	9.	Unallocated Childcare Cases Report	Mr D. Douglas / Mr C. McCafferty	Assurance
11.45 – 12 noon	10.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs D. Ferguson	Assurance
12.00 – 12.15 p.m.	11.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr. M O'Kane	Assurance
Performance Reporting - External Assurance				
12.15 – 12.30 p.m.	12.	End of Life Care Benchmarking Report	Mrs M. McClements/ Mr. B Beattie	Assurance
12.30 – 12.40 p.m.	13.	Committee Work Plan 2021	Mrs P. Leeson	Approval
12.40 – 12.45 p.m.	14.	Any other Business	Mrs P. Leeson	
The next Virtual meeting of the Performance Committee will take place on Thursday, 18th March 2021 at 9.30 a.m.				

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 18th March 2021
TIME: 9.30 a.m. – 12.30 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies:	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 3rd December 2020	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.10 a.m.	6.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.10 – 10.40 a.m.	7.	Integrated Performance Report PRESENTATION: Diagnostic Imaging	Mr. B Conway	Assurance
COFFEE BREAK				
11.00 – 11.15 a.m.	8.	Unallocated Childcare Cases Report	Mr P. Morgan	Assurance
11.15 – 11.30 a.m.	9.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
11.30 – 11.45 a.m.	10.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr. M O'Kane	Assurance
Performance Reporting - External Assurance				
11.45 – 12.15 p.m.	11.	Mental Health Benchmarking Report PRESENTATION	Mr B. McNeany	Assurance
12.15 – 12.30 p.m.	12.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 20th May 2021 at 9.30 a.m.

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 20th May 2021
TIME: 9.30 a.m. – 1.00 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Mrs H. McCartan, Non-Executive Director*	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 18th March 2021	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.10 a.m.	6.	Performance Report	Mrs A. Magwood	Approval
10.10 – 10.30 a.m.	7.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.30 – 11.10 a.m.	8.	Integrated Performance Report PRESENTATION: Cancer Services	Mrs M. McClements	Assurance
COFFEE BREAK				
11.30 – 11.50 a.m.	9.	Unallocated Childcare Cases Report	Mr P. Morgan	Assurance
11.50 – 12.10 p.m.	10.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
12.10 – 12.30 p.m.	11.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr. M O'Kane	Assurance
Performance Reporting - External Assurance				
12.30– 12.50 p.m.	12.	Health Quality Improvement Partnership (HQIP) Hip Fractures Database Annual Report	Mrs M. McClements	Assurance
12.50 – 1.00 p.m.	13.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 2nd September 2021 at 9.30 a.m.

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 2nd September 2021
TIME: 9.30 a.m. – 12.30 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Mrs H. McCartan, Non-Executive Director* • *Dr O'Kane, Medical Director (Dr Damian Gormley, Deputy Medical Director deputising)* • *Mr P. Morgan, Director of Children and Young People's Service (Mr Colm McCafferty, Assistant Director for Corporate Parenting deputising)* • *Director of Finance, Procurement and Estates (Mrs Alison Rutherford deputising)*	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 20th May 2021	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.00 a.m.	6.	Performance Report	Mrs A. Magwood	Approval
10.00 – 10.10 a.m.	7.	Year End Performance Report	Mrs A. Magwood	Approval
10.10 – 10.30 a.m.	8.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.30 – 11.00 a.m.	9.	Integrated Performance Report PRESENTATION: Maternity Services	Mrs M. McClements	Assurance
COFFEE BREAK				
11.15 – 11.30 a.m.	10.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr D. Gormley	Assurance
11.30 – 11.45 a.m.	11.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
11.45 – 12.00 noon	12.	Unallocated Childcare Cases Report	Mr C. McCafferty	Assurance
Performance Reporting - External Assurance				
12.00 – 12.15 p.m.	13.	Clinical Coding Monitoring Report	Mrs A. Magwood	Assurance
12.15 – 12.30 p.m.	14.	Draft Annual Report of the Performance Committee 2020/21	Mrs P. Leeson	Approval
	15.	Terms of Reference	Mrs P. Leeson	Approval
	16.	Meeting Dates for 2022	Mrs P. Leeson	Approval
	17.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 2nd December 2021 at 9.30 a.m.

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 2nd December 2021
TIME: 9.30 a.m. – 12.15 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Ms G Donaghy, Non-Executive Director* • *Dr M. O'Kane, Medical Director (Dr Damien Gormley, Deputy Medical Director)*	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 2nd September 2021	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 9.55 a.m.	6.	Performance Management Framework	Mrs A. Magwood	Information
9.55 – 10.10 a.m.	7.	Performance Report	Mrs A. Magwood	Approval
10.10 – 10.25 a.m.	8.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.25 – 10.45 a.m.	9.	Integrated Performance Report PRESENTATION: Mental Health *Attending:* • *Mr John McEntee, Assistant Director Disability Services* • *Dr Ivor Crothers, Clinical Director Psychology Services* • *Ms Stephanie Wethers, Head of Service Mental Health*	Mr J. McEntee	Assurance
COFFEE BREAK				
11.00 – 11.15 a.m.	10.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
11.15 – 11.30 a.m.	11.	Infection Prevention and Control and Antimicrobial Stewardship Report *Attending:* • *Mrs Trudy Reid, Assistant Director of IPC*	Dr D. Gormley	Assurance
11.30 – 11.45 a.m.	12.	Unallocated Childcare Cases Report	Mr C. McCafferty	Assurance
Performance Reporting - External Assurance				
11.45 – 12 noon	13.	CHKS External Benchmarking Performance Report	Mrs A. Magwood	Assurance
12.00 – 12.15 p.m.	14.	Committee Work Plan 2022	Mrs P. Leeson	Approval
	15.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 10th March 2022 at 9.30am

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 10th March 2022
TIME: 9.30 a.m. – 12.45 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Dr O'Kane - Dr Damian Gormley deputising* • *Mrs H. Trouton – Mrs Grace Hamilton deputising*	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 2nd December 2021	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.00 a.m.	6.	Presentation: Sickness Absenteeism *Attending: Maxine Williamson and Siobhan Hynds*	Mrs V. Toal	Information
10.00 – 10.10 a.m.	7.	Performance Management Framework – *updated framework*	Mrs L. Leeman	Approval
10.10 – 10.30 a.m.	8.	Performance Report	Mrs L. Leeman	Approval
10.30 – 10.45 a.m.	9.	Corporate Performance Scorecard	Mrs L. Leeman	Approval
COFFEE BREAK				
11.00 – 11.20 a.m.	10.	Integrated Performance Report PRESENTATION: Enhanced / Specialist Community Services *Attending: Gerard Rocks*	Mr B. Beattie	Assurance
Performance Reporting - *External Assurance*				
11.20 – 11.40 a.m.	11.	Sentinel Stroke National Audit Programme (SSNAP) *Attending: Dr Michael McCormick*	Mrs M. McClements	Assurance
11.40 – 11.55 a.m.	12.	CHKS External Benchmarking Performance Report *Attending: Lynn Lappin*	Mrs L. Leeman	Assurance
Performance Reporting - Internal Assurance				
11.55 – 12.10 p.m.	13.	Unallocated Childcare Cases Report	Mr C. McCafferty	Assurance
12.10 – 12.25 p.m.	14.	Infection Prevention and Control and Antimicrobial Stewardship Report *Attending: Trudy Reid*	Dr D. Gormley	Assurance
12.25 – 12.40 p.m.	15.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs G. Hamilton	Assurance
12.40 – 12.45 p.m.	16.	Any other Business	Mrs P. Leeson	
The next Virtual meeting of the Performance Committee will take place on Thursday, 19th May 2022 at 9.30am				

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 19th May 2022
TIME: 9.30 a.m. – 1.00 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Mrs H Trouton, Director of Nursing, Midwifery and AHPs (Mrs Dawn Ferguson, Assistant Director attending)*	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business i. Internal Audit Report on Performance Management	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 10th March 2022	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.10 a.m.	6.	Performance Report	Mrs L. Leeman	Approval
10.10 – 10.30 a.m.	7.	Corporate Performance Scorecard	Mrs L. Leeman	Approval
10.30 – 11.10 a.m.	8.	Integrated Performance Report PRESENTATION: *Unscheduled Care*	Mrs M. McClements/ Mr B. Beattie	Assurance
COFFEE BREAK				
11.30 – 11.50 a.m.	9.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr D. Gormley	Assurance
11.50 – 12.10 p.m.	10.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs D. Ferguson	Assurance
12.10 – 12.30 p.m.	11.	Unallocated Childcare Cases Report	Mr C. McCafferty	Assurance
Performance Reporting - External Assurance				
12.30 – 12.50 p.m.	12.	NHS – Acute Frailty	Mrs M. McClements / Mr B. Beattie	Assurance
12.50 – 1.00 p.m.	13.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 22nd September 2022 at 9.30 a.m.

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

Minutes of a meeting of the Performance Committee held on Thursday, 17th October 2019, at 2.00 pm in the Boardroom, Trust Headquarters

PRESENT:

Mrs S Rooney, Non-Executive Director (Chair)
Mrs R Brownlee, Trust Chair
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs A Magwood, Director of Performance and Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director *(item 5 onwards)*
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Interim Executive Director of Nursing and Allied Health Professions
Mrs S Hynds, Deputy Director of Human Resources and Organisational Development *(for Mrs Toal)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

1. WELCOME AND APOLOGIES

Mrs Rooney welcomed everyone to the first meeting of the Performance Committee. Apologies were noted from Mrs V. Toal, Director of Human Resources and Organisational Development.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. PERFORMANCE COMMITTEE – INTRODUCTION, PURPOSE AND REMIT

The Chair reminded members that at the Trust Board Workshop in June 2019, members identified the requirement for a Performance Committee to be established as a formal standing Committee of the Trust Board. Scope of powers delegated by the Board to this new Committee, together with draft Terms of Reference were agreed by the Board in August 2019.

The Chair stated that the purpose of the Performance Committee is to assist Trust Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines.

The Committee will provide oversight of the Performance Management Framework and through its utilisation will provide assurance to Trust Board that:

- Trust strategic performance objectives are being met
- Potential risks are identified and brought to the attention of Trust Board
- There is focus on the continual improvement of service delivery
- Trust resources are effectively targeted to support the achievement of high quality, safe and effective services and the delivery of key organisational objectives and targets

4. CHIEF EXECUTIVE'S ACCOUNTABILITY ARRANGEMENTS AND PERFORMANCE MANAGEMENT FRAMEWORK

The Chief Executive set the context for accountability within the HSC and highlighted the six key elements of the HSC performance management arrangements. He outlined his operational accountability arrangements and took members through the detail of a Director specific dashboard.

Mrs Magwood spoke of the current arrangements for Performance Management within the Trust and it was agreed that the Trust's

Performance Management Framework would be brought to the next meeting.

Mrs Leeson asked if the performance indicators have been agreed with the Department of Health (DoH). Mrs Magwood clarified the objectives and goals for improvements (OGIs) are included in the commissioning plan which the Trust is held to account for. The Trust has the opportunity to respond in its Trust Delivery Plan on whether these are achievable or not. The Chief Executive added the Trust is not involved in the definition of the targets and that is why the Transformation Implementation Group (TIG) has agreed to a review of the Performance Management Framework.

Dr O'Kane arrived to the meeting at this point

5. PROPOSED PERFORMANCE REPORTING TO COMMITTEE

a) Internal Assurance

Mrs Magwood presented a paper which identifies both the internal and external performance reporting in place and seeks consideration of a work plan to direct future integrated reporting. There was discussion on the monthly corporate performance scorecard. It was agreed that Trust Board would continue to receive the corporate performance scorecard on a monthly basis via email and it would be presented quarterly to the Performance Committee.

Ms Donaghy queried if the performance indicators from the performance scorecard are incorporated into the directorate domains dashboard. Mrs Magwood stated the Directorate domains dashboard is a work in progress and being further developed.

Mrs Magwood proposed themed reporting areas for integrated reporting i.e. those areas of challenged performance in the first instance.

These were agreed and scheduled for future meetings as outlined below. :-

December 2019	• Unscheduled Care • Elective Services
March 2020	• Cancer Performance • Children's Services (LAC and Child Protection issues)
May 2020	• Mental Health access times • Infection Control
September 2020	• Support to Carers • Adult Community Services and Annual Care Reviews • Self-Directed support / Direct Payments

Operational Directors will be invited to attend as appropriate. Input into the integrated reporting will be sought from the perspective of Human Resources, Governance, Professional (medical, nursing / AHP and social Work) and Finance / Estates where relevant.

b) External Assurance

Mrs Magwood presented the CHKS performance report. She stated that the report provides external assurance on a range of clinical and performance indicators which includes benchmarking at regional and national level. Mrs Magwood advised a drill down of the data at speciality level is carried out at operational level as appropriate.

Mrs Leeson queried the learning disability outpatient DNA rate of 9.8% compared to peer DNA rate of 0.75% and Mrs Brownlee referred to page 6, 3.7 Day Case Performance and noted the Trust's Trauma and Orthopaedics performance was lower compared to peers (46.5% v 61.15%) and asked what action the Trust was taking to improve this. Mrs Magwood provided assurance that the report is disseminated and shared with relevant staff for further review via their performance and governance fora for action / improvement in directorates.

Following discussion on service user/patient experience data, Mrs Magwood advised that the themed performance reporting would include patient and service user experience data.

The Chair asked if the data from this report will be included in the Directorate dashboard domains. Mrs Magwood stated the information from CHKS is targeted at service level however dashboards will be populated for specific domains as agreed at directorate / accountability meetings.

c) Executive Director of Nursing, Midwifery and AHPs

Mrs Trouton spoke to the above named report which provides assurance on the standard of professional practice of Nurses, Midwives and Allied Health Professionals (AHP) in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Framework and include areas regarding workforce, education training, and quality of practice.

Mrs Trouton highlighted the supervision data which requires registered nurses and midwives to avail of two formal supervision sessions annually. She noted this has not been met across the Directorates and the aim is to increase supervision uptake by 10% over the next quarter, however this is reliant on operational managers.

Members discussed the report and it was agreed that a shorter report on the key performance/quality indicators would be brought to the Committee and any key issues highlighted.

Reporting from the Executive Directors of Medicine and Social Work was raised. Mrs Magwood agreed to work with the Executive Directors to develop an agreed template.

6. DRAFT TERMS OF REFERENCE

Members reviewed the draft Terms of Reference. Ms Donaghy queried if the Director of Acute Services should be a member of the committee. The Chief Executive advised the Director of Acute Services, Director of Mental Health and Learning Disability and Director of Older People and Primary Care will be invited to attend the committee as and when required.

The Chief Executive confirmed that he would be attending meetings of the Committee. Mrs Magwood felt it would be beneficial for the Assistant Director of Performance Improvement to attend meetings. Members agreed to the membership being revised to include the Chief Executive and Assistant Director of Performance Improvement being 'in attendance.

Following discussion on escalation of risks, it was agreed to include escalation to the HSCB and PHA as appropriate.

Mrs Judt agreed to amend the Terms of Reference to reflect the changes outlined above for approval at the next meeting.

7. PROPOSED REPORTING TO TRUST BOARD

The Chair advised a Committee Chair Report will be submitted to Trust Board following each Committee meeting using the standardised template. Ms Donaghy noted her concern the performance dashboard will not be discussed at Trust Board. It was clarified the performance dashboard will continue to be circulated to Trust Board members and discussed in detail at each Performance Committee meeting.

8. FUTURE MEETING DATES

The proposed dates for 2019/20 were approved.

9. ANY OTHER BUSINESS

None noted.

The meeting concluded at 4.05 p.m.

Signed _____ ***Dated*** _____

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

Minutes of a meeting of the Performance Committee held on Monday, 9th December 2019, at 9.30 am in the Boardroom, Trust Headquarters

PRESENT:
Mrs S Rooney, Non-Executive Director (Chair)
Mrs P Leeson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mr B Beattie, Acting Director of Older People & Primary Care *(item 6ai only)*
Mrs A Magwood, Director of Performance & Reform
Mrs McClements, Interim Director of Acute Services *(items 6ai, 6aii only)*
Mr B McNeany, Director of Mental Health and Learning Disability *(item 6ai only)*
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing and Allied Health Professions
Mrs L Leeman, Assistant Director Performance Improvement
Mr S Gibson, Assistant Director Medical Directorate *(for Dr O'Kane)*
Ms F Leyden, Assistant Director of Social Work Governance *(for Mr Morgan)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

1. WELCOME AND APOLOGIES

The Chair welcomed those present. Apologies were noted from Mrs R Brownlee, Trust Chair, Ms G Donaghy, Non-Executive Director, Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work and Dr M O'Kane, Medical Director. The Chair welcomed Mr Gibson and Ms Leyden deputising for their respective Directors.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. MINUTES OF PREVIOUS MEETING HELD ON 17TH OCTOBER 2019

The Minutes of the meeting held on 17th October 2019 were agreed as an accurate record and duly signed by the Chair.

4. MATTERS ARISING FROM PREVIOUS MINUTES

None noted.

5. DRAFT PERFORMANCE MANAGEMENT FRAMEWORK

Mrs Magwood presented the draft Performance Management Framework for information.

The document provides information to the committee in exercising its function of overseeing the Trust's Performance Management arrangements. It is complementary to and integrated with the Trust's overarching Board Assurance Framework including established governance arrangements.

Mrs Magwood noted the changes to the Framework as outlined in members papers. She added that in August 2019 the Transformational Improvement Group advised of its intention to establish a Strategic Performance Management Oversight Board. Outputs from this will inform the further development of this Framework. Mrs Magwood drew members' attention to page 9 diagram 2 which highlights the purpose of each meeting and its remit. She provided assurance that through these meetings a performance structure has been established within the organisation.

Mrs Leeson welcomed the diagram on page 5 that explains the differentiating factors between the performance management and governance frameworks.

Mrs Toal referred to the service improvement section of the report and asked that Human Resources and Organisational Development be included. Mrs Leeman agreed to amend.

Mrs Magwood advised the framework will be reviewed annually.

6. PERFORMANCE REPORTING

a) Internal Assurance

i. Integrated Performance Report

- *Unscheduled Care – performance and issues to include Executive Director Professional issues.*

The Chair welcomed Mrs McClements, Mr Beattie and Mr McNeany to the meeting to discuss Unscheduled Care in their respective areas.

Mrs Magwood began by explaining the scope of areas included for review and assurance, the regional and local context and unscheduled care governance structures. She advised that the Medical Director and Executive Director of Nursing, Midwifery and AHPs contributed to the presentation and the scope of the report includes adult services only (including Older People and Mental Health services). Mrs Magwood informed members of a review currently underway regionally on urgent / emergency care; under the auspices of Emergency Care Collaborative chaired by the Chief Medical Officer. The purpose of the review was to scope the data across all Emergency Departments and create standardised policies.

Mrs Magwood spoke of the Unscheduled Care Governance Structures and the Regional Unscheduled Care Group that focuses on escalation, shared learning / planning and daily systems calls. She highlighted recent work under chair of Medical Director and Director of Nursing to bring forward a Clinical Leadership Model that will be clinically led, managerial supported and data driven.

Mrs Leeman presented the 6 Objectives and Goals for Improvement (OGIs) for Unscheduled Care and reported that all OGIs are failing to meet the target and noted this is the same pattern across the region.

Mrs Leeman guided members through each graph explaining the background and current position of each: GP OOH triaged within 20 minutes, Emergency Department % seen within 4 hours, Emergency Department waits over 12 hours, Emergency Department 2 hours to treatment, Non-Complex discharges from acute hospital within 6 hours and Complex Discharges within 48 hours.

In a response to a question asked by Mrs Leeson, Mrs Leeman advised the introduction of the Control Room has been valuable as every complex discharge is reviewed on a daily basis. Mrs Leeson enquired how the Trust compares across the region. Mrs Leeman advised that in relation to complex discharges, the Trust's performance is 72% against a regional average of 78% and for non-complex discharges; the Trust's performance is 92% against a regional average of 93%.

Mr McNeany presented information on Unscheduled Care pressures within Mental Health and Learning Disability focusing on Home Treatment / Crisis Response and Enhanced Mental Health Liaison to Emergency Department. He reported that demand was exceeding capacity and he particularly highlighted the increased expectations from ED Out of Hours. He advised that the key issues that are contributing to Unscheduled Care Pressures are; complexity of patients, workforce, lack of bed capacity, response times and sickness levels. Mr McNeany assured members that actions are being implemented to address the issues. For example, a Mental Health workforce planning group has been established reviewing training, skill mix, support roles and retention. Mrs Leeson noted the sickness rate for Mental Health staff is 2% higher than the region and asked for further clarification. Mr McNeany reminded members Mental Health is an extremely high pressurized area where attacks on staff, verbal and physical are key factors in a higher sick leave rate than other divisions. He indicated there were a number of developments to deal with this. He gave an example of reflective practice facilitated by the Psychiatry and Psychology Department. Mr McNeany stated he has liaised with the Interim Director of Acute Services to establish a Quality Improvement Project that focuses on repeat ED attenders for drugs and alcohol. This aims to reduce repeat presentations.

The Chair thanked Mr McNeany for his presentation.

Mrs McClements presented data on Unscheduled Care within the Acute Directorate focusing on Emergency Departments and Inpatient admission, flow and discharge. She reported on the Emergency Department activity trends, conversion from Emergency Department to admission, patient experience and workforce. The Chief Executive stated that it was interesting to note activity trends in the 'Conversion from Emergency Department to Admission' graph. He also stated it would be useful to get clarification on the reasons for a step change increase in non-elective admissions in May/June 2017. Mrs Leeman agreed to review this position further.

Action: Mrs Leeman

Mrs McClements pointed out that 'Patient Experience – leaving Emergency Department before treatment' was higher than comparative hospitals which she felt was reflective of the waiting times in the Emergency Department.

Mrs McClements spoke of the positive impact of Social Workers working at the weekend has had. She further highlighted that the Acute Directorate has the lowest sickness absence rate in the Trust. Mrs McClements noted the issue and impact of recruiting staff within the Pharmacy Department as posts are not funded to cover the out of hours period.

Workforce issues were discussed. Mrs McClements referred to the data included in the presentation which illustrates the demand to cover shifts in the Emergency Department for CAH and DHH, which highlights the staff available and temporary staff used. She noted her concern that the overall unscheduled care turnover rate between October 2018 and September 2019 is approximately 18%, with the highest turnover of 24% aligned to the CAH Emergency Department. In response to a question asked by Mrs Leeson, Mrs Toal stated the work will be undertaken to review the retention of staff and increase the use of exit interviews to gain a better understanding from staff.

Mrs McClements drew members' attention to key issues impacting the performance within Unscheduled Care as outlined in the

presentation. She advised the Trust has the highest number of patients attending the Emergency Department in CAH with a GP letter. Mrs Magwood asked how this is being addressed. Mrs McClements advised that Dr Rose McCullagh, Associate Medical Director for Primary Care is liaising with GPs to gain a better understanding on the reasoning behind this. An interface meeting is scheduled in January 2020 with GP and Consultants to discuss this issue and how to take it forward for improvements.

The Chair thanked Mrs McClements on her presentation.

Mr Beattie presented information on Unscheduled Care services within the Older People and Primary Care Directorate, focusing on:

- GP Out of Hours
- Domiciliary Care
- Residential and Nursing Homes and
- District Nursing and Intravenous Medicines Service.

Mr Beattie began by providing a high level summary on Urgent Out of Hours Care, highlighting the key issues. He reported on the low levels of GP participation to cover particular shifts, high level of requests for repeat prescriptions and routine interventions, advising that the current model was unsustainable. Mr Beattie spoke of the actions to date to address the issues and concerns, which include introducing new ways of working for Doctors, skill mix with Nurses and Pharmacists, move to urgent and essential appointments only, review of pathways to Mental Health and a project to encourage student doctors into General Practice.

Next steps were discussed, which included proposed new models of care and radical service reform to be discussed with the commissioner. Mr Beattie reminded members following a deep dive into the GP Out of Hours risk at the previous Governance Committee meeting, that the Chief Executive and himself agreed to formally write to the HSCB highlighting the need for a radical review and a proposed regional approach to introducing changes to the Urgent Care Out of Hours service.

Residential and Nursing Homes were also discussed. Mr Beattie presented a snapshot of data. He spoke of a number of key issues

affecting performance; recruitment difficulties and cost pressures. With the average bed occupancy in the Southern Trust the highest in NI, loss of beds across the Trust in the past 6 years, home closures, waiting times for assessment and the impact of the Mental Health Capacity Act, which may delay some placements. Mr Beattie informed members that the Trust will focus on supporting Residential and Nursing Homes by the Care Home Support Team via the Care Home Forum, increased presence in care homes, build on the work of the Trust in the Independent Sector Governance Forum and embed learning from Dunmurry Care Home.

The key issues and impacts on domiciliary care were discussed. Mr Beattie spoke of successful recruitment days in conjunction with Human Resources and the growth of the in-house workforce. He advised of the requirement for procurement of a new regional Domiciliary Care contract, which would be informed by the ongoing review of adult social care and include the introduction of live monitoring.

The Chair thanked Mr Beattie for his presentation.

Nursing / AHP, Social Work issues and Medical issues were discussed. Ms Leyden referred to the demands on the domiciliary care workforce from a professional governance perspective and stated that a system was in place to provide assurance about compliance with NISCC registration. Mr Gibson commented the loss of experienced Consultants has contributed to the overall performance. He added the limited number of side rooms creates additional pressures on staff and performance.

The Chair thanked everyone for their presentations.

Mr Beattie and Mr McNeany left the meeting at this point

- *Elective Care – performance and issues to included Executive Director of Professional issues.*

Mrs McClements presented the above named report which provides information on the monitoring of Elective Care service performance, key issues, risks and actions.

Mrs McClements advised that Elective Care continues to present challenges at a regional and local level. She spoke of the key issues namely; demand in excess of capacity, recurrent capacity gaps, workforce and unscheduled care pressures, waiting lists and lack of recurrent investment. She noted her concern on the length of waiting times across all elective activity areas and the impact that this has on patients. Mrs McClements assured members the Trust continues to manage risks in line with the Performance Management Framework and associated risks are identified and managed on the corporate risk register.

Mrs McClements drew members' attention to appendix 1 which demonstrates the longest waiter for each speciality in regards to outpatients, in-patient and day cases, backlog, planned and diagnostics.

Mrs Magwood advised that a priority in the transformation agenda is to enable improved access to elective care centres by establishing regional centres known as Day Elective Care Centres / Day Procedure Units to provide a dedicated resource for less complex surgery. This new approach is intended to protect elective care patients from the impact of unscheduled care pressures / bed utilisation, reducing the risk of harm whilst freeing capacity in secondary care. Mrs Magwood added this will reduce waiting times and provide an increased focus on red flag and urgent cases within the acute hospital sites.

ii. Executive Director of Nursing, Midwifery and AHPs Report

Mrs Trouton spoke to the above named report which provides assurance on the standards of professional practice of Nurses, Midwives and AHPs working in unscheduled care pressures. The indicators include areas such as workforce, education training and quality of practice.

Mrs Trouton reported the Trust continues to utilise over and above the Service Level Agreement (SLA) usage with the Clinical Education Centre and is the only Trust in the region to do so.

In response to a question asked by Mrs Magwood, Mrs Trouton advised inductions for new registrants are now held more frequently. She reminded members that new registrants avail of the preceptorship programme which supports them through a period of professional structured transition and consolidation. New registrants have been provided with green lanyards to wear which highlights to other staff they are new to the ward and may need additional support.

Mrs Leeson noted her concern in relation to Acute AHP work force pressures and asked for further information. Mrs Trouton spoke of the gaps within Acute AHP which has resulted in the deployment of a prioritisation work plan for AHP clinical work. She commented on the pressure staff are encountering, therefore staff are only able to work to red priorities which has also been prioritised which staff feel their skill set is being diluted. As the situation is not sustainable an Investment Proposal Template (IPT) has been progressed to help address the situation. The Chair referred to the wording in regards to Acute AHP workforce pressures and outcomes for patients and asked for it to be reviewed and an update on assurance provided at the next meeting.

Following a discussion the Chair requested that future reports should include information on appraisals and mandatory training, to which Mrs Trouton agreed to undertake.

Action: Mrs Trouton

iii. HCAI Report

Mr Gibson presented the HCAI report for assurance purposes. He advised there has been an increase in the number of C. Diff cases, reporting to date there has been 46 C. Diff cases against the annual target of 50 cases. He added that enhanced Antimicrobial Stewardship will be increased across wards and an increase in communication on the importance of infection control will be rolled out. Senior staff will meet twice weekly to appraise the situation.

iv. Corporate Performance Scorecard

Members discussed and approved the Corporate Performance Scorecard.

The Chief Executive noted the waits over 26 weeks for Endoscopy and a month on month increasing trend. Mrs Leeman advised there were a number of factors impacting on this including; vacancies associated with retirement of GP practitioner and nurse endoscopists; challenges in recruitment of nurse endoscopists; sickness in the consultant body impacting on the available cover for elective sessions, and the inability to source levels of additional activity at the same volumes as last year.

Mrs Toal advised that a new skill mix/structure for nurse endoscopists had been established. It was anticipated this would support future recruitment.

b) External Assurance

i. Sentinel Stroke National Audit Programme Results

Mrs McClements presented the progress update on the Sentinel Stroke National Audit Programme (SSNAP). She reported that the quarterly audit performance for Craigavon Hospital has been banded as a 'B' and DHH banded as a 'C' for the time period April 2019 to June 2019. She referred to the improvement plan included in the papers and provided assurance progress will be monitored by the Stroke Strategic Steering Group.

The Chair noted her concern that Out of Hours was not meeting the one hour target to administer lysis to patients. Mrs McClements commented this is still an issue as there are delays in CT reporting and medical staff not familiar with thrombolysis; however work is ongoing to address this.

Mrs McClements advised an update on Stroke Services will be discussed at the confidential section of Trust Board in January 2020.

Mrs McClements left the meeting at this point

ii. Summary of Briefing of Outcome of Acute Bed Modelling Exercise commissioned via Utilisation Management Unit (Health Innovation Manchester)

Mrs Magwood presented the above named report which provides assurance of the Trust's assessment of current and future Acute bed demand in the context of ongoing unscheduled care pressures arising from increasing bed day demand / demographic growth. She noted the Trust has experienced deterioration in key performance targets such as the 4hr and 12hr Emergency Department targets and 'low bed capacity' which has consistently been as a core contributing factor limiting the Trust's ability to make significant improvements.

The issue of the site infrastructure and need for further capital development was discussed in which Mrs Magwood provided assurance that the Trust continues to raise issues of the Trust's capital infrastructure requirements at every opportunity.

Mrs Magwood assured members the HSCB have been informed of the ongoing work and the report will be formally submitted to the HSCB.

Members provided the Committee of their support on the need to continue to raise issues of the Trust's capital infrastructure requirements with the Department of Health.

7. DRAFT COMMITTEE WORK PROGRAMME 2020

Members discussed the content of the work programme for 2020. Following a discussion it was agreed that the year-end performance report would be presented to Trust Board in June 2020. The committee work programme was approved for submission to Trust Board in January 2020.

8. DRAFT TERMS OF REFERENCE

Members reviewed the draft Terms of Reference following the suggested amendments at the previous meeting. Terms of Reference

were approved for onward submission to Trust Board in January 2020.

9. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.20 p.m.

Signed _____ ***Dated*** _____

SHSC Trust Performance Committee meeting 19th March 2020

Comments and Questions from members

- Members have reported that they welcome the very clear reporting format and detail provided in the performance reports.

- The performance scorecard report is much better, easily understood and highlights challenges and what action/s Director and Assistant Director are trying to take.

- In the Narratives on escalating waiting lists & inpatient day cases it constantly refers to the causes of this as workforce issues & awaiting Ministerial commitment. Would be helpful to see the narrative include some hard info on these plans going forward re assurance there will be light at end of tunnel. Would also like to see more comparative benchmarking / analysis of Southern Trust performance against other NI Trusts

- Overall concerns that because of workforce and capacity and demand issues that we are seeing a service that is creaking and only able to respond to red alerts and urgent while the other cohort of population with healthcare needs lie on ever growing waiting lists after which some of their needs extend to a chronic situation which then in the long run will cost the HSC more in terms of service care and treatment.

The Chair of the Performance Committee and Director of P&R held a tele-discussion on 15/4/20 to provide further clarification and resolve queries as required in response to the items raised by the Committee. The following additional responses to the issues raised are for noting:

- *A brief on the Ministerial commitment and objective to reduce waiting lists was referenced at the March 20 Performance Committee.*
- *Over the past few years the biggest challenge to delivering on the Trust's historic performance levels and the commissioned service and budget agreement has been related to the Trust workforce constraints across a range of areas, and in a number of areas this was further compounded by delays in Ministerial decision making during the 3 year period without a NI Government. Whilst a new Minister in place for 2021 was anticipated to address some service challenges relating to delays in decision making, the advent of the COVID 19 global pandemic response is expected to have significant impact in year.*
- *The performance team has previously included regional benchmarks in the Trust Board performance report; this will be reinstated to include benchmarking of Southern Trust performance in comparison to the other NI Trusts where relevant on the Performance Scorecard.*
- *Performance Committee are further advised that due to the impact of COVID 19 preparedness and response plans, the Trust is unable to deliver its commissioned level of core activity. Furthermore, the level of planned in-house additional work scheduled for Q1 2020/2021 to maintain urgent/ Red Flag demand can also no longer progress. Therefore, no plans have been progressed at this stage to undertaken routine work to reduce waiting lists. Active plans for validation of those waiting longest have also been stood down.*
- *The Trust is however, working with the regional commissioner in the context of identifying opportunities for a safe return to some critically urgent and cancer work in a risk managed approach whilst the Covid19 operational response continues. This will include utilisation of Independent Sector Acute Hospital capacity, which is an important component of any future plan to reduce waits for urgent red flag and cancer surgeries. This capacity is not currently available for additional routine elective work.*
- *As previously stated progress on elective waits in some specialities is reliant on HSC transformation including the development of day elective care centres, additional skilled workforce and the necessary infrastructure and bed capacity on an ongoing basis as well as specific parallel actions to target the backlog for reduction.*
- *On a positive note, a number of practice changes have been implemented including for example widespread use of virtual and telephone assessment, revised plans for utilisation of DHH theatres, and some policy changes e.g. new care pathways in gastroenterology . These opportunities and lessons learned will be further assessed and exploited where possible as the Trust moves to reset and kick start services going forward*

Minutes

- Page 6: Re unscheduled care attendances with letter from GP planned meeting with GPs to seek explanation for high number of ED referrals with GP letter. Scheduled for last Jan.
  Q What was the result of the discussions with Dr McCullagh and what outcomes if any.

- *The GP interface meeting scheduled in January had to be deferred due to unavailability of primary care colleagues. A further meeting planned for April has not yet taken place due to COVID19 response. The COVID19 bronze response has effectively fostered improved engagement with primary care colleagues and there is there is acceptance that the establishment of a wider range of direct access, rapid outpatient and ambulatory services will be a part of changing routes of referrals going forward.*

- P7. Increasing bed pressures on residential care homes.
  Q. Issue re e mail from Personal Information redacted by the USI.

- *An update is provided at confidential Trust Board.*

- P8 *Would appreciate a status update on Elective Care Centres.*

- *The Department published the Elective Care Plan in February 2017. The Plan sets out six commitments to address the issues facing elective care in Northern Ireland. Commitment 6 of the plan concerns the establishment of Elective Care Centres that will provide a dedicated resource for less complex planned surgery and other procedures.*
- *In 2019, to take forward the next phase of work on the development of regional day procedure centres, the Department established seven clinically driven task and finish (T&F) groups, one for each of the specialties identified as suitable for day case procedures, namely: General Surgery; Endoscopy; Trauma & Orthopaedics; Urology; Ear, Nose & Throat; Gynaecology; and Children's Services.*
- *In Feb 20, each group reported its findings to the DECC Project Board led by the CMO and next steps are subject to TIG endorsement and Ministerial approval.*

- P.10 minutes; Stroke performance in both CAH & DHH. In Jan 2020 TB were advised of new beds in CAH. *Would appreciate progress update on this & on training of Medics on thrombolysis & on delays in CT reporting which 2 issues were impacting on poor performance in this area.*

- *Estates enabling works to facilitate new bed provision on CAH site has been completed. Planning for final ward changes/configurations are delayed due to COVID response preparations. Senior Management Team to conclude decision making following legal advice and input from HSCB.*
- *Actions around training and reporting will be picked up in the post COVID period and a further update will be provided to Trust Board.*

Matters arising:

- On the increased unscheduled hospital admissions from ED it notes that these on analysis "majority were shown to have required a zero length stay"
  Q. We are often told that increasing ED attendances & emergency admissions are the reason for elective cancellations. The zero length of stay from ED attendances still confuses, what is meant by majority?, does this indicate inappropriate clinical assessment (by our staff, locums ?? or changes in medical staffing) for admission with a zero length stay and therefore creating extra pressure on availability of inpatient beds

- *An admission with a zero length of stay is not indicative of an inappropriate clinical assessment or inappropriate admission. Such patients may require to be admitted for this short period of time to allow for appropriate assessment, diagnosis and treatment planning, that is not achievable within the Emergency Department. A change in recording aligned to regionally agreed data definitions saw these recorded as admissions, not ED attendances, to reflect the nature of this input. This resulted in a step change in the trend data for admission from May/June 2017*
- *An acute bed modelling exercise undertaken by North West Utilisation Management Group and presented to Performance Committee in December 2019 confirmed the Trust has a significant deficit in bed capacity.*
- *Patients have always been managed in the Emergency Department for short period of diagnosis and treatment due to the absence of other dedicated facilities. The ongoing challenge for the Trust is provision of appropriate infrastructure, staff and facilities to manage the short stay episode which*

should ideally be managed in a dedicated area and not admitted to an inpatient bed. This is the aim of the Trusts plans for increasing introduction of ambulatory care models.

Item 5

- 34% increase in AHP waits is concerning esp excess of 40 WTE vacancies in Physiotherapy is very concerning, red" recorded performance and increases in excess waits noted especially in diagnostics, cancer response and treatments, diagnostics, endoscopy

- Rapid access chest pain clinic @16weeks - this is 4 months for someone with chest pain and potential cardiac event / Non-invasive cardiac investigations –w/l growing
  Q How is this being actively managed

- *Within the SHSCT an Emergency Department Chest Pain service is in place run by experienced chest pain nurses. This service facilitates active management of those presenting and reduces onward referral to the Trust's chest pain clinic.*
- *Demand is now managed across both hospital sites and patients asked to attend the site with the shortest wait time. Access times have reduced although demand continues to be high.*
- *New regionally agreed referral criterion has been put in place for rapid access chest pain clinics and robust implementation of the agreed referral criteria is undertaken with referrals being returned if they do not meet the clinical criteria. This has reduce the volume of patients meeting the criterion for this service*
- *Information is shared with primary care monthly on the waiting time to ensure GPs are aware of the current wait times and can manage urgent cases appropriately.*

- ED breaches – suggestion that some qualitative data that might further explain performance
- *The EDN patient experience team have met with Emergency Department colleagues to plan a piece of work capturing experience of those waiting in ED and building on previous work done in this area via 10,000 voices. This will be initiated post COVID.*

- Appreciated the WLI brief to address New deal /New approach, this will be difficult given both IH and IS requirements given current CV19 situation The extra money £6 million for extra capacity will only work if we get future buy in from the IS and can manage with workforce pressures at every point.
  Q Outside of current CV 19 activity have we secured cooperation from IS to take this forward?

- *A current initiative is underway with the IS where the DoH/HSCB has contracted regionally for use of IS hospital facilities for Trusts to share during COVID.*
- *A regional procurement exercise is planned to secure independent sector capacity onto a regional purchasing framework in preparation for a future Waiting list initiative. Initial planning with Trusts, proposed that Trusts take a lead on individual specialty management to seek to ensure equity of access to this capacity across Northern Ireland. This planning will need to re-start post COVID.*

- Acknowledgement of continued message throughout all areas is workforce and the shortage of staff across all areas which is preventing improvement and noting how this is highlighted to HSCB/DoH and the capacity required to make any in ways for improvement we will have to wait and see after we get through Coronavirus what really changes.

- Would like to see a considered plan of what the "new" may look like with all these new staff, new money and extra capacity?

- *The Trust's SMT have agreed proposals for a 'kick start' to services post covid, this will include active engagement on lessons learned to influence with the 'new' may look like.*

Item 6

Children's Services

- page 16 placement options and choices:

    - placement breakdowns subject to capacity and not match resulting which is concerning
      Q. Is this in relation to fostering or adoption or both?

- *Many care admissions occur on an emergency basis, ie out of hours and at weekends, therefore it is not possible to spend time on an immediate match as available placement are very limited and information on the child and young person is not fully known.*
- *We also have children coming into care who are highly traumatised, this is particularly relevant to adolescents and there is only a limited pool of carers able/interested in offering placements of this nature.*
- *Matching challenges are heightened for children with specific cultural requirements as a consequence of the high percentage of non-national LAC in this locality*
- *Despite this the service does work on seeking to secure a long term match for children; however this is rarely possible at the point of first admissions to care.*
- *LAC population in this Trust has increased in the region of 40% in the last 10 years and it remains very challenging to ensure Foster care recruitment has sufficiently increased to meet this demand. However this Trust has committed considerable time and resources to Recruitment and have experienced considerable success in this regard, however LAC admissions continue to increase.*

Q what has caused the reliance on non- kinship foster care option?

- *Social work practice has correctly focussed on placement with Extended family/Kinship carers as the preferred option when assessments indicate this to be the correct course of action.*
- *At present approximately 40% of new admissions are placed in kinship care options*

Q. Is there an issue with post placement support?

- *At present the CYP service is equipped to provide young people and their carers with the required support in their journey via fostering/Adoption. There is extensive work ongoing in respect of supporting the carers and children via collaboration between the Family Placement Service and Fieldwork social work colleagues where the key worker for the child is located.*
- *Each child has a specific assessment informed care plan and associated supports are put in place. Where necessary, specialised input is obtained from the Trust's Scaffold service which is a dedicated Psychology services for looked after children and their carers. Regular planning meetings are convened and formal LAC reviews are held at least once every 6 months where the child and carers needs are reviewed and associated decisions made.*
- *Where necessary there is direct input with Health and Education colleagues and bespoke measures are put in place to deal with any presenting challenges.*
- *The Trust established a post Adoption service in 2015 and significantly developed this via Transformation investments and this team now supports approximately 140 post adoption placements from a population of approximately 270 Adopted children in this Trust.*
- *There is some uncertainty in respect of how this post Adoption team can be sustained in the absence of recurrent funding going forward.*

- Slide 35 prof issues - *concerns expressed re the following*:
  - medical staff RCPCH standards not being met
  - consultant medical rota DHH
  - small pool of paediatric trainees

Cancer services

- Inability to recruit Consultant Oncologist
  Q what is current position I dealing with this?

- *The Trust has tried, unsuccessfully, to recruit this vacant post 3 times. Unfortunately there is a Regional shortage of Oncologists which has impacted on us.*
- *To progress this service the Trust has developed a Nurse-Led Acute Oncology Service model. Funding has been secured by the Trust to facilitate one of the Specialist Nurses to undertake the Acute Oncology course. At recent SACT peer review this service was commended as a way forward in delivering services to patients.*
- *The Trust participated in a Regional Acute Oncology Service Workforce Expansion Review and this review has recommended a 7-day model for Craigavon and a Monday-Friday model for Daisy Hill.*
- *The Trust has submitted its proposal to the Region with funding requested. However, this has not yet been supported.*

- Key statistics information
  Q where there is underperformance what /how are those patients not being seen being managed in terms of risk

- *Triage on receipt of RF referral is undertaken by clinicians; whilst patients are typically seen in order individual clinicians will highlight patients that need to be booked sooner.*
- *All cases are discussed at MDM and clinicians consider and stratify risk to develop individual treatment proposals. Patients will therefore be listed for treatment /surgery in line with their level of risk leading to some patients waiting longer than others.*
- *Cancer tracking process in place with standard arrangement for escalation of individual patients on the pathway to HoS, Individual Clinicians, and lead MDT as appropriate*

- Urological /Lung / Breast/Gynae/Haematology only measuring new suspected /confirmed while pts with recurrence are not being tracked
  Q why is this?

- *This is in line with Regional Departmental and NICAN guidance where only the first definitive treatment is 'tracked'. This is applied by all Trusts*
- *Patients re-presenting are known to the existing teams in the main and those identified by clinicians are referred to the cancer tracking team and will be recorded on the Cancer Patient Pathway information system (CaPPS) to allow clinical oversight facilitating regional and local MDT discussion and review.*

- Pathways to cancer diagnosis
  Q What are we actively doing to address this is there a transformational service approach / service delivery approach with GP's

- *A Cancer Strategic Forum is in place to review this recent report and consider any necessary actions, including sharing with primary care colleagues. Specific actions will be detailed in the tumour site actions plans*
- *The Trust will seek to update the work on the lung screening pilot to ensure this is part of planning*
- *Cancer Reference Groups have been refreshed and refocused on pathway development work; each CRG lead is progressing improvement work for their tumour site on a regional basis*
- *Actively engagement in peer review processes are in place to ensure our service is high quality and may lead to local service improvement or discussion with Commissioner around service expansion.*

- 40% theatre Nurse vacancies (tbc)
  Q how is this being managed and has there been any improvement?

- *On an average the Anaesthetic, Theatres and Intensive Care Division is working with 60 – 65 nursing wte absences due to vacancies, long term sickness and maternity leaves. In addition to general recruitment challenges, staffing levels have been in part impacted by staff moving to higher banded posts within the Trust.*
- *As a result, the Trust has sustained a reduction in elective theatre activity (c 25%) at the level that was made initially to manage winter pressures. The impact on elective theatres is further impacted currently as nursing staff have been deployed to support critical care as part of the COVID response.*
- *The Trust has undertaken a range of recruitment initiatives including recruitment fairs and specific recruitment drive, regional advertising, etc and has conducted follow up/exit interviews with staff leaving this area.*
- *In managing this the Division is utilising a range of agency staff and skill mix to backfill nursing roles; it remains challenging to secure long term commitment/contracts for this group of staff*
- *The Trust is working to consider skill mix/banding in this area to create a more robust structure, allowing for promotional opportunities in an effort to increase retention*

Siobhan
25th March 2020

Southern Health and Social Care Trust

Quality Care - for you, with you

Performance Committee

Committee Chair Report for Virtual Trust Board Meeting on 29th April 2020

In light of the current Covid-19 pandemic, the Performance Committee ('the Committee') did not meet in its formal format on 19th March 2020. However, to ensure that the governance arrangements around the Committee are managed in a way that is proportionate to the current situation, the following measures were put in place:-

- Members reviewed the papers and forwarded comments and questions to the Committee Chair within an agreed timeframe
- The Committee Chair collated these and forwarded to the Trust Chair and Chief Executive for response
- Responses were then communicated to Committee members by the Committee Chair and, if required, will be discussed at the next virtual meeting. This ensured that members had the appropriate advice and challenge necessary for effective decision making on those items that required approval.

The following is a summary of the areas considered by members to update the Board. The formal record of the meeting remains the approved minutes.

Summary of areas considered

- Minutes of previous meeting held on 9th December 2019 were approved via email.

Internal Assurance

- Performance Reporting - Corporate Performance Scorecard was approved via email.

- Integrated Performance Report

    - Children's Services – performance, issues and actions to include Executive Director Professional issues
    - Cancer Services – performance, issues and actions to include Executive Director Professional issues

- Unallocated Childcare Cases Report
- Executive Director of Nursing, Midwifery and AHPs Report
- Infection Prevention and Control and Antimicrobial Stewardship Report

External Assurance - Performance Reporting

- Cancer Services – Peer Review
- Children and Young People's Services – Regional Performance

Action(s) requested / required of Trust Board

- Note the areas considered
- Approval of previous minutes 19th December 2019

Mrs Siobhan Rooney
Committee Chair
On behalf of the Performance Committee
April 2020

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

Minutes of a Virtual Meeting of the Performance Committee held on Monday, 21st May 2020 at 12 Noon

PRESENT:

Mrs S Rooney, Non-Executive Director
Mrs R Brownlee, Trust Chair
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director (Chair)

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs A Magwood, Director of Performance & Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals
Mrs L Leeman, Assistant Director Performance Improvement
Mrs S Judt, Board Assurance Manager
Mrs S McCormick, Committee Secretary *(Minutes)*

1. WELCOME AND APOLOGIES

Mrs Leeson advised that due to technical difficulties, Mrs Rooney was unable to join the meeting via video conferencing, but would be joining during the course of the meeting via telephone. Mrs Leeson took over the Chair and thanked everyone for facilitating the later start time of 12 noon.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

- Feedback from Committee meeting on 19th March 2020:
  - Committee Chair report
  - Feedback questions and answers

Mrs Brownlee referred to the arrangements which had been adopted for the previous meeting scheduled for 19th March and acknowledged the huge amount of work that had gone into collating feedback and responses. Some discussion took place around the approach used to ensure governance arrangements were managed proportionately in the current Covid-19 climate.

Ms Donaghy referred to a previous query raised at the meeting in December 2019 on increased unscheduled hospital admissions from ED and said it was her understanding half of these were documented as requiring a zero length stay and asked for clarity around their recording. Mrs Leeman explained the operational factors around ED admissions with not all requiring an overnight stay. She stated that a change in recording aligned to regional agreed data definitions, saw these recorded as admissions as opposed to ED attendances. Members noted this resulted in a step change to the trend data for admission from May/June 2017 and in light of this, ED attendances and admissions are now recorded separately.

4. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented the Corporate Performance Scorecard for approval. The document provides information to the Committee in support of its function in overseeing delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines. Members noted the scorecard summarises actual performance against i) 2019/2020 Commissioning Plan Objectives and Goals for

Improvement (OGIs), ii) Performance Trajectories and iii) Key performance indicators (KPIs).

Mrs Magwood highlighted Annex 1 and 2. She referred to the current challenges as a result of a wide range of services across the Trust either reduced or suspended to enable Trust preparedness for Covid-19 and pointed out the scorecard includes data that shows the initial impact of the virus, however the overall impact is expected to be reflected in Trust performance well into the future. Members noted a number of areas for particular concern including; a reduction in referrals to family intervention and gateway teams, as well as red flag referrals and decreased footfall to ED services by almost 50%. Mrs Magwood advised recovery is anticipated post Covid-19.

Whilst members were mindful of reductions across some services, they welcomed the emergence of new ways of working. Mrs Magwood referred to the series of staff engagement sessions which will assist lessons learned post virus to help shape ongoing service and strategic development.

At this point, Mrs Magwood guided members through areas that reflect the key risks to performance against commissioning plan targets by exception, including increased waits for Allied Health Professionals (AHPs) and for the first time access challenges within the Child and Adolescent Mental Health Service. Increasing waits are also problematic within in-patient and day case planned repeat procedures and for Carers' assessments.

Mrs Leeson reflected that despite the current challenges, it was good to see the performance of breast services maintained at 14 days; however Children and Adolescent Mental Health Services (CAMHS) breaches were disappointing in the context of previous strong performance. Mr Morgan acknowledged those waiting more than 9 weeks however, he reminded members performance in this area has been consistently maintained pre Covid-19. Work to find alternatives to face to face contact has been a priority at this time and he stated ASD/CAMHS have been engaged with IT services to develop a secure visual platform system to undertake virtual new and review clinics where possible.

Mrs Brownlee said it was important that in light of the impact Covid-19 has had on performance across a number of key areas, progress should be monitored in a stepped approach at future Committee meetings and it would be beneficial to hear from the Chief Executive and associated Directors on plans for how a recovery of performance will take shape moving into the future. The Chief Executive agreed to progress this in advance of the next meeting in September 2020 and stated that post Covid-19 he would envisage a different set of performance targets emerging.

Action – Chief Executive/Directors

The Chief Executive went on to advise work has already commenced on how the Trust can begin to restart services safely, in line with the recent Ministerial/Department of Health led process in which Trusts have been asked to prepare a Stage 1 plan covering the period 1st June – 30th June 2020 which will then feed into the Department's Stage 2 plan covering the period from 1 July 2020 to 30 September 2020. The Chief Executive advised of his intention to share the draft restart plan with Non-Executive colleagues at the next weekly Non-Executive Director meeting for information.

Ms Donaghy referred to the detail within the Performance Scorecard on backlog clearance to be taken forward via the Independent Sector (IS) and asked if funds would be available as part of the re-start plan to assist with the lengthy Waiting Lists. She also stated she would like to see lessons learned post Covid-19 shared in the future. In responding, Mrs Magwood advised restart will be in slow steps in the Phase 1 Plan and in the first instance the Trust will seek to restart in line with current funding and available workforce. A range of measures are underway looking at how as an organisation we do things differently post Covid-19 and these will be shared with Trust Board over the course of time. Mrs Magwood pointed out that the IS will act as a mechanism to assist recovery; however a number of solutions including how we use both in house and independent sector i is being considered as part of a collaborative approach regionally with the intention of ensuring equitable access. In response to a question from Mrs Leeson on the additional 50 sessions of elective capacity available across the region, Mrs Magwood advised the Trust will engage fully with clinicians to assess those most clinically in

need, however she emphasised the capacity and throughput of these lists remains challenging.

Mrs Brownlee highlighted the huge number of patients waiting beyond their timescale in Endoscopy and emphasised the importance of effectively communicating with patients regarding long waits. The Chief Executive advised all cancelled outpatient appointments are followed up on. He reminded members that as the Trust looks to re-start, new models of care will emerge and interaction with the Health Service will dramatically shift, driving forward transformational change into the future.

Mrs Brownlee stated it was imperative the health and wellbeing of staff wearing Personal Protective Equipment (PPE) for long periods was a priority. Members were advised the HR Psychology Staff Support Service was focusing on staff at present. Moving into the recovery stage, Ms O'Neill advised the Trust will look at how it utilises baseline funds and will take into account the differential for the ongoing need for PPE.

In reflecting on Phase 1 of the re-start plan, Ms Donaghy referred to the high level of unscheduled care attendances with a GP letter, previously reported to Performance Committee in December 2019. Members were advised good working relationships have been developing with primary care colleagues through the Covid-19 bronze response and this will prove to be valuable in developing integrated services into the future.

Members approved the Corporate Performance Scorecard

At this point members discussed Item 7 on the agenda

7. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Trouton spoke to the above named report which provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in

unscheduled care pressures. The indicators include areas such as workforce, education training and quality of practice.

At the outset, Mrs Trouton recorded appreciation to teams across nursing, midwifery and AHPs for their responsive and flexible approach to the needs of the service throughout the Pandemic. Mrs Trouton welcomed the range of training made available for staff to upskill and develop themselves in response to Covid-19 emergency surge planning and advised that 1126 staff attended across 31 programmes.

In responding to a question from Mrs Leeson on staff turnover, Mrs Trouton advised the highest percentage occurs within Acute Services where staff commence in divisions such as ED and then choose to move into different pathways for a variety of reasons. Mrs Brownlee asked how the Organisation captures why staff leave post, to which Mrs Trouton advised that Operational Directorates provide staff with the opportunity to undertake an independent exit interview. Mrs Brownlee emphasised the importance of applying learning from these interviews.

AHP Waiting Lists compounded by Covid-19 were raised and Mrs Trouton was asked about the position on Departmental approval for additional AHP workforce places. In responding, she advised that Mrs McArdle, Chief Nursing Officer, along Heads of AHPs across the region, continue to lobby for additionality, however numbers are small. Mrs Brownlee asked was the increase in undergraduate places still insufficient to address the current workforce supply gap. The Chief Executive stated the Department of Health is required to commission AHP courses and he reminded members any increase in AHP undergraduate intake will require a number of years to translate into registrants within the Trust. It was agreed the Chief Executive would raise AHP Workforce at the Chief Executives Forum.

Action – Chief Executive

Ms Donaghy welcomed the improvements made in the first 6 months of 2019/20 in terms of the provision and uptake of Nursing and Midwifery supervision, however she asked for assurance that supervision is taking place in light of the poor response recorded in

the latter part of the financial year to requests for supervision information. Mrs Trouton advised that supervision is taking place informally, workforce pressures continue to impact and the completion of documentation can be an issue, however she stated nurses are well supported at line management level.

5. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report

- *Mental Health – performance and issues to include Executive Director Professional issues.*

Mrs Leeson welcomed Ms Jan McGall and Mrs Lynn Woolsey, Assistant Directors along with Dr Ivor Crothers, Clinical Director to the meeting. Members were provided with a comprehensive presentation, focusing on Workforce, Mental Health Inpatient Services, Mental Health Planned & Unscheduled Services including Memory Services and Psychological Therapies.

Ms McGall set the regional and local context and stated that mental health remains a priority area for Government with the mental health action plan now published. However, levels of need remain significantly high and across the region, mental health remains a key area challenge in regards to health inequalities reporting. Suicide rates in Northern Ireland reflect the worst in the UK and significant gaps in the rates between the most deprived and least deprived. Funding is comparatively lower in Northern Ireland at c6% of budget, compared with other UK regions allocated c12%. From a local perspective, demand for services beyond capacity remains a pressure point with benchmarking identifying NI has the lowest number of acute mental health beds (20), per 100,000 population in comparison to national counterparts (20-37). Furthermore, Community Caseloads per 100,000 (2832) are above the national average of 1654.

At this point Mrs Woolsey guided members through comparative and external data/benchmarking information to provide assurance that a range of external mechanisms are in place for reviewing performance and identifying improvement opportunities. Members also reflected on

the Mental Health Benchmarking Report included at Item 8 on the agenda.

Mrs Leeman provided a high level overview of the 11 Objectives and Goals for Improvement (OGIs) in the area of mental health. In relation to Adult Mental Health, she advised that whilst there had been a good improvement in waits over 9 weeks in early 2019/20, there was now an upwards trend. Mrs Leeman highlighted the increase in waits over 9 weeks in Dementia Services at March 2020 as a result of the impact of reduced clinics due to Covid-19. In relation to Psychological Therapies, members noted that 250 patients were waiting in excess of 13-weeks. Dr Crothers advised that clinical demand continues to be significantly higher than the resources available across all Psychology services. He spoke of the substantial regional shortfall in qualified clinicians and stated that this position is further compounded by ongoing vacancies in the current workforce. Dr Crothers went on to advise that timely referrals to the service remains a challenge.

Mrs Brownlee referred to the growing demand for Psychological Therapy Services and welcomed the focus on recruiting Graduates in the autumn 2020; however she noted the access time for new patients can be slow and asked the Chief Executive to keep this under review. Mrs Brownlee acknowledged the sterling work being progressed across Mental Health services despite lack of bed capacity and workforce pressures and she gave assurance Trust Board through the Chief Executive will continue to escalate all issues at a regional level.

Action – Chief Executive

Mental Health Discharges were discussed. Mrs Woolsey reported that at March 2020, 96% of patients were discharged from hospital within 7 days. She stated that patients were not assessed as medically fit for discharge until appropriate accommodation was sourced and accommodation in the community sector was an issue.

The continued increase in the number of Direct Payments was noted by the Committee.

Areas for enhancement and service development under Qualitative Standards were discussed. These included Self Directed Support, Substitute Prescribing, Same Gender Accommodation, Dementia Portal and Protect Life 2.

Mrs Woolsey spoke to the workforce information in Mental Health, including vacancies and sickness levels.

In relation to Inpatient Services, an update on the Royal College Invited Review Action Plan was provided. Of the 47 point action plan, the vast majority have either been completed or in progress and on track to complete within timeframe.

The issues and actions within Mental Health Elective Services were discussed. Ms McGall referred to the 800 more referrals from 2018/19 – 2019/20 in primary mental health care with no additional staffing resource.

Ms Donaghy referred to response times for Home Treatment/Crises Response with 75% recorded as seen within 2 hours and 87% within 4 hours and asked how this compared across the region. Mrs Woolsey advised the Southern Trust had performed well in comparison to regional counterparts and work continues to build on improved performance. Ms Donaghy went on to ask about the possibility of virtual consultations within mental health and across interventions into the future. Mrs Woolsey advised telephone and some virtual consultations have been in place throughout Covid-19 and this will be an option going forward.
At this point, there was discussion on professional issues – nursing and AHP and social work. Mr Morgan advised that the Trust has the lowest number of Approved Social Workers in the region and he spoke of an options appraisal paper being considered with regard to strengthening capacity of Approved Social Workers. Mrs Trouton stated that from nursing and AHP perspective, workforce supply, skill mix and funding remains an issue across the Trust.

The Chair thanked everyone for their contribution to the presentation.

Ms McGall, Mrs Woolsey and Dr Crothers left the meeting at this point

- *Infection Prevention and Control – performance and issues to included Executive Director of Professional issues.*

Mrs Leeson welcomed Mrs Trudy Reid, Assistant Director and Dr Martin Brown, Lead Consultant Microbiologist to the meeting to discuss Infection, Prevention and Control (IPC). The comprehensive presentation focused mainly on the Trust's response to Covid-19, performance against Health care associated infections (HCAIs) and Antimicrobial Stewardship Performance.

At the outset, Mrs. Reid referred to the IPC Strategy, the 10 elements of which are interdependent and designed to ensure excellence in IPC practice across the Trust. Mrs Reid emphasised HCAIs can be prevented when robust IPC measures are in place and relentlessly applied and the Trust continue to work to these high standards.

Mr Brown provided members with an overview of the Trust's IPC response to the Covid-19 Pandemic which included support to Independent Sector Providers.

At this point Mrs Reid guided members through a comprehensive range of comparative data demonstrating C. Difficile performance amongst inpatients across age cohorts, 65+ and 2+. Members welcomed the Action Plan setting out the measures required to assist in reducing the number of C. Difficile cases across the Trust. Further performance data was considered in relation to a number of other HCAIs.

In regards to Antimicrobial Stewardship Performance, members welcomed the important role the Outpatient Antimicrobial Therapy (OPAT) Service has played in improved performance with reduced readmissions by 50% and decreased average length of stay by 4.5 days of antibiotics.

The Chief Executive recorded thanks to Dr Hedderwick, Mrs Reid and Mr Brown for leading the high level IPC response to the Coronavirus Pandemic. He welcomed the enhanced staff put in place and the work undertaken across the whole team in recent challenging

circumstances. The Chief Executive referred to the post viral challenges to seeing a reduction in cases however, he emphasised the Trust has good expertise in IPC practices. The Chair welcomed the additional IPC staff and extra funding which had assisted performance in the past. Mr Brown referred to the importance of minimising the risk of infections and keeping Antimicrobial Stewardship under review. Mrs Reid assured members there is a collective commitment across IPC/Antimicrobial Stewardship and Operational teams to continue the work to drive down cases to the very minimum and maximise early learning post Covid-19.

In response to a question from Mrs Leeson about Covid-19 screening, Mrs Reid advised that testing capacity has increased significantly and laboratory staff have been working hard to analysis samples to ensure as many staff as possible remain in work to support the service at a critical time. Mrs Brownlee asked about testing in care homes. Mrs Donaghy asked if there was any analysis done on BME. The Chief Executive advised of a draft regional testing strategy which until the Department release, the Trust will continue to follow PHA guidance. Mrs Brownlee raised the importance of a clear public message in this regard.

In concluding the item, Mrs Leeson thanked both Mrs Reid and Mr Brown for their informative presentation.

Mrs Reid and Dr Brown left the meeting at this point

6. UNALLOCATED CHILDCARE CASES REPORT

Mr Morgan spoke to the above named report and advised a total of 44 unallocated cases as at 30 April 2020, a significant decrease on the previous reporting period (31 March), when 123 unallocated cases were reported. Mr Morgan pointed out there had been a marked reduction in referrals during April 2020 as a result of Covid-19 lockdown, however an increase in 'domestic incident' notifications from the PSNI to Children's services was concerning, with 375 recorded in April 2020. Members welcomed the Trust's proactive approach throughout the pandemic to ensure families affected by domestic violence remain well supported and informed regarding services available to them. Mr Morgan assured members that all child

protection referrals were responded to within 24 hours and all children seen and spoken to.

8. Performance Reporting - External Assurance

i) Mental Health Benchmarking Report

Members discussed the Mental Health Benchmarking Report in conjunction with Item 5i on the agenda.

9. ANY OTHER BUSINESS

None noted.

The meeting concluded at 3.45 p.m.

Signed _____ ***Dated*** _____

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 3rd September at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Mrs R Brownlee, Trust Chair
Ms G Donaghy, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs A Magwood, Director of Performance & Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals
Mrs L Lappin, Head of Performance *(for Mrs Leeman)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs L Leeman, Assistant Director Performance Improvement

1. WELCOME AND APOLOGIES

Mrs Leeson welcomed everyone to the meeting and noted the apologies above. She informed members that Mrs Siobhan Rooney's term of office as Non-Executive Director ended on 28th August 2020. The Committee acknowledged Mrs Rooney's contribution and commitment as Chair of the Performance Committee since its

inception. Mrs Leeson advised she will take on the role of Chair of the Committee and Mr John Wilkinson, Non-Executive Director, will join the committee on a temporary basis.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

The Chief Executive provided an update on the recent Covid-19 outbreaks in Craigavon Hospital. He advised that efforts continue to be focused on managing the situation and stated that staffing challenges remain within 3 South and the Haematology ward. He spoke of the actions taken to reduce the number of cases within the hospital, namely:- visiting has been suspended, face coverings are mandatory for everyone on site, the importance of social distancing has been reinforced and the introduction of wardens throughout the hospital site. The Chair welcomed the update and noted the challenging and difficult weeks ahead for staff involved.

4. MINUTES OF PREVIOUS MEETING HELD ON 21ST MAY 2020

The Minutes of the meeting held on 21st May 2020 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

AHP workforce supply gap was discussed. Mrs Trouton informed members of agreed uplifts to Physiotherapy, Occupational Therapy, Speech & Language Therapy and Radiography undergraduate intake numbers at Ulster University from October 2020/21. However, the numbers are small.

Ms Donaghy referred to page 5 of the minutes in relation to the number of unscheduled care attendances with a GP letter and queried if this was still a problem. The Chief Executive explained the

'No More Silos' work streams will begin to address this through Urgent Care Centres, however, until the Urgent Care Centres are established, unscheduled care attendances to ED with a GP letter will continue to be a challenge.

6. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented the monthly Corporate Performance Scorecard – July 2020 for approval. She advised that item 8 Year-End Performance Report is to be read in conjunction with the scorecard. The document provides information to the Committee in support of its function in overseeing delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines. Members noted the scorecard summarises actual performance against i) 2019/2020 Commissioning Plan Objectives and Goals for Improvement (OGIs), ii) Performance Trajectories and iii) Key performance indicators (KPIs).

Mrs Magwood drew members' attention to the challenges since the last report to Performance Committee and particularly noted the impact of Covid-19 on performance, particularly the elective position. She highlighted challenges in the following areas: diagnostic test – decrease in percentage of waits <9-weeks and growth in waits >26-weeks. Out-Patient waits for first assessment and increase in waits beyond clinically indicated timescale for review. In-Patient / Day Case Waits and Planned Repeat Treatments – decrease in percentage of waits <13-weeks and growth in waits >52-weeks. Increasing volumes of patients waiting beyond their clinically indicated timescale for planned repeat treatment.

Mrs Magwood stated that the Trust has received in-year investment of £200,000 for the 7th Urology Consultant. Recruitment is currently ongoing and it is anticipated that the 7th Consultant will be in post in Quarter 4. She did note that the additional capacity created by this post will be targeted to the red flags and urgent cases with little anticipated impact on routine waits.

Mrs Magwood stated that as part of the Trust's Rebuild Plans services continue to seek to increase core capacity in line with

relevant clinical guidance and Covid-19 precautions. The Trust's Covid response impacted on the level of available outpatient accommodation and noted that work is ongoing to assess the current accommodation that can be utilised for face to face outpatient assessments and to allocate this to the greatest demand. Furthermore, as part of the Rebuild Plan, the Trust is seeking to continue with virtual assessment as well as face to face and services are seeking to maximise this where possible.

The Chair noted the areas for concern, ongoing difficulties and the lack of recurrent investment. She referred to the Year-End Performance report section where it includes a snapshot of a number of areas where the Trust's performance is either more or less favourable than the Regional performance. Mrs Magwood highlighted work force challenges and funding available which impacts performance. She spoke of the 'no more silos' work that is being undertaken which it is hoped will contribute to improvements in performance.

The Chief Executive referred to table 2 within the Year-End Performance report which provides a summary of the 71 OGIs, comparing the Trust Delivery Plan assessment to the Year-End assessment. The table demonstrates that there were 60 (84%) OGIs that matched or were better than the End of Year Assessment to the TDP Assessment. He did note his disappointment on those targets that were less favourable at Year End Assessment compared to the TDP assessment.

Mrs Toal joined the meeting at this point

Ms Donaghy asked if performance going forward will be measured against the re-build plans. Mrs Magwood explained that the Department of Health agreed not to allocate new targets, however the targets will continue to be monitored through the accountability meetings with the Chief Executive alongside the re-build plans with the opportunity for potential suggestions and improvements.

Mr Wilkinson noted the areas that have not met their target in the Trust Delivery Plan and asked if there are any risks associated with those particular areas. The Chief Executive spoke of his concern in

relation to Acute hospital discharges into the community. He advised that progress was being made, however Covid-19 impacted this work. A working group has been established to review the patient flow; however the volume of patients is high. The Chair asked that this is an area of focus for the next report.

Action: Mrs Magwood

Mrs Toal stated that sickness absence levels had been on the rise pre Covid, and the levels of Covid related absences were increasing.

Members approved the Corporate Performance Scorecard

7. CORPORATE RE-BUILD PLAN

The Chief Executive spoke to the Corporate Re-build Plan included in members' papers for information. He informed members that the Department of Health has suspended work on the Commissioning Plan Direction for 2020/2021 and the Minister has directed that for the next two year period Trusts should commence service planning, delivery and deployment of resources to stabilise and restore service delivery as quickly as possible. This planning will balance the delivery of Covid-19 and non- Covid-19 activities and has been reflected in phased delivery plans for service rebuild which have been developed and shared with the public by all Trusts including, Phase 1 Rebuild Plan: June 2020 and Phase 2 Rebuild Plan: July – September 2020. Delivery plans for Phase 3 Rebuild Plan: October – December 2020 are in development will be submitted to the Department of Health on 23 September.

In addition to Rebuild plans, the Trust will also develop in parallel Surge Plans in keeping with the Department of Health's Regional Surge Planning Framework which should be published in late August. This surge Plan will reflect how the Trust intends to manage demand for unscheduled care in the October 2020 – March 2021 period.

Mrs Magwood commented on the performance management arrangements that are in place which include daily operational calls and Bi-weekly SMT bronze meetings, fortnightly monitoring of performance against a regionally agreed set of activity projections, monthly reporting to SMT on progress against Rebuild Plans, Chief

Executive Accountability Arrangements and external arrangements. Mrs Magwood reminded members that the Trust continues to report against the CPD objectives via its monthly corporate scorecard.

Mrs Brownlee spoke of the importance of Trust Board being kept updated on the Re-build plans and asked that an update be provided at the September Trust Board meeting. Mrs Magwood agreed to take this forward.

Action: Mrs Magwood

Mr Wilkinson asked for further information on the Phase 3 Re-build plan. Mrs Magwood stated that the winter surge plan would normally be developed at this time of the year with 9 measures in place. She advised that this has now been re-purposed to contribute to the re-build and surge plans. The Chief Executive added that the Management Board have agreed in principal the regional surge plans to address ICU capacity.

A discussion ensued on the Regional Engagement Strategy. The Chief Executive advised that this was discussed and approved at the Management Board. The Strategy includes regional and local responsibilities and each Trust will adopt the strategy and engage with staff. The Chair asked that the Regional Engagement Strategy be shared with members which the Chief Executive agreed to undertake.

Action: Chief Executive

8. YEAR END PERFORMANCE REPORT

Mrs Magwood presented the Year End Performance report for approval. She advised that the report was presented to Trust Board in June 2020; however the data was incomplete in some areas and members had asked that a more up to date report be presented to the Performance Committee.

Members discussed the content of the report along with item 6: Corporate Performance Scorecard.

Members approved the Year End Performance Report

9. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Support to Carers and Adult Community Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Brian Beattie, Acting Director of Older People and Primary Care, Mr Barney McNeany, Director of Mental Health and Learning Disability, Mr Gerard Rocks, Assistant Director of Promoting Wellbeing and Ms Kathy Lavery, Directorate Lead Social Worker in Mental Health to the meeting. Members were provided with a comprehensive presentation, focusing on Adult Community Services, Support to Carers and Self-Directed Support / Direct Payments.

Mr Beattie began by discussing Adult Community Services. He explained that the Indicator of Performance (IoP) standard seeks delivery of care management assessments within 5 weeks, which was being achieved in the main. He reported that a very small volume of patients waited in excess of 5 weeks. Mr Beattie informed members that the standing down of Delegated Statutory Functions (DSF) reporting, including Annual Reviews as part of the Covid-19 management response, further impacted on recent performance.

Short Breaks were discussed. Mr Beattie reported that there has been an overall increase in Short Break hours over the last 4 years, with the volume of Short Breaks delivered as community based hours having also increased. However, non-bed based breaks continue to reflect less than 45% of the total hours delivered. Demand for bed based breaks may reflect acuity of cohort, predominantly elderly. Investment in OPPC Integrated Care Team (ICT) staffing will support increased work with service users and families to ensure they access Short Breaks in keeping with their preference.

Mr Gerard Rocks presented information on support to carers in the Community & Voluntary Sector. He reported that during the Covid-19 crisis a COVID Community Helpline was created, which helped 2150+ beneficiaries between April - June responding to concerns re: access to food, medicine and social contact. Mr Rocks also highlighted that

information on a range of supports in the community is emailed regularly to carers on the Trust Carer's Register, which reaches 900+ carers. He spoke of the number of services contracted by SHSCT to provide Local Community Support as outlined in the presentation.

Mr Beattie highlighted the number Short Breaks for Young Carers available that are commissioned by the Trust and advised that these are provided by Action for Children. He spoke of the challenges in creating enough places versus the number of young carers requiring short breaks.

Ms Lavery presented information on the Carers Conversation Wheel, which had been co-produced by staff and carers in the South East Trust. It has been piloted in the Adult Physical Disability and Community Addictions services within the Southern Trust. Within both services the uptake of carers assessment had increased. It also highlighted that there was a reduction of inappropriate offers, which was a positive result. Ms Lavery commented that both pilots involved carers and carer representatives and were conducted using Quality Improvement (QI) methodology. Following the pilots, it is intended to roll the model out across all Directorates. Mr McNeany commented on the success of the pilot particularly using the QI method and felt this supports staff and carers. Mrs Toal asked if the terminology of 'carers assessment' could be amended to 'carers conversation'. Ms Lavery explained that as this is a statutory function the terminology cannot be changed.

In relation to Self-Directed payments, Mr Beattie reported that the Trust did not achieve the target of 955 direct payments in 2019/20. However, 910 service users were in receipt of direct payments, which demonstrates a 4.8% increase against the 10% target.

The Chair thanked Mr Beattie, Mr McNeany, Mr Rocks and Ms Lavery for the informative presentation.

Mr Beattie, Mr McNeany, Mr Rocks and Ms Lavery left the meeting at this point.

10. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

Dr O'Kane presented the Infection, Prevention and Control, Antimicrobial Stewardship report for assurance purposes. The paper provides data from April 2019 to July 2020 for PFA targets.

Dr O'Kane reported that the Trust saw an increase in Clostridium Difficile in 2019/20 with a significant rise in October 2019. She assured members that this was managed using the 'outbreak' management plan and an action plan was developed and implemented, which has resulted in a reduction of Clostridium Difficile cases.

Dr O'Kane explained that the IPC team and Microbiologist, while continuing to support the management of Covid-19 in the Trust and with the Independent Sector providers, are refocusing attention on C difficile, AMR and Gram negative bacteraemia with the current resources. The Infection Prevention and Control team and Microbiologists have provided advice and support to clinical / operational teams and care homes on the prevention of transmission of Covid-19, including zoning of Trust and Independent Sector provider's premises for managing PPE on sessional basis. Local testing has also been implemented.

Dr O'Kane informed members that one Consultant Microbiologist has resigned, however recruitment is underway with interviews scheduled by the end of September 2020.

In response to a question asked by Ms Donaghy, the Chief Executive advised that a bid has been submitted for additional resources to the IPC team to deal with the hospital and care home surge, however the main issue is the skill set and expertise within Infection Control that is required. Mrs Trouton explained that Nursing staff can develop their skills into the Infection Control area, however this takes time and requires staff to undertake training and complete courses.

Mr Wilkinson enquired if the repeated use of antibiotics has an impact on the number of infections. Dr O'Kane explained that the long term use of antibiotics, particularly in the older population poses a

significant increased risk of Clostridium Difficile and antibiotic resistance.

Dr O'Kane left the meeting at this point

11. UNALLOCATED CHILDCARE CASES REPORT

Mr Morgan spoke to the above named report and advised there was a total of 21 unallocated cases as at 31 July 2020, a decrease on the previous reporting period (31 March), when 44 unallocated cases was reported. He informed members that there was a high level of Child Protection and LAC activity associated with complexity of cases; however there were no unallocated Child Protection or LAC cases.

Mr Morgan reported that during COVID-19 contingency arrangements within the social work staff from the Parenting Service, Court Children's Service and Signs of Safety team were redeployed to support the Family Intervention Service. Partnership arrangements were strengthened between Children's Gateway Service, Armagh Down Women's Aid, Barnardo's, SPACE N.I. and NIACRO to provide early intervention outreach support to families affected by domestic violence and abuse that had a domestic incident notification made by the PSNI to Children's Gateway Service during the Covid-19 pandemic.

Vacancies were discussed. Mr Morgan highlighted that vacancies across the Gateway, Family Intervention and CWD Service have improved due to the immediate recruitment of final year social work students. Funding has also been secured for 3 senior social work practitioners to strengthen the CWD service. Recruitment for these posts is underway.

12. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Trouton presented the Executive Director of Nursing, Midwifery and AHPs report which provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability

Framework and include areas regarding workforce, education training, and quality of practice. This report is reflective of the Covid-19 surge impacts. Mrs Trouton informed members that the Chief Nursing Officer and the region stood down the need to collate Nursing Quality Indicator data at this time but the Trust is currently working closely with frontline teams to re-establish this reporting infrastructure.

Mrs Trouton referred members to page 4 of the report which demonstrates the vacancy rates of all Bands between April and June 2020, which is monitored fortnightly. She reported that the number of vacancies has decreased from 227 to 156 for the time period. Mrs Trouton informed members that in April this year 119 final placement pre-registration Nursing and Midwifery students joined the Nursing and Midwifery workforce in the Trust in Band 4 roles under the NMC Emergency Standards for Education, contributing to patient care during the COVID-19 pandemic.

AHP Workforce was discussed. Mrs Trouton referred to the table on page 7 that provides information on each Trust's vacancy rates by AHP profession as at 31st March 2020. The report highlights that the Southern Trust has 104 AHP vacancies (9.7%) which is the highest in the region, along with the Western Trust. The Trust's highest vacancy rate is in Physiotherapy and Mrs Trouton noted this is largely within the Older People and Primary Care Directorate. Mrs Toal added that the workforce team is reviewing the recruitment and retention process within Physiotherapy.

Mrs Trouton spoke of the flexible pool within the Trust. She informed members that Occupational Therapy and Physiotherapy have 36 unfilled vacancies within the flexible pool across these areas. Mrs Trouton assured members that the AD Steering Group is focusing particular attention on these areas with the view to increase AHP clinical elective activity and reduce waiting times.

Mrs Brownlee felt that the recruitment process to appoint AHPs was prolonged and asked how this will be addressed. Mrs Toal stated that she will raise this issue with Shared Services and feedback at the next meeting.

Action: Mrs Toal

Mrs Brownlee noted her concern on the long waiting lists for AHPs and asked how those patients are kept updated. Mrs Trouton advised she will take this forward with Mr Brian Beattie, Acting Director of Older People and Primary Care and feedback at the next meeting.

Action: Mrs Trouton

13. Performance Reporting - External Assurance

i) NHS Benchmarking Report – Management of Frailty in Acute Setting

The Chair welcomed Mrs McClements to the meeting to present the above named item. Mrs McClements referred to the report included in members papers and explained that the Trust is a member of the NHS Benchmarking Network (NHSBN) and in 2018/2019 agreed to participate in a scheduled review of the Management of Frailty and Delayed Transfers of Care. The report is to provide information to the Committee regarding performance management arrangements to monitor the management of frailty services in acute settings and to provide assurance that a range of mechanisms are in place and new improvement opportunities identified. Mrs McClements guided members through the report highlighting the findings. She noted that this work is in conjunction with the Acute, Mental Health, Older People and Primary Care and Planning teams.

Mrs McClements highlighted that the Southern Trust has the lowest percentage of Geriatricians relative to other NI Trusts and lower number of beds; however the Trust has the shortest length of stay for inpatient frailty patients. She added that pre covid-19 the Trust had a frailty ward; however in the current climate it has not been possible to sustain this but the intention is to reinstate it. Mrs McClements advised that the teams are currently focusing on increasing their training for frailty identification which will assist to define the skills, knowledge and behaviours that staff need in order to effectively support people living with frailty. She added that support from the commissioner is critical.

Mrs Brownlee reminded members the low number of Consultant Geriatricians within the Trust has been raised previously and a piece of work was commissioned to review this. She asked for an update on this work. Mrs McClements assured members that the actions identified through that piece of work resulted in the development of the "older persons assessment units" (Geriatrician led), greater focus on frailty work, internal networking across sites and services supported by Geriatricians and succession planning opportunities. Mrs Magwood gave assurance that workforce and infrastructure were on her agenda with the new Director of Commissioning. Mrs Brownlee asked that this matter continues to be an area of focus and any updates to be provided to the committee in future.

Action: Mrs McClements

Mrs McClements left the meeting at this point

14. TERMS OF REFERENCE

Members reviewed the revised Terms of Reference and endorsed it for Trust Board approval on 24th September 2020.

15. COMMITTEE WORK PLAN 2021

Members reviewed the committee work plan for 2021. As previously discussed the Corporate Re-build Plan will be included for each quarter. Members approved the Committee Work Plan for 2021.

16. MEETING DATES FOR 2021

The proposed dates for 2021 were approved.

17. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.30 p.m.

Signed _____ Dated _____

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 3rd December 2020 at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs A Magwood, Director of Performance & Reform
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs L Leeman, Assistant Director Performance Improvement
Mrs D Ferguson, Assistant Director, Nursing, Education and Workforce *(for Mrs Trouton)*
Ms J McConville, Assistant Director Specialist Child Health and Disability (*for Mr Morgan - items 1-8)*
Mr C McCafferty, Assistant Director, Corporate Parenting (*for Mr Morgan - items 9-14)*
Mr D Douglas, Assistant Director, Children & Young People's Services (*for Mr Morgan - items 9-14)*
Mrs S Judt, Board Assurance Manager
Ms J Brodison, Performance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals

1. WELCOME AND APOLOGIES

Mrs Leeson welcomed everyone to the meeting and noted the apologies above. She particularly welcomed Ms Dawn Ferguson and Ms Julie McConville deputising for their respective Directors. Mrs Leeson also welcomed Ms Julie Brodison, Performance Manager who was observing the meeting as part of her training and development.

Mrs Leeson informed members that Mrs Roberta Brownlee's tenure as the Trust Chair and member of the Committee ended on 30th November 2020. The Committee acknowledged Mrs Brownlee's contribution to the Performance Committee since its inception.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

None noted.

4. MINUTES OF PREVIOUS MEETING HELD ON 3RD SEPTEMBER 2020

The Minutes of the meeting held on 3rd September 2020 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

In relation to the AHP recruitment process through BSO Shared Services, Mrs Toal advised that on a rotational basis, each Trust takes a lead role in co-ordinating regional recruitment exercises and on review, a number of delays were highlighted. One of the issues noted was the processing of recruitment outcomes by selection panels onto the e-rec system, therefore relevant Trust HR / Resourcing teams will now work with the HSC Recruitment Shared

Service Centre in the involvement of the recruitment plans/timescales.

Mrs Magwood updated members on the issue that the Trust has a lower percentage of Consultant Geriatricians relative to other NI Trusts. She informed members that an initial meeting has been held with the new Director of Commissioning to discuss longstanding workforce reports and need for action to address. In respect of frailty, Mrs Magwood commented a further meeting with the HSCB Frailty Network and Trust representatives is due to be confirmed soon.

Dr O'Kane joined the meeting at this point

6. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented the Corporate Performance Scorecard and advised that regional work has now commenced on a new integrated planning / commissioning framework for HSC and advised the Commissioning Plan Direction / Trust Delivery Plan (CPD/ TDP) framework in its current format will cease. Until revised performance management arrangements are agreed, the Trust will continue to monitor against the existing framework (Corporate Dashboard) while also focussing on detailed drill down in target areas as agreed by the Performance Committee. It is anticipated a 'draft' regional framework will be developed by April 2021. Members noted the business of the Performance Committee may need to adjust to reflect this work going forward.

Mrs Magwood stated that the Trust's response to Covid-19 throughout 2020/2021 continues to impact on core service delivery and CPD targets. She reminded members that the Trust was not required to submit a TDP in 2020/2021, however monitoring continues based on extant CPD targets from 2019/20 as well as a range of key performance indicators (KPIs), predominantly focused on quality and safety domains.

Rebuilding Plans were discussed. Mrs Magwood reported that following the initial surge of Covid-19, the Trust has submitted phased plans to the DOH for rebuilding core services. Phase 3 (October 2020

– December 2020) has been impacted further as result of the second wave of the pandemic.

Mrs Magwood guided members through the scorecard which includes an assessment performance against established targets on a Red, Amber and Green (RAG) basis and associated analysis of trends and periods of variation. A summary of key risks in relation to the Trust's broader performance across a range of other areas considered by SMT were also included in the report.

The Chair asked about waiting lists in relation to Cancer Services and asked if there is comparison data against the UK. Mrs Leeman advised that the Trust is able to benchmark regionally but national targets are very different.

Mr Wilkinson asked what steps have been taken to address the backlog in waiting lists, in particular for cancer patients and how will the Trust ensure that red flag patients are dealt with appropriately. Dr O'Kane responded that access to services due to services being stood down in response to the pandemic is concerning as this may delay patients in the system. Mrs Magwood advised that the backlog of cases is incorporated into the Re-build Plans and work is underway with the regional network, local service teams and clinicians to discuss those patients who require urgent care through a prioritisation process by the Regional Cancer Network. Mrs Leeman added that additional capacity is required to treat the number of cancer patients and this has been discussed at a regional level.

Members discussed the fact that performance for complex and non-complex discharges remains variable and this is compounded by challenges associated with discharging some residents back to residential and nursing homes, associated with Covid management in these facilities. Mrs Ferguson advised of an expression of interest from OPPC to the independent sector which Mr Beattie was taking forward.

At this point Mrs McConville spoke of the impact of the pandemic on young people and families. She spoke of the importance of schools remaining open and noted that the CAMHS service is working hard to support children and their families during the pandemic. Mrs Leeson

raised the fact that families are under more pressures with inability to cope with increasing family disruption and care placement disruptions, and noted that in month there have been 7 placement disruptions (foster care breakdowns) and there is increasing evidence of adoptive placements becoming very fragile.

In response to a question asked by Ms Donaghy on annual appraisals which was assessed as a red rating, Dr O'Kane reported that 93% of appraisals have been achieved; however she spoke of the challenges to accomplish the OGI of 95% rate for medical staff. This has been impacted by the implementation of the new online re-validation and appraisal system. She further added that the Chief Medical Officer suspended Medical Appraisals due to pressures associated with Covid-19 and it is envisaged that these will be signed off by December 2020; however due to a 3rd surge this could prove difficult. Ms Donaghy noted that this is an area for close monitoring.

Members approved the Corporate Performance Scorecard

7. CORPORATE RE-BUILD PLAN SUMMARY

The Chief Executive provided a progress update on the Corporate Re-build Plan. He reminded members that the Trust commenced a phased plan to rebuild services after the initial wave of Covid-19 pandemic. The phase 3 Rebuild Plan (October 2020 – December 2020) was submitted to the Department of Health, however, due to the second wave of the pandemic, plans were accepted as 'paused' by the Minister for Health. He assured members that the Health and Social Care Board continues to monitor activity aligned to Phase 3 planned volumes. The Trust position at 31st October 2020 was outlined within the report.

The Chief Executive noted that while overall performance remained relatively strong, performance at the end of October - November 2020 demonstrated reductions in activity due to the impact of further services stood down as part of the Trust's response to the second wave of the pandemic. In particular, the following areas are anticipated to show reduced performance at 30 November 2020 due to staff re-deployment: Allied Health Professionals, Day Centres and In-Patients and Day Cases.

Mr Wilkinson asked on the position of elective care to which Mrs Magwood explained that a process is in place to identify alternative options to increase elective capacity locally and through regional collaboration.

8. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Disability Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Barney McNeany, Director of Mental Health and Learning Disability, Mrs Lynn Woolsey, Assistant Director of Inpatient Services (MH&LD) and Mr John McEntee, Assistant Director of Disability Services to the meeting. Members were provided with a comprehensive presentation in advance of the meeting, focusing on Disability Services.

Mr McEntee began by providing an overview of Disability Services. He explained that the Trust provides a wide range of specialist Learning Disability, Physical Disability and Sensory Disability services, which he spoke to in detail.

Mrs Woolsey presented information on In-patient Services. She explained the purpose of the Dorsy Inpatient Unit was to provide assessment and treatment for people with a learning disability who require inpatient treatment for mental and behavioural distress due to mental disorder. Mrs Woolsey reported on the admissions, discharges and delays, the detail of which was in members' papers.

Restrictive Practice was discussed. Mrs Woolsey reported in September 2020, the Dorsy ward in conjunction with all the wards in Bluestone Unit implemented Safety Crosses. This new method allows a more timely review of incidents of restrictive practices. The data has been shared with the Lived Experience and Carers Group (LECA) to co-produce and co-develop an action plan. She advised that learning has been extracted from the Muckamore Abbey Report and actions have been taken forward in relation to Governance, Audit & Data and Collective Leadership.

Mr McEntee reported on the Behaviour Support Services which is a psychology led service supporting individuals and services to manage behaviours that challenge using a PBS model, with a view to merge the service with the Crisis Response team.

Short Breaks was discussed. Mr McEntee explained that pre Covid-19 there were 28 funded respite beds across the Trust and this was reduced to 5 beds during the pandemic to allow for social distancing and infection control measures.

Mr McEntee spoke of the Adult Transition Service. He stated that the Trust was the first and currently the only Trust to have a dedicated Multi-Disciplinary Team to support service users at aged 18 years transitioning into adult services. Due to the emergence of the Covid-19 situation and its impact on service delivery, benefits of this service development using QI methodology has been deferred to June 2021.

Governance and Professional issues was discussed. Mr McEntee noted the significant reliance on AYE Social Workers and number of vacancies across all areas. He spoke of the Approved Social Worker (ASW) role and noted that the capacity has been reduced due to a number of factors. Mr McEntee added that to address this, ASW have been removed from Mental Capacity Act panel work to increased capacity to fulfil ASW rota requirements, a pilot is underway on a management of change proposal which will separate the ASW / ASG Lead roles for 12 month period and continue the focus to attract ASW programme.

Mr McNeany spoke of the significant estate issues for Day Care Centres and the impact this has on the level of care provided to service users. In relation to workforce, he noted the significant developments in using the collective leadership model down through the Directorate structure and envisaged that positive changes will be seen using this model for the future. The Chair added that Trust Board will be holding a workshop on the report from Muckamore Abbey and learning and recommendations from this report will be implemented into the Dorsy Unit.

Mrs Magwood noted the 20% vacancy rate within Learning Disability and asked how the Trust is actively encouraging nurses to enter into this area of care. Mrs Woolsey explained that there is an appetite for nursing care from students however the number of placements does not match the demand which has an impact on the workforce. Mrs Ferguson added that there has been an increase of preregistration places made available by the Department of Health since 2017 from 30 to 55 placements regionally; however this is still not enough capacity to fill the gap within Learning Disability. She explained that the Trust has invested into the Open University programme and ensuring that students receive good working experience which has resulted in a number of these students offered roles within the Trust.

The Chief Executive asked how the profile of Learning Disability within the Trust can be promoted. Mr McEntee commented that previously there was increased focus through the regional review of Learning Disability Services; however the progress has been slow and impacted by Covid-19. He added that once the review report is released, funding and commitment is required to drive this area forward. Within Physical Disability the no more silos work-stream will help streamline this area. The need for investment into the community to prevent hospital admissions is also paramount. Mr McNeany added that it would be beneficial to collate data in these areas onto a dashboard to receive real time data and which can be used to measure improvements. The Chief Executive suggested that Mr McNeany discuss with his team any particular areas that require SMT support and feed these back to the Chief Executive for further discussion.

The Chair thanked Mr McNeany, Mrs Woolsey and Mr McEntee, for the informative presentation.

Mr McNeany, Mrs Woolsey, Mr McEntee and Ms McConville left the meeting at this point.

Mr McCafferty and Mr Douglas joined the meeting at this point

9. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty and Mr Douglas presented the above named report and noted that as at 30th October 2020 there were 93 total unallocated cases. There are no unallocated Child Protection or Looked After Children (LAC) cases. Mr Douglas noted the high level of Child Protection and LAC activity associated with complexity of cases. Actions to manage risk of unallocated cases include weekly monitoring completed by team managers and monthly monitoring completed by Heads of Service and Assistant Director.

The impact of the pandemic was highlighted with the level of isolation the children encounter and the closure of schools. Mr Douglas stated that services had to adapt to respond to this. He provided assurance that risk assessments were undertaken for all Child Protection and LAC cases and decision was made in May 2020 to see these children in their own environment face to face while adhering to Infection, Prevention and Control measures.

Mr Douglas informed members that the Trust has appointed a senior social work practitioner and social work assistant to support the Children's Gateway Service respond to families affected by domestic violence and abuse.

Mrs Leeson referred to the challenges with children with disabilities. She made the point that there are children with disabilities who are not in receipt of statutory services who are also impacted by Covid-19 and it is important to be mindful of this. Mrs Leeson commended staff for their excellent work in Children's Homes.

Mr McCafferty informed members that short breaks which support families and children with disabilities have been up-scaled since August 2020 following a reduction during the pandemic due to infection control management.

Mr Cafferty provided assurance that every LAC case has a monthly review with their social worker.

Mr Douglas spoke of the support provided by Dr McGurk, Consultant Occupational Clinical Psychologist to Social Work staff and how this will be introduced for staff in the Gateway team.

Mr Cafferty noted the positive impact that foster and adoption families have on children and the system and spoke of the importance in promoting this area more.

Dr O'Kane and Mrs Toal left the meeting at this point

10. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Ferguson presented the Executive Director of Nursing, Midwifery and AHPs report which provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Framework and include areas regarding workforce, education training, and quality of practice. This report is reflective of the Covid-19 surge impacts.

Mrs Ferguson spoke of the significant work that has been undertaken in partnership with Human Resources to review Band 5 Nursing recruitment processes within the Trust to ensure nursing recruitment remains a top priority within the context of Covid-19 restrictions.

The Open University pre-registration nursing programme was discussed. Mrs Ferguson reported that there is 128 Trust staff undertaking the programme which includes 52 new students who commenced in September 2020, which is the biggest intake to date.

Mrs Ferguson reported for the period 1st April 2020 to 31st August 2020 that 24% of band 5 and above Nursing and Midwifery staff have completed their KSF. This is a decrease from the previous quarter, however she contributed this to the pressure and challenges teams have faced during the Covid-19 pandemic.

Supervision was discussed. Mrs Ferguson reported that the average compliance with meeting the AHPs Supervision Standards for period

ending 30th September 2020 was 68% which is an 8% increase compared to the last quarter. She added that more supervision is being carried out than being reported. In relation to Re-validation, Mrs Ferguson stated that staff have embraced the virtual platform and 526 who are new to the role of supervising and assessing student nurses have completed the 5 hour training programme.

Mrs Ferguson commented on the progress of the International Recruitment drive which recommenced in September 2020. To date 106 International Nurses have been placed in Southern Trust with a plan to accept 12 international recruits on a monthly basis. She raised an issue in regards to the availability of accommodation; however, this is being discussed with Ms O'Neill and the Estates team for a way forward.

Ms Donaghy referred to the revalidation status section of the report and asked for further clarity on extension period. Mrs Ferguson explained that the revalidation process for nurses was extended for 3 months during March to May 2020. The extensions are issued directly to the individual, not the Trust which has resulted in significant additional workload for both managers and the revalidation team liaising with nurses for evidence of the extension to ensure they can continue to work as a registered nurse/midwife. She provided assurance that that through the control measures in place two nurses were identified and were successfully supported to get back on to the NMC register.

11. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

The Chair advised that this item will be deferred to the next meeting.

12. Performance Reporting - External Assurance

i) End of Life Care Benchmarking Report

Mrs Magwood presented above named item. She provided background to the report that the Public Health Agency on behalf of the Regional Palliative Care in Partnership Programme commissioned the NHS Benchmarking Network to deliver National

Audit of Care at the End of Life (NACEL) in Northern Ireland with the five Health and Social Care Trusts. This report is to provide information to the Performance Committee to provide assurance that a range of mechanisms are in place and new improvement opportunities identified in respect of arrangements to manage and improve End of Life Care throughout the Trust.

Mrs Magwood guided members through the report highlighting the summary of the findings and scores for each audit area, compared to the NI Average score, for Craigavon Area and Daisy Hill Hospitals. She noted that the number of cases in Lurgan and South Tyrone Hospitals were small and not presented here although recommendations and learning will be applied. Mrs Magwood drew members' attention to the 6 recommendations for the Trust to focus on as outlined in the report. She provided assurance that the recommendations have been shared with key staff and engagement scheduled (December 2020) with teams to define actions that will support the outcomes sought, actions to be presented to the Locality Palliative and End of Life Programme Board and endorsed for inclusion in the annual work plan, content of performance report to be agreed at the locality Programme Board and arrangements for presentation to Board agreed and further audits planned.

Mrs Magwood added that Quality Improvement plans will be established through this report. The Chief Executive highlighted that a recommendation from the report is for it to be presented annually to Trust Board.

In response to a question asked by Ms Donaghy, Mrs Magwood reminded members that *'Grieving through Covid-19'* presentation was presented to Trust Board in September 2020 which outlined the challenges families faced while their loved one was in hospital. She added that hospital visiting was stood down, except for those patients on an End of Life pathway.

13. COMMITTEE WORK PLAN 2021

Members reviewed the revised committee work plan for 2021. A discussion ensued on the option to present one Integrated Performance Report theme as opposed to two at each meeting. It

was the consensus view that one themed presentation would be presented at each meeting, going forward.

Mrs Magwood assured members that SMT will continue to highlight to the committee if there are any areas of concern that require discussion at the committee. The Chair agreed to discuss the themed presentations for 2021 with Mrs Magwood.

Action: Chair / Mrs Magwood

14. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.30 p.m.

Signed _____ ***Dated*** _____

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 18th March 2021 at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Ms E Mullan, Trust Chair
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs A Magwood, Director of Performance & Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director (item 10 only)
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals
Mrs L Leeman, Assistant Director Performance Improvement
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

None

1. WELCOME AND APOLOGIES

Mrs Leeson welcomed everyone to the meeting and no apologies were noted. She particularly welcomed Ms Eileen Mullan, Trust Chair and Mr Eoin McAnuff, Boardroom Apprentice to his first Performance

Committee meeting. At this point she advised members on some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

None noted.

4. MINUTES OF PREVIOUS MEETING HELD ON 3RD DECEMBER 2020

The Minutes of the meeting held on 3rd December 2020 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

Cancer Services was agreed as the themed area for the next meeting.

The Chair requested that item 10 be discussed at this point

10. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

Dr O'Kane presented the Infection, Prevention and Control, Antimicrobial Stewardship report for assurance purposes. The paper provides data from 1st April 2019 to 31st January 2021 for PFA target. She advised that the deferred December report is included in members' papers.

Dr O'Kane reported that following the increase in Clostridium Difficile in 2019/20 with a significant rise in October 2019 she provided assurance that the team continues to work with Directorates to reduce Clostridium Difficile and the rates have reduced in 2020/2021.

The IPC team and Microbiologist between Covid-19 surges while continuing to support the management of Covid-19 in Trust and with Independent Sector providers are refocusing attention on C difficile, AMR and Gram negative bacteraemia with the current resources.

A discussion ensued on the long term use of antibiotics and Dr O'Kane explained that antibiotics have been used to treat patients with Covid-19 infection and this has increased the use of antibiotics throughout the Trust. She added that Dentists who were restricted in who they could treat during the pandemic also saw an increase in the use of antibiotics. Ms Donaghy referred to the monthly target monitoring report from PHA on secondary care antimicrobial prescribing data and asked if the Trust routinely receives feedback or a comparison to other Trusts from the PHA. The Chief Executive commented that feedback has been requested on a number of occasions. Dr O'Kane agreed to contact the PHA on this matter and feedback at the next meeting.

Action: Dr O'Kane

In regards to MRSA, Dr O'Kane reported that there have been three preventable MRSA bacteraemia from April 2020 to March 2021 and post infection views have been carried out to identify learning.

Antimicrobial Stewardship Activities were discussed. Dr O'Kane stated that due to Covid-19 pandemic, there was less availability of microbiology time to become involved in antimicrobial stewardship activities. However, pharmacist led antimicrobial stewardship rounds continued with monthly feedback on prescribing to the DHH and CAH Medical M&M. In addition, monthly antimicrobial stewardship reports were sent to all clinical, lead nursing and pharmacy staff within all directorates.

Mr Wilkinson commented that Infection Control will continue to be paramount for the safety of patients and enquired if the staffing levels within the IPC team were adequate. Dr O'Kane acknowledged that the IPC team is relatively small for the amount of work that they undertake throughout the Trust and community and explained that training a registered nurse to become an Infection Control nurse takes two years. Dr O'Kane added that recruitment for microbiologist

and band 7 IPC nurse, and band 6 ICPNs is in progress. She advised that an IPT (Investment Proposal Template) has been submitted to the HSCB. The Chief Executive added that he has written to the Permanent Secretary requesting additional support to enhance the IPC team.

Dr O'Kane left the meeting at this point

6. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented two reports for this section: Performance Report for assurance and Corporate Performance Scorecard for approval purposes.

Mrs Magwood began by updating the committee on regional planning and the development of a new Future Planning Model. Directors of Planning /Performance are the Trust representatives on the regional group led by the DOH/HSCB. This will see a new outcomes driven model, building on local relationships with primary care particularly advanced through the system response to the covid-19 pandemic towards a NI Integrated Care System (ICS) with prototypes to be established in each Trust geographic area. It is anticipated a new performance monitoring regime aligned to an integrated care system will be introduced based on a range of outcomes, indicators and targets (where appropriate). Updates on progress will continue to be provided to the Performance Committee. Mrs Magwood stated that during the transition period to this new planning regime the Trust continues to monitor performance through the monthly Performance Scorecard, Rebuilding Plans and Performance report to Committee.

Ms Donaghy asked how the integration and collaboration in building local relationships with Primary Care will be achieved. Mrs Magwood spoke of the relationships already in place with the LNC, GP Federation Leads and Associate Medical Director within OPPC. She advised that there is a great willingness to work together and she provided examples of achievements through the Covid-19 pandemic; emergency department phone first service, Paediatric Consultant providing a Paediatric Advice Line (PAL) to support GPs and to help reduce hospital admissions.

Mrs Magwood stated that the initial plan is to build up the relationship between Primary and Secondary care and the integrated care system will build on after and include for example other parties through our community planning relationships and inclusive of other statutory agencies and services users. She emphasised the importance of building relationships in the first instance.

Rebuild Plans were discussed. As previously reported, the recent wave of the pandemic significantly impacted the rebuild in the period January – March 2021. The Trust is currently developing plans for Quarter 1 of 2021/2022. This will identify planned actions aligned to the de-escalation of intensive care and critical acute services balanced with the necessity for staff to take annual leave / rest periods before resuming and/or scaling up core activities.

The Chair referred to the joint Covid-19 Contingency Framework for the delivery of services to vulnerable children that was developed by the Departments of Health and Education and asked if changes can be made in this area from this framework. Mr Morgan commented that there are opportunities from this framework for better working across education and health for vulnerable children but noted his concern in fully achieving this with the increase in referrals re-building services and overall capacity in the system.

Mr Wilkinson asked if a potential fourth wave occurs does the Trust have plans in place to secure performance. Mrs Magwood stated that the solution would be the ongoing collaborative work at a regional level to ensure that services are available throughout the region for all patients.

Annual Care Reviews in the Older People and Primary Care Directorate were discussed. Mr Wilkinson noted that the level of reviews undertaken on an annual basis has significantly decreased due to workforce challenges, Covid-19 outbreaks in homes and restrictions to reduce footfall. He asked how the Trust is addressing this. Mr Morgan commented that Mr Beattie has been proactive in securing additional social workers to undertake care reviews and utilise remaining staff to work differently to undertake these reviews.

Mr Wilkinson referred to the home treatment crisis response service. He commented on the importance of this service and how it helps to prevents hospital admissions. Mr Wilkinson noted the increase in admissions to this pathway and asked has an evaluation of the service been carried out recently. Mrs Magwood advised when the service was first introduced through the tiered model an evaluation was carried out by the MHLD Directorate. She referred to the Mental Health Benchmarking report which will be presented under item 11 and agreed to source if there is an updated evaluation on the home treatment crisis response service. She advised she will link in with Mr McNeany and feedback at the next meeting.

Action: Mrs Magwood

Mrs Magwood guided members through the corporate performance scorecard which includes an assessment performance against established targets on a Red, Amber and Green (RAG) basis and associated analysis of trends and periods of variation. A summary of key risks in relation to the Trust's broader performance across a range of other areas considered by SMT were also included in the report.

Members approved the Corporate Performance Scorecard

7. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Diagnostic Imaging – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Barry Conway, Assistant Director, Cancer and Clinical Services / Integrated Maternity & Women's Health to the meeting. Members were provided with a comprehensive presentation in advance of the meeting which focuses on Endoscopy, Cardiac Catheterisation and Physiological Measurement Imaging.

Mrs Leeman presented information on the Endoscopy and Cardiac Catheterisation service on behalf of Mrs McClements. She began by providing background to the Endoscopy service and reported that currently there are 4700 patients on the active waiting list. Mrs

Leeman spoke of the recurrent capacity gap challenges with delivery of core services as currently the Trust is funded for 10,490 scopes; however only delivered 70% of capacity in 2019/20 due to Operator issues. She added that due to the Covid-19 pandemic and restrictions there was reduced capacity in sessions due to Aerosol generation. Ongoing Nurse endoscopy turnover and vacancy also has an impact on core services. Mrs Leeman reported on the demands for the service including significant demand for red flag and urgent scopes, routine wait times increasing and planned / repeat patients waiting beyond clinical timescales. In regional context, Mrs Leeman reported that the Southern Trust has the largest volume of Red Flag and Urgent endoscopy waits, however this data was used to inform the split of additional non-recurrent funding to Trusts for Q1 of 2021/2022 with SHSCT receiving the largest share of allocated funding. In comparison to the Red Flag and Urgent waits the Southern Trust's volume of Routine & Bowel Screening waits is the lowest, with 13% out of the Regional total. Mrs Leeman reported on the actions to manage capacity and demand as outlined in the presentation.

Mrs Leeman reported on Cardiac Catheterisation Service. She informed members that the service has a well established medical & multi-disciplinary workforce which is attractive to recruitment. There are regional links via PCI rota and BHSCT sessions. The service has a well-regarded and accredited catheterisation laboratory serving inpatients and elective day cases and there is a Research and Innovation focus throughout cardiology. Mrs Leeman spoke of the challenges within the service; capacity is below demand for the Southern Trust population which impacts on access for inpatients, lengthening wait times for urgent and routine cases, vulnerability with singular lab on Acute site – risk to in-patient provision with downtime and lack of Regional contingency plan, infrastructure challenges, lack of capacity within Independent Sector with options only for outsourced modular capacity provision and patients not accessing the Cath lab within clinical timeframes.

Physiological Measurement (Cardiac non-invasive investigations) was discussed. Mrs Leeman spoke of the challenges in recruiting trained Clinical Physiologists trained to report echocardiograms, limited capacity to undertake in-house additionality, limited Independent Sector capacity option, no recurrent funding for capacity

gaps except for TTEs, TOEs now classified as Aerosol Generating Procedure (AGP) impacting capacity per session. Mrs Leeman drew members' attention to the actions to address these issues in the presentation which highlight that recruitment for band 7's is underway, the Trust is working collaboratively with the South Eastern Trust who have provided core capacity monthly to address an element of the long waiting TTEs and in-house additionality secured for TOEs. She added that 2 Cardiac Consultants have recently been appointed who are undertaking a data cleanse of the waiting list and a Quality Improvement project has commenced within the Echo Team.

Mr Conway presented information on Imaging. He guided members through the presentation reporting data on: imaging waits, elective access, activity and regional context. He informed members of the issues that the service is facing: demand and capacity challenges - recurrent gaps for some years, high level of urgent demand for imaging when compared regionally, working within new IPC environment - Covid guidance - reduced sessional capacity, challenging capital funding environment and on-going requirement for capital investment; on-going reliance of mobile / modular kit, new Regional Imaging Board established and the challenges within the workforce. Mr Conway spoke of the rebuild in services and noted that the waits are slowly decreasing.

Mr Conway informed members that the new CT services are now available on either side of catchment area DHH and STH and the Southern Trust is the only Trust in NI to provide Low Dose CT scanning. He spoke of the future developments; twin CT suite CAH (October 2022), DHH CT/MRI suite, DHH hybrid interventional Radiology suite, reporting and training facilities on CAH site and Radiology MDT room.

The Chair thanked Mrs Leeman and Mr Conway for the detailed presentation and welcomed the actions to address the issues highlighted.

Ms Mullan stated that it was evident that using the Independent Sector for short term use was the way forward in relation to Endoscopy waiting lists and asked if there is sufficient capacity within

the Independent Sector to carry this work out and what are the risks the Independent Sector using Trust facilities. Mrs Leeman explained that a number of Independent Sectors providers have approached the Trust who can offer their own staff to carry out these procedures, therefore capacity is not an issue, however the key risk is that the Independent Sector providers are not RQIA registered, therefore to use Trust facilities the Trust will be responsible for the governance arrangements and necessary checks will be undertaken. She advised that other Trusts have used this approach and learning from them has been identified and shared and she felt that this was an opportunity to address the waiting lists. In response to a question asked by Mr Wilkinson on the cost of utilising the Independent Sector, Ms O'Neill advised that it is more expensive that using Trust staff. She also confirmed that the cost of using the Independent Sector is funded separately.

Ms Mullan asked if there was a regional plan for a dedicated elective centre. Mrs Magwood advised that regional discussions are ongoing for this topic, for example, it has been suggested that Lagan Valley would continue to be the best fit for a dedicated elective care centre and the Trust working in collaboration with this service. She spoke of the opportunities and benefits of working collaboratively with other Trusts to provide treatment and care throughout the region to work differently and maximise sites and these opportunities to improve access for our population.

Mr Wilkinson noted his concern on the routine waiting lists and asked how those patients are managed. Mr Conway advised in the first instance the Radiologist ensures that from the information on the referral they are placed on the correct waiting list and correct diagnostic test. He added that work is ongoing to validate the waiting list to ensure that patient's circumstances have not changed or they no longer require a test. Mrs Leeman commented that Primary Care will inform the Trust if a patient is deteriorating and requires urgent diagnostic testing.

Ms Donaghy asked for assurance that once a diagnostic test is carried out that the patient receives treatment in a timely manner. Mrs Leeman spoke of the developed regional process for clinical oversight prioritisation of elective cases to ensure equity. For those

patients who require surgery there is a particular timeframe in when those patients are operated on. Each week the Trust provides the list with the most urgent cases requiring surgery with the region to ensure they are given priority for surgery. She noted that the cancer recovery plan and elective plan will address this.

The Chief Executive thanked Mr Imran Yousaf and Mr Conway for their excellent leadership in driving this service forward.

Mr Conway left the meeting at this point.

8. UNALLOCATED CHILDCARE CASES REPORT

Mr Morgan presented the above named report and noted that as at 29th January 2021 there were in total 93 unallocated cases. There are no unallocated Child Protection or Looked After Children (LAC) cases. He commented on the challenges faced with maintaining a full complement of staff in the context of social work vacancies, maternity/sick leave across the service and COVID-19 contingency arrangements. Mr Morgan provided assurance that management are liaising with Human Resources to address these gaps and to undertake regular recruitment. The Chair asked on the likelihood of securing additional staff. Mr Morgan stated with the rolling recruitment programme for the Family Intervention Team and Gateway teams he was optimistic that additional staff would be secured. He added that during the Covid-19 pandemic the Trust provided a wraparound service to placement students and he was positive that a healthy number of those students once graduated would return to the Trust.

Mr Morgan spoke of the benchmarking exercise undertaken by Mr Tommy Doherty in the HSCB which looked at the previous ten years data. The data showed that there has been a 67% increase in the number of children on the Child Protection register since 2012 and has been consistently rising from 2014. He added that the Looked After Children population has had a 42% increase from 2011. Mr Morgan stated that these increases across the system adds pressure to staff and has an impact on the number of unallocated cases.

The Chair asked since the pandemic, has there been a change to the severity of cases now presenting to the service. Mr Morgan commented that the data does demonstrate that the number of complex cases is increasing which is adding to the number of cases on the Child Protection Register. He spoke of challenges and pressures young people face and how the staff manage these circumstances.

In responding to a question asked by Ms Mullan, Mr Morgan explained that there has been an increase in referrals from the BAME and other communities into the system and he felt this was a reflection of the breakdown percentage in the population across the Southern Trust region. He added that the Trust is proactively working with these communities through the Southern Outcomes to ensure that they have access to all health and social care services. Mr Morgan spoke of the translation hub which provides a range of information to communities in their own language. The community volunteer sector also works proactively with these families to help and support them.

9. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Trouton presented the Executive Director of Nursing, Midwifery and AHPs report which provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Framework and include areas regarding workforce, education training, and quality of practice. This report is reflective of the Covid-19 surge impacts and largely covers the period November 2020 to February 2021. Mental Health and Disability Nursing Workforce Information presentation was included in members' papers.

Mrs Trouton guided members through the report and highlighted specific areas for noting. She referred to the information on supervision and stated that the average compliance with meeting the AHPs Supervision Standards for period ending 31st December 2020 was 65%. There was a small reduction in performance by 4% when compared with September 2020 and she attributed this to service

pressures linked to the second Covid-19 pandemic surge. Mrs Trouton commented that supervision within nursing and midwifery is an area of focus to ensure that nursing staff have the opportunity within their formal supervision to discuss their career progression and training. She felt that this proactive approach would help determine those staff wishing to undertake additional training and encourage them in planning career progression within the Trust; Mrs Trouton also advised that performance data will be used to highlight particular areas where there are vacancy gaps for specialised staff e.g. advanced AHP practitioners, advanced nurse practitioner, endoscopy nurses etc.

Nursing Quality Indicators were discussed. Mrs Trouton drew members' attention to the audit results by ward over the last 3 months. She stated that the team has reviewed widening out the indicators to new areas which now include ICU, Emergency Department, Maternity, CYP and OPPC. Mrs Trouton spoke of the challenges in the commencement of indicators for these areas however she reported that results are improving.

Ms Donaghy noted her concern on the midwifery formal supervision figures. Mrs Trouton reported that this is an area for ongoing improvements and high importance. It was noted in the figures presented that there was a 75% nil response as to whether formal supervision had occurred or not. She explained that the report can only include the actual number of formal supervision that took place as reported but work is ongoing on the recording of same.

Ms Mullan queried if supervision is on the Nursing, Midwifery and AHP Directorate Risk Register to which Mrs Trouton reported that it was.

11. PERFORMANCE REPORTING - EXTERNAL ASSURANCE

i) Mental Health Benchmarking Report

The Chair welcomed Mr Barney McNeany, Director of Mental Health and Learning Disability, Ms Jan McGall, Assistant Director Mental Health Services and Mrs Lynn Woolsey, Assistant Director Inpatient Services to the meeting to present the above named item.

Mr McNeany stated that the information is from the 2020-21 data from the NHS Mental Health Benchmarking dataset. Whilst the full report has not been provided to the Committee the presentation includes the areas that the Trust is closely aligned from a benchmarking perspective. He explained that for more than seven consecutive years, the NHS Benchmarking Network has been successful in providing Mental Health Trusts in England, Wales and Northern Ireland quality and performance data that inform future research, national policies and service transformation.

Ms McGall and Mrs Woolsey presented information for the following areas - Acute Adult; beds, occupancy rates, admissions, length of stay, restraint, workforce and vacancies, delayed transfers and re-admissions; Older Adult; beds, occupancy rates, admissions, length of stay, delayed transfers and re-admissions; and community mental health domains.

The Chair welcomed the informative presentation and stated that this report is an excellent tool to interrogate the Trust's performance and noted the challenges faced for the Directorate throughout the Covid-19 pandemic.

Mrs Magwood spoke of the importance of quality indicators and raised the issue of registered nursing vacancies. Mrs Trouton spoke of the recent success in reducing vacancies in this area and the effort to increase morale and attitude throughout this workforce.

In response to a question asked by Mr Wilkinson, Ms McGall explained that the dataset does provide some information as to quality of care provided to patients (e.g. caseload contacts) however the experience of the service user and analysis of their outcome is also important and captured via other means to ensure quality of care. The feedback from the peer support workers and the focus on the patient's life changes following their interaction with the service can also demonstrate how well services are performing. Mr McNeany added that the data on the readmission rate, use of seclusion and hands on intervention are important factors which demonstrate if unit is high performing. Mr Morgan added that the report shows a low number of patients detained under the Mental Health Act which is

also a good indication of the quality of community service provided. Mr McNeany informed members that discussions are underway with Trade Unions on the use of body worn cameras in the Bluestone inpatient unit and he felt that this would add another level of assurance to safeguarding measures for both patients and staff.

Mrs Woolsey spoke of the Nursing Quality Indicators already in place. She advised that work is underway to develop and introduce an additional set of specific nursing quality indicators into the unit. Such NQI's are also in place in Dementia Inpatients.

In regards to the readmission rate, follow up with patients after their discharged aims to be decreased from 7 days to 3 days in the year ahead, in line with best practice from the National Confidential Enquiry into Suicide. Ms Donaghy noted her concern that the length of stay rate could be viewed as both positive and negative. Mr McNeany agreed and explained that a balance is required between the length of stay and readmission rate. He advised that the length of stay varies depending on the diagnosis and in some cases there is a reasonable cause for readmission. Mrs Woolsey advised that going forward a piece of work will be undertaken to correlate the length of stay and readmission rate to understand if there are particular issues or an acceptable rationale and respond appropriately to the findings.

The Chief Executive welcomed the level of detail in the presentation and spoke of his concern is moving forward with a single Mental Health service for NI as the benchmarking data highlights the difference in service provided by other regional Trusts. He welcomed the focus on correlation of the length of stay and readmission rate. The Chief Executive thanked Mrs Woolsey and Ms McGall and their team for their hard work and dedication and in particular to Mr McNeany for the work that has been accomplished since joining the Trust. Mr McNeany added that it was important to note that from an assurance perspective, Mrs Woolsey and Ms McGall are taking forward work in regards to the Royal College of Psychiatrists Quality Improvement Standards for community and inpatients and this will provide a level of external assurance from peers.

12. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.30 p.m.

Signed _____ Dated _____

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 20th May 2021 at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive *(Items 9, 10 & 11 only)*
Mrs A Magwood, Director of Performance & Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals
Mrs L Leeman, Assistant Director Performance Improvement
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Mrs H McCartan, Non-Executive Director

1. WELCOME AND APOLOGIES

Mrs Leeson welcomed everyone to the meeting and noted Mrs McCartan's apologies. She particularly welcomed Mr McAnuff, Boardroom Apprentice 2020 and Mr Martin McDonald to his first Performance Committee. Mrs Leeson advised that Mr McDonald and

Mrs McCartan are now members of the Performance Committee and the Terms of Reference will be amended to reflect this change and presented for approval at the next meeting.

At this point, Mrs Leeson advised members on some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

None noted.

4. MINUTES OF PREVIOUS MEETING HELD ON 18th MARCH 2021

The Minutes of the meeting held on 18th March 2021 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

Maternity Services was agreed as the themed area for the next meeting.

6. PERFORMANCE REPORT

Mrs Magwood presented the Performance Report for approval. She advised that this report focuses on a broad range of issues and spoke of the areas of improvement / achievement. Included in the report was the Trusts' rebuild plans for restarting services after the pandemic. Mrs Magwood stated that it is anticipated longer term regional service reform is required to effect significant longer term achievement across a number of key areas and improvements to Trust infrastructure is needed in respect of hospital based services to support a safe return to services post-pandemic.

Mrs Magwood guided members through the report which provided updates in the following areas: Cancer Service Performance, CAH elective capacity, hospital infrastructure issues, unallocated cases, medical workforce pressures impacting core services, demand for elective services within CYP, access to services (Adult Mental Health Services), mental health inpatient demands, carers supports, Allied Health Professionals, ongoing performance of statutory functions (carers assessment, annual reviews), unscheduled care - care homes fragility of sector and GP Out of Hours.

Mrs Magwood reported that following the outworking's of the Covid related SAI and report recommendations by the Department's Nosocomial Support Cell, the Trust has successfully secured £8.7m of capital investment for expenditure in the 2021/2022 year across a range of areas to address some of the most critical clinical improvements required primarily at Craigavon Area Hospital. Ms O'Neill welcomed this investment and stated that discussions will take place with Mrs Magwood and Mrs McClements to produce a programme on where and how this funding is spent for maximum impact

The Mental Capacity Act was discussed. Mrs Magwood stated that the associated compliance with this legislation is impacting on all operational Directorates. The outstanding volume of legacy Deprivation of Liberty (DoL) cases in the community, the impact of new cases, review cases and returns from the Attorney General's office are significant. The volume of work in this area is resulting in significant and competing demands as staff working in these areas are impacted by pressure of backlogs and associated targets and the conflict between this work and increasing pressures in core services. Mrs Magwood advised that the Trust continues to seek to increase the workforce to undertake Deprivation of Liberty applications.

The Chair welcomed the detailed report and noted the importance for staff to take their annual leave and rest periods before resuming and / or scaling up core activities and asked if this was feasible. Mrs Magwood advised that a detailed Re-build Plan will be discussed at the next Trust Board meeting; however she commented that managers and teams are required to facilitate the need for staff to use their leave. Mr Morgan agreed that staff have worked tirelessly

through the pandemic and it is important for management to seek a solution to ensure that staff receive their annual leave.

Mr McAnuff referred to page 8 of the report on access to services within Mental Health and noted that as at the end of February 2021 the Trust accounted for 74% of the total excess waits regionally for Adult Mental Health and asked what other Trusts are doing differently. Mrs Leeman explained that different models are used across Trusts and Dr O'Kane explained the Southern Trust model. Mrs Magwood also spoke of the staffing gaps across Mental Health and the demands following Covid-19 which impacts on the waiting lists.

Dr O'Kane commented on the waiting lists within the Mental Health Directorate. She advised that resources are required to support the routine appointments and measures are in place to support those on a waiting list for routine appointments. Dr O'Kane advised that Ms Jan McCall is reviewing the system and they are having conversations nationally. Mrs Magwood spoke of the development of the Multi-Disciplinary Teams (MDTs) in primary care, one of which provides mental health support.

Mr McDonald commented on the challenge of obtaining a face to face appointment with GPs and felt that this has may have an impact on early diagnosis / treatment. Dr O'Kane stated that a meeting was held recently with the GPs for the way forward on easing out of the pandemic and noted that the GPs are keen to increase additional face to face appointments. She spoke of the positive impact that telephone and virtual appointments have been for some service users but agreed on the importance of face to face communication.

The Chair noted her concern that the waiting times for Speech and Language Therapy review appointments within the Children and Young People's Directorate has increased from 36 weeks to 60 weeks. She commented that this is beyond the clinically indicated timescale for review and asked for further clarity. Mr Morgan explained that Paediatric AHP services have been impacted significantly over the last year due to staff redeployment, vacancies sickness, and PARIS implementation. He explained that the increase can be attributed to demand and capacity issues and work is

underway to reduce the backlog of review appointments. Mr Morgan commented that the re-opening of special schools has seen the demand for AHP services rise by 15% and the team are working creatively and collaboratively to ensure that this need is met.

Members approved the Performance Report

7. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented the Corporate Performance Scorecard (March 2021 performance) for approval. The report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework. It includes an assessment performance against established targets on a Red, Amber and Green (RAG) basis and associated analysis of trends and periods of variation.

Mrs Magwood guided members through the report highlighting areas of improvement, for example, breastfeeding at discharge is above target for 2021/21; CAMHS, as at March 2021, demonstrated that 94.7% waiting less than 9 weeks than at April 2020 which is a considerable improvement. Areas of concerns were highlighted as outlined in the report. Mrs Magwood provided assurance that services and teams are reviewing available options and way forward to reduce waiting lists.

Ms Donaghy asked about the uptake of the flu vaccine. Mrs Toal stated that whilst the uptake was a significant improvement on the previous year, the Trust has not met the 75% target. The Trust continues to promote a range of initiatives such as the peer vaccine model. Ms Donaghy raised the increasing staff sickness absences to which Mrs Toal advised that Covid related sickness had an impact on absence levels. Mr Wilkinson referred to the data on Dementia and noted the number of patients waiting in excess of 9 weeks and asked what steps have been taken to improve this. Dr O'Kane contributed this increase as a direct consequence of the management response to Covid-19 during which time only urgent referrals were seen. Capacity for routine referrals is now being re-instated and an improvement in the volumes of waits in excess of 9-weeks is expected. The service is reviewing options to reduce the waiting list

and have approved weekend clinics and additional screening clinics. Dementia in patients under 65 was discussed. Dr O'Kane advised that the Head of Community Dementia is liaising with GPs to improve the waiting list for this cohort of patients by September 2021. Mrs Magwood added that there is no commissioned service for patients under 65 diagnosed with dementia. In response to a question asked by the Chair, Dr O'Kane commented that the numbers of patients under 65 with dementia may be small but still significantly important to ensure they receive the correct treatment within clinically indicated timeframe. The Chair stated the importance of the Chief Executive continuing to feed into regional discussions with regard to Dementia patients under 65.

There was discussion on the Regional Management Board and the new HSC framework for Northern Ireland. In response to question asked by Mr McDonald on the level of autonomy at a local level, Mrs Magwood advised that there a number of areas that still need clarified such as scope and control. She noted that the Elective Care Framework is about to be published. Mr Morgan spoke of the various forums on which the Trust is represented to try and influence the shape of the framework with a more focused community approach.

In regards to regionalisation, Ms Donaghy asked if plans are in place to communicate the way forward to the public. Mrs Magwood advised that this is a piece of work that needs careful consideration and work is underway regionally to address this. Mrs Leeman reiterated the importance of engaging publicly on regionalisation of services.

Members approved the Corporate Performance Scorecard

The Chair requested item 12 be discussed at this point

12. PERFORMANCE REPORTING - EXTERNAL ASSURANCE

i) Health Quality Improvement Partnership (HQIP) Hip Fractures Database Annual Report

The Chair welcomed Mrs McClements, Director of Acute Services to the meeting to present the above named item. She reported on the National Hip Fracture Database (NHFD) which is a national clinical

audit undertaken by the Royal College of Physicians on behalf of the NHS. Data is collected on all aspects of the care given to hip fracture patients in England, Wales and Northern Ireland aged 60 and over. The report provides information to give assurance that a range of mechanisms are in place to review the outcomes of the data and consider improvement opportunities identified in respect of arrangements to the care and outcomes of those presenting with hip fractures.

Mrs McClements guided members through the report highlighting the key areas of variation that are below national average: 1 - prompt Orthogeriatric Review: SHSCT 68% vs 86% nationally. Mrs McClements explained that the decrease represents the loss and non-replacement of 0.6 WTE Orthogeriatrican Consultant and has been negatively affected by the ongoing lack of weekend and bank holiday Orthogeriatric cover which guarantees a failure to meet this target for patients admitted at these times. Mrs McClements reported that the present Orthogeriatric team have shown notable flexibility regarding their job plan to facilitate the service which has improved the position; however the figure shows an ongoing under met need which can directly bring further improvements in patient care. 2 - prompt surgery: SHSCT 27% vs 69% nationally. Mrs McClements added that this is a clear representation of the capacity vs demand discrepancy that has been acknowledged for several years but without any notable increase in capacity created either in ward or theatre space.

Mrs McClements spoke of the areas that are above the national average: 30 day Mortality (recognised as among the best in the UK), NICE compliant surgery, post-op delirium, prompt mobilisation, return of patients to original residence. All of these targets show markers of high levels of quality care across the whole MDT which combines to ensure patients are receiving optimal standards across their operative journey and resulting in the high percentage able to return to their original residence.

Mrs McClements reported that to meet trauma demand the use of commissioned orthopaedic theatre time is required on a daily basis which has a significant impact on the orthopaedic waiting times. She added that a recent DoH capacity and demand report on the

orthopaedic service was deemed to be very significantly short in terms of capacity to deal with demand. She felt that to lose further capacity on the orthopaedic side to make up for a shortfall in trauma capacity should not be acceptable.

Mr McDonald asked if support is available regionally to which Mrs McClements spoke of the Regional Trauma Network which aims to work collaboratively with HSC Trusts in order to co-ordinate the delivery of trauma services across Northern Ireland, however she noted that there are known capacity issues across all Trusts.

Dr O'Kane left the meeting at this point

8. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Cancer Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mrs McClements, Director of Acute Services, Mr Barry Conway, Assistant Director Cancer and Clinical Services and Dr David McCaul, Clinical Director for Cancer Services to the meeting to present the above named item.

Mrs McClements began by presenting performance information in the following areas; breast cancer 14 day, 31 day performance and 62 day performance. Data was also included on targets pre and post covid. She presented data on regional performance and from the NI Cancer Registry.

In regards to the issues affecting cancer performance, Mr Conway reported that referrals during the pandemic have decreased; therefore there is a concern that patients may be missed. He spoke of the capacity gaps prior to the pandemic. Mr Conway highlighted the actions to address the local and regional issues as outlined in the presentation and spoke of the Regional Recovery Plan Workstreams.

Mr Conway stated that the need to comply with social distancing has had an impact on capacity issues and patient flow, however teams are working differently and an in innovative way to address this. He

spoke of the good news stories and in particular the lung cancer pilot that diagnoses early detection of lung cancer. Mr Conway advised that the Cancer Reset Cell plan is currently with the Minister for Health and positive feedback has been received to date. Following discussions with the Executive and once the plan is published; teams will then be able to begin to re-build the service. Members asked for the Cancer Reset Cell plan to be shared to which Mrs McClements agreed to undertake.

Action: Mrs McClements

In concluding the presentation, Mrs McClements spoke of the professional issues impacting cancer services; medical staffing – workforce issues for oncology & haematology, theatre nursing challenges, regional challenges and recent approval for non-recurrent funding to maintain required resources.

Dr McCaul thanked the committee for the opportunity to present information on cancer services and stated a significant issue from his perspective is resourcing the service and spoke of the current capacity gaps within Urology, GI, Haematology, Oncology and theatre nursing staff. He noted that this has major impact on theatre utilisation and welcomed the ongoing work to review the staffing issues to attract and retain staff. In responding to a question by Mr McDonald, Dr McCaul advised that there is a natural draw to the Belfast Trust and spoke of the different incentives provided there. Mr McDonald welcomed the work that is being undertaken by the subgroup that will link with Human Resources which can review the Trust's recruitment. In relation to the nursing capacity gap, Mrs Trouton added that she and Mrs McClements have met with nursing staff from Theatres to gain feedback and a better understanding on staff leaving these posts. She advised that this is a regional issue and Ms Mary Hinds is taking forward a theatre nursing workforce plan to address this.

In response to a question asked by the Chair, Mr Conway advised that all patients are tracked throughout their treatment: all scans, tests, appointments are tracked so the MDT team are always on the progress of each patient. Mrs Leeman noted that during the pandemic a number of patients opted to stop their treatment due to

their own concerns, anxiety and need for shielding with the pandemic. Mr Conway explained that those patients have been contacted to reinstate their treatment from April 2021.

Mr McDonald asked for further information on the Lung Cancer pilot. Mr Conway explained that Dr Gerry Millar set up an early screening pilot that took low dose CT chest scans to pick up early detection of lung cancer. Through updating the scanner and the software on the South Tyrone site this was achievable. He said that GPs can directly refer patients for this scan rather that a referral to a clinic, thus decreasing the wait time. Mr Conway advised that this pilot model has been presented at meetings as an innovated way to manage this cohort of patients and felt that the model could be replicated regionally, however an Investment Proposal Template will need to be progressed for funding to take this pilot forward.

Ms Donaghy enquired on the regionalisation of cancer services. Mr Conway explained that if the service is centralised the workforce will remain significantly limited as it is still the same pool of staff. Dr McCaul advised that centralisation may be successful for particular types of cancer but for others there will be a need for significant investment for infrastructure and workforce. Mr Conway commented that the Trust currently works collaboratively with other Trusts and the Independent Sector for certain services/diagnostics and felt that this was a step in the right direction for regionalisation, which is included in the re-build plans. In responding to a question by Ms Donaghy, Mrs Leeman provided assurance that the Southern Trust population has equity access to these regional services and is well represented. She spoke of the Cancer Re-set Plan and the Elective Plan and the importance of the two working together.

The Chief Executive joined the meeting at this point

9. UNALLOCATED CHILDCARE CASES REPORT

Mr Morgan presented the above named report and noted that as at 31st March 2021 there were in total 120 unallocated cases which is an increase from 93 in the previous quarter. There are no unallocated Child Protection or Looked After Children (LAC) cases. He provided assurance that weekly monitoring is completed by team managers

and monthly monitoring is completed by Head of Service and the Assistant Director. Mr Morgan confirmed that all LAC children and children on the child protection register have an allocated social worker and up to date plans in place.

Vacancies were discussed. Mr Morgan advised that vacancies across the Gateway, Family Intervention and Children with Disabilities Services continue to impact on the level of unallocated cases. He added that his Directorate is proactively liaising with Human Resources in regards to students and reported that five final year social work students that are currently placed in CYPS have been recruited to Gateway and are due to commence in mid July 2021. Mr Morgan spoke of the importance in providing a wrap-a-round service to social work students in supporting them for potential future employment with the Trust.

Mr Morgan informed members that a regional recruitment pilot of social workers is taking place during May 2021.

10. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Trouton presented the Executive Director of Nursing, Midwifery and AHPs report which largely covers the period from February 2021 to April 2021 and provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Framework and include areas regarding workforce, education training, and quality of practice.

Mrs Trouton guided members through the report and highlighted specific areas for noting. She was pleased to report that the NMC's New Future Nurse standards have been fully implemented and the referred members to the training numbers included in the report.

International recruitment was discussed and Mrs Trouton advised that since activity has been recommenced in September 2020, 56 International Nurses have commenced post in Southern Trust,

however due to the Covid-19 situation in India; the International Nurse recruitment has been paused.

Mrs Trouton highlighted that as part of the regional response to workforce challenges during Covid-19, the initiative whereby final placement nursing students would work as a Band 4 whilst awaiting registration the Trust was successful in securing 26 (90%) students who commenced as Band 5 when registration was completed.

Nursing Quality Indicators (NQI) was discussed. Mrs Trouton informed members that a 'stocktake' of NQIs was carried out in April 2021. She reported that there are currently 46 clinical areas completing NQIs across the organisation and approximately 88 additional clinical areas that are not monitoring NQIs.

Mrs Trouton highlighted her concern on the lack of corporate governance resources within the AHP structure. She stated that this has a significant impact on the level of information in regards to quality indicators, workforce, initiatives and practice placement. The Chief Executive added that work is underway with Mrs Trouton and the Assistant Director AHP Governance, Workforce Development and Training to discuss the issues highlighted and the way forward to secure additional resources.

Mrs Trouton referred to the information on supervision and stated that the average compliance with meeting the AHPs Supervision Standards for period ending 31st March 2021 was 74%, which is an increase from 65% in the previous quarter. She added that those services who have embraced a virtual approach have positively impacted the compliance rates. She did note her concern on the lack of assurance of formal professional Nursing & Midwifery supervision. Mrs Trouton attributed this to the surge 3 of Covid-19 and reported that the Corporate Nursing team are currently engaging with directorates to understand their current processes around supervision with a view to supporting directorates and teams to improve overall compliance. Mrs Trouton spoke of the importance of undertaking formal supervision as this supports the retention of staff.

In response to a number of questions on supervision, Mrs Trouton commented that she is keen to ensure that formal supervision is more robust as this contributes to improved culture and behaviours for staff

which positively impacts on the experience of service users. She confirmed that managers do receive supervision training and advised of a pilot on restorative supervision within ICU which is based on a regional model. Mrs Toal added that there is merit to review the induction for those staff stepping into sister and ward manager roles and work is underway to achieve this.

Mr Wilkinson asked for further clarity on the issue of consistency on maintaining green level compliance with designated Nursing and Midwifery quality indicators. Mrs Trouton explained that there are a number of reasons for this; high level of agency usage, high turnover of staff or sick leave. She added that her team are liaising with IT to introduce Qlikview' onto the wards which provides staff with live up to date information on NQI. Mrs Trouton felt that this would have a positive impact to rectify any issues in a timely manner.

Dr O'Kane returned to the meeting at this point

11. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

The Chair welcomed Mrs Trudy Reid, Interim Assistant Director Infection Prevention & Control to present the above named report. The paper provides data from 1st April 2019 to 31st March 2021 on infection data and antimicrobial stewardship data for PFA targets.

Mrs Reid presented information on C. Difficile monitoring which meets the requirement of the British Infection Association. She added that a Gastroenterologist is now a member of the C difficile team who have developed links with Acute Care at Home team to improve the management of C difficile and identify learning.

In regards to MRSA, Mrs Reid reported that there have been three preventable MRSA bacteraemia from April 2020 to March 2021 and post infection views have been carried out to identify learning.

Mrs Reid spoke of the outbreaks that occurred in 2020 and stated that there have been no outbreaks to date. She advised that Multi-disciplinary teams meet on a daily basis to ensure proactive measures are taken to prevent further outbreaks.

Antimicrobial Stewardship Activities were discussed. Mrs Reid reported that the current reduction in Covid-19 is allowing the IPC team and Microbiologists to review the Infection Prevention and Control / Antimicrobial Stewardship strategy with a short term work plan focusing on reconnect – refocus -reskill. This will focus on relationships, audit and upskilling of the workforces using a back to basics approach. Mrs Reid reminded members that the Antimicrobial Stewardship rounds were continued by the pharmacists in the SHSCT with SHSCT Stewardship work presented to the PHE at ESPAUR. She further added that Acute Medical Antimicrobial Stewardships rounds are commencing.

Mrs Reid noted that the IPC / Microbiology team are concerned about new variants of Covid-19, the risk of increased community transmission, vaccine escape, and virulence are likely to impact on hospital admissions and possible nosocomial transmission. Seasonal winter pressures, the impact of Covid-19, and potentially influenza, RSV and other respiratory viruses will impact on health services this winter. Therefore the requirement of additional isolation facilities with the current environmental constraints will be a significant challenge for the Trust.

Mr Wilkinson asked if the Trust is still supporting Care Homes. Mrs Reid confirmed that the IPC team continue to liaise with Care Homes to provide support and advice. She added that the IPC nursing staff continues to monitor the data and intervene early, if required. Mrs Reid said that a wraparound support service for care homes is in place while working closely with the Acute Care at Home team and District Nursing.

In responding to a question asked by Mr McDonald, Mrs Reid commented that if visiting is re-introduced at present, there is no plan for visitors to take a prior Covid test. She added that these rules may be subject to change if positive cases increase and the possibility of introducing lateral flow tests.

The Chief Executive recorded his thanks to Mrs Reid and her team for continuing to keep everyone safe.

13. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.45 p.m.

Signed _____ ***Dated _____***