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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 2nd September 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
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
Dr D Gormley, Deputy Medical Director *(for Dr O'Kane)*
Mr C McCafferty, Assistant Director of Corporate Parenting *(for Mr Morgan)*
Mrs A Rutherford, Assistant Director of Finance *(for Director of Finance, Procurement and Estates)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Mrs H McCartan, Non-Executive Director
Mrs A Magwood, Director of Performance & Reform
Dr M O'Kane, Medical Director
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Director of Finance Procurement and Estates

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

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and noted the apologies above. She particularly welcomed Dr Damien Gormley, Deputy Medical Director, Mrs Alison Rutherford, Assistant Director of Finance and Mr Colm McCafferty, Assistant Director of Corporate Parenting deputising for their respective Directors. She congratulated Mr McCafferty who has been appointed as the Interim Director of Children and Young People's Service / Executive Director of Social work who will take up this post following the retirement of Mr Paul Morgan.

At this point, the Chair advised members on some aspects of virtual meeting etiquette.

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. CHAIR'S BUSINESS

None noted.

4. MINUTES OF PREVIOUS MEETING HELD ON 20th MAY 2021

The Minutes of the meeting held on 20th May 2021 were agreed as an accurate record and will be duly signed by the Chair.

Ms Donaghy referred to page 3 of the minutes under the Performance Report and asked if managers and teams have been facilitated to take their leave over the summer period. Mrs Toal advised that it was likely that the majority of staff have been able to take their leave entitlement but did note that there would have been a number of staff that would have cancelled their leave on a voluntary basis in areas that were under extreme pressure.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

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In relation to the Cancer Re-set Cell plan, it was noted that the Cancer Services Recovery Plan has not been received yet; however it will be shared once it is available.

The Chair asked for an update on the Regional Engagement Strategy. The Chief Executive advised that the Regional Management Board have not progressed an overall engagement strategy. He spoke of the new Regional Planning Model which is being consulted on. The vision is one where local providers and communities would be empowered to come together to plan, manage and deliver care for their local population based on a population health approach, with certain services planned, managed and delivered at a regional level.

The Chief Executive noted that funding has not been allocated at this point. The Chair asked for Non-Executive Directors to be updated on the Regional Planning Framework and the Chief Executive agreed to do so.

Action: Chief Executive

6. PERFORMANCE REPORT

Mrs Leeman 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. Mrs Leeman advised that the regional work on new planning and performance arrangements, led by the Department of Health (DoH) and the Health and Social Care Board (HSCB), including Trust Directors of Planning/Performance, is ongoing. The DoH has initiated a targeted stakeholder consultation in respect of the 'Future Planning Model – Integrated Care System NI' which will close on 17 September 2021. Updates on progress will continue be included in this report to Performance Committee and will inform future review of the Trust's Performance Management Framework.

Mrs Leeman advised that overarching issues continue to reflect the standing risks previously reported associated with workforce, infrastructure and finance. She explained that wave 4 of the Covid pandemic commenced in mid July 2021, ahead of Regional modelling

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projections. Whilst hospitalisations were anticipated to be less intense than the third wave, the demand for intensive care capacity has required the Trust to move in mid-August to Level 3 of the Critical Care Network of Northern Ireland (CCaNNI) regional plan (operating 16 ICU bed spaces) which has significantly impacted elective surgical services. The high level of transmissibility of the Covid variant, and guidance on self-isolation, has been felt across the wider staff group impacting on staff availability.

Mrs Leeman highlighted that health visiting and school nursing continues to be impacted by the pandemic. In relation to health visiting, she reported that all efforts are being made to complete the missed two year health reviews, in an attempt to ensure that any additional service referrals are completed in time for support before those children start primary school.

Bed flow was highlighted as an area for concern. Mrs Leeman advised that on-going challenges in the sourcing of bespoke packages of care required for the safe and appropriate discharge of clients with the most complex needs is resulting in reduced inpatient bed flow with circa 6 beds almost permanently utilised by those waiting alternative placements. This also has an impact on elective waiting lists and she provided assurance that this is monitored on a daily basis.

Mr McDonald noted that £8.7m of capital funding has been secured for estates works which will improve the environment and reduce nosocomial infections. He enquired on the timeline on the implementation of the works. Mrs Leeman advised that a plan is in place and monitored at a weekly meeting between the Estates team and Acute Services and it is envisaged that the work will be completed by March 2022. She commented on the difficult winter period ahead and the challenges this will bring to bed capacity and flow. The Chief Executive informed members that during the development of these estate works it is expected that 29 beds will be lost. He spoke of the need to replace this capacity gap within the system and therefore the Trust will be looking at alternative measures which may include the use of other sites across the Trust and linking in with the private sector to increase bed capacity. Dr Gormley agreed that the winter ahead will be extremely challenging and the

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loss of an expected 29 beds is concerning and welcomed all options to reduce the demand on bed capacity.

In response to a question asked by Ms Donaghy on the regionalisation of services, the Chief Executive stated that all Trusts are in a similar position with significant demand and capacity gaps and he reiterated the importance of the Trust seeking out local solutions to meet the capacity issues while these upgrades to the estate infrastructure are undertaken.

Mr McDonald asked for an update on the development of an alternative model for GP Out of Hours. The Chief Executive advised that regional work is underway to review GP Out of Hours to move to an Out of Hours urgent care service which will include a multidisciplinary team. He added that the Northern Trust model is being reviewed as an alternative. The Chief Executive stated that the regional work will focus on the two centre model as opposed to the 5 centre model due to the shortage of GPs available.

The Chair noted the increase of children referred into care and the challenges of recruiting additional foster carers throughout the pandemic. Mr McCafferty stated that placement capacity is an issue and noted that disruption to placements has increased through the pandemic. He noted his concern that there has been a decrease in expression of interests of foster carers and advised that this is a regional issue with work ongoing to highlight the importance of foster carers and the work that they do. He reported that there has been a slight increase in potential foster carers coming forward which he welcomed.

Responding to a question asked by Mr Wilkinson on cancer elective surgery waits, Mrs Leeman advised that the Trust continues to work with the regional prioritisation group on a weekly basis. Clinicians from each Trust assess each patient for surgery needs against the capacity available and then divided up equally across the 5 Trusts. Furthermore the Trust continues to liaise with the Independent Sector who can provide a number of additional beds, however this is challenging due to their own private patient list and the capacity available is not as large as it was.

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A discussion ensued on GP activity and the impact this has on secondary care. Mr Wilkinson stated that the issue of GPs unable to see a patient face to face results in that patient potentially attending the Emergency Department. This then has an impact on demand for services and performance. Members requested if data on GP activity is available and if it could be provided for the next meeting. The Chief Executive agreed to take this forward.

Action: Chief Executive

Members approved the Performance Report

7. YEAR END PERFORMANCE REPORT

Mrs Leeman presented the Year End Performance Report. She reminded members that a Commissioning Plan Direction was not developed for 2020/2021, nor 2021/2022. Furthermore the Trust was not required to submit a Trust Delivery Plan (TDP) in 2020/2021 and as such Objectives and Goals for Improvement (OGIs), previously established, were not reassessed internally to ascertain achievability. For monitoring purposes the Trust continues to reflect the 2020/2021 performance against the assessment of achievability made in the 2109/2020 TDP. Whilst performance is assessed monthly / quarterly, the year-end report gives an opportunity to review the cumulative position and may reflect changes to the RAG assessments. Mrs Leeman reported that performance was impacted in year as result of the current pressures / pandemic response. The full Year-End Assessment Reference Report was included in members' papers. This included the year end position, comparative data were available and a narrative summary. A summary of waiting list volumes and longest waits by activity type and specialty was also included.

The Chair noted her concern on the AHP waiting times. Mrs Trouton explained that the main capacity gap in AHP relates to Physiotherapy. She noted that there are 55 vacancies within this service and furthermore staff from Physiotherapy have been relocated to other areas to address covid pressures within ICU and the covid wards. Mrs Trouton stated that this concern has been

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escalated to the Minister of Health and furthermore the number of pre-reg places for AHP is not increasing compared to nursing places. She commented that the new medical training school in Derry has resulted in 10 physiotherapists leaving to take up a post degree in medicine. Mrs Leeman added the Trust is exploring different options within the Independent Sector to provide AHP services.

Mr Wilkinson asked for an update on Mental Capacity Act. The Chief Executive advised that the Trust is making progress, but not to the degree that he would have hoped. Mr McCafferty spoke of the challenge in engaging Approved Social Workers (ASW) due to capacity issues. He noted that 3 ASW are due to be trained in September 2021. In relation to Children's Services, Mr McCafferty commented that the service is compliant with MCA; however he noted his concern that when Specialist Schools re-start and the use of restrictive practice is needed this will result in an increase of referrals to the MCA panel. He stated that it has not been confirmed which body is responsible for these referrals – Education Authority or Social Services.

Mrs Toal informed members that team leads have provided relevant staff with templates on completing MCA associated work and the importance of completing these. She noted the capacity and workload issues and the challenges that the teams encounter.

Mr McDonald reminded members the importance of the MCA and Deprivation of Liberty that it is a positive reassurance to family members and keeping focus on the personal benefit to the patient.
The Chief Executive requested an update on MCA to be provided for the next meeting.

Action: Mr McCafferty

Ms Donaghy highlighted that the target was not met for Ischaemic Stroke and asked for further clarity. Mrs Leeman felt that the target which showed crude statistics was not as much benefit to members compared to the National Sentinel Stroke Audit which provides a wider and broader quality of data for the complete stroke service. Dr Gormley agreed and stated that additional work is required on the definition of a stroke and the suitability of thrombolysis. Members

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requested that the National Sentinel Stroke Audit data be presented at a future meeting.

Action: Dr O'Kane

Members approved the Year End Performance Report

8. CORPORATE PERFORMANCE SCORECARD

Mrs Leeman presented the Corporate Performance Scorecard (June 2021 performance) for approval. The report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework. She reported that historic CPD objectives have been maintained for 2019/2020, 2020/2021 and 2021/2022. Mrs Leeman advised that improvements have not been achieved and performance further impacted in year as result of the current pressures/pandemic response. High level Service Delivery Plan monitoring (previously Corporate Rebuild) is now included in the CPD Performance Scorecard, June for September Performance Committee performance report.

Mrs Leeman drew members' attention to the cover sheet highlighting those areas of improvement and those areas of concerns, risk and challenge.

Mr McDonald noted that the annual appraisal of 'other staff' was 39% and felt that this was low. Mrs Toal commented that this has decreased from 65% in the previous year and attributed the low uptake to the significant impact of the pandemic, work pressures and capacity to undertake appraisals; however the number of appraisals is slowly increasing.

Ms Donaghy sought clarity that the Medicines Optimisation is on a risk register. Mrs Leeman confirmed that it is on the Directorate Risk Register due to the capacity gap in the workforce.

Mr Wilkinson referred to diagnostic testing and the waiting list initiative (WLI) to increase performance. He enquired how this additional work is remunerated whether through a contract or allocation. Mrs Leeman advised that if medical staff do opt in to do

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waiting list work the WLI they are governed by a DOH circular in terms of payment arrangements.

Mrs Toal added that the Elective Care Framework includes new proposals for elective care payments. Previously provisions were only available to Medical staff; however this new proposal now applies to all grades of staff. She advised that this will provide enhanced rates, however this is all at an early stage if pilot implementation across the region.

Members approved the Corporate Performance Scorecard

9. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. **Integrated Performance Report:** *Maternity Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mrs McClements, Director of Acute Services, Dr Beverly Adams, Divisional Medical Director and Ms Wendy Clarke, Acting Assistant Director of Integrated Maternity and Women's Health to the meeting to present the above named item.

Mrs McClements thanked the Committee for the opportunity to present information on Maternity Services. Ms Clarke began by providing background of the Maternity Services within the Trust. Hospital and Community Antenatal care are provided both on secondary and primary facilities, intrapartum care inclusive of home births, postnatal care and other services integral to delivery of maternity services such as; mental health, social services and links with the CYP directorate and health visiting. She reported that home births have increased. Ms Clarke spoke of the national standards and guidelines implemented across the service which are also used for benchmarking purposes and implementing recommendations.

Ms Clarke drew members' attention to performance of the obstetric outpatient attendances and reported that for 2019/20 there were 58,000 attendances across Consultant and Midwifery led clinics, early pregnancy problem clinic and day obstetric unit ward attendances. She noted the growth of attendances year on year, however advised

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that the pandemic reduced the number of attendances for 2020/21 and into 2021/22.

Maternity Ethnicity was discussed. Ms Clarke reported that the Southern Trust has the largest Black, Asian and Minority Ethnic (BAME) population and in particular East Timorese. She noted the challenges faced with the availability of information in other languages and ensuring the availability of interpreters.

In relation of birth rates, Ms Clarke advised that the Southern Trust has the largest birth rate in the region and although the regional birth rate is decreasing the Southern Trust continues to rise.

Ms Clarke highlighted a number of key facts; the Trust c.section rates compare favourably with the region, elective c.section rate remains consistent and focus is continuing to reduce emergency c.sections. A new method of measuring post-partum haemorrhage blood loss has been adopted. Ms Clarke noted that the Trust stillbirth rate equates to 31% of stillbirth rates regionally. She assured members that each case is reviewed and spoke of the Perinatal Mortality Review Tool (PMRT) that has been recently implemented. Ms Clarke added that a clinic for third trimester will be set up and will review patients; offer extra appointments and ultrasounds with the aim that this would reduce infections and stillbirths in the third trimester.

The presentation also focused on Maternity objectives and goals for improvement, health inequalities and workforce. In concluding the presentation, Dr Adams spoke of the issues facing the service in particular, staffing pressures, clinic space, skill mix, training requirements, governance issues and highlighted the actions taken to address service improvements.

Ms Donaghy enquired if there was a heightened fear of attending the unit during the pandemic. Ms Clarke replied that the rationale during the pandemic was to have reduced numbers of people on site, however if there was a concern at all, women were asked to come to the unit for a review and staff had the appropriate PPE in place.

Mr McDonald asked what the governance issues that the service is facing are. Dr Adams advised that Chairing and undertaking SAI

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reviews is demanding given the limited resources in place. She added that the recruiting and retaining a risk midwife is challenging, however a Risk Midwife is now in place. Dr Adams welcomed the additional resources to implement the PMRT which will help the service and patients greatly. The Chief Executive noted the staff capacity gap and stated that resources would have to be sourced from other areas.

In response to a question asked by Mr Wilkinson, Dr Adams explained that although the Southern Trust has the highest birth rate in the region, the unit does not have the highest number of staff. Ms Clarke spoke of the importance in ensuring equity and significant funding for the Trust is secured. She noted that the Trust also has the highest number of BAME population across the region with no extra funding available, therefore work is underway to address this regionally. Mr Trouton agreed that the lack of investment is challenging and added that funding for a Consultant Midwife is in place. This post will review the quality of care delivered to patients and be a clinical educator.

The Chair thanked Mrs McClements, Dr Adams and Ms Clarke for their informative presentation.

10. 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 2021 to 2nd August 2021 infection data and antimicrobial stewardship data for PFA targets.

Mrs Reid presented information on C. Difficile. She reported that rates reduced in early 2021/22; however Clostridium difficile rates are rising again. To date there is a total of 50 C. Difficile cases. A review of all cases is undertaken at the time of diagnosis and post infection review is completed on cases where it is considered learning may be identified. The cases are further reviewed at the Clostridium difficile working group. Mrs Reid highlighted the increase use of antibiotics which is high risk for C. Difficile infection. The IPC team is working with Acute Care at Home and GPs to reduce this usage. In

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responding to a question asked by Mr McDonald, Mrs Reid advised that the 50 cases have been reviewed along with their patient journey to establish the source of the infection whether community or hospital acquired, however no link between the cases was identified.

Mrs Reid noted that the Trust's and community have a high risk patient population for the use of antibiotics which increases the likelihood of C. Difficile. She did note that the compliance on the length of time antibiotics are administered for is good.

It was reported that C difficile NICE guidance has been updated and Mrs Reid assured members that in light of this the Trust guidance is being reviewed.

MRSA data was discussed. Mrs Reid advised of 2 preventable MRSA infections to date. She provided assurance that post infection views have been carried out to identify learning. Learning has been shared with the teams involved, clinical forum and Infection Prevention and Control Link Nurse Group. The Chief Executive welcomed the low number of MRSA infections. Mrs Reid attributed this increased screening on admission and good line management. She confirmed that no patients have died from an MRSA infection.

Mrs Reid presented information on Covid-19 cases. Community transmission is increasing which has an impact on hospital admissions and possible nosocomial transmission. Mrs Reid confirmed that there are 7 active outbreaks across the Trust. She explained that the normal range for patient length of stay is 2 to 3 days, however patients with Covid-19 are remaining in hospital on average for 8 days. The impact that these additional days have on bed flow and waiting times in ED is significant.

In concluding, Mrs Reid advised that seasonal winter pressures, the impact of Covid-19, and potentially influenza, RSV and other respiratory viruses will impact on health services. The requirement of additional isolation facilities with the current environmental constraints will be a significant challenge for the Trust.

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11. 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 April 2021 to June 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 Frameworks 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 through the regional HSC Band 5 recruitment streamlining pilot and the rolling Band 5 advert has resulted to date, with 65 post offers. A breakdown of these was included in tables 3 and 4 of the report. Mrs Trouton advised that an evaluation of the pilot is currently underway with a view to rolling out regional recruitment to nursing students for all fields of practice.

Mrs Trouton spoke of the new collaboration with the Open University who will be supporting 2 new bespoke programmes commencing September 2021. The first programme will offer 10 nursing assistants, the opportunity to complete an introductory pre-registration nursing programme. The second programme is in collaboration with the Southern Regional College (SRC), OU and SHSCT to offer 30 students the opportunity to complete a Pre – Nursing Health Care Level 4 certificate. It is envisaged that the student's will then undertake the BSc Nursing programme entering at Stage 2, therefore gain reducing the programme duration. Ms Donaghy welcomed this approach and felt it was important to provide an alternative route into the nursing profession for those students who may not have met the criteria for admission to university. Mrs Trouton agreed and Mrs Toal added that these students can also apply to the nurse bank list as well.

Care Opinion was discussed. Mrs Trouton reported that 232 stories were submitted for quarter 1 April-June 2021. Of these, 91% were non critical and 75% of feedback was reported by the patient and/or service user.

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Mrs Trouton reported on the Nursing Quality Indicators (NQI). She drew members' attention to the data covering Acute, OPPC, MHD, ICU, Emergency Department and CYP NQI figures. Sparklines were included which showed the compliance over the preceding 12 months. Mrs Trouton noted that there has been improvement across all directorates with further improvements still required. Clinical teams are responsible in completing their Quality Improvement Plans to help drive improvements and the patient safety, quality and experience division will continue to work closely with the operational teams to support ongoing improvement to demonstrate safe, high quality care.

International recruitment was discussed. Mrs Trouton reported that between January and March 2021 the Trust's target of 12 international nurses per month was reached. During May 2021 four nurses were recruited from Malta and in July two nurses arrived from England and South of Ireland. During August 2021, the Trust is expecting nine nurses. India has now moved to the amber list so once Department of Health funding is confirmed all of those with existing offers will be facilitated to arrive. The new tender exercise is also complete and allows recruitment in the future from worldwide (within the IR Code of Practice) so there will have more flexibility & diversity with the international nurse process.

Mrs Trouton drew members' attention to the Record Keeping audit. She reported that while the nursing record keeping audit is positive in many areas, some areas, particularly around discharge planning require improvement. This will be an area of focus for the team to take forward and a Record Keeping Workshop Schedule has also been developed which commenced in July 2021. The full results of the record keeping audit were included in the report. Mr McDonald noted his concern that the recording of the patient's contact number was 59%.

In relation to AHP workforce, Mrs Trouton advised that the Regional AHP Workforce Review Programme Steering Group met in July 2021. An update on the status of the regional workforce reviews by the range of professions was outlined in table 1 of the report. She reported on the number of vacancies across the Trust by profession

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as at 30th June 2021. She noted her concern on the number of vacancies and this has been raised with the Minister.

In response to a question asked by the Chair, Mrs Trouton explained that investment into Consultant Nursing posts will help to support the retention of staff and spoke of the importance that this will contribute to the Trust.

12. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty presented the above named report and noted that as at 30th July 2021 there were in total 87 unallocated cases which is a decrease from 120 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 McCafferty 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 and staffing were discussed. Mr McCafferty was pleased to report that five final year social work students which are currently placed in CYPS have been recruited to the Gateway Team and commenced in July and August 2021. He spoke of the regional recruitment pilot of social workers that took place in May 2021. He reported that to date only one FIT post has been filled from this regional recruitment and further regional recruitment continues to progress for those 'hard to fill' posts. Mr McCafferty noted the high prevalence of maternity leave across the service and advised that areas where there are gaps are regularly reviewed with the possibility of moving staff across teams to meet the demand.

Mr McCafferty informed members that the activity in the Social Work service has returned to pre-covid levels with a projected 45,000 home visits/Contacts per annum to be undertaken. He reported that there are 800-1000 referrals across the FIT and Gateway with majority responded to within the timeframe.

In concluding, Mr McCafferty reminded members of that the Children's Disability Social Work Service has been shortlisted for creating

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bespoke short break packages of care for high risk families during the Covid-19 pandemic.

The Chair welcomed the detailed report and recorded her thanks to the staff that have worked tirelessly through the pandemic and recognised that it is not a 9-5 role. In response to a question asked by the Chief Executive, Mr McCafferty explained that the Northern Trust has the lowest number of unallocated cases across the region. The Trust has liaised with the Northern Trust to look at their processes to establish if the Trust can adopt any elements of their processes to reduce the number of unallocated cases.

Ms Donaghy asked if long term sick leave and maternity leave is replaced. Mr McCafferty confirmed that approval is always granted to replace Maternity and substantive sick leave. The Trust will always seek to permanently replace maternity leave rather than seeking to fill the post on a temporary basis. However, at present the service is experiencing considerable recruitment challenges due to workforce shortage which is impacting on the number of unallocated social work cases.

Mr Wilkinson referred to the previous whistleblowing case within the FIT team and asked what the current situation is and asked on the welfare of the team. Mr McCafferty provided assurance by advising that an oversight group is in place to regularly monitor the situation. Regular quality supervision and appraisals are in place. Technology has improved through the roll out of smart phones for social workers. All frontline staff have the ability to work remotely from any site which they find beneficial. Mr McCafferty advised that the psychology team is available to all social workers to ensure their health and wellbeing is monitored. He added that the main issue remains the size of the caseloads and staffing issues which continue to be highlighted.

13. PERFORMANCE REPORTING - EXTERNAL ASSURANCE

i) Clinical Coding

Mrs Leeman presented the Clinical Coding Monitoring Report for April 2020 to March 2021. She advised that monthly reports are compiled by the Regional Coding Team and shared on the Clinical coding and

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Information Standards SharePoint site. Mrs Leeman reported that as at 31st March 2021 all regional Trusts achieved the target of 98% of all episodes coded within 3 months of discharge. The Southern Trust achieved 99.6%.

Key indicators for 20/21 were highlighted. Mrs Leeman advised that the coding performance continues to meet regional targets; a sustained commitment to timely coding for deaths has led to Southern Trust having 0 un-coded hospital deaths which was the highest performance in the Province. She reported that an area of improvement has been coding of offsite Independent Sector activity were the coding has achieved 100%. In relations to the depth of coding, Mrs Leeman added that the Trust has achieved an average of 7.7 codes per patient episode compared to the Regional average of 6.3.

Mrs Leeman noted that although the Trust currently has a stable, experienced and well-resourced team including Coding Supervisors, coding is a specialist skill which requires 2-3 years training. The department do not currently have any trainee coders therefore any turnaround in staffing could lead to reduced performance against targets. In response to a question asked by the Chair, Mrs Leeman explained that the background of this role is an administration function. The Chief Executive added as this is a background function that these roles can go un-noticed, however they are important and valuable to the organisation and he recorded his appreciation to the team for their work. He asked with the introduction of Encompass how this will affect these roles. Dr Gormley stated that a function of Encompass will include an element of automated coding, however he provided assurance that this will not take away from the work of the Clinical Coding team.

14. DRAFT ANNUAL REPORT OF THE PERFORMANCE COMMITTEE 2020/21

The Chair presented the Performance Committee Annual Report for 2020/21. She stated that its purpose was to report on the work of the Committee for the financial year under review. Following Performance Committee endorsement, the report will be brought to

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Trust Board for approval. The Chair recorded thanks to the Board Assurance Manager for producing this informative report.

15. TERMS OF REFERENCE

Members reviewed and endorsed the revised Terms of Reference for Trust Board approval on 28th October 2021.

16. MEETING DATES 2022

The proposed dates for 2022 were approved.

17. ANY OTHER BUSINESS

Non-Executive Directors undertook to complete the Performance Committee Self-Assessment following the meeting.

The meeting concluded at 12.40 p.m.

Signed _____ ***Dated*** _____

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PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Dr D Gormley, Deputy Medical Director *(for Dr O'Kane)*
Mrs A Magwood, Director of Performance & Reform
Mr C McCafferty, Interim Director of Children and Young People's Services / Executive Director of Social Work
Ms C Teggart, 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 L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Dr M O'Kane, Medical Director
Ms G Donaghy, Non-Executive Director

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and noted the apologies above. She particularly welcomed Ms Catherine Teggart to her first Performance Committee following her appointment and Dr Damien Gormley, Deputy Medical Director, deputising for Dr O'Kane.

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At this point, the Chair advised members on some aspects of virtual meeting etiquette.

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. CHAIR'S BUSINESS

The Chair informed members that Internal Audit is currently undertaking an audit on Performance Management and have met with her and Ms Donaghy. The Chair felt it would be beneficial for Internal Audit to have a meeting with the Chief Executive to seek his views and Ms Teggart agreed to arrange this through her office.

Action: Ms Teggart

4. MINUTES OF PREVIOUS MEETING HELD ON 2nd SEPTEMBER 2021

The Minutes of the meeting held on 2nd September 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.

6. PERFORMANCE MANAGEMENT FRAMEWORK

Mrs Magwood presented the draft Performance Management Framework (PMF) for information. She reminded members that this document provides information to the committee in exercising its function of overseeing the Trust's Performance Management arrangements. Mrs Magwood advised that the PMF was reviewed and noted by the Performance Committee in December 2019. This remained in draft with a view to finalise in line with the outputs of the HSC Strategic Performance Management Oversight Board which was to inform the further development of this, however in respect of a new integrated care system arrangement for Northern Ireland HCS, this is

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still subject to consultation and therefore it has not been formalised. Mrs Magwood added that the Local Area Integrated Partnership Boards, which were due to be established by April 2022, are not in place and in the interim existing Integrated Care Partnerships (ICPs) and Local Commissioning Groups (LCGs) will remain. As a result of the fluid environment associated with the pandemic and the impact on regional planning arrangements, the extant PMF framework has not been finalised. The paper details some of the interim arrangements that have been put in place to support performance management/assurances at this time.

Mrs Magwood noted that this is an opportunity to refresh and define the framework and the Chief Executive added that the role of the Regional Management Board would need to be reflected within the framework.

Mr Wilkinson noted that the connection with performance and governance is important and felt that this framework clarifies this.

Mrs McCartan stated it was good governance to update the framework to reflect the interim arrangements. Mrs Magwood agreed to undertake this and present this at the next meeting.

Action: Mrs Magwood

7. 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. Mrs Magwood advised that the regional work on new planning and performance arrangements, led by the Department of Health (DoH) and the Health and Social Care Board (HSCB), including Trust Directors of Planning/Performance, is ongoing. The DoH stakeholder consultation in respect of the 'Future Planning Model – Integrated Care System NI' has closed. Engagement with citizen hubs is ongoing facilitated by the Integrated Care Partnership. The Trust is a member of a number of work streams focused on development of an outcomes framework. Mrs Magwood noted that the Trust's Performance Management Framework was an agenda item today,

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which includes the interim arrangements established during the Covid-19 pandemic.

Mrs McCartan asked for an update on the funding bid to address the elective pressures. Mrs Leeman explained that an additional £10.5m of non-recurrent funding has been secured in year to address the elective waiting list pressures both in house and within the Independent Sector. Capacity has been secured at Independent Sector facilities in Belfast and Dublin to address those waits within Orthopaedics and Urology and potentially in the near future cardiac treatment. Mrs Leeman added that the Trust has secured endoscopy testing within the South Eastern Trust. She advised that there might be potential to increase the funding further in year; however, the Trust needs to ascertain if there is capacity within the Independent Sector in the first instance.

Mr McDonald commented that views expressed by staff noted that referrals to the Emergency Department from GPs increase on a Monday morning and asked if an audit can be undertaken to confirm this. The Chief Executive advised that an audit was undertaken a number of months prior which reviewed GP referrals on a Monday and it was highlighted that out of 103 referrals, 95 were legitimate referrals to the Emergency Department. He added that Elected Representatives have highlighted this issue through their constituents and he suggested that it would be beneficial to re-run the audit on the appropriateness of GP referrals to the Emergency Department. Mrs Magwood agreed to discuss with Acute Directorate colleagues and feedback at the next meeting.

Action: Mrs Magwood

The Chief Executive noted the increased waits for Endoscopy for both first examinations and follow up planned procedures and queried if the Trust has explored the Independent Sector to provide additional capacity. Mrs Leeman stated that the Trust is using capacity from the Ulster and Lagan Valley hospitals to address the waits. The Regional Endoscopy Implementation Group of which the Trust is a member has created an additional 10 slots on the Lagan Valley site and Mrs Leeman stated that the Trust will accrue a number of those slots when they are activated. She added that due to the lack of additional

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capacity across the region, the Trust has explored the option of insourcing independent sector providers to carry out Endoscopy procedures on Trust facilities. Mrs Leeman noted the challenges in relation to governance and pharmacy issues and work is underway to explore options to address these challenged. She advised that the Trust is prioritising red flag and urgent referrals for Endoscopy, which this then increases the waiting times for routine and review endoscopies and this risk remains on the corporate risk register.

The Chair referred to the Health Minister's announcement of a support package of up to £23m for domiciliary care for improved rates of pay to attract additional staff into the workforce. She asked if this would help improve delayed hospital discharges. The Chief Executive felt that this additional funding would help however, he noted that it will not dramatically increase the supply of domiciliary care. Mr McDonald stated that some independent domiciliary providers are providing staff with mileage rates to which Mrs Magwood added that this has been a barrier for Independent Sector before. The Chief Executive commented that as a social organisation it is important that the Trust drive social change and the importance of providing staff with a fair wage, beyond the living wage.

In responding to a question asked by Mrs McCartan, Mrs Magwood commented that to improve the current situation of the healthcare system, it requires system change, protected theatres and beds, increase in workforce across all areas and the upscaling of elective centres.

Mr Wilkinson spoke of the importance that service users have the same Social Worker throughout their journey. Mr McCafferty agreed, however he stated that workforce challenges locally and regionally have influenced the ability to ensure consistency.

A discussion ensued on the difficulty in retaining staff across all areas. Dr Gormley stated that Northern Ireland is becoming an unattractive place for medical trainees in terms of their training and maintaining their competencies. Dr Gormley added that there is also a concern with Senior Clinicians that that their skills are not being maintained since the pandemic as theatre lists have been scaled

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back due to pressures. Mrs Magwood stated that during planning for winter pressures in previous years, surgery was scaled back however, she spoke of the trend that surgery sessions have decreased throughout the rest of the year as unscheduled demand increased. She quoted Mark Taylor from the Royal College of Surgeons *'no trainees today, no surgeons tomorrow'.* Mrs Magwood noted the importance of ensuring that adequate training is provided for medical trainees in Northern Ireland. Mrs Toal added that there is a number of clinicians requesting career breaks, requesting to work in the private sector given the issue of pension tax for clinicians to undertake additional sessions and this will undoubtedly have an impact on the Trust's ability to maintain services. Mrs Toal stated that there will be a mind-set change needed in some areas around greater flexibility regarding work life balance options in order to attract and retain staff and to prevent them being lost to agencies Mr McDonald commented that incorporating these suggestions into the People Plan would benefit both the Trust and staff. Mrs Toal agreed as she felt that flexible working and work life balance is not just about childcare but also about how staff want to pursue different opportunities and interests outside of work.

Members approved the Performance Report

8. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented the Corporate Performance Scorecard (October 2021 performance) for approval. The report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework. She reported that historic CPD objectives have been maintained for 2019/2020, 2020/2021 and 2021/2022. Mrs Magwood advised that improvements have not been achieved and performance further impacted in year as result of the current pressures/pandemic response. High level Service Delivery Plan monitoring (previously Corporate Rebuild) is now included in the CPD Performance Scorecard.

Mrs Magwood drew members' attention to the cover sheet, highlighting those areas of concern, risk and challenge and those areas of improvement. Members noted that Adult Mental Health has shown a period of improvement and over the last 3 months, volumes

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have reduced by -38%; Dementia volume of waits of longer than 9 weeks demonstrates a continued improvement to pre-pandemic levels. The highest volume of waits in excess of 9-weeks was demonstrated in February 2021 and has now demonstrated a reduction of -65% at October 2021.

Mrs Toal noted her concern on the level of staff sickness absence and shared slides to provide an overview of the current situation. She stated that the overall sickness absence rate has increased from 6.41% in 2020/21 to 6.51% in 2021/22 and this equates to 64.20 average hours lost per WTE. 5.74% related to non-covid sickness with 0.77% related to covid for 2021/22. Mrs Toal noted that the sickness rate is increasing each month and is currently 7.79% as at September 2021. The Attendance Management Team continues to support Directorates in reducing their sickness absence levels and whilst Attendance Management Panels have been paused, sickness absence meetings (3, 6 and 9-months), led by HROD continue virtually. Mrs Toal did note that Occupational Health is working with GPs to help staff return to work where appropriate; however, there is a 2 to 5week waiting time to access Occupational Health. In responding to a question asked by the Chair, Mrs Toal explained that there has been an increase of staff sickness relating to mental health and stated that it is the Trust priority to ensure the wellbeing of staff. She noted that there is psychological support for staff however; this is in a limited capacity with recruitment ongoing to increase the capacity.

The Chair agreed that a deep dive on Sickness absenteeism figures be provided at the next meeting.

Action: Mrs Toal

Members approved the Corporate Performance Scorecard

9. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Mental Health – performance issues and actions to include Executive Director Professional issues.*

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The Chair welcomed Mr John McEntee, Assistant Director Disability Services, Dr Ivor Crothers, Clinical Director Psychology Services and Ms Stephanie Wethers, Head of Service Mental Health to the meeting to present the above named item. Members received the presentation in advance of the meeting.

Mr McEntee guided members through the presentation highlighting significant areas for discussion. He commented on Qualitative Standards regarding self-directed support, substitute prescribing, same gender accommodation and the dementia portal. The Dementia Portal is an on-going pilot, which allows dementia clients to access their appointments on-line along with a range of other resources. A number of issues were identified during the pilot affecting service users to use the portal and to date no service user has successfully engaged in the pilot due to challenges. Mr McDonald felt that the purpose of the portal was unclear how a service user with dementia could use it. Dr Crothers explained that a family member would assist in helping the service user, however he did acknowledge that this is challenging. Members asked for an update on the roll out / success of the portal at the next meeting.

Action: Dr O'Kane

Mr McEntee stated that training continues to focus on suicide prevention awareness and that the Trust continues to participate in the regional Toward Zero Suicide (TZS) Quality Improvement (QI) approach to service improvement within adult mental health (AMH) services.

In relation to Protect Life 2 the Regional review of crisis services has been completed with the report published by DOH. The Trust is awaiting an implementation plan for future service provision, which may include, amongst other things, the rollout of MATT (Multi Agency Triage Team) and crisis de-escalation. Protect Life Strategy continues to enable the Integrated Liaison Service to provide 24/7 cover in Emergency Departments in CAH & DHH and 2 x 0.5 WTE Staff are in place and offering timely support to those presenting to Emergency Departments with self-harm/overdose/suicidal ideation.

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Mrs Leeman noted the access times within adult mental health care sub-specialty areas including eating disorders, dementia, and primary mental health care (PMHC) with PMHC making up the largest part of this volume waiting for adult Mental Health services of 75%. She added that eating disorder access times have returned to pre-pandemic times. The numbers of patients waiting for PMHC are beginning to show improvement, however the numbers of patients waiting more than 9 weeks continues to show cause for concern.

Mr McEntee spoke of the demand for services and the impact of Covid-19. He reported that the NI population equates to c340k individuals who may need additional mental health support. The HSCB are anticipating that there will be approximately 32% increase in referral rate to Mental Health services over the next 3 years. Mr McEntee explained that each Trust operates mental health services differently. The Trust operates an assess and treat model and other Trusts, e.g. Belfast and South Eastern operate an assessment centre model, wherein individuals are seen quickly for assessment and then are placed on an internal secondary waiting list to begin treatment. These secondary waiting lists are not reported to HSCB.

Staff pressures were discussed. Mr McEntee stated that Medical staffing is significantly under pressure with regards to Consultant Psychiatrists and attributed this to a lack of trainees graduating to consultant level on a consistent basis to fill vacancy gaps. He added that higher trainees who have completed their training within the Trust tend to apply for consultant posts however the Trust get significantly lower proportion of trainees than other areas e.g. Belfast. Mr McEntee also advised that shortages are seen across all professional groups in mental health: nursing, social work, occupational therapy and psychology. He advised that the Trust is awaiting the regional mental health strategy, which has a focus on workforce issues for long-term sustainable plan.

Mr McCafferty spoke of the opportunity to increase training placements across all directorates and the importance of offering students a top quality training experience and added he would be keen to extend social work placements across the Mental Health division. Mr McEntee agreed on the importance of providing these

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placements and noted the challenges of ensuring that current staff have the capacity to facilitate this. Both Mr McCafferty and Mr McEntee agreed to have further discussions on this.

Ms Teggart highlighted the importance of partnership with voluntary community organisations and asked if the Trust has approached this sector. Ms Wethers explained that the geographical set up of the Trust and rural locations creates a number of challenges for implementing and sustaining community services. She advised that Mr Barney McNeany is in the process of engaging with local mental health voluntary programmes to establish if they can work in partnership with the Trust. Ms Teggart welcomed this approach and noted that it might be the case that those voluntary bodies may not know of the capacity gaps across the geographical area of the Trust and engagement is key to highlight this. Dr Crothers reminded members that until the single mental health service is available, conversations with all sectors is important. Mr McDonald declared an interest in the Community Relations Council. He spoke of the work that they undertake throughout the Trust area and felt it would be a good opportunity for the MHLD team to liaise with them to explore how mental health issues can be addressed throughout the community and raise the profile of services that the Trust can offer. Dr Crothers welcomed this suggestion.

In response to a question asked by Mrs McCartan on self-directive support, Mr McEntee explained that this approach is a way of providing social care support to service users to have informed choice about how support is provided to them. He advised that this approach is used across all 5 Trusts.

The Chair welcomed that the Primary Mental Health Service pathway is being reviewed and redesigned in partnership with East London Foundation Trust (ELFT). Ms Wethers advised that contracts between the Trust and ELFT are currently being worked through. She added that a desktop review of the current waiting list will be undertaken and patients contacted via phone if they still require access to services. Ms Wethers stated that while service users are waiting for treatment and aid, their recovery group work may be offered. Dr Crothers added that there is a perception that 1:1 therapy will be offered and the introduction of group based work will be

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beneficial, however he noted that this will take time to embed with both staff and service users. He stated that the impact of this work would not be available for at least 12 months and it was suggested that the outcomes should be incorporated into a future themed presentation to the committee.

Mr McEntee, Dr Crothers and Ms Wethers left the meeting at this point

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 August 2021 to October 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 Frameworks and include areas regarding workforce, education training, and quality of practice.

Mrs Trouton guided members through the report and highlighted specific areas for noting. The Nursing Quality Indicators (NQI) from July 2021 to September 2021 were discussed. Mrs Trouton noted that improvements have been made in Maternity Services from the last quarter with all areas achieving 100% in September. She added that the introduction of GREATix has been a positive route to provide feedback to teams on their compliance and felt that staff appreciated this positive culture.

In relation to MHLD NQIs, Mrs Trouton advised work in underway with Mr Joe Walker and the Home Treatment Crisis Response team regarding restrictive practice tools.

Mrs Trouton was pleased to report that the SHSCT Dysphagia Team Won an award in Patient Safety Education & Training Category at the HSJ Safety Awards. The project aim was to co-design and co-produce Dysphagia Awareness training for staff caring for people with swallowing difficulties.

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Nursing and Midwifery vacant posts were discussed as at 27 October 2021. Mrs Trouton reported that there are 231 vacancies within the Acute Directorate and of these 161 were band 5 roles. She added that work is continuing in partnership with Human Resources and operational directorates to address this which includes open recruitment for Band 5 nursing posts, regional streamlining of recruitment of pre-registration nurses into Band 5 posts, streamlining recruitment of Band 2 / Band 3 posts and programme to transition from Nursing Assistant to Senior Nursing Assistant. Mrs Trouton noted that 59 students are due to qualify in December 2021 and are awaiting their NMC registration.

International recruitment was discussed. Mrs Trouton explained that from August 2021 onwards there have been limited arrivals, which have been impacted by the ending of funding from the existing Business Case. A new Business case for the future funding of International Recruitment is with the DoH for approval and DoH initially confirmed that no further international nurse arrivals can be facilitated until new funding is in place. The risk of losing the pipeline of international nurses waiting to work in Northern Ireland was escalated and it was agreed that further arrivals could be facilitated 'at risk' within Trusts. A target of 12 nurses per month has been re-established.

In relation to AHP workforce, Mrs Trouton reported that there are 128 AHP vacancies across the Trust as at 30th September 2021. She noted her concern on the number of vacancies within Physiotherapy and how this affects the musculoskeletal service for patients.
Mrs Trouton stated that work is ongoing with Ms Teggart to produce a paper for funding for a corporate AHP structure. Members noted their concern on the high-level capacity gap across AHPs. The Chief Executive stated that there has not been great focus on AHP workforce policy review at the Department of Health due to pressures. Mrs Trouton advised that Jenny Keane has provided assurance that the Minister of Health is aware of the concerns and capacity gaps for AHPs and contributed the gap to the funding available. The Chair felt it would be beneficial to discuss the AHP workforce review further with the Trust Chair.

Action: Mrs Leeson

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Mrs Trouton spoke of the Open University pre-registration Nursing Programme. The Trust is committed to creating opportunities for Nursing Assistants to progress a career into Nursing. In collaboration with The Open University (OU), The Trust has commissioned a bespoke programme offering 10 Nursing Assistants the opportunity to complete an introductory pre-registration nursing programme. On completion, candidates can apply for a commissioned place on stage 2 of the OU BSc Nursing programme. Mrs Trouton explained that this route is beneficial for certain candidates and it gives an opportunity for local staff to continue their education and employment within their own community. Mrs Trouton informed members that as part of a workforce planning initiative and pilot, the Trust have been working in partnership with the Southern Regional College (SRC) providing practice placements for 30 students for a Pre-nursing Health Care Level 4 certificate programme commencing in September 2021. The Trust are providing 480 hours practice placement experience for each student over the period of the programme. These students have also been offered the opportunity to join the Nurse bank as Nursing Assistants to obtain further health care experience. To date, 25 of the students have joined the Nurse Bank. On completion of the programme, students will be encouraged and supported to secure permanent Band 3 Nursing Assistant posts with the Trust SHSCT and will be eligible to go on to apply for a place on the Open University Pre-Registration Nursing programme. Mrs Toal welcomed this pilot and felt it would be useful to use this model within Social Work to link in with SRC.

Mr McCafferty stated that the establishment of the Directorate Nursing Assurance Interface meetings has been very positive and helpful. Mrs Trouton agreed and noted the meetings discussed a 5-year workforce plan, which will feed into the people plan.

Mr Wilkinson as the Chair of the Patient and Client Experience Committee noted the importance of interfacing with service users as this determines how they feel their experience was received from the Trust. He particularly noted the importance of good communication through the pandemic and commended all the staff who have worked tirelessly throughout it.

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In response to a question asked by Mrs McCartan, Mrs Toal explained that GREATix started in the Trust within Anaesthetics with Dr Laure Martin and Dr James Crockett. As part of wider staff recognition SMT has approved a paper that this scheme will be rolled out across the Trust. A presentation on GREATix to Trust Board is planned for January 2022.

Mrs McCartan noted the bilingual language assessment within the Speech and Language Therapy section of the report. She asked if there is an impact on the language development with those children who are bilingual. Mrs Trouton explained that is a specialised area and there is a need for ongoing training of various stakeholders, particularly those within the education sector, to aid SLTs in meeting best practice guidelines. It highlights the need for further training for SLTs on the various contexts in which children may become bilingual, and the impact this may have on language development.

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 15th November 2021 on infection data and antimicrobial stewardship data for PFA targets. A number of appendices were included with the reporting which contained information on: SHSCT PFA targets, Monthly Target Monitoring Report, Hand hygiene audit, Commode audit, Independent Hand hygiene audit, Independent Commode audit, COVID 19 data and Trust data on Antimicrobial Stewardship report.

Mrs Reid presented information on the current situation of Covid-19 pandemic. She highlighted the figures locally, regionally and hospital occupancy on those patients diagnosed with Covid. She reminded members that with there is a delay with covid community cases presenting to hospital for admission. Mrs Reid noted a concern in the Newry and Mourne area with a significant increase in cases in the past 7 days with 700 cases per 100k. She stated that this is evident with the increase admissions to the Emergency Department in DHH and the challenges this incurs with the restricted environment. In

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relation to the aging estate, Mrs Reid spoke of the ventilation issues, multiple bed occupancy and lack of en-suite facilities. She advised that work is underway with the Estates team to refurbish wards following a £8.7m investment and the introduction of standalone HEPA ventilation filters. Furthermore, she added that enhancing staff testing is promoted and ensuring that staff and patients can avail of the vaccine. Mrs Reid reiterated that important message of hands, face and space.

Mrs Reid advised that the Trust compares favourably with the region regarding mortality of covid HCAI. Learning is identified through the Clinical Forum and shared across the directorates.

Data on Clostridium difficile (C. Difficile) was presented. Mrs Reid reported that C. Difficile rates are rising. For 2021/22 to date there is a total of 41 cases. She advised that following a review it was noted that two cases were linked and it was identified that antimicrobial prescribing was the cause. A review of all cases is undertaken at the time of diagnosis and post infection review is completed on cases where it is considered learning may be identified. The cases are further reviewed at the Clostridium difficile working group.

Mrs Reid stated that the use of antibiotics across the Trust and Community throughout the pandemic has increased. She attributed this to the decrease in surgical capacity and patients treated with repetitive antibiotics to treat their condition. She advised that she would be liaising with Dr Damani as a critical friend to discuss what further measures the Trust can introduce/change to reduce the number of these cases.

Mrs Reid informed members of a proactive approach by the antimicrobial stewardship team that provide advice on daily wards in the Acute Medical Admissions ward. She noted that feedback has been positive and following the pilot, it is envisaged it will be rolled out across other wards.

In response to a question asked by the Chair, Mrs Reid advised there has not been new targets set for MRSA and MSSA however, the Trust continue to monitor and report on these areas as a way of assurance to measure against.

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In concluding, Dr Gormley added that the RAMI score data demonstrates that the Trust is lower than other regional Trusts. He further noted that through the pandemic it has shown the importance of Informatics and commended the Informatics team being at the forefront of driving patient data.

12. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty presented the above named report and noted that as at 29th October 2021 there were in total 86 unallocated cases which is a decrease from 87 in the previous quarter. There are no unallocated Child Protection or Looked After Children (LAC) cases. He did note that the Trust has the lowest number of unallocated cases across the region.

Mr McCafferty highlighted the lack of available social work staff and how it has not been possible to cover sick leave related vacancies and therefore the remaining staff have to cover this work load. This is creating significant capacity issues within the service, however, complex family support cases, Looked after children and child protection referrals are prioritised. Mr McCafferty advised that Management is currently engaging with Staff side organisations in efforts to agree how other parts of the social work service can assist in managing the current capacity issues within the safeguarding Division. He felt that it is unlikely that any new social work staff will be recruited into Gateway and Family Intervention Team (FIT) until Summer 2022 when new social work staff qualify.

The Chair spoke of her recent Leadership Walk within FIT and spoke highly of the team's dedication and commitment. She noted that the level of abuse directed towards staff from service users was concerning. Mr McCafferty agreed and stated that the team is mindful of the profile of staff and the importance of zero tolerance to abuse of staff. He spoke of the recent case of a service user who was convicted of abuse towards staff and how this is taken extremely serious.

In response to a question asked by the Chief Executive, Mr McCafferty commented that referrals will continue to rise year on

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year, however there is no consistent trend from month to month. He noted that during July and August normally referrals would drop due to the schools closed however; this was not the case during the pandemic.

Mrs McCartan noted that this area is an unseen area due to the its sensitivity and confidentially and asked how staff morale is maintained to which Mr McCafferty responded that management ensure that staff are not working beyond their capacity and additional hours are kept to a minimum.

13. PERFORMANCE REPORTING - EXTERNAL ASSURANCE

i) CHKS External Benchmarking Performance Report

The Chair welcomed Mrs Lynn Lappin, Head of Performance to the meeting.

Mrs Magwood presented the CHKS external benchmarking performance report from April 2020 – March 2021. She explained that CHKS is a contracted service providing independent analysis and benchmarking of health service data against Northern Ireland and UK based peer groups. The analysis undertaken relies on the accuracy and completeness of clinically coded data.

Mrs Magwood drew members' attention to the data included on the cover sheet, which provides a high-level overview of statistics. Mrs Lappin added that regardless if the data is crude or risk adjusted the report provides an assurance that the Trust is relatively strong compared to NI Peers.

Mr McDonald welcomed the report as it provides an assurance that the Trust is doing well. The Chair agreed and felt it was a very valuable report to measure against peers.
Mrs McCartan queried how and where the report is shared. Dr Gormley added that the report is shared at the Morbidity and Mortality meetings and with Consultants, which is used for their appraisal and revalidation for individual mortality rates.

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Members felt it would beneficial for a training session to be arranged on understanding and interpreting data, on a yearly basis. Mrs Magwood agreed to take this forward.

Action: Mrs Magwood

Due to time constraints, the Chair requested that this item be discussed further at the next performance committee meeting.

Action: Mrs Magwood

Mrs Lappin left the meeting at this point

14. COMMITTEE WORK PLAN 2022

Members discussed the content of the work programme for 2022. The committee work programme was approved for submission to Trust Board in January 2022.

15. ANY OTHER BUSINESS

The Chair noted that this was the Chief Executive's last Performance Committee meeting as he leaves to take up a new post with NHS England. On behalf of the Committee, the Chair thanked him for his contribution to the work of the Committee over the years and wished him well in his new post.

The meeting concluded at 12.45 p.m.

Signed _____ Dated _____

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 10th March 2022 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:

Dr D Gormley, Deputy Medical Director *(for Dr O'Kane)*
Mr C McCafferty, Interim Director of Children and Young People's Services / Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs L Leeman, Assistant Director Performance Improvement
Mrs G Hamilton, Assistant Director Patient Safety, Quality and Experience *(for Mrs Trouton)*
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Mrs H McCartan, Non-Executive Director
Dr M O'Kane, Temporary Accounting Officer / Medical Director
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and noted the apologies above. She particularly welcomed Dr Damian Gormley and Mrs Grace Hamilton deputising for their respective Directors.

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At this point, the Chair advised members on some aspects of virtual meeting etiquette.

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. CHAIR'S BUSINESS

The Chair informed members that Mrs Leeman has been appointed as the Interim Director of Performance and Reform. Members congratulated and wished her well in her new role.

4. MINUTES OF PREVIOUS MEETING HELD ON 2nd DECEMBER 2021

The Minutes of the meeting held on 2nd December 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.

Mr McDonald asked for an update on item 7 Performance Report on the matters arising on the audit of appropriateness of GP referrals to the Emergency Department. Mrs Leeman stated that following discussions with the Acute Directorate a date has not been agreed to carry out this audit in DHH. She agreed to seek a further update and report back at the next meeting.

Action: Mrs Leeman

Ms Donaghy asked for an update on the Internal Audit report on Performance Management. Mrs Leeman explained that the draft report is currently with the Trust for factual accuracy checking. The final report will then be presented to the Audit Committee and subsequently to this committee in May 2022.

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6. SICKNESS ABSENTEEISM

The Chair welcomed Deputy Directors, Mrs Maxine Williamson and Mrs Siobhan Hynds to the meeting to present an overview on Sickness Absenteeism within the Trust. Mrs Toal introduced the item and advised that the presentation will focus on key data and trends, impact on service delivery, management issues and support for staff.

Mrs Hynds began by explaining that the sickness absence figures are up to December 2021 so do not represent the full 2021-22 year figure. It includes COVID sickness absence but excludes COVID self-isolation/shielding absences. . Sickness absence figures also exclude Domiciliary Care Workers (system / contracted hours issue). Mrs Hynds presented statistics on sickness absence and Covid self-isolation/shielding (non-sickness) and provide the sickness absence level over a 3 year period. She noted that, as at December 2021, the cumulative 2021/22 sickness figure was 7.01% an increase from 6.78% on the previous year. Mrs Hynds added that although the Trust sickness absence levels have increased, the Trust continues to have lower levels of non-COVID sickness absence in comparison to other HSC Trusts.

Regarding Covid sickness, Mrs Hynds reported that for 2020/21 the Trust had the highest level of COVID sickness absence and in 2021/22 (as at December 21) the third highest level. She attributed this to the link that the Southern Trust Council areas having the largest COVID 19 community transmission rates at certain times during the pandemic.

Mrs Hynds stated that 51% of staff have not had any episodes of sickness. Mr McDonald felt it would be valuable to review the factors such as demographics and age profile for this cohort of staff which might highlight trends. Mrs Toal agreed to undertake this and feedback at the next meeting.

Action: Mrs Toal

Mrs Hynds noted that corporate directorates who have the ability of homeworking throughout the pandemic have a lower level of sickness than those staff who cannot work from home.

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Mrs Williamson reported that there were no flu or viral sickness absences in 2020/21. She reminded members that pregnant women were shielding from 28 weeks during the pandemic. Mrs Williamson stated that Mental Health related absences were increasing and noted that in 2020/21 this was the number one reason for absences with stress the top reason. She continued to guide members through the presentation and spoke of the impact on service delivery across all directorates and provided examples of specific service areas affected. Mrs Williamson reported that the Functional Support Service division is above the baseline level of absences and advised that this is an area of focus. She informed members that the Trust has to be mindful that the longer hospital waiting lists is affecting many of Trust staff and how this has an impact on sickness levels.

Mrs Williamson spoke of the support available to staff through Occupational Health, Staff Health Protection and the Psychology Service. She presented a number of statistics on the activity within the Occupational Health department.

In concluding, Mrs Toal stated that the Trust is working to 'get back on track' in terms of normal sickness absence management within HROD and throughout the Directorates.

Mr McCafferty welcomed the presentation and asked that the presentation be shared with managers. Mrs Toal welcomed this suggestion and agreed to action this.

Action: Mrs Toal

Ms Donaghy commented that critical services and waiting lists are negatively impacted with sickness absenteeism and asked how this is being addressed. Mrs Toal explained that redeployment of staff is undertaken in areas where delivery of service is affected and the use of bank and agency staff is used. She added that the AHP flexible pool is used to cover long-term vacancies and maternity leave.

Ms Teggart noted that the Belfast and South Eastern Trusts sickness figures are lower than the Southern Trust and asked why this may be and if there is learning that can be implemented across the Trust. Mrs

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Toal clarified for Ms Teggart that this was not the case overall, and that it was the Covid absence levels that were higher due to higher Covid rates across the Southern council areas. Mrs Toal went on to confirm that the Trust's non-Covid sickness rate is lower than all other Trusts, and has been consistently this way for a number of years.

Ms Teggart spoke of 'Inspire Workplaces' which offers free confidential and immediate support for all staff and felt that this could be promoted more across the Trust. Mr Wilkinson agreed that that the Inspire service is an excellent tool and would welcome further promotion of the service across the Trust. Mrs Toal agreed to take this forward.

Action: Mrs Toal

7. PERFORMANCE MANAGEMENT FRAMEWORK

Mrs Leeman presented the Performance Management Framework (PMF) for approval. The document provides information to the committee in exercising its function of overseeing the Trust's Performance Management arrangements. Mrs Leeman reminded that the Performance Committee determined in December 2021 that the PMF should be updated to reflect the interim arrangements established during the Covid-19 pandemic. Mrs Leeman drew members' attention to the section of the report which highlights the change. She advised that the PMF will remain subject to change and will require to be updated to reflect the output of the new integrated care system model and aligned planning arrangements.

Members approved the Performance Management Framework

8. PERFORMANCE REPORT

Mrs Leeman 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. Mrs Leeman advised that the regional work on new planning and performance arrangements, led by the Department of Health (DoH) and the Health and Social Care Board (HSCB), including Trust Directors of Planning/Performance, is ongoing. The DoH stakeholder

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consultation in respect of the 'Future Planning Model – Integrated Care System NI' has closed. Engagement with citizen hubs is ongoing facilitated by the Integrated Care Partnership. The Trust is a member of a number of work streams focused on development of an outcomes framework. Mrs Leeman noted that the Trust's Service Delivery Plan for January 2022 – March 2022, which includes the Winter and Covid surge plan arrangements, has been published on the Department of Health's website.

Mrs Leeman highlighted the key risk areas; access to elective and cancer services, wait times at Emergency Department, inpatient bed demand for adult unscheduled care, access to social work workforce, mental health and disability support services, unallocated domiciliary care cases and ongoing covid transmissibility and impact of workforce. Mrs Leeman guided members through the detailed report which set out the broad performance of each directorate and the actions taken.

Mrs Leeman referred to section 1.1 of the report and noted her concern that waits over 12 hours in the Emergency Department continue to reflect an increasing trend. She advised that the graph highlights those patients who waited over 36 hours and members agreed that this is unacceptable.

In relation to Carers Assessment, Mrs Leeman advised that the older people's services have the largest volume of carer's assessments across the Trust. She explained that the volume of offers has decreased however, in actual terms noted the number of carers assessment actually undertaken reflected an improving trend indicating a more appropriate targeting of assessments. Mrs Leeman noted that there was evidence a level of need was being addressed with the provision of cash grants for short breaks and additional levels of self-directed support payments and domiciliary care hours Mrs Leeman added that work continues to ensure that carer assessments are completed.

In response to a question asked by Ms Donaghy, Mrs Leeman explained that patients are attending the Emergency Department with undiagnosed cancer and attributed this to patients not presenting to their GP and hospitals during the pandemic. Ms Donaghy asked if

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referrals have returned to pre-covid levels, to which Mrs Leeman stated that numbers are increasing and there is an unmet demand and an increase in patients added to waiting lists. Dr Gormley explained that the length of stay is impacted by the acuity of the patient. Ms Donaghy asked if it can be established as to whether those surgical patients on a waiting list have had their length of stay increased above the normal range for that condition. Mrs Leeman agreed to undertake this review and feedback at the next meeting.

Action: Mrs Leeman

Mr McDonald referred to section 4.4 - GP Out of Hours and noted that a review of this service has been initiated with the first meeting in February 2022. He asked what Directors are members of the review team to which Mrs Leeman confirmed that Mr Beattie and Ms Teggart are the leads for the Trust. She added that this work links in with the 'No More Silos' – urgent and emergency care work stream for which there was an ongoing consultation.

Members approved the Performance Report

9. CORPORATE PERFORMANCE SCORECARD

Mrs Leeman presented the Corporate Performance Scorecard (January 2022 performance) for approval. The report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework. She reported that historic CPD objectives have been maintained for 2019/2020, 2020/2021 and 2021/2022. Mrs Leeman advised that improvements have not been achieved and performance further impacted in year as result of the current pressures/pandemic response. High level Service Delivery Plan monitoring (previously Corporate Rebuild) is now included in the CPD Performance Scorecard.

Mrs Leeman drew members' attention to the cover sheet, highlighting those areas of concern, risk and challenge and those areas of improvement. She advised that access to services is highlighted throughout the report and in particular elective areas that are concerning. She noted that the statistics in the report are a reflection on the current position of the Trust.

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In response to a question asked by Mr McDonald, Mrs Leeman explained that the current targets are outdated, having been rolled over year on year from 2019/2020 and were in the main not available in the current environment. Mrs Leeman indicated that work on a new outcome framework was ongoing.

Mrs Leeman reminded members that the Minister for Health has set out his 'Elective Care Framework' and 'Cancer Recovery Plan', however the success of the plans will depend on a budget and workforce available.

Mr Wilkinson asked on the success of the validation of waiting lists and if this is having a significant impact. Mrs Leeman commented that validation of waiting lists is important to cleanse the lists and ensure that patients still require treatment. However, she advised that the number of patients waiting treatment that no longer require are small in comparison to the volume of waits and this has not made a significant inroad in reducing waiting lists.

Members approved the Corporate Performance Scorecard

The Chair requested that item 13 be taken at this point

13. UNALLOCATED CHILDCARE CASES REPORT

Mr McCafferty presented the above named report and noted that as at 31st January 2022 there were in total 296 unallocated cases which is an increase from 86 in the previous quarter. There are no unallocated Child Protection or Looked After Children (LAC) cases. He did note that whilst high, the Trust has the lowest number of unallocated cases across the region.

Mr McCafferty informed members that during the reporting period and as of the end of January 2022 there were two families, which consisted of four children on the Child Protection register who did not have a named social worker over a six-week period due to social work sick leave and vacancies.

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Mr McCafferty advised that the cases were risk assessed and that there was close inter-professional monitoring including home visits pending allocation to a named social worker. He advised that this was reported to the HSCB and provided assurance that both families were assigned a social worker from the 1st week in February. Mr McCafferty stated presently there are no unallocated Child Protection or Looked After Children (LAC) cases. He advised that an update on pressures within CYP will be presented to confidential Trust Board on 31st March 2022.

Mr McCafferty referred members to the unallocated cases over a 6 week period. He provided assurance that all unallocated cases within Gateway have been reviewed by a Senior Manager and prioritisation of actions identified. An action plan has been developed in respect of higher priority referral.

Workforce capacity issues across the social work service was discussed. Mr McCafferty advised that there is currently a regional shortage of qualified social workers available and who are willing to take up employment in front line children's services, and this will not improve until early Summer when newly qualified staff become available. Even then, there will not be sufficient numbers of new staff available to fill all vacancies.

Mr McCafferty drew members' attention to increase of referrals month on month since October 2021. Me McCafferty advised that at present there is a cross Divisional approach to managing the challenges and seeking to ensure that the most vulnerable and complex cases receive a social work service. He was optimistic that an improved positon would be achieved by early summer, however challenges are likely to remain for the medium term in relation to unallocated cases.

Ms Teggart noted that in some cases there may be families on the poverty line and asked if the Trust and the voluntary sector offer assistance. Mr McCafferty agreed that poverty is a key feature for many families and spoke of a number of charities who can help families in need however, this does not address the systemic issue associated with poverty. Mr McCafferty added that the Trust does offer family support through the FIT team and in addition via the Family Support teams.

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In relation to recruitment and retention, Mrs Toal stated that there will be 230 newly qualified social workers across the region however this will not address the capacity and vacancy issues as all five Trusts are in the same position. Responding to a question asked by Mrs Toal, Mr McCafferty advised that unlike nursing and medical there very limited international social workers available for recruitment. The Chair highlighted alternative routes into social work: social work assistants at the local training centres and the Open University.

10. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Enhanced / Specialist Community Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Brian Beattie Interim Director of Older People and Primary Care and Mr Gerard Rocks, Assistant Director of Promoting Wellbeing to the meeting to present the above named item. Members received the presentation in advance of the meeting.

Mr Beattie guided members through the presentation, which consisted of the commissioning plan direction, continuum of care, access and information service, community and voluntary sector service and potential new developments. He began by presenting data and information on OGIs for carers assessments, short breaks, direct payments and self-directed support.

In relation to Access to Services, Mr Beattie spoke of the importance of the right service at the right time. He reported that the Trust has 140 contracts in place with independent, charitable and social enterprise providers. Mr Beattie presented an overview of the Access and Information service within OPPC and advised that between 2018 and 2021 there has been a 15% increase in the number of referrals into the ICT service and within social work there has been an increase of 29% for the same reporting period. Approximately 53% of all referrals for Social Work are redirected from ICT Social Work by the Access and Information service.

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Mr Rocks presented information on Promoting Wellbeing and reported that this service manages 22 contracts with CV sector organisations with a total value of £550k per annum. He spoke of the overarching priority areas to provide early intervention and prevention, addressing social isolation and loneliness by building connections and capacity in communities, and tackling poverty and disadvantage. Mr Rocks explained that the target groups are: carers, BME groups including Travellers, older people and those communities experiencing inequalities in health.

In concluding Mr Beattie informed members of the potential future developments, namely: review access and information staff capacity to deal with increasing level of demands, increasing Social Worker capacity to support downturn of referrals to ICTs, dedicated PARIS support to enhance A&I systems and to support a data driven approach to management and commissioning of CVSE sector and commissioning of community and voluntary social enterprise contracts.

Mr McDonald commented on the need for the Trust to allocate further investment and resources to Health and Wellbeing. He felt that the pathways for referrals provided a richness of data to demonstrate the benefits of the using these pathways for a better outcome. Mr Rocks advised that this is an area of focus to better evidence the value of these pathways.

Ms Donaghy commented that the pandemic has had an economic effect on families and the increase need for people to turn towards food banks. Mr Beattie stated that there is an increasing trend of families highlighting to their social workers that they use food banks and this is concerning.

Mr Wilkinson welcomed the linkage with the community and voluntary sector and spoke on the importance of including in the education sector. He asked if an annual report from voluntary and community sectors is sought to demonstrate their achievements and outcomes. Mr Rocks advised that an annual report is not required however, through their contract management and end of year reviews, assurances are sought through these processes. Mr Beattie advised

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that he intends to bring a proposal to SMT during 2022/23 to scope the existing community and voluntary contracts against the corporate objectives and he envisaged that this may provide clarity in respect of whether any of the existing contracts should be amended/ended and if any new contracts should be commenced.

Ms Donaghy noted that EU funding is available until 2022 in relation to the mPower project and asked if funding is available beyond that. Mr Rocks advised that a number of options and discussions would be taken forward; however in the interim the learning from the mPower project will be reviewed on how best to implement it across the service.

Mr Beattie and Mr Rocks *left the meeting at this point*

Mr Wilkinson left the meeting at this point

11. SENTINEL STROKE NATIONAL AUDIT PROGRAMME

The Chair welcomed Dr Michael McCormick, Consultant Stroke Physician, Mrs Anne McVey, Assistant Director of Acute Services Medicine and Mr James Gilpin Stroke Service Improvement Lead to the meeting. Mrs McClements introduced this item and explained that the service has 19 dedicated acute stroke beds on the CAH site, DHH has a 30 bedded unit encompassing acute stroke and stroke rehabilitation patients alongside older peoples beds. She reminded members that following a local consultation on 2014 the outcome was a centralised model to support improvement of stroke services with acute beds centralised in CAH and rehabilitation beds at DHH. The infrastructure and investment required to deliver on the preferred model has not been actualised. In 2019, a subsequent regional public consultation was undertaken with CAH identified as a hyper-acute site. The outcome of the report was delayed and is as yet not concluded.

Dr McCormick presented data on the Sentinel Stroke National Audit Programme (SSNAP). He explained that the audit consists of two elements: clinical and organisational audit and explained the difference in both. Dr McCormick presented clinical audit comparable peer information on the status of stroke units across the region. He reported that the SSNAP quarterly audit performance in CAH has

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been banded as a level 'D' and DHH banded as a level 'C' in the quarter July – September 2021, comparative Trust analysis was included in table 1 of the report.

Dr McCormick reported on the areas of achievement. The Trust has a Stroke Improvement Group which meets regularly and reviews SSNAP data; the stroke service improvement lead has now returned to his post with an aim of focussing on key areas for improved performance following redeployment during covid; a Quality Improvement Project (QIP) has commenced on stroke identification in the Emergency Department and targeting ward of first admission;, a new consultant has been appointed to the Craigavon Area Hospital and has stroke dedicated sessions; a need for an increase in stroke Allied Health Professional capacity has been identified and an investment proposal has been developed, exploring the option to reconfigure and improve stroke services within the existing infrastructure to create a centre of frailty and stroke services and the collaborative working with non-acute colleagues in the management of early and support discharged for stroke patients.

Dr McCormick spoke of the areas of concern. He reported that the bed pressures on the CAH site affect the access to dedicated stroke beds. Overcrowding in the emergency department impacts on the ability to triage patients and ensure their treatment is administered in a timely manner. Dr McCormick explained that stroke services are provided across four different hospital sites, which dilutes staff within an already under-resourced service, which affects performance. The four-site model does not facilitate focused 7-day therapy and early supported discharge. Dr McCormick stated that the AHP staff co-hort is inadequate and falls below the recommended guidelines. He spoke of the need for AHPs cover over 7 days in particular Speech and Language therapists to undertake swallow reviews and the need to increase nursing staff to ensure the safe delivery of thrombolysis 24/7.

In concluding, Dr McCormick advised that solutions are required for the short term outlook, namely; workforce investment, prioritisation of stroke service, stroke assessments at weekends and dedicated ward. In relation to a long-term model, he spoke of the centre for stroke and frailty to facilitate consolidation.

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Mrs McClements agreed with Dr McCormick on the concern that stroke beds are not protected, that patients are being displaced and the infrastructure is not in place to provide the required level of care. She informed members that work is ongoing to establish a dedicated ward and there are a number of options being discussed, however the need for investment and infrastructure is required. Mrs McClements advised that discussions have taken place with OPPC if there is capacity to increase the workforce; however this is proving difficult due to their own capacity gaps.

Dr Gormley commented that the main outcome for these patients was to return home and the importance of receiving the correct treatment at the right time in a dedicated ward is crucial. He suggested that the team liaise with the Belfast Trust who can offer the learning identified through their introduction of therapy at the weekends. Dr McCormick welcomed this, however he stated that the Trust is unable to offer the same level of intensity of therapy available at the weekends, therefore this impacts the performance and length of stay for patients.

In response to a question asked by Ms Donaghy, Dr McCormick explained that target for administering lysis has decreased on both site particularly during covid. He attributed this to patients not presenting in a timely manner, rural setting for a co-hort of the population and challenges within the NIAS response times. He advised that DHH has the highest rate for carrying out Thrombectomy on patients which can be done within 24 hours of the patient presenting.

Ms Teggart asked that following the concerning figures presented what can Trust Board / Committees do to lend its support for further investment into the service? Mrs McClements explained that this issue has been raised with the stroke strategic group on a regular basis and the inequity across the region for funding. She added that the Trust has went at risk to create therapy roles and geriatricians in OPPC and Acute and work in ongoing with the planning department to keep the commissioners informed and up to date of the situation. Mrs McClements noted that additional resources are required within practice education facilitators, nurse specialists, succession planning, ambulatory service and an improve infrastructure. Ms Teggart

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welcomed this and commented that the data presented supports the need for this.

Mrs McVey commented that the stroke service staff have shown compassion and professionalism during a challenging time and would welcome the support from Trust Board.

The Chair thanked Dr McCormick for his presentation and asked that an update be presented at the December 2022 meeting. She advised that she would write to the Trust Chair and Chief Executive to alert them to the significant findings from SNNAP and the need to for this service to be an area of prioritisation.

Action: Mrs Leeson

12. CHKS EXTERNAL BENCHMARKING PERFORMANCE REPORT

The Chair welcomed Mrs Lynn Lappin, Head of Performance to the meeting. She reminded members that at the last meeting time did not permit for a full discussion.

Mrs Lappin presented the CHKS Annual Performance Report, which provides an overview of the Trusts performance across a range of efficiency and patient safety indicators for the 12-month period of April 2020 to March 2021. She explained that the analysis undertaken in this report relies on the accuracy and completeness of clinically coded data. 100 is the maximum score achievable and is the most favourable position. The Trust scores comparatively positively to the NI Peer – Southern Trust 95.76 versus NI Peer 93.33.

Mrs Lappin presented data on length of stay (LOS). She stated that Craigavon Area Hospital (CAH) LOS analysis demonstrates a higher LOS in comparison to the NI Peer. However, when risk adjusted the LOS demonstrates better performance than the Peer – CAH 84.48 versus NI Peer 92.50. Daisy Hill Hospital (DHH) demonstrates better performance to Peer in relation to LOS indicators, including risk adjusted – DHH RALI 83.14 versus NI Peer RALI 92.50. Mrs Lappin added that a group has been established to review the current length of stay and looking for options to reduce this appropriate; this group is being led by Dr Gormley.

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Readmissions were discussed. Mrs Lappin reported that the Trust's rate for readmissions within 30 days demonstrates better performance than the UK Peer and in line with NI Peers – Trust 8.3% versus UK Peer 9.8% versus NI Peer 8.3%.

Mrs Lappin noted the areas of concern. She advised that delayed discharge at the weekend for non – elective inpatients demonstrates a lower level of performance to that of the NI peer. Mrs Lappin stated that weekend discharges remains a longstanding challenge for the Trust with recent investment to extend services to in-patients across 7-days. To enable the Trust to improve performance further investment is required to enable full 7-day service provision.

In relation to Out-Patients, Mrs Lappin reported that the Trust's new to review out-patient ratio compares less favourably to both the UK Peer and the NI Peer – Trust 1:2.37 versus UK Peer 1:2.19 versus NI Peer 1:1.86. She attributed this decrease in performance with the Trust's New to Review ratio that is likely to have been impacted by the downturn in face to face out-patients with a focus on virtual appointments, which favoured review appointments over new appointments.

In response to a question asked by the Chair, Mrs Lappin explained that virtual appointments have worked well for a number of clinicians and services.

Dr Gormley advised that the data available from CHKS is very broad and if there were any data points that members would like included in future reports to inform him.

Mrs Leeman spoke of the resources within the Quality Improvement Team, which can be utilised to support data drive improvements and use their expertise to drive Quality Improvement across the Trust.

Mr McDonald referred to the readmission section and noted that the readmissions performance does not take into account any patients managed in Acute Care at Home (AC@H) and then subsequently admitted to a hospital bed. He asked if AC@H and virtual visiting has impacted admission rates and length of stay and if this can be

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compared to peers. Mrs Leeman agreed to undertake further analysis of this and feedback at the next meeting.

Action: Mrs Leeman

Mrs Lappin left the meeting at this point

14. 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 15th November 2021 on infection data and antimicrobial stewardship data for PFA targets. A number of appendices were included with the reporting which contained information on: SHSCT PFA targets, Monthly Target Monitoring Report, Hand hygiene audit, Commode audit, Independent Hand hygiene audit, Independent Commode audit, COVID 19 data and Trust data on Antimicrobial Stewardship report.

Mrs Reid presented information on the current situation of Covid-19 pandemic. She highlighted the figures locally, regionally and hospital occupancy on those patients diagnosed with Covid. She reminded members that with there is a delay with covid community cases presenting to hospital for admission. Mrs Reid reminded members that patients/visitors attending the Emergency Departments continue to be tested and outbreak meetings are continuing on a daily basis. Reflection from covid cases in Care Homes is continuing to be worked through for learning.

Mrs Reid reported that work has commenced on one side of 4 South ward in CAH to improve the toilet facilities, ventilation and felt that this was a good model to use going forward for improving additional wards.

Data on Clostridium difficile (C. Difficile) was presented. Mrs Reid reported that C. Difficile rates are rising. For 2021/22 to date there is a total of 61 cases an increase of 20 from the previous report. She advised that there has been one outbreak of Clostridium difficile involving two patients; incident management meetings have taken

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place. Learning has been shared at various forums and a serious adverse incident review is in progress. She further advised of a potential outbreak that is under investigation and is at an early stage.

Mrs Reid reported that there has been three preventable MRSA bacteraemia to date and post infection reviews have been carried out to identify learning. Learning has been shared with relevant teams involved. She provided background to the third cases and advised that it is being reviewed by the SHSCT and WHSCT.

Mrs Toal left the meeting at this point

15. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Hamilton presented the Executive Director of Nursing, Midwifery and AHPs report which largely covers the period from October 2021 to December 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 Frameworks and include areas regarding workforce, education training, and quality of practice.

Mrs Hamilton guided members through the report and highlighted specific areas for noting. She advised that for International recruitment, a regional plan is currently being developed to maximise overseas nurse recruitment to support Trust requirements. A requirement of 12 nurses per month was re-established and agencies are working to increase the pipeline of nurses. Seven nurses were recruited to the Trust in January 2022 and a further eight nurses are expected in February 2022. It is hoped that by March the target of 12 nurses per month will be reached. Mrs Hamilton stated that the vacancy levels across Acute and MHLD has reduced from October 2021 to January 2022.

Mrs Hamilton informed members that transformation work within the Dysphagia Service continues to progress and was pleased to report that RQIA has agreed to adopt the Trusts Dysphagia model regionally.

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Mrs Hamilton reported on Nursing, Midwifery and AHP vacancy rates. She noted that from November 2021 to January 2022, CYP vacancy rate has increased by 18.06 wte and the OPPC vacancy rate has increased by 12.08 wte. Mrs Hamilton advised that open recruitment drives continues and the Practice Development team continue to support students and encouraging them to remain in the Trust following graduation.

Supervision was discussed. Mrs Hamilton drew members' attention to page 21 of the report, which outlines the directorate and divisional position as at 31st December 2021 for the first and second supervision sessions. The graphs show the compliance over the first 3 quarters of 21/22. Ms Donaghy noted her concern that within the Acute Directorate the percentage of staff having received their first supervision session is 39% (a 2 % increase on last reporting quarter) and 21% having had their second supervision session. Mrs Hamilton stated that a change in culture around supervision is needed and this is an ongoing process to ensure supervision is completed and documented to reflect accurate numbers. She reinforced the need for protected time for managers to carry out supervision, however due to workforce gaps and daily pressures this is challenging to achieve. Mrs Hamilton advised that discussions have taken place in Acute to ensure that supervision is prioritised.

In relation of agency staff and cost of agency pay rate, Ms Teggart asked what the Trust is doing to reduce this. Mrs Hamilton explained that this is a regional issue and until action is taken collectively by all 5 Trusts, the Southern Trust continues to face challenges on rising agency costs and usage. Mrs Hamilton agreed to seek an update from the regional group of the status of agency pay rate.

Action: Mrs Hamilton

16. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.50 p.m.

Signed _____ Dated _____

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Southern Health and Social Care Trust

Quality Care - for you, with you

Medical Staff Appraisal and Revalidation Policy v4.4

Lead Policy Author & Job Title:	Medical Appraisal and Revalidation Management Team
Directorate responsible for document:	Medical
Issue Date:	30 September 2021
Review Date:	30 September 2023



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Policy Checklist

Policy name:	Medical Staff Appraisal Scheme
Lead Policy Author & Job Title:	Medical Appraisal Revalidation Management Team
Director responsible for Policy:	Dr Damian Scullion
Directorate responsible for Policy:	Medical
Equality Screened by:	Click here to enter text.
Trade Union consultation?	Yes ☐ No ☒
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	Click here to enter a date.
Date approved by SMT:	Click here to enter a date.
Policy circulated to:	All Medical Staff
Policy uploaded to:	SharePoint

Version Control

Version:	**Version 4.4**
Supersedes:	**Medical Staff Appraisal Scheme v4.0**

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1. Introduction

This document sets out the Trust's appraisal scheme for all Doctors/Dentist with a prescribed connection to the Southern Health and Social Care Trust (SHSCT - Trust).

Annual Appraisal is the core component of revalidation for all Doctors. The GMC states:

"*For the purposes of revalidation, it is essential that there is an effective appraisal system that includes an evaluation of each Doctors performance against the relevant standards. Doctors will need to maintain a folder or portfolio of information drawn from their practice to show how they are meeting the required standards"*

The GMC has produced two core documents that will underpin the implementation of revalidation for all licenced Doctors. The documents are "*The Good Medical Practice Framework for Appraisal and Revalidation*" and "*Supporting Information for Appraisal and Revalidation*"

The GMC Framework will form the basis of a standard approach for all appraisals in which Licenced Doctors must take part in order to revalidate. The SHSCT Medical Appraisal Policy follows the GMC guidance. The GMC Framework states that Responsible Officers (RO's) will base their recommendations for revalidation on the outcome of a Doctors annual appraisal over the previous 5 year cycle, combined with information drawn from the clinical governance systems of the organisation in which the doctor has worked. During their appraisals, doctors will discuss their practice and performance with their appraiser and use supporting information to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice.

One of the key element in the revalidation process is the supporting information that doctors will provide from their everyday practice in order to demonstrate that they are compliant with the professional standards. The information required will vary depending on the nature of the doctor's whole practice, but will include material such as audit, outcome data, and evidence of participation in Continuing Professional Development (CPD). This information should be brought together with other relevant clinical governance information to the annual appraisal.

Appraisal for doctors is a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on their work and to consider how his or her effectiveness might be improved. To review all relevant Trust information click here.

2. Purpose and Aims

The purpose of this policy is to outline the requirements and arrangements for conducting the Appraisal and Revalidation of Medical staff in the Trust, following direction by the General Medical Council (GMC) and other relevant bodies. Appraisal is not a new concept, however, the approach and use of information is clarified and strengthened. The aim of the policy is to

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ensure that, through an effective appraisal mechanism all licenced medical/dental staff, including locum/temporary doctors (employed for more than 6 months), participate in a consistent form of annual appraisal.

The objectives of the medical appraisal are to provide:

- Review regularly an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources.
- Optimise the use of skills and resources in seeking to achieve the delivery of service priorities.
- Consider the doctor's contribution to the quality and improvement of services and priorities delivered locally.
- To enhance the quality of professional work by planning their personal and professional development.
- Identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met.
- Provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider HSC.
- Contribute to the governance (serious adverse incident/ incident management and complaints) requirements of the organisation.
- Utilise the annual appraisal process and associated documentation to contribute to the requirements of revalidation.

In addition to the above, medical appraisal should:

- Be delivered by competent, trained appraisers.
- Be consistently applied.
- Be undertaken annually.
- Not be a one-off event but a continual process and an integral part of a learning culture.
- Relate to **all areas** of a doctor's practice (whole practice).

Doctors/Dentists in training will participate in appraisal through Northern Ireland Medical & Dental Training Agency (NIMDTA).

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3. *Policy Statement*

It is the duty of SHSCT to establish and keep in place processes for the purposes of monitoring and improving quality of health and social care.

The appraisal process:

(a) Will be accessible to all doctors (defined above).

(b) Should emphasise a positive and developmental approach.

(c) Should be fair and effective.

(d) Should be well informed.

(e) Should, where possible show how patient care and working within the NHS can be improved.

(f) Should be undertaken annually with skill, professionalism and confidentiality.

(g) Should provide adequate preparation time and be adequately prepared for by both the appraiser and appraisee.

(h) The detail of the appraisal is a confidential discussion between appraisee and appraiser which can be divulged with the consent of the appraisee.

4. *Scope of Policy*

The content of the policy applies to all doctors and dentists – Consultants, Associate Specialists, Speciality doctors, Locum, GPs – employed by SHSCT. An annual appraisal is required for all doctors and dentists, full-time and part-time, directly employed by SHSCT.

5. *Responsibilities*

5.1 Role of Chief Executive

The Chief Executive is personally accountable to the Trust Board for overseeing the appraisal process and confirming to the Trust Board that:

- Appraisals have been conducted for all medical staff.
- Any issues arising out of the appraisals are being properly dealt with.
- Personal development plans are in place for each doctor.
- Appraisers and appraisees are trained to undertake appraisal across the full range of headings within the appraisal scheme.

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- Appointment of a Responsible Officer, normally the Medical Director to make recommendations to the General Medical Council.

The Chief Executive will operate the system through the Medical Director/RO, Deputy Medical Director and Divisional Medical Directors and they will be accountable for ensuring any necessary action(s) arising from the appraisal process is/are undertaken.

5.2 *Role of Medical Director (MD) and Responsible Officer (RO)*

- The Medical Director, on behalf of the Chief Executive, will be responsible for ensuring the integrity of the appraisal policy and for managing potential operational difficulties so that the validity of the process is maintained.
- The Medical Director will ensure the necessary links exist between the appraisal process and other Trust processes concerned with clinical governance, quality and risk management and the achievement of service priorities. In discharging this accountability, the Chief Executive and Medical Director will have confidential access to Forms 3 and 4 and Personal Development Plans as part of the appraisal process.
- Individual doctors are responsible for participating properly in the appraisal process and for undertaking any identified development.
- Where the Medical Director and Responsible Officer have separate roles, it is essential to have a shared understanding and an effective relationship between the two roles.
- The Responsible Officer has overall accountability for all aspects of a Doctors appraisal.
- RO has a statutory duty to ensure the provision of suitable medical appraisal for all doctors with a prescribed connection to SHSCT.
- The RO will ensure there are sufficient numbers of trained medical appraisers in SHSCT.
- The RO has oversight for local clinical governance processes, focusing on the conduct and performance of Doctors.
- The RO must monitor and evaluate the fitness to practise of Doctors with a prescribed connection to the SHSCT.
- The RO makes recommendations to the GMC about a Doctor, the decision as to whether a doctor should be revalidated belongs to the GMC.
- The RO ensures systems are in place to record and collate all the necessary information, including record of any practice undertaken by the Doctor outside the organisation.

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5.3 Role of Divisional Medical Director (DivMD), Clinical Director (CD) Deputy Medical Director (DMD)

Main duties/responsibilities

- To work with the Appraisal & Revalidation team to ensure that all doctors are engaged in Appraisal & Revalidation in a timely fashion.
- Through medical management structures ensure that areas of concern raised with the appraisal and revalidation process are addressed.
- In conjunction with the Medical Directors office to be involved in oversight of revalidation and appraisal processes including undertaking at least eight appraisals annually, equating to 0.25 Additional Programmed Activity (APA) in job plans.

5.4 *Role of Medical Appraisal & Revalidation Team Leads*

The RO will ensure an adequate appraisal support team is in place to manage the appraisal system on their behalf. The medical leads for appraisal and revalidation are responsible for undertaking duties as delegated by the RO to ensure compliance with the policy.

This team consists of:

- RO/Deputy Medical Director for Appraisal & Revalidation
- Corporate Lead for Appraisal & Revalidation
- Consultant Lead for Appraisal & Revalidation
- SAS Lead for Appraisal & Revalidation
- Senior Appraisal and Revalidation Manager
- Revalidation Manager
- Revalidation Support Team Manager
- Revalidation Support Team

5.5 *Role of Appraiser*

Each recognised Trust appraiser will be recruited and selected in accordance with national guidance and must undertake a minimum of eight appraisals per annum (0.25 APA) and should be included in job plans. If a conflict of interest arises, the appraiser must abide by the Trust Policy and participate fully in the quality assurance programme.

The Medical Appraiser is responsible for:

- Adequate preparation for appraisal meeting, e.g. review the pre-appraisal documentation prior to the appraisal meeting and any missing evidence should be requested in advance of the discussion. The appraiser should review the previous Personal Development Plan (PDP).

- Ensure this is a supportive experience for the appraisee whilst also ensuring there is a balance of constructive challenge.
- Maintaining their own skills in the role of Medical Appraiser through participation in approved development activities.
- Participation in quality assurance process for Medical Appraisers.
- Any issues of concern regarding the quality of an appraisers work will be discussed with the medical lead for appraisal and revalidation.
- The Appraiser should provide a supportive environment conducive to raising concerns.
- Appraisers should undertake at least eight appraisals per year to maintain an appropriate level of quality and consistency.
- 0.25 APA is allocated per eight appraisals and should be included in job plans.
- A doctor will be appraised by the same allocated appraiser for a maximum of three years in any five years.

5.6 *The role of Appraisee*

Doctors with a prescribed connection to the SHSCT are professionally accountable for their engagement with the medical appraisal process as described in this policy. An Appraisal and Revalidation checklist is available to facilitate the Appraisee collate supportive evidence (see **Appendix 1**).

- Maintaining an online portfolio of supporting information to demonstrate the maintenance of their clinical and professional standards and where applicable their specialists skills.
- Undertaking appraisal once per year within the specified time by the SHSCT.
- Using the Trusts approved regional appraisal system (RASP) for completion of an annual appraisal.
- The Appraisee is responsible for arranging their appraisal meeting with the Appraiser allocated by the Medical Revalidation Support Team.
- Collates paperwork and prepares evidence for the appraisal meeting on all aspects of their role (scope of practice).
- Provides written reflections on their learning.
- Ensure they have reviewed the previous year's PDP, Reflection to be added around discussion of progress on PDP.
- Completes a Colleague and Patient Feedback once in 5 year cycle of revalidation (recommended in 3rd year of 5 year cycle)
- Are open to challenge and have constructive approach to their appraisal.

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- Ensures the time required to comply with revalidation requirements including preparation for and participation in the annual appraisal process is met in a timely way and within SPA allocated in each Doctor's job plan.
- A doctor will be appraised by the same allocated Appraiser for the maximum of three years in any five years.
- GPwSI – should submit their GP appraisal along with form CP2A annually to medical.revalidation@southerntrust.hscni.net
- Dentists are required to complete an annual appraisal.

6. *Key Principles*

The contents of the appraisal is based on GMC Guidance published in 'Good Medical Practice'. The appraisal process is as follows click here

Annual appraisal for every Doctor will be based on the same core set of supporting information. This core set of information is required for appraisal and for the purposes of revalidation as defined by the GMC in their document 'Guidance on supporting information for appraisal and revalidation' click here**.** Any additional guidance provided, for example, by the Royal Colleges, is advisory only.

Every appraisal will result in an agreed summary and Personal Development Plan.

Appraisal for every doctor will be based on a system which reflects the GMC's Good Medical Practice framework for appraisal and assessment and incorporates the supporting information required by the GMC for the purposes of revalidation.

All appraisers must have received appraiser training, refreshed once in every five years.

All appraisals will consider whole practice.

To ensure all doctors have robust evidence for revalidation, any doctor can only be appraised by the same appraiser three times within a five-year revalidation cycle. Over the course of the five-year revalidation cycle, appraisals will be carried out by a trust approved medical appraiser. It is considered good practice for doctors to have their appraisal performed by a medical appraiser from outside of their speciality as well as from within their specialty. (See **Appendix 1**)

7. *Key Performance Indicators*

The number of medical appraisals completed is a percentage of the number of those doctors eligible for appraisal within the appraisal year.

A completed appraisal is one where:

- The appraisal meeting has taken place and the outputs of the appraisal have been agreed and signed off by the Appraiser and Appraisee.
- The quality assurance of the appraisal – Second sign off process has taken place.

8. *Medical Appraisal Process*

8.1 *Appraisal Process (See Appendix 2) & Timescales*

8.1.1 Each Appraisee is responsible for having an annual appraisal which should include the timeframe 1st January to 31 December, to be completed on or before 31st March as agreed by SHSCT.

8.1.2 Each Appraisee is allocated an appraiser by the Medical Revalidation Team. The Appraisee should liaise with their Appraiser to arrange the appraisal meeting in a timely manner.

8.1.3 Appraisee are required to use electronic appraisal forms RASP and collate supporting information for the full scope of their work.

8.1.4 Appraisee's are required to make their full appraisal portfolio available to their appraiser two weeks in advance of scheduled Appraisal Meeting. Appraisee should inform their appraiser once the appraisal is ready.

8.1.5 The Appraiser will view the online appraisal, if additional information is required; the Appraiser will inform the Appraisee prior to meeting. The Appraisee should endeavour to have the additional information submitted prior to Appraisal Meeting.

8.1.6 Once the Appraisal Meeting has taken place between the Appraiser and the Appraisee, the outputs of the appraisal meeting will be agreed and signed off by both just after this meeting.

8.1.7 If significant concerns arise from the outputs of the appraisal, the Appraiser can, at any time, stop the meeting. The CD should be informed of any concerns immediately.

8.1.8 The appraisal will go through a quality assurance process called 2nd Sign off. This will be carried out by the Medical Leads for the Appraisal & Revalidation Team.

8.1.9 If, at 2nd Sign Off stage, further information is required the appraisal will be re-opened at the request of a Medical Lead for Appraisal & Revalidation.

8.1.10 The Appraiser and the Appraisee will be informed of the re-opening and will also be informed of specific information required.

8.1.11 Once the information requested has been submitted by the Appraisee, the appraisal is signed off by the Appraisee and the Appraiser. The appraisal will go through a further 2nd Sign off process and finally signed off and completed.

8.1.12 Appraisee's appraisal file is marked as complete, the Appraisee will receive a confirmation email from medical.revalidation@southerntrust.hscni.net

8.2 *Doctors with Performance Concerns*

8.2.1 In the event that the appraisal process indicates that a doctor is 'in difficulty', the Appraiser must discuss this with the Responsible Officer and relevant Clinical Director

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without delay, who will deal with the issues in accordance with the Trust's relevant policies and guidelines.

8.2.2 All doctors are all required to access the following key document - **Maintaining High Professional Standards in the Modern HPSS (**MHPS) click here. The SHSCT has developed its own policy click here. When a concern is considered to be serious, SHSCT defines clear roles and responsibilities for individuals investigating and managing the outcomes of a concern.

8.3 *Complaint about the Appraisal Process*

8.3.1 If an individual Doctor has concerns regarding their appraisal this should be raised in the first instance with their allocated Appraiser. If the concerns are not resolved at this stage the Doctor should contact their Clinical Director who will attempt to resolve the problem through discussion and mediation involving others as appropriate. In exceptional circumstances or when a concern cannot be resolved by these means the matter will be referred to the Medical Revalidation team via email.

8.4 *Scope of Practice*

8.4.1 The purpose of the Appraisal is to sign off the Appraisee's whole scope of practice including private practice.

8.4.2 RO's are required to sign of a Doctor (with a prescribed connection to the Trust) as having been appraised in terms of all additional roles which could include educational supervisor, undergraduate teacher, medical manager, appraiser, private practice or private roles such as sports medicine/medico legal etc. Documentation from all roles should be included in the Doctors supporting information folder. Developmental needs in the PDP should reflect the Doctors **full scope** of practice.

8.5 *Exempt Appraisals*

8.5.1 Where there is a gap in appraisal because of a break from professional practice (for example maternity leave, sick leave, career break/sabbatical) on return to professional practice the appraisal timeframe will be advised by the Medical Revalidation Team.

8.6 *Deferment of Appraisals*

8.6.1 There are exceptional circumstances when a Doctor may make a formal request to defer their appraisal.

8.6.3 The request to defer (see **Appendix 3**) will be considered by the Medical Revalidation Team taking into account the previous appraisal record and performance.

8.7 *Non-Engagement*

8.7.1 In the majority of cases Doctors participate actively in the system. However, for a small minority who do not participate the Medical Revalidation Team will use the procedures set out in the Engagement Protocol**.** (See **Appendix 4**).

8.7.2 The Engagement Protocol identifies the sequence of actions which are taken to support participation and advises Doctors of the potential implications regarding their revalidation and Licence to Practice.

8.8 *Training*

8.8.1 Training for Appraisers and Doctors will be organised by the Medical Revalidation Team with content managed by the Medical Leads for Appraisal & Revalidation.

8.8.2 The opportunity to become an Appraiser is open to all doctors with a prescribed connection to the Trust.

8.8.3 All Appraisers are required to undergo training, which is recognised by the Southern Health & Social care Trust as meeting national standards, prior to carrying out first appraisals.

8.8.4 The Trust is committed to raising consistency, quality and experience of medical appraisal through the appropriate training.

9. Revalidation Process

9.9.1. All Doctors with a prescribed connection to the SHSCT are required to revalidate every 5 years and is based on comprehensive appraisals undertaken over that five year period. It is designed to improve the quality of patient care by ensuring all Licenced Doctors with a prescribed connection to the SHSCT, remain up to date and fit to practice:

- For doctors to confirm that they meet this standards appropriate to their specialty.
- All non-training grade Medical staff are expected to go through the process of revalidation every five years. NIMDTA will be responsible for the revalidation of doctors in training.
- Revalidation is designed to improve the quality of patient care by ensuring that licensed doctors remain up to date and continue to be fit to practice.

9.9.2 The Medical Revalidation Team will inform all Doctors with a prescribed connection to the Trust their revalidation date 1-2 years in advance. The Trusts Revalidation Oversight Group, which consists of RO/Medical, Director/DivMD/Medical Lead/AD/Medical Revalidation Manager, meet on a monthly basis to review the

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portfolios of any Doctor coming up to their Revalidation date and to consider the recommendation for Revalidation. In some circumstances other parties may be invited to discuss the recommendation e.g. Clinical Director, in absence of DivMD.

The outcome of this meeting will be one of the following:

1. Positive Recommendation and sign off by RO.
2. Deferment – due to insufficient information/ break in practice.

In most cases this recommendation will be done without the Doctors involvement. However, in some circumstances it may be necessary to meet with the practitioner to review and assess the online portfolio to provide assurance of their progress towards Revalidation before making a recommendation.

9.9.3 In the event the RO is unable to provide an outcome 1 & 2 above, the RO will clarify what is required of the Doctor via the DivMD. It may be necessary for DivMD to meet with the Doctor to review and assess other contributory factors, before assurances can be provided to the RO and the Doctors revalidation can progress towards a positive recommendation. (See **Appendix 5**).

10.*0* *Policy Review*

The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation. The SHSCT will review this policy every three years.

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Appendix 1

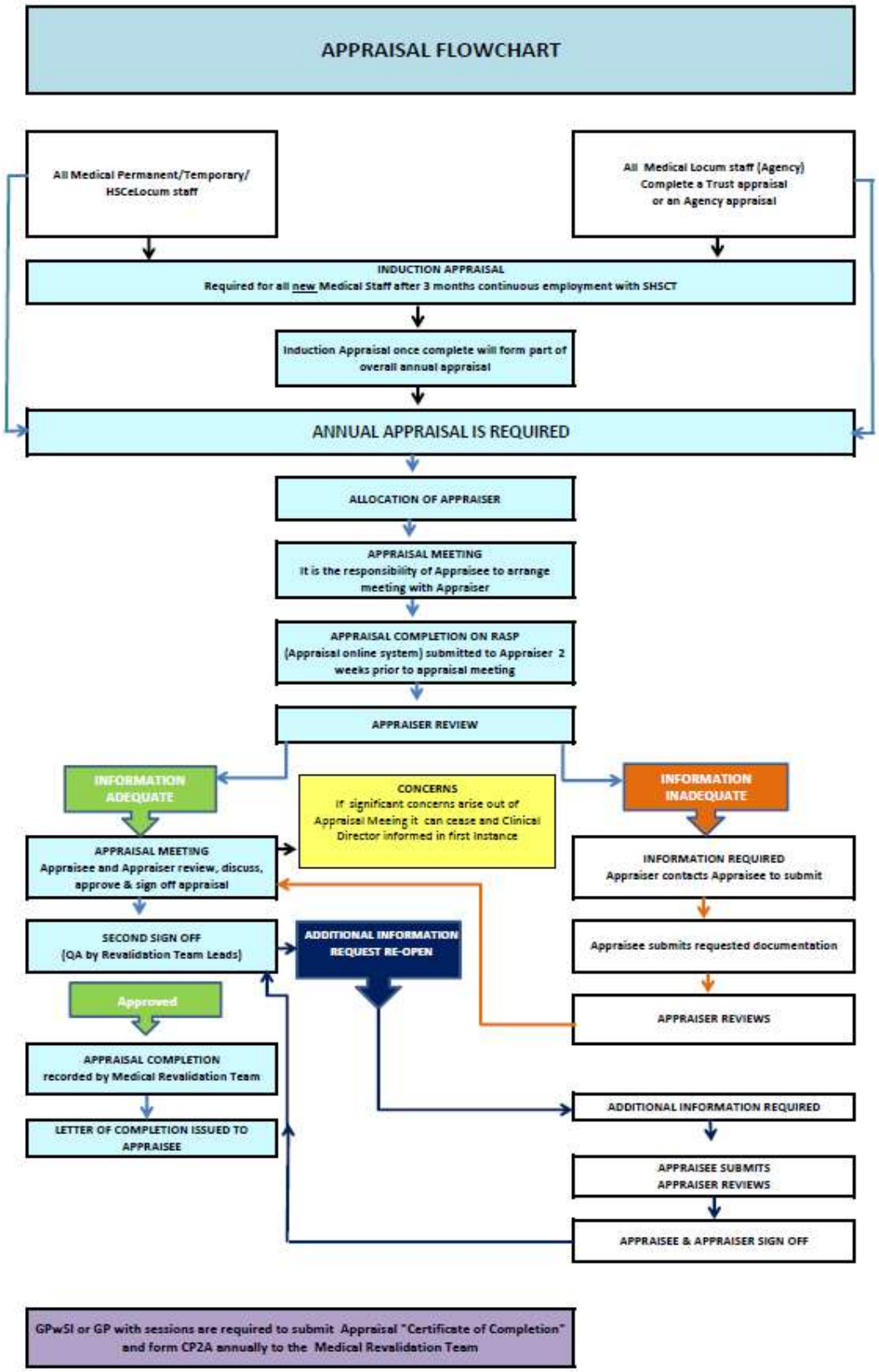
MEDICAL APPRAISAL DOCUMENT CHECKLIST

Remember to include:- *(Please click on each box to confirm forms have been completed)*	
FORM 1 – All parts to be completed by Appraisee	☐
FROM 1 – Investigations either GMC or MHPS must be referenced, uploaded to RASP and discussed during your Appraisal	☐
FORM 2 – all parts completed by Appraisee to include Whole Practice Appraisal i.e. Private / Medico Legal Work etc. ***NB: There is an updated requirement to include a signed Paying / Private Patient Declaration if the Appraisee undertakes any work of this nature inside or outside the Trust. There is also another new requirement to explain at what stage the Appraisee's job plan is in the approval process***	☐
FORM 2 – Up-to-date current Job Plan to be uploaded	☐
FORM 2 – Annual Education Review if applicable to be uploaded	☐
FROM 3 – Supporting Information - All four GMP Domains completed jointly by Appraisee and Appraiser to include list of supporting information, reflections and evidence of the discussion which took place during the Appraisal	☐
FORM 4 – Personal Development Plan – Review of previous PDP **PDP for the year ahead developed from discussions around the four GMP Domains**	☐
FORM 5 – All parts completed and relevant boxes ticked	☐
FORM 6 – Complete along with Appraisee sign off	☐
FROM 6 – Appraiser check list completed along with Appraiser sign off	☐
Once signed off appraisal will go through Second Sign Off process this is to QA's all appraisals ensuring they are of the standard required	

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Appendix 2



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Deferment Request Form

To be returned to Revalidation Team at [redacted]

Name:	
Address	
Telephone numbers :	
Email	
GMC number	
Please indicate the dates of your last 4 appraisals: (Month and year) and names of the appraisers	
Name of appraiser	

Please indicated WHY you wish to request a deferment of your appraisal and WHEN you would next like to be appraised	
Do you anticipate having any breaks in practice in the next 2 years?	
If you have missed any appraisals in the last 4 years please: indicate the reasons why	
Are you currently under investigation by your employer, NCAS, or GMC for any issue regarding your clinical performance?	
Any further comments	

Deferral Reason (please tick relevant boxes)		5. Missing Continuing Personal Development	
1. Missing Appraisal Activity		6. Missing Patient Feedback	
2. Interruption to practice		7. Missing Quality Improvement Activity	
3. No Colleague Feedback		8. Missing Significant Events	
4. Missing Compliments/Complaints		9. Missing Other Evidence	

Applicant Name:		**Date**	
Divisional Medical Director:		**Date**	
Clinical Director:		**Date**	

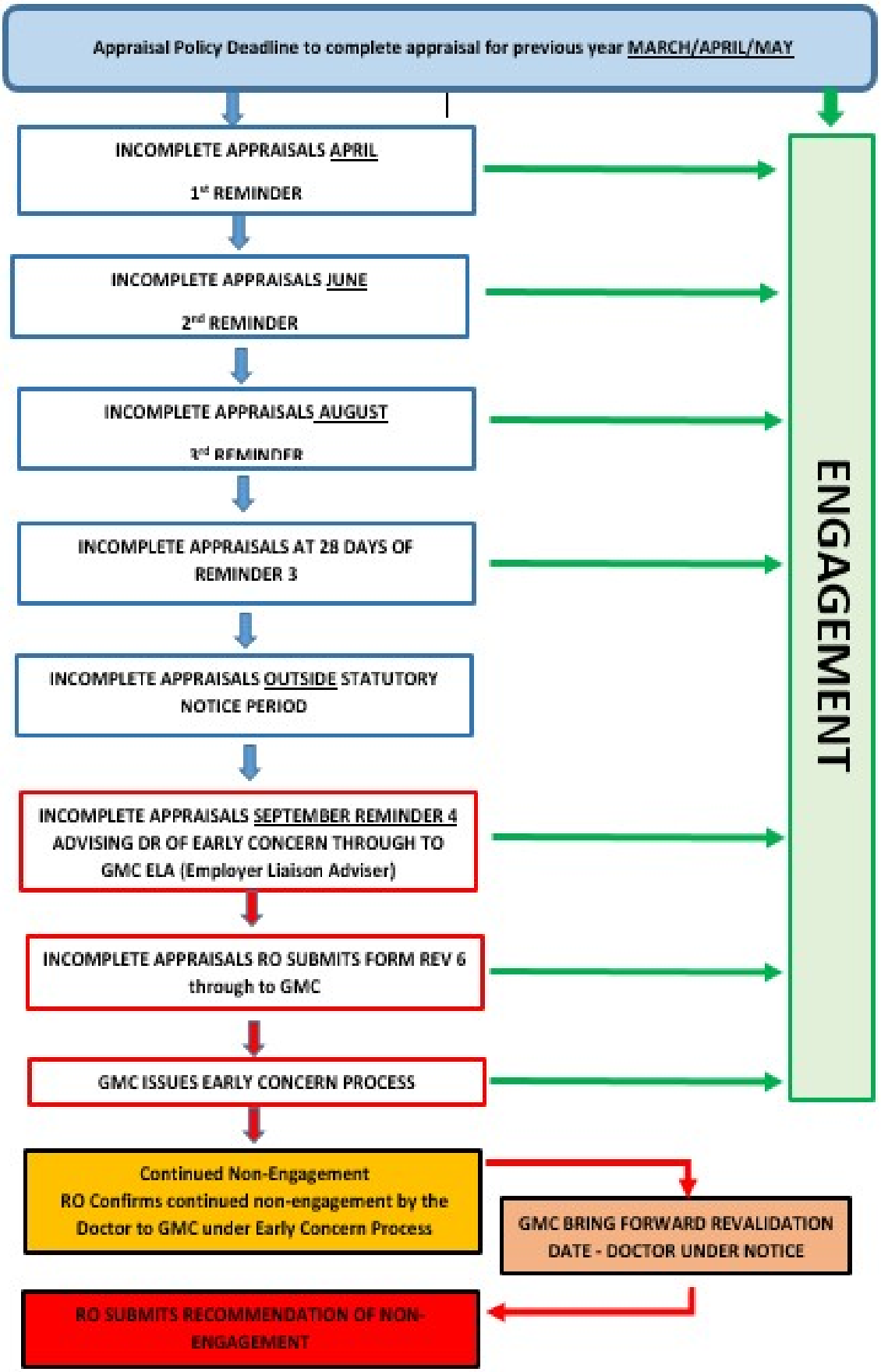
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Deferment Application Process

- The applicant must complete the application form and submit to their Associate Medical Director for approval.
- Associate Medical Director approved application forms must then be forwarded to the Medical Directors Office for final approval.
- The applicant will be informed of the outcome by the Medical Directors Office.

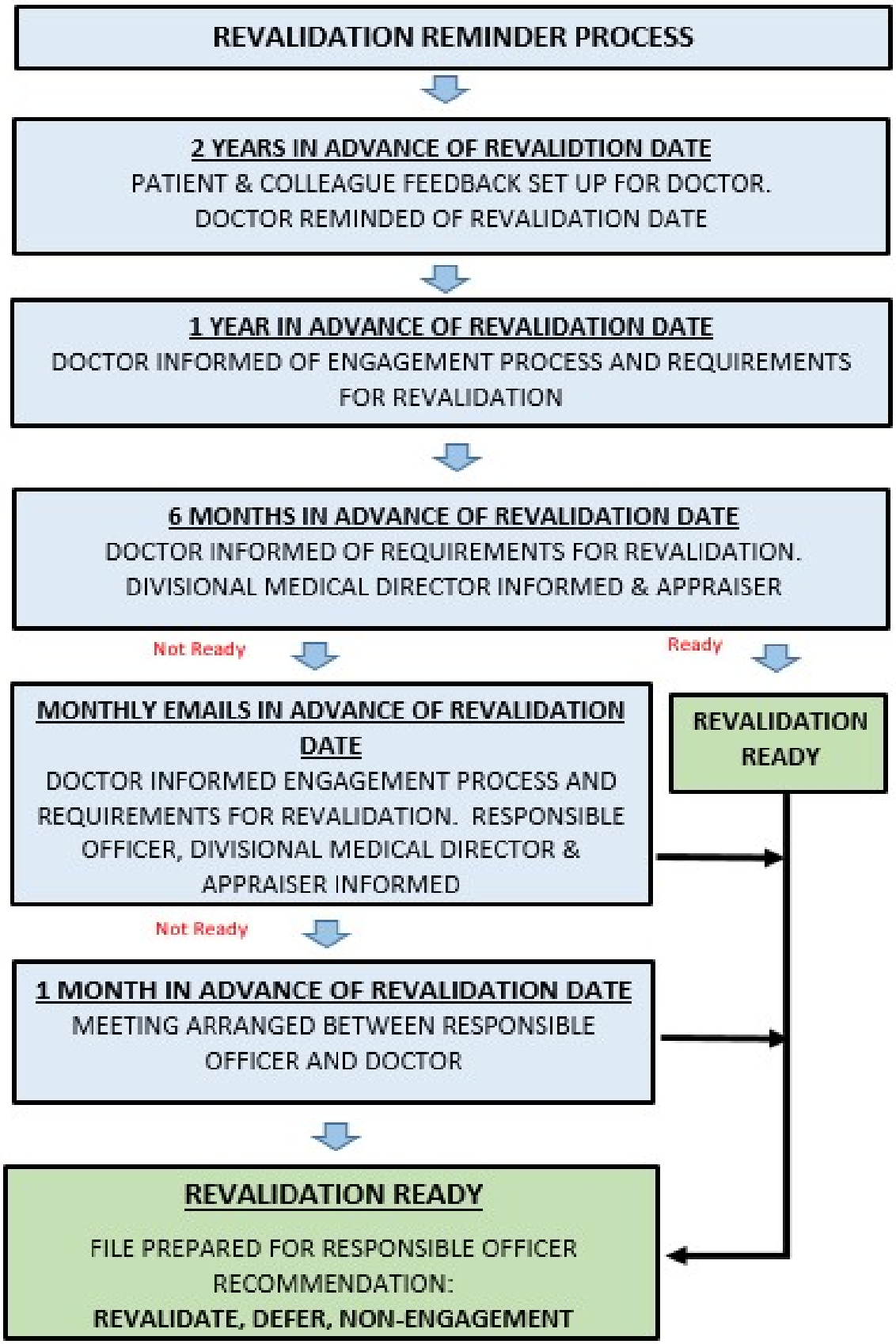
Appendix 4

MEDICAL APPRAISAL ENGAGEMENT FLOWCHART



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REVALIDATION REMINDER FLOWCHART



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APPRAISAL & REVALIDATION CHANGES FROM 2019 TO CURRENT

APPRAISAL	
Moved to online Regional Appraisal System (RASP) 2019	
⮜ 2019	**2019 ➢**
Appraisal on paper format	2019 Move to Electronic eportfolio
Dr held supporting information in Appraisal A4 folder, Medical Leads had no access to supporting documents Drs appraisals were in progress but no oversight of completion	2019 Eportfolio includes document library of all supporting information Medical Leads have access to full appraisal Medical Leads
QA of appraisals without supporting information	2019 QA of appraisals carried out on RASP before appraisal is marked as complete
	2019 Appraisal can be re-opened if it lacks supporting information, once uploaded, appraisal goes through further sign off and QA
No Regional Appraisal system	2019 rolled out the new online Regional Appraisal System across all Trusts in NI. Each Trust has a designated Trust Lead for the RASP system Regional Design Group set up and attendance by Revalidation Manager from each Trust. Regional Committee Group set up and attendance by Revalidation Manager and Medical Lead for Appraisal & Revalidation Regional Design Group Meetings are held on regular basis to ensure smooth running of the system Queries about the system are directed to the Trust Lead in the first instance for advice and/or to raise with BSO if technical Regional Design Group agree, develop, test, implement and QA all new processes required on the RASP system Regional Lead position is currently vacant due to funding, this will be vital for any future development of RASP system This system allows cross trust appraisals Doctors files are transferred over to new trust on request
Doctors had ability to choose Appraiser	2019/2020 - 2 New processes (a) Allocation of appraiser to appraise by Medical Revalidation Team (b) **Consultant appraise**: Consultants & SAS **SAS appraise**: SAS and lower grades
Appraiser training provided 2017	2020 - Appraiser training provided to update appraisers ensuring high standard

	maintained, this included refresher and new appraiser training 2022 Bespoke in house appraiser training will be provided on a regular basis to support appraisers Ongoing Ensure Medical Director/RO has a sufficient pool of appraisers available to carry out medical appraisals within SHSCT
Appraisers allocated PA's	2021 All Appraisers allocated 0.25PA's per 8 appraisals to be referenced in Job Plans
Appraisal completion notified at end of year to AMD's	2021 Completion of appraisals notified on a monthly basis to each DivMD 2021 new 1:1 DivMD meeting implemented with Medical Director 2021 Medical Revalidation Team provide information for 1:1 meeting to Medical Director 1 week prior to meeting date
Appraisal meetings occurred face to face	2020 Following pandemic appraisal meetings took place face to face or virtual with majority of meetings being held virtually
2014 Appraisal Flowchart (based on the paper format)	2021 Appraisal Flowchart updated to take into consideration new online system RASP
M&M attendance included in supporting information annually	2020 Updated M&M attendance certification included with 5 years attendance rates
SRT – individual reflections	2020/2021 SRT developed to include all reflections required for appraisal and maintain standard All reflections contained in one document in library (cut out need to search for reflections)
Private Practice Declaration Completed once and updated only if required May have been omitted from appraisal	2021 Private Practice Declaration revised to ensure completion on an annual basis by all Doctors 2021 Uploaded to annual appraisal & check process implemented at QA level to ensure inclusion 2021 Reflective template devised and completed by those Doctors who declare Private Practice
Appraisal Policy 2014	Appraisal Policy Update 2022
Audit of Appraisal forms carried out 2013	2020/2021 Audits of Appraisal, online system RASP and Appraisers carried out

REVALIDATION

⮜ 2019	➢ 2019
3 stage process which consisted of Doctor having two meetings - 8 & 4 weeks in advance of folder submission for revalidation. AMD sign off no concerns prior to Revalidation decision Revalidation decision 1 week prior to revalidation date	Implementation of new Revalidation Oversight Meeting - Restructuring of AMD to DivMD and CD's within Trust - Meeting includes new DivMD checklist of documents - Additional information from HR/Litigation/Complaints added to cover 5 years of revalidation cycle - Revalidation Oversight Meeting occurs on monthly basis schedule/timetable attached  MASTER REVALIDATION OVES - DivMD or deputised CD's attend all meetings - Attendance is required at all meetings by DivMD or deputised CD for shared learning - Folders are available week prior to meeting - DivMD presents Doctors revalidation folder at meeting for discussion - Based on discussion/evidence Medical Director/RO will make a recommendation for revalidation or deferment through to GMC

	- Once submitted to GMC and GMC approves decision, Doctor is notified of outcome and appropriate files updated
Revalidation Flowchart	Revalidation Flowchart updated
Revalidation Review form	2019 Revalidation review form updated 2020 DivMD checklist devised for Revalidation Oversight Meeting 2020 All moved to electronic format Shared directory folders with restricted access for safe transfer of information to Medical Director/RO, DivMD and Medical Leads of Revalidation Team
Patient & Colleague Feedback required 1/5 year of revalidation cycle a GMC requirement Set up 1 year in advance of revalidation date and Dr notified by Revalidation Team	2019 Patient & Colleague feedback set up 2 years in advance of revalidation date and Dr notified by Revalidation Team of same 2020 Check process implemented by Revalidation Team to ensure compliance and progression of surveys
Patient & Colleague Feedback required 1/5 year of revalidation cycle a GMC requirement Paper/online based ipads issued to wards for this purpose	2020 Patient Feedback developed to include patient mobile phone survey along with the paper format - Following pandemic difficulties were identified by Drs around the issue of paper based patient surveys due to infection control - Ipads unable to issue to Wards difficulties around the cleaning/ infection control of ipads - System was devised whereby the patient survey could be issued via text to the patients mobile phone either are ward level or clinic - Ability for patient to complete at their leisure - Ability for carer/family member to complete on patients behalf or help patient complete on own mobile - Once survey completed and submitted it goes directly onto the Drs survey on the P/CFB system - Eliminated photocopying, postage, and handling of paper based forms - Confidentiality :- Patients IP address on mobile not retained No patient identifiers on this system No chance of breach of confidentiality as maybe the case with paper format Patient mobile number is retained on BT texting system for a limited time only Patient receives link only for the Dr they have seen/spoken to. No chance of completing wrong survey - Extremely beneficial to the new working arrangements of virtual/telephone consultations - Ability to gather information when no face to face consultations take place

	- Doctors can still submit a mix of paper and mobile surveys to gain the 35 surveys required to generate their report - Text is issued on the BT Soprano texting system used within the SHSCT
Supporting information for revalidation to include: HR Complaints Incidents SAI's Litigation	2020 New processes updated to collate 5 years of information from HR/Complaints/ Litigation helps to better inform the Medical Director/RO in making a decision about a Drs revalidation 2020 Incorporated in new DivMD checklist so DivMD's are better informed to make a decision about a Drs revalidation

Southern Health and Social Care Trust

Quality Care - for you, with you

REPORT SUMMARY SHEET

Quality care – for you, with you

Meeting: Date:	Senior Management Team DATE
Title:	Clinical and Social Care Governance Report
Lead Director:	NAME 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	

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

Summary of Weekly Governance Activity DATE

	DIRECTORATE				
	ACUTE Number	MHLD Number	CYP Number	OPPC Number	TOTAL Number
New SAIs Notifications					
SAI Reports submitted to HSCB					
Ongoing SAIs*					
High Risk Complaints					
NIPSO Case Accepted for Investigation					
NIPSO Draft/Final Reports Received					
Early Alerts					

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

Ongoing SAIs reported last week – DATE X

Add New SAI notifications:
Acute X
MHD X
CYP X
OPPC X

Less SAI reports submitted: X

Ongoing SAIs reported week ended DATE X

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Grading of Formal Complaints Received DATE

Open Moderate Complaints

Outstanding Complaints as of DATE

Directorate	20dys - 1 month	1 - 3 months	3 - 6 months	6 - 9 months	9 - 12months	12months	Total
Acute							
CYP							
FINANCE							
MHD							
OPPC							
Total							

(Information is based on complaints which are recorded as - current stage - Investigation)

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ACUTE DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings – 8.30am – 9.30am)

1. **Status of SAIs -** Summary of the status of SAIs between DATE

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	Total

2. **SAI Notifications**
3. **SAI Reports**
4. **Intertrust and Interface Incidents**
5. **Catastrophic Incidents**
6. **Early Alerts**
7. **Never Events**
8. **Directors Oversight Groups**
9. **SJR Process for the Review of COVID Deaths in a hospital setting**
10. **RQIA**
11. **Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)**
12. **Complaints**

Outstanding Complaints > 3 months

ID	First received	Directorate	Description (Policies)	Grade	Update

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MENTAL HEALTH AND DISABILITY DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings – 8.30am – 9.30am)

13. Status of SAIs

Summary of the status of SAIs between DATE

More than 26 weeks	Less than 26 weeks	Level 3	Within Timescale	Total

14. SAI Notifications

15. SAI Reports

16. Catastrophic incidents

17. Early Alerts

18. Never Events

19. Directors Oversight Groups

20. Public Inquiry

21. RQIA

22. Complaints

Outstanding Complaints > 3 months

ID	First received	Directorate	Description (Policies)	Grade	Update

23. Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)

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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 – 8.30am – 9.30am)

24. Status of SAIs

Summary of the status of SAIs between DATE

More than 26 weeks	On Hold	Within Timescale	Total

25. SAI Notifications

Incident ID	Incident Date	Incident Description

26. SAI Reports

27. Catastrophic Incident's

28. Early Alerts

29. Never Events

30. RQIA

31. Directors Oversight Groups

32. Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)

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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 – 8.30am – 9.30am)

33. Status of SAIs

Summary of the status of SAIs DATE

More Than 26 weeks	Less than 26 weeks	Hold	Within Timescale	Total

34. SAI Notifications
35. SAI Reports
36. Catastrophic Incidents
37. Early Alerts
38. Never Events
39. RQIA
40. Process for the Review of COVID Outbreaks/Deaths in Independent Sector
41. Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)
42. Complaints

Outstanding Complaints > 3 months

ID	First received	Directorate	Description (Policies)	Grade	Update

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43. LITIGATION
44. MEDICATION INCIDENTS
45. SAFEGUARDING
46. INFORMATION GOVERNANCE
47. NEW STANDARDS AND GUIDELINES RECEIVED AND ASSURANCES DUE OR SUBMITTED
48. CLINICAL AUDITS AND REGIONAL PIVFAIT AUDITS
49. INFECTION PREVENTION CONTROL
50. INTERNAL AUDIT RECOMMENDATONS
51. CONTRACT COMPLIANCE
52. FALLS AND PRESSURE ULCERS INCIDENTS
53. APPROVAL STATUS OF DATIX INCIDENTS
54. AOB:

Attendees:

Apologies:

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

Case Review – updated 06.09.21

Name of Plaintiff:
Patient 90
(deceased)

Ref: Personal Information redacted by the USI

Date of Birth:
Personal Information redacted by the USI

Date of Incident: Personal Information redacted by the USI

Incident Location: CAH

Claim Date:
Personal Information redacted by the USI (date of letter of claim)

Involved Clinicians:

Trust Solicitor:
Personal Information redacted by the USI
DLS
Counsel: None at present

Case Summary

The letter of claim states the deceased was admitted to hospital in Personal Information redacted by the USI with ureteric stent irritation. A CT scan during this admission showed moderate bilateral hydronephrosis despite appropriately positioned stents. It was decided he would be admitted the following month on an elective basis for cystoscopy, replacement of his ureteric stents and bilateral ureterolysis. He was admitted to hospital on Personal Information redacted by the USI. The procedure was undertaken the following day. The letter of claim states the intraoperative course was uneventful and his condition was stable during the procedure but afterwards his blood pressure fell and his heart rate increased. He was administered a number of drugs in an attempt to improve his blood pressure with little success and he died that night.

The matter was a Coroner's investigation that was closed in Personal Information redacted by the USI with no inquest heard.

Legal Documents

Proceedings not issued at present.

Solicitor/Counsel Advices:

None at present

Previous Investigations:

IR2 ref: Personal Information redacted by

Description:
Patient admitted to ICU in extremis. Unexpected death after elective surgery.
Action taken on review:
Patient journey timelined and document attached to datix EK
Personal Information redacted by the - *Discussed with PMcA ; SAI report in draft at present & recommendations unavailable to implement. BK* Personal Information redacted by the

Complaint
No complaint as per check of datix web Personal Information redacted by the

SAI Undertaken:



Patient 90
HSCB 9.4.19.pdf

Updated Action Plan from the SAI:



Patient 90
[redacted] OCX

SAI and updated action plan from the SAI shared with Trust solicitor at DLS on Personal Information redacted by the USI.

Post Mortem report:



Post Mortem.pdf

Post Mortem report shared with Trust solicitor at DLS on Personal Information redacted by the USI.

Involvement Reports
None at present

Expert Reports:
None at present

Last updated Personal Information redacted by the USI Irrelevant redacted by the

Clinical Negligence Case Review Summary

Trust Ref: **No Ref**

Legal Dept Ref: Personal Information redacted by the USI

Plaintiff: Patient 90 **(DEC)**

Date of Treatment: Personal Information redacted by the USI

Date of Letter of Claim: Personal Information redacted by the USI

Details: Personal Information redacted by the USI

Specialty – **Urology**

Date of Review Meeting: Personal Information redacted by the USI

In Attendance - **Dr O'Kane, L Hainey, M Harvey**

Personal Information redacted by the USI

IAS 37 Figures:

	Estimated Settlement Figure	Probability
Low	**NIL**	**70%**
Medium	**-**	**-**
High	Personal Information	**30%**

Estimated Year of Settlement: 2023/24

Date of Issue: 07.10.21

Southern Health and Social Care Trust

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI	**4.** DATE OF INCIDENT/EVENT **5.** Personal Information redacted by the USI
6. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: NO ***Please select as appropriate***	**7.** IF 'YES' TO 5. PLEASE PROVDE DETAILS:
8. DATE OF SEA MEETING / INCIDENT DEBRIEF	

9. SUMMARY OF EVENT:

Patient 90 was admitted to Craigavon Area Hospital (CAH) on Personal Information redacted by the USI for elective urology surgery (cystoscopy, replacement of ureteric stents and bilateral ureterolysis). Following the procedure on Personal Information redacted by the USI Patient 90's condition deteriorated and he was admitted to the Intensive Care Unit (ICU) critically ill. Patient 90 suffered a cardiac arrest which was managed as per Adult Life Support (ALS) guidelines. Following discussion with Patient 90's wife cardiopulmonary resuscitation (CPR) was stopped and Patient 90 died on Personal Information redacted by the USI. Patient 90 was discussed with the coroner and a post mortem was requested.

The review team have drafted this report on the information available to them, the review team are aware that some of the clinical notes may not be available to them.

Causative Factor

The review team concluded Patient 90 had an unrecognised haemorrhage post operatively.

The review team note Patient 90's post mortem report. Patient 90 death was discussed with the Coroner who recommended a post mortem.
The Cause of death was reported after post mortem as 1(a) Intra-abdominal and retroperitoneal haemorrhage following cystoscopy, insertion of ureteric stents and ureterolysis. 11 Cardiomegaly
The post mortem reported noted *'Death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen……..The post-mortem examination also revealed that the heart, and in particular its two main pumping chambers the ventricles, was enlarged. Such enlargement of the heart, termed cardiomegaly, would without doubt have made him less able to withstand the stresses place upon the body by the effects of the blood loss. Indeed the severity of his heart disease was such that it could have caused his death at any time. Therefore as his pre-existing heart disease would have made him more susceptible to the effects of haemorrhage it would be best regarded as a contributory factor in his death'.*

Recommendation 1

The Trust should develop and implement guidance for clinical result sign off
Monthly audit of sign off will be presented to the Governance Fora

Recommendation 2

All patients undergoing elective surgery must have a formal pre-operative assessment completed prior to surgery, including liaison with other specialties to ensure maximal optimization of patients prior to procedure. The Trust will update the pre-operative guidance to recommend appropriately timely referral times and escalation of non-attendance.
Audit of surgical patient pre-operative assessment should be undertaken and be presented to the Governance Fora

Recommendation 3

Discussions regarding the risks and benefits of surgery must be clearly documented in the patient record and reflected on the patient consent form, to ensure patients are able to make informed consent.
Audit of surgical patient consent should be undertaken and be presented to the Governance Fora

Recommendation 4

Blood loss during procedure should be escalated during and at the end of the procedure, the blood loss must be recorded on the operation note.
Blood loss post operatively must be escalated to the surgical and anaesthetic teams.

Recommendation 5

VTE risk assessment must be completed for all patients prior to surgical intervention

SECTION 2

10. SEA FACILITATOR / LEAD OFFICER:
Mr Glackin Consultant Urologist

11. TEAM MEMBERS PRESENT:
Mr Glackin Consultant Urologist
Dr K O'Connor
(Coordinator Mrs T Reid Governance Coordinator

12. SERVICE USER DETAILS:
Complete where applicable
Patient 90 was a Personal Information redacted by the old male with a past medical history of atrial fibrillation myelodysplasia and arthritis/gout.

WHAT HAPPENED?

Patient 90 was a Personal Information redacted by the old male with a past medical history of atrial fibrillation (AF) (irregular heart beat) myelodysplasia and arthritis/gout. The chronology of events prior to his death is as follows.
The review team note on Personal Information redacted by the USI that a computerised tomography (CT) scan of chest and abdomen requested by doctor consultant physician Doctor 4 showed

1. Possible focal aortitis at the aortic bifurcation. (inflammation of the large artery)
2. Small ground-glass nodule in the right upper lobe - follow-up CT in 3 months is recommended to confirm persistence.
3. Clinical assessment of the right inguinal hernia is recommended as fluid and inflammation in the hernia sac raises the possibility of strangulation.
4. Potentially haemodynamically significant coronary atheroma.

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The discharge letter following this admission noted the potentially haemodynamically significant coronary atheroma, follow up noted Patient 90 was awaiting an outpatient echo.
Patient 90 had follow-up for the nodule in the right lung, on outpatient letter from a clinic on Personal Information redacted by the USI to Patient 90's General Practitioner noted '*The right lower lobe pulmonary nodule possible intra pulmonary lymph nodule…… follow-up of the pulmonary nodule in 6 months……. I will leave any further investigations in their hands".*

A BNP blood test (a blood test which measure proteins which can indicate heart failure) collected on Personal Information redacted by the USI was 1609pg/ml. The discharge letter notes Patient 90 was commenced on Aspirin and Frusemide (water tablet), this result was not documented on the patient discharge letter

Patient 90 was under the care of vascular surgery, rheumatology and urology in relation to his inflammatory periaortitis causing bilateral hydronephrosis (swelling of kidneys due to a build-up of urine), having repeat scans and medical follow up.

Patient 90 was under the care of haematology for management of myelodysplastic syndromes (MDS) are a type of rare blood cancer where you don't have enough healthy blood cells; he had a number of blood transfusions. Patient 90 was reviewed at haematology clinic on Personal Information redacted by the USI where it was noted 'He is due a pre op red cell transfusion on the Personal Information redacted by the USI.'

On admission there is no evidence of a venous thromboembolism (blood clot) risk assessment.

Patient 90 was added to consultant urologist Doctor 1 urgent waiting list on Personal Information redacted by the USI and was pre-admitted for surgery on Personal Information redacted by the USI.

Consultant anaesthetist Doctor 2 in a chronology of events highlighted that Patient 90 was a Personal Information redacted by the old male with a past medical history of atrial fibrillation (AF) (on beta-blocker and aspirin), myelodysplasia (MDS) and arthritis/gout. He presented for surgery with a history of retroperitoneal fibrosis and peri-aortitis. Of note, he was transfused 2 units of blood pre-operatively on Personal Information redacted by the USI in view of his haemoglobin (Hb) of 86g/l secondary to MDS. Other than this, there was nothing else to optimise pre-operatively. AF was rate controlled, and his functional status was reasonable.

Patient 90 was consented by Doctor 1 for cystoscopy, replacement of ureteric stent, Laparotomy and bilateral Ureterolysis.

The operation notes recorded "*cystoscopy with no stent encrustation. Right ureteric stent replaced with ease. Replacement of left ureteric stent required ureteroscopic guidance due to tortuosity of middle third of left ureter. 16F catheter. Midline abdominal incision. Right ureter adherent to right lateral wall of abdominal aorta. Left ureter densely adherent to lateral aspect of aortic bifurcation and left common iliac artery. Both ureters released throughout their lengths. Omentum bifurcated. Both ureters wrapped in omentum. Bilateral 20F Robinsons drains. Wound closed. Plan: To continue on IV benzylpenicillen 1.8g BD until Friday*".
Anaesthetic start time was 14:10, knife to skin was 14:42, end of procedure was 18:27 and anaesthetic end time was 18:36.
Total estimated blood loss in theatre is recorded as 1298mls. Patient 90 received one unit of blood (311mls) at 15:20 which was completed at 16:05 and a 2nd unit of blood (294mls) at 18:00 which was completed at 18:12.

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DATE														
TIME														
RESP	26	26	25	25	28	26	26	28	28		21	28	25	
SPO2 %	96		99				99		99			99	96	
TEMP	37.6	37			37				37					
BP	51/37		85/68	Not reading			99/60		103/84	83/74		59/47	69/41	
HR	112	112	112		80		150	146	133	126	141	130	135	126
O2			10L	10L		10L	10L		10L	10L		10L	10L	

Doctor 2 in a chronology of events highlighted that Patient 90 '*Blood pressure became more labile in the last 20 minutes of the case, although not to a major degree – he responded to small doses of metaraminol* (drug used to increase blood pressure)... *Emergence from anaesthesia and extubation was uneventful. The patient did not look particularly unwell on transfer to his bed (of note, not clammy/pale.)'* He was successfully extubate at 18:30 and transferred to the recovery ward

At 20:32 arterial blood gas pH 7.207, pCO2 3.08, pO218.4, acid base -17.7, Hb 81, glucose 20, lactate 11.6, potassium 6.6, sodium 136.

	9/5/18 13:00	9/5/18 19:30	9/5/18 22:25
Hb	86	82	68
Troponin		25	81
CRP			9.84
Haematocrit	0.278	0.262	0.229
Platelets	394	448	347
Sodium		133	142
Potassium		5.6	4.9
Urea		14.2	13.7
Bicarbonate		13.7	10.1
Creat		176	195
eGFR		33	29

Doctor 2 in a chronology of events noted that Patient 90 *'Shortly after arrival in recovery, the patient became agitated, restless and clammy. Arterial blood pressure (ABP) dropped precipitously, and it was clear he was very unwell. As he was trying to climb out of bed, remove lines and oxygen, and was disoriented, he required 2 x 2.5mg doses of haloperidol for sedation, in addition to boluses and then a peripheral infusion of phenylephrine for hypotension. Once he settled, a right internal jugular central catheter (CVC) was sited under ultrasound guidance (USSG) and noradrenaline (NA) infusion commenced immediately. As the patient had pulled out his left radial arterial line, a new line was sited in the right radial artery under USSG'*… amiodarone (drug used to slow heart rate) was prescribed for AF with a ventricular rate of 120-150. 1000ml of Hartmann's solution was given. Once these initial measures were established, he appeared to settle somewhat – HR 100-120/min, BP 90/50, SpO2 100%. I discussed his care with doctor 3 in intensive care who accepted him for further care. However he quickly destabilised again, becoming increasingly hypotensive (low blood pressure) and acidotic (can occur when the body cannot control the acid levels in the blood) on arterial blood gas (ABG) analysis, despite maximal doses of noradrenaline and adrenaline (drugs used to maintain blood pressure). Although his Hb did not drop much further, Doctor 1 reviewed him again to exclude bleeding. Doctor 1, Doctor 2 and Doctor 3 agreed that given the patient's precarious state and lack of compelling evidence of haemorrhage (Robinson drains in situ, Hb static,

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abdomen not distended), not to perform an emergency laparotomy. The working diagnosis was of cardiogenic shock, likely secondary to a cardiac event.
The fluid balance chart record shows drains were emptied at approximately 21:00 with a total output 1220mls recorded on the fluid balance chart. Total input was 1500mls Hartmans, and two units of blood intraoperatively and 1000mls postoperatively.

Patient 90 was commenced on Tazocin (antibiotic) in addition to his surgical prophylactic antibiotics. Patient 90 was administered steroids and treated for high potassium with 10ml 10% calcium chloride.

Patient 90 was transferred to theatre for intubation and insertion of dialysis line. There was ongoing intensive care including supra-maximal doses of inotropes and other resuscitative measures. Patient 90 was transferred to ICU at approximately 22:30.

It was noted the bed side echocardiograph (echo) (scan of the heart) (views were extremely poor) showed "*no tamponade ….it was not possible to assess myocardial function".*

Following insertion of a central line Patient 90 developed a pneumothorax (collapsed lung); a left intercostal drain was inserted without complication. At this time Patient 90 was receiving 90mls noradrenaline and receiving adrenaline boluses. Approximately 10 minutes after the intercostal drain was inserted Patient 90 lost cardiac output and CPR was commenced. Cardiac rhythm was noted to be Pulseless Electrical Activity throughout. Patient 90 developed profound metabolic acidosis pH6.79, HCO_3 10.0, base excess -19.3 and lactate 17.Despite CPR there was no return to spontaneous circulation and Patient 90 died at 23:10.

Patient 90 death was discussed with the Coroner who recommended a post mortem.
The cause of death was reported after post mortem as 1(a) Intra-abdominal and retroperitoneal haemorrhage following cystoscopy, insertion of ureteric stents and ureterolysis. 11 Cardiomegaly

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SECTION 3 - LEARNING SUMMARY

13. WHAT HAS BEEN LEARNED:

Causative Factor

The review team concluded Patient 90 had an unrecognised haemorrhage post operatively.

The review team note Patient 90's post mortem report. The cause of death was reported after post mortem as 1(a) Intra-abdominal and retroperitoneal haemorrhage following cystoscopy, insertion of ureteric stents and ureterolysis. 11 Cardiomegaly
'*The post mortem reported noted 'Death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen……..The post-mortem examination also revealed that the heart, and in particular its two main pumping chambers the ventricles, was enlarged. Such enlargement of the heart, termed cardiomegaly, would without doubt have made him less able to withstand the stresses place upon the body by the effects of the blood loss. Indeed the severity of his heart disease was such that it could have caused his death at any time. Therefore as his per-existing heart disease would have made him more susceptible to the effects of haemorrhage it would be best regarded as a contributory factor in his death'.*

Contributory Factors
Patient factors

Patient 90 had significant comorbidities which included:-
Inflammatory periaortitis causing bilateral hydronephrosis, myelodysplastic syndromes, atrial fibrillation (AF), insertion of ureteric stents, lower limb cellulitis and previous appendectomy.

A CT scan in Personal Information redacted by the USI noted a *'Potentially haemodynamically significant coronary atheroma',* the review team can find no evidence that follow up investigations were organised for this finding. However, it appears that other findings on the CT scan were actioned for follow up.

Despite the patient discharge letter noting an outpatient echo was required, the review team were unable to identify that the echo was completed prior to surgery, there is no evidence of an outpatient echo being requested, and the last record of an echo being completed was in Personal Information redacted by (EF 50%). Outpatient clinic letters highlight Patient 90 was under the care of cardiology for heart failure on the background of AF between Personal Information redacted by the USI.

There was a suspicion of coronary artery disease (CAD) in Personal Information redacted by but he has no symptoms suggestive of angina at present.' He had a Direct Current Cardioversion (DC Cardioversion) for AF in Personal Information redacted by and was on Bisoprolol (medication most commonly used for heart diseases) and aspirin, he had decline warfarinisation. Rate control was decided in [redacted] Patient 90 was reviewed by cardiology to until Personal Information redacted by the USI when he was discharged from cardiology to his GP's care.

The review team notes the post mortem findings that Patient 90s pre-existing heart disease would have made him more susceptible to the effects of haemorrhage it would be best regarded as a contributory factor in his death.

Task Factors-Guidelines, Policies and Procedures

Results follow up

The review team note that all findings on the Personal Information redacted by CT chest, abdomen and pelvis were not followed

up by the clinical teams.
The review team note there is no formal clinical result sign off guidance for the Southern Health and Social Care Trust (SHSCT), the Acute Directorate are developing guidance to implement clinical result sign off. The review team concluded that all results must be signed off and action taken to further investigate or manage findings.

A BNP blood test collected on Personal Information redacted by the USI was 1609pg/ml; this result was not documented on the patient discharge letter. The review team are of the opinion that here was no evidence to support if this was actioned.

Preoperative Assessment
Patient 90 was added to Doctor 1 urgent urology waiting list on Personal Information redacted by the USI and was pre-admitted for surgery at 15:50 on Personal Information redacted by the USI by Doctor 1's secretary. The review team noted that Patient 90 did not have a formal outpatient preoperative assessment as per Trust and National Institute for Clinical Excellence (NICE) guidance.
Patient 90 was booked for pre-operative assessment on the Personal Information redacted by the USI. The review team considered that this referral did not give sufficient time to appropriately pre-operatively assess and optimise Patient 90 for surgery.

Patient 90 was in the emergency department of Craigavon Area Hospital on Personal Information redacted by the USI and called with the preoperative team at 09:00, as his preoperative assessment appointment was booked for 13:45 they were unable to assess him. He was advised to contact the preoperative team later that day if he was unable to attend his 13:45 appointment. Patient 90 did not attend this appointment. The anaesthetist was informed by the pre-operative team that Patient 90 had not attended.

The review team note that on Personal Information redacted by the USI Patient 90's Brain Natriuretic Peptide (BNP) test was 1609 is a blood test that measures levels of a protein called BNP that is made by the heart and blood vessels. BNP levels are higher than normal when you have heart failure). SHSCT echocardiography in the preoperative assessment clinic guidance highlights heart failure (either systolic or diastolic dysfunction) is a major perioperative risk factor. The presence of heart failure doubles the risk of dying after major surgery (Patient 90 BNP was 1609pg/ml).
National NICE Chronic heart failure in adults: management (CG108) recommended refer patients with suspected heart failure and a BNP level above 400 pg/ml (116 pmol/litre) or an NTproBNP level above 2000 pg/ml (236 pmol/litre) urgently, to have transthoracic doppler 2D echocardiography and specialist assessment within 2 weeks. This guidance has been superseded by NICE guideline chronic heart failure in adults: diagnosis and management published: 12 September 2018 (nice.org.uk/guidance/ng106). However the review team noted that certain medications and medical conditions such as atrial fibrillation can affect BNP levels even in the absence of heart failure.

NICE guideline routine preoperative tests for elective surgery published: 5 April 2016 (nice.org.uk/guidance/ng45) recommends not routinely offering resting echocardiography before surgery. However, consider resting echocardiography if the person has:
a heart murmur and any cardiac symptom (including breathlessness, pre-syncope, syncope or chest pain) or signs or symptoms of heart failure. SHSCT guidance recommends a patient with known heart failure with a significant change in symptoms and an increase in BNP should have a preoperative echocardiogram.

Consultant 1 noted '*I do not regret the surgery as his quality of life was terrible due to the effects of indwelling ureteric stents. I do however regret not sending him for cardiac workup, including echo*

and coronary angiography. When he did have CT scanning performed in Personal Information redacted by the USI *, he was reported to have gross enlargement of his atrium, and appeared to have a haemodynamically significant, atheromatous plaque in his left main stem'.*

The review team considered that waiting lists for elective urology surgery and a cancellation could lead to a significant delay in relisting of a patient, however doctor 2 noted '*There was no push/ pressure to get the case done regardless'*

The review team concluded particularly in view of his comorbidities that Patient 90 should have had a formal preadmission pre-operative assessment with optimisation of his clinical condition prior to surgery. This assessment should have been organised sufficiently in advance of the surgery to allow for all appropriate investigations to be completed. This allows for patient optimisation and discussion regarding specific anaesthetic risk.

The review team noted that the consultant anesthetist Doctor 2 noted on the preoperative assessment on the day of surgery the Patient 90 comorbidities including ischaemic heart disease. The review team noted that Patient 90 had had previous anaesthetics which were uneventful.
Doctor 2 reported that '*induction of anaesthesia and intra-operative progress was largely uneventful'* and that Patient 90 was anaesthetically stable throughout the procedure. *'Blood pressure became more labile in the last 20 minutes of the case, although not to a major degree – he responded to small doses of metaraminol. Emergence from anaesthesia and extubation was uneventful. The patient did not look particularly unwell on transfer to his bed (of note, not clammy/pale.)'*
Doctor 2 highlighted there were serial arterial blood gases that showed that the haemoglobin and lactate were stable throughout the operative procedure. The review team concluded that these blood tests were missing from the notes.

The review team noted doctor 2's preoperative plan for an arterial line and venous access, and the anaesthetic management. The team notes a small amount of inotropes was administered during the procedure but these were not significant. The procedure was relatively long with the total procedure time 3 hours 45 minutes and the anaesthetic time 4 hours 27 minutes. The review team notes that there were no previous clinical notes available to doctor 2 on the day of surgery.
The review team considered that with the information available to the anaesthetist it was reasonable to progress with the surgery, the anaesthetic assessment and management of Patient 90 was appropriate.

Management of Patient 90 post-operative care

Post operatively he developed a labile blood pressure. He subsequently became agitated, tachycardic (fast heart rate) and hypotensive (low blood pressure) (NIBP 51/37). Patient 90 required further boluses of phenylephrine and 2x doses of haloperidol 2.5mg for agitation. Noradrenaline for inotropic support and amiodarone were administered. Patient 90 initially responded well but he developed anuria (no urinary output) and confusion. He was requiring increasing doses of inotropes.
Patient 90 was transferred to theatre for intubation and insertion of dialysis line. There was ongoing intensive care including supra-maximal doses of inotropes and other resuscitative measures. Patient 90 was transferred to ICU at approximately 22:30.
The review team note the plan was to attempt to stabilise the patient and transfer to ICU for haemofiltration/ dialysis. However, despite maximal efforts lost cardiac output and cardiopulmonary resuscitation (CPR) was commenced. Despite CPR there was no return to spontaneous circulation and Patient 90 died at 23:10.

The review team noted the clinical team's differential diagnosis of a sudden cardiac event.

The review team considered the discussion between Doctor 1, Doctor 2 and Doctor 3 who agreed that given the patient's precarious state and lack of compelling evidence of haemorrhage (Robinson drains in situ, Hb static, abdomen not distended), not to perform an emergency laparotomy. The review team noted the total output of 1220mls on the fluid balance chart of which 400mls was from surgical drains at approximately 21:00 plus the 1098mls at time of procedure (the review team note the blood volume lost in theatre was 1098 not 1298 on the measurement of blood loss in theatre). The review team note the World Health Organisation (WHO) surgical safety check list has questions on blood loss on the sign in and time out sections of the form but did not have this form available to them during the review. The review team have been informed it is custom to notify the surgical and anaesthetic team of blood loss of 500mls and 1000mls during the procedure and total blood loss at the end of the procedure. The escalation is not documented in the medical notes available to the review team, with the exception of the Measurement of Blood Loss in Theatre form. However, the review team noted there was equivalent fluid replacement.

The review team note that Hb appeared to be sustained at 82, however, haemodilution may not have occurred at that time. The review team note the Hb of 68 which was collected at 22:25. This result may not have been available to the clinical team before Patient 90's death.
The review team concluded that Patient 90 was at high risk of bleeding due to myelodysplastic syndromes, and the nature of the surgery. The intra operative blood loss, post-operative tachycardia and loss from operative drains indicated bleeding, which with Patient 90's history of heart failure would have been a contributory factor for hypovolemic shock. The review team note the post mortem findings '*death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen*,.

Communication
Consent
Patient 90 was consented by Doctor 1for cystoscopy, replacement of ureteric stent, laparotomy and bilateral ureterolysis.
The review team was unable to find documentation of detailed discussion of Patient 90's individual risks based on his comorbidities in the medical notes.
Ureterolysis a high risk surgical procedure which is rarely performed in the SHSCT urology department, with only a few per year. There is no documentation of alternatives e.g. nephrostomies or referral to other centers being discussed with Patient 90.

Patient 90 did not have a full preoperative outpatient assessment which would have identified all his individual anaesthetic risks to be assessed and discussed with Patient 90 to ensure informed consent.

Liaison with other teams
The review team was unable to evidence communication between Doctor 1 and the haematology team regarding optimisation of Patient 90 preoperatively; however, the review team note that Patient 90 did receive a blood transfusion pre-operatively. Patient 90's Hb was 86 and there would have been an anticipated blood loss of approximately 500mls with the proposed procedure. During the procedure the actual blood loss was 1098mls.

Patient 90 was added to a urology waiting list on Personal Information redacted by the USI and was pre-admitted for surgery at 15:50 on Personal Information redacted by the USI by Doctor 1's secretary and referred to the preoperative team the same day. The preoperative team booked Patient 90 for an assessment at 13:45 on Personal Information redacted by the USI. Patient 90 was in the emergency department of Craigavon Area Hospital on Personal Information redacted by the USI and called with the preoperative team at 09:00, as his preoperative assessment appointment was booked for 13:45 they were unable to assess him. He was advised to contact the preoperative team later that day if he was unable to attend his 13:45 appointment. Patient 90 did not attend his preoperative assessment later that day. The review team was informed that the pre-operative team informed the consultant

anaesthetist that Patient 90 did not attend his appointment.

The review team concluded that even if Patient 90 had been able to attend this appointment, it was not a timely referral to pre-operative assessment. The referral did not give sufficient time to appropriately pre-operatively assess and optimise Patient 90 for surgery considering his significant comorbidities.

14. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

15. RECOMMENDATIONS (please state by whom and timescale)

Recommendation 1

The Trust should develop and implement guidance for clinical result sign off
Monthly audit of sign off will be presented to the Governance Forums

Recommendation 2

All patients undergoing elective surgery must have a formal pre-operative assessment completed prior to surgery, including liaison with other specialties to ensure maximal optimization of patients prior to procedure. The Trust will update the pre-operative guidance to recommend appropriately timely referral times and escalation of non-attendance.
Audit of surgical patient pre-operative assessment should be undertaken and be presented to the Governance Forums

Recommendation 3

Discussions regarding the risks and benefits of surgery must be clearly documented in the patient record and reflected on the patient consent form, to ensure patients are able to make informed consent.
Audit of surgical patient consent should be undertaken and be presented to the Governance Forums

Recommendation 4

Blood loss during procedure should be escalated during and at the end of the procedure, the blood loss must be recorded on the operation note.
Blood loss post operatively must be escalated to the surgical and anaesthetic teams.
Monthly audits will be conducted and result presented to the Governance Forums

Recommendation 5

VTE risk assessment must be completed for all patients prior to surgical intervention.
Monthly audit of VTE risk assessment in the patient record/medicine prescription and administration record and WHO surgical safety check list blood loss section will be presented to the Governance Forum

16. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

17. FURTHER REVIEW REQUIRED? YES / NO
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)	
18. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**19.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
20. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
21. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
22. NAME:	**23.** DATE APPROVED:
24. DESIGANTION:	

SECTION 6
25. DISTRIBUTION LIST: HSCB Coroner's Office Family AD – Surgical Director of Acute

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:	Personal Information redacted by	**HSCB Ref Number:**	Personal Information redacted by the

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**	✓	**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	✓	**NO**		
	If **YES**, insert **date informed**: 26.11.18				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	✓	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	✓
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			✓

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SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed **(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**	✓	**NO**				
	If **YES**, insert **date informed**: 9.5.18						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**	✓	**NO**				
	If **YES**, insert **date report shared**: 9.4.19						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**	**Not Known**	
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	**8 April 2019**

Service User or their nominated representative

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Southern Health and Social Care Trust

Quality Care - for you, with you

Diagnostic (Radiology & Laboratory) Electronic Results Sign-off

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Lead Policy Author & Job Title:	Click here to enter text.
Directorate responsible for document:	Acute
Issue Date:	Click here to enter a date.
Review Date:	Click here to enter a date.

Policy Checklist

Policy name:	Click here to enter text.
Lead Policy Author & Job Title:	Click here to enter text.
Director responsible for Policy:	Directors Name.
Directorate responsible for Policy:	Choose Directorate.
Equality Screened by:	Click here to enter text.
Trade Union consultation?	Yes ☐ No ☐
Policy Implementation Plan included?	Yes ☐ No ☐
Date approved by Policy Scrutiny Committee:	Click here to enter a date.
Date approved by SMT:	Click here to enter a date.
Policy circulated to:	Eg Directors, Assistant Directors, Heads of Service for onward distribution to line managers, Global email, Staff Newsletter
Policy uploaded to:	Eg SharePoint, Trust website

Version Control

Version:	Eg Version 2_0
Supersedes:	Name of Policy and Year of Issue **or** N/A

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Eg Version 1_0	Click here to enter text	Click here to enter a date.	Click here to enter text
Eg Version 2_0	Click here to enter text	Click here to enter a date.	Click here to enter text

(delete as necessary and remove ALL yellow / red highlighting)

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Version Use:
V0_1 for a document which you are working on
V0_2 for a document you are working on (second draft prior to approval)
V0_3 for a document you are working on (third draft prior to approval)
V1_0 for a document which has been approved
V2_0 for a document which has undergone review
Where documents are in draft, a 'DRAFT' watermark should be incorporated into the document

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Diagnostic Tests – Electronic Review of Results and sign-off

1.0 Introduction

This Strategic Policy has been developed in response to a need to ensure good governance in terms of diagnostic test results. The introduction of NIECR offers a much more robust approach to recording that diagnostic results have been viewed and acted on than has hither too been possible. This document seeks to set out clearly the responsibility of clinicians with regard to acting on the results of diagnostic tests, in line with GMC good medical practice guidance[1].

All the statements in this Policy assume that individuals are acting within the guiding principles of the General Data Protection Regulations (GDPR) and Trust Policies on Information Governance.[2]

2.0 Purpose and Aims

Diagnostic tests can be used to determine what conditions, diseases or syndromes a patient may currently have or is likely to develop. These tests can be used in a variety of ways including screening, monitoring chronic conditions, suggesting diagnoses, ruling out or confirming suspected diagnoses, monitoring patients following treatment for side effects or recurrence, and predicting future events. Because of the variety of tests employed and the range of professional review and subsequent actions that may occur as a result of testing, there is an absolute need for clear pathways that identify how, when and to whom the results should be communicated.

The intention of this document is to minimise the risk to patients and to improve patient outcome and quality of care through acknowledging that results have been seen and acted on.

This document should be read in conjunction with the Trusts Laboratory Hand book and Radiology guidance.

3.0 Definitions

Diagnostic Testing Procedures

This Policy includes the management of test procedures and results relating to Diagnostic tests for Radiology and the Laboratory disciplines, namely, but not exclusively: Microbiology, Haematology, Biochemistry, Histopathology and Cytology.

4.0 Duties within the Organisation

[1] Published March 2013 | Updated April 2014 © 2013 General Medical Council

[2] Guide to the General Data Protection Regulation, Information Commissioner's Office 22 March 2018 1.0.097

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Chief Executive

The Chief Executive Officer for the Trust takes final responsibility for adherence to, and the implementation of all Policy Documents issued and approved by the appropriate Trust Committee(s)

Trust Board

The Trust Board receives regular reports concerning clinical governance issues within the Trust, and this should include a report every year concerning the matters related to this policy, particularly relating to the acknowledgment of receipt of test results and clinical incidents arising from the failure to act on a report.

Clinical Governance Committee

Ensures the development and adoption of organisation wide policy(s) relating to the management of diagnostic testing procedures

The IT Department

Supports the investigation of problems relating to failures within the system which might be related to receipt and/or delivery, correct attribution of patient or responsible clinician. Monitors adherence to the acknowledgment function

Clinical Directorates and Lead Clinicians

Ensures the development, and adherence to local operating procedures relating to diagnostic testing procedures and the management of associated risks. Monitors adherence to good Medical Practice with regard to Diagnostic tests

Healthcare and Administrative Staff

All healthcare and administrative staff involved in requesting, receiving, acknowledging and acting on diagnostic tests should be aware of their responsibilities in this role. They will be expected to undertake training as required and agreed. Formal training will be provided with regard to using the electronic processes for Diagnostic tests. Individual clinical departments may need to develop protocols or standing operating procedures (SOPs) to ensure safe and confidential practice.

5.0 Education and Training

All staff engaged by the Trust who are expected to access NIECR Sign-off will be expected to undergo a period of training to familiarise themselves with the system. All staff involved in diagnostic testing procedures, particularly junior and senior doctors, nursing and allied health professionals and clinical secretaries should be aware of the competencies needed and the training requirements expected by the organisation. Development of training in this

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area should be subject to a training needs analysis.

All staff will be expected to be aware of their responsibilities in relation to this policy.

This Policy will be disseminated to all staff through the Directorate Managers and Clinical Directors. All Clinical Leads will be expected to be aware of, and understand their responsibilities in terms of implementing this policy.

6.0 Responsibilities

6.1 Duties of Clinicians

a. When viewing results the clinician should document acknowledgment of results by 'Signing Off' electronically. By 'Signing Off' the result a Clinician is indicating that they have noted the result, and have taken appropriate action on the patients' behalf

b. The Requester of the test is the individual who has the responsibility for checking and acting on the test result. This responsibility may be delegated to a colleague with their consent, providing the requester is satisfied that the delegate has the qualifications, experience, knowledge and skills to act on the result. It is not acceptable to delegate responsibility for checking test results to untrained administrative staff.

c. Clinical teams will need 'fail-safe' mechanisms to ensure that results are reviewed in a timely manner, and that these results are acted on, particularly when the care of the patient is handed over to another provider or to primary care.

d. Clinical teams will need 'fail-safe' mechanisms to ensure that results are reviewed in a timely manner, at time of planned and unplanned leave including those requested by non-substantive staff.

e. Where a test has been requested on an inpatient but the result is not available by the time the patient is discharged, the requester remains responsible for checking the result of the test and communicating the result to the patient or GP as appropriate.

f. The requester or delegate should sign off their results electronically to indicate that appropriate action has been taken.

g. If an individual without authority to take clinical decisions notes a seriously abnormal result, they must bring this to the attention of someone within the clinical team who can make the decision in a timely manner.

h. It is the responsibility of the reporting doctor/practitioner to validate and authorise the result in a timely fashion. It is the responsibility of the Trust to have systems in place to ensure results are received by the referring staff.

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Ensuring correct patient identification and referrer attribution is a key requirement of the system to ensure prompt and appropriate patient management.

i. It is the responsibility of all participating staff to be familiar with relevant processes, policies, protocols and systems to ensure that errors are kept to a minimum.

j. It is the responsibility of the Trust and relevant clinical team to investigate and act upon adverse events associated with inappropriate action or lack of action on test results.

Non-compliance with this policy may result in disciplinary action.

6.3 Process for Sign-off of Diagnostic Test Results

Diagnostic test results will be distributed electronically through NIECR[3]. These results will be accessible to all users of the system. Those individuals or teams who have made test requests will be expected to view and act upon those results in a timely manner.

Results should be acknowledged in a timely manner however all results should be acknowledged within 15 days.

It is recognised that many patients will have test results available that have been requested by other teams, or in Primary Care. Acknowledgement of such results is the responsibility of the clinician who made the request, although there will be circumstances within the Trust where it would be more appropriate for the clinician with ongoing responsibility to acknowledge those results.

Critical Results

Timely and reliable communication of critical diagnostic results.

The Laboratory[4] and Radiology[5] maintain a trigger list for critical results – attempts will be made to communicate these by telephone.

Radiology unexpected findings (including first presentation of malignancy) will be communicated via radiology administrative staff to the referring clinician within 24-48 hours.

[3] exceptions are noted in the appendix A
[4] telephone limits (e.g. for life threatening results)
[5] Critical or unexpected results

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6.4 Taking Action on Diagnostic Test Results

It is the responsibility of the clinician or other individual accessing a result to act on that information in an appropriate and professional manner. If the individual who accesses the result cannot take appropriate action (such as a Medical Secretary), it is important that they bring this to the attention of someone who can.

Actions taken should be recorded and the method of communication indicated (face to face contact, phone call, letter, e-mail and so on)

Radiology tests requested by hospital clinicians may be copied to the GP but this is for information only. It remains the responsibility of the requester to ensure that the result is reviewed and acted upon.

6.5 Documenting Diagnostic Test Results

There is no need for paper copies to be filed in the notes. However, some Clinical Teams may feel that they wish to retain certain results as a paper copy. They should develop local policies for this.Otherwise the documentation may be in the form of a flow chart, or a written communication (electronic or paper based) to the patient, another carer, another team or the patient's General Practitioner

6.7 Audit

An audit of unacknowledged (not 'signed off') results will be undertaken on a regular basis. This will identify those teams or individuals who fail to acknowledge 'urgent" results within 48 hours or who do not appear to view or sign off their results.

8.0 Equality & Human Rights Considerations

TBA

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Appendix A

List of tests that are not currently available on the NIECR

1. Blood Bank investigations
2. Genetic tests
3. Some specialist referred tests (i.e. investigations in laboratories outside NI)
4. Genitourinary Medicine results (as these are anonymised without HCN, results are not transmitted to the NIECR)

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Southern Health and Social Care Trust

Quality Care - for you, with you

NIECR Project Board Meeting
Friday 31st May at 9.30 a.m. Trust headquarters Meeting Room CAH.

In attendance: **Dr Andrew Murdock**
Dr Damien Gormley
Siobhan Hanna
Stephen Beattie (BSO)
Katherine Robinson
Kate Cunningham
Jilly Redpath
Mary McCluskey

SUMMARY OF DISCUSSION/ACTIONS TO BE TAKEN

	AGENDA ITEM	ACTION TO BE TAKEN
1	**Apologies** Apologies were received from Mark Toal, Maria O'Kane, Denise Newell, Anita Carroll, Geoff Kennedy and Donna Muckian.	
2	**Minutes of the Previous Meeting** The minutes of the previous meeting were agreed.	
3	**Work stream Updates:** **Medicines Reconciliation / Immediate Discharge Summary** – Pierrette informed the group that the Med Rec &IDS Subgroup continue to meet on a regular basis. Amendments and changes have been presented to Orion for development, following this Stephen is to arrange a demo to be delivered by Aaron Jackson. Jilly suggested for a successful pilot BSO would require a focused pharmaceutical resource. **Immediate Discharge Summary** – These specifications have been passed to Orion and BSO are currently awaiting a date for	**Stephen to arrange med rec & IDL demo.**

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development work to take place.

Siobhan requested timelines around the developments and pilot of IDS as DXC will no longer support ECM after 30th March 2020. Meeting to take place in BSO at the end of June to decide on suitability of IDS and Med rec. Following decision Stephen and Gavin to demo to trust.

E-Triage

Currently live with IMWH, Paeds, Surgery (DHH), Dermatology, ICATS, Urology, Gastro, RACPC, Cardiology, Pain Clinic, Respiratory, Rheumatology, Diabetology, Endocrinology, Lipids and Chemical Pathology. Demo delivered to ENT and Haematology. Requested developments expected for third quarter on E-triage advice response and E-triage internal Referrals.

Sign Off

There were 24675 results Signed Off for April in the Southern Trust and we are currently leading the way in Sign Off for the region. Kate informed the group that a draft implementation plan has been sent to the medical director's office for comments. It was suggested that a NIECR Sign Off subgroup be set up and be chaired by the Medical Director and an SOP developed before roll out. Discussion around automatic Sign Off i.e. the person who views a result becomes responsible. It was suggested this could discourage NIECR use. Damien requested the availability of an exception report that would show results never viewed. Discussions were had around volume of Sign Off by specific wards; Mary informed the group that a development due in September of orders by location, will have an exception report for unseen results. Kate stated that some of the Junior Doctors requested hand held devices to improve and speed up Sign Off process, Siobhan stated that devices are available for wards if required. Siobhan asked if Sign Off figures for the Bluestone could be made available.

Siobhan to speak to Maria O'Kane about Chairing Subgroup if required

Mary to provide one off report on unviewed results.

IM to provide Sign Off figures for Urology in 3 South

IM to request if figures for the bluestone could be made available.

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	Siobhan enquired if staff where made aware that paper copy of laboratory results are not always available in case notes. Katherine Robinson to check. Trudy Reid and the Acute Governance team continue to encourage Sign Off within the inpatient setting within acute. **Radiology Ordering** There were 12895 radiology orders placed on NIECR in April. Currently GP's are still using Sectra. This has to be resolved by GP's using NIECR as an ordering tool before Sectra can be turned off. Denise Newell to provide percentage off Radiology orders requested on Sectra verses NIECR for next project board. Non solicited orders are now available, this means that staff will be able to see appointed tests in NIECR my orders even if ordered on Sectra. 24hour support for radiology ordering discussed. **Diabetic Pathway** Kate informed the group that the Diabetic Pathway was implemented throughout the Trust including antenatal and paediatric diabetic patients. The Pathway appears to be embedding within the Diabetic service. There is now a contingency plan available in case of system failure which allows the doctor to revert to the paper record but recording these onto the diabetic pathway at a later date is a big undertaking. Siobhan raised concerns about diabetic pathway reporting and asked when reports would be made available from BSO. Stephen stated that standardised reports will be available from BSO and some data will be made available for further interrogation by the Trusts Information Team. Reporting proof	**Katherine Robinson to check if formal communication available to inform staff that all inpatient laboratory results no longer filed in notes** **Denise Newell to provide percentage off radiology orders requested on Sectra verses NIECR.** **Stephen to check if the dropdown tabs within Radiology ordering can have further development.**

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	of concept is completed with BSO and Data warehouse. Meeting to be held with the information standards board. **Problem List** Pierrette stated that currently specialist nurses are using the Problem list. Infection control nurses are now putting the regional CPO's alert on. Oncology and haematology are recording Chemo alert. Jilly asked if chemo alert is regionally recorded, Stephen/Mary stated there were discussions ongoing and an index listing the alerts recorded by each trust may be made available in the future. Mary to provide an exception report to assist with cleansing of Problem list. It was suggested that any governance issues around the problem list could be dealt with by the Sign Off subgroup. A demo of Problem List arranged for disability services on 3rd June. Mary stated a monthly splunk report could be made available outlining recorded problems. **M&M development** Development completed on M&M in January. DOH reporting proposal in development. **KIS** Merlock and vision practices are now participating and making KIS records available on NIECR.	**Mary to provide an exception report to assist with cleansing of Problem list** **Mary to provide monthly splunk report for problem list**
5	**Data Quality** Stephen informed the group that data quality subgroup to be set up to look at data quality issues.	
6	**Risks** Resources within the Trust- A band 5 NIECR trainers post has been offered following interviews with view to a start date of 3rd June.	

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	The issue log was reviewed, a short discussion was had around performance issues, reporting and adoption records.	
7	**Clinical Content Group –** Andrew enquired if there would be time to finish the Lithium pathway as the NIECR project is to complete in September. Siobhan requested that Kate arrange a meeting to take forward the DAU discharge letter. eEMS lead, BSO representative Joanne McEvoy and Medical Staff from DAU to prioritise this integration into NIECR.	**Kate to arrange a meeting to take forward the DAU discharge letter**
8	**Governance Issues** Siobhan suggested that individual requests for access to NIECR, if in dispute be forwarded to the Information Governance Team for a decision. Mary raised the fact that Michael McKenna queried Occupational Health access. Siobhan stated that OH needs to go through due process before accessing NIECR. Currently 90 patients Opted out of NIECR which is causing issues with the source systems. ICO indicated opting out was not an option. Communication to be sent to these patients following legal advise.	**IM to raise IG issue at local level.**
9	**Usage Report** Usage report available to view.	
10	**AOB** Andrew asked when NIECR was to stop and Encompass to commence. He encouraged attendance at encompass: from Abstract to Reality. Siobhan enquired as to who was our representative on the Regional NIECR project board, currently Andrew Murdock	**Andrew Murdock to inform Siobhan when he is unable to attend Regional NIECR Project**

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	represents Maria O'Kane in her absence. Siobhan requested that Andrew inform her if he is not able to attend and she can insure representation.	**board**
11	**Date & Time of Next Meeting** 13th September 2019 Trust Headquarters Meeting Room CAH	

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			June
			55627
			27038
			7474
			6583
			4504
			101226

			May
			48799

		s	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
			5830	234	43	48	0	**55627**

		s	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
			3581	133	16	47	0	**36526**
			1800	100	27	1	0	**14944**
			355	0	0	0	0	**3504**
			3	0	0	0	0	**213**
			47	0	0	0	0	**194**
			22	0	0	0	0	**121**
			13	1	0	0	0	**111**
			6	0	0	0	0	**9**
			2	0	0	0	0	**4**
			1	0	0	0	0	**1**
			5830	**234**	**43**	**48**	**0**	55627

aisy Hill

		s	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
			3581	**133**	**16**	**47**	**0**	36526
			1360	60	7	2	0	**22171**
			767	72	9	45	0	**9267**
			1297	0	0	0	0	**3186**
			157	1	0	0	0	**1758**
			0	0	0	0	0	**143**
			0	0	0	0	0	**1**
			1800	**100**	**27**	**1**	**0**	14944
			808	6	3	1	0	**9993**
			626	94	24	0	0	**3286**
			359	0	0	0	0	**911**
			4	0	0	0	0	**498**
			2	0	0	0	0	**72**
			1	0	0	0	0	**117**
			0	0	0	0	0	**67**
			5381	**233**	**43**	**48**	**0**	51470

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HSC Business Services Organisation

Southern Health & Social Care Trust

Management of Waiting Lists - Pre-Operative Assessments & Patient Consent 2019/20

nqa ISO 9001 Registered Quality Management

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

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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern HSC Trust for their assistance and co-operation during the course of the audit engagement.

Control Log

Exit Meeting Held On:	None held (due to corona virus)
Working Draft Issued On:	10th April 2020
Management Actions Due By:	
Management Actions Received:	
Final Report Issued On:	

Distribution List

Shane Devlin	Chief Executive (Final Report Only)
Helen O'Neill	Director of Finance, Procurement and Estates
Melanie McClements	Interim Director of Acute Services
Dr Maria O'Kane	Medical Director
Ronan Carroll	Assistant Director of Acute Services
Alison Rutherford	Assistant Director of Finance

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Introduction

In accordance with the 2019/20 Annual Internal Audit Plan, BSO Internal Audit carried out an audit of Management of Waiting Lists focusing on Pre-operative Assessments and Patient Consent during September 2019 to March 2020. These 2 areas have not previously been subject to review by Internal Audit.

It is important to note that this audit was conducted before the impact of Covid 19.

A recent SAI case and previous work by Internal Audit in relation to Theatre Utilisation had indicated issues with timeliness of pre-operative assessments particularly in the current scenario of lengthy waiting lists. This led to concerns regarding patient safety where the Trust was potentially reliant upon pre-operative self-assessments which were out of date and also instances where these had to be rushed just ahead of surgery to ensure maximum utilisation of theatre slots, because previous assessments had time lapsed due to Waiting List length. Also in such scenarios, there is a query as to whether time was taken to properly discuss risks with the patient.

The **pre-operative assessment** is an opportunity to identify co-morbidities that may lead to patient complications during the anaesthetic, surgical, or post-operative period. Patients scheduled for elective procedures generally attend a pre-operative assessment 2-4 weeks before their date of surgery. The objectives of a pre-operative assessment are:

- to perform a structured preoperative anesthetic assessment of a patient prior to surgery and recognise when further assessment/optimisation is required;
- to explain options and risks of routine anesthesia to patients, in a way they understand, and obtain their consent for anesthesia;
- to formulate a plan for the management of common co-existing diseases;
- to ensure all elective patients who must undergo a surgical intervention under general anaesthetic (GA) or local anaesthetic (in some cases) are passed fit to do so.

Within the SHSCT, the specialties for which pre-operative assessments are performed are:

- Orthopaedics
- Gynaecology
- ENT
- General Surgery inc. breast surgery
- Urology; and
- Maxi-facial surgery.

This will be for all referrals triaged as Routine, Urgent or Red Flag. In cases involving a local anaesthetic where a patient is on a blood thinning drug, they don't do a full assessment as the patient must cease all such drugs in advance of the operation. Also where a patient is due to undergo endoscopy and they are on a blood thinning drug they must have a pre-operative assessment performed. Pre-operative assessments are not performed for patients admitted as inpatient or daycases via Emergency Departments (EDs).

In practice pre-operative assessments are carried out using a range of methods based on a risk assessment of the patients' medical history –

- Pre-op health questionnaire (virtual – online review of NIECR etc);
- Pre-op health questionnaire (conducted over telephone by band 5 or 6 nurse);
- Pre-op health questionnaire (conducted face to face with band 5 or 6 nurse);
- Anaesthetist review of health questionnaire (for certain conditions);
- Pre-op assessment (conducted face to face with consultant anaesthetist) or where there is a need to perform additional tests for certain conditions;

The completed questionnaire is filed on the patients' file and type and date of pre-operative assessment performed is recorded on Patient Administration System (PAS).

The Pre-operative Assessment (POA) Team is part of Anaesthetics, Theatres & Intensive Care (ATICS) within the Surgery, Elective Care & ATICS Division of the Acute Services Directorate. It provides services from Craigavon Area (CAH), Daisy Hill (DHH) and South Tyrone (STH) Hospitals, primarily in close proximity to Outpatient Departments. The POA team comprises 18 qualified nurses (14.68 wte). There are also 6.0 ~~8.00~~ wte administrative staff. A consultant anaesthetist provides one morning session per

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day (5 days a week) conducting virtual clinics at CAH. They will also see / advise on booked face to face appointments (those patients where risks are greater) and conduct tests on booked appointments where necessary. During the 6 month period from 1st October 2018 to 31st March 2019 there were approximately 14,000 pre-operative assessments (POA) performed of which approximately 900 were performed by Anaesthetists *(based on PAS figures)*.

In order to function efficiently and effectively the POA team must co-ordinate its work with a number of other services such as consultants and their secretaries and specialty theatre scheduling teams re timely notification of patients on upcoming consultant theatre sessions; specialty outpatient teams to perform timely pre-operative assessments for patients designated as red flag or urgent; and medical records. Failure to notify the pre-operative assessment team of patients who require a pre-operative assessment on a timely basis could result in patients not having their pre-operative assessment completed timely prior to surgery. If patients are admitted without being deemed as pre-op fit, this increases patient safety risk and potential for cancellation of surgery on the day. If patients require any blood tests or other tests, results may not be available prior to surgery where there are delays in notifications. Best practice guidance indicates pre-operative assessments are valid for a period of 13 weeks (3 months), and must then be re-performed, when the patient referred has not yet had surgery.

It is a general legal and ethical principle that valid **consent** must be obtained from a patient or their guardian before commencing an examination, starting treatment or physical investigation. For consent to be valid it must comply with the following principles:

- It must be given **voluntarily**, and freely without pressure or undue influence being exerted on the individual. Coercion from whatever source will invalidate consent.
- Given by an appropriately **informed** person (the individual or, where relevant, someone with parental responsibility for a young person under the age of 16). The patient/client needs to understand the nature and purpose of the procedure and the risks, benefits, alternatives and implications of no treatment or care. Any misrepresentation of these elements will invalidate consent. Information about anaesthesia should be given as well as information about the procedure itself. The Trust requires as evidence of good practice that patient/client records include a summary of the information given prior to gaining consent.
- The person must have **capacity** to consent and be able to comprehend and retain information relevant to the decision, understand the consequences, weigh up the information and arrive at a choice, and be able to communicate their choice.

Consent must be sought before commencing examination, treatment or care of a patient/client. If consent is sought after a patient/client is given routine pre-operative medication, it may be deemed to be invalid. For major activities, such as surgery under anaesthetic, it is good practice to fully inform the individual about the implications, potential risks and benefits well in advance of the proposed activity. This will allow the individual time to reflect on the information about the activity or event and for the professional to respond appropriately to questions. The health or social care professional should again check, before the activity starts, that the consent is still valid and that the patient/client has not had a change of mind about proceeding. If consent is not gained until just before the activity care event is due to start, at a time when the patient/client may be feeling particularly vulnerable, there may be doubt as to the validity of the consent gained.

The Southern Trust requires as evidence of good practice that information is provided to the patient to help inform consent and any decision by the patient to withdraw or refuse consent, is recorded in the patient record. It is important that a recording format is agreed and applied consistently and records should also include the information given to the patient or client to aid his/her decision and where refusal of consent by a patient/client prevents care being given.

Scope of Assignment

This audit covered Pre-operative Assessments and Patient Consent processes during the audit test period outlined below. Discussions took place with a number of consultants across the following specialties – ENT, Gynaecology, Urology, General Surgery and Anaesthetics. Discussions also took place with Pre-operative Assessment, Scheduling, and Booking Centre Teams, as well as consultants' secretaries. Reports were obtained from PAS through the Informatics Department showing:

i. All recorded pre-operative assessments for the 6 month period 1st October 2018 to 31st March 2019.

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ii. All elective inpatients and daycases recorded for the 3 month period 1st January 2019 to 31st March 2019.

Based on analysis of these reports, 105 patients' files were pulled and reviewed.
A copy of the Pre-operative Assessment Team database from CAH was obtained and used to supplement / verify reported data. Queries arising from testing were discussed with appropriate clinical staff.

The audit was based on the risks that due to increasing length of elective waiting lists, and pressure to maximise usage of limited elective theatre slots:

1. there is potential for increased patient safety issues during surgery due to issues with timeliness / elapsed pre-operative assessments performed on elective patients; and
2. failure to obtain timely informed patient consent resulting in patients' not fully understanding all surgical risks.

The objectives of this audit were:

- To ensure that pre-operative assessments are performed in a timely manner ahead of proposed surgery and are properly assessed by an appropriate individual well in advance of planned surgery.
- To ensure that valid patient consent is obtained and there is evidence of timely informed discussion of risks with the patient.

Note: We report by exception only, and where no issues and recommendations are made, the result of our work indicates that the key objectives and risks are being managed and that procedures are being adequately adhered to.

Level of Assurance

Pre-Operative Assessments

Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.

Patient Consent

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.

Executive Summary

Internal Audit can provide limited assurance in relation to Management of Pre-operative assessments. Limited assurance has been provided on Pre-Operative Assessments on the basis that 25% of patient files examined where a pre-operative assessment was required did not have a completed assessment form on the file - 63.6% were Urology cases; in 8.4% of sampled surgical cases the pre-operative assessment had expired.

Satisfactory assurance has been provided in relation to Management of Patient Consent on the basis that consent forms signed by the patient were available on all patient files examined, although we noted that extent and quality of completion of consent forms varied significantly.

There are 2 significant findings in this audit, impacting on the assurance provided:

1. Specialties such as Urology, General Surgery and Orthopaedics routinely do not provide theatre lists to the Pre-operative Asssessment Team 6 weeks in advance. Testing of 105 patient files found 7 cases where the pre-op was performed either on the same day or within 3 days of actual operation.

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As a consequence of high levels of red flags and urgent patients, some routine patients who are moved down the waiting list subsequently present through the ED pathway as their conditions deteriorate – testing found that of 17 patient files tested in Urology, 14 (88%) had presented through this pathway for stent insertions / replacements. Subsequently these patients must then have the stent removed typically 4-8 weeks later.
There are a number of other occasions when patients will only become known to PreOp Assessment team once a late theatre list is received, impacting on the ability to perform an appropriate PreOp assessment.
From 44 files tested which should have had a POA, there were 11 (25%) with none on file for the selected procedure - 7 (63.6%) were Urology procedures, and one each from Gynaecology, Orthopaedics, General Surgery and ENT.

2. An analysis of date of surgery against date of latest POA on PAS for the test period found that out of the 2,161 patient records matched i.e there was a POA completed, there were 182 records (8.4%) where the time between (date of surgery – date of latest pre-op) was greater than 91 days or 13 weeks. General Surgery, Gastro, ENT and Urology were the specialties with largest numbers of exceptions.

Other key findings of the audit are:

3. While all 100 sampled consent forms had been signed by the patients, the following exceptions were observed in completion of consent forms:
    - 9 consent forms were not signed by the consultant, evidencing the patient had consented to the procedure to be performed;
    - In 80 cases, the copy consent form had not been given to the patient;
    - 5 consent forms did not outline benefits / risks etc discussed with the patient;
    - 88 consent forms did not record evidence that relevant information leaflets on the surgery / procedures had been provided to the patient.
4. There are no documented procedures available for pre-operative assessment. A number of issues with the database system within the PreOp assessment team were observed.

There were no other findings in this report.

Summary of Findings and Recommendations

Finding		Number of Recommendations		
		Priority 1	Priority 2	Priority 3
1.	Notification of Elective Patients to Pre-operative Assessment	-	6	1
2.	Expiration of Pre-operative Assessments	-	1	-
3.	Patient Consent	-	2	-
4.	Documented Policies / Procedures for Pre-operative Assessment and Database	-	3	-

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Detailed Findings and Recommendations

1 Notification of Elective Patients for Pre operative Assessment (POA)

Findings

All elective patients who require a General Anaesthetic (GA) whilst undergoing a procedure are required to have a Pre-Operative Assessment (POAs) to assess their fitness for surgery. In practice the optimum time is to ensure patients' POAs takes place between 13 weeks and approximately 3 weeks ahead of planned surgery date. Consequently to ensure this happens in a timely manner and no patients scheduled for theatre are overlooked, it is essential that all elective theatre lists are prepared and notified to the POA team by the scheduling team or consultants' personal secretaries, 6 weeks in advance of the theatre date. In reality this does not happen in certain specialties such as Urology, General Surgery and Orthopaedics, as the lists are often prone to late changes. Testing identified one case where pre-op was performed on the same day as surgery, 2 cases one day in advance, 2 cases where 2 days in advance and 2 cases where pre-op was performed 3 days in advance of operating date.

The underlying reasons for late lists can be increasing numbers of red flag patients presenting, which when coupled with reduced availability of theatre sessions, often mean routine or less clinically urgent patients must be cancelled from lists at short notice. This has a knock on effect for those latter patients as not only does their waiting list time increase but quite often conditions deteriorate and they subsequently present through ED pathway and are admitted as an inpatient. *(See Urology stent cases below).*

There are a number of other occasions when patients will only become known to POA team once a late theatre list is received, such as:

- Private patients – they will not have been seen at the Trust Outpatient Department, and when they are subsequently referred as NHS inpatients will not have been assessed following a clinic attendance, as per urgent / red flag NHS patients;
- Patients admitted to wards (primarily through ED), who are subsequently discharged having had their immediate emergency resolved, but the consultant then adds them to the waiting list because they require further urgent surgery e.g. emergency Urology stent insertions, where the patient must return in typically 4-8 weeks for it to be removed (typically as a day case). Before the patient leaves hospital the discharging doctor should get them to complete a POA questionnaire, or to attend the POA Department in urgent / red flag cases;
- Patients who have had investigations either at the day procedure units or scope clinics, and are then referred following biopsy or other tests. In these instances as the test results are not known and consequently the consultant does not ask them to complete a POA questionnaire available at clinics;
- Outpatient attendees, whom the consultant refers for surgery but doesn't notify to POA at the time of their Outpatient visit – ideally all red flag / urgent cases should be sent immediately to POA team.

Using data analysis of PAS reports, Internal Audit reviewed a sample of 105 elective patient files for patients seen in the period 1st January to 31st March 2018 to ascertain whether the patient had required a pre-operative assessment prior to having their inpatient or day case procedure. Only 44/105 (42%) files examined required the patient to have a pre-operative assessment. Of the 44 files which should have had a POA, there were 11 (25%) with none on file for the selected procedure. These 11 cases can be analysed as follows:

- 7 (63.6%) were Urology procedures
- 1 was Orthopaedics
- 1 was Gynaecology
- 1 was ENT
- 1 was General Surgery

From the 61 cases where there was no pre-operative assessment, 17 urology stent removals / replacements were further examined to ascertain whether a Pre-Operative Assessment was carried out for the original stent insertions. 3/17 (12%) patient files did have a Pre-Operative Assessment booklet. The remaining 14 cases were all admitted through ED and consequently did not have a POA. Discussion with consultants indicated more patients, primarily because of the waiting time were presenting through ED route, and emergency temporary stent insertion was required to relieve immediate discomfort / pain. The

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stent is subsequently removed 4-8 weeks later. In some cases the stent may be routinely replaced every 3-6 months.

Implication(s)

Planning issues for POA Team when theatre schedules are presented late and new or updated POA is required at very short notice.
Patient safety risks where theatre schedules are not notified timely to the POA team and assessments are either not completed in advance of surgery or may be rushed in order to meet theatre scheduling e.g. all results of POA tests may not be known / completed etc.
Increased risk of cancellation of surgery on the day of operation because POA not completed, potentially resulting in loss of theatre time.

Recommendation 1.1	As previously reported in the 2018/19 Theatre Utilisation report, the surgical rotas should be prepared and made available on a timely basis, (6 weeks) to allow for efficient scheduling and booking of patients onto theatre lists and appropriate time for pre-operative assessments to be completed. Medical annual leave confirmed with 6 weeks notice. This will then enable the Heads of Service to develop the emergency and elective rotas for their specialities. Their rotas are forwarded to Theatres who then develop the overall theatre/anaesthetic rota. The Trust will aim for the final theatre/anaesthetic rota to be developed at 4 weeks minimum **Responsible Officer**: Not stated **Original Implementation Date:** Not stated
Priority	*2*
Management Action	**ACCEPTED / REJECTED – Accepted with rewording above**
Responsible Manager	Head of Service for ATICs and Surgical specialities
Implementation Date	April 2021

Recommendation 1.2	As previously reported in the 2018/19 Theatre Utilisation report, as per procedure, to allow timely completion of pre-operative assessments, patients listed in theatre sessions should be notified to Pre-Operative Assessment Team 46 weeks in advance of surgery date. **Responsible Officer**: Not stated **Original Implementation Date:** Not stated
Priority	*2*
Management Action	**ACCEPTED / REJECTED - Accepted with rewording above**
Responsible Manager	Head of Service for ATICs and Surgical specialities
Implementation Date	April 2021

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Recommendation 1.3	Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.

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Priority	2
Management Action	**ACCEPTED / REJECTED - ACCEPTED**
Responsible Manager	Katherine Robinson
Implementation Date	April 2021

Recommendation 1.4	Management should review and strengthen processes where ward admissions via ED, are subsequently re-booked for urgent surgery e.g. Urology Stent removals within 4-8 weeks, so they are promptly notified to the Pre-operative Assessment Team on discharge.
Priority	2
Management Action	**ACCEPTED / REJECTED - ACCEPTED**
Responsible Manager	Katherine Robinson
Implementation Date	April 2021

Recommendation 1.5	Management should review and strengthen processes to ensure all red flag / urgent cases added to waiting lists following investigative procedures in either the Day Procedure Units (DPU) or while attending Outpatient Departments (OPD), are promptly notified to the Pre-operative Assessment Team following attendance.
Priority	2
Management Action	**ACCEPTED / REJECTED – To be removed**
Responsible Manager	
Implementation Date	

Recommendation 1.6	Management should review and remind Surgical specialities in relation ~~Urology procedures in relation~~ to limited use of pre-operative assessments given the high volume of exceptions found.
Priority	2
Management Action	**ACCEPTED / REJECTED Accepted with rewording above**
Responsible Manager	Head of Service for ATICs and Surgical specialities
Implementation Date	April 2021

Recommendation 1.7	Management should retrospectively investigate the 11 exceptions noted where there was a pre-operative assessment expected but not performed, and identify learning.
Priority	3
Management Action	**ACCEPTED / REJECTED – Accepted, however, need the 11 exceptions forwarded to pre-op**
Responsible Manager	Lead Nurse and Pre-op Band 7 Sister
Implementation Date	April 2021

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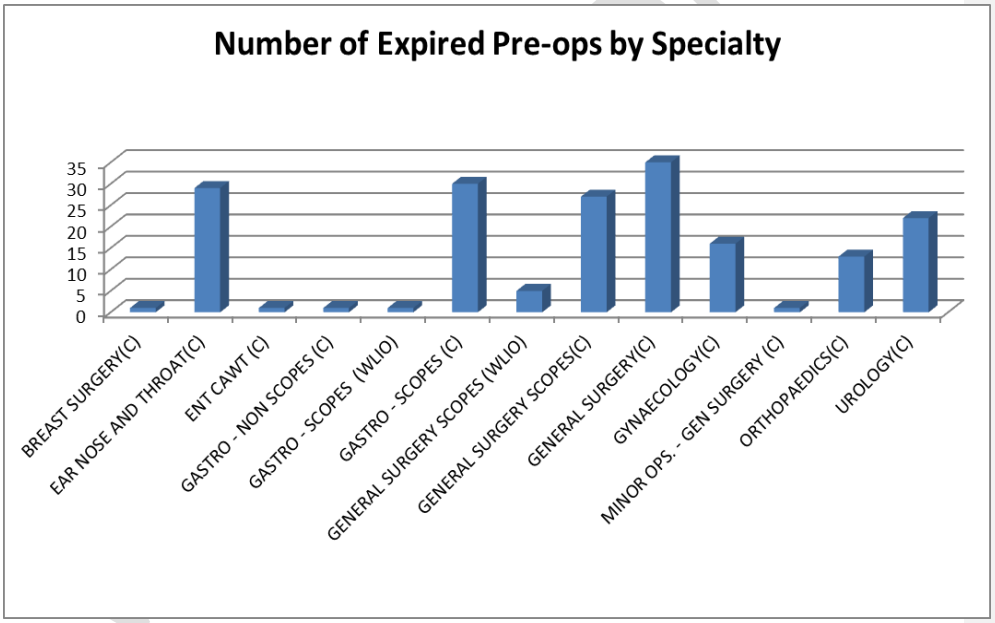
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2 Expiration of Pre operative Assessments

Findings

A paper Pre-op assessment questionnaire should be completed by patients following their attendance at a surgical outpatient clinic when advised that they require surgery. When the questionnaire /NIECR is reviewed by Pre Op Asssement staff, there is an escalation process in place for patients deemed more at risk or with certain conditions. Pre-operative assessments remain valid for a period of 3 months (13 weeks) from completion i.e. when the patient is passed fit for surgery. With the growth in waiting lists for urgent and routine procedures, particularly in specialties such as ENT, General Surgery, Orthopaedics, and Urology, there may have been significant change in the patient's condition over the intervening period since they were initially seen in POA or added to the inpatient waiting list, with in excess of 2 years or longer not unusual. This also means pre-op staff are reviewing patient data which is significantly out of date and consequently this increases the time necessary to review and update patient data.

An analysis of POAs from PAS for the 6 month period 1st October 2018 to 31st March 2019 against all elective inpatients and daycases recorded for the 3 month period 1st January 2019 to 31st March 2019 found there were 2,161 Elective Inpatient / Daycase patients that had a POA. In 182 (8.4%) of these cases, the time between (date of surgery – date of latest pre-op) was greater than 13 weeks. An analysis of exceptions by specialty is shown in the graph:



Implication(s)

Patient safety risks where POAs are out of date (greater than 13 weeks) particularly for routine / urgent patients who have been on waiting lists for considerable periods of time and their condition has changed / deteriorated significantly impacting their fitness for surgery.
Potential for greater risk of cancellation of surgery on the day of planned operation, resulting in loss of theatre time.
Increased time for aged referrals to be fully pre-operatively assessed / update patient clinical data. Also where time is limited ahead of theatre slot this potentially increases risk of rushing through patient's fitness for surgery.

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Where POAs must be completed more than once there is potentially a negative patient perception of the service efficiency and duplication of information.

Recommendation 2.1	Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including General Surgery, Gastro, ENT and Urology.
Priority	2
Management Action	**ACCEPTED / REJECTED** – Needs further discussion with auditors as ? understanding of expiry of pre op assessment
Responsible Manager	Pre-op Sister
Implementation Date	

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3 Patient Consent

Findings

It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting treatment or physical investigation. For consent to be valid it must be voluntarily given by an appropriately informed person who has capacity. We observed that the Trust's Policy on Gaining Consent is dated November 2009, and has not been subject to review since then and no regular training for new doctors.

Discussions with 8 consultants found that they were very aware of the issues and risks around consent and when it should be discussed with patients etc.

Of the 105 patient files and corresponding procedures examined, there were 5 cases where there was no consent form completed. In discussion with clinical staff it was deemed appropriate that there was no consent form due to the nature of the procedures. While all remaining 100 consent forms had been signed by the patients, the following exceptions were observed in completion of consent forms:

- 9 consent forms were not signed by the consultant evidencing the patient had consented to the procedure to be performed;
- 80 consent forms the copy had not been given to the patient;
- 5 consent forms did not outline benefits / risks etc discussed with the patient;
- 88 consent forms did not record evidence that relevant information leaflets on the surgery / procedures had been provided to the patient.

Implications

Absence of up to date policy and corresponding training may expose the Trust and clinicians to additional risks.
Non-recording of all aspects of the consent process could call into question the validity of consent where there is a subsequent complaint or legal action by or on behalf of the patient.

Recommendation 3.1	Management should review and update its Policy on Gaining Consent to ensure all the latest legal and ethical standards have been incorporated into the policy.
Priority	2
Management Action	**ACCEPTED / REJECTED - Accepted**
Responsible Manager	Associate Medical Director
Implementation Date	April 2021

Recommendation 3.2	All medical staff should be reminded of the importance of fully completing patient consent forms in order to fully comply with Trust procedures and minimise risk of future queries / concerns from patients.
Priority	2
Management Action	**ACCEPTED / REJECTED - Accepted**
Responsible Manager	Associate Medical Director
Implementation Date	April 2021

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4 Pre operative Assessment Policies / Procedures and Database

Findings

There are no documented procedures available for pre-operative assessment. We did note that within the POA Team a patient pathway flow-chart has been developed for internal use.

The database system within the Pre-operative Assessment Department for managing the referral of patients has been developed using an Excel spreadsheet and is very basic in recording patients referred to the service and recording actions taken. Testing found issues such as inconsistent recording, use of colour coding and variable quality of notes. Additionally Internal Audit was unable to use the database to match patient records to corresponding PAS data to verify completeness of records. There are separate databases for CAH and DHH~~STH~~ sites.

Implication(s)

Absence of clear documented policy and procedures resulting in ambiguity in processes for staff particularly new or inexperienced staff
Incomplete or inaccurate POA records e.g. not all attendees recorded or actions taken.

Recommendation 4.1	Management should produce comprehensive policy and procedures for pre-operative assessment processes and its interfaces with specialties and scheduling teams etc.
Priority	2
Management Action	**ACCEPTED / REJECTED** **Accepted**
Responsible Manager	Clinical Lead for Pre-Op, Head of Services, Lead Nurse for Pre-op & Pre-op Sister
Implementation Date	June 2021

Recommendation 4.2	Management should further document and strengthen its POA database procedures for managing and recording of pre-operative assessments to ensure quality and consistency of records.
Priority	2
Management Action	**ACCEPTED / REJECTED** **Accepted**
Responsible Manager	Clinical Lead for Pre-op and ATICS Head of Service
Implementation Date	Implementation date will be dependent on the introduction of Encompass and any funded required for a database system

Recommendation 4.3	In the longer term Management should assess the need to develop a more comprehensive solution to managing and recording pre-operative assessments, integrated with PAS / NIECR etc.
Priority	2
Management Action	**ACCEPTED / REJECTED** **Accepted**
Responsible Manager	Clinical Lead for Pre-op and ATICS Head of Service
Implementation Date	? April 2023 Implementation date will be dependent on the introduction of Encompass and any funded required for a database system

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Appendix A Definition of Levels of Assurance and Priorities

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.

Working Draft

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

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and other findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in in fulfilling their responsibilities.

Internal Audit Service – Ballymena Office
Greenmount House
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BALLYMENA
BT42 4TP
TEL 028 95362540

Internal Audit Service – Londonderry Office
Lime Cabin
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Clooney Road
LONDONDERRY
BT47 6WJ
TEL 028 95361727

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Pinewood Villa
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ARMAGH
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TEL 028 95361629

Working Draft

-

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

Southern Health and Social Care Trust

Quality Care - for you, with you

CAH Main Theatres

Measurement of Blood Loss in Theatre

Date: Time:

- 5 Small dry swabs in plastic container – 60g.
- 5 Large dry swabs in plastic container – 275g.

Addressograph

Weight of Small Swabs	Weight of Large Swabs	Output via Suction	Total
Total – 60g	Total – 275g	Total – Irrigations	

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

Weight of Small Swabs	Weight of Large Swabs	Output via Suction	Total
Final Total:	**Final Total:**	**Final Total:**	**Final Total:**

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Procedure for Calculating Blood Loss

Calculate Total Blood Loss in Swabs:

- Dry abdominal swabs & container & lid = 298g
- Dry small swabs & container & lid = 80g

Calculate Total Volume of Fluid in Suction:

- Hold suction canister up straight and check the volume in the canister at eye level to get an accurate record.

NB. *Do not add gelling agent until blood loss has been calculated as this alters the volume.*

- If using more than one suction canister, record the volume of blood on the lid of the suction canister when it is removed from the suction carousel and then add gelling agent so that blood loss can be calculated at the end of the case.

Calculate Total Volume of Irrigation Fluid used:

- When the surgical team is finished with irrigation, spigot the bag and weigh it to obtain a record of how much irrigation was used intra-operatively. The empty bag and spigot weighs 68g.

1g = 1ml

3000 – Volume left in bag – 68g = volume of irrigation used.

NB. Include the volume of table irrigation used by the Scrub Nurse.

Calculate Blood Loss:

- (Volume in suction + volume in swabs) – Volume of irrigation used = blood loss.

It is the responsibility of the Anaesthetic Nurse to calculate blood loss. If the Anaesthetic Nurse has gone to check in the next patient, she must delegate another Nurse to complete blood loss calculation and document it.

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Southern Health and Social Care Trust

Quality Care - for you, with you

Standard Operating Procedure

Title	Measurement of Blood Loss in Theatres
Document No	SHSCT / CAH / SOP
Revision Status	*5/2/20*
Author	Sr Johnston, Sr McArdle, Sr Naomi Henderson
Date	Feb'20
Review Date	Feb'21
Scope of the Procedure	Southern Trust Guidelines for the Management of Massive Blood loss Policy all staff familiar with policy working in surgery and endoscopy and staff are familiar with measurement and recording of blood loss.
Qualifications Required	RGN/HCA/NA/TA

Risks and Countermeasures	**Risks**	**Countermeasures**
	1. Not familiar with Massive Blood Loss Policy 2. Not identifying significant blood loss during surgery or endoscopy procedure 3. Incorrect recording of blood loss during a procedure in Theatres 4. Inadequate communication of blood loss	1. Massive Blood Loss Policy part of induction of all nursing staff 2. Use specific Theatre measurement of blood loss in Theatres 3. Ensure staff trained in weighing of swabs containing blood and the recording blood loss 4. Advise staff on essential communication during massive blood loss to surgeon and anaesthetist.

Emergency Shut Down Procedure (if equipment)	

Step No	**Instruction**	**Photograph / Diagram**
1.	All staff are advised of Massive Blood Loss Policy as part of their induction	
2.	Massive Blood loss simulation practice for teams minimum once per year in theatres/endoscopy areas	
3	All nursing and HCA undergo Blood competencies within theatre/endoscopy environment.	
4	Link nurses trained to be assessors in Blood competencies for nursing and medical staff.	
5	**Swab weighing and Blood Loss Calculation:** Swab weighing is used to determine blood loss and is normally requested by the anaesthetist.	

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6	Blood loss measurements are determined by deducting dry swab weight from used swab weight.	
7	Various manufacturers' swabs and mops have different dry weights, so dry swabs and packs should be weighed to determine the actual weight, unless the specific weights are already known. Swabs can be weighed singly, or in multiples of five according to the degree of blood loss and the age of the patient (blood loss being more critical in children).	
8.	Blood clots and contents of suction containers must be included in the blood loss total. NB Do not add gelling agent until measurements recorded as this alters the volume	
9.	A running total of blood loss is recorded on the 'Measurement of Intraoperative Blood Loss Form' and documented on the Theatre whiteboard for the anaesthetist and surgeon to see. It is the responsibility of the Anaesthetic Nurse to calculate blood loss. If the Anaesthetic Nurse has gone to check in the next patient, she must delegate another Nurse to complete blood loss calculation and document it.	.
10.	Regular communication of blood loss from swabs and suction containers must be communicated to anaesthetist who will keep surgeon up to date with on going progress.	
11	To estimate blood loss, fluids used surgically should be deducted from the total.	
12	This form must be filed in the patient's notes.	
13	*See Appendix 1 Procedure for Calculations Blood Loss*	
14	*See Appendix of Measurement of Intraoperative Blood Loss & Urinary Output*	

Southern Health and Social Care Trust

Quality Care - for you, with you

CAH Main Theatres

Measurement of Blood Loss in Theatre

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Weight of Small Swabs	Weight of Large Swabs	Output via Suction	Total
Final Total:	**Final Total:**	**Final Total:**	**Final Total:**

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Southern Health and Social Care Trust

THEATRE / RECOVERY
Care Pathway

Emergency	
Urgent	
Routine	

Write patient details or affix addressograph with HCN

Site	
CAH	
DHH	
STH	

NAME (CAPITALS)	SIGNATURE	INITIALS	DESIGNATION	ROLE

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PATIENT'S NAME.....HOSPITAL NUMBER.....

Specimens

Pathology [ ] Bacteriology [ ] Haemotology [ ] Biochemistry [ ] Other [ ]

Frozen section [ ] Time frozen section left department _____ None [ ]

Details checked by 2 nurses / 1 nurse / HCA [ ]

Specimens recorded in specimen book **Yes** [ ] **No** [ ] **N/A** [ ] Specimens Labelled **Yes** [ ] **No** [ ] **N/A** [ ]

Left for collection **Yes** [ ] **No** [ ] **N/A** [ ]

Pathology ---------- Time Collected ----------

Frozen Section ---------- Time Collected ----------

Urgent Specimen ---------- Time Collected ----------

IV Fluid Record Applicable [ ] Non Applicable [ ]

Line 1 Site				**Line 2 Site**			
Time	**Type of Fluid**	**Amount**	**Total**	**Time**	**Type of Fluid**	**Amount**	**Total**
Line 3 Site				**Catheterised At:**	**OUTPUT:**	**Residual**	

Input Total	
Line 1	
Line 2	
Line 3	
Intra-operative irrigation	
Total input	

Output Total	
Urine	
Blood Loss/Suction	
Blood Loss/ Swabs	
Nasogastric/Suction	
Total Output	

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Daily Fluid Balance & Prescription Chart

WIT-48297

Write in CAPITAL LETTERS or use addressograph

Surname: _____

First names: _____

Consultant: _____ Ward: _____

Hospital no: _____ DOB: _____

Health and Care no: _____

Hospital _____

Ward _____

Date _____

June 2014

Special Instructions:

For Hourly, Cumulative fluid recording today **Yes** ☐

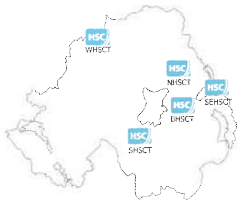
Adult

From their 16th birthday

FLUID INPUT (ml)

FLUID OUTPUT (ml)

	ORAL FLUID				INTRAVENOUS FLUID & MEDICINES* *Include volume of infused medicines										FLUID OUTPUT (ml)											
	ORAL		ENTERAL										Hourly Amount IN	Grand Total IN	URINE		BOWEL						COMMENTS		Hourly Amount OUT	Grand Total OUT	Overall Balance	Initials
	Fluid Type		Fluid Type		Fluid Type		Fluid Type		Fluid Type		Fluid Type																	
	Amount	Total	Amount	Total	Amount	Total	Amount	Total	Amount	Total	Amount	Total			Amount	Total	Amount	Total	Amount	Total	Amount	Total						
08.00																												
09.00																												
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06.00																												
07.00																												



INTAKE	8am	Day	8pm	Night	8am	Total
Oral						
Enteral						
Intravenous						
Grand Total IN						

—

OUTPUT	8am	Day	8pm	Night	8am	Total
Urine						
Bowel						
Other						
Other						
Grand Total OUT						

=

24 hour Fluid Balance (ml)

Balance

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

WIT-48298

ADULT

Write in CAPITAL LETTERS or use addressograph

Surname: _____

First names: _____

Consultant: _____ Ward: _____

Hospital no: _____ DOB: _____

Health and Care no: _____

Recent Weight _____ kg

Weighed ☐ __/__/__

Estimated ☐

Yesterday's Date	Grand total in	Grand total out	Balance

FLUID PRESCRIPTION ADVICE FOR ADULTS

Fluid therapy should involve the consideration of:-

- RESUSCITATION = B Fluid bolus volume for hypovolaemic shock.
- ROUTINE MAINTENANCE = M Varies with clinical state.
- REPLACEMENT - Correction of any obvious fluid deficit = D and ongoing losses = O (e.g. vomiting, drainage, insensible, diarrhoea).
- REDISTRIBUTION - Patients with [illegible] cardiac or cardiac disease, malnutrition, refeeding issues or post-operative.
- REASSESSMENT - include clinical assessments & glucose and U&E at least 24 hourly.
- Use the **oral** or **enteral** route whenever possible for giving fluids.
- Daily insensible loss = 500 - 800 ml.

Types of Fluid

Sodium chloride 0.9% provides the most important extracellular ions. It is indicated when RESUSCITATION by a fluid bolus is needed for shock and in sodium depletion. The administration of large volumes may give rise to sodium accumulation, oedema, and hyperchloraemic acidosis. *Compound sodium lactate (Hartmann's solution)* contains 5 mmol/L of potassium) can be used instead of isotonic sodium chloride solution during or after surgery, or in the initial management of the injured or wounded; it may reduce the risk of hyperchloraemic acidosis. *5% glucose (dextrose)* is an important source of free water for maintenance, but should be used with caution as excessive amounts may cause dangerous hyponatraemia, especially in the elderly.

ROUTINE MAINTENANCE fluids replace the normal fluid content of oral food intake, insensible loss & urinary output and are prescribed to provide optimal hydration in patients unable to fully use the oral or enteral route. Maintenance fluids should take into account the volume of fluid to deliver IV medications (antibiotics, analgesics). The total (oral, IV drugs and prescribed fluids) volume prescribed in healthy adults (without excess fluid losses) should be of the order of 30 ml/kg/day up to a maximum of 2.5L. Consider prescribing less fluid (e.g. 20-25 ml/kg/day) for patients who are older, frail, have renal impairment or cardiac failure. Consider using ideal body weight for obese patients.

Sodium requirement - 1 to 2 mmol/kg/day, so it is rarely necessary to give more than 1 litre of sodium chloride 0.9% or Hartmann's solution per day for maintenance IV fluids. Antibiotic and analgesic infusions may already provide some of this.
Potassium requirement - 1 mmol/kg/day, adjusted according to the serum potassium.
Phosphate, Magnesium - monitor & correct.

Many patients have specific needs to cover REPLACEMENT and/or REDISTRIBUTION of fluid and electrolytes.

REPLACEMENT of deficits & on-going losses - prescription should reflect the electrolyte composition of the fluid being lost.
Gastric losses - replace volume for volume with sodium chloride 0.9% with added potassium as required.
Lower Gastrointestinal losses - replace with Hartmann's solution or, if extra potassium is needed, sodium chloride 0.9% with added potassium.

Infusion Rates		
mls	hrs	ml/hr
500	4	125
500	6	83
1000	4	250
1000	6	167
1000	8	125
1000	12	83
1000	24	42
2000	24	83

Some patients have problems of internal REDISTRIBUTION and may develop sodium and water excess (leading to oedema and weight gain) which frequently can occur in the context of a low intravascular volume (and associated low urine output). Prescribing appropriate IV fluids for patients with redistributive type problems is particularly difficult since too little leads to intravascular hypovolaemia, low blood pressure, poor urine output and poor tissue perfusion, whilst too much may promote more oedema. In these patient groups, formulae-based equations should be used with caution. Fluid restriction may be needed and should be guided by senior input and regular REASSESSMENT.

Senior help should always be sought for complex on-going fluid losses, when the balance between fluid overload and deficit is unclear, for complex redistribution issues and especially when patients have diminished organ reserve.

*Based on NICE CG174

Solution	Composition of common intravenous solutions (mmol/L)				
	$[Na^+]$	$[Cl^-]$	[Glucose]	[Lactate]	$[K^+]$
5% Glucose (Dextrose)	0	0	278	-	-
0.45% Sodium Chloride	77	77	0	-	-
0.45% Sodium Chloride + 5% Glucose (Dextrose)	77	77	278	-	-
0.9% Sodium Chloride	154	154	0	-	-
Compound Sodium Lactate - Hartmann's solution	131	111	0	29	5
Plasma substitutes: gelatins, etherified starches	140 - 154	118 - 154	0	0 - 30	0 - 5
Plasma	135 - 145	95 - 108	3.5 - 7.0	0.4 - 2.2	3.5 - 5.0

Indications - all that apply: Fluid Bolus volume, Deficit, On-going loss volume, Maintenance, Drug Prescription

* Medicines must be recorded in Drug Kardex

** Model name, Serial number.

	Date	Time	Volume	Infusion Fluid/Type	Additives *	Rate ml/hour Range	Prescriber's Signature	Administered By	Checked By	Batch/Lot No. & Expiry Date	Pump Details **	Start Time	Finish Time	Volume given
				ⓐ										
				ⓑ										
				ⓒ										
				ⓓ										
				ⓔ										
				ⓕ										
				ⓖ										
				ⓗ										
				ⓘ										
				ⓙ										

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

AUDIT OF APPROPRIATE VTE PROPHYLAXIS & DOCUMENTED RISK ASSESSMENT

Ward _____

Auditor: _____

Week Commencing: _____

DATE	H&C NUMBER	ENOXAPARIN VTE PROPHYLAXIS PRESCRIBED?		IF YES, WAS IT IN LINE WITH TRUST POLICY?		IF NO, WAS IT CONTRA-INDICATED?		IF NOT CONTRAINDICATED, DOCUMENT REASON FOR DEVIATION FROM TRUST POLICY	WAS THERE A DOCUMENTED RISK ASSESSMENT?		ALL ELEMENTS PERFORMED? I.E. APPROPRIATE PRESCRIBING & RISK ASSESSMENT COMPLETED		IF APPLICABLE: NAME OF DOCTOR WHO DID NOT COMPLETE RISK ASSESSMENT FORM
		Y	N	Y	N	Y	N	Comment	Y	N	Y	N	

Please e-mail your completed audit form at the end of each week to Patient.Safety@southerntrust.hscni.net. Thank you.

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

2 Venous Thromboembolism (VTE) Risk Assessment for Hospitalised Adults (excluding obstetric patients)

Patient Name: WIT-48300

H&C Number.: _____ DOB: _____

Step 1: Assess for level of mobility – All patients

	Tick		Tick		Tick
Surgical patient		Medical patient expected to have ongoing reduced mobility relative to normal state		Medical patient NOT expected to have significantly reduced mobility relative to normal state	
Assess for thrombosis and bleeding risk below (Complete steps 2 – 5)				Risk assessment complete (Go to step 5)	

Step 2: Review thrombosis risk

Any tick for thrombosis risk factors should prompt consideration for thromboprophylaxis

Patient related	Tick	Admission related	Tick
Active cancer or cancer treatment		Significantly reduced mobility for 3 days or more	
Age >60		Hip or knee replacement	
Dehydration		Hip fracture	
Known thrombophilias		Total anaesthetic + surgery time >90 minutes	
Personal history/first degree relative with history of VTE		Surgery involving pelvis or lower limb with anaesthetic + surgery time >60 minutes	
One or more significant medical comorbidities (eg. heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)		Acute surgical admission with inflammatory or intra-abdominal condition	
Obesity (BMI >30kg/m^2)		Critical care admission	
Use of hormone replacement therapy		Surgery with significant reduction in mobility	
Use of oestrogen-containing oral contraceptive therapy		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Varicose veins with phlebitis			
Pregnancy or <6 weeks post partum (see obstetric risk assessment for VTE)			

Step 3: Review bleeding risk

Any tick should prompt staff to consider if bleeding risk is sufficient to preclude pharmacological intervention

Patient related	Tick	Admission related	Tick
Active bleeding		Neurosurgery, spinal surgery or eye surgery	
Acquired bleeding disorder (such as acute liver failure)		Lumbar puncture/epidural/spinal anaesthesia expected in the next 12 hours	
Concurrent use of anticoagulants known to increase risk of bleeding (such as warfarin with INR >2 or DOAC/NOAC such as apixaban, dabigatran, edoxaban or rivaroxaban)		Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	
Acute stroke		Other procedure with high bleeding risk	
Thrombocytopaenia (Platelets <75x10^9/l)		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Uncontrolled hypertension (>230/120mmHg)			
Untreated inherited bleeding disorder (such as haemophilia and von Willebrand's disease)			

Step 4: Tick the appropriate risk category

		Tick		Tick		Tick
Risk of VTE	High risk of VTE with low bleeding risk		High risk of VTE with significant bleeding risk		Low risk of VTE	
Thromboprophylaxis prescribed on kardex?	Yes		Type prescribed		Pharmacological eg. LMWH	
	No				Mechanical	

Step 5: Signature

VTE risk assessed on admission

Signature: _____ Print Name: _____

Date: _____ Time: _____

VTE risk should be re-assessed within 24 hours and whenever clinical condition changes

For further information on pharmacological and mechanical prophylaxis, refer to Trust Thromboprophylaxis Policy

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

What can I do to reduce the risk of a blood clot?

When you are unwell at home or in hospital (including recovering from an operation), it is important for you to move about when it is safe to do so. If you have difficulty moving around, you should move your toes, calf and leg muscles frequently, even if your leg is injured or in a cast.

It is also important to keep well hydrated. Ask your doctor how much you can drink.

What are the signs and symptoms of a blood clot?

If you experience any of the following symptoms during an illness, during a hospital stay or recovery at home, seek urgent medical advice at an Emergency Department or fracture clinic:

- pain or swelling in the leg;
- the skin on your leg becomes hot or discoloured (red, purple or blue);
- if you have a fractured leg, then any increase in pain or swelling, which does not settle when you elevate your leg for a period;
- your feet are numb or tingling;
- the veins near the surface of your legs appear larger than normal or you notice them more;
- you become short of breath;
- pain in your chest, back or ribs, which gets worse when you breathe in deeply;
- you cough up blood.

Where can I get more information?

The following healthcare professionals can provide you with further information or answer any questions you may have:

- the doctors and nurses looking after you in hospital;
- your Emergency Department or fracture clinic staff;
- your GP;
- your pharmacist;
- your physiotherapist;
- your practice nurse or district nurse.

Other useful contacts

National Institute for Health and Care Excellence
www.nice.org.uk

Lifeblood: the thrombosis charity
www.thrombosis-charity.org.uk
Tel: 01558 650 222

HSC Public Health Agency

Public Health Agency, 12–22 Linenhall Street, Belfast BT2 8BS. Tel: 0300 555 0114 (local rate).

www.publichealth.hscni.net

Adapted with permission from University Hospital of South Manchester and developed by the Northern Ireland VTE Collaborative Advisory group in conjunction with the HSC Safety Forum

01/15

HSC Health and Social Care

A guide to preventing blood clots





Patient information leaflet

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

What is a blood clot?

When you are inactive for a period of time, blood tends to collect in the lower parts of your body, often in the lower leg. This makes your blood move around your body more slowly, which can trigger a blood clot (also known as thrombus) to form and may block your veins.

Blood clots are more common in people who are unable to move freely, either due to continuing health problems or for temporary reasons such as taking a long journey, having an operation, being in bed with illness, having a leg cast or needing to use a wheelchair.

When a clot forms in one of the deep veins in your leg, thigh, pelvis or arm it is known as a deep vein thrombosis (DVT). The blood clot may cause long-term damage to your veins. If the clot comes loose, it can be carried to your lungs where it can cause a pulmonary embolism and this can be life threatening.

It is important that you understand why you may be at risk, what can be done to reduce your risk and also how to recognise the signs of a blood clot.

Why am I at risk of a blood clot?

There are certain things that may make you more likely to develop a blood clot around the time of an illness, operation or hospital admission.

Risk factors for developing blood clots:

- you or a member of your family has had a blood clot before;
- you are having an operation (note: you may be at even greater risk if you take a long journey in the four weeks before or after your operation);
- your ability to move is impaired for any reason;
- you are over 60 years of age;
- you are overweight;
- you have long-standing problems with your heart and lungs;
- you have had a recent heart attack or stroke;
- you have cancer or have had recent chemotherapy;
- you are on the combined pill, take hormone replacement therapy (HRT), are pregnant or have given birth within the last six weeks;
- you have inflamed varicose veins;
- you have a disorder that makes your blood more likely to clot;
- you have certain other health problems, eg some types of infections, inflammatory bowel disease or rheumatic conditions.

What methods may be used to reduce my risk of a blood clot?

The risk factors you have will help your healthcare professional decide which preventative methods to use on you. If you also have an increased risk of bleeding, that may determine which method is chosen.

- **Compression stockings**
  These are elasticated stockings specially designed to reduce the risk of blood clots. The stockings gently squeeze your feet and legs, helping your blood to move around your body more quickly.

  It is important to wear the stockings correctly until you are back to your usual level of activity.

- **Inflatable Compression Devices (ICDs)**
  These go around your legs (and sometimes feet) and inflate automatically at regular intervals.

  When inflated, they apply pressure which keeps your blood moving around your body.

- **Anticoagulants**
  These medicines can be used to prevent clots from forming and can be given as an injection under your skin or as a tablet. The drug normally prescribed in Northern Ireland is Heparin, which is given by injection. Heparin is of animal (porcine) origin so if you have any concerns about using animal products, please alert your doctor and he or she will discuss your other options.

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

Action Plan Patient 90

Reference number	Recommendations	Designated responsible person	Action required	Date for completion / timescale	Date recommendation completed with evidence
1	The Trust should develop and implement guidance for clinical result sign off. Monthly audit of sign off will be presented to the Governance Fora	NIECR/Governance group	Develop and implement guidance. **10/2/21** Update from Trudy Reid: Governance / NIECR group is working on clinical result sign off pre COVID. Good progress has been made with sign off numbers progressing, The last reports attached. Some delegation of sign off to nursing/midwifery was happening in specialist services Start has been made in the development of a policy Kate Cunningham had been doing sterling work at ward level Siobhan Hanna was seeing if we could get access to develop a dash board for		Electronic Sign-off (Laboratory) V0_2.dc 31052019_NIECR Project Board Minutes Dashboard sign off.docx

DRAFT

			result sign off		
2	All patients undergoing elective surgery must have a formal pre-operative assessment completed prior to surgery, including liaison with other specialties to ensure maximal optimization of patients prior to procedure. The Trust will update the pre-operative guidance to recommend appropriately timely referral times and escalation of non-attendance. Audit of surgical patient pre-operative assessment should be undertaken and be presented to the Governance Fora	Helena Murray	Update pre- operative guidance. An annual audit of patient charts re evidence of pre-operative assessment. **10/2/2021 –** Pre-operative guidance links attached internal audit completed a POA audit in Oct 2019 (page 7 of attached report).		Preoperative assessment | The Royal College of Anaesthetists (rcoa.ac.uk) Pre-operative assessment and patient preparation: the role of the anaesthetist (rcoa.ac.uk) Overview | Routine preoperative tests for elective surgery | Guidance | NICE PreOpandConsent19 20workdraft amendm
3	Discussions regarding the risks and benefits of surgery must be clearly documented in the patient record and reflected on the patient consent form, to ensure patients are able to make informed consent. Audit of surgical patient consent should be undertaken and be presented to the Governance Fora	Helena Murray	An annual audit of patient charts re evidence of informed consent and present findings at Governance Fora. **10/2/2021 –** HOS has checked with M&M leads of any audits		

DRAFT

			have been undertaken re consent. None have been completed in past year due to covid.		
4	Blood loss during procedure should be escalated during and at the end of the procedure, the blood loss must be recorded on the operation note. Blood loss post operatively must be escalated to the surgical and anaesthetic teams.	Helena Murray	Updating the Standard Operating procedure for blood loss during and post-surgery **10/2/2021** – Blood loss procedure is incorporated in to the care pathway, anaesthetic sheet and induction. Evidence attached		Measurement of Blood Loss Theatres.(Procedure for Calculating Blood Loss SOP for Measurment of Bloss Loss in Theat Measurement of Blood Loss.docx pathway.pdf fbc.pdf
5	VTE risk assessment must be completd for all patients prior to surgical intervention.	Helena Muray	A monthly audit of compliance with VTE assessment.		file (4).pdf

DRAFT

			10/2/2021 - point number 5 in the action plan is not met and will not be met. A VTE risk assessment for all inpatient elective patients is completed (attached as evidence) prior to surgical intervention. Patients whose intended procedure is a day-case will not have a VTE risk assessment completed. If they end up being a failed day-case their VTE risk assessment is completed when it is known that an overnight stay is going to be required. VTE assessment is not carried out At POA, a leaflet to patients who attend POA and they sign to say they have received it – "A Guide to preventing blood clots" by Public Health agency (attached as evidence)		 file.pdf  blood clot leaflet copy.pdf

DRAFT

Department of Justice

State Pathologist's Department

Institute of Forensic Medicine

Grosvenor Road

Belfast BT12 6BS

Tel: Personal Information redacted by the USI. (Direct) or

Personal Information redacted by the USI.

FNo. Personal Information redacted by the

Date: 19 July 2018

To Senior Coroner/Coroner for N.I.
Coroners Service for Northern Ireland

Dear Mr McGurgan

Tissues/Organs Retained at Autopsy

I wish to inform you that the report of the postmortem examination which was carried out on the body of -

Patient 90

was dispatched to you today.

As you will see from the Schedule of Retained Materials in the autopsy report, the following were retained for further examination:

1. ☑ Tissue samples for histology – **now** retained as paraffin embedded blocks and on glass microscopy slides.
2. ☐ Sample(s) of blood/urine/gastric contents/tissue (.....) for alcohol analysis/toxicology (retained in State Pathologist's Department prior to disposal).
3. ☐ Sample(s) of blood/urine/vitreous/tissue (.....) for biochemistry/microbiology (sample(s) consumed or destroyed following analysis).
4. ☐ Heart / Brain / (Other) .....

Now that the report has been completed I should be obliged if you would advise me, on the enclosed form PM3, as to how you wish the retained material, **including body fluids/tissue retained by State Pathologist's Department**, to be dealt with.

Please note:

1. It is **recommended** that the tissue blocks and slides be retained indefinitely as part of the medical record. If permission for retention of this material is given please also determine whether it can be used for teaching and/or research purposes.

2. That the retained organ material listed under (4) above is **NOT** required for either teaching or research purposes and therefore this option **should not** be offered to the next of kin.

Yours sincerely

Personal Information redacted by the USI

Pathologist

PM1

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

CORONER'S INSTRUCTIONS FOR DISPOSAL/RETENTION OF ORGANS/TISSUES/FLUIDS RETAINED AT POSTMORTEM EXAMINATION

From The Senior Coroner/Coroner – Coroners Service for Northern Ireland Regarding the death of – [redacted] Patient 90 Personal information redacted by the USI	**The following instructions were obtained from:** ..... **Relationship to deceased:** .....
Tissue(s) Retained for Histology: (Slides & Blocks) ☑ Paraffin embedded tissue blocks ☑ Glass microscopy slides *(A full inventory of the slides/tissues blocks can be provided on request)*	**SLIDES & PARAFFIN BLOCKS:** ☐ (i) The slides/blocks may be retained for the purpose of obtaining medical information which may be relevant to any other person (including a future person) ☐ (ii) may/may not be used for teaching and/or research purposes. ☐ (iii) The slides/blocks are to be returned to a funeral director instructed by the next-of-kin. ☐ (iv) The slides/blocks should be disposed of respectfully.
Body Fluid(s)/Tissue Retained for Toxicology: ☐ Blood ☐ Urine ☐ Tissue (specify) ..... ☐ Other (specify)	**BODY FLUID(S)/TISSUES:** ☐ (i) The body fluid sample(s) should be disposed of. ☐ (ii) The tissue sample(s) should be disposed of. ☐ (iii) The body fluid/tissue sample(s) should be retained. ***Specific instructions will be required for retention – please detail overleaf. For health and safety reasons, body fluids should <u>not</u> be offered for return to the next of kin.**
Organ(s)/Organ Parts Retained for examination: 1. ..... 2. ..... 3. ..... 4.	**ORGAN(S)/ORGAN PARTS:** ☐ (v) The organ(s) retained should be disposed of by respectful cremation ☐ (vi) The organ(s) should be retained pending collection by a funeral director instructed by the next-of-kin. ☐ (vii) The organ(s) should be retained pending legal proceedings. ☐ (viii) The organ(s) should be retained indefinitely in the State Pathologist's Dept. on the authority of the Coroner. ***Please note the organ(s) is/are <u>not</u> required for research and/or teaching purposes and this option should not be offered to the next of kin.**

Coroner's Stamp

Signed:.....

Senior Coroner/Coroner for Northern Ireland

Date: .....

PM3(rev)

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

Special instructions in respect of retention of:

(i) .....

(ii) .....

(iii) .....

.....

.....

.....

.....

.....

.....

THE QUEEN'S UNIVERSITY OF BELFAST
DEPARTMENT OF JUSTICE

REPORT OF AUTOPSY

Name: Patient 90 **Sex:** Male **Age:** Personal Information redacted by the USI **F .No:** Personal Information redacted by the USI

Date of Death: Personal Information redacted by the USI CGH

Date and Hour of Autopsy: Personal Information redacted by the USI 9.00 a.m.

Place of Autopsy: The Northern Ireland Regional Forensic Mortuary.

CAUSE OF DEATH:

I (a) INTRA-ABDOMINAL AND RETROPERITONEAL HAEMORRHAGE FOLLOWING CYSTOSCOPY, INSERTION OF URETERIC STENTS AND URETEROLYSIS

II Cardiomegaly

On the instructions of the Coroner for Northern Ireland, Mr. Patrick McGurgan, I, Peter J. Ingram, MB, BCh, FRCPath, DMJ(Path), registered medical practitioner, Assistant State Pathologist for Northern Ireland and Honorary Clinical Lecturer in Forensic Medicine at Queen's University of Belfast, made a postmortem examination of the body of

Patient 90

aged Personal Information redacted by the USI

identified to me in person at the Northern Ireland Regional Forensic Mortuary, on Friday Personal Information redacted by the USI by Constable A. Martin, P.S.N.I. Lurgan. The body was also identified by two hospital wristbands, one ankle band and toe tag.

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THE QUEEN'S UNIVERSITY OF BELFAST
DEPARTMENT OF JUSTICE

Name: Patient 90 **Sex:** Male **Age:** Personal Information redacted by the USI **F .No:** Personal Information redacted by the

Date of Death: Personal Information redacted by the USI CGH

Date and Hour of Autopsy: Personal Information redacted by the USI 9.00 a.m.

Place of Autopsy: The Northern Ireland Regional Forensic Mortuary.

HISTORY:

The following history is based on information supplied to the pathologist, at the time of the autopsy, by the investigating police officer and from other sources. The accuracy of the information contained in the history has not been verified.

He was married and he lived with his wife in Personal Information redacted by the USI He was retired but had previously Personal Information redacted by the USI He had a past medical history of inflammatory periaortitis/retroperitoneal fibrosis and myelodysplasia for which he attended haematology for regular blood transfusions. He was also known to suffer from atrial fibrillation. He had had his appendix removed in the past and had also suffered from lower limb cellulitis. In Personal Information redacted by the USI he underwent stent insertion into his ureters. He smoked ten cigarettes a day but did not drink alcohol.

In Personal Information redacted by the USI he was admitted to hospital with ureteric stent irritation. A CT scan during this admission showed moderate bilateral hydronephrosis despite appropriately positioned stents. It was decided he would be re-admitted the following month on an elective basis for a cystoscopy, replacement of his ureteric stents and bilateral ureterolysis.

He was admitted to hospital on Personal Information redacted by the USI The procedure was undertaken the following day. Personal Information redacted by the USI The intraoperative course was uneventful and he remained haemodynamically stable throughout. He also received prophylactic antibiotics intraoperatively. Postoperatively his blood pressure fluctuated and he required boluses of metaraminol. He was successfully extubated that evening at 6.30 p.m. and transferred to the recovery ward. He subsequently became agitated with a raised heart rate and low blood pressure (51/31 mmHg). He required further boluses of phenylephrine as well as two doses of haloperidol for his agitation. He had a right internal jugular line inserted and was commenced on noradrenaline for inotropic support as well as amiodarone. He initially responded well but his inotropic requirements gradually increased and he was exhibiting signs of cerebral hypoperfusion (confusion) and under perfusion of his kidneys resulting in anurea. He was noted to be cold and clammy peripherally. There was however no shortness of breath or complaints of chest pain. An ECG was unremarkable. His haemoglobin was 8.0 g/dl preoperatively and remained unchanged on subsequent blood testing. There was no evidence of abdominal swelling or of a raised body temperature. Despite the administration of 30 mls. of both noradrenaline and adrenaline his blood pressure remained low at 50 - 60 mmHg systolic. His inotropes were subsequently escalated to 40 mls. each and he was taken back to theatre for reintubation and the insertion of a central line. An initial troponin level was recorded at 26 which rose to 81 after three hours. However the abruptness of the deterioration coupled with global hypoperfusion was suggestive of a cardiac event and there was no evidence of a pulmonary embolism. He was also commenced on intravenous Tazocin to cover the possibility of a septic shower. Intravenous steroids, calcium chloride, digoxin and amiodarone were also given. He went on to develop a profound metabolic acidosis with a pH of 6.7 and a lactate of 17. Further surgery was considered but in view of his haemoglobin remaining stable and a soft abdomen it was decided that this would be inappropriate. A left subclavian dialysis line was inserted and the plan was to dialyse him for his

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metabolic acidosis. An ultrasound showed a left apical pneumothorax in association with the left subclavian and this was confirmed on chest X-ray. A left intercostal chest drain was subsequently inserted. About ten minutes after the chest drain was inserted his heart rate slowed to fifty beats per minutes. A central pulse could no longer be palpated and therefore cardiopulmonary resuscitation was instigated. The cardiac rhythm was of pulseless electrical activity throughout. Mini jets of adrenaline and calcium chloride were administered but the attempts at resuscitation ultimately proved futile. The resuscitative efforts were abandoned and life was subsequently pronounced extinct at 11.10 p.m.

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EXTERNAL EXAMINATION:

The body of an Personal Information redacted by man of good build, weighing Personal Information redacted by the and measuring Personal Information redacted by the USI Rigor mortis was present. A little hypostasis of purple colour stained the back of the body.

Eyes and Conjunctivae: There was arcus senilis of each iris. The conjunctivae were normal.

Ears and Nose: Normal.

Neck: A quintuple lumen intravenous catheter had been inserted on the right side and was held in place by surgical stitches and adhesive tape.

Chest: A dialysis line had been inserted on the left side at the front just inferior to the outer third of the clavicle. It was held in place by surgical stitches and an adhesive dressing. A chest drain had been inserted on the left side in the mid axillary line, 5 cm. inferior to the fold of the axilla, through a surgical incision, 3 cm. long. It was held in place by surgical stitches.

Abdomen: There was a sutured slightly wavy surgical incision, 16 cm. long, extending roughly vertically upwards from the symphysis pubis and bypassing the umbilicus to the right. There was a little bruising of its margins. It had been covered by some absorbent dressing and adhesive tape. Wide bore drains had been inserted in the right left and lower quadrants respectively, the right 5 cm. above and 9 cm. to the right of the symphysis pubis and the left 4 cm. above and 8 cm. to the left of the symphysis pubis. Both were held in place by surgical stitches. An oblique appendicectomy scar, 12 cm. long, was situated in the right lower quadrant.

Right Upper Limb: There were four bruised needle puncture marks on the back of the distal forearm. An intravenous cannula had been inserted through the skin on the back of the hand between the metacarpal bones of the thumb and index finger.

Left Upper Limb: An intravenous cannula had been inserted through the skin in the fold of the elbow and was held in place by an adhesive dressing. About 2 cm. medial to this a fine bore arterial cannula had been inserted and it was held in place by the same adhesive dressing. An intravenous cannula had been inserted through the skin on the back of the hand. There was a cluster of five slightly bruised needle puncture marks on the radial aspect of the distal forearm.

Right Lower Limb: There was brown discoloration of the skin of the distal half of the lower limb. A small surgical dressing had been applied on the inner aspect of the distal calf but when this was removed there was no significant underlying injury.

Left Lower Limb: The skin of the distal half of the lower limb was brown in colour. A small surgical dressing had been applied to the outer aspect of the distal calf. When this was removed there was a small black abrasion, 0.3 x 0.2 cm.

Scrotum: Testes present. A urinary catheter protruded from the tip of the penis.

INTERNAL EXAMINATION:

HEAD:

Brain: 1415 gm. It was pale in colour. Coronal sections at 1 cm. intervals revealed no focal abnormality.

Mouth: Normal. There were natural teeth, in poor condition, in each jaw and a number were missing.
Tongue, Pharynx: Normal.

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NECK AND CHEST:

Hyoid Bone and Laryngeal Cartilages: Intact.

Thyroid Gland: On section normal.

Pericardial Sac: Crossed by a few fine fibrous adhesions.

Heart: 650 gm. Enlarged two times.
Pulmonary Trunk and Valve: Normal.
Aortic Valve: Normal.
Mitral Valve: Normal.
Coronary Arteries: Of large calibre and widely patent although there was patchy focal calcification of their walls. No occlusion was identified.
Atria: Normal.
Left Ventricle: Moderately dilated; 12 mm. thick. There were some subendocardial flame haemorrhages on the septal wall. On section normal.
Right Ventricle: Moderately dilated; 3 mm. thick. On section normal.

Aorta: The abdominal segment was lined by heavily calcified atheroma but there was no evidence of aneurysmal dilatation or rupture.

Pleural Cavities: The tip of a chest drain was sited at the apex of the left chest cavity. There was a little lightly bloodstained fluid within the left pleural cavity. The right was normal.

Larynx, Trachea and Main Bronchi: Normal.

Lungs: The right weighed 605 gm. and the left lung 560 gm. The right lung was reasonably well expanded and the left lung moderately well expanded. They had a fluffy to jelly-like texture. They varied in colour from creamish-pink to reddish-purple. Section revealed no focal intrapulmonary lesion.

Oesophagus: Normal.

Chest Cage: There was a fracture of the 5th right rib towards the front with only slight bruising into the surrounding soft tissues.

ABDOMEN:

Abdominal Cavity: Both drains sat freely within the cavity. Within the cavity was a total of 600 ml. of fluid blood and blood clot, the majority of which was situated in the right paracolic gutter and on the undersurface of the liver. There was also significant, although immeasurable, haemorrhage into the fatty tissues at the back of the abdomen on either side.

Stomach: Normal. It contained a little mustard coloured fluid.

Intestines: Other than the aforementioned retroperitoneal haemorrhage the intestines themselves were unremarkable.

Duodenum: Normal.

Appendix: Had been removed.

Rectum: Normal. Empty.

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Liver: 1550 gm. On section normal.

Gallbladder: Normal.

Spleen: 330 gm. Of good size. On section normal.

Pancreas: Section revealed a slightly fibrotic gland.

Adrenal Glands: On section normal.

Genitourinary System: The bladder contained the tip of a urinary catheter. The bladder was empty. The tip of a pigtail catheter protruded from the right ureteric orifice. Both ureters were dissected and were found to be moderately dilated with patchy reddening of their mucosa. The tip of a pigtail catheter was situated within the distal left ureter. Both ureteric catheters extended into their respective renal pelves. Both kidneys weighed 180 gm. and were pale in colour. There was some haemorrhage into the tissues around the hilum of the left kidney, particularly in the region of the left renal vein. Both renal arteries and veins were dissected and there was significant bleeding around the left renal vein but no evidence of intimal damage. Both renal arteries and the right renal vein were intact. The pelves of both kidneys were moderately dilated but they were otherwise unremarkable.

Prostate: Enlarged three times by white nodules.

SCHEDULE OF RETAINED MATERIALS:

The following were retained for further examination:

1. Tissue samples for histology.

No organs were retained.

MICROSCOPY:

Coronary Arteries: Focally thickened by atheroma but not significantly narrowed. No occlusion was seen.

Left Ventricle: Normal.

Lungs: There was a mild grade of emphysema.

Liver: Slightly autolysed. There was no significant fatty change or cirrhosis.

Kidneys: There were chronic inflammatory cells in the interstitium.

Adrenal Gland: Normal.

Pancreas: Undergoing autolysis. There was a moderate grade of fibrosis.

Retroperitoneal Tissue with Haemorrhage: The presence of bleeding was confirmed.

Brain: Normal.

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COMMENTARY:

The history indicates that this Personal Information redacted by man was admitted to hospital, on an elective basis, to have the inner lining of his bladder examined using a scope, to have stents in the drainage ducts from both kidneys, or ureters, replaced and to undergo ureterolysis – where the ureters are freed from any external pressures or adhesions. His condition was stable during the procedure but afterwards his blood pressure fell and his heart rate increased. He was administered a number of drugs in an attempt to improve his blood pressure but with little success and he died that night.

Death was due to bleeding, or haemorrhage, into the abdominal cavity itself and into the fatty tissues at the back of the abdomen termed intra-abdominal and retroperitoneal haemorrhage respectively. A total of 600 ml., or just over a pint, of blood was present in the abdomen and there was significant bleeding into the retroperitoneal tissues. Whilst no specific bleeding point was identified it was undoubtedly the effect of this blood loss which was responsible for his deterioration after the operation and ultimately his death.

The postmortem examination also revealed that the heart, and in particular its two main pumping chambers the ventricles, was enlarged. Such enlargement of the heart, termed cardiomegaly, would without doubt have made him less able to withstand the stresses placed upon the body by the effects of the blood loss. Indeed the severity of his heart disease was such that it could have caused his death at any time. Therefore as his pre-existing heart disease would have made him more susceptible to the effects of the haemorrhage it would be best regarded as a contributory factor in his death.

No significant other natural disease was detected. He had had his appendix removed in the past but this was merely an incidental finding.

In addition to the abdominal surgery he had also had a drain inserted into his left chest cavity but this played no part in the fatal outcome.

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Clinical Negligence Case Review Summary

Trust Ref: **No Ref**

Legal Dept Ref: Personal Information redacted by the USI

Plaintiff: Patient 90 **(DEC)**

Date of Treatment: Personal Information redacted by the USI

Date of Letter of Claim: Personal Information redacted by the USI

Details: Personal Information redacted by the USI

Specialty – **Urology**

Date of Review Meeting: Personal Information redacted by the USI

In Attendance - **Dr O'Kane, L Hainey, M Harvey**

Personal Information redacted by the USI

IAS 37 Figures:

	Estimated Settlement Figure	Probability
Low	**NIL**	**70%**
Medium	**-**	**-**
High	Personal Information redacted by the USI	**30%**

Estimated Year of Settlement: 2023/24

Date of Issue: Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	Thursday 23rd June 2022	
Agenda item	Update on Clinical concerns within Urology	
Accountable Director	Dr Maria O'Kane Chief Executive	
Report Author	Name	Jane McKimm
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

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

1. Detailed summary of paper contents:

This paper outlines a brief update on the progress in response to the Public Inquiry into Urology Services in the Southern Trust. Given the short timeframe since the last update, it focuses on progress against the S21 notices.

Urology Services Inquiry

Evidence gathering for the USI is continuing. A total of 56 Section .21 Notices have been served on Trust witnesses since 14 April. Of these, 55 are being dealt with by SHSCT/DLS with one former member of staff instructing alternative legal representation.

By Friday 17th June, 18 S.21 Notices had been submitted, with a further 16 Statements to be submitted by 1 July. Two S.21 notices are currently in abeyance – ie. not currently being progressed with agreement from the USI.

USI site visit to Craigavon Area Hospital site.

On Wednesday June 15th, the USI panel visited the Craigavon Hospital site. The visit was at their request, and to help familiarise themselves with areas pertinent to the Inquiry.

They visited Trust Board HQ, Urology Wards, Admin offices in CAH, the Thorndale Unit among other areas.

Panel Members and legal representatives in attendance: Christine Smith (chair), Damian Hanbury (assessor), Sonia Swart (panel member), Martin Wolfe (senior counsel), Laura McMahon (junior counsel) and Eoin Murphy (solicitor).

Patient Lookback Process

As part of the Southern Trust Urology Review lookback exercise the Trust is continuing to progress with contacting and updating patients affected by this.

In December 2021 and January 2022 the Trust wrote to approx. 2114 patients to inform them of the Urology Lookback Review and advise them that their care was being reviewed at this time. The Trust was able to advise many patients (approx. 1300) that there were no concerns with their care. Other patient were informed that the review was ongoing.

The correspondence sent to patients in Dec / Jan referred to the work of the Urology Services Inquiry (USI) however, some of this information in the letters was subsequently found to be inaccurate regarding dates of announcement of the Public Inquiry and the purpose of the inquiry. The Trust has liaised with the USI to inform them of the Trust's intention to write formally to correct this information.

This process has now commenced and the Trust has prioritised the order in which they are sending these update and / or correction letters as follows:

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1. Patients who received initial correspondence that their care was being reviewed and this is complete with no clinical concerns found – their letter will advise this and correct inaccuracies and should not be controversial **(week commencing 6 June and continuing 13 June)**
2. Patients who received initial correspondence that their care was being reviewed and this is now complete – and clinical concerns were identified - their letter update on findings and next steps and correct inaccuracies **(week commencing 13 June)**
3. Patients who review remain incomplete – their letter will be advise there is still no update and inaccuracies will be corrected **(week commencing 13 June)**
4. Patients have had no correspondence to date at all (all correspondence with patients stopped in February '22 when the errors were discovered so some patients didn't get any letter) – their letter will introduce them to the Urology Lookback Review and advise of USI – **(week commencing 13 June)**
5. Patients who have has Structured Clinical Record Review (i.e. the processes which is being conducted in place of the regional SAI process) returned – their letter will update on SCRR and offer patient meetings to discuss further. It will also correct the inaccuracies **(week commencing 13 June)**
6. Patients who receive an original letter with no concerns but included inaccuracies – their letter will correct the inaccuracies (**week commencing 20 June**)

The sending of update and correction letters will continue over the coming weeks in the order detailed above and will cease when complete. All letters will signpost patients / families to the Trust Helpline for extra support.

Update from the USI

In a statement issued on June 13th, Chair of the panel outlined progress on discovery and plans for the patient/family hearings on June 21st, 22nd and 23rd of June.

The full statement can be found here:

Statement from Christine Smith QC, Chair of the Urology Services Inquiry providing an update on the Inquiry's work and planned hearings for June 2022 | Urology Services Inquiry

2. Areas of improvement/achievement:

Work continues in implementing recommendations from the Serious Adverse Incident process.

3. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

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WIT-48321

Healthcare Complaints
Analysis Tool



THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

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

Healthcare Complaints Analysis Tool
version 3, 2015

License

Healthcare Complaints Analysis Tool is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License.



Contact

More details about the Healthcare Complaints Analysis Tool and support for implementing it can be obtained from the authors:

Dr Alex Gillespie and Dr Tom Reader
Department of Social Psychology
3rd Floor
Queens House,
55/56 Lincoln's Inn Fields,
London WC2A 3LJ

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

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INTRODUCTION

This manual provides instructions on how to use the Healthcare Complaints Analysis Tool (HCAT) to analyse complaints from patients and families regarding poor healthcare experiences. HCAT enables organisational listening [1] through aggregating individual healthcare complaints so that patient concerns can facilitate service monitoring and organisational learning.

Why analyse healthcare complaints?

Healthcare complaints are often written with the aim of contributing to the improvement of services [2]. However, the tools for harnessing the potential of these insights have been limited [3-6]. Yet, we know that utilising patient experiences has the potential to enhance the quality and safety of healthcare delivery [7-12]. For example, "low-level" problems in caring for patients and following procedures have been shown to precede adverse events and wide-spread failures in healthcare delivery [13]. Identifying these low-level problems is important for ensuring the resilience and safety of healthcare systems [5], and the monitoring of patient experience is an additional way through which risks to patient safety can be identified [15]. More specifically, analysing letters of complaints to healthcare institutions ("healthcare complaints") made by patients and families is a potentially useful way to assess healthcare safety and quality [3-6].

Healthcare organisations can learn from letters of complaint because patients and their families are sensitive to, and able to recognise, a range of problems in healthcare delivery. Specifically, patients and their families process a huge amount of data, observing and evaluating all healthcare interactions [16]. Indeed, they have privileged access to information on continuity of care [17, 18], communication failures [19], dignity issues [20] and patient centred care [21]. Moreover, once treatment is concluded, patients and their families are relatively free to speak up about their experiences without fear of repercussions [22]. Finally, because patients and their families are outside the given healthcare organisation they provide an independent assessment of that organisation that is grounded in the changing norms and expectations of society [23].

What are healthcare complaints?

"Healthcare complaint" refers to an expression of grievance and dispute, typically written and communicated through a letter by a patient or their family, about the receipt of healthcare [24, 25]. Healthcare complaints are usually written to a healthcare organisation (or regulator) after a threshold of dissatisfaction with care has been crossed [26], are typically written by patients or families on behalf of patients [27], and are often written with the intention of improving future service provision [2]. Although the frequency of healthcare complaints relative to healthcare episodes is low, the total number of complaints can be substantial [6]. For example, the UK National Health Service (NHS) receives over 100,000 annually [28]. Complaints can focus on diverse problems (eg, car parking, prescribing errors), describe different types of harm (eg, physical,

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emotional), and have different underlying aims (eg, resolving upset, creating change, preventing future issues) [6]. The problems raised in a patient letter of complaint are often not identified by traditional systems of healthcare monitoring (eg, incident reporting systems, retrospective case reviews) [29, 30]. However, methodologies for researching patient complaints are poor, and there is a need for systematic and rigorous analytical tool for analysing healthcare complaint letters [3-6, 31, 32].

What is The Healthcare Complaints Analysis Tool (HCAT) for?

HCAT is the first standardised tool for analysing healthcare complaints in a rigorous and conceptually meaningful way. It is also the first tool that can reliability assess problem severity. The tool has been developed equally by Dr Alex Gillespie and Dr Tom Reader at the London School of Economics and Political Science. The tool is based on an empirically derived and theoretically guided framework through which information in a healthcare complaint can be reliably codified and assessed.

HCAT is designed to support healthcare institutions and national or international monitoring institutions. Results from HCAT can be used to: 1) systematically characterise the general and specific problems reported by patients within a particular healthcare institution; 2) differentiate between high and low-performing healthcare institutions (eg, in terms of the severity of problems reported); 3) identify healthcare institutions with especially high risk profiles (eg, in terms of patients reporting severe safety problems); 4) encourage learning and the sharing of information between institutions, and; 5) provide longitudinal data on complaint trends (eg, to test the effect of an intervention to improve patient experience).

HCAT is available under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License. It is free for practitioners and researchers alike to use. Support of varying degrees is available for using HCAT, and those interested should contact the authors, Dr Alex Gillespie and Dr Tom Reader.

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OVERVIEW: THE HEALTHCARE COMPLAINTS ANALYSIS TOOL (HCAT)

WIT-48326

The Healthcare Complaints Analysis Tool (HCAT) is an analytical tool for codifying and assessing the problems highlighted by patients and their families or advocates in letters of complaint. The categories and sub-categories for analysing complaints have been developed through a systematic review of the academic patient complaint literature [6], collaboration with relevant specialists, in-depth analyses of healthcare complaints, pilot studies, and reliability testing [33].

At the centre of HCAT is a coding taxonomy which can be used to distinguish the types of problems raised in healthcare complaints. The taxonomy consists of a three-level hierarchy of "domains", "problem categories", and exemplar "problem indicators" covering 36 sub-categories (for which reliability testing is ongoing). Table 1 outlines the core coding taxonomy. Using the taxonomy, analysts identify and code the types of problems reported by patients in a letter of complaint. Analysts then assess the severity of the problems reported in the letter of complaint, identify where in the care process problems were experienced, and report on the level of harm experienced by patients.

Table 1. HCAT Domains and problem category definitions

CLINICAL PROBLEMS	
Issues relating to quality and safety of clinical and nursing care provided by healthcare staff (ie, doctors, nurses, radiologists, and allied health professionals)	**Quality:** Clinical standards of healthcare staff behaviour
	Safety: Errors, incidents, and staff competencies

MANAGEMENT PROBLEMS	
Issues relating to the environment and organisation within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)	**Environment:** Problems in the facilities, services, clinical equipment, and staffing levels
	Institutional Processes: Problems in bureaucracy, waiting times, and accessing care

RELATIONSHIP PROBLEMS	
Issues relating to the behaviour of any specific member of staff towards the patient or their family/friends	**Listening:** Healthcare staff disregard or do not acknowledge information from patients
	Communication: Absent or incorrect communication from healthcare staff to patients
	Respect and patient rights: Disrespect or violations of patient rights by staff

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Each of the domains, and the problems that underlie them, are conceptually distinct: "Clinical problems" relate to the literature on human factors and safety [7, 34, 35]; "management problems" relate to the literature on health service management [36-38], and; "relationship problems" relate to the literatures on patient perspectives [39], including issues of communication [40], dignity [20], and patient rights [41]. Underlying each category is a number of sub-categories. These sub-categories can be used to classify the specific types of problems being identified within each complaint category (eg, to support organisational learning). However, although these sub-categories are based on a systematic review of the literature [6] and iterative coding [33], the reliability for the use of sub-categories is yet to be ascertained.

Who can use HCAT?

HCAT is free to use. It has been designed to be used by clinical staff (eg, nursing, medical staff), non-clinical staff (eg, administrative, patient experience), and healthcare researchers (eg, health psychologists, risk specialists). HCAT has been tested for reliability and accuracy [33]. The results show that educated users, provided they have been trained with the present manual and practiced with some sample complaints, will be able to analyse healthcare complaints in a similar and consistent manner.

Prior to using HCAT, assessors should:

- understand what a healthcare complaint is
- understand the utility and purpose of analysing complaints
- be familiar with the three-level hierarchy of "domains", "problem categories," and "indicators"
- know how to use the indicators to identify a problem category and severity
- understand how to apply the coding framework to analyse a patient letter of complaint
- understand what a "stage of care" is, and how to code it
- understand the meaning of patient harm
- undergo a calibration exercise whereby they use HCAT on pre-coded example letters (contact the authors for details on this training).

General guidelines

The purpose of HCAT is to support the analysis and aggregation of information on the types of problems experienced by patients and families (as reported in letters of complaint).

The purpose of HCAT is not to: 1) assess the veracity of issues raised by patients; 2) detail the specific clinical problems experienced by patients; 3) focus on the competencies of specific members of healthcare staff, or; 4) support the management of an individual letter of complaint.

When using HCAT, the information reported in a healthcare complaint should be taken at face value, and evaluated in a way that is non-judgemental of either patients or healthcare staff. From the perspective of patients, information provided in a letter of complaint usually reflect an upsetting or concerning experience, and whilst the system makes assessments of the types and severity of those experiences (in comparison to the range of problems raised by many patients), no judgement is made about the

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intentions of the complainant, their right to complain, or the importance attached by the complainant to the issues they describe (ie, both low and high severity complaints can provide crucial information on safety-related issues). Conversely, because healthcare complaints are written from the perspective of patients and families, relatively little insight can be provided on the perspective of healthcare staff who feature in a complaint (eg, on the wider system pressures influencing their behaviour), and thus the behaviour of specific staff members or groups is not examined.

The coding process should be strictly empirical, that is, focused on the actual words used in the letter of complaint (rather than extrapolation or interpretation). Central to the utility of HCAT is the fact that it is reliable (ie, that two people will code the same letter similarly). This reliability is achieved, in part, by requiring coders to focus on the text within each complaint (not judgements or inferences). To facilitate sticking closely to the text, assessors should become familiar with the type of words that indicate each of the main problem categories (reported below).

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The data entry for HCAT is most appropriately done via a computer, however, it can also be done using pen and paper. The following guide will, for ease of reference, assume that the pen and paper recording sheet at the end of this document is being used.

Coding a healthcare complaint using HCAT involves four-phases (A-D), each of which are described in the sections below (see table 2 for a summary).

Table 2. Four phases for coding a healthcare complaint

A. Identifying the presence of problem categories (and, if required, sub-categories) within the letter of complaint using the coding taxonomy, and assessing their severity
B. Specifying the stages of care at which problems occurred
C. Indicating the level of harm arising from the reported problem
D. Providing descriptive information about the letter of complaint

Section A: Identifying problems and assessing severity

The first stage in coding a healthcare complaint using HCAT is the identification of problems contained with a letter of complaint, and an assessment of their severity. The healthcare complaint coding taxonomy identifies three distinct domains (clinical, management and relationship) of healthcare complaint, comprising seven problem categories and 36 sub-categories.

To facilitate the identification of problems within a healthcare complaint, exemplar indicators have been developed for each. These are specified in greater detail in figures A1-A3 on the following pages, and are to be used to guide: 1) the identification of problem categories in a patient letter of complaint, and; 2) the assessment of problem severity.

Severity ratings should be independent of outcomes (ie, harm). The severity ratings are not comparable across problem categories. Rather severity ratings should be based on the indicators provided in the following pages. These severity indicators, which are based on the 36 sub-categories, were developed through iterative coding of a UK national sample of healthcare complaints (n = 1081), which entailed mapping severity for each problem category, and thus identifying independent severity distributions within each problem category and sub-category.

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To analyse a healthcare complaint, the following steps should be undertaken:

1 Read through the letter of complaint without coding anything

2 On second reading, identify the problem category (and, if required, sub-category) being complained about using the problem definitions and the keywords.

3 For each problem category identified, use the severity indicators in figures A1-A3 to determine the severity level. The indicators are exemplars of (1) low, (2) medium, and (3) high severity problems for each problem category.

i. If a problem category is not identified and attributed at severity score, it is automatically rated as 0 (not present).

ii. If one problem category is present at multiple levels of severity, only the highest level of severity should be recorded.

iii. If one event (eg, surgical complication) relates to multiple problem categories (ie, safety, communication) then all relevant problem categories should be recorded.

iv. Should further analysis be required, problems categories may also be coded in terms of the sub-categories that comprise them. Although each sub-category has an indicator at each severity level, the reliability of coding severity at this fine-grained level has yet to be established.

4 Use SECTION A on the HCAT form, at the end of this manual, to record the problem and severity coding.

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A1. Clinical Problems. Issues relating to quality and safety of clinical and nursing care provided by healthcare staff (ie, doctors, nurses, radiologists, and allied health professionals)

Quality: Clinical standards of healthcare staff behaviour

- Sub-categories: Neglect – Hygiene & personal care; Neglect – Nourishment & hydration; Neglect – general; Rough handling & discomfort; Examination & monitoring; Making & following care plans; Outcomes & side effects.
- Keywords: "not provided", "was not done", "did not follow guidelines", "poor standards", "should have", "not completed", "unacceptable quality", "not successful".

1. Low severity	2. Medium severity	3. High severity
Delay changing dirty bedding	Patient dressed in dirty clothes	Patient left in own waste in bed
Isolated lack of food or water	Nothing to eat or drink for one day	Patient dehydrated/ malnourished
Wound not dressed properly	Seeping wound ignored	Infected wound not tended to
Rough handling patient	Patient briefly without pain relief	Force feeding baby, resulting in vomiting
Patient monitoring delayed	Patient not monitored properly	Discharge without sufficient examination
Patient not involved in care plan	Aspect of care plan overlooked	Failing to heed warnings in patient notes
Patient left with some scarring	Patient required follow-up operation	Patient left with unexpected disability

Safety: Errors, incidents, and staff competencies

- Sub-categories: Error – diagnosis; Error-medication; Error – general; Failure to respond; Clinician skills; Teamwork.
- Keywords: "incorrect", "medication error", "did not notice", "mistake", "failed to act", "wrong", "poor coordination", "unaware", "missed the signs", "diagnosis".

1. Low severity	2. Medium severity	3. High severity
Slight delay in making diagnosis	Clinician failed to diagnose a fracture	Clinician misdiagnosed critical illness
Slight delay administering medication	Staff forgot to administer medication	Incorrect medication was administered
Minor error in recording patient progress	Delay noticing deteriorating condition	Onset of severe sepsis was not identified
Not responding to bell (isolated)	Not responding to bell (multiple)	Not responding to heart attack
A minor error filling-out the patient notes	Clinician overlooked information (eg, previous experience of an illness)	Clinician overlooked critical information (eg, serious drug allergy)
Minor misunderstanding among clinicians	Test results not shared with clinicians	Failure to coordinate time-critical decision

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A2. Management Problems. Issues relating to the environment and organisation within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)

Environment: Problems in the facilities, services, clinical equipment, and staffing levels • Sub-categories: Accommodation; Preparedness; Ward cleanliness; Equipment; Staffing; Security. • Keywords: "not available", "shut", "not enough", "dirty", "shortages", "broken", "poor equipment", "soiled", "used before", "poorly signed".		
1. Low severity	**2. Medium severity**	**3. High severity**
Noisy ward surroundings	Patient was cold and uncomfortable	Fleas, bed bugs, rodents
Patient bed not ready upon arrival	Patient placed in bed in corridor	Patient relocated due to bed shortage
Dirt and cigarette ends on main floor	Blood stains in bathroom	Overflowing toilet, faeces on floor
Parking meter not working	A temporary malfunction in an IT system	Medical equipment malfunctioned
Midwife repeatedly called away	Specialist not available	Severe staff shortages
Argument between patients	One patient bullying another patient	Patient assaulted by another patient
Institutional Processes: Problems in bureaucracy, waiting times, and accessing care • Sub-categories: Delay – access; Delay – procedure; Delay – general; Bureaucracy; Visiting; Documentation. • Keywords: "delayed", "postponed", "cancelled", "lost", "not admitted", "administrative problems", "not referred", "confused notes", "more paperwork", "unaware of me".		
1. Low severity	**2. Medium severity**	**3. High severity**
Difficulty phoning healthcare unit	Waited in emergency room for hours	Unable to access specialist care
Non-urgent medical procedure delayed	Medical procedure delayed	Acute medical procedure delayed
Phone calls not returned	Complaint not responded to	Emergency phone call not responded to
Appointment cancelled and rescheduled	Chasing departments for an appointment	Refusal to give appointment
Visiting times unclear	Visiting unavailable	Family unable to visit dying patient
Patient notes not ready for consultation	Patient notes temporarily lost	Another patient's notes used as basis for consultation

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A3. Relationship Problems. Issues relating to the behaviour of any member of staff towards the patient or their family/friends

Listening: Healthcare staff disregard or do not acknowledge information from patients • Sub-categories: Ignoring patients; Dismissing patients; Token listening • Keywords: "I said", "I told", "ignored", "disregarded", "battled to be heard", "not acknowledged", "excluded", "uninterested" and "not taken seriously".		
1. Low severity	**2. Medium severity**	**3. High severity**
Staff ignored question	Staff ignored mild patient pain	Staff ignored severe distress
Patient's dietary preferences were dismissed	Patient-provided information dismissed	Critical patient-provided information repeatedly dismissed
Question acknowledged, but not responded to	Patient anxieties acknowledged, but were not addressed	Patient pain acknowledged, but no follow through on pain relief
Communication: Absent or incorrect communication from healthcare staff to patients • Sub-categories: Delayed communication; Incorrect communication; Absent communication. • Keywords: "no-one said", "I was not informed", "he/she said 'X'", "they told me", "no-one explained", "contradictory", "unanswered questions", "confused", "incorrect".		
1. Low severity	**2. Medium severity**	**3. High severity**
Short delay communicating test results	Long delay communicating test results	Urgent test results delayed
Patient received incorrect directions	Patient received conflicting diagnoses	Patient given wrong test results
Staff did not communicate a ward change	Staff did not communicate care plan	Dementia patient discharged without the family being informed
Respect and patient rights: Disrespect or violations of patient rights by staff • Sub-categories: Disrespect; Confidentiality; Rights; Consent; Privacy. • Keywords: "rude", "attitude", "humiliated", "disrespectful", "scared to ask", "embarrassed", "inappropriate", "no consent", "abused", "assaulted", "privacy".		
1. Low severity	**2. Medium severity**	**3. High severity**
Staff spoke in condescending manner	Rude behaviour	Humiliation in relation to incontinence
Private information divulged to the receptionist	Private information divulged to family members	Private information shared with members of the public
Staff member lost temper	Patient intimidated by staff member	Patient discriminated against
Unclear information for consent	Consent was obtained just prior to a procedure, giving no discussion time	Do-not-resuscitate decision without obtaining consent
Lack of privacy during discussion	Lack of privacy during examination	Patient experienced miscarriage without privacy

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Section B: Specifying the stages of care complained about

The second stage in coding a healthcare complaint is the specification of the stages of care to which a patient's poor healthcare experience refers. **Only code stages when a problem category is identified within that stage of care**. Healthcare complaints can focus on a single event within one stage of care (eg, an operation), or to multiple events that occur across an entire institution. Within HCAT, five generic stages of care are identified (and a sixth "other" category). These stages have been drawn from research on patient "journeys" through healthcare systems [42, 43]. The stages of care are listed in table 4.

Table 4. Stages of care

1. Admissions:	This refers to when a patient arrives at healthcare unit, and is admitted to a unit or ward. For example, when initially receiving treatment at an accident and emergency unit, being referred to a clinician, or first arriving to receive care.
2. Examination and diagnosis:	This refers to when a patient is examined and diagnosed by clinical staff. For example, when being examined by an acute care ward, receiving a pre-operative diagnosis, or being assessed by a radiology team.
3. Care on the ward:	This refers to when patients are receiving clinical or nursing routine care (eg, food, water, washing, medication, wound dressing), being assessed and monitored by healthcare staff, and post-operative recovery.
4. Operation / procedures:	This refers to the operations and medical procedures performed on patients by healthcare staff. For example, when patients undergo surgery, give birth, receive emergency care, or undergo a routine procedure (eg, insertion of a tracheotomy).
5. Discharge / transfers:	This refers to patients being discharged from the healthcare unit. For example, when patients are discharged from hospital after a surgical procedure, or are transferred from an intensive care unit to a high dependency unit.
6. Unspecified or other	Where it is not possible to determine the stage of care, or it does not fit into the above categories

For the letter of healthcare complaint, indicate in SECTION B of the HCAT form (at the end of this document) which stages of care the problems identified in Section A referred to. All stages of care can be selected if the complaint refers to them all. In the case that it is not possible to determine the stage of care, please indicate "other".

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Section C: Level of harm reported in the complaint

The third stage in coding a healthcare complaint is to specify the level of harm experienced and reported in the letter of complaint. Harm is rated on the National Reporting and Learning System [44] used in the UK to classify harm reported in critical incidents outlined in table 5.

Indicate in SECTION C of the HCAT form the level of harm experienced by patients. Assessments of harm should focus on the overall harm **caused to patients by the problems raised in the letter of complaint**. For example, if the patient dies, but the complaint is about dignity after death, then the harm relates only to the consequences of the lack of dignity.

It is important to note that harm is independent from problem severity. For example, a patient describing a severe safety problem (eg, a medication error) may not have experienced harm due to the error being identified.

Table 5. Patient harm

0. N/A	No information on harm is reported
1. Minimal harm	Minimal intervention or treatment required (eg, from a bruise or graze)
2. Minor harm	Minor intervention required to ameliorate harm (eg, from a sprain, anxiety)
3. Moderate harm	Significant intervention required to ameliorate harm (eg, from a grade 2-3 pressure ulcer, healthcare acquired infection)
4. Major harm	Patent experienced, or faces, long-term incapacity (eg, from a dislocation, fracture, haemolytic transfusion, wrong medication side effect, post-traumatic stress)
5. Catastrophic harm	Death or multiple/permanent injuries (eg, wrong-site surgery, paralysis, permanent or chronic mental health problems)

Section D: Descriptive details

The final stage in coding a healthcare complaint is to specify basic descriptive details in relation to the complaint. These are defined in table 6. Record these details in SECTION D of the HCAT form.

Table 6. Hospital complaint details

1. Who made the complaint?	Indicate whether the complaint was made by a patient, family member, lawyer, or other third-party
2. What is the gender of the patient?	Indicate whether the patient complaining (or being complained on the behalf of) is male or female
3. Which staff groups does the complaint refer to?	Report whether staffing group or groups complained about are Administrative, Healthcare assistants, Medical Staff, Nursing Staff, Pharmacists, Physiotherapists, or unspecified/other

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REFERENCES

1 MacArthur CA, Ferretti RP, Okolo CM, *et al.* Technology applications for students with literacy problems: A critical review. *Elem Sch J* 2001;**101**:273–301.

2 Bouwman R, Bomhoff M, Robben P, *et al.* Patients' perspectives on the role of their complaints in the regulatory process. *Health Expect* 2015. doi:10.1111/hex.12373 [published Online Frist: 7 May 2015]

3 Gallagher TH, Mazor KM. Taking complaints seriously: Using the patient safety lens. *BMJ Qual Saf* 2015;**24**:352–5. doi:10.1136/bmjqs-2015-004337

4 Kroening H, Kerr B, Bruce J, *et al.* Patient complaints as predictors of patient safety incidents. *Patient Exp J* 2015;**2**:94–101.

5 Francis R. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009*. Norwich, UK: The Stationery Office 2010.

6 Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: A systematic review and coding taxonomy. *BMJ Qual Saf* 2014;**23**:678–89. doi:10.1136/bmjqs-2013-002437

7 Vincent C. *Patient safety*. Chchester, UK: John Wiley & Sons 2011.

8 Basch E. The missing voice of patients in drug-safety reporting. *N Engl J Med* 2010;**362**:865–9. doi:10.1056/NEJMp0911494

9 Koutantji M, Davis R, Vincent C, *et al.* The patient's role in patient safety: engaging patients, their representatives, and health professionals. *Clin Risk* 2005;**11**:99–104.

10 Pittet D, Panesar SS, Wilson K, *et al.* Involving the patient to ask about hospital hand hygiene: A National Patient Safety Agency feasibility study. *J Hosp Infect* 2011;**77**:299–303.

11 Ward JK, Armitage G. Can patients report patient safety incidents in a hospital setting? A systematic review. *BMJ Qual Saf* 2012;**21**:685–99. doi:10.1136/bmjqs-2011-000213

12 Lawton R, O'Hara JK, Sheard L, *et al.* Can staff and patient perspectives on hospital safety predict harm-free care? An analysis of staff and patient survey data and routinely collected outcomes. *BMJ Qual Saf* 2015;:369–76. doi:10.1136/bmjqs-2014-003691

13 Reader TW, Gillespie A. Patient neglect in healthcare institutions: A systematic review and conceptual model. *BMC Health Serv Res* 2013;**13**:156. doi:10.1186/1472-6963-13-156

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

14 Järvelin J, Häkkinen U. Can patient injury claims be utilised as a quality indicator? *Health Policy* 2012;**104**:155–62. doi:10.1016/j.healthpol.2011.08.012

15 Reader TW, Gillespie A, Mannell J. Patient neglect in 21st century health-care institutions: A community health psychology perspective. *J Health Psychol* 2014;**19**:137–48.

16 Pukk-Härenstam K, Ask J, Brommels M, *et al.* Analysis of 23 364 patient-generated, physician-reviewed malpractice claims from a non-tort, blame-free, national patient insurance system: Lessons learned from Sweden. *Postgrad Med J* 2009;**85**:69–73. doi:10.1136/qshc.2007.022897

17 Haggerty JL, Reid RJ, Freeman GK, *et al.* Continuity of care: A multidisciplinary review. *BMJ* 2003;**327**:1219–21.

18 Bodenheimer T. Coordinating care-a perilous journey through the health care system. *N Engl J Med* 2008;**358**:1064–71.

19 Rogers AE, Addington-Hall JM, Abery AJ, *et al.* Knowledge and communication difficulties for patients with chronic heart failure: Qualitative study. *BMJ* 2000;**321**:605–7. doi:10.1136/bmj.321.7261.605

20 Jacobson N. Dignity and health: A review. *Soc Sci Med* 2007;**64**:292–302. doi:10.1016/j.socscimed.2006.08.039

21 Stewart M. Towards a global definition of patient centred care. *BMJ* 2001;**322**:444–5.

22 Okuyama A, Wagner C, Bijnen B. Speaking up for patient safety by hospital-based health care professionals: A literature review. *BMC Health Serv Res* 2014;**14**:61. doi:10.1186/1472-6963-14-61

23 Toop L. Primary care: core values Patient centred primary care. *BMJ* 1998;**316**:1882–3. doi:10.1136/bmj.316.7148.1882

24 Bark P, Vincent C, Jones A, *et al.* Clinical complaints: A means of improving quality of care. *Qual Health Care* 1994;**3**:123–32.

25 Lloyd-Bostock S, Mulcahy L. The social psychology of making and responding to hospital complaints: An account model of complaint processes. *Law Policy* 1994;**16**:123–47. doi:10.1111/j.1467-9930.1994.tb00120.x

26 Mulcahy L, Tritter JQ. Pathways, pyramids and icebergs? Mapping the links between dissatisfaction and complaints. *Sociol Health Illn* 1998;**20**:825–47. doi:10.1111/1467-9566.00131

27 Carmel S. Patient complaint strategies in a general hospital. *Hosp Health Serv Adm* 1989;**35**:277–88.

28 The Health and Social Care Information Centre, Workforce and Facilities Team. Data on written complaints in the NHS 2011-12. Leeds, UK: The Health and Social Care Information Centre 2012.

29 Levtzion-Korach O, Frankel A, Alcalai H, *et al.* Integrating incident data from five reporting systems to assess patient safety: making sense of the elephant. *Jt Comm J Qual Patient Saf* 2010;**36**:402–10.

30 Christiaans-Dingelhoff I, Smits M, Zwaan L, *et al.* To what extent are adverse events found in patient records reported by patients and healthcare professionals via complaints, claims and incident reports? *BMC Health Serv Res* 2011;**11**:49. doi:10.1186/1472-6963-11-49

31 Clwyd A, Hart T. A review of the NHS Hospitals complaints system: Putting patients back in the picture. 2013.

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32 Donaldson L. An organisation with a memory: Report of an expert group on learning from adverse events in the NHS. Norwich, UK: The Statutory Office 2000.

33 Gillespie A, Reader TW. The Healthcare Complaints Analysis Tool: Development and reliability testing of a method for service monitoring and organizational learning. *BMJ Qual Saf (in press). doi: 10.1136/bmjqs-2015-004596*

34 Wachter RM, Pronovost PJ. Balancing "no blame" with accountability in patient safety. *N Engl J Med* 2009;**361**:1401–6.

35 Vries EN de, Ramrattan MA, Smorenburg SM, *et al.* The incidence and nature of in-hospital adverse events: a systematic review. *Qual Saf Health Care* 2008;**17**:216–23. doi:10.1136/qshc.2007.023622

36 Swayne LE, Duncan WJ, Ginter PM. *Strategic management of health care organizations*. Chichester, UK: John Wiley & Sons 2012.

37 Ferlie EB, Shortell SM. Improving the quality of health care in the United Kingdom and the United States: A framework for change. *Milbank Q* 2001;**79**:281–315. doi:10.1111/1468-0009.00206

38 Kenagy JW, Berwick DM, Shore MF. Service quality in health care. *JAMA* 1999;**281**:661–5. doi:10.1001/jama.281.7.661

39 Attree M. Patients' and relatives' experiences and perspectives of "good" and "not so good" quality care. *J Adv Nurs* 2001;**33**:456–66.

40 Mishler EG. *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex Pub 1984.

41 Pellegrino ED. Patient and physician autonomy: Conflicting rights and obligations in the physician-patient relationship. *J Contemp Health Law Policy* 1994;**10**:47–68.

42 Woloshynowych M, Neale G, Vincent C. Case record review of adverse events: A new approach. *Qual Saf Health Care* 2003;**12**:411–5.

43 Trebble TM, Hansi N, Hydes T, *et al.*, others. Process mapping the patient journey: An introduction. *BMJ* 2010;**341**:c4078.

44 A risk matrix for risk managers. National Patient Safety Agency 2008. http://www.nrls.nhs.uk/resources/?entryid45=59833&p=13

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Instructions	A. Use the manual to identify severity ratings for each problem category (from 0, not evident, to 3, high severity) B. Please indicate the stage(s) of care to which the letter refers C. Categorise the level of harm experienced by patients D. Please provide descriptive information on the complaint			**Reference number**
(A) Domain	**Category**	**Severity (0-3)**	**(B) Stages of Care**	**Tick relevant stages**
CLINICAL PROBLEMS Issues relating to quality and safety of clinical and nursing care provided by healthcare staff (ie, doctors, nurses, radiologists, and allied health professionals)	**Quality:** *Clinical standards of healthcare staff behaviour*		1. Admissions	
	Safety: *Errors, incidents, and staff competencies*		2. Examination & diagnosis	
MANAGEMENT PROBLEMS Issues relating to the environment and organisation within which healthcare is provided (for which administrative, technical, facilities and management staff are usually responsible)	**Environment:** *Problems in the facilities, services, clinical equipment, and staffing levels*		3. Care on the ward	
	Institutional Processes: *Problems in bureaucracy, waiting times, and accessing care*		4. Operation & procedures	
RELATIONSHIP PROBLEMS Issues relating to the behaviour of any specific member of staff towards the patient or their family/friends	**Listening:** *Healthcare staff disregard or do not acknowledge information from patients*		5. Discharge & transfers	
	Communication: *Absent or incorrect communication from healthcare staff to patients*		6. Unspecified or other	
	Respect and patient rights: *Disrespect or violations of patient rights by staff*			
	Unspecified/other			
(C) Please indicate the level of harm reported by the patient (1) negligible to (5) catastrophic (use 0 for N/A or unspecified) =	**(D) Please provide further details of:** **1. Who made the complaint?** ☐ Family member ☐ Patient ☐ Unspecified/other **2. Gender of patient?** ☐ Female ☐ Male ☐ Unspecified/other **3. Which staff group(s) does the complaint refer to?** ☐ Admin ☐ Medical ☐ Nursing ☐ Unspecified/other			

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29 JANUARY 2019 – 21 JUNE 2022
TRUST SENIOR MANAGEMENT TEAM
AGENDA & NOTES

2019	29/01/2019	8.1 SI Lead Urology Request
2020	15/09/2020	2. Trust Board Papers Approval
	06/10/2020	2. Urology SAI Update
	24/11/2020	1. USPI Update
2021	02/02/2021	8. PI & Level 3 SIA help needed
	23/02/2021	1. Staffing Support SAI/UPI
	09/03/2021	10. Paterson Inquiry
	16/03/2021	2. Action Log 2 & 9 March 2021
	13/04/2021	9.5 UI – EDON to lead
	27/04/2021	3. UPI Implementation Governance
	18/05/2021	6. TB Papers – concerns update
	25/05/2021	2. UPI Update
	20/07/2021	3.7 SCRR Update
	14/09/2021	5. Urology Corporate Risk Register
	26/10/2021	21. AOB – Director PI Ad
	09/11/2021	7. Governance Committee – Urology
	23/11/2021	7. UPI Funding Secured
	30/11/2021	6. Proceed UPI Director
2022	18/01/2022	5. TB Papers – Clinical Concerns Urology
	01/02/2022	7. Corporate Risk Register
	22/02/2022	4. Finance Report – no funding secured
	03/05/2022	12.2 Urology PI Update – Risk Mx Trust
	17/05/2022	11. UPI Spend
	07/06/2022	9. Monthly Spend UPI
	21/06/2022	5. Patient Letters Update/UPI Update

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains	HIGH
3829	ACUTE	13/09/2016	Safe, High Quality and Effective Care	Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	19/11/21 Update from Lead Nurse SEC- A working group is currently developing a criteria method to help guide the level of supervision required in nursing observations in relation to mental health"Enhanced Care Observation (ECO)". A training component is also being developed for staff prior to the pilot of this tool. There is a corporately led MDT working group who have produced a draft SHSCT point of ligature policy which has been shared for consultation prior to final approval. 20/09/2021- Lead Nurse SEC update- absconding policy used at ward level. Patients identified at risk will be placed in a bedspace as much as possible that provides supervision/visibility. Referral to Psych liaison. Also current working group to establish a "patient at risk" assessment tool which incorporates all levels of risk and care planning. There is also work ongoing regarding access to psych services within Acute. 20/09/2021- Escalated as per trust policy in ED. 18/08/2021- Absconding policy in place and escalated to HOS if incident occurs. Reported via Datix process. 09.03.2021- within ED a risk assessment is carried out if PSNI accompany patient under article 130 a joint risk is completed with nursing team. ED AMU review absconding patients with PSNI and mental health at interface meetings 24.02.2021- still ongoing issue and the staff adhering to policy and datix submitted with review taking taking place for each case. 24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating.	HIGH

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ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3971	ACUTE	28/08/2018	Provide safe, high quality care	Access to cath lab for NSTEMI patients- ST has the highest through put of patients through the Cath Lab in the region.	The ST have highest through put in the region and only have one Cath Lab. If the C Arm breaks down we will not be able to treat Cardiology patients requiring patients to be transferred to another Trust. SHSCT are concerned there is a potential to patient morbidity and mortality due to long waiting list. Standard 18d of Cardio vascular framework that eligible NSTEMI / ACS pts should have Cor Angio +/- PCI within 72 hrs of admission. Angiography within 72 hours improves outcomes for patients. (NICE). MINAP state: The performance of angiography and coronary intervention soon is an important facet of treatment for the majority of patients.	Monitored weekly. Access elective patients. Escalate number of patients waiting for in patient cath procedures daily to AD and Director. There is a Regional Cath Lab implementation group which has been in place since August 2020.	18/08/2021- Have escalated via Elective Performance meeting. Highlighted the impact of high volume of inpatient activity and need for 2nd Cath Lab to address. Meeting held re inpatient plan regarding sharing lists with Belfast and Western Trust. Criteria to be established. Access times monitored monthly. 07/06/2021- The SHSCT has raised with the HSCB the need for decisions re Cath Lab capacity to meet the demand to be made as soon as possible. The Consultant Cardiologist in the SHSCT recommend a second Cath Lab on site. A PID for phase 3 Cath Lab capacity project was finalised in Oct 2020 and it was shared with the interim Director of commissioning in the Board. The process has been delayed due to the impact of Covid. A Clinical Lead is to be appointed to take forward a capacity and demand exercise which will allow a number of different options to be considered. 24/02/2021- working through as part of cardiology network plan but the target is only 33% in 72 hours due to only one cath lab. 5 /11/20 KPI for N STEMI s getting to cath lab within 72 hours has dropped to 35 % from 45% this is impacting on length of stay and bed occupancy at ward level and resulting in patients being admitted to wrong ward 10/08/20 - Regional group has been established PID document agreed. Demand and Capacity for cath lab activity to commence when templates have been distributed to the Trusts. 14/5/2020. Modular Cardiac cath lab was removed in October 2019. Access times for NSTEMIS has dropped to 33% getting to Cath lab within 72 hours . Regionally agreed to establish group to review cath lab activity re access times and demands. 24.06.19 Monitored via MINAP only 50% getting to cath lab despite modular. High volumes of inpatient activity (monitored monthly for each site) Need to secure Funding permanent for modular. Need to reduce elective to facilitate inpatient. 13.08.18 Performance team to liaise with HSCB re funding	HIGH
773	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Theatres Endoscope Decontamination room	The interim Endoscope decontamination facilities at CAH theatres do not meet DHSSNI decontamination strategy. There are no transfer lobbies or staff gowning rooms. The process flow is severely compromised by the size of the extremely cramped unit. There is no room for expansion. The workload in the endoscope decontamination facility has increased considerably over the last number of years due to additional theatre and radiology sessions as well as additional clinics in ENT OPD and Thorndale Unit. There is inadequate space for holding the contaminated endoscopes for manual washing prior to the automated process in the endoscope washer disinfectors. This frequently creates a bottleneck and slows down the process flow and turnaround time. The endoscopes and transport trolleys have to be stored in the hospital corridor outside the endoscope decontamination room due to lack of space - increased risk of theft (trolley plus endoscopes). In the event of any prolonged endoscope washer disinfector downtime there would be significant disruption to endoscopic procedures in Theatres, Radiology, ICU or in ENT OPDand Thorndale Unit as there would be insufficient capacity to decontaminate the endoscopes on the Craigavon site. There would also be logistical issues and delays in turnaround times if the endoscopes had to be transported to another Trust site for decontamination ie Daisy Hill or South Tyrone. The endoscope washer disinfectors were installed in 2009 and have a working life of approximately 8 years. The Lancer endoscope washer disinfectors do not have the ability to perform channel patency tests to current DHSS guidance i.e. inability to perform partial blockage of the duodenal channel which is part of the quarterly channel patency testing regime. The EWD manufacturer has confirmed that they will support the FC 2/4 EWD models until 2022 for the electronics and until 2025 for mechanical parts.	Situation being monitored.	12/11/2021 A decontamination meeting is due to take place 19/11/2021 and a further update will be available after this meeting. 15/09/2021- Replacement ISIS EWDs were included in the paper for funding sent earlier this year. Funding still not approved. The procurement process for EWDs can take up to six months and risk remains with the current EWDs not being supported by the manufacturer beyond 2022. 28.06.2021- no update. 16.02.2021- draft paper re funding required has been shared with the Director of Acute Services. 10/08/20 - DOH has set up a regional RDS2 steering group to assess the current provision of decontamination services, identify any shortfalls in compliance with policy and develop a strategy to address any identified gaps. 3.10.19 Replacement EWDs are included on the capital funding list. May 2019 SHSCT provided a summary report to DOH on strategic planning relating to the decontamination of reusable medical devices 24.06.19, 8.8.18, 12.6.18, 7.3.18 Risk remains unchanged 113.9.16 Head of Decontamination Services will work with Acute Planner to explore options for a modular unit adjacent to CAH CSSD to replace the existing the interim arrangement. Given that CSSD will form part of Phase 1 for the CAH Redevelopment, a modular solution will be considered as a further interim arrangement although it will need to address existing concerns. Indicative costs to be detailed in the paper and logged for consideration under capital allocations for 17/18. 23.2.16 Following discussion at Acute senior management team with Head of Acute Planning, the risk will be addressed in the first phase of the redevelopment of the Craigavon site. On this basis it was agreed that nothing further would be done at this stage. 5.1.16 Short paper highlighting the risks shared with Planning Dept and Director of Acute Services	HIGH

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4177	ACUTE	20/06/2018	Safe, High Quality and Effective Care	Chiller Faults causing loss of time- MRI	Chillers are required to supply chilled water to the MRI scanner to remove heat produced during scanning and facilitate circulation of liquid helium which maintains the operation of the supercounducting magnet. For the scanner to operate at the highest levels of efficiency, the magnet inside the scanner has to be kept as cool as possible. Any increase in temperature will result if the the chiller is not operating will cause the scanner to no longer operate. This is a safety mechanism for the scanner to prevent boil off the liquid helium "quenching". This is when the wire in the electromagnet stops being superconducting and starts to generate a lot of heat. At this point, any liquid helium around the magnet repeatedly boils off and escapes from the vessel housing the magnet.	Single chiller per scanner with no back up available. Alarm system in place to business management system when chiller is not operating- no communication from switch or estates re this during recent breakdowns. Siemens will test this to check if the system is working.	08/07/2021- recent chiller failure- temporary chiller installed until fault can be replaced. Several days scanning lost while this was ordered and installed. RED FLAG exams delayed due to downtime. 21/11/2020- no change- still awaiting estates action ongoing follow up with estates for progress. 20/06/2018- automatic emergency bypass system needs integrated instead of manual- to be referred to capital department for design team. Additional secondary chiller with associated pipework as a backup- D/W David Thompson needs referred to capital department design team. Discussion with Estates Team and Switch in relation to procedure for notifying estates and MRI if chiller alarm goes off. Alarm system to be tested.	HIGH
4176	ACUTE	20/09/2021	Accessible and Responsive CareSafe, High Quality and Effective Care	Covid & Non Covid patients on AGPs being cared for in red Resus	Nosocomial Spread and patients at risk	ED consultants/management/IPC/Micro walkaround CDU identified as resus area for patients receiving AGPs CDU converted to Red Resus as IPC/Micro advice Lumira swabbing commenced in ED to determine Covid status The side room is used were possible to provide some protection for e.g. if one non-covid patient on AGP they will be nursed in side room and vice versa. However still a potential risk that aerosols will mix. When this is not possible patients in an open bay have the same air space which means that they are all in direct contact with one another. Covid positive patients in red resus are transferred to a Covid ward as soon as possible to reduce the risk. Ongoing escalation of red resus at APC meetings. All staff in red PPE. Walk around with Estates.	21/09/2021- Datix to be completed when non-covid/covid patients are nursed in red resus at any one time. Patients transferred out of red resus to appropriate ward when clinical condition permits is ongoing. Estates have confirmed that inability to undertake closing off cubical areas due to the estate structure. March 2020- CDU converted to red resus for patients on AGPs. All staff in red PPE	HIGH
3951	ACUTE	10/04/2018	Provide safe, high quality care	Delays in isolation	Due to lack of side rooms/one to one nursing/lack of bed capacity in the service. Risk of spread of infection. Failure to isolate promptly can lead to outbreaks, close of bays, increased pressure on service. May lead to potential patient harm through the spread of potentially preventable infection or due to a lack of beds.	Trust can emphasise the importance of IPC issues at bed meetings and elsewhere. A recent teaching sessions was arranged to do this amidst the winter pressures. Side rooms are often occupied for reasons other than IPC reasons. IPC reasons for isolation are often of critical importance in that severe harm can be done to other patients and staff by failure to isolate promptly. This is often not the case for other reasons patients are in side rooms and side rooms should be prioritised to maximise patient safety. The Trust should also look to ways to enhance the capacity to isolate a patient when the hospital is full and a patient needs isolated urgently e.g. where a patient could be moved out of a room to facilitate critical IPC isolation.	20/09/2021- all patients who attend ED have Lumira to determine covid status. PCR completed as per protocol. Risk assessments are completed when a high number of beds are closed due to an outbreak vs risks in ED. 01.06.2021- there has been 8.7 million pounds secured from the DOH address nosocomial infections which will allow estates work to progress. This will free up clinical space to accommodate patients. 24.01.21- delays in ascertaining results of swabs and screening and appropriate action delayed based on same and lack of isolation rooms to accommodate this.	HIGH
4155	ACUTE	01/04/2021	Provide safe, high quality careMake the best use of resourcesBe a great place to work	Haematology Outliers	Currently only providing a 6 bedded inpatient side room, augmented care capacity for Haematology patients. All other admitted Haematology patients are cared for throughout both medicine and surgery, without the necessary environment to ensure patient satiety regarding hospital acquired infections. Potential risk could be catastrophic for a haematology inpatient. Haematology patients are immunosuppressed and are amongst one of the most vulnerable client groups within the hospital setting. Ultimately if a patient is exposed to one of the many potential hospital acquired infection this could be life limiting.	Patients that are identified as immunosuppressed must be prioritised for an ensuite side room the estate is limited regarding same and as such we are not always able to accommodate this, patients are then placed in side rooms with shared toileting facilities Haematology Teams keep track of all outlying patients and review same providing clinical plans where necessary. Maximising discharges in Haematology Unit, in order to created capacity for admitted patients.	Action plan completed working collaboratively with the AD from workforce to address same	HIGH
3954	ACUTE	10/04/2018	Provide safe, high quality care	Lack of documentation	Root cause analyses are repeatedly picking up incidences of poor documentation e.g. lack of filling out of Clostridium difficile bundle, lack of documentation that the patient has been informed of a diagnosis of Clostridium difficile, lack of filling out of cannula charts, etc. Lack of documentation can reflect either that something that should have happened has not happened or just that it has not been documented. In the former there is a direct risk to patient safety (e.g. death from Staphylococcus aureus bacteraemia from a cannula that was not inspected properly and removed when it should have been, death from Clostridium difficile due to deterioration not being picked up due to lack of due diligence in the application of the bundle). In the latter there is still danger to the patient as staff subsequently on duty will not be able to see what was done as it is not documented. There is also significant risk to litigation to individual staff and the Trust as without documentation to say that good practice has been carried out there is no proof that it has been done.	Medical and nursing training would emphasise the importance of good documentation. Root cause analyses would emphasise the importance of this. The recurrence of this problem as demonstrated by repeat root cause analyses however would suggest that current control measures are not sufficient. When challenged regarding poor documentation excuses given are usually:- (a) A lack of education/awareness regarding aspect s of care bundles (b) A lack of time to document things due to service pressures Problem (a) could re resolved through additional education to staff through Lead Nurses, Ward Sisters and Clinical Directors to their teams where this is needed. Problem (b) can only be resolved by easing the pressure on nursing and medical staff in general. In general the experience of the IPCT is that nursing documentation is better than medical documentation, especially with regards to documenting when a patient has been informed of their diagnosis.	18/08/2021- RQIA guidelines shared with Cardiology Team following SAI. Audit to be carried out in October 2021. 24.02.2021- improvements have been made but still needs continually monitored	HIGH

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4196	ACUTE	16/12/2021	Safe, High Quality and Effective CareEffective organisational governance	Limited implementation and adherence to MCA NI 2016, completion of required STDO and TPA for all patients who lack capacity	Limited Implementation and adherence to the MCA NI 2016 , COMPLETION OF REQUIRED STDO and TPA for all patients whom are deemed to lack capacity in specific decisions .	The DOH training is available to all MDT staff and a live register is maintained of all MDT staff whom can complete the required statutory assessments and documentation , however due to all MDT staff workload capacity and also confidence there is minimal identification of these patients and therefore very low numbers of STDO IN Acute Hospitals .Lead Nurses have been asked to ensure when 1-1 ARE BEING REQUESTED AT WARD LEVELS THESE ARE NOT APPROVED FOR PERSONS WHOM LACK CAPACITY UNLESS A STDO process has commenced .MCA should form part of all daily WBM discussions .The current SOP is not fully implemented as these patients are not being identified early in their journey from ED also. All MDT should agree which staff member / profession is best placed to take forward the MCA process STDO / TPA, this should be shared equally among professions The current STDA are under the management of MHDD Additional bespoke training is available within the SHSCT for any MDT staff group to develop skills and knowledge	18/12/2021- Plan in 2022 that the STDA Team (4.0 wte staff) will come under the operational management of Acute / Non Acute and will suit within HSW management structure's , this will allow more focused work and support to wards , however the challenge will be developing MDT staff to take forward this work as part of their day to day duties	HIGH
4184	ACUTE	04/10/2021	Safe, High Quality and Effective CareEffective organisational governance	Misuse of POCT devices and non compliance with clinical governance procedures across the Trust	POCT demand has increased exponentially across the Trust, particularly in response to the Covid pandemic. Mistakes made during the course of POCT analysis and incorrect results acted on by the clinical team can have life-threatening consequences for the patient. The risk is not limited to the POCT team; the risk is applicable to all of the clinical teams across the Trust who are performing POCT and relying on the results to inform patient management. All of the following will cause incorrect results to be produced which, if acted upon, could be fatal for the patient and leave the Trust open to litigation: -Poor sampling technique resulting in poor quality of sample. -Lack of training or knowledge on the part of the operator regarding proper and correct use of the POCT device. -Lack of knowledge or reluctance regarding how to perform internal quality control and calibration (this checks if the machine is producing the correct results). -Inadequate compliance with external quality assurance procedures (this checks that the entire procedure from sampling through to result transmission is working as it should). -Lack of understanding of what will adversely affect results e.g. haemolysis, icterus, lipaemia, incorrect storage temperature for reagents. -Poor cleanliness and maintenance of the device and surrounding area. -Use of incorrect or out of date IQC/calibration or test cassettes. Other risks for the patient -Not using the correct H&C number - result will not transmit to NIECR. -Patient HCN mix up, results going into the wrong patient file. -Staff sharing barcodes - risk of an untrained operator using the device incorrectly. -Lack of POCT team support to deal with issues such as poor IQC/EQA performance and -troubleshooting. -Lack of IT support for issues such as devices losing connectivity. In addition, not all devices are able to connect to the Trust network so there is an increased risk with such devices where the POCT team are unable to adequately monitor their performance. -Users not informing POCT of issues with devices when they arise. Risk of faulty device being used to generate inaccurate results that are acted on by the clinical team. The risks to the user and patient are significantly more substantial than risks associated with performing tests in the main laboratory which is staffed by fully trained laboratory staff. Staff performing POCT have basic training in operating the devices and must adhere fully to the rules set out by the POCT team. Mistakes can have serious, fatal outcomes for the patient if the results produced are incorrect or misinterpreted and subsequently acted upon by the clinical team. Staff not adhering to the rules and standard operating procedures as laid down by the POCT team are open to disciplinary procedures. Mistakes made during the course of POCT analysis can leave the Trust open to litigation from the patient. The POCT team regularly audits aspects of the POCT devices and operators. There are repeated instances of staff sharing barcodes, not using H&C numbers, poor maintenance and cleanliness of equipment, failure to run IQC and EQA, poor sampling technique affecting sample quality, incorrect test cassettes being used,	- Online and/or face to face training available for all devices - training sessions are organised and readily available on request from the POCT team. - POCT staffing - POCT staffing has been extended but staffing levels have fluctuated with staff leaving and being replaced. There is a requirement for a Band 6 BMS to provide support to the POCT Band 7 and robustness across the service, particularly with the continuing increase in demand for POCT across all sites. - SOPs and information are available for all devices on the laboratory website and Sharepoint. - Regular audit of POCT in clinical areas is highlighting problems with regards device maintenance, compliance with IQC/EQA etc, and this information is regularly disseminated to all Heads of Service and Lead Nurses in areas of the Trust that use POCT. The emphasis is on these individuals to enforce the compliance with POCT rules within their teams in order to satisfy clinical governance requirements. - IT support is a constant issue within POCT and causes serious delays in troubleshooting and installation of POCT devices. We are currently recruiting a Band 6 IT person for labs, but they will require proper access and administration rights to IT systems (particularly cyber-security) in order to complete their work. This could be a problem if IT are unwilling to co-operate in this respect. These controls are effective to a certain extent, but non-compliance with POCT regulations within the clinical teams is a critical ongoing issue that is possibly not being taken seriously enough across the Trust. The risk to the patient is significant. Removal of devices from clinical areas where non-compliance with POCT rules has been identified as a serious issue - this will only be as a last resort, particularly in areas such as ED where POCT is essential for patient flow (e.g. Covid testing). However, this leaves the Trust open to litigation in the event of errors. Permanent blocking of users who consistently fail to comply with POCT regulations - this is not feasible in practice, particularly with many clinical areas short staffed. All we can do is ensure the individual's line managers are aware of non-compliance issues, and that they both sign an official form committing to compliance with regulations, and undergo re-training procedures.	17/12/2021- "Update Senior Management (CCS) on developments by Jan 2021 "Create a potential structure to provide further support to the Trust by end of Jan 2021 "Secure additional resource to plug the identified weaknesses in current structure TBA "Seek further investment in POCT Governance structure TBA "Reinforce adherence to protocols through existing governance structures Feb 2021 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing	HIGH
4157	ACUTE	06/05/2021	Provide safe, high quality careMake the best use of resources	MRI Capacity	MRI inpatient demand has significantly increased with an impact on the capacity for red flag, urgent and routine outpatient examination. There has been a 72% increases in inpatient MRI demand comparing March 20 and March 21. Currently there is no MRI facility available on the Daisy Hill Site and patients have to transfer to CAH for MRI imaging. Increased outpatient waiting list and waiting times. Potential for additional queries regarding inpatients to MRI staff adding additional pressures.	Currently some MRI referrals are being outsourced to the Independent Sector. However due to image quality the more complex outpatient MRI referrals remain in the Southern Trust	6/4/22 The MRI options paper is to be presented to SMT on Tuesday 12th April to seek approval to look at non Trust locations for a modular MRI unit. There is also an ongoing MRI optimisation project being facilitated by Siemens and the initial review of the service has occurred and we are currently awaiting feedback. 14/12/2021- brought to CW to raise with Director re corporate register move. The Department are working with planning on a Business Case for a low field strength MRI Scanner to be located at DHH. The Current MRI scanners located in CAH are due for replacement in 2023 and 2024 which are currently on the equipment replacement plan. The costs of low field MRI scanner for DHH has yet to be finalised	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH and the inability to off load patients from Ambulance due to overcrowding.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow. HALO role and ongoing monitoring	20/09/2021- ongoing, risk exacerbated by Covid- bed pressures sustained for long periods. Non commissioned beds have been opened. Surgical beds converted to medical beds. 09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams. Funding needs secured for medical gases for ambulance receiving area. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing escalation plan. 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	HIGH
4142	ACUTE	24/02/2021	Provide safe, high quality careBe a great place to workMake the best use of resources	Recruitment and Retention issues- Trust Wards	Patient safety risk. Identification the deteriorating patients, risk on escalation of same, lack of knowledge of in house processes, potential treatment/management/discharge delays. Increased pressure placed on core team, risk of burn out/work related stress. Potential lack of escalation/risk deteriorating patient not escalated. Potential risk of failed discharge/transfer due to lack of knowledge regarding processes. Risk of non-compliance with appropriate documentation required to manage patients holistic needs.	currently focusing prioritising recruitment to this area. Complete all outstanding e-reqs Internation nurse recruitment Target year 3 nursing students to this area to attract uptake Offer all bank and agency permanent positions Daily review and redeployment of staff to support the skill mix and staff levels with 2 South.	19/4/22. Still ongoing issue with recruitment and retention of Staff. Staffing levels reliant on Bank and Agency to fill gaps at ward level. 20/09/2021- 6 new start band 5 in DHH ED October 2021. 22 New start Band 5 CAH ED October 2021 28.06.2021- ATICS ongoing Band 5 recruitment drive. 8 x band 5 posts from peri-operative work stream. Applications closed 23.06.2021 Action plan completed working collaboratively with the AD from workforce to address this	HIGH
4156	ACUTE	19/08/2021	Provide safe, high quality careMake the best use of resources	Referrer MRI Safety	MRI is potentially hazardous and involves significant risk to patient safety. During the period 2019-2021 there has been an average occurrence (one every 3 weeks) of incidents involving incorrectly completed MRI safety referral information. These incidents have involved referrers stating that patients do not have any potential contraindications to undergo MRI(implants) however it is later identified by MRI Team that implants are in-situ. If these events keep occurring at the current rate there is an increased risk of morbidity and mortality because the source of risk has not been reduced.	The MRI Team screen and check all patients and completed questionnaires to attempt to ensure these errors are captured. E Learning MRI safety for referrers is available on HSC E Learning. Where possible notifications are sent to referrers involved to highlight the error and request that they complete the MRI safety training.	03/12/2021 - A national MR Safety training module is being developed and will be released in 2022. This module will replace the current MR Safety module on ELearning. A trend analysis report has been collated over the past 4 months which has not indicated any reduction in the number of incidents. 14/09/2021- requirement for a 3rd scanner, electrical infrastructure in DHH is an issue- cannot be brought forward. Modular MRI scanner on DHH currently. Cannot be progressed by division. To be discussed with Director of Acute Services t to have this risk moved back onto Directorate register. 16/08/2021- memo has been circulated by the medical director to all medical staff regarding the importance of correct protocol when filling out safety questionnaires for MRI. MD has asked for compliance audit data to be shared with MD and AMD to allow this issue to be addressed. A learning letter was sent out with the memo to be shared at the M&M meetings and Governance Co-coordinators to be raised at directorate governance fora and the AMD and DMD for sharing within teams. Posters to be placed on Trust desktops via Communications team by June 2021 The Department would like Referrer MRI Safety Training to become mandatory for MRI referrers by August 2021	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4143	ACUTE	11/03/2021	Best use of resourcesProvide safe, high quality care	Replacement programme for Radiology Equipment on all Sites to replace equipment on unsupported operating systems and provide mai	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose. There is equipment currently running on Microsoft Windows XP - the support ended in April 2014 leaving risks of ransomware attacks or hacking..Failure to patch as per schedule could result in the ability to access clinical systems on radiology equipment and server infrastructure. This has been highlighted by Tenable programme and could result in the loss of essential services.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging. Patching arrangement needs to be formalised. This needs developed with 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching - regional project looking at 3rd party suppliers being led by BSO. Targeted staff awareness, devices to be replaced, upgraded or if not possible must be segregated. IT working with Radiology to highlight all devices. "	10/02/2022 -In the financial year 21-22 the following equipment was replaced via Capital Monies: "3 Endoscopes "Technegas "3 General Ultrasound units "2 Breast Ultrasound units "2 Fluoroscopy units Capital priorities for the coming year are: "Funding for a 2nd CT Modular unit at DHH "Second CT scanner CAH "Replacement of 1 MRI scanner CAH "Replacement of DXA scanner and DR room at STH - this is in preparation for a Diagnostic Centre 14/09/2021- 10 year plan drawn up-investment per year shared with Regional Imaging Board- understand that SHSCT needs priority. "The equipment plan has been tabled at Trust SMT. Radiology have also presented to SMT to highlight the issues. This presentation has highlighted specific urgent requirements including breast imaging and fluoroscopy across both sites to include the required ventilation. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. There is ongoing review with IT regarding patching. " ongoing review with IT in relation to patching. All 3rd party contracts to be reviewed and amended to include patching- regional project. "To be amalgamated with 8, 10 and 11. The equipment plan has been presented at Trust SMT. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. "	HIGH
4185	ACUTE	12/10/2021		Risk of not being able to provide a round the clock blood sciences service on both CAH & DHH sites	There is a risk that that the critical provision of Blood Sciences may not be available on one of the main hospital sites. An inability to provide "round-the-clock" cover would compromise the provision of high quality care and in the case of Blood Bank could result in the requirement to close (temporarily) Daisy Hill to emergency admissions. In addition Obstetrics and other specialties, including Theatres would be put at unacceptable risk. Contingency measures that could be brought into operation in Chemistry could compromise patient flow and potentially compromise clinical care. Current contingencies within Haematology / Blood Bank carry even higher risks than Chemistry due to the critical nature of blood bank in particular. The stretching of staff across the 24 hour period and two sites together with the constantly increasing demand for laboratory services is also putting accreditation at risk. Type 1 Emergency Departments and Obstetrics have an absolute requirement for a Blood Bank. If the Blood Bank could not be operated at any stage of a twenty four hour period the Daisy Hill Hospital would not be able to maintain the Emergency Department and patients would need to be directed to other Emergency Departments with potential for delay and significant patient harm or death. It is sobering to reflect that critical hospital services are supported by rotas that are extremely limited and vulnerable to short notice illness with the potential for no available backfill. Unlike nursing agency bank staff are not readily available. In short inability to cover a gap could result in the emergency department having to close and patients on the Daisy Hill site being exposed to significant risk. Therefore the impact could be regarded as a catastrophic. The number of staff available on the Haematology / Blood Bank in the SHSCT is very limited, partly due to the very stringent requirements required to operate autonomously in this discipline. Currently the twenty four hour cycle is covered by too few staff and by utilising substantial overtime. Increased demand on staff has also the potential to increase sickness and stress further compounding the problem. Rotas are effectively so limited that even a few absences could cause one of the rotas to fail. The COVID pandemic has placed significant additional pressures on staff - increased demand and reduced availability of staff. Very tight rotas are highly vulnerable to these issues. Laboratory accreditation (UKAS ISO15189) is at risk where the focus is maintaining a service at the cost of maintaining a rigorous Quality Management System.	"Cross - cover from corresponding site (i.e. CAH cover for DHH) "Cross cover from other departments where relevant and safe "Additional staff in training (two staff due to complete training in the next six months) "Additional support staff through the 24 hour period "Agency support staff These controls have been enabled service provision to continue but they are insufficient to reduce the risk to an acceptable level "Additional Agency Biomedical Scientists - very limited supply (if they can be sourced at all) and likely to be off framework. Introduce additional risk - in terms of competency and experience. "Transferring Blood Bank samples to Craigavon - but there would be an unacceptable delay "Remote release of blood - unacceptable in a Major Haemorrhage scenario "Routinely providing remote Chemistry Biomedical Scientist support from the CAH site with support staff running samples on the DHH site	April 2022-Seek approval to recruit against overtime expenditure. Granted and in progress Discuss contingency with Clinical Leads/ senior staff. - Contingency is limited and has the potential to compromise patient safety Expedite training of B5 Biomedical Scientist. Despite best efforts training is slow due to the obvious constraints and COVID etc limiting further the supply of staff to train and be trained Expedite Chemistry training of Haematology / Blood Bank Biomedical Scientists. Recruit additional Biomedical Scientists and Support Staff. As above but additional staff slowly being recruited - training extremely challenging Discussion with HR around appropriate T&C for working shifts - especially at late notice etc. Procedure to describe the contingency. Completed and has provided some mitigation - however formal sign off from HR pending Plan to ensure return to schedule on all aspects of the Quality Management System. Dependent on above Remote release of results has been introduced where suitable.	HIGH
4049	ACUTE	07/08/2019	Provide safe, high quality care	Due to the staffing situation in Maternity there is an inability to accept Inutero Transfers from other Units for Neonatal Cots	The Trust is currently intermittently unable to accept inutero transfers for neonatal cots from other units. This is due to current maternity staffing level difficulties. Possible harm to mothers and babies who require a neonatal cot due to specific health needs and imminent delivery, therefore requiring transfer to this specialised facility. Potental for undue distress to baby and parents.	Continual monitoring of the staffing situation to make best use of existing resources. Transfer accepted when staffing levels permit.	16/03/2021- Ability to accept inutero transfers remains limited due to staffing and capacity ongoing recruitment continues, increased pressures to accept transfers due to regional neonatal capacity. Will continue to monitor Jun20 continue to monitor Dec19 Specific focus on recruitment - recruitment fayre undertaken and appointments made awaiting registration within next year. Retention of staff also focus within division to retain and recruit staff	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	19/4/22 . Due to gaps at ward level difficult to release staff to undertake training either Face To face or Virtual e learning. 18/08/2021- no change core mandatory training monitoring monthly but Face to Face training still an issue due to social distancing and reduced staff numbers per session. 01/06/2021- provisions have been made to allow staff to do training in their own time and to receive overtime payment to do so. 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	MOD
3663	ACUTE	29/04/2015	Provide safe, high quality care	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assesssement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to reitain a modular CT Scanner in DHH.	6/4/22 There has been a further meeting with HSCB to look at the options - there are currently 2 suppliers have submitted bids through PALS procurement. Only one supplier is within original budget. Still awaiting funding stream Dec2021- meeting with HSCB in January 2022. 03/12/2021 - Currently awaiting feedback from DOH regarding the IPT. The provider is querying if the lease will be extended by March 2022 as they have other third parties interested in the unit. 14/09/2021- Medium term plan to build a CT suite in DHH with 2x X-ray machines and one MRI. Finance and Planning have asked the Regional Imaging Board. Clarification has been sought but not yet received. Trust running at risk even without funding March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3957	ACUTE	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS	19/4/22. All wards DHH have 3 consultants aligned to them so all patients are seen daily. Need To review middle tier rota to support additional Medical Beds opened on DHH site. Recruitment in progress for substantive consultant posts. 20/09/2021- unable to secure acute physician for DAU. 18/08/2021- COW model in place and patients reviewed daily. New patients discussed at daily handover at 8.30am and also weekend handover at 12.45 on Fridays. 07/06/2021- There are 5 substantive Consultant post in DHH across Med/ Stroke/Respiratory and Gastroenterology. 4 out of 5 contribute to the 1:8 medical rota. The remaining posts are filled by Locum Consultants. there is a 1:12 weekend/bank holiday rota which is supported by colleagues from OPPC. There is now a substantive 1:8 middle tier rota. From August 2021 there will be a full middle tier out of hours rota with no locum's. At weekend/bank holidays there is an additional Consultant, registrar and SHO who work from 09:00-14:00 hours. 24/02/2021- review of medical staffing on DHH site currently taking place. E- Req in system for specialties. 13/05/20. Zoning introduced but issues identified with this system. Audit carried out. Medical rota is sufficient to provide daily senior review. 24.06.19 No change. Zoning introduce needs evaluated. Review workforce available.	MOD
3929	ACUTE	12/12/2017	Provide safe, high quality careMake the best use of resources	Declaratory Orders for patients who lack capacity	Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of liberty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes obo individuals without capacity.	Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievalbe not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision.	30.07.19 There will be partial implementation of Mental Capacity Act NI on 1 October 2019. This may aleviate some of the declarattory orders asTrust Authorisation panels are being set up. 7.3.18 Risk remains unchanged	LOW
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW
4099	ACUTE	11/08/2020	Provide safe, high quality careMake the best use of resources	Neurophysiology- Due to insufficient staffing levels risk of occasional department closure days	Occasional risk to inpatients as no staff to provide service. There is the occasional inability to provide an inpatients service for EEG. EEGs are an aid to diagnosis. there is no on call/weekend or bank holiday cover	As a rule x2 staff not permitted to have annual leave at the same time however in exceptional circumstances this can occur when staffing levels are insufficient. Change the working pattern for x1 P/T member of staff which will reduce lone working days and therefore reduce risk of closure days	03/12/2021 - A Band 5 MTO commenced in October which alleviates some of the departments staffing pressures. 14/09/2021- Lead has now retired. A new interim lead has been appointed. Continue to train 2 staff- progressing through the 2 year training programme currently. March 2021 - Lead due to retire in August 2021. 1 member of staff has taken a career break for 2 years. Another member of staff will shortly be going off on maternity leave. The remaining member of staff will increase their hours and be assisted by the trainee posts. Staff levels should be 3.22WTE	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust by DHSSPSNI	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbidity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, loss in confidence / negative publicity Service Capacity As of 30 June 2020 there are 2131 standards and guidelines identified on the Trust's S&G database. Of thes1622 were applicable to Acute Services (78%) Lack of suitable IT Recording System Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . In 2017/18 BSO gave the WHSCT significant funding to support a pilot of a modified Sharepoint system that would in the first instance record and track the implementation of NICE guidelines and Technology Appraisals. The Regional NICE Managers forum acted as the project group and whilst the scope of the project was not embracive of all the types of standards and guidelines endorsed regionally it was at least a starting point. The ultimate vision was that upon completion this system would then be shared across the HSC (including the HSCB/DHSSPNIS) to provide a harmonised / standardised system that would provide effective monitoring and traceability of guidance implementation. Unfortunately this pilot has not yet yielded these desired outcomes and in the interim the SHSCT continues to use an excel spreadsheet whose functionality falls well short of service requirements. Discussions have been undertaken with Mark Toal to seek out other possbile IT solutions - these have included Qlikvue / the new Datix S&G module (which remains in prototype) / Q Pulse. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents were data saving has not occurred due to capacity issues. As a safe guard a system back up is saved on a weekly basis. There is also the added frustration that if any of the directorate governance teams are using the shared excel spreadsheet no-one else can use it. This can impact on staff not being able to carry out their administrative duties on the system at that point in time. This is inefficient and there is a risk of a lack of timely data capture. S&G Backlog S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implementation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified Within Acute Services a directorate S&G forum has been established - inaugural meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implementation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implementation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administration processes maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance	24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less 10/08/20 - Risk reviewed and description of risk updated. 02/06/2020 standards still difficult to achieve with limited funding, staffing and equipment 09.03.2020, 5.12.16 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed. Due to ongoing work pressures Phase 1 (01/10/2015 to current date) and Phase 2 of the backlog review (all S&G issued from 01/04/2007 - 30/09/2015) will be undertaken from 01/01/2018 to 31/03/2018 has not been progressed as planned and will continue during 2019/20 workplan. Phase 1 (From 2017 to current date) has been completed. Phase 2 of the backlog (from April 2007 - Sept 2015) remains outstanding.	LOW
4090	ACUTE	09/03/2020	Provide safe, high quality careMake the best use of resourcesImproving Health and Wellbeing	Prescribing of valproate not in line with valproate Pregnancy Prevention (PREVENT) Programme	Valproate is associated with teratogenic risks (congenital malformations, neuro-developmental disorders) in children exposed to valproate during pregnancy. Children exposed to valproate in utero are at increased risk of lower IQ and of risk of developing neurodevelopmental disorders. In 2017 and 2018 the DoH issued a number of circulars in relation to the risks of prescribing valproate in women of childbearing age (HSC (SQSD) 19/17, HSS (MD) 8/2018 and HSS (MD) 27/2018) highlighting new resources to support the safety of girls and women who are being treated with valproate. Among the recommendations to Trusts was the requirement to develop an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care. In addition, all relevant resources are to be embedded in clinical practice for current and future patients, by revising local training, procedures and protocols.	Currently valproate is prescribed to a small number of patients under the care of SHSCT Consultants, all of whom have been made aware of the various DoH circulars and associated recommendations. A number of SHSCT Consultants sit on the Regional Valproate Group, chaired by PHA. The Trust has also recently established a task and finish group to address outstanding risks in relation to the recommendations in the circulars, namely the systemic identification of all girls and women who may be prescribed valproate. The Drugs and Therapeutics Committee also monitors the implementation of the recommendations within the circulars through the Medicines Governance Pharmacist, also a member of the Regional Valproate Group.	9 March 2020 Consultants manage their own registers of girls and women on vaproate.	LOW

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	12/11/21 Refurbishment in DHH for fracture clinic will not take place within financial year 2021/2022. Await confirmation of funding for 2022/2023. 08/09/2021- accommodation for refurb not available as yet. 28/06/2021- remains a risk. Investigating refurbishing Phase 1 OPD in DHH for fracture clinic. Plans developed at a cost of £60k. Waiting to here if funding is to be approved before commencing work. 15/02/2021- remains a risk. Due to the Covid 19 pandemic DHH fracture clinics remain in CAH however still risk due to no social distancing. One DHH clinic has moved to an evening clinic from November 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH 10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics. 18.09.19 Remain on Register until capital allocation 24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk	HIGH	DIV
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	19/11/21 ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessions in DHH 16/09/2021- OSL update- continues to monitor backlog. Due to Covid 19 pressures there are reduced theatre sessions and therefore the focus is on red flag. 08/09/2021- Due to the increase in Covid ICU patients, theatres have decreased sessions down to 3 all day urgent bookable in CAH and one AM session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL continues to monitor planned IPDC backlog. Theatres sessions has increased with DHH restarting 14/06/2021 with 15 theatre sessions. Only RF and urgent at present. Validating top 10 longest waiters each month. 15/02/2021- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to Covid. Currently one 1 urgent bookable list per day Mond to Friday. clinically urgent and priority 2 patients being scheduled. The Trust is currently facing the 3rd surge. No urgent bookable in DHH. 11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH 20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue 10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. 18/6/19 - planned IPDC backlog continues to be a clinical risk due to no capacity. risk has been impeded by medical leasing issue which has resulted in	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Endoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	19/11/21 Currently only clinical urgent and red flag priority 2 patients are being scheduled for endoscopy. Planned backlog continues to increase as no planned patients are being booked. Validation of planned endoscopy patients is still ongoing. Endoscopy capacity has decreased due to Covid 19 pressures, the redeployment of theatre based workforce continues to impact on capacity within South Tyrone Hospital (STH). The day clinical centre was redeployed to STH day procedure admission ward during the pandemic which still remains in day procedure. This was a 14 bedded ward historically used to run two endoscopy lists 5 days a week simultaneously. Until they return to CAH it is not possible for STH to return to a 19 planned endoscopy list per week. 16/09/2021- Planned endoscopy backlog validation is still in progress 28/06/2021- planned endoscopy backlog is currently being validated by the Gastro and General Surgical Team. 15/02/2021- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. as no planned endoscopy patients are being scheduled. Validation of planned endoscopy patients has commenced. 20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qfit test then prioritised for their colon. Still working on IS contract 10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional sessions	HIGH	DIV
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL update SEC, New regional guidance has been approved for Outpatient admin validation this will be for ENT, Urology and Trauma and Orthopaedics. From April 19 admin validation has been ongoing, new regional technical guidance has been approved and will commence Jan 2022 and the validation team admin support will increase, recruitment in progress.Capacity reduced due to Covid 19 social distancing guidance which is decreasing the number of booked clinics. IPC guidance is continually reviewed and updated. 160921 OSL update- Within outpatients admin validation is ongoing within the following areas: ENT, BFH and orthopaedics. OSL progressing decision with IPC if clinic sizes can be increased. 08/09/2021 - Currently only red flag and some urgent patients are being booked however demand is still greater than capacity. Redeployment of DSU and Theatre staff to ICU for surgery reduces theatre capacity on CAH, STH and DHH sites. Six urgent bookable sessions in CAH, fourteen trauma sessions and five urgent bookable sessions in DHH with cancellation of day surgery and endoscopy. 28/06/2021- OSL and HOS continue to monitor longest waiters. Currently due to social distancing reduced numbers continue and only red flag and urgent patients being booked. Agreed to contact IPC to see if we can increase numbers at clinics. Admin validation to commence. 15/02/2021New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 3rd surge at present. All outpatients cancelled again and outpatient staff redeployed. 0/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 2nd surge at present 10/8/2020 - New Outpatients backlog waiting times	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL and HOS continue to monitor outpatient stragglers >52 weeks. we are currently booking P2 priority patients due to Covid 19 patients. 16/09/21 OSL update- OSL and HOS continue to monitor top ten longest waiters for inpatient/day case. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL and HOS continue to monitor. Top 10 longest waiters to be validated on a monthly basis. Theatres sessions have increased with DHH restarting 14.06.2021 with 15 theatre sessions. Only priority 2 elective surgery on CAH site. 15/02/2021- New outpatient long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Still only RF and urgent patients being scheduled. Surge 3 all outpatients have been cancelled and staff redeployed to support the Wards 11/12/2020 - New outpatients long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Only RF and urgent patients being scheduled. Outpatient accommodation increased slightly from 14/12/2020 but not to full capacity. To continue with reduced numbers due to social distancing 20/10/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic. 10/8/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from	HIGH	DIV
4131	03/12/2020	Safe, High Quality and Effective Care	Trustwide	Reduction in elective capacity due to covid restrrictions-Urology ENT, Gen Surgery, Gynae and Orthopaedics	With the Covid-19 pandemic SEC ability to accommodate commissioned levels of activity is not being achieved resulting in increases in waiting times and volumes of patients on the elective and planned waiting list. As a result of increased waiting times and reduced capacity consequently patients may come to harm, increased levels of pain and discomfort and reduced quality of life	Mon-Friday 1x all day Urgent bookable on both sites CAH and DHH Due to limited elective capacity consultants clinically prioritise patients for surgery using the FSSA royal college guidelines, priority to cancer patients. Regional cancer rest meeting working towards equalising waiting times across the province. In house additionally from January 2021 on DHH site Endoscopy- weekend additional sessions in LV	12/11/2021ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessionsin DHH. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. THis will result in ongoing backlog in planned and surveillance surgical patients. Only priority 2 for CAH and DHH sites. 28/06/2021- DHH recommenced elective theatres x 15 sessions on the 07/06/2021. CAH elective sessions continue with reduced theatres- currently 2-3 urgent bookable per staff however this is staff dependent. Agency staff have taken leave July/August 21. 9/6/2021 the ongoing workforce issues will affect our ability to provide core operating sessions. Primarily for in patient theatres. The action in respect to recruitment is in place. advertisements are going out in June and 9 new registered nurses are due to commence work between June and Sept for CAH in patient theatres. we are currently working with the nurse bank and agency to attract theatres nurses and Dps from agency across mainland UK. 15/02/2021- ICU remains open to 16 patients, surge staff from day surgery and theatres/recovery remain in-situ. Currently in surge 3 03/12/2020- full de-escalation of CCaNNi critical care surge plan- this is currently medium surge and difficult to predict. Commencement of in house additionally from Jan 2021 for endoscopy and surgical specialties and the January sessions are currently being agreed. Increase urgent bookable theatre sessions	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3802	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Nurse Recruitment for Adult and Paed theatres	Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available.	We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions.	19/11/2021- no further update. 20/09/2021- Rolling nurse recruitment for Band 6 for paeds theatre is at advert. No paediatric surgery at present due to surge- redeployment of staff to ICU. 28/06/2021- Jan/Feb 2021x8 band 5 staff nurses recruited through peri-operative workstream. June 2021 band 5 applications closed, approx 8 band 5 have been recruited. Waiting on checks and start dates. Delivering of care x 1 Band 7 and 10 x Band 6's funding secured. ATICS going out to advertisement (3x CEPs Band 7- 1 funded and 2 at risk). 15/02/2021- regional peri operative recruitment drive closing date 05/02/2021, awaiting confirmation of applicants and interviews to be processed. ATICS remain with larger number of vacant adult and paediatric theatre nursing posts. 11/12/2020 - request through E&G for a commissioned paediatric nursing course for 21/22. Regional recruitment plans ongoing. HOS ATICS remains on group 20/10/2020 - regional recruitment plans ongoing. HOS ATICS sits on the group. 10/8/2020 - Since the covid-19 pandemic Paediatric theatre presently being used for outpatient ENT AGPs. No paediatric surgery currently on the DHH site. Only 2 paediatric nurses Band 6 at present, out for recruitment with BSO. Continues as risk. Continuing with recruitment drives for adult theatre nursing staff. Vacancies still remain. For retention Band 5 uplift to Band 6 successfully completed. 3/9/19 - only 3 paed nurses at present (1 is 16 hours only). Further nursing gap highlighted to AD and Director - paper attached 18/6/19 - Unfortunately continued high level of vacancies in ATICS. Theatre nursing paper has been submitted to the Acute Director. Continue to run main theatres in CAH and DHH at 30% reduction. Risk remains high. 28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019.	MOD	DIV
3804	27/05/2016	Safe, High Quality and Effective Care	Outpatients Dept	Pre Op Assessment	Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service	Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes.	20/09/2021- Pre-op staffing currently matches the requirements for urgent bookable. Recruitment required. Will update as necessary. 28/06/2021- remains unchanged will discuss way forward with AD. 15/02/2021- remains unchanged. 11/12/2020 - remains unchanged. Internal audit completed and addressing recommendations 2010/2020 - remains unchanged 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 18/9/19 - Lead nurse is interviewing this week for new pre-op nursing staff. Pre-op is one of the projects submitted under demography monies. 18/6/19 - Ongoing works pressures continue in pre-op due to demand. Group met to progress pre-op paper however planners will be not support without confirmed funding stream. To remain on RR. 28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff. 6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3800	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Anaesthetic cover for maternity services	We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards.	A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover.	19/11/2021- no change 20/09/2021- no change 28/06/2021- no change 15/02/2021- risk remains the same 11/12/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 20/10/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 10/8/2020 - no further update. Risk continues. 18.09.19 - HOS & LN's have met and are meeting again in the next month to go through figures for the nursing requirement 18/6/19 - meeting was held between gynae and ATICs, business case to be progressed. To be kept on RR 28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion. 6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres	MOD	DIV
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	19/11/2021- no change 28/06/2021- remains unchanged no funding. 15/02/2021- remains unchanged still no capital funding 11/12/2020 - remains unchanged 20/10/2020 - remains unchanged, no capital funding identified. 10/8/2020 - Still no capital funding, risk remains the same. 18.09.19 Still no capital funding risk remains the same 18/6/19 - still no capital funding identified, risk remains the same. 28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same.	MOD	DIV
4095	02/06/2020	Provide safe, high quality careBe a great place to work	Trustwide	Mishandling of Patient handover resulting in an Information Governance breach	There is a risk that the handover with patients details could be mislaid anywhere on site or in the community. Patient detail not being managed in a confidential manner thereby reveling the patient's private business and exposing the Trust to a breach in public confidence.	All disciplines of staff have been informed of the recent breaches in Information Governance and the consequence of same. All wards and departments have bins with clearly visible signage indicating they are for the disposal of the confidential handover prior to the end of their shift Regular reminders at patient safety briefings to adhere to Trust governance protocols Representative in Acute have met and agreed the content on the handovers. Incident and meeting note shared with OPPC, Peads and MH directorates.	12/11/20212 An Information Governance audit has taken place and results are pending to ascertain compliance with non identifiable patient from handovers.To await report to ascertain compliance to inform if this risk should remain on register. 20/09/2021- AD to confirm is this can be removed from risk register 28/06/2021- Additional confidential waste bins at doffing, exits and signs were erected re disposing confidential waste appropriately. 24/02/2021- continuously monitored 02/06/2020 Staff regularly reminded of necessity to adhere to Trust governance protocols.	LOW	DIV
750	28/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	STH Theatres and Day Procedure Unit requires UPS/IPS syste,	Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	12/11/2021- no change 20/09/2021- UPS/IPS need an injection of £200k. Estates are costing. 29/06/2021- less than 50% of the required installation has been completed. I have liaised with estates to advise of the next priorities if a phased approach for installation of further UPS/IPS is being considered when funding becomes available. I have listed the areas below detailing completed works in Green and the work that remains outstanding in red: Theatre 1 pendants Completed Theatre 2 pendants Completed Recovery area main theatre 6 bed spaces and defib plug Not completed DPU recovery 6 bed spaces and defib plug in reception Not completed DPU 1 procedure room pendants Not completed DPU 2 procedure room pendants Not completed DPU Decontamination unit (2 drying cabinets completed and 2 endoscope washers not completed) 15/02/2021- covid remains a priority for estates no change to risk 11/12/2020 - still with estates, priority to covid 20/10/2020 - no change and remains with estates. Priority being given to covid 10/8/2020 - no change, remains a risk. Helena to e-mail Estates re plan to address IPS/UPS. 18.09.19 No change	HIGH	HOS

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3801	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	JAG Accreditation	Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same.	JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation.	12/11/2021 No ATICS business meeting interface 15/09/2021- unchanged. 28/06/2021- unchanged. 15/02/2021- priority given to covid pandemic. Significantly reduced capacity available on all day surgery sites. 11/12/2020 - remains the same, priority being given to covid pandemic 20/10/2020 - Due to covid pandemic remains unchanged, currently going into 2nd surge 10/8/2020 - Dr P Murphy is the Interim Endoscopy lead. Endoscopy waiting times continue to be an issue in achieving JAG accreditation. 18.09.19 Require a led for JAG 28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR. 6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting.	MOD	HOS

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

Minutes of a virtual confidential meeting of the Governance Committee held on Tuesday, 16th November 2021 at 2.00 p.m.

PRESENT:

Ms E Mullan, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mr B Beattie, Interim Director of Older People and Primary Care
Mrs A Magwood, Director of Performance and Reform
Mr C McCafferty, Interim Director of Children and Young People's Services/ Executive Director of Social Work
Mrs M McClements, Director of Acute Services
Dr M O'Kane, Medical Director and Interim Director of Mental Health and Disability Services
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwives and Allied Health Professions
Mrs S Judt, Board Assurance Manager (Minutes)

1. **DECLARATION OF INTERESTS**

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

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

2. REVIEW OF MR A's COMPLIANCE WITH RELEVANT AUTHORITIES/GUIDANCE IN TERMS OF HIS PRIVATE WORK

The Chair advised that the above-named Internal Audit report had been remitted to the Governance Committee from the Audit Committee meeting held on 14th October 2021 given the clinical governance issues identified.

The Chief Executive stated that the Internal Audit review focused primarily on Mr A's change of status private patients work during the period 1 January 2019 to 30 June 2020. All the management actions have been agreed and will be taken forward within the timelines identified. He advised that this report is a review of one aspect of Mr A's practice and reviews of other aspects of his work are underway. The learning from these various strands will be taken forward through the structures put in place within the Trust and updates provided to Trust Board on emerging issues.

Discussed ensued on the Internal Audit recommendations.

Recommendation 2.1

This recommends that the Trust should consider charging for the identified private activity. Ms Donaghy raised the following points:-

i) The report does not state who should be charged and she asked why did the Trust determine that this recommendation applies to the patients/recipients of the private care? Did the Trust consider at any time that this recommendation may relate to Mr A being charged for the health care that he obtained free of charge for his private patients? If so, what was the outcome of that consideration and if not considered, why not?
ii) Has the Trust quantified the cost of the healthcare provided to Mr A's private patients?
iii) Does the Trust consider that recompense should be sought from Mr A in line with policy and procedures (and precedent) within the Trust?

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Dr O'Kane advised that this recommendation has been considered by the Trust and it was felt it would not be appropriate to charge these patients. As there was no evidence of private activity declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices raised for private treatment, both these indicated that Mr A did not perform private work on HSC premises. Dr O'Kane advised that advice had been sought from the Department of Health with regard to seeking recompense from Mr A, but their advice is that there is no mechanism to do so.

Recommendation 2.3

Ms Donaghy welcomed the fact that a number of recommendations in the report address strengthening the policies and procedures regarding the management of Consultants undertaking private practice. She raised the point that this recommendation states that *'Where concerns are raised about a Consultant's compliance, the Department of Health's framework 'Maintaining High Professional Standards in the Modern HPSS should be followed'* and asked if the Trust management accept that this is an adequate process? Ms Donaghy also asked if there was any other process, disciplinary or otherwise, in place to aid the Trust in the future management of private practice by Trust Consultants should a similar case to the current one arise?

Mrs Toal advised that for cases such as the one involving this Consultant, the MHPS, as the overarching framework, would be followed. Conduct concerns are one of the strands of the framework. Mr Wilkinson and Mrs Toal both emphasised the importance of robust Trust policy and procedures being in place to ensure appropriate behaviours.

Recommendation 1.4

The findings in the report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The report recommends that the Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. Ms Donaghy asked the following questions:-

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i) Is this an administrative process or will it be a robust process engaging with all Consultants to provide assurance that procedures are being followed?
ii) If the latter, can Trust Board be provided with a plan on how this will be undertaken and will those Consultant specialisms most likely to attract private work be reviewed as a priority?

Mrs McClements stated that as part of the revised process to govern the declaration of private practice, medical staff engaging in private practice will be required to provide signed confirmation that they are aware and will abide by the Trust Guidance on Private Practice and the regional Management of Private Practice in Health Service Hospitals in Northern Ireland (2007). Dr O'Kane provided assurance that systems were being strengthened as regards private patients and advised that the Trust has developed a private practice appraisal template to be signed off by the respective Clinical Director before appraisal.

Mr McDonald referred to the defined time period of this Internal Audit review i.e. 1 January 2019 – 30 June 2020 and queried the need to go back further in terms of Mr A's practice. He also raised the fact that the analysis conducted was largely based on the data provided by the Trust and Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete. Dr O'Kane stated that clinical concerns relating to Mr A's practice is a function of the look back exercise. She reminded members that previous concerns were raised in relation to Mr A in March 2016 and managed within the MHPS framework. Dr O'Kane stated that the transfer of private patients to the NHS goes back over 28 years of Mr A's practice and she was not sure what would be gained by going back over this without any robust hospital system in place to check. Mrs McClements advised that the current look back covers the 18-month period prior to Dr A's retirement. The focus of this is to provide assurance in respect of the safety of the patients involved and any probity issues identified will also be addressed. As issues come to light, there may be a need to go back over a longer timeframe.

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Mrs McCartan, Audit Committee Chair, stated that Mrs McClements had attended the Audit Committee meeting on 14th October 2021 for discussion on this item. Issues raised included wider learning generally and strengthening of systems of internal controls in relation to Job plans and appraisals/validations for all Consultants.

Mrs Leeson sought assurance that both private and NHS patients are seen based on clinical need. Dr O'Kane provided assurance that this was the case.

Mrs Leeson raised the Neurology Public Inquiry and the decision of voluntary erasure of Dr Watt's name from the medical register. She asked about the likelihood of this happening with the Urology Public Inquiry and if so, raised her concern that patients would not get answers to what had happened. Dr O'Kane acknowledged that this could happen and advised that there has been a significant level of medico-legal requests from patients associated with the Neurology Inquiry.

In terms of next steps, it was agreed that Audit Committee will monitor the implementation of the Internal Audit recommendations and a progress update on the recommendations will be brought to the Governance Committee in February 2022.

The meeting concluded at 2.30 p.m.

SIGNED: _____ DATED: _____

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

Recommendation 1.1	Medical Director and Director of Acute Services	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.	Oct-21	Surgical Division currently going through past urology schedules to identify sessions that Mr A had done and then matched with job plans No issues identified to date

Recommendation 1.2	Medical Director/Deputy Medical Director and all Divisional Medical Directors	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. • As part of the job planning process, the Trust should consider total working hours across HSC and private practice. Job plans should be signed and dated by the consultant and their Clinical Director.	Feb-22	As part of ongoing medical leadership review and strengthening exercises the following has been actioned: ***All consultants have an annual job planning review*** The Trust is actively progressing a programme of job planning review for all medical staff. As of 2nd February 2022 89% consultant staff signed off by relevant clinical and operational managers ***All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover.*** A revised Trust 'Declaration of Private Practice' has been created and issued to all medical staff (both Consultant and SAS grade) to be completed by all substantively employed staff for return to the Medical Revalidation team. The revised form requires the following information to be provided: • Confirmation to state if the doctor treats /intends to treat private outpatients/ medico–legal patients (inpatient/ day patient/ outpatients) in addition to their contracted work within the Trust • Confirmation they have appropriate medical protection / indemnity arrangements in place to conduct their private practice • Details of location(s) where they undertake your private practice • Confirmation if they intend to treat/intend to treat private outpatients/ medico–legal patients inside the Trust (i.e. on Trust premises) and if so ensuring they agree to complete a quarterly return to the paying patients office • Confirmation that any laboratory tests taken either on or off Trust premises must not be forwarded to the Southern H&SC Trust

				Laboratory for reporting and alternative arrangements for these has been made. • Confirmation that they have read and understood the following: - The Trust's Guidance on Paying / Private Patients and accept the responsibilities outlined therein - the Trust's Code of Conduct relating to on Paying / Private Patients and accept the responsibilities outlined therein - The regional guidance titled Management of Private Practice in the Health Service – November 2007 and accept the responsibilities outlined therein • Confirmation that any work carried out by medical secretaries to assist in paying / private patient work must be completed outside NHS working time and prior approval to retain the services of any member of staff should be agreed in advance with the Trust. • Confirmation that private patient work whether undertaken inside or outside the Trust must be included in my job plan and declared as soon as possible. Staff undertaking private practice are required to ensure their Clinical Director is aware of their intention, this is confirmed by a countersignature from the relevant clinical director on the Declaration of Private Practice form. An audit of job plans of Consultants who have declared their intention to conduct private practice will be undertaken in 2022/23 to ensure compliance with effective job planning processes. ***As part of the job planning process, the Trust should consider total working hours across HSC and private practice.*** The Medical Staff Declaration of Private Practice requires confirmation that any private patient work must be

				included within their job plan and declared as soon as possible. An audit of job plans of Consultants who have declared their intention to conduct private practice will be undertaken in 2022/23 to ensure compliance with effective job planning processes.

Recommendation 1.3	Medical Director/Deputy Medical Director and all Divisional Medical Directors	The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested: • Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. • Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. • Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. • The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.	Feb-22	As part of ongoing medical leadership review and strengthening exercises the following has been actioned: • ***Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed.*** The Trust Declaration of Private Practice requires the doctor to confirm that any laboratory tests taken either on or off Trust premises must not be forwarded to the Southern H&SC Trust Laboratory for reporting and alternative arrangements for these has been made. Further to this, a medical appraisal structured reflective template has been created and piloted for deployment in the 2021 appraisal round that is designed to assist reflections on private practice. This includes details of the doctors personal approach to risk and governance around private practice including how they access diagnostic testing. This template requires the clinician to detail volume and type of private practice completed over previous 12-month period including private practice location, inclusion in job plan, governance arrangements and scope. • ***Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately.*** The Medical Director is not able to approve or deny a consultant's indication to conduct outpatient work privately however there is a requirement to declare this type of work to the Medical Directors office via the completion of the declaration of private practice. In addition, via the Appraisal Structured Reflective Template details of this work and the clinical governance processes that provide assurance around this type of private practice. • ***Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority.***

				An audit programme is being developed for deployment in 2022/23, which will use multiple sources of information including clinical expertise to provide assurance that private patients are treated equally in terms of assigning of clinical priority as those who are referred via other HSC mechanisms. To support this audit process in 2022 the Trust is piloting an electronic version of the Change of Status form to assist with expediency and strengthen the formal record keeping process. • ***The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (i.e. outpatient / daycases / inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.*** The Declaration of Private Practice has been amended to identify the type of private practice undertaken. This information is reviewed by the relevant clinical director and will be used to inform both the appraisal and job planning process.

Recommendation 1.4	Assistant Director Systems Assurance	The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consulants must be reminded of their responsibility to ensure that all private work and change of status patients are declared. Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.	Feb-22	The Trust is in the process of reviewing its private practice guidance and reporting processes to identify any non-compliance. Several elements to strengthen this process are being introduced: • In 2022 an electronic change of status form is being piloted that when submitted will be copied to the relevant Head of Service and Clinical Director. The form has enhanced details of regarding the patients origins and referral details. • As part of the revised medical declaration process consultants are required to assure they are aware of the parameters of which their private practice should be conducted within. • Memo issued to remind medical staff of the following - Requirement of the completion of an Annual Declaration on Private Practice (including those doctors who do not undertake private practice) - Importance of ensuring that each private patient referred to an elective service has an appropriate formal referral letter submitted via the Trust Referral and Booking Centre using the same process as all NHS referrals. Each referral must be clearly marked 'PRIVATE TO NHS TRANSFER'. - That private patients should not join a waiting list via any other entry point including being directly booked by secretarial staff. An audit proposal has been created to provide assurance around these processes. - Ensuring that change of status forms are completed for all relevant private patient transfers to NHS and returned to the Paying Patients Officer

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Recommendation 1.5	Medical Director/Deputy Medical Director and all Divisional Medical Directors	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.	Oct-21	The Declaration of Private Practice has been circulated to all clinicians: The Medical Director issued a memo to remind to all of the importance of completing the 'Declaration'. The Revalidation Team are continuing to proactively engage with who have not responded in order to achieve 100% completion rate.  20220112 MEMO Medical Private Prac  20211029 Private Patients Declaration 
Recommendation 1.6	Assistant Director Systems Assurance	The Change of Status process should be strengthened. Specifically: • The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads. The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. Previously reported in 2019/20 • The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. Previously reported in 2019/20	Feb-22	The following actions have been taken to date: ***The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change.*** A revised electronic Change of Status form has been developed which for pilot which includes a mandatory field noting reason for transfer along with other more detailed information regarding the change of status event  DRAFT Change of Status Form.pdf ***The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads.*** The piloted electronic form will contain the following field and statement • *Planned Date of Transfer from Private to NHS to Approved Date of Transfer to NHS (pending Managerial acceptance)*

				• *Please note that your Clinical Director and Head of Service will be required to review the change of status submission prior to the change of status being confirmed. If there are any issues or requirements for additional information you the Clinical Director / Head of Service will contact you within 5 working days of receipt of the completed Change of Status form. Please note that the change of status will only be confirmed by the paying patients office following the expiry of the 5 day period.* ***The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads.*** The piloted electronic form submission will be duplicated to the clinical director and head of service for review. The management team will have 5 days to review and respond to question or reject the planned transfer. The below text will be included in the piloted form: • *Please note that your Clinical Director and Head of Service will be required to review the change of status submission prior to the change of status being confirmed. If there are any issues or requirements for additional information you the Clinical Director / Head of Service will contact you within 5 working days of receipt of the completed Change of Status form. Please note that the change of status will only be confirmed by the paying patients office following the expiry of the 5 day period.*

				The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. Previously reported in 2019/20 The piloted electronic form submission will be duplicated to the clinical director and head of service for review. The management team will have 5 days to review and respond to question or reject the planned transfer. The electronic form will have validation fields that will require details to be provided to allow the doctor to submit the document.
Recommendation 1.7	Assistant Director Systems Assurance, Assistant Director Functional Support Services	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable. The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.	01/02/2022 complete	An audit programme is being developed for deployment in 2022/23, which will use multiple sources of information including clinical expertise to provide assurance that private patients are treated equally in terms of assigning of clinical priority as those who are referred via other HSC mechanisms. The Trust has created a report in Business Objects and shared with Private Patient Officer to cross check. All secretaries reminded of codes and when to use. The reports are set up and PP officer runs them. Training re all the codes complete and all secretaries met with. An audit proposal has been created to provide assurance around these processes. This is pending agreement with Finance and Support Services to commence.

Recommendation 1.8	Assistant Director ATICS	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.	Feb-22 Implemented	New Process • Prescription pads are ordered via BSO e-procurement by Nursing staff • Now on receipt these are stored in locked cupboards • Cupboards located in each consultant rooms in outpatients • Only Nursing staff hold the keys for these cupboards and they take the prescription pads out at the start of clinic and return to the locked cupboard at the end. • Still to implemented will be that the Pads will be numbered and signed in and out of each of the cupboards to ensure control.
Recommendation 2.1	Medical Director	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.	01/07/2021 complete	This has been considered by the Trust and it was felt it would not be appropriate to charge these patients.
Recommendation 2.2	Assistant Director Functional Support Services and Operational ADs	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.	Feb-22	The Trust has commenced discussions within the divisions to agree and implement a written procedure for the use of protected review clinics appointment. Once agreed this will be shared and implemented with agreed timescales for monitoring compliance.
Recommendation 2.3	Assistant Director Systems Assurance	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework Maintaining High Professional Standards in the Modern HPSS should be followed.	Feb-22	As part of the revised process to govern the 'Declaration of Private Practice' all medical staff engaging in private practice are required to provide signed confirmation that they are aware and will abide by the Trust Guidance on Private Practice and the regional Management of Private Practice in Health Service Hospitals in Northern Ireland (2007).  20211029 Private Patients Declaration

Recommendation 3.1	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.	Sep-21	Due to covid 19 pressures there is limited theatre capacity. Currently only priority 2 patients according to the Federation of surgical speciality association (FSSA) guidelines are scheduled and these lists are all shared with Pre-OP as soon as they are identified by the consultant and added to the priority 2 spreadsheets.
Recommendation 3.2	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.	Sep-21	All private patients (PP) are listed onto the Patient Administrative System (PAS) by the secretarial admin staff and if they are priority 2 and added to the spreadsheet (3.1) then they are sent to Pre-Op and identified as previous PP. The report advised can be run via Business objects by Pre Op team
Recommendation 3.3	Director Performance & Reform/ AD Cancer & clinical Services	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.	Feb-22	There is a flag on NIPACS for private patient but previously, we would be have depended on the referrer to note this as 'free text' in the referral. We can ID a referral as private by the referral source which can hep indicate that likely to be private. Contact was made with BSO but their view is that this is for each Trust to establish their own process. Trust linking with colleagues in other Trusts to confirm their process for dealing with imaging referrals for private patients to influence our approach as there is currently no straightforward way to capture this.
Recommendation 3.4	Assistant Director Support Services	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.	Feb-22	PAS identifies "open registered patients". These are reviewed and reported on and followed up/ escalated for timely closure.
Recommendation 3.5	Assistant Medical Director Clinical Directors and Assistant Operational Directors	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.	Feb-22	This is a PAS function to prompt re "Discharge awaiting results" – DARO is used only for patients awaiting results and is reflected in monthly Service Administrators reports. Process for escalation currently to HOS and AD.

Recommendation 5.1	Director of Finance	The Trust should remind staff that all donations received from the public in respect of their care should be lodged to the Trust's Charitable Trust Funds only and that staff are not permitted to use their position of employment within the Trust to advance personal interests, causes or charities as it could give rise to reputational damage to the Trust.	Dec-21	To be completed by December 2022

Recommendation 1.1	Medical Director and Director of Acute Services	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.	Oct-21	Surgical Division currently going through past urology schedules to identify sessions that Mr A had done and then matched with job plans No issues identified to date

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				• *Please note that your Clinical Director and Head of Service will be required to review the change of status submission prior to the change of status being confirmed. If there are any issues or requirements for additional information you the Clinical Director / Head of Service will contact you within 5 working days of receipt of the completed Change of Status form. Please note that the change of status will only be confirmed by the paying patients office following the expiry of the 5 day period.* ***The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads.*** The piloted electronic form submission will be duplicated to the clinical director and head of service for review. The management team will have 5 days to review and respond to question or reject the planned transfer. The below text will be included in the piloted form: • *Please note that your Clinical Director and Head of Service will be required to review the change of status submission prior to the change of status being confirmed. If there are any issues or requirements for additional information you the Clinical Director / Head of Service will contact you within 5 working days of receipt of the completed Change of Status form. Please note that the change of status will only be confirmed by the paying patients office following the expiry of the 5 day period.*

				The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. Previously reported in 2019/20 The piloted electronic form submission will be duplicated to the clinical director and head of service for review. The management team will have 5 days to review and respond to question or reject the planned transfer. The electronic form will have validation fields that will require details to be provided to allow the doctor to submit the document.
Recommendation 1.7	Assistant Director Systems Assurance, Assistant Director Functional Support Services	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable. The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.	01/02/2022 complete	An audit programme is being developed for deployment in 2022/23, which will use multiple sources of information including clinical expertise to provide assurance that private patients are treated equally in terms of assigning of clinical priority as those who are referred via other HSC mechanisms. The Trust has created a report in Business Objects and shared with Private Patient Officer to cross check. All secretaries reminded of codes and when to use. The reports are set up and PP officer runs them. Training re all the codes complete and all secretaries met with. An audit proposal has been created to provide assurance around these processes. This is pending agreement with Finance and Support Services to commence.

Recommendation 1.8	Assistant Director ATICS	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.	Feb-22 Implemented	New Process • Prescription pads are ordered via BSO e-procurement by Nursing staff • Now on receipt these are stored in locked cupboards • Cupboards located in each consultant rooms in outpatients • Only Nursing staff hold the keys for these cupboards and they take the prescription pads out at the start of clinic and return to the locked cupboard at the end. • Still to implemented will be that the Pads will be numbered and signed in and out of each of the cupboards to ensure control.
Recommendation 2.1	Medical Director	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.	01/07/2021 complete	This has been considered by the Trust and it was felt it would not be appropriate to charge these patients.
Recommendation 2.2	Assistant Director Functional Support Services and Operational ADs	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.	Feb-22	The Trust has commenced discussions within the divisions to agree and implement a written procedure for the use of protected review clinics appointment. Once agreed this will be shared and implemented with agreed timescales for monitoring compliance.
Recommendation 2.3	Assistant Director Systems Assurance	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework Maintaining High Professional Standards in the Modern HPSS should be followed.	Feb-22	As part of the revised process to govern the 'Declaration of Private Practice' all medical staff engaging in private practice are required to provide signed confirmation that they are aware and will abide by the Trust Guidance on Private Practice and the regional Management of Private Practice in Health Service Hospitals in Northern Ireland (2007).  20211029 Private Patients Declaration

Recommendation 3.1	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.	Sep-21	Due to covid 19 pressures there is limited theatre capacity. Currently only priority 2 patients according to the Federation of surgical speciality association (FSSA) guidelines are scheduled and these lists are all shared with Pre-OP as soon as they are identified by the consultant and added to the priority 2 spreadsheets.
Recommendation 3.2	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.	Sep-21	All private patients (PP) are listed onto the Patient Administrative System (PAS) by the secretarial admin staff and if they are priority 2 and added to the spreadsheet (3.1) then they are sent to Pre-Op and identified as previous PP. The report advised can be run via Business objects by Pre Op team
Recommendation 3.3	Director Performance & Reform/ AD Cancer & clinical Services	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.	Feb-22	There is a flag on NIPACS for private patient but previously, we would be have depended on the referrer to note this as 'free text' in the referral. We can ID a referral as private by the referral source which can hep indicate that likely to be private. Contact was made with BSO but their view is that this is for each Trust to establish their own process. Trust linking with colleagues in other Trusts to confirm their process for dealing with imaging referrals for private patients to influence our approach as there is currently no straightforward way to capture this.
Recommendation 3.4	Assistant Director Support Services	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.	Feb-22	PAS identifies "open registered patients". These are reviewed and reported on and followed up/ escalated for timely closure.
Recommendation 3.5	Assistant Medical Director Clinical Directors and Assistant Operational Directors	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.	Feb-22	This is a PAS function to prompt re "Discharge awaiting results" – DARO is used only for patients awaiting results and is reflected in monthly Service Administrators reports. Process for escalation currently to HOS and AD.

Recommendation 5.1	Director of Finance	The Trust should remind staff that all donations received from the public in respect of their care should be lodged to the Trust's Charitable Trust Funds only and that staff are not permitted to use their position of employment within the Trust to advance personal interests, causes or charities as it could give rise to reputational damage to the Trust.	Dec-21	To be completed by December 2022

Southern Health and Social Care Trust

Quality Care - for you, with you

SOUTHERN HEALTH AND SOCIAL CARE TRUST

GOVERNANCE COMMITTEE

TERMS OF REFERENCE

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

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

1. CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Governance Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. MEMBERSHIP OF THE COMMITTEE

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust following recommendation from the Trust Chair and shall consist of not less than three members. A quorum shall be two members. One of the members will be appointed the Chair of the Committee by the Board.

3. ATTENDANCE

The following senior staff shall be invited to attend meetings:

- Chief Executive
- Medical Director
- Director of Finance, Procurement and Estates
- Director of Children and Young People's Services/Executive Director of Social Work
- Director of Mental Health and Disability Services
- Executive Director of Nursing, Midwifery and AHPs
- Director of Acute Services
- Director of Older People and Primary Care Services
- Director of Human Resources and Organisational Development
- Director of Performance and Reform
- Assistant Director, Clinical and Social Care Governance
- Head of Pharmacy and Medicines Management

Other members of Trust staff may be required to attend meetings as the Committee considers necessary.

The Board Assurance Manager, supported by the Committee Secretary, shall be secretary to the Committee and shall attend the meetings and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

Meetings shall be held on a quarterly basis.

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

5. AUTHORITY

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, through the relevant Director, and will be given the resources necessary to carry out its role. The Committee will be given full access to any information within the Southern Health and Social Care Trust that it requires to fulfil its function. The Committee is authorised by the Board to obtain external professional advice and to invite external personnel with relevant experience and expertise if it considers this necessary.

6. REMIT

The remit of the Committee is to ensure that:

- There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.
- Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
- Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board
- Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
- There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
- Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

In carrying out its work, the committee will utilise information from:

- Clinical and Social Care Governance systems
- Risk assessment and risk management systems
- Health and Safety
- Medicines management systems
- Information Governance systems
- Litigation systems
- National Audit outcomes
- Whistleblowing process

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

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to any reviews by Department of Health commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, other accreditation bodies, etc.).

The Committee will review the adequacy of all governance and risk management and control related disclosure statements (in particular the Governance Statement).

The Committee will work closely with the Audit Committee to provide comprehensive assurance to the Audit Committee's own scope of work.

The Committee will receive the minutes of the Trust's Mid-Year and End-Year Ground Clearing meetings for information.

7. REPORTING

The minutes of the Governance Committee shall be formally recorded by the Committee Secretary and submitted to the Trust Board following approval of the Governance Committee. The Chair of the Committee shall draw to the attention of the Board any issues that require executive action.

Any business conducted in a confidential session by the Governance Committee will be reported to a confidential session of the Trust Board.

Following each Committee meeting, the Chair of the Governance Committee will provide a written summary report on the meeting to the next Trust Board meeting.

The Committee will report to the Board annually on its work in support of the Governance Statement.

OTHER MATTERS

The Committee shall be supported administratively by the Board Assurance Manager and the Committee Secretary, whose duties in this respect will include:

- Agreement of agenda with the Chair.
- Collation and distribution of papers no less than 5 working days in advance of the meeting.
- Producing the minutes of the meeting and taking forward matters arising and issues to be carried forward.
- Advising the committee on pertinent issues.

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

Southern Health and Social Care Trust

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	Confidential 26th May 2022	
Agenda item	Update on Clinical concerns within Urology	
Accountable Director	Dr M O'Kane	
Report Author	Name	Jane McKimm
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

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

1. Detailed summary of paper contents:

This paper outlines the progress in response to the Public Inquiry into Urology Services in the Southern Trust.

Urology Services Inquiry

Evidence gathering for the USI is continuing. As at May 18th, 2022, there are 46 active individual S21 notices requiring response. These cover a range of former and current staff. The scope of discovery has now extended back to 2007 which adds to the complexity of the process. Current staff are balancing the need to maintain normal business with completing these very detailed responses. Staff recognise the importance of the S21 process and the care required to comply with the S21 requests. This is placing added pressure on the health system, and we continue to liaise closely with the Department of Legal Services.

Update - Public Inquiry Response Steering Group
Chair – Programme Director of Public Inquiry

Due to staff and organisational pressures, this group has been unable to meet since the last Trust Board.

Urology Oversight/Lookback Steering Group
Chair – Director of Acute Services

These meetings continued to be held fortnightly on Monday mornings when an update is provided on the oversight in respect of patients identified as previously being under the care of Mr O'Brien. The original lookback for these patients is being extended from January 2019 back to 2014 and this group will continue to have oversight of this work.

The Trust has undertaken a review of all patient information that has been issued to date, following a number of concerns raised about the accuracy of information provided to patients and families.

Public Inquiry Quality Assurance Group.
Chair – Trust Medical Director

To date the group has received updates on work relating to the following:

- Medical Leadership Development
    - Strengthening of Medical Leadership Structure

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

  - Introduction of Divisional Medical Director Clinical Governance Meetings
- Medical Appraisal and Revalidation
  - Establishment of Medical Revalidation Oversight Group
  - Development of Medical Appraisal Mentoring Scheme
- Medical Private Practice
  - Enhanced Declaration of Private Practice
- Urology and Cancer Services
  - Update on Urology SAI Recommendations
  - Update on MDM baseline assessment work

Patient Involvement

We continue to meet monthly with Service Users as part of the SAI recommendation implementation updates. There are also fortnightly meetings involving service users with representatives from external PPI and our Urology CNS to work on a targeted QI project for Urology Cancer Patients – the pilot of a questionnaire developed to focus on post diagnosis clinics. This has been extensively inputted to by the service users reflecting their own experiences. There are plans to create a relative/supportive person questionnaire to facilitate feedback from both sources. The aim is to roll this out to other tumour sites following the pilot and feedback.

A Macmillan Peer Volunteer programme which involves patients who have been through a cancer pathway offering support to Trust Urology patients is ready to start, initially involving 30 patients. Pending feedback the Trust will look at an extended roll out of the programme.

General Medical Council

The GMC investigating team are still internally progressing their case work and have no update at this stage.

Capacity

We remain with approx. 50 patients to be seen at clinic as part of the original Jan 2019 to June 2020 cohort. Clinic capacity was an issue in April and May due to conflicting/ higher priority patients (active cancer) and the unavailability of Consultants. A senior Consultant is retiring shortly, impacting on urology capacity.

Private Practice

This issue remains with the Department of Health for consideration of next steps.

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

Structured Clinical Record Review (SCRR) (previously referenced as SJR)

As previously advised there were 77 records identified as requiring an SCRR from the cohort of patients under AOB between January 2019 and June 2020. An internal screening process has been completed and there are a total of 53 patients confirmed SCRR. 2 patients remain under discussion of the original 77.

Information Line

There have been no further calls to the information line.

SAI Recommendations

The Monthly Task and Finish Super group continue to meet monthly to review SAI recommendations. Each MDT continues to work closely each month with the Cancer Services improvement lead to complete their individual action plans. Recent developments include:

Recruitment process for Cancer Information and Audit Officer to support the auditing of the MDTs and in particular the outcomes and actions based on the recommendations.

A Clinical Nurse Specialist (CNS) forum has been established which meets early next month for the 1st time with the aim of providing a supportive forum for all CNS and to allow discussion and sharing of ideas and development of QI improvement across all cancer sites and allowing specific support and training.

Of the 11 recommendations there are 7 green and 4 in amber.

Communications

The Trust has not received any media enquires since the last report

Update from the USI

Updated information on the USI can be found at:
https://www.urologyservicesinquiry.org.uk/news/update-christine-smith-qc-chair-urology-services-inquiry

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

2. Areas of improvement/achievement:	
The Trust is continuing to identify areas for improvement through the Task and Finish Group from the recommendations of the Serious Adverse Incident and are in the process of implementing these.	
3. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

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

Southern Health and Social Care Trust

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	31st March 2022	
Agenda item	Update on Clinical concerns within Urology	
Accountable Director	Dr M O'Kane	
Report Author	Name	Martina Corrigan
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

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

1. Detailed summary of paper contents:

The Programme Director post has been appointed, with Jane McKimm taking up a 12 month secondment on February 1st. The Programme Director heads up the Trust Public Inquiry Team, supporting the Trust in the delivery of the Public Inquiry response. The Trust has also secured a secondment post to provide Independent Assurance around the response process. Margaret O'Hagan, currently Director of Surgery and Clinical Services in the Northern Health and Social Care Trust will be working with the Public Inquiry Team providing reassurance to the USI about the integrity of the response, and guarding against any perception of Conflict of Interest. Margaret most recently has been seconded to the Department of Health to work on the implementation of Rapid Diagnosis Centres across Northern Ireland.

Urology Services Inquiry

Evidence gathering for the USI is continuing. This includes the completion of several Section 21 notices, including a number which have now been issued to individual staff – 6 notices served on four staff members (including former staff). The scope of discovery has now extended back to 2009 in some cases. Staff are required to stop their normal duties to complete these very detailed responses, which is placing additional pressure on the health system, and we continue to raise concerns about staff welfare through the Department of Legal Services (DLS).

Update - Public Inquiry Response Steering Group
Chair – Programme Director of Public Inquiry

This ensures that there is an effective response to all requirements of the USI. The most recent meeting included a presentation by the DLS about the PI, the obligations of continuing discovery, advice and information on S21 requests. The group will also oversee the support of all staff involved in the Public Inquiry, ensuring that, legal, professional and psychological support is available for all staff / ex staff. The group will support internal communications. The group will liaise as required with the Trust Lookback Steering group and the Quality Assurance Oversight Group. It will also link in with HSCB and DOH as required

Urology Oversight/Lookback Steering Group
Chair – Director of Acute Services

These meetings continued to be held fortnightly on Monday mornings when an update is provided on the oversight in respect of patients identified as previously being under the care of Mr O'Brien. The original lookback for these patients is being extended from January 2019 back to 2014 and this group will continue to have oversight of this work.

The Trust is undertaking a review of all patient information that has been issued to date, following a number of concerns raised about the accuracy of information provided to patients and families.

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

Public Inquiry Quality Assurance Group.
Chair – Trust Medical Director

The first meeting of this group took place on 31 January 2022 and has met monthly since. The group is tasked with the following:

The group will ensure there are effective quality assurance processes regarding medical professional governance and both clinical urology and cancer services within the Trust. This will include the following:

- To consider the effectiveness of current systems and processes to monitor and assure the safety of our systems
- To identify areas for improvement and formulate and develop measurable actions to address same
- To develop audit and other assurance mechanisms to provide corporate level assurance of the safety of our systems

The purpose of the group is to provide assurance to the Public Inquiry Programme Board on the following

- The monitoring of continuous and measurable improvement in the quality of medical professional governance regarding medical appraisal and revalidation
- That the processes and assurance mechanisms regarding the oversight of medical private practice and paying patients remain robust and effective
- That there is continuous and measurable improvement in the quality of both urology and cancer services which supports the delivery of safe, high quality patient care.
- Ensuring that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.
- To review proposed quality improvement priorities and to monitor performance and improvement against the Trust's quality priorities
- To seek assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

Patient Involvement

The Trust continue to meet monthly with the Service User group to provide updates on the SAI recommendations. A targeted Quality Improvement project has started with our service users focused initially on the information given and patient understanding of the journey they are about to go on. This is nearing the pilot stage when a questionnaire will be issued following first appointment (diagnosis) and will inevitably lead to further Quality Improvement work within the service. Service users have been very involved in the drafting of this questionnaire and the Trust have been supported by an external resource with experience in Public Involvement who had worked on the Hyponatraemia Inquiry

General Medical Council

The GMC have received all 9 SAI reports relating to Mr O'Brien. The GMC have advised that they have decided these cases will now formally be considered as part of their ongoing investigation into Mr O'Brien's practice. The Trust has informed the patients

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

and families and has shared patient casenotes with the GMC. The GMC are in the process of deciding on how Mr O'Brien's case will progress

Capacity

By the end of March 2022 there will be 47 patients remaining to be seen from the original cohort (January 2019-June 2020) with a plan in place to see these remaining 47 patients by end of April 2022.

Private Practice

The Trust discussed mechanisms for obtaining private practice records at the recent UAG meeting, 23rd February 2022. At this meeting the Trust has discussed with the DoH the potential role of the GMC to support access to private patient records. The Department of Health are currently considering the next steps.

Structured Clinical Record Review (SCRR) (previously referenced as SJR)

As previously advised there were 77 records identified as requiring an SCRR. Internal screening process has been completed and there are a total of 53 patients who now require an SCRR with a further 6 potential patients from this cohort. Consultants recommended through British Association of Urological Surgeons (BAUS) have commenced this work and the Trust are awaiting feedback on their findings. There have been a further 8 patients identified as meeting the threshold of an SAI and the Trust are awaiting feedback from DoH on how these and future patients are managed in terms of learning.

Information Line

Between December 2021 and March 2022 there have been 47 calls to the Information line.

SAI Recommendations

The Monthly Task and Finish Super group continue to meet and have updated key priorities of work towards a target implementation deadline of end of March/ start of April 2022. All MDT Leads continue to work through their action plans to address the findings in the MDT Baseline audits which has been completed across all tumour sites and these have been shared with Service Users.

Communications

The Trust has not received any media enquires since the last report

Update from the USI

The USI have provided an update on the progress of the USI:
https://www.urologyservicesinquiry.org.uk/news/update-christine-smith-qc-chair-urology-services-inquiry

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

The USI intends to hear from patients and families in mid-June. These hearings will not be in public but the legal representatives for the core participants will be in attendance and a formal written record will be kept/published.

The Inquiry intends to formally open hearings w/c 7 November 2022. The USI plans to sit for three days a week, in two week blocks, with week three used to prepare for the next set of witnesses. No information has been provided as yet about which witnesses will be heard first or which issues the Inquiry will be dealing with and when. Timings of hearings are subject to change and we will advise as more information comes available.

2. Areas of improvement/achievement:

The Trust is continuing to identify areas for improvement through the Task and Finish Group from the recommendations of the Serious Adverse Incident and are in the process of implementing these. For example, recruitment is in progress for an MDM Administrator, additional Cancer Trackers, additional clinical staff (Pathology, radiology etc) to attend the Cancer MDTs

3. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

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

Southern Health and Social Care Trust

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	27 January 2022	
Agenda item	Update on Clinical concerns within Urology	
Accountable Director	Mrs Heather Trouton	
Report Author	Name	Martina Corrigan
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

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

1. Detailed summary of paper contents:

The Trust's has established a Public Inquiry Programme Board. The Programme Board will be convened by the Chief Executive and will oversee the work of the Public Inquiry Response Steering Group, the Urology Lookback Steering Group and the Quality Assurance Oversight Group.

Urology Lookback Steering Group
Chair – Director of Acute Services

The meetings for this group commenced in November 2021 and are held every two weeks on Monday mornings.

The Urology Lookback Steering Group will provide oversight in respect of patients identified as previously being under the care of Mr O'Brien. The Group will also be responsible for providing the DOH with assurance regarding the rigour of approach pursued by the Southern Trust and the timeliness of patient review.

Patient Involvement

Monthly meetings continue to be held with two Service Users who have asked to be involved in the Task and Finish Group for the SAI recommendations implementation. There is an action plan for the meeting which incorporates the actions for all cancer specialities not just Urology. Service users have been involved in developing patient feedback resource and have also contributed to the formatting of the letters being sent to patients and relatives. Updates from the monthly Task and Finish Super Group (monthly meeting with representation from MDT Leads) are shared with service users to provide oversight of the work progressing across all cancer sites. All baseline assessments, audit tools and supporting policies, procedures and guidelines are provided to service users also.

General Medical Council

The GMC have received all 9 SAI reports relating to Mr O'Brien. The GMC have advised that they have decided these cases will now formally be considered as part of their ongoing investigation into Mr O'Brien's practice. The Trust has informed the patients and families and has shared patient casenotes with the GMC

Summary of Activity Table attached to this report

Trust Board Cover Sheet Urology Januar

Please see attached table for breakdown.

Capacity

As detailed in the attached table by end of January there will be 135 patients remaining to be seen with a plan in place to see these remaining 135 patients by end of March 2022. Three consultant urologists have committed to WLI and have displaced PA sessions and admin into own time. CNS have also committed to overtime to support these additional clinics. Patients in review backlog, those who contacted Information line and those subject to SCRR are priorities. Own consultants waiting list patients are being displaced to accommodate which is of concern to the Clinical staff. As patients are seen there will inevitably be need for further capacity for eg diagnostics as necessary. Table attached details the planned activity from January to March.

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

Private Practice

The Trust discussed mechanisms for obtaining private practice records with RQIA and the DoH on the 28th September, a revised correspondence is being developed by DoH based on the discussion with RQIA and the Trust.

Structured Clinical Record Review (SCRR) (previously referenced as SJR)

As per the above attached table there were 77 records identified as requiring an SCRR. Internal screening process has been completed and there are a total of 65 patients who will have an SCRR completed by the team who has been established for completing the SCRR. Out of the original 77 patients there are a further 6 patients who need an extensive note review to determine if they require an SCRR. There is also an additional 2 patients who have since been identified as meeting the criteria for an SCRR but the Trust have requested guidance from the DoH as to whether this process should continue for any patients identified as meeting the criteria of an SAI.

- The SCRR Process is based on the principles and methodology found in the Structured Judgement Review (SJR) process from Royal College of Physicians. It incorporates quality judgement over phases of care.

Information Line

Urology Information Line reopened from 12 December 2021. To date only two calls have been received and another three patients have contacted the Inquiry email. All of these patients had care reviewed and no concerns identified

Public Inquiry Response Steering Group

Chair – Director of Nursing, Midwifery and AHP's

The meetings for this group commenced in November 2021 and are held monthly on Friday afternoons.

This group will ensure there is an effective response to all requirements of the USI ensuring that all information as required by the USI panel will be made available and shared within the timescales requested. The group will ensure that there are robust data management systems in place to manage all information; collation, storage and transfer and in line with all information governance requirements. The group will ensure as far as is within the gift of the group that there is full openness, transparency and disclosure of all relevant documentation. It will also oversee the support of all staff involved in the Public Inquiry, ensuring that, legal, professional and psychological support is available for all staff / ex staff. The group will also ensure there is an effective communication plan in place both internally within the organisation and externally to inform the public where appropriate. The group will liaise as required with the Trust Lookback Steering group and the Quality Assurance Oversight Group. It will also link in with HSCB and DOH as required

Urology Service Inquiry

The Trust continues to work with the Urology Service Inquiry Team (USI) on providing evidence as outlined in the Section 21 notices. The Trust has now transferred evidence in relation to Section 21 notices for the three deadlines; 4 November 2021, 3 December 2021 and 10 December 2021. The Chief Executive has been serviced a Section 21 notice and is currently working with Senior Counsel in finalising this for end January 2022. The Trust met with our Senior Counsel in late December and outlined to them the difficulties that the Trust could be potentially facing in light of the ongoing pandemic and a letter was sent on our behalf to the USI detailing the predicted unscheduled and

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

staffing pressures that the Trust would be facing during January. The USI took recognition of this correspondence and agreed not to send any section 21 notices to the Trust during the first six weeks of 2022 without first having a discussion via DLS on the timescales.

A number of meetings with key personnel (Chief Executive, consultant urologists, managers etc) and senior counsel are currently being set up and will commence from 1st week in February 2022.

Quality Assurance Oversight Group.

Chair – Trust Medical Director

The meetings for this group will commence on 31 January 2022 and will be held monthly.

The group will ensure there are effective quality assurance processes regarding medical professional governance and both clinical urology and cancer services within the Trust. This will include the following:

- To consider the effectiveness of current systems and processes to monitor and assure the safety of our systems
- To identify areas for improvement and formulate and develop measurable actions to address same
- To develop audit and other assurance mechanisms to provide corporate level assurance of the safety of our systems

The purpose of the group is to provide assurance to the Public Inquiry Programme Board on the following

- The monitoring of continuous and measurable improvement in the quality of medical professional governance regarding medical appraisal and revalidation
- That the processes and assurance mechanisms regarding the oversight of medical private practice and paying patients remain robust and effective
- That there is continuous and measurable improvement in the quality of both urology and cancer services which supports the delivery of safe, high quality patient care.
- Ensuring that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.
- To review proposed quality improvement priorities and to monitor performance and improvement against the Trust's quality priorities
- To seek assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

SAI Recommendations

Weekly meetings take place on a Thursday with sub-group of the Task & Finish Group (Cancer Improvement Lead, AD of Cancer Services, HOS for Cancer, HOS for Clinical Assurance and co-chairs of super group and service user group) and this feeds into the monthly meetings with Task & Finish super- group involving leads of Cancer MDT's/ Tumour Sites.

All MDT's across all cancer sites have now had a baseline assessment completed and subsequent action plans devised for addressing deficits. MDT's Chairs have ownership of this.

The Principles document for MDT process is currently with MDT Chairs for comment and this is expected to be operational by end of January 2022.

SAI Recommendation Implementation progress is shared with Service User group as detailed above

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Internal Audit

The Trust have received the final Report of Internal Audit's findings into a review of Mr O'Brien's compliance this report has now been presented to Confidential Audit Committee and Governance Committee and the Trust are now working on a range of actions that has come from this report and this will be reported back to Governance Committee in February 2022.

Grievance Appeal

The grievance review report has been discussed with SMT members of the internal urology oversight group. The report has been shared with the doctor. The report will now be shared with the Trust's Urology Quality Assurance Oversight Group for sharing of learning from this review.

Staff Engagement

Mr Donal Lunny QC and Mr Michael McGarvey, along with the Trust Solicitors met with the clinical team in November 2021 where they advised of the expected processes for the USI. The teams had an opportunity to discuss and ask any queries/concerns at this meeting.

The Medical/Acute and Public Inquiry Directors held a meeting with the Urology Team (Clinicians/Clinical Nurse Specialists/Senior Managers) on 16 December 2021 which is the regular meeting with the team when they updated the Team on progress with the Inquiry, content of Section 21 Notice and progress with collecting and collating this information. The clinical team have agreed that now that the Inquiry has started that they would take up the offer of Mr Pengelly to meet with them over the next number of months which will be organised by the AD for the Inquiry.

Communications

The Trust have not received any media enquires since the last report

2. Areas of improvement/achievement:

- The Trust is continuing to identify areas for improvement through the Task and Finish Group from the recommendations of the Serious Adverse Incident and are in the process of implementing these. For example, recruitment is in progress for an MDM Administrator, additional Cancer Trackers, additional clinical staff (Pathology, radiology etc) to attend the Cancer MDT's.

3. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

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APPRAISAL & REVALIDATION CHANGES FROM 2019 TO CURRENT

APPRAISAL	
Moved to online Regional Appraisal System (RASP) 2019	
⮜ 2019	**2019 ➢**
Appraisal on paper format	2019 Move to Electronic eportfolio
Dr held supporting information in Appraisal A4 folder, Medical Leads had no access to supporting documents Drs appraisals were in progress but no oversight of completion	2019 Eportfolio includes document library of all supporting information Medical Leads have access to full appraisal Medical Leads
QA of appraisals without supporting information	2019 QA of appraisals carried out on RASP before appraisal is marked as complete
	2019 Appraisal can be re-opened if it lacks supporting information, once uploaded, appraisal goes through further sign off and QA
No Regional Appraisal system	2019 rolled out the new online Regional Appraisal System across all Trusts in NI. Each Trust has a designated Trust Lead for the RASP system Regional Design Group set up and attendance by Revalidation Manager from each Trust. Regional Committee Group set up and attendance by Revalidation Manager and Medical Lead for Appraisal & Revalidation Regional Design Group Meetings are held on regular basis to ensure smooth running of the system Queries about the system are directed to the Trust Lead in the first instance for advice and/or to raise with BSO if technical Regional Design Group agree, develop, test, implement and QA all new processes required on the RASP system Regional Lead position is currently vacant due to funding, this will be vital for any future development of RASP system This system allows cross trust appraisals Doctors files are transferred over to new trust on request
Doctors had ability to choose Appraiser	2019/2020 - 2 New processes (a) Allocation of appraiser to appraise by Medical Revalidation Team (b) **Consultant appraise**: Consultants & SAS **SAS appraise**: SAS and lower grades
Appraiser training provided 2017	2020 - Appraiser training provided to update appraisers ensuring high standard

	maintained, this included refresher and new appraiser training 2022 Bespoke in house appraiser training will be provided on a regular basis to support appraisers Ongoing Ensure Medical Director/RO has a sufficient pool of appraisers available to carry out medical appraisals within SHSCT
Appraisers allocated PA's	2021 All Appraisers allocated 0.25PA's per 8 appraisals to be referenced in Job Plans
Appraisal completion notified at end of year to AMD's	2021 Completion of appraisals notified on a monthly basis to each DivMD 2021 new 1:1 DivMD meeting implemented with Medical Director 2021 Medical Revalidation Team provide information for 1:1 meeting to Medical Director 1 week prior to meeting date
Appraisal meetings occurred face to face	2020 Following pandemic appraisal meetings took place face to face or virtual with majority of meetings being held virtually
2014 Appraisal Flowchart (based on the paper format)	2021 Appraisal Flowchart updated to take into consideration new online system RASP
M&M attendance included in supporting information annually	2020 Updated M&M attendance certification included with 5 years attendance rates
SRT – individual reflections	2020/2021 SRT developed to include all reflections required for appraisal and maintain standard All reflections contained in one document in library (cut out need to search for reflections)
Private Practice Declaration Completed once and updated only if required May have been omitted from appraisal	2021 Private Practice Declaration revised to ensure completion on an annual basis by all Doctors 2021 Uploaded to annual appraisal & check process implemented at QA level to ensure inclusion 2021 Reflective template devised and completed by those Doctors who declare Private Practice
Appraisal Policy 2014	Appraisal Policy Update 2022
Audit of Appraisal forms carried out 2013	2020/2021 Audits of Appraisal, online system RASP and Appraisers carried out

REVALIDATION

⮜ 2019	➢ 2019
3 stage process which consisted of Doctor having two meetings - 8 & 4 weeks in advance of folder submission for revalidation. AMD sign off no concerns prior to Revalidation decision Revalidation decision 1 week prior to revalidation date	Implementation of new Revalidation Oversight Meeting - Restructuring of AMD to DivMD and CD's within Trust - Meeting includes new DivMD checklist of documents - Additional information from HR/Litigation/Complaints added to cover 5 years of revalidation cycle - Revalidation Oversight Meeting occurs on monthly basis schedule/timetable  MASTER REVALIDATION OVES attached - DivMD or deputised CD's attend all meetings - Attendance is required at all meetings by DivMD or deputised CD for shared learning - Folders are available week prior to meeting - DivMD presents Doctors revalidation folder at meeting for discussion - Based on discussion/evidence Medical Director/RO will make a recommendation for revalidation or deferment through to GMC

	- Once submitted to GMC and GMC approves decision, Doctor is notified of outcome and appropriate files updated
Revalidation Flowchart	Revalidation Flowchart updated
Revalidation Review form	2019 Revalidation review form updated 2020 DivMD checklist devised for Revalidation Oversight Meeting 2020 All moved to electronic format Shared directory folders with restricted access for safe transfer of information to Medical Director/RO, DivMD and Medical Leads of Revalidation Team
Patient & Colleague Feedback required 1/5 year of revalidation cycle a GMC requirement Set up 1 year in advance of revalidation date and Dr notified by Revalidation Team	2019 Patient & Colleague feedback set up 2 years in advance of revalidation date and Dr notified by Revalidation Team of same 2020 Check process implemented by Revalidation Team to ensure compliance and progression of surveys
Patient & Colleague Feedback required 1/5 year of revalidation cycle a GMC requirement Paper/online based ipads issued to wards for this purpose	2020 Patient Feedback developed to include patient mobile phone survey along with the paper format - Following pandemic difficulties were identified by Drs around the issue of paper based patient surveys due to infection control - Ipads unable to issue to Wards difficulties around the cleaning/ infection control of ipads - System was devised whereby the patient survey could be issued via text to the patients mobile phone either are ward level or clinic - Ability for patient to complete at their leisure - Ability for carer/family member to complete on patients behalf or help patient complete on own mobile - Once survey completed and submitted it goes directly onto the Drs survey on the P/CFB system - Eliminated photocopying, postage, and handling of paper based forms - Confidentiality :- Patients IP address on mobile not retained No patient identifiers on this system No chance of breach of confidentiality as maybe the case with paper format Patient mobile number is retained on BT texting system for a limited time only Patient receives link only for the Dr they have seen/spoken to. No chance of completing wrong survey - Extremely beneficial to the new working arrangements of virtual/telephone consultations - Ability to gather information when no face to face consultations take place

	- Doctors can still submit a mix of paper and mobile surveys to gain the 35 surveys required to generate their report - Text is issued on the BT Soprano texting system used within the SHSCT
Supporting information for revalidation to include: HR Complaints Incidents SAI's Litigation	2020 New processes updated to collate 5 years of information from HR/Complaints/ Litigation helps to better inform the Medical Director/RO in making a decision about a Drs revalidation 2020 Incorporated in new DivMD checklist so DivMD's are better informed to make a decision about a Drs revalidation

Southern Health and Social Care Trust

Minutes of Associate Medical Directors Meeting

Friday 19th January 2019 – 2pm

Present:
Dr Maria O'Kane (Chair), Dr Ahmed Khan, Dr Philip Murphy, Dr Shahid Tariq, Dr Mary Donnelly, Dr Pat McMahon, Mr Simon Gibson, Mrs Ruth Montgomery
Item:
1.0 Apologies and Welcome • Dr Damian Scullion, Dr Martina Hogan, Dr Peter Sharpe, Mr Mark Haynes, Dr Gail Browne
2.0 Minutes of Last Meeting The minutes of the last meeting 8th November 2018 were discussed and agreed with an amendment from Dr Mary Donnelly regarding the Primary Care update. Phrase to be removed "as GP not experienced in reading results". **Winter Resilience Plan** – Mrs Laura White to send out latest version of Resilience Plan and schedule next meeting. It was suggested that the name of the Winter Ward could be renamed to the Acute Frailty Unit. **Action**: Mrs Laura White **Physician Associates –** Dr Maria O'Kane updated that 4 appointments have been made across DHH and CAH.
3.0 Agenda Items Requiring Decision **3.1 Appraisal and Revalidation** Dr Maria O'Kane discussed the Electronic Online Appraisal System. The anticipated implementation timetable and potential challenges resulting from this were discussed. Dr Maria O'Kane suggested that league tables are implemented to identify areas for improvement. **Action: Mr Simon Gibson** **Job Planning** The Job Planning policy implemented by Mrs Zoe Parks was briefly discussed. Dr Maria O'Kane discussed the benefits of adding a mentor/support system to the induction programme for 1st year consultants and the potential to increase SPA from 1.5 to 2 for six months on appointment. It was noted that when previously brought to SMT for approval, the cost implications and effect on clinical time had been reasons for refusal to approve. Decision to resubmit to SMT was agreed following analysis of costs incurred on locum spend and advertising for unfilled posts. Mr Simon Gibson provided an update on Job plans signed off within the last 12 months or awaiting 2nd/3rd sign off, with level at 76% - breakdown to be requested by division. AMDs agreed to prioritise completion of Job Plans prior to the 31st March deadline, in line with Internal Audit Recommendations.

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

Action: Mr Simon Gibson.

4.0 Agenda Items for Discussion

4.1 NHS Benchmarking – Good Practice Case Studies (NFF)
This paper was considered and noted.

4.2 OPIOID Prescribing
Dr Maria O'Kane discussed current volumes of OPIOID prescribing. Suggestion was put forward for Dr Tracey Boyce to meet with Dr Rose McCullough and Dr Mary Donnelly to propose potential actions to address this. Dr Ahmed Khan suggested that there may be scope for a QI project.
ACTION: Dr Tracey Boyce to take forward and provide action plan. AMDs to cascade information.

4.3 Coroner's cases
Request for Trust Litigation Team to contact Consultant in charge of patient's care to provide relevant names of those involved. Dr Maria O'Kane requested information on numbers of cases before decision can be made due to potential increase in workload.
Action: Mr Simon Gibson to request information from Ms Lynn Hainey.

4.4 Supporting Learning from Morbidity and Mortality review
Dr Maria O'Kane briefed the meeting on how the Trust was hoping to improve the process of learning lessons throughout the organisation. A suggestion was made that the name of the meeting could be changed to impress a more inclusive attitude to all staff to include nurses. Potential name change to Patient Safety Meeting suggested by Dr Ahmed Khan. A discussion was had to potentially incorporate the M&M Review into the Patient Safety Strategy. AMDs approved this paper for implementation.
Action: Mr Simon Gibson

4.5 International Medical Recruitment Project
It was noted that the process is lengthy with no guarantee of outcome. It was agreed that following a discussion with Medical Staffing, concerns can be fed back to Department.
Action: Dr Maria O'Kane

4.6 ECRs and IFRs
A brief discussion was had asking AMDs to remind staff to send all requests through the Medical Director's office.
Action: All AMDs

4.7 NIMLC
The AMDs discussed a range of concerns relating to the recent correspondence from NILMC. It was noted that these would be considered at the NIMLC Meeting in January.

4.8 IHI International Forum on Q&S Glasgow 2018

Dr Maria O'Kane discussed the IHI Forum and asked AMDs to encourage staff to attend.
Action: All AMDs

5 AMDs Reports

- Dr Pat McMahon discussed current staffing issues within Mental Health with two resignations and noted that the vacancies were to be advertised with potential interest from current staff. Appraisals for last year are all completed and new cycle starting. Dr Pat McMahon also discussed interface issues with PSNI/Ambulance service and Mental Health/Acute and updated on current coroner's cases.

- Dr Shahid Tariq updated the meeting on staffing levels and new appointments and discussed issues surrounding continuity of service provision when relying on support from Belfast Trust. Dr Maria O'Kane requested a summary email on staffing levels and issues. Dr Shahid Tariq reinforced his commitment to flexibility and work life balance for staff.
  Action: Mr Simon Gibson to email Mrs Zoe Parks regarding arranging meetings between Dr Maria O'Kane and any new starts

- Dr Mary Donnelly – GP interface with F1s was discussed and the associated benefits. There was a discussion regarding voice recognition dictation in relation to discharge letters and more detail on requests to GPs following discharge for follow up care. Dr Maria O'Kane noted that SHSCT should be known as a good organisation for GP training and as an employer of choice.

6 Any Other Business

Frequency and Timing of Meetings
Frequency and timing of future meetings was discussed with the decision made to maintain a monthly meeting to be scheduled on the third Friday of the month.
Action: Mrs Laura White

AMD 1:1 Meetings
AMD 1:1 Meetings to be scheduled as soon as possible.
Action: Mrs Laura White

Mandatory Training
Dr Maria O'Kane raised the issue of Mandatory Training for Consultant/SAS Grades.
Action: AMDs to reply to Dr Maria O'Kane

7 **Date of next Meeting for your diary:** Friday 15th February 2019, Time:1.30pm-3.30pm
Venue: Meeting Room, THQ, CAH with VC to Mr Simon Gibson's office, DHH

Minutes of Associate Medical Directors Meeting

Friday 15th February 2019 – 1.30pm

Present:
Dr Maria O'Kane (Chair), Dr Ahmed Khan, Dr Philip Murphy, Dr Pat McMahon, Dr Gail Browne, Dr Damian Scullion, Dr Martina Hogan, Dr Brian Donnelly, Mr Simon Gibson, Mrs Ruth Montgomery
Item:
1.0 Apologies and Welcome • Dr Shahid Tariq, Dr Mary Donnelly
2.0 Minutes of Last Meeting The minutes of the last meeting 18th January 2019 were discussed and agreed. **Matters arising - Job Planning** Dr Maria O'Kane gave an update on job planning and it was noted that an agreement had been reached for new consultant appointees to be given 2.00 SPAs in the first year of service and that a peer mentor/support system will be implemented for them to work alongside consultants and GPs. A review of the additional SPAs would occur after the first year.
3.0 Presentation by Dr Brian Donnelly Dr Brian Donnelly presented on the new on-line rota system for the Anaesthetics Department. The previous paper and excel system was discussed and the various inefficiencies were highlighted. Dr Brian Donnelly stated that the new electronic system provided a clearer system for ensuring appropriate levels of cover, easing pressure on administrative staff as well as ensuring easier distribution of staff across SHSCT sites. The system is available as a smartphone app which allows for instant communication with colleagues and has been well received overall by staff. It was noted that a similar system was available for Surgeons and Physicians which is compatible with the Anaesthetic system. Dr Maria O'Kane queried if cost benefit data could be provided to present to SMT in support of the system and suggested that Medicine could also perform a trial of the compatible version. This was agreed by Dr Gail Browne and Dr Philip Murphy. **Action: Dr Murphy and Dr Browne to consider detail**

DRAFT

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

4.0 Chairs Business

Dr Maria O'Kane summarised various issues:

4.1 Medicine Review

Work volume and pressures within Medicine were noted and the potential for SAS grade staff to "act up" as a potential solution to assist in relieving these pressures was being considered. It was also noted that a new start through the International Recruitment process had arrived in Northern Ireland with their family and is due to start work in Daisy Hill Hospital.

4.2 Surgical Review

It was noted that DHH and CAH issues had been discussed recently and that it had been agreed to carry out a review of certain Surgical specialties.

4.3 DMD Posts

Dr Maria O'Kane advised that two 5PA posts have been agreed in principle, one with a focus on Workforce and Education and one with a focus on Governance and Patient Safety. It was noted that Mrs Maxine Williams had recently been appointed to the Trust and would be involved with progressing these posts.

4.4 Governance…assurance of lessons learned

Assistant Director of Governance – Mrs Trudy Reid, has been working with Governance Leads to address "hot" Governance issues and will be providing a weekly report to SMT. This is supported by Governance Committee and Internal Audit.

4.5 Recruitment and Retention

Head of Patient Safety Data and Audit post has been shortlisted and interviews to be held 22nd February

4.6 Timing and frequency of AMD Meetings

In considering the timing and frequency of AMD meetings, there was a discussion in relation to the purpose and function of the meeting. It was noted that there were two potential purposes of this meeting, between:

- Active consideration and participation in operational decision making of the organisation
- To provide a strategic view on matters where medical leadership was required, and to consider and seek assurances on governance and patient safety issues

It was agreed to adjust the meetings to the fourth week of every month and to maintain the current monthly frequency as this was perceived as the most optimal solution to fit with varying schedules. New dates to be circulated if possible.

Action: Mrs Ruth Montgomery

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4.7 Teambuilding Workshop

In light of the discussion relating to the purpose and function of the AMDs detailed in 4.6, it was agreed that there would be benefit in holding an off-site workshop in June (once the AMDs had been appointed) to consider this and other strategic issues.

Date to be confirmed and circulated for diaries. Dr Maria O'Kane requested that the workshop should be facilitated by Beeches Management.

Action: Simon Gibson & Ruth Montgomery

5.0 Agenda Items Requiring Decision

- **Job Planning**

  Mr Simon Gibson provided updated information from Medical Staffing and advised that figures were currently 64% for completely signed off and 9% awaiting sign off. It was advised that the target of 100% sign off by 31st March was achievable.

- **Job Planning Appeal Training**

  AMDs were made aware of upcoming training- information to be circulated.

  Action: Mr Simon Gibson

6.0 Agenda Items for Discussion

- **Lessons Learned – Policy for the Management of Claims**

  Mr Simon Gibson discussed section 4.5 of the policy and clarified the role of the AMDs in relation to this. Concern was raised in relation to the speed at which this information was identified, and how learning was disseminated back into the organisation. It was noted that the quarterly meetings between litigation and the operational teams were being reinstated, which was welcomed

  Action: Simon Gibson to liaise with Lynn Hainey

4 AMDs Reports

- Dr Pat McMahon advised that there are no current issues within his department for discussion and that there is currently one vacant position.

- Dr Gail Browne briefly noted that she is currently involved with the Medical Education Strategy half day and Single Employer Meeting hosted by NIMDTA.

DRAFT

- Dr Philip Murphy – Patient flow pressures were discussed and noted information provided by Dr Damian Gormley which provided evidence that 45% Medical admissions have grown within the Trust.
  Regarding workforce, it was noted that 3 gastroenterologist and 3 endocrinologist posts were due to go out.

- Dr Ahmed Khan discussed current vacancies and Locum cover arrangements. Issues surrounding Paediatric Surgical Patient issues were noted and the Consultant Locum rate was discussed.

- Dr Martina Hogan discussed the Mesh Meeting recently attended and also noted that the regular cross site meetings were going well. It was noted that of the two recent GMC referrals, one was resolved and the second was awaiting information. No other issues were noted.

- Dr Damian Scullion advised that Dr Peter Maguire had retired, and Dr Ruth Forde had left to take up another post but it was noted that there were two new appointments to fill these vacancies.
  The challenges of the HDU in DHH were briefly discussed and it was noted that the biggest issue is the lack of middle tier anaesthetic cover.

5 Agenda Items for Information

- **Changes to receiving donations from the public**
  Mr Simon Gibson briefly advised the AMDs on the legal changes regarding receiving donations from the public with specific areas, such as wards and departments, can no longer directly receive and retain donations for their own “ring-fenced” use, but rather they must be attributed to the Directorate.

6 Any Other Business

- Dr Damian Scullion updated the meeting on the Online Appraisal System Training and expressed that the sessions to date had been overall well attended and well received. It was noted that there had been some discussion from attendees over concerns on confidentiality and GDPR issues but these were addresses confidently with reassurances that the system has been over three years of work and is continually evolving so any issues will be addressed as and when they arise.
- Dr Maria O’Kane advised that a request has been made to the IPC/Antimicrobial Team to present at next AMD meeting on a new pilot they are running.

7 Date of next Meeting for your diary: To be advised

DRAFT

Minutes of Associate Medical Directors Meeting

Friday 26th April 2019

Present:
Mr Simon Gibson (Chair), Mrs Ruth Montgomery Dr Ahmed Khan, Dr Pat McMahon, Dr Gail Browne, Dr Martina Hogan, Dr Rose McCullough, Dr Shahid Tariq, Dr Peter Sharpe, Dr Sara Hedderwick, Dr Martin Brown, Mrs Trudy Reid,
Item:
1.0 Apologies and Welcome • Dr Maria O'Kane, Dr Philip Murphy, Dr Damian Scullion, Mr Mark Haynes
2.0 Presentation by Dr Sara Hedderwick and Dr Martin Brown Dr Sara Hedderwick gave a presentation on Antimicrobial Stewardship, detailing statistics showing current regional and local resistance rates to antibiotics and the long term issues resulting from this. The need for an Antimicrobial Stewardship Programme was emphasised with a focus on the need for leadership and promotion from within the senior management team. Dr Martin Brown and Dr Sara Hedderwick stressed that the lack of governance structure for AMS was an issue as well as low attendance rates at the meetings. Some potential solutions were discussed briefly including a request from Dr Ahmed Khan for an update to the IPC Strategy and the potential to add AMS as a standing item to the AMD agenda. It was also suggested by Dr Rose McCullough that Keith McCollum could be invited to the June AMD Meeting. AMDs agreed to either attend or send a representative to the next AMT meeting. **Action: Mrs Ruth Montgomery to send out reminder email for the next AMT Meeting in June** **Action: Operational AMDs to identify representative to attend next Antimicrobial Team meeting**
3.0 Minutes of Last Meeting The minutes of the last meeting 22nd March 2019 were discussed and agreed. **Item 2.2** Dr Gail Browne gave a brief update on the previously discussed rota app, noting that Dr Wendy Baird was assisting in taking this forward for the Junior doctors.

DRAFT

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

4.0 Chairs Business

Mr Simon Gibson updated on items noted:

4.1 Medical Management Structures

4.1.1 Deputy Medical Directors

Mr Simon Gibson updated the AMDs that funding for the DMD posts was yet to be agreed but that approval from the Chief Executive to proceed had been confirmed.

4.1.2 Clinical Lead for International Doctors and Locum Medical Staff

The AMDs discussed this position and felt that this role required further consideration. The general consensus was that 1PA would not be sufficient to cope with the scope of the role between the two sites and perhaps it should not be the responsibility of one person. There was a suggestion that there should be coverage on each site and also by division or directorate. Mr Simon Gibson reiterated that there is an expectation regionally to deliver on this but agreed that further discussion would be beneficial.

4.1.3 Clinical Lead for Coronial Affairs

The role was clarified as having a focus on support for our medical staff and was unanimously agreed by the AMDs to be beneficial.

4.1.4 **Clinical Lead for Medical Negligence**

Mr Simon Gibson confirmed that this role would be a Trust focused role to support our litigation team and to undertake duties currently the responsibility of the Medical Director.

The AMDs agreed with the need for the post but felt the details will need to be understood, possibly with a small team rather than one person.

5.0 Agenda Items Requiring Decision

5.1 Acute Clinical Governance – Sign Off Results

Mrs Trudy Reid spoke at the meeting regarding current outstanding sign off figures and the need for a change in how clinical staff could proceed was discussed with the AMDs. It was considered that there would be benefit in having a block sign off option on the ECR system as the current method was time consuming. Suggestion was made that junior doctors could be delegated the task of sign off to help reduce numbers and Dr Ahmed Khan suggested that it should also be a topic brought up during M&M as it is a patient safety matter.

DRAFT

Various options were discussed on how best to proceed from this point. The Decision reached by the AMDs was that there would be an amnesty for current outstanding sign offs but that a solution would be required to prevent a repeat of it happening again. Each AMD would be responsible for taking this back to their own area to try and find a solution.

Action: All AMDs to consider and report back to the next meeting

6.0 Agenda Items for Discussion

6.1 NIMDTA Recruitment Update

Mr Simon Gibson briefly discussed the potential gaps in cover for the first round of allocations which would mainly affect Obstetrics & Gynaecology and Medicine. It was noted that there would be good cover in some areas.

6.1.1 F1 Summit Feedback

Dr Gail Browne gave an excellent, concise and professional feedback on the F1 Summit, to which a number of Southern Trust Representatives attended. It was reported that there were workshops and discussions on the day surrounding "quick fix" solutions to problems in specific areas. Dr Browne mentioned that the big issues appeared to focus on medicine and surgery, with the main grievances being that there was a lack of satisfactory induction and rotas were not available six weeks in advance. Other areas where issues were noted were surrounding excessive workloads, working weekends and the lack of educational value in the workload. Some solutions noted were that the rota issue was currently being discussed and addressed, the FY1s would also benefit from work shadowing opportunities and should be encouraged to attend ward rounds whenever possible to prepare them for FY2.

Action: AMDs to cascade to staff to encourage FY1s to join ward rounds

6.2 Attendance of Trust Board – September

Mr Simon Gibson noted that Dr Maria O'Kane wanted to offer to the AMDs the opportunity to attend Trust Board to sit in as an observer.

Action: AMDs to contact Mr Simon Gibson or Mrs Ruth Montgomery to notify of interest in attending (Dr Rose McCullough)

6.3 Appraisal – Connecting with Operational Services

Views were sought from the AMDs on the topic of concerns raised by doctors within their appraisals and the proper procedure for dealing with these. It was noted that when the GMC contacts the Trust following a referral, there may be consideration of whether a patient safety concern detailed within the appraisal had been addressed.

DRAFT

Currently, these concerns are recorded but not followed up and change to this process was discussed. Following discussion, the AMDs felt that the responsibility should lie with the appraiser to escalate to the appropriate CD and AMD and that also the appraiser should be providing guidance and support to the appraisee.
Action: All AMDs to cascade to staff

4 AMDs Reports

- Dr Pat McMahon advised that a job description had been turned down with the reason noted to be that the job was not 2.5 SPAs. The job description is being adjusted to accommodate a settling in period and will be resubmitted.

- Dr Shahid Tariq briefly mentioned a workforce issue which he noted to be relevant to all areas and all levels and sought clarification regarding TOIL conditions for senior members of staff. It was noted that HR feedback would be required on the issue.
Action: Mr Simon Gibson

There were no other AMD report updates

5 Agenda Items for Information

5.1 Photography of Service Users

The AMDs were made aware of the updated information and asked to cascade to staff.
Action: All AMDs

6 Any Other Business

6.1 Trust Bereavement Forum

Mr Simon Gibson advised that Dr Maria O'Kane was seeking a representative from within the AMD team to attend the Bereavement Forum Meetings on her behalf and feedback relevant updates.
Dr Rose McCullough advised she would like to take on this role and it was directed that Mrs Ruth Montgomery would provide the necessary details and inform the Bereavement Forum Co-ordinator.
Action: Mrs Ruth Montgomery

6.2 NEWS2

Mrs Trudy Reid discussed the release of the NEWS2 implementation with the AMDs for information. The new head injury chart was available for the AMDs to view, along with the site specific escalations. The new layout of the NEWS2 Tool was agreed to be an improved version.

7 Date of next Meeting for your diary: Friday 24th May 2019
(need to check venues)

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Minutes of Associate Medical Directors Meeting

Friday 24th May 2019

Present:
Mr Simon Gibson (Chair), Mrs Ruth Montgomery, Dr Gail Browne, Dr Geoff McCracken, Dr Rose McCullough, Dr Shahid Tariq, Dr Peter Sharpe, Dr Damian Scullion, Mrs Vivienne Toal, Mrs Zoe Parks
Item:
1.0 Apologies and Welcome • Dr Maria O'Kane, Dr Philip Murphy, Dr Pat McMahon, Dr Ahmed Khan, Mr Mark Haynes, Mrs Trudy Reid, Dr Martina Hogan
2.0 Presentation by Dr Declan Kelly, Clinical Fellow, ED Dr Declan Kelly gave a presentation on an app currently in development stages, relevant to the ED department but with potential to be used across all specialties. The app was noted to have a focus on relevance to junior doctors with features including staff introductions, easy to find policies and procedures as well as a unique method of online education tracking for mandatory and departmental training. Queries were raised over the upkeep of the app, in particular changing policies and procedures of the Trust, as well as Department of Health guidelines and updates. Dr Kelly advised that as the app was still in discussion stage, these were issues to be confirmed with the Trust if taken on board. Mr Simon Gibson advised that as this was a presentation based on requesting funding to proceed, a proposal should be made in writing to both Dr Maria O'Kane and Mrs Esther Gishkori for consideration of a pilot version.
3.0 Minutes of Last Meeting The minutes of the last meeting 26th April 2019 were discussed and agreed with actions noted. **AMT Presentation** It was reiterated to the AMDs to ensure attendance at the AMT meeting or send a representative. The next scheduled AMT meeting is 27th June. **5.1 Acute Clinical Governance – Sign Off Results** To be tabled to June meeting. **6.1.1 F1 Summit** Reminder for all AMDs to cascade to staff regarding encouragement of FY1s to join ward rounds. **6.1 Trust Bereavement Forum** Dr Rose McCullagh will represent Dr O'Kane at the Bereavement Forum Meetings

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

6.2 Attendance of Trust Board – September
Dr Rose McCullagh and Dr Gail Browne advised they would like to attend as observers at the Trust Board Meeting in September.

4.0 Chairs Business

4.1 Medical Management Structures

4.1.1 Medical Leadership Paper

Mr Simon Gibson advised the AMDs that the focus of the AMD away days in June would involve discussions surrounding Medical Management Structures and Leadership. AMDs were given advance notice to consider the Medical Leadership paper for discussion in June.

Action: All AMDs to read and consider the Medical Leadership Paper in preparation for the AMD away days

5.0 Agenda Items Requiring Decision

5.1 Covering Absent Colleagues – Mrs Zoe Parks/Mrs Vivienne Toal

Mrs Zoe Parks presented the LNC approved paper "Guidance on Consultants covering Absent Colleagues and Vacancies" and invited comment from the AMDs.
It was noted that the main areas of change surrounded Bank Holiday working rate and the removal of the daytime rate.
The AMDs agreed that the bank holiday rate and daytime rate should be matched with the rates shown in the document:

Period	Payment for availability time only (e.g. when on call)	Payment for actual work undertaken
Consultant Locum	Personal Information per hour	Personal Information per hour

There was a discussion on the issues of Time Off In Lieu and the potential knock on effects of allowing this as a standard practice and it was noted that this would be best decided on a case by case basis. Mr Simon Gibson stated that if Time Off In Lieu was requested, the manager should direct the request to Medical Staffing for guidance prior to any agreement.
Mrs Vivienne Toal advised that the English Scheme Advisory Board would meet on the 12th June to discuss and make decisions on these issues and that this would form the basis of how Northern Ireland would proceed.
Dr Tariq requested clarification on the appropriateness of claiming WLI rates over locum rates, an issue which has arisen due to current vacancies. Mrs Zoe Parks confirmed that this situation entitled the member of staff to claim the rates under the "covering for absent colleagues" policy rather than WLI rates as the work was providing cover for vacancies rather than reducing waiting lists.
Action: AMDs to forward any requests for time in lieu to Medical

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

Staffing for advice and direction.

Consultant Job Planning Update
Mrs Zoe Parks provided an update on Consultant Job Planning, AMDs were advised of their department signoffs as follows:

Name	Division	%
Dr Ahmed Khan	Children/Young People	65%
Dr Damian Scullion	AMD Anaes/ICU	56%
Dr Martina Hogan	Maternity/Women's Health	28%
Dr Philip Murphy	Medicine/Unscheduled Care & ED	24%
Dr Shahid Tariq	Cancer & Clinical Services	24%
Dr Pat McMahon	Mental Health	10%
Mr Mark Haynes	Surgery/Elective Care	6.3%

Action: **All AMDs to take forward "hot spots" and progress sign offs for review at next meeting under matters arising.**

6.0 Agenda Items for Discussion

6.1 Annual Mortality Report

Mr Simon Gibson discussed the Annual Mortality report, drawing attention to pages 7-9 which detailed the mortality analysis for the Southern Trust, reported by CHKS. The data was reviewed by the AMDs and noted to be within a mid-range and that the Southern Trust compared favourably to our peers. AMDs were content that figures were within normal range.

6.2 Summer Studentships

Mr Simon Gibson advised that 8 medical students had been successful in their application to undertake six weeks of work taking on specific projects.

- **The working experience of junior doctors**
- **Clinical Audit - Sepsis**
- **Experience of International doctors**
- **Clinical Audit – Outliers**
- **Clinical Audit - NEWS**

6.3 Buddying with GPs

Dr Rose McCullagh provided information on the consultant and GP buddying system and discussed the advantages for both sides. Dr McCullagh also briefly discussed Educational Mornings on a Saturday morning and asked if there would be any interest from the other AMDs to attend and discuss any issues they would like to get across to GPs. The idea is currently a work in progress and interest was being gauged at present. The AMDs supported this idea in principle and it was agreed to discuss further. Dr McCullagh also provided a magazine article for dissemination.

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

7 AMDs Reports

- Dr Shahid Tariq advised there were no issues to discuss.
- Dr Peter Sharpe noted that the three PhD students funded through the ECME Project had all commenced work.
- Dr Damian Scullion updated that the Pathfinder work was still ongoing and two new consultants had been recruited to Anaesthetics in DHH
- Dr Gail Browne advised that Dr Beverly Adams had accepted the position of Education Programme Director, working alongside Dr John Harty. Dr Browne also updated on a recent rota meeting where discussion was had on improving the rotas for Junior doctors. It was advised that two ADEPT fellows would be starting, and Dr Browne also noted that alongside Dr Murphy, there was enthusiasm to progress the app previously discussed for general medicine.
- Dr Rose McCullagh reiterated that there was a need to improve GP and consultant interface.

There were no other AMD report updates

8 Agenda Items for Information

8.1 Induction App

Dr Rose McCullagh briefly outlined the benefits of the Induction App including the convenience of having important contact numbers to hand and easy access to policies and procedures if the app was updated appropriately. Further research is being undertaken on the suitability of the app for the Southern Trust.

9 Any Other Business

9.1 Trust intranet guidelines for Junior Doctors

Dr Peter Sharpe outlined to Dr Gail Browne the importance of Junior Doctors availing of guidelines available on the Trust Intranet and familiarising themselves with these. A suggestion was made for an information session to be set up on DHH site.

Action: Dr Peter Sharpe

10 Date of next Meeting for your diary:

- AMD Away Day 20th and 21st June, Slieve Donard Hotel
- **AMD Meeting 28th June, 2pm – 4pm, Trust HQ Meeting Room, VC Simon Gibson's Office, DHH**

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

Minutes of Associate Medical Directors Meeting

Friday 26th July 2019

Present:
Mr Simon Gibson (Chair), Dr Shahid Tariq, Dr Meeta Kamath, Dr Pat McMahon, Dr Damian Scullion, Dr Gail Browne Mrs Fiona Davidson, Mrs Trudy Reid, Miss Lauren Weir
Item:
1.0 Apologies and Welcome • Dr Maria O'Kane, Dr Ahmed Khan, Dr Philip Murphy, Dr Peter Sharpe, Dr Martina Hogan, Mr Mark Haynes, Dr Mary Donnelly, Dr Rose McCullagh, Mr Stephen Wallace
2.0 Minutes of Last Meeting The minutes of the last meeting 28th June 2019 were discussed and agreed. **2.1** Matters arising **2.1.1- AMDs Feedback on Sickness Absence Policy** AMDs to consider and respond back to Lauren Weir for giving to Dr O'Kane **2.1.2- Management and Leadership training for AMDs and CDs** AMDs to consider and respond suggestions to Lauren Weir **2.1.3- Unsigned X-Rays and bloods** A Meeting with relevant AMD's was held and it was agreed to dispose of all results prior to 1st April 2018 as these were stored electronically. **2.1.4- Major Trauma repatriation to SHSCT** Deferred to Next Meeting **2.1.5- AMDs feedback on Medical Leaders Forum paper** All AMDs to make comments and report back to Lauren Weir. Deputy Medical Director posts going out in 2 weeks. **2.1.6- HR Paper on impact of 10 PA Reductions** Deferred to Next Meeting
3. Presentation – CHKS Mr Paul Schofield was welcomed and introduced to everyone. He explained who he was and introduced the Presentation on Readmissions in the UK and Northern Ireland. (copy of Presentation attached) Mr Paul Schofield offered to undertake 1-1 workshops on this topic. Contact Mrs Lesley Leeman for information on the workshops. The AMD's agreed that some Trusts code their admission dates differently, which may affect their results compare to the Southern Trust.

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

Mrs Lesley Leeman said that Mr Paul Schofield also provides training on icompare, which is open to all staff. Mr Simon Gibson requested that Mr Paul Schofield provided examples of the dashboard he spoke about to send round all the AMD's.

Dr Gail Browne asked were they able to seek charts and review them. Mrs Lesley Leeman confirmed that you can retrieve the charts and review them without having the case notes.

Dr Gail Browne suggested that this might provide a good audit project for trainees.

4. Chairs Business

Mr Simon Gibson briefly updated on the following items:

4.1. Pensions update following SMT discussion

Dr Shahid Tariq said that some staff were retiring because of the changes to pensions. He said that this is affecting his area of work.

Dr Damien Scullion said that many staff are going externally for Financial advice. There has been a delay in Job Planning. The reduction of PA's created more pressure on the diary exercise.

4.2. Action plan following AMD Development Day

Action: Lauren Weir to chase Paula O'Kelly regarding the Action plan from the AMD Development Day.

5. Agenda Items for discussion

Mr Simon Gibson briefly updated on the items for discussion:

5.1. Update from GP/Trust meeting

Deferred to next meeting

5.2. Job Planning Update

Dr Pat McMahon reinforced that no one wants to take on extra work due to the pension issues. He is currently working his way through all job plans. Of note one consultant wants to reduce working hours, and another is seeking advice. There will be an internal audit coming round again.

Dr Damien Scullion commented that the service couldn't survive with PA's reduced. Staff were continually going above and beyond for this work.

5.3. F1 Charter Recommendations

Mr Simon Gibson, Dr Maria O'Kane, Dr Gail Browne all went to the F1 Recognition Event. Dr Gail Browne stated that there were a number of issues brought up by the F1's.

- Provide all new F1 doctors with ward-based F1 shadowing all day for 2 full days;
- Deliver a formal induction for all F1 doctors to their clinical team at the start of each placement;
- Fully involve F1 doctors in planned patient reviews on a daily basis;
- Necessitate the participation of F1 doctors in the clerking-in of patients on average at least twice a week;
- Require the active participation of F1 doctors on ward rounds on average at least twice a week;
- Limit the time spent by F1 doctors on routine tasks of limited educational value to no more than 50% of their time;
- Ensure F1 doctors are aware of who the senior doctor is (and how to contact them) for advice for each shift;
- Provide feedback to all F1 doctors through their trained Clinical Supervisors on average on a weekly basis;
- Enable all F1 doctors to attend 3 hours of on-site, bleep-free, formal teaching per week;
- Assign F1 doctors to a clinical team as opposed to a clinical area;
- Ensure that F1 doctors working out of hours' shifts have access to hot food and an area to take rest breaks;
- Provide rooms where F1 doctors can rest after a night shift before travelling home;

6. AMDs Reports

- Dr Meeta Kamath briefed the meeting on the fact that 2 of the Daisy Hill consultants were not undertaking on-call which is causing service pressures.

- Dr Pat McMahon advised that they were currently down 2 consultants with a third about to leave. Beds are being 100% filled and patients have to use dayrooms, there has been an increase in demand. This department is using significant bank and agency. Staff although the GMC gave positive feedback.

- Dr Damien Scullion said they have had 1 resignation, and they will be putting out an ad for an ICU post. With regards to GMC, results had improved from last year. They currently have 3 new starts.

7. Any Other Business

Dr Shahid Tariq raised the issue of whether the Medical Director was required to sit on panels for CD posts. It was agreed that this was not necessary.

Mrs Fiona Davidson stated that the national, regional and local Clinical audit reports, when available, to be disseminated via AMDs and this was agreed.

8. Date of next Meeting for your diary:

- **AMD Meeting Friday 23rd August, 1pm-2pm, Trust HQ Meeting Room, VC Committee Room 1, DHH**

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

Minutes of Associate Medical Directors Meeting

Friday 23rd August 2019

Present:
Dr Maria O'Kane (Chair), Mr Simon Gibson, Dr Shahid Tariq, Dr Pat McMahon, Dr Damian Scullion, Dr Gail Browne, Mrs Fiona Davidson, Dr Ahmed Khan, Dr Martina Hogan, Miss Lauren Weir
Item:
1.0 Apologies and Welcome • Dr Philip Murphy, Dr Peter Sharpe, Mr Mark Haynes, Dr Mary Donnelly, Dr Rose McCullagh, Mr Stephen Wallace, Dr Meeta Kamath, Mrs Trudy Reid,
2.0 Minutes of Last Meeting The minutes of the last meeting 26th July 2019 were discussed and agreed. **2.1** Matters arising **2.1.1- AMDs Feedback on Sickness Absence Policy** AMDs to consider and respond back to Lauren Weir for giving to Dr O'Kane **2.1.2- Management and Leadership training for AMDs and CDs** AMDs to consider and respond suggestions to Lauren Weir **2.1.3- Major Trauma repatriation to SHSCT** Dr Maria O'Kane thinks there is a plan needing updated, the plan was sent the Mrs Melanie McClements. Mr Simon Gibson is going to send it on the Mr Mark Haynes. Once this has been done and completed this point can be closed. **2.1.4- AMDs feedback on Medical Leaders Forum paper** All AMDs to make comments and report back to Lauren Weir. Deputy Medical Director posts going out in 2 weeks. **2.1.5- HR Paper on impact of 10 PA Reductions** There is currently 2 Pension Sessions organised. The Craigavon session will take place on Wednesday 28th August at 5.30pm-7.00pm, held in THQ Boardroom. The Daisy Hill session will take place on Wednesday 4th September at 5.30pm-7.00pm, held in Dr Maria O'Kane has inquired if Tea and Coffee has been organised for these sessions. Dr Maria O'Kane would also like an email sent out to everyone attending just confirming times and locations. Action: Miss Lauren Weir to check with Joana Neves to see if Tea & Coffee has been organised for both Pension Sessions. Mr Simon Gibson is to invite Ann Carson to the Pension Session.

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

3. Chairs Business

Dr Maria O'Kane updated on the following items:

3.1. Mental Capacity Act – Deprivation of Liberty

Dr Maria O'Kane spoke about Thomas O'Dell's presentation (Attached). The commencement of the act is from 1st October.

3.2. Medical Leadership Structures – Deputy Medical Directors Post

3.3. Slieve Donard report – Next Steps and Action Plan
Action: Lauren Weir to chase Paula O'Kelly regarding the Action plan from the AMD Development Day.

3.4. GMC Trainee Survey 2019

3.5. Governance Update

Fiona Davidson updated that the 211 Guidelines are outstanding. The reminder emails are not going out. Acute directorate is a big issue. Fiona Davidson is to bring the report to the next AMD Meeting.
Action: Fiona Davidson to give report to Lauren Weir for sending out to AMD's & CD's.

4. Agenda Items for discussion

4.1. Update from GP/Trust meeting

The GP Interface Meeting has been arranged for Thursday 10th October at 3.30pm in THQ Boardroom. The invitation has been sent out from Dr Maria O'Kane's account. There is an update required from the AMD's for this. Mr Simon Gibson and Dr Maria O'Kane to meet in relation to this.

4.2. F1 Charter Recommendations

Dr Maria O'Kane doesn't think that the recommendation below is clear with regards to what it means. Dr Gail Browne is to speak to Lorraine next week regards this.

- Assign F1 doctors to a clinical team as opposed to a clinical area;

6. AMDs Reports

- Dr Martina Hogan updated on the staffing issues on the Daisy Hill site. She is going to update Dr Maria O'Kane on Tuesday 27th August at her 1-1.

- Dr Pat McMahon updated on the consultant issues he is having in his department.

- Dr Damien Scullion updated that the juniors are fine in Craigavon. There are ACCS in ICU and Medics. Mr Simon Gibson met with them today, he updated that they are all happy with the start and finish times. **Action: Mr Simon Gibson to email Dr Maria O'Kane with an update from his meeting with the Anaesthetics team.**

- Dr Gail Browne reminded everyone that the Junior Doctors Forum was on Tuesday 27th August at 12.30 in Lecture Theatre MEC. The GMC Survey needs replied by September. Dr Gail Browne said she feels we need to hold an event for FY2's as with all the attention going to FY1's they might feel left out. **Action: Dr Gail Browne, Mr Simon Gibson and Carmel Harney to organise something between them in relation to this.**

- Dr Ahmed Khan updated on currently staff shortages in CYP. Dr Ahmed Khan suggested that internationally recruitment should be used more for the middle tier jobs. **Action: Dr Ahmed Khan to put together a paper regarding staff shortages and present to Dr Maria O'Kane.**

- Dr Shahid Tariq updated everyone that Katherine has retired but she is still continuing to work until her replace starts in the role. He then went on to say he had interviews coming up for his department. He currently had 2 off, one off on maternity and the other has a sore back. He mentioned that there are more registrars coming out. Dr Shahid Tariq said it takes a long time for them to train for the current jobs. He briefly mentioned that the WLI work was not being done or was unable to be done and it was ongoing.

- Dr Maria O'Kane spoke about a 5 year plan for Labs. The jobs coming up where better paid. **Action: Dr Shahid Tariq to speak to CD to put together a paper for SMT.**

7. Any Other Business

Dr Sara Landy put together a list of everyone that was in retirement/working within the Trust. **Action: Miss Lauren Weir to get this document and bring it to the next AMD Meeting.**

Dr Maria O'Kane spoke about the doors in the nursing homes having codes and not everyone had access to out through the doors. They can't keep the clients locked in the nursing home they need to be able to get out. Dr Maria O'Kane spoke about the Locum doctors so far there had been no applicants for the post. There was 4 PA's, 2 for Daisy Hill and 2 for Craigavon.

400 doctors need training between OPPC and Acute. **Action: Mr Simon Gibson to arrange.**

Fiona Davidson has been meeting with Maxine Williamson regarding Patient Safety. Fiona Davidson is to liaise with Heather Trouton about this. **Action: Fiona Davidson is to present her presentation at the next AMD Meeting.**

8. Date of next Meeting for your diary:

- **AMD Meeting Friday 27th September 2pm-4pm, Trust HQ Meeting Room, VC Committee Room 1, DHH**

Minutes of Associate Medical Directors Meeting

Friday 27th September 2019

Present:
Dr Maria O'Kane (Chair), Mr Simon Gibson, Dr Peter Sharpe, Dr Shahid Tariq, Dr Pat McMahon, Dr Damian Scullion, Dr Gail Browne, Dr Ahmed Khan, Mrs Trudy Reid, Miss Lauren Weir
Item:
1.0 Apologies and Welcome Dr Philip Murphy, Mr Mark Haynes, Dr Mary Donnelly, Dr Rose McCullagh, Dr Meeta Kamath, Dr Martina Hogan,
2.0 Minutes of Last Meeting The minutes of the last meeting 23rd August 2019 were discussed and agreed. **2.1** Matters arising **2.1.1- Major Trauma repatriation to SHSCT** Dr Maria O'Kane asked was there any problems with this. Everyone agreed that there were no issues. It was agreed to close this item **2.1.2- HR Paper on impact of 10 PA Reductions** This paper was provided for information. Dr Peter Sharpe went to the Pension Sessions that were organised by the Trust, he said they were useful and worthwhile going to.
3. Chairs Business Dr Maria O'Kane updated on the following items: **3.1. Medical Leadership Structures – Deputy Medical Directors Post** The two Deputy Medical Director posts have been agreed and are with Mr Shane Devlin, Chief Executive for signing off. Once they have been signed off, they can be advertised. **3.2. GMC Trainee Survey 2019** It was noted that Tim Bennett and Laure Martin had recently completed a presentation to SMT. Dr Damien Scullion talked about the trainees and mentioned that a room had been identified to allow them an area to take some time out.

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

Dr Shahid Tariq said that all consultants need to be thanked after they do work, as he feels that the consultants do work and don't get appreciated.

4. Agenda Items for discussion

4.1. Summer Student Posters

Everyone felt that the Summer Students doing their Posters was useful and gave them good experience and helped some of the students that are now junior doctors within the Hospital. The Adept Fellows can use some of the projects for their work.

With the Southern Trust doing the Summer Student Projects each year, it provides the opportunity to show everyone that the Southern Trust is a welcoming place to work and is willing to help Medical Students throughout their studies.

Dr Ahmed Khan asked if the Trust is willing to take A level students on placements. They would have to do 3 or 4 hours work experience.

Dr Maria O'Kane talked about her role in swotUP. She mentioned that they are coming to the Southern Trust on 9th and 23rd November
Action: Miss Lauren Weir to check the dates and send out the all AMD's for their information/ interest.

4.2. Guidance on Coronor's Investigation

This was provided for information. All AMD's found this document very useful and helpful.

4.3. Medical Antibiotic Stewardship

It was noted that Antibiotic use when not required was increasing. Mrs Trudy Reid mentioned the duration of prescribing Antibiotics. Mrs Trudy Reid is to asked IPC to pull together all the data they have in relation to this
Action: Mrs Trudy Reid to ask IPC to pull together relevant data.

4.4. Standards and Guidelines Compliance Challenges

It was noted that the Neurology department were experiencing challenges in completing the updates to the S&G. Once this is completed they will be presenting it to SMT.

Dr Peter Sharpe talked about GAIN Guidelines.

4.5. Admin Issues

This has been deferred to October. Anita Carroll is to come to the AMD Meeting in October to present on the issues identified.

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

4.6. UU Medical School

Dr Maria O'Kane updated AMDs in relation to the meeting held with Professor Louise Dubras, as it was noted that 80% of students will stay where they train. There is a meeting with Professor Louise Dubras being arranged for Daisy Hill, for her to meet with the Medical Students.

4.7. Assurance Challenges around National Audit Study Recommendations

Mrs Fiona Davidson is to do a Presentation at the October AMD Meeting.

4.8. Patient Safety and Quality Meetings

These meetings are being arranged and are going to be taking over the M&M Meetings.
Action: More information is needed regarding these meetings.

4.9. Hyponatremia training and desist notices

Mrs Trudy Reid updated those present that a Hyponatremia Audit is about to commence.

4.10. Chief Executive Business

This document is provided for information.

5. AMDs Reports

Dr Damien Scullion gave an update on appraisal completion. It was noted that some were ongoing, some had finished and some hadn't even started. The online appraisal system was working well.
There are action plans required before sign off Appraisals. Dr Damien Scullion mentioned that there are 3 posts going out for advertisement.
Action: Miss Lauren Weir to arrange quarterly Revalidation Meetings

Dr Gail Browne advised that the FY1's were settling in, but a number of issues were still unresolved. She said that there had been one FY1 resignation from being a doctor. Dr Gail Browne briefed the meeting on a NIMDTA event at Riddell Hall, which she enjoyed and thought it was worthwhile going to.

Dr Pat McMahon said that his department had a resignation; they were leaving to go to another trust. He said that the current trainees were enjoying their placement. Dr Pat McMahon had met with Mr Barney McNeany regarding some of the staff safety issues he had been having within the department. He had suggested that maybe Bodycams were

	needed for the nursing staff on wards so that they have evidence when incidents take place Dr Shahid Tariq said that they have an advertisement going out in October. He spoke about the Ulster Hospital being in competition with the Southern Trust, he said that new hospital at Dundonald put them at an advantage as they had better equipment on the wards, better accommodation and more hospital space. Dr Shahid Tariq spoke about there was no extra space at either site for more facilities. Dr Shahid Tariq mentioned that they had got a new CT scanner in the department. Dr Maria O'Kane spoke about Mr Joe Rafferty from Mersey care who presentation to SMT. Dr Maria O'Kane felt that the presentation had a lot of impact to the trust. Mr Joe Raffery has been invited to come back to the Trust at a later stage. Mrs Trudy Reid said that a wide number of Clinical Guidelines were out of date and needed updating.
6.	**Any Other Business** There was no other business discussed at this meeting.
7.	**Date of next Meeting for your diary:** AMD Meeting Friday 25th October 2019, 2.00pm-4.00pm THQ Meeting Room V/L to Tutorial Room, DHH

Minutes of Associate Medical Directors Meeting

Friday 25th October 2019

Present:
Dr Maria O'Kane (Chair), Mr Simon Gibson, Dr Shahid Tariq, Dr Gail Browne, Dr Ahmed Khan, Mrs Trudy Reid, Dr Philip Murphy, Dr Rose McCullagh, Dr Martina Hogan, Mr Stephen Wallace, Dr Neville Rutherfoord-Jones, Miss Lauren Weir
Item:
1.0 Apologies and Welcome Mrs Fiona Davidson, Dr Damian Scullion, Dr Peter Sharpe, Dr Pat McMahon, Mr Mark Haynes, Dr Mary Donnelly,
2.0 Minutes of Last Meeting • **Medical Deputy Posts –** Closing date has been extended. There are interviews being organised for December. • **Guidance on Coroner's Investigation –** It was noted that these were live and online and AMDs should promote this with staff. • **Standards and Guidelines Compliance Challenges –** It was noted that there is a significant number of S&G's that come in which have to be dealt with. Mrs Trudy Reid thanked everyone for their help that they have given to date. • **Hyponatremia Training and Desist Notices** – It was noted that the Hyponatremia Training needs updated and that there is an audit coming up on compliance with Hyponatremia standards • **Chief Executive Business** – Dr O'Kane to get the Chief Executives briefing document sent out to all AMD's.
3.0 Governance Reports from Associate Medical Directors (items of common interest/concern) *3.1 Medicine & Unscheduled Care – Dr P Murphy* Dr Murphy raised his concern that the Mobile Cath lab had not been recommissioned with a consequential rise in inpatient stays and elective waiting lists, even with evening sessions in the Cath lab. It was noted that the PCI rota has been Job Shared with Belfast Trust. Dr Murphy reflected that there are currently 20 junior doctors in Craigavon which was insufficient given the workload pressures within the division. He raised his concern that there needs to be extra Junior Doctors at night, currently it is just locums.

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

3.2 Anaesthetics, Theatres & ICU – Dr D Scullion

Dr Neville Rutherfoord-Jones attending on behalf of Dr Damian Scullion. Dr Neville Rutherfoord-Jones raised his concern relating to the shortage of SAS Doctors with a high number of locums. He mentioned that the SAS Doctors are ok working during the day but after hours require enhanced supervision.

There are interviews taking place next month for an ICU Post and Anaesthetic Post. He mentioned that there are more Consultants needed to cover in Daisy Hill.

3.3 Children & Young People's Services – Dr A Khan

Dr Ahmed Khan raised his concerns in relation to PICU with the age differentials between units.

Action: Dr Ahmed Khan

3.4 Integrated Maternity & Women's Health – Dr M Hogan

Dr Martina Hogan told everyone that when she retires Dr Damian Scullion will be covering her role until a permanent appointment is made.

3.5 Older People & Primary Care – Dr M Donnelly/ Dr R McCullagh

Dr Rose McCullagh said that she wanted to take this opportunity to listen to issues of concern that staff had with General Practice, so that she can bring them back to General Practice. AMD's agreed to seek these issues from colleagues.

3.6 Medical Education & Training – Dr G Browne

Dr Browne raised her concern that it would be extremely challenging to deliver on a number of the 12 recommendations due to the extreme workload pressures within Medicine and Surgery on both sites. In addition, Dr Browne raised her concern that the 2020 National Training Survey would continue to reflect poorly on both sites due to these continuing workload pressures. Dr Browne asked for the support of Dr O'Kane in attempting to address these workload pressures. Dr O'Kane asked for evidence to demonstrate these workload pressures.

4.0 Governance Report from the Medical Director

4.1 Draft Mortality Report

4.1.1 Quarterly Mortality Report April 2018 – March 2019 (Attached)

It was agreed that there was no concerns with this report, as all indicators were within the norm.

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

4.1.2 Trust Speciality Indicator Report April 2018 – March 2019 (Attached)

It was agreed that there was no concerns with this report. Any comments regarding the two reports to go to Stephen Wallace.

4.2 Regional Medical Director Forum Update
With regard to the recent change in the law in relation to abortion, there is now a contact number for this if clarification was required.

4.3 Medical Leadership Update
Dr O'Kane met recently with Paula O'Kelly to progress this. There has been a paper submitted to E&G in relation in this. Dr O'Kane is going to talk to Vivienne Toal and Maxine Williamson regarding this and come back with an update to the AMD's.

4.4 Mental Health Capacity Acts (DoLs Training)
This training is now online, it is mandatory to do this training up to level 3. It will be decided who needs to do the Level 4 a/b training.

4.5 Locum Doctors
There is work currently being undertaken in relation to this. We are currently working on getting together what is needed for locums commencing within the Southern Trust and what is needed for the GMC prior to this.

5.0 Revalidation/Appraisal/ Responsible Officer

There was an update that the Online Appraisals is considered a medium risk as there is additional security beyond the firewalls which exist within BSO.

6.0 Litigation/ Medical Negligence

Mrs Lynne Hainey and Dr O'Kane met with Mr Mark Harvey, from BSO. It was noted that only 24% of negligence claims result in a settlement.

7.0 Any Other Business

7.1 Admin Issues
Mrs Helen Forde introduced herself and advised that she was presenting on a range of admin issues where she was seeking the support of the senior clinical leaders within the Trust. The issues discussed included:

<u>Outpatients</u>

- All medical staff are reminded to highlight RF, Cancer and high risk patients as appropriate on G2. This will ensure the clerical and admin staff can prioritise these communications.

- Junior doctors should select the appropriate supervisor (Consultant of clinic) on G2

for their clinic dictation. Unfortunately, frequently this is not done and therefore dictation will not appear on the appropriate worklists for clerical staff. In some circumstances they may not be visible to the appropriate staff at all

- Clinic outcome forms should be used to avoid unnecessary delays in the patient pathway, oc referrals, adding patients to waiting lists etc. The clinic outcome form records the outcome for each patient after their outpatient consultation, e.g. review in 6/52, review in 3/12, add to WL, Discharge etc. This is a vital communication tool for admin staff as they use the clinic outcome sheet to action any follow up immediately instead of waiting to listen to dictation, and so avoid delays in getting patients added to the WL/referred on to another consultant etc.

- I]f a patient needs reviewed within a specific timescale this needs highlighted by using the comment – Must be seen (MBS 3 months) or Urgent 3 months to ensure the patient is added to the urgent review waiting lists etc. When the booking centre are selecting patients for review at the outpatient clinics they select from the MBS and Urgent WLs first, and so ensure that these patients are seen within the required timeframe.

- Waiting list Proformas should be put in a separate envelope and placed on top of the charts after the clinic. When the secretary receives the envelope she will add the patients to the waiting list immediately. If the proformas is placed inside the patients chart this will cause a delay in adding the patient to the waiting list as they will not be dealt with until the clinic is typed.

<u>Inpatients</u>

E Discharges –

- The information recorded on the e-discharge letter is often unclear, eg 'review in due course', or refer to Dr Smyth. This is ambiguous– if a patient has to be reviewed then a timeframe must be stated.

- If a patient has to be referred on to another consultant/ specialty/ hospital full details of the consultant, the specialty and the hospital site must be recorded on the discharge letter.

- If a discharge letter is changed the ward clerk must be informed – eg it may be changed to record that a review appointment is required, but if the ward clerk hasn't been told that changes have been made they will not know to make the follow up appointment.

- Delay in completing a discharge letter or not completing one at all which could lead to a patient's review/referral not being made.

- Doctors not authorising the discharge letter when they have finished it – this

means the ward clerk cannot print the letter and therefore complete the follow up action and file the letter in the chart.

Misfiling

- Misfiling – some medical and nursing staff gather up patient documentation and put it all into one chart – this may contain more than one person's information. If that patient is then transferred to another ward without the ward clerk having had a change to check the loose filing the chart will contain incorrect information.

- Following an SAI where the Coroner was scathing about a missing Kardex the ward clerks have commenced a new process whereby when they are filing up the patient information at discharge they record any missing information. This has highlighted a problem with the Kardex. From 26/6/19 to date five Kardexs have been missing – the ward clerk searches for these but it does highlight a problem with this particular piece of documentation.

Results

- Results and X-rays on the ward must be signed – if they are not they must remain on the ward until such time as they are signed – this is leading to boxes of results being held at ward level. This has been highlighted by the Medical Director.

- Results in paper form should be viewed/actioned and not held back until a chart is available or previous clinic letter is typed. You can action the results and advise for urgent typing straight away.

Action: Mrs Helen Forde is to do a colour leaflet and send it to the AMD's for information.

Dr Gail Browne said that the FY1's had brought up that there is no Admin Support for CAH at the weekends for Blood Reports. They had mentioned to Dr Gail Browne that they would like the same Admin Support as DHH has on the Medical and Surgical wards.

Action: Mrs Forde to liaise with Dr Browne to resolve

7.2 M&M Internal Audit Review

Currently the M&M Team is working through the Internal Audit recommendations. The Regional meeting in 15th November.

7.3 Assurance Challenges around National Audit Study Recommendations

Mrs Fiona Davidson is working through these recommendations for the Audit. The Recommendations reports are to be sent out.

7.4 Clinical Guidelines Update

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

It was noted that a number of the Clinical Guidelines are out of date. There is a reminder to be sent out to each team.
8.0 Next Meeting/ Dates for your Diary AMD Meeting: Friday 22nd November 2019 at 2.00pm-4.00pm, THQ Meeting Room VC to Committee Room 1, DHH Medical Forum Meeting: Friday 6th December 2019 at 3.30pm, THQ Boardroom VC to Boardroom Bernish House, DHH

Southern Health and Social Care Trust

Associate Medical Directors Meeting

Friday 22nd November 2.00pm-4.00pm

Action notes

Present

Dr Maria O'Kane (chair)	Dr Pat McMahon
Dr Peter Sharpe	Dr Damian Scullion
Mr Simon Gibson	Dr Gail Browne
Dr Philip Murphy	Dr Shahid Tariq

1. **Apologies**

Dr Mark Haynes	Dr Mary Donnelly
Dr Ahmed Khan	Dr Rose McCullagh

2. **Minutes of the last meeting 25th October 2019**

The action notes were agreed

3. **Governance Reports from Associate Medical Directors [Items of common interest/concern]**

3.1. Anaesthetics, Theatres & ICU

Dr Scullion reported that there had been a resignation within ICU, and highlighted the impact upon the remaining ICU consultants. It was noted that this would create a 1 in 6 rota, which would be very onerous for a team that had been dealing with a heavy workload for a number of years. Dr Scullion also reported on the pressures within the SAI process within ATICs and the need for trained chairs within SAIs across all areas, especially where the existing coverage is weak. It was commented that there may be benefits during a SAI process if a significant concern was identified then there should be an opportunity for early identification. Dr O'Kane identified that the Governance processes within the Southern Trust are being reviewed

Dr O'Kane noted that there is a requirement to close off a significant number of M&M deaths which appear to be outstanding for a number of years, across a range of specialties. It was noted that a number of these were cases where more than one team was involved to move the case

Action: All AMD's

It was noted that appraisals and job plans were progressing within ATICs

3.2. Mental Health & Learning Disability

Dr McMahon summarized issues within his division, including information relating to ongoing SAI cases.

It was noted that a number of services were losing staff with the creation of a new Primary Care Multidisciplinary Team in Newry, which was creating challenges in the existing services

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Dr McMahon highlighted ongoing concerns with relation to restrictive practices, and that there was an event in 2020 to consider potential solutions to this.

An Old Age Psychiatry post has been appointed, but hasn't been finally accepted by the candidate

The Division had participated in the National Benchmarking process and also the National Thermometer scheme, and it appeared that the department was sitting within the norms.

Crisis Home Treatment Response was struggling to cope with the demand out of hours. A business case was being submitted for additional resources.

3.3. Medicine & Unscheduled Care

Dr Murphy identified three main issues of concern:

- Firstly, that C-Diff was a significant issue within 2 South.
- Secondly, there was an increasing difficulties in getting chairs for SAI.
- The third significant issue was the unrelenting demand within ED. Dr O'Kane summarized the actions taken since Tuesday to try and address this demand including placing 2 additional patients upon each of the wards. It was noted that this would place additional workload on doctors in training and when communication was made to the organisation relating to this topic, it would include Doctors in Training

It was noted that there had been an increase in appraisals being completed

3.4. Cancer & Clinical Services

Dr Tariq informed the meeting of the newly established Trust Cancer Group
It was noted that the recent visit of the Cancer Peer Review Group raised no concerns

Labs – Dr Tariq raised concerns relating to the accommodation in relation to Microbiology

Haematology – two posts were offered, one accepted. It was noted that more trainees were coming off the system

Radiology – it was identified that the impact of only having the modular CT scanner on the DHH site was a concern, especially given the high cost, and the length of time it takes to commission. A Consultant in Nuclear Medicine had been appointed

Dr Tariq reflected that the SAI process was not easy, and the support was not available. It was noted that Dr O'Kane had secured two senior managers (one 8b and one Band 7) to help with this process

It was noted that RQIA had recently visited Radiology on both sites, with action plans developed