Alert reference number: NHS/PSA/W/2018/009

Technical notes

Patient safety incident reporting

This issue was first raised with the NHS Improvement national patient safety team on social media.

As those attaching finger probes to ears or vice versa were unaware this could result in misleading readings, NRLS incident data could not be used to identify how often this error has delayed the recognition and response to deterioration.

We therefore engaged with the National Patient Safety Response Advisory Panel and used a questionnaire to survey 81 clinical staff from 12 organisations (acute and community), through our Medical Device Safety Officer (MDSO) network. Most respondents (80%) said they would attach a finger probe elsewhere, to the ear or another extremity, if they could not obtain a good recording from the finger. Of respondents, 74% reported they had local access to specific oximetry consumables that attach to ear lobes. Most did know that different oximeter probes were available for adult and paediatric patients and would not use an adult oximeter probe for a child.

Notes

This alert is designed to address the patient safety risks associated with inappropriate placement of pulse oximeter probes. It is outside the scope of this alert to provide comprehensive information on how pulse oximeters work and the many different factors that can interfere with their accuracy. Organisations should refer to manufacturers' instructions of oximeters in local use and use those to provide guidance and training for their staff to ensure accurate readings.

References

1. Patient Safety Alert: Resources to support the safe adoption of the revised National Early Warning Score (NEWS2) https://improvement.nhs.uk/news-alerts/safe-adoption-of-NEWS2/
2. Haynes JM (2007). The ear as an alternative site for a pulse oximeter finger clip sensor. Respiratory Care. 52(6):727-9. http://rc.rcjournal.com/content/52/6/727
3. Mannheimer PD (2007) The Light-Tissue Interaction of Pulse Oximetry. Anesthesia & Analgesia. December 2007 - Volume 105 - Issue 6 - p S10-S17 https://journals.lww.com/anesthesia-analgesia/fulltext/2007/12001/The_Light_Tissue_Interaction_of_Pulse_Oximetry.3.aspx
4. Walters TP (2007). Pulse oximetry knowledge and its effects on clinical practice. British Journal of Nursing 16(21):1332-40. https://www.ncbi.nlm.nih.gov/pubmed/18073672

Stakeholder engagement

- National Patient Safety Response Advisory Panel (for a list of members and organisations represented on the panel, see improvement.nhs.uk/resources/patient-safety-alerts/)

Advice for Central Alerting System officers and risk managers

This alert needs co-ordinated implementation rather than separate action by individual teams or departments. Pulse oximeters will almost certainly be used in at least some circumstances in almost all types of trusts and by general practitioners. If you are unsure who will co-ordinate implementation of this alert: for acute trusts, seek initial advice from a lead nurse in critical care outreach; for ambulance trusts, mental health trusts, community services, and general practices, seek advice from a senior clinical team member in a nursing, medical or paramedic role.

This alert also applies to staff in care homes where pulse oximeters are used.

Acknowledgement

Thanks to all the clinical staff who took part in the survey and therefore helped to inform this alert.

Sharing resources and examples of work

If there are any resources or examples of work developed in relation to this alert you think would be useful to others, please share them with us by emailing patientsafety.enquiries@nhs.net

Positive Assurance Template for HSCB Issued NICE Guidelines
May 2019

Health and Social Care Board

In line with NICE Circular HSC (SQSD) 2/13 and Circular HSC (SQSD) 3/13 which sets out the requirements for the monitoring and implementation of NICE Guidance, the HSCB seeks positive assurance on all NICE Guidance issued from September 2011 on the following:

1. The Trust has completed the initial required actions of targeted dissemination, identification of a clinical/management lead and implementation planning within three months of a Service Notification being issued by the HSCB.

2. The Trust has fully implemented all guidance within the required timescale from a HSCB Service Notification/DHSSPS Circular being issued.

A list of applicable guidance on which the HSCB seeks assurance is set out in the following sections:

SECTION A - Assurance on the planning/dissemination of Technology Appraisals

SECTION B - Assurance on the implementation of Technology Appraisals

SECTION C - Assurance on the planning/dissemination of Clinical Guidelines

SECTION D - Assurance on the implementation of Clinical Guidelines

SECTION E - Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Any issues regarding the implementation of NICE guidance should be forwarded to the HSCB NICE Inbox (HSCB-NICEInbox@hscni.net

SECTION A - Assurance on the planning/dissemination of Technology Appraisals

Recommended Technology Appraisals

NICE Ref	NICE Guidance Title	Service notification issued by HSCB	Expected Planning Completion Date	Assurance Provided *(Y/N)*	Material Issue/ Comment raised by Trust *(issue preventing implementation)*
TA 533	Ocrelizumab for treating relapsing–remitting multiple sclerosis.	20/12/2018	20/03/2019	Yes	
TA 534	Dupilumab for treating moderate to severe atopic dermatitis.	22/01/2019	22/04/2019	Yes	
TA 535	Lenvatinib and sorafenib for treating differentiated thyroid cancer after radioactive iodine.	07/12/2018	07/03/2019		N/A To SHSCT
TA 536	Alectinib for untreated ALK-positive advanced non-small-cell lung cancer.	07/12/2018	07/03/2019	Yes	
TA 537	Ixekizumab for treating active psoriatic arthritis after inadequate response to DMARDs.	20/12/2018	20/03/2019	Yes	
TA 538	Dinutuximab beta for treating neuroblastoma.	07/12/2018	07/03/2019		N/A To SHSCT
TA 539	Lutetium (177Lu) oxodotreotide for treating unresectable or metastatic neuroendocrine tumours.	04/01/2019	04/04/2019		N/A To SHSCT
TA 541	Inotuzumab ozogamicin for treating relapsed or refractory B-cell acute lymphoblastic leukaemia.	28/01/2019	28/04/2019		N/A To SHSCT
TA 542	Cabozantinib for untreated advanced renal cell carcinoma.	28/01/2019	28/04/2019		N/A To SHSCT

TA 543	Tofacitinib for treating active psoriatic arthritis after inadequate response to DMARDs	20/12/2018	20/03/2019	Yes	

I – Implemented
N/I – Not Implemented
N/A – Not Applicable

SECTION B - Assurance on the implementation of Technology Appraisals

Recommended Technology Appraisals

NICE Ref	NICE Guidance Title	Service notification issued by HSCB	Expected Implementation Date	Implementation Status *(please indicate)*			Reason for non-compliance *(Not Implemented or Not Applicable)*
				I	N/I	N/A	
TA 499	Glecaprevir–pibrentasvir for treating chronic hepatitis C.	04/06/2018	04/03/2019				N/A To SHSCT
TA 500	Ceritinib for untreated ALK-positive non-small-cell lung cancer.	04/06/2018	04/03/2019	✓			
TA 502	Ibrutinib for treating relapsed or refractory mantle cell lymphoma.	11/06/2018	11/03/2019	✓			
TA 507	Sofosbuvir–velpatasvir–voxilaprevir for treating chronic hepatitis C.	18/07/2018	18/04/2019				N/A to SHSCT
TA 509	Pertuzumab with trastuzumab and docetaxel for treating HER2-positive breast cancer.	18/07/2018	18/04/2019	✓			

SECTION C - Assurance on the planning/dissemination of Clinical Guidelines

Definitions:
Red - The Trust is unable to fully implement the guidance within the one year period without regional co-ordination and/or additional resources.
(A Section E template should be completed for these CGs)

Amber – The Trust is able to implement the guidance within the one year period without regional co-ordination and/or additional resources.
(A Section E template is not required, however status only applicable at initial 3 month review)

Green – The Trust has fully implemented the guidance.
(No further action required)

Blue - The Trust has fully implemented all of the recommendations with the exception of any recommendations which are not applicable to the Trust e.g. Applicable only to Primary Care or a procedure or diagnostic test recommended is not available in NI.
(Section E should be completed for these CGs. Any non-applicable recommendations must be specified)

NICE Ref	NICE Guidance Title	DHSSPS Circular issued	Expected Planning Completion Date	Implementation Status *(please indicate)*				If guidance is deemed not applicable, please provide explanatory note
				R	A	G	B	
NG 116	Post-traumatic stress disorder (updates and replaces CG26)	29/01/2019	29/04/2019					TBC – MHLD are taking the lead on this

SECTION D - Assurance on the implementation of Clinical Guidelines

Definitions:
Red - The Trust is unable to fully implement the guidance within the one year period without regional co-ordination and/or additional resources.
(A Section E template should be completed for these CGs)

Green – The Trust has fully implemented the guidance.
(No further action required)

Blue - The Trust has fully implemented all of the recommendations with the exception of any recommendations which are not applicable to the Trust e.g. Applicable only to Primary Care or a procedure or diagnostic test recommended is not available in NI.
(Section E should be completed for these CGs. Any non-applicable recommendations must be specified)

NICE Ref	NICE Guidance Title	DHSSPS Circular issued	Expected Planning Completion Date	Implementation Status *(please indicate)*			If guidance is deemed not applicable, please provide explanatory note
				R	G	B	
NG 82	Age-related macular degeneration.	20/03/2018	20/03/2019				N/A To SHSCT
NG 83	Oesophago-gastric cancer: assessment and management in adults.	21/03/2018	21/03/2019	✓			Awaiting feedback from Oncology team at BHSCT – E proforma to follow

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

CG No	
Title	
Date of Review	
Clinical Lead	
Description of major barrier/s to implementation	
Indicate any specific requirements to address the major barrier/s to implementation	
Description of any immediate patient safety concerns if CG is not implemented within 12 month timescale	
No.of recommendations applicable to organisation *(If a number are deemed n/a, please state)*	
No.of applicable recommendations currently implemented *(e.g. 99/100)* *Please specify any non-applicable recommendations*	
Additional resources required to ensure implementation	
Suggested revised compliance date if outstanding issues are addressed	

Southern Health and Social Care Trust

ACTION PLAN for Acute Services

Reference	**PL/2019/032**
Title of Clinical Guideline	Safer Temporary Identification criteria for unknown or unidentified patients
Submission Date for Assurance Response / Action Plan to HSCB:	5th June 2019
Date of Submission to Corporate Governance Office	5th June 2019
Update Position *(date provided)*	Not applicable
Operational Director	**Mrs Esther Gishkori**
Clinical Change Lead/ Designation	Dr Hilda Nicholl and wider MDT *(ED, Radiology, Laboratory, Information Technology, Administration Services)*

Recommendation	Current Control Measures	Current level compliance (%)	Action plan	Designated Lead	Deadline for completion
Actions to be taken by Chief Executives of Trusts					
Recommendation 1: Identify a leader who can bring together key parties including hospital informatics, emergency admissions, major incident response and pathology services	Dr Hilda Nicholl is the clinical change lead for implementation of the recommendations outlined in this patient safety alert. The working group that has been established to take forward this alert, under the leadership of Dr Nicholl, has confirmed that the Trust's Emergency Departments are the only 2 entry points for these patients.		No further action is required		Complete
Recommendation 2: Develop a system for the unique temporary identification of unknown patients using: the numbering system outlined in this alert, sex, estimated DOB, and 'name' based on non-sequential phonetic alphabet.	The SHSCT has in place a standard operating procedure for the 'Registration of Unknown Patient' in place (reviewed September 2018). However the processes that are currently in place do not meet the requirements of this patient safety alert.		There is a pilot being taken forward at a regional level of which SHSCT has expressed an interest to be part of for the Allocation of Temporary Health and Care Numbers. A meeting has been arranged for 20/06/2019 and group representatives from SHSCT are being sought.	Dr Nicholl Mary Burke Helen Forde Connor Murphy	31/12/2019 (but dependent on regional 'pilot' timescales)

	The SHSCT does not indicate an 'estimated DOB' and 'name' based on non-sequential phonetic alphabet. In accordance with the Trust's SOP, the patient's forename and surname will be denoted as 'unknown' and together with an indication of gender, this will automatically generate the next sequential ED number which will become the unique identifier upon which imaging and laboratory tests can be ordered. The working group have indicated that to denote an estimated DOB would be challenging as perception of age can be very subjective. As such the date of birth will left blank until the patient is identified.		As part of this work the requirements of this alert will be addressed. However the allocation of temporary HNC will ensure compliance against all of the specific identification recommendations – it will only address the recommendation that the Trust should have in place systems to allocate a number which is non-sequential. Regional discussion and agreement is required to ensure harmonisation of these systems across the HSC.		

Recommendation 3: Ensure all IT systems can accept the names and numbers in these formats.	Within the Trust's current processes for unknown patients a patient is registered on eEMS and a PAS number is also allocated. The allocation of the PAS number creates a temporary TC (temporary care) number that enables the patient to be registered on NIPACS and a radiology examination to be requested and assigned. However as indicated in recommendation 2 the patient's forename and surname will be denoted as 'unknown' and together with an indication of gender, this will automatically generate the next sequential ED number which will become the unique identifier upon which imaging and laboratory tests can be ordered.		Discussions to be undertaken with the Head of Laboratory Services to ascertain how, in a major incident situation the allocation of multiple ED identifier numbers can meet the requirements of the Blood Transfusion Team. As indicated in recommendation 2 this will also form part of the 'pilot' with BSO on the allocation of a temporary HCN on the NIECR system	Mrs Mary Burke Mr Geoff Kennedy	31/12/2019 (but dependent on regional 'pilot' timescales)

Recommendation 4: Develop a robust system for merging medical records once a patient's identity is confirmed	The SHSCT has in place a Procedure for Merging Patient Records on PAS that has been aligned to the current processes that are in place for identifying an unknown or unidentified patient. As part of the response to this patient safety alert this procedure has been re-circulated to all staff to remind them of the procedural arrangements that are in place, especially in the context of the learning outlined.		No further action is required		Completed
Recommendation 5: Communicate the key messages in this alert and your organisation's plan for safer identification systems to all relevant staff	***SHSCT Emergency Departments*** This patient safety alert has been circulated to all ED medical and nursing staff. It has been discussed at the medical specialty meeting held on 06/03/2019 and raised at the ED Governance meeting held on 24/04/2019		No further action is required		Completed

	A copy of the Patient Safety Alert and Standard Operating Procedures (Registration of Unknown Patient' / Merging Patient Records on PAS) will be shared to all relevant staff working in ED / Minor Injuries units. This patient safety alert has been discussed at the following forums: ***Acute S&G forum***: 5 February 2019 ***Acute S&G Professional Leads forum***: 29 April 2019				
Please confirm to the HSCB/PHA Alerts office at alerts.HSCB@hscni.net by **5 June 2019** that actions 1-5 above have been completed	**Following approval by Acute SMT this was sent to the Trust's Corporate Governance Team for onward submission to the HSCB on 5th June 2019**				

Compliance Scale

100% Compliance	**70-99% Compliance**	**40-69% Compliance**	**0-39% Compliance**	**Pending**	**Not Applicable**

Southern Health and Social Care Trust

ACTION PLAN for Acute Services

Reference	**HSC (SQSD) 33/18**
Title of Clinical Guideline	Management of life threatening bleeds from arteriovenous fistulae and grafts
Submission Date for Assurance Response / Action Plan to HSCB:	13 May 2019
Date of Submission to Corporate Governance Office	13/05/2019
Update Position *(date provided)*	Not Applicable
Operational Director	**Mrs Esther Gishkori**
Clinical Change Lead/ Designation	Dr Neal Morgan – Renal Consultant working with the wider MDT

Recommendation	Current Control Measures	Current level compliance (%)	Action plan	Designated Lead	Deadline for completion
Actions to be taken by Chief Executives of Trusts					
Identify a senior clinical leader in the organisation to lead the response to this alert	Dr Neal Morgan		None	Dr Neal Morgan	Complete
Develop an implementation plan to ensure the availability of local guidance that incorporates the advice in the British Renal Society's resources for the detection and management of LTB	Patient and Carers: Individual education to all AVF/AVG patients including written information since 2014* Renal Staff: Unit education on access complications complemented by AVF/AVG acute bleed protocol 2014* Currently all new AVF patients are educated on AVF bleeding when starting dialysis and every 6months thereafter		Patient and Carers: Individual education to all AVF/AVG patients complemented with written information and safety cards Following receipt of NPSA the patient information leaflet on action to take after an AVF/AVG bleed is being currently updated to incorporate the BRS guidance (2wks) Renal Staff: Unit education of all renal nursing staff, including new staff induction delivered by vascular access nurse specialists, added as 'hot topic' at safety briefings	Dr Neal Morgan and Sister Kay Donegan working with specialist vascular access nurses	Ongoing 30th June 2019 Ongoing for new staff, current staff education complete by 31st May 2019

	This NPSA was discussed at the acute S+G Professional Leads Forum on the 29th of April, lead nurses to circulate within their relative areas		Non-renal trust staff: Education to ED staff on DHH and CAH sites co-ordinated via Dr Morgan; discussion at medical and surgical M+M and at sisters meetings across acute sites Transport staff: To discuss education of transport staff responsible for transferring patients to and from dialysis with NIAS, so to ensure the requirements of the NPSA are included in induction and training updates		30th June 2019 30th June 2019 (KD)
Use local communication strategies (such as newsletters and awareness campaigns, etc) to ensure that all relevant staff and patients are aware of and have access to these resources	Management of AVF haemorrhage posters (from BRS) have been displayed in DHH and CAH ED		NPSA to be included in the next edition of the Southern Trust electronic newsletter Engage with BSO regarding an AVF alert within a NIECR patient record and to explore the possibility of linking BRS advice on AVF bleed within this alert (this will be discussed at regional nephrology forum 6th June 2019) As outlined above this NPSA will be included in specialist access nurse led staff and		31st May 2019 14th June 2019 Ongoing

			patient education programmes with continuous internal audit of compliance		

Compliance Scale

100% Compliance	70-99% Compliance	40-69% Compliance	0-39% Compliance	Pending	Not Applicable

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

SHSCT Assurance Response	
Reference	PL/2018/027 (Issued on 12 September 2018)
Title of Clinical Guideline	Resources to support safe and timely management of hyperkalaemia
Submission Date for Assurance Response / Action Plan to HSCB:	8th May 2019
Date of Submission to Corporate Governance Office	8th May 2019
Update Position *(date provided)*	Not Applicable
Operational Director	Mrs Esther Gishkori
Clinical Change Lead/ Designation	Dr Peter Sharpe (Consultant Chemical Pathologist) working with clinical colleagues in Non-Acute Hospitals and CYPS

Recommendation	Current Control Measures	Current compliance level	Action plan	Designated Lead	Deadline for completion
Actions to be taken by Chief Executives of Trusts					
Identify a senior clinician in the organisation to lead the response to this alert	Dr Peter Sharpe (Consultant Chemical Pathologist) is the senior clinician and change lead for implementing the recommendations outline in this Patient Safety Alert. As part of this lead role Dr Sharpe has discussed this alert with relevant medical colleagues working in Acute, Non Acute and CYP services to ensure awareness of this alert is highlighted.				Completed

Review or produce local guidance (including key steps or easy reference guides) for the management of hyperkalaemia that aligns with the evidence-based sources highlighted in the linked resources	The SHSCT has fully endorsed the regional GAIN guidelines for the Management of Hyperkalaemia in Adults (2014 with issued date within SHSCT: 14/07/2016). These are available on the Trust intranet. Following issue of the PSA the guideline has been reviewed and no further update required at present. Safeguard procedures are in place within the Trust lab system that if any blood sample indicates a Potassium level greater than 6.5mmol/L an automatic phone back is made to the relevant clinician for alerting A hyperkalaemia kit is available on wards containing medicines (except insulin) and insulin syringes for treatment of hyperkalaemia in adults. A guide for treatment,		As part of the implementation of this alert, work is ongoing within CYPS to link Trust paediatric guidelines to an internationally respected guideline on management of hyperkalaemia in children/young people. This will be shared with relevant staff once finalised.	Dr Thompson	31/05/2019

	preparation and monitoring is also in the kit. Following issue of the patient safety alert the NHS Improvement Awareness raising video has been placed on the Southern Trust's intranet *Sharepoint* section for clinical guidelines. This useful resource can be accessed when the guideline is being searched for on the system.				
Ensure that local guidance can be easily accessed by all staff including bank and agency staff	The regional GAIN guidelines are available on the Southern Trust's intranet *Sharepoint* section for clinical guidelines. The NHS Improvement Awareness raising video has also been posted here as a useful resource for staff. A copy of the patient safety alert was sent to Medical and Nursing Bank / Agency Managers for onward dissemination to staff				Completed

Ensure relevant guidance and resources are embedded in clinical practice by revising local training and audit	Within the SHSCT the Safe use of Insulin module is on the training tracker which all junior doctors have to complete. This training includes a section on insulin in hyperkalaemia. Insulin in the treatment of hyperkalaemia is in the Safe Administration of Medicines material for nursing staff and will be in the regional program. Broader training on hyperkalaemia is included in FY0 training – the clinical change lead for the implementation of this alert provides this training as part of the laboratory induction section				Ongoing Ongoing Ongoing

	A recent hyperkalaemia audit on adult patients being cared for with Acute Services has been undertaken and the audit results have indicated that hyperkalaemia is treated appropriately and in accordance with clinical guidance (see attached audit report).  SHSCT Audit report - Hyperkalaemia in Adu However the audit has identified the biomechanical monitoring (U&E and glucose) post treatment should be improved. The audit outcomes were shared with Acute SMT at the Acute S&G forum meeting held on 7th May 2019.		Share the summary audit outcomes with relevant medical and nursing staff by sending out in the next edition of the southern-I newsletter. Share the detailed audit outcomes with relevant medical and nursing staff at ward / department meetings. Share the detailed audit outcomes at the next M&M meetings across the relevant clinical specialities A re-audit is planned for July 2019 The audit has also highlighted several daily cases of pseudo-hyperkalaemia that are being urgently referred	Dr Sharpe Dr Loughrey Jilly Redpath Caroline Beattie Dr Sharpe Dr Loughrey Regional collaboration led by the HSCB	31/05/2019 31/07/2019

			from Primary Care for repeat U&Es. The audit results identified that in all of these cases the patients had normal potassium levels following repeat monitoring. Given the current capacity issues within ED this poses a significant challenge for the SHSCT. There needs to be a regional consensus on how to effectively deal with this challenge. The SHSCT would value support / leadership from the HSCB on how best to implement transformational changes within the wider regional system to reduce this impact, particularly on an already stretched ED resource.		

Use local communication strategies (such as the videos, newsletters, local awareness campaigns, etc) to make all staff aware that hyperkalaemia is a potentially life-threatening emergency and that its timely identification, treatment and monitoring during and beyond initial treatment is essential	Discussed at the Acute S&G forum meeting held on 18 September 2018 for onward sharing with relevant teams Discussed at the Acute S&G Lead Professionals Forum held on 24 September 2018 for onward dissemination to relevant staff The alert was included in the ED M&M agenda and the monthly ED safety newsletter (October 2018)		A communication has been sent to the Trust Communications team to include the alert / audit outcomes in the next southern-I newsletter	Dr Sharpe Dr Loughrey Jilly Redpath Caroline Beattie	31/05/2019

Compliance Scale

100% Compliance	70-99% Compliance	40-69% Compliance	0-39% Compliance	Pending	Not Applicable

Southern Health and Social Care Trust

ACTION PLAN for Acute Services

Reference	**SQR-SAI-2019-049 (AS)**
Title of Clinical Guideline	**Specific Cardiac Arrest Protocol for Patients fitting with Left Ventricular Assist Devices (LVAD)**
Date of issue from External Agency (HSCB alerts team)	**8th May 2019**
Submission Date for Assurance Response / Action Plan to HSCB:	**26th June 2019**
Date of Submission to Corporate Governance Office	**21st June 2019**
Update Position *(date provided)*	**Not Applicable**
Operational Director (interim)	**Mrs Melanie McClements**

Recommendation	Current Control Measures	Current level compliance (%)	Action plan	Designated Lead	Deadline for completion
Actions to be taken by Chief Executives of Trusts					
Recommendation 1 Disseminate this letter and attachments to all relevant staff;	This learning letter was disseminated from the Governance co-ordinator to all Acute Assistant Directors on 8 May 2019 for onward issue within their areas of responsibility This learning letter was reviewed at the Acute S&G forum held on 21 May 2019 This learning letter was included in the papers for the Acute S&G professional leads forum scheduled on 17 June 2019 – the lead nurses are to share with relevant ward / department managers to ensure dissemination to front line staff This learning letter was discussed at the Cardiology Governance meeting held on 30 May 2019 – the minutes and the Protocol will be shared with Cardiology team.		To also be included in the June 2019 edition of the ED Newsletter To be included in the M&M agenda for Anaesthetics / Surgery / Medicine (both CAH/DHH) / Cardiology To be included in the agenda of the next Acute Resuscitation Committee	Mrs Mary Burke (Head of ED) M&M chairs Mrs Anne McVey (Chairperson)	30/06/2019 21/06/2019 08/10/2019

	It has also been shared by the Head of Cardiology with Medical, Nursing and Cardiology Physiology staff The ward sisters working in 1 north and Coronary Care have taken the following actions: ✓ Discussed this learning letter at Patient Safety Briefings with staff ✓ Emailed all Nursing Staff a copy of the Protocol ✓ Ensured ongoing monitoring / reporting via Datix process any issues with LVAD patients				
Recommendation 2 Review and, as necessary, amend your Trust systems to ensure that they reflect the Requirements Under Current Guidance section of this letter	It has been clinically agreed that all LVAD patients must be admitted to 1 North Cardiology CAH) and Coronary Care (DHH) The Head of Cardiology Services has shared the protocol with the Head of Patient Flow The Trust's Resuscitation Department have placed the referenced BMJ 'Algorithms to		As an additional consideration, it was agreed that this will be raised at the next Regional Cardiology meeting the value of adding a LVAD alert to the NIECR system is to be explored – this would ensure ED staff are alerted should the patient present as an emergency to the service	Mrs Kay Carroll Head of Cardiology (SHSCT)	31/07/2019

	guide ambulance clinicians in the management of emergencies in patients with implanted rotary left ventricular assist devices' on the Resus section of the Acute Services / Cardiology *Sharepoint* site. The Trust's Resuscitation Department have placed the algorithm's on the SHSCT clinical guidelines section of the intranet A new LVAD section has been added to the Trust's Resuscitation Policy – the new updated version is pending approval at the next Committee meeting. The updated policy will have the hyperlink to the *Sharepoint* guidance and Freeman Hospital contact details included. Given the complexity of this clinical scenario it has been clinically decided that this will not be added into the Trust's mandatory resuscitation training for staff as this could prove to be confusing – the action that has been undertaken as part of this				

	learning review is deemed sufficient and appropriate. Patients with LVAD to be clearly Identified on transfer via SBAR Patients with LVAD to be clearly identified in Nursing documentation Alert section and at Nursing Handover				
Recommendation 3 Confirm by 26 June 2019 to Alerts.HSCB@hscni.net that actions 1 and 2 have been completed	Approved by the Interim Director of Acute Services on 19/06/2019 and submitted to corporate governance team on 21/06/2019 for onward submission to the HSCB				

Compliance Scale

100% Compliance	**70-99% Compliance**	**40-69% Compliance**	**0-39% Compliance**	**Pending**	**Not Applicable**

Southern Health and Social Care Trust

Acute Services Directorate

NICE Guidelines 'Section E' Update Report

Presented to Acute S&G forum on 10th April 2018

Report Author: ***Mrs Caroline Beattie***
Standards & Guidelines Manager – Acute Services

MASTER COPY (26/04/2019)

NICE Guideline 'E' proforma Update Report - MUSC Applicability

Summary Statement for Table 1 - those NICE guidelines that are on the HSCB Red Status report and led by Acute Services:		Summary Statement for Table 2 - those NICE guidelines that are on the HSCB Red Status report and led by another Directorate		Summary Statement for Table 3 - those NICE guidelines that have been regionally endorsed before 01/09/2011 and which do NOT form part of the HSCB Red Status report	
TABLE 1A Total Number of E proformas that are within their review date / ongoing monitoring and review	28	Total Number of E proformas that are within their review date / ongoing monitoring and review	1	Total Number of E proformas that are within their review date / ongoing monitoring and review	2
TABLE 1A - MUSC Applicability Total Number of E proformas that are within their review date / ongoing monitoring and review	15 (54%)	Total Number of E proformas applicable to MUSC that are within their review date / ongoing monitoring and review	1	Total Number of E proformas Applicable to MUSC that are within their review date / ongoing monitoring and review	2
TABLE 1B Total number of E proformas that are overdue for review (All of these are listed on theDirectorates NICE Guideline audit workplan)	16	Total number of E proformas that are overdue for review (All of these are listed on theDirectorates NICE Guideline audit workplan)	0	Total number of E proformas that are overdue for review (All of these are listed on theDirectorates NICE Guideline audit workplan)	1
TABLE 1B - MUSC Applicability Total number of E proformas that are overdue for review (All of these are listed on theDirectorates NICE Guideline audit workplan)	12 (75%)	Total number of E proformas that are applicable to MUSC and are overdue for review (All of these are listed on theDirectorates NICE Guideline audit workplan)	0	Total number of E proformas that are applicable to MUSC and are overdue for review (All of these are listed on theDirectorates NICE Guideline audit workplan)	1
TABLE 1C Total Number of E proformas that are still to be completed and submitted to the HSCB *(All of these are listed on theDirectorates NICE Guideline audit workplan)*	7	Total Number of E proformas that are still to be completed and submitted to the HSCB *(All of these are listed on theDirectorates NICE Guideline audit workplan)*	4	Total Number of E proformas that are still to be completed and submitted to the HSCB *(All of these are listed on theDirectorates NICE Guideline audit workplan)*	0
TABLE 1C - MUSC Applicability Total Number of E proformas that are still to be completed and submitted to the HSCB *(All of these are listed on theDirectorates NICE Guideline audit workplan)*	5 (71%)	Total Number of E proformas that are applicable to MUSC and are still to be completed and submitted to the HSCB *(All of these are listed on theDirectorates NICE Guideline audit workplan)*	4	Total Number of E proformas that are applicable to MUSC and are still to be completed and submitted to the HSCB *(All of these are listed on theDirectorates NICE Guideline audit workplan)*	0
TABLE 1D Red status stood down	5	Red status stood down	0	Red status stood down	0
TABLE 1D - MUSC Applicability Red status stood down	1	MUSC Applicability Red status stood down	0	MUSC Applicability Red status stood down	0
TABLE 1E: Regionally led with E proforma requirement stood down	2	Regionally led with E proforma requirement stood down	0	Regionally led with E proforma requirement stood down	0
TABLE 1E - MUSC Applicability Regionally led with E proforma requirement stood down	1	Regionally led with applicability to MUSC - E proforma requirement stood down	0	Regionally led with E proforma requirement stood down - MUSC applicability	0
TOTAL	58	Total	5	Total	3
TOTAL applicable to MUSC	34 (59%)	TOTAL applicable to MUSC	5 (100%)	TOTAL applicable to MUSC	3 (100%)
Total Number of E proformas that are indicated on Acute Services Risk Register	66				

TABLE 1A: Total Number of E proformas that are within their review date / ongoing monitoring and review

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Parkinson's disease in adults (updates & replaces CG35)	12/09/2017	HSC (SQSD) (NICE NG71) 30/17	MUSC	Anne McVey	Louise Devlin	Dr Forbes, Dr McCaffrey (Acute Services)	Yes	93%	Yes	Need to provide funding that would support the provision of specialist cognitive therapy to patients with Parkinson's Disease and provision of specialist treatment techniques such as the Alexander Technique for people with Parkinson's disease who are experiencing balance or motor function problems. In December 2018 funding to support the recruitment of 0.5 WTE Band 6 Neurology Nurse to work within the Parkinson's Service was agreed within OPPC Directorate. However further funding to support the recruitment of 0.5WTE Band 6/7 specialist post is required if the requirements of this guidance are to be fully implemented.	Yes	31/12/2020

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Spondyloarthritis in over 16s diagnosis and management	24/04/2017	NG 65	MUSC	Anne McVey	Louise Devlin	Dr Nicola Maiden	Yes	94%	Yes	*Following a recent workforce review a business case was developed and presented to Acute SMT in March 2017. The following requirements were identified to overcome the major barriers to implementation. These included a significant backlog of timely patient review appointments and ability to provide patients with emergency (urgent) appointments within clinics: Specific Requirements: 2.5wte B6 specialist nurses 1wte B7 specialist Occupational Therapist 1wte B7 specialist Physiotherapist 2.5wte B7 specialist Podiatry 0.5wte B7 specialist Orthotist 0.3wte B8a Clinical Psychologist + associated specialist patient appliances. The need for these resources also supports the full implementation of NICE CG 79 Rheumatoid Arthritis in Adults.	Yes	30/04/2019
Medicines Optimisation: The Safe and Effective use of Medicines to Enable the Best Possible Outcomes Updates and replaces CG76 Medicines Adherence	28/04/2015	NG 5	ATICS/CCS/IMWH/MUSC/SEC	Anne McVey, Barry Conway, Ronan Carroll	N/A	Dr T Boyce	Yes	78%	Yes	a) To achieve full compliance against this recommendation will require the following investment: 4 WTE Band 7 Pharmacists and 4 WTE band 4 Pharmacy Technicians b) These staff will then be able to support the existing Pharmacy service to deliver a 7 day working model including evening and weekend clinical pharmacy cover c) Regional agreement and funding to implement a regional electronic prescribing system across the HSC	Yes	31/10/2019
Idiopathic Pulmonary Fibrosis: Diagnosis and Management	02/12/2013	CG 163	MUSC	Anne McVey	Kay Carroll	Dr Liam Polley	Yes	53%	Yes	0.5 WTE Respiratory Consultant 1.0 WTE Interstitial lung disease specialist nurse (Band 6/7) 0.25 WTE Radiologist	Yes	30/04/2019
Stroke Rehabilitation in Adults: Guidance (Update received 30/01/17 A footnote has been added to recommendation 1.4.2.2 and 11/12/18	02/12/2013	CG 162	MUSC	Anne McVey	Kathleen McGoldrick	Noelleen Lambe/Catriona McGoldrick	Yes	87%	Yes	Please refer to previous submitted E proforma - AHP staffing required to provide 5 day service: a) Dietetics: CAH 0.1 wte Band 6 & 0.3 WTE Band 3, DHH 0.5 STE Band 6 & 0.43 WTE Band 3 b) OT: CAH 0.03 WTE Band 7, 0.3 WTE Band 5 & 0.1 WTE Band 3 DHH 0.5 WTE Band 7, 0.5 WTE Band 5, 0.5 Band 3 c) Orthoptics: CAH 0.2 WTE Band 7 DHH 0.3 WTE Band 7 d) CAH 0.5 WTE Band 5 DHH 0.5 WTE Band 7, 0.5 WTE Band 6, 0.75 WTE Band 5 & 1 WTE Band 3 e) Podiatry CAH 0.1 WTE Band 6 DHH 0.15 WTE Band 6 f) SLT: 0.3 WTE Band 6, DHH 1 WTE Band 6 Dedicated space at ward level to provide physiotherapy, OT and SALT E proforma submitted on the 17/05/18 indicates the following requirements: 1.1.2 1.1.8 Funding required for 7 day ESD service 1.1.9 Funding required for 7 day ESD service 1.2.1 Funding required for 7 day in patient service 1.2.16 Funding for AHPs to provide additional resource 1.2.17 Funding for AHPs to provide additional resource 1.6.3 There is no commissioned orthotic service, patients seen on an adhoc basis	Yes	30/04/2019
Cardiovascular Disease: Risk Assessment and Reduction including Lipid Modification	23/09/2014	CG 181	MUSC	Anne McVey	Cathie McIlroy	Dr Peter Sharpe	Yes	97%	Yes	There is a need to recruit 0.5WTE Band 6 Dietician to ensure the provision of specialist dietetic advice at the Lipid Modification clinics.	Yes	31/01/2021
Type 2 Diabetes in Adults: Management [This guideline updates and replaces NICE guidelines CG66, CG87 and NICE technology appraisals TA203 and TA248]	09/02/2016	NG 28	MUSC	Anne McVey	Louise Devlin	Dr M McConnell	Yes	95%	Yes	Investment in the Trust's Diabetology service to enhance the capacity of the MDT and improve service delivery is well recognised. The significant increase in the local prevalence of diabetes has been a key factor and as a result the Trust has over the last few years invested significant time in undertaking a Trust Root and Branch service review – this work has involved the collaborative approach between members of the entire MDT (secondary and primary care), service users and commissioners. This is being jointly led by Acute Services and OPPC and the resources that are required to remedy the service challenges form part of this work which is ongoing.	Yes	31/03/2020
Type 1 Diabetes in Adults: Diagnosis and Management - This guideline updates and replaces the sections for adults in NICE guideline CG15.	12/10/2015	NG 17	MUSC	Anne McVey	Louise Devlin	Dr M McConnell	Yes	92%	Yes	Investment in the Trust's Diabetology service to enhance the capacity of the MDT and improve service delivery is well recognised. The significant increase in the local prevalence of diabetes has been a key factor and as a result the Trust has over the last few years invested significant time in undertaking a Trust Root and Branch service review. This has recently been superceded by the transformational IPT's which are currently being taken forward within the inpatient service. This is being jointly led by Acute Services and OPPC and the resources that are required to remedy the service challenges form part of this work, which is ongoing	Yes	31/03/2020
Rheumatoid Arthritis in Adults - Update 02/02/2016 Update received 04/09/18 NG100 (updates and replaces CG79)	29/07/2013	CG 79	MUSC	Anne McVey	Louise Devlin	Dr N Maiden	Yes	89%	Yes	A workforce review has been undertaken by the MDT working group and the following requirements were identified to overcome the major barriers to implementation. These included a significant backlog of timely patient review appointments and ability to provide patients with emergency (urgent) appointments within clinics: Specific Requirements: 2.5wte B6 specialist nurses 1wte B7 specialist occupational therapist 1wte B7 specialist physiotherapist 2.5wte B7 specialist podiatry 0.5wte B7 specialist orthotist	Yes	31/03/2021
The Management of Acute Upper Gastrointestinal Bleeding C/R NCEPOD "Time to Get Control"	28/09/2012	CG 141	MUSC/SEC	Anne McVey	Louise Devlin	Esther Gishkori, Anne McVey, Ronan Carroll, Dr Philip Murphy, Mr Mark Haynes in collaboration with Medical Director.	Yes	61%	Yes	Issue 1 – If a dedicated daily endoscopy list is required, additional resources would be needed to establish and run this. Issue 2 – The Trust needs to recruit two additional Gastroenterologists who are trained in band ligation with the capacity to commit to an on call bleeding rota	Yes	30/06/2019
Epilepsy Update received 24/04/18	07/08/2012	CG 137	MUSC	Anne McVey	Louise Devlin	Epilepsy Working Group (Chair Dr K McKnight - Acute)	Yes	93%	Yes	Additional resources required to ensure implementation: Additional Consultant Neurologist (business case – awaiting outcome of regional review) Additional Epilepsy Nurse Specialists – this is particularly in regards to Adult Services and the need to support the care of mainstream adults Additional funding to support access to EEG services Additional funding to support access to Radiology services so that neuroimaging can be undertaken in a responsive timescales Additional funding to support access to dedicated neuropsychology / Clinical Psychological / Psychiatric services across all care directorates Additional administration support	Yes	30/11/2020
Non-Alcoholic Fatty Liver Disease (NAFLD): Assessment and Management	23/08/2016	NG 49	MUSC	Anne McVey	Louise Devlin	Dr Philip Murphy / Mrs Louise Devlin	Yes	78%	Yes	Funding to support the commissioning of ELF blood panel testing	Yes	31/03/2020
Cirrhosis in over 16s: Assessment and Management	23/08/2016	NG 50	MUSC	Anne McVey	Louise Devlin	Dr Philip Murphy / Mrs Louise Devlin	Yes	68%	Yes	a) Funding to purchase a fibroscan machine and staffing to support a new model of diagnostic testing within the Day Clinical Centre, CAH. b) Funding to support the commissioning of ELF blood panel testing	Yes	31/03/2020

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Multiple Sclerosis: Management in Primary and Secondary care	28/11/2014	CG 186	MUSC	Anne McVey	Louise Devlin	Dr Jamie Campbell	Yes	93%	Yes	Previously submitted E proforma indicated the following resource requirements: a) 1 wte Consultant Neurologist b) 1.5 MS Nurses E proforma submitted on the 13/05/18 indicates the following resource requirements: 1 WTE band 7 neuro-palliative care nursing specialist post Regional discussions and agreement is required regarding 1.5.8, 1.5.5, 1.5.8 and 1.5.33.	Yes	31/03/2020
Diabetes in Pregnancy: Management of Diabetes and its Complications from Preconception to the Postnatal Period - This guideline updates and replaces NICE guideline CG63	13/03/2015	NG 3	IMWH/MUSC	Barry Conway	Wendy Clarke	Dr Sahid/ Dr McConnell/Wendy Clarke / Louise Devlin	Yes	95%	Yes	As indicated the impact of harmonising practice across both sites since March 2018 has already necessitated the need for additional antenatal booking clinics for mothers with gestational diabetes. Additional clinics to accommodate the increase in review appointments have already been set up and are ongoing. The impact of harmonising guideline adherence across both service sites has resulted in a significant demand on current service capacity. As a consequence the following additional resources are required to meet the IADSPG guideline recommendations: • Additional Consultant and Speciality Doctor hours • 0.25 Band 7 Diabetic Specialist Nurse • 0.25 Band 7 Dietitian • 0.25 Band 6 Midwife • 0.25 Band 3 Clerical Officer	Yes	31/03/2020

TABLE 1B: Total number of E proformas that are overdue for review (All of these are listed on theDirectorates NICE Guideline audit workplan)

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Hypothermia: Prevention and Management in Adults having Surgery - Addendum Cross reference HSC (SQSD) (NICE) 13/2009 CG65	06/02/2017	CG 65	ATICS/SEC	Ronan Carroll	Helena Murray & Amie Nelson	Dr Jeff Brown, Sr Nicola McClenaghan	Yes	88%	Yes	Within the SHSCT there has been significant discussion regarding how to ensure full compliance against the updated NICE guidance can be achieved. An implementation proposal paper has been prepared by the clinical change lead and will be presented to the AcuteClinical Governance froum on 11 May 2018. However there is a need to get agreement on how regional consistency across the HSC can be achieved since there are implications in terms of medical device procurement, NEWS documentation and training for staff. Discussions by the regional NEWS forum have not established an agreed way forward.	Yes	31/01/2019
Multi-Morbidity Clinical Assessment and Management	18/11/2016	NG 56	MUSC	Anne McVey	Kathleen McGoldrick	Kathleen McGoldrick/Dr P McCaffrey / Catherine Sheeran	Yes	74%	Yes	A new regional working group is established and led by the PHA (Eleanor Ross). Trust representation from OPPC and Acute is in place. On 28/03/2019 there was the launch of the NI HSC Frailty Network. This will ensure consistency in approach with the regional perspective being brought back to the SHSCT Fragility Working group (multi-directorate and multi-professional membership) to ensure the outcomes are integrated in the trust work plan. E proforma is currently being updated and will be prsented to Acute S&G forum on 16/04/2019	Yes	28/02/2019
Nutritional Support for Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (Update received 7/8/17)	01/06/2016	CG 32	CCS	Barry Conway	Cathie McIlroy	Ashleigh Nelson (Enteral Feeding Group) Hilary Mathieson (Acute Parenteral Nutrition Team)	Yes	86%	Yes	a) 1 WTE specialist nurse – Band 7 b) 1 WTE dietician – Band 7 c) 0.5 WTE Consultant d) 0.75 WTE Band 8a prescribing pharmacist e) 0.5 Band 3 administrative support	Yes	04/07/2018
Fractures (Non-Complex): Assessment and Management	13/04/2016	NG 38	MUSC/SEC/CCS	Anne McVey, Barry Conway, Ronan Carroll	Mary Burke, Jeanette Robinson & Brigeen Kelly	Mr McKeown (T&O) Mr Holmes (ED) Dr Gracey (Radiology)	Yes	93%	Yes	A care pathway is in place with an initial x-ray undertaken and followed up within 10 days (if required). If there is a clinical suspicious that there is scaphoid fracture an MRI is requested. However in order to consider MRI for first line imaging there would need to be regional direction regarding the development of a regional scaphoid service that allows the patient to have a scan, hot report and sent to referral hospital for follow up treatment / management. The proposed management model is a patient would have a scan undertaken within 24 hours of ED attendance; report would be read by a trained radiographer and depending on the scan outcome appropriately managed. There is currently not the capacity within the MRI service to accommodate these additional patients. The MRI coil for extremity scanning is available but radiographer staff would need to be trained to provide a reporting service. Paper to support this quality improvement initiative to be developed and presented to SMT for consideration.	Yes	31/12/2018
Tuberculosis - supersedes CG 117 Clinical Diagnosis and Management of Tuberculosis and Measures for Prevention and Control	14/03/2016	NG 33	MUSC	Anne McVey	Kay Carroll	Dr Convery	Yes	85%	Yes	a) Currently there is 1 WTE TB Nurse specialist appointed within the SHSCT. This post holder currently cover all three geographical areas. To fulfil the requirements within the NICE guidance a further 1 WTE TB nurse needs to be appointed. b) NI New Entrant Screening Service – without the available resources the requirements of this service are outweighed by current service demand.	Yes	22/05/2018
Diabetic Foot Problems: Prevention and Management - This guideline updates and replaces NICE guidelines CG10 and CG119 and the recommendations on foot care in NICE guideline CG15.	12/10/2015	NG 19	MUSC/SEC/CCS	Anne McVey, Barry Conway, Ronan Carroll	Louise Devlin, Amie Nelson & Cathie McIlroy	Mr A Lewis, Dr M McConnell, Amie Nelson, Cathie McIlroy	Yes	79%	Yes	Investment in the Acute Services podiatry team – current IPT would indicate that 2 WTE Band 7 podiatrists would be required b) Investment in community diabetes specialist podiatry services – 2 WTE (in the first instance) c) Resource allocation to develop and sustain an integrated diabetic, vascular and podiatry clinic that is run on a weekly basis across both sites d) Investment to support the new regional model for managing diabetic patients with foot problems	Yes	31/01/2019
Melanoma: Assessment and Management	13/09/2015	NG 14	MUSC	Anne McVey	Kay Carroll	Dr A O'Hagan	Yes	94%	Yes	1.3.1 Managing suboptimal Vitamin D levels requires collaborative agreement with chemical pathology for policy development 1.6.4 Managing stages 0–II melanoma – this needs further NiCAN discusion 1.7.7 Palliative treatment for in transit metastases needs further regional discussion with oncology colleagues 1.8.6 Systemic anticancer treatment	Yes	30/11/2018
Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance. This guideline updates and replaces NICE guideline CG45 (published February 2007) & section 1.5.6 in NICE guideline CG62 (March 2008) (Update received 17/8/17) Update received 24/04/18	27/02/2015	CG 192	IMWH	Barry Conway	Wendy Clarke	Dr Beverly Adams, Joanne McGlade, Mr D Sim	Yes	79%	Yes	a) There is a potential for a patient to suffer a significant relapse in their mental health condition both during pregnancy and in the post-natal period and there is a risk that this could go undetected leading to a risk of harm to both mother and baby b) There is a lack of consistent monitoring and review of the patient's mental well being c) Use of medication during pregnancy many increase fetal congenital abnormality	Yes	01/09/2018
Acute Heart Failure: Diagnoses and Management	25/11/2014	CG 187	MUSC	Anne McVey	Kay Carroll	Dr Patricia Campbell	Yes	87%	Yes	Once the new Consultant Cardiologist takes up post the development of this heart failure service will be monitored to ensure this recommendation is met	Yes	31/12/2018
Intravenous Fluid Therapy in Adults in Hospital	22/07/2014	CG 174	ATICS/CCS/IMWH/MUSC/SEC	Ronan Carroll	Helena Murray	Dr C Shevlin	Yes	93%	Yes	This forms part of the work being led by Jennifer Lamont at RQIA. The key barriers for implementation were agreed and sent to the Trust's Corporate Goverance team on 17/5/17 for onward submission to RQIA.	Yes	30/09/2018
Myocardial Infarction Secondary Prevention (Updates & Replaces CG 48)	06/01/2014	CG 172	MUSC	Anne McVey	Kay Carroll	Dr Ian Menown	Yes	99%	Yes	Regionally there are no single sex programmes in Northern Ireland. Within SHSCT to provide Single Sex Rehab programmes the following issues were raised: a) The number of males requiring to attend exceeds the number of femaoles therefore would delay commencement of the programme for females b) Limits patient choice re venue c) Potential to increase travelling for female patients.	Yes	30/11/2018

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Falls in Older People: Assessing Risk and Prevention: Guidance	02/12/2013	CG 161	ATICS/CCS/IMWH/MUSC/SEC	Anne McVey	Kay Carroll	Falls Steering Group (T Reid and Kay Carroll Acute Reps)	Yes	55%	Yes	The Falls steering group meeting will review this guideline so that a Trust compliance can be determined with any key barriers identified for inclusion in update to the HSCB.	Yes	08/06/2016
Familial Breast Cancer: Classification, Care and Management of Breast Cancer and Related Risks in People with a Family History of Breast Cancer	02/12/2013	CG 164	CCS	Barry Conway	Fiona Reddick	Fiona Reddick Dr Fenton Amie Nelson	Yes	91%	Yes	Regional Agreement and Sign-off through the Network Site Specific Group	Yes	10/06/2016
Crohn's Disease: Management	29/07/2013	CG 152	MUSC	Anne McVey	Louise Devlin	Dr Andrew Murdock Dr S Bhat Mrs Louise Devlin Ms Ruth Hall	Yes	80%	Yes	a) 1 WTE Band 7 IBD Nurse specialist – this role will support the recently established Transition Clinic b) 1 WTE Band 3 Administration Assistant to support the IBD nursing team c) 0.25 PA per consultant time allocation within the job planning to facilitate a weekly IBD MDT meeting (n=10) d) 0.25 WTE Band 4 administration assistant to co-ordinate the MDT meetings and support the MDT team e) 1 WTE Band 7 Aseptic Pharmacist to resource the IBD Biologists service f) 0.5 WTE Band 7 Dietician	Yes	28/02/2019
Headaches: Diagnosis and Management	29/07/2013	CG 150	MUSC	Anne McVey	Louise Devlin	Dr R Forbes	No	0%	Yes	A Consultant Neurologist from the Southern Trust has been chosen as the lead for the development of the Regional headache service. The Southern Trust is currently developing a Business Plan (IPT) for another Consultant Neurologist to backfill the recognised gap that will develop in terms of SABA volumes and access if the consultant is released to lead on the Headache pathway regionally.	Yes	10/06/2016
Lung Cancer: Diagnosis and Management	29/07/2013	CG 121	CCS/MUSC	Anne McVey	Kay Carroll	Dr R Convery	Yes	60%	Yes	The Trust urgently needs to develop an Endoscopy/Bronchoscopy suite with dedicated staff & access for both in & outpatients.	Yes	01/04/2017

TABLE 1C: Total Number of E proformas that are still to be completed and submitted to the HSCB (All of these are listed on theDirectorates NICE Guideline audit workplan)

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Pancreatic cancer in adults diagnosis and management	09/04/2018	NG 85	SEC	Ronan Carroll	Fiona Reddick & Wendy Clayton	Mr M Yousaf	Partially Completed	Not yet determined	Yes	Pending as part of the completion of the baseline assessment tool	Pending	To be determined
Oesophago-gastric cancer: assessment and management in adults	21/03/2018	NG 83	CCS	Barry Conway	Fiona Reddick	Fiona Reddick	Partially Completed	Not yet determined	Yes	Pending as part of the completion of the baseline assessment tool	Pending	To be determined
Motor Neurone Disease: Assessment and Management - supersedes CG105	19/04/2016	NG 42	MUSC	Anne McVey	Louise Devlin	Dr Convery/Dr John/Dr Forbes				Pending as part of the completion of the baseline assessment tool	Pending	To be determined
Major Trauma: Assessment and Initial Management	13/04/2016	NG 39	MUSC/SEC/CCS	Anne McVey, Barry Conway, Ronan Carroll	Mary Burke, Jeanette Robinson & Brigeen Kelly	Dr Claire Shevlin	Yes	Not yet determined	Not yet determined	Pending as part of the completion of the baseline assessment tool	Pending	To be determined
Major Trauma: Service Delivery	13/04/2016	NG 40	MUSC/SEC/CCS	Anne McVey, Barry Conway, Ronan Carroll	Mary Burke, Jeanette Robinson & Brigeen Kelly	Dr Claire Shevlin	Yes	Not yet determined	Yes	Pending as part of the completion of the baseline assessment tool	Pending	To be determined
Spinal injury: assessment and initial management	13/04/2016	NG 41	MUSC/SEC/CCS	Anne McVey, Barry Conway, Ronan Carroll	Mary Burke, Jeanette Robinson & Brigeen Kelly	Dr Claire Shevlin	Partially Completed	Not yet determined	Yes	Pending as part of the completion of the baseline assessment tool	Pending	To be determined
Suspected Cancer: Recognition and Referral	19/08/2015	NG 12	ATICS/CCS/IMWH/MUSC/SEC	Barry Conway	Fiona Reddick	Fiona Reddick/10 Cancer MDT's	Partially Completed	To be determined	Yes	Pending as part of the completion of the baseline assessment tool	Pending	To be determined

TABLE 1D: Red status stood down

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Non-Hodgkin's Lymphoma: Diagnosis and Management	13/09/2016	NG 52	CCS	Barry Conway	Fiona Reddick	Dr Eswedi	Yes	100%	Yes	Previously this guidance had been escalated to the HSCB as 'blue status' since there were 3 recommendations (1.3.4, 1.5.7 and 1.5.8) that could not be implemented within the SHSCT since they relate to the use of Rituximab induction therapy and maintenance Rituximab therapy. Following a review of this in November 2018 Dr Boyd has now ensured this guidance has been implemented within the SHSCT - E proforma stood down and email sent to the HSCB to indicate this	Stood Down	STOOD DOWN
Fractures (Complex): Assessment and Management (Updated 13/11/17)	13/04/2016	NG 37	MUSC/SEC/CCS	Anne McVey, Barry Conway, Ronan Carroll	Mary Burke, Jeanette Robinson & Brigeen Kelly	Mr McKeown (T&O) Mr Holmes (ED) Dr Gracey (Radiology)	Yes	100%	Yes	All actions are now completed	Stood Down	STOOD DOWN
Bladder Cancer: Diagnosis and Management	17/04/2015	NG 2	SEC	Ronan Carroll	Martina Corrigan	Mr Mark Haynes	Yes	98%	Yes	Previously submitted E Proforma indicated that the following resources were required: Additional dedicated cancer nurse specialists working within the urology service – service review will quantify the specific additionality. Potential funding required to fulfil recommendations 1.2.3 and 1.8.2 – audit and service reviews will again determine the actual funding need. E Proforma was stood down on the 19/06/2018 as all external barriers have been removed	Stood Down	STOOD DOWN
Colonoscopic Surveillance for Prevention of Colorectal Cancer in People with Ulcerative Colitis, Crohn's Disease or Adenomas	29/07/2013	CG 118	CCS/SEC	Ronan Carroll	Amie Nelson	Mr Neil Dr S Murphy Mrs Eileen Murray	No	0%	No	Superceded by Royal College of Radiology guidance	Stood Down	STOOD DOWN
Ovarian Cancer	29/07/2013	CG 122	IMWH	Barry Conway	Wendy Clarke	Dr D Simm Mr G McCracken	No	N/A	N/A	Superceded by NICAN guidance	Stood Down	STOOD DOWN

TABLE 1E: Regionally led with E proforma requirement stood down

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Care of Dying Adults in the Last Days of Life	10/02/2016	NG 31	ATICS/CCS/IMWH/MUSC/SEC	Anne McVey, Barry Conway, Ronan Carroll	Fiona Reddick	OPPC with Acute Input if Required	Yes	90%	Yes	This guidance is being led by the PHA / HSCB so it has been advised that a Trust E proforma is not required albeit a Trust action plan is in place	Pending	Forms part of regional workstream- E proforma stood down.

TABLE 2: CROSS - DIRECTORATE: NICE Guidelines where lead is another Directorate but where the external barriers have been identified within Acute Services

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings - Update	20/07/2015	NG 10	MUSC	Anne McVey	Mary Burke	Mary Burke	Yes	0%	Yes	There is need for a major redevelopment investment for both Emergency Departments to provide a dedicated room that meets the requirements outlined in recommendation 1.5.8 The Trust can confirm that it has an Emergency Department sub group established as part of the CAH Redevelopment Project. This group are currently	Yes	20/03/2022
Sepsis recognition diagnosis and early management	14/09/2017	NG 51	ATICS/CCS/IMWH/MUSC/SEC	Anne McVey, Barry Conway, Ronan Carroll	All Heads of Service	Medical director is the Trust lead for implementation with a MDT working group established. Acute Representation - Trudy Reid, Dr Rodgers, Dr O'Connor, Dr McCormick, Sharon Holmes, Dr McCracken, Wendy Clarke	Yes	89%	Yes	This work is integrated into the trusts Sepsis 6 workplan that is led by the Medical Director. Work continues to progress and will also integrate the updated regionally agreed NEWS 2 chart.	Pending	To be determined
Intravenous fluid therapy in children and young people in hospital	20/06/2017	NG 29	ATICS/CCS/IMWH/MUSC/SEC	Anne McVey & Ronan Carroll	All Heads of Service	Medical director is the Trust lead for implementation with a MDT working group established. Acute Representation - Trudy Reid, Dr Rodgers, Dr O'Connor, Dr McCormick, Sharon Holmes, Dr McCracken, Wendy Clarke	No	To be determined	Not yet determined	Within the September 2018 HSCB positive assurance report in was indicated that this guideline was red status. At that time Acute services and CYPS had agreed to review and complete the BAT, this work remains ongoing. Following discussion at the governance co-ordinators meeting (held on the 21/03/2019) Caroline Beattie raised her concern that this work remains outstanding and needed to be coordinated within the trust Hypernatremia work plan. It was agreed that this would be included in the agenda of the next steering group, planned for early April 2019.	Pending	To be determined
Dementia - supporting people with dementia and their carers in health and social care Updated recommendations issued May 2016 (Updated by NG 97 August 18)	27/09/2011	HSC (SQSD) (NICE) 31/2011 CG 42	MUSC	Anne McVey	Kathleen McGoldrick	Kathleen McGoldrick	Yes	95%	Yes		N/A	To be determined
Challenging Behaviour and Learning Disabilities	20/07/2015	NG 11	MUSC	Anne McVey	Mary Burke	Edel Corr/Catriona McGoldrick	No	0%	Yes			To be determined

TABLE 3: E proformas completed for those NICE Guidelines issued prior to 01/09/2011 - E proforma completed but not submitted to HSCB. Included within the Acute Directorate Risk Register

Title of Correspondence	Date of Issue from External Agency	Reference	Applicable Division	Lead Assistant Director	Head of Service	Acute Clinical Change Lead	Has a baseline assessment or action plan been completed?	Overall level of compliance %	External Barriers Identified (NICE Guidelines Only)	Resources Required	Section E Completed	Review Date Section E Proforma
Unstable Angina and NSTEMI: Early management	24/03/2011	CG 94	MUSC	Anne McVey	Kay Carroll	Dr Michael Moore	Yes	96%	Yes	Within the Southern Health and Social Care Trust there is only one Cardiac Catheterisation laboratory theatre which is operational 9am to 5pm Monday to Friday. The Southern Health and Social Care Trust have only three Cardiac Interventionalists to provide current service.	Yes	30/11/2018
Stroke and Transient Ischaemic Attack	13/07/2009	CG 68	MUSC	Anne McVey	Kathleen McGoldrick	Dr M McCormick/Kathleen McGoldrick	Yes	95%	Yes	• Additional CT scanner equipment to support timely scans that will determine patient diagnosis and ensure timely commencement of treatment • Additional MRI scanner to support timely scans that will determine patient diagnosis and ensure timely commencement of treatment • Additional medical / nursing staff to support development of hyper-acute stroke bed model	Yes	30/06/2019
Familial Hypercholesterolaemia PRIORITY 1 for Acute Services	10/07/2009	CG 71	MUSC	Anne McVey	Kay Carroll	AD CCS/Dr Peter Sharpe working with relevant clinicians	Yes	97%	Yes	Additional funding needs to be secured to ensure that the doctor that has been employed for one clinic per month continues after the contract ends on 31/03/2018 There is a need to recruit 0.5WTE Band 6 Dietician to ensure the provision of specialist dietetic advice at the Lipid Modification clinics.	Yes	31/01/2021

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	**CG 94**
Title	Unstable angina and NSTEMI: Early Management
Date of Review	April 2019
Clinical Lead	Dr Michael Moore – Lead Cardiologist Mrs Kay Carroll – Head of Cardiology
Description of major barrier/s to implementation	***Recommendation 1.5.1*** The Trust's Cardiology service is unable to offer coronary angiography (with follow-on PCI if indicated) within 96 hours of first admission to hospital to patients who have an intermediate or higher risk of adverse cardiovascular events (predicted 6-month mortality above 3.0%) if they have no contraindications to angiography (such as active bleeding or comorbidity). It is noteworthy to indicate that whilst the NICE guideline indicates offering coronary angiography within 96 hours of first admission to hospital the NI cardiovascular service framework is 72 hours. Service performance against this standard is continually monitored.
Indicate any specific requirements to address the major barrier/s to implementation	Within the Southern Health and Social Care Trust there is only one Cardiac Catheterisation laboratory theatre which is operational 9am to 5pm Monday to Friday. The Southern Health and Social Care Trust have only three Cardiac Interventionalists to provide current service. A second additional Funded cardiac catherisation laboratory is required to address this
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	
No. of recommendations applicable to SHSCT ***(If a number are deemed N/A, please state)***	28

No. of applicable recommendations currently implemented ***(e.g. 99/100)***	27 (96.4%)		
Additional resources required to ensure implementation	• 1wte Cardiology Interventionalist • 4.5 wte Band 5 nurses • 1.5 wte band 6 Radiographer • 1.5 wte Band 7 Cardiac Physiologist		
Suggested revised compliance date if outstanding issues are addressed	30/04/2020		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	16 April 2019		
E Proforma Submitted by:	Mrs Kay Carroll *Head of Cardiology*	**Date**	12/04/2019
Assistant Director/s signature:	Anne McVey *Assistant Director Acute Services (MUSC)*	**Date**	07/05/2019
Director signature:	Personal Information redacted by USI PP E GISHKORI	**Date**	09.05.19
Date Submitted to Corporate Governance team for onward submission to HSCB	10/05/2019		

Southern Health and Social Care Trust

Quality Care - for you, with you

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	**CG 137**
Title	**Epilepsy**
Date of Review	November 2018
Clinical Lead	SHSCT Epilepsy Working Group (cross directorate with representatives from Acute Adult Services, Community Adult Epilepsy services, Learning Disability Epilepsy service, Paediatric Epilepsy service). The work is by Dr McKnight (Consultant Neurologist) and Dr Funston (Consultant Paediatrician with a specialist interest in Epilepsy)
Description of major barrier/s to implementation	The Trust's cross directorate working group for implementing the recommendations outlined in the guidance has been reconstituted. The baseline assessment has been reviewed and there are 19 recommendations that have an identified external barrier that will impede the Trust's ability to implement the guidance fully. These barriers are outlined below: ***Recommendations 1.5.7 / 1.8.3 / 1.8.4 / 1.11.1 / 1.11.2 / 1.11.3 / 1.6.32 / 1.6.33 (n=8)*** There is a lack / limited access to dedicated neuropsychology / Clinical Psychological / Psychiatric services across all care directorates ***Recommendations 1.8.1 / 1.17.3 / 1.17.4 / 1.17.5 / 1.17.6 (n=5)*** There is a lack of specialist nursing posts within the Acute Adult and Community Adult services as well as CYPS services. As a result many roles and responsibilities cannot be undertaken including the establishment of a formalised transition clinic between CYPS and Adult services. ***Recommendations 1.6.3 / 1.6.5 / 1.6.6 / 1.6.7 (n=4)*** There is a lack of EEG capacity and this has resulted in significant time delays in diagnostic testing for all patients ***Recommendation 1.6.22*** There is a lack of MRI capacity in adult services for those patients who require a general anaesthetic to undertake the diagnostic testing

	Recommendation 1.4.6 The Trust's Paediatric Services do not refer a patient with their first non-febrile seizure to the Paediatric Consultant - this referral is only made on presentation of a 2nd seizure. The Trust will continue with this practice within its paediatric service.
Indicate any specific requirements to address the major barrier/s to implementation	Additional resources required to ensure implementation: ✓ Additional Epilepsy Nurse Specialists – this is particularly in regards to Adult Services and the need to support the care of mainstream adults ✓ Additional administration support to support the medical consultant and nursing specialist posts ✓ Additional funding to support access to EEG services ✓ Additional funding to support access to Radiology services so that neuroimaging can be undertaken in a responsive timescales ✓ Additional funding to support access to dedicated neuropsychology / Clinical Psychological / Psychiatric services across all care directorates
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	There is a lack of dedicated Epilepsy specialist nurses within the SHSCT. This is across the Acute Adult, Community Adult and CYPS Epilepsy services. This shortage in nursing resource results in – • No formalised transition clinic which is fundamental to ensure the smooth transition of care for patients and their families from children to adult services. • Delays in access to nursing support / advice • Limited skill mix results in specialist nurses undertaking some roles which could be realigned to staff of another band or professional background (including administrative and clerical duties). This detracts from the specialist clinical role and ability to provide direct patient care (assessment and treatment) • Limited availability of contingency arrangements with no service cover in the OPPC directorate for adults with Epilepsy when the post holder is on leave. This results in failure to deliver service during those periods of leave. Consequently there are increased demands on consultant and GP time • All new patients are provided with information on self-management,(1.31) only those patients requiring emergency medication, those in need of domiciliary care and those who attend resource centres and some schools have a documented patient specific seizure management plan. The commissioned resource for Specialist Nurse is insufficient to provide individualised self-management education and care plans for every newly diagnosed patient.

	• There are inadequate resources available to support Quality Improvement initiatives • The Epilepsy Nurse Specialist would want to designate more time to train Practice Nurses and GPs, thus facilitating knowledge and skill to undertake effective annual reviews which support compliance and concordance with prescribed medication. • Enhanced training to Community Midwives, Health visitors, staff from Private Nursing homes, ICTs domiciliary care workers would improve outcomes for patients with epilepsy. Whilst the Epilepsy nurse does provide training in response to identified need, this training is not widely available due to resource limitations
No. of recommendations applicable to SHSCT *(If a number are deemed N/A, please state)*	283 (recommendations 1.10.9 and 1.15.3.16 – both are provided by either by the tertiary centre in BHSCT or at national centres (Manchester / Liverpool)
No. of applicable recommendations currently implemented ***(e.g. 99/100)***	264 (93%)
Additional resources required to ensure implementation	As indicated above ✓ Additional Epilepsy Nurse Specialist to support the care of patients being care for within Acute Adult & Community Adult Epilepsy services ✓ Additional Epilepsy Nurse Specialist to support the care of children and young persons. An IPT is currently being developed to support service development. ✓ Additional administration support across all directorate services ✓ Funding to support service delivery – EEG / Radiology (MRI) ✓ Funding to support access to dedicated neuropsychology / Clinical Psychological / Psychiatric services across all care directorates
Suggested revised compliance date if outstanding issues are addressed	2 year (November 2020)

APPROVAL:			
Date presented to Acute SMT Governance Forum	20th November 2018		
E Proforma Submitted by:	SHSCT Epilepsy Working group	**Date**	20/11/2018
Assistant Director:	Mrs Anne McVey ***Assistant Director of MUSC***	**Date**	20/11/18. (CB)
Acute Services Director signature:	Personal Information redacted by USI	**Date**	23/11/2018
CYPS Director Approval	Personal Information redacted by USI	**Date**	15/4/19
MHLD Director Approval	Personal Information redacted by USI	**Date**	23/2/19
OPPC Director Approval	Personal Information redacted by USI	**Date**	6/2/19

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	**CG 165**
Title	Hepatitis B (Chronic)
Date of Review	21 March 2019
Clinical Lead	Dr Philip Murphy
Description of major barrier/s to implementation	Following completion of the baseline assessment tool there are 8 recommendations that are not complied with. ***Recommendations 1.3.3, 1.3.5, 1.3.6, 1.3.7, 1.3.8*** A total of 6 recommendations are not able to be implemented due to the existence of an external barrier. All related to the Trust not being able to offer transient elastography as the initial test for liver disease in adults newly referred for assessment. The Trust has indicated the significant benefit of investing in a fibroscan machine. This would allow the service to offer patients the option of non-invasive transient elastography testing rather that the possible need to undergo an invasive liver biopsy undertaken. However despite recognition of the benefit of this equipment within the Trust there is no funding available to do so, given the current financial climate. ***Recommendations 1.1.1 and 1.1.2*** A further 2 recommendations are not complied with but are being progressed internally within the designated timescales. A total number of 75 guideline recommendations are deemed not applicable to SHSCT
Indicate any specific requirements to address the major barrier/s to implementation	Despite recognition by the Acute SMT to purchase a fibroscan machine there is no funding available to do so, given the current financial climate. The need for this equipment is on the directorate capital budget priority list. Initial *Cost Benefit Analysis* identifies the following: • Non-invasive diagnostic test - less painful experience for the patient with reduced risk of complications (M&M) / less need for overnight stay • Less dependency on Radiology - diagnostic testing would be undertaken in Day Clinical centre

	• Whilst there is up front purchase cost of approximately £50k with ongoing recurrent costs (maintenance / consumables / MDT involvement) the referral rate for liver biopsy could be dramatically reduced for patients with NAFLD and other hepatological conditions • Increased update in diagnostic testing - patients are not keen to have liver biopsy undertaken so difficult to clinical assess using validated markers - this baseline information would enhance the clinical management of these patients		
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	None indicated		
No. of recommendations applicable to SHSCT ***(If a number are deemed N/A, please state)***	20		
No. of applicable recommendations currently implemented<br***(e.g. 99/100)***	12 (60%)		
Additional resources required to ensure implementation	Funding to purchase a fibroscan machine and staffing to support a new model of diagnostic testing within the Day Clinical Centre, CAH.		
Suggested revised compliance date if outstanding issues are addressed	31/03/2020		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	2 April 2019		
E Proforma Submitted by:	Dr Philip Murphy *(Consultant Gastroenterologist)* Mrs Louise Devlin *(Head of Service)*	**Date**	21/03/2019

Assistant Director:	Mrs Anne McVey *Assistant Director - MUSC*	**Date**	02/04/2019
Director signature:	Personal Information redacted by USI	**Date**	03/04/2019
Date Submitted to Corporate Governance team for onward submission to HSCB	03/04/2019		

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	**CG 186**
Title	**Multiple Sclerosis**
Date of Review	February 2019
Clinical Lead	Dr Jamie Campbell – Consultant Neurologist
Description of major barrier/s to implementation	Following review of the previously completed baseline assessment tool (April 2018) the following 4 recommendations continue to have external barriers impeding full implementation: ***Recommendation 1.5.5, 1.5.8 and 1.5.33*** Consider mindfulness-based training, cognitive behavioural therapy or fatigue management for treating MS-related fatigue. The SHSCT does not have resources in place to provide cognitive behavioural therapy for these patients. Clinical Psychology input to the management of these patients is very limited and there is no access to Neuropsychology (BHSCT only). This needs to be reviewed regionally. ***Recommendation 1.6.10*** A neuro-palliative care nurse specialist post needs to be funded A further 2 recommendations (1.7.1 and 1.7.13) have been identified as requiring internal actions that continue to be progressed and completed by 31/03/2020. This includes the development of a steroid card for patients and a patient care pathway to ensure timely treatment of patients who have a relapse of their MS.
Indicate any specific requirements to address the major barrier/s to implementation	1 WTE band 7 neuro-palliative care nursing specialist post (recommendation 1.6.10) Regional discussions and agreement is required regarding 1.5.8, 1.5.5, 1.5.33

Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale			
No. of recommendations applicable to SHSCT ***(If a number are deemed N/A, please state)***	**92**		
No. of applicable recommendations currently implemented ***(e.g. 99/100)***	86 (93%)		
Additional resources required to ensure implementation	• 1 WTE band 7 neuro-palliative care nursing specialist post (recommendation 1.6.10) • Regional discussions and agreement is required regarding 1.5.8, 1.5.5, 1.5.33		
Suggested revised compliance date if outstanding issues are addressed	12 months – 31/03/2020		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	4th March 2019		
E Proforma Submitted by:	Dr Jamie Campbell Consultant Neurologist/ Louise Devlin	**Date**	28/02/2019
Assistant Director/s:	Anne McVey Assistant Director MUSC	**Date**	12/03/2019
Director signature:	Personal Information redacted by USI	**Date**	22/03/2019
Date Submitted to Corporate Governance team for onward submission to HSCB	03/04/2019		

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	**NG 3**
Title	Diabetes in Pregnancy
Date of Review	March 2019
Clinical Lead	Mrs Wendy Clarke - Head of Midwifery Mrs Louise Devlin - Head of Diabetic Services (Acute Services) Dr Shahid - Consultant Obstetrician Dr McConnell – Consultant Diabetologist
Description of major barrier/s to implementation	Following review of the baseline assessment tool the following assurance position can be confirmed: A total of 6 recommendations are not complied with and all of these are the result of external barriers which impedes the Trust's ability to implement. These recommendations are listed as 1.2.3, 1.2.8, 1.2.25, 1.3.16, 1.3.18 and 1.5.10. ***Recommendations 1.2.3 and 1.2.8*** Within the SHSCT IADPSG and not NICE guidance are adhered to across both sites (as per the regional Diabetes Pregnancy group). The IADPSG meets and exceeds the standard outlined within NICE. Significant work has been undertaken to achieve harmonisation of practice across both CAH and DHH sites and the new processes have been in place since March 2018. The impact of harmonising practice across both sites has necessitated the need for additional antenatal booking clinics for mothers with gestational diabetes. Additional clinics to accommodate the increase in review appointments on the CAG site has been identified and work is underway to progress this but to ensure sustainability additional funding is required ***Recommendation 1.2.25*** Within the SHSCT there is concern that Glibenclamide is being recommended for this purpose as the Summary Product characteristics contraindicate its use in pregnancy. This has been verified by the Director of Pharmacy. This drug is widely

	used in the USA but is not used within the SHSCT as it is considered inferior to either insulin/ metformin. ***Recommendations 1.3.16*** Within the SHSCT a structured educational programme is in place but very limited due to current staffing levels and service resourcing within both the Dietetic and Diabetic Specialist Nursing teams – as a consequence recommendation 1.3.16 continues not to be met. There is a need to provide a more responsive 1:1 service for patients. Investment in the Trust's Diabetology service to enhance the capacity of the MDT and improve service delivery is well recognised. The significant increase in the local prevalence of diabetes has been a key factor and as a result the Trust has over the last few years invested significant time in undertaking a Trust Root and Branch service review. This has recently been superceded by the transformational IPT's which are currently being taken forward within the antenatal service. This is being jointly led by Acute Services and OPPC and the resources that are required to remedy the service challenges form part of this work, which is ongoing. ***Recommendation 1.3.18*** There continues to be limited funding for the provision of CGM - there are approximately 1500 patients diagnosed with Type 1 Diabetes who are under the care of the Trust's diabetic service. Unfortunately there is only funding for 5 CGM machines so demand significantly outstrips demand ***Recommendation 1.5.10*** Within the SHSCT it is agreed practice to use a value of 2.6mmol/litre and not 2.0 as indicated within the guidance. This is much more sensitive value and is supported more robustly by evidence based practice. The SHSCT will continue to use the 2.6mmol/litre threshold to ensure patient safety
Indicate any specific requirements to address the major barrier/s to implementation	As indicated the impact of harmonising practice across both sites since March 2018 has already necessitated the need for additional antenatal booking clinics for mothers with gestational diabetes. Additional clinics to accommodate the increase in review appointments have already been set up and are ongoing. The impact of harmonising guideline adherence across both service sites has resulted in a significant demand on current service capacity.

	As a consequence the following additional resources are required to meet the IADSPG guideline recommendations: • Additional 1.25 PA Consultant and 1.25 Specialty Doctor • 0.25 Band 7 Diabetic Specialist Nurse • 0.25 Band 7 Dietitian • 0.25 Band 6 Midwife • 0.25 Band 3 Clerical Officer		
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	Service capacity constraints could reduce the Trust's ability to provide timely booking / review appointments to patients.		
No. of recommendations applicable to SHSCT ***(If a number are deemed N/A, please state)***	135		
No. of applicable recommendations currently implemented ***(e.g. 99/100)***	129 (95%)		
Additional resources required to ensure implementation	As indicated above		
Suggested revised compliance date if outstanding issues are addressed	31 March 2020		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	02/04/2019		
E Proforma Submitted by:	Mrs Wendy Clarke - Head of Midwifery Mrs Louise Devlin - Head of Diabetic Services (Acute Services) Dr Shahid - Consultant Obstetrician Dr McConnell – Consultant Diabetologist	**Date**	29/03/2019
Assistant Director/s signature:	Barry Conway *Assistant Director IMWH*	**Date**	02/04/2019

	Mrs Anne McVey *Assistant Director MUSC*		
Director signature:	Personal information redacted by USI	**Date**	03/04/2019
Date Submitted to Corporate Governance team for onward submission to HSCB	03/04/2019		

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

<table>
<tr><td>Clinical Guideline Number</td><td>NG 14</td></tr>
<tr><td>Title</td><td>Melanoma: Assessment and Management</td></tr>
<tr><td>Date of Review</td><td>March 2019</td></tr>
<tr><td>Clinical Lead</td><td>Dr A O'Hagan</td></tr>
<tr><td>Description of major barrier/s to implementation</td><td>The recommendations that are not met will require regional discussion with NIDAS/NICaN and Oncology Services to determine the way forward to ensure a regional consensus.</td></tr>
<tr><td>Indicate any specific requirements to address the major barrier/s to implementation</td><td>Following review of the previously completed baseline assessment tool, there are 4 recommendations that continue to not be met, all of which are impeded by external barriers.
<table>
<tr><th>Recommendation</th><th></th></tr>
<tr><td>1.3.1</td><td>Managing suboptimal Vitamin D levels requires collaborative agreement with chemical pathology for policy development</td></tr>
<tr><td>1.6.4</td><td>Managing stages 0–II melanoma – this needs further NiCAN discusion</td></tr>
<tr><td>1.7.7</td><td>Palliative treatment for in transit metastases needs further regional discussion with oncology colleagues</td></tr>
<tr><td>1.8.6</td><td>Systemic anticancer treatment</td></tr>
</table>
This is an improvement on the previously reported compliance of 83% in which 15 recommendations could not be met</td></tr>
<tr><td>Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale</td><td>None indicated</td></tr>
</table>

No. of recommendations applicable to SHSCT *(If a number are deemed N/A, please state)*	63		
No. of applicable recommendations currently implemented *(e.g. 99/100)*	59 (94%)		
Additional resources required to ensure implementation	Funding required if above recommendations were implemented regionally.		
Suggested revised compliance date if outstanding issues are addressed	31/03/2020		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	02/04/2019		
E Proforma Submitted by:	Mrs Jeanette Collins *Dermatology Service Improvement Lead* Mrs Kay Carroll Head of Service *(Haematology, Dermatology, Cardiology, Respiratory)*	**Date**	27/03/2019
Assistant Director/s signature:	Mrs Anne McVey *Assistant Director Acute Services (MUSC)*	**Date**	07/05/2019
Director signature:	Personal Information redacted by USI PP E GISHKORI	**Date**	09.05.19
Date Submitted to Corporate Governance team for onward submission to HSCB	10/05/2019		

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	**NG 49**
Title	Non-alcoholic fatty liver disease (NAFLD) assessment and management
Date of Review	March 2019
Clinical Lead	Dr Philip Murphy (Consultant Gastroenterologist)
Description of major barrier/s to implementation	Following previous submission of the E proforma to the HSCB in October 2017 this E proforma has been reviewed. There continues to be ongoing challenges in fully complying with all of the recommendations and this is summarised below. ***ELF Blood Panel*** Within the SHSCT provision of an ELF blood panel for these patients is not provided because there is no dedicated funding to provide this diagnostic test. This has been an on-going issue for the Trust's Laboratory services. As such recommendations 1.2.2, 1.2,4, 1.2.6, 1.2.7, 1.2.8 are not complied with. The Trust's Head of Laboratory Services is currently raising the funding issue with the Northern Ireland Pathology Network so that this guidance can be reviewed with a view to having the test commissioned.
Indicate any specific requirements to address the major barrier/s to implementation	Funding to support the commissioning of ELF blood panel testing
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	None indicated
No. of recommendations applicable to SHSCT ***(If a number are deemed N/A, please state)***	23

No. of applicable recommendations currently implemented ***(e.g. 99/100)***	18 (78%)		
Additional resources required to ensure implementation	Funding to support the commissioning of ELF blood panel testing		
Suggested revised compliance date if outstanding issues are addressed	12 months – 31 March 2020		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	02 April 2019		
E Proforma Submitted by:	Dr Philip Murphy Mrs Louise Devlin	**Date**	21/03/2019
Assistant Director:	Mrs Anne McVey *Assistant Director – Medicine & Unscheduled Care* Barry Conway *Assistant Director IMWH*	**Date**	02/04/2019
Director signature:	Personal Information redacted by USI	**Date**	03/04/2019
Date Submitted to Corporate Governance team for onward submission to HSCB	03/04/2019		

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	**NG 50**
Title	Cirrhosis in over 16's
Date of Review	March 2019
Clinical Lead	Dr Philip Murphy (Consultant Gastroenterologist)
Description of major barrier/s to implementation	This is also linked to the Trust's submitted E proforma for NICE NG 49 Following review of the previously completed baseline assessment tool (November 2017) the E proforma has been updated to reflect the current compliance position. There are 8 recommendations that are not complied with due to an external barrier. The summary of this is provided below: ***Recommendations 1.1.3, 1.1.4, 1.1.6, 1.1.7, 1.1.8, 1.1.11 and 1.1.12*** Within the SHSCT provision of an ELF blood panel for these patients is not provided because there is no dedicated funding to provide this diagnostic test. This has been an on-going issue for the Trust's Laboratory services. The Trust's Head of Laboratory Services is currently raising the funding issue with the Northern Ireland Pathology Network so that this guidance can be reviewed with a view to having the test commissioned. The Trust has indicated the significant benefit of investing in a fibroscan machine. This would allow the service to offer patients the option of non-invasive transient elastography testing rather that the possible need to undergo an invasive liver biopsy undertaken. However despite recognition of the benefit of this equipment within the Trust there is no funding available to do so, given the current financial climate The SHSCT is also not able to comply with NICE CG 165 Hepatitis B due to the need for investment in a fibroscan. A E proforma has also been submitted to the HSCB as part of the Trust's ongoing assurance process.

	Recommendation 1.2.1 This recommendation indicates that the SHSCT is to offer endoscopic variceal band ligation for the primary prevention of bleeding for people with cirrhosis who have medium to large oesophageal varices. The SHSCT does not currently comply with this recommendation since to do so will incur a significant resource requirement and it goes against a number of other guidelines for managing varices. Further regional discussion with the HSCB / DHSSPSNI is required since the estimated financial impact is significant.
Indicate any specific requirements to address the major barrier/s to implementation	1. Despite recognition by the Acute SMT to purchase a fibroscan machine there is no funding available to do so, given the current financial climate. The need for this equipment is on the directorate capital budget priority list. Initial *Cost Benefit Analysis* identifies the following: • Non-invasive diagnostic test - less painful experience for the patient with reduced risk of complications (M&M) / less need for overnight stay • Less dependency on Radiology - diagnostic testing would be undertaken in Day Clinical centre • Whilst there is up front purchase cost of approximately £50k with ongoing recurrent costs (maintenance / consumables / MDT involvement) the referral rate for liver biopsy could be dramatically reduced for patients with NAFLD and other hepatological conditions • Increased update in diagnostic testing - patients are not keen to have liver biopsy undertaken so difficult to clinical assess using validated markers - this baseline information would enhance the clinical management of these patients 2. Funding to support the commissioning of ELF blood panel testing. This is also linked to the submitted E proforma for NICE NG 49
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	None indicated
No. of recommendations applicable to SHSCT ***(If a number are deemed N/A, please state)***	25
No. of applicable recommendations currently implemented ***(e.g. 99/100)***	17

Additional resources required to ensure implementation	Funding to purchase a fibroscan machine and staffing to support a new model of diagnostic testing within the Day Clinical Centre, CAH. Funding to support the commissioning of ELF blood panel testing		
Suggested revised compliance date if outstanding issues are addressed	31 March 2020		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	2nd April 2019		
E Proforma Submitted by:	Dr Philip Murphy *(Consultant Gastroenterologist)* Mrs Louise Devlin *(Head of Service)*	**Date**	21/03/2019
Assistant Director/s signature:	Mrs Anne McVey *Assistant Director Medicine & Unscheduled Care* Barry Conway *Assistant Director IMWH*	**Date**	02/04/2019
Director signature:	Personal Information redacted by USI	**Date**	03/04/2019
Date Submitted to Corporate Governance team for onward submission to HSCB	03/04/2019		

Southern Health and Social Care Trust

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SECTION E -
Clinical Guidelines not implemented / not on track for implementation within 12 months of issue by DHSSPS

Clinical Guideline Number	NG 100
Title	Rheumatoid Arthritis in Adults
Date of Review	February 2019
Clinical Lead	Dr Nicola Maiden and MDT working group that was established to review guideline recommendations
Description of major barrier/s to implementation	• There is significant waiting times for new 'routine' Rheumatology appointments • There is currently a lack of sufficient review capacity at Consultant Outpatient clinics • Insufficient Nurse Specialist capacity • No specialist AHP service which includes physiotherapy, podiatry, orthotics, dietetics with inadequate Occupational Therapy service provision to meet current demand • No provision of psychological interventions to help people with Rheumatoid Arthritis adjust to living with their condition
Indicate any specific requirements to address the major barrier/s to implementation	A workforce review has been undertaken by the MDT working group and the following requirements were identified to overcome the major barriers to implementation. These included a significant backlog of timely patient review appointments and ability to provide patients with emergency (urgent) appointments within clinics: *Specific Requirements:* 2.5wte B6 specialist nurses 1wte B7 specialist occupational therapist 1wte B7 specialist physiotherapist 2.5wte B7 specialist podiatry 0.5wte B7 specialist orthotist 0.3wte B8a clinical psychologist + associated specialist patient appliances
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	The longer the disease is uncontrolled the greater the likelihood of damage to joints, increased pain and potential disability. Economic factors associated with reduced ability to remain in

	gainful employment and psychosocial factors associated with restricted lifestyle. In addition if disease is not optimally controlled from diagnosis then there is an increase in the likelihood that Biologic drugs will be required with consequent financial impact and exposure to increased immunosuppression for the patient.
No. of recommendations applicable to SHSCT *(If a number are deemed N/A, please state)*	36
No. of applicable recommendations currently implemented *(e.g. 99/100)*	32 (89%)
Additional resources required to ensure implementation	2.5wte B6 Specialist Nurses 1wte B7 specialist Occupational Therapist 1wte B7 specialist Physiotherapist 2.5wte B7 specialist Podiatrist 0.5wte B7 specialist Orthotist 0.3wte B8a clinical psychologist + associated specialist patient appliances
Suggested revised compliance date if outstanding issues are addressed	March 2021
ACUTE SERVICES APPROVAL	
Date presented to Acute SMT Governance Forum	4th March 2019 (lead directorate for implementation)
E Proforma Submitted by:	NICE Rheumatoid Arthritis guideline working group led by Dr Maiden
Assistant Director/s:	Mrs Anne McVey – MUSC Mr Barry Conway – Clinical & Cancer Services
Acute Services Director signature:	Personal Information redacted by USI **Date:** 22/03/2019

OPPC Director signature:	Personal information redacted by USI		28-03-19
Date Submitted to Corporate Governance team for onward submission to HSCB	03/04/19		

CLINICAL GUIDELINES ID TAG	
Title:	**Photography of Service Users Policy**
Author:	***Dr Catherine Weaver***
Speciality / Division:	***Informatics***
Directorate:	***Performance & Reform -***
Date Uploaded:	11/04/2019
Review Date	***October 2020***
Clinical Guideline ID	CG0605

Southern Health and Social Care Trust

Quality Care - for you, with you

Southern HSCT Photography of Service Users Policy

Lead Policy Author & Job Title:	Catherine Weaver
Directorate responsible for document:	Performance & Reform
Issue Date:	23 October 2018
Review Date:	01 October 2020

Policy Checklist

Policy name:	**Southern HSCT Photography of Service Users Policy**
Lead Policy Author & Job Title:	**Catherine Weaver**
Director responsible for Policy:	Aldrina Magwood
Directorate responsible for Policy:	Performance & Reform
Equality Screened by:	**Stephen Haughey**
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Policy circulated to:	Directors and Acute Governance Committee
Policy uploaded to:	Sharepoint

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Supersedes:	**N/A**		
Version History			
Version	**Notes on revisions/modifications and who document was circulated or presented to**	**Date**	**Lead Policy Author**
1.0	**Southern HSCT Photography of Service Users Policy**	09/10/2018	Catherine Weaver
1.1	**Updated contact details for PACS team**	13/02/19	**Catherine Weaver**

Contents

1.0 Introduction

1.1 Recording is widely used in the Trust to take pictures of service users for inclusion in their medical records, for teaching, research and use in publications, (in this policy the term 'service user' refers to patients and clients). This policy does not apply to CCTV images captured by the Trust and does not apply to images captured by the Communications Team for the purposes of PR.

1.2 Capturing images of service users can be an invaluable asset in treating a service user, mapping their progress or deterioration, or providing evidence in cases of interest to the police.

1.3 All recordings of service users, which illustrate a service user's condition or an aspect of treatment are part of that service user's medical record and protected under the Data Protection Act.

1.4 In this policy, the term "recording" (or "recordings") is used to refer to photography (either conventional or digital). It refers to original and/or copies of images. It does not include pathology slides containing human tissue or CCTV recordings of public areas on the Trust's premises.

1.5 With the ready availability of digital cameras, recordings can easily be taken by staff. As a consequence service users may be vulnerable to breaches in confidentiality and staff may be breaching the Data Protection Act and leaving themselves open to prosecution.

1.6 Recordings which illustrates a service user's condition or an aspect of the treatment, form a part of that service user's medical record and should be protected in the same way as with any other medical record. Recordings of service users should only be made when it is used to enhance the service user's care or treatment.

1.7 All images produced of service users are the property of the Trust as they are part of the service user's record. They do not belong to individual clinicians etc. This policy is not intended to be over-restrictive but aims to ensure all parties are protected. It recognises the essential role of photographic material for the benefit it brings to

service users. In this respect, it recognises the need for continued use of material already existing within the teaching domain prior to the implementation of this policy.

2.0 Purpose and Aims

2.1 This purpose of this policy is to provide clear information on service user Photography & Recording and to ensure particular care is taken to protect the recordings and control its storage and use.

2.2 The policy is designed to support staff and assist with decision-making regarding appropriate clinical photography and will ensure patient confidentiality is maintained.

2.3 This policy's scope covers all clinical images including those used for patient records, training of professionals and educational purposes.

3.0 Scope

3.1 This policy applies to all staff within the Trust who makes or uses recordings as an aid to diagnosis, for documentation in healthcare, for teaching, research, publication and follow up treatment.

4.0 Policy Statement

4.1 It is the policy of SHSCT that the recording, storing and use of recordings will comply with the requirements of the Data Protection Act, professional code{s} of conduct, and the Code of Practice on Protecting the Confidentiality of Service User Information (2012). All staff are required to comply with this policy.

4.2 It must be recognised that digital recordings are easier to copy in electronic form and are therefore more at risk of inappropriate distribution.

4.3 All recordings taken on site, regardless of who they are taken by, remain the property of SHSCT and copyright of the images is retained by the Trust.

4.4 In all recordings care must be taken to respect the dignity, ethnicity and religious beliefs of the service user.

5.0 Responsibilities

5.1 Explicit consent is not required if the images are for direct patient care however it is always best practice to inform the service user of the purpose of the recording. If the recordings are for secondary uses (eg research or teaching purposes) then explicit consent must be obtained from the service user.

5.2 It is the responsibility of each member of staff who will be using recording devices as part of a service user's care to be aware of this policy and work within its parameters.

5.3 Without care the use of mobile devices to take, store and transfer images can lead to breaches of patient confidentiality and of the Data Protection Act. Patients should feel assured that any personal information held by a healthcare professional will be held in confidence. This is the principle of patient confidentiality and the General Medical Council (GMC) has published guidance about how this is best achieved. The use of mobile devices by healthcare professionals to take and send images needs to take account of the GMC guidance and the DPA wherever the image is linked to patient-identifiable data.

5.4 There must be a fully justifiable purpose for photography to be carried out. Photographs are taken for one or more of the following reasons:

- As part of the service user's record;

- For educational purposes;
- For publication/open release (e.g. in journals/on websites)

5.5 Under Data Protection legislation, service users have the right to view their medical records; therefore the Trust has a responsibility to disclose those records made by Trust staff in the course of their work irrespective of why the image was taken.

5.6 In the case of digital camera images, the file must not be treated in any way before storage. It is recognised that while digitally originated images are intrinsically no different to traditional photographs, they are easier to copy in electronic form and are therefore more at risk of both image manipulation and inappropriate distribution. Particular care must therefore be taken by Trust staff to protect the image and maintain its integrity. All Trust staff who take photographs are responsible for:

• Adhering to this policy and ensuring appropriate consent is obtained, where required, using the Consent Form in Appendix 1.

• The security of recording equipment including media containing service user information.

• The quality and accuracy of data recorded.

6.0 Confidentiality

6.1 Confidentiality is the service user's right and may usually only be waived by the service user or someone legally entitled to do so on his/her behalf e.g. Power of Attorney. All staff are reminded that breach of confidentiality may be regarded as serious professional misconduct with inevitable disciplinary consequences and could result in serious litigation costs for the organisation.

6.2 In order to ensure that the service user's right to confidentiality is preserved, the Trust requires that you gain the patient's informed consent where required eg for secondary uses (teaching or publications). Where consent is required it should be sought before capturing a patient image.

6.3 It is the healthcare professional's responsibility to give the patient clear information on the risks and benefits of using an image captured on a mobile device – without this there is no informed consent.

Where consent is required it should be obtained using the consent form (Appendix 1) that covers use of the image for teaching and wider dissemination, ie on the internet.

7.0 Consent

7.1 Explicit consent is not required if the images are for direct patient care however it is always best practice to inform the service user of the purpose of the recording. If the recordings are for secondary uses (eg research or teaching purposes) then explicit consent must be obtained from the service user.

7.2 The patient, next of kin, patient's representative holding Power of Attorney or if a child, the patient's parent or guardian has a right to give informed consent to recording/s and to any future use to which the recordings might be put.

7.3 Before referring a patient for a service user recording the consent form should be filled in and signed by the requesting doctor and countersigned by the patient, next of kin, patients representative holding Power of Attorney or if a child, the patient's parent or guardian.

7.4 Recordings of the unconscious patient may be taken provided that informed consent is obtained beforehand or retrospectively. If the patient is having elective surgery, formal written consent should be obtained at the same time as the general consent to the procedure. If it is an emergency, the consent should be obtained as soon after the procedure as practically possible. The patient, next of kin, patients representative holding Power of Attorney or if a child, the patient's parent or guardian must be told that the photographs have been taken and the purpose fully explained and given the opportunity to disallow for teaching, research or publication purposes.

7.5 Photography without consent may be prescribed in certain circumstances e.g. the clinical recordings of vulnerable children where the recording of injuries is demonstrably to the patients benefit for example a suspected non accidental injury. Clinician authority is required in such cases. The decision needs to be fully documented in the patient's medical record.

7.6 If the patient is unable to consent to all aspects of medical care then a mental capacity assessment will be required prior to photography. If the patient cannot consent then the photography can still take place if it is deemed to be in the patient's best interest. The decision needs to be fully documented in the patient medical record.

7.7 In cases where the patient, next of kin, patients representative holding an Enduring Power of Attorney or if a child, the patient's parent or guardian request that clinical recordings be deleted then they should make a formal written request and a full investigation should be carried out to the reason behind this request and each case considered on individual merit.

7.8 In the case of research projects where recordings are required, the patient should give consent to photography when initially

agreeing to partake in the study. No subsequent consent is required however a record that the recording took place will be kept.

7.9 If recordings are required for teaching purposes they will only be released for this use if the appropriate level of consent has been given. Teaching purposes are situations where people, not necessarily directly involved in the patient's care will view recordings within a learning environment.

7.10 If recordings are required for publication they will only be released if the appropriate level of consent has been given. For publication requests this means that the appropriate level of consent is signed on the consent form.

7.11 If the recording is to be viewed by the public in any format then specific publication consent must be sought. The patient should also be made aware that once publication in a textbook or on the internet has taken place it may not be possible to withdraw consent as the information will be in the public domain.

7.12 In the case where a recording is to be used but the patient has since died then the original consent still applies. If consent was not sought before death then the patient's next of kin should be contacted to acquire retrospective consent.

8.0 Recordings of Children

8.1 In the case of children, the parent or guardian should provide consent. If the child reaches the age of 16 during the course of treatment or is judged to be capable of consenting in their own right at the start of treatment, the young person may consent.

8.2 Even where children are not able to give valid consent, there is a duty to seek their co-operation and to explain the purpose of the recording if this is feasible.

8.3 If a child is not willing for a recording to be used it must not be used, even if the person with parental responsibility consents. In the case of a non-accidental injury safeguarding concern, consent should be sought. However, if consent is withheld by the child and/or the parent, a Child Protection Joint Protocol investigation should be initiated which will include a Forensic examination if appropriate and necessary.

9.0 Recording without consent

9.1 Recording without consent may be appropriate in certain circumstances such as child protection concerns, suspected non-accidental injury of a child, or vulnerable adult, where it is unlikely that the parent, guardian or carer will give consent and the recording of injuries is demonstrably to the service user's benefit (Refer to Child Protection Guidance). In cases of service user recording, Consultant authority is required.

9.2 The situation may arise where a member of staff wishes to make a recording, but the service user is temporarily unable to give or withhold consent because, for example, they are unconscious or confused. In such cases, the member of staff may make such a recording, but the member of staff must seek consent as soon as the service user regains capacity. The member of staff must not use the recording until consent for its use has been received, and if the service user does not consent to any form of use, the recording must be destroyed.

9.3 Once the service user has regained consciousness they must be informed that a recording has been taken and if they object to the

use of the recording it must be destroyed. This must all be documented in the service user's medical records (MCA Code of Practice 2005).

9.4 If a consenting service user subsequently dies, permission should be sought for any new use outside the terms of the existing consent from the next of kin or personal representative.

9.5 If a service user dies before a retrospective consent can be obtained, material by which the service user is identifiable can only be released with the consent of the deceased person's representatives. In addition wherever possible the consent of the next of kin or near relatives should be obtained, particularly where the personal representatives of the deceased are not relatives.

9.6 Staff are reminded that the Duty of Confidentiality continues after the death of a service user and that, in addition, SHSCT staff continue to have duties under the Access to Health Records (NI) Order 1993.

10.0 Withdrawal of Consent

10.1 Service users have the right to withdraw consent for the use of recordings at any time. Withdrawal of consent must be recorded in the medical records. It is the duty of the staff member requesting the recording to ensure that records are appropriately updated.

10.2 In the case of electronic publication, it should be made clear to the service user that once the recording is in the public domain there is no opportunity for effective withdrawal of consent.

10.3 Service users must be informed that they are free to stop a recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the service user decides that they are not happy for any recording to be used, it must be destroyed.

11.0 Photography used for Treating / Assessing a Service User

11.1 Whilst consent to certain recordings, such as X-rays, is implicit in the service user's consent to the procedure, health professionals should always ensure that they make clear in advance if any recording will result from that procedure.

11.2 Recordings which are made for treating or assessing a service user must not be used for any purpose other than the service user's care, or the audit of that care, without the express consent of the service user, a personal representative or their next of kin.

11.3 Recordings of adults or children should be taken only if there are specific features that need recording for clinical reasons (e.g. assessing the progression of a skin lesion) or teaching (e.g. an important clinical sign that might only be seen rarely). Whole body shots should only be taken if absolutely necessary and for justifiable reasons.

11.4 Taking patient images with mobile devices where images are taken in the interests of clinical care form part of the patient record and are potentially legal documents. Poor-quality images cannot support accurate decision-making and may hinder diagnosis and patient care. It is therefore of paramount importance that wherever it is deemed in the patient's best interests to use mobile devices for image capture, every effort is made to achieve optimal quality.

12.0 Recordings for Education and Publication

12.1 If a member of staff wishes to make a recording of a service user specifically for education or publication purposes, they must first seek written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that it may not be possible to control future use of the material once it has been placed in the public domain.

12.2 When seeking to make recordings, if the service user lacks capacity it is good practice to inform or discuss with the carer or next of kin,

12.3 As with recordings made with therapeutic intent, service users must receive full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

12.4 If the service user is likely to be permanently unable to give or withhold consent for a recording to be made for education or publication purposes, the member of staff should seek the agreement of the service user's personal representative/next of kin. A member of staff must not make any use of the recording, which might be against the interests of the service user. Staff members should not make, or use, any such recording if the purpose of the recording could equally well be met by recording service users who are able to give or withhold consent (refer to MCA Code of Practice 2005).

12.5 Recordings required for Research purposes must follow the Trust's Medical Education and Research processes and should be

discussed with the Trust's Medical Education and Research Manager.

13.0 Release of recordings

13.1 Service users requesting copies of their recordings held in their medical/social care records should do so in writing via the Information Governance Team, where their request will be treated as a subject access request under Data Protection legislation.

Contact:
Information Governance Team
Ferndale House
10 Moyallen Road
Gilford
BT63 5JX
Tel: 37561458
Email: Foi.Team@Southerntrust.hscni.net

14.0 Storage of Recordings

14.1 All Trust staff will be professionally accountable for the correct storage of all images that they have taken. They will be responsible for erasing images from their devices immediately after use.

14.2 Photographs will be stored in the patients' main clinical record (NIPACS), Paris or other Information system or Secure Shared Drive. This will be the Electronic Patient Record whenever possible. The photograph will be uploaded at the earliest opportunity. Photographs should be deleted from the camera device as soon possible after the picture has been added to the clinical record. The photograph will be stored within the patient's clinical record in the appropriate Information System (eg NIPACS, Paris etc).

15.0 Equality and Human Rights Considerations

15.1 This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them. Using the Equality Commission's screening criteria; no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment. This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in the Act.

Alternative Formats

This document can be made available on request in alternative formats, e.g. Braille, disc, audiocassette and in other languages to meet the needs to those who are not fluent in English.

Copyright

The supply of information under the Freedom of Information Act does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

SHSCT holds the copyright of all existing recordings made of its service users and on its premises. Those signing contracts with book, journal or other publishers have a responsibility to delete from

the contract any suggestion that the copyright will pass to the publishers permanently.

Legislative Compliance, Relevant Policies, Procedures and Guidance

This policy will be made available on the Intranet to all staff. Staff must comply with relevant legislation, professional standards and guidance and other DHSSPS publications as follows:

Data Protection Act 2018

Code of Practice on Protecting the Confidentiality of Service User Information (DHSS) January 2012

Mental Capacity Act (MCA) Code of Practice 2005

Access to Health Records (NI) Order 1993.

Department of Health Using mobile phones in hospitals (2009)

General Medical Council Making and Using Visual and Audio Recordings of Patients (2011)

SHSCT Policy on Gaining Consent (Nov 2009)

www.gpoutofhours.hscni.net/service-standards-for-gp-out-of-hours/

Social Networking Policy

Procedure on staff use of Mobile Phones March 2013

Standard Operating Procedure to upload images into PACS

Guidance on the Upload of Photograph to Paris

APPENDIX 1

Southern Health and Social Care Trust

Consent Form for Service User Photography

Patient details (or pre-printed label)

HCN (or other identifier):_____

Patient's first names:_____

Patient's surname/family name:._____

Male Female

Date of birth:_____

Responsible health professional:_____

Job title:_____

Special requirements:_____

(eg interpreter required/other communication method)

Reason for the photo/video being taken:

_____

_____

_____

I understand that the photograph/video recording to which I have agreed are to be used for the purposes described above.

Yes □ **No** □

I agree for this photograph/video recording to be used for education/ publication/ research and I understand that once it is in the public domain I may not be able to withdraw my consent.

Yes □ **No** □

Patient's/ Legal Guardian's signature: _____

Date: _____

Health Professional's Name (PRINT): _____

Designation: _____

Health Professional's Signature: _____

Southern Health and Social Care Trust
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Bundle Compliance Report
01/05/2019 to 31/05/2019

	Total Charts	Non- Compliant	Compliant %
NEWS Bundle Compliance	**190**	**26**	**86%**
All Vital Signs Recorded		6	97%
Risk Score Totalled Correctly		4	98%
NEWS Score Correct		2	99%
Evidence of Appropriate Action		3	98%
Frequency of Observations Recorded on Chart		0	100%
Observations Recorded to Frequency		19	90%

	Total Charts	Non- Compliant	Compliant %
NEWS B Bundle Compliance of score of 5 and above	**21**	**6**	**71%**
Is There Documented Evidence of Appropriate Escalation		8	62%
Is the Frequency of Observations Amended to Reflect the NEWS Score		7	67%

	Total Charts	Non- Compliant	Compliant %
Falls A Bundle Compliance	**190**	**39**	**79%**
Asked about fear of falling		6	97%
History of falls		5	97%
Urinalysis performed		34	82%
Call bell working and in reach		3	98%