



Ms. Trudy Reid
Head of Governance
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

24 March 2023

Dear Madam,

**Re: The Statutory Independent Public Inquiry into Urology Services in the
Southern Health and Social Care Trust**

**Provision of a Section 21 Notice requiring the provision of evidence in the
form of a written statement**

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant

information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and/or has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI

Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 3 of 2023]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: Trudy Reid
Head of Governance
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.
2. The Notice requires you to do the acts set out in the body of the Notice.
3. You should read this Notice carefully and consult a solicitor as soon as possible about it.
4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.
5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 28th April 2023**.

APPLICATION TO VARY OR REVOKE THE NOTICE

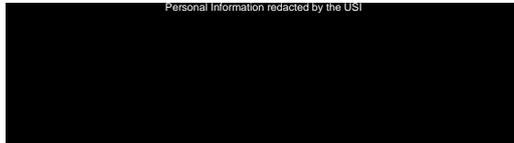
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 21st April 2023**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 24th March 2023

Signed:

Personal Information redacted by the USI


Christine Smith QC
Chair of Urology Services Inquiry

**SCHEDULE****[No 3 of 2023]**

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:
 - (i) an explanation of your role, responsibilities and duties, and
 - (ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.

It would greatly assist the inquiry if you would provide the above narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.
3. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.



There may be some repetition in your answers to these questions and your narrative. The key is to ensure that you address the questions asked below, whether in this section or in your general narrative in reply to Q1.

(i) In her Section 21 Notice reply to the Inquiry at WIT-87634, **Tracy Boyce** states:

“4.6 In February 2016 the Director of Acute Services at the time, Esther Gishkori agreed to the replacement of the Acute Governance Lead (Attachment 2) and Trudy Reid was recruited into the role. She started this role on 4th April 2016.

4.7 ... I continued to mentor and support the Governance Lead as they needed someone to facilitate their work. This involved meeting Trudy Reid every Tuesday morning to discuss any issues the team were having and accompanying her to brief Ms Gishkori on Governance issues once per week.”

...

- (a) During your tenure, who did you understand to be in charge of governance and risk within (1) acute services, and (2) urology services?
- (b) What was your understanding of the way in which governance issues might be brought to your attention? What is your view of the efficacy of those methods of identifying governance concerns?
- (c) Please explain your understanding as to whom you were expected to report as Acute Governance Lead? To whom did you actually report and how often did these reports/meetings occur? If meetings, did they have an agenda and were they minuted? If so, please provide all minutes and agendas.

 **Urology Services Inquiry**

- (d) If not covered by your answer above, did you have any meetings with Esther Gishkori regarding governance issues? If yes, how often did these meetings occur? If there are available agendas and minutes, please provide them.
- (e) Did you have any meetings or discussion with Mrs Gishkori and/or Tracy Boyce or anyone else regarding governance issues or concerns within urology? If yes, and not set out in your previous answers, please set out all details of such meeting and discussions, including dates, times, locations, those present, and details of what was discussed and any follow up actions or reviews to decisions made. Please include all relevant documentation.
- (f) If any actions were taken as a result of these meetings, how, if at all, did you assess the effectiveness of these actions?
- (g) Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.
- (h) What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?
- (ii) In her Section 21 Notice reply to the Inquiry at WIT-87634, also **Tracy Boyce** states the following -

...

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“4.8 I put this weekly governance briefing meeting into Ms Gishkori’s diary when I realised that she was not going to take back the Director’s responsibility for Governance. I decided that the meetings were necessary as Ms Gishkori was attending Senior Management Team meetings where issues of governance and risk were being discussed. In my opinion she needed to be briefed to be able to represent the Acute Directorate position accurately. Unfortunately, the meetings were often cancelled by Ms Gishkori. I do not have any notes of these meetings, as they would have been in my paper diary for the year which I no longer have in my possession. Ms Reid may be able to provide notes of these meetings.

- (a) If not already provided, please detail and provide all notes documentation relevant to any meetings you may have, as referred to in Ms Boyce’s last sentence.

- (b) What is your view of the availability of Esther Gishkori to discuss governance issues (i) when specifically needed by you, and (ii) more generally? Did she (or others) cancel governance meetings with you? If yes, please provide all details.

- (c) Were you ever involved in briefing, either in person or in writing, the Senior Management Team when issues of governance and risk were being reported or discussed? If yes, please provide all details. If no, who was responsible for providing such briefings?

- (d) Were you aware if any issues you raised regarding governance and risk were brought to the Senior Management Team? If yes, please explain in full. If no, what were the issues, and how are you aware they were not brought to the Senior Management Team?

- (e) Did you ever feel that issues of governance and risk you raised were not dealt with properly or at all?



1. If yes, please provide all details, including the names of those to whom you spoke about the issues.
 2. If no, how did you assure yourself that issues raised by you were properly addressed?
- (f) Are you aware of any issues of governance, either raised by you or others, being brought to the attention of the Board and/or any of the Board Committees?

4. *Per Katherine Robinson at WIT-60389*

...

31. **“Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.**

31.1 In December 2016 when the secretary declared that there were clinics that were not dictated a system of oversight was put in place whereby the HOS asked us to keep a close eye to ensure all clinics were dictated on. The SA kept a close eye on this and reported through to the HOS. The secretary was advised again that it was her responsibility to advise us of this via the backlog report.

31.2 Also Trudy Reid as Head of Governance approx. Oct 16/17 started to put in place a ‘delays action plan’ following some SAIs (Series Adverse Incidents). This referred to work I was already doing, however Trudy Reid may have had other pieces of work I was not aware of. Please see: 27. 20161017 to 20170307 Es f TR and Ors Delays Action Plan

...



- (a) Please explain in full the “*delays action plan*” put in place by you as referred to by Ms Robinson at para 31.2.
- (b) Please detail all systems of oversight and monitoring used and/or developed by you in response to concerns or risks. Please set out in full the reasons why you felt it necessary to develop such systems, what the aim of those systems were and how effective you considered them to be. How did you assess or assure yourself of their effectiveness? Were these systems subject to review? Please explain your answers in full.
- (c) If these systems were introduced in response to SAIs, please explain why you think the risk and governance issues those systems were designed to address were not flagged before SAI stage? What was wrong with the systems existing at that time that the issues were not identified? If they were identified by existing systems, why were they not addressed?
5. Did you consider, as Acute Governance Lead, that you were adequately supported by your line managers and other staff? Please explain your answer in full, with examples as relevant.
6. During your tenure, where you offered any support for quality improvement initiatives? If yes, please explain and provide any supporting documentation.
7. What, in your experience, was *the culture* within (i) Acute Services and (ii) urology, regarding governance? For example, do you think there was enough time to properly manage and respond to governance issues? Did you feel that governance concerns raised by or through you were adequately addressed?
8. What is your overall view of *the effectiveness* of governance systems within –
1. Acute services generally, and
 2. Urology service in particular



Do you think the governance arrangements, overall, were and are fit for purpose?

9. What, in your opinion, could have improved the effectiveness of the governance structures and systems in place during your tenure?

10. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

11. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Note: An addendum amending this statement was received by the Inquiry on 8 September 2023 and can be found at WIT-100367 to WIT-100408. Annotated by the Urology Services Inquiry.

UROLOGY SERVICES INQUIRY

USI Ref: Notice 3 of 2023

Date of Notice: 24th March 2023

Witness Statement of: Trudy Reid

I, Trudy Reid, will say as follows:-

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:

(i) an explanation of your role, responsibilities and duties, and

1.1 In relation to this response my role was acute governance coordinator. The roles of the post are outlined in *1. Appendix File ACG Structures 2016*. Human resources records notes suggest I commenced this post on the 1st May 2016. However, in my diary I appear to have commenced my role on the 4th April 2016.

1.2 I am a registered general nurse and qualified in September 1989. I have completed the Adult Intensive Care course and post graduate diploma section of a MSC in Infection Prevention and Control.

1.3 When I commenced my role as Acute Governance coordinator I did not receive an induction or handover from the previous post-holder. I attended and organized training courses, and completed eLearning in relation to my role, including RCN Education Conference 16/3/2016, Delivering Safer Care Together Creating accountable care organisations 02/03/2017, Falls learning event 30/03/2017, Risk Assessment Workshop 27/04/2017, Serious Adverse Incident (SAI) Training One Day Investigation Workshop 18/05/2017, Corporate Training Safe guarding children and adults 25/7/2017 HSC

Collective Leadership Strategy for Cultures of High Quality and Compassionate Care (Michael West) 20/10/2017 ,BMJ Learning Reducing the risk of hyponatraemia when administering intravenous fluids to children 05/04/2017, Exploring the Sepsis Care Bundle 10/04/2018, Patient Safety Congress 9th and 10th July 2018, Investigation of Adverse Incidents Masterclass Programme 11th and 12th September 2018, Proteus leadership course 14/09/2018, 2nd and 3rd October 2018, 28/01/2018 and 29/11/2018, 23/01/2019 and 24/01/2019 and 27/03/2019 and 28/03/2019 and Mental Health Workshop Promoting Violence Reduction Through Quality Improvement incidence of aggression and violence in inpatients settings 10/4/2019 bundle.

Please see attached Job Role document (2. *Job Roles*) which contains a table of a description of all my roles within the Trust.

- (ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.**

1.4 I highlighted that the structures within acute clinical governance required development for example development of audit processes and the requirement for an audit committee to provide a systematic and integrated approach for the identification and prioritisation of risk-related audits. An audit committee and a systematic approach to audit would also provide assurance on the level of compliance in respect of the risk-related audits identified above, and/or propose recommendations for improvement, and/or act as an early alert system. I facilitated the redevelopment of the Acute Audit Committee: the first meeting was on 22/9/2017 but due to lack of administrative support and attendance the last meeting was held on 22/09/2018.

1.5 I escalated and shared information on incidents reported, SAIs and some complex complaint cases with the Assistant Directors, Directors and Associate Medical Directors. These were discussed and escalated at screening meetings, 1:1 meetings and Acute Governance Meetings. Risks identified from reviews and actions

required for improvement were shared in the same way. I facilitated working groups and committees to progress workstreams identified from standards and guidelines, safety and quality letters, SAIs and complaints.

1.6 I escalated delays in screening, reviews and report writing at screening meetings, 1:1 meetings with Directors, and Governance Committees as well as weekly circulation of reports.

1.7 I escalated issues when the information systems did not allow for effective and timely reporting. The Datix system at the time was a number of versions behind the other Trusts systems. It has recently been upgraded from Version 12.2.0.1 to 14.1.2. There were 60 upgrades to the Datix system involved with this upgrade to bring the SHSCT to the same Datix version as the other Trusts in the region. The litigation team used a separate version of the Datix system to record litigation cases. The Standards and Guidelines system was on an excel spread sheet impacting on the ability to provide reports. Audit data and reports were mostly manually recorded and not always centrally collated. Triangulation of risks was therefore challenging. These issues were escalated at 1:1 meetings with Mrs Gishkori, Acute Governance and Governance Coordinators meeting.

1.8 Timeliness of completing screening, complaints and SAI reviews were escalated at 1:1 meetings with Dr Boyce, Mrs Gishkori, screening meetings Acute Governance and 1:1 conversations. The weekly reports also demonstrated the workload and delays in progressing and finalising reviews and responses.

1.9 I highlighted during my tenure the challenges of the limited staffing resource within the Acute Governance team based on the workload within the Acute Directorate. The staffing resource available did not allow for the development of governance structures to meet the full requirements of a clinical governance structure. The limited resource did not allow for the timely completion of reviews, sufficient proactive work streams to address risks or to

develop the service to provide robust governance structure. The structure suggested when I applied for the Acute Governance Coordinator the post was not progressed – *1. Appendix File ACG structure 2016.*

1.10 The structure at the time included a small complaints team with 2 full time staff members and 3 part-time administration staff. As part of a review of capacity one staff member was asked to concentrate significant amounts of their role on SAI administration. One of the part time team also supported the operational teams with risk register updates. During my tenure there were 5 weeks of unplanned leave.

1.11 The standards and guidelines team had one part-time lead and an administration assistant. During my tenure there were 9 weeks of unplanned leave.

1.12 Equipment management role was a staff member seconded from the estates team who provided part time cover.

1.13 A member of staff to support the governance around point-of-care testing was appointed in June 2018.

1.14 Temporary support was provided from the corporate governance team, they mostly provide M&M chair support.

1.15 In relation to SAIs and other governance functions there were two lead nurses and a redeployed ward sister when I commenced. One lead nurse was immediately returned to their substantive lead nurse role and completed the SAIs they had initially commenced over the coming months. The second lead nurse in May 2016 reported she had been approached by an AD and given two options: one to downgrade to band 7 in Acute Governance, or; move to 8A lead nurse in Surgery and Elective Care. Given the workload and personal circumstances redeployment back to lead nurse role in Surgery and Elective Care did not happen until October 2017 (*4. Appendix RE: Governance re-*

structure-Confidential- Connie re redeployment).

1.16 Two additional nursing staff commenced in June and July 2017 these staff were redeployed from patient support roles where they proactively worked with patients and service users and wards to locally resolve complaints and concerns. These redeployments reduced one layer of governance to address the need to support SAI reviews and report writing. There was also a redeployed nursing sister in the team. During my tenure there were 103 weeks of unplanned leave within this team.

1.17 Nursing governance staff were asked to provide support with SAI reviews, regrettably for a number of reasons including sickness absence. Minimal support was provided.

1.18 The sickness absence within the Acute Governance team impacted on the ability to progress the development of governance structures, time line development, review of incidents and complaints, drafting of SAI reports. The limitations in staffing also prevented the development of proactive work streams to address learning identified from reviews and risks identified.

1.19 A further governance structures paper was developed: *5. Appendix Acute Governance structure 05 06 2018* but all posts had not been progressed when I moved to another role. Please see:

5.-7. *5. Appendix Acute Governance structure 05 06 2018, A1-A2*

1.20 Attached is a search of my diary from 04/04/2016 to 06/01/2019. Please see *8. Appendix Diary search re meetings* (This extract does not include team meetings or preparation for screening and report writing. Not all meetings attended would be in my diary due to changes and amendments to outlook and meetings that were cancelled were not always cancelled in my diary).

It would greatly assist the inquiry if you would provide the above narrative in

numbered paragraphs and in chronological order.

1.21 I commenced post as Acute Governance Coordinator on 4th April 2016 (*please see 2. Job Roles*).

1.22 My appointment was to be one of a number of appointments to improve the clinical governance structures within the Acute Directorate. The roles and responsibilities included:

- a) Corporate liaison
- b) Level 3 investigations
- c) Level 2 investigations
- d) Lessons learnt implementation
- e) Allocation of SAIs
- f) Development of report the Directorate and individual Divisions...
- g) Preparation of Agendas for AD and AMD governance meeting
- h) Quality assurance of SAI reports
- i) SAI screening process

1.23 From commencement of my role I highlighted that the resources available within the governance team did not allow for development of robust governance systems and processes and did not allow for timely screening, reviews or report writing. Limited staffing resource prevented proactive work streams to support changes required to reduce risk or monitor implementation of actions from learning. This risk was consistently escalated during my tenure.

1.24 In September 2016 I note from email with information of incidents relating to delays to Dr Boyce, Mrs Trouton and Mr Conway the commencement of work in relation to delays in treatment and care: I refer to *9a.-9b. Delays in appointments diagnosis or treatment data Tracey 09 30 2016, A1*. In relation to the administrative issues, administrative teams produced and circulation of reports to escalate risks including triage reports, dictation reports, typing backlog reports: I refer to email *11. Delays meeting checking re triage with KR 02 10 2017*. To help address some of the risks relating to delays I progressed a number of meetings including meetings

regarding electronic result sign off, to try to develop guidance for electronic sign off. Draft guidance on electronic sign off was developed but not approved (*please see 12. RE Sign off guidance 12 20 2018*).

1.25 I continued to provide governance support for screening for SAIs and facilitating SAIs. There was a significant volume of work associated with this which took significant time to complete. The resource available did not allow for timely completion of this work. Between 2016 and 2019 there were 45 SAIs notified and a number of other in-depth reviews of care for learning. In relation to urology SAI  was presented at Acute Clinical Governance on 15/03/2017.

1.26 A letter was received by Dr Boyce from the SAI panel on 15/12/2016 raising a number of concerns. This identified non-triage of referrals as a risk. Work progressed to identify missing triage and a number of cases were identified as 'missing triage'. Five initial cases were identified for SAI and an independent chair was identified on 15/06/2017. Final formal screening was completed 25/07/2017. A further case was identified and added to the SAI in March 2018. Staff interviews progressed from February 2018 to June 2018. SAI reports were finalised after my tenure. See attached table with SAIs, reviews of care and complaints I was aware of during my tenure (*please see 13. Urology SAI and Complaints 1 and 14.*)

1.27 In addition to this I facilitated a number of committees and working groups to help progress work streams actions from SAIs and standards and guidelines etc. These included National Early Warning Score, Sepsis 6, Conscious Sedation Committee, Learning Disability, Acute Services Lead Nurse, Midwife, AHP and Radiographer S&G forum was established. This forum was developed to ensure S&G the actions established to meet the requirement in the circulars were shared with frontline staff and were embedded within local practice.

1.28 8. Appendix xx Diary search remeetings is a chronology from my diary of meetings attended during my tenure, this excludes team meetings and preparation time for meetings, time to prepare time lines and report writing. There may have

been meetings that were not recorded or have been removed when removing recurrent meetings. I left the post of Acute Governance Coordinator on 03/01/2019.

- 2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry (“USI”). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust’s Solicitor, or in the alternative, the Inquiry Solicitor.**

2.1 I provided a number of documents for discover, however having reviewed the questions in this document, the breadth of the questions means that there are some documents which I will need to provide in ongoing discovery

- 3. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.**

There may be some repetition in your answers to these questions and your narrative. The key is to ensure that you address the questions asked below, whether in this section or in your general narrative in reply to Q1.

(i) In her Section 21 Notice reply to the Inquiry at WIT-87634, Tracy Boyce states:

“4.6 In February 2016 the Director of Acute Services at the time, Esther Gishkori agreed to the replacement of the Acute Governance Lead (Attachment 2) and Trudy Reid was recruited into the role. She started this role on 4th April 2016.

4.7 ... I continued to mentor and support the Governance Lead as they needed someone to facilitate their work. This involved meeting Trudy Reid every Tuesday morning to discuss any issues the team were having and accompanying her to brief Ms Gishkori on Governance issues once per week.”

...

(a) During your tenure, who did you understand to be in charge of governance and risk within (1) acute services, and (2) urology services?

3.1 In relation to clinical governance the Chief Executive has overall responsibility for clinical governance with responsibility delegated to the Executive Director of Medicine (medical director).

3.2 Governance is everyone's responsibility. Medical, nursing and AHP staff are members of professional bodies such as the GMC and NMC. These bodies lay out governance responsibilities for their member. Staff also are required to follow Trust policies, procedures and guidance.

3.3 The Trust has a corporate governance team which is aligned to the medical directorate management structure and each directorate has an operational governance team. To accurately respond to this question, I requested the terms of reference for the Governance Committee from the Board Assurance Manager.

3.4 The Trust Governance Committee terms of reference 2019 sets out the the remit of the Committee which is to ensure that:

- a) There are effective and regularly reviewed structures in place to support the effective implementation and continued development of integrated governance across the Trust.

- b) Assessment of assurance systems for effective risk management which provide a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.
- c) Principal risks and significant gaps in controls and assurances are considered by the Committee and appropriately escalated to Trust Board
- d) Timely reports are made to the Trust Board, including recommendations and remedial action taken or proposed, if there is an internal failing in systems or services.
- e) There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance.
- f) Recommendations considered appropriate by the Committee are made to the Trust Board recognising that financial governance is primarily dealt with by the Audit Committee.

Please see attached 16. Appendix Terms of reference

3.5 Professional Governance for Doctors, Nurses, Midwives and Allied Health Professionals (AHP) and social workers is aligned to the Executive Directors of Medicine, Nursing and Social Work.

3.6 During my tenure it is my experience that professional issues being addressed through professional lines were not always known to the acute clinical governance team and visa versa. The Medical Director would have had governance processes such as appraisal and latterly I became aware of what I now know to be the Maintaining High Professional Standards (MHPS) process.

3.7 The Executive Director of Nursing, Midwifery and AHPs is responsible for nursing and AHP professional governance. The Executive Director of Nursing, Midwifery and AHPs post was combined with an operational Director remit until 2018.

3.8 With the passage of time and hearing about other processes ongoing at the time it is difficult to remember exactly when I became aware of the MHPS process

but I do not recall being aware that there was another review process ongoing regarding Mr O'Brien until informed by Dr Boyce approximately on 04/08/2016.

Please see:

17a.-17b. appendix Concerns raised by an SAI panel 1st, A1

3.9 When I commenced as Acute Governance Coordinator I could not source terms of reference for the Acute Governance meetings. I developed terms of reference which were approved at Acute Governance meeting on 12/01/2017 and Acute Clinical Governance on 06/02/2017. Within the Acute Directorate the governance structure was laid out in the terms of reference for two specific clinical governance meetings.

- a. Acute Governance Committee (21. Acute Directorate Governance Group Terms of Reference)
- b. Acute Clinical Governance Committee (22. Acute Clinical Governance Terms of Reference)

3.10 The committees are strategic Governance Groups to specifically address all matters pertaining to this area of the Directorate's business. It will provide effective and robust assurances in the following areas:

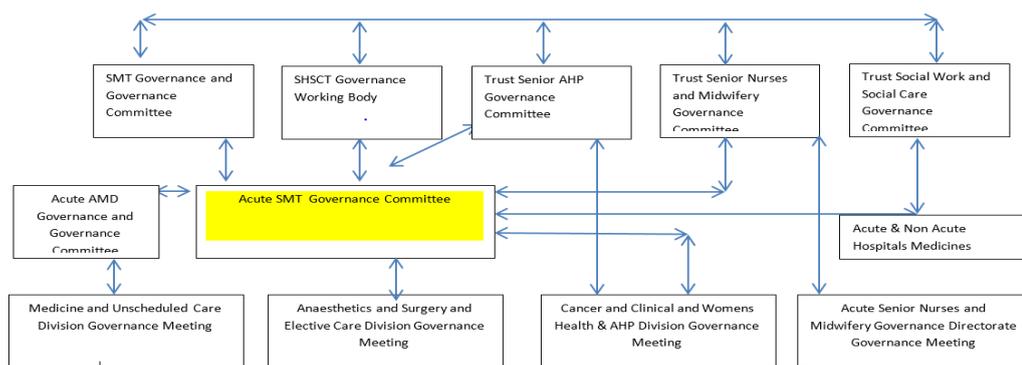
- a) Provide clarity and transparency of function
- b) Drive Quality and Safety
- c) Provide adequate assurances to the SMT, Trust Board, Professional Bodies and the Public, on areas relating to risk, patient safety and non-compliance

3.11 The purpose of the Acute Clinical Governance Group is to develop, integrate, promote and monitor all aspects of governance in the acute division including clinical & social care, professional, financial, medicines, estates and human resources governance. The Forum aims to promote an ethos of awareness, accountability, continuous learning and improvement.

3.12 The Acute Clinical Governance terms of reference were shared and approved at the 13/1/2017 meeting and Acute Governance terms of reference on 07/02/2017.

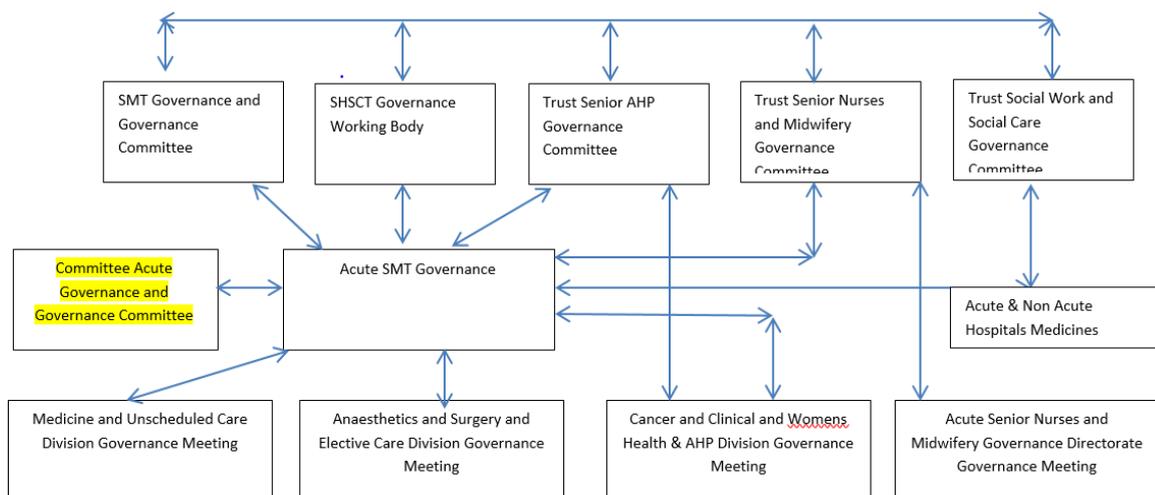
3.13 My team and I provided a number of reports for each of these meetings to highlight the complaints, incidents, and SAIs. Standards and guidelines, Effectiveness and Evaluation and Patient Safety reports were also provided. These reports provided data on audit outcomes and compliance with NICE and other guidelines.

3.14 Mrs Gishkori was the chair of the Acute Governance meetings and thus responsible for governance and escalation of risks to other Governance



forums and Governance Committee.

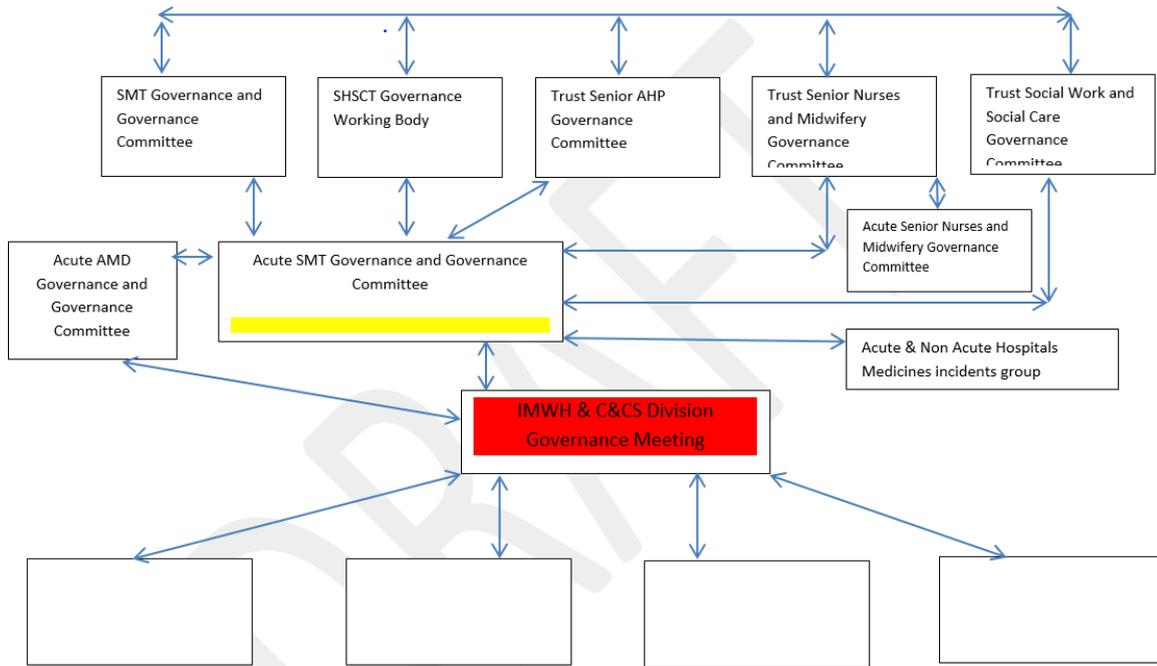
Please see 21. Appendix Acute Directorate Governance Group Terms of Reference.



3.15 Each service had its own service meetings which would have included clinical governance and these would have been escalated to the Divisional Governance meeting. Divisional Governance meetings risks and concerns should have escalated to the Directorate meetings. When I commenced the Governance Coordinator post I developed draft terms of reference for the ADs for their consideration for their governance meetings. I provided a number of reports for each of these meetings to highlight the complaints, incidents, and complaints reports. Not all ADs requested reports for their meetings.

3.16 In general, I was requested to attend and provide information for the Medicine and Unscheduled Care (MUSC) and Integrated Maternity and Womens Health and Cancer and Clinical Services (IMWH & CCS) divisions.

3.17 Divisions should have had meetings which included clinical governance with risks and concerns escalated to the acute governance committee. The structures were considered to be similar to the diagram below which was drafted in 2016 as part of draft terms of reference. I do not have a copy of the final drafts of the terms of reference for the divisional groups.



3.18 At service level, including urology, the Head of Service Mrs Corrigan and Clinical Director/Associate Medical Director Colin Weir would have had day-to-day responsibility for governance within their service area. The Associate Medical Director would have clinical expertise and oversight with the Head of Service providing operational/management support and expertise. The Associate Medical Director and Head of Service would both have been concerned with governance as clinical governance is a framework for continuously improving the quality of their services and safeguarding high quality of care.

3.19 As Acute Governance Coordinator I was not involved in the day-to-day governance issues arising within Urology, this would have been with the Urology team at their operational meetings. If I was asked I would have provided information on complaints, incidents, etc. I do not recollect being asked to provide reports for these meetings. If incidents or complaints were escalated or identified these were taken to the screening meetings for review. I was involved in facilitating SAI review meetings.

3.20 Urology data would have been provided in the information circulated on a weekly basis to the Director of Acute Services and the Assistant Directors and

also at Acute Governance and Acute Clinical Governance meetings.

- (ii) **What was your understanding of the way in which governance issues might be brought to your attention? What is your view of the efficacy of those methods of identifying governance concerns?**

3.21 Governance issues were brought to my attention in a number of ways:

Verbal updates

3.22 A staff member or team identifying a governance issue, e.g., a clinical incident were required to verbally inform the governance coordinator as part of the notification/escalation of an incident. On occasion this did not happen and I was notified in retrospect by other directorate governance coordinators or found out via informal discussions.

3.23 At the time of commencing as Acute Clinical Governance Coordinator the directorate did not have internal guidance on management of reporting incidents which met the threshold for Serious Adverse Incident (SAI). This Trust guidance was aligned with the regional guidance. I developed guidance to outline the escalation process for reporting incidents, identifying roles and responsibilities when managing the SAI process. Please see *30. Acute Serious Incident SAI guidance*

Datix Incident Management System

3.24 The Southern Health and Social Care Trust (SHSCT) has an electronic Datix Incident reporting system which allows staff to report adverse incident occurrences from their local computer workstations. Incidents are reported by completing the IR1 form via the Datix system. There had been a gap in Governance Coordinators in the Directorate and as governance had been mostly managed in the Divisions at times risks and incidents were not escalated to me. In an effort to make myself aware of clinical incidents that potentially

required a more in-depth review including SAI I or one of the governance team attempt to do a high level review of Datix reports.

3.25 Datix reports include everything from minor incidents to catastrophic incidents. The wording on reports does not always fully reflect the incident and thus I relied on further escalation by the services to identify some additional risks. The wording may have suggested a less significant issue when in fact there were significant risks.

3.26 While Governance Coordinator Datix system was an older version of Datix version 12.2.02 it has recently been upgraded to Datix 14.1.2 to bring the SHSCT into line with the region. It was challenging to run reports on the older version of the Datix system and make changes to the system. The litigation team used a separate version of the Datix system to record litigation cases. Staff feedback on the system was sought before I commenced post and some changes were made, although some staff continued to comment that the system made reporting challenging.

Screening meetings

3.27 Incident screening meetings usually include the Assistant Director (AD), Associate Medical Director (AMD) and/or the Clinical Directors (CD), and a member of the governance team. The AD and clinicians review the Datix report or complaint and where available the timeline and or clinical notes (governance team having reviewed clinical notes to extract a chronology of events). This is to see if an incident meets the criteria for an SAI and also to identify any early learning. I escalated incidents from the governance team's review of Datix at these meetings. I have also been notified by the operational teams at incident screening meetings of incidents or other governance concerns.

3.28 On occasion, meetings were cancelled but the screening information, which had been prepared to support the meetings, was forwarded to the screening team to remind them of the cases requiring screening and highlighting delays and allowing preparation should an additional meeting be facilitated.

3.29 I do not have details of all cancelled meetings however my recollection is that

Surgery and Elective Care and Anaesthetics, Theatres and Intensive Care (SEC and ATICS) meeting were cancelled more often than MUSC. An example of meetings that did not progress: initial screening emailsent on 06/06/2017, with reminder emails on 16/6/2017, 7/07/2017, 18/07/2107, screening took place on 26/07/2017. Screening did appear to progress on the 25/07/2016. Please see:

29a.-29h Screening Uro 16 06 2017, A1-A7

31a-31h. 20170629 Screening meeting 06 29 2017,A1-A7

32a.-32f. 20170707 Screening 07 07 2017 urol screening holiday arrangement

33a.-33f. 20170718 Screening SEC 07 18 2017 uro, A1-A5

34. Appendix Re Screening delay 29 06 2017

35a.-35g. 20170726 Screening and Notification Forms for approval, A1-A6

3.30 Challenges and delays in screening were escalated at 1:1 meetings Esther Gishkori noted challenges with screening including on the 14/11/18, 21/11/2018, 19/12/2018 and 07/01/2019. Please see an example of directors notes:

38a-e. appendix Directors Meeting Agenda 21 11 2018,A1-A4

3.31 A report from the Acute Governance team highlights the number of SAI reports submitted from 1 May 2016 to 6 January 2019 were as follows:

- a) 2016 – 14
- b) 2017 – 15
- c) 2018 – 15

3.32 I had limited input into the obstetrics and gynaecology screening. There were occasional exceptions when I was asked to assist with facilitating SAIs or to debrief meetings. On occasions I provided advice and support to the Risk Midwife. The reason for this was historically IMWH had an Obstetrics Risk Midwife who facilitated obstetrics and gynaecology screening and governance within the obstetrics and gynaecology service.

Morbidity and Mortality (M&M) review

3.33 On occasions the M&M reviewed defined a case as SOM 4 which means cases meet the SAI threshold. I reviewed the M&M minutes to identify such cases and review the outcome of cases that following screening meetings were referred to M&M for peer review.

Complaints

3.34 Complaints are an expression of a patient or service user’s dissatisfaction with a service and can highlight governance issues. On occasion formal complaint investigations identified concerns that met the threshold for SAI.

3.35 In the period 1 May 2016 to 6 January 2019 there were 7 complaints that converted to SAI’s.

| Complaint number | Date of receipt | SAI number | Date of Notification | Specialty |
|--|------------------------|--|-----------------------------|----------------------------|
| Personal Information redacted by the USI | 19.02.16 | Personal Information redacted by the USI | 16.05.16 | Cardiology |
| | 14.09.16 | | 14.06.17 | Dermatology (Led by BHSCT) |
| | 20.02.17 | | 13.12.16 | Emergency Department |
| | 15.02.17 | | 04.10.17 | Cardiology |
| | 15.05.17 | | 05.06.17 | Emergency Department |
| | 21.12.16 | | 22.09.17 | Urology |
| | 01.05.18 | | 28.09.18 | Orthoptics |

3.36 A report from the acute governance team highlighted that during my tenure as acute governance coordinator there were 1745 complaint, queries and MLA enquiries.

3.37 Complaints came into the complaints office and were forwarded to the appropriate operational team to investigate and respond.

3.38 The volume of complaints meant that I did not have the capacity to review complaints, however, if the governance team were concerned about a complaint meeting the threshold for an SAI they then escalated this to me.

3.39 If the governance officer receiving the complaint was concerned by the content of the complaint or the operational team reviewing the complaint this was escalated to an appropriate screening meeting.

3.40 The operational teams reviewing the complaints were aware of the SAI guidance. At the Acute Governance Meeting on 7th June 2016 I presented guidance of the process for reporting of serious adverse & reporting early alerts- June 2016 update to as a simple guide to the processes.

3.41 A Serious Adverse Incident is defined as any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage.

3.42 On occasions ADs escalated if they considered complaints met the threshold for SAI for screening. On occasions if complaints were complex including complaints referred to the Ombudsman I assisted some of the ADs with review of notes, documents and development of time lines to facilitate the review and responses.

Litigation team

3.43 The litigation team shared information on cases referred to the coroner with the Acute Governance team. The Acute Governance team was aware of some of the cases as they were in the SAI process. There were some cases

which were not in the SAI process. These were cases where the Coroner identified learning for the Trust for cases which had not already been reviewed in the SAI process. The governance team used a different version of the Datix system for recording their information.

3.44 Litigation cases would have to have been notified to the Acute Governance team and operational teams for required action to be taken.

(iii) explain your understanding as to whom you were expected to report as Acute Governance Lead? To whom did you actually report and how often did these reports/meetings occur? If meetings, did they have an agenda and were they minuted? If so, please provide all minutes and agendas.

3.45 Governance Coordinators in other Directorates reported directly to the Directorate Director, it was my anticipation this would be the same in the Acute Directorate. However, I reported to Dr Tracey Boyce (Director of Pharmacy) who was my line manager on behalf of Esther Gishkori (Director of Acute Services).

3.46 I had regular meetings with Tracey Boyce, usually weekly, these were informal in nature, and formal minutes were not taken. I would have brought information reports, workload concerns and information and queries on investigations.

3.47 Having contacted Information Technology team they have confirmed that removing a recurring meeting will also remove all appointments that had been scheduled in the past. Please see attached table of meetings with Tracey (*41. meetings with Tracey*)

3.48 I had a recurring meeting invitation with Mrs Gishkori in my diary on Wednesday mornings from 15th June 2016 until 2nd January 2019. The meetings were cancelled on occasions. I do not have a full record of when

meetings happened or were cancelled. Please see attached table of meetings with Esther (*42. meetings with Esther*).

3.49 I had a recurring meeting invitation in my diary for Wednesday mornings from 15th June 2016 until 2nd January 2019. The meetings were cancelled on occasions. I do not have a full record of how often they were cancelled but have emails regarding cancellations, emails were 11/30/2016, 02/07/2017, 02/28/2017, 10/24/2017 and 11/28/2017 but at times they were cancelled or postponed without email notification.

3.50 I was not always available for the weekly meetings but Dr Boyce or one of the Acute Governance Team would have been available to attend the meeting. The dates I have planned or unplanned leave or study leave included 06/07/2016, 27/07/2016, 10/08/2016, 02/11/2016, 2/11/2016, 14/12/2016, 14/02/2017, 12/07/2017, 26/07/2017, 09/08/2017, 16/08/2017, 01/11/2017, 27/12/2017, 21/02/2018, 21/3/2018, 28/03/2018, 25/07/2018, 01/08/2018, 8/08/2018, 15/08/2018, 12/09/2018, 03/10/2018, 10/10/2018, 28/11/2018, 12/12/2018, 26/12/2018.

3.51 The meetings with the Director were informal in nature and did not have a formal agenda and formal minutes were not taken initially. Weekly governance reports were developed and circulated to Acute SMT for information and action. The weekly governance reports were used as the basis of discussions. An example of a weekly governance report which was circulated to the Director and Assistant Directors (please see *43a-43n. Appendix Governance Report 10 10 2018*) issues that were discussed when meetings did take place. As time progressed, where time permitted, I developed an agenda and briefing notes. The dates where agendas or notes are available are 02/01/2017, 10/05/2018, 30/05/2018, 06/06/2018, 13/06/2018, 14/10/2018, 31/10/2018, 14/11/2018, 21/11/2018, 18/12/2018 and 07/02/2019. An example of notes from these meetings (*38a.-38e. Appendix Directors meeting notes 21 11 2018*).

Acute Governance meetings

3.52 The terms of reference for the meetings are noted in 21. Acute Directorate Governance Group Terms of Reference. The Group was to provide effective and robust assurances in the following areas:

- a) Provide clarity and transparency of function;
- b) Drive Quality and Safety;
- c) Provide adequate assurances to the SMT, Trust Board, Professional Bodies and the Public, on areas relating to risk, patient safety and non-compliance.

3.53 The meetings were scheduled monthly with Acute Governance on Tuesday afternoons attended by the Director Mrs Gishkori and the Acute Assistant Directors or their Assistant Directors.

| Date of Meetings in 2016 | Date of Meeting in 2017 | Date of Meeting in 2018 |
|---------------------------------|--------------------------------|--------------------------------|
| 05/04/2016 | 07/02/2017 | 07/02/2018 |
| 03/05/2016 | 07/03/2017 | 06/03/2018 |
| 07/06/2016 | 04/04/2017 | 01/05/2018 |
| 02/08/2016 | 02/05/2017 | 06/06/2018 |
| 06/09/2016 | 06/06/2017 | 07/08/2018 |
| 04/10/2016 | 01/08//2017 | 02/10/2018 |
| 16/11/2016 | 05/09/2017 | 06/11/2018 |
| | 05/10/2017 | 04/12/2108 |
| | 05/12/2017 | |

3.54 Governance meeting dates during my tenure as Acute Clinical Governance Coordinator are in the table below.

Acute Clinical Governance meetings

3.55 The terms of reference for this group are noted in 22. Acute Clinical Governance Terms of Reference. The Group was to provide effective and robust assurances in the following areas:

- a) Provide clarity and transparency of function;
- b) Drive Quality and Safety;
- c) Provide adequate assurances to the SMT, Trust Board, Professional Bodies and the Public, on areas relating to risk, patient safety and non-compliance.

3.56 The meetings were monthly Acute Clinical Governance on Friday Mornings attended by the Director Mrs Gishkori and the Acute Assistant Directors or their Assistant Directors and the Associated Medical Directors or their Clinical Directors.

3.57 The Acute Clinical Governance meetings had a more clinical focus and draft SAI reports were presented for review, comment, challenge and learning.

3.58 Governance meeting dates during my tenure as Acute Clinical Governance Coordinator are in the table below

| Date of Meeting in 2016 | Date of Meeting in 2017 | Date of Meeting in 2018 |
|--------------------------------|--------------------------------|--------------------------------|
| 12/02/2016 | 13/01/2017 | 12/01/2018 |
| 13/05/2016 | 10/02/2017 | 09/02/2018 |
| 10/06/2016 | 14/04/2017 | 09/03/2018 |
| 08/07/2016 | 12/05/2017 | 13/04/2018 |

Examples of the minutes are *118. Appendix 2018 11 09 Acute Clinical Governance Action Notes*

Acute Audit Committee

3.59 Clinical audit is the cornerstone of assurance. Clinical audit is a way to find out if healthcare is being provided in line with standards. Audit is used to promote quality improvement. The Corporate Governance Team (Effectiveness and Evaluation) provide support on audit mostly to medical staff including support with National

| | | |
|------------|------------|------------|
| 08/12/2016 | 09/06/2017 | 11/05/2018 |
| 12/09/2016 | 14/07/2017 | 08/06/2018 |
| | 11/08/2017 | 10/08/2018 |
| | 13/10/2017 | 07/09/2018 |
| | 08/12/2017 | 10/10/2018 |
| | 08/12/2017 | 06/11/2018 |
| | | 14/12/2018 |

Audits, e.g., The National Confidential Enquiry into Patient Outcome and Death (NCEPOD), as well as morbidity and mortality meetings.

3.60 When I commenced post as Acute Governance Coordinator I recognised that there was limited acute audit support. There previously had been a strong audit commitment within the medical teams as reported by various medical and operational staff. I met with Dr G Browne on 02/02/2017, I do not have a note of the meeting but recollect that she highlighted that teams were still committed to audit but it was felt that lack of administrative support for audit teams and senior leadership support. The example given was that the Medical Director did not attend the audit forum annual meeting/poster presentation.

3.61 I discussed with Mrs Gishkori and asked if she would support and chair a new audit committee, Mrs Gishkori highlighted she was committed to audit and would chair the audit committee to evidence senior commitment to audit.

3.62 The remit of the Acute Audit Committee was outlined in *22. Acute Clinical Governance Terms of Reference*. It was to provide a systematic and integrated approach for the identification and prioritisation of risk-related audits arising from:

- a) the Corporate Standards & Guidelines Group;
- b) trends arising from complaints, incidents, SAls, litigation etc.;
- c) significant audits identified by Divisions to minimise harm / risk to patients, clients, staff and the Trust. Dates of meeting 22/09/2017, 28/03/2018, 04/05/2018, and 22/09/2018. Examples on notes appendix 60a-60g. *20180323 Acute Audit Committee Agenda , A1-A6*

3.63 The audit committee meetings commenced on the 22/09/2017 but I remember Mrs Gishkori did not always attend all or part of the meetings and no additional administrative support was available for clinicians to facilitate audit. Subsequently attendance at the acute meetings reduced, meaning meetings were often not quorate. The poor attendance led to meetings not continuing and the last meeting was held on the 22/09/2018.

(a) If not covered by your answer above, did you have any meetings with Esther Gishkori regarding governance issues? If yes, how often did these meetings occur? If there are available agendas and minutes, please provide them.

3.64 The meetings above are the meetings I recollect or have recorded having with Mrs Gishkori. There may be others but I do not have a record of them or clear recollection of them.

(b) Did you have any meetings or discussion with Mrs Gishkori and/or Tracy Boyce or anyone else regarding governance issues or concerns within urology? If yes, and not set out in your previous answers, please set out all details of such meeting and discussions, including dates, times, locations, those present, and details of what was discussed and any follow up actions or reviews to decisions made. Please include all relevant documentation.

3.65 The meetings I had with Mrs Gishkori and/or Dr Boyce are outlined above. There were some other meetings that discussed governance which I attended. The meetings discussed general governance issues.

3.66 I attended Governance committee to outline the ongoing work on Managing the Deteriorating Patient on 10/5/2016.

Governance Coordinators' meetings

| Date of meeting | Appendix |
|------------------------|-----------------|
| 01/07/2016 | |
| 11/08/2016 | Apologies sent |
| 02/09/2016 | |
| 29/11/2016 | |
| 11/01/2017 | Apologies sent |

| | |
|------------|----------------|
| | |
| 15/02/2017 | Apologies sent |
| 12/04/2017 | |
| 02/06/2017 | |
| 28/06/2017 | |
| 09/08/2017 | Apologies sent |
| 12/10/2017 | Apologies sent |
| 14/09/2017 | |
| 04/12/2017 | |
| 07/02/2018 | |
| 14/3/2018 | Apologies sent |
| 11/4/2018 | |

An example of the minutes of the Governance Coordinators meetings are in 68.
20170628 Governance Coordinator

Screening meetings

3.67 Screening meetings usually included the Assistant Director, Associated Medical Director and/or the Clinical Directors, and a member of the governance team. The AD and clinicians reviewed the Datix reports or complaint and where available the timeline and or clinical notes (Governance Team reviewed clinical notes to extract a chronology of events) to see if an incident met the criteria for an SAI and to identify any early learning. Please see some examples of meetings preparation in response 3.29:

74a.-74h. 20170616 Screening Uro 16 06 2017, A1-A7

31a.-31h. 20170629 Screening meeting 06 29 2017, A1-A7

32a.-32f. 20170707 Screening 07 07 2017 urol screening holiday arrangement

33a.-33f. 20170718 Screening SEC 07 18 2017 uro

MUSC and IMWH Governance Meetings

3.68 Medicine and Unscheduled Care (MUSC) and Integrated Maternity and Womens Health governance meetings we held. I provided papers for these meetings.

Serious adverse incident meetings

3.69 I attended a number of Serious Adverse Incident meetings as Governance Coordinator to support the meeting and SAI process including draft report writing.

Lessons Learned Meeting

3.70 I attended a number of Lessons Learned meeting.

Patient and Public Involvement (PPI) meetings

3.71 I attended a number of PP meetings.

Meetings with Dr Wright (Medical Director)

3.72 I has a limited interface with the Medical Director but did discuss Governance issues with Dr Wright.

3.73 Dr Wright chaired the Trust Sepsis group which I facilitated, I also note emails regarding NEWS meeting and a Thrombosis Committee meeting.

3.74 I have emails to Dr Wright, examples include, meeting with Dr Wright 06/13/2016 regarding chairing an SAI on 7/6/2018 and an email on 29/03/2017 regarding an independent chair for a urology SAI. *Please see 81. 20170411 E re Expert Panel Members for SAI.*

3.75 Other examples include meetings on the 25/22/2016 when I met Dr Wright regarding results sign off. On the 20/11/2017 I met with Dr Wright, AMD Primary Care and Consultant Physician Emergency Department regarding a complaint.

Meetings with Dr Khan (Medical Director)

3.76 I had a limited interface with the medical director but did discuss some governance issues with Dr Khan. I have reviewed my emails and note emails regarding hyponatraemia, NEWS, governance assurance template and SAI. On review of my emails in my system I have emails to Dr Khan on 27/09/2018 regarding Urology 83. *appendix CONFIDENTIAL-DRAFT- reports Dr Khan 09 27 2018.*

3.77 I would have had discussions with others about governance issues. The location of my office on the administration floor in Craigavon Area Hospital allowed for regular discussions with Assistant Directors, Heads of Service and others daily, I do not have specific recollections or notes of these discussions.

3.78 In relation to specific SAI's I would have had meetings with other staff, e.g., 22/8/2018 a debrief meeting regarding an SAI relating to a homicide.

3.79 My general recollection is that I reported any concerns I was aware of.

(a) If any actions were taken as a result of these meetings, how, if at all, did you assess the effectiveness of these actions?

3.80 From screening meetings I would have progressed Serious Adverse Incident reviews and updated papers reflecting outcomes.

3.81 To aid my memory I have reviewed notes of some of the acute governance meetings and on reflection the notes do not fully reflect discussions and actions arising from the meetings.

3.82 On 07/02/2017 the development of dashboards on Datix was noted I progressed this work with David Cardwell in the Acute Clinical Governance team- this work was challenging to take forward due to staffing resources and the Datix system, however, some dashboards were developed. Datix software has dashboard infrastructure, at the time there was no Datix manager and the Acute Directorate had limited capacity to progress dashboards. Dashboards are information from the Datix system which allows graphical monitoring of incidents. This was not sophisticated enough to identify fine detail but would have allowed monitoring of incidents open and closed or specific results on for example violence and aggression trends. As different Datix versions were in use triangulation of data remained challenging.

3.83 In 02/08/2016 Acute Governance meetings it notes, 'Trudy is working on putting the recommendations into a database for each division to update'. I progressed this work and a report was available with the report and action plans were embedded. A version of this report with a summary of the SAI and recommendations was regularly circulated as a reminder to operational teams to progress works required to ensure that recommendations were implemented. The report was also shared at Acute Clinical Governance meetings and noted in a reformatted presentation on 07/02/2017.

3.84 Actions in relation to standards and guidelines were progressed via many working groups. Refer to: Acute Services Accountability Report - Standards and Guidelines - (1st April 2018 to 31 March 2019) *85a. 20180918 Standards and Guidelines Accountability Report and 85b. 20190806 Standards and Guidelines*

Accountability Report.

3.85 Notes of Acute Governance meeting on 06/09/2016 noted the requirement to add risk of absconding patients to the risk register, this was added on 13/09/2016.

3.86 I highlighted the challenges of the limited staffing resource within the Acute Governance team based on the workload within the Acute Directorate.

3.87 An Acute Governance meeting on the 7th February 2017 noted 'SAI Support – we have a huge backlog of SAIs and screening to be completed. Maria Dineen is going to set up a training programme for us. There was a discussion re staff who could be released to join the governance team to fill the roles originally planned. Esther to speak to SMT about the idea – for approval.'

3.88 I am not aware if resource for the acute governance team was discussed at SMT. I am aware of an email regarding a proposed acute governance structure sent to Mrs Gishkori from Dr Boyce in preparation for a meeting with Mr Devlin: see 5. *Appendix Acute Governance structure 05 06 2018*, 6. *Appendix Acute Governance structure 05 06 2018 A1* and 7. *Appendix Acute Governance structure 05 06 2018 A2*.

3.89 I also noted workforce challenges on meeting agendas/notes with Mrs Gishkori. On 02/08/2016 the Acute Governance committee note referencing discussion with the Director of Older People and Primary Care (OPPC)/Executive Director of Nursing 'Governance structures update – Esther briefed on her meeting with the nursing governance/practice development staff' from memory this was related to the possibility of the nursing governance team assisting with SAI and governance in the Acute Directorate. The nurses were asked to assist, however for a number of reasons including sickness absence there was limited impact on reducing workload. Work force and/or structures were discussed on multiple occasions and noted on 10/05/2017, 24/10/2018 and 14/11/2018. On the 21/11/2018 which noted, 'Update from finance in relation to Consultant PA's and band 5 and 6 posts. SAI workload remains challenging in relation to

capacity for reports and also engagement / response. Esther will further discuss with Finance – including the PA's for consultant and audit facilitators. The role and importance of both roles were discussed in providing assurances regarding governance in the directorate. Advert for Interim Acute Clinical Governance Coordinator closes Friday. SAI's that are currently in the system can be completed by Trudy if agreed by the new Medical Director'. Also noted on 19/12/2018 and 07/01/2019.

3.90 Work pressures and staffing were also discussed at meetings with Tracey Boyce on numerous occasions including following an email (*please see 87a.-87e. Team work load 10 May 2017,A1-A4*)

3.91 Equipment Management post was discussed, this post was progressed.

3.92 I organised SAI training with Consequence (Maria Deen, this training took place on 28th June 2016 and the training with CLS Investigation of Adverse Incidents Masterclass. Training was organised by the Corporate Governance Team in May 2017. I organised an additional Programme - Learning and Responding when things go wrong on the 11th – 13th September 2018 to support review of complaints and SAIs.

3.93 General Governance Training and complaints training was delivered internally to improve awareness of Governance, improve reporting and investigation of incidents and complaints. The training was limited by the team resource, sessions were mostly in 2018. The dates Incident training was provided included 1/2/2018, 3/4/2018, 3/05/2018, 11/05/2018, 08/06/2018, 25/06/2018, 17/09/ 2018, 26/09/2018, 17/10/2018, 25/10/2018 and 19/11/2018. Other in-house training included Nurse Induction training 13/04/2017 and 24/11/2017. Band 6 nurse training dates included 04/04/2017.

3.94 I set up a number of working groups and committees to progress actions from Standards and Guidelines and SAIs. These included Conscious Sedation Group which was implemented following a SAI to action a recommendation. I was a

member of and facilitated a number of groups including the Deteriorating Patient group for the implementation of NEWS 2 and the Sepsis 6 group.

3.95 Insulin QI group: some of the work progressed in this group was related to regional work streams but also addressed some of the recommendations in Trust SAIs.

3.96 For some of the work streams, teams were able to facilitate audit to provide assurance, regrettably there is insufficient capacity to provide audit assurance on all actions from work plans or for all work streams.

3.97 I facilitated the Acute Services Lead Nurse, Midwife, AHP and Radiographer Standards and Guidelines (S&G) forum. This forum was developed to ensure S&G the actions established to meet the requirement in the circulars were shared with front line staff and were embedded within local practice (please see *89. Appendix TOR Acute Services Lead Nurse Midwife AHP and Radiographer Standards and Guidelines Forum*).

3.98 It was a challenge to assess the effectiveness of all actions as the resources available within the Acute Governance Team did not allow for continual follow up actions.

3.99 Operational teams were responsible for the completion of actions in SAIs, complaints and standards and guidelines. The Acute Directorate is exceptionally busy and the resources available within the operational teams limited.

3.100 In an effort to assist with monitoring of SAI recommendations I developed an action plan template and a spread sheet with a brief description of the SAI and recommendations.

3.101 The audit capacity within the Directorate did not allow for audit relating to actions to ensure consistent application of the required standards.

(g) Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

3.102 When I identified incidents which raised concerns regarding a practitioner I escalated these including: at screening meetings; 1:1 meeting with the Mrs Gishkori, and; Tracey Boyce, and; Acute Governance and Acute Clinical Governance meetings. The persons informed included assistant directors, associated medical directors and the director. The purpose of SAI is to identify learning for implementation to help prevent incidents reoccurring. In relation to urology please see attached table with SAIs, reviews of care and complaints I was aware of during my tenure, these highlighted a number of concerns regarding Mr O'Brien's practice, including not triaging letters and not referring a patient to pre-operative assessment. There may have been other incidents and complaints however I do not remember being involved in specific reviews for such cases (*please see 13. Urology SAI and Complaints 1*).

3.103 I discussed incidents and SAIs with Esther Gishkori at 1:1 meetings and Acute Governance and Acute Clinical Governance meetings, they were included in Governance Papers for the Acute Governance meetings.

3.104 I discussed with Dr Boyce on our regular support meetings. Incidents were discussed at screening meetings.

3.105 From my recollection, in general, as Governance Coordinator there were no specific issues raised in relation to the urology service outside the incident and complaint processes.

3.106 I have latterly become aware of the MHPS process. From my memory I was not involved in the MHPS process at the time, professional governance and

clinical governance were separate. I became aware of a 2nd process from Dr Boyce approximately on 04/08/2016. Please see:

17a. Appendix Concerns raised by an SAI panel 1st

Dr Wright (Medical Director)

3.107 I had a limited interface with the Medical Director but did discuss Governance issues with Dr Wright.

3.108 Dr Wright chaired the Trust Sepsis group which I facilitated, I also note emails regarding NEWS meeting and Thrombosis committee.

3.109 I have emails to Dr Wright, examples include, meeting with Dr Wright 06/13/2016 regarding chairing an SAI on 7/6/2018 and an email on 29/03/2017 regarding an independent chair for a urology SAI. Other examples include meetings on the 25/22/2016 when I met Dr Wright regarding results sign off. On the 20/11/2017 I met with Dr Wright, AMD Primary Care and Consultant Physician Emergency Department regarding a complaint

Dr Khan (medical director)

3.110 I had a limited interface with the medical director but did discuss some governance issues with Dr Khan. I have reviewed my emails and note emails regarding hyponatraemia, NEWS, governance assurance template and SAI. On review of my emails in my system I have emails to Dr Khan on 27/09/2018 regarding Urology 83a-b. *Appendix CONFIDENTIAL-DRAFT- reports Dr Khan 09 27 2018.*

3.111 My recollection is that I reported any concerns I was aware of.

(h) What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

Incidents

3.112 When concerns regarding incidents were known incidents were reviewed for learning. Screening meetings were held to identify those incidents which required a SAI review.

3.113 Information on the incidents and SAIs were shared with the Acute SMT.

3.114 When I commenced as Governance Coordinator I noted in the Acute Directorate there was not a central repository of SAIs and recommendations readily available for the operational team. In an effort to assist with monitoring of SAI recommendations I developed an action plan template and a spreadsheet with a brief description of the SAI and recommendations I was able to access and then new SAIs as they were finalised. This spread-sheet also included the recommendations so that teams were fully aware of all recommendations so action plans could be developed or updated.

3.115 Early Alerts and SAI notifications were shared with HSCB and DOH.

3.116 The SAI process was implemented to identify learning, regrettably this often took longer than required for a number of reasons including, screening delays, identifying a suitable chair, chair availability and limited resources within the Acute Governance Team and the workload for the Acute Governance Team.

3.117 It was noted on 24/10/2018, 'There are delay's in SAI reports due to capacity of the governance team, Acute Clinical Governance coordinator currently is writing all the reports'. On the 14/11/2018 at the weekly briefing session with the Director of Acute Services it was noted 'SAI workload remains challenging in relation to capacity for reports and also engagement / response: 36a.-36e. 20181114 Directors Meeting 14 11 2018, A1-A4

3.118 SAI recommendations were shared at Acute Clinical Governance and Acute Governance. During my tenure the Acute Governance team populated the SAI action plan templates to assist operational teams with the expectation that recommendations would be actioned by each operational

team. 30. *Acute Serious Incident SAI Guidance*– ‘Ensure that any SAI review action plan/recommendations are implemented & monitored and that any learning is disseminated appropriately. The HOS will provide regular updates to the relevant governance fora on the implementation of recommendations’

3.119 At times when reviewing action plans, when responding to HSCB or coroner’s office, no action plans were traceable or I required teams to be prompted to update action plans 97a-97b. *Appendix Action plan email and action plan 06 15 2016* with attached action plan.

3.120 The operational teams within the Acute Directorate were very busy managing services on a day-to-day basis with limited administrative support. The teams were small and therefore challenged in progressing work streams required to address some actions from SAIs.

3.121 In relation to some concerns and actions I worked with teams to develop actions related to risks or learning identified, for example, for a SAI relating to conscious sedation I facilitated the commencement of a Trust Conscious Sedation Committee to progress the development of Conscious Sedation guidance.

Standards and Guidelines

3.122 NICE guidelines and Safety and Quality letters are received by the Trust and shared and discussed with SMT.

3.123 In January 2017 an Acute Services Clinical Standards and Guidelines forum was constituted following the stepping down of the Corporate Standards and Guidelines forum. The purpose of the meeting was to review the S&G actions and gaps and provide assurance.

3.124 Review of the Trust compliance with the guidance including NICE guidelines was assessed and actions planning implemented to maximise compliance with Standards. On occasions the Trust could not comply with standards and guidelines due to external barriers and resource implications.

Funding resource for the implementation of guidelines was not provided when guidelines were regionally endorsed and disseminated for implementation. The Standards and Guidelines Manager, Caroline Beattie, and Guideline leads who were often Consultants facilitated and led on work-streams that were required for the progression of actions to enable the Trust to meet the requirements in the guidelines.

3.125 Regionally NICE guidance did not come with a funding stream and many guidelines had significant recommendations, with significant resource requirements to fully implement. When the Trust could not fully implement guidance due to resource constraints or regional barriers, Eproformas were submitted to HSCB detailing gaps the Trust could not close without funding or obtaining regional input and action.

3.126 In order to further strengthen the accountability arrangements I facilitated the establishment of the Acute Services Lead Nurse, Midwife, AHP and Radiographer S&G forum. This forum was developed to ensure that the actions required to implement the recommendations in NICE and other guideline including safety and quality letters were the actions were shared with front line staff and were embedded within local practice *89. Appendix TOR Acute Services Lead Nurse Midwife AHP and Radiographer Standards and Guidelines Forum*

3.127 Other guidelines such as GAIN guidelines distributed by RQIA did not have a specific resource within the Acute Directorate. Operational teams were responsible for implementation of guidance. The work relating to implementing and updating actions was significant. Updates for GAIN guidelines from RQIA was requested on 23/3/2018 and was to be returned by 20/4 /2018, however, it took to 11/05/2018 to return all the updated action plans for Patient Discharge, Theatre Practice, People with Learning Disability in Acute Hospitals, Older People in Acute Hospitals, Medicines Optimisation, Palliative end of life care, Perinatal Mental Health, Specialist Sexual Health, Management of Controlled Drugs, Hospital at Night & Weekend, Review of CG 42.

3.128 Operational teams found certain guidance challenging to implement for

example the Guidelines on Caring for People with a Learning Disability in General Hospital Settings, I facilitated the implementation of a number of actions with the support of Sinead Hughes from OPPC including running two workshops 14/11/2017 and 27/09/2018 to raise awareness particularly for acute staff in relation to patients with learning disability and the learning disability passport to help assist the implementation of the guidelines.

Audit Committee

Acute Audit Committee

3.129 Audit is the cornerstone of assurance, clinical audit. Clinical audit is a way to find out if healthcare is being provided in line with standards. Audit is used to promote quality improvement. The Corporate Governance Team (Effectiveness and Evaluation) provide support on audit mostly to medical staff including National Audits, e.g., NCEPOD as well as morbidity and mortality meetings.

3.130 When I commenced post as Acute Governance Coordinator I recognised that there was limited acute audit support. There previously had been a strong audit commitment within the medical teams as reported by various medical and operational staff. I met with Dr G Browne on 02/02/2017 I do not have a note of the meeting but recollect that she highlighted that teams were still committed to audit but it was felt that there was a lack of administrative support for audit teams and senior leadership support. The example given was that the medical director did not attend the audit forum annual meeting/poster presentation.

3.131 I discussed the requirement for robust clinical audit and the feedback from Dr Browne with Mrs Gishkori and asked if she would support and chair a new audit committee. Mrs Gishkori highlighted she was committed to audit and would chair the Acute Audit Committee. However, when the audit committee meetings commenced Mrs Gishkori could not always attend all the meetings and no additional administrative support was available for clinicians to facilitate audit

and subsequently attendance at the acute meetings reduced, meaning meetings were not quorate. The poor attendance led to meetings not continuing, the first meeting was on 22/9/2017 and the last meeting was on 22/09/2018. Audit did continue with the support of the Corporate Governance Team, the Corporate Governance team provide updates on these at the Acute Governance meeting. On occasions the Corporate Governance Team had to support me finalising the acute audit plan by meeting with clinical and operational teams.

Risk Registers

3.132 Risks were highlighted on Risk Register, a member of the Acute Governance Team met with the operational teams to support the operational teams and provide administrative support to update the risk registers.

The Risk Registers were discussed at the Acute Governance Meetings, the Director 1:1 meetings and circulated to ADs as part of the governance reports. The Directorate and Corporate Risk registers were to reflect the live risks within the Directorate. At times the risk registers were not updated, I sent reminders and discussed at the Acute Governance Meetings to support the updating of Risk Registers. Please see:

99a.-99c. 20181029 Risk Register 10 29 2018,A1-A2

101a.-101b. 20181126 CRR to Governance Committee, A1

(iv) In her Section 21 Notice reply to the Inquiry at WIT-87634, also Tracy Boyce states the following :

...

“4.8 I put this weekly governance briefing meeting into Ms Gishkori’s diary when I realised that she was not going to take back the Director’s responsibility for Governance. I decided that the meetings were necessary as Ms Gishkori was attending Senior Management Team meetings where issues of governance and risk were being discussed. In my opinion she needed to be

briefed to be able to represent the Acute Directorate position accurately. Unfortunately, the meetings were often cancelled by Ms Gishkori. I do not have any notes of these meetings, as they would have been in my paper diary for the year which I no longer have in my possession. Ms Reid may be able to provide notes of these meetings.

(a) If not already provided, please detail and provide all notes documentation relevant to any meetings you may have, as referred to in Ms Boyce's last sentence.

3.133 In addition, I met with Mrs Gishkori with Dr Julian Johnston as part of the SAI review. Please see *103. Appendix Interview with Esther Gishkori 12.2.18*. The response above include the notes of meetings.

3.134 I would have had discussions with Mrs Gishkori while on the administration floor but I have no specific recollection nor can I identify minutes from these discussions.

(b) What is your view of the availability of Esther Gishkori to discuss governance issues (i) when specifically needed by you, and (ii) more generally? Did she (or others) cancel governance meetings with you? If yes, please provide all details.

3.135 If there was an urgent or specific requirement to discuss a governance and urgent matter if Mrs Gishkori was available I would have met with her.

3.136 My recollection was that on occasion Mrs Gishkori was not available for weekly governance meetings routine updates (see previous responses).

(c) Were you ever involved in briefing, either in person or in writing, the Senior Management Team when issues of governance and risk were being reported or discussed? If yes, please provide all details. If no, who was responsible for providing such briefings?

3.137 Information and briefing were shared as outlined in previous answers with Acute SMT.

3.138 In relation to Corporate SMT, the corporate governance team developed the agenda and papers for SMT governance. The SMT governance report was developed by the corporate governance team, this was shared with the Governance Coordinators for comment. I shared drafts of the papers with Mrs Gishkori and provided updates prior to the meeting and provide supporting information as required. The Corporate team would have provide the committee and members of SMT with the papers prior to the Governance Committee. An example is included in *104a.-104p. 20161208 FW Urgent Governance reports meeting with EG and for Governance Committee 08 12 2016, A1-A15.*

3.139 I attended Governance Committee to outline the ongoing work on Managing the Deteriorating Patient on *10/5/2016 (please see 105. Appendix 20160510 Approved Governance Minutes).*

3.140 I attended SMT Governance on 30th November 2018 as an observer.

3.141 Mrs Gishkori was Chair of the Acute Governance and Acute Clinical Governance Committees and a member of Trust SMT and Governance Committee would have been responsible for escalating risks.

(d) Were you aware if any issues you raised regarding governance and risk were brought to the Senior Management Team? If yes, please explain in full. If no, what were the issues, and how are you aware they were not brought to the Senior Management

Team?

3.142 I escalated risks to the Acute SMT at various meetings including Acute Governance, Acute Clinical Governance, screening meetings, and weekly reports as referenced in responses above.

3.143 In relation to Corporate SMT it is my recollection I was only aware of the reports that wereshared with me going to Governance Committee.

(e) Did you ever feel that issues of governance and risk you raised were not dealt with properly or at all?

1. If yes, please provide all details, including the names of those to whom you spoke about the issues.

3.144 I am not aware if Mrs Gishkori escalated issues escalated by me to SMT.

3.145 I am aware of some of the information presented to the Governance Committee. The reports included high level information but I am not aware of the detailed discussion at Governance committee

2. If no, how did you assure yourself that issues raised by you were properly addressed?

3.146 I highlighted on a number of occasions the challenges of the limited staffing resource within the Acute Governance team based on the workload within the Acute Directorate. The staffing resource available did not allow for the timely completion of reviews, sufficient proactive work streams to address risks or to develop the service to provide robust governance structure. The structure suggested when I applied for the Acute Governance Coordinator the post was not progressed. Please see:

1. Appendix File ACG structure 2016

3.147 The structure at the time included a small complaints team with 2 full time staff members and 3 part-time administration staff. As part of a review of capacity on staff member was asked to concentrate significant amounts of their role on SAI administration. One of the part time team also supported the operational teams with risk register updates. During my tenure there was 5 weeks of unplanned leave.

3.148 The standards and guidelines team had one part time lead and an administration assistant. During my tenure there was 9 weeks of unplanned leave.

3.149 Equipment management role was a staff member seconded from the estates team who provided part time cover.

3.150 A member of staff to support the governance around point of care testing was appointed in June 2018.

3.151 Temporary support was provided from the corporate governance team, they mostly provide M&M chair support.

3.152 In relation to SAIs and other governance functions there were two Lead Nurses and a redeployed ward sister when I commenced. One lead nurse was immediately returned to their substantive lead nurse role and completed the SAIs they had initially commenced over the coming months. The 2nd lead nurse in May 2016 reported she was approached by an ADand given two options one to downgrade to band 7 in Acute Governance or move to 8A lead nurse in Surgery and Elective Care. Given the work load and personal circumstances to redeployment back to lead nurse role in Surgery and Elective Care did not happen until October 2017.

3.153 Two additional nursing staff commenced in June and July 2017 these staff were redeployed from patient support roles where they proactively worked with patients and service users and wards to locally resolve

complaints and concerns. These redeployments reduced one layer of governance to address the need to support SAI reviews and report writing. There was a redeployed nursing sister in the team, One of the administration team from the complaints department supported this team. During my tenure there were 103 weeks of unplanned leave.

3.154 Nursing governance staff were asked to provide support with SAI reviews, regrettably for a number of reasons including sickness absence minimal support was provided.

3.155 The workload was significant for a small team, examples of the volumes of incidents, complaints and SAI's re illustrated below

3.156 The table below highlights the Incident reports by year during my tenure by service area:

| | 2016 | 2017 | 2018 | 2019 | Total |
|--|------|------|------|------|-------|
| Booking / Admin | 12 | 19 | 12 | 0 | 43 |
| Scheduling Team | 19 | 25 | 72 | 0 | 116 |
| Acute Directorate AHP's | 3 | 14 | 13 | 0 | 30 |
| Anaesthetics, Theatres and IC Services | 444 | 606 | 613 | 9 | 1672 |
| Cancer Services | 20 | 50 | 63 | 3 | 136 |
| Diagnostic Services | 67 | 129 | 139 | 2 | 337 |

| | | | | | |
|---------------------------------|----|----|----|---|-----|
| Laboratory Services | 10 | 20 | 57 | 0 | 87 |
| Pharmacy | 29 | 76 | 87 | 0 | 192 |
| Decontamination Services | 37 | 74 | 51 | 0 | 162 |
| Health Records | 11 | 13 | 15 | 0 | 39 |
| Linen Services | 21 | 23 | 33 | 0 | 77 |
| Locality Support Services (A&D) | 4 | 4 | 5 | 0 | 13 |

| | | | | | |
|-----------------------------------|-------------|-------------|-------------|-------------|--------------|
| Locality Support Services (C&B) | 242 | 348 | 378 | 4 | 972 |
| Locality Support Services (Newry) | 87 | 64 | 74 | 0 | 225 |
| Genito-Urinary Medicine (GUM) | 0 | 2 | 6 | 0 | 8 |
| Midwifery and Gynaecology | 629 | 907 | 865 | 23 | 2424 |
| Acute Hospital Social Workers | 1 | 3 | 3 | 0 | 7 |
| Cardiac Services | 127 | 184 | 203 | 3 | 517 |
| Emergency Department Services | 455 | 670 | 874 | 20 | 2019 |
| General Medicine | 1006 | 1484 | 1447 | 33 | 3970 |
| General Surgery | 611 | 859 | 955 | 20 | 2445 |
| Outpatients | 21 | 43 | 36 | 0 | 100 |
| Total | 5872 | 7634 | 8019 | 2136 | 15591 |

3.157 The number of SAIs submitted by year to HSCB and DOH by year are below.

- a) 2016 – 14
- b) 2017 – 15
- c) 2018 – 15

3.158 In the same time period there were 1745 complaints, enquiries and MLA queries.

3.159 The information above on complaints incidents and SAIs was provided by the Acute Governance Team. Please see:

108. Table – Complaints by service area April 2016 to January 2019 provided by the Acute Governance Team 1

3.160 I note from an email to Helen Walker (AD Human Resources) permission to appoint permanent governance managers. Please see:

109a-109b. Appendix Acute Governance team 05 12 2017 work load, A1.

3.161 I continued to escalate concerns regarding staffing resource being unable to meet the needs of the service of a regular basis

3.162 I am not aware if resource for the acute governance team was discussed at SMT. I am aware of an email regarding a proposed acute governance structure sent to Mrs Gishkori from Dr Boyce in preparation for a meeting with Mr. Devlin (5. *Appendix Acute Governance structure 05 06 2018, 6. Appendix Acute Governance structure 05 06 2018 A1 and 7. Appendix Acute Governance structure 05 06 2018 A2*). On 02/08/2016 the Acute Governance committee note referencing discussion with the Director of Older People and Primary Care (OPPC)/Executive Director of Nursing 'Governance structures update – Esther briefed on her meeting with the nursing governance/practice development staff' from memory this was related to the possibility of the nursing governance team assisting with SAI and governance in the Acute Directorate. The nurses were asked to assist, however for a number of reasons including sickness absence there was limited impact on reducing workload.

3.163 In relation to staffing, the narrative in question 2 describes the limited resources available within the Trust. I also noted work force challenges on meeting agendas/notes with Mrs Gishkori including 07/01/2019, 19/12/2018, 21/11/2018 which noted 'Update from finance in relation to Consultant PA's and band 5 and 6 posts. SAI work load remains challenging in relation to capacity for reports and also engagement / response. Esther will further discuss with Finance – including the PA's for consultant and audit facilitators. The role and importance of both roles were discussed in providing assurances regarding governance in the directorate. Advert for Interim Acute Clinical Governance Coordinator closes Friday. SAIs that are currently in the system can be completed by Trudy if agreed by the new Medical Director'. Also noted on 14/11/2018 and 24/10/2018.

3.164 When I commenced post as Acute Governance Coordinator I recognised that there was limited acute audit support. There previously had been a strong audit commitment within the medical teams as reported by various medical and operational staff. I met with Dr G Browne on 02/02/2017 I do not have a note of the meeting but recollect that she highlighted that teams were still committed to audit but it was felt that there was a lack of administrative support for audit teams and senior leadership support. The example given was that the medical director did not attend the audit forum annual meeting/poster presentation.

3.165 I discussed with Mrs Gishkori and asked if she would support and chair a new audit committee. Mrs Gishkori highlighted she was committed to audit and would chair the Acute Audit Committee.

3.166 The Audit Committee meetings commenced but Mrs Gishkori did not always attend all the meetings and no additional administrative support was available for clinicians to facilitate audit and subsequently attendance at the acute meetings reduced meaning meetings were not quorate. The poor attendance led to meetings not continuing, the first meeting was on 22/9/2017 and the last meeting was on 22/09/2018.

3.167 The resource within the team during my tenure did not allow for the full breadth of Governance to be dealt with in a full and timely manner.

(f) Are you aware of any issues of governance, either raised by you or others, being brought to the attention of the Board and/or any of the Board Committees?

3.168 In relation to Corporate SMT I was only aware of the reports that were shared with me going to Governance Committee.

4. Per Katherine Robinson at WIT-60389

...

31. “Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

31.1 In December 2016 when the secretary declared that there were clinics that were not dictated a system of oversight was put in place whereby the HOS asked us to keep a close eye to ensure all clinics were dictated on. The SA kept a close eye on this and reported through to the HOS. The secretary was advised again that it was her responsibility to advise us of this via the backlog report.

31.2 Also Trudy Reid as Head of Governance approx. Oct 16/17 started to put in place a ‘delays action plan’ following some SAIs (Series Adverse Incidents). This referred to work I was already doing, however Trudy Reid may have had other pieces of work I was not aware of. Please see: 27. 20161017 to 20170307 Es f TR and Ors Delays Action Plan

...

(a) Please explain in full the “delays action plan” put in place by you as referred to by Ms Robinson at para 31.2.

4.1 During my tenure I noted at times systems of oversight, action and monitoring were not always implemented. One such was example during incident review reporting there were a number of incidents where delays in diagnosis care were identified. The incidents recurred, there did not appear to be an action plan to address the ongoing risks of delays. I felt it important to have an action plan to address the risks of delays in diagnosis and appointments. I asked for a report to be run on the incidents that occurred where delays were contributing factors. As a Head of Service I was also aware in the patient journey where delays could occur which impacted on patient care. In September 2016 I note from emails the commencement of work in relation to

delays in treatment and care. Please see:

*111a.-111b. 20161004 Delays in appointments diagnosis or treatment, A1
113a-113b. Tracey, Heather and Barry meeting 30/09/2016*

4.2 The actions in relation to electronic result sign off on NIECR were taken forward through a number of meetings including one with Dr Wright on 26/11/2016 (please see 114. Appendix Sign off RW Nov 2016).

4.3 On the 19/12/16 I emailed a small working group regarding a Delays meeting with a list of potential areas where delays in patient care could occur from reviewing the incidents and experience as a head of service.

4.4 I sent an email on 05/06/2017 to Dr Boyce with incidents and action plan prior to Acute Governance refer to *115 a -115 c. appendix Delays 06 05 2017 Tracey prior to meeting.*

4.5 Acute Governance meeting notes reflect 'Diagnostic delays report shared for action to be discussed at Acute Clinical Governance with AMDs/CDs/ADs' on 06/6/06/2017. Delay incidents and the delays action plan shared and discussed at Acute Clinical Governance. Discussions regarding the action plan occurred, there was specific notes in relation to electronic sign off for radiology results *117. appendix 20170609.* Actions and monitoring of the action plan were to be taken forward by operational teams.

4.6 In relation to the administrative issues administrative teams restarted the production and circulation of reports to escalate risks including triage reports, dictation reports, typing backlog reports. Please see *11. Delays meeting checking re triage with KR 02 10 2017.*

4.7 Due to capacity issues within the operational teams and the perceived challenge of electronic sign off I facilitated a number of meetings to try to develop guidance for electronic sign off. Draft guidance on electronic sign off was developed but not approved (*please see 12. RE*

Sign off guidance 20 Dec 2018).

4.8 It was considered that the Northern Ireland Care Record (NIECR) system provided challenges for full implementation of electronic sign off, there were a number of technical issues which the Trust linked with Business Service Organisation (BSO) to action.

4.9 BSO did not provide reports that allowed monitoring of sign off in a full and timely way. Denominator detail was not available, the data available was the number of results signed off. Therefore, percentage sign of data by clinician by test was not available. BSO provided the Trust with reports which had data on the number of tests electronically signed off by health care professionals. The data in these reports was 6 weeks in arrears. When trying to improve services it is important to provide feedback in real time to encourage change in practice and improvement with compliance.

4.10 The Trust asked for reports with more timely data and denominator information, BSO were unable to provide this information.

4.11 There were some NIECR system issues such as misalignment of results, some issues were human error, and others systems issues. The Trust team worked with BSO to highlight areas where change was required as each was identified.

4.12 Timely and accurate information allows for rapid feedback to teams, the data and feedback allow for plan do study act (PDSA) cycles to aid improvement to systems and in practice. An example of the reports available are in the *118. Appendix 20181106 Acute Clinical Governance Action notes*.

4.13 The staffing resource available in the Acute Governance Team did not allow for regular review of action plans (refer to question 5 for Acute Governance Team staffing).

(b) Please detail all systems of oversight and monitoring used and/or

developed by you in response to concerns or risks. Please set out in full the reasons why you felt it necessary to develop such systems, what the aim of those systems were and how effective you considered them to be. How did you assess or assure yourself of their effectiveness? Were these systems subject to review? Please explain your answers in full.

4.14 As referred to in previous responses a number of systems of oversight and monitoring were used and developed.

4.15 A number of reports I circulated weekly included: re-opened complaints, major and catastrophic incidents, SAI recommendations, current complaints report, incident review position reports, ombudsman weekly complaints report, SAI report, coroner's queries reports (examples of these are referred to in previous answers).

4.16 The Acute Governance and Acute Clinical Governance reports included similar reports to those circulated weekly. In addition, Patient Safety Audit reports showed compliance against regionally agreed standards including Surgical Site Infection Rates, NEWS, Central line bundle compliance, malnutrition Universal Screening Tool, Critical medicine omitted, crash calls, WHO surgical check list, Stroke data including time to thrombolysis, emergency care, neutropenic sepsis and sepsis 6, venous thrombolysis risk assessment, compliance with falls bundle and falls rates, skin care pressure ulcer bundle compliance and pressure ulcer rates and compliance with delirium bundle. The reports were used to provide information and assurance that standards are met or to ensure operational team could progress required actions for improvement as required

4.17 The reports provided teams with data and information on the quality of care against regionally agreed standards and informs actions required to improve standards where required.

4.18 Operational teams were responsible for the completion of actions in SAIs, complaints and standards and guidelines. The Acute Directorate is exceptionally busy and the resource available within the operational teams was limited.

4.19 In an effort to assist with monitoring of SAI recommendations I developed an action plan template and a spread sheet with a brief description of the SAI and recommendations. The spread sheet had a link to the SAI report and the action plan embedded.

4.20 Screening reports were designed to monitor screening progress and actions as the volume and complexity of screening and at times delays in screening made it important to have records. The reports were designed to inform me and the ADs and Directors of the risks, actions required and progress or lack of progress against actions, workload including delays in progress.

4.21 Reports on compliance with standards and guidelines were provided with actions to highlight the actions progressed and the gaps and actions to be progressed including E proformas.

4.22 An Acute Services Lead Nurse, Midwife, AHP and Radiographer S&G forum was established. This forum was developed to ensure S&G the actions established to meet the requirement in the circulars were shared with front line staff and were embedded within local 89. *Appendix TOR Acute Services Lead Nurse Midwife AHP and Radiographer Standards and Guidelines Forum.*

4.23 The Acute Audit Committee remit re-established to provide a systematic and integrated approach for the identification and prioritisation of risk-related audits arising from:

- a) the Corporate Standards & Guidelines Group,
- b) trends arising from complaints, incidents, SAIs, litigation etc.
- c) significant audits identified by Divisions to minimise harm / risk to patients, clients, staff and the Trust.

4.24 The audit committee meetings commenced but Mrs Gishkori did not always attend all the meetings and no additional administrative support was available for clinicians to facilitate audit and subsequently attendance at the acute meetings reduced meaning meetings were not quorate. The poor attendance led to meetings not continuing. However, clinical audit did continue with the support of the corporate clinical governance team and reports were presented to Acute Governance and Acute Clinical Governance Committees.

4.25 To progress key pieces of work I facilitated or was a member of a number of groups including conscious sedation committee, Sepsis 6 group, insulin QI group and others to progress regional actions and recommendations from SAIs. Operationally there appeared to be limited capacity to facilitate these meetings.

4.26 The resources available in the Acute Governance Team did not allow for regular review of action plans. Time was required to develop screen incidents, develop timelines to allow for review of complex cases and in preparation for SAIs, facilitate the SAI process and meetings, write SAI reports, and facilitate various meetings to progress some work streams.

(c) If these systems were introduced in response to SAIs, please explain why you think the risk and governance issues those systems were designed to address were not flagged before SAI stage? What was wrong with the systems existing at that time that the issues were not identified? If they were identified by existing systems, why were they not addressed?

4.27 The operational teams within the Acute Directorate were very busy managing services on a day to day basis with limited administrative support. The staffing resource within the divisions were focused on the

daily operational challenges and had limited resources to address significant governance work streams to improve systems and processes.

4.28 Limited audit resource meant that assurance audits were not always available to thus identify areas for improvement and allow early action planning to reduce risks.

4.29 The resources to continually monitor systems and processes were limited by the numbers of staff, the volume of work and limited data available.

4.30 During my tenure April 2016 to January 2019, there had been a limited governance team in place (refer to question 5 for details on Acute Governance team staffing).

4.31 The information and reporting systems did not meet the needs of the service. Audits were mostly manually recorded and reported. Reports were run on an adhoc basis and could be difficult to interpret due to the format available. Examples of the information provided are in the Acute Clinical Governance papers and example is *118. Appendix 20181106 Acute Clinical Governance Action notes*.

4.32 Reports from systems such as Datix were run as regular adhoc reports and more bespoke reports when required. Dashboards were developed, this took time and there was limited resource within the team to develop dashboards.

4.33 The Datix system was Version 12.2.01 and it was challenging to run reports to provide information to all teams to help provide appropriate information, with limited trend data to identify risks.

4.34 The Datix system used by litigation was another version of datix. Standards and guidelines information was recorded an Excel document. Audits were recorded and reported manually.

4.35 The Directorate and Trust had limited or no data analytic expertise. Data analytic expertise facilitates appropriate reporting of data to allow identification of variances, trends, and allows teams to hypothesize, draw conclusions, identify risk and identify the potential for change and improvement. The provision of accurately timely reported data allows services to demonstrate the impact of quality improvement initiatives. Triangulation of data from different sources and systems was challenging with the systems available and resource within the team.

5. Did you consider, as Acute Governance Lead, that you were adequately supported by your line managers and other staff? Please explain your answer in full, with examples as relevant.

5.1 Dr Boyce did provide me with support and guidance, we met usually weekly or more often as required (refer to previous responses). Dr Boyce and I worked closely to try to implement governance structures, escalate risk and implement actions required where possible within the resources available. When I highlighted challenges these were escalated at meetings with Mrs Gishkori. Dr Boyce met with Mrs Gishkori and me when providing weekly updates, at Acute and Acute Clinical Governance committees. Dr Boyce often took notes at the committee meetings freeing up some of my time so I could progress other actions. However, in other Directorates the Governance coordinator reported directly to their Director.

5.2 The Acute Directorate is very busy with significant resource required for day today operational management of the service. Therefore, at times Mrs Gishkori was not available weekly briefing and other meetings such as the Audit Committee.

5.3 The main constraining factor in implementing governance systems and processes was the development of an Acute Governance team to develop governance systems. When I moved to the Acute Clinical Governance Coordinator post the structures and roles and responsibilities were documented in *1. Appendix*

File ACG structure 2016. When I commenced Connie Connolly was one of the 8A nurses supporting SAI report writing, reported she was approached by an AD and given two options one to downgrade to band 7 in Acute Governance or move to 8A lead nurse in surgery and elective care. Please see:

4. RE Governance re- structure- Connie re deployment

5.4 It was my personal impression that the operational work-load took precedence over the resource required for robust governance structures and governance team work load at the time. This led to delays in incident reviews and report writing, monitoring of action plans and implementation of work streams to address risks.

5.5 With the support of Dr Boyce, Mrs. Connelly remained in post until 16/10/2017.

5.6 Two additional nursing staff commenced in June and July 2017 these staff were redeployed from patient support roles where they proactively worked with patients and service users and wards to locally resolve complaints and concerns. These redeployments reduced one layer of governance to address the need to support SAI reviews and report writing.

5.7 See narrative above regarding staffing resource provided which outlines the resource available within the Acute Governance team. The workload is also noted in previous answers.

5.8 On 5/06/2018 an email from Dr Boyce to Mrs Gishkori provide a paper on new proposed clinical governance structures to be share with Mr Devlin. I do not recollect receiving feedback from the meeting with Mr Devlin.

5.9 The staffing resource noted in the paper was not implemented during my tenure.

5.10 In 12/04/2018 recruitment of 2 band 7s was approved these staff did not commence to October 2018 and the 2nd after I left the post.

5.11 While support on a day to day basis was good the lack of commitment to build the Acute Governance team to allow for the

development of governance structures, allow timely actions, report writing and oversight made for a significant challenge. The workload meant that I frequently worked additional hours in an attempt to meet the demands of the post. Additional hours were referenced to meetings and noted on 21/11/2017.

5.12 The Acute Directorate is very busy with significant resources required for day today operational management of the service and at times screening meetings were unable to be facilitated with the attendance of assistant directors and clinicians, examples are highlighted in previous responses. This challenged my ability to ensure timely review of incidents and escalation to SAI for learning.

5.13 Due to the business of the Acute Directorate it was challenging at times to get updates for action plans, GAIN guideline updates, complaints, etc.

6. During your tenure, were you offered any support for quality improvement initiatives? If yes, please explain and provide any supporting documentation.

6.1 During my tenure there was limited support offered for quality improvement initiatives.

6.2 In relation to workload and team structures support was requested from the Quality Improvement (QI) I team regarding the 'Productive Office'. Completion of a course was required with QI support provided during the course. However, with the ongoing workload neither I nor David Cardwell could commit to completion of the QI course.

6.3 The diabetes QI project had some QI support initially. This was a project designed to reduce the risks of administration of insulin and provided training sessions on diabetes. The project was developed because of incidents and SAIs involving diabetic patients and insulin administration.

6.4 I also note from my emails that some QI support was also provided for falls and pressure ulcers work-streams

6.5 I do not recollect any additional QI support for governance work streams.

7. What, in your experience, was the culture within (i) Acute Services and (ii) urology, regarding governance? For example, do you think there was enough time to properly manage and respond to governance issues? Did you feel that governance concerns raised by or through you were adequately addressed?

7.1 The Acute Directorate is very busy with significant resources required for day-to-day operational management of the service. There had been a focus on performance and finance in recent years. However, good performance increases efficiency and flow of patients both electively and non-electively to reduce waiting times and risk. There was a verbal commitment to governance but operational challenges and available funding limited time to proactively manage and respond to governance issues. A Clinical and Social Care Governance Assurance Template completed in 2018 noted a number of weaknesses and opportunities within the Acute Clinical Governance systems.

7.2 It is my opinion that the resource required to operationally and clinically manage the daily operations of the acute directorate left limited time to proactively address clinical governance processes and risks. Systems of oversight and monitoring were not well developed, some actions were taken forward by operational teams but this was not always shared with the governance team, or if not able to be progressed this was not always shared. Some work streams were supported by both the operational and governance teams.

7.3 I believe this is also demonstrated by the move of the 8A nurse from governance to lead nurse post and the redeployment of the patient support nurses to support the SAI process rather than recruiting additional staff.

7.4 There was also a lack of commitment and/or funding to providing support clinical teams, and to the audit committee to facilitate robust audit programmes with Acute Audit Committee oversight.

7.5 The lack of capacity within the Acute Governance team also limited the ability to develop the clinical governance structures to address weaknesses within the service.

7.6 Clinical Governance is the system through which healthcare organisations (NHS and private sector) are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish .

| | |
|--|---|
| Elements of Clinical Governance | |
| Clinical Effectiveness | Clinical effectiveness is a collection of activities and tools, based on research and measurement |

| | |
|--------------------------------|--|
| | that are used to improve the quality of healthcare. The activities include, but are not limited to, guidelines, audit, research and evaluation |
| Risk Management | Risk management is a complex set of clinical and administrative systems, processes, procedures, and reporting structures designed to detect, monitor, assess, mitigate, and prevent risks to patients – Step 1: Identify Your Risks. ... Step 2: Analyse All Risks. ... Step 3: Evaluate and Prioritize Every Risk. ... Step 4: Treat Your Risks. ... Step 5: Monitor Your Risks. |
| Patient and Public Involvement | Patient and Public Involvement ensures a diverse range of patients and the public, especially people with lived experience, are involved in influencing the direction and delivery of health care |

| | |
|-------------------------------|--|
| <p>Audit</p> | <p>“clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes” HQIP</p> <p>The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in trusts</p> |
| <p>Staff Management</p> | <p>Staff management – having robust policies and procedures in place. Building an open culture for raising and resolving issues and concerns.</p> <p>Establishing a mechanism for measuring and maximising staff input and performance. Ensuring that recruitment and long-term management strategies are aligned with your clinical governance goals and objectives</p> |
| <p>Education and Training</p> | <p>Professional development needs to continue throughout health care professionals career to remain updated on latest guidelines thus enhancing patient safety</p> |
| <p>Information</p> | <p>Information analysis, interpretation and presentation of health data and information. This enables the planning, improvement and delivery of patient services and care.</p> <p>Safe record management and storage.</p> |

Risk management

7.7 Risks were identified in many ways including through incident reporting and complaints. The limitations of the Datix system provided challenges for

staff reporting incidents and in getting real time data from the system.

Risks were identified during the SAI process, delays in the SAI process delayed identification of learning and risks

7.8 Risks were identified from external reports such as those provided by internal audit. There were internal audit reports which would have included review of the Trust including Acute processes.

| 2026-17 | 2017-18 | 2018 -19 | 2019-20 |
|-------------------------|-----------------|------------------------|------------------------|
| Risk Management | Risk Management | Risk Management | Risk Management |
| Incidents – Acute Falls | | Standards & Guidelines | Incidents – Medication |

7.9 Limited audit data and ability to triangulate data made it hard to identify, triangulate and manage all risks.

7.10 Risks were identified and divisional, directorate and corporate risk registers were updated. Vivienne Kerr in the acute governance office worked with the operational teams to provide administrative support and remind staff to update risk registers.

7.11 Due to the business of the service it was challenging at times to get the risk registers updated.

7.12 Risk management general training was included in in-house governance training in an effort to improve reporting and risk assessment.

Clinical Effectiveness

7.13 The support for many of the clinical audit was provided by the corporate governance team.

7.14 Standards and guidelines work streams added to clinical effectiveness by review of services against a standard and then developing actions and work streams to develop systems and processes to meet the standard. The Standards and Guideline Lead, Caroline Beattie, provided significant support to the operational teams and clinicians to ensure works were progressed to meet the standards or articulate the gaps and formalise the reporting of these in E proformas which were submitted to the Acute Governance Committee and the Health and Social Care Board (HSCB).

Patient and Public Involvement

7.15 There was patient and public involvement within the acute directorate, however no specific resource to facilitate this. Each service would have engaged patients and public during development of services, but this was not always consistent or proactive.

7.16 There was Corporate Patient and Public Involvement Committee.

Staff Management

7.17 The operational teams managed their staff in line with Trust Human Resources guidance.

7.18 Various guidelines were updated as part of the Standards and Guideline workstream although at times clinical and operational resource to update guidelines made this challenging.

7.19 The Trust had a clinical guideline site managed by the Medical Directorate office where clinical guidelines were hosted and accessed.

Audit

7.20 Audit was undertaken at many levels and reported to divisional teams and corporate governance effectiveness and evaluation teams.

7.21 Audit was reported by the corporate governance team in the patient safety reports at acute governance and acute clinical governance.

7.22 The audit committee meetings commenced but Mrs Gishkori did not always attend all the meetings and no additional administrative support was available for clinicians to facilitate audit and subsequently attendance at the acute meetings reduced meaning meetings were not quorate. The poor attendance and lack of additional resource for audit led to meetings not continuing. However, clinical audit did continue with the support of the corporate clinical governance team and reports were presented to Acute Governance and Acute Clinical Governance Committees.

7.23 The lack of an audit committee meant there was no local acute oversight of audit activity meaning that triangulation of data was challenging. This impacted on the ability to identify risk and risk manage.

Education and training

7.24 When I commenced the Governance Coordinator post there appeared to have been limited governance training.

7.25 The limited number of staff within the Acute Governance Team and workload made it challenging to provide proactive training. However, the Corporate Governance team organised SAI training – training was provided by Consequence UK training in February and 1 day 3rd February 2016, 11th and 12th February 2016 and 7th and 8th March 2018 organised by.

7.26 In June 2016– I subsequently organised a further session using Consequence UK on the 18th May 2017.

7.27 I became aware of Clinical Leadership Solutions who provide training on SAIs. CLS provided on Investigating Incidents Building Competency 19th October 2018 and Investigating Incidents Master Class - 24th and 25th June 2019 and 16th 17 September 2019

7.28 With the Acute Governance team internal in-house training sessions were provided on clinical governance on nursing induction, Incident

reporting training & Datix training.

7.29 Incident training was provided dates included 1/2/2018, 3/4/2018, 3/05/2018, 11/05/2018, 08/06/2018, 25/06/2018, 17/09/ 2018, 26/09/2018, 17/10/2018, 25/10/2018 and 19/11/2018.

7.30 Other in-house training included Nurse Induction training dates included 13/04/2017 and 24/11/2017. Band 6 nurse training dates included 04/04/2017.

7.31 Training needs for diabetes was identified and the QI team worked with CEC to develop a training course that met the needs of the service NEWS 2 training was identified and facilitated with Nursing Governance colleagues. Sepsis 6 training and information posters were designed.

7.32 Other service related training including mandatory training would have been assessed and organised by the operational teams. Training was available through various channels, e.g., conferences, Education Commissioning Group (ECG), Clinical Education Centre (CEC), etc. It is my recollection that operational challenges were prioritised over training at times.

7.33 Corporate mandatory training uptake was variable (*please see 123a.- 123c. appendix Mandatory training 09 05 2017*).

Information

7.34 The electronic Datix Incident reporting system which allows staff to report adverse incident occurrences from their local computer workstations was used to run information reports on incidents. Datix system was Version 12.2.01 and it was challenging to run reports to provide information to all teams to help provide appropriate information.

7.35 The Datix system has recently been upgraded from Version 12.2.0.1 to 14.1.2, there were 60 upgrades to the Datix system involved with this upgrade to bring the SHSCT to the same Datix version as the other Trusts in the region.

7.36 When I commenced there were adhoc reports run. I worked with the team to try to develop a number of reports for the directorate and change the format of information to be more user friendly. There were also efforts to develop a number of dashboards on the Datix system.

7.37 In a survey in 2016 conducted by the Corporate Governance Team some of the feedback regarding the Datix reporting system highlighted that the complexity of the Trust Datix incident reporting form could potentially be a barrier to incident reporting. Please see:

124. 20161028 Adverse Incident Survey Summary Report

7.38 The litigation team used a separate version of Datix to maintain their records and support reporting.

7.39 There was no Datix manager in the Trust to focus on the governance reports, IT did provide systems support. Datix provide some support at additional cos, however as the system was version 12.2.0.1 even the external support was required to make changes to the system encountered challenges in making changes.

7.40 There was limited data expertise within the Trust to assist with triangulation of data. The systems available made any triangulation of risk, incident, complaint, litigation, coronial information, and audit data almost impossible.

7.41 This limited the ability to make linkages and understand full risks in services. Lack of expertise in data analysis was also a challenge in ensuring the information produced articulated the risk and need for change.

7.42 Standards and Guidelines records were on an excel database which was not fit for purpose and made reporting challenging. Funding was not routinely available to facilitate the full implementation of NICE and other guidelines E-proformas were drafted to highlight the external barriers to

implementation but due to commissioning and ability to routinely access E proformas they did not always inform business cases and service development.

7.43 In relation to urology governance, at service level, including urology, the Head of Service and Clinical Director/Associate Medical Director would have had day-to-day responsibility for governance within their service area. The Associate Medical Director would have clinical expertise and oversight with the Head of Service providing operational/management support and expertise. The Associate Medical Director and Head of Service would both have been concerned with governance as clinical governance is a framework for continuously improving the quality of their services and safeguarding high quality of care. I do not recollect requests for data for the urology meetings, however information provided in weekly reports and to Governance Committees included urology information.

8. What is your overall view of the effectiveness of governance systems within –

1. Acute services generally, and

8.1 In 2018 the Directorates were asked to complete a Clinical and Social Care Governance Assurance Template, a number of weaknesses were identified (*please see 126a.-126b. 20181010 Clinical and Social Care Governance Assurance Template, A1*). This was submitted on 10/10/2018 to Dr Khan, Mrs Marshall, Mrs Gishkori and Dr Boyce (*126a.-126b. 20181010 Clinical and Social Care Governance Assurance Template, A1*)

8.2 In relation to overall view of the effectiveness of governance systems within Acute my view was that, as per the governance assurance template and the responses regarding the requirements for a clinical governance system in question 7, there were weaknesses, challenges and gaps in the governance system. The workforce resource and information systems impacted on the effectiveness of the governance systems.

2. Urology service in particular

8.3 Urology governance was within the urology operational team, I was not directly involved with the urology governance meetings. At service level, including urology, the Head of Service and Clinical Director/Associate Medical Director would have had day-to-day responsibility for governance within their service area. The Associate Medical Director would have clinical expertise and oversight with the Head of Service providing operational/management support and expertise. The Associate Medical Director and Head of Service would both have been concerned with governance as clinical governance is a framework for continuously improving the quality of their services and safeguarding high quality of care. I do not recollect requests for data for the urology meetings, however information provided in weekly reports and to Governance Committees included urology information.

Do you think the governance arrangements, overall, were and are fit for purpose?

8.4 In 2018 the Directorates were asked to complete a Clinical and Social Care Governance Assurance Template, a number of weaknesses were identified refer to (*please see 126a.-126b. 20181010 Clinical and Social Care Governance Assurance Template, A1*). This was submitted on 10/10/2018 to Dr Khan, Mrs Marshall, Mrs Gishkori and Dr Boyce.

8.5 Internal Audit reports reviewed Trust processes but would have included Acute Services systems and processes.

| 2016-17 | 2017-18 | 2018 -19 | 2019-20 |
|---|---|---|---|
| Risk Management Satisfactory compliance | Risk Management Satisfactory compliance | Risk Management Satisfactory compliance | Risk Management Satisfactory and compliance |

| | | | |
|--|--|---|--|
| Incidents – Acute Falls Satisfactory compliance | | Standards & Guidelines Limited compliance | Incidents – Medication Trust Satisfactory compliance Independent Sector Limited compliance |
|--|--|---|--|

8.6 In relation to overall view of the effectiveness of governance systems within Acute my view was that, as per the governance assurance template and the responses regarding the requirements for a clinical governance system in question 7 and 8, there were weaknesses, challenges and gaps in the governance system. The workforce resource and information systems impacted on the effectiveness of the governance systems.

9. What, in your opinion, could have improved the effectiveness of the governance structures and systems in place during your tenure?

9.1 In my opinion it would have been good to have a review of the Acute Governance Structures with recommendations on improvement required to ensure governance structures were fit for purpose.

9.2 The Governance Assurance Template did highlight weaknesses. At the time and now, in my opinion, additional staffing resource in the Acute Governance team to allow the development of governance structures and systems including audit for improvement and assurance would greatly assist. Specialist training to equip governance staff for their roles would have improved the effectiveness of governance structures and systems. Dedicated highly trained SAI chairs to facilitate timely completion of SAIs for learning. Improved IT systems such as Datix, the S&G database, audit tools and information systems would allow for timely reporting and triangulation of data.

10. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

10.1 As a reflective practitioner I can always identify areas of improvement in my personal practice. Timelines of reporting and oversight of actions were areas that cause me particular concern. Delays in completing SAI reviews and complaints responses will have caused particular distress to patients and/or their families.

10.2 As highlighted above there were weaknesses in the Acute Governance structures and outline in previous responses the resource within the Acute Governance team limited the ability to improve governance systems.

10.3 The timeliness of screening meetings would have been one way to improve timeliness of commencing reviews and identifying all learning. Improved reporting and monitoring systems would allow for improved reporting and triangulation of data to allow identification of risk.

10.4 The Trust still does not have the most recent upgrades to the Datix system. The new version of Datix has greater functionality. The functionality includes incident reporting and investigation modules, litigation modules, safeguarding modules, complaint modules, and risk modules. The newer versions have improved reporting and analytical tools. All the information on one system should allow for improved reporting, data analysis, and triangulation of data. This would allow for trend analysis, and risk identification and areas for improvement actions.

10.5 Operational and governance staffing resource and finance are required

to proactively and in a timely manner review incidents, identify risks and implement standards and guidelines such as NICE and GAIN allow the early implementation of best practice and thus reduce risks to patients and staff.

Within the governance team the resources available did not meet the demands of the service and the workload previously articulated answers above. The workforce capacity meant that development of more robust systems and processes could not be progressed. It was my personal impression that the operational work-load took precedence over the resource required for robust governance structures and governance team work load at the time. This led to delays in incident reviews and report writing, monitoring of action plans and implementation of work streams to address risks.

11.If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

11.1 In relation to this response my role was acute governance coordinator from my recollections I have no other views to state. I provided a number of documents for discovery, however having reviewed the questions in this document, the breadth of the questions means that there are some documents which I will need to provide in ongoing discovery.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone

numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

Signed: Trudy Reid

Dated: 16th May 2023

Section 21 Notice Number 6 of 2023**Witness: Trudy Reid****Index**

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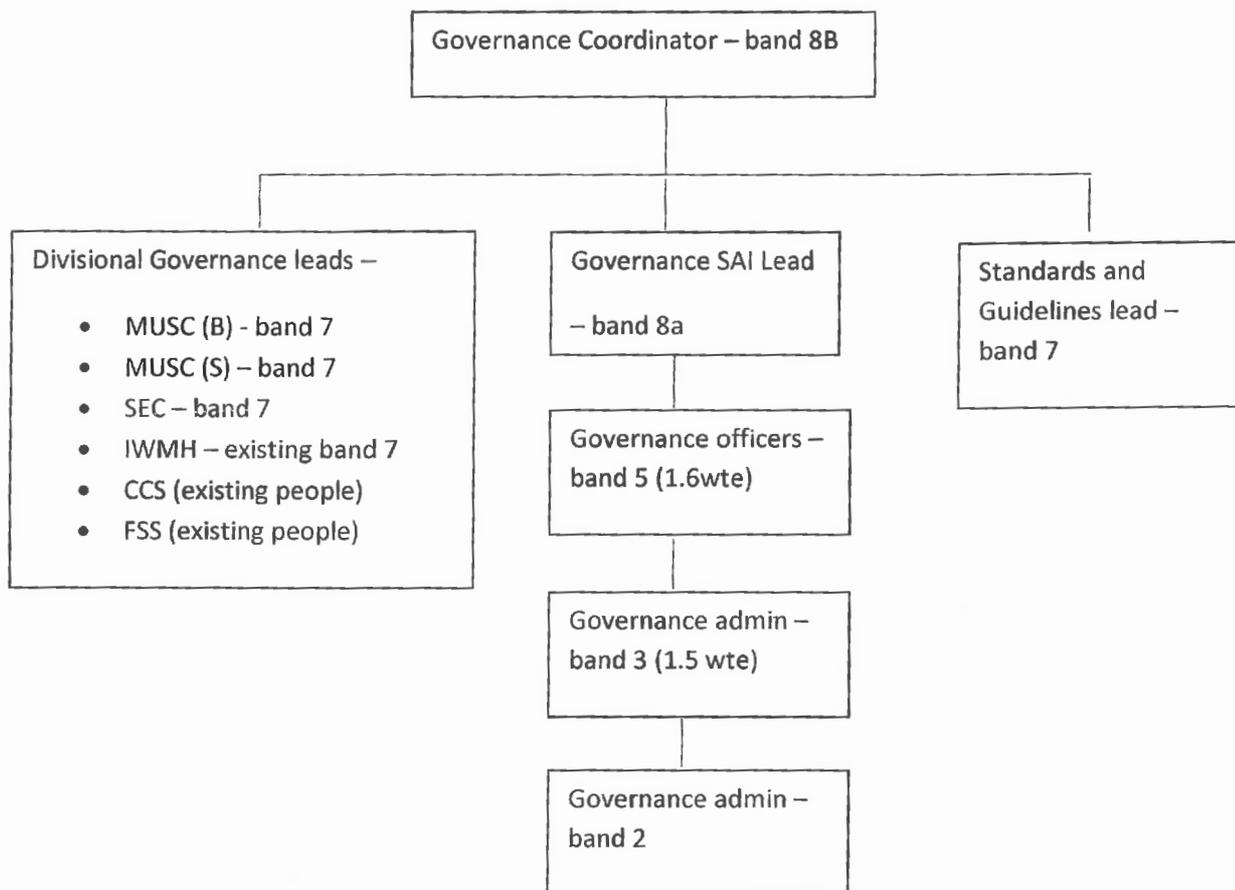
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| 74e. 20170616 Screening Uro 16 06 2017 A4 |
| 74f. 20170616 Screening Uro 16 06 2017 A5 |
| 74g. 20170616 Screening Uro 16 06 2017 A6 |
| 74h. 20170616 Screening Uro 16 06 2017 A7 |
| 81. 20170411 E re Expert Panel Members for SAI |
| 83. Appendix CONFIDENTIAL - DRAFT- Reports Dr Khan 27 09 2018 |
| 83a. Appendix CONFIDENTIAL - DRAFT- Reports Dr Khan 27 09 2018 A |
| 83b. Appendix CONFIDENTIAL - DRAFT- Reports Dr Khan 27 09 2018 A2 |
| 85a. 20180918 Standards and Guidelines Accountability Report |
| 85b. 20190806 Standards and Guidelines Accountability Report |
| 87a. Team work load 10 May 2017 |
| 87b. Team work load 10 May 2017 A1 |
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| 87d. Team work load 10 May 2017 A3 |
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| 89. Appendix TOR Acute Services Lead Nurse Midwife AHP and Radiographer Standards and Guidelines Forum |
| 93. 20180212 E to Dr Wright Re Urology SAI Queries |
| 97a. Appendix Action Plan email and action plan 06 15 2016 |
| 97b. Appendix Action Plan email and action plan 06 15 2016 |
| 99a. 20181029 Risk Register 10 29 2018 |
| 99b. 20181029 Risk Register 10 29 2018 A1 |
| 99c. 20181029 Risk Register 10 29 2018 A2 |
| 101a. 20181126 CRR to Governance Committee |
| 101b. 20181126 CRR to Governance Committee A1 |
| 103. Appendix Interview with Esther Gishkori 12.2.18 |
| 104a. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 |
| 104b. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A1 |
| 104c. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A2 |
| 104d. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A3 |
| 104e. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A4 |
| 104f. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A5 |
| 104g. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A6 |
| 104h. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A7 |
| 104i. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A8 |
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| 104k. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A10 |
| 104l. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A11 |
| 104m. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A12 |
| 104n. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A13 |
| 104o. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A14 |
| 104p. 20161208 FW Urgent Governance reports meeting with EG 08 12 2016 A15 |
| 105. Appendix 20160510 Approved Governance Minutes |
| 108. Table – Complaints by service area April2016 to January 2019 provided by the Acute Governance Team 1 |
| 109a. Appendix Acute Governance team 05 12 2017 work load |
| 109b. Appendix Acute Governance team 05 12 2017 work load A1 |
| 111a. 20161004 Delays in appointments diagnosis or treatment |
| 111b. 20161004 Delays in appointments diagnosis or treatment A1 |
| 113a. Tracey Heather and Barry meeting 30 09 2016 |
| 113b. Tracey Heather and Barry meeting 30 09 2016 |
| 114. Appendix Sign off RW Nov 2016 |

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| 115a. Delays 06 05 2017 tracey prior to meeting |
| 115b. Delays 06 05 2017 tracey prior to meeting A1 |
| 115c. Delays 06 05 2017 tracey prior to meeting A2 |
| 117. appendix 20170609 |
| 123a. appendix Mandatory training 09 05 2017 |
| 123b. appendix Mandatory training 09 05 2017 |
| 123c. appendix Mandatory training 09 05 2017 |
| 124. 20161028 Adverse Incident Survey Summary Report |
| 126a. 20181010 Clinical and Social Care Governance Assurance Template |
| 126b. 20181010 Clinical and Social Care Governance Assurance Template A1 |

Acute Governance Structure – for discussion



Roles and responsibilities

Governance Coordinator band 8B

- Corporate liaison
- Level 3 investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Level 2 investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Lessons learnt implementation
- Allocation of SAIs
- Development of reports for the Directorate and individual Divisions (numbers, trends, Trust Governance reports, etc
- Preparation of Agendas for AD and AMD governance meetings
- Quality assurance of SAI reports
- SAI screening process

Governance SAI lead – band 8A

- Level 2 SAI investigations – facilitation and preparation of the report in conjunction with the appointed chair and review team, family meetings, etc
- Maintenance of 'lessons' learnt database (SAIs, M&Ms, Safety Alerts, etc)
- Management of Governance Officers and Administration team
- Governance training (Datix, SAI process, etc)

Divisional Governance Leads – band 7

- Weekly review of divisions IR1 reports
- Liaison between ward manager and HOS re IR1s and their management
- Preparation of timelines for screening of potential SAIs
- Level 1 SEA investigations in their Division – facilitation, preparation of the report, family meetings, etc
- Attendance at Divisional Governance meetings, etc
- Implementation of lessons learned

Directorate Governance monthly meetings

Acute Clinical Governance (Friday am – includes AMDs)

- Continue as before in relation to draft SAI reports
- Ask other Directorates to send rep to meeting if they want an SAI report considered
- Bring lessons learned implementation problems/ issues?
- Agree what inputs S&G, corporate audit, etc will have to meeting

Acute Governance meeting (Tuesday pm – mainly ADs)

- Put the current 'reports presenters onto a quarterly cycle and ask them to email a monthly report to each Divisional meeting. For example
 - M1 = Complaints trend report and Risk Registers
 - M2 = Patient support trends and S&G report
 - M3 = Patient Safety initiative report and Corporate Audit report
- Devote remainder of meeting to implementation of learning
 - Divisional progress updates against lessons learnt database
 - Discussion of barriers to implementation
 - Setting up short task and finish groups for cross Directorate issues, etc
 - Consideration of audit results to measure implementation success
 - Etc
- Do we invite all governance band 7s as well as 8A and 8B, corporate nursing and AHP governance leads.
- What about medic input – done through existing Divisional meetings and Friday Am meeting?

| Date Commenced Post | Date Left Post | Contract Type | Position | Please see: |
|----------------------------|-----------------------|-------------------------------|--|---------------------------------------|
| 18/04/2005 | 31/07/2007 | Permanent | Infection Control Nurse Hgrade and band 7 | 2a. JD Senior Infection Control Nurse |
| 01/08/2007 | 30/09/2009 | Permanent | Lead Nurse Infection Control (8A) | 2b. JD Lead Infection Control Nurse |
| 01/10/2009 | 23/04/2012 | Permanent | HOS- General Surgery(8B) | 2c. JD 8B Head of General Surgery |
| 24/04/2012 | 01/01/2013 | Temporary Move to Higher Band | AD - Surgery and Elective Care (8C) | |

| | | | | |
|----------------|----------------|---------------------------------|---|---|
| 02/01/20 13 | 30/04/201 6 | Permanent | HOS-Trauma and Orthopaedics (8B) | |
| 01/05/201 6 | 06/01/201 9 | Permanent | Governance CoordinatorAcute Directorate (8B) | 1. Appendix File ACG structure 2016 |
| 07/01/20 19 | 31/07/202 2 | Permanent (Temp HigherBd) | Asst Dir Clin & Soc CareGov (8C) | |
| 23/03/20 20 | 01/08/202 2 | Permanent (Temp HigherBd) | Interim Assistant DirectorIPC (8C) | 2d. JD Interim Assistant Director Infection Prevention and Control |
| 01/08/20 22 | 31/12/202 2 | Permanent (Temp HigherBd) | Interim Director of Surgery & Elective Care, Cancer and Clinical Services and Integrated Maternity and Women's Health | 2e. Appendix xx Interim Director of Surgery & Elective Care, Cancerand Clinical Services and Integrated Maternity and Women'sHealth |
| 01/01/20 22 | | Permanent | Dir Of Medicine & Unscheduled Care Services | 2f. JD Director of Medicine and Unscheduled Care |

H504/67

CRAIGAVON AREA HOSPITAL GROUP TRUST**JOB DESCRIPTION****JOB TITLE:** Senior Nurse Infection Control Grade H**REPORTS TO:** Consultant Microbiologist**RESPONSIBLE TO:** Director of Nursing & Quality

JOB SUMMARY: The postholder is expected to provide advice and direction on all matters relating to Infection Control apart from those situations where medical advice is required, and to be accountable for Strategic Infection Control Policy development, implementation and monitoring on a Trust wide basis.

Core responsibilities include education and training/professional development and audit of infection control practices:

The post is to provide cover to the Craigavon Area Hospital Group Trust but may involve the provision of expert advice to other Health Care facilities within the Southern Health and Social Services Board.

DUTIES AND RESPONSIBILITIES**1.0 Clinical Responsibilities**

- 1.1 Co-ordinate the operation of a ward based laboratory liaison surveillance system, monitor alert infections and alert conditions and detect outbreaks of infection.
- 1.2 Identify outbreaks of infection within the Trust facilities and ensure that they are managed in accordance with the Trust's policies for the management and control of infection.
- 1.3 Take responsibility for the identification of sources and trends in infection patterns and ensure that those who take decisions on clinical matters are fully informed of this.
- 1.4 Analyse and collate relevant surveillance data on infection and ensure that this is recorded and communicated to those who have a legitimate interest.
- 1.5 Develop evidence based guidelines, procedures and protocols for the prevention and control of infection.
- 1.6 Provide highly specialised advice on infection prevention and control measures to all disciplines of staff within the Trust, the patient, their relatives and members of the public, as required.
- 1.7 Advise on the planning, implementation and evaluation of care for patients with infection and those who may be potentially exposed to infection.

- 1.8 Advise where required, on the specific care of individual patients with infection or those who may be at risk from it.
- 1.9 Take responsibility for the auditing of infection control practices and revising infection control standards.

2.0 Management Responsibilities

- 2.1 Ensure that the Trust's Infection Control Strategies are in keeping with the National Strategies for the Prevention and Control of Infection.
- 2.2 Develop an Annual Infection Control programme for the Trust which addresses all infection prevention and control activities on a priority basis, to ensure that the Trust will fulfill its commitment to prevent and control infection where this is possible.
- 2.3 Produce and review infection control policies for the Trust which are evidence based and reflect current knowledge and trends in Infection Control.
- 2.4 Oversee the implementation of these policies throughout the Trust and ensure that compliance with the policies is monitored.
- 2.5 Provide an infection control service to all disciplines of staff within the Trust ensuring that relevant service provision is available which is suited to the needs of the individual disciplines.
- 2.6 Develop and co-ordinate the presentation and content of education programmes on infection control within the Trust to medical, nursing, professionals allied to medicine and other groups as required.
- 2.7 Prepare staff for change and take responsibility for implementing this where matters relevant to infection control are concerned.
- 2.8 Provide expert infection control advice for all disciplines of staff throughout the Trust.
- 2.9 Provide expert advice on the infection control implications of external contractors i.e. catering, cleaning and commissioning of new facilities with the Trust.
- 2.10 Provide expert advice on guidance to strategic development within the Trust.

3.0 Research

- 3.1 Ensure that all Trust infection control policies are evidence based.
- 3.2 Ensure that all research relevant to infection control is critically analysed and applied to practice.
- 3.3 Initiate and develop research matters within the Infection Control Department.

4.0 Professional Development

- 4.1 Ensure that knowledge and skills are up to date.
- 4.2 With reference to new infections, knowledge must be acquired and disseminated to other professional groups to ensure the safety of both staff and patients.
- 4.3 Act as a supervisor for the purpose of clinical supervision of other infection control nurses and others.
- 4.4 Contribute towards the professional development of nurses and other professional groups by advising on curriculum development and delivery in association with universities and other education providers.

GENERAL REQUIREMENTS

The postholder must:

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and report any accidents/incidents, defects with work equipment or inadequate safety arrangements to his/her manager.
- Comply with Trust's policy on smoking.
- Treat those with whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

January 2005

Lead Infection Control Nurse

Ref: 88207132

Closing Date: 04 July 2007 12:00

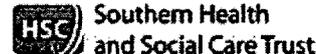
Location: To be confirmed

Contract: Permanent

Salary: Band 8A (£34,048 - £42,278)

Hours: Full-time / Job Share

Interview Dates: To be confirmed



Job Description:

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: Lead Infection Control Nurse

REPORTS TO: Director of Infection Control & Prevention

ACCOUNTABLE TO: Assistant Director of Cancer & Clinical Services

Job Summary

To manage and develop the Trust's Infection Control Nursing service, and in conjunction with the Director of Infection Prevention and Control to have overall and continuing responsibility for developing, planning & implementing infection control strategies to reduce risk of healthcare-care associated infection to patients, staff and visitors.

Main Duties & Responsibilities

- Provide highly specialised advice and information on infection prevention and control to all relevant stakeholders regarding the care of patients.
- Plan and develop training & education to ensure the delivery of appropriate specialised Infection Control information to all.
- Responsible, with Director of Infection Prevention and Control, for the development of evidence based infection control policies, their implementation and monitoring across the whole Trust.
- Responsible for the audit and surveillance of Healthcare Associated Infections [HAI's] and related issues.
- Responsible for the maintenance of and development of links with internal and external stakeholders to promote the reduction of HAI's.
- Responsible, with Director of Infection Prevention and Control, for setting and monitoring standards in infection prevention and control.
- Responsible for organizing and participating in the on call Infection Control Nurse rota.

Responsibility for Patient Care

1. Responsible for the provision of highly specialised verbal and written information or advice to patients, staff and others about sometimes sensitive and confidential infection control issues.
2. Responsible for analysing and rigorously reviewing all aspects of the patients' programmes of care, interpreting information and using knowledge and judgement to provide highly specialist advice to recommend a new course of action where necessary
3. Responsible for maintaining accurate and legible patient notes in accordance with Trust and national professional policies and guidelines.

Responsibilities for Human Resources

1. Responsible for the supervision & management of the Infection Control Nursing Team.
2. Responsible for annual appraisals using the KSF framework, supporting personal development of staff through induction and training, allocation of responsibilities and workload.
3. Responsible for recruitment of new team members as required.
4. Responsible for training and education of all staff across the Trust on infection prevention and control issues through Induction and annual updates.
5. Assess, identify and evaluate own specialist knowledge and practice needs in relation to knowledge and skills required to meet the demands of the job.
6. Understand own role and scope, identify own development needs and take responsibility for their continuing professional development and performance whilst maintaining a personal development plan.
7. Work with others to develop, identify and implement appropriate learning opportunities and apply learning to practice and any future developments.
8. Reflect on overall learning and development opportunities in order to improve learning strategies and opportunities and how this can contribute to the development of services and the organisation.
9. Provide specialist advice at a strategic level to develop specialist practice across professional and organisational boundaries e.g. regional/national working groups, informing national policy.

Responsibilities for Physical and Financial Resources

1. Responsible for giving advice to the Trust on the appropriate use of financial resources to facilitate the reduction and prevention of HAI's, in relation to:
 - the purchase and supply of equipment,
 - the planning and development of buildings and facilities,
 - the tendering process for support services relevant to Infection Prevention and Control.
2. Responsible for ensuring efficient and effective use of material resources/supplies within the team
3. Monitor, control and store resources/supplies according to the requirements and specifications of the clinical environment
4. Be a member of the Trust Medical Devices Group, reviewing products to ensure both quality and cost effectiveness.
5. Provide highly specialist advice on capital developments in relation to infection control, to ensure appropriate facilities reduce the risk of healthcare associated infection.

Communications

1. Responsible for the communication of verbal and written reports to appropriate committee's, managers, and staff within the Trust, at all levels, on all issues pertaining to Infection Prevention and Control.
2. Responsible for drawing attention of appropriate managers to risks which pose a danger to patients, staff, visitors or the Trust. These issues may be complex and highly sensitive in nature.
3. Use well developed persuading, negotiating, interpersonal skills in relation to sensitive or contentious information to a wide range of staff. To appreciate the operational issues, which may result, and work to minimise disruption to service provision as a result of infection control issues.

Leadership

1. Profile leadership in the area of infection control to all Trust staff
2. Responsible for inspiring others and encouraging them to seek advice and solutions to problems
3. Challenge others to take an active part in developing knowledge, ideas and work practice
4. Challenge tradition and take risks accepting joint responsibility for any arising problems and tensions and using these to inform future practice
5. Utilises networking and political awareness to develop the service
6. Responsible for promoting the service and disseminating good practice both internal and external to the Trust.

Policy and Service Development

1. Responsible for the development of evidence based infection control policies for the whole Trust. Support the implementation & monitoring of these policies. Disseminate sometimes highly complex information to all levels of staff and contractors about these policies.
2. Work in partnership with the Director of Infection Prevention and Control and others to define and clarify the strategic direction of the infection control service and any areas for potential service improvement.
3. Engage all interested parties/users of the service in the planning of service development in partnership with the organisation(s)
4. Liaise with the Microbiology laboratory, Consultant in Communicable Disease Control, Communicable Disease Surveillance Centre/Health Protection Agency and DHSSPS to ensure a robust infection control service.
5. Adhere to Trust policies, procedures and current legislation which relate to own workplace and contribute to service development.
6. Contribute to future service design from identification to implementation of service development projects.
7. Appraise draft policies and strategies for their effect on the service and make recommendations for service improvement.
8. Identify outcomes of service evaluation and offer constructive views on how they should change as a result.
9. Develop specialist protocols, standards and guidelines in own specialist area and propose policy of service changes which impact beyond own area of activity.

10. Evaluate with others the effectiveness of any changes and how these have improved services.

Planning and organising

1. Responsible for the planning and organisation of the workload of the Infection Control Nursing team.
2. Responsible with Director of Infection Prevention and Control , for the development of the Infection Prevention and Control annual programme, annual report and infection control reduction plan with relevant stakeholders, internal & external to the Trust.
3. Responsible with Director of Infection Prevention and Control, for organizing Infection Prevention and Control committees.
4. Responsible for developing strategic plans for the infection control service, adjusting as necessary.
5. Responsible for planning and leading specialist nursing service provision including education and training.
6. Present complex information to people at corporate level in relation to service requirements where there are identified issues with efficiency and effectiveness.
7. Monitor progress of work recognising changing priorities and implement corrective actions where necessary.

Analysis and data management

1. Responsible for the development and management, in conjunction with relevant stakeholders, of systems which allow the Trust to understand the Infection Control issues that are relevant.
2. Responsible for the collection, analysis and dissemination of surveillance and audit information relating to Infection Prevention and Control across the Trust and externally, where appropriate.
3. Monitor the incidence of hospital acquired infection and collaborate with the Director of Infection Prevention and Control.
4. Identify, interpret and analyse highly complex situations and utilise judgemental skills across a range of options
5. Monitor, review and update targeted surveillance of infections ensuring relevant information is relayed to clinicians to influence practice and minimise risk.
6. Produce an annual report on Infection Control to the Director of Acute Services.

Research, Development and Audit

1. Initiate and develop research projects in response to identified needs.
2. Keep up to date and act consistently with quality standards and guidelines within their own clinical area and associated areas.
3. Alert others to new developments and lead them in understanding how their practice should change to improve quality.
4. Audit, evaluate and review the quality of their own work and others, and where necessary make the appropriate improvements.
5. Lead on audit programmes in relation to infection control practice, knowledge and the environment across the Trust.

6. Understand the quality agenda and how standards of care can be maintained utilising current quality systems and standards.
7. Identify and investigate poor quality and performance promptly, identify contributing factors and agree methods for addressing them.
8. Inform and influence Clinical Governance issues.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS code of conduct.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Assistant Director of Cancer and Clinical Services / Director of Infection Control & Prevention.

Personnel Specification:

PERSONNEL SPECIFICATION

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health & Social Care Trust and:

- Be currently a registered nurse (part 1)
- Have a University degree and worked for at least 2 years in a senior Infection Control role*.
OR
- Have worked for at least 5 years in a senior Infection Control role*.

AND

- Delivered against challenging performance objectives for a minimum of 2 years in the last 6 years meeting a range of key targets and making significant** improvements.
- Worked with a diverse range of stakeholders internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- A proven track record of governance and organisational skills for a minimum of 2 years in the last 6 years.
- A full current driving licence with access to a car or a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at nhsleadershipqualities.nhs.uk.

Particular attention will be paid to the following:

- Self Belief
- Self Management
- Seizing the Future
- Drive for Results
- Leading Change Through People
- Holding to Account
- Effective and Strategic Influencing

**"senior role" is defined as experience gained at Grade G or above.

**"significant" is defined as contributing directly to key corporate objectives of the organisation.

June 2007

**Other
Information:**

Downloads: [SHSCT rpa + pocva](#)

Instructions: [Instructions for Completing Application Form](#)

73209162

**JOB DESCRIPTION**

| | |
|-------------------------|---|
| JOB TITLE | Head of General Surgery |
| BAND | 8B |
| DIRECTORATE | Acute |
| INITIAL LOCATION | To Be Confirmed |
| REPORTS TO | Assistant Director of Surgery & Elective Care |

JOB SUMMARY

- To be responsible for the operational management and strategic development of General Surgery services across the Southern Trust.
- To be responsible for leadership, service provision and service development of General Surgery services and ensuring high quality patient centred services.
- To be responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets.
- To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Division's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources.
- As a head of service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives.

KEY DUTIES / RESPONSIBILITIES**1. Quality & Governance**

- 1.1 Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.
- 1.2 Be committed to supporting honest, open communication and effective multi-disciplinary working.
- 1.3 Develop appropriate mechanism/forums for accessing the views of and

engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

- 1.4 Support the Assistant Director with the implementation of quality initiatives such as Investors in People and Charter Standards.

2. Leading & People Management

- 2.1 Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.
- 2.2 Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.
- 2.3 Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.
- 2.4 Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.
- 2.5 Ensure the division implements and adheres to Trust HR policies and procedures.
- 2.6 Work in partnership with Trade Unions and staff representatives in developing the workforce, managing employee relations and changing working practices.

3. Service Delivery

- 3.1 Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.
- 3.2 Support the Assistant Director in achieving key access and performance targets for each service through robust planning and service improvement.
- 3.3 Make sure that services are delivered to the standard and quality expected by the DHSSPS, Regional Authority and by the Trust Board.
- 3.4 Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.
- 3.5 Identify and contribute to local and national development initiatives e.g. clinical networks and national programmes.
- 3.6 Make sure that all recommendations arising from RQIA inspections are implemented in a timely manner.

- 3.7 Act as a member of the division's senior management team and contribute to its policy development processes.
- 3.8 Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.
- 3.9 Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

- 4.1 Assist with the development of the strategic plan for the delivery of operational services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSSA priorities.
- 4.2 Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic planning initiatives and targets.
- 4.3 Work with members of relevant teams on the innovative development of new and existing services.

5. Financial & Resource Management

- 5.1 Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.
- 5.2 Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.
- 5.3 Participate in contract and service level negotiations with commissioners.
- 5.4 Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.
- 5.5 Update and monitor the operational policies of the Division and take account of risk management needs.
- 5.6 Ensure procedures are in place to report, investigate and monitor clinical incidents putting action in place to address areas of concern.

- 5.7 Ensure that environmental standards are appropriate for safe & clean care delivery.

6. Information Management

- 6.1 Ensure the effective implementation of all Trust information management policies and procedures within the Division.
- 6.2 Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

7. Corporate & Divisional Responsibilities

- 7.1 Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Elective Services.
- 7.2 Attend meetings of the Trust Board, its' committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/ Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.
- 7.3 Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the directorate's management team.
- 7.4 Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.
- 7.5 Participate in and comply with requirements in the production of performance reports.
- 7.6 Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, and codes of conduct, operations and accountability.
- 7.7 Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.
3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.
4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.



Southern Health
and Social Care Trust

PERSONNEL SPECIFICATION

| | | |
|--------------------|---|------------------|
| JOB TITLE | Head of General Surgery Band 8B | |
| DIRECTORATE | Acute Services | |
| SALARY | £44,258 – £54,714 per annum pro rata | |
| HOURS | 37.5 per week (Job share may be considered) | |
| Ref No: | 73209162 | June 2009 |

Notes to applicants:

1. You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE / SKILLS

1. Hold a relevant¹, University Degree or recognised Professional Qualification or equivalent qualification **AND** Two years experience in a Senior Role² **OR** Have at least 5 years experience in a Senior Role².
2. Have a minimum of 1 years experience in a lead role delivering

¹ 'relevant' will be defined as a business or health related field

² 'Senior Role' is defined as Band 7 or equivalent or above.

objectives which have led to a significant³ improvement in service.

3. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant³ change initiative.
4. Have a minimum of 2 years experience in staff management.
5. Hold a full current driving license valid for use in the UK and have access to a car on appointment⁴.

The following are essential criteria which will be measured during the interview stage

6. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources.
7. Have an ability to provide effective leadership.
8. Demonstrate evidence of highly effective planning and organisational skills.
9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

INTERVIEW ARRANGEMENTS – FOR NOTING BY ALL CANDIDATES

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at www.nhsleadershipqualities.nhs.uk Particular attention will be given to the following competencies:

- *Self Belief*
- *Self Management*
- *Drive for results*
- *Holding to account*
- *Seizing the future*
- *Leading change through people*
- *Effective and strategic influencing*

³ 'Significant' is defined as contributing directly to key Directorate objectives

⁴ This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Informal enquiries to: Email: [Personal Information redacted by the USI]

Tel: [Personal Information redacted by the USI]

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

ROLE DESCRIPTION

| | |
|-------------------------|---|
| JOB TITLE | Interim Assistant Director Infection Prevention and Control |
| BAND | Band 8c |
| DIRECTORATE | Medical Directorate |
| INITIAL LOCATION | Craigavon Area Hospital |
| REPORTS TO | Medical Director |
| ACCOUNTABLE TO | Chief Executive |

JOB SUMMARY

The post holder will provide expert clinical advice and leadership for the infection control service on behalf of the Medical Director to ensure service users are protected from the risk of acquiring infection and sustaining an environment in which excellence in care can flourish. To deliver this the post holder will work closely with Trust Directors, Executive Director of Nursing, Senior Medical staff, Heads of Departments and Link Practitioners for Infection Prevention and Control.

The post holder will provide challenge to inappropriate healthcare hygiene practice, and will be responsible for the development and implementation of strategy, policies and plans for the infection prevention and control service for the Trust. The post holder will actively promote strategies to raise awareness of infection control and decontamination issues within the Trust.

KEY DUTIES / RESPONSIBILITIES

1. Act as the Trust expert and clinical lead for infection prevention and control, providing expert advice to clinicians, managers and other staff to manage infectious outbreaks and other untoward incidents
2. Review, develop and implement a strategy and policies for Infection Prevention and Control across the organisation
3. Responsible for providing infection control and prevention input in the procurement of specialist equipment
4. Provide expert advice on equipment decontamination issues and work closely with managers to support comprehensive Decontamination audits
5. Ensure delivery of an annual programme of infection control audits, advising on the use of suitable audit tools for local audits and regularly undertaking major audits

using appropriate research tools, analysing and evaluating the outcomes and ensuring change in practice as required

6. Lead on the monitoring of the incidence of health-related infection, management of outbreaks, investigation of hazardous practice, complaints and Serious Adverse Incidents relating to infection control
7. Lead on the interpretation of national policy relating to infection prevention and control, which will be adapted to local level and monitor the implementation of these policies
8. Work in partnership with the Department of Health, Public Health Agency, Health and Social Care Board and other partner organisations for the prevention and control of infection and management of communicable infections
9. Work in partnership with the Department of Health, Public Health Agency, Health and Social Care Board other agencies and organisations to identify gaps in service and interventions in relation to infection prevention and control, and in identifying trends in infection diseases
10. Produce infection prevention and control reports outlining progress with the Key Performance indicators identified in the annual plan

Setting Direction and Leadership

11. On behalf of the Medical Director provide IPC specialist advice to Trust Senior Management Team, COVID Bronze Group and COVID Bronze operational group
12. Provide leadership, guidance and oversight on the activities of the IPC team
13. Liaise with Secondary and Primary care colleagues, including General Practitioners to advise on COVID 19 care pathways with the goal of a coordinated pathway for service users
14. Liaise with Silver command group and escalate issues from a local level as appropriate

Personal Protective Equipment (PPE)

15. Interpret national and regional guidance on application of PPE for Trust staff
16. Provide guidance to Trust staff on appropriate PPE relevant to each clinical setting
17. Provide advice to the Director of Finance who has responsibility for PPE procurement on PPE in line with requirements in national and regional guidance
18. Represent the Trust/medical director on regional workgroups on regional management of current and future PPE strategies and usage

Secondary Care Support

19. Oversee the provision of IPC advice and training to Trust teams who provide services within secondary care
20. Oversee the provision of advice to clinical teams who are designing new patient pathways and services in the context of COVID
21. Oversee the provision of IPC advice to secondary care staff



Social Care Support

22. Oversee the provision of IPC advice and training to Trust teams who provide services within the community
23. Where appropriate as directed by DOH, support the Public Health Agency in the provision of IPC advice to independent sector providers
24. Oversee the monitoring and intelligence relating to Southern Area care homes to inform a proactive IPC response to potential and actual community COVID outbreaks

Screening, Testing and Contact Tracing

25. Interpret national and regional guidance on provision of screening and testing arrangements
26. Oversee local Trust implementation of regional screening, testing and contact tracing programmes
27. Represent the Trust/medical director on regional workgroups on regional screening, testing and contact tracing



Job Description

JOB TITLE Interim Director of Surgery & Elective Care, Integrated Maternity & Women’s Health, and Cancer & Clinical Services

LOCATION Trust Headquarters, Craigavon Area Hospital

REPORTS TO Chief Executive

JOB SUMMARY

The post-holder will be a member of the Trust’s Senior Management Team and Trust Board and will be accountable to the Chief Executive for leading the delivery of safe, effective and high quality services within the portfolio of the Directorate. The Trust is committed to a collective approach to leadership at all levels. S/he will play a key strategic role in leading and managing the acute services within their portfolio, in line with the principles and regional strategic direction for health and social care.

As a Director, the post-holder will be an effective and influential ambassador for the Trust. S/he, working collaboratively with other Director colleagues, will provide transformational leadership and drive in delivering improved integration of acute and primary care/community services.

The Director will be a strong upholder of the Trust’s values and provide exemplary and visible leadership. S/he will inform and shape Trust strategies, support the communication and consultation on such strategies, share corporate responsibility for the achievement of the Trust’s corporate objectives and for driving forward a culture of safe, high quality care, innovation, learning for improvement, development and modernisation.

As a member of the Trust’s Senior Management Team, the Director will take lead responsibility for corporate issues outside their immediate sphere of responsibility. S/he will work alongside Director colleagues to ensure a cohesive, multidisciplinary and dynamic senior team.

PORTFOLIO OF SERVICES (OVERALL BUDGET - £147M : WORKFORCE – c2,200)

| SERVICES | |
|---|---|
| <ul style="list-style-type: none"> • Critical Care • Theatres & Recovery (Elective & Emergency) • Surgical Wards & Outpatients • Ambulatory services • Cancer Services | <ul style="list-style-type: none"> • Clinical Services including Laboratories, Radiology & Audiology • Integrated Maternity & Women’s Health – wards / outpatient / ambulatory services |

KEY RESULT AREAS**SERVICE DELIVERY**

1. Act as an ambassador representing the Trust on regional work streams, which will include influencing policy direction, contributing to and / or leading on strategic development, implementation, review and evaluation of plans for modernising and reshaping of services within the remit of the Directorate.
2. Provide strong strategic and operational collective leadership and management to all clinical and non-clinical services and staff across the Directorate with a clear focus on patient safety and experience, clinical governance and person centred care.
3. Lead the development and implementation of the Directorate's strategic plan in line with the Trust's Corporate Plan, Health and Wellbeing 2026 - Delivering Together and other key strategic reforms.
4. Work collaboratively with regional colleagues to strengthen the achievement of scale and spread of evidenced based local service improvement models. Seize opportunities for Trust participation in the testing of prototypes / pilots that will enable innovation to inform further system wide learning.
5. Influence and work collaboratively with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.
6. Work closely with other Directors to ensure efficient patient flows into, through and out of acute hospital care, including the effective management of discharge planning in liaison with community services.

QUALITY, GOVERNANCE & PERFORMANCE

7. Ensure that the needs of patients are at the core of how the Directorate delivers its services and are in accordance with DOH Quality Standards for Health and Social Care and other relevant requirements. This will include driving up the quality of care, improving outcomes and enhancing the patient experience in line with the principles for change contained in Health and Wellbeing 2026: Delivering Together.
8. Lead and be accountable for ensuring excellent standards of governance in the Directorate to include compliance with all relevant professional requirements and standards, safeguarding policies and procedures, clinical audits, the assessment and management of risk and the implementation of all relevant learning and best practice from Inquiries, Royal Colleges, Standards and Guidelines etc.

9. Ensure ongoing, critical evaluation of the Directorate's performance, taking corrective action as required, to maximize performance against specific Objectives & Goals for Improvements (OGIs) and agreed trajectories for improvement.
10. Ensure the management of complaints and SAIs within the Directorate comply with DOH and Trust complaints procedures / SAI procedures and are underpinned by candour, transparency and a culture of continuous improvement.

SERVICE MODERNISATION & ORGANISATIONAL DEVELOPMENT

11. "Horizon scan and plan" and lead on the Directorate's response to strategic and cross cutting issues so as to ensure the Trust is best placed to meet future challenges and meet need.
12. Identify and drive the necessary changes to culture and practice within the Directorate to support the strategic and transformational agenda and ensure the focus for transformation is understood, accepted and delivered.
13. Lead the development and implementation of workforce modernisation initiatives.

LEADERSHIP AND PEOPLE MANAGEMENT

14. Provide exemplary and visible leadership and promote a strong positive model of valuing staff, effective communication and engagement so as to enable staff to perform to the best of their abilities to deliver high quality care and support and be involved in the transformation agenda.
15. Promote and maintain highly positive working relationships with trade union colleagues and ensure effective engagement with them in planning for and implementing service reforms and changes.
16. Ensure that management structures and practices in the Directorate are fit for purpose and support a culture of effective team working, collective leadership, continuous improvement and innovation, always striving to remain focused on person-centred care for citizens of the Trust's area.
17. Ensure the effective implementation of all Trust people management policies in the Directorate and the achievement of all relevant targets such as relating to corporate mandatory training, personal development plans, the management of sickness and absenteeism, turnover etc.
18. Ensure the Directorate has a robust workforce strategy to enable all service changes and plans.
19. Ensure the effective management of staff health and safety and support in the Directorate.

20. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.
21. Maintain staff relationships and morale amongst the staff reporting to him/her.
22. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
23. Participate, as required, in the selection and appointment of staff in accordance with procedures laid down by the Trust.
24. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

FINANCIAL & RESOURCE MANAGEMENT

25. Be accountable for the management of the Directorate's budget (pay and non pay) and the meeting of all financial targets by each division and service.
26. Ensure the effective implementation of all Trust financial policies and procedures in the Directorate, which include ensuring the safe custody of patients' property and the use of endowments and gifts.
27. Lead and be accountable for the effective management, use and maintenance of all physical assets in the Directorate.

CORPORATE & COLLECTIVE LEADERSHIP

28. Demonstrate exemplary standards of corporate leadership and share a collective responsibility for all Trust corporate decisions, initiatives and the effective implementation of same.
29. Actively promote a culture of collective leadership within the Trust, and across organisational boundaries, in line with the *HSC Collective Leadership Strategy*.
30. Be accountable for the delivery of the Trust's "Our People Framework" within their Directorate as a means to support the delivery of strategic objectives and to continually improve the skills, capabilities and engagement of the workforce within the Directorate.
31. Share a collective responsibility for the Trust's financial performance and the achievement of all quality, safety and other legislative requirements.
32. Share a collective responsibility for the Trust's overall corporate governance processes to include the implementation of an integrated governance framework

that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

33. Lead by example, to ensure the Trust demonstrates respect through its culture and actions, for all aspects of diversity in the population it serves and the staff who provides the services.
34. Share a collective responsibility for the Trust's corporate planning, policy and decision making processes as a member of the Directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
35. Continually strive to develop self and improve capability in the leadership of the Trust and its staff.
36. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC Staff.
37. Participate in the Director on-call rota.

RAISING CONCERNS - RESPONSIBILITIES

38. Promote and support effective team working, fostering a culture of openness and transparency.
39. Ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.
40. In the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

EMERGENCY PLANNING AND BUSINESS CONTINUITY

41. Lead on the development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004 and the General Data Protection Regulations (GDPR). Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.
7. Take responsibility for his/her own ongoing learning and development, including full participation in Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
8. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Chief Executive.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION

JOB TITLE Interim Director of Surgery & Elective Care, Integrated Maternity & Women's Health, and Cancer and Clinical Services

ESSENTIAL CRITERIA

The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the selection / interview stage. You must therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted.

| Factor | Criteria |
|-----------------------------------|---|
| Qualifications/ Experience | <ol style="list-style-type: none"> 1. Currently working as Assistant Director or on the Assistant Director On-Call in Acute Services Directorate OR working as Assistant Director in Older People & Primary Care Directorate 2. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant¹ subject. 3. A minimum of two years' experience in a senior management² role in a major complex organisation³ |
| Other | <ol style="list-style-type: none"> 4. Hold a full current driving licence valid for use in the UK and have access to a car on appointment⁴. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. |

Selection / Interview stage

Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the *NHS Leadership Academy Healthcare Leadership Model*. Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role.

¹ **'relevant subject'** will be interpreted to mean any business, administrative, corporate function or health related qualification.

² **'senior management'** is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation.

³ **'major complex organisation'** is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders.

⁴ This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Notes to applicants:

- 1. We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;*
- 2. You must clearly demonstrate on your application form how you meet each of the required criteria – failure to do so will result in you not being shortlisted.*
- 3. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn.*

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trust's Smoke Free Policy

Director of Medicine & Unscheduled Care Services



Working together



Excellence



Openness & Honesty



Compassion

JOB DESCRIPTION

JOB TITLE **Director of Medicine & Unscheduled Care Services**

INITIAL LOCATION Trust Headquarters
Craigavon Area Hospital

REPORTS TO **Chief Executive**

JOB SUMMARY

The post-holder will be a member of the Trust's Senior Management Team and Trust Board and will be accountable to the Chief Executive for leading the delivery of safe, effective and high quality services within the portfolio of the Directorate. The Trust is committed to a collective approach to leadership at all levels. S/he will play a key strategic role in leading and managing the acute services within their portfolio, in line with the principles and regional strategic direction for health and social care.

As a Director, the post-holder will be an effective and influential ambassador for the Trust. S/he, working collaboratively with other Director colleagues, will provide transformational leadership and drive in delivering improved integration of acute and primary care/community services.

The Director will be a strong upholder of the Trust's values and provide exemplary and visible leadership. S/he will inform and shape Trust strategies, support the communication and consultation on such strategies, share corporate responsibility for the achievement of the Trust's corporate objectives and for driving forward a culture of safe, high quality care, innovation, learning for improvement, development and modernisation.

As a member of the Trust's Senior Management Team, the Director will take lead responsibility for corporate issues outside their immediate sphere of responsibility. S/he will work alongside Director colleagues to ensure a cohesive, multidisciplinary and dynamic senior team.

PORTFOLIO OF SERVICES**(OVERALL BUDGET - £137M : WORKFORCE – c2,100)**

| SERVICES | |
|--|--|
| Acute Medical Wards & Outpatients | Non-Acute Hospitals |
| Hospital Social Work | Pharmacy & Medicines Management |
| Emergency Departments, Urgent Care Centre & GP Out of Hours services | AMU, Ambulatory and Patient Flow Teams |
| Allied Health Professionals | |

KEY DUTIES / RESPONSIBILITIES**SERVICE DELIVERY**

1. Act as an ambassador representing the Trust on regional work streams, which will include influencing policy direction, contributing to and / or leading on strategic development, implementation, review and evaluation of plans for modernising and reshaping of services within the remit of the Directorate.
2. Provide strong strategic and operational collective leadership and management to all clinical and non-clinical services and staff across the Directorate with a clear focus on patient safety and experience, clinical governance and person centred care.
3. Lead the development and implementation of the Directorate's strategic plan in line with the Trust's Corporate Plan, Health and Wellbeing 2026 - Delivering Together and other key strategic reforms.
4. Work collaboratively with regional colleagues to strengthen the achievement of scale and spread of evidenced based local service improvement models. Seize opportunities for Trust participation in the testing of prototypes / pilots that will enable innovation to inform further system wide learning.
5. Ensure collaborative working with primary care providers, GP Federations, commissioners, user groups and the voluntary and independent sectors in the design and delivery of services in order to inform service improvement.

Quality Care - for you, with you

6. Influence and work collaboratively with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.
7. Work closely with other Directors to ensure efficient patient flows into, through and out of acute hospital care, including the effective management of discharge planning in liaison with community services.

QUALITY, GOVERNANCE & PERFORMANCE

8. Ensure that the needs of patients are at the core of how the Directorate delivers its services and are in accordance with DOH Quality Standards for Health and Social Care and other relevant requirements. This will include driving up the quality of care, improving outcomes and enhancing the patient experience in line with the principles for change contained in Health and Wellbeing 2026: Delivering Together.
9. Lead and be accountable for ensuring excellent standards of governance in the Directorate to include compliance with all relevant professional requirements and standards, safeguarding policies and procedures, the assessment and management of risk and the implementation of all relevant learning and best practice, including from Inquiries, Royal Colleges and Standards and Guidelines etc.
10. Ensure ongoing, critical evaluation of the Directorate's performance, taking corrective action as required, to maximize performance against specific Objectives & Goals for Improvements (OGIs) and agreed trajectories for improvement.
11. Ensure the management of complaints and SAIs within the Directorate comply with DOH and Trust complaints procedures / SAI procedures and are underpinned by candour, transparency and a culture of continuous improvement.

SERVICE MODERNISATION & ORGANISATIONAL DEVELOPMENT

12. "Horizon scan and plan" and lead on the Directorate's response to strategic and cross cutting issues so as to ensure the Trust is best placed to meet future challenges and meet need.

Quality Care - for you, with you

13. Identify and drive the necessary changes to culture and practice within the Directorate to support the strategic and transformational agenda and ensure the focus for transformation is understood, accepted and delivered.
14. Lead the development and implementation of workforce modernisation initiatives.

LEADERSHIP AND PEOPLE MANAGEMENT

15. Provide exemplary and visible leadership and promote a strong positive model of valuing staff, effective communication and engagement so as to enable staff to perform to the best of their abilities to deliver high quality care and support and be involved in the transformation agenda.
16. Promote and maintain highly positive working relationships with trade union colleagues and ensure effective engagement with them in planning for and implementing service reforms and changes.
17. Ensure that management structures and practices in the Directorate are fit for purpose and support a culture of effective team working, collective leadership, continuous improvement and innovation, always striving to remain focused on person-centred care for citizens of the Trust's area.
18. Ensure the effective implementation of all Trust people management policies in the Directorate and the achievement of all relevant targets such as relating to corporate mandatory training, personal development plans, the management of sickness and absenteeism, turnover etc.
19. Ensure the Directorate has a robust workforce strategy to enable all service changes and plans.
20. Ensure the effective management of staff health and safety and support in the Directorate.
21. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.
22. Maintain staff relationships and morale amongst the staff reporting to him/her.

Quality Care - for you, with you

23. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
24. Participate, as required, in the selection and appointment of staff in accordance with procedures laid down by the Trust.
25. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

FINANCIAL & RESOURCE MANAGEMENT

26. Be accountable for the management of the Directorate's budget (pay and non pay) and the meeting of all financial targets by each division and service.
27. Ensure the effective implementation of all Trust financial policies and procedures in the Directorate, which include ensuring the safe custody of patients' property and the use of endowments and gifts.
28. Lead and be accountable for the effective management, use and maintenance of all physical assets in the Directorate.

CORPORATE & COLLECTIVE LEADERSHIP

29. Demonstrate exemplary standards of corporate leadership and share a collective responsibility for all Trust corporate decisions, initiatives and the effective implementation of same.
30. Actively promote a culture of collective leadership within the Trust, and across organisational boundaries, in line with the *HSC Collective Leadership Strategy*.
31. Be accountable for the delivery of the Trust's "Our People Framework" within their Directorate as a means to support the delivery of strategic objectives and to continually improve the skills, capabilities and engagement of the workforce within the Directorate.
32. Share a collective responsibility for the Trust's financial performance and the achievement of all quality, safety and other legislative requirements.
33. Share a collective responsibility for the Trust's overall corporate governance processes to include the implementation of an integrated governance framework

Quality Care - for you, with you

that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

34. Lead by example, to ensure the Trust demonstrates respect through its culture and actions, for all aspects of diversity in the population it serves and the staff who provides the services.
35. Share a collective responsibility for the Trust's corporate planning, policy and decision making processes as a member of the Directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
36. Continually strive to develop self and improve capability in the leadership of the Trust and its staff.
37. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC Staff.
38. Participate in the Director on-call rota.

RAISING CONCERNS - RESPONSIBILITIES

39. Promote and support effective team working, fostering a culture of openness and transparency.
40. Ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.
41. In the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

EMERGENCY PLANNING AND BUSINESS CONTINUITY

42. Lead on the development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

GENERAL REQUIREMENTS

The post holder will be required to:

43. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
44. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
45. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - a. Smoke Free policy
 - b. IT Security Policy and Code of Conduct
 - c. standards of attendance, appearance and behaviour
46. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
47. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
48. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004 and the General Data Protection Regulations (GDPR). Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.
49. Take responsibility for his/her own ongoing learning and development, including full participation in Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
50. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

Quality Care - for you, with you

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Chief Executive.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION

| | |
|---------------------------------|---|
| JOB TITLE | Director of Medicine & Unscheduled Care Services |
| DEPARTMENT / DIRECTORATE | Acute Directorate |
| SALARY | Level 4 £76,602 - £102,136 (Pay Awards outstanding) |

Ref No: X

<August 2022>

Notes to applicants:

- You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
- Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note The Organisation reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
- Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

| Factor | Criteria | Method of Assessment |
|-------------------|--|----------------------------------|
| Experience | <ul style="list-style-type: none"> Possess a minimum of three years' experience at Director or Assistant Director level or equivalent level in a major complex organisation² AND clear significant³ personal evidence of:- <ol style="list-style-type: none"> managing major service improvement and transformation; implementing financial control high level leadership and people management skills; | Shortlisting by Application Form |

| | | |
|-------------------------------------|--|----------------------------------|
| | <p>d. effective governance and risk management;</p> <p>e. building strategic relationships with external agencies / partners</p> <p>OR</p> <ul style="list-style-type: none"> • A minimum of two years' experience at Director or Assistant Director level or equivalent level in a major complex organisation² and clear significant³ personal evidence of:- <ul style="list-style-type: none"> a. managing major service improvement and transformation; b. implementing financial control c. high level leadership and people management skills; d. effective governance and risk management; e. building strategic relationships with external agencies / partners <p>AND</p> <p>A minimum of two years' experience within adult acute hospital services and / or adult community services at Senior Management level⁴.</p> | |
| Qualifications/ Registration | <ul style="list-style-type: none"> • Possess a university degree or recognised professional qualification or equivalent qualification in a relevant¹ subject¹ | Shortlisting by Application Form |
| Knowledge | <ul style="list-style-type: none"> • Knowledge of HSC Service reform • Knowledge of current trends in information technology and data analysis | Assessment/Interview |
| Other | <ul style="list-style-type: none"> • Hold a full current driving licence valid for use in the UK and have access to a car on appointment⁵. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. | Shortlisting by Application Form |

Selection / Interview stage

Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the *NHS Leadership Academy Healthcare Leadership Model*. Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role.

¹ *'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification.*

² *'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders.*

³ *'significant' is defined as contributing directly to Key Corporate Objectives of the organisation concerned.*

⁴ *'senior management' is defined as experience gained at Head of Service / Service lead level or equivalent in a major complex organisation*

⁵ *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

As part of the Recruitment & Selection process it may be necessary for The Organisation to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

THE ORGANISATION IS AN EQUAL OPPORTUNITIES EMPLOYER

| HSC Value | What does this mean? | What does this look like in practice? - Behaviours |
|--|--|---|
|  <p>Working Together</p> | <p>We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.</p> | <ul style="list-style-type: none"> • I work with others and value everyone’s contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible |
|  <p>Compassion</p> | <p>We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.</p> | <ul style="list-style-type: none"> • I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others |
|  <p>Excellence</p> | <p>We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.</p> | <ul style="list-style-type: none"> • I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking ‘could we do this better?’ |
|  <p>Openness & Honesty</p> | <p>We are open and honest with each other and act with integrity and candour.</p> | <ul style="list-style-type: none"> • I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice |

All staff are expected to display the HSC Values at all times



From: [Boyce, Tracey](#)
Sent: 18 May 2016 22:10
To: [Connolly, Connie](#)
Cc: [Reid, Trudy](#); [Walker, Helen](#)
Subject: RE: Governance re- structure-Confidential

Sensitivity: Confidential

Connie

Ronan had spoken to me last week – I explained that a date for the ‘change over’ had not been set by Esther as the identification of the band 7 governance post people had not happened and also that you had to finish up the cases you were working on before you could move.

I also said that we needed to set up the SAI training for the band 7s, lead nurses and HOS so that they can take on the governance work and at the moment that is looking like the end of June at the earliest.

I am going to speak to Esther about this as we need direction about the plans for the structure and when it will all be finalised so that we can plan a date for the changeover that everyone is signed up to.

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy

Personal Information
redacted by the USI



Learn more about mental health medicines and conditions on the Choiceandmedication website <http://www.choiceandmedication.org/hscni/>

From: Connolly, Connie
Sent: 18 May 2016 12:30
To: Boyce, Tracey

Cc: Reid, Trudy; Walker, Helen
Subject: Governance re- structure-Confidential
Importance: High
Sensitivity: Confidential

Hi Tracey- you may have already been contacted by Ronan, but I wanted to update in relation to my position as Lead Nurse

I spoke to Ronan today. Ronan made it clear that I have 2 choices

1 Remain in governance as a Band 7

2 Take up my substantive Lead Nurse Band 8a post in SEC. This would include Male Surgical, Female Surgical, High Dependency and Trust- Wide Outpatients.

I have informed Ronan that I would be taking Option 2.

Timeframe:

Ronan is very keen that re-deployment is done in 4-6 weeks

I made it very clear that I want to finish with the families I have engaged with. I will follow the Corporate view/decision re this.

Given that I need to rapidly refresh acute training and finish the incomplete SAI's, I would like you to consider how our/my workload will be transitioned.

The responsibility for screening and progressing will need to be considered urgently. Has the governance element within the Acute Lead Nurse 8a role been agreed? Who will be investigation and writing reports in the new structure. Who will be meeting the families?

As you can appreciate, I will have limited resource for induction of the Band 7 with immediate effect.

I concede you may not have all of the answers, but I want to assure you I will do my very best to support whatever measures are put in place during this difficult transition.

Connie

Connie Connolly



Lead Nurse | Acute Governance | Acute Directorate | Admin Floor | Craigavon Area Hospital | 68 Lurgan Road | Portadown BT63 5QQ | Tel: Personal Information redacted by the USI | Mob: Personal Information redacted by the USI



Stinson, Emma M

From: Boyce, Tracey [Personal Information redacted by the USI]
Sent: 05 June 2018 11:12
To: Gishkori, Esther
Cc: Reid, Trudy; Stinson, Emma M
Subject: FW: Acute Governance structure
Attachments: Appendix A Org chart 31 May 2018.docx; Acute Governance Enhanced Structure proposal 31 May 2018.docx

Hi Esther

Just realised that you probably needed a paper to go with this for the Acute team discussions and Shane – rather than just a chart.

Please find attached a draft paper for your consideration.

Kind regards

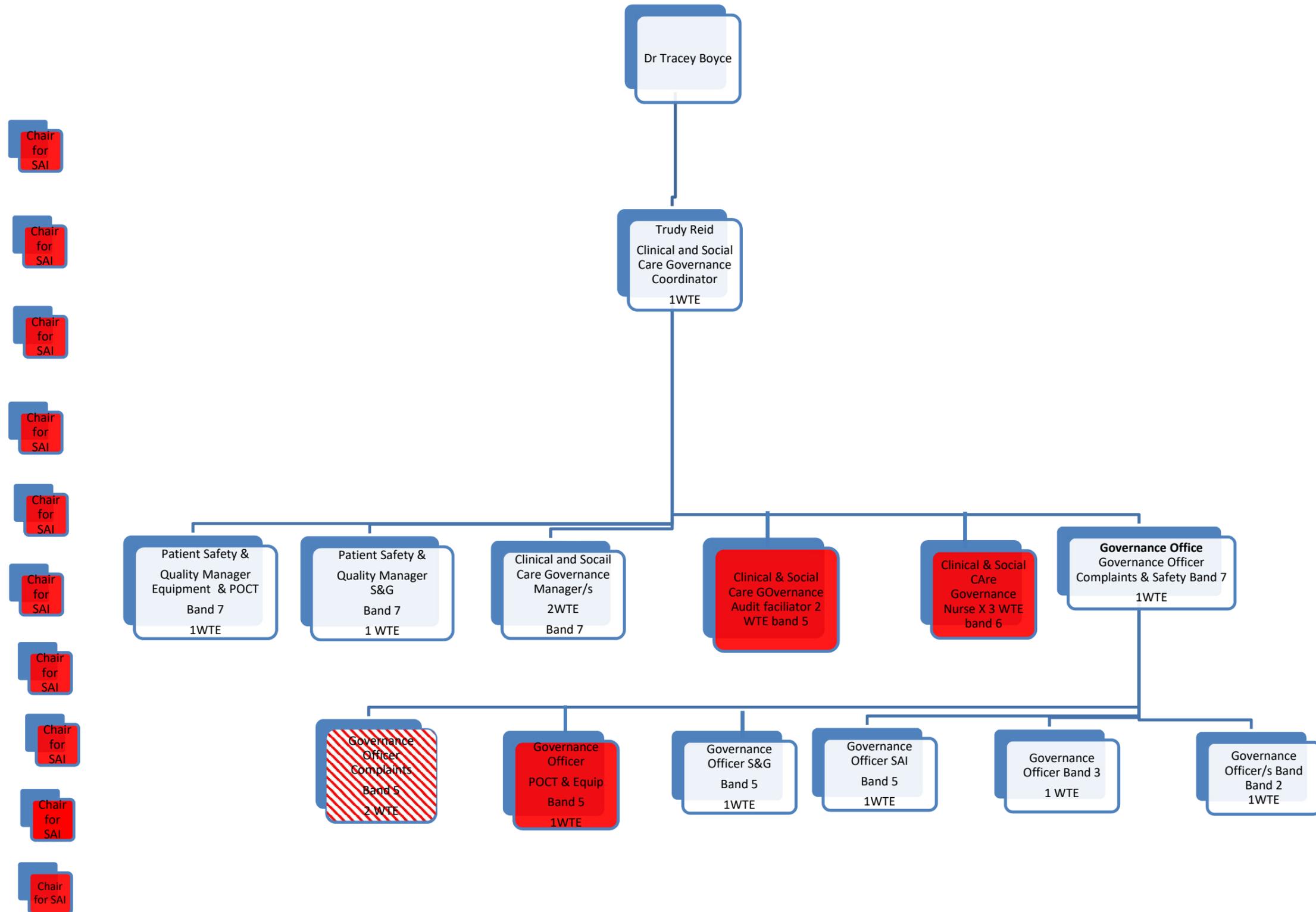
Tracey

Dr Tracey Boyce
Director of Pharmacy

[Personal Information redacted by the USI]



Learn more about mental health medicines and conditions on the Choiceandmedication website <http://www.choiceandmedication.org/hscni/>



Acute Governance Enhanced Structure – proposal for discussion

31ST May 2018

Additional funding may become available to enhance the Clinical Governance structure within the Acute Directorate in 2018/19. This paper proposes the additional posts/roles that would be added to the existing structure.

The existing structure of the Acute Governance Team is outlined in Appendix A. The existing posts are coloured blue and the proposed new posts are coloured red.

The introduction of additional posts would allow the Acute Governance team to introduce proactive governance activities such as governance dashboards, incident trend analysis, additional governance training and learning events related to trends/patterns identified from Trust incident reports.

Rationale for proposed new posts

3 wte band 6 Governance Nurses

- These posts would be embedded in the MUSC and SEC teams to work with them on their 'day to day' data and complaint responses (potentially one for SEC, one for ED and one for the rest of MUSC – but need to agree this with the ADs if funded).

2 wte band 5 audit facilitators

- The Audit facilitator posts will be aligned to the Divisions within Acute, supporting the teams in their clinical audit work. At present there is no support for audit within Acute.

1 wte band 5 Equipment/POCT governance officer

- 1 Band 5 governance officer to work with the equipment management/POCT band 7, as from previous discussions with the Directors of Planning and HR, these post will need to take on the cross Directorate work which is not being addressed at the moment, rather than just focussing on the Acute Directorate.

1 band 5 Equipment/POCT governance officer

- 1 additional band 5 governance officer to improve our response to complaints, Ombudsmen enquires and risk register work/training for staff.

0.5 'Governance' PA for 10 consultants

- By creating 10 consultants with 0.5PA for governance we could address the current problems we have with the availability of Consultant medical staff for SAI chairs and other governance working groups. This also fits with the proposal Dr Kahn discussed with the Acute SMT in May. The model would merge aspects of IWMH Medical governance and also MHD's approach to leadership of SAIs. We would provide advanced SAI leadership training for this team of consultants.

Tracey Boyce
Director of Pharmacy/Acute Governance
31st May 2018

Chronology of meetings from diary and notes (excluding report writing, team meetings)

| | |
|------------|---|
| | |
| 04/04/2016 | Acute Drug Allergy Working Group |
| 05/04/2016 | Director of Pharmacy Governance meeting |
| 05/04/2016 | Acute SMT governance |
| 05/04/2016 | HSCB |
| 07/04/2016 | GIRFT |
| | Annual Leave 08/04/2016 |
| 11/04/2016 | Management of Offenders Protocol |
| 12/04/2016 | Blood Hound Implementation Group |
| 13/04/2016 | Decontamination committee |
| 14/04/2016 | S&G review meeting |
| 15/04/2016 | Delirium training |
| 15/04/2016 | Corporate governance meeting |
| 19/04/2016 | Butterfly scheme |
| 21/04/2016 | Director of Pharmacy |
| 22/04/2016 | AD CSCG |
| 22/04/2016 | Emergency Planning |
| 25/04/2016 | MUSC screening |
| 26/04/2016 | Regional Delirium Advisory Group |
| 27/04/2016 | Director of Pharmacy |
| 27/04/2016 | Medicines incidents review |
| 27/04/2016 | Nurse Bank Manager |
| 27/04/2016 | AD Human Resources |
| 28/04/2016 | Nurse Bank Manager |
| 03/05/2016 | AD CSCG re Presentation |
| 04/05/2016 | Nurse re roles |
| 04/05/2016 | HCAI Strategic Infection Prevention and Control Forum |
| 05/05/2016 | S&G meeting |
| 06/05/2016 | NJR |
| 9/05/2016 | Governance presentation |
| 10/05/2016 | Blood Hound Implementation Group |
| 10/05/2016 | NEDS and AD Governance presentation |
| 11/05/2016 | AD MHD |
| 11/05/2016 | Screening ED |
| 11/05/2016 | AD SEC & ATICS transfer complaint |
| 12/05/2016 | Standards and Guidelines |
| 13/05/2016 | Acute Clinical Governance |
| 13/05/2016 | Governance Pharmacist re sedation incident |
| 16/05/2016 | Standards and Guidelines |
| 16/05/2016 | Decontamination meeting |
| 17/05/2016 | Lessons Learned |
| 18/05/2016 | Weekly governance meeting |
| 19/05/2016 | Incident meeting F Rice re SAI |
| 19/05/2016 | Director of Pharmacy |
| 23/05/2016 | Meeting with MHD |

| | |
|------------|---|
| 23/05/2016 | MUSC screening |
| 24/05/2016 | Acute Operational Audit Work Plan with Corporate Governance/Audit |
| 24/05/2016 | Dash Board training for governance leads |
| | Annual Leave 25/05/2016 |
| 26/05/2016 | S&G meeting |
| 26/05/2016 | AD CSCG Governance |
| 27/05/2016 | Weekly Governance coordinator meeting |
| 31/05/2016 | Regional Ward collaborative |
| 01/06/2016 | AD CSCG |
| 03/01/2016 | AD MUSC |
| 03/01/2016 | Weekly Governance coordinator meeting |
| 06/06/2016 | AD MUSC re SAI |
| 06/06/2016 | Acute Service Directorate Nursing and Midwifery Leadership/Governance forum |
| 06/06/2016 | Acute Governance Committee |
| 06/06/2016 | Datix meeting |
| 07/06/2016 | Acute Director re complaint |
| 07/06/2016 | Governance SMT |
| 08/06/2016 | Managing difficult people |
| 09/06/2016 | Standards and Guidelines |
| 09/06/2016 | AD CSCG re time line |
| 10/06/2016 | Acute Clinical Governance |
| 13/06/2016 | Regional Zero tolerance to violence |
| 13/06/2016 | NICE guideline meeting |
| 15/06/2016 | Acute Director and Director of Pharmacy meeting |
| 15/06/2016 | Paediatric lead nurse re PEWS |
| 15/06/2016 | GAIN focus group 1 |
| 16/06/2016 | SMT cover for Director |
| 17/06/2016 | Clinical Guideline |
| 20/06/2016 | AD MUSC re PEWS |
| 21/06/2016 | Acute Director meeting |
| 21/06/2016 | Acute Directorate PL/EL Claims Review Group |
| 21/06/2016 | Dash Board |
| 22/06/2016 | Acute Director and Director of Pharmacy meeting |
| 22/06/2016 | SAI review meeting |
| 22/06/2016 | Complaints phone call |
| 23/06/2016 | M&M Monitoring Group Meeting Agenda |
| 23/06/2016 | Standards and Guidelines meeting |
| 23/06/2016 | Health Roster session |
| 24/06/2016 | SAI review meeting |
| 27/06/2016 | Family engagement meeting |
| | Heather re Risk register |
| 28/06/2016 | Serious Adverse Incident Training |
| 29/06/2018 | Acute Director and Director of Pharmacy meeting |
| 29/06/2018 | HCAI clinical forum |
| 29/06/2018 | Emergency Planning |
| 29/06/2018 | Meeting re complaint |
| 30/06/2016 | Brain Injury |
| 30/06/2016 | SAI review meeting |
| 04/07/2016 | SAI Personal information review meeting |
| | Governance Conference 05/07/2016 – 06/07/2016 |

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|------------|---|
| 07/07/2016 | Standards and Guidelines |
| 08/07/2016 | Acute Clinical Governance |
| 08/07/2016 | MUSC screening |
| 13/07/2016 | Acute Director and Director of Pharmacy meeting |
| 13/07/2016 | Director of Pharmacy |
| 18/07/2016 | Review of obstetric SAI report |
| 19/07/2016 | Director of Pharmacy |
| 20/07/2016 | Acute Director and Director of Pharmacy meeting |
| 21/07/2016 | AD MUSC & AD CSCG telephone meeting governance re SAI |
| 21/07/2016 | Standards and Guidelines |
| 21/07/2016 | Health and Safety Executive re SAI |
| | Annual Leave 25/7/2016-29/7/2016 |
| 02/08/2016 | Governance meeting |
| 03/08/2016 | Acute Director and Director of Pharmacy meeting |
| | Annual leave 04/08/2016-15/08/2016 |
| | |
| 17/08/2016 | Acute Director and Director of Pharmacy meeting |
| 17/08/2016 | AD CSCG Governance re SAI |
| 17/08/2016 | HOS GSUR re risk assessment re fire escapes |
| 18/08/2016 | Director of Pharmacy JD and structure etc. |
| 18/08/2016 | Prioritisation and Risk Review Group |
| 18/08/2016 | AMD SEC re date for finalising SAI |
| 18/08/2016 | Major Evacuation Training |
| 19/08/2016 | M&M |
| 22/08/2016 | Domestic Services Manager |
| 22/08/2016 | AD SEC re Screening |
| 23/08/2016 | AD CSCG re SAI |
| 23/08/2016 | MUSC screening |
| 24/08/2016 | Acute Director and Director of Pharmacy meeting |
| 24/08/2016 | Meeting re complaint referred to ombudsman |
| 25/08/2016 | Medication Incident Review Meeting |
| | Annual Leave 26/08/2016 and 31/08/2016 |
| 01/09/2016 | SAI meeting And Family engagement |
| 02/09/2016 | AD SEC & ATICS re SAIs, RQIA guidelines and Filters |
| 02/09/2016 | Learning letter |
| 02/09/2016 | AMD MUSC re SAIs |
| 05/09/2016 | SAI <small>Personal Information</small> |
| 05/09/2016 | SAI family engagement telephone call |
| 05/09/2016 | Senior Nurse Meeting |
| 06/09/2016 | MHD Governance Coordinator re SAI |
| 06/09/2016 | Acute Governance meeting |
| 07/09/2016 | Acute Director and Director of Pharmacy meeting |
| 07/09/2016 | AD MUSC |
| 08/09/2016 | Checking of pregnancy |
| 09/09/2016 | Acute Clinical Governance |
| 09/09/2016 | MHD Governance Coordinator re SAI |
| 09/09/2016 | SAI review meeting |
| 09/09/2016 | Meeting re Datix |
| 12/09/2016 | SAI family engagement telephone call |

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| 13/09/2016 | Blood Hound Implementation Group |
| 14/09/2016 | Acute Director and Director of Pharmacy meeting |
| 15/09/2016 | AD CCS and re Complaint |
| 15/09/2016 | AD MUSC re RQIA |
| 15/09/2016 | AD CCS and re Complaint |
| 16/09/2016 | Director of Pharmacy |
| 16/09/2016 | Equipment Management Steering Group |
| 16/09/2016 | Equipment Management Steering Group |
| 19/09/2016 | AD CSCG re SAI ToR and family engagement |
| 19/09/2016 | Sepsis Group |
| 19/09/2016 | SAI family engagement telephone call |
| 20/09/2016 | SAI ^{Personal information} review meeting |
| 21/09/2016 | Acute Director and Director of Pharmacy meeting |
| 22/09/2016 | Patient Client Experience Committee |
| 22/09/2016 | Standards and Guidelines meeting |
| 22/09/2016 | National audit meeting with AQ |
| 23/09/2016 | Access to wards and departs promoting pts and staff safety |
| 23/09/2016 | AD MUSC meeting |
| 23/09/2016 | Meeting re Datix reported incident |
| 26/09/2016 | Medication incident review meeting |
| 26/09/2016 | SAI family engagement telephone call |
| 26/09/2016 | AD MUSC meeting |
| 27/09/2016 | Acute Director and Director of Pharmacy meeting |
| 28/09/2016 | 'i-Compare' |
| 28/09/2016 | HCAI Clinical Forum Meeting |
| 29/09/2016 | Standards and Guidelines |
| 30/09/2016 | Meet SAI review team |
| 30/09/2016 | SAI review meeting |
| 30/09/2016 | Medicine governance meeting |
| 30/09/2016 | Delays in diagnosis/x-ray/admin with ADs |
| 03/10/2016 | AD MUSC |
| 03/10/2016 | Caroline and Anne |
| 03/10/2016 | SAI family engagement telephone call |
| 03/10/2016 | Nursing induction programme |
| 04/10/2016 | Acute Governance |
| 05/10/2016 | Acute Director and Director of Pharmacy meeting |
| 06/10/2016 | RQIA Scotland - |
| 07/10/2016 | Datix re pressure ulcers |
| 07/10/2016 | AD MUSC re Internal Audit |
| 10/10/2016 | Equipment audit |
| 11/10/2016 | Director Pharmacy |
| 12/10/2016 | Annual leave |
| 13/10/2016 | Standards & Guidelines |
| 13/10/2016 | Acute Clinical Governance |
| 17/10/2016 | SAI ^{Personal information} review meeting |
| 18/10/2016 | Governance pharmacist |
| 18/10/2016 | Director Pharmacy |
| 19/10/2016 | RQIA meeting - Renal Unit |
| 20/10/2016 | Tracey and Heather |
| 21/10/2016 | Medicines incident meeting |

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| 21/10/2016 | SAI working group |
| 21/10/2016 | AD MUSC |
| 25/10/2016 | Health and Safety manager |
| 25/10/2016 | IMWH Governance |
| 26/10/2016 | Acute Director and Director of Pharmacy meeting |
| 26/10/2016 | Behavioural insight team re complaints |
| 26/10/2016 | HCAI Clinical Forum |
| 26/10/2016 | Checking of Pregnancy Group |
| 27/10/2016 | Datix Meeting |
| 27/10/2016 | Standards and Guidelines |
| 27/10/2016 | Consultant Obstetrician |
| 28/10/2016 | AD MUSC |
| | Annual leave 31/10/2016 |
| 01/11/2016 | SMT |
| | Annual leave 02/11/2016-04/11/2016 |
| 07/11/2016 | MUSC screening |
| 07/11/2016 | Radiology governance meeting |
| 07/11/2016 | Delayed Diagnosis & appointments working group |
| 07/11/2016 | SAI family engagement telephone call |
| 07/11/2016 | Delayed Diagnosis and appointments - working group |
| 09/11/2016 | Acute Director and Director of Pharmacy meeting |
| 09/11/2016 | SAI <small>Personal information</small> review meeting |
| 10/11/2016 | AD CSCG |
| 11/11/2016 | Acute Clinical Governance |
| 11/11/2016 | AD MUSC |
| 14/11/2016 | Review of notes not triaged-meeting organised by Lead nurse for governance |
| 14/11/2016 | MUSC screening |
| 14/11/2016 | End of bed documents meeting |
| 15/11/2016 | Standards and Guidelines meeting |
| 15/11/2016 | Director of Pharmacy |
| 16/11/2016 | Acute Director and Director of Pharmacy meeting |
| 16/11/2016 | AD CSCG |
| 16/11/2016 | AD MUSC |
| 17/11/2016 | Tracey and Nigel |
| 17/11/2016 | AD MUSC |
| 18/11/2016 | SAI review meeting |
| 18/11/2016 | PCE committee |
| 21/11/2016 | "We know we can't change the past, but we can use the past to inform the present and influence a better future." Mrs Margaret Murphy |
| 22/11/2016 | SAI review meeting |
| 22/11/2016 | AD MUSC |
| 23/11/2016 | Acute Director and Director of Pharmacy meeting |
| 23/11/2016 | AD Human resources |
| 24/11/2016 | Medicines incident meeting |
| 24/11/2016 | Standards and Guidelines |
| 25/11/2016 | AD Human resources |
| 25/11/2016 | Lab Sign Off Meeting with Medical Director |
| 28/11/2016 | Ligature risk assessment in ED |
| 28/11/2016 | MUSC screening |

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|------------|---|
| 28/11/2016 | Access to Wards/Departments |
| 29/11/2016 | AD CSCG |
| 29/11/2016 | Acute Directorate PL/EL Claims Review Group |
| 29/11/2016 | Director of Pharmacy |
| 30/11/2016 | Acute Director and Director of Pharmacy meeting |
| 30/11/2016 | Delays meeting |
| 30/11/2016 | AD MUSC |
| 30/11/2016 | HCAI Clinical Forum Meeting |
| 01/12/2016 | Patient and Client Experience Committee |
| 02/12/2016 | Director of Pharmacy and Nigel re equipment |
| 02/12/2016 | Mental Health Order – Northern Ireland (1986) |
| 02/12/2016 | SAI review meeting |
| 02/12/2106 | Medicines Governance Meeting |
| 05/12/2016 | Heather meeting re governance |
| 05/12/2016 | Family engagement telephone call |
| 06/12/2016 | Director of Pharmacy |
| 06/12/2016 | SMT |
| 07/12/2016 | Acute Director and Director of Pharmacy meeting |
| 08/12/2016 | Standards and Guidelines |
| 09/12/2016 | Acute Clinical Governance |
| 09/12/2016 | AD Human Resources |
| 09/12/2016 | IMWH/CCS Divisional Governance meeting |
| 09/12/2016 | SAI review meeting |
| 12/12/2016 | Meeting RE Ombudsman Complaint |
| 13/12/2016 | AD MUSC |
| | Director of Pharmacy |
| | Annual Leave 14/12/2016-16/12/2106 |
| 19/12/2106 | Medicines incident meeting |
| 19/12/2106 | Checking of Pregnancy |
| 21/12/2106 | Acute Director and Director of Pharmacy meeting |
| 21/12/2106 | Internal Audit |
| 21/12/2106 | AD MUSC Gain Guidelines meeting with |
| 22/12/2016 | Standards and Guidelines |
| | Annual Leave 24/12/2016 |
| 28/12/2016 | HCAI Clinical Forum Meeting |
| 29/12/2016 | AD MUSC |
| 29/12/2016 | HoS and Lead Nurse ED |
| 03/01/2017 | Head of Health Records |
| 03/01/2017 | Director of Pharmacy |
| 04/01/2017 | Acute Director and Director of Pharmacy meeting |
| 05/01/2017 | Standards and Guidelines |
| 06/01/2017 | Booking Centre Manager Delays meeting |
| 09/01/2017 | POCT meeting –AD IMWH/CCS |
| 09/01/2017 | Time to get Control |
| 09/01/2017 | Senior Nurses forum |
| 10/01/2017 | Governance Pharmacist |
| 10/01/2017 | Director of Pharmacy |
| 11/01/2017 | Acute Director and Director of Pharmacy meeting |
| 11/01/2017 | Screening ED |

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| 11/01/2017 | Measurement for Improvement |
| 12/01/2017 | Meeting re SAI |
| 13/01/2017 | Acute Clinical Governance |
| 16/01/2017 | MUSC screening |
| 17/01/2017 | Director of Pharmacy |
| 17/01/2017 | Standards and Guidelines |
| 17/01/2017 | AD CSCG re SAI |
| 18/01/2017 | Acute Director and Director of Pharmacy meeting |
| 18/01/2017 | AD MUSC Screening ED |
| 18/01/2017 | SAI review meeting-endoscopy |
| 19/01/2017 | Standards and Guidelines |
| 20/01/2017 | Data base S&G meeting |
| 20/01/2017 | Medicine meeting |
| 23/01/2017 | Information Governance |
| 23/01/2017 | NCEPOD Time to get Control |
| 23/01/2017 | Confirmed Datix dashboard meeting |
| 24/01/2017 | HoS meeting IMWH/CCS |
| 24/01/2017 | Director of Pharmacy |
| 24/01/2017 | Regional Complaint meeting |
| 24/01/2017 | Falls meeting |
| 25/01/2017 | Acute Director and Director of Pharmacy meeting |
| 25/01/2017 | HCAI Clinical Forum meeting |
| 25/01/2017 | SAI review meeting |
| 25/01/2017 | Complaint pre meeting |
| 26/01/2017 | SAI review meeting |
| 27/01/2017 | Kate Cunningham X-Ray system |
| 27/01/2017 | Restrictive interventions |
| 27/01/2017 | AD IMWH/CCS adverse incident learning |
| 31/01/2017 | CHKS |
| 01/02/2017 | Acute Director and Director of Pharmacy meeting |
| 01/02/2017 | RCA SAI training –web meeting |
| 01/02/2017 | Decontamination committee |
| 02/02/2017 | Consultant Anaesthetist GB Audit |
| 02/02/2017 | Standards and Guidelines |
| 02/02/2017 | Consultant obstetrician and AD IMWH/CCS re SAI project |
| 02/02/2017 | Endoscopy meeting |
| 06/02/2017 | Meeting to review PSA Injectable Medicines/identification and labelling of invasive lines and tubes. |
| 06/02/2017 | Family engagement telephone call |
| 06/02/2017 | Meeting nurse endoscopists |
| 07/02/2017 | Heathers governance meeting |
| 07/02/2017 | HOS cardiology re falls |
| 08/02/2017 | Acute Director and Director of Pharmacy meeting |
| 08/02/2017 | Adverse Incident meeting Trust |
| 08/02/2017 | Director of Pharmacy |
| 08/02/2017 | Meeting nurse endoscopists |
| 09/02/2017 | Phone call OPPC Acute clinical governance |
| 10/02/2017 | Acute Clinical Governance |
| 10/02/2017 | Endoscopy meeting |
| 10/02/2017 | Urgent meeting with MDH re SAI |

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| 10/02/2017 | access to wards |
| 10/02/2017 | Endoscopy meeting |
| | Annual Leave 13/02/2017 – 20/02/2017 |
| 21/2/2017 | Line Labelling |
| 21/2/2017 | Director of Pharmacy |
| 22/2/2017 | Acute Director and Director of Pharmacy meeting |
| 22/2/2017 | QI Network Session Leading Transformational Change. |
| 22/2/2017 | SAI <small>Personal information</small> review meeting and family engagement |
| 23/02/2017 | Surgical and an Anaesthetic Representative to attend the Focus Group with RQIA |
| 23/02/2017 | SAI <small>Personal information</small> review meeting |
| 27/02/2017 | Meeting re Never Events |
| 27/02/2017 | AD MUSC |
| 01/03/2017 | Acute Director and Director of Pharmacy meeting |
| 01/03/2017 | MUSC Screening |
| 01/03/2017 | Booking centre manager & head of health records |
| | Annual leave 03/3/2017 |
| 06/03/2017 | AD MUSC |
| 06/03/2017 | SEC screening |
| 08/03/2017 | Acute Director and Director of Pharmacy meeting |
| 08/03/2017 | Family engagement |
| 08/03/2017 | IV line labelling |
| 08/03/2018 | SMT |
| 09/03/2017 | Standards and Guidelines |
| 09/03/2017 | P&C experience committee |
| 10/03/2017 | Acute Clinical Governance |
| 13/03/2017 | Spinal meeting with Medical Director and Acute Director |
| 13/03/2017 | Falls |
| 14/03/2017 | Director of Pharmacy |
| 14/03/2017 | New safeguarding procedures |
| 15/03/2017 | Acute Director and Director of Pharmacy meeting |
| | Annual leave 20/3/2017 -21/3/2107 |
| 22/03/2017 | Acute Director and Director of Pharmacy meeting |
| 23/03/2017 | Medicines meeting |
| 23/03/2017 | Family engagement meeting regarding SAI report |
| 23/03/2017 | IMWH/CCS screening |
| 24/03/2017 | IMWH/CCS quartly Governance Meeting |
| 27/03/2017 | IMWH/CCS screening |
| 28/03/2017 | Director of Pharmacy |
| 28/03/2017 | Consultant Cardiologist |
| 29/03/2017 | Acute Director and Director of Pharmacy meeting |
| 29/03/2017 | CMO Correspondence re Labelling |
| 30/03/2017 | Falls learning event (attendee) |
| 03/04/2017 | Lead Nurses Forum – Policy Implementation |
| 04/04/2017 | SEC Band 6 Induction Re: Governance Issues |
| 05/04/2017 | Acute Director and Director of Pharmacy meeting |
| 05/04/2017 | Risk of death and severe harm from error with injectable Phenytoin |
| 06/04/2017 | RQIA Review of Emergency Mental Health & Learning Disability Services in Northern Ireland |
| 06/04/2017 | NCEPOD Cardiac Arrest Procedures: Time to Intervene” |
| 10/04/2017 | SAI review meeting |

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| 10/04/2017 | Lead Nurses Forum – Policy Implementation |
| 11/04/2017 | AD SEC & ATICS – HoS – Dashboards |
| 11/04/2017 | Governance pharmacists and Standards and Guidelines Lead |
| 12/04/2017 | Acute Director and Director of Pharmacy meeting |
| 12/04/2017 | Governance pharmacists and Standards and Guidelines Lead Bowel prep |
| 12/04/2017 | Endoscopy meeting |
| 13/04/2017 | AD CSCG & OPPC Clinical Governance coordinator |
| 14/04/2017 | Acute Clinical Governance Meeting |
| | Annual Leave 18/04/2017 |
| 19/04/2017 | Acute Director and Director of Pharmacy meeting |
| 19/04/2017 | SAI Personal information redacted by the USI review meeting |
| 19/04/2017 | Working Group – Review of Outstanding actions for Safe use of Oral Bowel |
| 21/04/2017 | Governance Meeting with Acute Director and Director of Pharmacy |
| 24/04/2017 | MUSC screening |
| 25/04/2017 | Health and Safety Committee |
| 25/04/2017 | Restrictive interventions |
| 25/04/2017 | Line label |
| 25/04/2017 | RQIA update |
| 26/04/2017 | Acute Director and Director of Pharmacy |
| 27/04/2017 | Risk Management Workshop |
| 28/04/2017 | HoS MUSC RQIA base line assessment |
| 02/05/2017 | SAI review meeting |
| 03/05/2017 | Acute Director and Director of Pharmacy |
| 04/05/2017 | SAI Personal information redacted by the USI review meeting |
| 08/05/2017 | IMWH & CCS screening |
| 09/05/2017 | AD SEC & ATICS pre coroners court |
| 09/05/2017 | AD SEC & ATICS screening |
| 10/05/2017 | Acute Director and Director of Pharmacy |
| 10/05/2017 | RQIA audit restraint and seclusion |
| 11/05/2017 | Personal Information redacted by the USI & HoS cardiology –QI re fall, pressure ulcers and diabetes |
| 11/05/2017 | Falls meeting |
| 12/05/2017 | Acute Clinical Governance |
| 12/05/2017 | Absconding patient |
| 12/05/2017 | Clifford |
| 16/05/2017 | Safe guarding LASP group Zest |
| 16/05/2017 | Director of Pharmacy |
| 16/05/2017 | SOP Open Systems meeting |
| 17/05/2017 | Acute Director and Director of Pharmacy |
| 17/05/2017 | Screening ED |
| 18/05/2017 | SAI TRAINING |
| 24/05/2017 | Acute Director and Director of Pharmacy |
| 24/05/2017 | Quality Improvement Network-using patient experience to drive quality |
| 24/05/2017 | Label meeting |
| 24/05/2017 | Policy for the Checking of Pregnancy before surgery, x-ray / diagnostics and chemotherapy |
| 25/05/2017 | Photography & line labelling |
| 25/05/2017 | SAI review meeting |
| 26/05/2017 | AD IMWH & CCS and Consultant Microbiology |
| 26/05/2017 | Head of Service Facilities |
| 26/05/2017 | Incident re power |

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| 31/05/2017 | Acute Director and Director of Pharmacy |
| 01/06/2017 | 100% challenge |
| 01/06/2017 | Estates officer |
| 01/06/2017 | MHD Governance Coordinator and PSNI |
| 02/06/2017 | Governance Coordinator meeting |
| 02/06/2017 | Delays meeting |
| 05/06/2017 | Barry and Director of Pharmacy |
| 05/06/2017 | MUSC screening |
| 05/06/2017 | Senior Nurses Forum |
| 06/06/2017 | Acute Governance |
| 06/06/2017 | Safe guarding incident |
| 06/06/2017 | NCEPOD Time to Intervene Meeting with AD's |
| 07/06/2017 | Acute Director and Director of Pharmacy |
| 09/06/2017 | Acute clinical governance |
| 09/06/2017 | AD Medical Directorate line labelling |
| 09/06/2017 | Safe guarding meeting |
| 12/06/2017 | Access to wards and departments |
| 12/06/2017 | Absconding Patients |
| 12/06/2017 | AD MUSC |
| 14/06/2017 | Acute Director and Director of Pharmacy |
| 14/06/2017 | SAI review meeting |
| 15/06/2017 | 100% Challenge |
| 15/06/2017 | Delirium advisory group meeting |
| 16/06/2017 | 100% Challenge |
| 20/06/2017 | SAI <small>Personal information</small> review meeting |
| 21/06/2017 | Acute Director and Director of Pharmacy |
| 21/06/2017 | AI meeting |
| 21/06/2017 | Datix meeting re falls |
| 22/06/2017 | Vulnerable adult training for lead nurses |
| | Annual leave 23/06/2017 |
| 26/06/2017 | Governance pharmacists –Diabetes |
| 27/06/2017 | GAIN Guidelines/RQIA 'Caring for People with a Learning Disability in General Hospital Settings' |
| 27/06/2017 | Consultant anaesthetist DS |
| 28/06/2017 | Acute Director and Director of Pharmacy |
| 28/06/2017 | Governance coordinators meeting |
| 29/06/2017 | IMWH future planning Governance |
| 30/06/2017 | SAI <small>Personal information</small> review meeting |
| 03/07/2017 | Senior Nurses Forum |
| 04/07/2017 | AD MUSC |
| 04/07/2017 | SEC & ATICS screening |
| 05/07/2017 | Acute Director and Director of Pharmacy |
| 06/07/2017 | HoS cancer re SAI |
| | Annual leave 10/07/2017 – 14/07/2017 |
| 17/07/2017 | AD IMWH & CCS re complaints |
| 17/07/2017 | SET re incident |
| 17/07/2017 | Consultant PHA re swab result |
| 19/07/2017 | Acute Director and Director of Pharmacy |
| 19/07/2017 | QI lead re project and insulin |
| 19/07/2017 | SAI review meeting |

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| 20/07/2017 | Obstetrician re SAI |
| 20/07/2017 | AD IMWH & CCS |
| 21/07/2017 | PEG meeting |
| 21/07/2017 | Anaesthetist re CG 65 – Hypothermia review of Section e |
| 25/07/2017 | Director of Pharmacy |
| | Annual leave 26/07/2017 |
| 27/07/2017 | Ombudsman complaint follow up |
| 27/07/2017 | Adult Safeguarding new procedures |
| 27/07/2017 | Adult safeguarding new procedures |
| 28/07/2017 | Director of Pharmacy re AD CSCG letter |
| 31/07/2017 | MUSC Screening |
| 31/07/2017 | Governance pharmacist |
| 01/08/2017 | Governance pharmacist & Standards & Guidelines lead re ISO connectors |
| 01/08/2017 | Acute Director and Director of Pharmacy |
| 01/08/2017 | Director of Pharmacy and Lead nurse governance |
| | Annual leave 03/08/2017 -18/08/2017 |
| 21/08/2017 | Medicine incident review |
| 21/08/2017 | Call with Litigation |
| 22/08/2017 | Emergency planning lead |
| 22/08/2017 | HoS cardiology re falls |
| 22/08/2017 | AD MUSC re complaints and SAI info for PSNI |
| 22/08/2017 | Family engagement fall |
| 23/08/2017 | Acute Director and Director of Pharmacy |
| 23/08/2017 | ED physician re SAI |
| 24/08/2017 | SEA meeting |
| 24/08/2017 | AD MUSC |
| 24/08/2017 | HoS T&O re staffing |
| 24/08/2017 | Director of Pharmacy |
| | Annual leave 29/08/2017 |
| 30/08/2017 | Acute Director and Director of Pharmacy |
| 30/08/2017 | SAI review meeting |
| 30/08/2017 | AD MUSC |
| 30/08/2017 | SEC & ATICS screening |
| 30/08/2017 | SAI review meeting |
| 30/08/2017 | HoS Functional Services |
| 31/08/2017 | Consultant physician ED re SAI |
| 31/08/2017 | SAI <small>Personal information</small> review meeting |
| 01/09/2017 | SAI review meeting |
| 01/09/2017 | Ann re Audit |
| 01/09/2017 | Safety manager re NQI |
| 01/09/2017 | Haematologist re SAI recommendations |
| 05/09/2017 | Patient Client Experience |
| 06/09/2017 | Acute Director and Director of Pharmacy |
| 06/09/2017 | SAI review meeting |
| 06/09/2017 | Guidance for Acute Staff re: Bomb Threats |
| 06/09/2017 | Director of Pharmacy |
| 07/09/2017 | Litigation telephone call re coroners cases and complaints |
| 08/09/2017 | Acute Clinical Governance |
| 11/09/2017 | Lead Nurse forum Super absorbent gel |
| 12/09/2017 | Mass casualty event |

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| 13/09/2017 | Acute Director and Director of Pharmacy meeting |
| 13/09/2017 | MHD Governance coordinator |
| 13/09/2017 | Oxygen Cylinders/piped medical oxygen |
| 13/09/2017 | HoS MUSC re complaint referred to ombudsman |
| 15/09/2017 | IMWH incident Screening |
| 15/09/2017 | IMWH incident Screening |
| 15/09/2017 | OPPC governance coordinator discharges from acute |
| 19/09/2017 | LASP |
| 20/09/2017 | Acute Director and Director of Pharmacy meeting |
| 20/09/2017 | Medicines incident review |
| 20/09/2017 | Results meeting |
| 21/09/2017 | SEC & ATICS screening meeting |
| 21/09/2017 | SAI ^{Personal information} screening meeting |
| 22/09/2017 | Consultant Haematologist |
| 22/09/2017 | IMWH & CCS screening |
| 22/09/2017 | Joint sisters meeting re GAIN |
| 22/09/2017 | Audit Committee Chaired by Director |
| 22/09/2017 | IMWH & CCS Governance meeting |
| 22/09/2017 | Lead Nurse ED re CCTV |
| 25/09/2017 | AD SEC & ATICS re H complaint |
| 26/09/2017 | Review of Phase 1 Backlog of Standards & Guidelines |
| 26/09/2017 | ISO connectors meeting |
| 27/09/2017 | Acute Director and Director of Pharmacy meeting |
| 27/09/2017 | AI meeting |
| 28/09/2017 | Acute DSF Action Plan |
| 02/10/2017 | Senior Nurses Forum |
| 03/10/2017 | Phone Jillian Johnston |
| 03/10/2017 | Lead Nurse and sister re pt who left 2SS and collapsed in car park |
| 03/10/2017 | Standards and Guidelines |
| 04/10/2017 | Acute Director and Director of Pharmacy meeting |
| 04/10/2017 | Julian Johnston |
| 04/10/2017 | Complaint meeting |
| 05/10/2017 | Kay medicine sisters Datix and Risk Matrix training |
| 06/10/2017 | Sandra and David |
| 06/10/2017 | AD MUSC update and outstanding actions |
| 09/10/2017 | Governance Pharmacist re AG |
| 09/10/2017 | Acute Lead Nursing, Midwifery & Radiology S&G Forum |
| 09/10/2017 | Caroline |
| 10/10/2017 | Consultant Anaesthetist RS |
| 10/10/2017 | Call to Ombudsman re complaint |
| 10/10/2017 | Paul re SAIs |
| 11/10/2017 | Acute Director and Director of Pharmacy meeting |
| 11/10/2017 | MUSC screening |
| 11/10/1027 | HoS cardiology |
| 11/10/2017 | Meet Executive Director of Nursing RE RQIA |
| 11/10/2017 | SAI meeting with family member |
| 11/10/2017 | Mary Burke |
| 12/10/2017 | Meeting re SAI and trainees |
| 12/10/2017 | Caroline |
| 12/10/2017 | Sepsis meeting |

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| 12/10/2017 | Governance coordinator |
| 13/10/2017 | Acute Clinical Governance |
| 13/10/2017 | David re old Datix incidents not closed. |
| 13/10/2017 | Caroline |
| 13/10/2017 | Kay video link |
| 13/10/2017 | Helen Walker re HR issues team |
| 13/10/2017 | Anita phone re Radiology |
| 16/10/2017 | Heather screening |
| 16/10/2017 | Anne re ombudsman complaint |
| 17/10/2017 | OMBUDSMAN re <small>Personal Information redacted by the USI</small> allow travel time |
| 18/10/2017 | Acute Director and Director of Pharmacy meeting |
| 18/10/2017 | Rachel re junior doctor support for SAI |
| 19/10/2017 | Anne Quinn |
| 19/10/2017 | Medicine incident meeting |
| 19/10/2017 | Meeting re flow boards |
| 19/10/2017 | Meeting re results flow |
| 20/10/2017 | SAI <small>Personal Information redacted by the USI</small> |
| 20/10/2017 | Kay re falls |
| 20/10/2017 | Catriona re RQIA |
| 20/10/2017 | Learning disability |
| 23/10/2017 | SEPSIS MEETING |
| 23/10/2017 | HOLD UROLOGY SAI |
| 23/10/2017 | Health & Safety Committee Meeting |
| 23/10/2017 | AD SEC & ATICS and AMD SEC |
| 23/10/2017 | Catriona re RQIA reports |
| 23/10/2017 | HOS Cardiology re falls |
| 23/10/2017 | Caroline -meeting |
| 24/10/2017 | Acute Director and Director of Pharmacy meeting |
| 24/10/2017 | David re PM, SAI Letters, Service User Feedback Form, Staffing Budget, C Complaint, Q Com plaint |
| 24/10/2017 | PD & MMcA meeting |
| 25/10/2017 | Acute Director and Director of Pharmacy meeting |
| 25/10/2017 | SAI <small>Personal Information redacted by the USI</small> |
| 25/10/2017 | Governance Lead Nurse |
| 25/10/2017 | Confirmed meeting with CYP re Checking Pregnancy |
| 25/10/2017 | AD CCS re meeting |
| 25/10/2017 | Meeting re thermometers |
| 25/10/2017 | AD Human Resources walker re staffing issues |
| 26/10/2017 | Consultant Radiologist |
| 26/10/2017 | ED Consultant re DHH datix |
| 26/10/2017 | Paula re time lines |
| 26/10/2017 | SAI review meeting |
| | Annual leave 30/10/2017 to 5/11/2017 |
| 06/11/2017 | Senior Nurses Forum |
| 07/11/2017 | Rachel re SAI and junior doctor |
| 08/11/2017 | Acute Director and Director of Pharmacy meeting |
| 08/11/2017 | Roisin re SAI |
| 08/11/2017 | SAI review meeting |
| 08/11/2017 | Ann Quinn re death certificate |
| 09/11/2017 | AD SEC & ATICS |

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| 10/11/2017 | Acute Clinical Governance |
| 10/11/2017 | 100% challenge |
| 10/11/2017 | Heather |
| 13/11/2017 | AD SEC & ATICS re complaint |
| 13/11/2017 | Nurse Training (Governance) |
| 13/11/2017 | Meeting with Heather |
| 13/11/2017 | Sandra Waddell |
| 14/11/2017 | Sepsis in pregnancy |
| 14/11/2017 | ISO connectors |
| 14/11/2017 | Meeting with Lead Nurse Theatres, S&G lead and Governance Pharmacist re Injectable Medicines |
| 15/11/2107 | Acute Director and Director of Pharmacy meeting |
| 15/11/2017 | Katherine Robinson |
| 16/11/2107 | Pauline McSherry Radiology Rep for SAI |
| 16/11/2107 | Head Injury working group |
| 16/11/2107 | AD SEC& ATICS screening meeting |
| 16/11/2017 | Phone call to patient/family member |
| 16/11/2017 | Phone call to patient/family member |
| 16/11/2017 | Phone call with MHD Governance Coordinator |
| 17/11/2017 | Redevelopment meeting |
| 17/11/2017 | Meeting with IPC lead Nurse & Waste Manager re Polymer Gels |
| 20/11/2017 | Meeting with Heather |
| 20/11/2017 | Meeting with B Cullen |
| 20/11/2017 | Acute Lead Nursing, Midwifery & Radiology S&G Forum |
| 21/11/2017 | Acute Governance Workshop re structure |
| 21/11/2017 | Heather and Director of Pharmacy re POCT |
| 21/11/2017 | |
| 21/11/2017 | AMD SEC and AD SEC & ATICS re screening |
| 24/11/2017 | Cross site working group |
| 27/11/2017 | Complaint – family meeting |
| 27/11/2017 | complete Risk Assessment - polymer gels (if not using time for restrictive use of injectable meds) |
| 28/11/2017 | Urology SAI meeting |
| 28/11/2017 | prep screening with Ronan |
| 28/11/2017 | Director of Pharmacy |
| 28/11/2017 | complete Risk Assessment - polymer gels (if not using time for restrictive use of injectable meds) |
| 29/11/2017 | Acute Director and Director of Pharmacy meeting |
| 29/11/2017 | Patient Client Experience |
| 29/11/2017 | Director of Pharmacy |
| 30/11/2017 | Meeting with litigation |
| 1/12/2017 | Annual leave |
| 04/12/2017 | Governance Coordinator |
| 04/12/2017 | Acute Physician Audit of sepsis |
| 05/12/2017 | Consultant Anaesthetist LM |
| 06/12/2017 | Director and AD Pharmacy meeting |
| 06/12/2017 | SAI <small>Personal information</small> meeting |
| 07/12/2017 | Meeting to Review Phase 1 Backlog Database |
| 08/12/2017 | Acute Clinical Governance |
| 08/12/2017 | 100% Challenge |

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| 08/12/2017 | Heather re-sign off screening |
| 11/12/17 | SAI review meeting SAI <small>Personal Information</small> |
| 11/12/17 | Tony Glackin |
| 11/12/17 | Meeting with Patricia McVeigh Comms Team and Caroline re Checking Pregnancy Leaflets |
| 11/12/2017 | Acute Lead Nursing, Midwifery & Radiology S&G Forum |
| 12/12/2017 | Patient client experience |
| 12/12/2017 | Anita re results |
| 13/12/2017 | Acute Director and Director of Pharmacy meeting |
| 13/12/2017 | Sepsis 6 |
| 14/12/2017 | Dr Hogan |
| 14/12/2017 | Kate Cunningham regarding sign off |
| 15/12/2017 | Joint sister meeting re GAIN learning disability |
| 15/12/2017 | Screening |
| 15/12/2017 | IMWH/CCS quarterly Governance Meeting |
| 15/12/2017 | Internal Audit |
| 18/12/2017 | Demo of sign off |
| 18/12/2017 | Claire McNally OPPC Governance Coordinator re SAI |
| 18/12/2017 | Director of Pharmacy |
| 18/12/2017 | Medicines incidents |
| 18/12/2017 | QI lead and Governance Pharmacist (QI) |
| 18/12/2017 | Caroline |
| 19/12/2017 | SEC screening |
| 19/12/2017 | S&G meeting |
| 20/12/2017 | Acute Director and Director of Pharmacy meeting |
| 21/12/2017 | Director of Pharmacy |
| | Annual Leave 22/12/2017 – 28/12/2017 |
| 03/01/2018 | ED Consultant |
| 04/01/2018 | Confirmed Head Injury Leaflet Subgroup |
| 04/01/2018 | Consultant Anaesthetist LM |
| 08/01/2018 | Neutropenic Sepsis Audit |
| 09/01/2018 | Director of Pharmacy |
| 09/01/2018 | Flu meeting |
| 10/01/2018 | Acute Director and Director of Pharmacy meeting |
| 11/01/2018 | Datix Review |
| 11/01/2018 | SAI action plan |
| 11/01/2018 | Director of Pharmacy re post |
| 11/01/2018 | Incident meeting with NIAS |
| 11/01/2018 | Julian Johnston phone call |
| 12/01/2018 | Acute Clinical Governance |
| 12/01/2018 | Meeting AD MUSC |
| 12/01/2018 | Learning from Inquest |
| 12/01/2018 | Flu meeting |
| 12/01/2018 | Phone call with an SAI Chair |
| 12/01/2018 | Phone call Kate Cunningham re flu result issue |
| 15/01/2018 | SAI <small>Personal Information</small> meeting |
| 16/01/2018 | Meeting AD MUSC |
| 16/01/2018 | Adverse Incident Lessons Learned Project meeting |
| 17/01/2018 | Acute Director and Director of Pharmacy meeting cancelled due to snow |
| 17/01/2018 | Meeting with Director P&R Aldrena Magwood |

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| 17/01/2018 | Claire Shevlin |
| 17/01/2018 | SAI <small>Personal Information redacted by the</small> meeting |
| 18/01/2018 | IT manager & David re Datix Changes |
| 18/01/2018 | DPU DHH Datix 1:1 training |
| 18/01/2018 | Deaf awareness Always event |
| 18/01/2018 | IT re Datix |
| 18/01/2018 | MHD Governance Coordinator re Datix and SAI |
| 18/01/2018 | Acute Audit Committee - CANCELLED due to conflicting meeting |
| 19/01/2018 | Medicine Governance meeting |
| 22/01/2018 | Derek McKillop |
| 22/01/2018 | Lead Nurse, AHP, Radiology Forum Lead Nurse, AHP, Radiology Forum |
| 23/01/2018 | IV line meeting Anne and Caroline |
| 24/11/2018 | M Burke and G Hampton |
| 24/11/2018 | Flu |
| 25/01/2018 | Caroline and Ann re NCEPOD |
| 25/01/2018 | Regional Line Labels - Pre Tender Meeting |
| 26/01/2018 | IV fluid therapy for C&YP in hospital (NICE NG 29) |
| 26/01/2018 | SEA meeting |
| 26/01/2018 | RCA Team Meeting for SAI <small>Personal Information</small> |
| 31/01/2018 | SEA meeting |
| 31/01/2018 | NCEPOD for Anne |
| 31/01/2018 | SEA meeting |
| 31/01/2018 | SAI meeting to review family questions |
| 01/02/2018 | Consultant Surgeon MY regarding SAIs |
| 01/02/2018 | MUC Sisters re Governance and Datix |
| 01/02/2018 | Falls meeting |
| 02/02/2018 | Annual leave |
| 05/02/2018 | Governance coordinator re re SAI action plan |
| 05/02/2018 | ASN&MGF |
| 06/02/2018 | HOLD for meeting Dr Rankin and Dr |
| 06/02/2018 | Standards and Guidelines meeting |
| 06/02/2018 | Acute Governance |
| 07/02/2018 | Acute Director and Director of Pharmacy meeting |
| 07/02/2018 | Governance Coordinators meeting |
| 07/02/2018 | ED meeting |
| 07/02/2018 | Director of Pharmacy update |
| 07/02/2018 | Head injury meeting |
| 09/02/2018 | Acute Clinical Governance |
| 09/02/2018 | SAI <small>Personal Information</small> meeting |
| 09/02/2018 | Meeting AD MUSC |
| 09/02/2018 | IV fluids |
| 12/02/2018 | Urology SAI meeting |
| 12/02/2018 | Lead Nurse, AHP, Radiology Forum |
| 12/02/2018 | Governance Pharmacist and Lead Nurse re 1 S medication omitted Datix |
| 13/02/2018 | LASP meeting |
| 13/02/2018 | Sepsis Working Group Meeting |
| 13/02/2018 | Director of Pharmacy |
| 14/02/2018 | Acute Director and Director of Pharmacy meeting |
| 14/02/2018 | Obstetric MBRACE |

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| 14/02/2018 | ED Screening |
| 14/02/2018 | Adult and Paeds IV fluids - Hyponatraemia |
| 14/02/2018 | Clinical Audit with Anne Quinn |
| 15/02/2018 | Brigeen- IV audit |
| 15/02/2018 | SAI <small>Personal Information</small> |
| 16/02/2018 | Annual leave |
| | 19/02/2019 – 24/02/2018 <small>Personal Information</small> |
| 26/02/2018 | Regional Sepsis meeting |
| 28/02/2018 | Acute Director and Director of Pharmacy meeting |
| 28/02/2018 | Executive Director of Nursing re Hyponatraemia |
| 01/03/2018 | Patient Safety and Human Factors: 'Everyone's Business' |
| 02/3/2018 | Annual leave |
| 05/03/2018 | Executive Director of Nursing and Anne Quinn re Hyponatraemia |
| 07/03/2018 | Acute Director and Director of Pharmacy meeting |
| 07/03/2018 | Hyponatraemia oversight group |
| 07/03/2018 | HSE inspection safer sharps |
| 07/03/2018 | SAI review meeting |
| 07/03/2018 | Falls |
| 07/03/2018 | Executive Director of Nursing and AD Medical Directorate and Director of Pharmacy re hyponatraemia |
| 08/03/2018 | SAI review meeting |
| 09/03/2018 | Acute Clinical Governance Meeting |
| 12/03/2018 | Hyponatraemia and Lead Nurse, AHP, Radiology Forum |
| 13/03/2018 | MAPA |
| 13/03/2018 | IV Fluids in Adults RQIA Audit |
| 13/03/2018 | Director of Pharmacy |
| 14/03/2018 | Acute Director and Director of Pharmacy meeting |
| 14/03/2018 | SAI <small>Personal Information</small> meeting |
| 14/03/2018 | SEC Screening |
| 15/03/2018 | AD MUSC meeting |
| 15/03/2018 | Governance Coordinators meeting |
| 16/03/2018 | Annual leave |
| | 20/03/2018 – 21/03/2018 Annual leave |
| 22/03/2018 | IV fluids in adults |
| 22/03/2018 | SAI screening maternity |
| 23/03/2018 | Audit Meeting |
| 23/03/2018 | SAI report family meeting |
| 23/03/2018 | IMWH/CCS quarterly Governance Meeting |
| 26/03/2018 | Annual leave |
| 27/03/2018 | Hyponatraemia |
| | 28/03/2018 – 30/03/2018 & 03/03/2018 Annual leave |
| 04/04/2018 | Anne Quinn re Hyponatraemia |
| 05/04/2018 | Executive Director of Nursing re nursing and IV fluids |
| 05/04/2018 | Executive Director of Nursing and Anne Quinn re IV fluids |
| 05/04/2018 | Insulin QI project prep |
| 09/04/2018 | INSULIN QI project workshops |
| 10/04/2018 | Acute Directorate Work plan 2018/19. and CG174 completed audit proforma Anne Quinn |
| 10/04/2018 | Director of Pharmacy |
| 10/04/2018 | Dental Screening |

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| 10/04/2018 | Acute Clinical Governance |
| 10/04/2018 | Pre op Nurse re Gynae pre op |
| 11/04/2018 | Acute Director and Director of Pharmacy meeting |
| 11/04/2018 | Anne Quinn re M&M |
| 12/04/2018 | Phoned Sister re staff interview |
| 12/04/2018 | Staff interviews- re SAI |
| 12/04/2018 | Governance Pharmacist re Insulin QI |
| 12/04/2018 | Caroline, Barbara & Roisin re SAI - S&G |
| 13/04/2018 | Acute Clinical Governance |
| 13/04/2018 | Sepsis Meeting |
| 13/04/2018 | Phone meeting -Maria Deneen re Risk workshop |
| 13/04/2018 | AD CCS re RQIA |
| 13/04/2018 | Hyponatraemia |
| 16/04/2018 | Insulin QI project workshops |
| 17/04/2018 | Incident meeting |
| 18/04/2018 | Acute Director and Director of Pharmacy meeting |
| 18/04/2018 | Standards and Guidelines |
| 18/04/2018 | Helen Forde –sign off |
| 18/04/2018 | RQIA IV fluid focus group |
| 18/04/2018 | Director of Pharmacy |
| 20/04/2018 | AD MUSC McVey RQIA and complaints |
| 20/04/2018 | FY1 FORUM |
| 23/04/2018 | Lead Nurse, AHP, Radiology Forum |
| 23/04/2018 | Anne Quinn |
| 24/04/2018 | Philip and Mark |
| 24/04/2018 | Director of Pharmacy |
| 24/04/2018 | Checking Pregnancy Working Group meeting |
| 24/04/2018 | Anne Quinn |
| 25/04/2018 | Acute Director and Director of Pharmacy meeting |
| 25/04/2018 | AD MUSC team re RQIA templates |
| 25/04/2018 | HCAI Infection Prevention and Control Clinical Forum |
| 25/04/2018 | Michael Ross re Thermometers |
| 26/04/2018 | Insulin QI |
| 27/04/2018 | Lessons Learned Forum |
| 27/04/2018 | Heather Trouton |
| 27/04/2018 | Medicine Governance Meeting |
| 27/04/2018 | Pre-meeting for the RQIA Visit has been arranged to discuss Personal information |
| 30/04/2018 | Heather re RQIA |
| 01/05/2018 | Falls meeting |
| 01/05/2018 | SAI Personal information meeting |
| 02/05/2018 | Acute Director and Director of Pharmacy meeting |
| 02/05/2018 | AD MUSC meeting |
| 02/05/2018 | PSNI re CCTV from SAI |
| 03/05/2018 | Incident Management Training |
| 03/05/2018 | Staff interviews re SAI |
| 03/05/2018 | SAI guidance review Ronan |
| 04/05/2018 | Staff interviews re SAI |
| 04/05/2018 | Meeting with CX re SAI |
| 04/05/2018 | Acute Audit Committee |

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| 04/05/2018 | Meeting with litigation manager |
| 04/05/2018 | AD MUSC and AMD MUSC re SAI for CYP |
| 08/05/2018 | SAI <small>Personal Information</small> meeting |
| 09/05/2018 | Meeting with Director |
| 09/05/2018 | AD MUSC meeting re SAI notes |
| 11/05/2018 | Acute Clinical Governance |
| 11/05/2018 | Incident Management Training |
| 11/05/2018 | Deborah O'Hanlon re pilot |
| 14/05/2018 | AD SEC |
| 14/05/2018 | SAI review |
| 15/05/2018 | Clinical Result Sign Off |
| 15/05/2018 | Complaint meeting |
| 15/05/2018 | Standards and Guidelines |
| 15/05/2018 | AD CCS |
| 16/05/2018 | Acute Director and Director of Pharmacy meeting |
| 16/05/2018 | Meeting with Gareth Hampton |
| 17/05/2018 | SAI interview with staff |
| 17/05/2018 | Phone Mrs Burns |
| 17/05/2018 | G Kennedy Screening meeting |
| 18/05/2018 | AD MUSC re complaint meeting |
| 18/05/2018 | AD MUSC meeting |
| 22/05/2018 | Director of Pharmacy |
| 22/05/2018 | Regional fluids meeting |
| 23/05/2018 | SAI <small>Personal Information redacted by the</small> meeting |
| 23/05/2018 | G Kennedy re SAI |
| 23/05/2018 | Director of Pharmacy and Heather re structure |
| 24/05/2018 | Consultant microbiologist |
| 24/05/2018 | POD cast Insulin |
| 24/05/2018 | Falls meeting |
| 25/05/2018 | Renal consultant re IV fluids in adults |
| 25/05/2018 | SEC screening |
| 25/05/2018 | MHD Governance coordinator –re SAI report |
| 29/05/2018 | Meeting re falls |
| 30/05/2018 | MUSC screening |
| 30/05/2018 | SOP injectable meds and arterial lines |
| 30/05/2018 | AD MUSC re complaint |
| 31/05/2018 | AD CCS screening meeting |
| 01/06/2018 | CSCG officer re RQIA |
| 01/06/2018 | Heather Trouton & Director of Pharmacy |
| 01/06/2018 | Learning disability meeting |
| 01/06/2018 | Director of Pharmacy update |
| 01/06/2018 | AD Human Resources |
| 04/06/2018 | Director of Pharmacy and Dr Johnston |
| 05/06/2018 | Annual Leave (unexpected meeting cancelled) |
| 06/06/2018 | Acute Director and Director of Pharmacy meeting |
| 06/06/2018 | Interview with staff with SAI |
| 06/06/2018 | DLS interview re SAI |
| 06/06/2018 | Anne Quinn re IV fluids |
| 07/06/2018 | AD CCS Screening |
| 08/06/2018 | Acute Clinical Governance |

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| 08/06/2018 | Incident Management Training |
| 08/06/2018 | Complaints meeting with Corporate Governance & Northern Ireland Public Services Ombudsman Office |
| 11/06/2018 | SAI meeting Urology |
| 11/06/2018 | Cervical Screening |
| 11/06/2018 | Lead Nurse, AHP, Radiology Forum |
| 11/06/2018 | Meeting re- rejected Results |
| 12/06/2018 | Annual leave |
| 13/06/2018 | Acute Director and Director of Pharmacy meeting |
| 13/06/2018 | Adult IV fluid meeting with AD MUSC and Medical staff |
| 13/06/2018 | Hyponatraemia RQIA review |
| 14/06/2018 | Incident DHH Theatres |
| 15/06/2018 | Deteriorating Patient: Assessment, Intervention and Management – Regional meeting |
| 15/06/2018 | ED incident Medical Director, AD MUSC |
| 18/06/2018 | Insulin workshop |
| 18/06/2018 | SAI review meeting |
| 19/06/2018 | Meeting with consultants |
| 19/06/2018 | Clinical Result Sign Off |
| 19/06/2018 | Pod cast- Insulin |
| 20/06/2018 | Acute Director and Director of Pharmacy meeting |
| 21/06/2018 | Incident review meeting |
| 21/06/2018 | Trusts Accessible Information Strategy Group |
| 21/06/2018 | Anne Quinn re post |
| 21/06/2018 | Policies – update - Jillian Doogan |
| 22/06/2018 | Checking pregnancy |
| 22/06/2018 | IMWH/CCS Division Governance Forum |
| 25/06/2018 | SAI review meeting |
| 25/06/2018 | Medicines governance |
| 25/06/2018 | Incident Management Presentation |
| 26/06/2018 | Insulin |
| 26/06/2018 | SAI review meeting |
| 26/06/2018 | Labs – LIMS meeting |
| 26/06/2018 | SAI meeting with MHD |
| 27/06/2018 | Acute Director and Director of Pharmacy meeting |
| 27/06/2018 | Governance Coordinators meeting |
| 27/06/2018 | POCT meeting |
| 28/06/2018 | Anne Quinn re audit |
| 28/06/2018 | Consultant Haematologist |
| 28/06/2018 | CCS screening |
| 29/06/2018 | AD Functional Service meeting re Datix |
| 29/06/2018 | SAI discussion AMD MUSC |
| 29/06/2018 | AD MUSC |
| 02/07/2018 | SN&MGF |
| 02/07/2018 | SAI <small>Personal Information</small> review |
| 03/07/2018 | Litigation meeting with SEC |
| 04/07/2018 | Acute Director and Director of Pharmacy meeting |
| 04/07/2018 | Audit committee |
| 06/07/2018 | Director of Pharmacy |
| 06/07/2018 | SAI review meeting |

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| 06/07/2018 | SAI family meeting |
| 06/07/2018 | Incident meeting |
| | Patient Safety Conference 09/07/2018- 10/07/2018 |
| 11/07/2018 | Acute Director and Director of Pharmacy meeting |
| 11/07/2018 | Director of Pharmacy and AD CCS |
| 13/07/2018 | SEC & ATICS screening |
| 16/07/2018 | Thrombosis committee |
| 18/07/2018 | Acute Director and Director of Pharmacy meeting |
| 20/07/2018 | Audit meeting cancelled |
| 20/07/2018 | Hyponatraemia Oversight Group |
| 23/07/2018 | Review of implementation plan: safe use of oral bowel prep |
| 23/07/2018 | Medicines incidents meeting |
| 23/07/2018 | Meeting with POCT - Serum Testing CPBS |
| 23/07/2018 | Controls Assurance |
| 24/07/2018 | Learning Disability |
| 24/07/2018 | NEWS oversight group |
| | Annual leave 25/07/2018 |
| 26/07/2018 | AD Human Resources |
| 27/07/2018 | Meeting re SAI MUSC, Functional Service and CSCG |
| | Annual leave 30/7/2018 – 15/8/2018 |
| 16/08/2018 | Standards and Guidelines |
| 20/08/2018 | Regional Interagency Guidance on dealing with persons who go missing from Emergency Departments |
| 20/08/2018 | AD MUSC |
| 21/08/2018 | SAI review meeting (a urology case) |
| 21/08/2018 | Update AD SEC & ATTICS on screening |
| 22/08/2018 | Acute Director and Director of Pharmacy meeting |
| 22/08/2018 | Staff debrief post SAI review |
| 22/08/2018 | Meeting re SAI urology |
| | Annual leave 23/08/2018 to 24/8/2018 |
| 28/08/2018 | SAI review meeting |
| 29/08/2018 | Acute Director and Director of Pharmacy meeting |
| 29/08/2018 | Meeting with potential new staff member |
| 29/08/2018 | Litigation meeting |
| 29/08/2018 | SAI <small>Personal information</small> review meeting |
| 30/08/2018 | Meeting re complaint referred to ombudsman |
| 30/08/2018 | AD MUSC |
| 30/08/2018 | Risk Midwife |
| 31/08/2018 | Meeting re SAI |
| 31/08/2018 | Meeting OSL |
| 31/08/2018 | Meeting with family re SAI |
| 03/09/2018 | SAI review meeting |
| 03/09/2018 | MUSC screening |
| 04/09/2018 | SAI <small>Personal information</small> review meeting |
| 05/09/2018 | Acute Director and Director of Pharmacy meeting |
| 05/09/2018 | Heather Trouton |
| 05/09/2018 | Refurbished Hydrotherapy Suite in the Physiotherapy Department, Craigavon Area Hospital |
| 05/09/2018 | Director of Pharmacy |
| 05/09/2018 | Consultant meeting re SAI |

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| 06/09/2018 | ABO incompatibility Incident |
| 06/09/2018 | Family meeting re SAI |
| 06/09/2018 | NEWS 2 |
| 07/09/2018 | Acute Clinical Governance |
| 07/09/2018 | Litigation meeting |
| 07/09/2018 | Heads of Service and Lead Nurses re Datix |
| 07/09/2018 | IMWH/CCS Divisional Governance Forum |
| 07/09/2018 | AD MUSC |
| 10/09/2018 | Consultant Haematologist |
| 10/09/2018 | Urgent meeting re CMO HSS MD 13/2018 Vaginal Tapes Pause in Procedures |
| 10/09/2018 | Checking Pregnancy before Surgery Meeting |
| 10/09/2018 | IMWH SAI Screening |
| | SAI training 11/09/2018- 13/09/2018 |
| 14/09/2018 | Leadership Course |
| 17/09/2018 | Incident Management Training |
| 17/09/2018 | Hyponatraemia Oversight Group |
| 17/09/2018 | SAI Personal information review meeting |
| 17/09/2018 | Consultant telephone meeting re SAI reports |
| 17/09/2018 | Engagement phone call and update on SAI |
| 18/09/2018 | Internal audit |
| 18/09/2018 | Consultant meeting re Incident |
| 18/09/2018 | Booking centre manager = re Urology SAI |
| 19/09/2018 | Acute Director and Director of Pharmacy meeting |
| 19/09/2018 | SAI review meeting |
| 20/09/2018 | Learning disability |
| 21/09/2018 | Place of safety training |
| 21/09/2018 | Trust Sepsis Working Group Meeting |
| 22/09/2018 | Audit |
| 24/09/2018 | Lead Nurse, Midwifery, Radiology & AHP Meeting |
| 24/09/2018 | AD MUSC re SAI |
| 25/09/2018 | Surgical Paediatric meeting |
| 25/09/2018 | Acute Governance Team Workshop |
| 26/09/2018 | Acute Director and Director of Pharmacy meeting |
| 26/09/2018 | Incident Management Training |
| 27/09/2018 | Acute Directorate Learning Disability Awareness Training |
| 01/10/2018 | Senior leaders forum |
| | Leadership Course 02/10/2018-03/10/2018 |
| 04/10/2018 | Oral Bowel Prep QI Meeting |
| 04/10/2018 | Esther re SM action plan |
| 04/10/2018 | FSS Divisional Meeting (Datix Presentation) |
| 04/10/2018 | SAI Personal information review meeting |
| 05/10/2018 | Internal Audit Forum |
| 08/10/2018 | SAI review meeting |
| 08/10/2018 | AD MUSC re SAI |
| | Governance teams MD and AD Governance, Directors, and Governance coordinators |
| 08/10/2018 | Lead Nurse, AHP, Radiology Forum |
| 09/10/2018 | Director of Pharmacy |
| 10/10/2018 | Coroners Court |

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| 11/10/2018 | Coroners Court |
| 11/10/2018 | Phone meeting Governance coordinator MHD |
| 12/10/2018 | Acute Clinical Governance |
| 12/10/2018 | Heather Trouton |
| 12/10/2018 | Melanie McClements |
| | Action plan meeting with MHD re SAI |
| 16/10/2018 | Leadership Course |
| 16/10/2018 | Standards and Guidelines |
| 17/10/2018 | Acute Director and Director of Pharmacy meeting |
| 17/10/2018 | Incident Management Training |
| 17/10/2018 | Orthoptist re SAI |
| 17/10/2018 | SAI review meeting |
| 19/10/2018 | SAI <small>Personal information</small> review meeting |
| 23/10/2018 | Director of Pharmacy |
| 23/10/2018 | IBD meeting |
| 24/10/2018 | Acute Director and Director of Pharmacy meeting |
| 24/10/2018 | Insulin QI meeting |
| 24/10/2018 | Clinitek install plans |
| 24/10/2018 | DMD MUSC meeting re SAI |
| 25/10/2018 | Maternity SAI |
| 25/10/2018 | Incident Management Training |
| 26/10/2018 | External overview re SAI |
| | HoS planning |
| 30/10/2018 | Litigation re Datix |
| 30/10/2018 | Diabetic nurses re Insulin QI |
| 30/10/2018 | NEWS 2 Implementation Oversight Group |
| 31/10/2018 | Acute Director and Director of Pharmacy meeting |
| 31/10/2018 | Staff meeting re SAI |
| 01/11/2018 | Regional EWS2 Meeting |
| 02/11/2018 | Annual Leave |
| | CHKS data with Head of Performance |
| 07/11/2018 | Acute Director and Director of Pharmacy meeting |
| 07/11/2018 | POCT re urinalysis placement |
| 07/11/2018 | Band 6 Induction Executive Director of Nursing |
| 07/11/2018 | Equipment management |
| 07/11/2018 | Litigation manager re coroners support for staff |
| 07/11/2018 | AD MUSC and Litigation manager |
| 08/11/2018 | SAI <small>Personal information</small> review meeting |
| 08/11/2018 | Preparation meeting for family engagement meeting |
| 08/11/2018 | Hyponatraemia 14-16 year old children in adult wards |
| 08/11/2018 | AD CCS re incidents and POCT |
| 09/11/2018 | Acute Clinical Governance |
| 09/11/2018 | Family engagement meeting (incident) |
| 12/11/2018 | Hyponatraemia Oversight Group |
| 12/11/2018 | Coroners feedback session |
| 12/11/2018 | Lead Nurse, AHP, Radiology Forum |
| 13/11/2018 | AD MUSC |
| 13/11/2018 | Fraud awareness training |
| 13/11/2018 | Medical device steering group meeting |
| 14/11/2018 | Acute Director and Director of Pharmacy meeting |

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| 14/11/2018 | Staff feedback meeting following incident learning |
| 15/11/2018 | Meeting with union representative |
| 15/11/2018 | Consultant meeting |
| 15/11/2018 | AD re RQIA and incident |
| 16/11/2018 | Trust QI event Insulin poster |
| 19/11/2018 | Incident Management Training |
| 20/11/2018 | Review of reports |
| 20/11/2018 | Sedation Committee |
| 20/11/2018 | Phone call to Lead nurse re outcome of endoscopy meeting |
| 21/11/2018 | Acute Director and Director of Pharmacy meeting |
| 21/11/2018 | Lead nurse individual discussions regarding hyponatraemia guidelines |
| 21/11/2018 | AD MUSC re complaints |
| 21/11/2018 | Peg Tube Guidelines meeting |
| 22/11/2018 | SAI <small>Personal information</small> review meeting |
| 23/11/2018 | Meeting re incident grading |
| 23/11/2018 | AD performance |
| 23/11/2018 | AD MUSC and DMD MUSC re family meeting |
| 23/11/2018 | AD MUSC NMC and RQIA |
| 26/11/2018 | AD CCS re risk register |
| 27/11/2018 | Equipment management |
| 27/11/2018 | AD MUSC performance and IA |
| | Leadership Course 28/11/2018 -29/11/2018 |
| 30/11/2018 | Internal Audit meeting |
| 30/11/2018 | SAI <small>Personal information</small> review meeting |
| 03/12/2018 | Complaints Management |
| 04/12/2018 | Consultant Cardiologist |
| 04/12/2018 | Family engagement meeting |
| 05/12/2018 | Acute Director and Director of Pharmacy meeting |
| 05/12/2018 | AD MUSC Audit of NEWS chart |
| 05/12/2018 | Family engagement phone call |
| 06/12/2018 | SMT Governance |
| 10/12/2018 | Lead Nurse, AHP, Radiology Forum |
| 11/12/2018 | SEA review meeting |
| 11/12/2018 | Urology SAI review meeting |
| 12/12/2018 | Acute Director and Director of Pharmacy meeting |
| 12/12/2018 | Acute Director and Director of Pharmacy meeting |
| 12/12/2018 | Regional QI Sepsis Group Innovation Factory |
| 13/12/2018 | Interviews for Datix administrator |
| 14/12/2018 | Acute Clinical Governance meeting |
| 14/12/2018 | Obstetric incident debrief |
| 14/12/2018 | SAI <small>Personal information</small> review meeting |
| 17/12/2018 | Review of restrictive practice interventions for the Band 7 and 6 staff in the acute and non-acute hospital sites. |
| 17/12/2018 | Telephone call Nursing Education re DKA training |
| 17/12/2018 | SAI <small>Personal information</small> review meeting |
| 19/12/2018 | Acute Director and Director of Pharmacy meeting |
| 19/12/2018 | Acute Director |
| 20/12/2018 | Acute Resuscitation Committee |
| 21/12/2018 | Governance Pharmacist |
| 31/12/2018 | Meeting with doctor |

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| 31/12/2018 | Sister 1N re Datix |
| 31/12/2018 | Respiratory Physician |
| 02/01/2019 | Acute Director and Director of Pharmacy meeting |
| 02/01/2019 | Medical Director and AD Medical Directorate |
| 03/01/2019 | SAI meeting |
| 04/01/2019 | Telephone call Haematologist |
| 04/01/2019 | Meeting New Governance Coordinator |
| 04/01/2019 | Consultant Haematologist re SAIs |
| 04/01/2019 | Phone call locum Consultant |

From: [Reid, Trudy](#)
Sent: 30 September 2016 16:16
To: [Boyce, Tracey](#); [Trouton, Heather](#); [Conway, Barry](#)
Subject: Delays in appointments diagnosis or treatment.xlsx
Attachments: [Delays in appointments diagnosis or treatment.xlsx](#)

As discussed

Trudy

Delays in appointment / diagnosis

| Datix number | Patient details | HCN | Summary of issue | Outcome | Recommendations if any |
|--|----------------------|----------|---|---|---|
| Personal | Personal | Personal | CT renal was done on 17/9/15. Report was received by secretary on 25/9/15. CT raised a suspicion of myeloma. Report was seen by me on 26/9/16 and I requested urgent OPD within 1-2 weeks with a specific mention that 'I am happy to see him as an extra patient' But, an OPD appointment was made only 13/7/16. MRI and blood tests requested 13/7/16. We need to wait for the reports. Hopefully, there is no malignancy. | 13/07/16 - OPD letter - In essence, it is unlikely that there is any sinister problem but still I have requested an MRI spine and arranged for all relevant blood tests. | |
| Personal | Personal | Personal | It was reported from nursing home regarding below mentioned patient that she suffered TIA on 10th July at 9.00 am the care assistant was walking this nursing home resident to the toilet, whereby she loss power in her leg, care assistant lowered the patient called nursing staff who reported patient was unable to speak or stick out the tongue and had loss of right arm power and patient felt weak with it, observation were stable except BP was 78/50. It all resolved within 2-3 minutes This patient was seen on 06/06/16 at pacemaker check clinic, patient had episode of Paroxysmal Atrial Fibrillation, Cha2ds2vasc =4, the cardiac physiologist brought it to my attention, as this patient has mild Personal and was being transferred to Belfast, the importance of being on anticoagulation was highlighted in view of age and eGFR and no murmur, choice of DOAC was done, However the family preferred to get it referred to GP, Personal, urgent letter was dictated on 06/06/16 with information of the GP outlined, I also called the surgery to make sure that they had anticoagulant clinic locally and this patient warrants anticoagulation in view of AF on PPM check I was contacted on 11 July @11.30 am to report patient had experienced a TIA, On investigating further it seemed that the GP had not received any correspondence from us, hence anticoagulation was not commenced. | Discharged Personal 20/4/16 | |
| Personal | Patient 138 | Personal | Patient was waitlisted for removal of ureteric stent on 17/11/2014, This request was registered in the book in stone treatment centre. A green booking form was also filled in at the same time. But this was overlooked. Patient had to have the stent in unnecessarily too long He was reviewed in clinic today and realised that the stent was still insitu. Arranged to remove the stent only today.. | | |
| Personal | Personal | Personal | SECRETARY TOOK A PHONE CALL FROM A PATIENT TO SEE IF SHE WAS ON THE WL FOR A REPEAT OGD AS SHE HAS BARRETT'S OESOPHAGUS, NOTES WERE IN CAH SO SECRETARY COULD NOT CHECK AT THIS TIME AS SHE IS BASED IN STH. SHE CHECKED WITH GP WHO CONFIRMED THEY HAVE A LETTER FROM 1.3.12 SAYING OGD TO BE REPEATED IN 2 YEARS. THE PATIENT WAS NOT ADDED TO THE WL. PATIENT WAS SCOPED BY A GPSE. PATIENT ADDED TO WL AND HAS BEEN GIVEN A DATE TCI ON 24/6/16 | TCI 24/06/16 letter dictated 3/8/16 This lady had a surveillance upper GI endoscopy for Barrett's metaplasia. The OGD did indeed confirm Barrett's. Biopsies have not shown any evidence of dysplasia or malignancy. She will be booked for a repeat OGD in 2 years time. | |
| Personal | Breast clinic | | Failure by A&C agency/bank staff to follow A & C protocol re printing appointment letters over 3 clinic sessions 140 patients affected. 140 PATIENTS DID NOT RECEIVE APPOINTMENT LETTERS. Immediate response by A and C team to rebook and phone patients. | | |
| Personal | Personal | Personal | Chest x-ray performed 2014. Correctly reported tumour but not actioned. Represents now with abnormal CXR and CT has confirmed tumour. H&C Personal GP has made patient aware of 2014 x-ray Patient currently on lung cancer red flag pathway I have informed patient we will investigate above | OPD letter 9/6/16 poorly differentiated squamous cell carcinoma and his PET scan showed an FDG positive lesion in the right upper lobe with uptake in the hilar node and also a right paratracheal node. | Litigation request |
| Personal | Personal | Personal | X-ray 4/7/15 not picked up 26/08/15 - not SAI was pending Personal report patient cancelled for TURP elective surgery due to suspicious lesion on CXR. Had been seen at preassessment where cxr (3/7/15 taken when inpatient) had been seen by preop anaesthetist and report noted bulky hilum. No follow up noted. Repeat cxr organised for 1/9/15. Lesion looked worse and decision taken to cancel elective surgery by myself and surgeon. | Died Personal under care of palliative team | |
| Personal | Personal Information | Personal | PATIENT RANG IN TO CHECK WHEN HE WOULD SEEN AST GRATRO - THIS ALERTED GASTRO SEC IN ACH AS PATIENT WAS NOT ON PAS. PATIENT WAS ATTENDING A NURSE LED CLINIC AND WAS SEEN AS A WALK IN AT DR Personal RF CLINIC Personal DICTATED A REFERRAL TO GASTROENTEROLOGY. THIS WAS RECORDED ON THE NURSE CLINIC SHEET, THE CHART WAS SENT TO THE TYPIST, BUT AS THE PATIENT WAS NOT ON THE SHEET AS A WALK IN, THE LETTER WAS NOT PICKED UP TO BE TYPED AT THE TIME. THE REFERRAL WAS ACTIONED ON 24/3/16 WHEN A CLEAR UP WAS DONE ON DIGITAL DICTATION. REFERRAL TO GASTRO MADE AND GRADED AS URGENT. HEAD OF SERVICE FOR DERM AND ADMIN MADE AWARE. ACTIONS BY SERVICE ADMINISTRATOR •Admin Staff to ensure that if there are comments on the clinic sheet to follow up and pass to the relevant secretary. The secretaries to ensure that a fortnightly check of G2 is done for outstanding letters. Spot checks by SA extended to ensure that there is no outstanding dictation on G2 that is older than that recorded on the backlog report. | Clinic 8/6/16 letter states Certainly at this point I am not compelled to proceed with endoscopy. I will ask the GP if they can arrange a helicobacter breath test for this man and if positive eradicate. If he has steroids I would suggest PPI cover | |
| | Personal Information | | screened some time as SEA - Barry wanted Helen to take forward as SEA but I think we need a clinician can we discuss - oesophageal CA see attached info Personal patient undergoing OGD as per Barrett's syndrome review on 10 March 2010. Hardcopy histology report stated: 'special status for P53 highlight the area of concern, strengthening the interpretation of dysplasia. Further biopsies are advised.' GP re-referred patient on 26 May 2015 upon noting the absence of any further review. Histology samples from examination on 17 June 2015 revealed esophageal mucous membrane adenocarcinoma. | | |
| Personal Information redacted by the USJ | Personal | Personal | Personal 29 YEAR OLD ATTENDED AFTER rta KNEE PAIN XRAY INITIALLY READ BY ED DOCTOR NORMAL OFFICAL REPORT WAS THEN MADE BY REPORTING RADIOGRAPHER 2DAYS LATER REVEALING A FRACTURE. NO REPORT WAS FLAGGED TO SENIOR ED STAFF UNTIL HER ATTENDANCE TO ED PHYSIO ON THE 6TH JANUARY WHEN THE OFFICAL REPORT WAS NOTED AND ACTED UPON. NOTE ALSO IS THE LADY DID PHONE HER GP ON THE 29TH DEC WITH INCREASING PAIN AND THE GP WAS NOT ABLE TO PROVIDE PATIENT WITH INFO FROM HER ED ATTENDANCE OR READ THE OFFICAL REPORT FROM THE XRAY SYSTEM | Letter 2/9/15 This lady is now almost 9 months from her operation. She is undergoing physio in Personal. With regards to mobilisation she now walks without aids and pain free. She finds that she cannot walk quite as far or as fast as before. The only movement that she has any problems with is walking down stairs when the knee feels a little weak. | Radiology Department to send electronic notification of unexpected abnormal findings to referring clinician, creation and distribution for Name and Date stamp for each Emergency Department Clinician who are responsible for x-ray audit in the Emergency Department. Each patient record to be stamped by Clinician who undertakes the daily audit, Multi-disciplinary process needs to be formalised and documented in relation to the management and processing of abnormal x-ray findings. This process needs to reflect any amendments made in response to this SAI investigation. SHSCT Clinicians to consider making an entry in PACS detailing clinical findings and or management plan. This will support the Radiologists assessment to flag or not to flag any notable findings, |

| | | | | | | |
|----------------------|-------------|--------------------------------|--|---|--|--|
| Personal | Patient 128 | 01/08/2014 Personal | In August 2012 Personal Patie underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Patie was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013. Patie did have a CT scan in May 2013 as arranged but was not reviewed in June. On 20th August 2014, concerned that Patie might have recurrent disease, Patie's GP referred Patie back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan. | RIP Personal | The Review Team recommends a robust system for managing overdue Uro-oncology review is established. of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust. must be actioned if required and signed off by an appropriate person. discharge letter should be dictated for every Urology patient. team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker | 2) A handover 2) A 3) All radiology reports 4) A timely 5) The review |
| Personal | Personal | 30th October 2013. Personal | (CAH) with a six month history of painless rectal bleeding. Patie was seen in November 2007 at which time a rigid sigmoidoscopy was carried out and barium enema arranged. This was done on 4th January 2008. The subsequent correspondence to the GP (21/02/08) indicated the barium enema revealed a constant filling defect consistent with pedunculated polyp therefore a flexible sigmoidoscopy would be arranged. Perso underwent colonoscopy on 30th October 2013. An un-resectable 2cm polyp, which was suspicious of malignancy, was noted in the distal sigmoid colon. A 4x3cm soft tissue lesion was seen on CT scan (07/11/13) - malignancy could not be ruled out. On 12th November 2013 Perso underwent a "high anterior resection and right hemi-colectomy". The histology findings confirmed a "Dukes A tumour (adenocarcinoma), and 6mm nodule containing metastatic neuroendocrine carcinoma" within the "high anterior resection" specimen and a "neuroendocrine carcinoma" contained within the "right hemicolectomy". Perso was referred to an Oncologist for further management and was seen on 24th May 2014, treatment was not required at this time. | Letter April 16 Mater Hospital Personal female admitted electively for left hepatectomy. Previous right hemicolectomy and anterior resection in 2013. Asymptomatic on admission. Had been feeling well up until lesions were noted. MRI liver in January showed two masses in segment 1Vb of liver. No intra or post op complications. Post op, pain controlled with paracetamol. Personal is feeling well, eating and drinking, sitting out of bed and mobilising on ward. | Recommendation 1 Consideration should be given to developing and introducing an electronic system of request for endoscopy The current requesting system should be reviewed to incorporate a stringent method for checking that endoscopy requests have been actioned by the secretarial support team. Recommendation 2 Recommendation 3 Currently General Practitioners receive a regular bulletin from the Trust on current waiting times for each specialities' procedures/investigations. The circulation list should be expanded to include all clinicians so that they are aware of these times, so that when they are explaining the plan for a patient's on-going treatment/investigation, they can give the patient an indication of when to expect an appointment. | Recommendation 2 |
| Personal | Personal | Personal | This patient was undergoing bowel investigations. Previous history of Rt hemicolectomy and ileostomy for malignancy. Colonoscopy done on 6/3/14 and 5/4/14 with polypectomys done on both occasions. Patient reviewed by consultant 26/8/14 and patient informed that there evidence of malignant disease in polyps. Patient should have been reviewed in April 2014 with results. Cons informed pt and wife of omission | Letter 28/7/16 I am pleased to say that Personal recent CEA was normal at 2.5. I look forward to seeing him again at his next review appointment. | Creation of Trust-Wide Standard Operating Procedures for the clerical teams in relation to allocation of review appointment following investigative procedures. This will have to include input and support from Clinicians in all specialities to ensure that each procedure reflects each specialty's processes. Creation of Trust-Wide written guidance in relation to the validation of reports, results and histology by each Consultant-Lead team. This guidance will need to reflect both a Corporate and Consultant response to the governance responsibilities when managing patient results. The Operational Teams responsible for implementation of change will need to seek agreement on a basic minimum standard, as well ensure that Trust-Wide, each specialty produce any variances in writing for inclusion. Consultant and clerical annual leave/sick leave contingency planning needs to be considered. | |
| Personal | Person | Personal HCN | Missed cancer. Anaemia CT Colon- May 14 ? cancer ascending colon. Direct visualisation advised- not booked. Patient presented April 15 Obstructing caecal cancer with Liver mets- likely incurable disease. | Deceased Personal | The SHSCT Acute Services continue to monitor and reduce the Surgical Review Backlog and waiting times Wide Outpatient Consultation Rooms are furnished with the waiting times for Review patients for each Consultant on a monthly basis Consultation Rooms are furnished with Radiology waiting times for routine procedures instruction that all Doctors are expected to provide clear and precise instruction in relation to patient review. The SHSCT need to consider formally discouraging the term 'in due course' within every speciality. | The Trust- The Trust-Wide Outpatient The SHSCT Induction includes |
| Personal | Perso | Perso | Patient anaesthetised for a procedure. After anaesthetic induced the surgeon decided that surgical intervention was inappropriate and the patient was woken and sent to recovery | Letter 13/12/15 Personal died prior to my post-take ward round after being admitted drowsy and clinically septic. We were away of his metastatic colorectal carcinoma and appropriate comfort measures had been commenced from point of admission and he had been declared not for cardio pulmonary resuscitation. I apologise for the delay in this notification. | Trust-Wide written guidance needs to be created in relation to the validation of reports, results and histology by each Consultant-Lead team. This guidance will need to reflect both a Corporate and Consultant response to the governance responsibilities when managing patient results. The Operational Teams responsible for implementation of change will need to seek agreement on a basic minimum standard, as well ensure that Trust-Wide, each specialty produce any variances in writing for inclusion. Consultant and clerical annual leave/sick leave contingency planning needs to be considered. There needs to be agreement and documented process that if there is a mis-match between proposed/current management, Radiology will electronically flag the abnormal result to the Clinician making the imaging request. There is a fundamental need to ensure that clinicians provide adequate clinical history in a format suitable to PACS and the Radiologist on submission of Radiology requests. The SHSCT need to consider implementation of a Pre Op Investigation Pathway or check list which records current and timely information in relation to preoperative investigations (where relevant). This needs to be available on the day of admission to the medical and nursing staff admitting the patient in an easily accessible format. The action plan needs to include investigations done for NHS patients which are done in the private sector. The SHSCT Radiology team require the current process in relation to the hardcopy circulation of hardcopy x-ray reports to be revised to ensure more timely delivery. Target delivery times for reports, the format of reports need to be agreed and maintained. The action plan needs to include investigations done for NHS patients which are done in the private sector. Acute Services within the SHSCT need to consider training, process map and the utilisation of the 'PACS worklists' option in an effort to support the timely management of radiological requests for clinicians. The Review Panel recommends that there is regular communication or meetings in relation to clinical and radiological mis-matching on both Acute sites in the first instance. These meetings should be open to all specialities to provide a forum to discuss and address any issues around classifications of referral or clinical mis-matches. The action plan needs to include investigations done for NHS patients which are done in the private sector. | |
| Personal Information | Patient 10 | Patient 10 | Patient Personal Patient 10. Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney. US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate. MRI performed 2/9/2014 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had. Had a further CT on 29/10/2014 as follow-up for breast cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney, (previously investigations noted)' Patie was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine by the [GP (on basis that MRI had reported a benign cyst)]. Referral was not triaged on receipt. Patie sent OP appointment for 6/1/2016. Consultant had noted in clinic preparation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Patie was seen in clinic on 6/1/16. the sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan. | Letter OPD 16/08/16 Diagnosis: Currently undergoing treatment for breast cancer Complex renal lesion felt likely to be cystic renal cancer Outcome: Outpatient review 8 weeks I reviewed this lady today. She continues on her breast cancer treatment. She tells me her chemotherapy had to be discontinued. I also note she was admitted with an atypical chest infection towards the end of June. Her next treatment is radiotherapy and this is due to start in the next week or two for duration of 5 weeks of treatment. I plan to review her in 8 weeks. She has had a follow up CT scan which was performed during her admission and on this CT scan the renal lesion is unchanged in size. Providing all is well when I see her in 8 weeks I will look to arrange her renal surgery. | Under review | |
| Personal | Personal | Personal | patient attended with history of fall, facial bruising denied neck tenderness. discharged following asesment and facial bones x rays. attended ED DHH 2 days laer with vomiting. CT brain NAD, no c spine tenderness, admitted as minor head injury to femaile surgical ward. Ct C spine 23/10/15 showed c spine fracture. | Solicitor letter received regarding compensation | Feedback should be given to relevant staff as a way of informing practice Emergency Nurse Practitioner Head Injury protocol needs reviewed to define clearly "Minor Head Injury" and advise on the exclusion of additional neck injury in high risk patients | The |
| Personal | Perso | 13.05.16 Personal | 29 year old attended ED with head injury and neck pain after fall in nursing home. was discharged back to NH after x rays. returned ED 3 days later unwell. admitted UTI, off feet. subsequently established C Spine fracture was not indentified on her initial attendance 12/05/15. patient arrested and died on ward Personal | Died Personal | The report should be shared with operational teams for learning There should be a senior review on vulnerable patients with head/neck injuries. prior to discharge from ED is required to wait for an extended period of time in the ED for return to a Nursing Home they should have a nursing assessment and care documented. following a recent relevant ED attendance should have a thorough review of notes and investigations from the first attendance examination should be carried out on all patients admitted to MAU in a timely manner. appropriate procedures in place for when discharge back to nursing homes is either not appropriate or possible in the out of hour's period. for the timely reporting of ED X rays | There When a patient Patients re-attending A full assessment and The Trust should have The Trust should create a system |
| Personal | Personal | 29/07/2016 Personal | Patient attended gynae OP with intermenstrual and postcoital bleeding on several occasions diagnosis of cervical cancer made on 29/07/2016 investigation and referred onwards to BCH | | The patient is aware that the clinical findings are not typical of a cervical tumour A smear sent about a year ago was inadequate with a recommendation for a repeat in 3 months The patient states that the treatment room nurse took smears in the interim which do not seem to have been sent possibly because they were heavily blood stained 3 inadequate smears would have resulted in colposcopy When I took a smear she bled extremely heavily and I think this is possibly where the opportunity was missed I presume Tim will investigate Might need to involve the GPs surgen Perso | |

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|--------|----------|---|--|---|----------------------|
| Person | P | 19/11/2013 Personal | Personal Information was assessed at the Dermatology OPD Craigavon Hospital on 19/11/13. A dermatofibroma was diagnosed and a plan to review him in 2 months at the Dermatology Outpatients Clinic was planned. There was a delay in his review, he was actually reviewed 23/12/14. At this review a diagnosis of possible cancerous nodule was made. This was excised on 12/03/15. He has been referred to plastics UHD for possible further surgical excision. He has been referred to oncology. 10 month Delay in patient being reviewed at dermatology OPD. cancerous tumour. datix completed as case screened for SAI level 1 | <p>opd LETTER 18/7/16</p> <p>His scar remains well settled. He is still obviously quite annoyed by the physical appearance of it and we will refer him to Changing Faces in this regard.</p> <p>He hasn't heard back from them.</p> <p>He has a couple of actinic lesions on his hands which I have treated today with cryotherapy but has no other lesions on skin examination or no local or regional lymphadenopathy.</p> <p>We will see him back in 3 months time for continued melanoma follow-up.</p> | Need recommendations |
| Person | Person | 20/07/2015 | Patient Per attended Craigavon Hospital Emergency Department with chest pain on 12 April 2012 and was subsequently discharged. He had a chest x-ray which was reported as a soft opacity projected over the right lower zone and further assessment was advised. He had a further chest x-ray on 21 April 2013 that did not mention opacity. On 16 June 2015 a further chest x-ray report recorded suspicions of lung neoplasm. A CT chest on 10 July 2015 confirmed a bronchogenic carcinoma. | | Not complete |
| Person | Personal | 16/12/14 Personal | PATIENT DISCHARGED WITH MISSED #NOF. RECALLED FROM THE X-RAY AUDIT | | |
| Person | Personal | 19/08/2016 reported 21/09/2016 Personal | Missed fracture HCN Personal Feed back from CAh fracture clinic | | |

Stinson, Emma M

From: Reid, Trudy [Personal Information redacted by the USI]
Sent: 10 February 2017 20:12
To: Robinson, Katherine
Cc: Boyce, Tracey
Subject: Delays meeting

Katherine at the delays meeting you highlighted you are running the triage and other reports again, we were discussing them at Acute Clinical Governance this morning, can I check who do you send them to?

Regards,

Trudy

Trudy Reid
Acute Clinical and Social Care Governance Coordinator
Craigavon Area Hospital
68 Lurgan Road
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BT63 5QQ
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Mobile [Personal Information redacted by the USI]

From: [Reid, Trudy](#)
Sent: 20 December 2018 14:57
To: [Yousuf, Imran](#); [Robinson, Jeanette](#)
Cc: [Cunningham, Kate](#)
Subject: RE: Sign off guidance
Attachments: [Draft SHSCT Guidance Document Diagnosis Tests - Including the Requestin....doc](#)

Hi following our discussion this afternoon I wonder if we could review the guidance before our next governance meeting and the MRCN meeting in January?

Regards,

Trudy

Trudy Reid
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Craigavon Area Hospital
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Mobile Personal information redacted by the USI

From: Yousuf, Imran Personal Information redacted by the USI
Sent: 17 October 2018 22:23
To: Reid, Trudy
Cc: Robinson, Jeanette
Subject: RE: Sign off guidance

Hi Trudy,
I can check these with Jeanette and get back.

Imran

From: Reid, Trudy
Sent: 16 October 2018 12:42
To: Yousuf, Imran
Cc: Conway, Barry; Boyce, Tracey
Subject: FW: Sign off guidance
Importance: High

Dear Imran I wonder if we could discuss the wording in the guidance for sign off that would suit our Trust, I am trying to amend to Salisbury Policy for our Trust. Please see attached
Regards,

Trudy

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Mobile [Personal information redacted by the USI]

From: Reid, Trudy [Personal Information redacted by the USI]
Sent: 17 July 2018 20:00
To: Yousuf, Imran
Cc: Boyce, Tracey
Subject: Sign off guidance

Dear Imran I wonder if we could discuss the wording in the guidance for sign off that would suit our Trust, I am trying to amend to Salisbury Policy for our Trust. Please see attached
Regards,

Trudy

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| CLINICAL GUIDELINES ID TAG | |
|-----------------------------------|--|
| Title: | Diagnostic Tests – Including the Requesting Process and Review and Acknowledgement |
| Author: | |
| Specialty / Division: | |
| Directorate: | Acute Services |
| Approval By: | |
| Version: | 001 |
| Date Uploaded to Trust intranet: | |
| Review Date | |
| <i>Clinical Guideline ID</i> | |

Guidance Document

Diagnostic Tests – Including the Requesting
Process and Review and Acknowledgement

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