TABLE OF CONTENTS

TABLE OF CONTENTS

Foreword

I am delighted to introduce our very first Trust-wide Safety Strategy for the Southern Trust. We want to feel that we are 'safe today and safe tomorrow'.

Safety has always been a key priority throughout our organisation and we have many examples of award winning best practice and excellence across our services.

Building on some of the great work already in place, this new strategy aims to take a co-ordinated and focused approach in supporting staff to ensure that we are always doing our very best to improve safety.

Despite the ongoing challenges across health and social care, we all have a responsibility to continually improve the delivery of safe, reliable and effective care.

Through this strategy, we hope to create a culture where safety is central to everything we do and ensure that we are always striving to be safe, kind and excellent towards each other and the people in our care.

Dr Maria O'Kane
Chief Executive

1. INTRODUCTION

The Southern Trust Safety Strategy is a key part of the overall Trust Five Year Vision for all who deliver care, those we care for, their carers and the wider community.

What do we mean by "Safety"?

"Safety is the avoidance of unintended or unexpected harm to people during the provision of healthcare. We view patient safety as a core component of quality in healthcare, alongside clinical effectiveness and patient experience."

In the Southern Trust, we will have a relentless focus on working to improve the safety, reliability, and effectiveness of the care we deliver. Safety underpins everything we do and our drive is to maximise the things that go right and minimise the things that go wrong for individuals receiving our care.

At the heart of this strategy is a drive towards building safer systems in which to treat patients, clients and carers. This is a **Total Systems Safety** approach.[1] (IHI, 2020). This will mean a need to shift from a reactive investigatory approach to a proactive learning approach in which risks are anticipated and system-wide safety processes are established and applied across the entire health care continuum. This will reduce these risks and make health and social care safer for those we can for and our colleagues who deliver care.

Improving safety is a continuous process, requiring new approaches, concepts and solutions, tailored to each setting to make effective, sustainable change.[2] This strategy outlines these, and our model to improve safety based on **foundations** of **values, behaviours, leadership and culture** and **three key dimensions**, **Involve (Heart), Insight (Head) and Improve (Hands).**

Safety is a complex subject and we face many challenges (see **Appendix 1**). It is not possible to cover all aspects within this strategy, however we will set out key areas for implementation in the coming years. The strategy also interfaces with many strategies, policies and procedures we already have within the Trust. We will not duplicate these, however we will remain committed to ensure safety is their key focus. These include: Health and Safety strategies and guidelines and Human Resource Strategies in relation to workforce planning.

OUR SAFETY MISSION IS TO:

BE RECOGNISED AS THE TRUST WHERE SAFETY IS OUR KEY FOCUS & EMBEDDED IN EVERYTHING WE DO.

OUR SAFETY VISION IS TO:

WORK TO IMPROVE SAFETY, REDUCE HARM & SUPPORT EACH OTHER TO PROVIDE HIGH QUALITY SAFE CARE.

2. Our Safety Strategy Model.

Our Model is adapted from that of the NHS Safety Strategy (2019) and The WHO (2017) “Making Healthcare Safer”, taking into account the latest research and evidence into elements that are known to influence safety.

We have built our strategy **foundations** on individual, team and organisational values and behaviours, leadership and culture as these underpin everthing we do to improve safety. They apply to all those who deliver care, regardless of role, grade or setting.

Our model also has **three key components, Involve, Insight and Improve**.

Involve

Supporting & engaging with colleagues, those we care for and their carers for safety.

Our Colleagues

- ✓ Ensuring Psychological Safety.
- ✓ Connecting with Front-line colleagues.
- ✓ Safety-Focused Teams.
- ✓ Safety Briefs and Huddles.
- ✓ Handovers and communication at transitions of care
- ✓ Developing New Roles.

Our Patients, Clients and Carers

- ✓ Enhancing person-centred safety.
- ✓ Service user and carers’ experiences of safety.
- ✓ Shared decision making across the Trust.
- ✓ Involvement and partnership in safety incident reviews.

Insight

Improving safety understanding by gathering data from numerous sources to inform safety improvement

- ✓ Learning Systems.
- ✓ Safety Messages.
- ✓ Safety Event Management.
- ✓ Learning from Deaths.
- ✓ Measuring and Monitoring Safety.

Improve

Delivering effective and sustainable change

- ✓ New Approaches
- ✓ Learning and Development
- ✓ IT and Technology
- ✓ Quality Improvement

3. Our Foundations for Safety.

VALUES & BEHAVIOURS

"Safety is everyone's business and comes first in all we do!"

Our **values** and **behaviours** create an environment where safety can thrive and are essential to the success of this strategy. We are all responsible for living and demonstrating these in our everyday work. Our Trust values are to ensure;

Working together - We work together for the best outcome for people we care for and support.

Excellence - 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.

Compassion - 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.

Openness and Honesty - We are open and honest with each other and act with integrity and candour

What do we walk past?!
See, Act, Report & Take Part in Change.

Figure 1: Our Behaviours

Be Curious

We need to think differently by focusing on what goes right the majority of times, despite our everyday pressures, challenges and conflicts. Having a constantly inquiring mind will lead to safer care, i.e. noticing what is happening around you at all times, when care goes right, identifying when care could go wrong and exploring why care does go wrong.
If we can capture good practice and potential harm, and act on these, we can change to a proactive approach to learning, rather than the restrictive process of only recording incidents when they occur and waiting for outcomes to learn. **(see also Section 6 Safety 1 to Safety 11**).

Be Curious! Ask yourself …

Does what I'm doing make sense?

What is working well?

Is there a better way to do this?

What does the patient, client or carer think?

How will this affect the patient, client or carer at this time, or in the future?

Do the guidelines work, or could they be improved, in our setting?

What can I do to change things?

LEADERSHIP & CULTURE

"We are all leaders, regardless of roles, responsibilities and setting!"

Effective leadership and positive cultures are interlinked, and are vital to improve safety.[iii] [iv] [v]

Leaders have key responsibilities to:

In addition we can all lead to:
Develop the learning system: Fully engaging in transparency; understanding and applying safety science, developing reliability and resilience.
Support innovation: Creating space for adaptive, improvement work.

Create psychological safety: Making sure that our colleagues and those we provide care for can comfortably voice concerns, suggestions, and ideas for change.

Foster trust: Creating an environment of accountability, non-negotiable respect, ensuring that people feel their opinions are valued, and any negative or abusive behaviour is swiftly addressed.

In our Trust we adopt a collective leadership approach where;

- ✓ Leaders create positive, supportive environments for staff, who then create caring, supportive environments for patients, service-users and carers.
- ✓ All who give, and receive care are involved in solving problems, to ensure quality and to promote inclusion and safety improvement.
- ✓ Everyone takes responsibility for the success of the organisation as a whole.
- ✓ Leaders ensure that the service-user and carer voice is heard and their contributions are built into improving safety.

We are all responsible for our behaviours and attitudes when working with others to maintain a positive culture!

Building a **positive, just and restorative culture** is a major determinant for safety. [vi] [vii] [viii]We will work along-side our colleagues in Human Resources and Organisational Development in their work to improve our culture. The following elements all contribute to the safety culture we want to achieve. [ix]

A strong safety culture "is built on trust and balances fairness, learning and accountability, focusing on proactively predicting and addressing risk, improving systems design and managing human behaviour to improve patient safety" (NMC, 2019).

Figure 2: Elements of a Safety Culture

We want to build a Safety Culture where:

- ✓ The right actions occur after an incident.
- ✓ All contributing factors are investigated.
- ✓ The individual will not be blamed if their actions were well-intended and justified. Only those who show reckless behaviour, or a deliberate harmful act will be held to account.
- ✓ Investigation asks "what" is responsible, rather than "who" is responsible.
- ✓ Relationships and trust is restored, where those involved are supported in the short and long-term.
- ✓ Everyone takes accountability for their practice.

4. Our Key Components: INVOLVE

INVOLVE

(HEARTS)

4A. Involving and Supporting Our Colleagues

Our colleagues are our greatest asset and we are committed to providing support that enables us to continue to improve safety and make our Trust the best place to work. This is highlighted in "Our People Framework" which should be read in conjunction with this strategy.
For colleagues involved, incidents can be distressing and lead to psychological harm, demoralisation and a lack of confidence.

The **"OUR PEOPLE FRAMEWORK"** focuses on our culture and valuing our people. If we want to provide the best care, we need to provide the best support for our people by **CREATING A GREAT PLACE TO WORK**.

Schwartz Rounds
Staff gave feedback on what would help their psychological wellbeing and support in their roles. As a result **Schwartz Rounds were introduced in 2022**. To date 9 have been help with over 200 staff attending. Evidence shows that attendance can reduce isolation, gain insight into colleagues' roles, provide a safe space to reflect on similar difficulties and reduce stress.

It is estimated that 85% of healthcare professionals report being emotionally affected in the aftermath of a safety incident, becoming a "second victim".
(Lachman, et al, 2022).

4.1. Supporting **psychological safety** is vital to build confidence to report safety concerns, without the fear of blame, punishment or negativity from colleagues.

Unless our colleagues are given the necessary respect, support, and resources, they are more likely to fail to follow safe practices, not work well in teams, and make errors.

4.2. Connecting with Front-line Colleagues

To improve insight and offer support, it is vital that those who are in senior roles with responsibility for decision-making and allocating of resources are fully engaged with our front-line colleagues. We know that voluntary incident-reporting systems and existing data will not provide a complete picture of safety. [x] Through this strategy we will increase, formalise and report on Leadership Safety Walks. Not only will these identify areas for improvement and safety concerns, they give opportunities to show appreciation for the work our colleagues do, encourage open dialogue, foster a culture of trust and respect, and share the organisation's attitude and approach to safety.
A potential questions bank, discussion template and action plan for Leadership Safety Walks are shown in **Appendix 2, Template Booklet, Section 1**. [xi]

4.3. Developing Safety Focused Teams

We're all in this together! Teams perform better than their best individual members. [xii]

We need to continue to develop our teams to improve safety and support each other.

Effective teams not only protect patients from risks and improve safety they also create a more positive, engaging, and resilient workplace.
This can lead to significant improvements in morale, increased engagement, creative problem-solving and, most importantly, commitment to safety.

Greatix is our employee recognition scheme. It's an opportunity to recognise excellence and feedback to nominated individuals, showing staff that their work is valued. It's a chance for us to share and learn from these examples; to encourage learning, development and leading by example.

Effective teams exist when;

- ✓ Colleagues trust and support each other.
- ✓ Colleagues communicate openly and frankly, giving constructive feedback if necessary.
- ✓ Conflict is seen as healthy, worked through and resolved.
- ✓ Teams regularly assess their effectiveness and work on continual improvement.
- ✓ Information is shared freely.
- ✓ Members work towards goals and objectives of the team and organisation.

We need our teams and services to come together to co-ordinate and integrate care around the individual. Safety issues can arise when we work in services that are designed in silos, e.g. delayed care, misdiagnosis and poor communication. If we use a multidisciplinary approach across boundaries we will increase our shared understanding of each other's' roles and partner in a meaningful way with those who use our services.

4.4. Using Safety Briefings and Huddles to Improve Communication and Collaboration

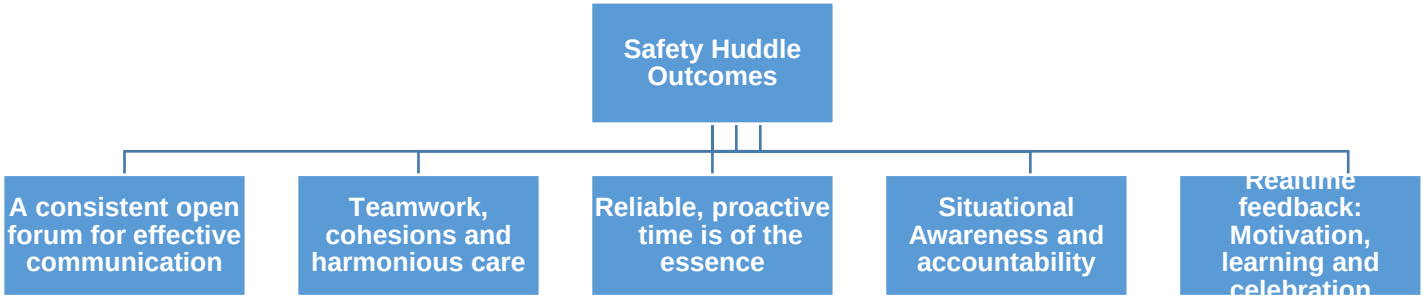
Communication failures among healthcare personnel are significant contributors to medical errors and patient harm. When used consistently, safety briefs and huddles are an effective and efficient way for healthcare teams to share information.

Safety Briefings are a simple, easy-to-use method that front-line colleagues can use to share immediate information about potential safety problems and concerns on a daily basis. Used in aviation and other industries, safety briefings incorporate discussions of safety into the daily routine, 24 hours a day, 7 days a week. E.g. In theatres prior to a complex procedure where the individual is known to be at high risk, or in community MDTs where urgent discharge planning is required.

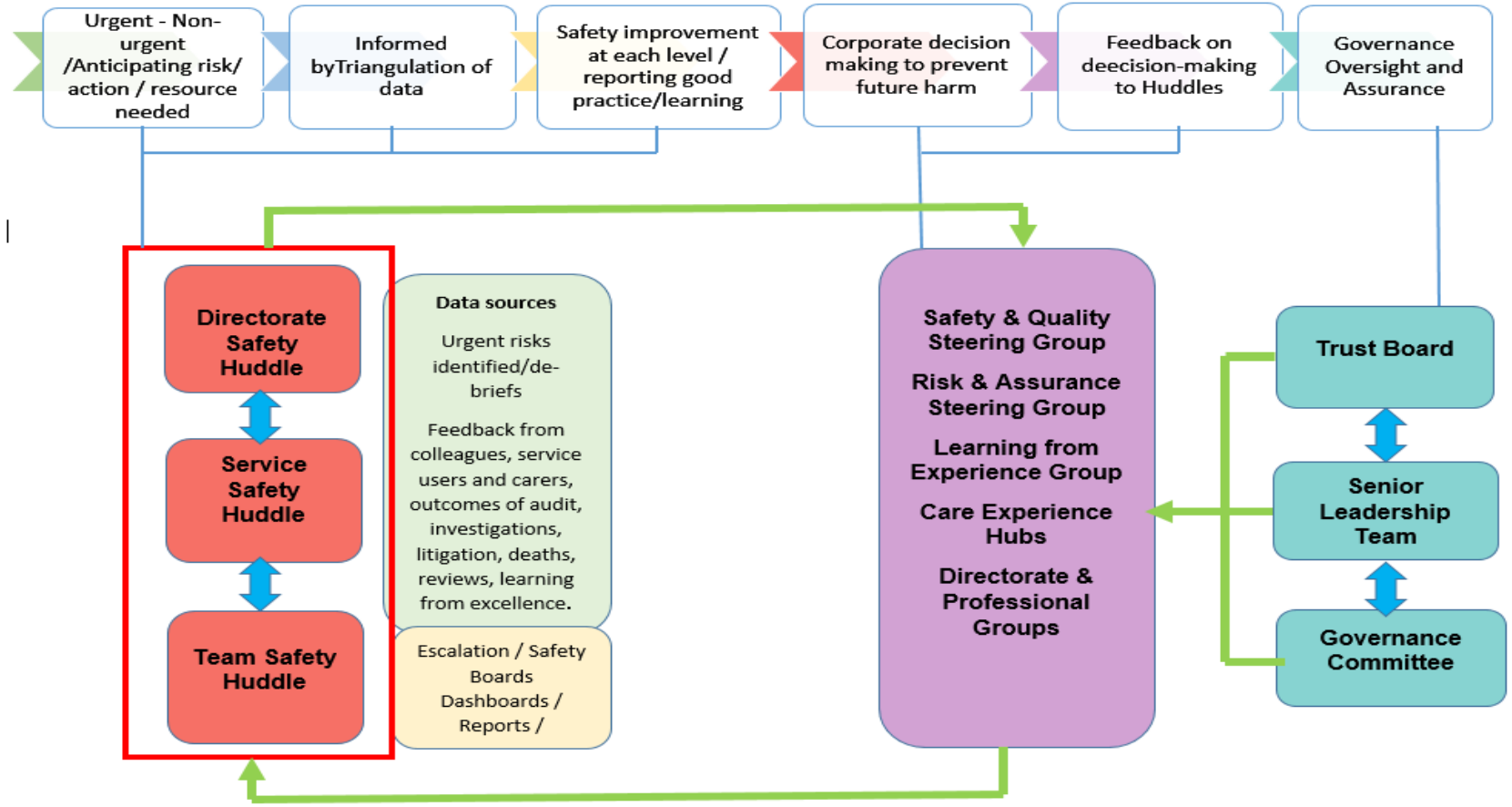
Safety Huddles are planned, structured team events for problem solving and updating the safety plan for those most at risk. Whereas safety briefings are usually adopted in front-line settings, safety huddles can be adapted for different settings and at all levels in the Trust.[1] [1]

See **Appendix 2, Template Booklet, Section 2 for example templates.**

Having Safety Huddles at Team, Directorate and Senior Leadership level provides a continuous feedback mechanism for decision-making, actions and learning. The positive outcomes of this approach are outlined in **Figure 3** below.



Leadership Safety Huddles provide a decision-making and assurance forum to gain insight on safety issues to aid decision making. This in turn is fed into assurance and performance reports to the Senior Leadership Team and Trust Board. [xiii] Feedback on decisions and investments to be made are in turn communicated back to Directorate and Team Huddles. Figure 4 below illustrates this framework. **Figure 4: Levels and Communication Flow for Safety Huddles.**



4.5. Improving Communication at Handovers and Transitions of Care.

Communication is the root cause of most errors because hospitals lack a systematic, universal method to accurately transfer important information (The Joint Commission, 2017). **Clear, consistent communication strategies has been shown to improve handovers by 60%, reduces readmission by nearly 50%, and preventable adverse events by 30%.**

We want to improve communication during handovers, and when individuals are at increased risk of harm, i.e. transitions of care. This will require greater engagement with individuals by including them in discussion and incorporating the individual's experience and preferences into the process. We can increase safety through use of structured communication support tools, e.g. SBAR, checklists, patient discharge summaries and person-held records.

For examples of use of the SBAR tool, please see **Appendix 2, Template Booklet, Section 3.**

4.6. Developing New Roles – We're all safety Champions!

During initial implementation additional front-line support may be required to focus on training and development, safety improvement plans, gather and share information and learning, offer guidance and spread safety messages. **A Safety Link Practitioner role** will be developed to provide

What will we do in practice?

- ✓ Support implementation of the **"Our People Framework"** and uptake of psychological safety supports.
- ✓ Increase & formalise Leadership Safety Walks, safety briefings and huddles.
- ✓ Work along-side our HROD department to improve team working.
- ✓ Create **Safety Link Practitioner** roles within Directorates.
- ✓ Improve **Handovers** and **Transitions** of care.

INVOLVE

(HEARTS)

4B. Involving and Supporting Those We Care For

The Southern Trust is committed to involvement of those who use, and interface with, our services to ensure partnerships are real and meaningful. This Safety Strategy will be implemented in tandem with the **"Working Together Strategy**" that aims to ensure the best possible patient experience through involvement and improvement.

Care Experience Hubs

Integral to the "Working Together Strategy" is the set-up of a Care Experience Hub. It brings together staff, service users and carers who will devise and oversee a service improvement plan, based upon service user feedback, for their relevant Directorate.

We use Care Opinion

This is an online feedback platform for service-users to share their experiences of health and social care. Feedback is then shared with our Trust.

Care Opinion

The **"WORKING TOGETHER STRATEGY"**. Key themes are to;
WORK TOGETHER TO LISTEN AND IMPROVE,
TRAIN AND LEARN FOR IMPROVEMENT, AND
KEEP EVERYONE INFORMED.

4.7. Person-centred Safety.

Are individuals and their carers someone to whom we provide care? Or are they active partners in managing and redesigning their care?

Patients, clients and carers experience life-long care journeys across the entire continuum of care. They have a unique and essential perspective on care delivery, their own safety, and their insights on "what matters to them" are critical for creating safer care. They often notice safety issues that busy healthcare workers do not, e.g. sharing advice given by other practitioners or noticing potential medication errors. Increased partnership is linked to improved clinical effectiveness, fewer adverse events and everyone has a shared responsibility for safe care.[xiv]

Figure 5 shows some practical approaches that can improve person-centred safety

We want to support individuals and their carers to be encouraged, empowered and active participants in addressing their own safety needs. This means we will understand what safety means in their personal circumstances and identify what they may need to help them make informed decisions and choices. e.g. improving access to their own data, access to tools and knowledge and mechanisms to report safety concerns.

4.8. Shared decision-making.

Health and care professionals have a professional duty set out in their codes of conduct to listen to people and respond to their preferences and concerns.[xv] [xvi] [xvii]Shared decision-making is a vital approach to ensuring this happens.

The **NICE Shared Decision Making Guidance (NG 197)**[xviii] is now being rolled out. A regional Stakeholder group has been set up by the PHA and SPPG with representatives from all Trusts, professions, service users and carers to develop a plan to embed this guidance's recommendations into practice. Implementation will require a Trust-wide, coordinated approach, apply to numerous settings and front-line services.

NHS England's (2019) "Shared decision making Implementation Framework" shown in **Figure 6** illustrates strategic and practical methods for implementation.

Figure 6: Shared Decision-making Implementation Framework.

Shared decision making is a collaborative process that involves a person and their healthcare professional working together to reach a joint decision about care. It could be care the person needs straightaway or care in the future, for example, through advance care planning. (NICE, 2021).

4.9. Involving Patients, Clients and Carers Following Safety Events.

We have a "Duty of Candour" towards anyone who has been harmed in our care. **Figure 7** below outlines what those involved can expect:

It is essential that there is open, collaborative, compassionate and partnership approach that captures the patient, clients and carers experience, and involves them in the investigation process, action planning and implementation if they so wish. Timely response, support and engagement will give us a wider understanding of the event and impact on those we care for.

Support for patients, clients and carers is given by colleagues and our liaison service in Corporate Governance. Due to resources we can only offer support to those involved in high level Serious Adverse Events and complex complaints. We aim to extend this support to additional levels of SAIs, complaints and other patient safety reviews.

It is widely recognised that individuals' safety is impacted by health inequalities and being in a vulnerable group, such as an ethnic minority group, being elderly or having a learning disability. [xix] [xx]In Trust and Directorate Safety Improvement Plans their particular safety needs will be included and their voices heard.

What will we do in practice?

- ✓ Capture individuals' and carer's perspective on safety
- ✓ Introduce practical Tools to enhance person-centred safety
- ✓ Implement **NICE Shared Decision Making Guidance (NG 197)**
- ✓ Improve how we involve patients, clients and carers in safety incident reviews.

5. Our Key Components: INSIGHT

INSIGHT

(HEADS)

"To err is human, to cover up is unforgivable and to fail to learn is inexcusable". (Donaldson, 2016)

5.1. Gaining Insight from Our Learning Systems

Learning from the past to inform current and future practice is essential, however more can be done to improve our learning systems. We know that where there are effective systems, processes and behaviours in place, recovery from the physical and emotional effects of an incident, learning and improvement are more likely. [xxi]

A vast amount of potential learning is generated from numerous sources in and outside the Trust and we are continually developing our systems to capture, share this and feedback outcomes of investigations.

During 2022/23 over **374 circulars** were received by the SHSCT.

- NICE Guidance,
- Regional Safety & Quality Learning Letters,
- RQIA report recommendations and
- National Patient Safety Alerts.

Significant work has been undertaken by Teams across all specialties to ensure these are shared and embedded within current practice.

Figure 8 shows some of our sources of learning.

The Role of a Learning System

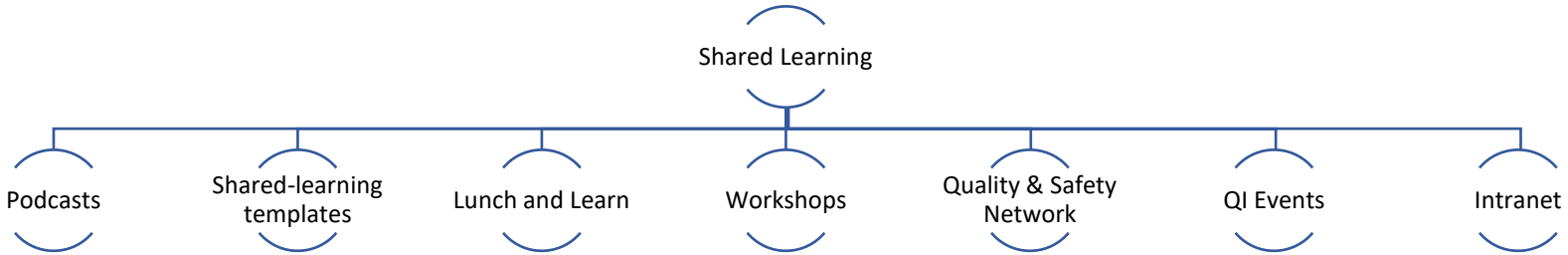
Learning systems are established organizational processes that integrate internal and external information, including patient and employee feedback and best practices, while leveraging technology to enable widespread learning and the implementation of changes to improve practices and promote safety. Most importantly, actions to improve practice are tightly and reliably linked with learning in these systems so that each — both learning and action — supports the other.

Learning systems can help improve culture, leadership, and governance; patient and family engagement; and workforce safety, ultimately creating total systems safety and preventing harm for all.

Adapted from AHRQ

5.2. Sharing Safety Messages

In addition, we have many methods and forums to share learning that can be used to learn about safety. We plan to develop a strategy to share safety learning using these, and the numerous sources in the Trust. **Figure 9** shows several methods to share safety messages.



5.3. Positive Approaches to Learning

Appreciative Inquiry and Learning from Excellence looks at times when people have seen things working at their best. It helps explore the circumstances surrounding when things work well so that we can identify, highlight, and thereby grow good practices more often and the conditions that enable them.[xxiixxiii xxiv] By using this positive approach we can bring people together, building relationships, "levelling the playing field" of hierarchy, roles and provide an environment where everyone is heard.

What will appreciative inquiry look like in practice?

- ✓ Colleagues will give a personal "high point" story of a time when something worked well for them.
- ✓ Think of the subject and ask "when did we best deal with this?"
- ✓ Consider what enabled this to happen.
- ✓ How could, or did, the organisation support you to be at your best?
- ✓ What did you learn?

5.4. Safety Event Management and Reporting Systems

Understanding and improving our incident management and reporting systems will be crucial for leaning and improvement. Patient safety is the priority, however there are additional essential outcomes as shown in **Figure 10.**

In 2023 our **Shared Learning Policy** was introduced.

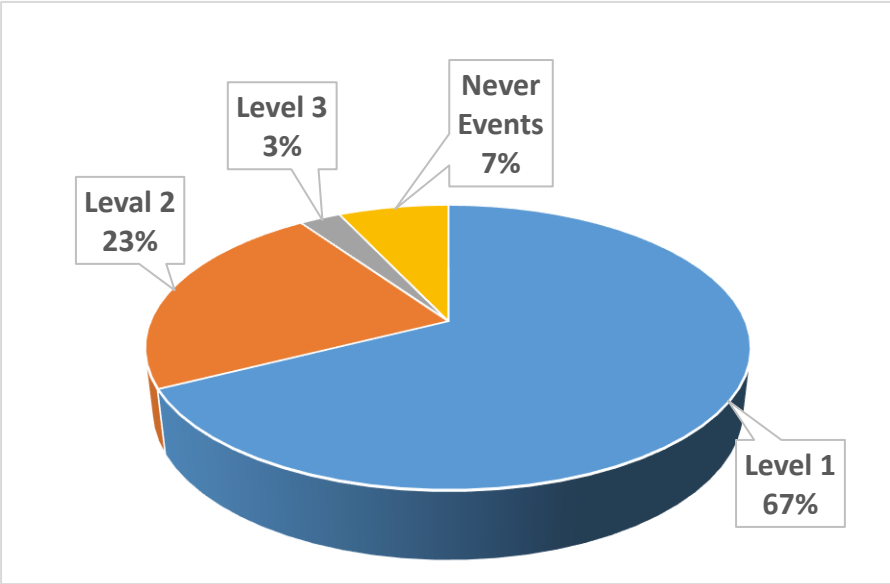
By using a standardised, continual approach to gather, collate and circulate learning, we can learn from each other and identify areas for improvement. Completed templates are collated and circulated by our Corporate Governance department.
See Appendix ***

Figure 10: Outcomes of Safety Event Management

The key aim of safety event management is to provide a clear explanation of how our organisation's systems and processes affected safety, such as the tools, technologies, environments, tasks and work processes involved. By accepting that human error is expected, this systems approach will encourage colleagues to report incidents and more proactively report good practice and where incidents have been avoided.

In 2022/23 **22,841 safety incidents** were recorded on our Datix System. Out of this 106 were Serious Adverse Incidents.

Figure 11 shows the number and level of SAIs in 2022/23



We want to make sure we are reviewing safety events in a timely way and as appropriate to their level to ensure the depth of investigation is appropriate. 67% of our incidents are categorised at level 1, however they are often investigated in depth where less input may be all that is required. This substantially increases the resource required and delays learning and improvement.

Often we need to learn from, and discuss, errors quickly to provide early learning, prevent further risk and provide immediate psychological support to those involved. We will spread ways to do this across the Trust, e.g. **urgent communication channels**, **use of early learning tools, hot de-briefs and rapid reviews.**

Mental Health is now using the **Structured Early Learning Tool (SELT),** with plans to roll out to other areas following positive reviews.

This allows the team to carry out early screening of any case where learning in terms of safety and/or quality of care can be highlighted.

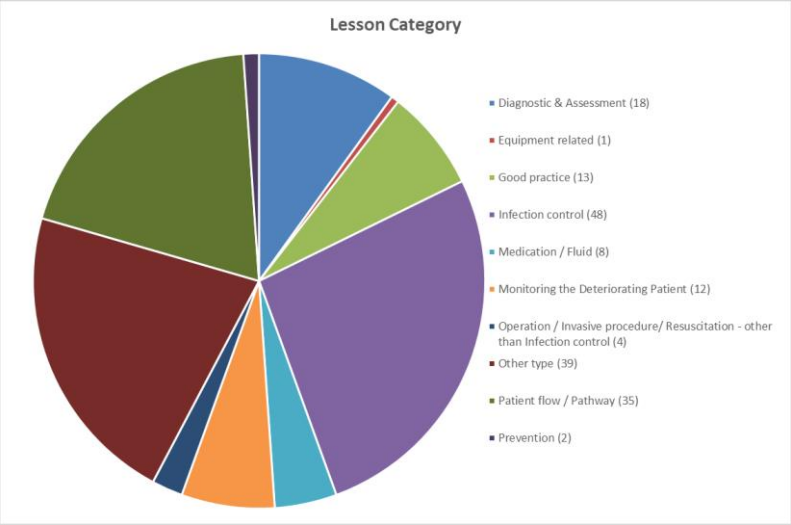
Regionally, work is currently ongoing to develop a revised, up to date framework for responding to safety events. This will replace our current procedure, including the thresholds, criteria for SAIs, levels of review and fixed timelines. Instead it will support flexibility, a safety culture that is open and compassionate and the system-focused approach outlined in this strategy. We will be involved in the development, consultation and roll-out of this process.

5.5. Learning from Deaths

Learning all we can from critically examining care that patients receive before they die can teach us how to deliver safer care. The Regional Mortality and Morbidity Review Process (RMMR), based on the NIECR IT platform, captures details on cause of death, reviews by medical staff, monitoring, scrutiny of any avoidable factors or areas of learning and subsequent actions associated with the patient's death.

Regional and Trust guidelines were issued to standardise how the process should be followed and how Patient Safety Review "M&M" meetings are carried out. We still have work to do to apply these guidelines, including; meeting timescales along the RMMR process, increasing multi-disciplinary, operational and governance involvement, using "Trigger Tools" to identify cases to be discussed, (see **Appendix 2: Template Booklet, Section 5a & b**), using SBAR templates and sharing learning.

A Regional report outlining themes arising from the RMMR process is regularly sent to each Trust. **Figure 12** below shows the categories (2022/23). Using this data will help us identify themes for safety improvement. From this we can see Infection Control, Patient Flow/Pathway, medication and other are the highest percentage of themes captured.



Definitions of Themes

- **Monitoring the Deteriorating Patient** (Failure to act on Investigation; Failure to Observe/Record/Escalate NEWS; Delays; No DNACPR)
- **Diagnostic & Assessment** (Missed, Delayed or Inappropriate; Inadequate assessment; Inappropriate Investigation, Checking Lab Results)
- **Prevention** (Sepsis, Falls, Pressure ulcer, Suicides, VTE, Cardiac Arrest, etc.)
- **Medication / Fluid** (Wrong Patient, Drug, Dose, Route, Time; Inappropriate; Omitted; Monitoring; Side-effects; Allergy)
- **Infection control** (HCAI issue)
- **Operation / Invasive procedure/ Resuscitation** (Other than Infection control; Perioperative, Wrong site/ patient/ procedure/ implant)
- **Patient flow / Pathway** (Inappropriate Discharge, Handover, Lack of beds, Continuity of care)
- **Equipment related** (Failed, Faulty, Misused, Misread, Not Available)
- **Good practice** for dissemination
- **Other type** (not fitting into above categories)

5.6. Measuring and Monitoring Safety

One of the recommendations made by Don Berwick in his 2013 review into patient safety was that all NHS organisations should: '…routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics.'

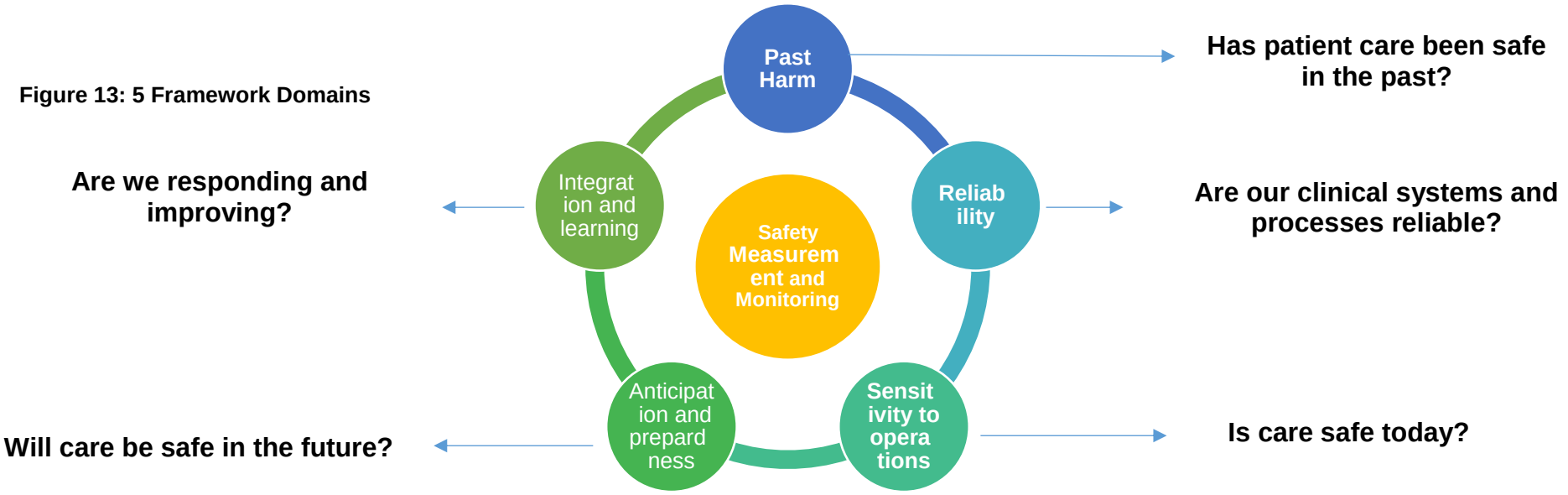
Measuring and monitoring safety Includes triangulation of quantitative and qualitative metrics from care in the past and present to inform how we reduce harm in the future. We will introduce the Charles Vincent Framework et al as outlined by the Health Foundation, (2016). The framework consists **of five 'dimensions'** and associated questions that organisations, teams or individuals can use to help understand the safety of their services. Used over time, this will help to give a rounded, accurate and 'real time' view of safety and will support efforts to identify those areas which present the greatest opportunity for safety improvement.

The aim of using this framework is to:

- ✓ Move safety from "absence of harm" to "presence of safety".
- ✓ Give an improved holistic and wider view of safety.
- ✓ Capture baseline information.
- ✓ Provide a consistent approach to monitoring and reporting safety across the Trust.
- ✓ Break down the complex wide scope of safety into manageable chunks,
- ✓ Produce a framework that can be adapted to include new metrics as safety parameters increase.

Figure 13 shows the 5 Dimensions of the Framework.

Figure 13: 5 Framework Domains



Applying the Framework.
Introducing this framework will take time to discuss with all stakeholders to look at measures we currently gather, their usefulness, and any gaps or areas of weakness. Application will vary in each setting and can be used at all levels in the organisation. Prompts for using the framework and data used in each dimension are shown in **Appendix 3A and 3B.**

What will we do in practice?

- ✓ Develop a framework for sharing safety messages.
- ✓ Further roll-out of Shared Learning Policy and process.
- ✓ Increase reporting of safety events, including good practice and near misses.
- ✓ Implement the Regional Safety Event Management Framework.
- ✓ Ensure appropriate investigation of safety events and introduce use of Early Learning Tools.
- ✓ Progress a standardised approach to the Patient Safety Review Process.
- ✓ Implement the Vincent et al Framework for Measuring and Monitoring Safety.

6. Our Key Components: IMPROVE

6.1. Our New Approaches.

6.1.1. Defining Safety: Safety I and Safety II – A New Way of Thinking

Eliminate the Negative, Accentuate the Positive

We need to change our current approach to safety, by moving our focus from reacting to accidents and incidents after they occur **(Safety-1)** to also proactively looking at what is working well in practice and continually learning and improving. **(Safety-II).** This shift will improve how we learn, motivate and engage our colleagues, and become a more resilient organisation. [xxv]

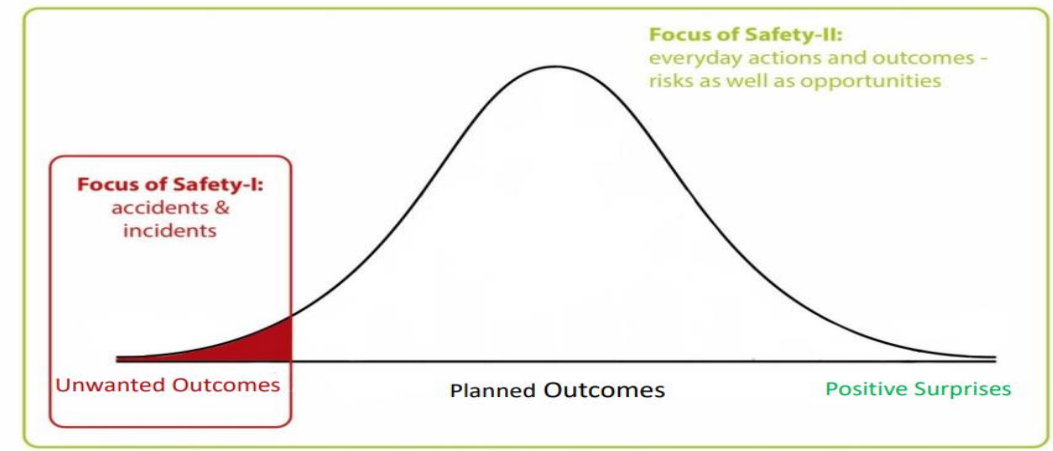
Safety – I
Traditionally we consider our services as "safe" where the number of adverse outcomes are as low as possible and with a focus on failure, rather than when care succeeds. This is a Safety - I approach that responds reactively to incidents and risks.

This approach is used to report and analyse incidents and errors by looking at failures in practice and systems. It assumes that processes are predictable, with less emphasis on human factors, complexity and the need to adapt to changing environments. Safety-1 requires the ability to prevent something going wrong by;

- ✓ Finding the causes of what goes wrong (RCA),
- ✓ Eliminate causes, disable possible cause-effect links, and
- ✓ Measure results by how many fewer things go wrong.

Safety – II
We want to adopt the principles of Safety - II, moving from "avoiding something going wrong", to a proactive approach, of "ensuring that everything goes right". If we also focus on what goes right, we can understand and improve everyday performance be safer.

Figure 14 shows the difference in focus between **Safety - I** and **Safety - II.**



Within this strategy we will introduce initiatives that will help us implement a Safety-11 approach, e.g.

- ✓ Embedding our values and behaviours into practice.
- ✓ Inquiring, being curious and challenging everyday practice.
- ✓ Improving culture and communication using huddles, debriefs and handovers.
- ✓ Learning from good practice and near-misses to anticipate risks and errors.
- ✓ Partner with colleagues and those who receive our care to improve safety
- ✓ Build new approaches and concepts into training and development.

6.1.2. Approaches to Risk Management

One size does not fit all!

Understanding how risk is defined impacts on how safety is improved in different settings.[xxvi] Our current risk management systems do not allow for variability in the type of work that we do. To move to this new approach, we need to build on our current Risk Strategy to introduce more flexibility that will take into account the context in which we work and how we manage the risk that we and our patients are exposed to.

6.1.2.1. Ultra-Safe

In some settings of high risk (eg provision of radiotherapy, administration of blood products, etc), there is a need for a controlled environment in which procedures can be highly standardised in order to minimize the risks as much as possible. We call these

situations “**ultra-safe**.” In this situation, we use highly constrained procedures and processes to standardize the care provided in order to reduce variation with systems of fail-safes built in to assist staff in undertaking the required procedures.

6.1.2.2. Ultra-Adaptive

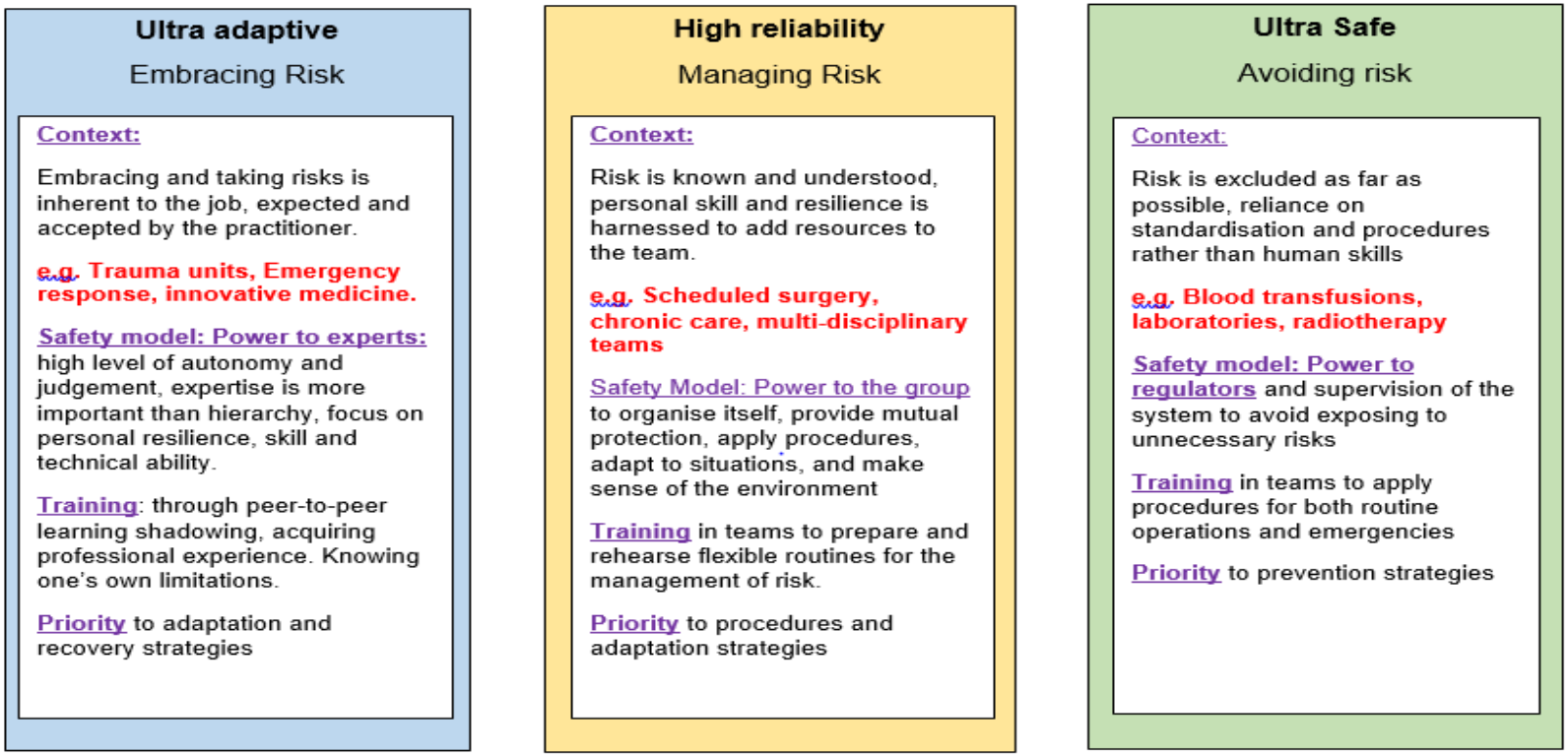
In other settings, the patient presentation is much more variable with a need to care to be individually tailored to patients in a relatively more ‘hostile’ environment – such a situation exists in emergency departments. In these situations, due to the highly variable nature of the care provided, there is a need to focus on supporting staff to provide care in this dynamic environment and therefore the contribution of staff to providing safety in care is highly valued. In these settings, we embrace risk and recognise that the staff themselves are the key to mitigating risk and enhancing safety. This is an “**ultra-adaptive”** situation.

6.1.2.3. High-Reliability

Finally between these two extremes, we have the “**high-reliability”** setting in which there is a combination of the use of constrained procedures whilst also recognising the value of staff to manage the variation in care that has to be provided. Such settings include operating theatres in which a significant number of procedures are performed and different types of patients but in the more controlled theatre environment.

By recognising the settings in which we work as ultra-adaptive, high reliability or ultra safe, we can target our interventions to support safety. **Figure 15** gives detail on context, model and how training can be adapted to suit each setting.

Figure 15: Ultra-adaptive, High-reliability and Ultra-safe approach to risk.



6.2. Learning, Training and Development

A vital element of improvement is through mandatory, professional and non-mandatory **training and development.** [xxvii] [xxviii] Initial implementation of this strategy will focus on developing:

- ✓ Learning and training strategies most appropriate to your setting.
- ✓ Understanding safety science and new approaches.
- ✓ Training on SAI processes, investigation and QI techniques.
- ✓ Aligning current training and development with additional modules known to improve safety.
- ✓ Co-developing and co-producing safety information and training with colleagues, service-users and carers.
- ✓ Introducing alternative ways to train, e.g. greater use of simulation training.
- ✓ Supporting your professional skills and competencies.

The **NHS Patient Safety Syllabus (2019)** is an example of a framework for learning about safety.
It has competency based modules:

- ✓ Systems approach to patient safety.
- ✓ Learning from Incidents.
- ✓ Human factors, performance and safety management.
- ✓ Creating safe systems.
- ✓ Being sure about safety.

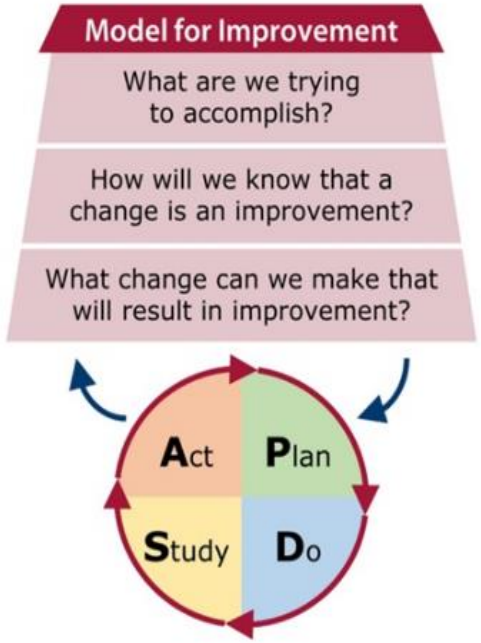
6.3. Quality Improvement

Structured Quality Improvement is integral to improving safety. [xxix] [xxx]At any one time our Quality Improvement Division supports over 100 initiatives across the Trust.

We want to build on this work by offering our colleagues training and development of skills, time, resources and opportunities to become involved in safety improvement at all levels and settings. When need is identified, a systematic improvement approach,

such as the Model for Improvement will be used. This model combines a systematic methodology with subject-matter knowledge to create the desired improvements. [xxxi]The Model is made up of three questions and a Plan-Do-Study-Act (PDSA) cycle for testing changes to assess whether or not they lead to improvement.

Figure 16: Quality Improvement Model and PDSA Cycle.



What's going on?

We recently launched the **Quality and Safety Network** to encourage shared learning and sharing of improvement by connecting individuals across the organisation with a passion to improve quality and safety.

For completed examples of this model, please see **Appendix 4.**

There are other models, and tools to structure change, e.g. LEAN or Six-Sigma, which can be applied as appropriate to the change to be introduced.

The Quality Improvement Programme, **"Getting Better Together"** will be rolled out. This involves small teams of "improvers" identifying need and leading on change initiatives. This will lead to greater multidisciplinary collaboration, a sense of group ownership and sharing of learning across the Trust.

It is vital we share the learning from the changes that are introduced and celebrate improvements. We will collate and coordinate sharing of safety initiatives and their outcomes through organised programmes "March to Safety" and "Safetember, the Annual Quality Assurance report, Shared Learning Events, Southern I and Sharepoint.

What will we do in practice?

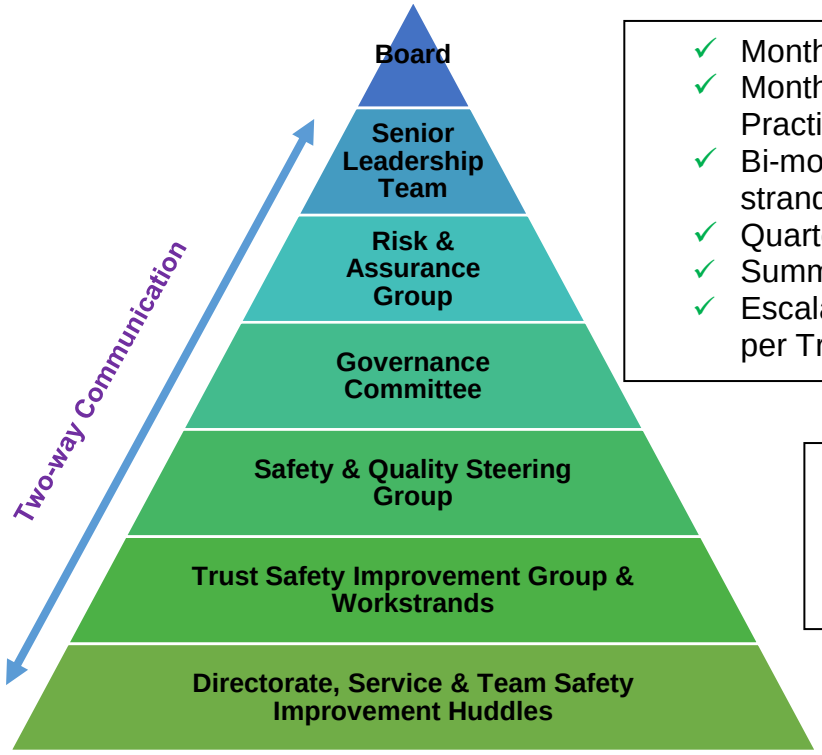
- ✓ Develop a learning and develop syllabus for safety, including new approaches and quality improvement techniques.
- ✓ Roll-out the "Getting Better Together" programme ethos.
- ✓ Produce an annual outline of events to highlight safety initiatives and celebrate successes.

7. Initial Implementation

This strategy is comprehensive and will require resource, change of mind-set, enthusiasm and collaboration to ensure improving safety becomes an ongoing drive in everyday practice. Initially a **Trust Safety Improvement Group** will be formed to provide leadership, coordination and support to roll-out the strategy. On review of the Strategy the need for this group will be evaluated.

7.1. How will we report our progress?

Informal and formal mechanisms will be set up and will use existing pathways to report progress as outlined in **Figure 17.**



- ✓ Monthly feedback within Directorates, Services and Teams
- ✓ Monthly report to Safety Improvement Lead from Safety Link Practitioner
- ✓ Bi-monthly report to Trust Safety Improvement Group from Trust Work-strand Leads
- ✓ Quarterly Report to Safety & Quality Steering Group
- ✓ Summary & by exception reporting to senior fora**.**
- ✓ Escalation and reporting of safety events, good practice and learning as per Trust systems and procedures.

Quality Network events, Quality Assurance Report, "Safetember" and "March to Safety", Safety Improvement Showcase Event, Trust Communications, e.g. Sharepoint, Southern-!, Social Media.

7.2. Creating Safety Improvement Plans.

Integral to implementation will be development of a centrally held Trust Safety Improvement Plan and equivalent plans within Directorates and Services. It is anticipated that plans will vary in each Directorate, however in principle planning should:

- ✓ Create local ownership and accountability by involving all levels of colleagues from a range of backgrounds in prioritising initial areas of need, identifying goals and roles and responsibilities.
- ✓ Be developed, co-designed and co-produced with patients, clients and carers.
- ✓ Be an open, ongoing process where plans are flexible to allow for re-prioritisation.
- ✓ Incorporate how learning will be shared and full roll-out achieved.
- ✓ Ensure vulnerable groups are represented, e.g. those with mental health or learning difficulties, the elderly, children.

Identify 3 to 5 areas to ensure plans are achievable over the next 5 years. These should be a combination of:

- ✓ **Cross-cutting system themes** as outlined in this strategy, e.g. improving communication at handovers/transitions, starting safety huddles, sharing safety messages.
- ✓ **Safety specific**, e.g. medication safety or violence and aggression.
- ✓ **Disease specific,** e.g. Sepsis or Cancer care.
- ✓ **Immediate need** identified through recommendations, risk registers, outcomes of safety event investigation.

Identify a senior leader to drive change forward and Safety

Link Practitioners to coordinate, support and share initiatives.
Plan patient, client and carer engagement.

- **What would success look like?**
- **What do we need to do in order for that success to be realised?**
- **What are the things that would make the most difference?**
- **What data will be use and how will we measure success?**
- **Who can we learn from, who is getting this right?**
- **What are the interventions, tools, technology or solutions that have been proven to work in this area?**
- **What resources do we need?**

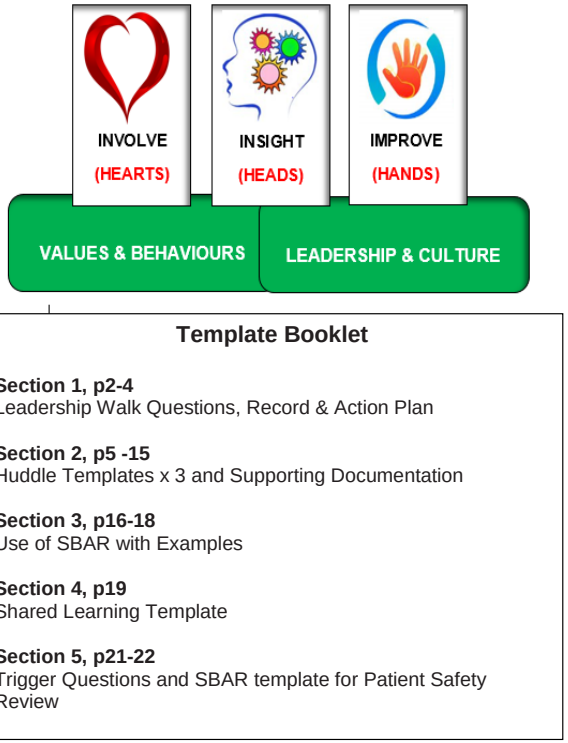
Appendix 1: The Challenges We Face

1. The Health and Social Care system has become steadily more complex as technology and knowledge increases. This complexity brings inherent risks.
2. Although we have progressively improved safety, learning from the past to inform current practice and for the future, more can be done to share insight and empower people who need our services.
3. The increasing complexity of healthcare is creating new or previously unrecognised risks. Furthermore the increasing age of our patient population means that we are often delivering care to people with multiple chronic conditions. The associated poly-pharmacy, in some circumstances results in additional harm. Prolonged hospital stay, increased acuity, delay in discharge, patient deconditioning and co-morbidities are all recognised to increase the risk of patients having an adverse event whilst in our care.
4. Cost and efficiency is at the forefront of our improvement work and we must be mindful of budget limitations; the financial and human cost of poor outcomes should not be under-estimated. Despite the increased complexity of the care we are providing, budgets must be controlled and resources will potentially be restricted. It is therefore more important than ever that we consider the outcomes of our work and specifically in relation to patient safety carefully monitoring staffing, resources including training and equipment and the state of our facilities.
5. The SHSCT has a dedicated, diverse and skilled workforce, however challenges exist to recruit and retain staff into permanent posts, resulting in a reliance on agency, bank and locum staff, which can affect consistency of care, and therefore safety risks. As an organisation we recognise that our staff are our greatest asset and we are committed to developing a culture of learning, transparency and openness that enables us to continue to improve patient safety and make the SHSCT an excellent place for staff to work in.
6. Cyber-security is an ongoing threat in relation to healthcare systems. Due to the increasing volume of data captured in the medical records and the ability for the computerised patient data records to be widely accessed we are likely to see an increase in non-clinical patient harm due to information governance breaches. Therefore we need to consider and establish tighter security and access in order to persuade our patients that the benefit of using I.T. for storing healthcare records outweighs the minimal number of breaches.
7. Antimicrobial resistance is a recognised and increasing concern. It is estimated that if current trends continue, the number of extra deaths attributed to antimicrobial resistance will be higher than any other single disease. We must as a matter of urgency change our antimicrobial prescribing practices and prevent our patients from acquiring infections whilst they are in our care.
8. Diagnostic errors and delays have been acknowledged and are particularly evident in our learning from litigation. However, due to the growing complexity of patients with multiple chronic illnesses, combined with multiple health care providers and healthcare records, we need to carefully monitor outcomes and consider where we need to strengthen our diagnostic processes, referral pathways and IT record systems.

9. In Northern Ireland, waiting lists have reached crisis point, recognised at all levels, in all settings, as a major safety concern for our population, In June 2021, the DHSSPSNI have published their 5 year strategy to address this, “The Elective Care Framework – Restart, Recovery, Redesign”, to lay out short to long-term actions to being waiting lists down through major investment in all aspects of healthcare delivery and design. Unfortunately this has not yet been implemented.
10. The NHS has an increasing awareness of important approaches to improving patient safety. These include: the role of systems thinking and design; the power of proactive risk assessment and hazard analysis; the value of human factors and ergonomics in improving systems and processes; and the impact of quality improvement methodologies through initiatives like the Patient Safety Collaboratives, the work of organisations like the Health Foundation and specific projects. We know from recent engagement exercises, reports and reviews that we still face huge challenges in using these approaches, in being truly open and transparent, and in consistently improving safety across all parts of the NHS. (NHS Improvement, 2017).

Appendix 2: Template Booklet

Please click on Figure



Appendix 3A: Prompts for using the Charles Vincent et al Framework.

Past Harm

- ✓ Identify the different types of harm that can exist in your setting
- ✓ Use a range of safety measures, while understanding their strengths and limitations
- ✓ Ensure the measures are valid, reliable and specific

Reliability

- ✓ Specify the level of reliability you would expect in areas of standardised practice
- ✓ Use local and national audits and initiatives to monitor reliability
- ✓ Understand what contributes to poor reliability

Sensitivity to Operations

- ✓ Select an appropriate mix of formal and informal safety monitoring mechanisms
- ✓ Use this information to take timely action to avert safety issues
- ✓ Reflect on whether current structures and committees enable timely action to be taken

Anticipation and preparedness

- ✓ Don't wait for things to go wrong before trying to improve safety
- ✓ Explore new opportunities to develop systematic ways to anticipate future risks
- ✓ Use a variety of tools and techniques to build an understanding of the factors that give rise to safety issues

Integration and Learning

- ✓ Use the analysis of incidents as a starting point to reveal the wider issues in the system
- ✓ Place more emphasis on learning, feedback and action than simply on data collection
- ✓ Integrate and tailor information to make it meaningful from the ward to the board

Appendix 3B: Type of data collated in each of the five domains using the Charles Vincent Framework:

Past Harm
Includes psychological and physical measures
Incident reports, mortality data, NQIs, investigations, litigation, complaints, surveys, care opinion, violence & aggression, absenteeism.

Integration and Learning
Ability to respond to, and improve from, safety information –
benchmarking data, safety strategy outcomes, improved safety metrics, impact analysis of improvement plans, reflection, learning from excellence, dashboards,

Reliability
Are our clinical systems and processes reliable?
Process measures, compliance with targets, debriefs, audits & assessments, handovers, supervision, reflective practice, risk assessment.

Anticipation and preparedness
Will care be safe in the future?
Ability to anticipate, and be prepared for, safety training, feedback, % appraisals, number of incidents, capacity, MDT meetings, collective leadership fora.

Sensitivity to Operations
– is care safe today?
Information and capacity to monitor safety in real-time - Safety walks, handovers, huddles, quality reviews, staffing levels, feedback, daily briefings skill mix

Adapted from Vincent c, Burnett S, Carthey J. (2016). "The Measurement & Monitoring of Safety", The Health Foundation.

Appendix 4: Example of the Q.I. Model and PDSA Cycle.

Example in practice: USING THE QUALITY IMPROVEMENT MODEL

INTRODUCING SAFETY HUDDLES

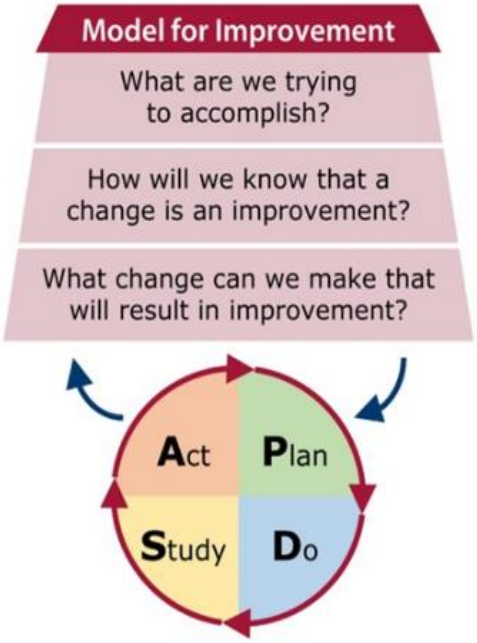
1. **Preparation**
- Build team engagement
- Provide independent support to embed principles of Safety Huddles

2. Getting Started
- Produce associated paper-work

3. Diagnose Problem
- Be flexible. Agree one “harm”, e.g.falls, and build in others when the huddle is established.
- Produce a data and measurements board
- Complete PDSA cycle

4. Implement Solution
- Begin Safety Huddles

5. Evaluation
- Feedback findings
- Address difficulties
- Scale up Trust-wide when ready



Example in Practice: USING THE PDSA CYCLE

INTRODUCING SAFETY BRIEFINGS.

What do we want to accomplish? (Aims)

- Increase staff awareness of patient safety issues,
- Create an environment where staff freely share information about safety issues without fear of reprisal,
- Integrate safety into the daily routine,
- Change the culture

How will we know that a change is an improvement? (Measures)

- Number of safety issues identified by staff
- Amount of information shared among staff
- Number of "near misses," i.e., errors caught before reaching the patient, reported
- Number of patients raising safety questions,
- Number of errors prevented by patient questions,
- Percentage of staff who perceive Safety Briefings as valuable

What change can we make that will result in an improvement? (Changes)

Conduct Safety Briefing on a patient care unit twice per shift.

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HSC Southern Health and Social Care Trust

	To support the Board in fulfilling these functions effectively, it established 6 Committees with Board approved Terms of Reference.. Committee structures are outlined below.
Membership	• Chaired by Trust Board Chair • 7 Non-Executive Directors • Chief Executive • 4 Executive Directors (Finance; Medical; Nursing, Midwifery & AHPs and Social Work - also Director of Children & Young People's Services('CYPS')) • In attendance: - Directors of Performance and Reform; Human Resources and Organisational Development; Acute Services; Older People & Primary Care ('OPPC')
Frequency	Approximately 7 meetings held in public per year
Examples of Business	Each Trust Board agenda is structured under the 3 key domains of Strategy, Accountability and Culture
Comments on operation and assurances	As described throughout this document I believe the Trust Board is an effective structure for the overall governance of the Trust. Questions 23 to 41 draw out details about the operation and assurance of the Trust Board.

Senior Management Team

Function	The Senior Management team (SMT) is accountable to me, the Chief Executive. It is responsible for the leadership, strategy, and priorities of the Trust and to oversee all aspects of Operational activities to ensure that the Trust meets its Statutory Requirements and provides high quality and effective services. .
Membership	• Chaired by Chief Executive • Operational Service Directors (Acute, Children's and Young Persons CYP, Older Persons and Primary Care OPPC and Mental Health and Learning Disability MHLD), • Executive Directors (Finance, Medical, Nursing & AHPs and Social Work – also Director of CYPS) • Directors of Performance and Reform and Human Resources • Attended by Head of Communications
Frequency	Twice Weekly – Formal meeting and informal meeting
Examples of Business	• Strategy and Planning • Delivery and Performance • Communication and Engagement • Governance and Risk Management • Board Responsibilities
Comments on operation and assurances	The SMT is a key mechanism through which I am able to discharge my responsibilities to manage the Trust. The formal meeting occurs every Tuesday morning and the agenda is set by me and the team members to cover key operational and strategic issues. It allows a space for checking and challenging and is a conduit for information from external structures e.g. the Regional Management Board (RMB).

	As can be seen in appendix 13 the author concluded "*The analysis demonstrated that many of the building blocks for good governance are in place e.g. a Board Assurance Framework, Corporate Risk Register, Risk Management Strategy and operational policies e.g. adverse incident reporting, health and safety management, claims and complaints management. However, gaps in controls and assurances in these systems and processes have been identified and recommendations made"* It is important to note, and as articulated in the minutes of the Trust Board Workshop 27/2/2020 (appendix 14), I perceived that the Trust Chair, Roberta Brownlee, was annoyed with the way I had commissioned and managed the review. She felt that as Chief Executive I did not have the right to commission such a report as the management of the non-executive functions were not within my gift. You can note from the minutes that I agreed that we would move forward with the actions relating to clinical and social care governance only. As a result of the clinical and social care governance review I secured investment in increasing both the resource assigned to and organisational profile of the Clinical and Social Care Governance (CSCG). In 2019 I approved (appendix 15) an additional £1/2 million spend on strengthening CSCG within the Trust. Major changes have been delivered in the management of SAIs, Complaints and Standards and Guidelines. Currently under my direction the Trust Medical Director is redesigning a sub-committee structure to bring together a greater range and deeper cut of CSCG information for consideration by SMT and Trust Governance Committee. (appendix 16)

Q12	**Is the Board appraised of those departments within the Trust which are performing exceptionally well or exceptionally poorly and how is this done? Is there a committee which is responsible for overseeing performance, where does it sit in the managerial structure and hierarchy and how does the Trust Board gain sight of these matters?**
Response	*Is the Board appraised of those departments within the Trust which are performing exceptionally well or exceptionally poorly and how is this done?* The Trust operates a performance committee which assists the Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines. The full terms of reference are provided below along with the Trust Performance Management framework which is part of the Board Assurance Framework and complements the Trust's Governance Arrangements. The Trust has recently invested in increased Business Intelligence solutions that support 'dashboard' dynamic performance indicators that will allow for corrective and interventional actions to be made in a timely manner. *Is there a committee which is responsible for overseeing performance, where does it sit in the managerial structure and hierarchy and how does the Trust Board gain sight of these matters?* As described in question four, in October 2019, we introduced a new performance committee

Function	Assists the Trust Board in exercising one of its key functions of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines.
Membership	• Chaired by Non-Executive Director • Four Non-Executive Directors • In attendance: - Chief Executive - Executive Directors (Finance, Medical, Nursing & AHPs and Social Work – also Director of CYPS) - Director of Performance and Reform

196 Q. We'll do that. We'll come back to that this afternoon.
A. Yes.
197 Q. I suppose, just in general terms then, when we are looking at governance and scene setting, rather than just focus on the date, part of the terms of the reference the Inquiry would be interested in is the way in which governance operates and how reliable it is and how any unreliability may lead to outcomes that impact on Patient Safety. 12:39

Just in general terms, as the Medical Director how did you re-assure yourself about the information that you were given and the Governance systems that you were responsible for? How did you re-assure yourself that they were fit for purpose? 12:39
A. I think, as I stated at the beginning, I was concerned about them, and that's why, obviously, I asked for the review of governance structures across the Trust.
198 Q. If we just pause there. I don't want to stray into that just at the moment. When you go into the job you say you were worried about them. What triggered that concern? 12:39
A. I think it seemed to take a lot of time to get information. Also then it seemed to take -- you know, again, when I went looking for information around Mr. O'Brien it seemed to take an inordinate amount of time and effort to pull down things that should automatically be there. That concerned me. Then I realised there were people involved in all of this 12:40

and that very often they were trying to do other jobs and get this done for me at the same time. So there was that aspect of it. I think, you know, some of the electronic systems had only been developed about 2016/2017, so in terms of getting information beyond that was really problematic. Again in terms of the systems then bringing together, for example, Serious Adverse Incidents, complaints, it all seemed to be dealt with in silos down through the different Directorates but not shared or given oversight by the Medical Director. Again, I think historically there had been a view that governance was managed by the Operational Directors and the Medical Director was there, then, basically to comment or give an opinion on some of the processes, without it being a full assurance process. There was very little audit going on of actually governance processes. There was very little, I think, transparency in relation to how some of those things were done. Again, back to my earlier comments in terms of trying to get information, if I asked for anything at all that was governance related, and given at this point in time I was mostly concentrating on the Acute Directorates and, to some extent, the Mental Health Directorate which also was undergoing significant challenge at that point in time too, it took an inordinate amount of time to get the information. Then sometimes it wasn't of good quality and you had to go back and ask for it again. Then you had to try and make sense of how it all fitted

12:40
12:40
12:41
12:41
12:41

together, I think what I increasingly realised was then that my sense of governance and what that should look like, in terms of being systems and processes to ensure Patient Safety, was not that shared with the organisation. I think over the years what had happened was, between numerous changes in Chief Executive, Medical Director, Acute director, Mental Health Director, that, as I say, they had lost their narrative in terms of how understanding how a good governance structure within a Trust should function to ensure patient safety, but when there had been savings to be made, those were the posts that disappeared. They kept the Clinical posts but in terms of the governance structure post -- there was no clinical audit team. For example, there was no Datix Manager. The SAIs were managed in a whole different series of ways. How complaints were dealt with were always within the Directorates but never coming to the Medical Director's office. There were things like that that you should automatically expect to find in an organisation that weren't there. 12:42 12:42 12:42 12:43

199 Q. Was part of that the sense that people worked in their own lines of management?

A. Yes.

200 Q. I don't want to use the word "silo", but there were events that people knew what their line were doing but not necessarily what the other? 12:43

A. Yes.

201 Q. Do you think then by its very nature that structure led

was the only link they had. In the hospital we didn't really have any link with them apart from contacting them about their surgery. GPs were fundamental.

164 Q. Okay. You made quite a lot of comments about culture. We have had from a variety of people that there have been problems with the silos of management and leadership. We have heard about hierarchy and problems that might cause. We have heard that everybody was working very hard to do their best throughout many parts of the Trust. What, in your view, was -- apart from just focusing on performance, I am not really talking about that, was there anything about the culture that you felt was detrimental to taking all these things forward? 12:25 12:25

A. Apart from what you've just said? 12:25

165 Q. Those are the things we have heard about but was there anything else missing? What was missing from your perspective, because clearly you have strong feelings about this? Everybody talks a lot of talk about strategy and culture and all these things but when you've worked in a system, sometimes you can identify some specific things that need development to go forward. What would they be? 12:25

A. I believe in terms of communication, there were silos. In terms of management that would have been above me, people didn't necessarily follow their roles and responsibilities. That was actually a trend right across, and I would say that to you. Roles and responsibilities, for me, is every bit as important as 12:26

18.1 As Medical Director (1st December 2018 – 30th April 2022), I did not have any operational responsibility for delivery of Urology Services. However, I had responsibility for professional medical standards and behaviour, integrated corporate governance and patient safety.

18.2 I refer to the tabular answers given in my response to question 17 in terms of the identification of posts that were vacant during my tenure.

18.3 I also refer to the tabular answers given in my response to question 17 regarding staffing challenges and vacancies. As Medical Director I did not have operational responsibility for management of the vacancies or remedies regarding same but did share the concern for the potential impact of these vacancies on the other staff and on patient safety.

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

19.1 Any Trust service with sub-optimal staffing has the potential to impact on the capacity of the service to provide care for patients. In terms of the governance processes that surround any given service, these should still exist. However, it can be challenging to deliver where there is inadequate staffing.

19.2 As a result, Governance processes in Urology were not as well developed as they required to be. As outlined in detail in my answer to Question 21 below, they are being developed to address shortcomings.

19.3 Staffing shortages led to further lengthening of Waiting Lists.

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

20.1 Aside from the changes made to the Medical Leadership Structures referenced in answer 21 below, I am unaware of changes in medical roles, duties and responsibilities in the unit.

such a future however, the staff had indicated it was essential that the culture of the Trust needed to change. A transition that would be central to such a change, it was agreed at the meeting with staff would be a change of culture from a Performance driven top down culture to a Safety and Quality Culture built on commitment by leadership of the Trust Board and Senior Management engaging with staff at every level of the Trust.

- Vivienne continuing with her account of Dr O'Kane's Presentation said that the Chief Executive had informed the Board that she had now asked Elaine Wilson the Director for Planning, Performance and Informatics to begin to draft a new Organisational Vision for the Trust that would be underpinned by a new 5 years Strategic Plan. She advised the meeting that the Chief Executive had asked the Trust Board to agree that these two critical pieces of work should be commenced immediately. She said that Dr O'Kane had emphasised to the Board that we needed to commit leadership to co-produce the Vision and Strategy by involving **all Stakeholders**.
- Vivienne advised the meeting that the Senior Leadership Team were now examining the development of the Principles that should inform how this important strand of work would be developed. She advised that in progressing this discussion that to date Senior Leadership had agreed the following Key Principles:
    - Safe and Quality Care
    - Investing our resources where they add most value

Southern Health and Social Care Trust

Quality Care - for you, with you

Job Description

JOB TITLE Medical Director

INITIAL LOCATION Trust Headquarters,
Craigavon Area Hospital

REPORTS TO Chief Executive

ACCOUNTABLE TO Chief Executive

JOB SUMMARY

The Medical Director is an Executive Director and member of Trust Board. The postholder will advise the Trust Board and Chief Executive on all issues relating to professional Medical workforce, clinical practice and quality and safety outcomes.

The postholder is the Trust's nominated Responsible Officer and will also carry lead Director responsibility in a number of organisationally critical areas including Health Care Acquired Infection (HCAI), Research & Development and Emergency Planning.

As a member of the Trust Board and the senior management team he/she 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 change, innovation, development and modernisation.

KEY RESULT AREAS

GOVERNANCE

1. To lead in the development of a framework to ensure a strong infrastructure of medical leadership within the Trust, including the development of a competency framework to drive succession planning.

2. Provide professional leadership and guidance to support Associate Medical Directors (AMD's), Clinical Directors (CD's) and Lead Clinicians throughout the Trust in relation to governance of the medical workforce including clinical practice and service change.

3. Work with other Directors to inform, support and provide assurance on the systems for the effective identification and management of clinical governance concerns, ensuring that any learning is incorporated into professional practice and systems.

4. As a member of the Senior Management Team and Trust Board, the Medical Director has corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds.

5. As the designated Responsible Officer for the Trust, the postholder will have responsibility and accountability for the following key areas;

a) The effectiveness of medical appraisal of the medical workforce, for quality and standard of CPD to meet development needs arising from appraisal, and for revalidation.

b) The provision of expert advice and assurance to the organisation in relation to the Trust's processes for addressing concerns about a medical practitioner's fitness to practice (as set out in the Trust's Guidelines for Handling Concerns about Doctors' and Dentists' Performance).

c) The designated Trust officer for referring concerns about a medical practitioner to the General Medical Council.

d) Providing professional advice to SMT as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of SMT Governance, to regularly review this information, and to provide assurance or expert input into necessary steps to address any issues arising from same.

e) Providing regular 'Responsible Officer' reports on the medical workforce to SMT, Governance Committee and Trust Board

6. Designated lead Director for strategic management of Patient Safety initiatives, and the link Director with the Patient Safety Forum and other regional Fora.

7. While the operational responsibility and accountability for patient safety rests with operational Directors, the postholder will be responsible for;

a) Participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the organisation and providing strategic and professional advice on implementation.

b) Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by SMT, within the wider Clinical and Social Care Governance arrangements of the Trust.

c) Reviewing and monitoring the impact of Patient Safety Initiatives and providing regular Patient Safety reports to SMT, Governance Committee and Trust Board.

8. Professional lead in relation to Information Governance, specifically the Trust's nominated Caldicott Guardian, and chair of Trust Information Governance Committee.

SERVICE DELIVERY

9. Strategic management and co-ordination of effective Emergency planning within the Trust, including Pandemic Planning.

10. Responsible for ensuring a Major incident policy is in place for the Trust, and suitable support is in place for the testing, recording and subsequent modification of the policy and attached plans are reviewed constantly and reported on at agreed intervals.

11. Responsibility for Controls Assurance Standards (CAS) for Emergency Planning and Research Governance with provision of Annual Reports to Trust Board.

12. Management of ECRs and Drug Requests for Southern Trust patients, and responsible for medical evaluation, decision-making and liaison with Commissioner in relation to same.

13. Responsible for the strategic management of the clinical aspects of HCAI and Infection Control within the Trust, including the line management of the Infection Control Team and responsibility for CAS for infection control and provision of Infection Prevention and Control Annual Report to Trust Board. The postholder will liaise as appropriate with the Director of Acute Services who is responsible for environmental hygiene.

14. Develop and implement health surveillance methodologies for the Trust.

15. Responsible to Trust Board for the discharge of medical statutory functions.

LITIGATION

16. To provide medical leadership advise to the Director of Human Resources & Organisational Development in respect of medical litigation including effective integration with wider clinical governance systems and engagement and involvement of other Directorates.

17. Lead Director for the Trust's Medical Negligence and other related committees to:

    a) provide an investigation and management service on behalf of the Trust in relation to claims of litigation in respect of clinical negligence and associated matters

    b) assist HM Coroner with enquiries and the preparation of statements prior to inquests

    c) liaise with the HSCB and/or the Department of Health as necessary for follow up action subsequent to sudden death or significant adverse incidents.

18. Lead decision-maker for management of medical negligence. Provision of regular reports to SMT, Governance Committee and Trust Board to provide assurance of effectiveness of Litigation function, systems and processes.

MEDICAL EDUCATION, & TRAINING

19. The postholder will be responsible for the quality of medical education and training within the Trust working closely with education and training bodies and ensure the Trust has a highly skilled career grade medical workforce. This will include accountability for the quality of undergraduate training including delivery of QUB Accountability Framework and utilisation of SUMDE budget, and the provision of Annual Report to Trust Board.

20. Lead on the post graduate training of junior doctors in training within SHSCT, including managing the relationship between NIMDTA and the Trust, and ensuring the Trust and NIMDTA work in partnership to maintain a high standard of education and related patient safety.

21. Lead on the work related to the newly established "Sub Deanery" for Queens University (QUB) Medical School within SHSCT, including managing the relationship between QUB and the Trust, and ensuring the Trust and QUB work in partnership to maintain a high standard of education and supervision of the Medical students placed with SHSCT. This work includes an Annual report and financial report on the funding provided to SHSCT by QUB in respect of the work of the sub-deanery.

22. Management of the Associate Medical Director (AMD) for postgraduate Medical Education, induction and training for Junior Doctors, QA / evaluation of training and supporting operational Directors to address issues arising from Deanery and PMETB evaluation and inspections.

23. Responsible for the development and maintenance of professional standards and education liaising with professional and education bodies as necessary.

24. Provide advice on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to patients and clients.

25. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC's guidance 'Duties of a Doctor', 'Good Medical Practice' and related documents, and succeeding and replacement documents or the GDC's lifelong learning requirements.

26. Ensure the implementation of an effective process of professional self-regulation for doctors employed by the Trust.

RESEARCH & DEVELOPMENT

27. The postholder will be responsible for the strategic and operational management of Research and Development within the Trust, including the line management of the AMD for Research and Development and associated support staff. This role includes responsibility for CAS for Research and provision of Research and Development Annual Report to Trust Board.

28. Responsible for the Trust's Research Committee to agree a programme of research and development and ensure the extant legal and regularity permissions are obtained.

QUALITY

29. Promote the highest possible standard of medical practice, advice and support to ensure the development of a quality culture with an emphasis on the need for continuous improvement.

30. Promote quality initiatives such as Investors in People and Charter Standards in the Trust and support the development and delivery of a Trust Quality Improvement Framework.

31. Ensure that medical standards are clear and defined in contracts/service level agreements for the provision of services to other Trusts or with independent service providers.

32. Continue to develop and maintain appropriate Quality Indicators, including a comprehensive Mortality Report and provide information and assurance on the intelligence from such indicators to operational Directors, Chief Executive and Trust Board.

33. To ensure that the Mortality and Morbidity process within the Trust underpin and quality assure the mortality indicators and other indicators of quality and opportunities for learning and improvement.

34. Keep up to date with policies and guidelines on good practice from the Royal Colleges, GMC, universities etc. and identify opportunities to enhance the quality of services provided by the Trust.

FINANCIAL AND RESOURCE MANAGEMENT

35. Responsible for the management of the directorate's revenue budget and ensure the meeting of all financial targets.

36. Participate in contract and service level negotiations with commissioners.

37. Advise and assist in the development of capital investment strategies across the Trust, ensuring these reflect and contribute to meeting targets set by the HSCB and the Trust's Corporate Plan.

CORPORATE MANAGEMENT

38. Contribute to the corporate decision making of the Trust Board and ensure compliance with the Trust's Standing Orders and Standing Financial Instructions.

39. Contribute to the Trust's corporate planning, policy and decision making processes as a member of the senior management team and ensure the Trust's objectives and decisions are effectively communicated.

40. Develop and maintain working relationships with other director colleagues and non-executive directors to ensure achievement of Trust objectives and the effective functioning of the senior management team and Trust Board.

41. Establish collaborative relationships with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.

42. Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

43. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

44. Ensure appropriate risk management arrangements are in place to deliver safe medical services to patients and minimise the potential for actions against the Trust.

45. Participate in the assurance that an effective system of clinical risk management and adverse event reporting is in place.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

46. Ensure the development of strong medical leadership in the Trust.

47. Oversee, and participate in the arrangements for consultant and associate grade appraisals.

48. Participate in arrangements for recognition of clinical excellence including providing advice on nominations and citations for Distinction and Meritorious Service awards.

49. Ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.

50. Support managers both in establishing and reviewing performance targets with individual consultants, recognising workloads and other pressures on medical staff, and ensuring that adequate mechanisms are in place for the welfare of medical staff.

51. Provide advice and guidance on medical workforce policy driving forward a culture of change, innovation and development and modernisation of services.

52. Responsible, in association with HROD for the management of disciplinary matters and complaints relating to medical staff.

53. Review individually, at least annually, the performance of immediately managed staff, provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.

54. Maintain staff relationships and morale amongst staff.

55. Delegate appropriate responsibility and authority consistent with effective decision making, while retaining overall responsibility and accountability for results.

56. Participate, as required, in the selection and appointment of Trust staff in accordance with procedures laid down by the Trust.

57. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

58. Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

59. Actively promote the development of an emergency management strategy with the Directorate to ensure a state of preparedness to respond to a range of internal and external emergency situations.

GENERAL REQUIREMENTS

60. 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.

61. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

62. 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

63. All employees of the Trust are required to be conversant with the Trusts policy and procedures on records management. Trust Directors are responsible to the Chief Executive for all records held, created or used as part of their business including 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 exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

64. 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.

65. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

66. 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 grade may be assigned from time to time.

67. To understand 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 postholder works.

68. To be aware 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

Quality Care - for you, with you

TITLE: Associate Medical Director

DIRECTORATE/ DIVISION: Acute Services – Surgery / Elective Care

REPORTS OPERATIONALLY TO: Director of Acute Services

REPORTS PROFESSIONALLY TO: Medical Director

ACCOUNTABLE TO: Chief Executive

COMMITMENT: Maximum of 3 PAs - to be agreed with Director

LOCATION: Craigavon Area Hospital / Daisy Hill Hospital

JOB SUMMARY

The Associate Medical Director (AMD) will as a member of the Directorate Senior Management Team, play an active role in contributing to the strategic direction and the on-going provision of high quality services which are safe and efficient.

Specifically, the AMD will be responsible and accountable for the medical staff within the specialty and their role in the provision of services. As a senior medical leader within the Trust the AMD will work closely with the Director / Assistant Directors of Acute Services to provide medical management within the Directorate and contribute to the overall vision, direction and performance of the organisation with respect to the medical staff and their role in service delivery. The AMD will also be responsible for the safety and capability of the medical workforce within the specialty, providing the Director of Acute Services with defined information for assurance purposes to the Medical Director. The AMD will demonstrate a commitment to lead by example with regard to clinical and social care governance.

The post will be appointed for one year and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

KEY RESPONSIBILITIES

1. LEADERSHIP & MANAGEMENT RESPONSIBILITIES

The AMD will work closely with the Director/ Assistant Directors of Acute Services to provide effective leadership within the Directorate**.**

The AMD Surgery & Elective Care will work closely with the AMD's MUSC, ATICs and Cancer & Clinical Services to ensure effective clinical interfaces and patient pathways for out of hospital care, ambulatory care and admission for inpatient care are in place, reviewed and actioned.

The AMD Surgery & Elective Care will work regionally on behalf of the Trust in the development of quality and safety standards for the service and will hold responsibility in the Trust for clinical leadership of these standards.

He / she will also contribute to effective service delivery within the department by managing implementation of the following policies;

Appraisal

- Co-ordinate the approved appraisal system, ensuring a process is in place and operating within guidelines.
- Ensure necessary training (within the agreed budget) is available for medical staff (non-training grades) within the Directorate / sub Directorate, manage the approvals process for same and oversee the Division's utilization of the budget for medical training and development.
- Monitor the implementation of appraisal within recommended timescales.
- Undertake appraisal for Clinical Directors.
- Prepare an annual Directorate / sub Directorate Appraisal report for the Director of Acute Services to submit to the Medical Director (in relation to required Annual Trust Board Report).

Job Planning

- Provide leadership and support for Job planning within the Division for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors and Lead Clinicians and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Division / Directorate's service capacity needs and Service and Budget Agreement with our Commissioner

Implementation of HR policies for Medical Staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support

Education and Training

- Liaise with the Associate Medical Director for Education and Training and College Tutors to ensure a plan is in place by specialty for the training of junior doctors in keeping with NIMDTA and GMC requirements (including managing the balance between service delivery and training demands).
- Provide leadership in implementing and achieving compliance with the European Working Time Directive.

2. CLINICAL GOVERNANCE RESPONSIBILITIES

The AMD in conjunction with the Assistant Directors and Director of Acute Services will be responsible for having systems and processes in place to review and manage remedial action emerging from incidents, complaints, risk identification and assessment, litigation, audit and clinical indicators. The AMD will have responsibility for the specialty M&M meetings and to ensure emergency medicine contributes to other specialty M&M meetings.

The AMD will be directly responsible to the Director Of Acute Services for patient safety. This includes ensuring processes are in place to identify, review and take remedial action when patient safety issues arise.

The AMD will be responsible for managing potential underperformance of medical staff within the Directorate. With full assistance from HR, the AMD will be responsible for leading the Trust's process for Maintaining High Professional Standards within the Division.

OTHER CLINICAL GOVERNANCE RESPONSIBILITIES

Divisional Governance Forum

- Chair the Divisional Specialty Governance Group and participate as agreed in Directorate governance arrangements.
- Work with the Trust / Directorate Governance Co-Ordinator to ensure effective governance of services.

Standards

- Provide advice to the Director of Acute Services and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc.
- Work with relevant managers and colleagues on required implementation plans and lead the implementation of such plans in relation to the medical workforce and clinical practice.
- Act upon the recommendations of any external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) working on the development and roll out of an implementation plan in conjunction with the Director/ Assistant Director of Acute Services.
- Assist in the preparation for external inspections.

Public Health and urgent operational issues

- Provide advice to Director of Acute Services, Medical Director and colleagues (e.g. swine flu, HCAIs).
- Contribute as appropriate to the development and implementation of contingency plans and lead the implementation of these plans in relation to the medical workforce.

3. CORPORATE RESPONSIBILITIES

As a senior medical leader within the Trust the AMD will participate and contribute to the corporate performance of the Trust. He / she will share responsibility with other senior managers in the Trust for Trust activities and for the overall performance, clinical and service strategy.

The AMD will also be required to:

- Attend meetings of the Directorate Management team and / or regular meetings with the Director of Acute Services.
- Contribute to the Business Plan of the Directorate to help achieve Trust Delivery Plan priorities.
- Monitor activity against the plan and determine / advise on required actions in conjunction with Director / Assistant Directors of Acute Services
- Lead the implementation of such plans as they apply to the medical workforce and / or clinical practice.

OTHER CORPORATE RESPONSIBILITIES

Service Development & Improvement:

- Maximise the effectiveness and efficiency of the services within the Division across the Trust's hospital network.
- Regularly review key service data in conjunction with Director / Assistant Director / Heads of Service of Acute Services and advise on delivery options.
- Provide a medical perspective on protocols / pathways related to service improvements.
- Provide input to decisions on the medical capacity required for service developments.
- Provide clinical leadership on service reconfiguration within the Division and Directorate.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's specialty collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

Communication

- Facilitate good communication with medical staff, (through planned meetings with consultant staff and other opportunities).
- Provide effective communication with other clinical and non-clinical managers in support of good multidisciplinary team working.
- Actively promote the development of clinical and professional networks across the Trust's hospital network.
- Actively participate in the AMD Forum which is led by the Medical Director.

GENERAL REQUIREMENTS

The post holder will be required to:

- 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.

- 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.

- Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Infection Control
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

- 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.

- Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

- 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.

- 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. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which appointee will work.

- 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

Quality Care - for you, with you

Meeting: Date:	Senior Leadership Team (SLT) – 6th June 2023
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Stephen Austin, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information

Overview: Provide SLT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance

Please note the information included in this paper relates to Governance activity between 22.05.2023 – 28.05.2023. Exceptionally, there may be Governance activity reported outside of this timescale for information to SLT e.g. in this case, Governance activity between 29.05.23 and 31.05.23 (the latter being the cut-off date for submission of the report for SLT papers) which requires notification rather than waiting to the next weekly report.

Ongoing SAIs

- **Ongoing SAIs – 94** – MUSC/SCS – 39, MHD – 39, CYP – 3, ACS – 13

SAI Notifications

- **MUSC/SCS –** Personal Information –Death of hypoglycemic Service User.

SAI Reports

- **SCS / CYP –** Personal Information - Delay in transfer to RVH for blocked shunt. Patient deceased.

Early Alerts

- **MHD –**Consultant staffing issues within the adult outpatient mental health services.
- **ACS –** GP OOHs

Litigation

- Any live/listed Clinical Negligence Claims Hearings have either been vacated or settlement discussions are ongoing

Urology Cases –

- SARS – The number of SARs at 90+ days is currently 41. The redaction process (particularly within MUSC/SCS) is causing a long delay in getting these closed off, to consider redaction committee, assistance offered from CYP Directorate for redaction of critical MUSC/SCS SARs.

Medication Incidents

Increase in Medical incidents within DHH.

- Personal Information **–** MUSC – Patient prescribed meropenem and tazocin for approx. 8 days (duplication of therapy). Noted by pharmacy and nursing staff who requested antibiotics to be reviewed, identified on micro ward round and tazocin stopped. Microbiologist had previously advised that the patient be switched from tazocin to meropenam. ?Advice misinterpreted.

  Similar incidents have been reported. An Antimicrobial report is due to be presented to the Performance Committee for wider discussion. Work is required to progress the learning identified within these cases.

Safeguarding

- Number of new adult safeguarding referrals is 42
- Number of new adult safeguarding referrals meeting threshold for Adult Protection Gateway team is 16
- There was 1 new case for escalation – 3 whistleblowing letters received identifying trends relating to a range of care concerns. To be addressed at Contracts Performance meeting.
- 3 cases that were previously awaiting PPS decision
- 20 new referrals received for ACS, 12 from one Care Home identified and reported following audits carried out within the home.

Southern Health and Social Care Trust

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Information Governance

- The Trust is currently down to 3 outstanding FOIs
- There has been one new data breach reported to the ICO in this period. This in relation to a social media post by a member of staff which included Personal Identifiable information. Work has commenced to remind staff that photographs of service users is not permitted unless explicit consent has been obtained.
- Deputy Medical Director highlighted the hard work by staff in reducing the number of FOI requests exceeding Legislative Timeframes.

Clinical Audit

- After a very successful Clinical Audit meeting, a prospective audit plan will be put in place

IPC

- C.diff cases have increased from 3 to 6 during May.

Stakeholders described the challenges in managing the large volume of standards and guidelines that are received from external agencies. During 2017/18, a total of 230 guidelines were received from external agencies, 23 were not applicable to the Trust of the remaining 207 there were 39 that were not applicable to Acute Services. Senior stakeholders identified the challenges in managing standards and guidelines which have cross directorate applicability.

In April 2012, the Trust established a Corporate Standards and Guidelines Risk and Prioritisation group. The aim of this group was to provide a corporate forum to ensure that the Trust has in place a systematic and integrated approach for the implementation, monitoring and assurance of clinical standards and guidelines across all of its care directorates. The Reviewer understands that the Group was stood down in January 2017 to be replaced by monthly meetings between the Corporate Assistant Director Clinical and Social Care and Directorate Governance leads.

All of the Directorates have systems in place for the management of Standards and Guidelines. Acute Services have a robust system in place for the dissemination of Standards and Guidelines which represents a best practice model. The system was developed and is managed by a Patient Safety and Quality Manager (Standards & Guidelines) who is a NICE Scholar and a member of the Acute Services Clinical and Social Care Governance Team. The system includes a Standards and Guidelines Operational Procedures Manual, a reporting schedule, process maps including a process map for clinical change leads and an Accountability Reporting system for Acute Services. The downside of this system is that it is person dependent. The Patient Safety and Quality Manager also identified that the lack of clinical audit in providing assurance that standards and guidelines had been implemented was a systems issue.

Other challenges include identifying a clinical/managerial lead for guidelines – as there is an apprehension surrounding taking on the responsibility/accountability for change lead role.

Positive assurance statements go directly back to HSCB via the Corporate Clinical and Social Care Governance team. Previously they would have been approved by SMT prior to issue. ***It is recommended that a level of corporate oversight is reinstated (in line with the Assurance & Accountability framework S4.1).***

An 'Accountability Report' of the Trust's compliance with Standards and Guidelines had previously been reported to the Governance Committee on a twice yearly basis. ***It is recommended that the Accountability (Compliance) reporting arrangement is reinstated***.

The Trust will be required to comply with IHRD Recommendation 78 ~ *Implementation of clinical guidelines should be documented and routinely audited*. The challenges in respect of clinical audit are outlined in Section 4.15. It is anticipated that as part of the final stage of the IHRD Implementation Programme Assurance Framework HSC organisations will be required to provide independent

That, plus then we couldn't get -- increasingly we were having to go back corporately and said we couldn't get any of the consultants to lead the implements on new standards in guidelines. We just couldn't do it. 11:21

108 Q. Thank you. I'll just point this out to the Panel. Below this table is a two-page report, quite a concise report, which speaks to much of what Dr. Boyce has just said orally. I don't think I need to go to it directly but it is there for the Panel to read. 11:22

I am almost afraid to ask this question: Was this delivered during your time?

A. No. I think that was around 2018 when Mrs. Gishkori had various periods of ill-health. The plan was that 11:22 Esther was taking this. That's why the two-page briefing note was with this, so that Esther could take it to the Chief Executive at her one-to-ones and pitch to get it funded. I understand from the timings that Esther was off for periods of time. At one point 11:22 during that phase, Anita Carroll was acting into the role with other Assistant Directors. To be fair, Anita, she chased it up; she realised we didn't know where it was because Esther was off. You know, was the Chief Executive, I think it was Mr. Devlin at the time, 11:23 aware of it or not. So then Anita took it to Shane, I understand, to check. But it was never funded certainly in my time.

109 Q. You were able to step away from these extra governance

mechanism, how we are getting on with that, you know, that kind of stuff.

79 Q. Was it ever the case that people came back to you, directorates and divisions came back to you and said we don't have capacity to implement this guideline, there are issues around this? 10:55

A. In my time, no. I haven't experienced that, people coming back and saying absolutely not, it's not going to work.

80 Q. What's the process by which you reassure yourself that guidelines not only have been made aware to the correct people but that they are actually being used and being used properly? 10:55

A. Yeah. So to be fair, there was -- it wasn't a clear -- we didn't have an audit trail of are those being used; are those working well? Ideally, you would want to be able to go down the system and say right, okay, where are we at with these guidelines, let's audit them, let's see how well they are working, what are the issues with them. But in my time, I didn't have the time to do that and neither did the audit team, to be able to do all that sort of stuff. So, you were relying very much on the operational teams coming back to you and saying, look, that's not going to work. 10:56 10:56

Generally speaking, in maternity they have their own guidelines committee, and guidelines are shared through that committee and they are discussed and they are circulated through, and then there is feedback through

79 Q. I was just going to ask that. Was audit not viewed or how did things become so skewed that audit wasn't viewed as an integral part of quality improvement?

A. It should be. But the resource went to focus on quality improvement training, supporting the quality improvement as opposed to supporting the audit element of that. 11:10

80 Q. Now you go on to say, at paragraph 1.4 of your statement, that you facilitated the development of an acute Audit Committee. The first meeting got off the ground on 22nd September 2017, but you say due to a lack of administrative support and attendance the last meeting was held on 22nd September 2018. So it lasted but a short year. I suppose, first of all, what was your ambition for the Audit Committee, what were you seeking to achieve with its commencement? 11:10 11:11

A. I wanted to refocus audit, to have a process of oversight of audit and that audit would be linked to standards and guidelines and risk identified within SAIs or complaints or incidents that we identified. So in that way there would be an oversight, that the recommendations would be known and actioned and that the teams would have felt engaged, would have developed some administrative support for them, provided some form of spreadsheet or database to hold all of those recommendations to ensure they were actioned. 11:11 11:12

81 Q. Yes. During that year did you feel the Audit Committee was getting somewhere or, if we look at some of the reasons why it collapsed, and you set those out in your

audit in recent times or has there not been any identifiable change?

A. It's a huge change. So we have a member of staff from the audit team assigned to urology for audit purposes. She attends our Patient Safety meetings with us. She's constantly in communication with us with regard to the ongoing audit projects and, indeed, just yesterday was in contact with me about -- I think it's one of them on there or it's one that's on the current one. It's one of the ones through BAUS. It is there. It's the top one.

So it's a much greater engagement and it's led to a massive improvement through the audit programme that we undertake in the team. As you say, what we have there is multiple levels of priority in terms of the department for audit, and they go down from "external must dos", down to "for interest", if you like, audit. The findings are presented at our Patient Safety meeting by our trainees. They have presented at our regional audit meeting for urology as well, and I know the trainees are looking at -- where appropriate, they're looking to put their projects in for presentation at national meetings as well.

[Technical pause].

CHAIR: I think it might be better if we just sit on -- hopefully you can do it quickly -- rather than rise

through them because at the time of the statement it wasn't clear whether they had actually taken place, so you might be able to provide further information on that.

11:49

One of the things he does mention is that he now receives monthly reports showing how cancer MDTs are working. Is that something that you feed to him?

A. Yeah, so that's done. I suppose we always had really highlighted the need, and through the Cancer Peer Review Process we were highlighting to the Health and Social Care Board, the need for data managers within Trusts, and that's something that we've been highlighting for a number of years. Unfortunately, there was no funding to do that. I think obviously Cancer Services has grown, the demand has grown, the numbers are going rapidly upwards, there's now one in two people diagnosed with cancer. So, I don't believe the funding has went in tandem with that to bring in the additional resources to meet the needs of that.

11:49

11:49

11:50

We did highlight the need for data managers to monitor more of our MDTs and to pull the figures and to audit and to make that really meaningful information. On the back of the USI work, we have now recruited an audit person who runs reports randomly from each of the MDTs to look at how outcomes are taken forward and if they are. I think that's a very positive step forward.

11:50

not so much piecemeal but in a fashion that was difficult for you as a NED and perhaps amongst your NED colleagues difficult to grapple with the information, it was disparate and didn't join up or triangulate in the way that would have been most useful, is that right? 14:55

A. Well in my view governance is a dynamic process, I mean you're always looking at improving, it changes all the time. Certainly the June Champion Report was a significant improvement, in my opinion, in how we did our business around governance. Certainly we did have governance reports before that, but in my opinion they were almost in silos. I think what this report does is bring all those areas together so that you can triangulate the data. It also included additional reporting on Managing High Professional Standards. I had asked for judicial reviews to be included because I think that's a very good indicator of what the issues are, certainly for our service users. We get much more detailed reporting in SAIs, on complaints, on clinical audit. So when all those reports are brought together and there is analysis done, mostly by the Medical Director I have to say, that gives you a much more comprehensive understanding of where the pressures and the risks are. 14:55 14:56 14:56 14:57

192 Q. Try to think back to a time before this service was available to you, before this kind of reporting was available to you. So in those early years in your role as a NED, is it possible to describe, I suppose, the

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REPORT SUMMARY SHEET

Meeting Date	Governance Committee 6th September 2018
Title	SHSCT Clinical Audit Strategy, June 2018
Lead Director	Dr Ahmed Khan, Medical Director (Interim)
Corporate Objective:	Safe, high quality care
Purpose:	To provide a strategy for delivering on clinical audit within the Southern Trust

Summary of key issues for SMT

Key issues

This paper describes:

- a strategy and structure for overseeing clinical audit processes to provide an assurance to SMT and Trust Board that clinical audit is being appropriately managed and delivered;
- the arrangements for presenting the Trust's consolidated annual clinical audit work programme to SMT for assurance and approval;
- the clinical audit reporting arrangements to SMT, Governance Committee and Trust Board.

Key issues / risks for discussion:

- Ensuring that clinical audit is delivered consistently across all operational directorates, in line with national guidance
- Ensuring there is a sufficient number of staff in the corporate clinical audit team and operational directorates to support delivery of the approved clinical audit work programme.

Summary of SMT challenge/discussion:

- The Clinical Audit Strategy was approved, for onward referral to Governance Committee
- The strengthened interface between clinical audit and quality improvement was endorsed.
- Further work is required to review the resources to support clinical audit/M&M and QI.
- An extension was granted until 31 July 2018, to facilitate two Operational Directorates in compiling their clinical audit work programmes 2018/19.

Southern Health and Social Care Trust

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SHSCT Clinical Audit Strategy

June 2018

Table of Contents

Executive statement

The Southern Health & Social Care Trust is committed to delivering effective clinical audit in the clinical services it provides. The Trust sees clinical audit as a cornerstone of its arrangements for developing and maintaining high quality patient-centred care.

This strategy outlines the arrangements for defining, prioritising, approving, supporting, monitoring and reporting on the Trust's annual national, regional and local clinical audit work programme. The strategy also strengthens the assurance processes, as the foundation of our quality improvement efforts underpinning the Trust's Quality Improvement Strategy.

It is expected this one year clinical audit strategy, in line with the Trust's wider governance and assurance mechanisms, will inform and enhance the process of improving clinical services.

Dr A Khan
Medical Director (Interim)

1.0 Organisational context

Clinical audit forms an integral part of the clinical and social care governance framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit.

This strategy seeks to establish a common framework across the Trust to ensure clinical audit activity follows best practice guidance, and strengthens the assurance processes as the foundation of our quality improvement efforts underpinning the Trust's Quality Improvement Strategy. The value of audit projects is realised within the clinical assurance process and in terms of the improvements arising as result of clinical audit outcomes.

Effective national, regional and local clinical audit activities contribute to the delivery of the Trust's corporate objectives. It is important therefore that clinical audit is not seen as an isolated quality improvement activity, but as one of a set of tools which teams and services can use to improve the quality of care that is delivered to service users.

In developing an annual clinical audit work programme, it is essential to consider the links to wider quality and governance frameworks such as recommendations arising from serious adverse incidents, risk management processes, NICE standards and guidelines, etc.

HQIP advocates that if organisations are to gain the greatest benefit from clinical audit, certain pre-requisites must be in place (Appendix A).

2.0 Definition of clinical audit

For the purposes of this Strategy, HQIP's definition of clinical audit will be used, as follows:

> *"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"*

3.0 Aims

The aims of this strategy are to:

- Use clinical audit as a process to embed and measure clinical quality at all levels within the Trust, demonstrating the benefits of audit through assurance, and highlighting areas for improvement in the quality of care and services to the patient/service user.

- Identify and develop a prioritised annual national, regional and clinical audit programme, which reflects organisational need.

- Ensure a consistent approach to prioritising, developing, monitoring and reporting on clinical audit activity throughout the Trust.

- Ensure effective and timely reporting on the outcomes of audit activity

- Incorporate the recommendations arising from the internal audit of clinical audit (Appendix B).

4.0 Scope

This strategy is intended to inform, support and apply to all staff working in the SHSCT who have an interest in and responsibility for contributing to and overseeing the development, direction and delivery of national, regional and local clinical audit activity.

5.0 Developing and prioritising operational directorate national, regional and local draft clinical audit work programmes

This strategy describes the processes of developing and prioritising the Trust's clinical audit programme which reflects key national, regional and local drivers for clinical audit ("top-down" requirements), balanced against directorate/division/service priorities and the interests of clinicians ("bottom-up" initiatives).

The first step in developing a comprehensive annual work programme is the identification of all the clinical audit projects which must be undertaken in order to meet external monitoring requirements. HQIP propose clinical audit programmes be categorised into 4 distinct elements, with "external must do" audits being assigned the highest priority as Level 1 projects.

The HQIP defined priority levels for clinical audits are as follows:

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Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	• National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, other national audits and 'internal must dos'	• National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Clinical Excellence Standards & Guidelines • Complaints • Re-audit • Regional audits initiated by RQIA / GAIN	2
Level 3 audits, 'divisional priorities'	• Local topics important to the division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

The Trust's paper, *National Clinical and Social Care Audits and Clinical Outcome Review Programmes*' endorsed by SMT on 2 March 2016, highlighted a list of national audits for 2016/17 approved *by NHS England Quality Accounts*. These projects are identified as Level 1 in the table above.

The *NHS England Quality Accounts* List of national audits will be circulated annually to operational directors, Associate Medical Directors and Assistant Directors for identification of audits relevant to their areas of responsibility and inclusion in the directorate's "Level 1" annual clinical audit work programme.

HQIP propose internal 'must-do' clinical audits, which emanate from governance issues or high profile local initiatives, be classified as Level 2 audits.

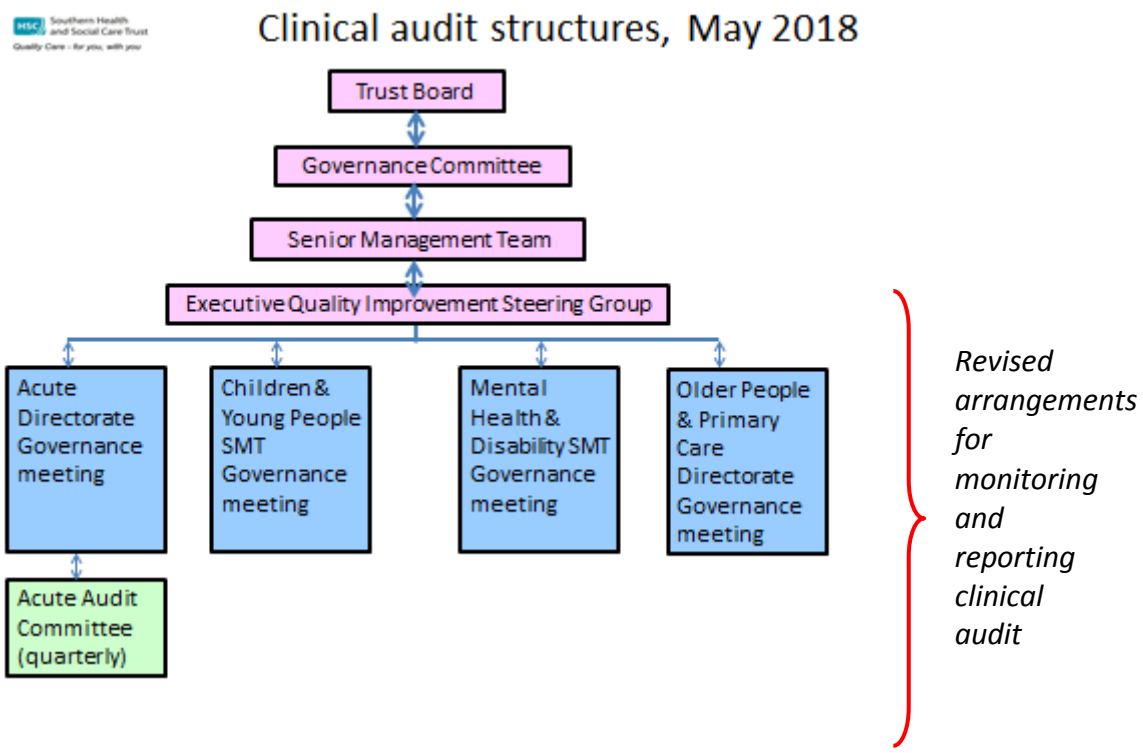
When the 'must-do' Levels 1 and 2 audits have been identified, directorates should, where appropriate, propose projects they believe would be of benefit to patients, service users, clinicians and managers. These audits should be classified as Level 3 and Level 4 audits, as determined by the operational directorates.

Taking the 4 levels of audit into consideration as appropriate, operational directorate's should agree their draft clinical audit work programme within the operational structures outlined in 6.0 below, The work programme should be forwarded to [redacted] for collation in the Trust's draft annual clinical audit work programme, which the Medical Director will take forward for review and approval. The draft clinical audit work programme 2018/19 is outlined in Appendices D and E below.

The arrangements for seeking approval of clinical audits should be agreed within operational directorate structures.

6.0 Approval of the annual clinical audit work programme

The Medical Director will present the Trust's draft annual clinical audit work programme to Executive Quality Improvement Steering Group / SMT for review and approval. Following approval, the work programme will be forwarded to Governance Committee and Trust Board for information.



7.0 Additions to the annual clinical audit work programme

On occasion new audits may be identified throughout the year. Compiling and prioritising the annual clinical audit work programme should not stifle projects that emerge during the year that will contribute to improvements in care.

Some of these projects might be new 'must-do' audits which could not be determined when the work programme was being developed, while others may represent innovative ideas from clinicians which are as valid and important as ideas proposed when the programme was originally developed. Existing quality improvement work may also identify emerging work areas for clinical audit

New projects identified within year will be highlighted to the Executive Quality Improvement Steering Group / SMT by Operational Directors.

These audits should also be highlighted to [redacted] for registration on the Trust's centralised clinical audit database.

8.0 Registration of clinical audits

All clinical audit projects must be notified to [redacted], for recording on the Trust's centralised clinical audit database.

9.0 Monitoring and reporting schedule

Audit findings and recommendations should be discussed within the appropriate operational directorate structures.

For corporate reporting purposes, a standardised reporting template to assist directorates in summarising the audit findings and areas for improvement, for inclusion in the 6 monthly audit assurance report to Senior Management Team, is outlined in Appendix C. These audit summaries should be approved within operational directorate structures and forwarded to [redacted] for inclusion in the 6 monthly audit assurance report.

The reporting schedule is outlined below:

Audit activity should be included as a standing agenda item within the appropriate **sub-committee structures** as determined by each operational directorate	Monthly
Monitoring of national, regional and local clinical audit should be discussed within the appropriate **operational directorate** structures (Table 6.0 above)	Quarterly as a minimum
The Trust's Audit Assurance Report should be presented to the Executive Quality Improvement Steering Group, and following approval will be forwarded to the Senior Management Team, Governance Committee and Trust Board for information.	6 monthly

10.0 Quality assurance processes for data submission to external host organisations

The nominated Consultant Audit Lead/Supervisor will ensure data being submitted to an external host organisation is in keeping with Data Protection Act, Caldicott Guidance and the Trust's Information Governance protocols.

He/she will liaise with the relevant Associate Medical Director, Assistant Director and Operational Director to approve data prior to submission to an external host organisation and will be supported in this role by the Clinical Audit Facilitators, as required.

11.0 Resources to support the clinical audit work programme

The current staffing level in the corporate clinical audit and M&M team and operational directorates is insufficient to support and deliver the draft clinical audit work programme, 2018/19.

There may be potential to consider the resource requirements jointly with admin support for M&M, in light of the Hyponatraemia Inquiry recommendations, as M&M and clinical audit are intrinsically linked.

12.0 Review arrangements

This strategy will be reviewed in 1 year's time.

June 2018

SHSCT Clinical Audit Strategy

Action Plan, February 2018 (updated June 2018)

	Proposed action	Lead	Timescale
1	Directorates should ensure clinical audit structures exist to support the promotion, development, monitoring, reporting and quality assurance of clinical audit activity at operational level	Operational Directors	March 2018
2	The NHS England Quality Accounts List of national audits should be forwarded to operational directorates in February, for their review in developing a draft annual clinical audit work programme	Head of Service, clinical audit	Feb 2018
3	Operational directorates should develop and deliver their annual clinical audit work programme, in line with the prioritization criteria in the clinical audit strategy.	Operational Directors, AMDs & Assistant Directors, in consultation with service teams	March 2018 – extended to 31 July 2018
4	The Medical Director will present the Trust's consolidated annual clinical audit work programme to the Executive Quality Improvement Steering Group / SMT for assurance and approval	Medical Director	April 2018 –extended to 31 July 2018
5	The arrangements for seeking approval of clinical audits should be agreed within operational directorate structures	Operational Directors, AMDs & ADs	Sept 2018
6	Clinical audit projects agreed within year should be highlighted to the Executive Quality Improvement Steering Group / SMT, and registered with [redacted]	Operational Directors	prn
7	Following corporate approval, the clinical audit strategy should be launched within operational directorates	Head of Service, clinical audit	asap after approval
8	Operational Directorates should encourage the registration of all approved clinical audit activity. Details of audits to be registered on the Trust's centralised audit database should be forwarded to [redacted]	operational directorate "approval arrangements"	Ongoing
9	**Operational level:** Audit findings should be discussed within the appropriate operational directorate structures. **Corporate reporting:** Completed audit templates (Appendix C) should be approved within operational directorate arrangements and forwarded to [redacted] for inclusion in the 6 monthly audit assurance report.	Clinical Audit Leads Audit Committee arrangements at operational level	Ongoing 6 monthly

10	The Medical Director will present the 6 monthly audit report to the Executive Quality Improvement Steering Group / SMT, and following approval submit to Governance Committee and Trust Board for information.	Medical Director	May, Nov. May 2018 report - extension to 31 July2018
11	Clinical audit presentation to Governance Committee, including progress on outstanding recommendations from the Internal Audit of clinical audit	Head of Service, AD, Medical Director's team	Autumn 2018
12	Consider the potential to review clinical audit and M&M resources in light of the Hyponatraemia Inquiry recommendations and the interface between M&M and clinical audit	Medical Director	tba

HQIP Clinical audit best practice criteria		Appendix A
	Theme	**Reference source**
1.	Clinical audit is a quality improvement activity and therefore it functions best as part of a planned programme of quality improvement that has been approved by the Board and/or senior management of the organisation.	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001
2.	The Board should have dedicated time set aside to review both the clinical audit programme and the outcomes of individual projects	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001
3	An effective clinical audit programme will cover the requirements and needs of a number of stakeholders including the Board, clinicians, service users and commissioning bodies. The programme should be developed in accordance with clear policy and agreed following consultation with clinicians, managers and patient representatives. The programme should be closely monitored and progress reported regularly at Board and service delivery level. An annual report, linked where appropriate to the Trust quality account, should be presented to both the Board and patient groups for scrutiny before publication.	HQIP, Clinical audit policy and strategy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/N{PCA/2016-007
4	Service user and public involvement in clinical audit should be embedded in the organisation's Personal & Public Involvement (PPI) strategy. The clinical audit programme should include patient-focused projects, and the roles played by service users and lay representatives should be acknowledged in clinical audit reporting at all levels.	HQIP, Patient and Public Involvement (PPI) Strategy: www.hqip.org.uk/BPCA2016-003 HQIP,Patient and Public Invovement in Quality Improvement: www.hqip.org.uk/BPCA/2016-004 HQIP, Developing a patient and public involvement panel for quality improvement: www.hqip.org.uk/BPCA2016-005 HQIP, Introductin to quality improvement for pateints and public: www.hqip.org.uk/BPCA2016-006

5	In deciding which clinical audits should be undertaken, the following factors should be considered: Clinical priorities, including clinical risks, adverse incidents and patient safety Organisational priorities, including service redesign and development Patient and service user prioritiesCommissioner priorities and specifications, including Commissioning for Quality and Innovation Frameworks (CQUINs) and NHS Standard Contract requirements The outputs from the national Clinical Auidt and Patient Outcomes Programme (NCAPOP) and other national clinical audits Professional revalidation, appraisal and training needs	HQIP, Developing a clinical audit programme: www. Hqip.org.uk/BPCA2016-007 Using clinical audit in commissioning: www.hqip.org.uk/BPCA2016-008 HQIP, Srtatutory and mandatory requirements for clinical audit: www.hqip.org.uk/BPCA2016-009 HQIP, Guide to involving junior doctors in clinical audit: http://www.hqip.org.uk/rsources/involving -junio-doctors-in-clinical-audit/ GMC, Guidance on revalidation: http://www.gmc-uk.org/doctors/revalidatin.asp
6	Clinical audit is only one of a range of quality improvement methodologies and should not be used if another is more appropriate.	HQIP, Guide to quality improvement methods: www.hqip.org.uk/BPCA2016-010
7	Organisations must have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation. The findings from clinical auidts may be used as part of the Board Assurance Framework, but full assurance can only be obtained if the quality improvement aims of the project have been achieved. Governance plans should include arrangements for participation in local and regional cross-organisational audits	HQIP, A guide for NHS Boards and partners: www.hqip.org.uk/BPCA2016-001 HQIP, Clinical audit policy and strategy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/BPCA2016-007
8	Policies and procedures must be in place to ensure that clinical audit (and all other quality improvement activities) are undertaken in a way that complies fully with current information governance legislation and guidance, and in consultation with local information governance leads and Caldicott guardians	HQIP, Information governance for local quality improvement: www.hqip.org.uk/BPCA2016-011

9	All staff within an organisation should be made aware of, and comply with, the governance arrangements in place, including local policy and protocols on proposing, registering, undertaking and reporting on clinical audits	HQIP, Clinical audit policy and stratgegy guidance: www.hqip.org.uk/BPCA2016-002 HQIP, Developing a clinical audit programme: www.hqip.org.uk/BPCA2016-007 HQIP, Guide for clinical audit leads: www.hqip.org.uk/BPCA2016-012
10	The organisation must enable the conduct of good quality clinical audit by providing appropriate resources to support the process. This includes dedicated time for audit and an appropriate level of funding. Organisations should have in place: A senior clinician able to lead on clinical audit across the whole organisation Clinical leads for quality improvement at service delivery level Clinical audit practitioners who can manage the audit programme and support the process A programme for supporting doctors in training to ensure that the clinical audit and quality improvement activities they undertake as part of their training to deliver benefits to the organisation.	HQIP, Developing a clinical audit programme: ww.hqip.org.uk/BPCA2016-007 HQIP, Guide for clinical audit leads: www.hqip.org.uk/BPCA/2016-012 HQIP, Guide to involving junior doctors in clinical audit: www.hqip.org.uk/BPCA2016-014
11	The organisation should seek to improve the knowledge and skills of all staff in quality improvement. Training in clinical audit should be available for all staff and where appropriate for lay representatives. All staff should be encouraged to participate in clinical and other networks that provide knowledge sharing and opportunities for staff development	A promise to learn – a commitment to act: improving the safety of pateitns in England (the Berwick report): htpps:/www.gov.uk/government/publications/Berwick-review-into-patient-safety HQIP, Guide to involving junior doctors in clinical audit: www.hqip.org.uk/BPCA2016-014 HQIP, Developing a patient and public involvement panel for quality improvement: www.hqip.org.uk/BPCA2016-005

Internal Audit recommendations on Clinical Audit (as at Feb 2018)	Appendix B

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18
CC CLINICAL AUDIT (15/16/16)

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.1 INTEGRATED GOVERNANCE STRATEGY				
1	1	As previously recommended in both the Board Effectiveness Audit 2015-16 and the Clinical and Social Care Governance Audit 2015-16, the Integrated Governance Strategy should be updated, approved and re-issued. The Strategy should accurately reflect the current committee structure within the Trust and the current reporting arrangements and requirements. **Responsible Officer:** Assistant Director Clinical & Social Care Governance (ADCSCG) **Original Implementation date:** June 2016	**Duplicate recommendation** refer to D – above - Governance Including Board Effectiveness This recommendation has not been counted in the results table above.	
1.2 CLINICAL AUDIT STRATEGY				
1	1	The Trust should develop a comprehensive Clinical Audit Strategy. The Strategy should accurately reflect the committee structure across the Trust and the reporting arrangements. It should also include a combination of national, regional and local priorities with sufficient resources identified to facilitate completion of the programme. **Responsible Officer: Head of Audit/ Assistant Director CSCG** **Original Implementation Date: 1st July 2017**	**NOT IMPLEMENTED** The Medical Director has reflected on the changing nature of Audit and the national move towards Quality Improvement (QI), rather than simply Audit. Discussion is ongoing with a view to relaunching Clinical Audit with a view to making QI a more central theme within any audit programme.	**Revised Implementation Date:** 1st September 2018
1.3 COMMITTEE STRUCTURES FOR CLINICAL AUDIT				
1	2	The Terms of Reference for the Acute Audit Committee should be approved and the committee reinstated if appropriate. **Responsible Officer: Director of Acute Services** **Original Implementation Date: 1st September 2017**	**NOT IMPLEMENTED** All structures presently in place will be reviewed.	**Revised Implementation Date:** 1st September 2018

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.4 GOVERNANCE ARRANGEMENTS AT CORPORATE LEVEL				
1	2	Management should strengthen the governance and oversight arrangements in respect of clinical audit activity. This should include the following: • An annual overarching corporate clinical audit programme, to be approved by the Governance Committee. • Regular reports covering all clinical audit should be submitted regularly to the SMT and Governance Committees to monitor progress against the programme. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As noted above, the Medical Director has reflected on the changing nature of Audit and the national move towards Quality Improvement (QI), rather than simply Audit. Discussion is ongoing with a view to relaunching Clinical Audit with a view to making QI a more central theme within any audit programme.	**Revised Implementation Date:** 1st September 2018
1	2	The CSCG team should put in place a corporate process for sharing outcomes and monitoring areas of clinical improvement, to ensure that the outcome of all audits including local audits are shared with the appropriate staff. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date:** 1st September 2018
1	2	Governance / Audit leads within Directorates complete the registration process for recording the rationale for participation in the national audits and for prioritising directorate led audits against corporate targets. **Responsible Officer: Directorate Audit Leads** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date:** 1st September 2018

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
1.5 DIRECTORATE LEVEL				
1	2	Directorate audit plans should be developed annually for approval at Directorate Governance Committee. These should then be submitted for approval at SMT Governance Committee. This information should be shared with the corporate CSCG team. **Responsible Officer: Directorate Audit Leads & ADCSCG** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
1	2	Divisional audit plans should be developed annually for approval at Directorate Clinical Governance Committee. Subsequently regular reporting on progress against plans and major findings should be reported. **Responsible Officer: Directorate Audit Leads** **Original Implementation Date: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
1	2	Regular reports should be produced and provided to the CSCG Corporate Team by each directorate detailing progress against approved directorate plans and major findings from audits completed. **Responsible Officer: Directorate Audit Leads & ADCSCG** **Original Implementation: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**

SHSCT
MID YEAR FOLLOW UP ON OUTSTANDING INTERNAL AUDIT RECOMMENDATIONS 2017/18

PRIORITY UNDER PREVIOUS DEFINITIONS	PRIORITY UNDER NEW DEFINITIONS	AUDIT RECOMMENDATIONS	PROGRESS AS AT SEPTEMBER 2017	REVISED IMPLEMENTATION DATE
2.1 WRITTEN STANDARD OPERATING PROCEDURES (SOP) FOR CLINICAL AUDIT				
2	2	The Trust should ensure that written procedures for all aspects of the clinical audit are reviewed, updated and issued to all relevant staff as soon as possible. These should reflect current practice and link to a Clinical Audit strategy. **Responsible Officer: Assistant Director CSCG** **Original Implementation: May 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
2.2 DATABASE OF CLINICAL AUDITS				
2	3	There should be a central database maintained with the details of all ongoing clinical audits within the Trust, whether local, regional or national. Each directorate should have access to the relevant section within the database to allow it to be kept up to date. **Responsible Officer: Assistant Director CSCG** **Original Implementation :1st September 2017**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**
2.3 TRAINING FOR CLINICAL AUDIT				
2	2	Training for clinical audit should be considered by management. The training needs should be assessed and an appropriate training programme developed. **Responsible Officer: Assistant Director CSCG** **Original Implementation Date: Implemented**	**NOT IMPLEMENTED** As above	**Revised Implementation Date: 1st September 2018**

Standardised reporting template for inclusion in 6 monthly audit assurance report **Appendix C**

Audit assurance report template for completion by the clinical audit lead

Audit title	
Audit type	e.g. national, regional or Trust
Host organisation	
Audit lead	
Contact details	Personal Information redacted by the USI
Time period	Continuous Snapshot (please specify dates)
Directorate	
Division / speciality	
Report accessed via	

1.0 The 3 most important performance indicators in SHSCT, as identified by the clinical audit lead.

Please include compliance against the national / regional compliance, where available

		SHSCT compliance	National or regional compliance
1.			
2.			
3.			

2.0 If appropriate, areas for improvement, actions taken and status

National, regional, Trust recommendations		
Recommendation	**Action taken**	**SHSCT status as at date**
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced

Please continue overleaf as required.

NB where an existing audit template is available e.g. NCEPOD, please submit this instead of completing section 2.0 above

Southern Health and Social Care Trust

Quality care – for you, with you

SMT COVER SHEET

Meeting/Date	SMT Meeting – 18th January 2022	
Accountable Director	Dr Maria O'Kane Medical Director	
Title	Patient Safety and Clinical Audit Resourcing Proposal Strengthening Structure and Function	
Report Author	Name	Fiona Davidson & Joanne McConville
	Contact details	Personal Information redacted by the USI Personal Information redacted by the USI
This paper is presented for: ***Approval***		

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

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

1. Detailed summary of paper contents:

- The proposal paper sits within the context of the Clinical & Social Care (CSCG) Governance Review 2019, the September 20200 CSCG Resourcing proposal. It recommends the establishment of a dedicated clinical audit function and a strengthened Patient Safety Data and Improvement function.
- The proposal seeks the overall investment of £600,533 over a two year phased implementation. (£303,582 of this investment was previously set out in phases 2 & 3 of the CSCG Sept 2020 Resource paper to SMT).
- Currently the Patient Safety Data and Improvement Team have a mixed role and function across mortality and morbidity, patient safety indicator monitoring, clinical audit and SHSCT clinical guidelines. Lack of capacity, has over time prevented a robust focus on clinical audit. The Clinical Audit Strategy (2018) identified insufficient resources were available to support the organisational function.
- Currently facilitation of the Patient Safety Peer Review (M&M) process is limited, particularly at sub-specialty and in assuring the sharing and implementation of learning.
- The pandemic requirements of 7/7 daily mortality reporting has placed additional requirements on a small departmental team requiring additional cover arrangements that could be sustained with the investment proposed in this paper.

2. Areas of improvement/achievement:

- The successful implementation of the regional policy and mortality reporting system since 2018 despite the on-going challenges of the RMMRS reporting functionality.
- The establishment of daily pandemic mortality reporting processes since April 2020.
- Patient safety indicator monitoring continues to report on key improvement areas known to reduce avoidable harm to patients and service users.
- The annual National Audit Assurance report submitted to Governance Committee in November 2021 details the continued levels of clinical commitment and engagement in National Audit programmes. National Audit Assurance Summary Report_PostSMT_GC_161121.pdf

3. Areas of concern/risk/challenge:

- The identification and sharing of key learning from mortality and morbidity processes is comprehensive, timely and effective.
- Areas of concern or risk identified in national audit reports and local audit action plans have effective organisational oversight and escalation processes.
- The provision of a comprehensive clinical audit function is reflective of an organisation that is culturally curious, learning and improvement focused at service level.
- Measurement of safety and audit outcomes are key elements for triangulation, integral to good governance. Their role in improvement and assurance underpins quality service provision, part of the over-riding Trust objective of promoting safe, high quality care.

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

Corporate Risk Register	Clinical audit processes are part of a directorate's assurance gathering processes on evidencing safe and effective care. Identifying areas of risk at directorate, and as required corporate levels.
Board Assurance Framework	The role of clinical audit as a tool for governance sits in context of the SHSCT Board Assurance Framework (BAF) where clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care, a core Trust objective.

PATIENT SAFETY & CLINCAL AUDIT RESOURCING PROPOSAL

STRENGTHENING STRUCTURE & FUNCTION

Medical Directorate

January 2022

Table of Contents

1. Purpose of paper

The paper sits within the context of the Clinical & Social Care (CSCG) Governance Review 2019 and the CSCG structure and function proposal 2020. It's purpose is to;

1. Outline **benefits** and **challenges** of separating the patient safety and clinical audit functions currently provided within a single, mixed function team;
2. To detail the **additional resources** required to strengthen both these functions in the role of providing assurance of safe and effective care;
3. Provide high level detail on the additional resourcing required to deliver re-aligned and re-purposed structures.
4. Provide an indicative costing for the proposal of:
   - Establishing a Clinical Audit Team: £352,400
   - Enhancement of the Patient Safety Data and Improvement Team: £248,133
   - Provide details on a phased approach to implementation

2. Introduction

2.1 Good Governance[1]

This is the framework for assurance, decision-making, accountability, and optimal use of resources, which provides a safe and supportive environment for the delivery of high quality care to patients, service users, and citizens. Governance covers the culture, vision, values, structures, policies, processes and over-arching assurance framework that support an organisation to take decisions and meet agreed strategic objectives. **(See Figure 1).**

The good governance elements that relate specifically to this proposal include;

- Quality & Safety: Systems and Structure and
- Effectiveness and Added Value (audit)

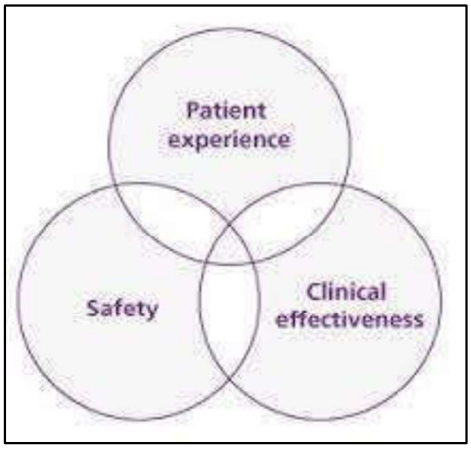
[1] Good Governance Handbook, Healthcare Quality Improvement Partnership (HQIP) and the Good Governance Institute (GGI) March 2021

Figure 1: The 10 Key Elements of Good Governance

2.2. Clinical and Social Care Governance.

Clinical governance is "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson, 1998). Within public healthcare services in Northern Ireland we can expand this definition to include social care governance. Clinical and Social Care governance is an umbrella term. It describes activities that not only sustain and continuously improve high standards of patient care, but also provide quality assurance.

2.3 Quality, Improvement and Assurance



Lord Darzi (2008) defined **'High quality care for all: NHS next stage review'** under the three dimensions in **Figure 2**, which must all be present to provide a high quality service:

Figure 2: Dimensions of High Quality Care

- **Patient experience**: quality care is delivered for a positive experience, including being treated according to individual wants or needs, and with compassion, dignity, and respect.
- **Clinical effectiveness**: quality care is delivered according to the best evidence regarding what is clinically effective in improving an individual's health outcomes
- **Patient safety**: quality care is delivered to prevent all avoidable harm and risks to an individual's safety.

Two other areas of work within quality are also recognised within health and social care organisations;

- **Quality improvement** in healthcare is a process that seeks to enhance patient experience and individual health outcomes, through measuring and improving the effectiveness and safety of clinical services.
- **Quality assurance** in healthcare is the planned and systematic monitoring of activity to ensure that the standards for safe, clinically effective services and positive patient experience are met.

3. The Current Patient Safety Function - CSCG

The Patient Safety function of the CSCG Division of the Medical Director's Office currently comprises of:

- **Clinical Audit –** National Audit Programmes, central audit registry and NCEPOD local reporter role
- **Patient Safety Peer Review Process –** Mortality and Morbidity (M&M) outcome review
- **Patient Safety Indicator Monitoring –** Continuous surveillance of key patient safety indicators e.g. Falls, VTE assessment, Pressure Ulcers
- **Clinical Guidelines –** Maintenance of the central repository for locally developed / adopted guidelines for aspects of care[2]

Currently the Patient Safety Data and Improvement Team has a role in each function, however lack of capacity has, over time prevented a robust focus on clinical audit and full facilitation of the Patient Safety Peer Review Process.

[2] This function is due to transfer to the Management of Standards, Risk and Learning

Figure 1 on page 6 includes **quality, safety** and **audit** as key elements integral to good governance, as their role in improvement and assurance underpins quality service provision, part of the over-riding objective of safe and effective care.

This proposal, in addition to the identified investment for a dedicated and strengthened clinical audit function, also seeks to enhance the current Patient Safety Data and Improvement Team to ensure the patient safety function is adequately supported, facilitated and resourced.

3.1. Clinical Audit: Role, Function and Audit Cycle

The role of clinical audit as a tool for governance sits in context of the SHSCT Board Assurance Framework (BAF) where clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care. The following excerpts state it's endorsement as an accepted core organisational governance function.

'Clinical audit needs to capture the imagination of boards, clinicians and commissioners as a worthy, cost effective and successful endeavour. It needs to provide assurance of safe and improving service delivery both within and beyond professional, departmental and organisational boundaries'[3]

'Clinical audit is a significant mechanism for providing assurance on the quality of services provided. It also contributes to a) a culture of safety and b) an organisational system of learning and development'[4].

'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement.'[5]

[3] Clinical audit: a guide for NHS boards and partners, HQIP March 2021, page 3
[4] Vincent, C. Burnett, S and Carthy, K @ Health Foundation (2013).
[5] The National Institute for Health and Clinical Excellence (NICE) published 'Principles for Best Practice in Clinical Audit', 2002

HQIP[6] a leading authority on clinical audit, defines clinical audit as 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. **Figure 3** demonstrates the four stages of the clinical audit cycle:

Stage 1: Preparation and Planning: to agree required standards and clinical audit methodology

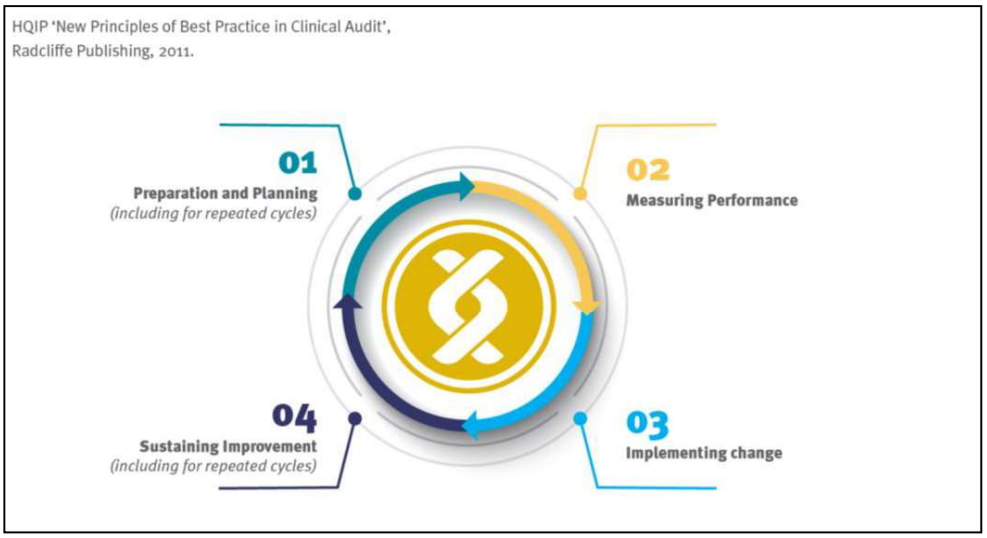
Stage 2: Measuring Performance: data collection in order to evaluate performance against required standards

Stage 3: Implementing Change: using action planning where shortfalls are identified

Stage 4: Sustaining Improvement: through monitoring and service development, with repeated clinical audit cycles as required

Clinical audit processes (that monitor against evidence-based standards as part of an ongoing, planned annual quality assurance programme) can demonstrate that high quality care is being delivered. Support of this core function across the organisation is therefore required.

Figure 3: Stages of the Audit Cycle



[6] The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement. We are an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices.

3.2. Current Challenges for Clinical Audit

Since 2015/2016[7] a number or reports have highlighted and identified that a strengthened clinical audit function in SHSCT is required. This is to facilitate and provide assurance (across the organisation) that the four stage audit function and it's governance is embedded and operating effectively. Firstly that this is in place in each in each directorate, at a local level in relation to SHSCT designed and based audits, through to larger cross directorate or regional audits and participation in full scale National Programmes.
Most significantly the Clinical Audit Strategy (2018) acknowledged that there was insufficient resourcing to support the audit function and programmes.

As will be set out in section 4 the current staffing resource sits within a mixed function patient safety data and improvement team. As an estimate the equivalent of 0.5 – 1 w.t.e post within this complement currently supports the clinical audit function[8]. There is no resource for ensuring access to health records for audit. Therefore additional investment remains the requirement to support strengthened and improved systems and process for designing, implementing and undertaking clinical audit programmes as well as the governance and monitoring of those programmes.

Whilst the 2018 Strategy identified administrative support, it is acknowledged that infrastructure is also required at a clinical audit / QI lead level to create an organisational network of clinical leaders and champions. The latter investment is being progressed via the recent medical leadership proposals. The 2020 CSCG paper also set out an initial proposal for a centralised clinical audit team, working alongside directorates to support and facilitate clinical audit activity.

Since Sept 2020, the Medical Director has established a Systems Assurance Division, charged with progressing the clinical audit function[9] aspect of the 2020

[7] Internal audit Report 2015/16, 2018 Clinical Audit Strategy and the CSCG Governance Review (2019)
[8] NCEPOD Local Reporter Role and part of facilitator role in supporting Specialty Patient Safety Meetings
[9] 1.0 w.t.e Head of Clinical Audit Post was approved July 2021 to establish the strategic direction and governance function (with currently 0.6 w.t.e post holder)

CSCG paper. As a result this paper proposes the removal of clinical audit from the mixed function CSCG Patient Safety Data and Improvement Team to allow both to be developed, and re-aligned in order to perform the required organisational functions. This proposal recommends that a separate team function be established and dedicated to provide focus on this work, in the short to medium term (1 – 5 years).

High level systems and processes need to be strengthened that govern and report clinical audit performance to relevant Trust Board Committees (currently Governance Committee), highlighting priorities, gaps, risks and areas of best practice.

A strengthened clinical audit function requires as a matter of priority:

- Updated Clinical Audit Strategy
- Clinical Audit Policy and Procedures
- Clinical Audit Resource Plan (outlined in this proposal)
- Clinical Audit Training Plan
- Assurance Reporting Schedule

4.0. Patient Safety Function: (Morbidity & Mortality)

There are many different methods available for studying adverse events that arise within a healthcare system; studying Mortality and Morbidity (M&M) outcomes aims to reduce the frequency of these events through learning from past experience and changing practice. It is therefore important that Trusts demonstrate they are systematically and continuously reviewing patient outcomes.

In October, 2018 the SHSCT adopted regional guidance (DoH 2016) for the Regional Mortality and Morbidity (M&M) Process. The key aims outlined in the Regional Policy and subsequent SHSCT Guidance were to;

- Outline expectations and provide guidance and direction on systems and processes for mortality and morbidity functions within Trusts.
- Reduce variation across Trusts regarding the role of M&M leads and the structure and format of M&M meetings. This is in order to ensure consistency so that M&M meetings are effective, produce shared learning from incidents and patient care and, ultimately, improve patient safety throughout Northern Ireland.

Although there is still additional developmental work required to fulfil all the requirements, the Trust is making steady process to comply with the regional process. A staff team of 4.6 w.t.e supports this and the clinical audit function across Bands 7 – 3.

4.1. The SHSCT Patient Safety Peer Review Process.

There are several elements included in this process;

a) Specialty Mortality Review and Patient Safety Meetings, (SMR&PS meetings), known as M&M Meetings.
b) The M&M Chairs and Strategic Oversight Group meetings
c) Use of the Regional Mortality and Morbidity Review system (RM&MRs)
d) Random Case Selection
e) Introduction of the Structured Judgment Review (SJR) Process

4.1.1. Specialty Mortality Review and Patient Safety Meetings, (SMR&PS meetings), known locally as 'M&M' or 'Patient Safety' Meetings.

M&M meetings are, ***"a routine forum for the open examination of adverse events, complications and errors which have led to illness or death of a patient, and which are reviewed in order to learn from these events so as to improve the management and quality of care.'***

There are key areas to be reviewed as outlined in **Appendix 1.**

The M & M Meeting Structure, including the break-down and number of M&M meetings (as of November 2021) are shown in **Appendix 2.**

4.1.2. Linkages to Appraisal and Revalidation

During annual appraisals, doctors are expected to use supporting information to demonstrate that they are continuing to meet the principles and values set out in *"Good Medical Practice"*

Attendance and participation in M&M meetings plays an important role in appraisal and revalidation. This should include:

- the <u>timely</u> completion of Consultant mortality reviews;
- satisfactory attendance at meetings; and
- active participation in learning and discussion at meetings.

4.1.3. The M &M Chairs and Strategic Oversight Group meetings

The M&M Chairs meetings are held quarterly, with main responsibilities to:

- Inform the further development of arrangements and processes for sharing best practice and learning arising from M&M.
- Provide advice on the management of specialty M&M meetings, identifying areas for organisational improvement.
- Ensure the effective management of specialty M&M meetings, in line with the Regional M&M guidance, providing an early alert within operational directorate governance arrangements and to the Medical Director, where appropriate
- Promote key actions arising from the RM&MRS database

The Strategic Oversight Group.

The forum was set up to provide assurance and oversight of the M&M process, attendance and outcomes. This is corporately led, multi-disciplinary in nature with attendees drawn from senior medical and nursing management, along with Directors and governance senior staff. In addition they review;

- Aggregated mortality data and information such as Standardised Hospital Mortality Ratios and Risk Adjusted Mortality Indexes (RAMI) for comparison purposes e.g. Summary Hospital-level Mortality Indicator (SHMI).
- High level issues arising from the M&M meetings
- Consideration of learning outcomes and potential improvements.
- Monitoring progress of regional and Internal audits in relation to the M&M process and subsequent action plans.

4.2. Regional Mortality and Morbidity Review system (RM&MRs)

The RM&MR system is hosted on the Northern Ireland Electronic Care Record (NIECR). It allows the;

- Accurate recording of the details from all patient deaths, completion of the Medical Certificate of Cause of Death or notification to the Coroner;
- Review by the Consultant, followed by the monitoring, examination and scrutiny of any avoidable factors or areas of learning and subsequent actions

associated with the patient's death by ward or unit based' multidisciplinary (M&M) clinical teams to identify and analyze the causes of harm, learning and thus avoiding the repeating of harm."

- Monitoring of expected timescales for each functions above.

5.0. Patient Safety Indicator Monitoring

This role is carried out by the Patient Safety Assurance Manager (1.0.w.t.e, Band 6) with part-time administrative support. The function of this post is to hold a comprehensive portfolio of long-term patient safety audits and quality indicators. This includes reporting on compliance of targets relating to;

- The Deteriorating Patient, (NEWS2),
- Regional QI Sepsis work
- WHO Surgical Checklist
- MUST
- Ventilator Associated Pneumonia
- Crash Call
- Falls, Pressure Ulcers, Delirium, VTE, Surgical Site Infection
- Stroke
- Critical Meds

6.0. Clinical guidelines

The maintenance of the central repository for locally developed / adopted clinical guidelines is currently provided by a Patient Safety and Guideline Support Officer (1.0.wte, Band 4). Approximately 20 hours (53%) of this post is aligned to this function, with the remainder aligned to M&M support. As part of the proposed structural changes, the clinical guideline system maintenance component of this post will transition to the Medical Directorate's new Standards, Risk and Learning service. The plan is that with additional funding for 17.5 hours (47% and outside of this proposal paper) this post will be retained as a full time Senior Governance Assistant post (Band 4) whose role will support the wider standards, risk and learning remit. Within the Patient Safety Data and Improvement Team an additional 20 hours of funding will be required to secure a full time Band 4 post that will be used to focus

solely on M&M support.

7.0. Current Challenges: Patient Safety Data and Improvement Team

There are significant challenges within the Patient Safety Data and Improvement Team which need additional resources, restructuring and job planning to resolve.
These include;

- Current staffing levels have prevented facilitation of sub-specialty M&M meetings, leading to delays in completing administration tasks, extract learning and ensure performance processes are completed as per regional M&M guidance.
- The Patient Safety and Improvement Team[10] have only 3 staff members (2.8 wte) providing facilitation to 10 key meetings and there is minimal administrative support for this function, currently, provided by 2 x Band 4s (1.8 wte), and 1 x Band 3 (1 wte). Facilitators are working to maximum capacity and therefore additional staff, (at the appropriate grade) are required to provide increased support. Additional staff would be 2 x wte Band 5 facilitators and 1 x wte Band 4 support

Appendix 3 shows meetings supported by a facilitator and those with ad-hoc or no support.

- The level of work required to facilitate an M&M meeting can be substantial and is intensive before, during and after meetings. It is the close working with meeting Chairs, timely preparation and production of documentation that makes this role so beneficial.
- A lack of clarity in relation to roles and responsibilities with different bandings carrying out similar functions. Staff members, for a variety of historical job role reasons, have also developed discrete areas of directorate work and therefore cross cover, contingency and succession planning is difficult. The workload is also disproportionately distributed.
- System level improvement capturing trends in data, collating, triangulating and sharing learning for potential service improvement have not been possible

[10] Led by 1 x 8b Head of Patient Safety Data & Improvement

within the current structure. This includes Trust-wide patient safety strategy development and implementation.

- There is a need for a designated team lead post to bring the team together and manage HR requirements, e.g. recruitment, supervision, appraisal, training, application of policies and guidance in relation to staffing.
- Whilst M&M processes are in place, the required timescales for Consultant review and discussion at M&M groups is not consistently followed[11] and some deaths have not been reviewed or discussed at M&M meetings as required. Furthermore, the process is not yet capturing learning in consistent and effective manner. Therefore, this is a manual function provided by the Patient Safety and Improvement Team.
- The COVID-19 pandemic has required daily reporting of deaths to the PHA since April 2020 including all week-ends and bank holidays. This became part of the remit of the team and is provided by only 3 members of staff and senior cover by the HoS for the team. Although remunerated, it is entirely voluntary to participate, and despite efforts to increase staff on this small rota, this has not been possible for 19 months.
- New interim arrangements have been put in place during the pandemic.. This has resulted in additional workload for those with a M&M support function, who are working with minimal or no additional support. This has increased the length of meetings, and can also lead to accumulation of cases requiring review, again increasing workloads for facilitators.
- The Patient Safety Indicator Monitor function is provided by 1 member with no cross cover or contingency planning.

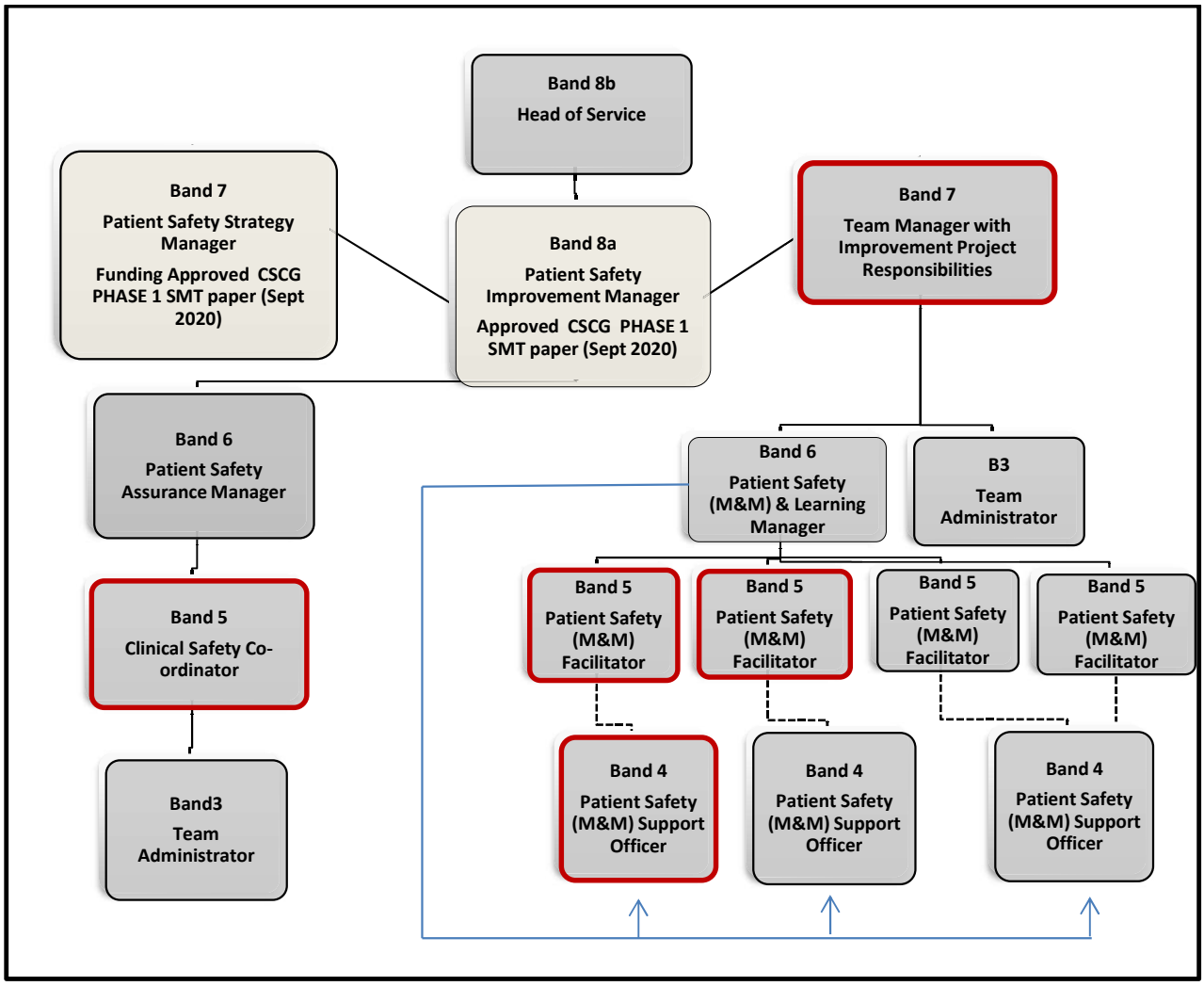
8. Patient Safety Data & Improvement Team – Proposed New Structure (existing and additional posts)

A major difficulty within the team's function was the inability to fulfil its audit function due to lack of capacity. With additional resources and new posts a greater number of M&Ms could be facilitated and improvement initiatives taken forward.

Figure 3 outlines the proposed new structure. Existing staff (grey), Approved 20/21 (taupe, noted on diagram) and new (red).

[11] Monitoring against timescales is not supported by an RM&MRS reporting tool and so pilot internal systems have to be developed to undertake this function.

Figure 3: Existing & Proposed Additional Staff

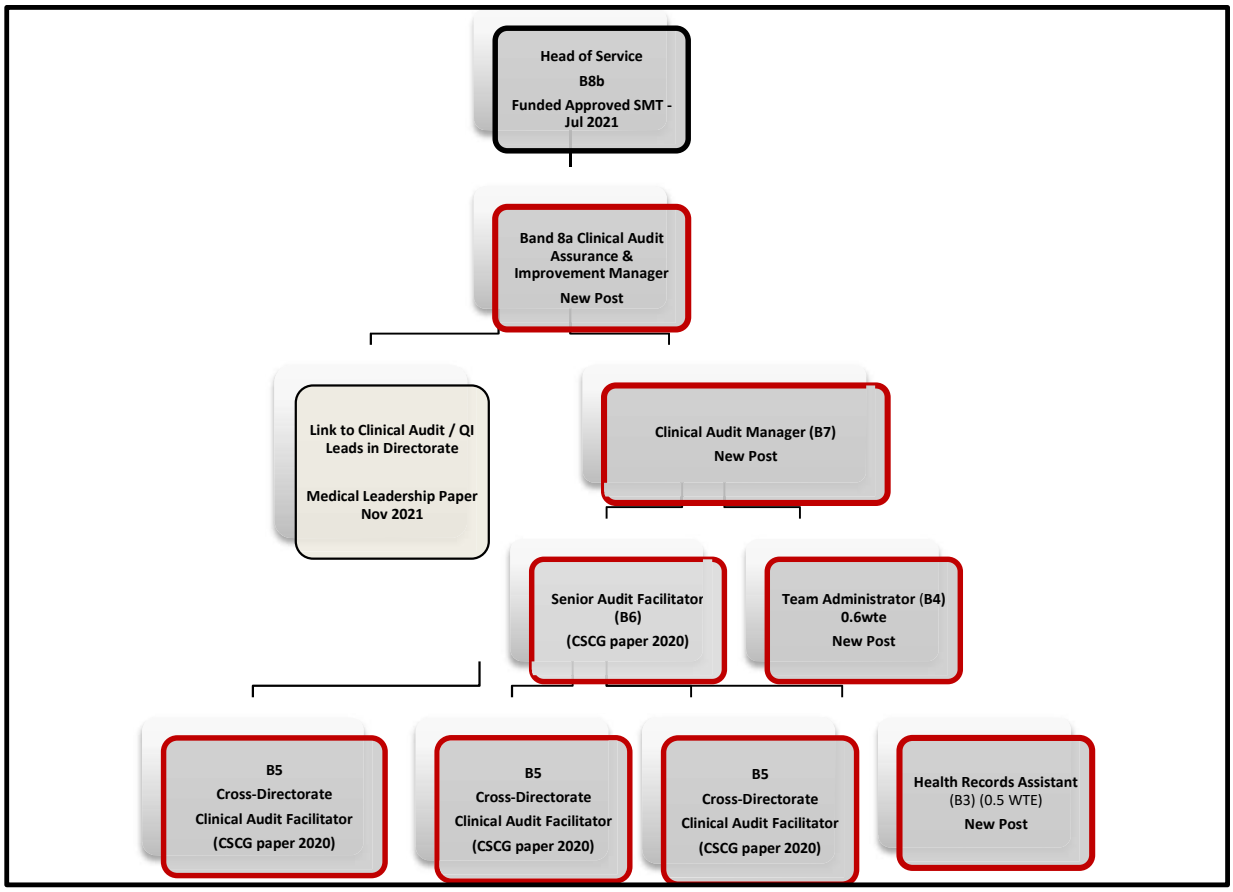


9. Patient Safety Data & Improvement Team – New Staff Functions

Role Title	Band	High Level Responsibilities
Patient Safety & Improvement Team Manager (with improvement project responsibilities)	7	- Manage the Patient Safety and Improvement Team - Implement and monitor compliance with HR Policies, Procedures and Guidance, including supervision, appraisal, performance management, leave and overtime. - Develop a training plan for the team - Clarify roles, responsibilities and processes within the team - Oversee and report on key team functions - Oversee, and participate in. service improvement initiatives.

Clinical Patient Safety Co-ordinator	5	- Work along-side the Patient Safety Assurance Manager to: - Ensure long-term patient safety and quality indicators are met including reporting on compliance of targets, identifying trends and be involved with resulting service improvement initiatives. - Produce reports, spreadsheets and data in relation to patient safety indicators. - Take part in COVID19 reporting on rota
Patient Safety (M&M) Facilitator x 2	5	- Work within a pool of Facilitators, covering leave when required, - Facilitate allocated M&M meetings, including liaison with M&M leads, recording notes and learning from meetings, recording attendances, organising presentations, retrieving notes and other duties. - Extract Learning to contribute to learning data bases and dissemination - Contribute to service improvement projects as directed by line management - Supervise Band 4 staff where allocated. - Take part in COVID19 reporting on rota
Patient Safety (M&M) Support Officer x 1.53	4	- Work with the Patient Safety Facilitator in their M&M role, providing administrative support.

10. Clinical Audit - Proposed New Team Structure



11. Clinical Audit - New Staff Functions

Role Title	Band	High Level Responsibilities
Head of Clinical Audit (Funded July 2021)	8b	- The Head of Clinical Audit is responsible for the development of the Trust policy and strategy in relation to clinical audit practice. - The service delivery of the corporate clinical audit function. - The quality assurance and governance of clinical audit function, it's monitoring and reporting. Strategic Review underway – September 2021
Clinical Audit Assurance & Improvement Manager (New Post)	8a	- Promote clinical engagement – clinical directorate leads required as part of medical leadership model and to strengthen professional governance. - Ensure operational directorate engagement and ownership. This will require a formal communication links to be established via governance forums or the re-instated of directorate level clinical audit committees. - Establish clinical audit links within CSCG to Standards and Guidelines, Patient Safety Meetings and Serious Adverse Incidents and across organisational directorates and to quality improvement priorities and QI support. - Promote connections to the audit divisions and activities of other corporate directorates e.g. nursing and finance to maximise efficiencies and share audit findings, intelligence and learning. . - Overseeing strengthening assurance processes and reporting to appropriate fora. - Development of the clinical audit improvement programme
Clinical Audit Manager (New post)	7	The Clinical Audit Manager is responsible for: - The day-to-day operational matters in relation to delivery of the Clinical Audit Programme and line management of the Trust's team of Clinical Audit Facilitators. - The performance reporting of the clinical audit function - Trust's requirements as NCEPOD local reporter - Developing the clinical audit training plan and resource library
Senior Clinical Audit facilitator (Training & Facilitation) (New Post) (Funding Phase 2 CSCG Paper Sept 2020)	6	The Senior facilitator is responsible for working closely with the clinical audit manager in the management and delivery of the clinical audit function throughout the Trust. - Project manage specific aspects of the Trust's prioritised work programme and have lead responsibility for the monitoring and progression of same. - Participate in the monitoring and reporting on the work plan for the clinical audit functions. - Provide advice, guidance and facilitation to multidisciplinary teams undertaking audit projects in respect of project design and the development of project techniques. - Manage the allocation of clinical audit facilitation staff to individual audit projects. - Plan and oversee the delivery of the Trust clinical audit training programme. - Responsible for the maintenance of the clinical audit programme management

Clinical Audit Facilitator Phased (3 new posts) (Funding Phase 2 CSCG Paper Sept 2020)	5	Clinical Audit Facilitators will: - Assist clinical staff with the completion of audit paperwork and information governance requirements - Register the project on the trust clinical audit database - Reach agreement with the specialty audit convener and the audit project lead as to the level of support that the facilitator can provide to the project – the decision will take account of Divisional and Trust priorities This advice and support may include the following: a) Appropriate methodology for the proposed project b) Literature searching and developing measurable clinical standards c) Design of audit tools d) Choosing sample size e) Organising availability of clinical case-notes f) Extraction of data from hospital information systems (where available) g) Data analysis and reporting h) Producing presentation materials - Monitor the progress of registered audits - Participate in and help organise meetings within the Division to allow presentation of audit proposals and results - Attend Divisional Governance/Quality meetings to enable the discussion and escalation of issues relating to clinical audit activity
Team Administrator (0.6 WTE) (New Post)	4	- To provide a comprehensive and supporting administrative function to the clinical audit team - Maintenance of the central clinical audit repository and reporting
Health Records Assistant (Equivalent Funding 0.5 WTE Post)	3	Equivalent funding within support services division to ensure year round access to adequate medical records resource. It is essential to facilitate audit programme submissions that chart / note retrieval is timely to enable clinician / professional reviewer access to charts and records.

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12. Cost & Benefits of New Posts (not previously approved Sept 2020 or July 2021)

New Posts for Enhanced Patient Safety Data & Improvement Team				
Post	**Band**	**Benefits**	**Indicative Cost**	**Total Cost**
Patient Safety & Improvement Team Manager (with improvement project responsibilities	**7**	- Improved team working and motivation - Establishment and implementation of robust operational policies and procedures - Development of clear roles, responsibilities and functions within the team currently required - Provide work plans and training plans for members of staff and a robust induction plan not available at present	**£64,000**	**£64,000**
Clinical Patient Safety Co-ordinator	**5**	- Increased support for Patient Safety Assurance Manager to enable further analysis of trends and improvement initiatives. - Increased availability for COVID19 reporting	**£44,000**	**£44,000**
Patient Safety Facilitators x 2	**5**	- Increased facilitation and support to existing and new M&M meetings - Increased availability for COVID19 reporting	**£44,000**	**£88,000**
Patient Safety Support x 1.5	**4**	- Provide support to Patient Safety Facilitators relating to their M&M function.	**£34,000**	**£52,133**
Total				**£248,133**

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Clinical Audit Team				
Post	**Band**	**Benefits**	**Indicative Cost**	**Total Cost**
Clinical Audit Assurance & Improvement Manager	**8a**	Strengthened assurance of clinical audit function as part of board assurance framework	**£67,000**	**£ 67,000**
Clinical Audit Manager	**7**	Audit function and team performance management	**£64,000**	**£64,000**
Senior Clinical Audit Facilitator (Training & Facilitation)	**6**	Training programme design and delivery. Project management of prioritised audit programmes	**£54,000**	**£54,000**
Clinical Audit Facilitator	**5 x 3**	Improved support directly to clinical leads in the delivery of audit programmes	**£44,000**	**£132,000**[12]
Team Administrator 0.6 wte	**4**	Delivery of a robust administrative system to support the team objectives and maintenance of central repository.	**£34,000**	**£ 20,400**
Health Records Support 0.5 wte	**3**	Essential component in the design and delivery of clinical audit programmes is timely access to records	**£30,000**	**£ 15,000**
Total				**£352,400**

[12] Band 5 Business Partner Posts included in the CSCG Resourcing Paper of Sept 2020. These would now become part of the corporate clinical audit team.

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13. Options Summary

Option 1 – Do Nothing – No Investment in Additional Resourcing

Option 2 – Phased approach to investment and additional funding over 2 years

Option 3 - Funding for resourcing is agreed as proposed (not phased)

13.1. Clinical Audit Team

Preferred: Option 2 - Phased approach to investment and additional funding over 2 years

Post	Band	Indicative Cost	Total Cost
Clinical Audit Assurance & Improvement Manager	**8a**	**£67,000**	**£67,000**
Clinical Audit Manager	**7**	**£64,000**	**£64,000**
Senior Clinical Audit Facilitator	**6**	**£54,000**	**£54,000**
Clinical Audit Facilitator	**5**	**£44,000**	**£44,000**
Health Records Support 0.5 wte	**3**		**£15,000**
		Year 1	**£244,000**
Post	**Band**	**Indicative Cost**	**Total Cost**
Clinical Audit Facilitator	**5 x 2**	**£44,000**	**£88,000**
Clinical Audit Administrator (Team & Database)	**4 x 0.6**	**£34,000**	**£20,400**
		Year 2	**£108,400**

N.B. The table above indicates FYE Costs based on 21/22 mid-point. Any recruitment January – March 2022 would incur only Q4 expenditure

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13.2. Enhanced Patient Safety Data & Improvement Team: New Posts

Preferred: Option 2 - Phased approach to investment and additional funding over 2 years

Post	Band	Indicative Cost	Total Cost
Patient Safety Data & Improvement Team Manager (with improvement project responsibilities)	**7**	**£64,000**	**£64,000**
Patient Safety (M&M) Facilitator x 2	**5**	**£44,000**	**£88,000**
		Year 1 (21/22)	**£152,000**
Post	**Band**	**Indicative Cost**	**Total Cost**
Clinical Patient Safety Co-ordinator	**5**	**£44,000**	**£44,000**
Patient Safety (M&M) Support Officer x 1,5	**4**	**£34,000**	**£52,133**
		Year 2 (22/23)	**£96,133**

N.B. The table above indicates FYE Costs based on 21/22 mid-point. Any recruitment January – March 2022 would incur only Q4 expenditure

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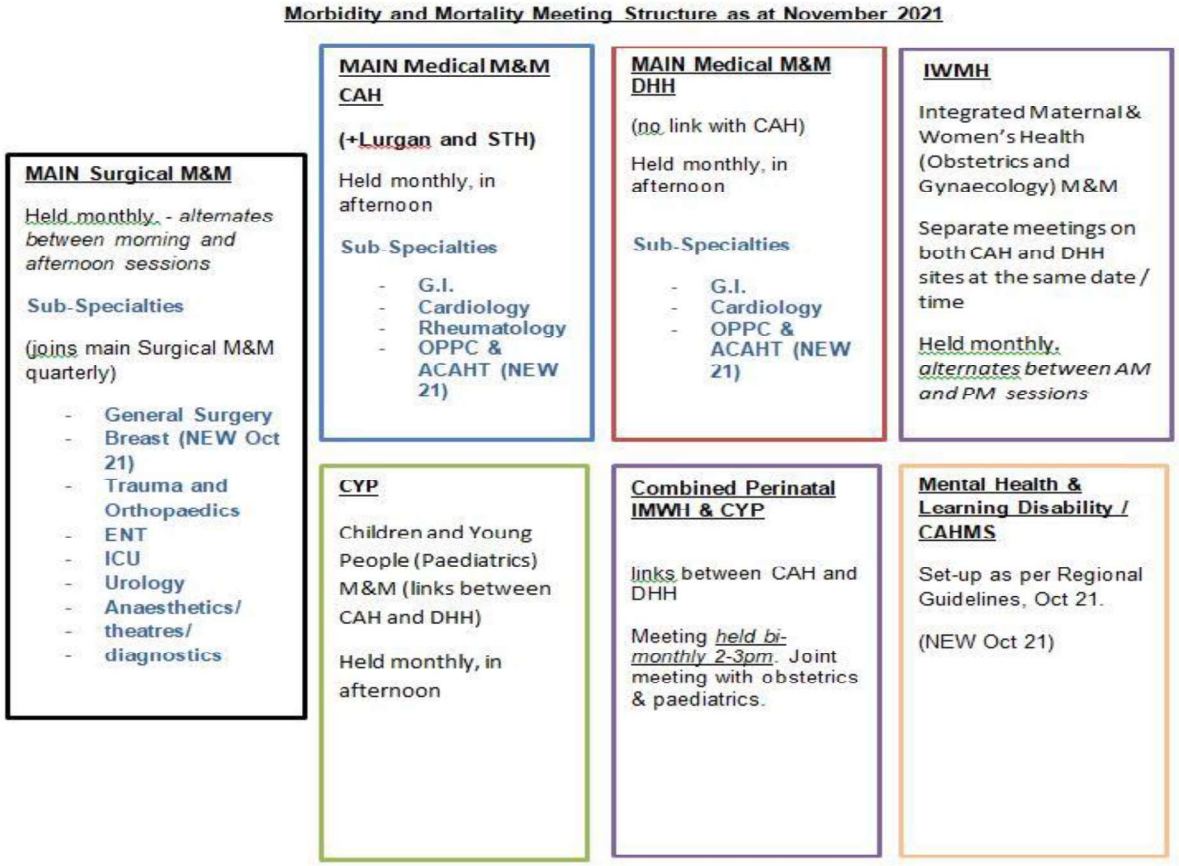
Appendix 1: Areas to be reviewed at M&M meetings

Mortality & Morbidity Review	Patient Safety
Mortalities. (all deaths occurring on a hospital site) Morbidity. (relating to complications or adverse outcomes from care and/or treatment.) Complication. (arises following a procedure, treatment or illness, and is secondary to it.) Misadventure, (Any injury or adverse reaction resulting from any medical treatment,) Also: re-admission rates, returns to theatre, complications of care, infections, falls & other specialty outcomes.	Safety alerts Medication issues / errors Recommendations from Serious Adverse Incidents (SAIs) investigations Litigation outcomes Complaints Patient Safety Data Audits / Patient Safety Indicator findings Regional Safety and Quality Issues Clinical Audit and Benchmarks

Appendix 2: M&M meeting structure



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Appendix 3: Support provided to M&M meetings by Facilitators

FULLY SUPORTED BY FACILIATOR	AD-HOC OR NO SUPPORT BY FACILITATOR
- MAIN Surgical M&M - Combined Anaesthetics, Radiology, Intensivists, Theatres. - Emergency Department **(Approximately 400 cases for review per annum + any escalated cases from sub-specialties)**	**Surgical Sub-specialties (Individual meetings)** - General Surgery - Trauma and Orthopaedics - ENT - ICU - Urology - Anaesthetics/ - theatres/ - diagnostics **(Approximately 300 cases per annum)**
- MAIN Medical M&M CAH - MAIN Medical M&M DHH - Gastroenterology **(Approximately 850 cases for review per annum)** - Integrated Maternal & Women's Health (IMWH) - CYP - Combined IMWH & CYP - Gynaecology / Audit Meeting **(Approximately 45 cases for review per annum)**	**New M&Ms (Oct 21)** - Mental Health / learning Disabilities / CAHMS - Breast (Surgical) - OPPC / ICAHT **(Approximate numbers to be established)** **NB: Numbers brought to Main Medical M&M meetings will reduce with a separate OPPC & ICAHT meeting**

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Appendix 4: Current Funding and Additional Costs.

Role Title	Band	No. of Posts	Funded	Currently Funded (Mid- Point of Scale with Goods and Services)	Additional Cost (Mid- Point of Scale with Goods and Services)
Patient Safety Data and Improvement Team					
HoS Patient Safety Data and Improvement Team	8b	1	Yes	£80,188	
Patient Safety Data and Improvement Manager	8a	1	Yes	£67,000 To be recruited	
Patient Safety Strategy Manager	7	1	Yes	£64,000 To be recruited	
Patient Safety & Learning Co-ordinator	6	1	Yes	£54,000	
Patient Safety Assurance Manager	6	1	Yes	£54,000	
Patient Safety (M&M) Facilitators	5	2 (1.8 wte)	Yes	£79,200	
Patient Safety & Guideline Support[13]	4	1	Yes	£34,000	
Patient Safety (M&M) Support	4	2 (1.8 wte)	Yes	£61,200	
Patient Safety Team Administrator	3	2 (1.6 wte)	Yes	£48,000	
Patient Safety Team Manager (Improvement Project Manager)	7	1	No		£64,000
Clinical Safety Co-ordinator	5	1	No		£44,000
Patient Safety (M&M) Facilitators	5	2	No		£88,000
Patient Safety (M&M) Support	4	1.5	No		£52,133
			Total	**£477,588**	**£248,133**
NB: Within the CSCG Resource Paper September 2020 £138,105 of this additional funding was previously identified as being required in Phase 2 and Phase 3 ((B7) and business partner posts (B5))					

[13] Function moving to Standards, Risk and Learning

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Role Title	Band	No. of Posts	Funded	Currently Funded (Mid- Point of Scale with Goods and Services)	Additional Cost (Mid- Point of Scale with Goods and Services)
Clinical Audit Team					
Head of Clinical Audit	8b	1	Yes	£80,188	
Clinical Audit Assurance & Improvement Manager	8a	1	No		£67,000
Clinical Audit Team Manager	7	1	No		£64,000
Senior Clinical Audit Facilitator	6	1	No		£54,000
Clinical Audit Facilitator (CSCG 2020 Paper BP Posts)	5	3	No		£132,000
Clinical Audit Administrator (Database)	4	0.6	No		£ 20,400
Health Records	3	0.5	No		£ 15,000
			Total	**£80,188**[14]	**£352,400**
NB: **Within the CSCG Resource Paper September 2020 £165,477 of this additional funding was identified as being required in Phase 2 and Phase 3 (clinical audit (B6) and business partner posts (B5))**					

[14] Current staffing expenditure equates to 0.6 W.T.E

with that. My question to you is: what efforts have you made to take that further? Have you been able to have any discussions with the Medical Director or other senior people in the Trust to put such things in place so you don't have to have such laborious processes?

A. With regards the outcomes data, I think we are in a very difficult position. We do not have the reliable hospital episode outcomes data available for us to even partake in the same outcomes monitoring arrangements that would be within Services in England and Wales. We don't have -- we discussed prostate cancer. If we looked at prostate cancer, we just don't have the capability to provide the data that would be provided to the National Prostate Cancer Audit, for instance. We are not going to fix that data availability rapidly, and so, if you like, the alternative approach is to approach with standardised audits of conditions and practices, and that's where we've been establishing within the Urology team, is an audit programme actually looking at them outcomes and using the standardised tools available. Again, if we look at prostate cancer or bladder cancer within the NICE guidance there are audit tools that can be used in that, and so they have been brought in to be part of a standard audit programme to look at that.

189 Q. I would imagine this is a trust-wide issue in terms of indicators so my question was really have you had support from senior people in understanding the importance of all of this and the fact that it would

and change. Talking to the urologists, there was legal or administrative difficulties submitting Northern Ireland patients to BAUS, the British Association of Urological Surgeons Audit. I mean is that something that's still a problem in your view, or if it is, is that something that you can help us with? 12:47

A. Yeah. So, there have been some challenges in terms of how patient information is shared. It's and information governance challenge. There was some legislation passed in 2016 that needs to be updated in order to enable that. I think at the time that the legislation was passed a number of Assembly members had some concerns about how patient information would be used. But there are, I think, strong arguments as to why being part of national clinical audits would be a good thing for everybody, including for those patients, in terms of giving greater assurance about safety and quality and identifying any areas of concern at an earlier stage, which is part of the fundamental problem that underlines both this Inquiry and the Neurology Inquiry. So it is something that, you know, I don't know whether it's something the Inquiry is going to make a recommendation around, but I can absolutely see the benefits of removing anything that would be an inhibitor in that area. 12:47 12:48 12:48 12:48

73 Q. MR. HANBURY: Thank you. Just the last one from me really. Long outpatient waits and waits for follow-ups and things is a recurrent theme in England as well as Northern Ireland. I was interested -- just one comment

which have been fully implemented."

So it seems that there are two quite important items that are still on the to do list?

A. Yes. In relation to the SAI recommendations, I think, you know, as that team has reviewed what has come out of this in the past, you know the recommendations that come through Serious Adverse Incidents should be smarter, you know, just in terms of meeting that criteria and, you know, the "E-R" at the end of "smart" now is in terms of, you know, being subject to evaluation and also being resourced, right. So that features in the discussions around this. So one of the frustrations in all of this is that we have hundreds of SAI recommendations across the organisation. So, you know, what they're being encouraged to do is to pick the themes out of that to try and get the work done, because otherwise I think it feels far too overwhelming for the directorates, and they're never going to get to the end of it. So there's work being done in relation to all of that. And then that automatically lends itself to audit in relation to, you know, in the same way as we've seen in this process, you come back to see whether or not those recommendations have been embedded. 15:21 15:21 15:21 15:22 15:22

The other area that's down below that that I think is worth mentioning, is the development of the professional governance information system. Now,

-----Original Message-----
From: Corrigan, Martina [redacted]
To: Aidanpobrien [redacted]; myhillsboro [redacted]; Akhtar, Mehmood [redacted]; O'Brien, Aidan [redacted]; Young, Michael [redacted]
CC: Dignam, Paulette [redacted] Hanvey, Leanne [redacted]; McCorry, Monica [redacted] Troughton, Elizabeth [redacted]
Sent: Wed, 27 Jul 2011 5:30
Subject: FW: Results

Dear all

Please see below for your information and action

Thanks

Martina

Martina Corrigan

Head of ENT and Urology

Craigavon Area Hospital

Tel: [redacted] (Direct Dial)

Mobile: [redacted]

Email: martina.corrigan [redacted]

From: Trouton, Heather
Sent: 25 July 2011 15:07
To: Reid, Trudy; Devlin, Louise; Corrigan, Martina
Cc: Mackle, Eamon; Brown, Robin; Sloan, Samantha
Subject: Results

Dear All

I know I have addressed this verbally with you a few months ago , but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and

that one does not wait until the review appointment to look at them.

Thank you

Heather

Southern Health & Social Care Trust IT Department [redacted]

Corrigan, Martina

From: Corrigan, Martina
Sent: 07 February 2016 18:33
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael; Farnan, Turlough; Korda, Marian; Leyden, Peter; McCaul, David; Reddy, Ekambar; Hall, Sam; Ted McNaboe [redacted]
Subject: FW: Radiology and Patholoy results

Dear all

See below from Heather

Martina

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

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Trouton, Heather
Sent: 29 January 2016 12:51
To: McAlinden, Matthew
Cc: Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy
Subject: FW: Radiology and Patholoy results

Could you please send the email below to all the consultant?

Happy to discuss if required
Thanks

Heather

From: Trouton, Heather
Sent: 18 January 2016 14:49
To: Trouton, Heather
Subject: Radiology and Patholoy results

Dear All

Following the outcomes of several SAI's, we are writing to remind all consultants that it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed.

Any concerns regarding the process of how these get to your attention should be raised with your secretary in the first instance.

Kind regards
Eamon and heather

the vast majority of them. The first 13 were to do with corporate governance at a point in time and, again, I think in fairness, Eileen, as Chair of the Trust, has really grasped those 13 now, but there was a period of time when that took a bit of debate for us to try and understand, and I think, you know, fair to say before Eileen arrived a realisation and acceptance that actually the corporate governance across the organisation needed to be strengthened, along with all of the other governance aspects that were there. 14:10 14:11

So I think that gave me a framework then in terms of improvement in relation to the overall corporate governance of the organisation and has, you know, been helpful to me in developing then the operational governance within the Trust. So we have concentrated on completely reforming the way we undertake corporate governance and, again, that has taken a lot of engagement, reflection, discussion, and we now have a revised corporate governance structure in place that brings patient safety and the quality of care very much into the minds of staff within the organisation, and feeds into the Governance Committee and sits alongside the Risk and Assurance Committee - or, sorry, the Risk Assurance and Audit Committee - that basically then quality assures some of that work that comes in. And then the other committees that are developed, the other five committees that are alongside that then are to support the overall approach to corporate governance. 14:11 14:11 14:12

what you don't know, and we'll look at some of the information that was coming to the Governance Committee and the Board and the confidential meetings. But it does seem as if there was perhaps inadequate information brought up, and I will come on and ask you later on about the position now --

A. Okay.

27 Q. -- and the way in which information makes its way, but if the terms of reference are the same for the Governance Committee now when Mrs. Leeson takes over, would you be content that those terms of reference are able to be satisfied by the way in which information is now brought to the Governance Committee?

A. I am. I suppose we're at a changeover in relation to what comes to the Governance Committee and how it is coming to the Governance Committee. I would say a lot of it is as a result of what's come through this Inquiry in terms of the approaches that are being deployed at an operational governance level then to feed through to our Governance Committee. So I'm not sure whether you want me to speak to that now or maybe we talk about it later. Because I can see it starting to happen in a more fruitful and meaningful way in respect to previously. If you even go back, the escalation piece to Trust Board, you can't escalate something unless you know there is something to escalate. What I put in place now is a requirement of Committee Chairs in their report to the Trust Board, there is a section there, they need to detail

10:27 10:27 10:27 10:28 10:28

SAIs were about and if there is anything in essence connecting the dots, rather we have 54, we have completed 22, there is 33 outside the realms. So it was moving it more into is there intelligence within this information that we need to be considering. That is a journey we travelled 2016-2020 and 2020 through to now, we are seeing that evolve more so in relation to the reporting. 11:02

Specific and serious SAIs and the learning from it, in the early part of my tenure we wouldn't necessarily have seen that coming through. But certainly as time has moved on then it's an opportunity to review and the seriousness of it has come through either committee or to Trust Board and we need to take stock and reflect and ensure, and certainly from our perspective as a Trust Board is there anything we needed to do differently as well as what's happening within the Trust itself. 11:02

52 Q. Does the Board or the Governance Committee have any involvement in the outworking of SAI recommendations or ensuring that themes of governance that might emerge are dealt with operationally by executive directors and the SLT generally? 11:02

A. When they have come to the Board or through the Committee, the serious ones that have come to us, then an action plan would be expected, that action plan and then a follow up to the Board or the Committee in due course as to the progress that is being made on that. 11:03

was it always something that you had an appreciation of?

A. I suppose with my background I would have understood that, you know SAIs are very, very important, I think the information that was provided to governance was more around numbers. Now there is a much fuller description of what the issue is, the progress that is being made and what the outcome is so that you are able to understand. One example is the high incidents of, in terms of litigation in maternity and obstetrics, so we looked at that in particular, what was causing that. I mean, a lot of it is historical, it's delay. Some of these families have had to wait nearly 20 years to get these cases resolved. So I think in terms of that sort of information and data that you're given, it is very helpful to understand that, particularly around that issue, that it just didn't happen in one year. 15:00 15:00 15:01

194 Q. One of the things that the Inquiry has been somewhat exercised with as a result of hearing evidence, and we'll look at one of these cases in a short time, is the apparent delay in moving an incident report through the various stages, if it is screened in for Serious Adverse Incident Review, moving it from start to finish and beginning to learn lessons and implement actions from the recommendations and findings. This report, and I don't have the reference to bring you to the page number, but you will have seen this, I hope, it shows whether the Trust is in compliance or out of compliance with expected timelines or time limits for SAI 15:01 15:02

IMPROVEMENTS TO DATE - REPORTING
Enhanced quarterly reporting to Governance Committee
Introduction of a standalone Service User Feedback Report to Governance Committee
Weekly reporting / escalation of issues to SLT
Quarterly Reporting to Safety & Quality Steering Group
Quarterly Reporting to Standards, Compliance and Regulation Steering Group
Introduction of Patient Safety Data & Improvement Team (M&M) Report to Safety & Quality Steering Group
Extended scope of Weekly Governance meeting agenda
Reporting of outstanding Enquiry responses at Weekly Governance meeting
IMPROVEMENTS TO DATE – INCIDENT MANAGEMENT
Development of Datix system for recording, monitoring and reporting of SAI Recommendations
Monthly updates requested on progression of SAIs from Operational Directorate Governance teams, with maintenance of central database
Escalation of SAI progression to AD CSCG as required
Escalation of Overdue SAIs to SLT
IMPROVEMENTS TO DATE – DATIX INCIDENT MANAGEMENT SYSTEM
Datix Upgrade
Development of Datix System for recording, monitoring and reporting of RQIA recommendations
IMPROVEMENTS TO DATE – SERVICE USER FEEDBACK
Quarterly meetings with NIPSO and PCC to assist with progression, oversight and assurance
IMPROVEMENTS TO DATE – LIAISON SERVICE
Extended scope of Liaison Service to support the Urology Lookback Review and Cervical Cytology Review
Extended scope of Liaison Service to support Complex Complaints

So we are - we do use all of that information and we do take it really seriously, and we use it, you know, as areas of improvement in some of the areas particularly where we're concerned. 11:24

50 Q. Yes. Again some of the specific infrastructure that has been invested in an appointment of a patient liaison officer in 2021?

A. Yes.

51 Q. That remains a feature of the environment? 11:24

A. Yes. Very much so. Yes, yeah.

52 Q. We know that in terms of the material that's gathered for governance complaints features in those reports and is also the subject of the one-to-one discussions at service level with the Medical Director team. 11:25

A. Mmm.

53 Q. I want to bring you to the update document that you supplied us with and which we looked at briefly yesterday in the context of adverse incidents, but you've also set out some update information in relation 11:25 to service user feedback. So if we go to TRU-306448. You catalogue for us - just scrolling down. Yeah. So you catalogue improvements to date in terms of service user feedback and - so you have quarterly meetings with the Ombudsman's office as well as with PCC, the Patient 11:26 Client Council.

A. Mmm.

54 Q. So tell me about that, those interfaces? Who attends on The Trust's behalf?

A. So those I don't attend, but those will take place between directors and assistant directors, and the various organisations.

55 Q. And why has - why have those interfaces been opened? Why do those meetings take place, the purpose? 11:26

A. I think for learning, because I think our experience is - obviously these are, these are very well established organisations that represent the public and, again, it's a very rich source of information for us in terms of driving improvement and what they're concerned 11:26 about. And, again, you know, if there are things that we haven't communicated particularly clearly, it gives an opportunity for us to, you know, improve on that, you know, in relation to our explanation. So, you know, the feedback I get in relation to these meetings 11:27 is very, very helpful.

56 Q. Yes. And then under a related heading, there's a liaison service?

A. Yes.

57 Q. It has been used in association with Urology Lookback 11:27 Review as well as in the Cytology Review. Again, what is the purpose of the liaison service and how does it assist your work and your Senior Leadership Team's work in relation to improvement issues?

A. So this team is affectionally known as FLO, which is 11:27 Family Liaison Officer, and we have approximately five people in the system, and they come from a background of working with individual service users and families, and we, we grew this service again in the course of the

pandemic in supporting people who were coming through with Covid. And, again, based on our experience in relation to all of that, extended that then to Urology and more recently to Cytology. But also, we also use these individuals in supporting families and 11:28
individuals through serious adverse incidents. So it's heavily used. As you saw yesterday, approximately half of our serious adverse incidents are located in mental health and disability, so they do spend a significant amount of time supporting families and service users in 11:28
mental health services and that - again the feedback we get from that is enormously helpful in terms of, you know, bringing education both ways and clearing up inconsistencies that, you know, are adding distress, and also, you know, providing a rich source of 11:29
information, I hope, to the service users and families in terms of how we're doing our business. Because, you know, I think we're very aware that we use one language that's common to all of us within health and social care, but it's not easily understood by anybody outside 11:29
of all of that. So, again, these individuals provide a really important bridge between ourselves and the public in terms of making sure that we're being clear and we're communicating clearly.

58 Q. And as you know improvement never stops. 11:29

A. Yeah.

59 Q. If we go on to - if we scroll down two pages I think to 50 in this sequence. So further initiatives in respect of service users set out here. You're looking to

develop a service user feedback awareness training package, and you're planning to pilot service user feedback process in the coming months. Going over the page to 51, we can see there implementation of the public service Ombudsman's model complaints handling procedure is on the agenda for discussion. Development and implementation of a complaints reviewer training package, and the development of a pathway for liaison service involvement in complaints. So how confident are you, Dr. O'Kane, that you've got the building blocks in place to better engage with your patient body for the purposes of learning? 11:30 11:31

A. I think we interface with thousands of patients and I think it's really difficult capturing all of this. This was one of the things I know that I have, you know, wondered how we can do this much better. I went in the past to visit - when Navina Evans was Chief Executive of the East London Mental Health Foundation Trust, I went to visit her, because they do this particularly well, and she described to me their system of actually involving service users in the compilation of the complaint response in terms of sending that back to the service user, right, or their family. We haven't got to that point yet, and there's all kinds of machinations around from a confidentiality point of view and all of that, how you would manage this. But ideally I would like us to be doing this at that level so that we - because I think - we tend I think as a system, and this is germane I think to all of health 11:31 11:31 11:32

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
A - Management of Complaints 15-16 Satisfactory	Priority 2 Finding 1.2	The Trust should further develop its systems, including Datix to assist managers monitor and learn from multiple complaints from a complainant and multiple complaints regarding an individual	31/03/2016	ADCSCG	Partially Implemented	The post has now been filled and Work has commenced on the upgrade of DATIX.	31-Mar-22
	Priority 2 Finding 2.1	The Trust should utilise the Patient Association checklist to review and strengthen the management of the complaints process and engagement with complainants. This will require amendment to Trust policy.	31/03/2016	ADCSCG	Partially Implemented	The Trust is working on embedding the Healthcare Complaints Analysis Tool which provides a reliable and robust framework through which healthcare complaints can be monitored, learnt from and examined in relation to healthcare outcomes. The tool is currently being used for all complaints and is being trialled in MHLD directorate to drive quality improvement initiatives.	31-Mar-22
	Priority 2 Finding 2.1	More formal processes for recording discussions and investigations undertaken into complaints should be developed and these should be recorded on the complaints files along with copies of relevant supporting document	30/09/2016	ADCSCG	Partially Implemented	The post has now been filled and Work has commenced on the upgrade of DATIX.	31-Mar-22
B - Case/Care Management 16-17 Limited	Priority 1 Finding 1.1	Management should ensure that person centred care plans are fully completed for all clients and signed off by all relevant parties e.g. service user/advocate/carer etc. They should also include all details of other parties who have received a copy of the care plan.		Heads Of Service	Partially Implemented	There has been work completed on the Case Management SOP but it not yet finalised it is hoped that this will be completed by 31/12/21. The documentation group continues to be on hold across OPPC due to other competing demands / COVID related.	31-Mar-22
C - Clinical Audit 16-17 Limited	Priority 2 Finding 2.1	The Trust should ensure that written procedures for all aspects of the clinical audit are reviewed, updated and issued to all relevant staff as soon as possible. These should reflect current practice and link to a Clinical Audit strategy.	31/05/2017	Assistant Director CSCG	Partially Implemented	A new Head of Clinical Audit has been appointed and the Clinical Audit strategy is now being reviewed.	31-Dec-21
D - Absence Management 16-17 Satisfactory	Priority 2 Finding 2.4	The Trust should ensure the Absence Management Protocol and Procedure is updated as a matter of priority to reflect any changes in practice with regards to absence management. Compliance with this protocol and procedure should be re-enforced with Managers.	Oct-16 Nov-17 Mar-18	Head of Employee Engagement & Relations	Partially Implemented	The revised implmentation date has not passed.	31-Mar-22
E - Non Pay Expenditure 17-18 Limited & Satisfactory	Priority 2 Finding 3.1	The Trust should establish a holistic approach to monitoring non-contract expenditure, locally procured contract spend and expenditure on Direct Award Contracts.	01/10/2018	Director of Finance	Partially Implemented	A number of staff have now been appointed to this team over Autumn 2020, however COVID has delayed significant progress.	31-Mar-22
F - Management of Domiciliary Care 17-18 Limited	Priority 1 Finding 3.1	The service model needs considered regionally and procurement should be taken forward in line with agreed service requirements and taking into account requirements to be able to verify service delivery. Consideration should be given to action that can be taken in the interim, in line with legal and procurement advice.	01/04/2018	Assistant Director Older Peoples Services	Partially Implemented	The regional project for the live monitoring system has been paused due to COVID 19. The South Eastern Trust are piloting a sytem which links to the payroll Southern Trust are laising with SET in conjunction with this.	31-Mar-22
G - Performance Management 17-18 Satisfactory	Priority 2 Finding 1.2	The formal Consultant Leave Policy should be agreed signed off and formally adopted. All medical rotas should be completed and provided to the booking centre six weeks in advance to enable appropriate clinic planning and patient booking.	01/12/2018	Director HROD and Medical Director, Director of Acute Services, Assistant Directors of Acute Support Services	Partially Implemented		
H - Management of Medical Staff 17-18 Limited	Priority 2 Finding 2.2	Claim forms should be completed in line with Trust WLI procedure i.e. signed in advance by the Assistant Director and Associate Medical Director.	01/08/2018	Directors of Acute Services, Mental Health and Disability, Older People and Primary Care and Children and Young People Services	Partially Implemented	stephen to send comment	
I - Risk Management 17-18 Satisfactory	Priority 2 Finding 1.1	As previously recommended, a standard pro-forma of a risk register should be adopted throughout the Trust. All directorate risk registers should then be reviewed and gaps in information should be completed. Management should ensure that all relevant information is recorded in relation to risks identified and that a consistent approach is adopted	Mar-16 Jun-16 Jun-17 Sep-18 Mar-18	Assistant Director of CSCG, Assistant Director – Clinical & Social Care Governance	Partially Implemented	Work in this area is still ongoing and has been delayed due to the impact of COVID-19.	31-Mar-21
J - IT Cyber Security 17-18 Limited	Priority 2 Finding 2.2	SHSCT should ensure that its Business Continuity Planning framework and in particular Business Continuity Plans of operational service areas adequately takes account of potential loss of dependent ICT systems through cyber attack or other incident.	01/03/2018	Assistant Director Medical	Partially Implemented	Paul IT	
	Priority 2 Finding 3.1	SHSCT ICT should review, update and fully deploy Service Transition Assurance Processes. This should be deployed retrospectively to existing live services.	01/09/2019	Head of IT	Partially Implemented		

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	Priority 1 Finding 5.1	SHSCT should:• Introduce the capability to ensure all network connected devices are known to SHSCT ICT, that devices joining the network are detected and that these are used to create a specific inventory • Strengthen risk management actions around devices which are not managed by SHSCT ICT. • For SHSCT ICT managed devices, ensure products to manage these devices are appropriately configured and baselined against the central inventory to allow meaningful comparison between products to help ensure complete oversight.	Sep-19	Head of IT	Partially Implemented		
	Priority 2 Finding 6.1	SHSCT ICT should consider and implement the recommendations from the Microsoft review of SHSCT patching processes during November 2017, to include moving managed servers into maintenance windows and that patching is deployed to managed servers on a timely basis.	Jan-20	IT Server & infrastructure Manager	Partially Implemented		
	Priority 2 Finding 13.1	SHSCT ICT should enhance their internal management reporting including regular summary information on server and client patch compliance and unsupported operating systems, applications etc. against an appropriately defined baseline.	Jun-18	Cyber Security manager	Partially Implemented		
K - Standards & Guidelines 18-19 Limited	Priority 2 Finding 2.1	The Trust Standards and Guidelines spreadsheet should be fully populated by all directorates, and processes introduced to ensure it is properly managed and timely updated both by Corporate and Directorate Teams. Additional fields should be added to the Trust Standards and Guidelines spreadsheet to record directorate data regarding actions taken to comply with standards is recorded on a timely basis, and to enable accurate reporting of compliance on a standard by standard basis.	01/09/2019	Assistant Director of Clinical and Social Care Governance and Operational Directors and Directorate Governance Leads.	Implemented	This work has progressed and a process is now in place to ensure that standards and guidelines are reviewed and disseminated. The spreadheet has been developed to incorporate additional fields. A weekly emial is sent to Directorates detailing all new standards and guidlines.	
	Priority 2 Finding 3.1	Internal Audit acknowledges that due to the volume of standards and guidelines received it would not be feasible to audit compliance for all. However based on the overall risk rating or profile of the standard or guideline, management should include audits of compliance with high risk Standards and Guidelines within directorate clinical audit plans from 2018/19, taking into consideration the Trust Clinical Governance Strategy.	01/06/2019	Assistant Director of Clinical and Social Care Governance and Operational Directors and Directorate Governance Leads.	Partially Implemented	Caroline beattie to send update	
	Priority 2 Finding 5.2	Management should consider further development of its systems to introduce automated mailing of timely reminders to prompt directorate operational governance teams when actions are due.	01/09/2019	Assistant Director of Clinical and Social Care Governance	Partially Implemented	This work has progressed and a process is now in place to ensure that standards and guidelines are reviewed and disseminated. The spreadheet has been developed to incorporate additional fields. CAROLINE TO SEND INFO TO CLOSE	
L - Contracts with Vol Sector (inc Surestart) 18-19 Limited	Priority 2 Finding 5.1	On finalisation of the regional approach to define a common methodology to comply with the legislation and on agreement of the relevant contract clauses, the Trust should take timely action to ensure that all contracts issued are GDPR compliant.	2019/20	Head of Contracts	Partially Implemented	The revised implementation date has not passed.	31-Mar-22
M - Case/Care Management 18-19 Satisfactory	Priority 2 Finding 1.1	The roll out of the successful pilot of the electronic service user care plan which auto-populates from NISAT and builds on the person centred approach should take place across all Integrated Care Teams (ICTs).	01/12/2019	Assistant Director of Primary Care & ICT Head of Service	Partially Implemented	The EDC1 – meetings have commenced again and this is very much on the agenda and being worked through. Input is required Trustwide and so the implementation group needs to be extended. An SMT paper has been drafted in relation to the EDC1 and this has been shared with OPPC Director and ADs, in terms of the roll out and the need for resouces.	31-Mar-22
N - Payments to Staff 18-19 Limited	Priority 2 Finding 2.3	The Trust should develop learning points from the exceptions noted and issue these to all managers throughout the Trust and appropriate training provided as necessary.	30/09/2019	Head of Employee Relations (ER)	Partially Implemented	The revised implementation date has not passed.	31-Mar-22
	Priority 2 Finding 3.2	The Trust should review all staff with 3 or more staff numbers and where there has been no payment made against a corresponding staff number in the past 12 months, put in place an appropriate process to promptly remove all redundant staff numbers on HRPTS to ensure that the OM structure is fully reflective of the actual staffing position.	30/09/2019	Head of Employee Relations (ER)	Partially Implemented	The revised implementation date has not passed.	31-Mar-22
O - Infection Prevention Control 18-19 Limited & Satisfactory	Priority 2 Finding 1.1	All clinical staff should be actively involved in the Antimicrobial Stewardship process. Additionally, Directors, Assistant Directors, medics, nursing and pharmacy staff must have ownership of AMS. Antimicrobial audit results should be discussed with the pharmacist, medical staff, nurses, and microbiologist at ward level.	01/10/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 1.2	A planned programme of both Microbiologist and Antimicrobial Pharmacist ward rounds should be promptly established and reported through the appropriate governance arrangements within directorates and action taken to rectify non-compliance and errors.	01/04/2020	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	

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	Priority 2 Finding 1.3	Reports should be disseminated to the appropriate staff. Format and content should be considered for the target audience, specifically nursing, pharmacy and junior medical staff.	01/06/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 2.1	Arrangements for addressing non-compliance with antibiotic policy and antimicrobial stewardship should be reviewed and strengthened.	01/08/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 2.2	Communication between the Clinical Pharmacists, the Antimicrobial Pharmacists, the Microbiologists and the Ward Team including the Ward Sister should be strengthened to ensure that there is regular and adequate discussion in relation to the use of antibiotics on all wards.	01/10/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 3.1	Management should strengthen the governance and corporate oversight arrangements in respect of compliance with Antimicrobial Stewardship, by ensuring that the AMT attendance is maximised and the Terms of Reference are appropriate.	01/06/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 3.2	The AMT should develop a formal Clinical Engagement Plan to include targeted training for clinicians on specific wards, engagement with clinicians through Mortality and Morbidity fora, and improved engagement on AMS issues with the Medical Director.	01/10/2019	Medical Director	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 5.1	Training on antimicrobial prescribing and stewardship should be expanded across clinical staff groups /areas and focussed training for nursing staff should be introduced.	01/10/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 5.2	The Antibiotic Stewardship e-learning package should be agreed and finalised, and an implementation plan put in place. This should identify staff to be trained and the timetable for roll out. Also the rate of uptake should be monitored.	01/10/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 6.1	AMT should review the Antimicrobial Stewardship policies. They should discuss and make a recommendation to the HCAI Strategic Forum as to the most appropriate platforms to make these policies and procedures available to staff.	01/07/2019	Medical Director plus all Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 7.1	Results of IPC audits should be displayed on all wards and good practice from high performing areas replicated in poor performing wards. Action plans to address wards who regularly perform poorly in audits should be developed, implemented and monitored.	01/10/2019	Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
	Priority 2 Finding 7.2	The HCAI Clinical Forum should decide appropriate IPC information wards should display on their notice boards and ensure that all wards comply.	01/10/2019	Operational Directors	Partially Implemented	stphen and trudy to complete narrative and send evidence.	
P - Mortality & Morbidity 18-19 Limited	Priority 2 Finding 1.1	The Trust should improve the corporate oversight of performance against targets for both the initial consultant review of a death and M&M meeting review within 6-8 weeks. Management should keep under review deaths which have not been subject to timely consultant review and should establish if there are any trends or areas where this is particularly prevalent. To enable this to happen, the M&M Chair must record the date that deaths are discussed, on NIECR.	01/09/2019	Medical Director	Partially Implemented	The RMMRS does not have reporting functionality this dashboard reports are collated. Going forward work is ongoing with the Business Intelligence team to develop an app that will assist reporting. Timescales of 48 hours for Consultant review tasks to be completed remains a challenge. This target was set by the Department to allow Consultants to review what was noted on the MCCDs.	31-Mar-22
	Priority 2 Finding 1.2	The reasons for the delays found in adding some patient death details to NIECR should be reviewed and addressed by the Trust.	01/06/2019	Medical Director	Partially Implemented	The RMMRS does not have reporting functionality this dashboard reports are collated. Going forward work is ongoing with the Business Intelligence team to develop an app that will assist reporting. Timescales of 48 hours for Consultant review tasks to be completed remains a challenge. This target was set by the Department to allow Consultants to review what was noted on the MCCDs.	31-Mar-22
	Priority 2 Finding 2.1	The process for identifying, recording, sharing and implementing learning (local cross speciality and regional) needs further development and complied with consistently. This will require engagement with M&M groups, training, increased central monitoring and a review of required recording and reporting processes to ensure they are effective.	01/12/2019	Medical Director	Partially Implemented	SJR pilot has been discussed at the M&M Chairs meetings. Work has been commenced in the Mental Health Directorate. The Action log template is being piloted by ICU and DHH Medical. This matter has also been raised at the M&M Chairs meetings. Newsletters in place for CAH Medical and consideration to expand this for other M&Ms has been noted.	31-Mar-22
	Priority 2 Finding 4.1	The Trust should follow up with M&M Leads and the Consultants to ensure the deaths not recorded on NIECR have been subject to review at a M&M meeting.	01/09/2019	Medical Director	Partially Implemented	check with Raymond - stephen to send comment	

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	Priority 2 Finding 5.1	The Trust Integrated Governance Strategy should be reviewed and updated to reflect the role of the M&M Outcome Review Group and the M&M Chairs Group. It should also reflect how these two groups fit into the overall governance arrangements within the Trust.	01/12/2019	Medical Director	Partially Implemented	stephen to come back	
	Priority 2 Finding 6.1	The Trust should work to ensure M&M meetings are consistently multidisciplinary. This could potentially include the introduction of a quorate membership for all M&Ms which would include membership of key staff from other disciplines.	01/11/2019	Medical Director	Partially Implemented	This is unchanged and has been highlighted at the M&M Chairs meetings also	31-Mar-22
Q - WLI Follow up 18-19 N/A	Not Prioritised Finding 1	The Trust should consider the conduct of medical staff and approving officers involved in the Radiology WLI process. Given the findings of this review, the Trust should also seek to address the cultural issues that have facilitated and accommodated the payment of 4 hour sessions for activity that takes less time to deliver. (Radiology Only)	31/03/2020	Director Acute Services	Partially Implemented		
	Not Prioritised Finding 3	The Trust should update its work allocation methodology, to increase the volume of work allocated to a 4 hour WLI session and ensure that 4 hours work is completed outside core time. (General Surgery and Radiology – Cardiology not previously reviewed)	30/09/2019	Director Acute Services	Partially Implemented		
	Not Prioritised Finding 6	Management must ensure that all waiting list sessions are signed, dated and approved in advance by the Assistant Director and Associate Medical Director as per procedure. This must include details of the specific number of procedures/cases/examinations to be performed and that there is sufficient activity equating to 4 hours work. (General Surgery and Radiology – Cardiology not previously reviewed)	30/09/2019	Director Acute Services	Partially Implemented		
	Not Prioritised Finding 9	All job plans should be reviewed and updated annually by the AMD in conjunction with the respective Consultant. The AMD and Director of Acute Services should ensure the four job plans referred to in section 4, are reviewed and updated. (General Surgery and Radiology – Cardiology not previously reviewed)	30/04/2019	Director Acute Services	Partially Implemented		
R - IT Cyber Security 18-19 Limited	Priority 1 Finding 1.1	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. HSCNI needs to appropriately align ICT / Information / Cyber Security governance arrangements to the technical configuration of the HSCNI networks and information assets within a model which includes clear accountability and decision making.	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 1 Finding 1.2	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. HSCNI needs to appropriately align ICT / Information / Cyber Security governance arrangements including clear accountability to the nature of the HSCNI ICT structures. Good practice suggests that Chief Information Security Officer role should be established.	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 1 Finding 1.3	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. HSCNI should strengthen ICT / Information / Cyber Security governance across the HSCNI by implementing an appropriate Information Security governance framework across the HSCNI (e.g. ISO 27001).	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 1 Finding 2.1	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. A framework for Policies, Standards, Guidelines and Procedures for ICT / Information / Cyber Security should be implemented across the HSCNI. Clear accountable arrangements for ensuring compliance with agreed policies and standards should be established.	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 2 Finding 3.2	SHSCT should establish a formal project to segregate all Network Assets. This should contain appropriate project management methodologies including realistic milestones and be subject to regular monitoring to completion.	30/09/2020	Cyber Security manager	Partially Implemented		

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	Priority 2 Finding 5.1	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. HSCNI should ensure a regional mechanism is in place to ensure that:• The definition of an External Gateway (to the HSCNI WAN) is appropriately agreed.• Existing External Gateways are retrospectively approved. • Proposals for introducing new External Gateways are appropriately approved at a regional level.• Regular assurances on External Gateways (and the remediation of any identified vulnerabilities) against HSCNI policy requirements and an agreed assurance framework should be provided by the HSCNI organisation owners.• HSCNI organisations should provide regular assurances on how any unknown External Gateways are being pro-actively detected.	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 2 Finding 7.1	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. Information Security Operations Centre should be put in place. This is a function where information systems including applications, databases, data centres and servers, networks, endpoints are monitored, assessed and protected.	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 2 Finding 7.2	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. A project to fully map and document the HSCNI network design with a view to understanding all data traffic flows (including clarity over Access Control Lists and ensuring that there is a current requirement) should be undertaken.Once a holistic and transparent picture is achieved, appropriate arrangements to enhance security on core links should be put in place (including consideration of Firewalls and IPS installation).	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 2 Finding 8.1	SHSCT should risk assess all existing Third Party Providers with access to SHSCT network assets and take appropriate mitigation steps.	31/12/2019	IT Contracts & Governance Manager	Partially Implemented		
	Priority 2 Finding 8.2	SHSCT should ensure that all relevant contracts should contain provisions to ensure minimum security standards are in place.	31/12/2019	IT Contracts & Governance Manager	Partially Implemented		
	Priority 2 Finding 8.3	This recommendation is being reported in BSO, HSCB and Trusts 1819 IT Audit reports. As strategic lead for IT in HSCNI, the HSCB eHealth and Care Lead is the owner of this recommendation. A formal framework for Third Party Providers connecting to the HSCNI WAN should be put in place. This should incorporate:• Minimum security requirements for Third Parties connecting to HSCNI network should be reviewed. Appropriate methods to ensure compliance with these requirements should be introduced. • All contracts should clearly state the minimum security standards.• Appropriate methods to ensure compliance with minimum security standards should be introduced.	31/03/2020	eHealth and Care Lead (HSCB)	Partially Implemented		
	Priority 2 Finding 9.1	SHSCT ICT should strengthen how ICT Administrators connect and authenticate onto all management consoles (including Cisco Prime, ISE and ForcePoint). Multifactor authentication should be implemented.	31/12/2019	IT Comms Manager	Partially Implemented		
S - Theatre Utilisation 18-19 N/A	Not Prioritised Finding 2.1	The Trust should review its current utilisation of the emergency theatres at both hospital sites and ensure that they are used to optimum capacity and utilisation. Whilst it is appreciated that the nature of emergency theatres means that they must be available for emergencies, there may be potential for clinicians to explore further safe utilisation of these theatres and staff, during the day.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 2.2	An utilisation report for emergency theatres should be regularly run and monitored by Management.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		

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	Not Prioritised Finding 2.3	Based on the utilisation of DHH emergency theatre, there is a rationale for reviewing available emergency theatre hours in DHH and also considering utilising CAH more fully for expedited category patients.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 3.3	Management should review the processes in place for surgical pre admission in particular where there are significant waiting lists.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 3.4.	The Trust should introduce renewed awareness campaigns for DNAs or CNAs and the overall impact this has on waiting lists etc.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 4.1	The Trust should establish how these issues can be addressed in light of on-going pressures on inpatient beds.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 6.1	In order to achieve the required 6 week notice period for pre-operative assessments and timely notification of patients management should consider reviewing the Medical leave policy.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 6.2	The surgical rotas should be prepared and made available on a timely basis, to allow for efficient scheduling and booking of patients onto theatre lists and appropriate time for pre-operative assessments to be completed.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 7.1	As per procedure, to allow timely completion of pre-operative assessments, patients listed in theatre sessions should be notified to Pre-Operative Assessment Team 6 weeks in advance of surgery date.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 8.1	The governance arrangements around the management of theatre utilisation should be clarified.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
	Not Prioritised Finding 9.2	The Theatre Escalation procedure should be reviewed to ensure it is still appropriate and an agreed future review date included on the document.	30/09/2019	Assistant Director of Acute Services	Partially Implemented		
T - Board Effectiveness 18-19 Satisfactory	Priority 2 Finding 3.2	The Trust should seek to improve Trust Board's involvement in planning and strategy. We understand this is the intended focus of the Board in their next phase of development.	31/03/2020	Chair and Chief Executive	Implemented	The Trust process for development of a new corporate plan commenced with Trust Board at a Strategic Planning workshop in February 2020 prior to the emergence of the Covid 19 pandemic. Due to Covid 19, strategy development has been rolled forward from 2020/21. The Trust Board held a Workshop on 26th August 2021 which focused on the development of a 5-Year Strategic Plan for the Trust for 2022-2027 as well as the content of a 1-Year Plan which will form the key foundation for the longer term strategy.	
U - Charitable Funds 19-20 Satisfactory	Priority 2 Finding 2.2	The Trust should continue preparatory work and planning for the rationalisation of the Charitable Trust Funds incorporating any learning from BHSCT.	31/03/2021	Assitant Director Finance	Not Implemented	Limited progress has been possible during 2020/21 due to other priorities during the pandemic work is ongoing towards the previously revised implementation of 31/03/22	31-Mar-22
V - Fire Safety 19-20 Limited	Priority 2 Finding 3.1	Nominated Fire officers must ensure that Fire training and associated records are completed in a standardised format in line with Trust procedures. Nominated Fire officers must report to Fire safety Committee on a quarterly basis to confirm that fire training and the necessary documentation has been completed for their areas of responsibility.	31/10/2019	Nominated Fire Officers	Partially Implemented	Staff have been reminded of the need to complete mandatory Fire safety Training however uptake due to COVID has remained minimal.	31-Mar-22
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019	All Directors	Partially Implemented		
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019		Split	Staff continue to be reminded of the need to complete mandatory Fire safety Training.	31-Mar-22
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019		Split	Position remains the same due to COVID - 19.	31-Mar-22
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019		Split	Staff are continually reminded of need to complete CMT.	31-Mar-22
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019		Split	All staff have been reminded of the responsibility to complete CMT.	31-Mar-22
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019		Split	Staff contine to be reminded to ensure CMT is up to date - this includes Fire safety training.	31-Mar-22

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019		Split	Position remains the same due to COVID - 19.	31-Mar-22
	Priority 2 Finding 3.2	Directors should closely monitor staff attendance at Fire safety training within their directorates where there is low compliance actions should be taken to address the issues.	31/10/2019		Split	Staff continue to be reminded of the importance of completeing CMT.	31-Mar-22
W - Non Pay Expenditure 19-20 Satisfactory	Priority 2 Finding 1.2	For the non-social care procurement spend above, the Trust should ensure appropriate procurement processes to cover this expenditure in the future.	31/03/2020	Assistant Director Primary Care and Assistant Director Enhanced Services	Partially Implemented	The Trust circulated guidance on appropriate procurement processes to all staff via global email and OPPC senior management highlighted this information to heads of services on 19 April 2021. PaLS aim to have local tenders for Postural Support and Orthotics advertised early September 2021 with the aim to have compliant agreements in place by December 2021/January 2022. Engagement by Trust Contract Adjudication Group (CAG) nominees is virtual to ensure timeframes are met.	31-Jan-22
	Priority 2 Finding 1.3	The Trust should liaise with PALs in relation to the 9 suppliers with multiple order lines to ensure appropriate procurement processes are in place or put in place for future expenditure.	31/03/2020	Assistant Director Primary Care and Assistant Director Enhanced Services	Partially Implemented	OPPC Heads of services aligned to the 9 suppliers with multiple order lines have been liaising with PaLs colleagues to ensure appropriate procurement processes are in place / put in place for future expenditure. OPPC Heads of services have been reminded, as instructed by PaLs: "Going forward, Head of Services should monitor what is being approved for purchase and liaise with PaLS for advice and guidance on the best compliant route." PaLS continue to review non contract spend requisitions received from the Trust and identify compliant procurement routes and advise accordingly.	31-Jan-22
X - Core HR 19-20 Satisfactory	Priority 2 Finding 2.1	HR should determine what is available within the system to enable them to carry out regular review and challenge of user activity for users where there is a contravention of the Segregation of Users (SOD) Matrix.	30/04/2020	Head of Workforce Information	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
Y - Pharmacy Procurement & Contract management 19-20 Satisfactory	Priority 2 Finding 2.2	DACs should be put in place for the 92 items referred to above.	30/06/2020	Lead Procurement Pharmacist	Partially Implemented	OPPC Heads of services have been reminded, as instructed by PaLs: "Going forward, Head of Services should monitor what is being approved for purchase and liaise with PaLS for advice and guidance on the best compliant route." (attached)	
Z - Annes Homecare 19-20 Limited	Priority 2 Finding 6.2	Given the variation between commissioned time and the actual time provided by Ann's Home Care as identified in Finding 1, the Trust should consider further necessary steps and the potential for overpayments. The Trust should also engage appropriately with other HSC Trusts utilising this provider.	30/03/2020	Assisstant Director OPPC	Partially Implemented	Correspondence has been shared with AHC on 18 June 2021 which indicated the Trust commitment to recoup £5,216 identified as over claimed in the audit. A performance notice for deficits identified remains in place and updated information was requested as part of the communication.	31-Dec-21
	Priority 2 Finding 6.3	Given the findings of this report the Trust should consider the rigor of their current spot checking process.	30/03/2020	Head of Domiciliary Care	Implemented	IA agreed to close this recommendation on the basis that the monitoring officers complete runs and report to HOS and descrepacies are challenged.Until live monitoring this is as much as Trust can do.	
AA - Payments to Staff 19-20 limited	Priority 2 Finding 2.1	The Acute Services Directorate should issue guidance to staff to ensure that payments to staff are made in line with Agenda for Change Regulations and such divergences don't recur. This should include guidance that in future no overtime payments are made to staff on Band 8A and higher.	30/06/2020	Director of Acute Services	Partially Implemented		
AB - Management of Children In Adult wards 19-20 limited	Priority 1 Finding 1.1	The Trust must develop an action plan to promptly substantially improve compliance with all required Hyponatremia training for clinical staff.	31/07/2020	Assistant Director Acute Services (ATICs, Surgery & Elective Care) & Interim Assistant Director of Nursing, Midwifery Workforce & Education.	Partially Implemented		
	Priority 2 Finding 2.1	Heads of Service should ensure their staff complete the necessary mandatory safeguarding training. Action should be taken when quarterly compliance is below the minimum requirement.	31/03/2021	Operational Assistant Directors	Partially Implemented		
	Priority 2 Finding 3.1	The Trust should develop a policy on caring for and safeguarding children and young people who are admitted to adult wards. This policy needs to be formally approved and circulated to all necessary staff. In the interim Management should ensure that the recently finalised flowchart summarising SHSCT's Admission Protocol for Young People aged 14-15 years 364 days is formally issued to all staff, accessible on SHSCT intranet and action taken to fully embed within the Trust.	31/10/2020	Interim Assistant Director of Clinical & Social Care Governance and Assistant Director of Nursing, Safety, Quality & Patient Experience.	Implemented	The Trust have developed a policy on caring for and safeguarding children and young people who are admitted to adult wards. The Policy was approved by Scrutiny Committee in April 2021.	
	Priority 2 Finding 3.2	The Trust should ensure that all relevant staff are subsequently trained and aware of the application of this policy.	31/03/2021	Operational Assistant Directors	Partially Implemented		

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	Priority 2 Finding 4.1	In light off the policy development, all expectations of the considerations taken must be included in the patient centred care plan and all documentation required should be detailed in the policy. Consideration should be given to the use of Paediatric specific documentation for 14-16 year olds on designated Adult wards within the Trust, similar to that used within the SHSCT Paediatric Unit. Use of appropriate pressure ulcer risk assessment, PEWS, and paediatric kardex should be included in this. The Trust should use the learning from exceptions highlighted, to inform the new policy (referred to in finding 3 above).	31/10/2020	Interim Assistant Director of Clinical & Social Care Governance and Assistant Director of Nursing, Safety, Quality & Patient Experience.	Implemented	The Trust have developed a policy on caring for and safeguarding children and young people who are admitted to adult wards. The Policy was approved by Scrutiny Committee in April 2021.	
	Priority 2 Finding 4.2	An audit process should be implemented to monitor that the correct documentation is used and fully completed.	31/12/2020	Lead Nurses	Partially Implemented		
	Priority 2 Finding 5.1	The Trust's Action Plan against the 96 O'Hara recommendations should be revamped to provide a more meaningful picture of the Trust's position regarding implementation at any point in time. It is appreciated that this is linked with regional work to develop assurance frameworks around each recommendations, issue regional directions and confirm implementation of recommendations.	31/10/2020	Interim Assistant Director of Clinical & Social Care Governance and Assistant Director of Nursing, Safety, Quality & Patient Experience.	Partially Implemented	A band 8 has been appointed to take the lead on the implementation of these receomendations with the nominated Trust leads. Progress has been made in nominating leads.- Caroline to provide updated templared action plan for sept 21.	
	Priority 2 Finding 6.1	The Trust should work regionally to ensure that any policy on Intravenous Fluids for Children and Young People reflects any Trust concerns and that it is approved and issued on a timely basis to SHSCT staff.	31/05/2020	Interim Assistant Director of Clinical & Social Care Governance.	Implemented	The Trust have worked regionally to ensure that any policy on Intravenous Fluids for Children and Young People reflects Trust concerns and that it is approved and issued on a timely basis to SHSCT staff. – Regional Policy was updated and issued in May 2020. This policy is on the intranet	
	Priority 2 Finding 9.1	Given that the frequency of reporting by the Trust's IHRD Oversight Steering Group to SMT has reduced and Trust Board only receive updates from this group twice per year, consideration should be given to more detailed update reports being presented to both SMT and Trust Board.	30/11/2020	Interim Assistant Director of Clinical & Social Care Governance and Assistant Director of Nursing, Safety, Quality & Patient Experience.	Implemented	Report quarterly to SMT and subsequently to Governance Committee and Trust Board.	
AC - IT cyber security 19-20 Satisfactory	Priority 2 Finding 1.1	SHSCT ICT should ensure that there are appropriate Policies, Standards, Guidelines and Procedures (PSGP) in respect of: • Active Directory Passwords • Clear and agreed roles and responsibilities in respect of allocating high privileged AD user accounts • AD user activity logging, to ensure appropriate isolating, monitoring and auditing of AD user account activity. This should include monitoring of changes to privileged groups being performed by appropriate person independent of the person allocating AD user accounts. This should be aligned to the regional development of PSGP (per recommendation 2.1 SHSCT IT Audit 18/19).	31/12/2020	Head of IT	Partially Implemented		
	Priority 2 Finding 1.3	SHSCT ICT should develop and implement a work plan to put a Privileged Access Management (PAM) solution in place.	31/03/2021	Cyber Security Manager	Partially Implemented		
	Priority 2 Finding 1.4	SHSCT should strengthen processes around service account management, including rules for creation, ownership / maintenance and password resets.	31/10/2020	IT Service Delivery Manager	Not Implemented		
	Priority 2 Finding 1.5	SHSCT ICT should formalise the recommendations arising from the Microsoft AD Security Assessment exercise (November 2019) into a monitored action plan with target implementation dates. Where any recommendations are not going to be implemented then these should be agreed with senior ICT management.	31/12/2020	IT Server & Infrastructure Manager	Partially Implemented		
	Priority 2 Finding 1.6	SHSCT ICT should ensure that its Active Directory user accounts are all maintained in line with the principle of least privilege. This should include the following specific tasks: • Critically review users in the Domain Admin group (minimum number but more than one) • Removing standard users from the Domain Admin group • Critically review the requirement for the amount of service accounts in the Domain Administrator Group • Enhance security over the built-in administrator account • Mark all privileged accounts as sensitive.	31/10/2020	IT Service Delivery Manager	Partially Implemented		

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	Priority 2 Finding 2.1	SHSCT should implement a procedure to ensure that internal movers are only provided access to resources in line with the principle of least privilege.	30/09/2020	IT Service Delivery Manager	Partially Implemented		
	Priority 2 Finding 3.1	SHSCT should formalise current work in deploying their Single Sign On into action plan with application and user targets against time milestones. For those applications that cannot integrate with the Single Sign On product, a corporate Password Manager solution and roll out should be put in place. Users should be appropriately educated in respect of preferred approach and in using these products.	31/03/2021	IT Service Delivery Manager	Partially Implemented		
	Priority 2 Finding 4.1	SHSCT ICT should, in conjunction with the Trust Risk Management team: • Review architecture of all risk registers operating in respect of ICT risks to ensure appropriate structure and correlations. • Identify all sources for identifying ICT risks and consider roles and responsibilities for recording risks from these sources. • Review the revised ICT risk registers structure for completeness.	30/09/2020	Head of IT	Partially Implemented		
AD - Recruitment (Non Medical Staffing) 19-20 Limited	Priority 2 Finding 1.1	SHSCT should develop and implement an action plan to improve recruitment times. The following should be considered: • Develop processes and reports to measure timeliness of all stages of the recruitment journey within the Trust. • Establish targets for each stage of recruitment journey, monitor performance against these and take appropriate actions (e.g. escalate regular breaches). • Continue to regularly capture and discuss issues with BSO RSSC (e.g. through customer forum meetings). • Provide further education to hiring managers on roles and responsibilities including focus on common delay causes.	31/12/2020	Head of Resourcing	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 1.2	Trust management should work with BSO RSSC management to develop a process for more effective management of waiting list to avoid, where possible, cases were posts have to be placed "On Hold" to enable replenishment of waiting list, recognising that posts may need to be placed 'On Hold' due to a range of issues including workforce supply constraints.	31/12/2020	Head of Resourcing	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
AE - Risk management 19-20 Satisfactory	Priority 2 Finding 1.1	The Trust's risk appetite should be clearly defined, documented in an annual risk appetite statement and communicated to all staff. The defined risk appetite should then be used throughout the Trust to assist in scoring and managing risk.	30/09/2020	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)	Partially Implemented	Work in this area is currently ongoing and Board workshops have been arranged. Previously arranged directorate meetings had to be cancelled.	31-Mar-22
	Priority 2 Finding 3.1	As previously recommended, the introduction of the Datix Risk Management module would ensure a standard pro-forma of a risk register is adopted throughout the Trust. All directorate risk registers should then be reviewed and gaps in information should be completed. Management should ensure that all relevant information is recorded in relation to risks identified and that a consistent approach is adopted using the regionally agreed scoring template / standards.	31/01/2021	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)	Partially Implemented	jenny to put in previous wording - duplicate	
	Priority 2 Finding 4.1	The requirement for Risk Management training should be clarified across the Trust and appropriate records maintained of training.	30/11/2020	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)	Partially Implemented	Work in this areas has not progressed as previously anticiapated.	31-Mar-22
AF - Whistleblowing Processes 19-20 Satisfactory	Priority 2 Finding 1.1	The Trust should review and strengthen its communication and reporting processes with third party organisations, both prescribed and investigatory to ensure that whistleblowing cases are promptly notified to the Trust and that where external investigations are performed these take place within agreed timescales.	30/09/2020	Deputy Director of HR & Corporate Financial Accountant / FLO	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 1.2	The Head of Employee Relations should implement an appropriate reporting template to ensure that all delays to the investigating process are promptly notified, and fully recorded on the WB log. This should be regularly monitored by the Head of Employee Relations. The Trust should consider introducing the role of a Whistleblowing Advocate within each Directorate to promote the WB process and support whistleblowers.	30/09/2020	Head of Employee Relations	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 2.1	A request for more investigators should be made through Directors, in particular targeting Acute and Mental Health & Disability Directorates where current uptake is minimal and training provided as necessary.	30/11/2020	Deputy Director – HR Services	Partially Implemented	The revised implementation date has not passed.	31-Jan-22

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	Priority 2 Finding 3.1	Learning from Whistleblowing cases should be appropriately shared across Directorates using an appropriate medium / forum.	30/09/2020	Deputy Director – HR Services	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
AG - Absence management 19-20 Limited	Priority 2 Finding 1.1	A robust review should be undertaken of the reporting and recording arrangements for sickness absence of medical staff. The review should include: • Clarity and standardisation of the process to ensure consistent notification of all medical staff sick absence (including when cover arrangements are organised between medics) • Reinforcing with medical staff, the professional and contractual obligation to notify sickness absence • Clarity over responsibility for recording medical staff absence on HRPTS.• Consideration and strengthening of assurance mechanisms in place within the Trust around compliance with the agreed new processes. • Strengthening the Trust's ability to monitor cancellations of outpatient clinics etc due to medical staff sick absence.	31/07/2020	Deputy Director – HR Services	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 1.2	All exceptions noted above should be investigated and the appropriate corrective action should be taken.	30/04/2020	Deputy Director HR, in conjunction with Acute Senior Management Team	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 2.1	Trust policy in relation to Occupational health Triggers and Referrals should be re-enforced with line managers.	30/04/2020	Operational Directors	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 2.2	Attendance Officers should consistently monitor compliance with referral triggers to Occupational Health Services within their Directorate on a monthly basis. It is acknowledged that this is normal HR process however exceptions were identified in completion of this work.	31/03/2020	Head of Employee Relations	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 3.1	All Directors should reinforce with their Line managers the need to ensure absence details whether input directly to HRPTS, uploaded via E-Roster or excel sick return are complete and accurate i.e. in agreement with off duties / rotas.	31/03/2020	All Directors	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 3.2	All exceptions noted above should be investigated and appropriate corrective action should be taken.	31/03/2020	Deputy Director HR, in conjunction with relevant Directors	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 3.3	All staff should ensure self and medical certifications are promptly forwarded to their designated senior manager, who should actively pursue all missing certificates.	31/03/2020	All Directors	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 4.1	Return to work procedures should be re-enforced with line managers on an ongoing basis.	31/03/2020	Operational Directors (supported by Attendance Officers)	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 5.1	As previously recommended all outstanding actions arising from the regional review of absence management should be confirmed / agreed and develop a timeline for completing these and their subsequent roll out where appropriate.	31/12/2020	Head of Employee Relations	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 5.2	As previously recommended the Trust should ensure the Absence Management Protocol and Procedure is updated as a matter of priority to reflect any changes in practice with regards to absence management. Compliance with this protocol and procedure should be re-enforced with Managers.	31/12/2020	Head of Employee Relations	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 6.1	Processes for managing contact with employees during sickness periods should be re-enforced with Managers. Where an employee is on long term sickness absence the frequency of contact should be agreed with the employee at the outset of the absence. A record should be maintained of contact to support regular contact with employees and review meetings held during their period of absence.	31/03/2020	Head of Employee Relations	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 6.2	The Trust procedure should be updated to reflect the actual timescales applied for the completion of case review meetings and these should be consistently adhered to.	31/12/2020	Head of Employee Relations	Partially Implemented	The revised implementation date has not passed.	31-Jan-22

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	Priority 2 Finding 7.1	Line Managers should be encouraged to attend Attendance at Work training. Levels of attendance should be recorded.	31/03/2020	All Directors	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 7.3	Attendance Officers should perform a monthly analysis of all multiple sickness periods within their designated directorate to identify potential cases where leave has been inappropriately re-entered as opposed to extended. The managers identified should be reminded of the need to extend the absence period on HRPTS rather than record a new episode of absence each time, where there is no break in the absence period.	30/04/2020	Head of Employee Relations	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 8.1	The requirement for a system solution to this issue should be included by the Trust when specifying the replacement system for HRPTS.	31/03/2020	Deputy Director HR	Partially Implemented	The revised implementation date has not passed.	31-Jan-22
AH - Medication Incidents 19-20 Limited/Satisfactory	Priority 1 Finding 1.1	Management should take action to ensure that all medication incidents arising in the Independent Sector are logged and managed through DATIX web where appropriate to do so.	31/08/2020	AD for Older People.	Implemented	This has been raised with the exec Director of Nursing and a presentation was given all areas of IS governance this included medication incidents. All medication incidents alerted to OPPC now go on datix.	
	Priority 2 Finding 1.2	The AD of Older People Services should work with the Contracts Department to develop a communication to IS providers outlining the information that should be provided in relation to the nature of incidents arising in the Independent sector and consider how this information should be reviewed	30/11/2020	AD OPPC	Implemented	A letter has been sent to all commissioning teams and Assistant Directors that when they become aware of incidents they should be recorded on DATIX where appropriate. A meeting was held in April to agree the parameters of incidents that needed to be included on DTIX the meeting will include Pharmacy Trust governance and OPPC.	
	Priority 2 Finding 1.3	The Chair of the Independent Sector (IS) Governance Committee should review with this committee the processes in place with regard to contract compliances and Datix reporting with a review to ensuring the transparency and completeness of medication incident reporting by the IS.	30/11/2020	AD OPPC	Partially Implemented	An 8A OPPC Goernance lead has been appointed and TOR for the committee and new governance structures are now to be agreed.	31-Mar-22
	Priority 2 Finding 2.1	Management should ensure that Datix Web is used to record learning from medication incidents. Where learning is not identified, a rationale should be included in DATIX web in line with Trust procedures.	31/01/2021	Interim Assistant Director of Clinical & Social Care Governance (ADCSCG) / Operational Directors	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 2.2	Management should take action to ensure that Datix Web is being fully accurately and consistently completed with information recorded in the correct fields.	31/01/2021	Operational Directors	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 2.3	Timeframes for the completion of investigation should be established. Performance against these timeframes should be formally monitored.	31/01/2021	Interim Assistant Director of Clinical & Social Care Governance (ADCSCG)	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 3.1	Timeframes for the completion of investigation should be established. Performance against these timeframes should be formally monitored.	31/01/2021	Operational Directors	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 4.1	The Trust should consider making incident management training mandatory for relevant staff. Corporate visibility of Incident Management Training should be monitored; this should include oversight not only of the total number of staff that have received this training but also the total number of breakdown of staff that have not yet received this training.	31/01/2021	Interim Assistant Director of Clinical & Social Care Governance (ADCSCG)	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 5.1	Medical Director should obtain assurance that Doctors at all grades are aware of the incident management process, including in the use of DATIX web. Where possible, medical staff should be involved in the investigation and management of prescribing medication incidents involving medical staff.	31/01/2021	Interim Assistant Director of Clinical & Social Care Governance (ADCSCG)	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 5.2	Management should take action to ensure that all staff are reporting all medication incidents as required.	31/01/2021	Interim Assistant Director of Clinical & Social Care Governance (ADCSCG)	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 5.3	Management should take action to ensure that medication incidents are reported as soon as possible and ideally within 24 hours of occurrence or from the point of awareness. Approvals should be completed within 14 day target. Performance in this area should be formally monitored with action taken to address outliers and trends.	31/01/2021	Interim Assistant Director of Clinical & Social Care Governance (ADCSCG)	Partially Implemented	caroline to confirm and send evidence.	

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	Priority 2 Finding 6.1	Contact with service users regarding medication incidents should be recorded in Datix Web going forward, where applicable in accordance with relevant procedure.	31/01/2021	Interim Assistant Director of Clinical & Social Care Governance (ADCSCG) / Operational Directors	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 7.1	Management should develop a regional procedure to ensure that all stages of the medication incident process, including recording, approval, investigating, use of Datix Web and learning is taking forward consistently across all 5 HSC Trusts.	31/03/2021	All Governance Teams	Partially Implemented		
	Priority 2 Finding 7.2	The Trust should consider the analysis above to help inform and drive improvement in respect of the management of medication incidents when compared to the regional position.	31/03/2021	All Governance Teams / Operational Directors	Partially Implemented	caroline to confirm and send evidence.	
	Priority 2 Finding 9.1	Management should regionally consider the good practice identified above with the aim of reducing medication going forward across HSC. Management should implement the NHS Medication Safety Thermometer across the Trust.	31/03/2021	All Governance Teams / Operational Directors	Partially Implemented	caroline to confirm and send evidence.	
AI - [redacted] 19-20 Unacceptable	Priority 1 Finding 1.1	The Trust should review the findings of this report and engage with the facility to ensure action is taken to address the detailed findings included within this report. The Trust should agree an action plan, that addresses the issues raised and how these will be taken forward, including timescales for implementation of recommendations, MPS Head Office should be requested to complete a full reconciliation of the residents' bank accounts to the Sage individual ledger accounts held to ensure that all balances are fully accounted for and correctly up to date. This should be provided to the Trust and the resident's balances should be re audited.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Partially Implemented	Finance wrote again to home owner and spoke with him on 14 November 2020 specifying the information required. He sent partial information so fince wrote back on 9 and 19 December 2020 but he did not provide any further information. It is not possible to reconcile the Residents' accounts as the full listing of residents' balances was not provided. The outstanding information required was further detailed in the Trust's termination of contract letter dated 12 March 2021 viewed by audit. The Trust has also been liaising with the appointed administrator PKF. In light of the closure of the home, it will not be possible to re-audit the resident's monies balances.	
	Priority 2 Finding 2.1	The Trust should request that MPS investigate the suspense ledger figure of £23,007.84 and ensure that all unallocated expenditure is appropriately apportioned to the correct residents ledger account. MPS should ensure all adjustments or corrections in the suspense accounts are supported by appropriate documentation / explanations.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Partially Implemented	This information was not provided per above.	31-Mar-22
	Priority 2 Finding 2.2	The Trust should request that MPS ascertain next of kin or other appropriate persons of former / deceased residents and ensure all balances held in the suspense account are appropriately discharged.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Partially Implemented	This information was not provided per above. In contact with PKF the appointed administrator for MPS Ltd, finance, spoke with the former administrator in the Valley. She advised the balance on the death/discharge listing was approx. £28k and agreed to forward this to SHSCT. This has not yet been received at SHSCT.	31-Mar-22
	Priority 2 Finding 3.1	The Trust should request that MPS ensures all negative balances are brought into credit.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Partially Implemented	This information was not provided per above. When Residents transferred to other Homes, the administrator forwarded their personal monies balance to SHSCT. It has not been possible to verify that these balances are correct as there has not been a final terminal reconciliation provided by MPS. There has been no request to SHSCT for monies to clear the negative balances.	31-Mar-22
	Priority 2 Finding 3.2	The Trust should remind MPS that they should notify the Trust where they are the residents' appointee, of any balances they hold in excess of £500 and arrange for excess sums to be returned to the Trust and to the residents' PPP account.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	No longer applicable as the Valley has closed and Residents' monies have been forwarded with the client.	
	Priority 2 Finding 4.1	The Trust should remind MPS that transactions from clients' monies should be recorded on the cash ledger as they occur. All transactions should be clearly recorded in black ink to prevent changes being made retrospectively.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	This was advised as part of the Performance Notice. No longer applicable as the Valley has closed.	
	Priority 2 Finding 4.2	The Trust should remind MPS to ensure adequate cash is held at the Home to fund residents' expenditure. Borrowing from other sources, such as the Home's petty cash or business account should not occur as per Nursing Home Standards.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	This was advised as part of the Performance NoticeNo longer applicable as the Valley has closed.	
	Priority 2 Finding 4.3	The Trust should remind MPS that the residents' cash balance should be reconciled daily by the Administrator and signed as correct on the cash ledger, and countersigned as correct weekly by the Home Manager.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	This was advised as part of the Performance NoticeNo longer applicable as the Valley has closed.	
	Priority 2 Finding 4.4	Receipts should be retained to support all client expenditure. The Trust should request that the 2 cases referred to should be fully investigated by Home Management.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	This was advised as part of the Performance NoticeNo longer applicable as the Valley has closed.	
	Priority 2 Finding 5.1	MPS and the Trust should ensure that all residents accounts are appropriately reconciled and brought up to date with any potential deficits being made good.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Partially Implemented	This information was not provided per above.	31-Mar-22

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
	Priority 2 Finding 5.2	The Trust should engage with Healthcare Ireland and MPS to ensure improvement in control is embedded across aspects of managing residents' monies as outlined in the recommendations in this report. In particular we would highlight need for:• Regular reconciliation of residents' bank accounts and cash balances to supporting ledger records; • Action to clear deceased / discharged residents' monies is promptly taken:• Patient suspense accounts should not be opened or used; • Excessive cash and ledger balances should not be held on behalf of residents' – surplus monies should either be returned to the placing Trust (PPP Accounts) or to next of kin where they are appointee; • Receipts for all expenditure to be retained and signed by purchasing staff; • Residents' property records should be regularly updated and checked.	31/07/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	This was advised as part of the Performance NoticeNo longer applicable as the Valley has closed.	
	Priority 2 Finding 6.1	The Trust should request that MPS update all residents' property records urgently to ensure that they have a complete and comprehensive record going forward.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	This was advised as part of the Performance NoticeNo longer applicable as the Valley has closed.	
	Priority 2 Finding 7.1	The Trust should advise MPS of the need for written procedures for the Management of Residents' Comfort Fund and all relevant staff should be trained in this procedure.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Implemented	This was advised as part of the Performance NoticeNo longer applicable as the Valley has closed.	
	Priority 2 Finding 7.2	The Trust should request that a full reconciliation of the cash and bank balance of the Residents' Comfort Fund should be prepared and appropriately reviewed on a monthly basis by the Manager.	30/06/2020	Assistant Director for Older People's Services and Assistant Director for Disability Services	Partially Implemented	Finance, wrote again to Home owner and spoke with him on 14 November 2020 specifying the information required. He sent partial information Finance wrote back on 9 and 19 December 2020 but he did not provide any further information. It is not possible to reconcile the Residents' accounts as the full listing of residents' balances was not provided.	31-Mar-22
AJ - Waitling List - Pre op and Consent 19-20 Limited/Satisfactory	Priority 2 Finding 1.1	As previously reported in the 2018/19 Theatre Utilisation report, the surgical rotas should be prepared and made available on a timely basis, (4 weeks) to allow for efficient scheduling and booking of patients onto theatre lists and appropriate time for pre-operative assessments to be completed.	30/04/2021	Head of Service for ATICs and Surgical specialities	Imp Date Not Passed	The outstanding information required was further detailed in the Trust's termination of contract letter dated 12 March 2021 (attached).	
	Priority 2 Finding 1.2	As previously reported in the 2018/19 Theatre Utilisation report, as per procedure, to allow timely completion of pre-operative assessments, patients listed in theatre sessions should be notified to Pre-Operative Assessment Team 4 weeks in advance of surgery date.	30/04/2021	Head of Service for ATICs and Surgical specialities	Imp Date Not Passed		
	Priority 2 Finding 1.3	Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.	30/04/2021	Booking centre manager	Imp Date Not Passed		
	Priority 2 Finding 1.4	Management should review and strengthen processes where ward admissions via ED, are subsequently re-booked for urgent surgery e.g. Urology Stent removals within 4-8 weeks, so they are promptly notified to the Pre-operative Assessment Team on discharge.	30/04/2021	Booking centre manager	Imp Date Not Passed		
	Priority 2 Finding 1.5	Management should review and remind Surgical specialities in relation to limited use of pre-operative assessments given the high volume of exceptions found.	30/04/2021	Head of Service for ATICs and Surgical specialities	Imp Date Not Passed		
	Priority 2 Finding 2.1	Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including General Surgery, Gastro, ENT and Urology.	30/04/2021	Lead Nurse and Pre-op Band 7 Sister	Imp Date Not Passed		
	Priority 2 Finding 3.1	Management should review and update its Policy on Gaining Consent to ensure all the latest legal and ethical standards have been incorporated into the policy.	30/04/2021	Associate Medical Director	Imp Date Not Passed		
	Priority 2 Finding 3.2	All medical staff should be reminded of the importance of fully completing patient consent forms in order to fully comply with Trust procedures and minimise risk of future queries / concerns from patients.	30/04/2021	Associate Medical Director	Imp Date Not Passed		
	Priority 2 Finding 4.1	Management should produce comprehensive policy and procedures for pre-operative assessment processes and its interfaces with specialties and scheduling teams etc.	30/06/2021	Clinical Lead for Pre-Op, Head of Services, Lead Nurse for Pre-op & Pre-op Sister	Imp Date Not Passed		

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
	Priority 2 Finding 4.2	Management should further document and strengthen its POA database procedures for managing and recording of pre-operative assessments to ensure quality and consistency of records.	30/04/2023	Clinical Lead for Pre-op and ATICS Head of Service	Imp Date Not Passed		
	Priority 2 Finding 4.3	In the longer term Management should assess the need to develop a more comprehensive solution to managing and recording pre-operative assessments, integrated with PAS / NIECR etc.	30/04/2023	Clinical Lead for Pre-op and ATICS Head of Service	Imp Date Not Passed		
AK - Management of Patient Journey - Referrals 19-20 Satisfactory	Priority 2 Finding 2.1	Management of Acute Services should work with the Head of Acute Information to establish if a report can be developed which would enable management to track and monitor who booked the referral onto PAS to ensure that the IEAP protocol is followed for all referrals.	31/12/2020	Assistant Director Acute Services – Functional Support Services	Partially Implemented	stephen wallace to provide commentary/evidence	
	Priority 2 Finding 4.1	As per IEAP guidance, all outpatient referrals should be allocated to appointment slots in chronological order. An appropriate system should be introduced to allow this to be regularly monitored by the Trust and significant outliers / exceptions investigated.	31/12/2020	Heads of Service and Operational Support Leads	Partially Implemented		
AL - Management of Private & Paying Patients 19-20 Limited	Priority 2 Finding 1.1	As per IEAP guidance, all outpatient referrals should be allocated to appointment slots in chronological order. An appropriate system should be introduced to allow this to be regularly monitored by the Trust and significant outliers / exceptions investigated. There should be a mandatory requirement to indicate changes of status on PAS. A report from PAS should then be regularly reviewed and reconciled to Change of Status forms received.	31/05/2021	Assistant Director – Workforce and Education/Assistant Director – Functional Support Services	Partially Implemented	#REF!	
	Priority 2 Finding 1.2	To further enhance control, there is a case for reviewing the practice of 'consultant to self' referrals, from the private sector and introducing additional controls where a consultant does refer to self.	31/05/2021	Private Patient Office	Imp Date Not Passed		
	Priority 2 Finding 1.3	Service Directorates and in particular specific services such as Radiology, should strengthen their scrutiny and challenge of service requests that could potentially originate from the private sector. Service areas should be particularly alert where services/treatments are only available on the HSC.	31/05/2021	Assistant Director – Cancer and Clinical Services, Assistant Director – Workforce and Education	Imp Date Not Passed		
	Priority 2 Finding 1.4	The Trust should ensure the Integrated Elective Access Protocol (IEAP) is adhered to for all appointments. The Trust should review and monitor non adherence to the IEAP and central booking process, with a view to providing training where required and enforcing the central role of the Appointments/Booking Office. Where Consultants ask for fixed appointments to be made for patients out of chronological order, this should be captured and monitored. The Trust should consider whether this is due to clinical need, consultant preference/practice, or potentially inequitable practice.	31/05/2021	Assistant Director – Workforce & Education/Assistant Director – Functional Support Services	Imp Date Not Passed		
	Priority 2 Finding 2.1	The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form ie "NB: until this form is approved by the Medical Director the patient will remain private and may be liable for charges".	31/05/2021	Deputy Medical Director	Imp Date Not Passed		
	Priority 2 Finding 2.2	The Medical Director should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the Medical Director.	31/05/2021	Deputy Medical Director	Imp Date Not Passed		
	Priority 2 Finding 3.1	The Trust should review and update all consultant job plans in line with the annual job planning process. This should include all details of private practice carried out. As part of this job planning process the Trust should consider' total working hours across HSC and private practice.	31/05/2021	Deputy Medical Director/Assistant Director – Workforce and Education	Imp Date Not Passed		

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	Priority 2 Finding 3.2	As per the Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003), the Trust must ensure that: • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. Job plans should be signed and dated by the consultant and their Clinical Director.	31/05/2021	Medical Director/Deputy Medical Director/All AMDs	Imp Date Not Passed		
	Priority 2 Finding 3.3	Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.	31/05/2021	Medical Director/Deputy Medical Director/All AMDs	Imp Date Not Passed		
	Priority 2 Finding 4.1	All consultants should be instructed to fulfil their responsibility and submit their returns promptly and to accurately declare all paying work on a timely basis, to ensure the Trust does not suffer a loss in income.	31/05/2021	Deputy Medical Director/Assistant Director – Workforce and Education	Imp Date Not Passed		
	Priority 2 Finding 5.1	The Trust should continue to ensure that all staff in the community setting are fully aware of their responsibility to identify new referrals to the paying patient officer where there is a query arising in respect of the "ordinarily resident" status of the patient to enable appropriate review before services are put in place which the Trust could ultimately become liable for and should also avail of training and support provided by the Finance Directorate.	31/01/2021	Head of Financial Services	Not Implemented	Training has not been completed due to COVID .	31-Mar-22
	Priority 2 Finding 5.2	The Trust should strengthen control over systems to capture potentially chargeable income in respect of patients not ordinarily resident in the UK. This includes exploring access for Finance staff to PARIS.	28/02/2021	Head of Financial Services	Implemented	The Ivani request for access to Paris has now been activated and Finance now have access to PARIS.	
	Priority 2 Finding 6.1	The procedures in relation to private medical practice should be agreed, finalised and issued to all staff as a matter of priority.	28/02/2021	Assistant Director – Workforce and Education	Partially Implemented		
AM - GMGR 20-21 Satisfactory	Priority 2 Finding 1.1	Management should attempt to locate the required missing minutes, agendas and papers for the relevant legacy Trusts. In the event that they cannot be located, the Trust should update their assurance to the Department of Health.	30/06/2021	Board Assurance Manager	Implemented	This recommendation has been implemented as far is is possible all records in both stores have been fully catalogued and the Trust have exhausted all avenues however have still been unable to locate legacy minutes etc. have	
AN - Non Pay Expenditure 20-21 Satisfactory	Priority 2 Finding 2.3	The Trust should ensure that any new members of staff undertaking the role of FPM approver are provided with adequate training, particularly with respect to their responsibility to check against contract rates.	30/06/2021	Senior Financial Manager – Systems Team	Implemented	FPM invoice approver emails have been disseminated twice.	
AO - Risk Management 20-21 Satisfactory	Priority 2 Finding 1.1	As previously reported in the Risk Management report 2019/20, the Trust's risk appetite should be clearly defined, documented in an annual risk appetite statement and communicated to all staff. The defined risk appetite should then be used throughout the Trust to assist in scoring and managing risk.	30/09/2021	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)	Partially Implemented		
	Priority 2 Finding 3.1	As previously recommended, the introduction of the Datix Risk Management module would ensure a standard pro-forma of a risk register is adopted throughout the Trust. All directorate risk registers should then be reviewed and gaps in information should be completed. Management should ensure that all relevant information is recorded in relation to risks identified and that a consistent approach is adopted using the regionally agreed scoring template / standards	30/09/2021	Assistant Director of Clinical and Social Care Governance	Imp Date Not Passed	duplicate	
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021	All Directors and Chief Executive	Imp Date Not Passed	not completed	

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	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split	Not yet implemented in Finance.	31-Dec-21
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 3.2	All risks recorded on Directorate Risk Registers should be subject to timely review and update. Risk Register actions should be forward looking, include a timeframe for implementation and a responsible officer for implementation recorded against each action. In addition a risk owner should be identified for each individual risk	30/06/2021		Split		
	Priority 2 Finding 4.1	On appointment of the 2 posts a scoping exercise should be conducted to establish what risk management training is required by staff at different bands and with varying degrees of responsibility for Risk Management.	30/08/2021	Assistant Director Clinical & Social Care Governance (ADCSCG) / Interim (ADCSCG)	Not Implemented	this has not progressed.	31-Mar-22
AP - Revenue Business cases 20-21 N/A	Not Prioritised Finding 2.1	Trusts should work together to document a consistent policy around how they comply with the requirement to have a brief justification in place when a business case template does not need to be completed, for normal recurrent or maintaining existing services expenditure. This should define the evidence required that options have been considered and expenditure can be justified as representing value for money.	30/09/2021	Assistant Director of Finance - Financial Management and Assistant Director of Planning	Partially Implemented	Time to close out this action requires extension to end of October as due to current service pressures we have been unable to have a detailed discussion with AD finance and Planning Colleagues in others Trusts.	31-Oct-21

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
	Not Prioritised Finding 3.1	All Revenue Business Case central database fields should be fully and accurately completed to enable appropriate monitoring, tracking and follow-up particularly in relation to PPEs.	30/09/2021	Assistant Director of Finance - Financial Management and Assistant Director of Planning	Implemented	The amended Trust Business case database now includes all information we have added a few additional fields to help monitor and track. The team has been instructed to ensure all fields are populated and this is being checked now on a monthly basis and before we submit our database for test drilling purposes to the DOH.	
	Not Prioritised Finding 7.1.2	Monitoring should include reporting of lessons learnt and how these are shared across organisations, and performance reporting on the completion of PPE's	30/09/2021	Assistant Director of Finance - Financial Management and Assistant Director of Planning	Implemented	The Trust table and share all completed PPEs at the Strategic Investment Committee, which has members from all Directorates. The performance data is contained within the completed PPES for all to review and were it hasn't been achieved it is flagged up. PPEs are shared with the DOH and are selected for test drill . Completed PPES demonstrates the lessons learnt from individual investments. We also share the comments received back from the DOH on Test drill in relation to PPES so that we can improve processes.	
	Not Prioritised Finding 7.2	On completion and submission to the commissioner the date should be recorded on the central register to improve monitoring arrangements	30/09/2021	Assistant Director of Finance - Financial Management and Assistant Director of Planning	Implemented	The amended Trust Business case database now includes all information we have added a few additional fields to help monitor and track. The team has been instructed to ensure all fields are populated and this is being checked now on a monthly basis and before we submit our database for test drilling purposes to the DOH.	
AQ - Payments to Staff 20-21 Limited	Priority 2 Finding 1.1	The Trust should continue to review and develop the financial governance controls surrounding the completion, approval and sending of timesheets to PSC. This should also include increasing roll out of the new ETM02 timesheet across all of its wards and teams with accompanying guidance and training. Furthermore the Trust should target managers in departments / services which routinely submit high volumes of additional payments/ allowances to provide enhanced training / education on applicable terms and conditions of service and how to accurately record using new ETMO2 documentation / reduce common errors.	30/09/2021		Implemented	The Trust continues to review and develop the financial governance controls surrounding the completion, approval and sending of timesheets to PSC. This now includes the complete roll out of the new ETM02 timesheet across all wards and teams with accompanying guidance and training. The Trust has target managers in departments / services which routinely submit high volumes of additional payments/ allowances to provide enhanced training / education on applicable terms and conditions of service and how to accurately record using new ETMO2 documentation / reduce common errors.	
	Priority 2 Finding 1.2	Trust Management should in conjunction with PSC monitor and review managers routinely submitting high volumes of manual timesheets to PSC with a view to reducing the volume of occurrences outside normal payroll processing and control processes. This also should be applied to managers routinely sending late submissions to PSC for processing / off-cycles.	30/09/2021		Partially Implemented	Late timesheets – identified 161 managers who submitted late timesheets this year, currently drafting a message to go out to these managers to remind them of deadlines. Spreadsheet set up to record these on a monthly basis so we can identify repeat offenders.	31-Jan-22
	Priority 2 Finding 1.3	Management should review the above exceptions and make recovery where appropriate to do so.	30/06/2021		Implemented	Management have reviewed all of the exceptions noted by audit and recovery has been sought were appropriate.	
	Priority 2 Finding 2.1	As previously reported all managers should be reminded of the importance of timely and thoroughly checking of their staff in post reports upon receipt from Financial Management, and to respond as to its accuracy or otherwise.	31/03/2021		Imp Date Not Passed	Due to work pressures around Covid the Trust have not been able to make progress against this recommendation however advised that all relevant stakeholders who are involved in the production and distribution of the Staff Listing reports are meeting on 28th Sept at 9.30am to review the current process, seek areas of improvement if doable and contact the HR link in NHSCT to explore the recent solution implemented there to see if this would offer a workable solution for SHSCT	31-Mar-22
	Priority 2 Finding 2.2	As previously reported Financial Management should liaise with Workforce Information to identify how the Staff listing report can be generated and subsequently issued more promptly following month end to all directorates.	30/06/2021		Partially Implemented	Due to work pressures around Covid the Trust have not been able to make progress against this recommendation however advised that all relevant stakeholders who are involved in the production and distribution of the Staff Listing reports are meeting on 28th Sept at 9.30am to review the current process, seek areas of improvement if doable and contact the HR link in NHSCT to explore the recent solution implemented there to see if this would offer a workable solution for SHSCT	31-Mar-22
	Priority 2 Finding 2.3	In the cases of identified overpayments spanning 2 or more Staff Listings periods HR and Financial Management should confirm whether managers have signed off SIP reports during the period/s of overpayment, and where they have, subsequently escalate such information to senior directorate management for their awareness and appropriate action.	30/09/2020		Partially Implemented	Work is ongoing however due to current pressures this work has not progressed as quickly as had been hoped.	31-Oct-21
	Priority 2 Finding 3.1	HR Management should ensure that the new checking controls are fully embedded, and performed on a timely basis following receipt of the Unauthorised Senders Report so that the authorised sender framework is properly maintained and controls in respect of additions and deletions are in place.	30/09/2020		Implemented	HR Management have implemented checking controls these checks are now performed on a timely basis following receipt of the Unauthorised Senders Report in order that authorised sender framework is properly maintained and controls in respect of additions and deletions are in place.	
AR - Budgetary Control 20-21 Satisfactory	Priority 2 Finding 1.1	The Trust should continue to work with HSCB and DoH to improve longer term financial stability.	31/03/2022		Imp Date Not Passed	Implementation date not passed.	
	Priority 2 Finding 2.1	Management should resume accountability meetings for the 2021/22 year and ensure that actions identified within Directorates to reduce Budget Deficits and achieve savings targets are implemented.	31/03/2022		Imp Date Not Passed	Implementation date not passed.	

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
	Priority 2 Finding 3.1	The Trust SMT should prioritise actions necessary to implement recommendations arising from the 'Return to Balance' report to ensure long term achievement of budget targets in the Acute Services Directorate, to secure additional funding and to realign allocations according to need.	31/03/2022		Imp Date Not Passed	Implementation date not passed.	
	Priority 2 Finding 4.1	A series of CP refresher courses should be planned.	31/03/2022		Imp Date Not Passed	Implementation date not passed.	
AS - Self Directed Support (SDS) Payments 20-21 Limited	Priority 2 Finding 1.1	The Trust should monitor performance in terms of annual review of SDS packages. All SDS packages should be subject to an annual review.	28/02/2022		Implemented	The Trust have a model office in place and the 89a report is available to capture all outstanding direct payment Annual Reviews the Trust are working to ensure that all outstanding annual reviews are completed as quickly as possible. A SOP has been developed and a staff escalation flowchart is in place these will be implemented via an SDS implementation group which is pending.	
	Priority 2 Finding 2.1	Management should review and strengthen escalation processes where keyworkers fail to resolve issues on a timely basis regarding client failure to submit required financial monitoring information or resolution of queries arising from monitoring.	30/09/2021		Partially Implemented	A SOP for staff escalation will detail this process and is currently being developed. Alongside existing financial arrangements.	31-Oct-21
	Priority 2 Finding 2.2	DPMT should ensure they hold a current commissioning form for all active clients in receipt of payments on the electronic client file. Missing forms should be followed up with respective keyworkers.	30/06/2021		Partially Implemented	Work has progressed with 68% of commissioning forms on file and 72% of insurance certificates on file. The exercise is dependent on third parties to complete, however the target would be in region of 85-90% at least.	30-Nov-21
	Priority 2 Finding 2.3	Management should ensure up to date signed Contract / Payment Agreements are available for all SDS clients.	28/02/2022		Partially Implemented	This is included within our Case Management SOP within ICTs and all will be implemented within the practitioners forum work is ongoing.	31-Dec-21
	Priority 2 Finding 2.4	Keyworkers should ensure all changes to direct payment packages are promptly notified to the DPMT, so that clients are in receipt of correct payment and reduce risk of over or under payments.	28/02/2022		Implemented	There is a monthly report from DP team and a new business manager is in post, the report goes to team leads for validation and is then sent back to the HOS for ICT.	
	Priority 2 Finding 3.1	Management should continue to liaise with the PARIS Implementation Team to develop ways to improve the completeness of the data collection for reporting purposes.	28/02/2022		Partially Implemented	This will be facilitated via the SDS Implementation group who are meeting regularly with the PARIS team.	31-Dec-21
AT - Management of Community & Voluntary Contracts During COVID 19 Satisfactory	Priority 2 Finding 1.1	Actions agreed by the Trust to progress validation and sample checking of activity reported by Voluntary/Community organisations, planned to commence in 2021/2022, should be implemented to reduce reliance on the contractors for accurate activity data.	31/03/2022		Imp Date Not Passed	The implementation date has not passed.	31-Mar-22
	Priority 2 Finding 2.1	Contract owners should seek Providers to feedback a service user perspective on alternative service delivery arrangements adopted due to COVID-19 through their engagement with Provider organisations.	30/06/2021		Imp Date Not Passed		
	Priority 2 Finding 2.1	Contract owners should seek Providers to feedback a service user perspective on alternative service delivery arrangements adopted due to COVID-19 through their engagement with Provider organisations.	30/06/2021		Partially Implemented	A number of contracts are currently being consulted with service users to gather their views on how the service is currently being delivered. Dependant on the contract, feedback is collected through a variety of mediums. (For example, service user's satisfaction surveys have been utilised and changes to some services have been made in response to needs arising from COVID pandemic). Additionally, the reporting of case studies and quotes are included in some feedback. Our in-year contract monitoring returns and/or contract review meetings are picking up on the views of service users and that these are being communicated to us by the relevant providers.	31-Mar-22
	Priority 2 Finding 2.1	Contract owners should seek Providers to feedback a service user perspective on alternative service delivery arrangements adopted due to COVID-19 through their engagement with Provider organisations.	30/06/2021		Partially Implemented	MHLD are in discussions with the Contracts department with a view to having this included in the monthly and quarterly reports received from the providers as part of the contract review process this would allow contract owners to review and escalte issues where necessary.	31-Mar-22
AU - ICT Procurement & Contract Management Satisfactory	Priority 2 Finding 1.1	The Trust should develop the ICT Procurement section of the Trust Procurement Strategy to include the following:• A reference and link to the eHealth and Care Strategy for NI. • The connection and prioritisation between Trust and regional ICT procurement. • Procurement route to market selection criteria. • When to use ICT PaLs and the TFA.	30/11/2021		Imp Date Not Passed		
	Priority 2 Finding 1.2	The Trust should ensure that there is appropriate Standard Operating Procedures (SOP) documented in relation to ICT procurement and contract management.	31/10/2021		Imp Date Not Passed		

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	Priority 2 Finding 2.1	SHSCT ICT should ensure that Trust procurement requirements are followed. This should include: • Adherence to procurement thresholds. • Use an appropriate procurement route to market for existing services that are being extended. • Business cases should be completed where applicable.	30/06/2021		Imp Date Not Passed		
	Priority 2 Finding 3.1	Any SHSCT ICT staff with contract management responsibilities should undertake appropriate training.	31/10/2021		Imp Date Not Passed		
	Priority 2 Finding 3.2	SHSCT ICT should ensure that there are appropriate Policies, Standards, Guidelines and Procedures (PSGP) in respect of the full life cycle of ICT equipment. This should include receipt, stock management, deployment and disposal ensuring adequate audit trail over individual assets.	31/10/2021		Imp Date Not Passed		
	Priority 2 Finding 3.3	SHSCT should ensure that all contract supporting documentation is appropriately maintained. This should include: • Terms & Conditions.• Agreed contract sum (original contract value) & • Approval for additional contract funds.• Minimum contract review meeting dates (planned vs actual) & meeting notes.• Dates of actual expenditure and by whom.	31/01/2022		Imp Date Not Passed		
	Priority 2 Finding 3.4	SHSCT should take urgent measures to adequately mitigate the risk of having large numbers of devices with unsupported Windows 7 operating system on the HSCNI in January 2021 and beyond.	31/03/2022		Imp Date Not Passed		
	Priority 2 Finding 3.5	The central register of all ICT contracts should be further developed to include more relevant referencing and appropriate detail such as contract value, capital allocation and expenditure profile.	31/01/2022		Imp Date Not Passed		
	Priority 2 Finding 3.6	For all ICT contracts there should as a minimum be an annual contract review meeting to ensure that all contractual obligations are met. All meetings should be documented using the contract monitoring meeting form. In addition to implementing a contract review process for all appropriate contracts, consideration of the following needs to be incorporated into contract management processes, which was not noted on any of the contract review templates provided to Internal Audit. - Regular reviews occur by Finance and / or ICT on the actual expenditure incurred on the contracts versus the original contract sum. There is appropriate approval where additional capital funding is required for any project (Contract variations).	31/03/2022		Imp Date Not Passed		
AV - Management of medical Locums 20-21 Limited	Priority 1 Finding 1.1	Management should escalate development of the E-locum System regionally to ensure longer term block bookings can be captured via the system to facilitate an appropriate audit trail that contracted agencies were contacted in first instance, similarly to ad-hoc bookings.	31/03/2022		Imp Date Not Passed	The revised implementation date has not passed.	31-Jan-22
	Priority 2 Finding 1.2	Management should strengthen service directorate accountability over long term locum bookings and extensions, through a regular review process with HR utilising targeted Medical Locum Reports (quarterly), to timely consider alternative options for covering such long term vacancies.	31/10/2021		Implemented	Internal Audit viewed the workforce metrics that were discussed at the 15 June 2021 with regards to Locum data and infographics. This was discussed with Director of Acute Services, Head of Service, Clinical Leads (AMD's / CD's). Further oversight groups will be arranged regularly to discuss all areas with a focus on those areas who use the most locum bank and agency.	
	Priority 2 Finding 1.3	Direct Award Contract documentation should be put in place, where appropriate and in line with PALS advice, for off-contract Locum spend.	31/06/21		Implemented	All DACs for the Medical Locum Team are now signed off	
	Priority 2 Finding 2.1	Management should work with other Trusts and DoH to progress the proposal agreed by the HR Medical Network for standard regional locum rates, and to develop an agreed approach in order to reduce expenditure or increase its ability to control expenditure, when using locums. The recommendations identified in the Trust's Return to Balance action plan to reduce reliance on locum cover should be taken forward.	31/12/2021		Imp Date Not Passed	Implementation date not passed.	31-Dec-21

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	Priority 2 Finding 3.1	The recommendations identified in the Trust's Return to Balance action plan to reduce reliance on locum cover should be taken forward. The Trust should continue its focus on senior and middle grade medical recruitment to ensure that where possible all necessary actions are taken to avoid use of recruitment agencies. In addition they should review the skill mixes and different ways of working in areas of high agency spend.	31/12/2021		Imp Date Not Passed	Implementation date not passed.	31-Dec-21
	Priority 2 Finding 3.1	The recommendations identified in the Trust's Return to Balance action plan to reduce reliance on locum cover should be taken forward. The Trust should continue its focus on senior and middle grade medical recruitment to ensure that where possible all necessary actions are taken to avoid use of recruitment agencies. In addition they should review the skill mixes and different ways of working in areas of high agency spend.	31/12/2021		Split		
	Priority 2 Finding 3.1	The recommendations identified in the Trust's Return to Balance action plan to reduce reliance on locum cover should be taken forward. The Trust should continue its focus on senior and middle grade medical recruitment to ensure that where possible all necessary actions are taken to avoid use of recruitment agencies. In addition they should review the skill mixes and different ways of working in areas of high agency spend.	31/12/2021		Split	The Trust are continually working towards this however due to the current situation this is very difficult.	31-Mar-21
	Priority 2 Finding 4.1	Management should consider system development work so that the online HSC E locum system records pre-employment checks at outset of booking/registration, which can then be checked on a periodic basis (but not after every shift) so there is assurance for locums who work ad hoc shifts.	31/12/2021		Imp Date Not Passed	Implementation date not passed.	31-Dec-21
	Priority 2 Finding 5.1	Management should escalate development of the E-locum System regionally to include confirmation through locum self-declaration that doctors working on a short-term basis through non-contracted locum agencies, HSC e-locums or doctors employed in the Trust completing additional hours are not in breach of the Working Time Directive when they take on additional shifts.	31/12/2021		Imp Date Not Passed	Implementation date not passed.	31-Dec-21
AW - Adult safeguarding 20-21 Limited	Priority 2 Finding 1.1	The Blueprint implementation project board should resume meeting as soon as possible to review and update its Adult Safeguarding Blueprint 2017 – 2022 and take forward specific recommendations from the Independent Review. Additionally the blueprint should be updated to reflect changes as these are developed regionally through the Interim Adult Protection Board for Northern Ireland (APBNI).	30/05/2021		Partially Implemented	A Director's Oversight Group has been established to drive the improvements identified by the Internal Audit. The Oversight group has now agreed the governance structure for oversight of adult safeguarding within the Trust and has priortised the internal audit recommendations. It has been agreed that the Adult Safeguarding Blueprint Group will be reconvened as an operational group with renewed membership. The Blueprint group will be accoutable for the delivery of the Balanced Scorecards for their respective Directorates. Directorate Adult Safeguarding leads have been agreed with interim plans in Acute and OPPC to support the work and the leads will report on behalf of the DIrectorate to the Blueprint group. The first meeting of the Blueprint group is scheduled for 13th October with extended membership reflecting operational assistant directors and professional leads to embody the responsibility that safeguarding is everyone's business.	31-Oct-21
	Priority 2 Finding 1.2	The Director of OPPC should nominate the most appropriate person within the Directorate to act as the responsible person for Adult Safeguarding.	30/05/2021		Partially Implemented	An Interim HoS has been appointed to have responsibility for leading on adult safeguarding within the Directorate. A Direcotrate lead social worker is to be recruited as a new post and they will assume this role going forward. The Interim HoS has engaged with the Directorate Adult Safeguarding Leads Meetings above and has met with professional leads across OPPC to begin to establish a cascade mechanism of communication on adult safeguarding across the Directorate.	30-Nov-21
	Priority 2 Finding 1.3	The Director of Acute Services should nominate the most appropriate person within the Directorate to act as the responsible person for Adult Safeguarding.	30/05/2021		Partially Implemented	An Interim HoS has been appointed to have responsibility for leading on adult safeguarding within the Directorate. The Acute Director is considering future arrangements and support to engage the MDT across Acute.	31-Dec-21
	Priority 2 Finding 1.4	The Medical Director should nominate an appropriate medical representative to partner with the LASP to promote and represent both medical staff and the wider Acute directorate in the Adult Safeguarding processes.	30/05/2021		Implemented	The Medical Directorate has nominated and agrred an appropriate medical representative to partner with the LASP to promote and represent both medical staff and the wider Acute directorate in the Adult Safeguarding processes.	
	Priority 2 Finding 1.5	The Chair of LASP should address low attendance by SHSCT LASP Partners	30/06/2021		Implemented	Members have been written to to confirm commitment and representation to partnership. A number of staff have retired or moved on and this has provided opportunity to review Trust representation. In addition deputy nominations have been made to ensure a presence at future meetings for the service area.	
	Priority 2 Finding 2.1	The Trust should review all relevant policies and guidance to ensure that there is clarity as to how safeguarding concerns/incidents are recorded and reinforce this clarification with staff.	30/09/2021		Partially Implemented	The Trust has had meetings with HSCB, SET and ST re DATIX and Adult Safeguarding Interface. An agreed outcome for Assistant Director Governance Leads to discuss at September meeting. ST and SET to prepare discussion paper for presentation at regional AD Governance leads meeting (13th Sept) in order to reach a consistent HSC Trust position.	31-Dec-21

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	Priority 2 Finding 2.2	The Trust should clarify when Adult Safeguarding Cases are to be reported on Datix by developing a guide / checklist for its staff and including completing the checkbox on PARIS for such cases.			Implemented	As above. The Trust can confirm that the DATIX report field on the PARIS APP1 document is mandatory for completion by the referrer. (C/F recommendation 3.2)	
	Priority 2 Finding 2.3	Management should enhance reporting information presented to the Social Work and Social Care Governance Group. As per recommendation 3.3 inclusion of KPIs and data from balanced scorecards when developed should initially be presented weekly to the Corporate Governance Group.	31/07/2021		Implemented	Adult Safeguarding HoS Presents corporate ASG data to Corporate Weekly Governance debrief meeting. A weekly report is prepared from this meeting for SMT to inform them of referral rate, protection cases that have interfaces with other processes such as SAI, complaints or wher there are complex, high risk cases that require escalation. Similarily MHD Directorate have commenced a weekly governance debrief and the same Directorate data is shared at this meeting. The SWSCG Group comprises of the SW leads and is chaired by the Exec Dir of SW. As the Directorate ASG leads will now be responsible for collating the data and reporting to the Adult Safeguarding Blueprint and their Directorate Governance Groups on progress against their Directorate Balanced Scorecards there is no requirement to table at the SWSCG Forum. Draft KPI's have been developed and are out for comment with Directorates and will be implemented for testing in quarter 3.	
	Priority 2 Finding 2.4	The Trust should update the Trust Incident Reporting Procedure.	31/09/21		Partially Implemented	A Regional Incident Management policy was issued to Trusts with a recommendation that it be operationalised by 30th June 2020. Work has commenced to operationalise the Regional Incident Reporting Policy in the Trust. Further engagement is required with Governance Coordinators. Timescale for completion is 30th November.	31-Dec-21
	Priority 2 Finding 3.1	Adult Safeguarding Management should ensure all staff fully complete all fields in the APP1 form when completing referrals. Management should also review what fields are mandatory on APP forms including date fields.	30/06/2021		Partially Implemented	Adult Protection Services and PARIS CIS leads have reviewed mandatory fields in APP1 referral format and continue to review PARIS system and update SOP's as learning emerges. Cross reference recommendation 2.2) Operational management continue to reinforce this paractice area	31-Mar-22
	Priority 2 Finding 3.1	Adult Safeguarding Management should ensure all staff fully complete all fields in the APP1 form when completing referrals. Management should also review what fields are mandatory on APP forms including date fields.	30/06/2021		Split	Adult Protection Services and PARIS CIS leads have reviewed mandatory fields in APP1 referral format and continue to review PARIS system and update SOP's as learning emerges. Cross reference recommendation 2.2) Operational management continue to reinforce this paractice area	
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	Priority 2 Finding 3.2	Appropriate supervision / quality review processes should be introduced to IO / DAPO staff follow the Standard Operating Procedures and record all APP forms and case notes on PARIS ensuring that a rationale for all decisions made during the process are fully documented on the system.	31/10/2021		Implemented	Supervision arrangements for DAPO staff have been reviewed across all Directorates. All Band 8a and Band 8b social work staff across MHD are aligned to Band 7 DAPO staff .All DAPO staff in Acute report directly to the Band 8b HSW Head of service for supervision of DAPO work. Within OPPC all DAPO's are aligned to the Band 8a SW or Band 8b.	
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	Priority 2 Finding 4.1	The Trust should continue to explore models of service delivery in conjunction with the DoH and Adult Safeguarding Transformation Board.	31/03/2022		Partially Implemented	The Trust is currently undertaking a QI adult protection pilot project. The HoS Adult Safeguarding reports to the Interim Adult Protection Baorad NI on the progress of the pilot and is due to report findings in Feb 2022. The Trust has reviewed its Adult Safeguarding Policy in line with regional developments. Additions of 2 new pieces of legislation are included for reference and a tracking date for next review updated to reflect strategic change coming from Transformation Board and APBNI. This policy revision is subject to approval from policy scrutiny group.	31-Mar-22
	Priority 2 Finding 4.2	The Trust should ensure the Adult Safeguarding Checklist is used in the supervision process by all DAPOs to direct the supervisor when reviewing and discussing Adult Safeguarding cases assigned.	31/07/2021		Implemented	The checklist has been reviewed and reissued to staff to support the supervision process.	
	Priority 2 Finding 4.3	The Trust should ensure that there is sufficient staff trained and available to provide the DAPO function..	31/07/2021		Implemented	MHD have undertaken a pilot DAPO rotation to address workload pressures with DAPO staffing across the Directorate and to provide equitable opportunity for staff to maintain competence and confidence in carrying out the role. To support this a dedicated SSWp for MHD has been put into post to undertake the more complex, time intensive DAPO cases such as Joint Protocl. This in particular will provide easement to DAPO's who are team leaders. A review of DAPO availability across OPPC has also been undertaken with additional staff being appointed to udnertake DAPO work in CHST. (refer to supervision strucutre attached at pfinding 3.2) A Directorate wide support arrangement is in place to meet demand at this level. Within Acute there are additioanl band 7 socail work posts who will also carry reponsibility for DAPO function. This resource will meet existing demand within Acute services.	
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	Priority 2 Finding 4.4	Within the Acute MH setting, the Ward Manager should return to screening and approving the APP1 before submission to the APGT.	30/06/2021		Implemented	Within the Acute MH setting, the Ward Managers have returned to screening and approving the APP1 before submission to the APGT.	
	Priority 2 Finding 5.1	The Trust should ensure that IO/DAPOs attend the required number of support forums for CPD purposes. Attendance should be monitored at appropriate management forum.	31/05/2021		Partially Implemented	Attendance is taken at each Support Fora and uploaded to HRPTS by SSTDT. A tracking system has been implemented within the SSTDT to moonitor engagement with teh CPD fora on an annual basis. Where a staff member has not engaged this is flagged with the staff member and line manager to address. Goingforward staff attending initial IO, DAPO and ABE training will be informed of this CPD tacking system. This has also been shared with current staff through the fora.	31-Dec-21
	Priority 2 Finding 5.2	A review of IOs / DAPOs should be carried out to ensure that the Trust has adequately qualified staff correlating to service need across directorates. Areas which have a high volume of referrals such as Care Home Support Team who should have enough trained IOs / DAPOs to meet demand.	30/11/2021		Implemented	Refer to finding 4.3 above for MHD rotation pilot. CHST within OPPC have recruited an additional SSWp who have responsibility to undertake DAPO functions. This will be further enhanced later in the year with the appointment of a 2nd ASW/Safeguarding lead to the team. (refer to supervision structure in finding 3.2)	
AX - Information Governance 20-21 Satisfactory	Priority 2 Finding 1.1	Trust Managers should ensure that all data breaches are fully and promptly recorded on the DATIX system using the IR1 process and the appropriate checkbox completed on DATIX to ensure onward reporting to the Information Governance Team.	30/06/2021		Implemented	Reminders have been sent to staff of the importance of reporting incidents on the Datix Incident Management System. All incidents are reviewed at IG Managers Team Meeting to ensure consistency with Datix reported incidents. Also reviewed at 1:1 Supervision	
	Priority 2 Finding 2.1	The Trust should ensure escalation procedures are actioned with Assistant Directors / Directors to increase managers FOI request response compliance with the legally required timeframe of 20 days.	30/06/2021		Implemented	#REF!	
	Priority 2 Finding 3.1	The Trust should ensure escalation procedures are actioned with Assistant Directors / Directors to increase managers SAR request response compliance with the legally required timeframe of 30 days and 90 days in complex cases.	28/02/2021		Implemented	Escalation emails are sent to Assistant Directors & Copied to the SIRO. A Weekly report is sent to the SIRO of outstanding FOIs. Attendance at Directorates SMT to remind staff of the importance of complying with the timeframes for FOIs had commenced but was paused due to COVID 19.	
	Priority 2 Finding 3.2	The Trust should review processes for classifying SARs, as complex requests may not always be appropriately identified and therefore the incorrect timescale applied.	31/03/2021		Implemented	Escalation emails are sent to Assistant Directors. Outstanding SAR requests are included in weekly governance report which is subsequently sent to SMT (which SIRO is a member).	
	Priority 2 Finding 4.1	The Trust should work to improve its compliance with mandatory Information Governance Training in a return to Business as Usual. As per the ICO recommendation, the process for generating and reporting on compliance figures should be reviewed to ensure accuracy of reporting.	31/05/2021		Partially Implemented	Checking process for classification of SARS by Information Governance Managers on a weekly basis. Complex SARs are found predominantly in CYP and MH. At present the focus has been on these Directorates as they have the most complex requests with the longest processing timescales. Request for Acute Services are predominantly simple requests – request for X-Ray image / reports or ED attendances. Therefore the meeting have only been scheduled with CYP and MH.	31-Mar-22
	Priority 2 Finding 5.1	Going forward the Information Governance Forum should meet in accordance with the terms of reference.	30/06/2021		Implemented	ELD to provided a list of those staff who do not have current Mandatory Training and the Information Governance Team send reminders to all staff. Email Prompt sent to staff who appear on the report from ELD with expired CMT for Information Governance. Most recent Corporate figures for CMT were provided to Internal Audit.	
AY - Governance During COVID Satisfactory	Priority 2 Finding 1.1	In line with requirements of the Trust Corporate Emergency Management plan, the Trust should ensure that a log is maintained which records the time and details of events, decisions made, information passed onto others, instructions issued or requests made, including financial approvals..	30/04/2021		Imp Date Not Passed	simon to provide comment and evidence	
	Priority 2 Finding 1.2	The terms of reference of Bronze Incident & Operational Groups, and subgroups in directing, and approving emergency COVID-19 actions including expenditure should be clarified.	30/09/2021		Imp Date Not Passed	simon to provide comment and evidence	
	Priority 2 Finding 2.1	Management should ensure that the individual learning points identified from the first wave are taken forward and shared across the organisation promptly to ensure that this learning helps to inform new ways of working in the ongoing pandemic.	31/10/2021		Imp Date Not Passed	simon to provide comment and evidence	
	Priority 2 Finding 2.2	The Trust Pandemic Plan and the Lockdown plan should be promptly updated following the outcome of the review of lessons learned as a result of COVID-19.	31/10/2021		Imp Date Not Passed	simon to provide comment and evidence	
	Priority 2 Finding 3.1	The central COVID-19 register should where possible include the volume of items received or a monetary value where this is applicable and can be easily identified. The register should be updated to accurately reflect what was actually received.	30/04/2021		Implemented	The central COVID-19 register should where possible does now include the volume of items received or a monetary value where this is applicable and can be easily identified. The register has been updated to accurately reflect what was actually received.	
	Priority 2 Finding 3.2	The Trust Gifts, Hospitality and Sponsorship Policy should be reviewed, updated and reissued to staff.	31/03/2021		Implemented	The Trust Gifts, Hospitality and Sponsorship Policy has been reviewed, updated and reissued to staff.	

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
AZ - Independent Homes Payment Validation 20-21 N/A	Not Prioritised Finding 1	The Trusts should proceed to retract funding in the scenarios regionally agreed ie: • Where a home did not submit a return • Where a home has declared an underspend against the grant funding of over £1,000.	31/03/2021		Implemented	Details of Interal Audit findings have been shared with all Trusts on 7 April & 19 May 2021. SHSCT had one retraction of £10k from Forest Lodge on 16 March 2021 (FPL Batch ref to G000054240). No grant underspends > £1k needing retraction.	
	Not Prioritised Finding 2	The Trusts should ensure that expenditure incurred relating to loss of income identified by homes is retracted where appropriate.	31/05/2021		Implemented	Details of Internal Audit findings were shared with all Trusts 7 April & 19 May 2021. No SHSCT Loss of income claims.	
	Not Prioritised Finding 3	The Trusts need to engage with DoH to determine the best way forward where homes have utilised grant monies for staff incentive schemes in the context of the staff recognition payment due to be paid to the Independent Sector.	31/05/2021		Implemented	The Trust confirmed with DOH as per email of 28/5/21 which agrees that staff bonus payments are not to be retracted. Internal Audit viewed Minute of DOH meeting of 26/5/21.	
	Not Prioritised Finding 4	The Trusts should share this report with HSCB / DoH to facilitate learning in application in any future funding schemes – particularly in respect of setting timescales for spend; recovery mechanisms of underspend/ inappropriate spend; definitions of acceptable spend and also in the context of any potential for duplicate funding across public sector Covid-19 support schemes.	31/03/2021		Implemented	Correspondence was sent DOH & HSCB 9 April 2021 which Internal Audit viewed together with the Minute of meeting 26/5/21.	
BA - Review of Funding to Independent Domicillary care Providers 20-21 N/A	Not Prioritised Finding 1	The HSC Trusts should engage with the DoH in respect of the course of the action that should be taken in respect of the 4 providers that had not paid staff in line with the scheme requirements to date). Further engagement should take place with regards to the 3 providers where sample testing identified underpayments. Funding retractions may be required if appropriate resolution and assurance is not received.	31/05/2021		Implemented	Minute of DOH meeting of 26 May 2021. WHSCT AD actionned with Connected Health. No other SHSCT provider for action.	
	Not Prioritised Finding 2	The HSC Trusts should engage with DoH to consider the way forward with those providers that did not provide returns/further requested information/ or where information requires further validation. This includes:• 13 providers who have not yet submitted a return.• 2 providers who have not provided validating payroll information • 5 providers who have not submitted payslips as requested.	31/05/2021		Implemented	Minute of DOH meeting of 26.5.21. SHSCT lead Trust for Peacehaven who was non return - letter issued 8/7/21 and 24/8/21. Trackars and Enable Care Services letters issued also 9/7/21. Response received from Trackars follow up continuing with Enable Care Services.	
	Not Prioritised Finding 3	The HSC Trusts should write to all providers highlighting that instances of duplicate funding across government support schemes have been identified. This letter should reinforce that duplicate government funding streams should have not been availed of and where this has occurred, the provider should make contact with HMRC. The Trust should also seek confirmation from the 2 providers that have confirmed they have utilised duplicate funding that they have notified and resolved this with HMRC.	30/06/2021		Implemented	Letter issued 9 July 2021 to providers for which SHSCT host. Email attached. Specific letter issued to Anns Homecare by SHSCT (attached). No response received 19/8/21. Reminder letter dated 26 August 2021.	
	Not Prioritised Finding 4	The lead Trusts should consider the outcome of this report in terms of the specific 10 complaints received in relation to providers and should engage with the providers to obtain assurance that the complaints are appropriately investigated and addressed.	30/06/2021		Partially Implemented	Letters have been sent to one provider and the other complaints are being investigated.	31-Oct-21
	Not Prioritised Finding 5	The Trusts should share this report with HSCB / DoH to facilitate learning in application in any future funding schemes – particularly in respect of setting timescales for spend; recovery mechanisms of underspend/ inappropriate spend; definitions of acceptable spend and also in the context of any potential for duplicate funding across public sector Covid-19 support schemes.	31/05/2021		Implemented	This was actioned as per minute of meeting with DoH 26 may 2021.	
BB - IT Line of Business 20-21 Limited -Medcom & Trium Satisfactory Abacus & Bactraq	Priority 2 Finding 1.1	An action plan to clarify and agree clear ownership and responsibility over the Medcon system should be put in place. This should include:• Formalising ownership including Information Asset Ownership, contract manager (to manage the contract), and system manager (to manage users, address day-to-day issues and raise functionality issues with the supplier).• Ensuring that the supplier provides assurances over its SLA obligations.• Monitoring supplier performance.	31/03/2022		Imp Date Not Passed		

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
	Priority 2 Finding 1.2	Cardiology should work with the supplier and ICT to address functionality issues with Medcon. This may include implementing a system upgrade. This upgrade should be subject to appropriate change control and structured, comprehensive user acceptance testing.	31/03/2022		Imp Date Not Passed		
	Priority 2 Finding 1.3	Cardiology should work with the supplier and ICT to address functionality issues with Medcon. This may include implementing a system upgrade. This upgrade should be subject to appropriate change control and structured, comprehensive user acceptance testing. Errors identified by Internal Audit should be addressed in the first instance.	31/08/2021		Imp Date Not Passed		
	Priority 2 Finding 1.4	Cardiology should ensure that an up to date BCP is developed that incorporates considerations of working practices in the scenario where Medcon is unavailable. This should incorporate Disaster Recovery with Recovery Points Objectives (RPOs) and Recovery Time Objectives (RTO) agreed with ICT and/or system supplier. The BCP should be subject to testing with any lessons learned appropriately fed back into an updated BCP.	31/03/2022		Imp Date Not Passed		
	Priority 2 Finding 1.5	A Network / System Access Agreement should be put in place with the supplier of the Medcon LoB application. This should be assessed in conjunction with SHSCT ICT. Appropriate actions to address any areas of concern should be agreed.	31/03/2022		Imp Date Not Passed		
	Priority 2 Finding 2.1	The Trust should ensure that appropriate support arrangements are put in place for Trium CTG archiving as soon as possible. As part of this, the Trust should determine whether a system upgrade is due and ensure it is appropriately applied if applicable.	31/05/2021		Imp Date Not Passed		
	Priority 2 Finding 2.2	A regular review of the Trium CTG user base should be introduced. This should include ensuring all users with access still require access, and the level of access currently granted is appropriate to their job role.	31/08/2021		Imp Date Not Passed		
	Priority 2 Finding 2.3	Maternity Services should document contingency arrangements to take account of circumstances where Trium CTG is not available. This should be aligned and agreed with ICT. It should be subject to regular review and testing. Any lessons learned from testing should be fed back into the BCP.	31/08/2021		Imp Date Not Passed		
	Priority 2 Finding 2.4	Regular password resets and password complexity requirements should be implemented in line with Trust requirements. Trium CTG integration with Single Sign On (to reduce dependency on memorised passwords) should be assessed. This could assist in mitigating risks linked to passwords (such as no forced resets) and also save staff time.	31/08/2021		Imp Date Not Passed		
	Priority 2 Finding 3.1	A Network / System Access Agreement should be put in place with the supplier of the Abacus LoB application. This should be assessed in conjunction with SHSCT ICT. Appropriate actions to address any areas of concern should be agreed.	30/09/2021		Implemented	A Network / System Access Agreement for the Abacus system is now in place.	
	Priority 2 Finding 4.1	The user base of BackTraq should be reviewed to ensure all roles are held in line with the principle of least privilege. Users who no longer require access should be removed, and user privileges (including those of generic users) should be restricted where possible. A regular review of users and their access rights to BackTraq should be introduced.	30/04/2021		Implemented	The user base of BackTraq was reviewed as required, and user privileges have been appropriately restricted in line with the principle of least privilege.	
	Priority 2 Finding 4.2	SHSCT should ensure that the DAA is accurate with regards to sensitive data held on the BackTraq system that has GDPR implications. The supplier's data processing activities stated in the DAA and the SLA should align.	30/04/2021		Implemented	This has now been clarified and agreed with the system supplier.	

NAME OF AUDIT / ASSURANCE LEVEL	PRIORITY / REPORT FINDING REF.	AUDIT RECOMMENDATION	ORIGINAL IMPLEMENTATION DATE	RESPONSIBLE MANAGER	STATUS	PROGRESS AS AT SEPTEMBER 2021	REVISED IMPLEMENTATION DATE
	Priority 2 Finding 4.3	The Business Continuity Plan should be updated to ensure Recovery Time Objectives (RTOs) are recorded and reflect the service offered by ICT. The BCP should be subject to regular review and testing. Any lessons learned from testing should be fed back into the BCP.	30/04/2021		Implemented	The Business Continuity Plan has been appropriately updated and is subject to regular review.	
	Priority 2 Finding 5.1	Common issues and agreed improvement actions identified in this audit in respect of the sample LoB applications should be shared for learning purposes with other Information Asset Owners across the Trust.These areas of learning include:• Ensuring appropriate support arrangements are in place with suppliers.• Putting network / system access agreements in place which are then risk assessed with appropriate actions undertaken.• User account management.• Clarity around Information Asset Ownership.• Visibility to server operating system versions and other middleware software and the current and future compatibility with LoB applications to help plan LoB application updating. • Password controls in line with Trust standards. • Business Continuity Planning (with scenarios where the application is unavailable).	30/09/2021		Imp Date Not Passed		

51.6 Within the Acute Directorate, specific risks identified may be recognised on the Risk Register. I have commented elsewhere in this statement (e.g., at Q46) that it is my view that the concerns related to the capacity:demand mismatch are not reflected adequately on the Risk Register. *Please see:*

53. 20161117_Procedure for the Reporting and Follow up of SAIs Version 1.1. Nov 2016

54. 20180401 Ref 2i - Regional Your Right to Raise a Concern Policy and Procedure

55. Ref 2i - YOUR RIGHT TO RAISE A CONCERN (Whistleblowing) Regional HSC Framework

52. ~~47.~~ **Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.**

52.1 As consultant, I have felt supported by the medical line management hierarchy. For example, when I was approached with regards in-reach into Belfast Trust for nephron sparing surgery, the Southern Trust medical and professional management teams were fully supportive of this, despite the local impact of a reduction in the clinical time I spent in Southern Trust, recognizing the system wide benefits.

52.2 When I started as Clinical Director, and subsequently Associate Medical Director, no induction process was afforded to me and, in particular, when I commenced as AMD no handover period or process was in place. In particular, I did not receive any briefing of any prior or ongoing concerns with regards to medical staff. It is notable that no AMD was in post for approximately 12 months between Dr McAllister's departure and me taking up the role.

52.3 During my time as a medical manager, I have raised a concern that no additional administrative support (e.g., PA) is available to clinical managers, although it is provided to professional management colleagues. Certainly, for

Carroll, Ronan

From: Corrigan, Martina [redacted]
Sent: 08 June 2018 18:07
To: Carroll, Ronan; Haynes, Mark
Subject: RE: Urology Waiting Lists

Yes I will look at next week

Regards

Martina

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

INTERNAL: EXT [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Carroll, Ronan
Sent: 08 June 2018 18:06
To: Haynes, Mark; Corrigan, Martina
Subject: RE: Urology Waiting Lists
Importance: High

Martina
Can we look at this pls
Ronan

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

From: Haynes, Mark
Sent: 08 June 2018 17:52
To: Carroll, Ronan; Corrigan, Martina
Subject: Re: Urology Waiting Lists

Hi Ronan

The numbers of lists for June were;

Week 1 - 10
Week 2 - 10
Week 3 - 8 (2 lost due to audit)
Week 4 - 10

So effectively we have lost a list a week for June despite the changes. This was better than the original impact of the loss of extended day operating but is not 11 per week. Additionally 11 per week will not address our large backlog and is unlikely to even maintain status quo as lists were growing prior to any reduction in theatre time.

Mark

Sent from my BlackBerry 10 smartphone.

From: Carroll, Ronan
Sent: Friday, 8 June 2018 17:13
To: Corrigan, Martina; Haynes, Mark
Subject: FW: Urology Waiting Lists

Mark
The meeting you refer to as I understood it did enable urology to get its core 11 sessions – so somewhat surprised. Martina? I certainly recall gynae losing a session and giving to urology
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI
Ext [redacted]

From: Haynes, Mark
Sent: 08 June 2018 13:28
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M; Devlin, Shane
Subject: RE: Urology Waiting Lists

Dear Esther

Following on from below, a meeting took place. However, that meeting was to resolve the issues of the impact of the loss of extended day operating on the urology team such that the impact of this was spread across the surgical teams. The meeting did not result in Urology having its full number of weekly theatres (11 with backfill), nor was it intended to address any increase in urology operating to address the waiting list backlog.

In preparation for the meeting, waiting time information across different specialities were collated as below (as at 25/5/18);

Specialty	Urgent Inpatients	Weeks Waiting	Routine Inpatients	Weeks waiting	Urgent Daycases	Weeks waiting	Routine Daycases	Weeks waiting
Urology	596	208	237	225	378	173	541	212
ENT	29	1x38 19	142	64	64	23	923	80
General Surgery	113	147	75	139	437	131	901	121
Breast	16	1 x 41 27	15	82	10	1 x 19 4	9	38
Orthopaedics	200	1 x 160 85	1155	171	130	1 x 101 80	805	128
Gynae	28	11	168	50	26	1 x 26 6	106	44

As such, consideration needs to be given as to how the clinical risk associated with such significant waiting time disparities across specialities should be managed. As highlighted in my previous e-mail, amongst the urology cases are patients where there is well documented increased risk associated with longer waiting times. Unfortunately given the current constraints of available theatre time and inpatient beds along with nursing staffing pressures, I cannot see a solution that doesn't impact on the waiting times of patients from other specialities. However, I do not believe we can justify accepting the current situation.

Could we look to meet at some point next week to discuss this, perhaps we could use our 1:1 meeting next Tuesday with Ronan, Martina and Barry joining us?

From a urology team perspective, I think it would also be helpful to meet the full consultant team. We are all available on Thursday 14th June at 12:30 and would be happy to meet then if that suits?

Thanks

Mark

From: Gishkori, Esther
Sent: 22 May 2018 18:05
To: Haynes, Mark
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed; Reid, Trudy; Stinson, Emma M
Subject: RE: Urology Waiting Lists

Dear Mark,
Thank you for sharing this.
Prima Fascia, it looks like the death of this gentleman could have been avoided.
Ronan,
For this reason, please begin the SAI process in the first instance. Once screened, we can grade appropriately.
Also though, Mark reports here that the longer urology patients have to wait, the higher the incidence of an adverse incidence occurring.
I know that regionally urology is an issue but during our conversation with Mark today, he told us we had the longest waiters. I need to understand fully why this is but also if we have it within our gift to improve the situation within the Trust without making any other service unsafe or unstable.
I would also be grateful if you would, in the first instance, set up a meeting with Mark, you, me, Martina and Barry so that initial steps to reduce this waiting list can be discussed and actioned.
Shane,
For your information only at this point. I will keep you informed as we go but am happy to discuss at any point.
Dr Khan,
You are welcome to join us any time although the first few steps in this are probably operational. I will of course copy you into all correspondence.

Many thanks
Best,
Esther.

From: Haynes, Mark
Sent: 22 May 2018 13:31
To: Gishkori, Esther
Cc: Young, Michael; O'Brien, Aidan; Glackin, Anthony; ODonoghue, JohnP; Carroll, Ronan; Corrigan, Martina; Khan, Ahmed
Subject: Urology Waiting Lists
Importance: High

Dear Esther

I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients.

As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times from referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionate impact on Urology as we have, as a speciality, three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running.

The clinically urgent cases are at a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serious sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and / or encrustation of ureteric stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and it's associated risk of death, as a post-operative complication. This risk has been quantified as 1% after 1 month, 4.9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patient who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow.

Tragically, a 70 year old male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure.

Unless immediate action is taken by the trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.

The private sector does not have a role to play in the management of this problem (previous experience) and the trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases).

Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4 additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of

our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list.

Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale.

I am happy to meet to discuss timescales to implement the changes required.

Yours Sincerely

Mark Haynes

as was and SPPG in terms of getting more commissioning in and around that to try to build it up. And they did, they have managed to build up the number of CNS's and urologists, but not at the pace we needed. Essentially, right from the get-go, I think what -- he was certainly raising it. I think it was being raised in different places, but I don't know whether we were forcible enough about that or whether we didn't go the right way around it. But it certainly took quite a period of time, really, for that to gain any purchase and to get some investment, as far as I can see. 16:08 16:08

385 Q. MR. HANBURY: In the same sort of line, obviously as surgeons we are very worried about patients being on the waiting list for a long time and, obviously, they had come to harm and they are not necessarily seen back in clinic to make sure they are all right. And there are initiatives for potential harm reviews after, say, a certain length of time, say a year or something. Is that something that you brought in or you would like to see happen? 16:09 16:09

A. I'm not sure whether they have -- I know that I hear mention -- and I haven't thought about this specifically -- I know that I hear mention of patients that they are concerned about as being long waiters that they have checked up on. So that definitely does get discussed. I haven't asked specifically is that done through the CNSs or is that done through other aspects of urology. But I can certainly check that out and see. But I know, certainly, those long waiters are 16:09

piece of work done out of a report that had come out of the Patient Client Council around the waiting lists in Northern Ireland and the people on them. I recall a time at which the Trust Board had asked about that, about the experience of people on the waiting list. 11:56
So, there had been a patient experience piece done as well. I remember it because we had said, well, is there -- I remember actually Mark Haynes had done a piece about do you contact people who have been essentially languishing on the waiting list for a long 11:57
time, but it was quite morally distressing even for clinicians to do so when you had no solution for how you were going to be able to see them and when.

There was a lot of work done around that sort of 11:57
things; that people were recognising the difficulties and the potential harm essentially to people on long waiting lists.

220 Q. Is it ever the case that the Commissioner or the HSCB, with an awareness of the issues that are causing 11:57
problems, offer help or seek to provide, for example, funding for Peer Review or speciality review or an external audi? Is it ever the case that they would unilaterally approach the Trust, or is it a wait-and-see for them? 11:57

A. I'm not aware of them having approached us to suggest that. I suppose what I would say, to be fair to both Commissioner and the services, is that if you approached them to seek that sort of funding for

also done is redesigned all of the feeder committees, all the subcommittees and the Terms of Reference, you know, the purpose of those, how they're chaired and the information is presented and triangulated, and then in addition to that we have changed our structure of Senior Leadership Team meetings to mirror this, but also to make sure that they are used to best effect in terms of feeding the committees for Trust Board. 10:15

So one of the areas, for example, is the - we have a risk and assurance meeting once a month over the last few months in the Senior Leadership Team, and basically that brings together a lot of the quality and safety concerns that are then brought into Governance Committee. So that again, based on the layers of feed that come up through the weekly governance reporting, the governance reports from the individual divisions and directorates into that meeting, and then to go to our monthly pull together essentially of all of our governance business within one large senior leadership team meeting, we then also feed this into the governance meeting of the Trust. 10:16 10:16 10:16

15 Q. Yes.

A. So everything has - in terms of Board to bed, it's about trying to get a line of sight either direction so that the information flows and that people have a good understanding of the business and the concerns. 10:17

16 Q. Yes. I think as we move on this morning we'll look at your clinical and social care governance reforms. We

Register that we have access to I think is WIT-62044, and it's from September 2022. Is that a living document that will have been revisited regularly, or is this something that has to await further developments through the Board Assurance Framework and that line of work, which is ongoing as I understand it? 11:03

A. So the Corporate Risk Register is updated every month, at the risk and assurance part now of the Senior Leadership Team. So I see that one says September 2022. 11:04

39 Q. Yes.

A. There should be a February 2024.

40 Q. Okay.

A. Yes.

41 Q. Maybe we just haven't looked hard enough. 11:04

A. Yes. Yes. Yeah.

42 Q. But it's - I'm not terribly interested in the substance of it for the purposes of our questioning. Do you think that the Risk Register and the approach to defining risk is well understood, whether at corporate level or within the directorates or divisions? 11:04

A. I think it has got better over time, and as we have moved it away from being in the past I think it would have come up through the Governance Committee and there would have been some discussion at Trust Board, but it wasn't a live part of the Senior Leadership Team's discussion on a regular basis. We've moved on from that, and with the whole reorganisation and development of corporate document this is very much a live 11:04

time, and in order of clinical priority. I appreciate that the issue of having patients' clinical records at home for longer periods was raised and is dealt with elsewhere in this response.

228. I am unaware of having retained to myself any duties which are typically performed by a medical secretary.

(Q 33 – 37)

229. I worked alongside many nurses and ancillary nurses in virtually all areas of my practice during my tenure at the Trust, in the management of inpatients in wards, in theatre and in outpatient clinics in various hospitals. Indeed, I have been privileged to have known, to have worked with and to have been supported by so many nurses and ancillary colleagues in caring for patients.

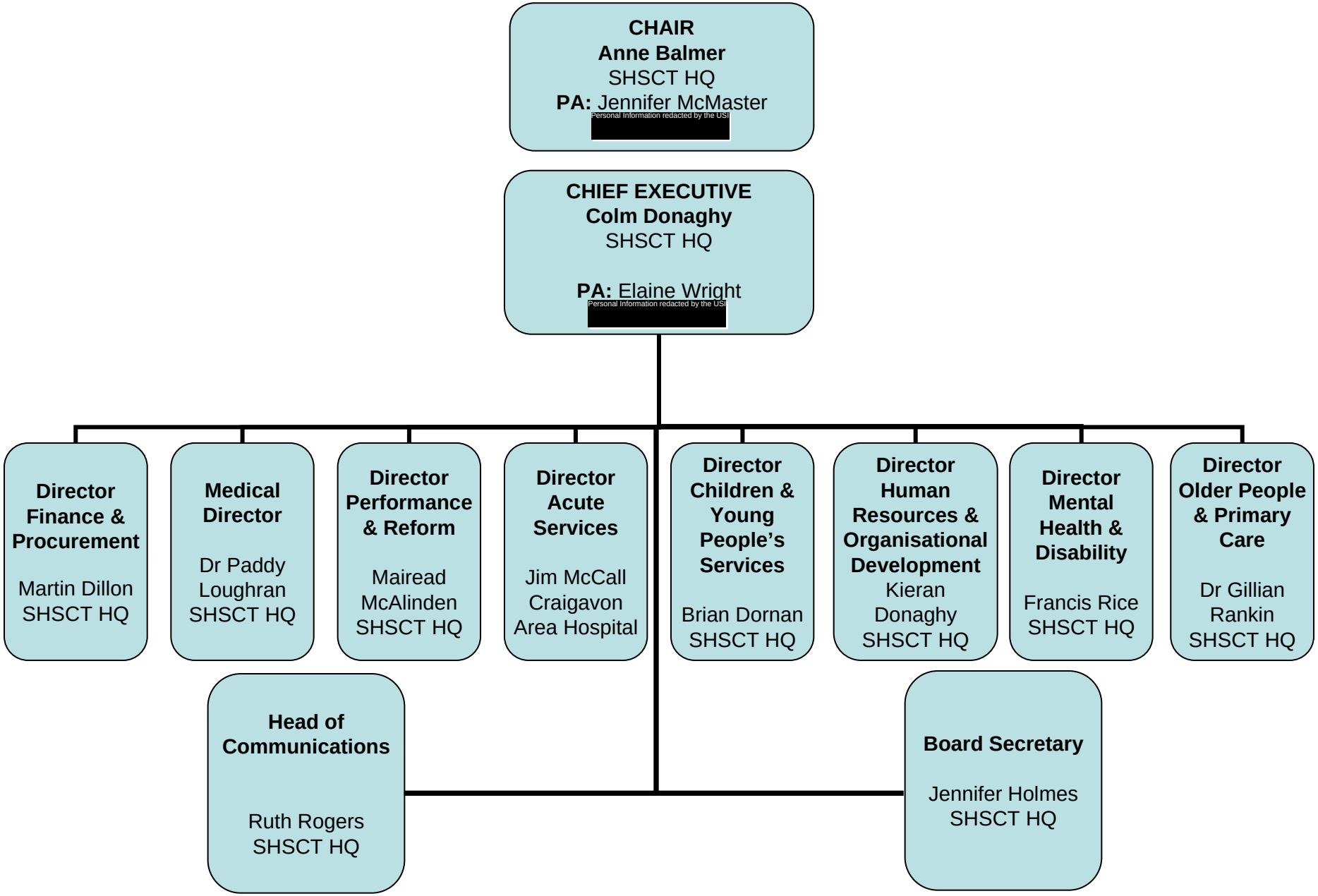
230. As I have already related, I was initially welcomed to Ward 2 South at Craigavon Area Hospital in 1992 when I was granted a total of four inpatient beds. I have recounted how the numbers of beds occupied by urology patients increased over the following years, and I have described how many nurses embarked upon journeys of discovery and learning of new pathologies, new managements and new skills required for the optimal care of patients. The founding of CURE played a crucial role in the development of urological nursing skills as it enabled us to

fund nurses attending conferences and training courses, such as those in urodynamic studies provided by Professor Abrams in Bristol.

231. The first ten years were replete with enthusiasm and ambition, hard work and commitment to caring for patients to the highest standard that we could provide. I have described the successes of Eileen O'Hagan and of Jerome Marley [see paragraph 35], both of whom were nurses on a ward which had no experience of urology prior to 1992. Their successes alone are reflections of the progress that was made in those early years. It was indeed a privilege and pleasure to be a part of it.

A. Of course. Of course.
346 Q. Did you tell anyone?
A. Yes, you can tell -- we did tell people. I mean, when I founded or set up CURE with Roberta Brownlee, we had four or five SPRs who did higher degrees, I mean I was very, very research-orientated, and I believe in a thing called clinical research, which clinicians should be doing, rather than laboratory research. 16:39
347 Q. Yes.
A. And I think that audit-generated research is so valuable because it closes the loop and all of that. But there is a limit to what you can do in addition to swimming against the tide of an inadequate service. 16:39
348 Q. I'm not suggesting that all clinicians should do this. I'm merely suggesting did you ask the question? Do you agree it's an important question? 16:39
A. Oh, absolutely yes.
349 Q. And you've talked about speaking to patients about the risks of various treatments and their choice.
A. Hmm. 16:39
350 Q. Did you document all of those risks in the notes and in letters to patients, for example?
A. No.
351 Q. Why didn't you?
A. Because -- because I'm not very good at writing and talking at the same time. So, you know, it's -- I did it. 16:40
352 Q. Mm-hmm.
A. And I think it's -- I mean that relationship between

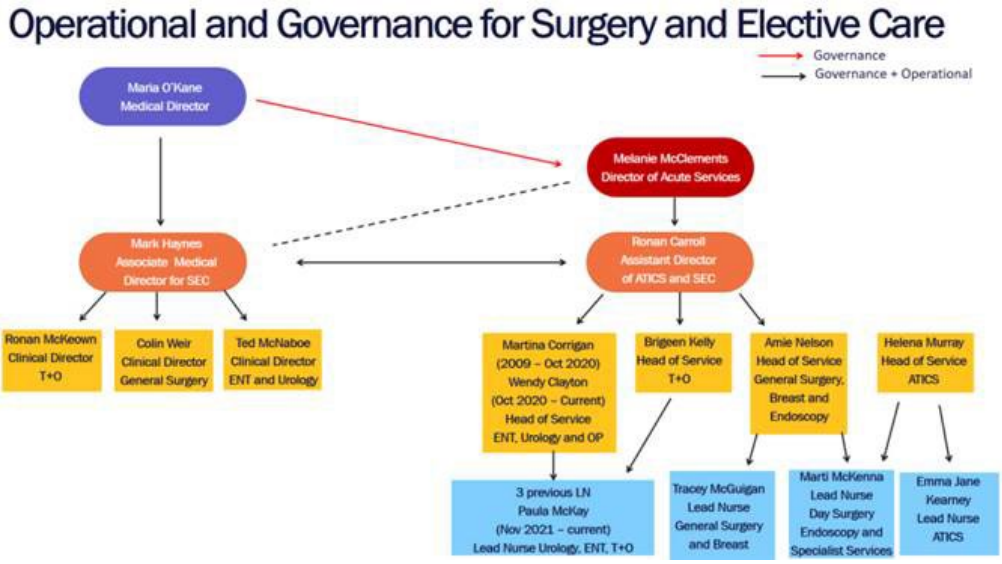
Office of the Chair & Chief Executive



Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

***governance of urology services*, differed from and/or overlapped with, for example, the roles of the Director of Acute Services, Assistant Directors, the Clinical Director, the Medical Director, Associate Medical Director, the Clinical Lead, urology consultants or with any other role which had governance responsibility.**

8.1 I believe the Head of Service role and responsibilities for operation and governance overlap partially with the Assistant Directors, the Clinical Director, the Associate Medical Director (which is now known as Divisional Medical Director (DMD)), the Clinical Lead, and the urology consultants.



Operational Responsibility

8.2 It is the Head of Service responsibility to oversee governance systems ensuring action plans and recommendations are followed through. I do have responsibility to monitor performance, highlight waiting time risks, and ensure clinical activity is undertaken in accordance to job plans.

Governance responsibility

8.3 It is the Head of Service's responsibility to support the medical and nursing staff, ensuring processes are in place to monitor governance. This is a shared responsibility with the AD, CD and AMD, for example:

a. Complaints – ensure complaint responses are investigated and responded to by the relevant staff, e.g., a nursing ward issue complaint would be by the Lead Nurse and Ward Sister; patient care or clinical complaints would be by the medical team; and performance issues would be responded to by myself as Head of Service.
b. Litigation – ensure litigation responses are complete within timeframe; I would receive escalations if deadlines are not met.
c. Oversight of the Corporate Senior Management Team (SMT) audits, these include weekly hand hygiene and commode audits. For April 2022, the ward 3 south achieved 100% for both audits

or it couldn't happen to me, to a more rigorous system-wide approach to how we embed, how we do some of our systems and processes. The journey isn't over.

Yes, I believe, the organisation learned. The leaders of the collective leadership team that I keep referring to, really came on board to try and make a difference. I really hope that continues in the -- 15:33

323 Q. We have heard that the Clinical Directors and sometimes Divisional Medical Directors and other people were too busy to get to the Acute Governance meeting, well, the clinical one, to do the incidence screening. For example. Or to go to other key meetings; understandable because there's a lot of pressure. Partly, I think, people not seeing the full importance of it. 15:33

A. Mm-hmm.

324 Q. Have you seen a change in that in terms of people's appetite for governance; the governance that you described is not so interesting? 15:33

A. I think there is a big commitment to it. There's not always great attendance to our clinical fora because they are busy people. However, I think they have -- I actually think in a perverse sort of way, if it's right to say this, the focus from the Inquiry has encouraged them as they work through Section 21s and whatever to think triangulation in a different way, and that ability to look at the picture standing back a wee bit, I think there's somebody thinking, no, there's a 15:34

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: Personal Information redacted by the USI

2019.04.12

Q40.191.1

ACUTE CLINICAL GOVERNANCE

Date: Friday, 12th April 2019
8am, Board Room (beside the Canteen), CAH

1.0	**Apologies**: Neville Rutherford Jones, Ronan Carroll, Damian Scullion **Attendances – Tracey Boyce, Esther Gishkori, Anne McVey, Una Bradly, Martina Hogan, Chris Clarke, Philip Murphy Kathryn Boyd, Barry Conway, Aoife Currie, Ted McNaboe Patricia Kingsnorth, Mark Haynes.**	
2.0	**Matters Arising/Actions** ask Caroline Beattie will link with Aoife and Ronan re: ;learning.	
3.0	**Standards and Guidelines** papers provided for review	Caroline Beattie
4.0	**Audit** **Papers provided for review**	ADs and AMDs
5.0	**Dr Murphy shared the SAI reports for** Personal Information redacted by the USI **learning re: NEWS score training should be mandatory for all medical and nursing staff. A discussion took place re: the escalation of a deteriorating patient. Particularly for agency and bank staff. This should be included in a staff induction – progress with training teams.** Personal Information redacted by the USI **learning shared Dr Haynes advised there is a pathway for the stable fractured – under age of 65 they go to T+O and over 65 go to medical. Unstable fractures should go to the spinal team. A discussion took place around this process. Chest injury also occurred in this case. Repatriation also was a problem in this case. There is a need for clearer guidance. Esther advised there is a process in place for major trauma patients to be managed in Belfast. Expectation would be consultant to consultant for repatriation. There are issues with the Belfast Trust to provide capacity to care for trauma patients. This case should be fed back to the regional group. Spinal injuries have never been admitted to Southern Trust. Duncan Redmill is leading on the regional trauma**	Patricia Patricia

Waiting Time Request | [redacted] | [redacted]

14.12.15 - Patient was admitted to hospital on 7.12.15 and had his surgery, he was discharged from ward 3 South on Wednesday 9.12.15.
MLA advised waiting times for Urology has increased significantly and the Urology team are giving priority to their cancer patients which is a high demand and current waiting list for non cancer patients is 70 weeks. Patient added to waiting list at end of April 2015 therefore another it will be another 44 weeks before patient gets date. Consultant has written to patient.

if someone complained about the length of time that they were on a waiting list, they were given the next available appointment?

A. Yes.

286 Q. Are you suggesting that the way to get moved up the waiting list is to complain? 13:01

A. No, I'm not suggesting that.

287 Q. Okay.

A. What I am saying is that that was a resolution or a remedy that the service was able to offer to people who complained. It wasn't that, you know it wasn't just widely known that if you make a complaint you get moved up the waiting list, and that wasn't the case. 13:01

288 Q. So but what -- I'm sorry, maybe I'm not being clear on it. If I write in and complain, I have been on this waiting list for months, years, whatever, what are you doing about it, I would be given an appointment within a short period of time? 13:02

A. Yes. But I accept that that doesn't look at the root cause of why there is a long wait. 13:02

289 Q. My point, though, is that, if people know to complain, then they can leapfrog over the waiting list, essentially?

A. Mm hmm.

CHAIR: Okay, thank you. I have no further questions. Thank you very much, Mr. Cardwell, that's been informative on many levels. Mr. Wolfe, I think that's our witness list for today, am I right? 13:02

MR. WOLFE KC: Thank you, Mr. Cardwell. Ms. McMahon is

Belfast Trust and was pivotal in setting up the Cancer Team and Service at the Bridgewater Suite. There was no overlap of Governance requirements from Cancer services into Acute, and no monitoring from governance teams that I was aware of. I feel this was a significant gap and a significant oversight, because of the different requirements, roles and responsibility for a nurse working on a ward versus a Nurse Specialist. Having a robust audit process similar to the NQI system used on wards would have allowed for oversight. I accept my responsibility in not being aware of these sooner, but I feel there was opportunity for this to be made known to me before it was.

22.6 Recent work on the concept of "No More Silos", I believe this has been a contributing factor in the issues that have been identified. The ability of teams to function in a vacuum, having numerous specialties within one team, with line management not aligned to the specific sub-specialties, resulted in elements of oversight being missed. The Thorndale Unit provides a good example of this: a Urology Outpatient Service, managed by the Acute Surgical Directorate, with both benign and cancer specialists, with responsibility to Cancer Patients but no oversight from Cancer Services and CNS line managed by a Lead Nurse who sits under Surgical Directorate with no experience of working within cancer services. Also recognizing the "triggers" we would use to highlight an issue, for example, complaints: this wasn't the case for Urology Outpatients, in fact in my entire tenure as Lead Nurse I only recall one complaint. I cannot recall the exact nature of the complaint but I can remember it was minor and dealt with very quickly. This in comparison to Ward 3 South, which had extensive complaints, demonstrated how issues were identified.

Question 23: Through your role, did you inform or engage with performance metrics or have any other patient or system data input within Urology? How did those systems help identify concerns, if at all?

23.1 As discussed previously, the only performance metrics I engaged with initially were those based on nursing performance and environmental standards. The concerns identified pertained to the overall poor performance

INPATIENTS/DAY CASES

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	IPDC Planned Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-13 Wks	13+to 17Wks	17+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL	
SEC	Breast Surgery	8% (+8)	8% (+11)	No	September 2017	IP	53 weeks	29	1	2	1	0	0	5	5	2	**45**	57 weeks
SEC	Breast Surgery					DC	48 weeks	23	0	0	2	1	1	0	2	0	**29**	52 weeks
MUSC	Cardiology	-2% (-9)	Not available	TBC	August 2016	IP/DC	71 weeks	272	115	109	80	61	33	35	24	23	**752**	63 weeks
CYPS	Community Dentistry	-15% (-27)	-36% (-209)	No	Not applicable	IP/DC	20 weeks	241	4	4	0	0	0	0	0	0	**249**	16 weeks
MUSC	Dermatology Cons-Led	13% (+34)	11% (+38)	Yes	June 2018	IP/DC	55 weeks	200	27	21	32	16	16	12	3	1	**328**	59 weeks
MUSC	Dermatology Nurse-Led	41% (+34)	48% (+53)	TBC	Not applicable	IP/DC	35 weeks	86	14	4	10	11	6	0	0	0	**131**	33 weeks
SEC	Ear, Nose & Throat (ENT)	-34% (-246)	-40% (-380)	No	April 2018	IP	74 weeks	71	8	12	17	17	15	12	13	25	**190**	76 weeks
SEC	Ear, Nose & Throat (ENT)					DC	89 weeks	383	116	109	162	92	71	75	72	50	**1130**	93 weeks
MUSC	Gastroenterology (Non-Scopes)	667% (+342)	664% (+454)	Yes	January 2017	IP/DC	Non-Scope = 20 weeks Scope = 53 weeks	9	1	1	0	0	0	0	1	2	**14**	Non-Scope = 24 weeks
MUSC	General Medicine	-6% (-26)	-6% (-34)	No	June 2018	IP/DC	4 weeks	1	0	0	0	0	0	0	0	0	**1**	Projection Outstanding
MUSC & OPPC	Geriatric Specialties combined	380% (+10)	440% (+15)	TBC	Not applicable	IP/DC	Not applicable	0	0	0	0	0	0	0	0	0	**0**	Not applicable
SEC	General Surgery (includes Haematuria & Minor Ops)	-19% (-272)	-26% (-499)	TBC	October 2016	IP	157 weeks	64	12	7	7	5	7	9	18	60	**189**	161 weeks
SEC	General Surgery (includes Haematuria & Minor Ops)					DC	140 weeks	593	123	110	114	70	56	123	130	336	**1655**	145 weeks
IMWH	Gynaecology	-12% (-75)	-10% (-87)	TBC	Not applicable	IP	52 weeks	102	27	22	12	15	18	12	3	0	**211**	46 weeks
IMWH	Gynaecology					DC	50 weeks	191	12	9	4	1	1	0	2	0	**220**	54 weeks
CCS	Haematology (incl Nurse-Led)	81% (+233)	78% (+301)	Yes	July 2018	IP/DC	4 weeks	53	0	0	0	0	0	0	0	0	**53**	Projection Outstanding
MUSC	Neurology	109% (+107)	101% (+131)	Yes	April 2018	IP/DC	15 weeks	32	6	0	0	0	0	0	0	0	**38**	18 weeks
SEC	Orthopaedics	-9% (-44)	-17% (-113)	Yes	August 2016	IP	126 weeks	249	107	75	89	75	106	104	129	569	**1503**	139 weeks
SEC	Orthopaedics					DC	158 weeks	265	75	52	94	87	62	57	50	323	**1065**	131 weeks
CYPS	Paediatric Medicine	-53% (-16)	-43% (-17)	TBC	Not applicable	IP/DC	66 weeks	23	3	5	7	2	1	9	7	11	**68**	63 weeks
ATICS	Pain Management	-32% (-45)	-27% (-49)	Yes	May 2016	IP/DC	157 weeks	68	26	18	30	12	33	36	71	282	**576**	156 weeks
MUSC	Rheumatology	17% (+123)	10% (+100)	Yes	March 2018	IP/DC	18 weeks	224	8	1	0	0	0	0	0	0	**233**	15 weeks
MUSC	Thoracic Medicine	-2% (-3)	-12% (-21)	Yes	Not applicable	IP/DC	4 weeks	13	0	0	0	0	0	0	0	0	**13**	<9weeks
SEC	Urology	12% (+129)	5% (+75)	Yes	July 2016	IP	235 weeks	131	35	23	34	35	30	32	62	460	**842**	239 weeks
SEC	Urology					DC	222 weeks	253	69	51	80	58	68	86	60	248	**973**	226 weeks

DIAGNOSTICS - ENDOSCOPY

Division/ Directorate/Programme of Care	Specialty	SBA Performance +/- at 30/06/18 (incl. IRR)	SBA Performance +/- at 31/07/18 (incl. IRR)	Known Capacity Gap	IPDC Planned Backlog Position at 31/07/2018 *(Longest Waiter)*	Activity Type	End of JULY 2018 Position (Actual) Longest Waiter	Timebands (in Weeks) - WL Position at 31 July 2018										Projected End of AUGUST 2018 position (Longest Waiter)
								0-9 Wks	9+ to 13Wks	13+to 17Wks	17+ to 21Wks	21+ to 26Wks	26+ to 31Wks	31+ to 36Wks	36+ to 42Wks	42+ to 52Wks	52+ Wks	TOTAL
SEC	Endoscopy - Symptomatic	-22% (-581)	-24% (-831)	Yes	May 2015	Diag. IP	47 weeks	4	1	3	0	0	1	0	1	1	0	**11**	49 weeks
SEC	Endoscopy - Symptomatic					Diag. DC	90 weeks	866	146	76	76	82	34	28	15	29	37	**1389**	93 weeks
ATICS	Endoscopy - Bowel Cancer Screening (BCS)	15% (+18)	13% (+20)	No	Not applicable	Diag. IP/DC	24 weeks	117	0	2	4	1	0	0	0	0	0	**124**	10 weeks

Mrs Magwood pointed out the challenges around training specialist nurses, however she advised that additional in-year recurrent funding has assisted to provide additional in-house and independent sector capacity.
Mrs McCartan referred to the longest wait in terms of inpatient and day case waits within Urology at 257 weeks. Members recognised challenges within Urology regionally. Mrs Magwood assured members controls are in place to review and manage lengthening access times.
The Chair referred to the challenges within Psychological Therapies where recruitment and retention issues continue to impact capacity. The Chief Executive advised that the current model is not fit for purpose and there is no funding allocated in year by HSCB to facilitate additionality from the independent sector in this area. Mr McNeany stated that an internal review of Psychological Therapies has been agreed to be undertaken in Quarter 4 of 2018/19 to deliver a strategic framework for the Trust. In addition, Mr McNeany advised that work remains ongoing regionally in terms of workforce issues and parity with other regional models. The Chair highlighted the increasing challenge of patients presenting with early onset dementia and the lack of funding for this cohort.

In response to the Chair, Mrs Magwood highlighted improvements in some areas. Ms Mullan referred to the workforce challenges and asked if a whole system approach could be taken to alleviate the pressures. The Chief Executive welcomed the publication of the regional Workforce Strategy and spoke from an internal perspective of work to make the organisation an attractive place to work. It was agreed that the regional workforce strategy would be circulated to Trust Board members.

The Board approved the Performance Report (ST903/19)

ii) Finance Report (ST904/19)

Ms O'Neill spoke to the above named report and advised the cumulative outturn at month 9 is a deficit of £1.223m however she noted movement in-month with a surplus of £107k recorded.

Members considered the areas of overspend causing most concern as at month 9 December 2018. Ms O'Neill emphasised the need for all Directors to continue to review their current expenditure trends now and identify areas for potential cost containment/reduction to ensure that the current overspend is returned to balance. Members noted that when compared to December 2017 figures, the Trust is currently paying for an additional 375 WTE's.

during the SAI Review of the 9 urology patients and the Overarching Review, the Chair and I met with the Urology MDT members and some of them described noticing a considerable difference in resources in the Southern Trust in comparison with Trusts in England where there was good follow-up and where tracking was more robust, more of a priority, and had administrative support. One doctor advised us that there were weekly trackers who would liaise with consultants, enabling them to meet their cancer timelines whereas in our Trust the trackers were only funded in respect of 31-day and 62-day targets and not to act as a broader failsafe system. Please see:

107. 20210218 Notes of Meeting with MDT 18.2.2021

19.3 I think that communication or triangulation of knowledge was also poorer than it could have been. For example, I wasn't made aware in a timely manner of the MHPS process or of the recommendations that flowed from it. I was made aware verbally by Martina Corrigan, following the Dr Johnston SAI, that there were measures in place involving administration staff monitoring the triage of letters and tracking of case notes involving Mr O'Brien. I was under the impression that this monitoring was working well. However, I was under so much pressure with the day-to-day work in governance that I didn't have time to check on it to assure myself that it was effective. I do not know if a broader information / knowledge base in this regard would have made a difference but it might have done.

19.4 The workload in Acute Services and Governance was heavy and staff were constantly trying to deal with the day to day pressures within busy hospitals. There simply wasn't enough time to do compliance audits regarding the adherence to recommendations arising out of all SAIs and complaints. This was a limitation. Audits were limited to compliance directly related to patient care, for example, audits of surgical site infections and infection rates for patients on ventilators (VAP). Whilst these are important, there also needs to be audits regarding the implementation of and adherence to recommendations and guidelines to protect patients and provide good standards of care

4.10 When I first came into post my office was on the Administration Floor in the main Craigavon Hospital building, which did help me hear if any incident had occurred because staff would drop by the office and tell me given its central and accessible location. However, my team and I were moved off the main hospital site in June 2019 as there was lack of suitable accommodation. This meant that it was more difficult to ascertain if something had happened. I had asked the Facilities Manager to scope an office back on the Administration Floor but this couldn't be facilitated.

4.11 Another drawback was that, sometimes, Surgical Screening was unable to take place due to the absence of either a Clinical Director or Associate Medical Director (or both). This was often due to competing clinical commitments. This meant that no decisions could be made regarding the screening of adverse incidents and to determine what the most appropriate method of addressing them was. Also, this impacted on the progress of existing SAIs if there were review panel members to be selected (usually the consultants were nominated by the AMD or CD). I didn't have similar concerns with screening within the other Divisions of Acute Services, so this was unique to Surgical. I raised this issue on numerous occasions with both Ronan Carroll, Assistant Director, and Mrs Melanie McClements, the Acute Director. This didn't improve until April 2020, when screening meetings began taking place over 'Zoom' and surgeons were stood down from elective work during the first Covid lockdown. Eventually, the screening day was changed to facilitate all the relevant medical personnel to attend. Screening meetings were not minuted. Rather, an outcome of screening was added to an Excel document.

4.12 Audits carried out within Acute were compliance driven ensuring a high standard of patient care. For example, the Malnutrition Universal Screening Tool (MUST) Audit, to provide assurances that patients in hospital were getting adequate nutrition, or audits on Fluid Balance Charts or Early Warning Score Charts which were directly reflective of good standards of patient care. I understand the Audit Department were not adequately resourced to assist with quality assurance audits to assess the effectiveness of our governance systems and processes. On reflection there was a missed opportunity to be

management of Standards and Guidelines (S&G) and there were two meetings a fortnight to ensure that the Acute Assistant Directors and Acute Director were aware of the Trust's responsibilities and responses required regarding S&G. I also oversaw the equipment management of medical devices within the Trust.

3.4 There was a separate team within the Trust responsible for Clinical Audit, M&M and Quality Improvement that were not under my remit.

3.5 I kept the Director of Acute appraised of any outstanding issues regarding screening, for example, when screening didn't occur and the reasons for this. This was an issue with surgical screening and the lack of attendance of the Associate Medical Director and Clinical Director as they had competing clinical priorities which made it difficult for them to attend most screening meetings. This was addressed and there was good improvement from April 2020. This may have been related to the Covid pandemic response in that all meetings became accessible remotely, which made attendance for medical managers (who were also busy clinicians) easier.

3.6 There was a separate process followed through Human Resources when issues were identified regarding a staff member's competences. As stated above at Question 1(i), the operational teams are responsible for the competency of, or professional issue with, any registrant and any issues of such a nature would be addressed through this route. Usually, the Medical Director's Office or Executive Director of Nursing would be made aware of any such issues. They would not be shared at my level in view of the confidential nature of them. Of course, the problem with that is that it prevents one from having all the information when an SAI Review is conducted. Practices have now changed somewhat so that any staff member mentioned in an SAI has to discuss this at revalidation.

3.7 As both a Lead Midwife and Risk Midwife, I was aware of midwives being referred for Supervisor of Midwives Investigations or to the NMC. These were robust investigations and could often result in sanctions. Therefore, it was not unusual for these processes to be kept confidential amongst a select number of people. However, as a Band 7 Risk Midwife I would have been made aware that a process had commenced in respect of a named individual, even though

being involved in that whole review. Not so much Urology, but in surgery in general or medicine, it seems to be -- there seems to be still that fear aspect of it that requires a lot of reassurance, and reassurance from the viewpoint of finger-pointing. You know, you need to make sure that you are doing it from a systems viewpoint rather than just finger-pointing, because that's not good and it's not good for anybody. Equally, making sure that the learning is out there and shared back. 14:58

332 Q. But how would you transfer that? Can you think of anything practical, because it's quite an important issue, I think, for the future?

A. I'm just trying to think of what I had done at the start whenever I started as a midwife over ten years ago. I think our whole -- it was that putting your champions in place from your consultants and then setting that tone for learning. 14:59

333 Q. In that regard, for example, when you had your screening meetings, did anybody consider bringing a wider consultant body into that? Not just using CDs and AMDs, they are so busy, why not bring other people in; was that talked about? 14:59

A. It wasn't talked about, no, but it's a very good point.

334 Q. When you didn't have enough people to screen, how long do you think that delayed things, because there seems to be big delays in this system? 14:59

A. Oh, it was easily six months more.

335 Q. Okay.

I would not have been provided with any details, nor did I require any details in my role. I feel this should have happened regarding the MHPS investigation. I did not need to know all of the details; just that there was a separate investigation taking place for a particular staff member. I would then have been more informed and better able to identify any recurrent issues with a particular staff member, thereby enhancing governance.

Urology

3.8 I believe the overall responsibility for governance in Urology rested with the Assistant Director of Surgery, Associate Medical Director, and Clinical Directors who would then escalate appropriate issues to the Director of Acute Services, Medical Director, and Chief Executive. I understand there is also a governance responsibility sitting with the Chair of the MDM for Urology to ensure that recommendations made at MDM are actioned.

3.9 There appeared to me to be a “disconnect” between what was happening regarding operational decisions within Divisions and what was shared with the Acute Clinical Governance Coordinator. I was only made aware of any issues through the SAI processes or through Datix, complaints, or the Hospital at Night Report (this is a report that the Bed Manager provides every morning, detailing any incidents or issues that occurred overnight on each hospital site and which includes the number of patients waiting on beds in the Emergency Department). An example of an issue or incident could be an unexpected death on the ward or if a high-risk patient absconded. Each of these information routes might prompt me to seek further information on and / or clarification of the issue raised. Sometimes, the Assistant Director for the Division would let me know of any concerns in their Departments but generally this usually only occurred when a response was required for HSCB and my assistance was called upon. The limitation inherent in these communication channels is that you are relying on someone telling you of any issues or submitting a Datix. On reflection it was not sufficiently robust and I think there was a missed opportunity to discuss clinical concerns, perhaps as a standing agenda item, at the Acute Governance Meeting (when all the operational Assistant Directors, the Director of Acute, and the Clinical Governance Coordinator are present).

3.10 Whilst I do not believe there was ever any intention to cover up issues, I believe that some serious issues were escalated to my senior colleagues rather than to me given the confidential nature of them. The MHPS case regarding Mr O'Brien is an example of this.

3.11 The Acute Directorate is so vast that I believe it would be impossible to have complete governance oversight of it at my level within the organisation. Whilst I could deal with issues that were made known to me, I believe those with the overall responsibility for governance in Urology (as identified above) may have had greater oversight or a greater ability to have oversight.

4. 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?

4.1 I believe that 'governance' is an umbrella term to describe the framework by which healthcare organisations are accountable for continuously improving the quality of their service and safeguarding high quality care. This is achieved through, risk management (including complaints, clinical incidents, equipment management and Standards and Guidelines), training and education, audit, clinical effectiveness, research and development, and patient and public involvement.

4.2 Governance issues were usually highlighted from a Datix (incident report) which would be generated at an operational level. It was my responsibility to ensure all the Datix submitted were reviewed on a daily basis (working hours) and any major or catastrophic incidents were reviewed and screened weekly by the Acute Senior Management Team, which included the Associate Medical Director for the Division, Clinical Director for the Division, Assistant Director for SEC, and a governance officer in the event that I was unavailable. There are limitations with the Datix system in that, once a Datix review is completed, the Datix is closed and, unless a report is generated to look specifically at themes, then it does not remain visible to the governance team. In the circumstances, when I came into post in early 2019 I was not aware that there had previously

This was because the Acute Governance team was chronically under resourced for the size of the tasks expected of them."

This should be amended to state: "Overall, in my opinion, the governance arrangements in the Acute Directorate ~~where~~ were not fit for purpose. This was because the Acute Governance team was chronically under resourced for the size of the tasks expected of them."

11. At paragraph 44.1 (WIT-87673) I have stated: "*I would like to add information about a telephone call that I inadvertently witnessed as it I think it may be evidence of some level of pressure on one of the Acute Services Directors who did not fully investigate Mr O'Brien's practice*."

This should be amended to state: "I would like to add information about a telephone call that I inadvertently witnessed as it I think it may be evidence of some level of pressure on one of the Acute Services Directors who did not fully address ~~investigate~~ Mr O'Brien's practice."

Major Amendments

12. At paragraphs 27.11 to 27.13 (WIT-87657 to WIT-87658) I have stated:

> "27.11 On 9th November 2016 one of the lead nurses who had been transferred into the Acute Governance team in 2014, Connie Connelly, gave me a letter of concern *(Attachment 24)* about an SAI that she had been working on *(Attachment 25).* The SAI review was considering the case of Patient 10. Ms Connolly was a panel member in the investigation which was being chaired by Mr Anthony Glackin, Consultant Urologist. The letter was unsigned.
>
> 27.12 The panel's concerns included:
>
> (a) That the root cause of the SAI was Mr O'Brien's lack of action in relation to the triage of Patient 10's referral letter from her GP.

were those concerns and with whom did you raise them and what, if anything, was done?

43.1 Overall, in my opinion, the governance arrangements in the Acute Directorate where not fit for purpose. This was because the Acute Governance team was chronically under resourced for the size of the tasks expected of them.

43.2 The clinical staff also did not have protected time for governance activities. When they were under severe patient flow/bed pressures, as often experienced in the Southern Trust Acute Service, the governance activity had to be put on hold.

43.4 When I was asked to look after the Acute Governance team for a period of time in October 2014 I realised that there was a back a backlog of unopened incident reports on Datix *(Attachment 32).* This backlog had not been escalated before and was unknown to the Director (Debbie Burns). These incidents, once reviewed, led to a backlog of SAI reviews.

43.5 The fact that the Governance Lead post had been given up as a saving in 2014 also demonstrated a lack of understanding of the importance of good clinical governance in my opinion. It was impossible for me to take on the full role of the governance lead on top of my substantive post as the Director of Pharmacy. As my registration as a pharmacist could have been at risk if I did not ensure the safe running of the pharmacy service, the best I could do was to offer every Tuesday morning in my diary to assist the members of the Acute Governance team as best as I could.

43.6 The two Band 7 governance officers on the team at the time were very inexperienced as they had been redeployed at short notice after the lead nurse role was stood down at that time too. I had to identify training for them to try to get them up to speed with incident investigation and report writing skills as quickly as possible.

in. I worked in the Governance Department i.e. it was called Safe and Effective Care. I managed audit, standards and guidelines. I also looked at complaints in a different way; standard 48 and ISO. Then I moved to prison healthcare, where I was the governance lead for two years before becoming the assistant director. I felt very, very comfortable in that Trust with the amount of governance support that was around me; I knew I needed that. But when I joined the Southern Trust, there was really none of it there. There was nothing that I could... 12:28 12:28

So Tracey thinks that I wanted to hold on to her because I was inexperienced. That is not the case at all. I wanted to hold on to her because I actually did rate her as excellent. She had a lot of experience in governance and I needed, as a starting point, an assistant director to be in charge of governance. Doesn't matter if she delegated all of her work to Trudy, that didn't matter. I just needed an assistant director to be answerable to me, the way everything else was. I did ask for a whole time equivalent assistant director, but the finances. You know, governance was the bottom of the pile, to tell you the truth, in the Southern Trust. You know, the finances just weren't there. We had to work with whatever we had. It was all about putting money into front-facing, which was important. 12:29 12:29 12:29

281 Q. Yes.

Clayton, Wendy

From: Carroll, Ronan
Sent: 02 May 2022 14:55
To: Carroll, Ronan
Subject: FW: Governance Structure within ACute Services

Ronan Carrroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob - Personal Information redacted by USI

From: Carroll, Ronan Personal Information redacted by USI
Sent: 15 March 2018 13:05
To: Conway, Barry Personal Information redacted by USI
Subject: FW: Governance Structure within ACute Services

Barry
Sorry didn't include you as was simply following on the previous emails
Ronan

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

From: Carroll, Ronan
Sent: 15 March 2018 11:48
To: Gishkori, Esther; Boyce, Tracey; Walker, Helen; McVey, Anne; Trouton, Heather
Cc: Haynes, Mark; Scullion, Damian; Kelly, Brigeen; Corrigan, Martina; Murray, Helena; Nelson, Amie; Clayton, Wendy
Subject: RE: Governance Structure within ACute Services
Importance: High

Esther,
Tks for the update – totally unaware of any recruitment to these positions and as this person will be part of ATIC/SEC, the same successful model in IWMH, I would ask to be part of the recruitment process
Ronan

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

From: Gishkori, Esther
Sent: 15 March 2018 11:12
To: Carroll, Ronan; Boyce, Tracey; Walker, Helen; McVey, Anne; Trouton, Heather
Cc: Haynes, Mark; Scullion, Damian; Kelly, Brigeen; Corrigan, Martina; Murray, Helena; Nelson, Amie; Clayton, Wendy
Subject: RE: Governance Structure within ACute Services

Ronan,
Governance is everyone's business, especially documentation, communication, and communication with relatives and patients.
Training has to be initiated at operational level but I agree, everyone does need some help with the whole process for the implementation of learning which I feel we could get better at.

The recruitment process is underway to bolster the governance team but as there will only be one of them per division, there will be still be responsibility on the operational teams to deliver.
Tracey or Trudy may want to comment on the recruitment process
Thanks
Esther.

From: Carroll, Ronan
Sent: 15 March 2018 08:35
To: Carroll, Ronan; Boyce, Tracey; Gishkori, Esther; Walker, Helen; McVey, Anne; Trouton, Heather
Cc: Haynes, Mark; Scullion, Damian; Kelly, Brigeen; Corrigan, Martina; Murray, Helena; Nelson, Amie; Clayton, Wendy
Subject: RE: Governance Structure within ACute Services
Importance: High

Esther
Last Friday I attended a very informative talk given by Mr Patrick McGurgan one of NI's coroner's. in summary he said, and this will be no surprise, that continuously Trust's fail to

1- Document comprehensively
2- Communicate openly and with understanding with pts/relatives
3- Train/Update and provide evidence of learning

Which again brings me to my concern with regard to the above. We are approximately 19mths into restructuring and no further forward with respect to having the agreed structure in place.
So yet again I ask can I be assigned a Risk/governance B7 who will work with the HOS/LN/AMD's to manage all elements of governance
Ronan

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

From: Carroll, Ronan Personal Information redacted by USI
Sent: 19 January 2018 10:08
To: Carroll, Ronan; Boyce, Tracey; Gishkori, Esther; Walker, Helen; McVey, Anne; Trouton, Heather
Cc: Haynes, Mark; Scullion, Damian; Kelly, Brigeen; Corrigan, Martina; Murray, Helena; Nelson, Amie; Clayton, Wendy
Subject: RE: Governance Structure within ACute Services
Importance: High

Esther,
We are now a further 3mths since I sent the email below. The structure which we all signed up to has not materialised and in fact I am unsure of what the actual structure is.
I have discussed this with my AMD's & HoS and similar to the model that appears, to us, to work very well in IWMH (Anne & heather will have experience of this model) I would request that we are assigned a Risk/governance B7 who will work with the HOS/LN to manage all elements of governance within ATICs/SEC.
Ronan

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

From: Carroll, Ronan Personal Information redacted by USI
Sent: 30 September 2017 15:57
To: Boyce, Tracey; Gishkori, Esther; Walker, Helen; McVey, Anne; Trouton, Heather
Subject: RE: Governance Structure within ACute Services
Importance: High

Tracey
Yes – we all agreed 2 B7 for MUSC 1 SEC/ATICs so we have 3 Connie, Edel, Cathie with Paula supporting/Floating.

We are 18mths into the restructuring would be great to get this finally bottomed with AD's clear who they had reporting to them
Helen/Esther please come back to me if this is not in order pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by USI

From: Boyce, Tracey
Sent: 29 September 2017 17:09
To: Carroll, Ronan; Gishkori, Esther; Walker, Helen; McVey, Anne; Trouton, Heather
Subject: RE: Governance Structure within ACute Services

Hi Ronan
That's a great idea re Cathy helping out with the governance work – we would be delighted to have her.

We currently don't have a budget for governance – how would the funding work out? Would it be on the same basis that Sharon was helping the team?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by USI

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

From: Carroll, Ronan
Sent: 29 September 2017 12:34
To: Carroll, Ronan; Gishkori, Esther; Boyce, Tracey; Walker, Helen; McVey, Anne; Trouton, Heather
Subject: RE: Governance Structure within ACute Services

Dear all
Further to my email below for which I received no update on my query Esther/Helen I am asking is there any issue in me bringing Sr Cathie Rocks in to replace the role of Sharon Kennedy to work in ATICs/SEC.
Personal Information redacted by the USI could as I understand it work 5days weekly
I would be keen to support her and achieve direct support for ATICs/SEC
Ronan

Ronan Carroll
Assistant Director Acute Services

approaching learning I think probably through different systems and processes, but not - we don't have an overarching approach to learning and embedding some of this in the system. So the discussions I've been having with the governance team and the Medical Director have now been around how do we bring that into the body of the organisation? 14:17

So one of the other things that has happened over the last 18 months or so since I was appointed Chief Executive is that I have replaced a lot of the staff who have retired or left to go to other places, by a new team of Directors. So we have just finished the last replacement of an Executive Director. And in addition to that, in order to make sure that we pursue the agenda of embedding improvement in the organisation, I have appointed for the next two years in the first instance a Director of Transformation and Improvement, who will take forward the outworkings of what we've learned, again under those domains that I mentioned earlier in relation to this Public Inquiry, but also to look at what is coming out of the Neurology Public Inquiry, potentially Muckamore Abbey, you know, any other learning that's there. Plus dealing with some of the issues within the Trust in terms of how we address specific areas in terms of concerns in relation to improvements, such as overcrowding, and all of the ED issues that you would hear about. So that's now in place. 14:17 14:17 14:18 14:18

with patients that might be made to make them aware. She also was concerned that this appeared to be a continuation of the behaviours that led to the Serious Adverse Incidents previously.

Q51. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q65 will ask about any support provided to Mr O'Brien).

542. In the earlier days of my tenure as Acute Services Director, the support for the team focused on building capacity, recruiting medical and nursing staff (substantive preferably and locum/ agency if necessary), stabilising the teams focusing on quality care and involving the professional Executives, Medical Director and Executive Nurse, in operational plans that required professional support and oversight, reducing bed complement to improve the nurse to patient bed ratio and reducing patient safety risks.

543. Once the more serious concerns noted above were communicated to the urology team, the need for additional patient reviews on an already stretched team, with vacant posts and significant backlogs, waiting lists and waiting times, increased anxiety levels. As a result of the announcement of a Public Inquiry into urology services, regular meetings were set up to check in with the team, offer 1:1 or peer support if they felt that would be helpful, and access to psychological support internally within the Trust or via INSPIRE was offered (independent contract available for staff health and wellbeing). The Director of Human Resources was kept appraised of the concern among urology staff as the psychology services and wrap around support sits within her brief.

544. Regular team meetings were offered at the pace and level that the team requested, monthly in the first instance and then scheduled whenever a communication needed to be shared. This offer was one of support with the spirit of one team working on resolving the issues together, staying united and strong and focused on patient safety. Having the Medical Director, Chief Executive and Executive Nurse in attendance was an opportunity to discuss any concerns among the team.

545. The consultants were concerned regarding the displacement of their priority patients by the need to review Mr O'Brien's patients as identified. As their concerns related to lack of capacity, subject matter experts were sourced from British Association of Urology Specialists (BAUS) to offset some of the demand of the patient reviews. In addition, an independent sector contract was agreed for approximately 236 oncology patients to be reviewed as a matter of priority. These approaches were an attempt to retain some capacity for their priority patients.

this in any disrespect to the families - the issue is why did it happen and how did it happen. Clearly, normal mechanisms to prevent variance from best care, normal mechanisms to ensure involvement of all professionals in care, things that - we've talked about, you know - you may have seen 15/20 years ago in cancer services; there should have been structures there to ensure that that did not happen. There should have been internal governance as well as external quality assurance through peer review. Any service can have difficulties, any service can have problems, but it should have an active and agile governance structure to prevent patient harm, and it clearly wasn't there. 12:37 12:37

MR. WOLFE KC: If we scroll down and over the page, please. You set out the recommendations and action planning. You say that the recommendations, of which there are, I think, 11, that they represent an enhanced level of assurance. Just help us with that term. What does that term mean? 12:37

DR. HUGHES: The recommendations are based around returns that you would have to make, including additional returns above and beyond what a normal cancer team would expect to do. The rationale behind that, there was a major deficit in how the public viewed the service. The remaining team had to deal with this downside and patient engagement process. So it was to ensure that the service, going forward, did meet the standards, did say what they promised to do in the Cancer Peer Review and made sure there was no 12:38 12:38

the action plan. You explain it was intended to provide evidence of a high quality service going forward. You say the recommendations were routine expectations of a functional high-quality service. Just on the point you made that they're over and above what a cancer team would normally have, I'm just trying to marry that -- 12:41

DR. HUGHES: The assurance process, the data required to provide the assurance is probably over and above what is required. The actual standards are no different than what anybody else would have to attain. Part of the deficit was that they had made returns on the basis of standards to a peer review which were not proven to be factual. 12:41

MR. WOLFE KC: So, you're not suggesting that the assurance mechanisms which were to be new to this cancer team and this multi-disciplinary team, you're not suggesting that they ought to have been in place necessarily prior to your investigation. What you were saying is "I'm pushing this higher bar because I think this service reputationally and otherwise actually requires it". 12:41 12:42

DR. HUGHES: Yes, that's what I'm saying. Normally, the assurance mechanism would be a selected number of cases, just for example, to provide assurance, but because the deficits identified in the service provided by this team were a range, they needed a proportionate enhanced assurance mechanism. That could be rolled back in the fullness of time but I think because of the 12:42

41.1 In my view, there was not a failure to engage fully with the problems within Urology Services once Trust Board were informed of the issues on 27th August 2020. From that date, Trust Board has had oversight and has been provided with regular progress reports. Board minutes attest to the scrutiny and challenge of members.

41.2 Prior to 27th August 2020, in my view there was a failure to engage fully with the problems within Urology services. From a Board perspective, Dr Rankin's briefings to Trust Board on 30th September 2010 and 25th November 2020 (ten year's earlier) advised of clinical concerns, but lacked sufficient detail.

42. **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?**

42.1 I consider that overall mistakes were made in that the information provided to Trust Board was not timely and lacked sufficient detail. In terms of what could have been done differently, the information could have been presented more regularly and in such detail to enable Board members to fulfil their role and responsibilities.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

MR. WOLFE KC: Thank you.

Dr. Hughes, back to your Section 21 statement again for the final of the key themes that you identify for us arising out of the nine cases. 11:57

WIT-84170. Here you talk about the lack of coherent escalation/governance structures. Do I interpret that correctly to mean that while there may have been some escalation, it wasn't done coherently or in such an effective way as to produce change, and that's coupled with an absence of effective governance structures to enable that to be done? 11:57

DR. HUGHES: Yes. It was really twofold. I think they were ineffective in escalating things they knew about, but I think the structures were very poor. The structures were very much based on who the professional was. So, it was the responsibility of nurses one way, and responsibility for doctors in another direction, and a tendency to say "That's not my responsibility". 11:58

Whereas governance is based on patient outcomes and patient deficits. They should have had a very clear, coherent responsibility written into the cancer structures that whatever happens in cancer care on cancer patients, there is a definite responsibility for cancer services around that. Too frequently I heard the words "Well, that's not our responsibility". 11:58

I don't think it is helpful that you have a leadership

things outside of more resource being put in that can improve the service for patients but also for the staff delivering that care.

164 Q. We can see, you touched earlier, you touched several times on the role of the region, which is manifest through the operation of PIG, as I described it earlier, the Programme Improvement Group. I think you reflected positively about that group. Can you help us better understand what that group is, how often it meets, what its objectives are, and how does it work? 16:25

A. So I haven't reread but there is a terms of reference that was updated, I think, earlier this year and sent round. Essentially the group is made up of representatives from SPPG, who chair it, there's Department of Health representatives. From each Trust that provide urological services, there are clinical representatives and there's managerial representatives. It is a proactive group at all levels, with good relationships, and relationships that do challenge how things are being done. So we have had discussions that you could describe as lively or challenging, but there is no issue with having them discussions and them challenging conversations. But everyone in that group is working towards a positive outcome in the delivery of care, and the GIRFT report has provided a framework going forwards for many of the work streams that will come out from that PIG Group. 16:25 16:26 16:26 16:27

165 Q. I think it is fair to say that the GIRFT Report wasn't long off the press when it was discussed at the PIG

meeting in November. We can touch on that briefly, TRU-320308. We can see that the attendees at that meeting, including yourself and your colleague Mr. Tyson, Mr. Glackin. As you say, chaired by David McCormack of the SPPG and attended by various stakeholders, including representatives of the Belfast and Southeastern Trust, Southwestern Trust and the Department of Health. If we scroll down, you can see that GIRFT has just been reported and it's on the agenda, summarised by Mr. McCormack. Over the page, he sets out, I suppose, the action that's going to be required, which involves some prioritisation of the recommendations, Task and Finish Groups to be set up within each urology unit but a clear understanding that there would need to be a regional focus. The Inquiry can see from documents supplied that this was the subject of further discussion at the January meeting and no doubt so on. 16:28 16:28 16:28

In terms of the benefits that the implementation of GIRFT might bring, where do you see those benefits being most obvious for the Southern Trust? 16:29

A. As I say, the drive supported the direction of travel we wanted to go. The establishment of a specialist service in Southern Trust provides, I think, some confidence that we will be able to recruit and attract people into a specialist post. The support for the network for kidney cancer service is really important because there has been a change in how kidney cancer is 16:29

managed surgically, which has inevitably meant the number of kidney removals, whole kidney removals, in each Trust has dropped dramatically. The number of open operations for big cancers has dropped dramatically. Left in isolation, there was always a risk of the kidney cancer surgeons finding themselves unable to continue in the districts where support, outreach and cross-network working will hopefully prevent that from happening. 16:30

It's very clinically led so the goals are driven by GIRFT, which is body coming with -- which is clinicians lead the final -- do the inspections and write the report. It is supported by us as clinicians. That clinical leadership in delivery of this will hopefully mean that we will have a service that is not only safe for patients but what we want and what we see as the best way of delivering care. 16:31

I think the name of the group, Getting It Right First Time, gives it away. If someone is referred with suspected kidney cancer, they should see a kidney cancer surgeon, and that's this goal but split across all of the services. 16:31

166 Q. I suppose to bring it back to a slightly more sober place, perhaps, the GIRFT report - I'm not going to try to bring it up on the screen because I think I've lost that battle already - the GIRFT report reflects in its executive summary that Northern Ireland has witnessed 16:31

Getting it Right First Time

Urology across Northern Ireland

October 2023

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to enable the urgent restoration of elective urological services and the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Written by:

Kieran O'Flynn: GIRFT Joint National Urology Clinical Lead, Consultant Urological Surgeon, Northern Care Alliance.

John McGrath: GIRFT Joint National Urology Clinical Lead, Consultant Urological Surgeon, Royal Devon University Healthcare NHS Foundation Trust

Foreword

Getting It Right First Time (GIRFT) is a national Programme in England developed by the GIRFT National Team under the Chairmanship of Professor Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice. It helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The High Volume Low Complexity (HVLC) programme is a priority data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic. It aims to reduce the backlog of patients waiting for planned operations, improve clinical outcomes and access to services through standardised clinical pathways (HVLC programme - Getting It Right First Time - GIRFT).

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the Chairmanship of Professor Tim Briggs, was approached by the Northern Ireland Department of Health Elective and Cancer Services team to conduct a review of Urology across Northern Ireland using the GIRFT methodology and HVLC principles.

This report describes the findings and recommendations from the review, as well as laying out the objectives and the approach followed by the RNOH GIRFT team.

Kieran O'Flynn

Joint GIRFT Clinical Lead for Urology Surgery, Consultant Urological Surgeon at Northern Care Alliance

John McGrath

Joint GIRFT Clinical Lead for Urology Surgery, Consultant Urological Surgeon at Royal Devon University Healthcare NHS Foundation Trust.

Contents

1. Executive Summary

This report is based on the data and observations from RNOH/GIRFT's face to face visits to all the Trusts in Northern Ireland to review their urology services. **Figure 1** shows the schedule of the visits. **Annex A** provides a full list of hospitals included in this review.

Figure 1: Schedule of visits

Trust	Visit Date
South Eastern Trust	Tuesday 16th May and Wednesday 17th May 2023
Belfast Trust	Wednesday 17th May 2023
Northern Trust	Thursday 18th May 2023
Southern Trust	Thursday 18th May 2023
Western Trust	Friday 19th May 2023

We have made a series of recommendations in this report which aim to tackle waiting lists, improve structures and ways of working and improve the quality of care. Consideration is given to other cross-cutting areas to improve performance, awareness and the governance of urology services across Northern Ireland.

It is now essential that the recommendations made in this report are immediately taken forward to improve care for patients and to put in place a structure and ways of working across Northern Ireland to deliver them. This will involve the Trusts working together and a blurring of their historical boundaries. Furthermore, it is essential that the changes introduced to increase elective surgery are resilient during the winter months; and must deliver elective care for 48 weeks per annum. We can no longer accept "shut down" of elective care during winter; it is not in the best interest of patients and will not reduce waiting lists.

We have made a total of **40 national recommendations** in this report. These include recommendations for the Department of Health to take forward nationally **(Section 2.1)** and recommendations where the Department of Health should encourage the implementation of over-arching recommendations to all Trusts, as many improvements apply to all providers **(Section 2.2)**.

Through a combination of Trust meetings and a review of the data provided, we observed variation in practice within Trusts, between Trusts and also when compared to NHS England urology metrics; some of the variation is unwarranted. Where we have observed this, we have challenged the Urology Teams and provide appropriate recommendations. Separate recommendations for each of the Trusts are detailed in **Annex B-F.**

We have provided a number of useful links to GIRFT Urology pathways and good practice guidance in **Annex G** along with a glossary of terms and abbreviations in **Annex H.**

The review team met with senior clinicians, managers and members of the trust executives at each of the five trusts providing services across Northern Ireland. There was an overwhelming sense amongst the people that we spoke with that provision of urological services across the Province had deteriorated over the past decade and that long-term planning was hampered by the absence of a functioning administration at Stormont and the current political vacuum.

The direct consequence of this is that budgetary planning is difficult, with in-year budgeting becoming the norm. Nevertheless, the RNOH/GIRFT team were very impressed with the

strides that colleagues had made in discussions about how service should evolve in the specialty of Urology.

Given the population in Northern Ireland of 1.86 million, it is neither possible nor desirable that all elements of the specialty can be delivered to a high standard in each hospital. Rationalisation and delivery of high-quality services are essential to ensure that clinicians with the requisite experience and skills are available to manage routine and complex care. While this principle has been accepted in urological oncology (provision of surgery for prostate, bladder, kidney and penile malignancies) and surgical andrology, there is a general acceptance across the British Isles that surgery of bladder outflow obstruction, complex stone disease, female and functional / neuro-urology should also move in this direction. It is to the immense credit of the Urologists in Northern Ireland that planning for this scenario is well advanced. Implementation should be the next step to ensure a vibrant and sustainable service for Northern Ireland's population.

2. Recommendations

2.1 General Recommendations for Northern Ireland Urology

No.	Department of Health Recommendations
1	DoH should establish a group of relevant stakeholders to lead on the development of an action plan to implement the GIRFT recommendations, allocating responsibilities to relevant people to share the workload. The group will need to align with existing regional and local structures to ensure no duplication.
2	The DoH should continue to encourage and support Trusts to strengthen clinical coding processes, including the routine sharing of data with clinical teams.
3	The DoH should ensure that good governance arrangements are in place to enable patients to have timely access to investigations and ensure that all clinicians seeing outpatient referrals have access to Northern Ireland Electronic Care Record (NIERC), thereby avoiding duplication of imaging and unnecessary repeat appointments. This predominantly relates to the use of 'outsourcing'; there should be a focus on long term provision of outpatient care in order to obviate the need for this short-term support. This should be explored with the rollout of Encompass.
4	The DoH should support Trusts to strengthen clinical networking to further promote mutual aid, where differences in waiting access times and or differences in the volumes of backlogs exist.
5	The DoH needs to urgently work with providers to address the under-provision of theatre capacity in regard to the provision of major urological cancer surgery, including cystectomy, radical prostatectomy and renal surgery. In the first instance, Belfast Trust should also work to ensure the full delivery of commissioned theatre list for the urology service within the Belfast Trust.
6	DoH should consider supporting a formal renal surgery network at sites outside of Belfast City Hospital (BCH) that currently offer this surgery; this could help to de-pressurise other major urological cancer pathways at the City site.
7	The Public Health Agency (PHA), in conjunction with BHSCT, should initiate a strategic review of the provision of robotic assisted surgery for Northern Ireland in Urology and other specialties, recognising the likely developments in robotic surgery in the next decade.
8	The DoH should promote and enable further examples of cross-site working between clinical teams for the delivery of both benign and cancer urological services.
9	The DoH should consider initiating a review into the funding mechanisms for trusts providing specialist care in both oncology and sub specialist urology practice, ensuring that trusts are not disadvantaged by undertaking specialist work.
10	The DoH should continue to ensure that Trusts are actively working to reduce the reliance on external outsourcing of clinical care; this can be achieved through implementation of the GIRFT recommendations and principles
11	The DoH should formalise the plans for the long-term provision of surgical andrology for Northern Ireland.

12	The DoH should formalise plans for the long-term provision of female and functional urology for Northern Ireland in conjunction with recommendations made in the GIRFT Uro-gynaecology report.
13	The DoH, in association with the Northern Ireland Medical and Dental Training Authority (NIMDTA), should undertake a review to ensure the national selection in Urology is the right model for recruitment into the specialty.
14	The DoH, in association with NIMDTA, to review the distribution of Urology trainees across NI, ensuring equity and access to training opportunities.
15	DoH, in partnership with trusts, should ensure robust processes/pathways and audit particularly of sub-specialty services to ensure they meet minimum quality standards, e.g. prostate cancer diagnostic pathways/ RARP/Cystectomy/ penile cancer etc. Quality standards should be agreed by subspecialist urologists in each area but already available for many subspecialty areas.

2.2 General Recommendations for the NI Department of Health and all Trusts

Northern Ireland Urology General Recommendations	
Outpatient Care	
1	As a priority, The DoH should support and encourage each Trust to plan for and establish a Urology Investigation Unit, where such a facility does not already exist (GIRFT Urology Investigation Units Guidance), to maximise the efficiency of elective outpatient services.
2	The DoH should ensure that Trusts strengthen the Advice and Guidance services and all referrals should undergo robust clinical triage by a senior clinician (medical or nursing), with downgrading of inappropriate red flag referrals (GIRFT Urology Outpatient Guidance).
3	As a matter of urgency, The DoH must support and encourage Trust Urology Teams to redesign and enhance their capacity to provide single-visit outpatient consulting and assessment (diagnostic) services for patients, with pre investigation imaging, where indicated arranged at triage prior to attendance.
4	The DoH should ensure that Trusts review their outpatient practice with a view to reducing the number of unnecessary review appointments, aspiring to a new to follow-up ratio of 1:2.
5	The DoH should promote greater adoption of virtual reviews as well as further nurse specialist input into outpatient pathways.
6	The DoH should ensure that Trusts are offering patient-initiated follow-up (PIFU) rather than routine clinical review to suitable patients. Trusts should ensure that there are robust mechanisms in place for such patients to gain timely access back into secondary care.
7	The DoH should ensure that outpatient pathways are standardised across all Trusts to ensure there is consistency nationally for patient undergoing outpatient investigation or treatment.
8	Trusts should rapidly implement a flexible cystoscopy and transurethral laser ablation (TULA) service for 'red patches' and recurrent superficial bladder cancer in the outpatient setting.
Inpatient Urology and HVLC	
9	Trusts should ensure that suitable procedures (flexible cystoscopy, flexible cystoscopy and Botox, transperineal biopsy procedures, urodynamics etc.) are **not** routinely

	performed in Trust theatres. These should be performed in an outpatient procedure room by default, not inpatient theatres '**Right procedure, right place' approach**'.
10	The PIG should ensure that there is continuous improvement work on moving existing in-patient pathways to daycase pathways and moving daycase pathways to an outpatient setting, where appropriate.
11	Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2 sessions of theatre activity for 42 weeks of the year, when not Consultant of the Week.
12	Trusts to implement the GIRFT guidance on theatre productivity, with appropriate listing and maximising theatre efficiency with SPPG oversight.
13	Where not already done, The DoH should ensure that Trusts implement an action plan for increasing the percentage of elective operations undertaken as day surgery, using the BADS guidance (Day case surgery - Getting It Right First Time - GIRFT).
14	The DoH should continue to ensure that Trusts have access to and efficiently utilise 'cold' HVLC sites, thereby ensuring that protected elective capacity is maintained regardless of winter or acute care pressures.
15	The Department of Health should continue to encourage Trusts to collaborate ensuring that there is equitable access across Northern Ireland for patients in regard to more specialist services for example: bladder outflow obstruction surgery, Percutaneous nephrolithotomy (PCNL), Extra-corporeal shock wave lithotripsy (ESWL) and Sacral nerve stimulation (SNM).
Urgent and Emergency Care (UEC)	
16	As an immediate action, Urologists (in collaboration with general surgery and emergency department colleagues) should develop contemporary, clear protocols for patients with urological conditions requiring urgent and emergency care (UEC). This is of particular importance for the Northern HSC where re-configuration of the current service is advised.
17	The Department of Health should ensure that Trusts offering on-site UEC services in urology should urgently develop ambulatory assessment facilities, where they do not already exist.
18	The Department of Health should ensure that Trusts offering on-site acute urological care should support clinical teams in developing a fully staffed 24/7 middle grade rota – these can comprise of an extended workforce, including doctors, nurse practitioners and or physicians' associates.
19	Each Trust must ensure there is a clear protocol and service-level agreement in place with an IR provider for the provision of interventional radiology, including out-of-hours cover.
20	Trusts must ensure there are established pathways for the provision of urgent ureteroscopy, extra-corporeal shockwave lithotripsy (ESWL) and bladder outflow surgery after acute presentation.
Specialist Urological Provision	
21	Performance Implementation Group to develop an approach for the delivery of Bladder Outlet Obstruction surgery (BOO) predicated on the use of two HVLC sites in Lagan Valley and Omagh Hospitals with agreed regional pathways.
22	The DoH should ensure that percutaneous nephro-lithotomy (PCNL) surgery for Northern Ireland should be centralised at Craigavon Area Hospital with agreed regional pathways.
23	The DoH should ensure that provision of extra-corporeal shockwave lithotripsy (ESWL) for Northern Ireland should be centralised at Craigavon Area Hospital, providing a timely service for urgent referrals.
24	The DoH should continue to ensure a co-ordinated approach to waiting list validation for outpatient and admitted pathways, with regular reporting of the clinical backlogs.

25	The DoH should continue to actively work to reduce the reliance on external outsourcing of clinical care through implementation of the GIRFT recommendations and principles

3. Project Objectives

The aim of this review was to:

- Identify areas of improvement to help the Department of Health to have a better understanding about how Urology services are being delivered across the country with the ultimate aim of improving patient outcomes.
- Ensure Urology services are being delivered in line with the Elective Care Framework and the Department of Health's strategic direction on the expansion of the elective care centres regional model.
- Identify recommendations to improve the patient pathways for Urology in all Trusts in Northern Ireland through production of a final report.

4. Our Methodology and Approach

We followed the GIRFT methodology, structured as follows:

- **Data gathering** and structuring shared ahead of the deep dive visits
- **RNOH communication** about the programme (including HVLC)
- **Deep dive engagements** for each Trust, with relevant stakeholders present
- **National level report** explaining findings and recommendations.

Prior to each visit we issued a questionnaire to each Trust which asked for information on the workforce; on call arrangements; recruitment and the provision of urology services.

We examined the data looking for unwarranted variation e.g. differences between hospitals in areas such as:

- **Overall Activity Metrics** (Urology elective inpatient spells, day case spells, Virtual outpatient Attendance, RTT Pathways)
- **Emergency Urological Care** (Urology emergency admissions, Emergency stone admissions, Urinary retention, Urinary tract infection /Urosepsis, Testicular torsion)
- **High Volume Low Complexity (HVLC) Procedures** (Transurethral resection of bladder tumour (TURBT) procedures, bladder outflow obstruction procedures, ureteroscopy and stent management procedures)
- **Oncology (Kidney and Ureter)** (radical nephrectomy for cancer procedures, nephrectomy for benign disease procedures, partial nephrectomy procedures)
- **Oncology Prostate** (Radical prostatectomy procedures)
- **Stone management** (PCNL procedures, extracorporeal shockwave lithotripsy (ESWL))
- **Female and Functional** (stress urinary incontinence, colposuspensions, autologous fascial sling procedures, paraurethral bulking agents for incontinence, cystoscopy and botox procedures sacral neuromodulation)
- **Andrology** (Peyronnies disease, Urethroplasty procedures).

The deep dive engagements took place from Tuesday 16th May to Friday 19th May and were led by Kieran O'Flynn and John McGrath. Each deep dive was an opportunity for the Trust to provide an overview of their Urology services and current issues; this was followed by a review of the GIRFT data and a detailed discussion. All the meetings were well attended by a mixture

of colleagues in Urology roles (clinicians, theatre staff, senior managers and allied health professionals) and colleagues from the Department of Health, all of whom contributed to the excellent discussions. This allowed the review team to gain a good understanding of the issues facing each Trust and their hospitals and to suggest improvements.

5. Urology Services Overview

Urology services are provided at four of the five Trusts. There is limited urological provision in the Northern Health and Social Care Trust. Patients requiring urological care are referred, depending on their postcode, to either Belfast Trust or Western Health and Social Care Service based at Altnagelvin. Similar arrangements apply for patients needing urgent and emergency care.

Urology is a broad specialty encompassing diseases of the kidney, bladder, prostate and genitalia. Approximately 40% of referrals are to establish a potential diagnosis of cancer (most commonly prostate or bladder cancer). These referrals are 'red flagged' and, due to their number, pose particular challenges in the arrangements for early assessment and management. Other common reasons for referral are lower urinary tract symptoms in older men and recurrent Urinary tract infections (UTI's - predominantly in women). All Trusts provide routine urological care, but each has encountered different challenges in relation to the timeliness of the care provided and for most patients unfortunately experience significant delays in getting access to both a timely diagnosis and/or treatment. The underlying reasons are explored further in the report.

The provision of specialist urological care is disparate throughout the province and is detailed in **Figure 2**. Most urological oncology (with the exception of penile cancer) is provided at Belfast Trust, with nephrectomy also being performed at Altnagelvin Area Hospital, Craigavon Area Hospital and the Ulster Hospital.

As can be seen from **Figure 2**, many elements of subspecialist practice in Urology are delivered at more than one trust. This has largely developed for historical reasons or due to the interests of a particular surgeon. For many elements of subspecialty practice, the numbers of procedures performed are small and this mitigates against developing a genuine expertise. The ability to deliver such services has also been hampered by the Covid pandemic, when much specialist non-oncological surgery was deferred, leading to de-skilling of surgeons. It is now opportune to consider how these services should be delivered in the future, ensuring that patients get access to high quality care, irrespective of their postcode.

In urological practice, transurethral prostatectomy (TURP) was considered the sentinel operation for the specialty. While bladder outflow obstruction surgery is currently delivered at all trusts, development in this area of urological practice mean that there are a number of newer treatment modalities available, many of which can be delivered safely as daycase procedure. Given the numbers of procedures performed in Northern Ireland each year, it is neither practicable nor financially viable for all newer modalities to be delivered at all trusts. Consolidation of these services is recommended and further discussed in **Section 8** of this report.

Figure 2: Provision of Specialist Services in NI

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Oncology					
Radical Nephrectomy	Y	N	Lap-nephrectomy only	Y	Y
Partial Nephrectomy	Y	N	Referred to Belfast City Hospital	Referred to Belfast City Hospital	Referred to Belfast City Hospital
Nephro ureterectomy	Y	N	N	Y	Y
Cystectomy	Y	N	Referred to Belfast City Hospital	Y	Referred to Belfast City Hospital
Radical prostatectomy	Y	N	Referred to Belfast City Hospital	Referred to Belfast City Hospital	Referred to Belfast City Hospital
Penile Cancer	Referred to Altnagelvin Area Hospital	N	Referred to Altnagelvin Area Hospital	Referred to Altnagelvin Area Hospital	Y
Stone disease					
PCNL	Y	N	Y	Y	Y
ESWL	Y	N	N	Y	Y
Female and Functional					
Stress Incontinence	Y	N	N	Y	Y
Bladder reconstruction	Y	N	N	N	Y
SNM	Y	N	N	N	Y
Andrology					
Urethroplasty	N	N	Y	N	Y
Peyronnies surgery	N	N	N	N	Y
Surgery for male stress incontinence	N	N	N	N	N

6. Workforce and Training

The Urology workforce for Northern Ireland is detailed in **Figure 3**. The ratio of urologists per head of the population is one of the lowest in Europe and lags behind that in England.

There are a number of factors that contribute towards Northern Ireland's difficulty in recruiting and retaining a workforce in the specialty. These include geography, national trainee selection, remuneration, onerous on-call rotas and limitations in the ability to develop sub-specialist practice in the specialty. Given the current working conditions with a significant on-call burden, currently limited subspecialty practice and the failure to develop specialist nursing, it is difficult to see how the hospitals in Northern Ireland can continue to attract high calibre consultant Urologists in the future.

Across the four home nations, it is estimated that there are approximately 120 unfilled consultant posts in the specialty. As only 50 National training number's (NTN's) exit training each year with a Certificate of Completion of Training (CCT) in Urology, there is an undersupply of trainees and consultant recruitment for many trusts is challenging. Units with fewer than 8 consultants have particular difficulty attracting new consultants, again largely because of onerous on-call arrangements and a limited subspecialty practice.

Northern Ireland and its constituent hospitals are approaching a tipping point with its over-reliance on a locum workforce and the anticipated retirement and relocation of consultants in the near future. The Department of Health will need to explore methods to incentivise recruitment into units where there have been repeated attempts to appoint substantive consultants but no suitable applicants found. On the mainland, there have been measures such as enhanced salary, improved re-location packages and negotiation on the starting salary point for new appointees. Other measures, such as networked on-call to reduce overall frequency, can enhance a consultant's working life and remove the current disincentives.

Whereas each trust would like to support the development of new consultant appointments in Urology, development of a functioning Urology Area Network model was effectively paused at the onset of the Covid pandemic; in the interim, much discussion has taken place and there is a renewed interest in inter-hospital working. Good progress has been made in developing plans for the provision of specialist services across Northern Ireland and these are discussed elsewhere in the report.

Figure 3: Current medical workforce

Trust	Funded Consultant Urologists	Consultant Urologists WTE	Trainees WTE	Trust doctors WTE	Physician Associate	Comments
Belfast HSC	8.8	8	5 StR (Funded = 5.0wte; 4.4wte in post) and 1 CT Doctor (Funded = 1.0wte)	1 (Funded = 3.0wte; 2 in post inc. 1 agency)	0	2x Trust (Specialty Grade) Doctors recruited Sept 2023 to take up positions before December 2023. In addition, there are, 2x temporary Clinical Fellows and 1x temporary LAS Doctors in post.
Northern HSC	0	0	0	0	0	
South Eastern HSC	7	6(1 on mat leave)	1	3	2	1 consultant post vacancy 1 locum consultant currently covering maternity leave
Southern HSC	6	4.41	3 (4.5 funded)	0.87 (1.1 funded)	0.5 (0.5 funded)	Current advertisement for 3 urologists Includes 1 long term agency locum 1 works half time at Belfast City
Western HSC	9	7.6	3 (0 funded)			2 vacant posts consultant posts

Each unit remains understaffed with respect to Urology Clinical Nurse Specialist (CNS) support, detailed in **Figure 4**, and this has a major impact on the functioning of the unit. There is a paucity of CNS provision in diagnostics, with CNS provision of prostate biopsy, flexible cystoscopy, flexible cystoscopy and Botox limited to Craigavon Area Hospital.

Figure 4: Current Whole Time Equivalent (WTE) clinical nurse specialist (CNS) and physician associate (PA) provision in Urology in NI

Role	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Band> 8c and above	-	-	-	-	-
Band 8b	-	-	-	-	-
Band 8a	1.00	-	1.00	2.42	-
Band 7	2.00	-	1.00	4	6.27
Band 6	3.00	-	2.00	0	3.52
Band 5	0	-	-	0	0
Physician Associate	-	-	2	0.5	-

As shown in **Figure 5,** there is currently no provision of flexible cystoscopy and laser ablation for recurrent superficial bladder cancer across NI; this is frequently delivered by nurse specialists in England (see section on outpatient provision). Such arrangements are standard elsewhere in the UK, where these services are provided in a dedicated outpatient setting / Urology Investigation Unit (UIU).

Figure 5: Provision of clinical nurse specialist roles by Trust

Role	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Flexible Cystoscopy	N	N	Y	Y	N
Flexi Cystoscopy and TULA	N	N	N	N	N
Flexible cystoscopy and botox	N	N	N	Y	N
Male lower urinary tract symptoms	Y		Y	Y	Y
Transperineal prostate biopsy	N	N	N	Y	N
Prostate cancer surveillance	Y	N	Y	Y	Y
Renal cancer surveillance	Y	N	Y	Y	Y
Stone clinic	Y	N	Y	Y	Y
Andrology	N	N	Y	N	Y
Continence	Y	N	N	N	Y

There needs to be rapid expansion in terms of numbers of specialist nurses but also a rapid upskilling of the workforce. The latter may be accelerated using an academy style model at one or more Trusts, where there could be a focused effort on training lists and mentors.

7. Outpatients and diagnostics

The facilities for outpatient assessment in Urology vary considerably across Northern Ireland. Each of the sites are highly constrained by the lack of space and suitable consultation and treatment rooms. The average waits by Health and Social Care Trust and the facilities available are shown in **Figures 6 and 7**. The consequence of this is that patients cannot be seen at the same time by members of the Urology team (doctors, nurses and Physician Associates); as a direct consequence, patients often have repeat appointments to see different staff members and outcomes are delayed. The constraints almost certainly contribute to the heavy reliance on ‘outsourcing’ for outpatient referrals and diagnostics.

Figure 6: Average waits by Health and Social Care Trust Northern Ireland[1] Accessed 16/6/23

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Red flag*	2	N/A	2	5	1
Urgent**	14	N/A	17	30	7
Routine	68	N/A	87	155	16
Outsourcing arrangements	A percentage of routine appointments.	N/A	A percentage of red flag cystoscopies and TP biopsies.	A majority of red flag and urgent appointments.	A percentage of no-red flag patients and cystoscopies related to COVID backlog.

**Red Flag:* *These appointments are allocated to patients with suspected Cancer diagnosis and are the highest priority.*
***Urgent:* *These appointments are allocated to patients with urgent care needs other than Cancer.*

Trust Urology Teams must, as a matter of urgency, redesign and enhance their capacity to provide single-visit outpatient consulting and assessment (diagnostic) services for patients, avoiding the necessity for outsourcing and repeat attendances.

The most glaring example is at Altnagelvin Area Hospital, where some urology activity is delivered in the ground floor outpatients department, but patients have other elements of outpatient care delivered in rooms adjacent to the ward using rooms and facilities that are cramped and ill-suited for the assigned roles. This is compounded by the fact that neither the nursing offices nor the consultant offices are located close by. Co-location of facilities would enhance team working and greatly facilitate throughput. The lack of dedicated space means that it is not possible to provide a contemporary transperineal prostate cancer diagnostic service as the allocated room is required for flexible cystoscopy and haematuria / recurrent bladder tumour assessments. The direct result is long waiting time for prostate and bladder cancer diagnostics due to inadequate facilities and understaffing.

Craigavon Area Hospital does have a co-located investigation unit though it is currently shared with other services when not required by the Urology service. There is a compelling case to use this area exclusively for urology, given the volume of outpatient and diagnostic work that will need to be delivered. This will be particularly pertinent when outsourcing of outpatient referrals ceases and additional capacity will be needed, which may include a need to expand the current unit to provide additional consulting / procedure rooms.

Relatively low staffing levels in the urology departments of Northern Irelands Hospitals are undoubtedly a source of real pressure when considering the ability to meet the outpatient demand.

The number of clinical nurse specialists is particularly low, given Northern Ireland's size and population. The nurses work exceptionally hard, largely concentrating their work on oncology provision with little dedicated CNS provision for 'benign urology'. At Altnagelvin Area Hospital, the oncology nurses are part of the Oncology directorate and hence lack the flexibility to cover both oncology and functional urology to meet the demands of the service. As discussed in

[1] My Waiting Times NI - DOH/HSCNI Strategic Planning and Performance Group (SPPG) – formerly HSCB

Section 6, there is an urgent need to extend the role of specialist nurses and practitioners to meet the demand of the outpatient workload. Expansion of the medical workforce alone is not a sustainable long-term solution.

There is a definite sense across all units that both the nursing and medical urology team feel under-supported in the provision of contemporary facilities for the delivery of outpatient care. The current models do not serve the specialty well, as most units nationally have or are in the process of transitioning to a Urology Investigation Unit (UIU) type model. A UIU means that flexible cystoscopy, laser ablation, urodynamics and local anaesthetic prostate biopsy can be provided in one location by the extended Urology team, comprising medics and CNS's with a special interest. By co-locating facilities into one place, there is greater scope for one-stop models of care, as well as improved interaction and flexibility within the clinical team. Throughout the country, Urology has largely morphed into an outpatient specialty where, with appropriate and modern practices, patients can be rapidly seen and assessed without recourse to day-case or inpatient attendance. If implemented effectively, a functioning UIU can have a dramatic effect on the number of patients requiring day-case procedures or overnight stays. It is estimated that only 1:12-14 patients seen in UIU will then require some form of admission. One of the highest priorities for redesign of urological care in Northern Ireland should be the delivery of UIUs at all the urology units, scoped to provide a level of future-proofing in regard to the expected growth in demand for urological services, as the population ages. The recommendations are in line with the Richards Report[2] on development of diagnostic facilities.

Figure 7: Availability of outpatient facilities by Trust

Trust	Site	Urology Investigation Unit	Comment
Belfast HSC	Royal Victoria	No	Emergency care only
	Belfast City Hospital	No	Space available on level 3 for development of investigation unit delivering flexi cystoscopy and TPB
Northern HSC	Antrim Area Hospital	No	Limited in-reach model by visiting Urologist. BHSCT provides two clinics a week in Mid Ulster Hospital. SNS follow-up is delivered (nurse led with support from Medtronic)
	Causeway Hospital	No	Outreach OP clinics and flexible cystoscopy (Altnagelvin team)
	Whiteabbey	No	Flexible cystoscopy (delivered by Belfast Trust)
South Eastern HSC	Ulster Hospital	No	Flexible cystoscopy and TPB done in inpatient facility
	Lagan Valley	No	Daycase facilities only at present

[2] NHS England » Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England

	Downpatrick	No	Limited capacity to deliver flexi cystoscopy
Southern HSC	Craigavon Area Hospital	Yes	Flexible cystoscopy and TPB delivered but facilities shared with other services if rooms not being utilised by the urology team at present
	Daisy Hill Hospital	No	Outpatient activity commenced August 2023, Day case and 23 hours stay facilities only at present
Western HSC	Altnagelvin Area Hospital	No	Disparate facilities across the hospital site
	South West Acute Hospital	No	No outpatient activity
	Omagh Hospital	No	Flexible cystoscopy in daycase theatre

None of Northern Ireland's Urology units offer transurethral ablation of bladder lesions (TULA). Investment in a dedicated handheld laser at each of the sites would enable access to flexible cystoscopy and laser ablation of small bladder tumours, avoiding the necessity for repeat visits or a daycase procedure. Many units nationally have found this investment be worthwhile with significant cost savings. The development of a TULA service has the potential to significantly reduce the requirement for day case cystoscopy and biopsies and treatment of small bladder lesions. The capital outlay is small, and the learning curve is short, with very rapid release of theatre capacity at all sites. As services nationally transition from day case to outpatient delivery, it's important that mechanisms are in place to record this significant activity.

There remain significant pressures with the 'trial without catheter' (TWOC) service in outpatients. Improving this element of the service, with timely access would enable more patients to be put on day surgery pathways and avoid long lengths of stay. A properly resourced TWOC service with a Standard Operating Model (SOP) across the Trusts should be seen as a priority for the Urology teams.

The diagnostic pathway for patients suspected of having prostate cancer is not optimal. Patients referred with a high Prostate Specific Antigen (PSA) and suspected prostate cancer are generally first seen in outpatients and then referred for a prostate MRI scan. Most units in England have adopted a straight to test model, subject to satisfactorily completed pro-forma from the GP. This approach is endorsed by NHS England NHS England Prostate Cancer Timed Diagnostic Pathway. Due to litigation fears, some consultants in NI prefer to see patients in outpatients before ordering an MRI scan. The pathway is also delayed due to limited access to MRI, delays in reporting and frequently delays in accessing transperineal biopsy (LATP) in outpatients and delays in pathology reporting. Without improvements to diagnostic resources in Northern Ireland, it will not be possible to deliver these pathways at the pace that is required for rapid diagnosis. It is noted that the NICAN Urology CRG are currently undertaking a pathway project relating to this and reflecting the approach advocated in the NHS England pathway document. It is recommended that the rapid role of this pathway following the initial pilot is supported across all trusts.

Prostate biopsy services have generally morphed from transrectal to transperineal biopsy, with the majority of services now being delivered in outpatients. The appointment of a prostate

cancer navigator and a nationally agreed pathway has the potential to shorten the pathway and enable an upfront MRI, prior to first appointment, for those patients who meet the criteria. The NICAN Urology Clinical reference group should take this forward.

8. Elective Care

Based on the returned data from each of the Health and Social Trusts, it is difficult to make a direct comparison between the provision of the sentinel procedures in NI compared with England where Model Hospital[3] statistics are collected for 170 different metrics in the specialty. Some general observations can, however, be made. Each clinical team expressed concerns that the data collected did not reflect actual case volumes and while the data provides some insight, it cannot always be relied upon for capacity planning.

There is certainly scope nationally for significant improvement with day-case rates across the 'sentinel' procedures referred to in the GIRFT data pack (exemplars being TURBT and bladder outlet surgery), which should help relieve the pressure on in-patient beds. Further improvement should now be possible if the right facilities are provided and the philosophy regarding 'daycase as default' is built into the booking rules for these procedures and the pathways are supported by a dedicated nursing team. The development of the Daycase Unit at Lagan Valley Hospital has shown that it is possible to deliver TURBT, bladder outflow obstruction and ureteroscopy safely as a day case and this initiative is warmly applauded and should be replicated elsewhere. An important principle has been the concept that it is a system resource that can be used by multiple units, working to common standards. Single Patient Tracking List (PTL) waiting lists will be vital to eliminate inequities in access times between Trusts. This will necessitate consistent approaches to the evaluation and listing of patients for the respective procedures.

When compared to Model Hospital, the daycase rate for TURBT is likely to be below the England average at 19%. The current English national benchmark performance is 44% with examples in exemplar units of 80%. Barriers in NI include the limited availability of daycase facilities, a culture of admitting the patients anticipating an overnight stay although not required, surgeon and patient preference and the limited opening hours of daycase facilities where they exist.

Intravesical Mitomycin instillation is a vital component of TURBT and should be done in theatre at the end of the procedure, followed by a trial without catheter in the recovery area ahead of discharge. Although this is done in some units (for example, WHCST) there were no data available on Mitomycin instillation in the individual units, it was acknowledged that there are difficulties in delivering this effectively across all of NI. Reasons cited include lack of personnel, lack of training and resistance from pharmacy and theatre staff as well as disruption of the day-case pathway.

Urology Units in NI are encouraged to use 'day case as default' for the majority (60-70% at least) of bladder tumour resections and evidence nationally suggests that the *routine* use of post-operative catheterisation is not necessary. There are significant pressures on the delivery of TURBT at the City Hospital, largely due to constraints on access to theatre slots. This issue could potentially be addressed by provision of daycase facilities at either the Mater Hospital or Lagan Valley Hospital. Trans-urethral laser ablation (TULA) for small recurrent bladder lesions, provided in an outpatient setting also has the potential to free up theatre space. All units should implement a TULA service as a matter of priority.

[3] NHS England - Model Hospital

The current provision of surgery for bladder outflow obstruction (BOO), **shown in Figure 8**, is poor, both in terms of treatment options and unacceptably long waiting times. At the time of writing, over 300 patients from across Northern Ireland have been waiting for bladder outflow surgery for more than four years. Whereas most BOO surgery in NI is delivered as an in-patient procedure, daycase surgery for BOO is uncommon but ripe for development. Many units in England now offer daycase surgery for BOO, with the current benchmark for England being 26% and exemplar units achieving a daycase rate in excess of 80%.

Excluding the backlog caused by Covid, men awaiting bladder outlet surgery represents the largest patient cohort nationally on the urology waiting list. Approximately 750 men require BOO surgery on an annual basis in NI. This need is not currently being met with patients experiencing long delays. As a consequence, some patients have been referred to Dublin for their treatment. Men with larger prostates, who have developed urinary retention, do particularly badly as they are not suitable for some of the newer available modalities and cannot currently access Holmium Enucleation of the Prostate (HoLEP) which would be the current standard of care.

Figure 8: Available surgical options for the treatment of male bladder outflow obstruction, by hospital.

Trust	Site	Available options for surgical treatment of BOO	Comment
Belfast HSC	Royal Victoria	Nil	
	Belfast City	TURiS and Prostate artery embolisation (PAE)	
Northern HSC	Antrim Area	None	Mid Ulster Hospital Magheraflt-Urolift
	Causeway	TURiS	
South Eastern HSC	Ulster Hospital	TURiS	HOLEP cases have commenced with mentoring to be completed by September 2023
	Lagan Valley	TURiS, REZUM and Greenlight laser	Urolift in development. Rezum and greenlight at LVH is utilised by other trust surgeons (e.g. Southern)
	Downpatrick	None	
Southern HSC	Craigavon	TURiS, Greenlight	
	Daisy Hill	TURiS	
Western HSC	Altnagelvin	TURiS	
	Omagh	Daycase TURiS	

Bladder outlet obstruction (BOO) surgery is now recognised an area of sub-specialist expertise and there is an emerging consensus that patients should have access to all suitable options,

including Trans Urethral Resection in Saline (TURiS), Greenlight laser, Urolift, REZUM and HoLEP. There should be a two-centre model for the majority of BOO surgery in Northern Ireland, predicated on the nominated, protected elective capacity sites in Lagan Valley Hospital and Omagh Hospital. Holmium laser enucleation of the prostate poses a particular challenge as it is ideal for men with larger prostates but is not currently available at any sites. The service is being developed with mentoring of 2 consultants at the Ulster Hospital. There are 2 Surgeons in Southern Trust are also trained to deliver HoLEP with plans currently in place to utilise the Daisy Hill 23 hour stay elective unit to deliver this

There should be regional pathways in place for patients requiring BOO surgery and ideally there would be nurse-led assessment of these men and nurse-led consent for each of the procedures that form part of a regional pathway. This was explored at each of the deep dive visits and there was broad agreement for nurse-led consent and development of single PTL waiting lists for each of the BOO procedures.

Given the significant pressures on theatre access at inpatient sites, it will be important for patients, nurse specialists and urologists to be aware that a day case option should always be explored first as this will result in more timely care. The GIRFT Academy guide provides an algorithm for patient suitability for each of the procedure types: GIRFT Urology Guidance - Bladder Outlet Obstruction.

The practice of ureteroscopy appears to have changed over the past few years with more hospitals delivering the procedures as day case. 78% of ureteroscopies performed in South Eastern Trust are currently being delivered as day cases in line with contemporary practice in England, undoubtedly aided by the daycentre at Lagan Valley, this is being delivered by surgeons from South Eastern, Belfast and Southern Trusts. Trusts should aim to deliver the same day case rates across NI for all patients undergoing ureteroscopy, recognising that with the move of suitable patients to HVLC centres those patients undergoing ureteroscopy in inpatient setting are inevitably complex and will have a longer LOS.

9. Urgent and Emergency Care (UEC)

The current provision of urgent and emergency care in shown in **Figure 9**. In common with other regions in England, Trusts in Northern Ireland have seen an increase in the number of patients admitted with urological conditions. The true demand for urological care is likely to be under-represented as most patients with a urological diagnosis are coded under General Surgery at the time of initial admission.

There is an overwhelming impression that the pathways for patients with urological diagnoses requiring urgent or emergency care do not function satisfactorily, and a post code lottery exists with regard to adequacy of emergency care provision. There needs to be an urgent addressing of the issues described below.

The underlying problems with UEC relate to poorly designed and functioning pathways, a fragmented middle-tier emergency care urology service and inadequate provision of acute beds for those patients requiring onward admission from Northern Health and Social Care Trust to either Altnagelvin or the Belfast Trust. At the heart of the issue are communication problems between the trusts and a lack of formal dialogue in agreeing these clear and standardised protocols.

Antrim Area Hospital and Causeway Area Hospital have no urological cover on-site and rely on inter-hospital transfer for patients requiring on-going urological care, based on postcode. Surgeons, ED clinicians and medical staff report significant problems referring patients to both Belfast City and Altnagelvin Hospital, with delays and at times a reluctance to transfer certain

patients. There was a specific issue highlighted with deployment of non-specific advice from the on-call urology team ('admit locally' was the term entered in patient notes) and then difficulty getting consistent advice from the neighbouring urology unit the following day. Patients experience delays at Antrim Area Hospital and Causeway Area Hospital and spend an unreasonable length of time, either in the ED department or on a ward, without adequate consultant supervision. Criticism can be levelled both ways. 20-30% of admissions in the generality of surgery have a urological component. Working in a hospital with a functioning ED unit and no urology cover means that the staff will have to engage with urological problems and cannot abrogate responsibility for patients who require admission and stabilisation. There is an urgent need for co-designed urgent and emergency pathways for the common acute urological conditions that outline standards of care for patients and the responsibilities of the referring and the admitting units.

Figure 9: Provision of urgent and emergency care, by hospital.

Trust	Site	Emergency admissions	Inpatient Urology
Belfast HSC	Royal Victoria	Y	Y
	Belfast City	N	Y
Northern HSC	Antrim	Transfer	N
	Causeway	Transfer	N
South Eastern HSC	Ulster Hospital	Y	Y
	Lagan Valley	Transfer	N
	Downpatrick	Transfer	N
Southern HSC	Craigavon	Y	Y
	Daisy Hill	Transfer	Some 23hr stay
Western HSC	Altnagelvin	Y	Y
	SWAH	Transfer	N

It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Area Hospital directed to Altnagelvin.

Arrangements at the Royal Victoria for the reception of emergency urological admissions are inadequate. By default, patients are admitted through the ED department as a Urology Assessment Unit does not exist. From ED, patients are then admitted to ward 4 (an orthopaedic ward), which has little dedicated urological nursing and is perceived as having a

lesser interest in the urological patients by comparison to its base specialty of orthopaedics. For a hospital of this size, there should be provision of an ambulatory assessment unit, either as a stand-alone clinical area or within a generic surgical assessment unit. Referrals from general practice or surrounding hospitals would then be sent directly to the assessment unit, allowing more rapid access to urological care and relieving the pressure of inappropriate routing through ED.

Due to service pressures, Urologists have difficulty accessing confidential enquiry into Peri-operative deaths (CEPOD) theatre lists for the acute management of haematuria or emergency ureteroscopy for stones. Under these circumstances, patients are more likely to get a ureteric stent (rather than primary ureteroscopy and laser lithotripsy) with inevitable delays in their long-term management. This contrasts with efficient pathways for emergency cholecystectomy in general surgery. Access for category one cases, such as acute testicular torsion, was reported to be good and there was no sense that these more urgent cases were delayed. The same was true of percutaneous drainage of the kidney in interventional radiology at BCH but this was not the case in other sites.

Whereas most patients with urinary retention do not require admission, patients do require a timely trial without catheter following ED attendance. In many Trusts, the arrangements appear to be haphazard: patients sometimes get a TWOC in the community or at the admitting hospital, but if that fails they are then re-catheterised and referred for consideration of onward surgical treatment. Patients then wait months or years for an appointment and definitive surgical treatment. It is well accepted that patients with indwelling catheters experience greater morbidity with recurrent Urinary tract infections (UTIs), haematuria and urosepsis. The inability to provide a timely service for these patients results in more emergency and unscheduled care. Given the elective backlogs, there is an urgent need to streamline the pathway for men who present with urinary retention and fail a subsequent TWOC. Such measures could include dedicated, rapid-access outpatient slots or a TWOC service based in the setting of a UIU (where there is clinical expertise on-site to support a same-day, shared-decision on the need for bladder outlet surgery).

The situation with regard to patients presenting with ureteric colic varies across the province. There appears to be no up to date pathway in the Northern area for the onward referral of patients needing emergency stone treatment. Clinicians at Antrim and Causeway were unclear as to the modalities of treatment that might be offered for a patient presenting with acute ureteric colic (either ESWL or acute ureteroscopy). Despite NICE guidance supporting its use, acute ESWL is rarely used across the province and provision of acute ureteroscopy is generally poor at all sites. There needs to be a clear pathway in place to ensure that patients can easily be referred from all sites for acute onward ESWL and this should be built into the plans for the fixed-site lithotripsy service at Craigavon Area Hospital. In terms of acute ureteroscopy, pathways should also be developed for either surgery at the time of initial admission (reliant on CEPOD access) or a ‘book and return’ model of care. The latter can also work well in protected elective care sites, such as Lagan Valley.

Access to interventional radiology by trust is detailed in Figure 10 and is essentially limited onsite to normal working hours in most Trusts, with the exception of the Royal Victoria Hospital. Given the current workforce issues in interventional radiology, access to these services will inevitably be constrained; a functioning SOP with service level agreements at each Trust is required to ensure timely access to the service, with a guaranteed repatriation once the immediate crisis is resolved.

10. Specialist Care

10.1 Oncology

The current arrangements for major oncological surgery are shown in **Figure 10** and are derived from the pre-visit questionnaire. The estimated figures for the uro-oncological surgery requirement are shown in **Figure 11** below.

The majority of operative uro-oncology is provided for at Belfast City Hospital, but there are significant capacity challenges in delivering a timely service. At present, Belfast City Hospital has seven theatres, two of which are undergoing refurbishment on a rolling basis. It is estimated that this process will not be completed for the next 18-24 months. Although there is a DaVinci Robot in place, it is underused and even if it was operated at full capacity it is unlikely that an operative programme based on a single robot would be sufficient to meet NI needs. This is particularly true as the provision of radical cystectomy and radical nephrectomy has now moved towards robotically-assisted surgery as the approach of choice.

Figure 10: Provision of Oncology by Health Board in Northern Ireland

	Belfast HSC	South East HSC	Southern HSC	Western HSC
Laparoscopic nephrectomy	Y	Y	Y	Y
Partial nephrectomy	Y	N	N	N
Nephroureterectomy	Y	N	Y	Y
Cystectomy	Y	N	N	N
Radical prostatectomy*	Y	N	N	N
Penile Cancer	N	N	N	Y

**Majority of patients requiring radical prostatectomy are transferred to the Mater Private Hospital in Dublin.*

With appropriate investment and recruitment, there are sufficient volumes of work in NI to justify a second robotic surgery programme at Altnagelvin Hospital. Ideally, it would be implemented as part of a cross-specialty platform, given that colorectal surgery and gynaecological surgery is beginning to transition at pace towards a robotic approach. Recruitment of surgeons with the necessary skills will be the major barrier to expansion of the robotic provision but establishing a second, high-volume robotic service at the Western Trust would appeal to certain individuals and would likely make Western Trust a more attractive place to deliver urology.

Radical prostatectomy; Provision of robotically assisted radical prostatectomy (RARP) is currently predicated on three surgeons operating at Belfast City Hospital. Approximately 56 procedures were performed in 2022 (internal data) with an average length of stay of 1.68 days (England average 1.7 days). Patients requiring RARP from across NI are currently managed on a central register. Because of the numbers involved and constraints on the service, a

majority of patients requiring RARP are then referred to the Mater Hospital in Dublin for their treatment.

Based on the RARP rate of 150 procedures per million of the population in England, it is estimated that the true requirement for RARP on an annual basis in NI is approximately 270 procedures. It is likely that many patients who are eligible for surgery do not currently choose RARP, either in Belfast or Dublin, and instead opt for active surveillance or radiotherapy as a result of the long waits for the procedure or the need to travel. This is a phenomenon that has been observed in more rural parts of England or where access times are poor.

The average specialist unit in England delivers 150 cases per year with each operating surgeon performing an average of 50 cases per annum. Given NI's requirements, supplying the service would require 6 surgeons in the fullness of time, with back-up support from properly staffed nursing and administrative teams. Based on a two-session day, and two RARP being delivered per list, 120 lists would need to be provided across the network to meet the demand.

The Department of Health needs to urgently work with providers to address the under-provision of theatre capacity for the provision of major urological cancer surgery, thereby addressing delays to treatment. In doing so, there should also be a clear commitment to re-patriate pathways for patients who are currently required to travel out of Northern Ireland for specialist cancer surgery

Cancer Nephrectomy; The majority of renal surgery is also likely to become robotically-assisted in the near future, in keeping with this change of practice on the mainland and this will further increase the need for robotic surgery provision.

Both open and laparoscopic nephrectomy are provided at 4 Health and Social Care Trusts in NI. Outside Belfast, laparoscopic nephrectomy is the most commonly performed renal operation. Patients with small renal lesions are referred to Belfast for robotically-assisted partial nephrectomy (RAPN) or ablative treatments. The practice is changing rapidly in England. Robotically-assisted nephrectomy and robotically-assisted partial nephrectomy are becoming established as the standard operative techniques, with the more specialised units providing robotic partial nephrectomy and robotic nephroureterectomy. It is likely that nephroureterectomy followed by radical nephrectomy will transition to a robotically-assisted approach as standard in the future, further decreasing the requirement for open surgery. The ratio for partial nephrectomy to total nephrectomy is approximately 70:30.

Based on the available data, NI has a requirement for approximately 180 nephrectomies per year. In a contemporary practice, approximately 125 will be partial nephrectomies and 55 either laparoscopic or open. Partial nephrectomy (RAPN) surgery should only be on a single site, with IR availability. There is a compelling need to improve the provision of nephrectomy across NI (approximately 180 procedures per annum) and robotically-assisted partial nephrectomy at Belfast City Hospital. This should include a networked service for renal surgery as outlined above.

Within the Department of Health, a discussion should be initiated and a strategy will need to be developed regarding the current viability and future provision of the nephrectomy service across NI. Ideally, there should be provision of total nephrectomy across the Province with a single, virtual service linked by a single MDT, so that sickness and holiday leave can be covered. The minimum requirement in the future should be based on at least six trained surgeons providing the range of robotic and open procedures with appropriate governance and oversight.

Cystectomy; Open cystectomy is currently provided at Belfast City Hospital by three surgeons. There were no data available from the data pack between April 2019 and March 2020, but it is estimated that the annual requirement for cystectomy in NI is a minimum of 56 procedures per year though could be higher depending on disease characteristics. The practice of cystectomy is rapidly changing in the UK and a robotically assisted approach has become the commonest modality in England. By necessity, this change in practice will again need to be factored into a strategic plan for the service; as new consultants take up their posts, most will have completed a robotics fellowship. Radical cystectomy, in common with RAPN, should only be delivered on a single site due to its complexity and lower-case volumes.

There were no concerns expressed in relation to the pathway across NI with respect to cystectomy. Although there is no concrete evidence, there is anecdotal evidence that patients experience significant delays in accessing surgery due to inadequate list availability. Cystectomy is the most time critical pathway in urological oncology and every effort should be made to ensure that patients receive their surgery in a timely fashion (ideally no longer than 30 days from decision to treat). Generally speaking, there will be two patients a week requiring radical cystectomy (when other indications such as pelvic exenteration are included) and the team at BCH should make every effort to regularly provide this capacity and minimise delays in treatment.

There needs to be improved capacity for the provision of radical cystectomy surgery, with adequate and timely theatre access for the delivery of approximately 70-90 procedures per year (based at Belfast City Hospital). Consideration should be given to developing a robotically-assisted approach for this procedure.

Figure 11: Estimated number of urological oncology procedures requiring to be delivered per year in Northern Ireland

Procedure		Estimated number of procedures required /year	Comment
Nephrectomy		180	Based on approximately 70% patient being suitable for partial nephrectomy
	Laparoscopic or open nephrectomy	55	
	Partial nephrectomy	125	
Cystectomy		60-70 (for bladder cancer)	
Radical prostatectomy*		270	
Penile Cancer		25	Many patients will require multiple procedures

Penile Cancer; the penile cancer service is currently based at Altnagelvin Hospital and is essentially staffed by a single consultant with support from an experienced, retired and returned colleague. While this arrangement works well at present there are obvious concerns regarding the resilience of the service in the event of unplanned leave and or sickness. Although the numbers of new penile cancers are relatively small (approx. 30-40 per year), many will require multiple diagnostic and therapeutic procedures. It is important that this service remains linked to a designated penile cancer centre either in North West of England

or in Eire, both to ensure resilience for this single-handed service and peer support for more complex patients. There is currently a MDT in place with the Christie Hospital, Manchester.

Provision of penile cancer surgery should ideally be based on service delivery by two trained surgeons, ensuring the resilience of the service.

10.2 Stone Management

The current provision of stone service in NI can be shown in **Figure 12.** The advancements in both our understanding of the natural history of stone disease allied with developments in technology over the past decade mean that much stone surgery can be delivered endoscopically using suitably powered lasers; all trusts provide ureteroscopy with the exception of the Northern Health and Social Care Board, which are reliant on an in-reach model at Causeway Hospital, supported by the Urology team from Altnagelvin. Extracorporeal shockwave lithotripsy (ESWL) and the provision of percutaneous nephrolithotomy (PCNL) remain important elements of a contemporary service. In England the numbers of PCNLs performed annually have steadily decreased as better technology means that more patients can be treated endoscopically. ESWL retains an important role in the management of renal calculi and the urgent treatment of patients presenting with ureteric colic. Its' use is supported by NICE guidance, both on efficacy and cost comparison.

Figure 12: Current provision of stone services in Northern Ireland

	Belfast HSC	Northern HSC	South Eastern HSC	Southern HSC	Western HSC
Site(s)	Royal Victoria and Belfast City	Causeway	Ulster and Lagan Valley	Craigavon and Daisy Hill	Altnagelvin
Ureteroscopy and laser fragmentation	Y	Y	Y	Y (CAH + DHH)	Y
PCNL	Y	N	Y	Y (CAH)	Y
ESWL	Y	N	N	Y (CAH)	Y

The provision of PCNL is dependent on securing a suitable access track with radiological screening, either performed by the operating surgeon or more commonly an interventional radiologist. The number of patients requiring PCNL in Northern Ireland is small and it is generally agreed that the service should be placed in one hospital, helping to free up theatre time in other units. The agreed model is that centralisation of PCNL surgery and more complex endourological procedures should take place at Craigavon Area Hospital, led by the Southern team. This will require the provision of an all-day operating list for PCNL, supported and funded for a minimum of 42 weeks of the year with two PCNLs on each list. Case volumes for the more complex endourological procedures will also need to be assessed as these will require additional theatre capacity within the unit.

Centralisation of static ESWL should also take place at Craigavon Area Hospital; this will require the provision of ESWL 5 days a week, supported by trained radiographers and clinical staff (including a dedicated clinical nurse specialist). There should be a single referral system in place for all Trusts to enable timely access to both acute and elective ESWL. Such an arrangement will enable the Department of Health to disinvest in mobile lithotripsy services.

Each trust providing an emergency service must ensure there are established pathways for the provision of urgent ureteroscopy and/ or ESWL. Such models of care work well elsewhere in England. For ureteroscopy and laser lithotripsy, this can include a 'book and return' model to the acute site or a HVLC hub site.

10.3 Female and Functional urology

Due to the pressures on core urology, emergency care and limited theatre access, the provision of female and functional urology has struggled for in NI for many years. The Covid pandemic has exacerbated poor access to care for these patients and many women with stress urinary incontinence and other functional issues have had difficulty accessing appropriate surgery.

Figure 13: Current provision of female and functional procedures in Northern Ireland

Procedure /Condition	Current provision(Urology)	Comment
Surgical management of urinary stress incontinence	Belfast City, Craigavon and Altnagelvin	Element of this service should be provided in association with urogynaecology at designated sites
Vesicovaginal repair (VVF)	Altnagelvin and Belfast City and Craigavon	Altnagelvin
Ureteric injury **(Trauma and iatrogenic)**	All centres	Constraints in theatre access at BCH and long waits hamper the service
Bladder augmentation	Altnagelvin and Belfast (in-reach)	As above
Urethral reconstruction*	Altnagelvin	As above
Insertion of artificial urinary sphincter	Not currently commissioned or provided in N Ireland	Service could be provided in a 23-hour surgical unit. Altnagelvin may be best placed to consider this.
Congenital and acquired neuropathic bladder management	Belfast City, Altnagelvin and Craigavon	Provision of services for these patients (including those with MS) occurs on an ad hoc basis
Videourodynamics	Altnagelvin and Belfast City	New facilities developed at Belfast City

*Linkage to sub-specialty MDT

There have, however, been pockets of good care and positive developments in Northern Ireland. The best developments have been at Altnagelvin where video-urodynamics (used to establish a diagnosis with bladder pressure monitoring, combined with radiological imaging) and sacral nerve stimulation (SNS) have been commissioned and are providing a good service for the region. As seen in **Figure 13**, provision of surgery for urinary stress incontinence

(provided by a Urology service) is delivered at Belfast, Craigavon and Altnagelvin. Surgery for Genuine Stress Incontinence (GSI) is also provided by urogynaecologists across Northern Ireland and it is difficult to get precise estimates about how much is being done by each specialty.

Surgery for female and functional problems unfortunately occupies a low priority for many busy hospitals. This is evidenced by the situation at Belfast City and Craigavon where, despite having an Urologist trained in this area of practice, access to theatre is constrained by the unmet demand of the oncology service. This situation is unlikely to be resolved for the foreseeable future. Patients continue to be referred to Belfast City Hospital without a realistic timeframe for surgery.

Compounding this issue is the requirement to deal with other aspects of functional urology which can have a profound effect on patients' lives. These include the surgical management of intractable incontinence, and the long-term management of patients with congenital neuropathic bladder and other neurological issues which affect bladder function (e.g. iatrogenic trauma, MS, stroke, spinal cord injury and vesico-vaginal fistula). Belfast Health and Social Care Trust is the designated Mesh Centre for management of patients with vaginal tape erosions, which requires a combined urogynaecology, urology and pelvic surgery input. While the clinical expertise is available, surgical facilities underpinning activities in functional urology are inadequate to meet current demands. Surgical techniques have developed significantly over the past decade and internationally more of these patients are being managed using robotic techniques, which are destined to become standard management in the next decade. They should be equally available to patients from Northern Ireland. Currently the robot is only commissioned for radical prostatectomy and partial nephrectomy.

Due to the small numbers involved, elements of female and functional urology for NI should be properly commissioned and resourced. Options include limiting investigative and surgical options to one or two centres in the province or considering disinvesting from some elements of the subspecialty (e.g. urethral reconstruction, mitrofanoff procedures). There is little or no prospect of this service being delivered at the City Hospital in Belfast and alternative site(s) must be identified for the provision of care within six months.

10.4 Andrology (including Urethral Reconstruction)

Access to benign andrology and urethral reconstruction surgery in Northern Ireland has been extremely limited over the past few years due to the huge pressures elsewhere in the service, including the long cancer waits, the Covid pandemic and limited theatre access. Northern Ireland has one trained andrologist for the region who is fully committed to delivering a high quality penile cancer.

Figure 14: Estimated Andrology Requirements for Northern Ireland

Procedure	Rates per 100,000 in UK practice*	Anticipated requirement per year in NI (based on population of 1.868 million)
Artificial urinary sphincter insertion	0.63	12
Penile prosthesis insertion (new)	0.44	8
Urethral surgery (including hypospadias repair)	4.2	79
Urethral surgery (excluding hypospadias repair	1.08	20
Penile cancer procedures	0.66	13
Corporoplasty	0.77	15
Male Infertility procedures	0.69	13

The projected andrology requirements for Northern Ireland are shown in **Figure 14**, based on current UK data. In Northern Ireland, at present, two consultants provide urethral reconstruction, but the bulk of their work is in the provision of core urology, stones and emergency care. As a consequence, patients with urethral stricture disease can wait significant periods of time for definitive treatment.

In the England, andrology services are largely predicated on a population of 7 million and the number of surgeons with a low volume practice in the subspecialty has declined significantly over the past few years.

At a minimum, andrology services for NI should be properly commissioned and limited to single centre. However, the anticipated volume of procedures is low and does not lend itself to the development of genuine subspecialty expertise. The Department of Health should commission a review of surgical andrology for NI. Options for the service might include:

1. Centralise the provision of surgical andrology at Altnagelvin hospital. This would require an expansion of current commissioning, an increase in surgeons providing the service (challenging both in terms of geography and identifying the right personnel) allied with increasing specialist nurse support.
2. Centralise the provision of surgical andrology at the Ulster and Lagan Valley Hospital. Much surgical andrology can now be delivered using a 23-hour facility; services would need to be developed at the Lagan Valley Hospital to support this. It would also require an expansion of current commissioning, an increase in surgeons providing the service allied with increased specialist nurse support.
3. Disinvest in the provision of benign surgical andrology and refer patients to units in Ireland or England.
4. Examine the feasibility of a solution based on a population of 7 million.

Annex A - Full list of hospitals

Trust	Hospital
Northern Trust	Antrim Area Hospital
	Causeway Hospital
	Mid Ulster Hospital
	Magherafelt Hospital
Western Trust	Altnagelvin Hospital
	Omagh Hospital and Primary Care Complex
	South West Acute Hospital
	Roe Valley Hospital
	Limavady Hospital
Southern Trust	Craigavon Area Hospital
	Daisy Hill Hospital
South Eastern Trust	Ulster Hospital
	Lagan Valley Hospital
Belfast Trust	Belfast City Hospital
	Mater Hospital
	Royal Victoria Hospital

Annex B - Southern Health and Social Care Trust Findings and Recommendations

Findings	Recommendations
Workforce	
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of National Training Number's (NTN's) accredited each year.	The Trust should continue to address barriers to recruitment, where these are within their control. A middle grade rota can comprise an extended workforce that can include advanced nurse practitioners and physician's associates in addition to more usual medical roles. Developing areas of sub-specialist practice can also aid recruitment and retention of staff.
The unit receives 3 NTN's per year; there is an unequal distribution of trainee numbers across Northern Ireland.	The Training Programme Director (TPD) for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.
Facilities including HVLC site	
While outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are adequate, much of the Urology Investigation Unit (UIU) is currently occupied by other services if there is an outpatient room available. Urology has primary use of the outpatient rooms in Thorndale, it is only utilised by other services if the rooms are not utilised	Subject to funding, the Trust needs to urgently re-establish the UIU. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	Trust management should ensure that Trusts are optimising their theatre capacity in order that each urologist has, as a minimum, 2 sessions of theatre activity for 42 weeks of the year, when not Consultant of the Week.
The protected elective capacity at Lagan Valley Hospital is an impressive development, led by the South Eastern Trust but also utilised by Southern and Belfast teams. It has enhanced the daycase opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	The Lagan Valley facility is a key component of elective recovery. The Southern Trust needs to ensure that the facility is used to maximum effect by its clinicians, aiming for maximum utilisation of available lists and unnecessary cancellations at short notice due to annual leave and professional leave.
Outpatients and diagnostics	
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in

	advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.
Oncology	
Up to 25% of patients currently admitted for a transurethral resection of bladder tumour (TURBT) or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	The day case TURBT pathway for Craigavon Area Hospital should be developed further at Lagan Valley Hospital and Daisy Hill Hospital for stable ASA 3 patients and below and become the default pathway for patients who are suitable for a day case approach.
Current provision of Mitomycin-C is problematic	In theatre Mitomycin-C should be the default option for suitable patients, irrespective of the facility in which the procedure is performed.
Radical nephrectomy is provided by two surgeons at Craigavon Area Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital using an in-reach model	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in Northern Ireland. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent from work for other reasons.
Urgent and emergency care	
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be

	used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed across Urology departments in NI.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery at the Lagan Valley facility.
Specialist services	
Stone service.	It has been agreed that Extra-Corporeal Shock Wave Lithotripsy (ESWL) and Percutaneous Nephrolithotomy (PCNL) surgery will be centralised at Craigavon Area Hospital. This will require the provision of 42 all day lists per year (2 procedures per list).There will need to be additional capacity for other types of complex endourological stone procedures.
ESWL.	The facilities for the delivery of ESWL will need to be upgraded to facilitate the delivery of 4-5 patients for ESWL per half-day list.
There is currently under-provision of benign andrology surgery across NI.	Given the regionalisation of this service in WHSCT the trust should consider disinvesting in the provision of benign andrology. There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as part of a regional andrology service for NI, including the continued provision of penile cancer surgery at Altnagelvin Hospital.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.

Annex C - South Eastern Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
The specialist nursing team is under-staffed when compared to the workload. There are significant opportunities that could be explored for extended roles.	Subject to funding, the Clinical Nurse Specialist (CNS) team should be expanded further as a priority area of development for the Trust. Their roles should continue to be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established. Given the expansion of bladder outlet surgery services, a CNS should be employed to manage the lower urinary tract symptoms (LUTS) pathway.
There are two physician's associates (PAs) in post in the unit and there is significant scope for them to support service delivery in both acute and elective care.	The department should refer to the new Urology PA curriculum that has been developed as well as the GIRFT Academy UIU guide to map out the career development plan for the PAs and how they will contribute to the long-term vision for the service.
The unit only receives 1 NTN trainee per year but there is significant scope to offer more training within the unit (*e.g*. training in BOO surgery at Lagan Valley).	The TPD for urology should continue to work with individual units to ensure that trainees are allocated to departments in line with the trainees' educational needs and that areas of particular training value are utilised well.
Facilities including HVLC site	
The current outpatient and diagnostic facilities are not adequate for the service, given that a majority of urological investigations treatment are outpatient-based.	A headline priority for the Trust should be the urgent development and delivery of a UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work (including re-patriation of outsourced work). A UIU is the ideal place to provide office accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
The protected elective capacity at Lagan Valley is an impressive development, led by the South Eastern Trust but also utilised by Southern and	The Lagan Valley facility warrants continued support and expansion of capacity. It is a key component of elective recovery. Likewise,

Belfast teams. It has enhanced the day case opportunities and created a hub for a regional bladder outlet service, enabling significant progress on recovering the waiting list. The unit is highly efficient and appears to be working well.	investment in any further technologies that are required is likely to be good use of resources with the opportunity for patients across NI benefitting from this excellent service. The South Eastern team should continue to lead on development of the networked BOO surgery service across NI.
Outpatients and diagnostics	
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Turnaround times for MRI scans and reporting delays in biopsy results mean that the suspected prostate cancer pathway is significant delayed.	Further efforts must be made to reduce the delays in access to and reporting of imaging and pathology.
Oncology	
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting. Lagan Valley Hospital would be a good site for this service, based in a procedure room.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	The day case TURBT pathway should be developed further at Lagan Valley Hospital and become the default pathway for patients who are suitable for a day case approach.
Radical nephrectomy is provided by a single surgeon at the Ulster Hospital. Patients requiring partial nephrectomy are referred to BCH.	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in NI. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent

	from work for other reasons. This will also mitigate against differences in access times should they occur.
Urgent and emergency care	
Further improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute extra-corporeal shockwave lithotripsy (ESWL).	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy at Lagan Valley Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed between the two departments.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the excellent work that has already been done on the BOO surgery service to date.
Specialist services	
There is currently under-provision of benign andrology surgery across NI.	There are now good examples nationally of delivering andrology surgery in 'cold' elective sites. Clinicians with expertise in this area should work as part of a regional andrology service for NI, including the continued provision of penile cancer surgery at Altnagelvin.
PCNL is done in small numbers currently and this should be addressed.	It has been agreed that PCNL surgery will be centralised at Craigavon Area Hospital and the business case has already been worked through.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.

Annex D - Belfast Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
For a major cancer centre, the specialist nursing team is grossly under-staffed when compared to the workload. There are significant opportunities that could be explored for extended roles, once staffing levels are improved.	The CNS team should be expanded further as an urgent action for the Trust. A cancer centre serving 1.8 million people would be expected to have a CNS team that is sub-specialised, with each CNS having a specific area of interest (bladder, kidney, prostate and penile / testicular). They should be able to cross-cover colleagues. Nursing roles should continue to be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established.
The current consultant complement is currently understaffed to provide the cancer services with respect to robotic prostatectomy, cystectomy and elements of renal cancer surgery	The trust should expand the number of consultants to provide urological surgical oncology for Northern Ireland subject to funding.
Cross-site working is challenging for the Belfast team as they are required to cover both the City Hospital and the Royal Victoria Hospital.	Expansion of middle grade support is needed to support the delivery of emergency care and to alleviate some of the issues associated with split-site working. A modern, middle grade workforce should include extended roles such as physician associates or nurse practitioners.
Outpatients and diagnostics	
The current outpatient and diagnostic facilities are not adequate for the service, given that a majority of urological investigations treatment are outpatient-based.	A headline priority for the Trust should be the urgent development and delivery of a UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work (including re-patriation of outsourced work). A UIU is the ideal place to provide office accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as	A TULA service should be implemented promptly. It is a low-cost innovation with a

an outpatient under local anaesthesia using TULA.	short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Facilities including HVLC site	
There can be difficulties in offering timely treatment for patients requiring less major forms of surgery (for example, TURBT). This is due to the pressures associated with the major surgery workload.	The day case TURBT pathway should be developed further, with consideration given to using the facilities at either the Mater Hospital or at Lagan Valley Hospital. Daycase TURBT should become the default pathway for patients who are suitable for a day case approach. Decompressing the service at Belfast City Hospital would help to alleviate pressures and ensure more equitable access to surgery for patients.
Approximately 40-50% of TURBT procedures can be done as a day case, facilitated by in-theatre administration of Mitomycin-C.	Every effort must be made to ensure that suitable patients get access to intravesical Mitomycin at the time of their surgery.
Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	Addressing the waiting time for men with lower urinary tract symptoms should be a priority for the trust. The pathway should dovetail with the work that has already been done on the networked BOO surgery service to date. The delivery of elective BOO surgery should be focused on the South Eastern team, which will also alleviate some of the pressures in Belfast due to the major cancer workload.
Oncology	
Theatre provision is wholly inadequate for the delivery of major urological cancer surgery in N Ireland. There are long delays to treatment and a high proportion of patients needing specific forms of cancer surgery (radical prostatectomy) are required to travel to Southern Ireland for their care. A DaVinci robot is available, with trained surgeons, but it is significantly under-utilised.	There is the clinical expertise to be able to offer the full range of surgical treatment options to patients from across NI, diagnosed with urological cancer. The prime reason that patients are currently delayed in their care or having to travel elsewhere is due to the lack of theatre facilities at Belfast City Hospital. All specialties are competing for theatre access in a highly constrained environment comprising only 5 functioning operating theatres. This capacity gap needs to be urgently addressed and this report includes estimates of the capacity that is required to make the service self-sufficient and able to treat the

	population without the need to travel out of NI. Trust management to ensure the robot is utilised throughout the week, given the volume of robotic surgery that needs to be performed. Subject to funding, serious consideration needs to be given to a second robotic service in Altnagelvin Hospital, as Belfast Trust is clearly not in a position to accommodate the required expansion of services necessary to meet the population need. Robotically-Assisted Partial Nephrectomy (RAPN) and radical cystectomy should remain on a single site but robotic-assisted laparoscopic prostatectomy (RALP) and other renal surgery could be performed across two sites with robust MDT and governance arrangements. The Trust need to be extremely cautious of expanding robotic programmes into new surgical specialties ahead of addressing their capacity for the treatment of patients with urological cancer, where robotically-assisted surgery is the standard of care for major urological cancer. DN this needs to be moved to WHSCT or as a regional recommendation
There is expertise in the delivery of more complex aspects of major kidney cancer surgery.	The Belfast team should participate in the formation of a virtual MDT with colleagues undertaking single-handed, laparoscopic nephrectomy across NI to ensure equitable access to surgery in the event of consultant annual leave / unexpected absence.
Urgent and emergency care	
The Royal Victoria Hospital lacks an ambulatory area for urology and patients are initially directed to ED from primary care.	For a centre of this size, the Royal Victoria Hospital should have a dedicated ambulatory area for the management of patients with urological conditions requiring urgent and emergency care. Patients should not be directed to ED from primary care or other centres. This is inappropriate and they should be managed through an ambulatory unit.
There is currently a postcode-based system for patients who attend Antrim Area Hospital, with	It is our recommendation that the current postcode-based system is removed and the

an overly complex arrangement that extends to Altnagelvin Hospital. It is not conducive with safe patient care and there needs to be greater ownership of this issue by a single provider.	arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin Hospital (see Western recommendations).
Patients requiring admission are currently admitted to a ward that is predominantly focused on orthopaedics and not overly experienced in urological care.	The current ward setting is not working well for the provision of admitted emergency care for patients with urgent urological conditions. The Trust needs to urgently develop a more suitable ward base in order to meet this need.
There are no offices available to the Urology team on the Royal Victoria Hospital site, where the majority of acute services are delivered.	The clinical team should be provided with access to adequate office facilities to allow them to undertake their administrative work whilst on call.
Further improvements could be made with regard to the management of acute stone patients. This should include improved access to 'hot' ureteroscopy and improved use of acute ESWL.	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy, offering suitable patients treatment at Royal Victoria Hospital. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for primary treatment in suitable patients. A seamless referral pathway needs to be agreed between the two departments.
Men presenting with acute urinary retention face long delays in getting access to appropriate treatments.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the networked BOO surgery service to date. The delivery of BOO surgery should be focused on the South Eastern team, which has the potential to alleviate some of the pressures in Belfast due to the major cancer workload.
Specialist services	
PCNL is done in small numbers currently and this should be addressed.	It has been agreed that PCNL surgery will be centralised at Craigavon Area Hospital and the business case has already been worked through.

Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust.
Because of the pressure on theatre space at Belfast City Hospital, there are long delays for patients requiring benign reconstructive surgery.	Greater use should be made of HVLC sites (Lagan Valley Hospital (day case) and potentially the Mater Hospital for the delivery of short stay (23 hours) female and functional urology For patients requiring more complex surgery, services should be developed at Altnagelvin Hospital with an in-reach model

Annex E - Western Health and Social Care Trust Findings and Recommendations

Finding	Recommendation
Workforce	
The specialist nursing workforce is a strength at Altnagelvin Hospital, with CNS's delivering flexible cystoscopy, LUTS assessment clinics, ED clinics and cancer follow-up clinics.	Subject to funding, the CNS team should be expanded further as a priority area of development for the Trust. Their roles should be extended to include delivery of LA trans-perineal prostate biopsy, flexible cystoscopy and Botox. TULA could also be considered, once established.
The medical workforce remains reliant on locum appointments and has difficulty recruiting to substantive posts. This is a recognised problem nationally across the UK due to unfilled consultant posts and a lack of NTNs accredited each year.	The department should continue to address barriers to recruitment, where these are within their control. This would include a more robust middle grade rota of cover for on-call as the current consultants are largely the first point of contact for four acute Trusts (Causeway, SWAH, Antrim and Altnagelvin). A middle grade rota can comprise an extended workforce that can include advanced nurse practitioners and physician's associates in addition to more usual medical roles. Developing areas of sub-specialist practice can also aid recruitment and retention of staff. Please see below regarding robotic surgery. The Department of Health should also consider incentivisation of terms and conditions in the Western Trust, in order to attract consultants into the area.
Outpatients and diagnostics	
Waiting access times for outpatients at the Western Trust are the best in NI (see Figure 5). The team are to be congratulated on this, particularly given the lack of dedicated outpatient facilities highlighted below.	Learning from the Western Trust should be shared with other sites to understand how the waiting times can be improved at other Trusts.
Accommodation for medical and nursing staff is inadequate with cramped facilities and poorly linked to other clinical areas.	Please see the recommendation on development of a UIU.
Outpatient facilities for consulting, diagnostic procedures and therapeutic interventions are wholly inadequate and are of the lowest standard of all the urology units in NI. They are also disparate in terms of their location throughout the Trust. It will remain difficult provide efficient and timely outpatient care	The Trust needs to urgently develop and deliver plans for a co-located UIU subject to funding. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place and be future-proofed in terms of the anticipated growth in outpatient work. A UIU is the ideal place to provide office

without urgent investment and re-design of facilities.	accommodation for clinical and administrative staff so that training and clinical interaction can be facilitated.
Cancer pathways need to be further streamlined and designed to avoid inefficiencies in terms of clinician time.	There should be a 'straight to test' approach for suspected prostate cancer patients requiring an MRI scan. It is not good use of clinician time to telephone patients in advance of the test and this could be managed by standard template letters. There should be protected ultrasound slots for patients being assessed for suspected cancer in relation to haematuria. With development of the UIU, a gold standard approach would be a sonographer working alongside the haematuria flexible cystoscopy list.
Up to 25% of patients currently admitted for a TURBT or bladder biopsy could be managed as an outpatient under local anaesthesia using TULA.	A TULA service should be implemented promptly. It is a low-cost innovation with a short learning curve and could lead to rapid capacity release in theatres, by moving such patients out of theatre and into an outpatient setting.
Facilities including HVLC sites	
Theatre facilities at Altnagelvin Hospital are inadequate, with the majority of operating lists being offered in a theatre that has been decommissioned previously, on more than one occasion. The theatre footprint is too small for a modern operating theatre and cannot safely accommodate the patient, the staff and the wide array of urological equipment that is needed to undertake contemporary urological surgery.	There need to be urgent plans for the provision of suitable operating theatres for urological surgery. A majority of such surgery can be performed in daycase facilities, with a smaller component requiring in-patient care (usually due to patient co-morbidity or case complexity). It is not acceptable to continue delivering surgery in the existing facilities in the medium to long term.
Theatre capacity has not been restored following the pandemic and the consultants no longer have access to an all-day theatre list.	As a minimum, each consultant needs access to a main theatre for 2 sessions per week 42 weeks of the year.
Minor and intermediate procedures continue to be undertaken in theatre at the Causeway Hospital but the set-up is highly inefficient. The team have not been given access to daycase beds and problems with patient flow means that start-times of 10.30am or later are common. The lists are poorly utilised in terms of volume of work.	Elective surgical work at the Causeway Hospital should be reviewed with consideration of future provision in-house at Altnagelvin Hospital or Omagh.
Flexible cystoscopies are being performed in theatre at the Causeway Hospital.	This practice needs to stop and should be provided in an outpatient setting by default. It is an inappropriate use of a theatre environment.

Oncology	
Given the significant shortfall in the ability of Belfast Trust to provide the necessary resource for major cancer surgery, serious consideration needs to be given to a second robotic platform at Altnagelvin Hospital.	With appropriate investment and recruitment, there are sufficient volumes of work in NI to justify a second robotic surgery programme at Altnagelvin Hospital. Ideally, it would be implemented as part of a cross-specialty platform, given that colorectal surgery and gynaecological surgery is beginning to transition at pace towards a robotic approach. At present, only 50 of an estimated 250 men undergo RALP in Belfast and our predictions are that the province needs 5-6 RALP surgeons across the two sites if it is to meet this need. Renal surgery is also likely to become robotically-assisted in the near future, in keeping with this change of practice on the mainland. Recruitment of surgeons with the necessary skills will be the major barrier but establishing a high-volume robotic service at the Trust would appeal to certain individuals and make Western Trust a more attractive place to deliver urology. It would also complement the facilities that are provided at the oncology centre for patients requiring radiotherapy or chemotherapy. This development could be critical in ensuring long-term viability of the urology service in the West. Implementation of this recommendation will be subject to funding.
Radical nephrectomy is provided by a single surgeon at Altnagelvin Hospital. Patients requiring partial nephrectomy are referred to Belfast City Hospital.	The nephrectomy service should be formally provided as part of a networked service across the various Trusts that offer this surgery in NI. There should be a single MDT and the ability to cross-cover each other's clinical practice in the situation whereby a single-handed surgeon is on leave or absent from work for other reasons. This will also mitigate against differences in access times should they occur.
Altnagelvin Hospital is the referral site for penile cancer services in NI. It is predominantly a single-handed practice with over 75% of the consultant's theatre capacity being used this work. For this reason There is very little benign work being performed.	Ideally, the service would be expanded with appointment of another andrologist but, in the current climate, it is unlikely that another andrologist could be found and appointed due to a national shortage. To mitigate the risks associated with single-handed practice, the unit needs to have a close-working

	relationship with services on the mainland. This is currently at The Christie NHS Foundation Trust in Manchester.
Urgent and emergency care	
Urgent and emergency care pathways are not functioning consistently across the Trusts that sit within catchment for the Altnagelvin on-call team. This is particularly true in regard to the Trusts in the Northern sector (Causeway and Antrim) but also applies to South West Acute Hospital (SWAH). As a result, there is significant variation in the provision of acute urological care leading to postcode variation for patients.	Urgent action is needed to clarify these pathways and agree the arrangements for the provision of urgent and emergency care. The Urology Teams at Altnagelvin, in association with General Surgery and ED colleagues in the Northern Trust and Belfast Health and Social Care Trust, should develop contemporary clear protocols and care pathways for Urology patients requiring transfer and onward specialist urological treatment. These should include pathways for acute ureteric colic, urinary retention, haematuria and urosepsis management. It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin Hospital.
Interventional radiology provision is predicated on a single radiologist and is predominantly only available 'in-hours'. There are plans for an outreach, networked model later this year supported by Belfast Trust.	Ensure there is a clear protocol in place with associated access arrangements for the provision of interventional radiology, including out-of-hours cover.
Improvements could be made with regard to the management of acute stone patients. This includes improved access to 'hot' ureteroscopy and improved use of acute ESWL.	The department should further develop their use of a 'book and return' pathway for urgent ureteroscopy. Once established, the acute lithotripsy service at Craigavon Area Hospital should be used by default for suitable patients. A seamless referral pathway needs to be agreed between the Western team and Craigavon Area Hospital.
Specialist services	
While andrology surgery is offered at Altnagelvin Hospital, the service is reliant on a single surgeon and with the pressures of the penile cancer service, there is little time or resource available for the service	Ideally, the service would be expanded with appointment of another andrologist but, in the current climate, it is unlikely that another andrologist could be found and appointed due to a national shortage.
Stone service	It has been agreed that ESWL and PCNL surgery will be centralised at Craigavon Area Hospital.

Men awaiting bladder outlet surgery represent one of the longest backlogs in urology and is a particular problem in NI. Men at greatest risk of poor care are those who have indwelling catheters.	The department should have a urinary retention pathway that allows for rapid access back to the service for a TWOC and or assessment for bladder outlet surgery. The pathway should dovetail with the work that has already been done on the BOO surgery pathway at the Lagan Valley facility. There should be a networked approached to this service.
Pathways for female and functional urological treatments need to be clearly agreed and described.	Assessment and common treatments (such as botox / intra-vesical therapies) should be provided at the Trust. There is consensus that the service for more complex or refractory patients will be centralised to Altnagelvin Hospital.
Other observations	
The clinicians cited a disconnect between the previous management team and the clinical team, with a lack of business meetings since the initial COVID surge. It was felt that there was still some work to do to ensure the current relationships functioned well.	There should be a regular (monthly at least) meeting between the clinical team and the service management team, with opportunities to link in with more senior managers and executives. Meetings should have formal agendas, minutes and actions. Actions should be reviewed at each meeting.

Annex F - Northern Trust Findings and Recommendations

Findings	Recommendation
Workforce	
The community continence team nursing team is under-resourced and communication with the Urology teams at Altnagelvin Area Hospital and Belfast City Hospital is patchy.	Strengthening the links between the community team and urological services would enable better access to urological services (e.g. LUTS treatment and Stone management) for patients .
Outpatients and diagnostics	
Patients are traveling long distances to either Belfast or Derry for outpatient consultations	A priority for the Trust should be the further development of the UIU at Whiteabbey. Facilities to consult, perform outpatient diagnostics and offer therapeutic interventions need to be brought into one place enabling patients to be seen and managed without having to travel into Belfast
Facilities including HVLC sites	
Under-utilisation of Urology daycase facilities at both Causeway Hospital and Antrim Area Hospital.	Given the current shortage of urological in the Western Health Trust a review of elective urology at Causeway should be undertaken. Better use of the daycase facility at Antrim Area Hospital aligned with GIRFT principles should be introduced.
Urgent and emergency care (UEC)	
There is no on-site provision of specialist urological care in Antrim Area Hospital or Causeway Hospital. Initial triage and care for common urological conditions (including torsion) is provided by the acute general surgical team. A percentage of patients also end up being cared for by physicians on the medical wards. Depending on a patient's postcode, patients requiring onward urological care are referred to either Altnagelvin Hospital or Belfast Trust. A number of concerns were raised by the local teams (represented by ED, general surgery, medicine and anaesthesia at the site visit). • There were no clear protocols in use for the management of common urological conditions. • Although advice could be sought from the urology on-call team at Altnagelvin or Belfast Trust, specific management plans were not always clear. • 'Admit locally' was said to be a common initial instruction from the on-call team to	It is our recommendation that the current postcode-based system is removed and the arrangements between Trusts simplified in the interests of safe patient care. All patients attending Antrim Area Hospital who require onward care should be directed to Belfast Trust and those attending the Causeway Hospital directed to Altnagelvin. As a matter of urgency, senior clinical leaders from the relevant specialties at each Trust should meet and agree the re-configuration of services. There needs to be clear protocols in place for the common urological emergencies. As a minimum, these should include pathways for urosepsis, haematuria, acute ureteric colic, urinary retention and epididymo-orchitis. The focus should be on ambulatory models of care, where safe to do so. There should be explicit guidance as to how patients could be reviewed at Belfast Trust for longer-term management plans or subsequent attendance at urology ambulatory assessment units.

ED / acute take, leading to further calls between hospitals to clarify the plans for onward care. • When transfers were required, they were often delayed and subject to site meetings between the referring and receiving Trusts. • There was consensus that patients requiring urological input were not receiving the same timely input or urological oversight that patients in the urology units had access to.	Operational site teams should be part of these discussions, to agree how patient transfer can be optimised in order to mitigate against delays in specialist urological input. The urology on-call team at the receiving unit(should ensure that clear plans are given for immediate care of the acute urology patients as well as clear advice on what follow-up is required and how that will be arranged. Following introduction of these pathways, a follow-up meeting between clinical leads should take place after 3 months to check that they are effective in delivering safe urological care in the acute setting.
Oncology and Subspecialist Urology	
When patients who had undergone oncological procedures performed at another trust presented with complications, there were unnecessary delays in transferring patients.	A SLA and clear pathways should be rapidly instituted to enable the swift transfer of patients requiring specialist urological care.
Other	
Clinicians and senior managers present at the site visit could not recall any recent meetings between clinical leads at each Trust to address issues of mutual concern.	Given the issues raised in this review, it would be sensible to schedule an annual meeting between senior clinical leaders across the Trusts to ensure ongoing oversight and governance.

Annex G: Useful links to GIRFT Urology Pathways and Good Practice Guidance

To access the documentation, please click on the links below.

1) NHS England - Model Hospital
2) GIRFT National Urology Report
3) Diagnostics: Recovery and Renewal Report.
4) MedTech Funding Mandate policy 2022/23: guidance for NHS commissioners and providers of NHS-funded care
5) Day case surgery rates
6) GIRFT Good Practice Guide for Urology
7) Clinically-led Specialty Outpatient Guidance
8) Urology Outpatient Transformation
9) Urology: Towards better care for patients with bladder cancer
10) Urology: Towards better care for patients with acute urinary tract stones
11) Urology: towards better care for patients with bladder outlet obstruction
12) Urology: the path to recovery
13) Specialised kidney, bladder and prostate cancer services.
14) Minor peno-scrotal surgery pathway
15) Cystoscopy plus (rigid cystoscopy, endoscopic lower urinary tract procedures)

Annex H: Glossary of Terms and Abbreviations

Abbreviation	Term
A and G	Advice and guidance
BADS	British Association of Day Surgery
BOO	Bladder outflow obstruction
BPH	Benign Prostatic Hyperplasia
Bladder reconstruction	A surgical procedure to form a storage place for urine following a *cystectomy*. Usually, a piece of bowel is removed and is formed into a balloon-shaped sac, which is stitched to the *ureters* and the top of the urethra. This allows urine to be passed in the usual way.
CEPOD	Confidential enquiry into Peri-operative deaths; CEPOD lists are a means of prioritising patients for surgery, based on clinical need
CNS	Clinical Nurse Specialist
Cystectomy	Surgery to remove all or part of the bladder.
Cystoscope	A thin, lighted instrument used to look inside the bladder and remove tissue samples or small tumours.
ED	Emergency department or erectile dysfunction
ESWL	Extra-corporeal shock wave lithotripsy
GIRFT	Getting it Right First Time
GSI	Genuine stress incontinence
Haematuria	The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, whilst microscopic haematuria is only visible with the aid of a microscope.
HES	Hospital Episode Statistics. HES is the national statistical data warehouse for England of the care provided by NHS hospitals and NHS hospital patients treated elsewhere.
HoLEP	Holmium enucleation of the prostate; surgical treatment for BPH
HVLC	High volume low complexity
LATP	local anaesthetic transperineal (prostate biopsy)
LUTS	lower urinary tract symptoms
IR	Interventional radiology
Laparoscopic surgery	Surgery performed using a laparoscope; a special type of endoscope inserted through a small incision in the abdominal wall.
MRI	Magnetic resonance imaging. A non-invasive method of imaging which allows the form and metabolism of tissues and organs to be visualised (also known as nuclear magnetic resonance).
MDT	Multi-disciplinary teams
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health Care Excellence
NIEPC	Northern Ireland Electronic Patient Care
NIMDTA	Northern Ireland Medical and Dental Training Authority
NTN	National training number
PCNL	Percutaneous nephrolithotomy; key hole surgery on the kidney to treat renal stones
Prostatectomy	Surgery to remove part, or all of the *prostate gland*. Radical prostatectomy is the removal of the entire *prostate gland* and some of the surrounding tissue.
PA	Physician Associate

PAE	Prostate artery embolisation
RARP	Robotically-assisted radical prostatectomy
PIFU	Patient initiated follow-up
Rezum	Surgical treatment for benign prostate enlargement
RNOH	Royal National Orthopaedic Hospital
PSA	Prostate Specific Antigen
RTT	Referral to treatment time
SLA	Service level agreement
SOP	Standard operating procedure
SNS	Sacral nerve stimulation (treatment for refractory bladder over-activity)
TP	Trans perineal (as in transperineal biopsy)
TPD	Training Programme Director
TRUS	Tran-rectal ultrasound
TULA	Transurethral laser ablation
TUR	Trans-urethral resection
TURBT	Transurethral resection of bladder tumour
TURis	Trans-urethral resection in saline
TURP	Trans-urethral resection of the prostate (TURP); Surgery to remove tissue from the prostate using an instrument inserted through the urethra. Used to remove part of the tumour which is blocking the urethra.
TWOC	Trial without catheter
UAN	Urology Area Network
UEC	Unplanned and emergency care
UIU	Urology Investigation Unit
Urolift	Surgical treatment for benign prostate enlargement
VVF	Vesico-vaginal fistula (an abnormal communication between the bladder and vagina)
WTE	Whole time equivalent