Initial call made to Debbie Murray by Monica McAlister **(DoH) on** 04/06/21 at 09.12 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Monica McAlister	Organisation	SHSCT
Position	Assistant Director Older People's Services	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

Irrelevant information redacted by the USI has an ongoing COVID-19 outbreak (commenced 19 May 2021). To date 12 residents and 7 staff members have tested positive. 11 of the residents were fully vaccinated and 1 resident had received the first dose of vaccine only. 1 staff member was fully vaccinated and the other 6 had not received any doses.

The SHSCT Infection Prevention & Control Nurse has visited the home to review IPC and PPE practices and continues to provide ongoing telephone advice and support. Discussions are ongoing with IPC and Microbiology to explore if testing for variant types should be commenced within the home.

To date (04 June 2021) two of the residents that tested COVID positive in Irrelevant information redacte have passed away, the first on Irrelevant information redacted by the USI. A third resident that tested COVID positive was admitted to Daisy Hill Hospital on 02 June 2021.

The cause of death for the first deceased resident is recorded on NIECR as metastatic neuroendocrine tumour with aortic valve replacement listed as other significant condition. This man was discharged from the Hospice to Irrelevant information redacted by the USI on 14 April 2021 for end of life (EOL) care. This resident had only received his first dose of vaccine.

The second resident who died was also receiving EOL care and due to have a syringe pump erected on the day they died. When the GP called to certify the death she advised that she would be contacting the Coroner as the cause of death was possibly COVID related.

The Coroner has advised the GP that the cause of death would be recorded as old age / natural decline. Recorded on NIECR is old age and bowel obstruction with COVID-19 recorded as secondary. This resident was fully vaccinated.

The third COVID positive resident was admitted to Daisy Hill Hospital on 02 June 2021 and is potentially for discharge back to Irrelevant information redacted by the USI today. This resident is fully vaccinated.

As of today, 04 June 2021 there are 9 COVID positive residents in Irrelevant information redacted and 3 staff continue to self-isolate. Virtual monitoring remains in place for 5 positive residents via the Acute Care at Home AC@H.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Claire McNally

Contact details:

Email address (work or home): [redacted] Personal Information redacted by the USI

Mobile (work or home): [redacted] **Telephone (work or home):** [redacted] Personal Information redacted by the USI

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DoH:

Early Alert Communication received by: …….... Office: ……..……..

Forwarded for consideration and appropriate action to: ……..…… Date: ….....

Detail of follow-up action (if applicable) ……..……

ANNEX A

Initial call made to:

Spoke to Chris Matthews @10:25

(DHSSPS) on _____ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Cathrine Reid	Organisation	Southern Health & Social Care Trust
Position	Interim Assistant Director of Primary Care	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated

DESCRIPTION OF INCIDENT:

There is a risk to providing a safe and timely OOHs service, due to reduced GP cover. The clinical cover at 11am is as follows:

Saturday 5 June 2021
Red eye –there is a GP until 2am however there are 2 nurse advisors throughout the red eye period,
Morning – there are 7 GPs instead of 9 and 2 Nurse Advisors,
Afternoon - there are only 3 GPs instead of 8, 2 Nurse Advisors, and 1 GP on home triage
Evening – there are 3 GPs in base instead of 9, 1 Nurse Advisor,

Sunday 6 June 2021
Red eye –there is no GP however there are 2 nurse advisors throughout the red eye period,
Morning – there are 5 GPs and 3 Nurse Advisors and 1 Nurse Practitioner
Afternoon - there is only 2 GPs instead of 9 and 1 Nurse Advisor and 2 GPs on home triage
Evening – there are only 8 GPs instead of 9, and 3 Nurse Advisors

Monday 7 June 2021
Red eye –there is 1 GP and 2 Nurse Advisors during this period

IMMEDIATE ACTION TAKEN:

There is on-going work within the service to secure further GP and nurse cover for this weekend.
Internal escalation and contingency planning has commenced. Urgent / essential appointments will be only offered when the service is operational with GP cover. When no GP in base this is will be a triage only service.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: **Claire McNally**
Telephone (work or home) Personal Information redacted by the USI
Email address (work or home) Personal Information redacted by the USI

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:
Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: …
Detail of follow-up action (if applicable…….

ANNEX A

Initial call made to:

Spoke to Chris Matthews @11:55

(DHSSPS) on [ ] **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Cathrine Reid	Organisation	Southern Health & Social Care Trust
Position	Interim Assistant Director of Primary Care	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated

DESCRIPTION OF INCIDENT:

There is a risk to providing a safe and timely OOHs service, due to reduced GP cover. The clinical cover at 11am is as follows:

Wednesday 2 June 2021
Red eye –there are no GPs with 2 Nurse Advisors during this period

IMMEDIATE ACTION TAKEN:

There is on-going work within the service to secure further GP and nurse cover for this weekend.
Internal escalation and contingency planning has commenced. Urgent / essential appointments will be only offered when the service is operational with GP cover. When no GP in base this is will be a triage only service.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: **Claire McNally**
Telephone (work or home) Personal Information redacted by the USI
Email address (work or home) Personal Information redacted by the USI

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: …
Detail of follow-up action (if applicable…….

ANNEX A

Initial call made to:

Spoke to Chris Matthews @09:20

(DHSSPS) on [ ] **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Cathrine Reid	Organisation	Southern Health & Social Care Trust
Position	Interim Assistant Director of Primary Care	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated

DESCRIPTION OF INCIDENT:

There is a risk to providing a safe and timely OOHs service, due to reduced GP cover. The clinical cover at 11am is as follows:

Saturday 29 May 2021
Red eye –there is no GP however there are 2 nurse advisors throughout the red eye period,
Morning – there are 10 GPs instead of 9 and 1 Nurse Advisor,
Afternoon - there are only 5 GPs instead of 8, 2 Nurse Advisors, 1 Nurse Practitioner and 1 GP on home triage
Evening – there is **no** GP in base instead of 9, 1 Nurse Advisor, 1 GPs on Home Triage

Sunday 30 May 2021
Red eye –there is no GP however there are 2 nurse advisors throughout the red eye period,
Morning – there are 8 GPs and 1 Nurse Advisor
Afternoon - there is only 3 GPs instead of 9, 2 Nurse Advisors and 2 GPs on home triage
Evening – there are only 4 GPs instead of 9, and 3 Nurse Advisors

Monday 31 May 2021
Red eye –there are 3 Nurse Advisors during this period
Morning – there are 10 GPs and 2 Nurse Advisors
Afternoon - there is only 3 GP instead of 9 and 3 Nurse Advisors
Evening – there are only 4 GPs instead of 9, and 2 Nurse Advisors

Tuesday 1 June 2021
Red eye –there is a GP in base until 2am with 2 Nurse Advisors during the red eye, and then a GP on home triage 6am – 8am

IMMEDIATE ACTION TAKEN:

There is on-going work within the service to secure further GP and nurse cover for this weekend.
Internal escalation and contingency planning has commenced. Urgent / essential appointments will be only offered when the service is operational with GP cover. When no GP in base this is will be a triage only service.
A contingency plan is in place for no clinical cover between 2am and 5am.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: **Claire McNally**
Telephone (work or home) Personal Information redacted by the USI
Email address (work or home) Personal Information redacted by the USI

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:
Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: …
Detail of follow-up action (if applicable…….

Initial call made to Mark Lee @ 3.50pm **(DoH) on** 26/05/21 **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Roisin Toner	Organisation	SHSCT
Position	Assistant Director for Enhanced Services	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

On Wednesday 19 May 2021 a Whistleblowing statement was received by SHSCT alleging substandard care delivery on a Non Acute Hospital ward (Ward 2 Loane House, South Tyrone Hospital). The Whistleblowing statement was received from a Health Care Agency whose Health Care Assistant worked an agency shift from 07:30-20:30 on 15 May 2021.

In light of the allegations within the letter, a Trust Whistle Blowing Oversight Committee took the decision to precautionarily suspend one band 6 Registered Nurse and two Band 3 Health Care Assistants with immediate effect. A safeguarding investigation was commenced which will be investigated under joint protocol with PSNI. RQIA were informed on Friday 21 May 2021.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Claire McNally

Contact details:

Email address (work or home): Personal Information redacted by the USI

Mobile (work or home): Telephone (work or home): Personal Information redacted by the USI

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ……..... Office: ……..……..

Forwarded for consideration and appropriate action to: ……..…… Date: ……..

Detail of follow-up action (if applicable) ……..……

Initial call made to Debbie Murray by Monica McAlister **(DoH) on** 26/05/21 09:16am **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Monica McAlister	Organisation	SHSCT
Position	Assistant Director of Older People Services	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

RQIA held a serious concerns meeting with the Management from Greenpark Care Home in Armagh on 25/05/21 following a recent pharmacy inspection last week.

RQIA have issued 2 Failure to comply notices around;

1. Medication Management
2. Governance and Management oversight.

Actions agreed:

- Greenpark have to submit a revised action plan to RQIA as soon as possible. Greenpark has voluntarily agreed to close to new admissions.
- The previous Care Home Manager has been drafted back into the home to support the current temporary Manager over the next few weeks.
- 3 safeguarding referrals in relation to medication incidents have been received into the Trust today.
- Greenpark have until 20/07/21 to progress actions and satisfactorily rectify concerns.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Monica McAlister

Contact details:

Email address (work or home): Personal Information redacted by the USI

Mobile (work or home): Telephone (work or home): Personal Information redacted by the USI

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ……..... Office: ……..……..

Forwarded for consideration and appropriate action to: ……..……. Date: ….....

Detail of follow-up action (if applicable) ……..……

ANNEX A

Initial call made to:

Spoke to Chris Matthews @12:25

(DHSSPS) on [ ] **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Cathrine Reid	Organisation	Southern Health & Social Care Trust
Position	Interim Assistant Director of Primary Care	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated

DESCRIPTION OF INCIDENT:

There is a risk to providing a safe and timely OOHs service, due to reduced GP cover. The clinical cover at 11am is as follows:

Saturday 22 May 2021
Morning – there are 9 GPs instead of 9 and 1 Nurse Advisor and 1 Nurse Practitioner,
Afternoon - there are only 3 GPs instead of 8, 3 Nurse Advisors
Evening – there is only 1 GP instead of 9, 2 Nurse Advisors, 2 GPs on Home Triage

Sunday 23 May 2021
Red eye –there is no GP however there are 2 nurse advisors throughout the red eye period,
Morning – there are 7 GPs and 2 Nurse Advisors and 1 Nurse Practitioner
Afternoon - there is only 1 GP instead of 9 and 3 Nurse Advisors
Evening – there are only 4 GPs instead of 9, and 3 Nurse Advisors

Monday 24 May 2021
Red eye –there are 3 Nurse Advisors during this period

IMMEDIATE ACTION TAKEN:

There is on-going work within the service to secure further GP and nurse cover for this weekend.
Internal escalation and contingency planning has commenced. Urgent / essential appointments will be only offered when the service is operational with GP cover. When no GP in base this is will be a triage only service.
A contingency plan is in place for no clinical cover between 2am and 5am.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: **Claire McNally**
Telephone (work or home) [redacted]
Email address (work or home) [redacted] Personal Information redacted by the USI

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:
Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: …
Detail of follow-up action (if applicable…….

ANNEX A

Initial call made to Debbie Murray by Monica McAlister **(DoH) on** 19/05/21 at 12noon **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name	Monica McAlister	Organisation	SHSCT
Position	Assistant Director for Older People's Services	Telephone	Personal Information redacted by the USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

On 17 May 2021 the Southern Health and Social Care Trust became aware that over the weekend of 15/16 May 2021, [redacted] the owner of the Valley Care Home, contacted the former Registered Manager of the Valley Care Home and advised her that he was appointing an Administrator as he was entering into insolvency. [redacted] advised that the Administrators would notify the staff in due course. At this stage the Trust is unclear if this affects his NI business only or his UK business in totality.

The staff in the Valley Care Home have already been notified by the former Registered Manager.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Claire McNally

Contact details:

Email address (work or home): Personal Information redacted by the USI

Mobile (work or home): Telephone (work or home): Personal Information redacted by the USI

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

ANNEX A

Initial call made to:

Spoke to Chris Matthews @14:35

(DHSSPS) on [ ] **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Cathrine Reid	Organisation	Southern Health & Social Care Trust
Position	Interim Assistant Director of Primary Care	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated

DESCRIPTION OF INCIDENT:

There is a risk to providing a safe and timely OOHs service, due to reduced GP cover. The clinical cover at 1pm is as follows:

Tuesday 18 May 2021
Red eye – No GP, 2 nurse advisor throughout the red eye period

Wednesday 19 May 2021
Red eye – No GP, 2 nurse advisor throughout the red eye period

IMMEDIATE ACTION TAKEN:

There is on-going work within the service to secure further GP and nurse cover for this weekend.
Internal escalation and contingency planning has commenced. Urgent / essential appointments will be only offered when the service is operational with GP cover. When no GP in base this is will be a triage only service

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: **Claire McNally**
Telephone (work or home) Personal Information redacted by the USI
Email address (work or home) Personal Information redacted by the USI

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:
Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: …
Detail of follow-up action (if applicable…….

ANNEX A

Initial call made to:

Spoke to Chris Matthews @09:55

(DHSSPS) on [ ] **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Cathrine Reid	Organisation	Southern Health & Social Care Trust
Position	Interim Assistant Director of Primary Care	Telephone	Personal Information redacted by the USI

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated

DESCRIPTION OF INCIDENT:

There is a risk to providing a safe and timely OOHs service, due to reduced GP cover. The clinical cover at 11am is as follows:

Saturday 15 May 2021
Red eye – No GP, 2 nurse advisor throughout the red eye period
Morning – there are 9 GPs instead of 9 and 2 Nurse Advisors,
Afternoon - there are only 6 GPs instead of 8, 3 Nurse Advisors
Evening – there is only 1 GP instead of 9, 2 Nurse Advisors, 3 GPs on Home Triage

Sunday 16 May 2021
Red eye –there is no GP however there are 2 nurse advisors throughout the red eye period,
Morning – there are 9 GPs and 2 Nurse Advisors and 1 Nurse Practitioner
Afternoon - there are only 2 GPs instead of 9 and 3 Nurse Advisors
Evening – there are only 7 GPs instead of 9, and 3 Nurse Advisors

Monday 17 May 2021
Red eye –there is a GP until 2am and then a GP on home triage 5am – 8am. DUC are contracted to provide nurse cover on this shift, however they have advised if no SHSCT GP or Nurse available, they will not provide nurse cover. *Therefore there is no clinical cover between 2am and 5am.*

HSCB has aslo been advised of this situation

IMMEDIATE ACTION TAKEN:

There is on-going work within the service to secure further GP and nurse cover for this weekend.
Internal escalation and contingency planning has commenced. Urgent / essential appointments will be only offered when the service is operational with GP cover. When no GP in base this is will be a triage only service.
A contingency plan is in place for no clinical cover between 2am and 5am.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: **Claire McNally**
Telephone (work or home) Personal Information redacted by the USI
Email address (work or home) Personal Information redacted by the USI

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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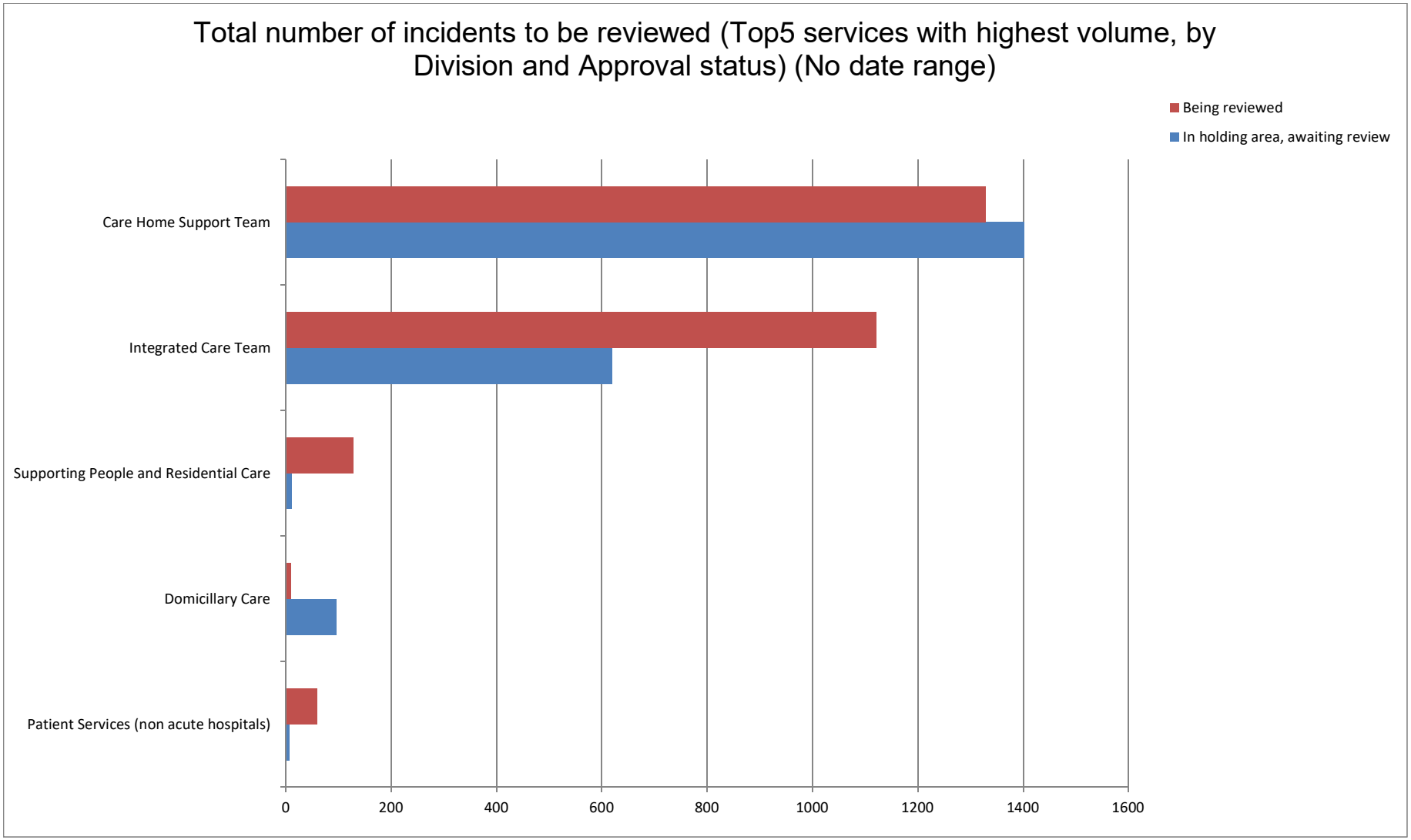
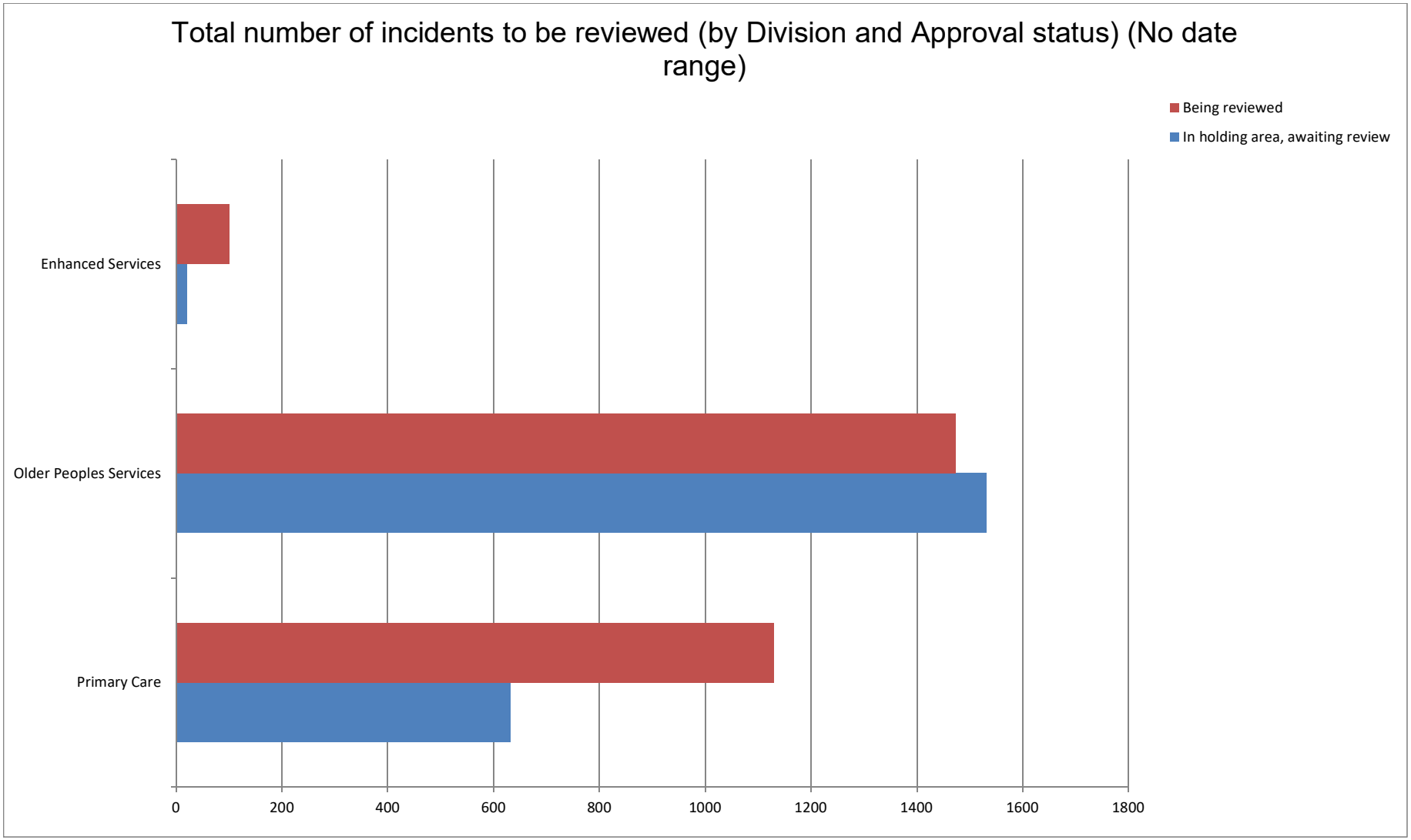
FOR COMPLETION BY DHSSPS:
Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: …
Detail of follow-up action (if applicable…….

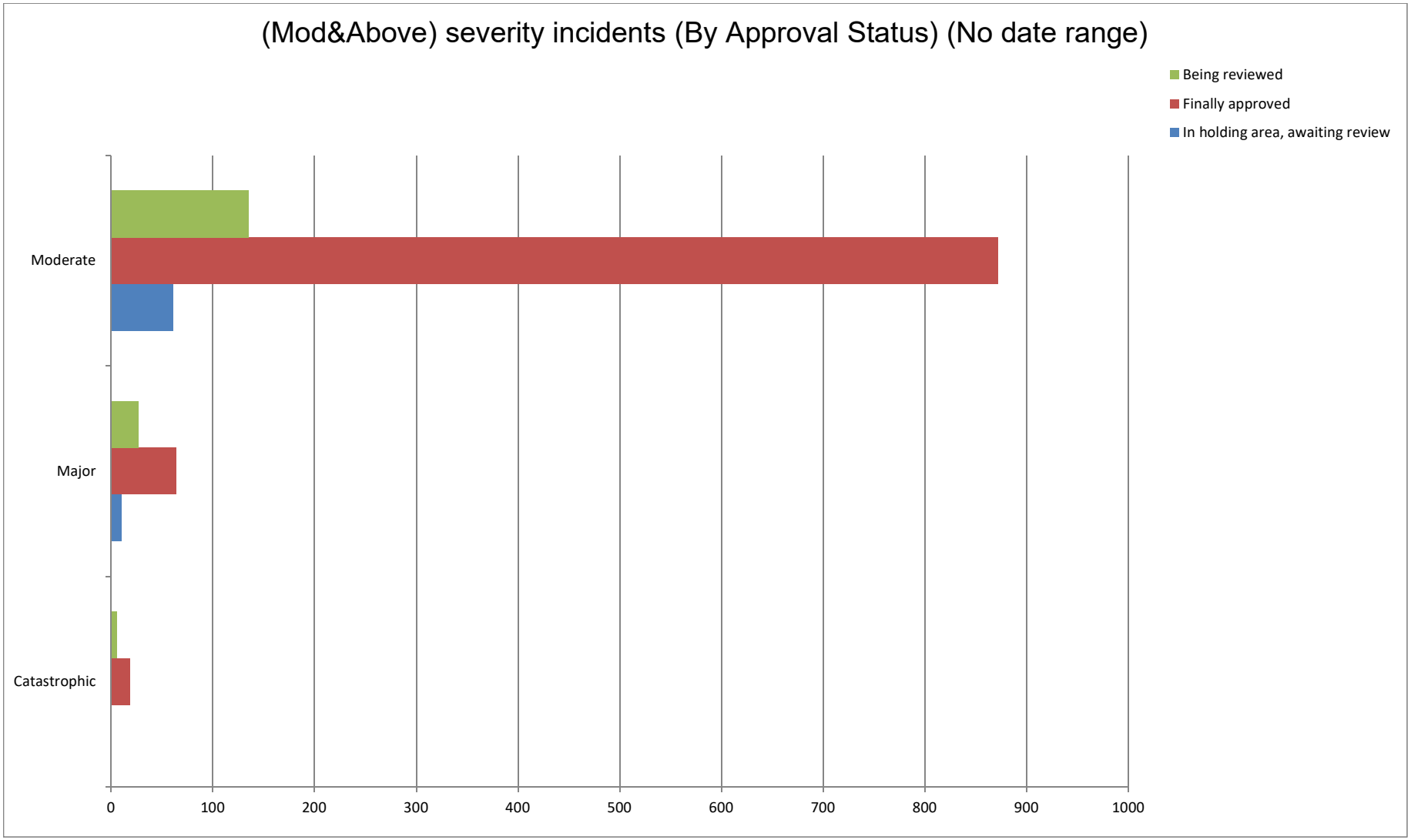
	In holding area, awaiting review	Being reviewed
Patient Services (non acute hospitals)	7	59
Domicillary Care	96	9
Supporting People and Residential Care	12	128
Integrated Care Team	620	1121
Care Home Support Team	1402	1328


Total number of incidents to be reviewed (Top5 services with highest volume, by Division and Approval status) (No date range)
Being reviewed
In holding area, awaiting review
Care Home Support Team
Integrated Care Team
Supporting People and Residential Care
Domicillary Care
Patient Services (non acute hospitals)
0
200
400
600
800
1000
1200
1400
1600

	In holding area, awaiting review	Being reviewed
Primary Care	632	1130
Older Peoples Services	1531	1473
Enhanced Services	20	101


Total number of incidents to be reviewed (by Division and Approval status) (No date range)
Being reviewed
In holding area, awaiting review
Enhanced Services
Older Peoples Services
Primary Care
0
200
400
600
800
1000
1200
1400
1600
1800

	In holding area, awaiting review	Finally approved	Being reviewed
Catastrophic	1	19	6
Major	10	64	27
Moderate	61	872	135


(Mod&Above) severity incidents (By Approval Status) (No date range)
Being reviewed
Finally approved
In holding area, awaiting review
Moderate
Major
Catastrophic
0
100
200
300
400
500
600
700
800
900
1000

Current Serious Adverse Incidents OPPC

	Service User	Care Area	Team	Current Position
1.	Personal Information redacted by the USI	Care Home CSp # / dislocation injury	CHST	Deferred as with ASG
2.		DCW administering meds/ falsifying records	THC	AD requested to nominate panel
3.		Syringe driver manangement	AC@H	Report in final draft stage
4.		Attempted suicide. PNH	CHST	Report being drafted
5.		Carer on Resident abuse PNH	CHST	Notified
6.		Misappropriation of money by carer PNH	CHST	Notified
7.		Attempted suicide PNH	CHST	Notified
8.		Mistaken identity	CHST	Notified
9.		Choking	NAH	Notified
10.		Choking	Community	To be notified
11		Suicide	MHD led	OPPC supplying record of OOHs involvement. Second meeting due.

DIRECTORATE RISK REGISTER - May 2021

Description/Change in position		
Risks removed	-	
Risks reduced	-	
Risks increased	-	
Risk added:	-	
Comment(s):	-	

Overview of OPPC Directorate Risk Register

Risk Grading Domain	Count
(Extreme)	**1**
Safety & Quality	1
(High)	**3**
Operational performance / Service improvement	1
Safety & Quality	2
(Medium)	**3**
Safety & Quality	3
Grand Total	**7**

RR	Division	Date Identified	Risk ID	Domain	Corporate Objective	Category
(High)	ENH	02/12/2013	GPOOH / 01	Safety & Quality	Promoting safe, high quality Care	Patient Safety
(High)	OPS	04/12/2015	OP/DC/24	Operational performance / Service improvement	Provide safe quality care	Domiciliary care capacity issues
(Medium)	PC		OP/DC/12	Safety & Quality	Promoting safe, high quality Care	Health and Safety
(Medium)	PC		PC/IIP1	Safety & Quality	Promoting safe, high quality Care	Patient Safety
(Medium)	ENH	18/10/2019	BMP/01	Safety & Quality	Promoting safe, high quality Care	Patient Safety
(High)	OPS	01/09/2019	OP/IS/2019	Safety & Quality	Promoting safe, high quality Care	Independent Care Home Sector
(Extreme)	ENH	11/02/2021	BMP/02	Safety & Quality	Promoting safe, high quality Care	Patient Safety and Financial Security

ENHANCED SERVICES - MAY 2021

Date Identified	Risk ID	Domain	Corporate Objective	Category	Title/Description	Potential for Harm	Control Measures	Likelihood	Severity	Initial RR	Change	Action Plan	Action Completion	Nominated Lead	Risk Mgt Level	Date Reviewed	Review Date
02/12/2013	GPOOH / 01	Safety & Quality	Promoting safe, high quality Care	Patient Safety	When clinical capacity in the GP OOHs is lower than service demand, there is the potential for compromised patient safety. The Trust may not be able to deliver a full timely, compliant OOH service due to difficulty filling all rota GP sessions.	**Impact being:** • No available GP during some operational hours • 5 Incidences of no Red Eye GP cover in the Trust area for the service. The 1st Quarter in 2019 saw an average of 65% of nights with less than 2 GPs on duty within the Trust area for the Red Eye shift. Rating 4x3 =High • Repeat failure to meet regional set waiting time standards/targets. Rating 5x3 =High (The 1st quarter in 19/20 saw 78% of urgent calls triaged within 20 minutes, while in July this was 76%). • Patient's diagnosis and/or treatment may be delayed. Rating 1x3= low • Likely increase in waiting times leading to increased complaints. Rating 1x3 = Low (This is evidenced in increase in formal complaints received first 2 months Quarter 1 2019/20)	**Service delivery planning** • Advanced rota planning, daily reviewing contingency actions for GPs, nurses & Operational staff. • Requests via SMS / emails and telephone calls to GPs, nurses to assist with workload. • Datix system in place to record clinical incidents – monitoring and investigations as per policy • Complaint investigation and sharing of the learning as per policy • Monthly clinical meeting with Medical Managers, Nurse Team Lead and HOS, chaired by Clinical Lead. • Regional OOHs meeting every quarter • SHSCT and HSCB Performance / Governance meeting every quarter • Home triage for GPs embedded in cover as advanced forward planning rather than reactionary to lengthy triage waits. • Senior Managers are engaging with the Urgent and Emergency Care Review Team • Urgent and essential appointments only (no longer seeing routine cases). • Meeting in June between Trust and HSCB senior managers to discuss the current situation **Staffing/Resourcing** • Dalriada provides nurse triage from 12midnight to 8 am dailySunday to Thursday. SHSCT Nurse Triage on Friday and Saturday. • Nurse triage shifts embedded in rota/clinical cover. • Nurse Advisors triaging Urgent calls. • Pharmacy service is now embedded. • Recruitment of GPs for salaried sessions and ongoing recruitment of "as and when" and salaried GPs • 4th round recruitment of nurses advisors has taken place (Jan19) • The Local Enhanced Scheme was in place from 17/18 and for 18/19 and again in 19/20. • KPIs monitored hourly and reported daily by HSCB to providers. • 2019/20 Trust additional costs scheme implemented with a specific element to encourage GP clinical cover on Saturday afternoons and evenings. Enhanced rated offered for Friday evenings. • Medical management structure in place. • Performance management of GPs/ Nurses and pharmacists in place • GP Clinical Forum established • Education programme in place for GPs FY0 led programme in place (Completed May19)	5	3	15 (High)	-	• Scope possibility of moving to urgent and essential appointments only. • Meeting organised with MHD services to look at direct referral pathways to OOHs Mental Health Services • Scope use of PGDs to allow Nurse Advisors to dispense medication in certain conditions rather than replacing case for triage with GP. • Meeting to discuss potential for all nurse advisors to undertake urgent triage (currently only some undertake this function). •Meeting to be organised with MHD services to look at direct referral pathways to OOHs MH Services. •Progress the agreed actions arising from the options paper on short and long term proposals. •GP OOHs service has an action plan in place which includes measures to control the risk - review of this plan is ongoing. ---------- **Update/Summary of current position:** 09.08.19 - SMT met in August to discuss this risk and concluded that the risk was mitigated with Nurse Triage and the meeting with the HSCB. There have been 5 episodes of no GP cover during the Red Eye period since March, and a contingency plan is in place with no incidents to date. Failure to meet regional targets is more likely since March 2019, with the occasions of no GP cover on the Red Eye and decrease in GP cover over all shifts. The actual impact is evidenced through extended waiting times outside of the regional KPIs, There is an increase in the percentage of vacant GP hours. 15.08.19 - Director returned	Ongoing	HSCB and Trust Senior Management	**Directorate**	Nov-19	Jan-20
18/10/2019	BMP/01	Safety and Quality	Promoting Safe High Quality Care	patient safety improving our services	Standards and Guidelines	Lack of dedicated Clinical time to fully scope newly issued S&G for applicability, define the actions needed to implement the recommendations and drive these forward. Lack of dedicated operational time to fully scope newly issued S&G for applicability, define the actions needed to implement the recommendations and drive these forward.	• HOS assumes change lead for the S&G and scopes in the knowledge of their service. •Governance Coordinators facilitate with initial scoping and review in absence of discrete service knowledge	3	3	9 (Medium)		• Risk Escalated to Medical Director • Risk escalated to Operational Directors • Non compliance for each S&G to be risk rated to allow prioritisation	ongoing		For consideration at Corporate level	Dec-19	Jan-20
11/02/2021	BMP/02	Safety and Quality	Promoting Safe High Quality Care	Patient Safety and Financial Security	Access to Services Financial Balance	• Risk of patients needing to access GP Practice services not been able to avail of the appropriate clinical input due to lack of GPs in the practice. • Risk of BMP not achieving financial balance due to lack of capacity and ability to provide sufficient income generation services.	• Escalation to HSCB, DoH • HSCB "Rescue Team" assisting with some locum cover although not consistent and not on all days • Triage of Urgent patients in BMP being carried out by GP colleagues in Urgent Care Centre. • Full use of remote triage • Prescribing pharmacists employed within the practice • Multidisciplinary alternative patient pathways put in place • Enhanced rates offered to attract sessions from locum GOPs, agency GPs, other Trust employed GP.	5	4	20 (Extreme)		Concerted efforts continue to try and recruit additional GP sessions. SHSCT working closely with HSCB to achieve a solution. Regular meetings and daily updates.	ongoing	Brian Beattie, Interim Director OPPC Dr Maria O'Kane, Medical Director	For consideration at Corporate level	25.02.21	Daily.

OLDER PEOPLE SERVICES - MAY 2021

Date Identified	Risk ID	Domain	Corporate Objective	Category	Title/Description	Potential for Harm	Control Measures	Likelihood	Severity	Initial RR	Change	Action Plan	Action Completion	Nominated Lead	Risk Mgt Level	Date Reviewed	Review Date
04/12/2015	OP/DC/24	Operational performance / Service improvement	Provide safe quality care	Domiciliary care capacity issues	Lack of available capacity to accept care packages in both Statutory and Independent sectors resulting in outstanding care packages on a daily basis. This can cause hospital delays and inability to start or increase new or existing packages in a timely way in line with eligible need	Commissioned care not availble which may result in increased demands on families, interim care options (following risk assessment) including temporary placements in care homes and financial burden to Trust as agreement for funding support during placement, due to lack of capacity, not being allowed to disadvantage service users financially.	Meetings with domiciliary care providers to agree actions to improve uptake of packages; Winter pressures incentive to encourage uptake by providers; Prioritisation of higher risk / needs by local teams to target earliest possible packages; Ensure high risk clients have appropriate interim care arrangements in place to address identified need in absence of available domiciliary care package; Piloting of new domiciliary care model in Armagh & Dungannon area which focuses on outcomes and independence to reduce unnecessary demand; Increased professional assessment by Occupational Therapists to tailor packages to meet need; Recruitment drives for additional THC staff to increase capacity in line with duty of care; Progressing procurement of IS providers and contract support to address capacity issues; Update SMT/ Trust Board regularly	5	3	**15 (High)**	–	Rolling recruitment program for THC DCW's. Ongoing monitoring of all clients and package needs in Armagh & Dungannon where there is now only one home Care OT's in post . Trust is in process of procuring IS providers. recruitment posters and pop up stands designed and continuing to be used. Advert on Trust face book. Issues with Scrutiny did slow up teams ability to timely commence workers , Trust has lost some staff because of this as they have went on to get another job. This has recently been discussed and a new process put in place. In process of setting up recruitment fayres to take place shortly. Outcome of Banding for DCW's has now been upgraded to Band 3. Recruitment processes being reviewed in light of restrictions due to Covid 19. Trust communications team supporting trecruitment drive. Potentially for dedicated admin	Ongoing	Claudine McComiskey	Directorate	Aug-20	Dec-20
01/09/2019	OP/IS/2019	Safety and Quality	Provide safe Quality Care	Independent Care Home Sector	Instability in Independent Care Home sector.	•Potential for home closure at short notice with Trust responsibility to provide alternative placements for their service users. • Vulnerable dependent service users potentially in a position where they are not provided with appropriate care or placed in an inappropriate placement • Service users remaining in an acute / non acute hospital bed or ICS facility when medically fit for discharge, increasing their risk of functional decline/increased dependence, falling and acquiring a hospital infection. • Risk to Service users health and wellbeing, physical, mental and emotional due to having to move from their Care home or to placemeents further away from thier families or local community. • Negative publicity for Trust•	• HSCB has re-established a Regional Group with all Trusts, PHA, Board and Dept represented with oversight of the Independent Sector market and trends, to develop a risk management strategy and future plans/approaches. • RQIA are also involved in this regional group • Regional Nursing Home Contingency standard operational procedure now finalised and shared with Trust on what action to be taken in the event of teh a Care home collapse. Risk escalation process to SMT Early arlert mechanism to the Board and Department regarding conserns • Daily collation, review and circulation to commissioners of bed availability across the Trust • Ongoing review by key workers of all care home placements to ensure service users are placed appropriately in relation to their category of care, ie residential / nursing etc. Quarterly interface meeting with care homes to discuss challenges in the sector and explore solution provide support and training as required. Use of Transformational monies to recuit 2 Band 6 clinical nurses and 1 physio into the OPPC Care Home Sipport Team. Currently reviewing the role and makup of the Care Home Support Team to ensure it is fit for supose. Actively engaging in the DOH and CPEA workshops which reviewed the COPNI recommendations into Dunmurray Manor Care Home and will implement its findings as approprite. Currently reviewingly the Trust TOR and role of the SHSCT IndependenGovernance Sector Meetings to ensure the apporoprite sharing of information trends concerns etc	3	4	**12(High)**			Ongoing	Monica McAlister	Directorate	Dec-19	Jan-20

PRIMARY CARE - MAY 2021

Date Identified	Risk ID	Domain	Corporate Objective	Category	Title/Description	Potential for Harm	Control Measures	Likelihood	Severity	Initial RR	Change	Action Plan	Action Completion	Nominated Lead	Risk Mgt Level	Date Reviewed	Review Date
April 16 restructured and attributed to transcribing risk	OP/DC/12	Safety & Quality	Promoting safe, high quality Care	Health and Safety	Lack of compliance with RQIA standards in relation to medicines management in domiciliary care - current risk is around nursing capacity and transcribing - Elizabeth Smith and Jilly have reviewed - Primary Care to host risk.	Injury to client. Trust operational guidance not fully operational.	Medication training programme for staff. Shared best practice with Independent Sector. Sitting on regional group	4	3	12 (Medium)	–	**GENERAL POSITION** The Southern Trust has proactively taken actions to mitigate the risks associated with managing medicines in Community settings. This includes: • Annual Competency based training re medicines management for domiciliary care workers completed for all staff from Sept to Dec 2015 . • A registered nurse has been seconded in the Newry and Mourne area, progressing medicines review and safer systems. The post holder moved to Armagh and Dungannon area and has recently moved into the Craigavon & Banbridge areas. Core teams support the ongoing work in Newry/Mourne and Armagh & Dungannon areas to prevent regression of project work to date. • A rolling audit will be carried out in N&M and the A&D areas as part of an exit strategy • The Transcribing procedures have been revised (October 2015) and now include specific guidance for community nurses completing MIS for DCWs • A Transcribing E learning training programme has been developed and uploaded onto the E-learning platform. All community nurses who will be required to transcribe to complete this by 01 April 2016 • Risk assessment revised November 2015. • Audit risk assessments for new service users to ensure compliance with guidelines commencing November 2015. • Further training/ awareness sessions planned for key workers completing medication assessments. • Single patient medication files are being tested across providers to minimise risk of error. • A regional business case is being developed by HSCB to secure funding to deliver an interim system which includes a specialist medicines assessment and provision of appropriate solutions for service users who are identified as potentially requiring domiciliary care support in the area of medicines management. Statutory domiciliary care agencies recently inspected by RQIA – no requirements identified. **PRIMARY CARE DIVISION**: Ongoing capacity issues in community nursing teams is affecting safe medicines administrations by domiciliary care staff due to lack of timely provision of detailed care plans, medication instruction sheets, adherence to procedures etc... An options paper is being finalised and will be shared for consideration by the Medicines Steering Group/ SMT. Consideration to be given to employing Pharmacy Technicians to provide capacity	Ongoing	M McAlister/ B Beattie	Corporate	May-17	Aug-19
Oct-17	PC/II1	Safety & Quality	Promoting safe, high quality Care	Health and Safety	Missed Insulin calls	Injury to client.	The following control measures are in place: All nurses to adhere to NMC Standard for Medicine Management. All nurses to adhere to Caseload Management Principles. All nurses to adhere to CNAC delegation framework. Staff must report appropriately and complete a Datix for all near misses/ drug errors and participate in root cause analysis. Strive to ensure adequate staffing numbers and skill mix. Ensure training in Microsoft calendar management/ desk diary as per Standard Operating Procedure (SOP) within caseload Management principles. Ensure agreed access to electronic calendar. Trusts' Policies/Procedures/Guidelines to be adhered to. Trust Medicine Management Code to be adhered to. Staff to attend the 3 year Mandatory update on Management of Medicines. Staff to use Trust mobile phones as per SOP aimed at improving communication between team members.	3	3	9 (Medium)	-	Work commenced to introduce a change to Operational Hours within District Nursing. In the interim the teams are mitigating against this risk by ensuring that they have a handover at 3.30pm, to confirm that the staff to who the calls are delegated are aware of the visits they must do at the end of their shift/evening visits. This is an interim arrangement until we progress the changes to the operational hours and can go live with mobile working.	Completed	D Tumilty/ B Beattie	Directorate	Nov-18	Aug-19

PROMOTING HEALTH & WELL BEING - MAY 2021

Date Identified	Risk ID	Domain	Corporate Objective	Category	Title/Description	Potential for Harm	Control Measures	Likelihood	Severity	Initial RR	Change	Action Plan	Action Completion	Nominated Lead	Risk Mgt Level	Date Reviewed	Review Date
NIL																	

Received from Shane Devlin on 14/02/22 Annotated by the Urology Services Inquiry.

Health and Social Care Board

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Sent by email only

To: Trusts Chief Executives

For cascade to:
Medical Directors
Directors of Nursing
Heads of Pharmacy & Medicines Management
Drug & Therapeutics Chairs
Governance Leads

2nd June, 2021

Dear Colleague

MedSafe Newsletter

Please find attached a copy of MedSafe Newsletter issue 24, the Medicines Governance team's newsletter on learning from reported medication incidents.

I would be grateful if you could disseminate this document as appropriate within your organisation and encourage the application of learning that has been identified.

Yours sincerely

Personal Information redacted by the USI

Joe Brogan
Assistant Director of Integrated Care
Head of Pharmacy and Medicines Management

CC. Regional Safer Medicines Sub Group
Regional Governance Team Pharmacists, Secondary Care

Enc. MedSafe newsletter issue 24

Medicines Governance Team

Issue 24 June 2021

MedSafe

sharing learning

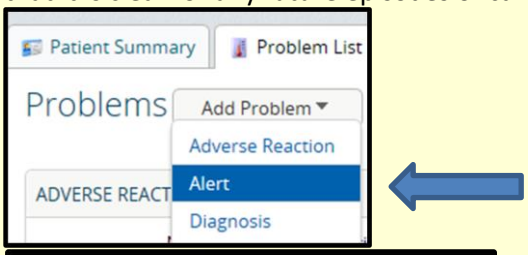
The following medication incidents have been reported in HSC Trusts during 2020. Learning points have been identified for HSC staff to promote safer prescribing, dispensing and administration of medicines and facilitate shared learning between HSC trusts.

DAPT duration and cessation

A patient was admitted with increased confusion and left sided weakness. A CT brain was performed and confirmed a diagnosis of acute intracranial haemorrhage. On assessment of the patients' medicines, it was noted the patient was admitted on dual antiplatelet therapy (DAPT) with aspirin and prasugrel, which may have contributed to their bleed. On review it was discovered DAPT should have been switched to monotherapy after 12 months following primary PCI. This timeframe meant the patient was on DAPT for approximately 16 months longer than intended prior to admission.

Learning Points

- ✓ Review all patients who are prescribed DAPT to confirm the duration of treatment is still appropriate and their review date has not passed.
- ✓ The date DAPT should be reviewed or stopped must be clearly documented following any cardiology advice or intervention. This information should be included onto further discharge letters and NIECR (insert an alert on the patient summary page- new function see below) so that it is clear for any future episodes of care.



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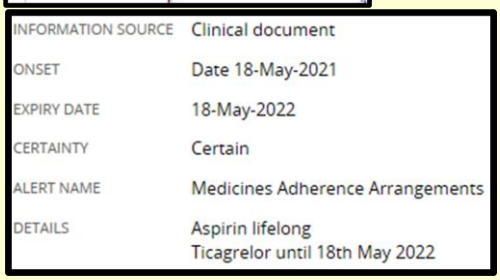


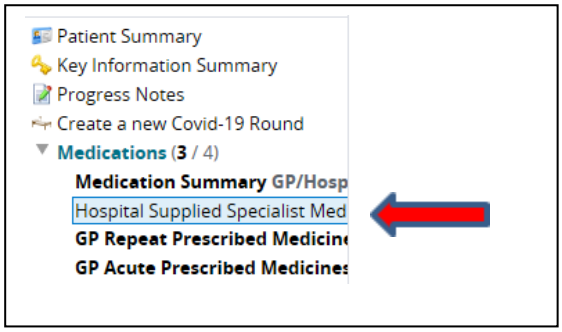
- ✓ Where DAPT duration cannot be confirmed, staff must seek advice from the local cardiology team.
- ✓ When patients admitted on DAPT have an acute change in clinical status, staff should liaise closely with cardiology to ensure any early discontinuation or change in DAPT is appropriate.

HSCB Safety and Quality Learning Letter 'Combination anti-platelet therapy for patients who have had a coronary stent Link and the accompanying information for professional staff Link provides additional guidance.

Clozapine omission and ECR medicines form

A patient was admitted to hospital for suspected acute NSTEMI with raised troponin. Following medicines reconciliation it was identified the patient was prescribed and taking clozapine prior to admission, which had not been identified or prescribed on admission. As the omission was greater than 48 hours and due to the patient's acute presentation, it was subsequently decided to hold clozapine given the risks of cardiac adverse effects.

NIECR has recently been updated to include red/amber list medicines. It can be found in the medication section under medication summary (see below)



Learning Points

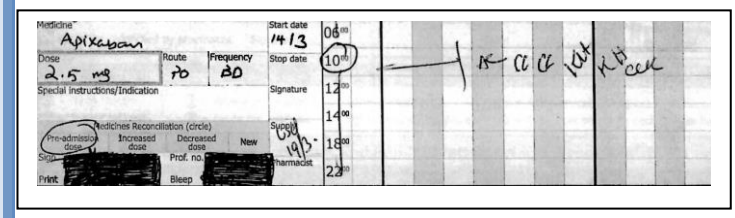
- ✓ Clozapine is a critical medicine, and omission for more than 48 hours may necessitate a re-titration of treatment in line with local guidelines. Where re-titration may be required, advice should be obtained from psychiatry colleagues.
- ✓ Clozapine is a 'red list' medicine and alongside other medicines not issued by the GP, it may not be initially obvious as part of the patients medication history. Check hospital supplied specialist medicines on NIECR (see above).
- ✓ Staff should ensure they confirm all medications a patient is taking on admission as part of the medicines reconciliation process as these could be relevant in terms of their acute presentation with regard to adverse effects.

MedSafe

Medicines Governance Team

Frequency of DOACs

A patient with a history of atrial fibrillation (AF) was admitted to hospital for an elective procedure. The patient's apixaban (a direct oral anticoagulant (DOAC) used for prevention of stroke and systemic embolism in non valvular atrial fibrillation (NVAF) was put on hold prior to the procedure. When the apixaban was re-prescribed post procedure the frequency was correctly prescribed as twice daily (BD) however only ONE administration time on the patient's Kardex was circled. This led to the patient being administered apixaban 2.5mg ONCE daily for 6 days before this was spotted.



The administration frequency of DOACs can vary depending on the DOAC being prescribed (see table below)

Apixaban	Always **TWICE** daily
Dabigatran	Always **TWICE** daily
Rivaroxaban	**Normally ONCE** daily (but can be Twice daily for a set period of time depending on indication). Check product SPC or BNF before prescribing
Edoxaban	Always **ONCE** daily

Learning Points

- ✓ Confirm the frequency is appropriate for the medicine and formulation, check reference sources if unsure.
- ✓ Always check the prescribed frequency matches the number of administration times circled; do not simply follow the pattern of administration signatures from previous medicine rounds.

Check Allergy Status

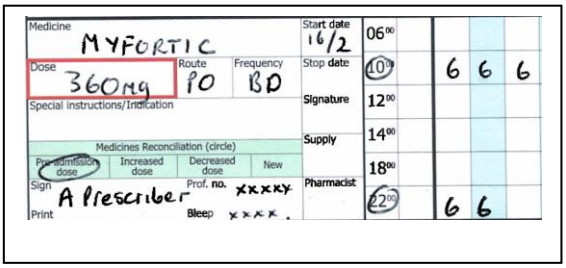
Patient prescribed aztreonam for sepsis however had a documented allergy to this. Patient received aztreonam for three days and developed all over body rash (acute generalised exanthematous pustulosis). Loss of fluid from pustules contributed to acute renal failure. Rash and renal function gradually improved

Learning Points

- ✓ Check allergy status each time a medicine is prescribed, administered and dispensed.

Missed doses of critical medicines

A patient admitted to hospital with a staphylococcus aureus bacteraemia missed 5 doses of their critical medicine, Myfortic® (mycophenolate sodium). The patient received a renal transplant in 2012 and had been prescribed Myfortic® 360mg BD to prevent organ rejection. Missing doses of anti-rejection medicines can lead to the patients' immune system damaging the transplanted organ which can lead to organ failure.



The ward did not stock Myfortic®. Myfortic® was not recognised as a critical medicine by ward staff and was therefore not ordered from pharmacy. When Myfortic® was ordered from pharmacy it was placed on an individual patient order which can take a few days to arrive in. The order was not chased up.

Learning Points

- ✓ Check ward stock, if not stocked on the wards, order from pharmacy.
- ✓ Chase up stock before next dose is due.
- ✓ Check SPC or BNF for the indication of medicines you do not recognise.
- ✓ If the medicine is considered a critical medicine call the on-call pharmacist if the Pharmacy Department is closed to arrange supply.

If you have any comments on this bulletin, please contact Angela Carrington, Regional Medicines [redacted]
Received from Shane Devlin on 04/02/22 Annot [redacted]

Southern Health & Social Care Trust
Summary of Fire Safety Training by Directorate / Division including % of staff trained as at 31st Mar 2021
Prepared by/HR Contact: Bronagh Donnelly
Date 19/05/21

		Key: % Trained			
		0% - 59%			
		60% - 79%			
		80% - 100%			
Directorate	**Division**	**Not Trained**	**Trained**	**Head Count**	**% Trained**
Acute Services	ATICS & Surgery & Elective Division	582	441	1023	**43%**
	Director's Office	8	8	16	**50%**
	Functional Support Services Division	572	520	1092	**48%**
	IM&WH and Cancer & Clinical Services Division	404	740	1144	**65%**
	Medicine Division	383	386	769	**50%**
	Pharmacy Division	82	145	227	**64%**
	Unscheduled Care Division	194	198	392	**51%**
Acute Services Total		**2225**	**2438**	**4663**	**52%**
Chief Executive's Office	Chief Executive's Office Division	1	5	6	**83%**
	Communications Division	4	4	8	**50%**
Chief Executive's Office Total		**5**	**9**	**14**	**64%**
Children & Young People's Services	Corporate Parenting Division	98	268	366	**73%**
	Director's Office Division		2	2	**100%**
	Family Support & Safeguarding Division	246	305	551	**55%**
	Social Care Governance Division	3	6	9	**67%**
	Social Services Training Unit Division	8	11	19	**58%**
	Specialist Child Health & Disability Division	255	461	716	**64%**
Children & Young People's Services Total		**610**	**1053**	**1663**	**63%**
Executive Directorate of Nursing & Midwifery and AHP's	AHP Governance & Workforce Planning Division	4	3	7	**43%**
	Director's Office Division		1	1	**100%**
	Nursing & Midwifery Education and Workforce Division	9	15	24	**63%**
	Nursing Safety Quality, Patient Experience Division	6	14	20	**70%**
Executive Directorate of Nursing & Midwifery and AHP's Total		**19**	**33**	**52**	**63%**
Finance & Procurement	Director's Office Division	1	1	2	**50%**
	Estates Services Division	63	108	171	**63%**
	Financial Accounting Division	27	49	76	**64%**
	Financial Management Division	8	40	48	**83%**
Finance & Procurement Total		**99**	**198**	**297**	**67%**
HR & Organisational Development	Director's Office Division	5	6	11	**55%**
	Education Learning & Development Division	2	9	11	**82%**
	Employee Relations Division	5	22	27	**81%**
	Equality Assurance Division	1	3	4	**75%**
	Litigation Division	2	14	16	**88%**
	Medical Staffing Unit Division		14	14	**100%**
	Medical Staffing Unit Division - Medical/Dental	27	4	31	**13%**
	Occupational Health Division	29	33	62	**53%**
	Resourcing Division	9	19	28	**68%**
	Staff Side Division	8	2	10	**20%**

	Vocational Workforce Assessment Division	1	11	12	92%
	Workforce Information Division	1	12	13	92%
HR & Organisational Development Total		**90**	**149**	**239**	**62%**
Medical	Director's Office Division	13	16	29	55%
	Governance Division	13	25	38	66%
Medical Total		**26**	**41**	**67**	**61%**
Mental Health & Disability Services	Director's Office Division	25	14	39	36%
	Learning Disability Division	280	332	612	54%
	Medical Division	18	40	58	69%
	Mental Health Division	211	332	543	61%
	MH&D Inpatient Division	54	131	185	71%
	Physical Disability Division	63	142	205	69%
	Psychology Division	14	36	50	72%
Mental Health & Disability Services Total		**665**	**1027**	**1692**	**61%**
Older People & Primary Care	Director's Office Division	1	5	6	83%
	Enhanced Services Division	323	426	749	57%
	Older People Division	1164	273	1437	19%
	Primary Care Division	331	442	773	57%
	Promoting Wellbeing Division	21	67	88	76%
Older People & Primary Care Total		**1840**	**1213**	**3053**	**40%**
Performance & Reform	Best Care Best Value Division	4	3	7	43%
	Corporate Planning Division	1	12	13	92%
	Director's Office Division		2	2	100%
	Informatics Division	58	74	132	56%
	Performance Improvement Division	9	9	18	50%
Performance & Reform Total		**72**	**100**	**172**	**58%**
Grand Total		**5651**	**6261**	**11912**	**53%**

This report has been compiled and is intended for use only by the official recipient.

If you believe the information in this report does not accurately reflect the current position, please contact the Organisational Development & Learning Department

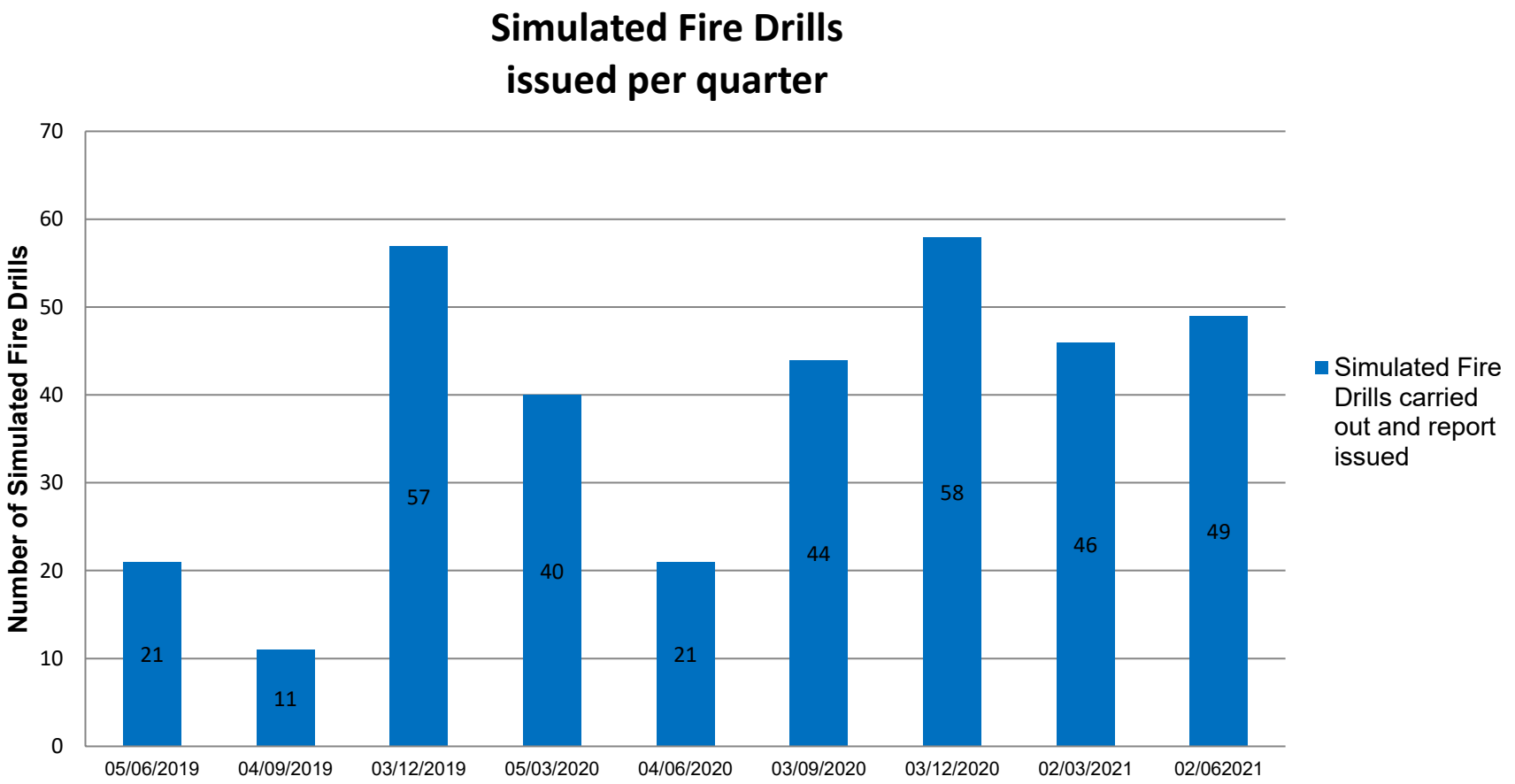
Please remember your responsibilities under data protection legislation, for example ensure personal information is kept secure (for example not left in view of unauthorised staff or visitors), is only used for the purpose intended, and is not shared with anyone who should not have access to it. Also, once personal information has been used for its intended purpose it should be appropriately destroyed, or kept in a secure location if it is required for future use.

Directorate & Facility Name	Fire Safety Non Compliance			
	Fire Alarm test log sheet outstanding		Fire Drill log sheet returned outstanding	
	No Records	Last date received	No Records	Last date received
Older People & Primary Care				
Banbridge Polyclinic		04/09/2020		11/09/2020
Ballygawley Health Centre		05/11/2020		10/02/2021
Clover, Longstone (new team on site)		15/10/2018		15/10/2018
Drs Out of Hrs, CAH		12/05/2021		12/06/2018
Dungannon Clinic		05/10/2020		21/06/2019
Gilford HC		27/08/2020		14/09/2020
Haven Close		22/01/2021		16/02/2020
The Limes		12/01/2015	×	
Orior House, DHH (ACAH)		29/04/2021		06/05/2020
Riverside, Bannvale (Governance)		09/12/2020		09/12/2020
Mental Health & Learning Disability				
Acorns, SLH		08/10/2020		03/07/2017
Armagh Resource Centre		10/12/2020		18/03/2020
Bannvale, Zest		28/09/2020		10/09/2020
Bannvale House		02/11/2020		01/12/2020
Bowen's Close		03/02/2019		29/08/2020
Coronation Block, STH		04/03/2021		20/12/2017
Edenderry House		12/03/2021		17/01/2020
Granville		01/09/2020		03/09/2020
The Laurels		01/09/2020		03/09/2020
Main Building, St Lukes		15/10/2020		03/12/2019

Manor Centre		28/08/2020		19/05/2021
Offices Psychology, STH		14/06/2017		20/12/2017
Old School House, Seagoe		25/11/2019		20/09/2018
Staff Accommodation (HTCR), SLH		22/01/2021		11/02/2017
Transport Dept, Edward St, Newry		15/12/2020		06/09/2019
Woodlawn House		28/10/2020		05/11/2020
Children & Young People's				
Bessbrook Clinic		28/12/2020		30/11/2020
Bocombra Children's Centre		03/02/2020		27/04/2021
Bungalow, Lurgan Hospital		24/11/2020		22/06/2020
Carland Lodge (CYP Accom)		30/01/2018		27/12/2018
Cedarwood, Longstone		30/04/2020		03/09/2020
Dromore HC		11/01/2021		03/06/2020
Drumalane House		26/08/2020		03/12/2019
Drumglass Lodge		18/09/2020		08/10/2020
Haven Court (CYP Accommodation)		27/02/2020	×	
Hollow Drive, SLH		10/06/2020		06/03/2018
Surestart, ARKE		14/06/2017		22/01/2019
Surestart, Blossom		25/11/2020		23/10/2020
Surestart Dungannon		11/09/2020		30/09/2020
Surestart Kilkeel		06/10/2020		11/03/2020
Villa 2, CYP Centre		10/09/2020		09/01/2014
Vela House (CYP Accommodation)		04/03/2020	×	
Medical				
Beechfield House		10/07/2020		10/07/2020
Finance				
Estates Workshops, STH		01/04/2021		07/05/2020

HR & Organisational Development				
Firbank, CAH		04/09/2020		03/04/2020
St Luke's Hill Building		29/04/2021		03/07/2019
Acute				
Bernish House, DHH		03/12/2020		19/10/2020
Canal View, DHH		16/12/2020	×	
Tower Block, CAH (Social Work Team)		07/09/2020		05/05/2020
Drs Homes 1 & 2, DHH		01/05/2020		29/07/2020
Laundry, CAH		23/10/2020		18/02/2021
Mortuary, CAH		30/11/2020		26/02/2020
Mortuary, DHH		30/04/2020		26/02/2020
Performance & Reform				
Brackens, CAH		04/12/2020		11/09/2020
Closed Records, SLH		04/12/2020		15/10/2020
Glendale, Bannvale		28/05/2016		27/02/2020
Rowans, CAH		03/01/2020		10/01/2020

Appendix 2



Acute Drills Stats

Outstanding Drills		01/06/2021	
Location	Day	Night	Totals
CAH	2	0	2
DHH	0	0	0
LH	0	0	0
STH	0	0	0
SLH	0	0	0
Total O/S	2	0	2

Completed Drills		01/06/2021	
Location	Day	Night	Totals
CAH	65	33	98
DHH	29	14	43
LH	15	3	18
STH	20	3	23
SLH	1	1	2
Total Completed	130	54	184
	132	54	186
Total Drills O/S and completed			186

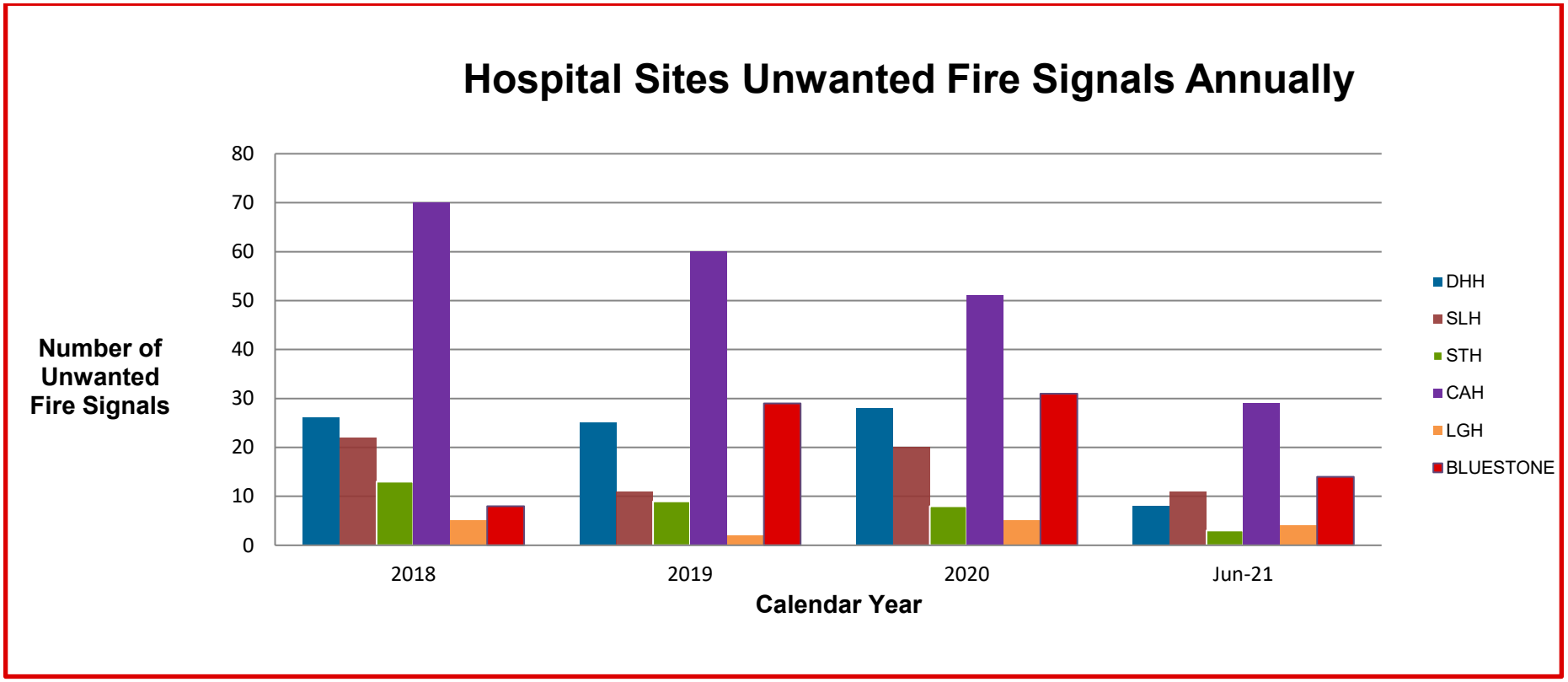
	%
DAY DRILLS	
% CAH DAY Drills completed	97.01%
% DHH DAY Drills completed	100.00%
% STH DAY Drills completed	100.00%
% LH DAY Drills completed	100.00%
% SLH DAY Drills completed	100.00%

NIGHT DRILLS	
% CAH NIGHT Drills completed	100.00%
% DHH NIGHT Drills completed	100.00%
% STH NIGHT Drills completed	100.00%
% LH NIGHT Drills completed	100.00%
% SLH NIGHT Drills completed	100.00%

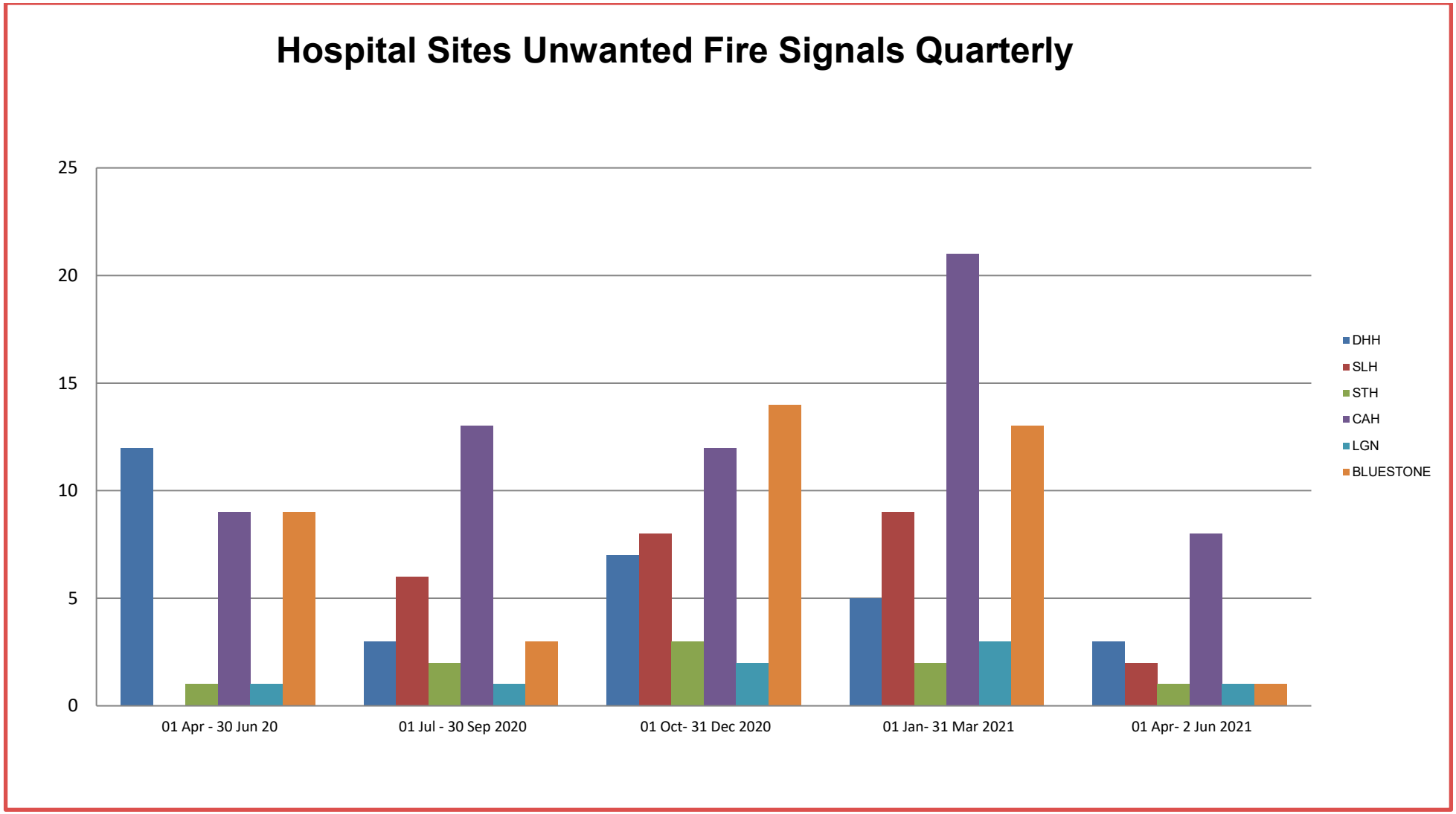
OVERALL %	
% of Day Drills Completed	98.48%
% of Night Drills Completed	100.00%
% Combined Day & Night Completed	100.00%

*Extra Night Drill added 02 Feb 2021(CAH Recovery now ICU 2)

Appendix 3



TOTAL NUMBER OF UNWANTED FIRE CALLS PER YEAR						
Year	**STH**	**SLH**	**LGH**	**BLUESTONE**	**DHH**	**CAH**
2018	13	22	5	8	26	70
2019	9	11	2	29	25	60
2020	8	20	5	31	28	51
2 June 2021	3	11	4	14	8	29



Unwanted Fire Calls Craigavon Area Hospital 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
04/01/2021	1421	CAH	CAH 05 Laundry zone A02 Ground	No	No	Laundry rang to say steam set off. Will call Estates	Yes	Acute
13/01/2021	1746	CAH	CAH 22 Grd Flr Zone B38	Yes	No	Steam set off alarm	No	Acute
14/01/2021	1040	CAH	CAH 22 Grd Flr Zone B38	Yes	No	Fault	No	Acute
19/01/2021	1418	CAH	MCP CAH31 Grd Flr zone A03 Paeds	No	No	Parent pressed MCP by mistake	Yes	CYP
20/01/2021	1610	CAH	CAH22 Grd Flr Zone B38 OPD B1005	Yes	No	Workmen in area, lots of dust, detector not covered	Yes	Acute
23/01/2021	0931	CAH	CAH05 Laundry zone A04 Ground	No	No	Laundry rang to say false alarm	Yes	Acute
25/01/2021	1401	Other	Moylinn	Yes	No	No info given	No	MHD
25/01/2021	1624	CAH	CAH20 4th Floor zone S04 Maternity	Yes	No	E cigarette set alarm off	No	Acute
29/01/2021	0608	CAH	CAH06 First Flr xone 1 North MCP	Yes	No	MCP set off on purpose	No	Acute
30/01/2021	2230	CAH	2 North 2nd Floor	Yes	Yes	2 North rang to say fire in kitchen - Burnt Toast	Yes	Acute
01/02/2021	1005	Other	Moylinn	Yes	No	Weekly fire test, did not inform switchboard	No	MHD
05/02/2021	1520	CAH	CAH06 1st Floor C05 MCP	Yes	No	someone broke the break glass'	No	Acute
10/02/2021	1529	CAH	CAH21 Ground Floor xone B05	Yes	No	someone broke the break glass'	No	Acute
19/02/2021	0620	CAH	Willowbank A05 Flat 25	Yes	No	Porter came to say system fault	Yes	Acute
19/02/2021	0700	CAH	Willowbank A05 Flat 25	No	No	Faulty Head	Yes	Acute
21/02/2021	2116	CAH	Willowbank A05 Flat 25	Yes	No	Faulty Detector to be replaced tomorrow	Yes	Acute
25/02/2021	0706	CAH	CAH12 1st Floor zone C23	Yes	No	High temp in Theatre 1 Electrical UPS room	Yes	Acute
02/03/2021	0820	CAH	Ground Floor b01 b1337	Yes	No	Staff member hit MCP	No	FPE
04/03/2021	0611	CAH	CAH09 Ground Flr zone B13 Kitchen MEC	Yes	No	Staff member burnt plastic in microwave	No	MED
06/03/2021	1347	CAH	CAH21 MCP Ground Flr zone B06	No	No	AMU Nurse rang to say patient set off	No	Acute
17/03/2021	0958	CAH	Neonatal	No	Yes	Staff rang to say 'burnt toast'	No	Acute
18/03/2021	1702	other	Moylinn	Yes	No	Moylinn rant to say dehumidifier set off alarm	Yes	MHD
18/03/2021	1947	other	Edenderry House	Yes	No	No info given	No	MHD
31/03/2021	1130	CAH	CAH07 Zone B33 Trauma	Yes	No	Faulty Detector	Yes	Acute
31/03/2021	1430	CAH	CAH07 Zone B33 Trauma	Yes	No	Faulty Detector	Yes	Acute
12/04/2021	1210	CAH	1 West	No	No	Domestic Set off with steam	No	Acute

13/04/2021	0601	CAH	CAH10 Elms zone C02 2nd Flr Flat D C003	Yes	No	Faulty Detector	Yes	Acute
13/04/2021	0726	CAH	CAH10 Elms zone C02 2nd Flr Flat D C003	Yes	No	Faulty Detector	No	Acute
14/04/2021	1558	CAH	CAH 26 Grd flr zone B17	Yes	No	S/B phoned NIFRS by mistake/ informed drill on ward	No	Acute
22/04/2021	1443	CAH	CAH31 Grd Flr zone A01 Paeds A001	Yes	No	Faulty light in Blossom set alarm	Yes	CYP
16/05/2021	1600	CAH	CAH03 Basement Zone A08 Main	Yes	No	MCP hit	No	Acute
23/05/2021	1105	CAH	CAH05 Energy Ctr A01 Grd Flr A014 Void	Yes	No	Boiler House Alarm	No	FPE
27/05/2021	1132	CAH	CAH11 zone B07 Willowbank	Yes	Yes	Fault		Acute

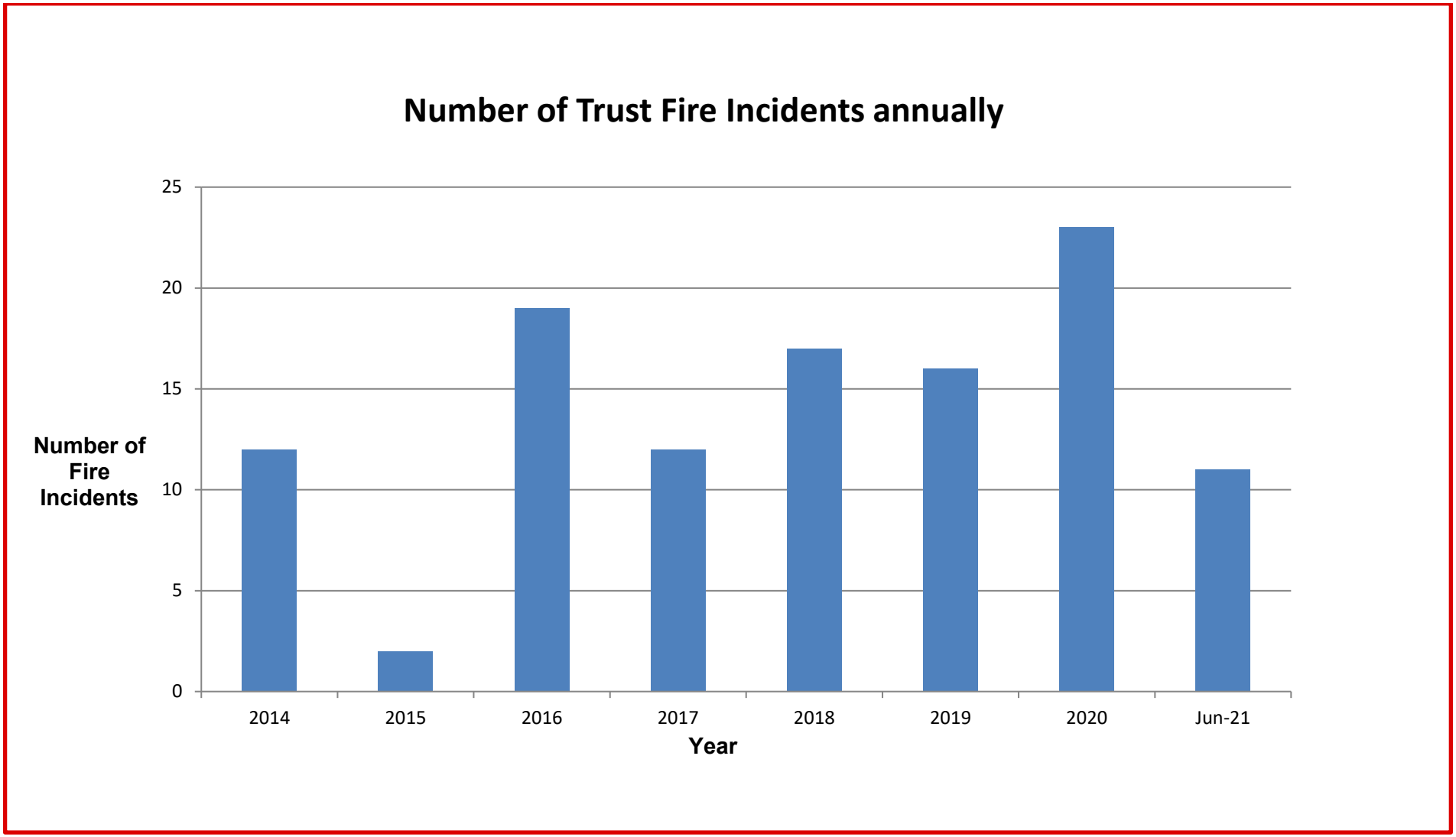
Unwanted Fire Calls - Bluestone Unit - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
02/01/2021	1052	Bluestone	CAH Bronte Ward Rm 10 CAH13	Yes	Yes	Patient lit small decoration, staff put in water	Yes	MHD
28/01/2021	0608	Bluestone	CAH Bronte a14	No	No	Patient set off MCP	No	MHD
08/02/2021	1415	Bluestone	Bronte Zone Panel 13 A16	Yes	No	Patient hit breakglass unit	Yes	MHD
09/02/2021	0808	Bluestone	Silverwood Zone A18	No	No	False Alarm'	Yes	MHD
09/02/2021	1927	Bluestone	Silverwood Zone A18	No	No	Patient knocked MCP off wall	Yes	MHD
10/02/2021	1420	Bluestone	CPU Rosebrook CAH 30 Zone A22	Yes	No	Patient hit breakglass unit	Yes	MHD
14/02/2021	0822	Bluestone	CAH14 Silverwood zone A12 MCP	No	No	Patient had set off	Yes	MHD
21/02/2021	1121	Bluestone	Cloughmore	No	No	Patient set off	Yes	MHD
27/02/2021	1250	Bluestone	Silverwood	No	No	Ward confirmed no fire, patient activated	Yes	MHD
02/03/2021	0027	Bluestone	MCP CAH 14 Silverwood A09 corridor A207	No	No	Ward staff rang to say false alarm	Yes	MHD
06/03/2021	1930	Bluestone	CPU Rosebrook zone A22	No	No	False Alarm'	Yes	MHD
27/03/2021	1626	Bluestone	MCP Dorsy Unit Zone Bz8	No	No	Staff rang to say testing	Yes	MHD
30/03/2021	1319	Bluestone	Willows A01 Bedroom 5	Yes	No	Patient heat styling tools set off	Yes	MHD
08/04/2021	0330	Bluestone	MCP CAH 14 Silverwood A10 A198	No	No	Staff in Bluestone advised Patient set off	Yes	MHD

Unwanted Fire Calls - St Lukes - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
08/01/2021	0706	SLH	Haven Court Bungalow SLA14	Yes	No	Pipe had burst in roof	No	FPE
19/01/2021	0200	SLH	SLA 19 Staff Accommodation	Yes	No	Faulty Detector	No	FPE
24/01/2021	2240	TH	Ashleigh House	Yes	No	*No Record*	No	FPE
26/01/2021	1102	SLH	SLA 24 Catholic Chapel	Yes	No	Possibly power disruption	No	FPE
26/01/2021	2005	SLH	SLA25 Hotel Services	Yes	No	*Faulty detector head*	No	FPE
27/01/2021	2143	other	61-67 Loughgall Rd	No	No	*Noleen rang to say person smoking*	Yes	MHD
29/01/2021	1654	SLH	SLH12 First Floor clinical area MCP	No	No	Workmen set off	Yes	MHD
15/02/2021	1234	SLH	Main Building	Yes	No	Workmen set off from Ward 2	Yes	MHD
24/02/2021	0750	SLH	SLA09 Elmwood/ATU	Yes	No	Faulty detector	Yes	MHD
24/02/2021		TH	Grange Building Towerhill	No	No	Staff rang to say no fire	Yes	MHD
16/03/2021	1155	SLH	Haven Court Bungalow SLA14	No	No	Accidently set off by SPIE	No	CYP
22/03/2021	1411	SLH	SLA 38 Mullinure Zone A06	Yes	No	Faulty detector	No	MHD
23/03/2021	0923	SLH	SLA12 zone 4 ward 4	Yes	No	Set off by SPIE	No	MHD
25/03/2021	1842	TH	Armagh Community Hospital	Yes	No	False alarm	No	OPPC
07/04/2021	1248	TH	Boiler House	Yes	No	*No Record*	No	FPE
12/04/2021	1709	TH	Grange Building Towerhill	Yes	No	Faulty Detector removed	Yes	MHD
22/04/2021	0505	TH	Milford Building	Yes	No	No Record	No	MHD
24/04/2021	1800	SLH	SLA12 Zone Ward 5	Yes	No	False alarm	No	MHD
29/04/2021	1132	SLH	SLA12 Ward 6 Grd Floor	Yes	No	No Record	Yes	MHD

Unwanted Fire Calls - South Tyrone - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
15/02/2021	903	Clogher	Clogher Valley H & Day Care Centre	Yes	No	SPIE working and didn't advise switchboard	Yes	OPPC
16/02/2021	1630	STH	MCP STH17 06 Main Block zone F02	Yes	No	Someone hit MCP to exit ward (GP)	No	OPPC
28/02/2021	0926	STH	STD-04 Workshop zone A05 area A002	Yes	No	Faulty detector	No	FPE
05/04/2021	1819	STH	MIU STD 17 02 zone B13	Yes	No	*Burnt Toast*	No	Acute

Unwanted Fire Calls - Daisy Hill Hospital - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
20/01/2021	1650	DHH	Drs House 1 - Garage	Yes	No	No cause identified by security	Yes	Acute
25/01/2021	1129	DHH	DHN04 1st Flr Maternity OPD	Yes	No	Breakglass hit by hoist	No	Acute
01/02/2021	2149	DHH	DHN14 BH Zone D04 2nd Flr d038	Yes	No	Break glass was hit by someone'	Yes	Acute
18/02/2021	1732	DHH	DHN07 Dr House 1 B02 First Flr B-012	Yes	No	Doctors burnt food. 2 x pies	Yes	Acute
08/03/2021	915	DHH	Clanrye	Yes	No	Contractors	Yes	FPE
20/04/2021	810	DHH	Clanrye	Yes	No	Test not communicated at S/B handover	Yes	CYP
11/05/2021	1054	DHH	B09 Lower Ground Floor	No	No	Staff member spray deodorant	Yes	Acute
24/05/2021	1700	DHH	Clanrye HouseDHN12 Zone A02 Grd A019		No	Paint fumes	Yes	CYP

Unwanted Fire Calls - Lurgan Hospital - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
19/01/2021	1333	LGH	LGH 05 Ground Floor zone A16	Yes	No	No details provided	No	OPPC
25/02/2021	0919	LGH	LGH 07 Boiler house zone A01	Yes	No	Contractors working in area set off alarm	Yes	FPE
24/03/2021	1359	LGH	LHL 07 Ambulance Building zone A0	Yes	No	No caused noted	No	Other
07/05/2021	1030	LGH	LGH 06 Grd Floor A12 Day	No	No	Alarm set off by Contractors - not aware they were to let s/b know in area	No	OPPC

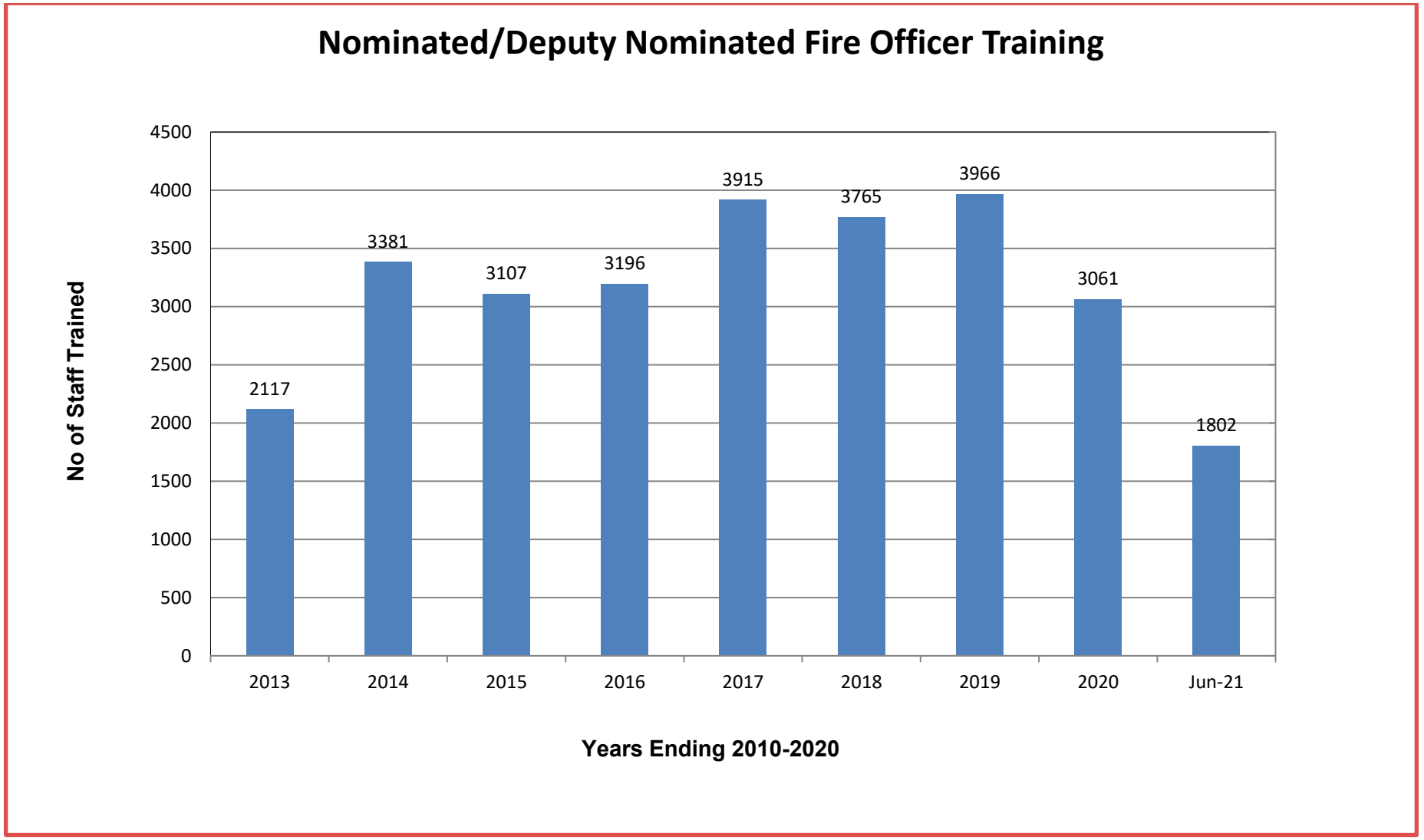


Fire Incidents Trust Wide 2021			
Date	Facility	Cause/Reported As	Datix Ref
02/01/2021	Bronte Ward, Bluestone	Patient lit a small christmas decoration and staff put in in a glass of water.	W128058 W128079
04/01/2021	Edward St Transport Dept	2 x Trust vehicles found to have fire damage when staff arrived on duty for work.	W126384
10/01/2021	Slieve Roe	Staff member noticed smell of smoke around the distribution board. Staff member then called the NIFRS, Estates, Facility Manager. Smell of smoke traced back to a socket in the Laundry area being used to power washing machine. Electrician attended to arrange temporary supply from another circuit and Estates to follow up with Contractor.	W12689
30/01/2021	2 North, CAH	Toast left unattended in toaster, sparking, room filled with smoke. NIFRS in attendance	W128058 W128079
13/02/2021	Supported Living 9 Hawthorne Drive, Armagh	Fire in kitchen at 1240 hrs, pot left unattended by occupant on cooker. NIFRS in attendance.	W128962
02/03/2021	Aldergrove House	Staff member discovered a fire from light fitting in the kitchen. Staff member was in clinical room when lights went out, on checking other areas discovered smoke and fire in the area of the fluorescent light fitting on the ceiling. Member of staff was alone in building and called the Fire and Rescue Service. Estates Department contacted to make the area safe and provide temporary lighting.	W130026
16/03/2021	External to JMP	Evidence of fire found in corner of back car part of John Mitchel Place Health Centre.	W130807
13/04/2021	External to DAU, DHH	Bin fire caused by patient smoking and disposing of lit cigarette. Extinguished by staff member using water extinguisher from mobile waiting area.	W135499
29/04/2021	External to Clanrye, DHH	Member of public reported to reception car on fire. Porters responded and cleared the area. NIRFS extinguished a short time later.	W133624

13/05/2021	Bocombra CC	YP set fire to some paper and card on bedroom floor. Detected by another young person passing. Staff entered to discover fire was out and room enveloped in smoke.	W134510
20/05/2021	Bungalow, LGH	Attempt at lighting a fire at the rear door of Bungalow with slates removed and smashed. Fire burnt itself out and strong smell of smoke in kitchen.	W135210

Appendix 5

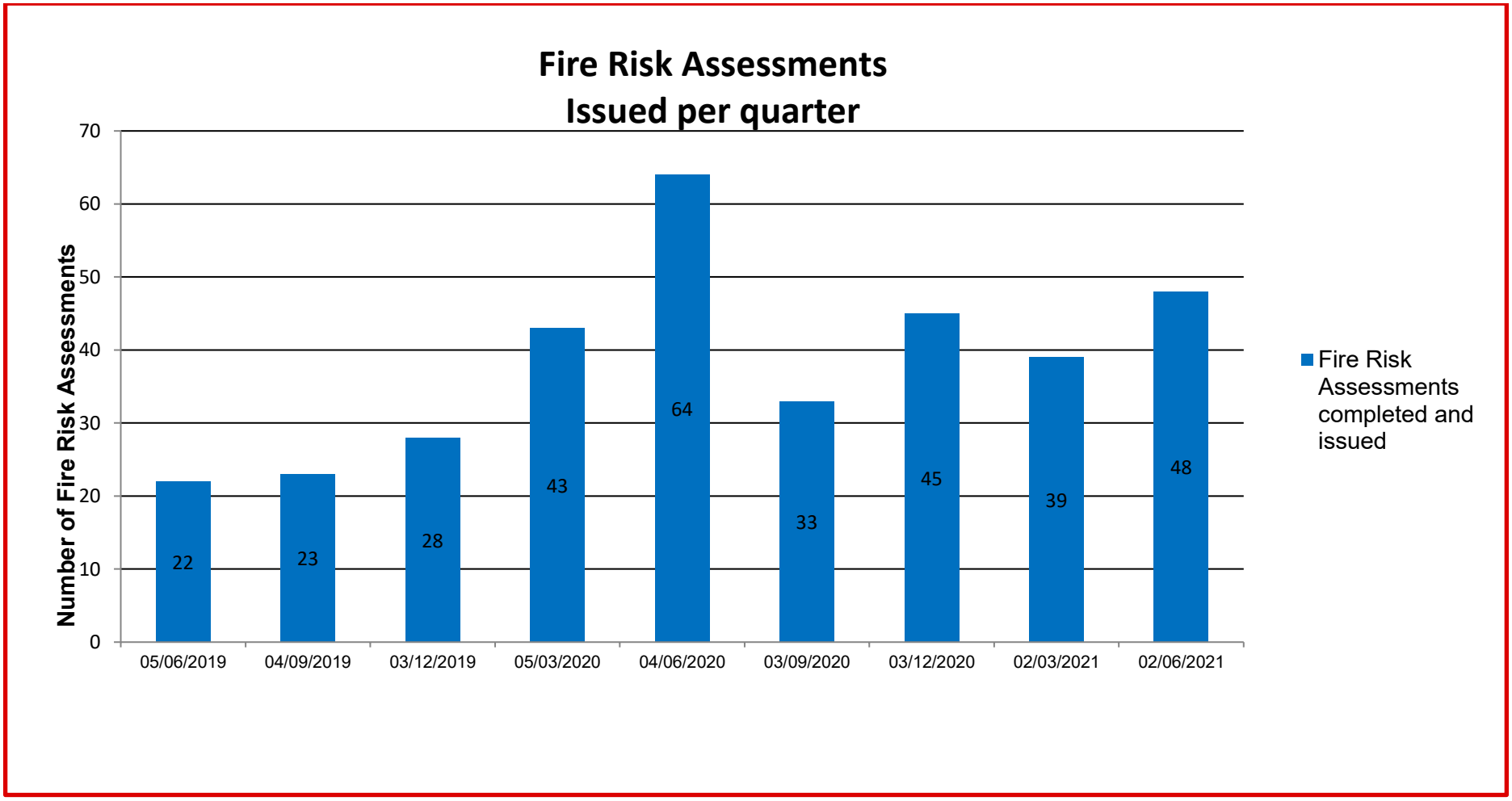
Trust Facility reported to have no Nominated Fire Officer	
Directorate	**Facility**
HROD	**Cherry Villa, Longstone** (Covid 19 Tracing Team)
OPPC	**Armagh Community Hospital** – (Nominated Fire Officer to be appointed due to retirement of staff member - Physio Department hold majority staff, other Depts have DNO's appointed to cover) **Orior House, DHH** – Nominated Fire Officer to be appointed from Acute Care at Home team which has majority representation in this facility. **Clover, Longstone** (new location for Manual Handling Team)
P & R	**Ferndale, Bannvale** (DNO'S to be appointed - Staff based here from Informatics, Practice Education and one staff member from Nursing Governance)



NOMINATED/DEPUTY NOMINATED FIRE OFFICERS TRAINING		
Year	**No of Sessions**	**Attendance**
2012	108	1814
2013	126	2117
2014	136	3381
2015	127	3107
2016	142	3196
2017	139	3915
2018	150	3765
2019	138	3966
2020	188	3061
June 2021	102	1802

OTHER FIRE SAFETY TRAINING PROVIDED BY FIRE SAFETY DEPARTMENT 2021		
SPECIFIC FIRE TRAINING SESSIONS		
Venue	**No of Sessions**	**Attendance**
Theatres	1	9
BED EVACUATION LIFT TRAINING		
Venue	**No of Sessions**	**Attendance**
LURGAN/CAH		CANCELLED DUE TO COVID
MAJOR FIRE EVACUATION TRAINING FOR BED MANAGERS		
Venue	**No of Sessions**	**Attendance**
Virtual Training via Zoom	1	22
FIRE ALARM TRAINING		
Venue	**No of Sessions**	**Attendance**
VARIOUS FACILITIES	4	8

Appendix 7



Fire Safety Resources

Fire Safety– Investment in Building Infrastructure		
Period	**Maintenance (e.g. TSC/ FRA works)**	**Contracts (e.g. Extinguishers/Fire Alarm/Emergency Lighting)**
01/01/20 – 30/05/20	£45,026.95	£90,560.18
01/06/20 – 31/08/20	£51,310.00	£44,680.81
01/09/20 – 30/11/20	£30,358.71	£35,049.91
01/12/20 – 28/02/21	£65,806.82	£34,039.80
01/03/21 – 31/05/21	£43,950.00	£77,351.61

Directorate Attendance at Fire Safety Committee 2020

Directorate	March 2020	June 2020	Sept 2020	Dec 2020
Acute	x	x		
CYP				
Finance				
HROD	x			
Medical	x	x	x	
MHD	x	x		x
OPPC		x		
P & R		x		x

Directorate Attendance at Fire Safety Committee 2021

Directorate	March 2021	June 2021	Sept 2021	Dec 2021
Acute				
CYP				
Finance				
HROD				
Medical				
MHD	x			
OPPC				
P & R				

Comac, Jennifer

From: McAlister, Monica
Sent: 03 June 2021 10:59
To: Toner, Roisin; Reid, Cathrine; Rocks, Gerard; Gough, Iain; OBrien, Anna; Gordon, Christine; Stafford-Barton, Laura; Martin, Elena; Lawrence, Victoria
Cc: Beattie, Brian; McNally, ClaireA
Subject: ++++Actions required from the Fire Safety Committee meeting 03/06/21+++
Attachments: Fire Training at 31.03.21 for Fire Safety Committee.xlsx; Notes Update Fire Safety Committee Mtg Jun 21.docx

Importance: High

Dear all,

I attended the Fire Safety committee meeting this morning there are a number of actions that require immediate attention.

There are 10 OPPC facilities that are non-compliant with the weekly fire alarm testing/ fire drills / evacuation procedures . I am unsure which AD overs all 10 areas.

ACTION:

1. Christine I think you may this information can you advise which AD oversees the 10 areas as listed in the 2nd attachment.
2. Once we know who has over sight can the aligned AD follow up and ensure the weekly firm alarm testing/ fire drills / evacuation procedures are actioned immediately and a process is in place to complete as required.
3. RQIA will be attending Cherry Villa and Clover at some stage to undertake an announced fire audit of the facility they will be seeking compliance with weekly fire alarm testing/ fire drills / evacuation procedures as well as looking at staff compliance with fire training . Can Ads alert the teams located in these 2 facilities to ensure they are compliant with fire training. Victoria in Gerard's absence can you alert Gerard's teams as required.
4. It was noted that in OPPC the Directors office was 83%, Enhanced 57%, Older People 19%, Primary Care 57%, Promoting Wellbeing 76% compliant with Fire safety training see attachment 2. Can you follow up with your respective teams as required. Iain can you support me and the LM with increasing compliance. Maybe Anna we could send out a flyer across all teams that June/ July is our OPPC Fire Safety focus months?
5. We will receive info re vacant designation fire officers across our aligned facilities that will require follow up I will share with you all once received.

Brian I understand that you will be receiving a commutation seeking assurance that all the above actions have been followed up.

Thanks everyone in advance.

Monica McAlister
Assistant Director Older People
Southern Health & Social Care Trust
Bannvale House
Gilford BT635JX
Office Personal Information redacted by the USI
Mobile Personal Information redacted by the USI
Email Personal Information redacted by the USI

Southern Health & Social Care Trust
Summary of Fire Safety Training by Directorate / Division including % of staff trained as at 31st Mar 2021
Prepared by/HR Contact: Bronagh Donnelly
Date 19/05/21

		Key: % Trained			
		0% - 59%			
		60% - 79%			
		80% - 100%			
Directorate	**Division**	**Not Trained**	**Trained**	**Head Count**	**% Trained**
Acute Services	ATICS & Surgery & Elective Division	582	441	1023	**43%**
	Director's Office	8	8	16	**50%**
	Functional Support Services Division	572	520	1092	**48%**
	IM&WH and Cancer & Clinical Services Division	404	740	1144	**65%**
	Medicine Division	383	386	769	**50%**
	Pharmacy Division	82	145	227	**64%**
	Unscheduled Care Division	194	198	392	**51%**
Acute Services Total		**2225**	**2438**	**4663**	**52%**
Chief Executive's Office	Chief Executive's Office Division	1	5	6	**83%**
	Communications Division	4	4	8	**50%**
Chief Executive's Office Total		**5**	**9**	**14**	**64%**
Children & Young People's Services	Corporate Parenting Division	98	268	366	**73%**
	Director's Office Division		2	2	**100%**
	Family Support & Safeguarding Division	246	305	551	**55%**
	Social Care Governance Division	3	6	9	**67%**
	Social Services Training Unit Division	8	11	19	**58%**
	Specialist Child Health & Disability Division	255	461	716	**64%**
Children & Young People's Services Total		**610**	**1053**	**1663**	**63%**
Executive Directorate of Nursing & Midwifery and AHP's	AHP Governance & Workforce Planning Division	4	3	7	**43%**
	Director's Office Division		1	1	**100%**
	Nursing & Midwifery Education and Workforce Division	9	15	24	**63%**
	Nursing Safety Quality, Patient Experience Division	6	14	20	**70%**
Executive Directorate of Nursing & Midwifery and AHP's Total		**19**	**33**	**52**	**63%**
Finance & Procurement	Director's Office Division	1	1	2	**50%**
	Estates Services Division	63	108	171	**63%**
	Financial Accounting Division	27	49	76	**64%**
	Financial Management Division	8	40	48	**83%**
Finance & Procurement Total		**99**	**198**	**297**	**67%**
HR & Organisational Development	Director's Office Division	5	6	11	**55%**
	Education Learning & Development Division	2	9	11	**82%**
	Employee Relations Division	5	22	27	**81%**
	Equality Assurance Division	1	3	4	**75%**
	Litigation Division	2	14	16	**88%**
	Medical Staffing Unit Division		14	14	**100%**
	Medical Staffing Unit Division - Medical/Dental	27	4	31	**13%**
	Occupational Health Division	29	33	62	**53%**
	Resourcing Division	9	19	28	**68%**
	Staff Side Division	8	2	10	**20%**

	Vocational Workforce Assessment Division	1	11	12	92%
	Workforce Information Division	1	12	13	92%
HR & Organisational Development Total		**90**	**149**	**239**	**62%**
Medical	Director's Office Division	13	16	29	55%
	Governance Division	13	25	38	66%
Medical Total		**26**	**41**	**67**	**61%**
Mental Health & Disability Services	Director's Office Division	25	14	39	36%
	Learning Disability Division	280	332	612	54%
	Medical Division	18	40	58	69%
	Mental Health Division	211	332	543	61%
	MH&D Inpatient Division	54	131	185	71%
	Physical Disability Division	63	142	205	69%
	Psychology Division	14	36	50	72%
Mental Health & Disability Services Total		**665**	**1027**	**1692**	**61%**
Older People & Primary Care	Director's Office Division	1	5	6	83%
	Enhanced Services Division	323	426	749	57%
	Older People Division	1164	273	1437	19%
	Primary Care Division	331	442	773	57%
	Promoting Wellbeing Division	21	67	88	76%
Older People & Primary Care Total		**1840**	**1213**	**3053**	**40%**
Performance & Reform	Best Care Best Value Division	4	3	7	43%
	Corporate Planning Division	1	12	13	92%
	Director's Office Division		2	2	100%
	Informatics Division	58	74	132	56%
	Performance Improvement Division	9	9	18	50%
Performance & Reform Total		**72**	**100**	**172**	**58%**
Grand Total		**5651**	**6261**	**11912**	**53%**

This report has been compiled and is intended for use only by the official recipient.

If you believe the information in this report does not accurately reflect the current position, please contact the Organisational Development & Learning Department

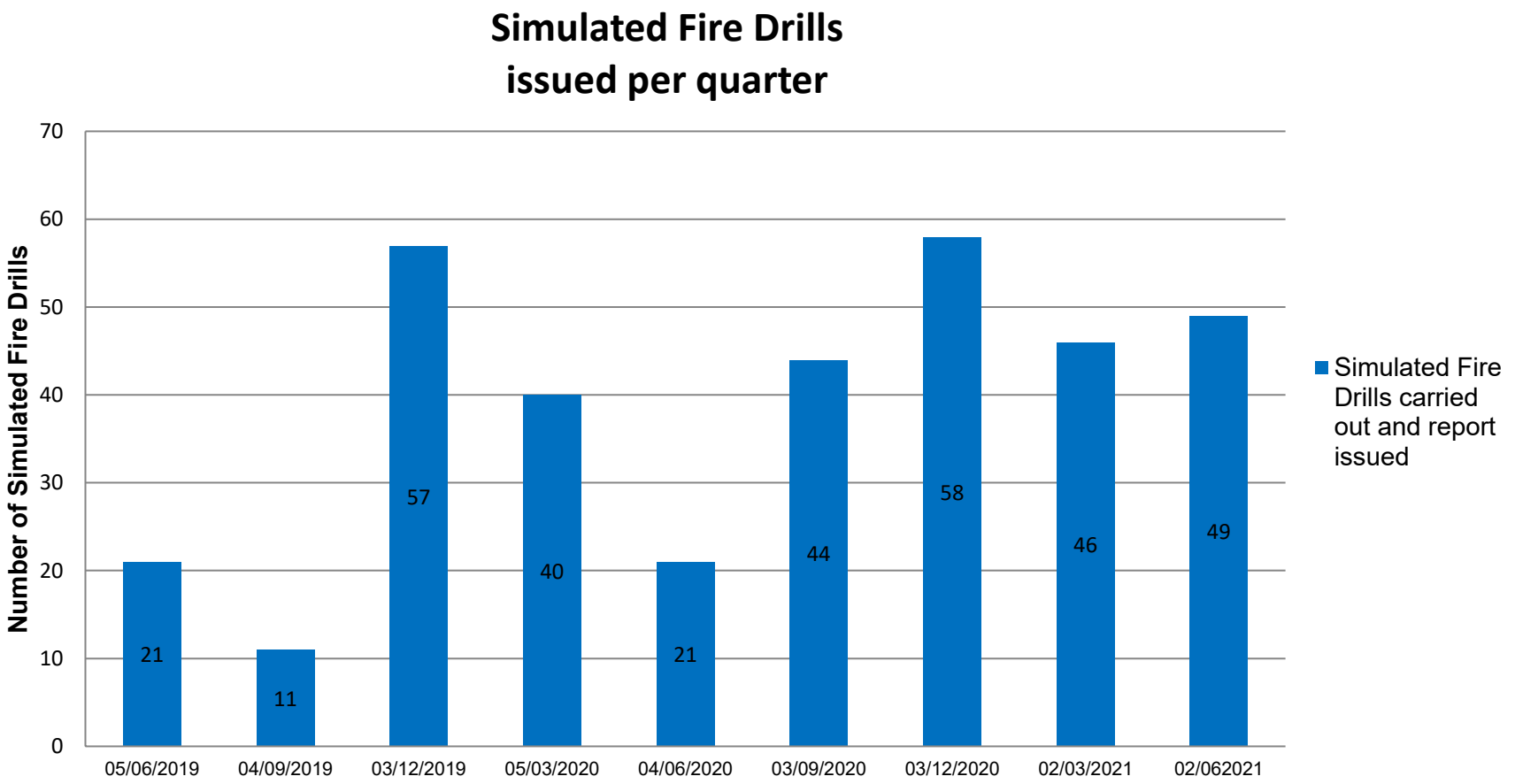
Please remember your responsibilities under data protection legislation, for example ensure personal information is kept secure (for example not left in view of unauthorised staff or visitors), is only used for the purpose intended, and is not shared with anyone who should not have access to it. Also, once personal information has been used for its intended purpose it should be appropriately destroyed, or kept in a secure location if it is required for future use.

Directorate & Facility Name	Fire Safety Non Compliance			
	Fire Alarm test log sheet outstanding		Fire Drill log sheet returned outstanding	
	No Records	Last date received	No Records	Last date received
Older People & Primary Care				
Banbridge Polyclinic		04/09/2020		11/09/2020
Ballygawley Health Centre		05/11/2020		10/02/2021
Clover, Longstone (new team on site)		15/10/2018		15/10/2018
Drs Out of Hrs, CAH		12/05/2021		12/06/2018
Dungannon Clinic		05/10/2020		21/06/2019
Gilford HC		27/08/2020		14/09/2020
Haven Close		22/01/2021		16/02/2020
The Limes		12/01/2015	×	
Orior House, DHH (ACAH)		29/04/2021		06/05/2020
Riverside, Bannvale (Governance)		09/12/2020		09/12/2020
Mental Health & Learning Disability				
Acorns, SLH		08/10/2020		03/07/2017
Armagh Resource Centre		10/12/2020		18/03/2020
Bannvale, Zest		28/09/2020		10/09/2020
Bannvale House		02/11/2020		01/12/2020
Bowen's Close		03/02/2019		29/08/2020
Coronation Block, STH		04/03/2021		20/12/2017
Edenderry House		12/03/2021		17/01/2020
Granville		01/09/2020		03/09/2020
The Laurels		01/09/2020		03/09/2020
Main Building, St Lukes		15/10/2020		03/12/2019

Manor Centre		28/08/2020		19/05/2021
Offices Psychology, STH		14/06/2017		20/12/2017
Old School House, Seagoe		25/11/2019		20/09/2018
Staff Accommodation (HTCR), SLH		22/01/2021		11/02/2017
Transport Dept, Edward St, Newry		15/12/2020		06/09/2019
Woodlawn House		28/10/2020		05/11/2020
Children & Young People's				
Bessbrook Clinic		28/12/2020		30/11/2020
Bocombra Children's Centre		03/02/2020		27/04/2021
Bungalow, Lurgan Hospital		24/11/2020		22/06/2020
Carland Lodge (CYP Accom)		30/01/2018		27/12/2018
Cedarwood, Longstone		30/04/2020		03/09/2020
Dromore HC		11/01/2021		03/06/2020
Drumalane House		26/08/2020		03/12/2019
Drumglass Lodge		18/09/2020		08/10/2020
Haven Court (CYP Accommodation)		27/02/2020	×	
Hollow Drive, SLH		10/06/2020		06/03/2018
Surestart, ARKE		14/06/2017		22/01/2019
Surestart, Blossom		25/11/2020		23/10/2020
Surestart Dungannon		11/09/2020		30/09/2020
Surestart Kilkeel		06/10/2020		11/03/2020
Villa 2, CYP Centre		10/09/2020		09/01/2014
Vela House (CYP Accommodation)		04/03/2020	×	
Medical				
Beechfield House		10/07/2020		10/07/2020
Finance				
Estates Workshops, STH		01/04/2021		07/05/2020

HR & Organisational Development				
Firbank, CAH		04/09/2020		03/04/2020
St Luke's Hill Building		29/04/2021		03/07/2019
Acute				
Bernish House, DHH		03/12/2020		19/10/2020
Canal View, DHH		16/12/2020	×	
Tower Block, CAH (Social Work Team)		07/09/2020		05/05/2020
Drs Homes 1 & 2, DHH		01/05/2020		29/07/2020
Laundry, CAH		23/10/2020		18/02/2021
Mortuary, CAH		30/11/2020		26/02/2020
Mortuary, DHH		30/04/2020		26/02/2020
Performance & Reform				
Brackens, CAH		04/12/2020		11/09/2020
Closed Records, SLH		04/12/2020		15/10/2020
Glendale, Bannvale		28/05/2016		27/02/2020
Rowans, CAH		03/01/2020		10/01/2020

Appendix 2



Acute Drills Stats

Outstanding Drills		01/06/2021	
Location	Day	Night	Totals
CAH	2	0	2
DHH	0	0	0
LH	0	0	0
STH	0	0	0
SLH	0	0	0
Total O/S	2	0	2

Completed Drills		01/06/2021	
Location	Day	Night	Totals
CAH	65	33	98
DHH	29	14	43
LH	15	3	18
STH	20	3	23
SLH	1	1	2
Total Completed	130	54	184
	132	54	186
Total Drills O/S and completed			186

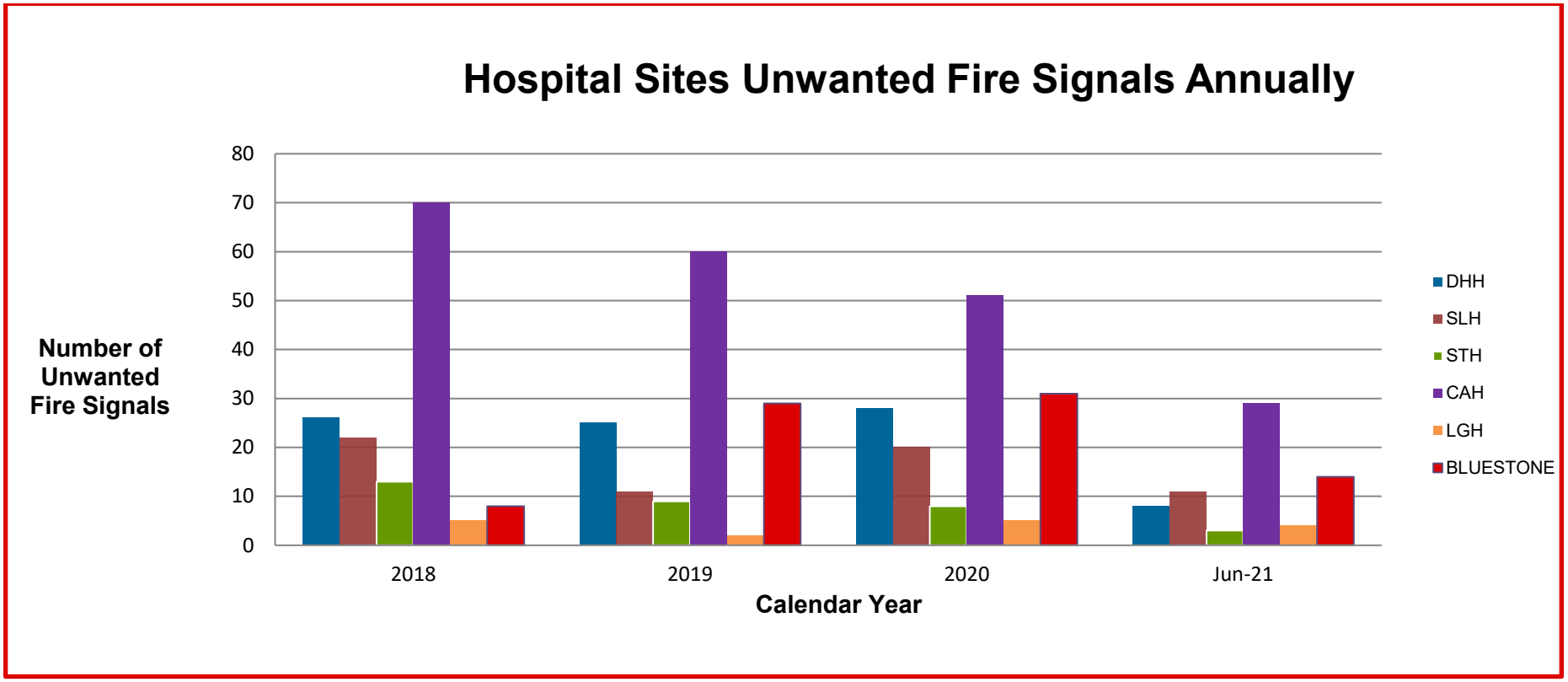
	%
DAY DRILLS	
% CAH DAY Drills completed	97.01%
% DHH DAY Drills completed	100.00%
% STH DAY Drills completed	100.00%
% LH DAY Drills completed	100.00%
% SLH DAY Drills completed	100.00%

NIGHT DRILLS	
% CAH NIGHT Drills completed	100.00%
% DHH NIGHT Drills completed	100.00%
% STH NIGHT Drills completed	100.00%
% LH NIGHT Drills completed	100.00%
% SLH NIGHT Drills completed	100.00%

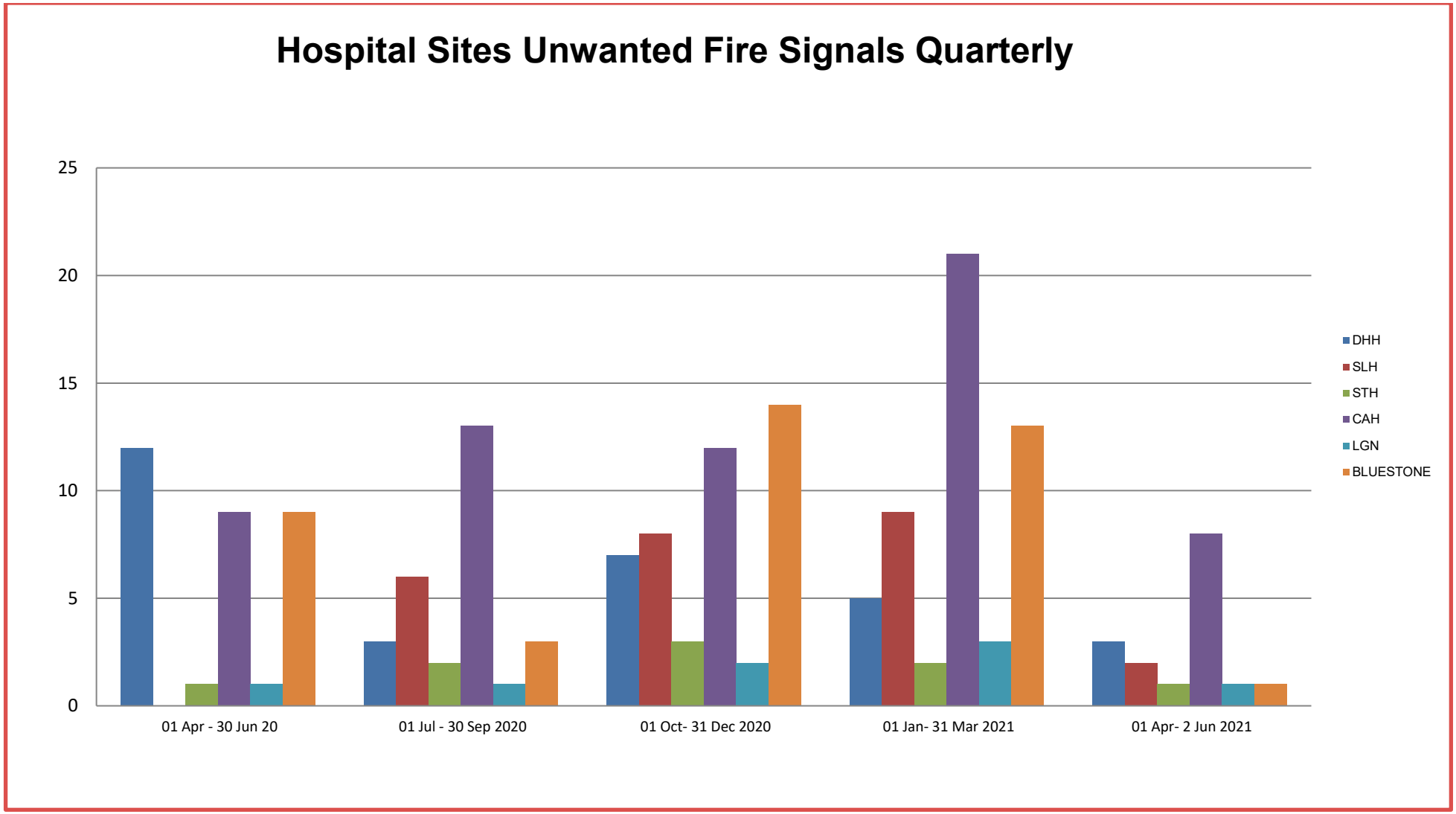
OVERALL %	
% of Day Drills Completed	98.48%
% of Night Drills Completed	100.00%
% Combined Day & Night Completed	100.00%

*Extra Night Drill added 02 Feb 2021(CAH Recovery now ICU 2)

Appendix 3



TOTAL NUMBER OF UNWANTED FIRE CALLS PER YEAR						
Year	**STH**	**SLH**	**LGH**	**BLUESTONE**	**DHH**	**CAH**
2018	13	22	5	8	26	70
2019	9	11	2	29	25	60
2020	8	20	5	31	28	51
2 June 2021	3	11	4	14	8	29



Unwanted Fire Calls Craigavon Area Hospital 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
04/01/2021	1421	CAH	CAH 05 Laundry zone A02 Ground	No	No	Laundry rang to say steam set off. Will call Estates	Yes	Acute
13/01/2021	1746	CAH	CAH 22 Grd Flr Zone B38	Yes	No	Steam set off alarm	No	Acute
14/01/2021	1040	CAH	CAH 22 Grd Flr Zone B38	Yes	No	Fault	No	Acute
19/01/2021	1418	CAH	MCP CAH31 Grd Flr zone A03 Paeds	No	No	Parent pressed MCP by mistake	Yes	CYP
20/01/2021	1610	CAH	CAH22 Grd Flr Zone B38 OPD B1005	Yes	No	Workmen in area, lots of dust, detector not covered	Yes	Acute
23/01/2021	0931	CAH	CAH05 Laundry zone A04 Ground	No	No	Laundry rang to say false alarm	Yes	Acute
25/01/2021	1401	Other	Moylinn	Yes	No	No info given	No	MHD
25/01/2021	1624	CAH	CAH20 4th Floor zone S04 Maternity	Yes	No	E cigarette set alarm off	No	Acute
29/01/2021	0608	CAH	CAH06 First Flr xone 1 North MCP	Yes	No	MCP set off on purpose	No	Acute
30/01/2021	2230	CAH	2 North 2nd Floor	Yes	Yes	2 North rang to say fire in kitchen - Burnt Toast	Yes	Acute
01/02/2021	1005	Other	Moylinn	Yes	No	Weekly fire test, did not inform switchboard	No	MHD
05/02/2021	1520	CAH	CAH06 1st Floor C05 MCP	Yes	No	someone broke the break glass'	No	Acute
10/02/2021	1529	CAH	CAH21 Ground Floor xone B05	Yes	No	someone broke the break glass'	No	Acute
19/02/2021	0620	CAH	Willowbank A05 Flat 25	Yes	No	Porter came to say system fault	Yes	Acute
19/02/2021	0700	CAH	Willowbank A05 Flat 25	No	No	Faulty Head	Yes	Acute
21/02/2021	2116	CAH	Willowbank A05 Flat 25	Yes	No	Faulty Detector to be replaced tomorrow	Yes	Acute
25/02/2021	0706	CAH	CAH12 1st Floor zone C23	Yes	No	High temp in Theatre 1 Electrical UPS room	Yes	Acute
02/03/2021	0820	CAH	Ground Floor b01 b1337	Yes	No	Staff member hit MCP	No	FPE
04/03/2021	0611	CAH	CAH09 Ground Flr zone B13 Kitchen MEC	Yes	No	Staff member burnt plastic in microwave	No	MED
06/03/2021	1347	CAH	CAH21 MCP Ground Flr zone B06	No	No	AMU Nurse rang to say patient set off	No	Acute
17/03/2021	0958	CAH	Neonatal	No	Yes	Staff rang to say 'burnt toast'	No	Acute
18/03/2021	1702	other	Moylinn	Yes	No	Moylinn rant to say dehumidifier set off alarm	Yes	MHD
18/03/2021	1947	other	Edenderry House	Yes	No	No info given	No	MHD
31/03/2021	1130	CAH	CAH07 Zone B33 Trauma	Yes	No	Faulty Detector	Yes	Acute
31/03/2021	1430	CAH	CAH07 Zone B33 Trauma	Yes	No	Faulty Detector	Yes	Acute
12/04/2021	1210	CAH	1 West	No	No	Domestic Set off with steam	No	Acute

13/04/2021	0601	CAH	CAH10 Elms zone C02 2nd Flr Flat D C003	Yes	No	Faulty Detector	Yes	Acute
13/04/2021	0726	CAH	CAH10 Elms zone C02 2nd Flr Flat D C003	Yes	No	Faulty Detector	No	Acute
14/04/2021	1558	CAH	CAH 26 Grd flr zone B17	Yes	No	S/B phoned NIFRS by mistake/ informed drill on ward	No	Acute
22/04/2021	1443	CAH	CAH31 Grd Flr zone A01 Paeds A001	Yes	No	Faulty light in Blossom set alarm	Yes	CYP
16/05/2021	1600	CAH	CAH03 Basement Zone A08 Main	Yes	No	MCP hit	No	Acute
23/05/2021	1105	CAH	CAH05 Energy Ctr A01 Grd Flr A014 Void	Yes	No	Boiler House Alarm	No	FPE
27/05/2021	1132	CAH	CAH11 zone B07 Willowbank	Yes	Yes	Fault		Acute

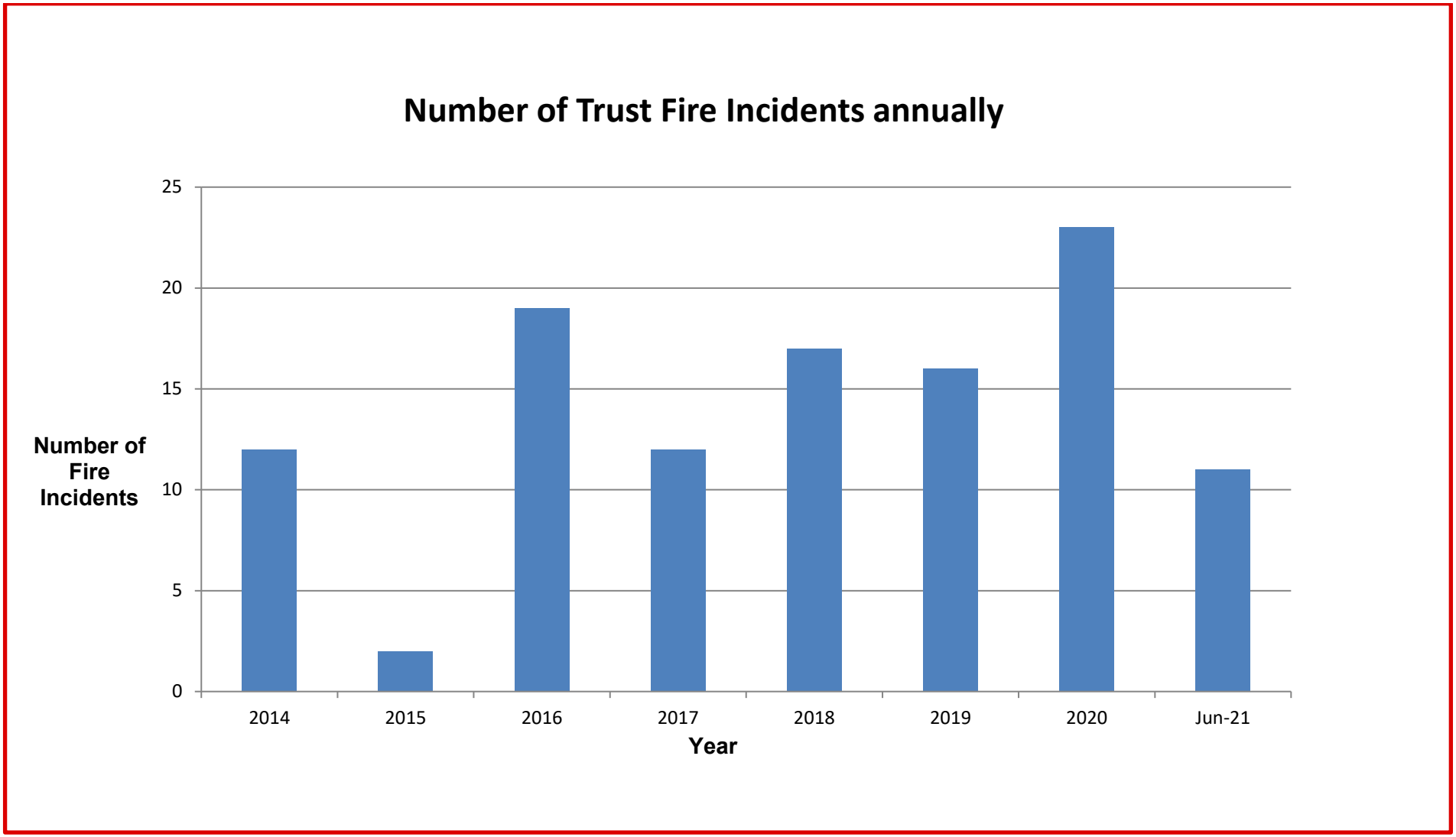
Unwanted Fire Calls - Bluestone Unit - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
02/01/2021	1052	Bluestone	CAH Bronte Ward Rm 10 CAH13	Yes	Yes	Patient lit small decoration, staff put in water	Yes	MHD
28/01/2021	0608	Bluestone	CAH Bronte a14	No	No	Patient set off MCP	No	MHD
08/02/2021	1415	Bluestone	Bronte Zone Panel 13 A16	Yes	No	Patient hit breakglass unit	Yes	MHD
09/02/2021	0808	Bluestone	Silverwood Zone A18	No	No	False Alarm'	Yes	MHD
09/02/2021	1927	Bluestone	Silverwood Zone A18	No	No	Patient knocked MCP off wall	Yes	MHD
10/02/2021	1420	Bluestone	CPU Rosebrook CAH 30 Zone A22	Yes	No	Patient hit breakglass unit	Yes	MHD
14/02/2021	0822	Bluestone	CAH14 Silverwood zone A12 MCP	No	No	Patient had set off	Yes	MHD
21/02/2021	1121	Bluestone	Cloughmore	No	No	Patient set off	Yes	MHD
27/02/2021	1250	Bluestone	Silverwood	No	No	Ward confirmed no fire, patient activated	Yes	MHD
02/03/2021	0027	Bluestone	MCP CAH 14 Silverwood A09 corridor A207	No	No	Ward staff rang to say false alarm	Yes	MHD
06/03/2021	1930	Bluestone	CPU Rosebrook zone A22	No	No	False Alarm'	Yes	MHD
27/03/2021	1626	Bluestone	MCP Dorsy Unit Zone Bz8	No	No	Staff rang to say testing	Yes	MHD
30/03/2021	1319	Bluestone	Willows A01 Bedroom 5	Yes	No	Patient heat styling tools set off	Yes	MHD
08/04/2021	0330	Bluestone	MCP CAH 14 Silverwood A10 A198	No	No	Staff in Bluestone advised Patient set off	Yes	MHD

Unwanted Fire Calls - St Lukes - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
08/01/2021	0706	SLH	Haven Court Bungalow SLA14	Yes	No	Pipe had burst in roof	No	FPE
19/01/2021	0200	SLH	SLA 19 Staff Accommodation	Yes	No	Faulty Detector	No	FPE
24/01/2021	2240	TH	Ashleigh House	Yes	No	*No Record*	No	FPE
26/01/2021	1102	SLH	SLA 24 Catholic Chapel	Yes	No	Possibly power disruption	No	FPE
26/01/2021	2005	SLH	SLA25 Hotel Services	Yes	No	*Faulty detector head*	No	FPE
27/01/2021	2143	other	61-67 Loughgall Rd	No	No	*Noleen rang to say person smoking*	Yes	MHD
29/01/2021	1654	SLH	SLH12 First Floor clinical area MCP	No	No	Workmen set off	Yes	MHD
15/02/2021	1234	SLH	Main Building	Yes	No	Workmen set off from Ward 2	Yes	MHD
24/02/2021	0750	SLH	SLA09 Elmwood/ATU	Yes	No	Faulty detector	Yes	MHD
24/02/2021		TH	Grange Building Towerhill	No	No	Staff rang to say no fire	Yes	MHD
16/03/2021	1155	SLH	Haven Court Bungalow SLA14	No	No	Accidently set off by SPIE	No	CYP
22/03/2021	1411	SLH	SLA 38 Mullinure Zone A06	Yes	No	Faulty detector	No	MHD
23/03/2021	0923	SLH	SLA12 zone 4 ward 4	Yes	No	Set off by SPIE	No	MHD
25/03/2021	1842	TH	Armagh Community Hospital	Yes	No	False alarm	No	OPPC
07/04/2021	1248	TH	Boiler House	Yes	No	*No Record*	No	FPE
12/04/2021	1709	TH	Grange Building Towerhill	Yes	No	Faulty Detector removed	Yes	MHD
22/04/2021	0505	TH	Milford Building	Yes	No	No Record	No	MHD
24/04/2021	1800	SLH	SLA12 Zone Ward 5	Yes	No	False alarm	No	MHD
29/04/2021	1132	SLH	SLA12 Ward 6 Grd Floor	Yes	No	No Record	Yes	MHD

Unwanted Fire Calls - South Tyrone - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
15/02/2021	903	Clogher	Clogher Valley H & Day Care Centre	Yes	No	SPIE working and didn't advise switchboard	Yes	OPPC
16/02/2021	1630	STH	MCP STH17 06 Main Block zone F02	Yes	No	Someone hit MCP to exit ward (GP)	No	OPPC
28/02/2021	0926	STH	STD-04 Workshop zone A05 area A002	Yes	No	Faulty detector	No	FPE
05/04/2021	1819	STH	MIU STD 17 02 zone B13	Yes	No	*Burnt Toast*	No	Acute

Unwanted Fire Calls - Daisy Hill Hospital - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
20/01/2021	1650	DHH	Drs House 1 - Garage	Yes	No	No cause identified by security	Yes	Acute
25/01/2021	1129	DHH	DHN04 1st Flr Maternity OPD	Yes	No	Breakglass hit by hoist	No	Acute
01/02/2021	2149	DHH	DHN14 BH Zone D04 2nd Flr d038	Yes	No	Break glass was hit by someone'	Yes	Acute
18/02/2021	1732	DHH	DHN07 Dr House 1 B02 First Flr B-012	Yes	No	Doctors burnt food. 2 x pies	Yes	Acute
08/03/2021	915	DHH	Clanrye	Yes	No	Contractors	Yes	FPE
20/04/2021	810	DHH	Clanrye	Yes	No	Test not communicated at S/B handover	Yes	CYP
11/05/2021	1054	DHH	B09 Lower Ground Floor	No	No	Staff member spray deodorant	Yes	Acute
24/05/2021	1700	DHH	Clanrye HouseDHN12 Zone A02 Grd A019		No	Paint fumes	Yes	CYP

Unwanted Fire Calls - Lurgan Hospital - 2021								
DATE	TIME	SITE	LOCATION	NIFRS attendance	Fire	Cause	IR1 COMPLETED	DIRECTORATE
19/01/2021	1333	LGH	LGH 05 Ground Floor zone A16	Yes	No	No details provided	No	OPPC
25/02/2021	0919	LGH	LGH 07 Boiler house zone A01	Yes	No	Contractors working in area set off alarm	Yes	FPE
24/03/2021	1359	LGH	LHL 07 Ambulance Building zone A0	Yes	No	No caused noted	No	Other
07/05/2021	1030	LGH	LGH 06 Grd Floor A12 Day	No	No	Alarm set off by Contractors - not aware they were to let s/b know in area	No	OPPC

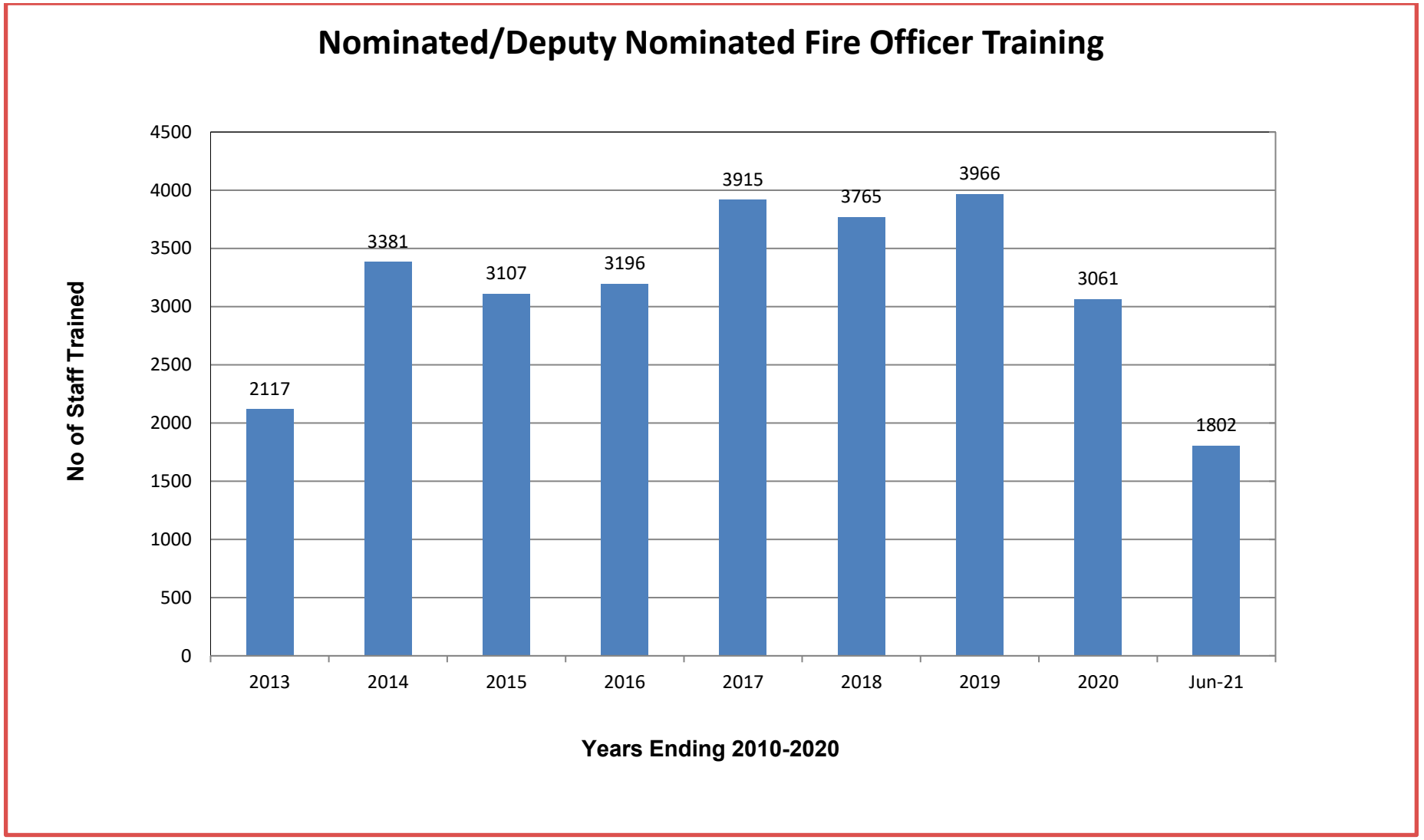


Fire Incidents Trust Wide 2021			
Date	Facility	Cause/Reported As	Datix Ref
02/01/2021	Bronte Ward, Bluestone	Patient lit a small christmas decoration and staff put in in a glass of water.	W128058 W128079
04/01/2021	Edward St Transport Dept	2 x Trust vehicles found to have fire damage when staff arrived on duty for work.	W126384
10/01/2021	Slieve Roe	Staff member noticed smell of smoke around the distribution board. Staff member then called the NIFRS, Estates, Facility Manager. Smell of smoke traced back to a socket in the Laundry area being used to power washing machine. Electrician attended to arrange temporary supply from another circuit and Estates to follow up with Contractor.	W12689
30/01/2021	2 North, CAH	Toast left unattended in toaster, sparking, room filled with smoke. NIFRS in attendance	W128058 W128079
13/02/2021	Supported Living 9 Hawthorne Drive, Armagh	Fire in kitchen at 1240 hrs, pot left unattended by occupant on cooker. NIFRS in attendance.	W128962
02/03/2021	Aldergrove House	Staff member discovered a fire from light fitting in the kitchen. Staff member was in clinical room when lights went out, on checking other areas discovered smoke and fire in the area of the fluorescent light fitting on the ceiling. Member of staff was alone in building and called the Fire and Rescue Service. Estates Department contacted to make the area safe and provide temporary lighting.	W130026
16/03/2021	External to JMP	Evidence of fire found in corner of back car part of John Mitchel Place Health Centre.	W130807
13/04/2021	External to DAU, DHH	Bin fire caused by patient smoking and disposing of lit cigarette. Extinguished by staff member using water extinguisher from mobile waiting area.	W135499
29/04/2021	External to Clanrye, DHH	Member of public reported to reception car on fire. Porters responded and cleared the area. NIRFS extinguished a short time later.	W133624

13/05/2021	Bocombra CC	YP set fire to some paper and card on bedroom floor. Detected by another young person passing. Staff entered to discover fire was out and room enveloped in smoke.	W134510
20/05/2021	Bungalow, LGH	Attempt at lighting a fire at the rear door of Bungalow with slates removed and smashed. Fire burnt itself out and strong smell of smoke in kitchen.	W135210

Appendix 5

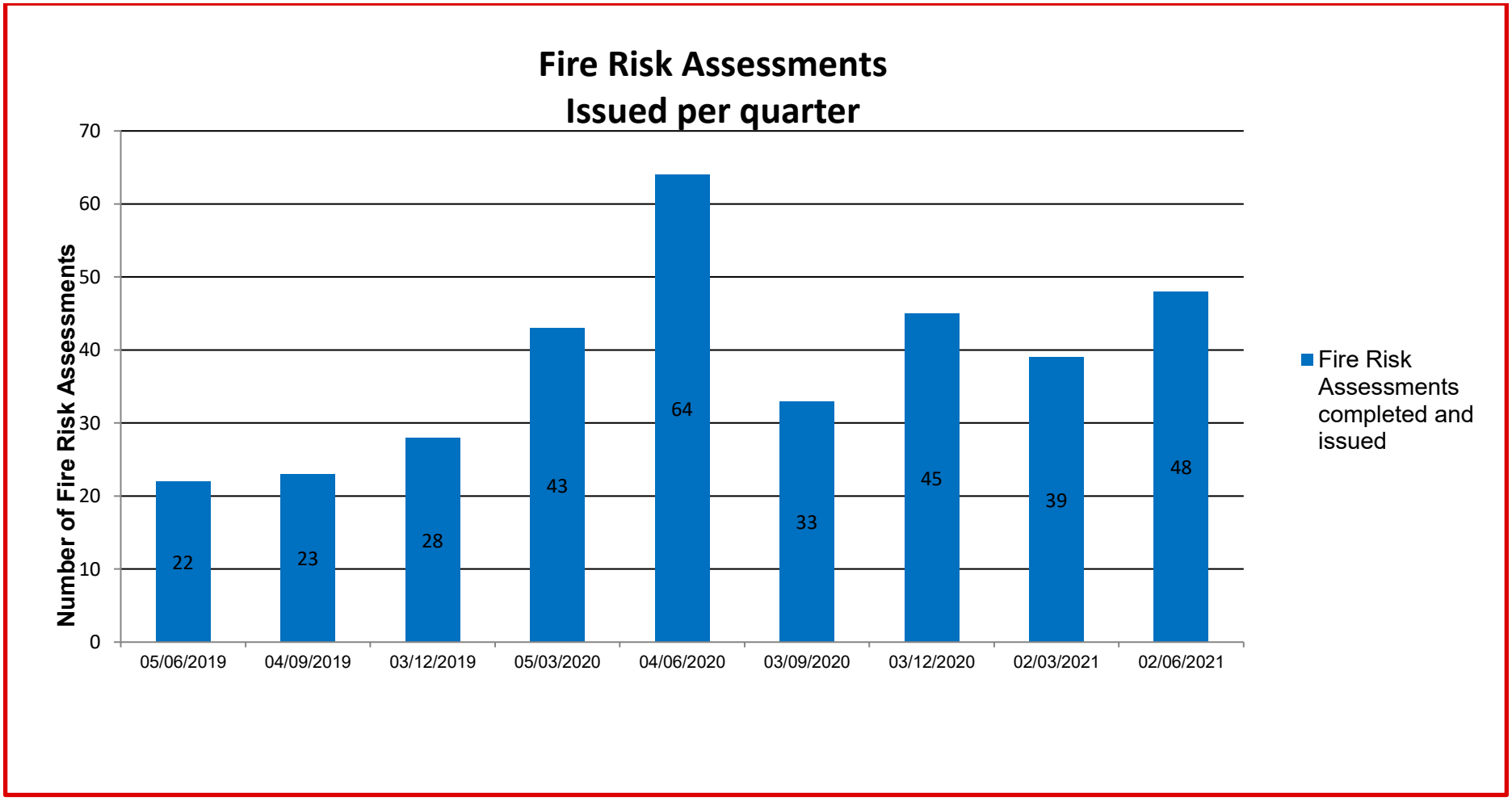
Trust Facility reported to have no Nominated Fire Officer	
Directorate	**Facility**
HROD	**Cherry Villa, Longstone** (Covid 19 Tracing Team)
OPPC	**Armagh Community Hospital** – (Nominated Fire Officer to be appointed due to retirement of staff member - Physio Department hold majority staff, other Depts have DNO's appointed to cover) **Orior House, DHH** – Nominated Fire Officer to be appointed from Acute Care at Home team which has majority representation in this facility. **Clover, Longstone** (new location for Manual Handling Team)
P & R	**Ferndale, Bannvale** (DNO'S to be appointed - Staff based here from Informatics, Practice Education and one staff member from Nursing Governance)



NOMINATED/DEPUTY NOMINATED FIRE OFFICERS TRAINING		
Year	**No of Sessions**	**Attendance**
2012	108	1814
2013	126	2117
2014	136	3381
2015	127	3107
2016	142	3196
2017	139	3915
2018	150	3765
2019	138	3966
2020	188	3061
June 2021	102	1802

OTHER FIRE SAFETY TRAINING PROVIDED BY FIRE SAFETY DEPARTMENT 2021		
SPECIFIC FIRE TRAINING SESSIONS		
Venue	**No of Sessions**	**Attendance**
Theatres	1	9
BED EVACUATION LIFT TRAINING		
Venue	**No of Sessions**	**Attendance**
LURGAN/CAH		CANCELLED DUE TO COVID
MAJOR FIRE EVACUATION TRAINING FOR BED MANAGERS		
Venue	**No of Sessions**	**Attendance**
Virtual Training via Zoom	1	22
FIRE ALARM TRAINING		
Venue	**No of Sessions**	**Attendance**
VARIOUS FACILITIES	4	8

Appendix 7



Fire Safety Resources

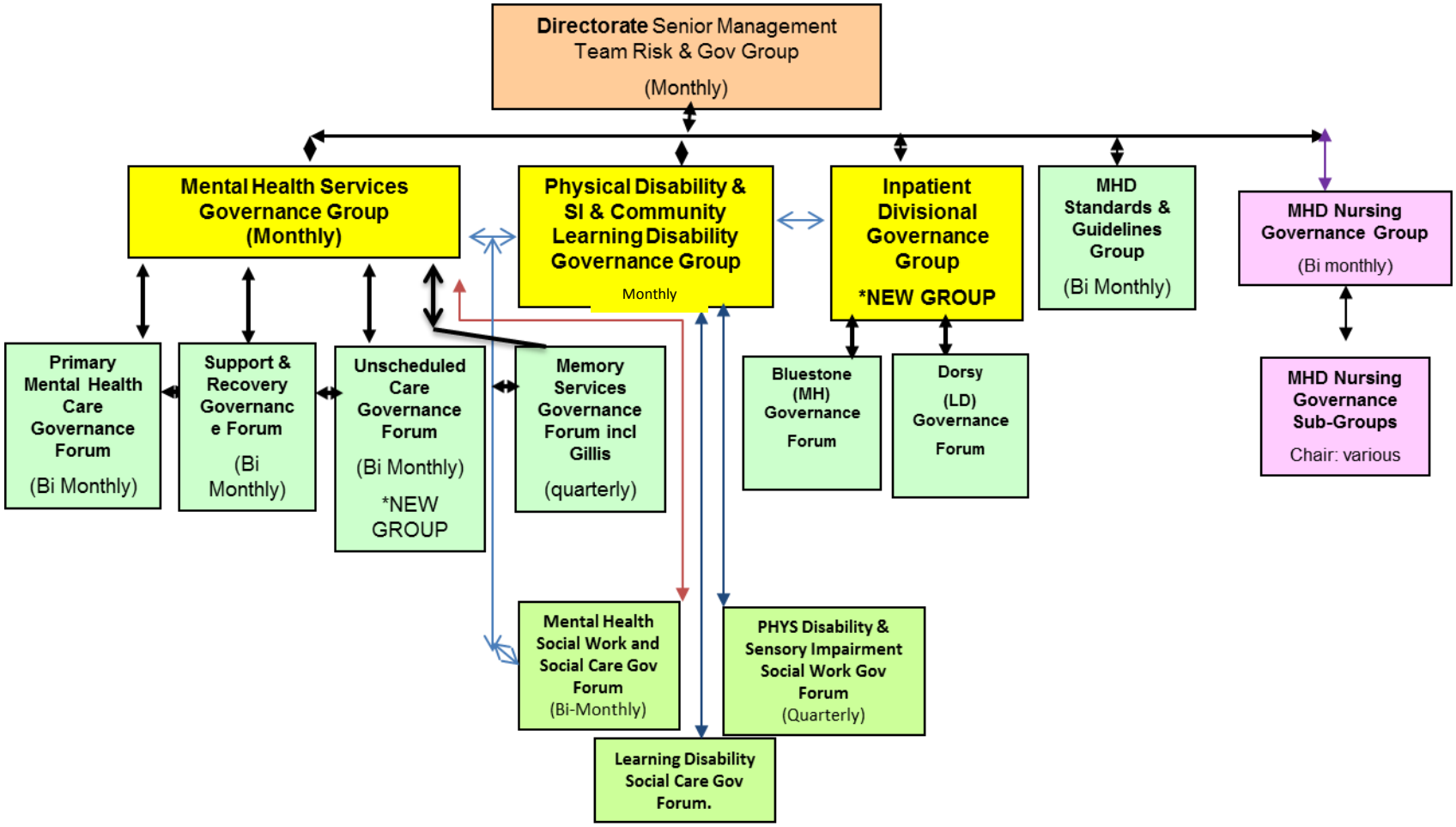
Fire Safety– Investment in Building Infrastructure		
Period	**Maintenance (e.g. TSC/ FRA works)**	**Contracts (e.g. Extinguishers/Fire Alarm/Emergency Lighting)**
01/01/20 – 30/05/20	£45,026.95	£90,560.18
01/06/20 – 31/08/20	£51,310.00	£44,680.81
01/09/20 – 30/11/20	£30,358.71	£35,049.91
01/12/20 – 28/02/21	£65,806.82	£34,039.80
01/03/21 – 31/05/21	£43,950.00	£77,351.61

Directorate Attendance at Fire Safety Committee 2020

Directorate	March 2020	June 2020	Sept 2020	Dec 2020
Acute	x	x		
CYP				
Finance				
HROD	x			
Medical	x	x	x	
MHD	x	x		x
OPPC		x		
P & R		x		x

Directorate Attendance at Fire Safety Committee 2021

Directorate	March 2021	June 2021	Sept 2021	Dec 2021
Acute				
CYP				
Finance				
HROD				
Medical				
MHD	x			
OPPC				
P & R				



Received from Shane Devlin on 04/02/22 Annotated by the Urology Services Inquiry.

Granville – Governance Meeting

Agenda – 10th September 2021

Irrelevant Information Redacted by the USI

Meeting ID: Irrelevant Information Redacted by the USI

Passcode: Irrelevant Information

ITEM	ATTACHMENTS
1. Welcome & Apologies	
2. Incident Reporting/Complaints awareness Training update	
3. Overlap with Dorsy Oversight Group- discussion	
4. Covid / PPE update	
5. Incident Data	
6. Complaints	
7. Safeguarding	
8. Safety Huddle Update	
9. Health Roster Update	
10. Any Other Business	

Southern Health and Social Care Trust

AGENDA

MH&LD Inpatient Overarching Governance Group

29th September 2021

	Agenda Item	Agenda Item Lead
1.	Apologies	Chair
2.	Review and agreement of previous minutes Review of actions of last meeting (*not addressed as part of this agenda*) Membership of Inpatients Overarching Governance Group Patient experience – Jennie Lee to get this rolled out to all wards Risk Register – update from Jennie Lee on alcohol free gel. Invite to Lifeline for next meeting – Jennie Lee/Tracey	Chair
3.	Datix – Trends, Analysis, Risk, Action Plans	Tony Black

Southern Health and Social Care Trust

AGENDA

MH&LD Inpatient Overarching Governance Group

29th September 2021

		Lynn Woolsey Jennie Sims
4.	Unit Risk Register ➢ Update for approval – highlighted sections for discussion  Unit Risk Register WD September 21.xls	William Delaney
5.	Standards and Guidelines	Lynn Woolsey
6.	Complaints  Acute MH Gov_Complaints...	Tony Black

Southern Health and Social Care Trust

AGENDA

MH&LD Inpatient Overarching Governance Group

29th September 2021

7.	Quality Improvement Plan	Dr Wethers
8.	Audit Plan	Dr Wethers
9.	RQIA Quality improvement Plans	William Delaney
10.	SAIs	Tony Black
11.	Professional Governance updates (*by exception*): ➢ Nursing ➢ Medical ➢ Social Work ➢ AHP ➢ Pharmacy ➢ Psychology.	Jennie Sims Dr McMahon Helen Dougan Ailene MacDonald Aaron Coulter Dr Brian Magee
12.	Policies and Procedures (*for approval*)	
13.	Nursing Quality Indicators (*for noting*)	

Southern Health and Social Care Trust

AGENDA

MH&LD Inpatient Overarching Governance Group

29th September 2021

<table>
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➢ KPI Summary Report MHD

<table>
<tr><th>Directorate</th><th>Link to Report</th><th>Comment</th></tr>
<tr><td>MHD</td><td>click here</td><td></td></tr>
</table>

</td><td>Lynn Woolsey</td></tr>
<tr><td>14.</td><td>Patient Experience</td><td>Jennie Sims</td></tr>
<tr><td>15.</td><td>Operational Issues</td><td></td></tr>
<tr><td>16.</td><td>AOB</td><td></td></tr>
</table>

Southern Health and Social Care Trust

AGENDA

MH&LD Inpatient Overarching Governance Group

29th September 2021

17.	Date of Next Meeting – **27th October 2021**	Chair
18.	**Confidential Section** ➢ Safeguarding investigations ➢ SAI's	Helen Dougan Tony Black

Unit Risk Register List of identified Risks

1	Ligature risks (a) through the intentional use of potential weight bearing structures, as listed within the MHD Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool, and (b) patient's property
2	The risk of Dementia patients being cared for in Willows ward
3	The Management of self-harm due to the existing hand soap, hand towel and toilet role holders through causing a suspended ligature. This is to read in conjunction with both the individual PQC risk assessments for patients clinical and existing ligature risk asessement for the ward.
4	Risk of intoxication and self-immolation through the ingestion and or use c There is an increased risk with the availability of alcohol based hand gels which staff are using at present due to COVID
5	The risk of Emollients: New information about risk of severe and fatal burns with paraffin containing free emollients. This is to be considered separately and also in conjunction with the risk of self immolation identified at risk number 9.
6	The management of self-harm due to the existing windows through the use of the window furniture, removable rubber or closing the window on a ligature causing a suspension. This is to read in conjunction with both the individual PQC risk assessments for patients and clinical and existing ligature risk assessment for the ward.
7	Self-harm caused by patients on themselves in a red area. Refer to the principle that Red sections - deemed highest risk. Current preventative measures as outlined above are reasonable practicable measures however the risks still remain due to the nature of the Mental Health ward. This is to read in conjunction with both the individual PQC risk assessments for patients clinical and existing ligature risk assessment for the ward.
8	Self harm casued by patients on themselves in amber areas. Refer to the principle that amber sections deemed lower risk, current preventative measures as oultined ar resonable precaticable measures however the risk still remain due to the nature of the mental health ward. This is to be read in conjunction wit bothe the individaul clinical risk assessments for patients and existingligature risk assessments
9	Harm caused by patients on themselves, other patients members of staff or members of public. Violence and Aggression
10	Slips, trips and falls
11	The management of violence and aggression within the Bluestone Unit
12	There has been sightings of vermin (mice within the courtyard of Bluestone). Vermin carry the risk of leptospirosis and are unhygenic
13	Risk of death and severe harm from ingesting superabs orbent polymer gel granules. These gels are only used in Mental Health in relation to the disposal of secretions from suctioning. Suctioning is currently a AGP and is not undertaken in Bluestone except in an emergency/ECT
14	The safe use of profiling beds in Willows, Cloughmore, Bronte and Silverwood
15	The Management of Plastic bags as a means of self-harm
16	Self-harm through the ingestion of and the management of COSSH substances
17	The Management of Fire within Bluestone and the management of unauthorised smoking
18	The risk of absconding
19	The risk of harm through inappropriate storage and changing of oxygen heads. Oxygen is highly flammable in a fir
20	Medical Gases The safe provision of oxygen of patients
21	Handling Cash and Valuables
22	Decrease in available staff and abiltiy to complete mandatory training
23	The management of CPR and the cleaning of static beds
24	Workplace temperature/ventiliation/air quality
25	Display screen equipment
26	Work related stress for employers
27	Staff Risk of contracting occupational dermatitis due to increased hand washing/use of sanitiser
28	Staff at risk of headache, fatigue, musculosketal injury
29	The use of undesignated beds
30	The risk of harm through the misuse of drugs and alcohol by patients
31	Staff, service users, visitors Risk of contracting COVID-19 if IPC procedures and guidance is not followed and we cannot adhere to 2 m social distancing
32	Only one exit on clinical room and other rooms
33	Pedestrian safety when availin of prescribed leave off the ward
34	The safe administration of prescribed medications to patien
35	The risk of Legionella
36	Patients are provided with regular hot drinks and hot meals. There is an increased risk of patients throwing hot drinks at fellow patients and staff and using such to harm themselves.
37	Self-harm caused by patients on themselves in an green area. Green section is lowest risk. Current preventative measures as outlined above are reasonable practicable measures however the risks still remain due to the nature of the Mental Health Ward.
38	

SHSCT - Directorate of Mental Health & Disability - Risk Register Template Bluestone Unit — Team / Facility: Bluestone Unit — Sep-21

Risk ID	Title/Description	Nominated Risk Lead	Potential for Harm	Control Measures	Likelihood	Consequence	Residual Risk Rating	Action Plan	Nominated Lead for Actions	Review Date	Monitoring	Review / Changes
1	Ligature risks (a) through the intentional use of potential weight bearing structures, as listed within the MHD Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool, and (b) patient's property.	Bluestone Management team, Associate Medical Director, governnace and estates	Harm to patients: Serious physical injury Potential loss of life. Harm to staff: Physical injury Emotional distress Poor staff morale. Harm to the organisation: Non-compliance with Health & Safety Legislation Complaints Potential public and employer liability claims Adverse publicity Internal/external enquiry Recruitment/retention problems Financial risk.	The current preventative measures as outlined below are reasonable, practicable measures however risks still remain due to the Mental Health estate and patients. • Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool compliance. - Individual multi-disciplinary risk assessment and working. • Risk Screening Tool and PQC assessments • Identification of risk at daily handover and safety briefs on commencement of duty • Therapeutic and recreational activities provision with 1:1 staff:patient engagement • Staff training in management of violence and aggression - MAPA appropriate level to area of work • Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards • Observation Policy & Procedure including 15 minute visual health and wellbeing patient checks • Senior management review and approval of minor works requests, and escalation for approval of major capital works • Policy for the management of Violence and Aggression and Use of Restraint • Incidents recording and management on Datix as per Trust policy and all ligature related incidents to be reviewed at the Acute MHS governance group re trend analysis. • CCTV for incident review • Alarm systems • Access to Emergecy Services and emergency equipment, including	Possible	Catastrophic	Extreme	1. Recruitment of staff to comply DoH delivering care policy. 2. Development of SHSCT Ligature Cutter Policy. 4. Update search Procedure re Restricted access to sharps and harmful objects based on individual clinical risk assessment Intervention Skills Training). • LIgature rescue training for staff.	Estates and Bluestone Senior Mgt team, Health & Safety. Governance Team.	27/09/2021	1 monthly review	1. Recruitment ongoing. 2. Development of Truts ligature policy ongoing. 3. Ligature and Suicide Risk Environmental Assessment and Management Tool compliance updated. 4. Restricted access to sharps and harmful objects based on individual clinical risk in draft form. 6 Trust now has licence to deliever STORM training. 7 Ligtaure rescuet training is outstanding-Trust MAPA team have been trained and training will be delievered once policy as per number 2 complete.
2	The risk of Dementia patients being cared for in Willows ward	Head of Services for Bluestone and Gillis and Assocaite Medical Director	Risk of inadvertent harm to Dementia patients within Bluestone Unit Patients who have a diagnosis of dementia and who are admitted to Bluestone because of a lack of dementia beds availability present with an increased risk of harm as admission wards have a mixed presentation of patients and challenges. Risk to the organisation There may be complaints and litigation to the Trust for injury/serious injury to patients. This is a foreseeable risk in light of individuals with dementia being cared for in adult acute mental health admission wards. Description of Risk: (Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider) There has been a catastrophic event in Gillis/Dementia assessment Unit in which the death of a service user occurred as a result of push/fall on one service user by another service user. Gillis is an identified	• Individuals with dementia can be cared for on continuous observations (1:1 or 2:1) dependant on their presentation in Bluestone Unit • PQC clinical risk assessments • Dementia patients to be cared for only in Willows ward within Bluestone Unit • Trust Observation Policy & Procedures • Incidents to be recorded on Datix as per Trust policy • Trend analysis of incidents of falls • CCTV for incident review • Emergency alarm system with a prescribed system for maintenance and routine testing of these systems/alarms. • On call medical staff • Falls care plans • Daily handover and safety brief on commencement of duty for all staff • Ongoing review of SGVA protection/management plans • Therapeutic and recreational activities • Availability of profiling bed, hoist and and manual handling equipment • Manual handling training for staff • The ward environment has controlled access and egress • Mapa training for staff • Prescribed medications are regularly reviewed • Occupational therapy input at • Individualised MDT care plan • The daily bed state is completed to identify the number of Gillis patients admitted to Bluestone • Policy for the management of Violence and Aggression and Use of Restraint	Likely	Major	High	There is a lack of specialist MDT/additional medical staff in Willows, Gillis to provide some input.	Dr McMahon to address potential additional medical support	27/09/2021	1 monthly review	New physcian associate emploted in Willows ward

3	The Management of self-harm due to the existing hand soap, hand towel and toilet role holders through causing a suspended ligature. This is to read in conjunction with both the individual PQC risk assessments for patients clinical and existing ligature risk asessement for the ward.	Bluestone Management team, Associate Medical Diretor and estates		The current preventative measures as outlined below are reasonable, practicable measures however risks still remain due to the Mental Health estate and patients. • Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool compliance. - Individual multi-disciplinary risk assessment and working. • Risk Screening Tool and PQC assessments • Identification of risk at daily handover and safety briefs on commencement of duty • Therapeutic and recreational activities provision with 1:1 staff:patient engagement • Staff training in management of violence and aggression - MAPA appropriate level to area of work • Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards • Observation Policy & Procedure including 15 minute visual health and wellbeing patient checks • Senior management review and approval of minor works requests, and escalation for approval of major capital works • Policy for the management of Violence and Aggression and Use of Restraint • Incidents recording and management on Datix as per Trust policy and all ligature related incidents to be reviewed at the Acute MHS governance group re trend analysis. • CCTV for incident review • Alarm systems • Access to Emergecy Services and emergency equipment, including	Likely	Catastrophic	Extreme	There is ongoing work andregular meetings to address the ligature risks. Pineapple are trying to develop a new bespoke unit for the bathrooms nd new potential anti-ligature equioment to be considered	Bluestone Management Team/H&S/Estates Dept	27/10/2021	1 monthly review	This matter is a standing item at the Trust ligature policy group meeting
4	Risk of intoxication and self-immolation through the ingestion and or use of alcohol based hand gels There is an increased risk with the availability of alcohol based hand gels which staff are using at present due to COVID	Head of Service		The current preventative measures as outlined below are reasonable, practicable measures however risks still remain due to the Mental Health estate and patients. Automatic fire detection system in place Please cross reference to individual fire risk assessment and evacuation procedures Staff mandatory fire training Sufficient Nominated Fire Officers at ward level Over-ride keys for accessing main bathrooms and visitors Additional fire blankets installed at ward level and all staff aware of their position All staff aware of progressive horizontal evacuate Personal evacuation plans for specific patients Access to Emergency services Access to emergency crash team and medical staff Staff emergency alarms Patients do not have unescorted access to the nurses station or clinical room where wall mounted hand Cutan foams are stored Staff training in management of violence and aggression - MAPA Staff are ILS and BLS trained Daily handover and safety brief on commencement of duty All inpatient patients often have access to lighters and are counselled on admission and post incident of authorised smoking on the dangers of smoking in hospitals There can be controlled access and egress to courtyard Regular fire checks Pat testing of electrical equipment Staff emergency alarms PGD on Nicotine Smoking cessation nurse available	Rare	Major	High			27/10/2021	1 monthly review	No update
5	The risk of Emollients: New information about risk of severe and fatal burns with paraffin containing free emollients. This is to be considered separately and also in conjunction with the risk of self immolation identified at risk number 9.	Head of Service	Patients	Continuous individual clinical risk assessment and multi-disciplinary working. Automatic fire detection system in place. Staff mandatory fire training. Sufficient Nominated Fire Officers at ward level. Over-ride keys for accessing main bathrooms and visitors. Additional fire blankets installed at ward level and all staff aware of their position. All staff aware of horizontal evacuate. Personal evacuation plans for specific patients. Access to NI Fire Brigade and Emergency services. Access to emergency medical staff. Staff emergency alarms. Staff training in management of violence and aggression - MAPA. first and second on call doctor available. Access to NIAS. Access to crash team. Staff are ILS and BLS trained. Additional support from senior management Monday-Friday from 0900-1700. Daily handover and safety brief on commencement of duty. All staff aware of the enclosed letter circulated by the CMO. Access to a Pharmacist, New COSSH cupboards installed	Rare	Catastrophic	Extreme			27/10/2021	1 monthly review	

6	The management of self-harm due to the existing windows by closing the window on a ligature causing a suspension. This is to read in conjunction with both the individual PQC risk assessments for patients and clinical and existing ligature risk assessment for the ward.	Head of Service	Patients/Staff	Added to the Unit risk register On-going individual Clinical Risk assessment and multi-disciplinary working. Individual client risk assessment and management of aggression care plan including Risk Screening tool and comprehensive risk assessment of patients policy Daily handover and safety brief on commencement of duty Therapeutic and recreational activities Staff training in management of violence and aggression - MAPA appropriate level to area of work Standards for daily 1:1 patient and staff engagement Observation by staff in all main areas at all times Restricted access to sharps and harmful objects based on individual clinical risk assessment Prescribed continuous observations in clinically indicated Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards Observation Policy & Procedure General visual checks on patients Access to PSNI-999 Additional support from senior management Monday-Friday from 09.00-17.00 Policy for the management of Violence and Aggression and Use of Restraint Incident to be recorded on Datix as per Trust policy CCTV for incident review IN CORRIDORS Emergency alarm system with a prescribed system for maintenance and routine testing of these systems/alarms. on call medical staff Senior Nurse holding the bleep Governance and Clinical Audit procedures Induction	Rare	insignificant	Low	Installation complete		27/10/2021	1 monthly review	This work has been completed so this will be removed from the risk register after the governence agenda
7	Self-harm caused by patients on themselves in a red area. Refer to the principle that Red sections - deemed highest risk. Current preventative measures as outlined above are reasonable practicable measures however the risks still remain due to the nature of the Mental Health ward. This is to read in conjunction with both the individual PQC risk assessments for patients clinical and existing ligature risk	Head of Service	Patients/Staff	The current preventative measures as outlined below are reasonable, practicable measures however risks still remain due to the Mental Health estate and patients. • Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool compliance. Currently being updated. - Individual multi-disciplinary risk assessment and working. • Risk Screening Tool and PQC assessments • Identification of risk at daily handover and safety briefs on commencement of duty • Therapeutic and recreational activities provision with 1:1 staff:patient engagement • Staff training in management of violence and aggression - MAPA appropriate level to area of work • Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards • Observation Policy & Procedure including 15 minute visual health and wellbeing patient checks • Senior management review and approval of minor works requests, and escalation for approval of major capital works • Policy for the management of Violence and Aggression and Use of Restraint • Incidents recording and management on Datix as per Trust policy and all ligature related incidents to be reviewed at the Acute MHS governance group re trend analysis. • CCTV for incident review • Alarm systems • Access to Emergecy Services and emergency equipment, including Hoffman's Knives and master keys. • Clinical governance arrangements. • Induction, training & supervision for staff.	Likely	Moderate	Medium	1. Recruitment of staff to comply DoH delivering care policy. 2. Development of SHSCT Ligature Cutter Policy. 4. Update search Procedure re Restricted access to sharps and harmful objects based on individual clinical risk assessment Intervention Skills Training). • LIgature rescue training for staff.	Bluestone Mgt Team and Estates	27/09/2021	1 monthly review	1. Recruitment ongoing. 2. Development of Truts ligature policy ongoing. 3. Ligature and Suicide Risk Environmental Assessment and Management Tool compliance updated. 4. Restricted access to sharps and harmful objects based on individual clinical risk in draft form. 6 Trust now has licence to deliever STORM training. 7 Ligtaure rescuet training is outstanding-Trust MAPA team have been trained and training will be delievered once policy as per number 2 complete.

8	Self-Harm caused by patients on themselves within amber parts of the ward patient wards. Refer to the principle that Red sections - deemed highest risk. Current preventative measures as outlined above are reasonable practicable measures however the risks still remain due to the nature of the Mental Health ward. This is to read in conjunction with both the individual PQC risk assessments for	Head of Service	Harm to patient/carers Physical injury/emotional distress Harm to Staff: Physical injury/emotional distress Poor staff morale Harm to the organisation: Non-compliance with Health & Safety Legislation Complaints Potential public and employer liability claims Adverse publicity Internal/external enquiry Recruitment/retention problems Financial Damage to property Risk to Patients:	The current preventative measures as outlined below are reasonable, practicable measures however risks still remain due to the Mental Health estate and patients. • Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool compliance. - Individual multi-disciplinary risk assessment and working. • Risk Screening Tool and PQC assessments • Identification of risk at daily handover and safety briefs on commencement of duty • Therapeutic and recreational activities provision with 1:1 staff:patient engagement • Staff training in management of violence and aggression - MAPA appropriate level to area of work • Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards • Observation Policy & Procedure including 15 minute visual health and wellbeing patient checks • Senior management review and approval of minor works requests, and escalation for approval of major capital works • Policy for the management of Violence and Aggression and Use of Restraint • Incidents recording and management on Datix as per Trust policy and all ligature related incidents to be reviewed at the Acute MHS governance group re trend analysis. • CCTV for incident review • Alarm systems • Access to Emergecy Services and emergency equipment, including Hoffman's Knives and master keys. • Clinical governance arrangements. • Induction, training & supervision for staff. • Incident debrief & identification of learning • Compliance with regional alerts re potential ligature risks. • Night lights in the patients bedroom and viewing panels in doors to enhance observation. • Magnetic anti-ligature curtains, anti-ligature fixed furniture and fixed beds with exception of profiling beds which are risk assessed. • Email circulated to all wards to highlight the risk and inform staff of the risk.	Possible	Moderate	Medium	1. Recruitment of staff to comply DoH delivering care policy. 2. Development of SHSCT Ligature Cutter Policy. 4. Update search Procedure re Restricted access to sharps and harmful objects based on individual clinical risk assessment Intervention Skills Training).	Senior Management Team within Bluestone	27/09/2021	1 monthly review	1. Recruitment ongoing. 2. Development of Truts ligature policy ongoing. 3. Ligature and Suicide Risk Environmental Assessment and Management Tool compliance updated. 4. Restricted access to sharps and harmful objects based on individual clinical risk in draft form. 6 Trust now has licence to deliever STORM training. 7 Ligtaure rescue training is outstanding-Trust MAPA team have been trained and training will be delievered once policy as per number 2 complete.
9	Harm caused by patients on themselves, other patients members of staff or members of public. Violence and Aggression.	Head of Service	Staff/Visitors/Contractors	The current preventative measures as outlined below are reasonable practicable measures however risks still remain due to the nature of Mental Health wards and patients. On-going individual Clinical Risk assessment and multi-disciplinary working. Individual client risk assessment and management of aggression care plan including Risk Screening tool and comprehensive risk assessment of patients policy Daily handover and safety brief on commencement of duty Ongoing review of SGVA protection/management plans in operation Therapeutic and recreational activities Staff training in management of violence and aggression - MAPA appropriate level to area of work 1:1 patient and staff engagement Restricted access to sharps and harmful objects based on individual clinical risk assessment Prescribed continuous observations in clinically indicated Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards Observation Policy & Procedure General visual checks on patients Controlled access and egress on front door Controlled access and egress on nurses station Patient have controlled access and aggress to their bed rooms Access to PSNI-999 Additional support from senior management Monday-Friday from 09.00-17.00 Policy for the management of Violence and Aggression and Use of Restraint Incidents to be recorded on Datix as per Trust policy Increased agency usage of staff to provide additional support Rapid tranquilisation policy	Possible	Moderate	Medium		Senior Management Team within Bluestone	27/09/2021	1 Montly review	Ligtaure rescue training is outstanding-Trust MAPA team have been trained and training will be delievered once policy as complete

10	Slips, trips and falls	Head of Service	Patients/Staff/Visitors/Contractors	• Risk Screening Tool and PQC assessments • Identification of risk at daily handover and safety briefs on commencement of dutyThe current preventative measures as outlined below are reasonable practicable measures however risks still remain due to the nature of Mental Health wards and patients. Patients cared for on continuous observations Standards for daily 1:1 patient and staff engagement Trust Observation Policy & Procedures Hoists and slide equipment available Incidents to be recorded on Datix as per Trust policy Trend analysis of incidents of falls CCTV for incident review Emergency alarm system with a prescribed system for maintenance and routine testing of these systems/alarms. on call medical staff Falls care plan Daily handover and safety brief on commencement of duty for all staff Therapeutic and recreational activities Manual handling training for staff Occupational therapy input at weekly MDT meetings Additional support from senior management Monday-Friday from 09.00-17.00 Appropriate footwear Regular cleaning of the floors Use of wet floor signs Health and Safety Environment Awareness Physiotherapy *assessments and* involvement Multidisciplinary Team Meeting reviewing medication Referral to falls clinic if necessary Falls Assessment on all admissions which includes clinical observation	Likely	Minor	Medium	No further action required		27/09/2021	1 monthly review	
11	Decrease in available staff and abiltiy to complete mandatory training	Head of Service/AD	Staff/Patients/Trust	Access to temporary staff/ Block booking of agency through the corporate bank. Communication with corporate bank to utilise regular agency staff to promote consistency for patient care Monitoring of sickness on a regular basis Access to occupational health Normative staffing levels have been agreed. Numbers of staff per shift has been increased Regular recruitment drives Trust policies which include: Family Friendly Policies, Working Well Together Policy, Supervision Opportunities Support (management / peer) Training /Induction (Trust /Local) European Working Time Directive Employee Assisted Programme – Inspire Tool Kit for managing work- Use of short term relief / cover from another ward to facilitate planned training Prioritising those staff most in need Prioritising mandatory training over commissioned courses Ward manager support workers who monitor and book training Annual Personal Development plans Minimum of bi-annual supervision for nursing staff. Health roster has commenced with the first live off duty commencing on the 2 December 2019. Daily meeting to clarify staffing and redeploy as necessary across wards Staff redeployed from Community services New staff commenced and new staff to commence	Almost Certain	Moderate	High	Ongoing pressures with staff and new posts created. Senior staff linking in with BSO to expidite new appointmnets	Bluestone mgt Team	27/09/2021	1 monthly review	Risk rating reviewed due to staffing pressures and absence rates

12	The management of violence and aggression within the Bluestone Unit RQIA as the regulator has highlighted the impact of violence and aggression within Rosebrook ward. A new addendeum has been devised to be added to this unt risk register	Head of Service	Harm to Staff: Physical injury/emotional distress Poor staff morale Harm to patient/carers Physical injury/emotional distress Harm to the organisation: Non-compliance with Health & Safety Legislation Complaints Potential public and employer liability claims Adverse publicity Internal/external enquiry Recruitment/retention problems Financial Damage to property	The current preventative measures as outlined below are reasonable practicable measures however risks still remain due to the nature of Mental Health wards and patients. On-going individual Clinical Risk assessment and multi-disciplinary working. Individual client risk assessment and management of aggression care plan including Risk Screening tool and comprehensive risk assessment of patients policy Daily handover and safety brief on commencement of duty Ongoing review of SGVA protection/management plans in operation Therapeutic and recreational activities Staff training in management of violence and aggression - MAPA appropriate level to area of work daily 1:1 patient and staff engagement Restricted access to sharps and harmful objects based on individual clinical risk assessment Prescribed continuous observations in clinically indicated Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards Observation Policy & Procedure General visual checks on patients Controlled access and egress on front door Controlled access and egress on nurses station Patient have controlled access and aggress to their bed rooms Access to PSNI-999 Additional support from senior management Monday-Friday from 09.00-17.00	Almost Certain	Moderate	Medium	There is an agreed action plan as reflected in the RQIA Qality Improvement Plan and on the wards general risk assessment which can be cross referneced	Collective leadership team	27/10/2021	1 monthly review	
13	There has been sightings of vermin (mice within the courtyard of Bluestone). Vermin carry the risk of leptospirosis and are unhygenic	Head of Service	Patients/Staff/Visitors/Contractors	Staff to be vigilant when they are completing patient health and welling visual checksStaff ro be vigilant when they are completing patient health and welling visual checks Trust cleanliness audits Bait boxes can be added on request Medical staff and serology and biochemistry lab available for physical health monitoring Datix for incident review outdoor structures used by staff have been removed due to vermin	Unlikely	minor	Low	All staff to complete a Datix from if the observe vermin so that the number of sightings can be monitored.		27/09/2021	1 monthly review	

14	Risk of death and severe harm from ingesting superabs orbent polymer gel granules. These gels are only used in Mental Health in relation to the disposal of secretions from suctioning. Suctioning is currently a AGP and is not undertaken in Bluestone except in an emergency/ECT	Head of Service	Patients	Limited use of superabsorbent polymer gel granules in Bluestone Only ordered and distributed by one ward manager who is responsible for ECT All stocks are stored in the COSSH cupboard Added to safety brief and general risk assessment Suction is an AGP so requires RED PPE. Risk to be added to safety brief and handover sheet To be added to COSSH risk assessments CMO guidance letter,	Unlikely	Minor	Low	Ward Staff to be trained on the use of superabsorbent polymer gel granules.	Sr Mary Donnelly	27/09/2021	1 monthly review	
15	The safe use of profiling beds in Willows, Cloughmore, Bronte and Silverwood	Head of Service	Patients	Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement Emergency personal staff alarms Prescribed continuous observations and engagement policy General visual checks on patients. Observation and engagement policy CCTV cameras for review of incidents Incidents to be recorded Datix as per Incident reporting policy, Trend analysis of incidents Search policy Staff mandatory fire training Sufficient Nominated Fire Officers at ward level Master keys for accessing all rooms Access to emergency medical staff A local incident review will be completed after each incident Bed lock out function available. Where a patient requires use of profiling bed for clinical reason they must be individually risk assessed as suitable for using same. Individuals are risk assessed to identify appropriate area to be nursed in, level of observation required and to identify bed requirement. TORM training for staff (Skills Training on the Risk Management Self Harm Mitigation- Suicide) ASSIST training for staff (Applied Suicide Intervention Skills Training) Hoffman's ligature knife available Access to BLS/ILS training	Possible		Low			27/09/2021	1 monthly review	

16	The Management of Plastic bags as a means of self-harm	Head of Service	Patients	Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement Emergency personal staff alarms Regional review on the management of plastic bags in mental health hospitals Prescribed continuous observations and engagement policy ¼ hour visual checks on patients. Patients and carers advised on admission of the risks and use of plastic bags at ward level during their stay. CCTV cameras for review of incidents Hoffman's ligature knife available for use Incidents to be recorded on IR1s as per Incident reporting policy, Bins & Bags have been removed from all red and amber areas on the ward. Signage displayed throughout the ward. search policy rapid tranquilisation policy Staff training in management of violence and aggression - MAPA First and second on call doctor available Access to NIAS Access to crash team Staff are ILS and BLS trained Additional support from senior management Monday-Friday from 09.00-17.00	Possible	minor	Low	The mental health programme needs to develop a policy and procedure around the management of self-harm. The mental health programme need to review the absence of plastic bags as it contributes to a poor patient experience and issues re waste management.	Bluestone Management Team	27/09/2021	1 monthly review	
17	Self-harm through the ingestion of and the management of COSSH substances	Head of Service	Patients/Visitors/Staff/Contractors	This risk assessment is to be cross referenced with and read in conjunction the COSSH risk assessments in bLUESTONE COSSH Cupboard and items stored within Domestic staff trained re COSSH Data sheets available Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement Emergency personal staff alarms Prescribed continuous observations and engagement policy ¼ hour visual checks on patients. CCTV cameras for review of incidents Incidents to be recorded on Datix as per Incident reporting policy, search policy rapid tranquilisation policy Staff training in management of violence and aggression - MAPA First and second on call doctor available Access to NIAS Access to crash team Additional support from senior management Monday-Friday from 09.00-17.00 Staff are ILS and BLS trained Continuous individual clinical risk assessment and Multi-disciplinary working daily 1:1 patient and staff engagement Emergency personal staff alarms Prescribed continuous observations and engagement policy	possible	Minor	Low			27/09/2021	1 monthly review	

18	The Management of Fire within Bluestone and the management of unauthorised smoking	Head of Service	Patients/Staff/Visitors/Contractors	Please reference to individual fire risk assessment and evacuation procedures. AsBluestone has open inpatient ward, patients often not have access to lighters and are counselled on admission and post incident of authorised smoking on the dangers of smoking in hospitals There an be controlled access and egress to courtyard Regular fire checks Pat testing of electrical equipment Additional support from senior management Monday-Friday from 09.00-17.00 Automatic fire detection system in place Staff mandatory fire training Sufficient Nominated Fire Officers at ward level Over-ride keys for accessing bathrooms and Additional fire blankets installed at ward level and all staff aware of their position All staff aware of progressive horizontal evacuate Personal evacuation plans for specific patients Access to NI Fire Brigade and Emergency services Access to emergency medical staff Staff emergency alarms Staff training in management of violence and aggression - MAPA First and second on call doctor available Access to NIAS Additional support from senior management Monday-Friday from 09.00-17.00 PGD on Nicotine	Possible	Minor	Low	All wards are awaiting to see about the reconnection of his outdoor cigarette lighter and a new cigarette bin.	Estates	27/09/2021	1 monthly review	External cigarette parts ordered and will be installed once received.
19	The risk of absconding	Head of Service	Patients/members of the public	Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement Prescribed continuous observations Observation and engagement Therapeutic and recreational activities Controlled access and egress Emergency personal Alarms 1/4 hourly visual checks on patients CCTV coverage to enable incident review Entry and Exit Policy Absconding intervention commenced at ward level including sign in/sign out sheet and post absconding score Post absconding debriefing Regional Guidance from Public Health Agency on patients absconding from mental health inpatient wards. Trust, Procedure on Absconding Incidents to be recorded on Datix as per Incident reporting policy Reglonal KPI for Absconding New assurance report for monitoring methods of absconding returned to HOS monthly Additional support from senior management Monday-Friday from 09.00-17.00 Policy for the management of Violence and Aggression and Use of Restraint Daily handover and safety brief on commencement of duty	Likely	Minor	Low		Estates	27/09/2021	1 monthly review	New doors have been installed across all wards which has reduced incidents of absconding through forcing the front door open.

20	The risk of harm through inappropriate storage and changing of oxygen heads. Oxygen is highly flammable in a fire	Head of Service	Patients/Staff/Visitors/Contractors	Oxygen is stored within the designated clinical room Appropriate signage available The storage of oxygen is referenced on the fire risk assessment and fire evacuation plans Only suitably competent and trained staff change the head on oxygen cylinders The Bluestone porter is available office hours and the portering service is available 24 hours per day NIFB aware that oxygen is stored on the Bluestone site Excess oxygen is stored outside, new COSSH cupboards installed	Rare	Minor	Low	New fire retarden COSSH cupboard to be ordered		27/09/2021	1 monthly review	new COSSH cupboards installed
21	Medical Gases The safe provision of oxygen of patients	Head of Service	Patients/Staff	All patients are prescribed oxygen on kardex' s Patients can be administered oxygen as a PGD Patients are assessed on admissions and NIECR is reviewed to ensure that patients are not at risk of CO2 retention with high flow oxygen Registered staff only are trained and administer oxygen therapy to patients Continuous individual clinical risk assessment and Multi-disciplinary working Patients wear ID bracelets Policy and procedure available on the administration and storage of oxygen Appropriate equipment is available in the administration of oxygen to patients Monitoring SPO2 equipment is available NEWS charts, monitoring, training	Rare	Minor	Low	No further action required		27/09/2021	1 monthly review	

22	Handling Cash and Valuables	Head of Service	Patients/Staff	Trust policies and Procedures Cashiers office in acute hospital 2 staff required to sign patients cash and valuables Regular inpatient audit to monitor compliance BSO independent audit Guidance on management of property if a patients is life extinct Mental Capacity Act Patient authorisation book for withdrawals Signage at ward level Datix for incident monitoring RQIA reviews	Unlikely	Minor	Low	No further action required		27/09/2021	1 monthly review	
23	The management of CPR and the cleaning of static beds	Head of Service	Staff/Patients	Observations policy and procedures Manual handling policies and procedures Immediate Life Support (ILS) training Infectio BLS training Continuous individual clinical risk assessment and Multi-disciplinary working Where a patient requires use of profiling bed for clinical reason they must be individually risk assessed as suitable for using same. Incidents to be recorded on Datix as per Incident reporting policy Access to the Crash Team Maintenance of contract beds General visual checks on patients Emergency alarm system with a prescribed system for maintenance and routine testing of these systems/alarms. Crash trolley/Oxygen/defibrillator available It has to be recognised that this would likely be an emergency event and the individual may require to be transferred to the floor for emergency care and treatment. Patients are to be encouraged to make their own bed Staff if appropriate are to make the beds while on their knees Access to individual ergonomic assessments Task rotation, staff are to consider the routine cleaning schedule to reduce long periods undertaking bed cleaning and variation of tasks i.e. breaking up into shorter periods during the shift Rotation- staff are to consider rotation of staff and duties as far as possible within the facility. Staff advised to change position regular All patients on admission to hospital should have an ergonomics /manual handling risk assessment completed. This is available on the Trust SharePoint page Hoists available for use but it has to be noted that they cannot be used with static bed All redeployed staff have had manual handling refresher training before commencement in Bluestone and Willows	Possible	minor	Low	The HOS has engaged the ergonomic team and devised and shared this risk assessment with the ergonomics and the team have agreed to provide specific advice/training to mental health staff in relation to the safe mobililsation of the patient to the floor with 1-2 staff available. This training is provided to primary care staff in the community settings. Staff may need to be provided PPE if they are kneeling to make beds.	Ward Managers	27/09/2021	1 monthly review	

24	Workplace temperature/ventilation/air quality	Head of Service	Staff	Staff Induction Staff breaks Availability of air conditioning in the nursing office Individual risk assessment Access t Windows that can open around the ward Internal Temperature monitoring on wards Access to courtyard	Rare	Minor	Low	No further action required		27/09/2021	1 monthly review	
25	Display screen equipment	Head of Service	Staff	Staff Induction Staff breaks Individual risk assessment Assistance wit eye tests Screen protectors available Ergonomics assessment available Staff to be encouraged to take regular breaks Appropriate and supportive chairs Document holders available if required Wrist rest pads available Task rotation Induction on new equipment	Rare	Minor	Low	No further action required		27/09/2021	1 monthly review	

26	Work related stress for employers	Head of Service	Staff	Access to temporary staff/ Block booking of agency through the corporate bank to ensure safe staffing Communication with corporate bank to utilise regular agency staff to promote consistency for patient care Monitoring of sickness on a regular basis Access to occupational health Normative staffing levels have been agreed. Numbers of staff per shift has been increased Regular recruitment drives Trust policies which include: Family Friendly Policies, Working Well Together Policy, Supervision Opportunities Support (management / peer) Training /nduction (Trust /Local) European Working Time Directive Employee Assisted Programme – Inspire Tool Kit for managing work- Use ofshort term relief / cover from another ward to facilitate planned training Prioritising those staff most in need Annual Personal Development plans Minimum of bi-annual supervision for nursing staff. Daily meeting to clarify staffing and redeploy as necessary across wards Staff redeployed from Community services New staff commenced and new staff to commence	Unlikely	Minor	Low			27/09/2021	1 monthly review	
27	Staff Risk of contracting occupational dermatitis due to increased hand washing/use of sanitiser	Head of Service	Staff	Staff are referred to Occupational Health as and when required. Staff to follow guidance as recommended by Occupational Health in relation to hand care Datix to be completed when a doctor diagnoses occupational dermatitis as this is reportable under RIDDOR as an occupational disease. Record the name of the doctor who diagnoses the condition as this is required for reporting to HSENI.	Unlikely	minor	Low			27/09/2021	1 monthly review	

28	Staff at risk of headache, fatigue, musculosketal injury	head of service	Staff	Where staff are working from home, the requirements of DSE Procedure apply. Share DSE procedure with staff and remind staff to set up their workstation in line with the minimum standards contained in Appendix 1 and to inform their manager where this is not possible Remind staff to complete DSE eLearning awareness training Advise staff who work from home to adopt the best practice guidance outlined in the 12 point workstation set up guide Advise staff who work from home to complete the DSE self-assessment. When completed this should be discussed with the manager. Advise staff who work from home that portable DSE e.g. laptop should be placed on a firm surface at a comfortable height Remind staff to organise their work activity to allow them to move away from the screen to allow a postural change	Unlikely	minor	Low			27/09/2021	1 monthly review	
29	The use of undesignated beds	Head of Service	Patients	Continuous individual clinical risk assessment and Multi-disciplinary working daily 1:1 patient and staff engagement Emergency personal staff alarms Prescribed continuous observations and engagement policy General visual checks on patients. Observation and engagement policy CCTV cameras for review of incidents Incidents to be recorded Datix as per Incident reporting policy, Trend analysis of incidents Search policy Staff mandatory fire training Sufficient Nominated Fire Officers at ward level Mater keys for accessing all rooms Access to emergency medical staff A local incident review will be completed after each incident Bed lock out function available. Where a patient requires use of profiling bed for clinical reason they must be individually risk assessed as suitable for using same. Individuals STORM training for staff (Skills Training on the Risk Management Self Harm Mitigation-Suicide) ASSIST training for staff (Applied Suicide Intervention Skills Training) Hoffman's ligature knife available BLS/ILS training Access to the Crash Team Staff training on the use of beds. Maintenance of beds by Hill Rom. Measures taken to reduce the length of the electric cable. Emergency alarm system with a prescribed system for maintenance and routine testing of these systems/alarms. Staff First and second on call medical staff	Almost Certain	Moderate	Medium	new monitoring process in place		27/09/2021	1 monthly review	

30	The risk of harm through the misuse of drugs and alcohol by patients	Head of Service	Patients/Staff/Visitors/Contractors	Continuous individual clinical risk assessment and Multi-disciplinary working Emergency personal staff alarms Staff training in management of violence and aggression - MAPA Standards for daily 1:1 patient and staff engagement Prescribed continuous observations Southern Trust Policy on Continuous observations Observation and engagement policy ¼ hourly minute visual checks on patients Controlled access and egress ward for review of incidents Access to PSNI Therapeutic and recreational activities Incidents to be recorded on Datix as per Incident reporting policy New search policy Body scanner available Urine drug testing Alcometers available rapid tranquilisation policy. CCTV cameras installed in main corridors of the ward Twice daily security checks are completed in Rosebrook First and second on call doctor available Access to NIAS Access to crash team Staff are ILS and BLS trained Additional support from senior management Monday-Friday from 09.00-17.00 Access to PSNI Policy on absconding Policy on the management of individuals who present as intoxicated approved at governence forum	Possible	Moderate	Medium			27/09/2021	1 monthly review	
31	Staff, service users, visitors Risk of contracting COVID-19 if IPC procedures and guidance is not followed and we cannot adhere to 2 m social distancing	Head of Service	Staff/Patients/Contractors	Individual clinical risk assessment Isolation procedures on admission This could include leaving seats empty. Providing more storage for workers for clothes and bags. devices such as keypads. of transmissio cleaning devices between use. Using signs and posters to build awareness of good handwashing technique, the need to increase handwashing frequency, avoid touching your face and to cough or sneeze into a tissue which is binned safely, or into your arm if a tissue is not available. Setting clear use and cleaning guidance for toilets to ensure they are kept clean and social distancing is achieved as much as possible. Providing hand drying facilities – either paper towels or electrical driers. Cleaning Frequent cleaning of work areas and equipment between uses, using your usual cleaning products. Frequent cleaning of objects and surfaces that are touched regularly including door handles and keyboards, and making sure there are adequate disposal arrangements for cleaning products. Review layouts and processes to allow people to work further apart from each other. Using remote working tools to avoid in-person meetings. Avoiding transmission during meetings, for example avoiding sharing pens, documents and other objects. Providing hand sanitiser in meeting rooms. Holding meetings outdoors or in well-ventilated rooms whenever possible. Staggering break times to reduce pressure on the staff break rooms or places to eat and ensuring social distancing is maintained in staff break rooms. Returning to work Providing clear, consistent and regular communication to improve understanding and consistency of ways of working. Engaging with workers through existing communication routes and worker representatives to explain and agree any changes in working arrangements. Developing communication and training materials for workers prior to returning to site	Possible	Minor	Low	Ongoing actions as directed by the government and Trust		27/09/2021	1 monthly review	

32	Only one exit on clinical room and other rooms	Head of Service	Staff	The current preventative measures as outlined below are reasonable practicable measures however risks still remain due to the nature of Mental Health wards and patients. Two registered nursing staff usually administer prescribed medications from the clinical room On-going individual Clinical Risk assessment and multi-disciplinary working. Individual client risk assessment and management of aggression care plan including Risk Screening tool and comprehensive risk assessment of patients policy Daily handover and safety brief on commencement of duty Therapeutic and recreational activities Staff training in management of violence and aggression - MAPA appropriate level to area of work daily 1:1 patient and staff engagement Observation by staff in all main areas at all times Prescribed continuous observations in clinically indicated Observation Policy & Procedure General visual checks on patients Controlled access and egress on nurses station Access to PSNI-999 Additional support from senior management Monday-Friday from 09.00-17.00 Policy for the management of Violence and Aggression and Use of Restraint Incidents to be recorded on Datix as per Trust policy Rapid tranquilisation policy CCTV for incident review Body scanner available Emergency alarm system with a prescribed system for maintenance and routine testing of these systems/alarms. Access of Occupational Health First and second on call medical staff Senior Nurse holding the bleep Staff attack panels are located in the offices. Zero Tolerance Policy Governance and Clinical Audit procedures	Possible	Minor	Low			27/09/2021	1 monthly review	
33	Pedestrian safety when availin of prescribed leave off the ward	Head of Service	Patients	Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement Specialist OT assessment Controlled access and egress Emergency personal Alarms 1/4 hourly visual checks on patients CCTV coverage to enable incident review Entry and Exit Policy Absconding intervention commenced at ward level including sign in/sign out sheet Post absconding debriefing Regional Guidance from Public Health Agency on patients absconding from mental health inpatient wards. Trust, Procedure on Absconding Incidents to be recorded on Datix as per Incident reporting policy Access to first on call and second on call doctor Mental Capacity Act Mental Health Order	Unlikely	Insignificant	Low	No further action required		27/09/2021	1 monthly review	

34	The safe administration of prescribed medications to patients	Head of Service	Patents	Two registered nursing staff usually administer prescribed medications from the clinical room Patients wear ID bracelets Policies and procedures available Drug Kardexes are available for administration of prescribed medications Availability of first and second on call doctors Availability of pharmacist Anaphylaxis kit and training BNF AVAILABLE NMC Code Staff refresher training Staff experience Staff registration with the NMC Staff competences Sufficient numbers of trained staff available Datix forms completed for incident review Trend analysis Medicines management group	Unlikely	Insignificant	Low	Staff update their medicines management training on three yearly basis.		27/09/2021	1 monthly review	
35	The risk of Legionella	Head of Service	Patients/Staff	The Southern Trust has policy on Legionella Infrequently used taps are flushed	Rare	Minor	Low			27/09/2021	1 monthly review	

36	Patients are provided with regular hot drinks and hot meals. There is an increased risk of patients throwing hot drinks at fellow patients and staff and using such to harm themselves.	Head of Service	Patients/Staff	Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement Emergency personal staff alarms Supervised meals and hot drinks at all time Prescribed continuous observations and engagement policy 1/4 hour visual checks on patients. Observation and engagement policy CCTV cameras for review of incidents Incidents to be recorded on Datix forms as per Incident reporting policy, Staffing levels increased due to high acuity of ward and increased number of incidents. Rapid tranquilisation policy Additional support from senior management Monday-Friday from 09.00-17.00 Policy for the management of Violence and Aggression and Use of Restraint Seclusion available Food hygiene courses for all staff Patient support /domestic staff available to assist with cooking, providing and cleaning up after meals Daily handover and safety brief on commencement of duty	Unlikely	Minor	Low			27/09/2021	1 monthly review	
37	Self-harm caused by patients on themselves in an green area. Green section is lowest risk. Current preventative measures as outlined above are reasonable practicable measures however the risks still remain due to the nature of the Mental Health Ward.	Head of Service	Patients/Staff	Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement Prescribed continuous observations Southern Trust Policy Observation and engagement policy. ¼ hourly visual checks on patients Therapeutic and recreational activities Emergency personal staff alarms Anti-ligature curtain rails in bays. Anti-ligature sinks, cupboard handles Entry and Exit Policy for Acute Inpatient CCTV cameras installed for review ward for review of incidents STORM training for staff (Skills Training on the Risk Management Self-Harm Mitigation-Suicide) ASIST training for staff (Applied Suicide Intervention Skills Training) Incidents to be recorded on Datix as Body scanner available Hoffman knife available Staffing levels increased due to high acuity of ward and increased number of incidents. search policy rapid tranquilisation policy Staff training in management of violence and aggression – MAPA First and second on call doctor available Access to NIAS Access to crash team Staff are ILS and BLS trained Additional support from senior management Monday-Friday from 09.00-17.00 Access to PICU Daily handover and safety brief on commencement of duty	Possible	Minor	Low	A colour coded drawing of the ward to accompany this risk assessment is to be developed by Estates. The Mental Health programme needs to develop a policy and procedure around the management of self-harm.	Estates/Chris Horisk/Bluestone Management Team/Bluestone Management Team	27/09/2021	1 monthly review	
38	To reflect compliance with the Directorate risk register the risk from delayed discharges has been added to the Bluestone Unit Risk Register	Head of Service	Harm to patient/carers due to inappropriate placement Harm to Staff: Poor staff morale Harm to the organisation: Complaints Potential public and employer liability claims Adverse publicity Internal/external enquiry	Continuous individual clinical risk assessment and Multi-disciplinary working Standards for daily 1:1 patient and staff engagement, patient choice protocol, delayed discharge meetings, HTT inreach practitioner, PMSID returns and regualr review of delayed discharge, social work team	Possible	Minor	Low	Ongoing work around placements and timely discharge of patients	Bluestone Mnagement team	27/09/2021	1 monthly review	None
				p									

Received from Shane Devlin on 14/02/22 Annotated by the Urology Services Inquiry.

Comac, Jennifer

From: Sloane, Diane
Sent: 22 July 2021 11:11
To: Murphy, Lorna
Cc: Craughwell, David; Black, Tony
Subject: Acute MH Gov_ComplaintsIncidents 01-05-2021 30-06-2021
Attachments: Acute MH Gov_ComplaintsIncidents 01-05-2021 30-06-2021.docx

Hi Lorna,

Please find attached Acute Governance Report.

Kind Regards
Diane

Acute Mental Health Services Governance Group
Adverse Incidents & Complaints Update for Meeting on 28th July 2021

1.0 Complaints Received: Time Period for Data: 01 May 2021 - 30 June 2021

ID	First received	Speciality	Description	Outcome	Current Stage	Subject Of Complaint
FORMAL						
13472	03/06/2021	Psychiatric Inpatient Services Cloughmore	Service user dissatisfied with the decision made by the Doctor in Bluestone to section him under the Mental Health Act	The trust response explains the assessment process and why it was necessary to detain the service user during this time. A timeline of events is included with this justification. The letter states the legal advice given to the service user at the time and further information should he be unhappy with this response.	CLOSED	Clinical Diagnosis
13584	24/06/2021	Psychiatric Inpatient Services Bronte	An inpatient is unhappy with her care and pending discharge as she still feels suicidal.		Ongoing	Discharge / Transfer Arrangements
INFORMAL						
13548	16/06/2021	Resource Centres	Service user is unhappy about his appointment with the Dr running 35-40mins late, during this time his anxiety increased and no member of staff came to inform him that his appointment was running late and check on him. Once he got to see his Dr he felt his behaviour was unsympathetic and unprofessional.	Complaint has been resolved with an appointment with the Doctor.	Local Resolution	

13503	10/06/2021	Psychiatric Inpatient Services Rosebrook	An inpatient has phoned to complaint that she is being held in Bluestone as she has no where else to go but feels she should be released to the care of her mum, friend or housing executive. She feels she is mentally stable so therefore cannot be detained. She is also concerned about the staffing levels are she feels they are under enormous pressure with the current inpatients and unable to take her out for walks.	Nursing staff in Rosebrook engaged with and spoke with Personal Information and reassured her that she was safe in the ward and that she would not be placed in danger. They discussed how to deal with and remove herself from any situations that evolved when the ward and other patients may be unsettled, rather than becoming involved. With regarding to her being able to discharge her SW explained why at this time it is not possible and the routes they are currently exploring and she apologised that staff are not always available to take her for a walk.	Local Resolution	
13539	16/06/2021	Psychiatric Inpatient Services Bronte	The family of an inpatient are enquiring if her medial team are aware that she does not want to leave bluestone this weekend as planned as she still is feeling suicidal.	Discharge has been delayed after discussions with her consultant and keyworker.	Local Resolution	
13496	09/06/2021	Psychiatric Inpatient Services Willows	The son of a service user is not happy regarding the restrictions on visiting in Bluestone.	Complainant was offered Video link. It was explained to him the guidelines and he was happy with that	CLOSED	
REDIRECTED						
13546	16/06/2021	Psychiatric Inpatient Service Cloughmore	The solicitors of a service user are looking the service user released from Bluestone and are seeking his papers as discussed via telephone on the 15.06.21 with staff.	Redirected to Medico Legal	CLOSED	

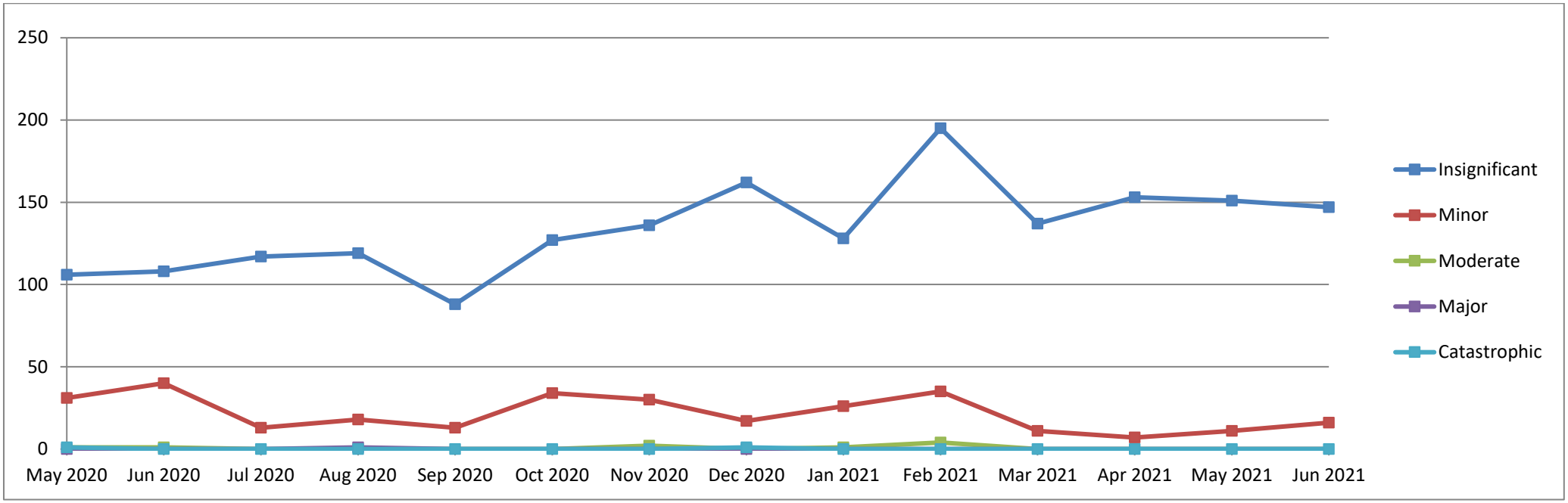
Compliments Received: May - June 2021

May 2021: Silverwood = 6 Cards, 1 x Email, 1 Letter & 1 Verbal

June 2021: Bronte = 10 x Chocolates, 1 x Buns, 4 x Cards, 1 x Flowers

2.0 Incidents reported where severity was recorded as Moderate and Above: Time Period for Data: 01 May – 30 June
None

2.1 Incidents by Severity by Month. (Incidents Reported 01 May 2020 – 30 June 2021)



2.2 All Incidents Awaiting Review by Year and Speciality

Speciality / Team	2016	2017	2019	2020	2021	Total
Inpatient Addiction Services	1	0	0	0	0	1
Psychiatric Inpatient Services - BRONTE	0	0	0	0	13	13
Psychiatric Inpatient Services - CLOUGHMORE	0	0	0	3	11	14
Psychiatric Inpatient Services - ROSEBROOK	0	1	1	0	38	40
Psychiatric Inpatient Services - SILVERWOOD	0	0	0	0	4	4
Psychiatric Inpatient Services - WILLOWS	0	0	0	0	14	14
Psychology Department	0	1	1	8	4	14
Resource Centres	0	0	0	0	2	2
Total	1	2	2	11	86	102

2.3 All Incidents Awaiting Review by Speciality and Severity

Speciality / Team	Insignificant	Minor	Moderate	Catastrophic	Total
Inpatient Addiction Services	0	0	1	0	1
Psychiatric Inpatient Services - BRONTE	7	6	0	0	13
Psychiatric Inpatient Services - CLOUGHMORE	5	8	0	1	14
Psychiatric Inpatient Services - ROSEBROOK	33	5	2	0	40
Psychiatric Inpatient Services - SILVERWOOD	4	0	0	0	4
Psychiatric Inpatient Services - WILLOWS	10	3	0	1	14
Psychology Department	8	6	0	0	14
Resource Centres	0	1	1	0	2
Grand Total	67	29	4	2	102

Southern Health and Social Care Trust

Nursing & Midwifery Quality Indicators (NQIs) Summary Report

eport Produced By:

atient Safety, Quality & Experience Division

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MHD Directorate

August 2021

Nursing & Midwifery Quality Indicators (NQIs) Report

August 2021

Introduction

A key theme for the Health and Social Care Trusts is **safety, quality and experience (SQE)**. Pivotal to this theme is the fundamental objective to ensure performance is closely monitored, that good performance is recognised and poor performance challenged.

Each month the Nursing Governance Department collate, analyse and report on indicators of nursing performance in avoiding preventable harm to patients. With this monthly report it aims to provide ownership of practice, acknowledge achievement and identify concerns. It also aims to prompt shared learning for continuous improvement in providing safe, effective care and a positive experience for the people we care for.

Note:

- Data should be inputted by the last day of each month.
- If there is no information for a particular ward this is because no data was entered at the time of the data run.
- 10 charts should be completed for each of the audits including NEWS Part B and Falls Part B. Senior staff should put measures in place to track patients who meet the audit criteria across the month to ensure the required 10 audits are completed.

Contents:

- Overall Summary
- Directorate Report
- Divisional Report
- Ward Reports (FileMaker)
- Total Falls & Pressure Ulcers
- Training - COMING SOON
- Supervision - COMING SOON!
- Patient Experience - COMING SOON!
- Resources

MHD Directorate

August 2021

NQI

Audit Results

Overall Summary

Directorate Report

Divisional Report

Ward Reports (FileMaker)

Outcomes

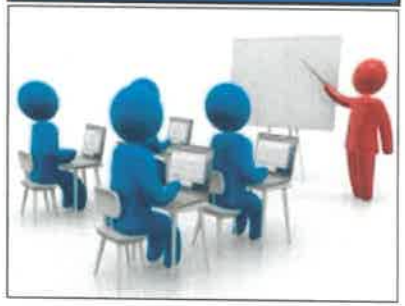
No. of Falls & Pressure Ulcers

Patient Experience COMING SOON

Care Opinion
What's your story?

10,000
TEN THOUSAND MORE VOICES

Training COMING SOON



Supervision COMING SOON!

MHD Directorate

Resources

- List of wards completing NQIs
- List of NQI Audits
- NQI Guidance Document
- Quality Improvement Template
- Quality Improvement Plan Guidance
- Link to NQI SharePoint Site

Data Sources

Data Sources	
NQI Audits	NQI FileMaker Database (NOAT – excel audit tool)
Total Falls on ward	Institute for Healthcare Improvement (IHI) Database
Hospital Acquired Pressure Ulcers	

Southern Health and Social Care Trust

DIRECTORATE OF MENTAL HEALTH & DISABILITY SERVICES

DMHD Monthly Complaints Meeting Tuesday 12th October @ 4:30pm

Join Zoom Meeting

Irrelevant Information Redacted by the USI

AGENDA

1. Attendance & Apologies

2. Review of Mental Health approach to complaints

3. Overview of progress of complaints and legal issues

4. Involvement of Service Users and Family Liaison Officers

5. Date of Next Meeting – Tuesday 9th November @ 4:30pm, ZOOM

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

Directorate of Mental Health & Disability Services - Weekly Governance Debrief

Date: 1st June 2021

Data Subject *as coded on datix	**Total Prev week**	**Detail if applic.**	Info Source
No. of New SAIs			MHD GOV - DATIX
No. of New Early Alerts			MHD GOV - DATIX
Incidents with Moderate/Major & Catastrophic Severity*		1. Line Graph 2. Listing report. ID, Incident date, description, action taken, service area, approval status	MHD GOV - DATIX
- Medication Incidents*		1. Line Graph 2. Listing report. ID, Incident date, description, action taken, service area, approval status	MHD GOV – DATIX

- Incidents related to staffing shortages*. - A) Organisational – Service Disruptions inc Human Resources – Human resources availability – Insufficient number of staff breaks down by Healthcare and non-professional - B)Staff – Exposure to Hazard – Workplace Stressor/Demands – Staffing Levels		1. Line Graph 2. Listing report. ID, Incident date, description, action taken, service area, approval status	MHD GOV - DATIX

- Violence & Aggression Incidents *		1. Line Graph only	MHD GOV - DATIX
- No. of Incidents involving Restrictive interventions & type of intervention*		1. Line Graphs 2. Table for preceding week.	MHD GOV - DATIX
No. of new High Risk/ High Profile			MHD GOV - DATIX

Complaints			
No. of New NIPSO Referrals		Ongoing cases Vs New	MHD GOV
No. of New Regulatory/Professional Body Referrals			JENNY
No. of New Litigation/Coroners cases			LYNNE
Safeguarding Update			DEBORAH
MCA update			KATHY
No. of Assessments and Detentions under MHO		Include ASW and Medical Detentions.	KATHY
Waiting Lists		**Mental Health Services:**	ADs
		Disability Services	
No. of New Raising Concerns			JENNY

Issues			
Staff Absence			JENNY
New Standards & Guidelines Received (incl safety alerts)			MHD GOV
No. of Crisis Response Referrals LD in the previous week			John
No of Crisis Response Referrals MH in the previous week			Jan
RQIA Inspections Reports (by exception)			AD's
AOB by exception			All

Southern Health and Social Care Trust

DIRECTORATE OF MENTAL HEALTH & DISABILITY

DIRECTORATE GOVERNANCE GROUP

Terms of Reference

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DMHD GOVERNANCE GROUP TERMS OF REFERENCE.

1.0 Constitution

The Senior Management Group of the Mental Health & Disability Directorate established a strategic Governance Group to specifically address all matters pertaining to this area of the Directorate's business.

2.0 Main Purpose

The purpose of the MHD Governance Group is to develop, integrate, promote and monitor all aspects of governance in mental health & disability services including clinical & social care, professional, financial, medicines, estates and human resources governance. The Forum aims to promote an ethos of awareness, accountability, continuous learning and improvement.

3.0 Membership

- Chairperson - Director for MHD Services
- Assistant Director of Mental Health Services
- Assistant Director of Inpatient Services (MH and LD)
- Chair of MHD Nursing Governance Forum
- Assistant Director of Community Learning Disability Services & Physical Disability & Sensory Impairment Services & Chairperson of Community LDIS/PDSI Governance Forum
- Assistant Director of Human Resources MHD
- Associate Medical Director(AMD) & Chair of Acute MHS Governance Forum
- Clinical Director Learning Disability & Chair of Dorsy Governance Group
- Mental Health Clinical Lead – Psychology
- Assistant Director AHP Governance, Workforce Development & Training
- Assistant Director for Nursing Governance
- Assistant Director of Social Work Governance, Workforce Development & Training
- Assistant Director for Nursing Workforce, Development & Training
- MHD Social Work Lead
- MHD Nursing Lead
- Clinical & Social Care Governance Coordinator – MHD
- Chair of MH Social Work & Social Care Governance Forum
- Chair of LDIS & PDSI Social Work Governance Fora

Others will be co-opted onto this group as necessary e.g. Litigation, finance, pharmacy and estates operational and governance leads. Where by exception a member is not able to attend they must nominate a deputy to attend in their place. The deputy should have authority to take decisions on behalf of the standing member.

4.0 Frequency of Meetings

Meetings will be held monthly.

Venue: Zest Conference Room, Bannvale in first instance.
A quorum will be six members which must include the operational director and/or assistant director and the AMD and/or a nominated clinical director and a professional governance assistant director/lead.

5.0 MHD Governance Group - Members main responsibilities.

5.1 Provide specialist knowledge and expertise relevant to their area of work and responsibility;
5.2 Report and communicate with others within MHD and across the Trust on the progression of actions required within their area of knowledge and expertise; and report on any barriers to the implementation of those actions.
5.3 Contribute to the development of, and agree actions within any Task and Finish / Subgroups required in order to meet the aims of the MHD Governance Group.
5.4 Contribute to the development of, and agree, systems and processes to support the provision of information on assurances on clinical and social care excellence within the Directorate.

6.0 Authority
The MHD Governance Group is authorised by the Trust Governance Committee to progress or investigate any activity within its terms of reference, to satisfy the Governance Committee via the Trust CSCG Working Body that effective governance arrangements are in place within DMHD.

7.0 Main Responsibilities and Activities of the MHD Directorate Governance Group

- To review and monitor the MHD Governance Structure to ensure it facilitates the operation of effective governance arrangements.
- To ensure that an effective risk identification, mitigation and escalation process is in place which includes the completion of risk assessments, maintenance of risk registers and development of action plans to minimise and manage risk as appropriate.
- To consider those risks referred to the Directorate Governance Group which cannot be managed at Division level and/or may require consideration in respect of addition to the Directorate and/or Corporate Risk Registers.
- To ensure that there is effective reporting, investigation and follow-up of adverse and serious adverse incidents including monitoring the implementation of actions identified following incident investigation/reviews.
- To ensure that complaints are appropriately investigated/monitored/managed and areas of learning/recommendations from the investigation of complaints are implemented into practice.
- To assess the internal/external applicability of learning from incident/complaint investigations and share that learning with other directorates/external agencies as appropriate.
- To consider the findings of relevant internal and external reports/reviews and review progress towards any associated action plans (incl RQIA and Internal Audit reports).
- To consider, review, develop and implement governance policies and procedures as necessary.
- To identify and inform a programme of multiprofessional audit and service evaluation and monitor the implementation of recommendations emanating from same.
- To identify training needs which may arise from governance related activity and develop an MHD directorate specific training plan to progress same. Training identified

may be delivered through Regional ECGs, Social Services Training Unit or through local resources.

- To monitor compliance with statutory functions, workforce development, continuous professional education and development and ensure that professional and regulatory body standards and guidelines are in place and adhered to.
- To review, monitor and provide assurances regarding the implementation of clinical standards and guidelines in MHD.

8.0 Communications with Other Groups and Committees

The group will communicate with Trust groups/teams on any significant issue and any other external agency that may provide assistance. Such groups may include the Trust Governance Committee and SMT Governance Group; the Trust Governance Working Body; the SHSCT Senior AHP Governance Forum; the SHSCT Senior Nursing & Midwifery Governance Group and MHD Nursing Governance Group; the SHSCT Social Work & Social Care Governance Group & MHD sub-groups; the Trust Standards & Guidelines Prioritisation and Risk Review Group. Internal, external auditors can be invited as attendees to the group if there is any matter they wish to bring directly to the groups attention. Intelligence and learning from National/Regional Professional Fora that may impact/influence the work of the MHD Governance Group will be shared.

9.0 Standing Agenda Items:

The following will be listed as standing agenda items. Members can request additional items to be included via the Chairperson.

- Apologies
- Action Sheet from the Previous Meeting
- Issues generated by SMT Governance / Trust Governance Working Body / Governance Committee
- Professional Governance Updates by exception regarding:
  - Compliance with Professional/Regulatory Bodies Standards
  - Delegated Statutory Functions
  - Workforce Standards, Training, Education & Development
  - Referrals to Professional Regulatory Bodies
- Updates from MHD Divisional Risk & Governance Fora to include by exception:
  - Issues arising from Adverse Incident & Complaints and M&M Activity
  - Progress Update on the Implementation of Recommendations from SAI reports and other relevant internal and external reports.
  - Risks escalated to the Directorate Governance Group from Divisional Governance Groups.
  - Implementation of Clinical & Social Care Standards and Guidelines
  - Overview of Progress against Medical Device/Patient Safety/Facility Alerts.
- Reconciled Directorate Risk Register
- Directorate Multiprofessional/Clinical Audit Programme

- Confidential Section (as and when required)

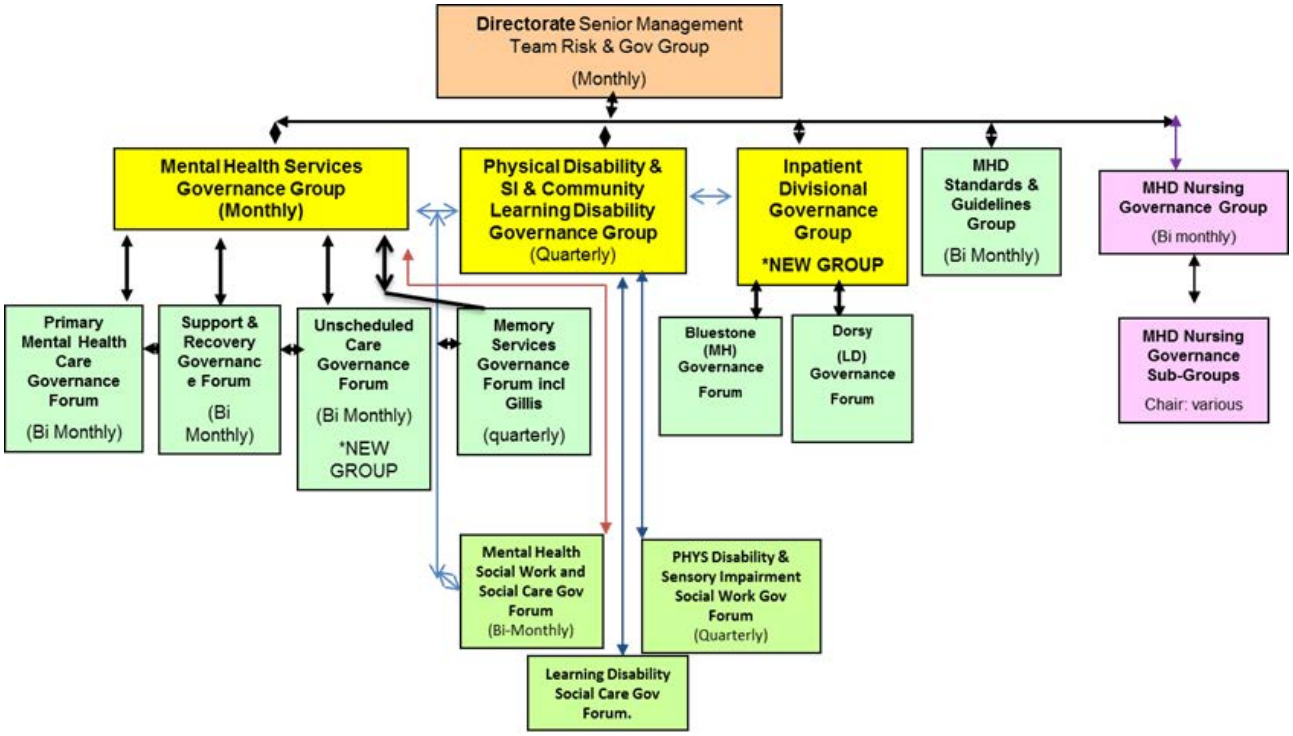
9.1 Generation of Agenda Items

Any member can submit an agenda item which is not listed above by emailing tracy.griffin @southerntrust.hscni.net. If there are documents to be tabled to support the item then these should be sent to Tracy for circulation to the group at least 5 working days in advance of the meeting. Typically, agenda items which should be submitted are where

a) the risk or concern has ramifications beyond the immediate area of clinical or managerial control and it can no longer be managed within the division.

b) the risk or concern cannot be satisfactorily managed within the division because of a lack of resource or authority or existing standards and guidance ignore or contribute to the risk.

10.0 Governance Groups / Fora



SUMMARY:

The Directorate of Mental Health & Disability revised its Clinical & Social Care Governance Structure/processes within the context of streamlining existing governance fora and improving it's assurance and accountability framework to assist the Directorate in discharging it's functions in relation to the provision of safe and effective care. The revised Governance structure /processes will have clear integrated arrangements for accountability and reporting, a coherent programme of quality improvement activity; and risk management processes, including mechanisms for detecting and dealing with poor professional performance. The Directorate will promote the themes of Safety, Effectiveness and Patient / Client Experience. In order to integrate the various strands of governance the Directorate has expanded upon the membership of it's SMG Governance Group to now regularly include the Assistant Directors of Professional Governance / Workforce Development and Training who are part of the Trust's overall governance structures and as such will participate as full members of the SMG Governance meetings. This will allow the Assistant Directors to become well informed about the range of clinical and social care governance issues impacting on safe and effective care to patients and clients within the directorate in a timely manner and promotes the effective management of the interface between professional and corporate governance issues. The Directorate will continue to develop and promote a 'safety culture', where open reporting of incidents and balanced analysis are encouraged in principle and by example.

Responsibilities:

Directorate Divisional, Service Area & Professional Governance Fora

It is the responsibility of each forum to operate within it's defined terms of reference. In the first instance each forum, as a group, will be responsible for ensuring that all actions required from it are progressed and assurances are provided regarding same. One example of this would be that each forum needs to ensure that recommendations from SAIs / other investigations/ reviews are reviewed, the relevant person(s) are identified to implement same and a means of obtaining evidence of that implementation is determined. The forum, via the chairperson, will then update the directorate governance group regarding the implementation status of those recommendations.

Chairs of Divisional and Service Area Governance Fora.

The divisional, service area and professional governance fora chairpersons & co-chairs will act as the conduit between the MHD Directorate Governance Group and their respective governance fora. They will be responsible for ensuring that actions/issues arising from their respective governance fora are tabled and discussed at the Directorate Governance Group (if required) and vice versa.

Southern Health and Social Care Trust

DIRECTORATE OF MENTAL HEALTH & DISABILITY
DIRECTORATE GOVERNANCE GROUP

Meeting on Tuesday 20th July 2021 at 3.00pm
VIA ZOOM

Join Zoom Meeting

Irrelevant Information Redacted by the USI

Meeting ID: Irrelevant Information Redacted by the USI

Passcode: Irrelevant Information

AGENDA

1.0 Apologies: Dr Maria O'Kane, Tony Black

2.0 Issues generated by SMT Governance / Governance Committee / Audit Committee / Policy Scrutiny Committee / Fire Safety Committee /Patient & Client Experience Committee / Internal Audit Forum

- Infection Prevention & Control
- Fire Safety

3.0 Granville Supported Living - Update - John

4.0 Professional Governance Updates by exception.

- AHP
- Social Work
- Nursing
- Medical
- Psychology

6.0 Safeguarding Update - Deborah

7.0 Updates from MHD Divisional Risk & Governance Fora by exception – Assistant Directors

8.0 Directorate Risk Register

DMHD DIR Risk Reg 18-05-21.pdf

9.0 Complaints Update Incl NIPSO cases

10.0 Confidential Section by exception updates

SAIs:

- ID85765 [redacted]
- ID110541 [redacted]
- ID112242 [redacted]
- ID118422 [redacted]
- ID120173 [redacted]
- ID94571 [redacted]
- ID127058 [redacted]
- ID69712 [redacted]
- ID118414 [redacted]

11.0 Any Other Business

SHSCT - Directorate of Mental Health & Disability - Directorate Level Risk Register as of 18 May 2021

NOTE - Oct 13 - PMHC Risk de-escalated to MH Divisional Register.
Nov 13 - Inadequate accommodation for admin staff in DHH Mental Health Dept de-escalted to MH Divisional Risk Register,
Dec-13 :Adult Safeguarding Risk - removed from Directorate risk register. To be placed on Adult Safegurding Team register.
Jan14 - New risk added relating to some GPs not signing Form 3s for patients in Bluestone.
Feb 2014 - Two New Risks added 1) regarding potential closure of HHBC and 2) Internal Audit of Finances in Supported Living

Apr 14 - One New risk added - 1) Gillis MC

Jun-14 Jun 14 - One New risk added - Delayed discharges (also listed on CRR)

Aug 14 - One new risk being assessed regarding staff levels.

Sep-14 Sep 14 - Care Mgt Risk Rating Redcued from Major to Moderate

Dec-14 Dec 2014 1. dom Care Overspend Risk Removed as mitigated. .2 Contract Owner Risk Added. 3.Financial Adult Supported Living Schemes De-escalated

Jan-15 Jan 2015 - PMHC Capacity & Demand Risk escalated to MHD Dir RR from MHS Risk Reg. Mar 15 risk level reduced from extreme to high.

Feb 2015 - CIS (PARIS) implementation added to Dir RR

Apr 2015 - Risk escalated again relating to some GPs not signing Form 3s for patients in Bluestone.

June 2015- Clubs/Organisations/Societies Using Trust Facilities / Trust Transport Out of Hours & Gillis MC Risks De esclated from Directorate Risk Register to Divisonal Level

Sept 2015- GPs not signing Form 3s for patients in Bluestone. Risk removed as risk resolved at this time.

Dec 2016 - New Risk Added - Recruitment/Delays

Mar 2017 - new risk added SDS.

June 2017 - Risks removed/de-escalated: PMHc Demands; Case Management, Contract Owner responsibilities/role; Prisons interface Risk; supervison of meds dom care;

July 2017- Integrated Transport Risk added.

August 2017 - Medical workforce risk Added

Feb 18 - Declaratory Orders Risk added

May 2018 - Risk added re Isolation of Gillis MC on SLH site.

Feb 2019 - SDS risk deescalated from DRR

May 2019 - Adult Safeguarding Risk Added to DRR

July 2019 - Integrated Transport Risk Removed

Nov 2019 - MCA risk added

August 2020 - Declarotory Orders risk removed. New risks to be added re Covid19 and also the discontinuation of Priadel when risk assessments are completed. Pridel risk no longer a n issue.

October 2020 - 3 new risks added by Acute MHS - Ligatures, Viol and Aggression and Dementia patients admitted to willows

May 2021 - PMHC Risk added. / OP Waiting List Risk Added.

Source	Title/Description	Potential for Harm	Control Measures	Risk Rating	Action Plan	Nominated Lead for Actions	Last Review Date
MHS and LDIS	Effective risk management of patients who present with significant risk histories, complex challenging behaviours who do not have a definitive mental health or learning disability diagnosis, but have been known to childcare services in the recent past. Incl autism)	• Physical / emotional harm to public as a result of persons offending behaviours. • Risk history becoming public knowledge placing patient at risk from community. • Potential litigation against Trust, who hold a duty to care. • Adverse publicity arising out of any litigation, offending behaviours. • Complaints	• Cases are currently held in MH and LDIS Forensic Services, although there are no interventions being delivered. • Regular review at MDT meetings • Service links in with carer and undertakes regular assessment of clients.-MHD previously met with Paul Morgan and a CYP Asst Dir re this issue.	HIgh	**Update:** MH Services will deal with this risk issue on a case by case basis. Risk Listing now only refers to Disability services who will continue with focused engagement with the Commissioner on this gap in commissioning. As of 13/8/20 add to collective leadership team meeting agenda for further discission. 11-02-21 - Recognition that there are no properly commissioned ASD services	john McEntee	18/05/2021

LDIS and MHS	Safeguarding of Residents within Hebron House/Bawn Cottage. The Trust has, over a prolonged period, and in liaison with the Home Owners, maintained and improved the Trust and Home's systems of financial control to minimise the likelihood of further financial abuse. This process has continued to identify issues of concern which require regular on-going extensive operational and professional resources across departments to manage risks highlighted.	Potential negative publicity (local, regional, national) Litigation from Home Owners and/or residents/their relatives. Complaints. Elected representative involvement Emotional distress to clients. Impact on resources which would need to focus on moving clients.(potential additional cost of placements) Allocation of Trust resources for potential civil action by home owners. Allocation of Trust resources regarding sourcing alternative placements etc.	• Review of Residents within the Care Management process. Resident's reviews are held more frequently if required. • Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out 5 moved • Liaison with the residents, relatives/families where appropriate. • Weekly Trust meetings to review status & regular updates provided to Trust Board / SMT. • Regular updates from Trust HHBC group provided to DHSS/HSCB/RQIA/Other Trusts • Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel. • Regular advice/support/direction by Trust Legal Advisers • Contract Review Meetings with HHBC and quarterly operational meetings – contract compliance process. • Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives. • Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff. •The ongoing safeguarding arrangements and risk control measures continue to be monitored through the operational case management process in line with the implementation of the new Regional Adult Safeguarding: Prevention, Protection in Partnership, 2016 procedures • Contacts with RQIA • Scoping exercise has been completed should alternative placements be required and would need to be revisited. • Suspension of new admissions/respite bed reviewed at HHBC steering grou . • Trust "Procedure for Responding to RQIA Alerts & Other Performance Management issues within Social Care Contracts". • Ongoing processes with OCP / RQIA / NMC / HSCB re SAI, Disclosure & Barring Service (DBS) • New Trust Case Management Guidance & Training Programme completed • Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices.	*Extreme	NB: multifacted risk assessment with different gradings for each risk issue. Extreme rating is listed as this is the highest. See risk assessment for other details. • Ongoing liaison with the residents, relatives/families where appropriate. • Suspension of new admissions/respite beds reviewed at HHBC Steering group. Current controls to remain as agreed by SMT and Trust Board. Judical Review application submitted. Judicial review appliation withdrawn by HHBC. Sept 18: Current controls to remain as agreed by SMT and Trust Board. NMC hearing- no further progress as of 22/11/2018. Trust meeting with DLS on 18-01-19 for update meeting. Updates provided to DOH 2020. Risk assessment updated Jan 21	John / Noeleen	18/05/2021
MHS / OPPC	Long Term placements for clients with challenging behaviour resulting in delayed discharge from hospital (Gillis and Dorsy and Bluestone Unit	• Reduced access to Beds • Potential Overspend • Complaints • Litigation. • Incidents • Adverse Media • Physical/Verbal Assault • Increased Sickness Absence	• M'disc Team assessments • Monthly delayed discharge meeting (which includes OPPC Memory Team) for all Mental Health Wards incl Gillis. • The MDT in Gillis now use the definition of "Multidisciplinary Fit" for discharge when deciding when a patient is fit for discharge. Patient level detailed delayed discharge information is circulated to the MDT in Gillis and the 3 x relevant staff in the Community Memory Teams on a monthly basis	Medium	• Discussions with Commissioners have highlighted the need to enhance community services to better support individuals in their own homes or independent sector homes to manage more challenging behaviours. Currently no funding has been made available to enhance memory services or procure a specialist home for people with dementia and challenging behaviours. Consequently individuals whose discharge is delayed remain in Gillis much longer. • Discussions with regional and local Commissioners have sought to bring to the fore the current gap in Commissioning plans for inpatient dementia services, including multi-disciplinary input form pharmacy, social work and psychology. Some in year non recurrent allocations have helped with the overspend in bank nursing hours to meet need but will not enhance multi-disciplinary input. There remains no clear commissioning strategy for inpatient services or for people under 65 yrs old with dementia.	Lynn/Jan Stephen / Kiera	18/05/2021
MHS	Implementation of the PARIS system within MHD - Initial Risk Raised by the HTCR Team. Discussed at MHd Gov Group who agreed to list on Dir Risk Reg due to implications for wider MHD as CIS is rolled out.	• Patient/public safety compromised if essential information not recorded and shared due to time and effort required to input in to PARIS • Potential to increase current recording effort two fold – capacity/resource issues • Potential for critical information not being captured/communicated due to a reduced amount of information being entered on the system or not being readily accessible in a timely manner to staff that have to decide on treatment and risk management. • Staff not able to input the information on to the system within duty shifts -Possible beach of professional regulatory requirements. • Increased Staff stress • Record keeping errors, • Compromised communication. • Lack of availability of information for investigations eg PVA/SAI, external enquiry. • Physical /Emotional injury to patients /clients and staff • Adverse Media / Complaints / Litigation	HTCR Team has endeavoured to have staff develop their key-board skills by using outlook and word. We have ensured staff have been freed up to attend PARIS training and still have concerns about the impact of the new system. Training to date has been focused on PARIS processes and limited focus on the care delivery documentation. We have suggested a couple of work-arounds i.e. use of voice recognition software but have been told this falls outside the scope of the project, we have also suggested the use of digi-pens but have been told this can't happen. When the system is rolled out we will have to have a shift coordinator located at base every day. This already has resource implications because we would frequently rely on the person undertaking this role to be able to go out on assessments and home visits. Suggested solutions have previously been submitted to the CIS project team who advise this is outside of the remit of project This remains an issue ie none of the proposed solutions have been adopted. Eg - Voice recognition software / Digi-pens- (currently used by PSNI). Advised by Ann Mc Ghee that there are no additional admin resources This has been tried, staff have endeavoured to take ownership of inputting data on to the system however inspite of their best efforts this is getting in the way of care delivery. As a work around we need to consider how better we can make use of admin resource. - Training:All staff have basic keyboard skills & attended 2 of 3 PARIS system training sessions. It was suggested to the CIS project manager that staff would benefit from some form of on-line key-board skills training package. Details of training were sent through in June 14 Following PARIS training and since implementation staff have said that training on PARIS alone and not having the opportunity to use the forms they use for service delivery during training has proved to be an opportunity missed. This has been fed through to the PARIS team with the hope that this can be factored in to future training for teams about to go-live, unfortunately we are eing told that the trainers cant be expected to know all teams forms. The solution would be for trainers to support staff from running a patient through from referral to assessment etc.	HIGH	- Ongoing: implementation in MHD. There is a significant degree of change in how teams are expected to work to fulfil the needs of PARIS. Teams are uncovering system snags and developing work-arounds. PARIS Project group has been of benefit. Concerns raised re suitability of the system to support care provision. May 2017 update: PARIS project pilot ongoing in Support & Recovery service to identify recording difficulties and to resolve any ongoing prolems with inputting data. Support & Recovery Service has began to use PARIS to facilate MDT meetings and this has proved beneficil and efficent. The PARIS project pilot group are planning to introduce WINDIP to assist with the storing of PARIS records. NOV 2017 update: PMHCadded to risk assessment. which has been shared with Mark toal by Adrian Corrigan. As of 13/8/20 ongoing risk issues identified retain on register.	Asst Dir / Hos /	18/05/2021
MHD	Delays in recruitment processes and failure to attract/appoint appropriate staff	• Unsafe staffing levels • Increased sickness absence due to pressure and stress • Physical/emotional harm to staff and/or clients/patients • Inability to fill rotas • Inability to provide safe & effective care • Complaints • Inadequate skill mix to provide care • Litigation • Adverse media • Internal or external enquiry or investigation	Agency Cyclical recruitment properly monitored and reviewed to ensure waiting lists are updated. Creation of the training role (growing our own) with specific interest in disability and mental health additional hours for existing workforce Transfer of staff to meet need.	HIGH	Recruit staff on adverts specific to MH Directorate rather than Trust generic and provide in-house specialised training. Undertake recruitment drives with advertising specific to Disability Directorate. Workforce planning in specific areas to define ongoing need. As of 13/8/20, recognised improved position with regards to BSO support, regional lack of professionally qualified staff remains.	Asst Dirs and Asst Dir of HR	18/05/2021

MHD	Risk to business continuity and service delivery due to a shortages of Consultant Psychiatrists in mental health & disability services	• Inability to provide safe & effective care, fully meet needs of the service and patients assessed needs. • Inadequate skill mix to provide required level of intervention and care • Increased Waiting Lists • Litigation • Adverse media • Complaints • Adverse Incidents incl SAIs • Reduced Staff Morale • Staff burnout. • Increased Sickness Absence • Failure to comply with professional regulatory standards. • Failure to comply with mandatory training requirements.	Use of locum staff in Psychiatry of Old Age and Intellectual Disability however this has the potential to create a significantoverspend in the MHD medical budget. - Offer of additional clinics to current consultant staff and specialty doctors - Additional PAs for cross cover of part absent colleagues work/duties, collapsing the 2 consultant on-call rotas to form 1 to cover both services. - Ongoing recruitment - Consideration of other staff – such as temporary specialty doctors to provide some senior cover	High	Continue with controls. Recent Consultant advertisements listed	Assoc Med Director	18/05/2021
MHS	Gillis MC isolation issue.	Gillis Memory Centre is a unit with 12 female and 12 male beds based in Mullinure Health & Wellbeing Centre, St Lukes Hospital site, Armagh. It is the only facility which provides inpatient assessment beds for people with dementia in the Southern area. Those patients that are admitted to the Gillis unit are often presenting with very distressed behaviours and complex co-morbidities and all efforts to carry out a comprehensive assessment in the community have been exhausted by the community teams. Gillis is the only inpatient unit on the St Lukes site. The unit is isolated from other inpatient units and as a result do not have support from other nursing, medical or AHP staff in an emergency situation such as a physical aggression from a patient a fire or a medical emergency. In the event of a medical emergency such as collapse staff must act in the patient's best interest until the emergency services arrive. On average there are two such incidents per month. Staffing levels must reflect the need for supervision on a 1-1 or 2-1 basis, staff breaks and CPD. There is no opportunity to avail of staff from other wards. There is no security staff on the St. Lukes site.	Measures to manage this have been put in place including having a specialty doctor is on site Monday to Friday 9am until 5pm. The Consultant is on the ward approximately three days per week. Staff levels are maintained at level that they can manage any unpredicted or emergency situation. Medical cover is provided by on call doctors base in Bluestone on the Craigavon Hospital site. There is no access to additional nursing staff during the nights or weekends unless through the bank system. Gillis have access to services from the Acute care at home team to attend to medical situations and were appropriate prevent admission to the Craigavon area hospital which is 14 miles away.	Low	continue controls and retain on register	HoS Memory Services, AD MHS	18/05/2021
MHD	Delivering effective, evidence based Safeguarding Practice	See Risk Assessment	The Corporate Adult Safeguarding Blueprint Project Board and workstreams were developed to gain organisational support to the implementation of the new policy and procedures and to engage all areas of service delivery in ownership of adult safeguarding. Training is available to staff through the SSWTDT and additional CPD Practitioner Support Fora are available for those staff fulfilling functions under the policy As part of the Adult Safeguarding Service Review the adult safeguarding team are providing additional ad hoc information sessions to support teams Professional supervision should be available to staff as per Trust Policy Safeguarding leads receive additional 1 -1 meetings with Trust Adult Safeguarding Specialist on bi monthly basis to reflect on issues raised by the practitioner within their area of work. This does not provide supervision on all aspects of individual cases. A small baseline audit of practice was carried out in 2018. This resulted in individual reflective learning for practitioners through direct supervision and a shared themed approach to learning at safeguarding fora. Workforce Profile completed 2018	extreme	1. Pre audit review of Audit sample selected by the Independent Review team for the Regional Adult Safeguarding Audit. An extension of this audit will be undertaken to review a further 30 cases. 2. A formal feedback session was held with all DAPO and their supervisors on 29th April to appraise staff of Internal early learning from the DoH audit on adult safeguarding in care homes 3.Adult Protection Supervision checklist developed and provided at workshop as a support for supervisors of adult protection work. All protection cases to be brought through supervision 4.Monthly dashboard developed by Gateway team for HoS to cross reference referral progress during supervision and to QA the HSCB data return 5.Remedial action has been taken to consider and implement lessons learned from audit to date through the DAPO and IO Support Fora and also through the supervision process. 6. A further reaudit will take place within the reporting year to measure improvements 7.PARIS Implementation to be prioritised 8.Blueprint approved exploration of Service Development Proposal via engagement with staff. Trade Unions invited to café conversation workshops. Proposal considers options to address identified risks. 9.Testing of thresholds for the management of individual cases within the gateway team using additional new regional adult protection funding 10.Accommodation pressures impacting on delivery of service due to expansion of team – linking with Estates and MHD Directorate to prioritise request. Deborah to update these actions as of 13/8/20.	Deborah Hanlon	18/05/2021

Trust Wide	Compliance and implementation of MCA (2016) Phase 1	Risk of litigation against the Trust if procedures are not fully implemented and adhered to. Financial harm to Trust if IPT scoping exercises are not accurate. Failure of a fully functioning service will lead to a failure to comply with this legislation. Risk of complaint for failure to adhere to MCA implementation After one year post implementation risk of staff being prosecuted if none adherence to DoLS processes. Adverse media/reputational damage	SHSCT is preparing to • Arrange for assessments of mental capacity, best interests and medical examinations and reports to be undertaken from 2nd December • Operate multi-disciplinary panels for the approval of applications for a DoLS from 2nd December. • Put in place arrangements for short-term detentions authorisations from 2nd December • Put in place administrative and governance infrastructure to support the operation of STDA's, Trust Panels; monitor forms and processes; and report on activity as required from 2nd December. • Cover expenses for the provision of Medical Reports by authorised medical practitioners that are not directly employed by the SHSCT (generally patients GP) • Release key staff to complete the training required to authorise them to perform legal duties and functions (including; complete formal assessments of capacity; make Best Interests determinations; provide prescribed medical reports; make application to the Trust panel; sit as a member of a Trust Panel). DOH are directly commissioning training to enable Trust staff and others to perform required functions. DOH have asked all Trusts to identify key staff to be seconded for 16 weeks (until 14/12/19) to complete a Train the Trainers programme for implementation within the Trust to provide training in the longer term. DOH have requested a Lead Director be identified for the Trust to oversee and ensure appropriate arrangements are implemented across all Programmes of Care, including Acute Hospital services. HSCB/PHA requested SHSCT identify a senior staff member to join an implementation working group led by HSCB to ensure regional consistency and legal validity of arrangements.	extreme	See risk assessment. Corporate risk Register entry updated Aug 2020.	Angela Harkin Director MD and AMDs	18/05/2021
Acute MHS	Ligature risks (a) through the intentional use of potential weight bearing structures, as listed within the MHD Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool, and (b) patient's property. A risk of potential ligatures has also been identified through the strings and elastic materials that are attcahed to the PPE and face masks that staff are required to wear in amber areas.	Harm to patients: Serious physical injury Potential loss of life. Harm to staff: Physical injury Emotional distress Poor staff morale. Harm to the organisation: Non-compliance with Health & Safety Legislation Complaints Potential public and employer liability claims Adverse publicity Internal/external enquiry Recruitment/retention problems Financial risk. The risk of elastic the ties from surgical masks has been added to the unit risk register under the ligature risk. There is a potential risk as Masks are in areas outisde of the wards but we have no visitiors attending and small numbers of patients who are assessed and well enough to avail of time off the ward. Inlight of the risks which was highlighted in teh western Trust we have tried to ident the M231 masks for use.	The current preventative measures as outlined below are reasonable, practicable measures however risks still remain due to the Mental Health estate and patients. • Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool compliance. Currently being updated. - Individual multi-disciplinary risk assessment and working. • Risk Screening Tool and PQC assessments • Identification of risk at daily handover and safety briefs on commencement of duty • Therapeutic and recreational activities provision with 1:1 staff:patient engagement • Staff training in management of violence and aggression - MAPA appropriate level to area of work • Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards • Observation Policy & Procedure including 15 minute visual health and wellbeing patient checks • Senior management review and approval of minor works requests, and escalation for approval of major capital works • Policy for the management of Violence and Aggression and Use of Restraint • Incidents recording and management on Datix as per Trust policy and all ligature related incidents to be reviewed at the Acute MHS governance group re trend analysis. • CCTV for incident review • Alarm systems • Access to Emergecy Services and emergency equipment, including Hoffman's Knives and master keys. • Clinical governance arrangements. • Induction, training & supervision for staff. • Incident debrief & identification of learning • Compliance with regional alerts re potential ligature risks	extreme	1. Recruitment of staff to comply DoH delivering care policy. 2. Development of SHSCT Ligature Cutter Policy. 3.• Inpatient Ligature and Suicide Risk Environmental Assessment and Management Tool compliance. Currently being updated. 4. Update search Procedure re Restricted access to sharps and harmful objects based on individual clinical risk assessment 5. Incidents recording and management on Datix as per Trust policy and all ligature related incidents to be reviewed at the Acute MHS governance group re trend analysis. 6.Training for staff including Basic Life support, STORM training for staff (Skills Training on the Risk Management Self Harm Mitigation- Suicide), ASSIST training for staff (Applied Suicide Intervention Skills Training). • Llgature rescue training for staff.	Estates and Bluestone Senior Mgt team, Health & Safety. Governance Team.	18/05/2021

Acute MHS	The management of violence and aggression within the Bluestone Unit	Harm to Staff: Physical injury/emotional distress Poor staff morale Harm to patient/carers Physical injury/emotional distress Harm to the organisation: Non-compliance with Health & Safety Legislation Complaints Potential public and employer liability claims Adverse publicity Internal/external enquiry Recruitment/retention problems Financial Damage to property	The current preventative measures as outlined below are reasonable, practicable measures however risks still remain due to the Mental Health estate and patients. Individual multi-disciplinary risk assessment and working. Risk Screening Tool and PQC assessments Identification of risk at daily handover and safety briefs on commencement of duty Therapeutic and recreational activities provision with 1:1 staff: patient engagement Staff training in management of violence and aggression - MAPA appropriate level to area of work Update search Procedure re Restricted access to sharps and harmful objects based on individual clinical risk assessment Procedure for Search of Patients, their Belongings and the Environment of Care within Adult Mental Health and Learning Disability Inpatient Wards Observation Policy & Procedure including 15 minute visual health and wellbeing patient checks Senior management review and approval of minor works requests, and escalation for approval of major capital works Policy for the management of Violence and Aggression and Use of Restraint Incidents recording and management on Datix as per Trust policy amd all ligature related incidents to be reviewed at the Acute MHS governance group re trend analysis. CCTV for incident review Alarm systems Personal emergency alarm checking by individual staff; staff to check their department sensors weekly; prescribed system for maintenance and routine testing of these systems/alarms (Estates responsibility) Access to Emergency Services and emergency equipment, including Hoffman's Knives and master keys. Clinical governance arrangements. All ligature incidents to be reviewed at the Unit	Medium		william delaney	18/05/2021
Acute MHS	The risk of Dementia patients being cared for in Willows ward	"Risk of inadvertent harm to Dementia patients within Bluestone Unit Patients who have a diagnosis of dementia and who are admitted to Bluestone because of a lack of dementia beds availability present with an increased risk of harm as admission wards have a mixed presentation of patients and challenges. Risk to the organisation There may be complaints and litigation to the Trust for injury/serious injury to patients. This is a foreseeable risk in light of individuals with dementia being cared for in adult acute mental health admission wards. Description of Risk: (Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider) There has been a catastrophic event in Gillis/Dementia assessment Unit in which the death of a service user occurred as a result of push/fall on one service user by another service user. Gillis is an identified dementia assessment unit but with increased pressure on the availability of dementia beds, individuals with dementia are being admitted to Bluestone Unit. Bluestone is a busy and dynamic 74 bedded which is for the admission of individuals with a mental illness but not dementia. Individuals with dementia who are admitted to Bluestone present an increased and foreseeable risk of unforeseeable events which may include falls, increased risk of choking, unpredictable aggression towards staff and others, risk of aggression towards themselves"	• Individuals with dementia can be cared for on continuous observations (1:1 or 2:1) dependant on their presentation. • PQC clinical risk assessments • Dementia patients to be cared for only in Willows ward within Bluestone Unit • Trust Observation Policy & Procedures • Incidents to be recorded on Datix as per Trust policy • Trend analysis of incidents of falls • CCTV for incident review • Emergency alarm system with a prescribed system for maintenance and routine testing of these systems/alarms. • First and second on call medical staff • Falls care plans • Daily handover and safety brief on commencement of duty for all staff • Ongoing review of SGVA protection/management plans • Therapeutic and recreational activities • Availability of profiling beds • Manual handling training for staff • The ward environment has controlled access and egress • Mapa training for staff • Prescribed medications are regularly reviewed • Occupational therapy input at • Individualised MDT care plan • The daily bed state is completed to identify the number of Gillis patients admitted to Bluestone • Policy for the management of Violence and Aggression and Use of Restraint Regular interface meetings have now commenced between Gillis and Bluestone to reduce the risk of dementia patients in Willows ward	High	There is a lack of specialist MDT staff in Willows, Gillis to provide some input. There have been a number of interface meetings to attempt to address the issues of bed availability and inappropriate placements	william delaney	18/05/2021

MHS	OP Review and PMHC Waiting Lists MHS	Demand outweighs capacity across PMHCT Risk of being unable to meet set access times for service users due to reduced capacity of staff. Risk of harm to service users due to lengthy wait times for both urgent and routine appts.	PMHC have 6.8wte vacant 2.4 WTE have been brought in through nurse bank to assist across teams. 2 nurse posts successfully recruited due to commence April 2021. Internal and External recruitment is ongoing. Bank and agency staff continue to be sought Review of staff caseload and capacity within same to provide additional assessment slots Team Leads to refer as appropriate, staff to Occupational Health for further support Regular supervision, team talk and time out for teams HOS informed and issues raised at PMHC Governance. AYIPP JD awaiting sign off by TU – currently with AD HR. Consultant Psychiatrist supporting triage to review urgent requests and offer alternative advice if appropriate. Team leads reviewing availability of capacity in other localities to ensure no geographical disadvantage Wait list reviewed with hub coordinator around suitable support from hub OT developing group as means of throughput	High	Longest wait 33weeks with appt booked Recruitment ongoing for N&M and C&B – interviews scheduled Apr 2021 Bank and Agency exploration continues 0.2 recruited for C&B area Breach letters sent to longest waiters Priority booking of urgent referrals Listen & Learn sessions set up with AD and HOS Feedback gathered from staff on improvement ideas Interface meeting with CAT and ILS set up Wait list reviewed with hub coordinator around suitable support from hub Exploring groups with RC. AS per MHD GOv Group 18/5/21 - Workshop to be organised to focus on PMHC and OP Review Waiting list issues.	Head of [illegible] MH&LD	18/05/2021

PMHC Governance Group – Desk-Top Client

AGENDA – 11th May 2021 – Chair Dr J O'Neill

1.0 Apologies
2.0 Action Sheet from the previous meeting
3.0 PMHC Multi-professional/Clinical & Social Care Audits
4.0 Issues generated by MHD Directorate/MHS Divisional Governance Group
5.0 Professional Governance Updates to include:
  5.1 Compliance with Professional/Regulatory Bodies Standards
  5.2 Delegated Statutory Functions
  5.3 Workforce Standards, Training, Education & Development
  5.4 Referrals to Professional Regulatory Bodies
6.0 Updates to include:
  6.1 Issues arising from Adverse Incident & Complaints Activity
  6.2 Progress Update on the Implementation of Recommendations from SAI reports and other relevant internal and external reports
  6.3 Risks/concerns escalated to the PMHC Governance Group
  6.4 Implementation of Clinical & social Care Standards and Guidelines
  6.5 Overview of Progress against Medical Device/Patient Safety/Facility/Alerts
7.0 PMHC Risk Register
8.0 Triage Issues/Interfaces
9.0 Any Other Business –

Dr O McCambridge -

- what step 2 resources are available to refer to; can we get info on these e.g. work that each service carries out
- Is there a mechanism for step up and down between step 2 and 3
- what type of referrals are PMHC taking now and what are CBT taking now
- resource centres: which step is this work aimed at
- transfer between addictions and PMHC and CBT (e.g. holding cases open once treatment complete with addiction service.

Tony Black –

- Learning from Medication Incidents October – December 2020.

10.0 Date and Venue of Next Meeting – 14th September 2021

Southern Health and Social Care Trust

DIRECTORATE OF MENTAL HEALTH & DISABILITY
DIRECTORATE GOVERNANCE GROUP

Meeting on Tuesday 21st September 2021 at 3.00pm
VIA ZOOM

Join Zoom Meeting

Irrelevant Information Redacted by the USI

Meeting ID: Irrelevant Information Redacted by the USI

Passcode: Irrelevant Information

AGENDA

1.0 Apologies:

2.0 Notes of Previous Meeting

Notes of MHD Gov Group Aug 2021.pdf

3.0 Follow-up Discussion re future role, function and frequency of this governance group - Barney

4.0 Issues generated by SMT Governance / Governance Committee / Audit Committee / Policy Scrutiny Committee / Fire Safety Committee /Patient & Client Experience Committee / Internal Audit Forum

- Infection Prevention & Control

5.0 Dorsy Oversight – Escalation of Issues by Exception

6.0 Granville Oversight – Escalation of Issues by Exception

7.0 Directorate Risk Register / Risk Management

- ASW Risk to be added to DRR.

ASW Risk Assmt
June 2021 (2).doc

- MCA Risk updated.

MCA Risk Ax
updated 130921.doc

8.0 Professional Governance Updates by exception.

- AHP
- Social Work
- Nursing
- Medical
- Psychology

7.0 Safeguarding Update - Deborah

8.0 Updates from MHD Divisional Risk & Governance Fora by exception – Assistant Directors

9.0 Complaints Update Incl NIPSO cases

10.0 Confidential Section by exception updates

SAIs:

- ID85765 [redacted]
- ID110541 [redacted]
- ID112242 [redacted]
- ID118422 ([redacted]
- ID120173 ([redacted]
- ID94571 [redacted])
- ID127058 [redacted]
- ID69712 [redacted]
- ID118414 [redacted]

11.0 Any Other Business

Southern Health and Social Care Trust

Directorate of Mental Health & Disability Services Notes of SMG Risk and Governance Meeting held on Meeting on Tuesday 17th August 2021 at 3.00pm VIA ZOOM

PRESENT: Dr Maria O'Kane, Barney McNeany, Jan McGall, Jenny Johnston, Deborah Hanlon Kathy Lavery, Dr Pat McMahon, John McEntee, Tony Black Dr Ivor Crothers, Joe Walker,
Apologies: Grace Hamilton, Dawn Ferguson, Dr Arun Subramanian, Lynn Woolsey, Carmel Harney

	Issue	Action(s) & Person(s) Responsible
1.	**Role, function and frequency of this governance group.** Given that there is now a weekly governance debrief in place in addition to weekly huddle, CLT meetings etc the group considered the role of the directorate level governance group. Maria referred to the WHO Safety, Quality and Experience model and agreed to source same. Maria also referenced the SQE strand which is part of the overall strategic direction/corporate plan discussions at Trust SMT. Barney displayed a scorecard and agreed to review the group's function and produce a proposed role/function for the next meeting with a view to promoting a culture of learning from experience and Quality improvement. The benefits of improving a sense of psychological safety for staff were also discussed. Actions: • Tony to send to Barney current ToR for this group and SQE graphic he has to inform his review of this group/s role/function. • Barney to produce draft paper by next meeting. • The group discussed the potential for implementing the Greatix and/or Improve Apps. Maria to ask Cons Anaesthetist to participate in some of these meetings with view to piloting Greatix. • Maria to source and send to group "Learning From Experience" paper written by Fiona Davidson.	Barney/Maria/Tony
2.	**MHD Directorate Risk Register** Meeting was held with AD's regarding the current risks listed on the DRR which will be revised to reflect those amendments to the DRR.	ADs
3.	**Confidential/Sharing Section updates.** • ID94571 Personal Information redacted by – Closure letters to be issue. TB to speak with Maria. Family advised to go to NIPSO if they wish to do so. • ID69712 Personal Information redacted by the – meeting to be arranged with BHSCT (most likely October)/ Action plan updated and RAG status of recs returned to PHA.	ADs
4.	**AOB** None	
	Date of next meeting Tuesday 21/09/2021 – 3.00pm via Zoom.	

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SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM		Risk ID No
Directorate: Cross Directorate	Facility/Department/Team: Mental Health	Date: 4th June 2021
Where is this being carried out? (e.g. Trust premises/home of client/staff/ private nursing home etc) SHSCT	Objective(s) i.e. Corporate, Legislative requirements etc.: Management of the Trust's statutory responsibilities under the Mental Health (NI) Order 1986 specifically in relation to Approved Social Worker assessments for detention.	

Risk Title: (Threat to achievement of objective)
MH (NI) Order 1986 Article 115. (1)

Outline the potential for harm: *(Consider injury to client, staff, litigation, etc)*

Risk to service users

Insufficient numbers of Approved Social Worker availability to provide a robust rota covering emergency assessments for detention under the MHO would leave acutely unwell and potentially mentally distressed patients at risk of harm to themselves or others in the community.

Harm to Trust
Failure to have a fully functioning ASW service meeting emergency MHO requirements will introduce a risk of litigation against the Trust if they fail to meet their statutory requirements under Article 115 (1)
Risk of complaint or litigation from families & carers of patients negatively impacted by the lack of compulsory admission to hospital.
Risk to internal relationships between mental health services with other responsibilities also involved in cases.
Risk of direct harm to the patient or others potentially leading to forensic involvement and avoidable complications would contribute to serious adverse media/reputational damage.

Description of Risk:
(Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider)

The MHO Art. 115 require all Trusts including SHSCT to “appoint a sufficient number of approved social workers for the purpose of discharging the functions conferred on them by this Order”.

Decreasing ASW availability is leaving the currently operating MHO rota vulnerable to multiple gaps. Absence rates have been high, between 25-33% since March 2020, but recently absences have increased again and we are currently operating the rota with 50% of the trusts appointed ASW’s.

The challenges to the Trust include:

- Maintaining a safe ASW rota
- Staff capacity to support the rota at short notice (all teams are under pressure with staff vacancies / templated services / MCA)
- 10 ASWs are also managers who are not available to provide additional support due to the demands within their management roles – no easement available for this cohort (all support is good will)
- DAPO demands on many of our ASWs ie 20 (54%) of our ASWs also undertake the DAPO role
- Operational management responsibilities v’s professional responsibilities. Not all operational managers understand the critical need to maintain the rota (someone else’s problem)
- The ASW service is a Trust wide responsibility however very limited support from OPPC / CYPS.
- Increase demands on the ASW role with the introduction of MCA. Best practice advises that MCA extensions should be carried out be an ASW- the Southern trust are unable to achieve this. MCA Trust Panels must include an ASW, however this role is currently being staffed by retired / bank ASWs. This is not a sustainable model going forward. Core ASWs do not have capacity within their current workload.
- No authority for the ASW Lead to direct an ASW to step up to support the Rota when needed.

Summary of current control measures: (Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive).

- Release of ASW's from MCA trust panels rota to support the MHO rota
- Increase in number of days on rota and contingency for certain ASW's
- Regular emails circulated requesting additional support and to cover absences.
- ASW training has been prioritised
- Job descriptions within a number of MH teams have included a commitment to undertake the ASW programme ie Support + Recovery / Acute MH.
  2 Lapsed ASWs are being supported to reregistered and undertake shadowing asap.

Are these controls: (a) Effective or (b) **Require Further Action** *(if [b], complete Action Plan)*

Please list control measures considered but discounted and why (where appropriate):

- Use of retired staff – those available are working with the MCA team and do not have capacity to undertake ASW rota duties.
- ASW agency staff – there are currently no agency ASWs , however this option will be kept on the agenda.

Initial Assessment of Risk	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating
	ALMOST CERTAIN	MAJOR	EXTREME

ACTION PLAN OF FURTHER CONTROL MEASURES REQUIRED (risk treatment):

Action/Treatment	Action Lead	Start Date	Target Date	Progress/Review Date
All available ASW's to increase their rota commitment by an additional day/month (= 20 days which would considerably bolster the rota) Requires core team support for reduction of caseloads in recognition of extra responsibilities.	Dir lead SW / ASW Lead / HOS			
Release of ASW availability from within existing resources. A small team of ASW's operating at 50% ASW would provide additional MHO rota cover	For consideration			
Consider additional payment for ASWs with management responsibility who cannot be afforded any easement	for consideration			
Improve Communication with Core Team line managers	ASW LEAD	Immedia te		
Communication with ASW's	ASW LEAD	Ongoing		
Continue to promote the ASW programme particularly across OPPC / CYPS				

Date of first review (to be determined by risk rating)			
Predicted Risk Assessment once all control measures are implemented. (Residual Risk rating)	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating V Low(Green), Low(Yellow), Moderate (Amber) or High(Red)
	POSSIBLE	MAJOR	HIGH

ANTICIPATED RESOURCE IMPLICATIONS (details and cost)				£
To support ASW caseload easement backfill would be required				
Funding identified?	**Yes**	**No**	**N/A**	**Source of funding**

Action	Date	By Whom (PRINT & SIGN)

Risk Assessor(s)		
Name (PRINT & SIGN) ANN MOIR	Designation ASW LEAD	Date 8.6.21
Manager		
Name (PRINT & SIGN) KATHY LAVERY	Designation DIR LEAD SW	Date 8.6.21

MONITORING			
Summary of current position			
Current Risk Rating	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)
	ALMOST CERTAIN	MAJOR	EXTREME
Name (PRINT & SIGN)	Designation		Date of Review

Summary of current position			
Initial Assessment of Risk	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating
	ALMOST CERTAIN	MAJOR	EXTREME
Name (PRINT & SIGN)	Designation		Date of Review

Summary of current position			
Current Risk Rating	**Likelihood**	Consequence/ **Impact**	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)
Name (PRINT & SIGN)	Designation		Date of Review

SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM		Risk ID No
Directorate: Cross Directorate	Facility/Department/Team: Acute/ Community and Corporate Services	Date: Commenced October 2019 **Last updated 04 May 2021(in red)** **Last updated 31st May 2021(in blue)**
Where is this being carried out? (e.g. Trust premises/home of client/staff/ private nursing home etc) SHSCT		Objective(s) i.e. Corporate, Legislative requirements etc.: Implementation of the Mental Capacity Act (2016) Phase 1 Provide safe and effective care

Risk Title: (Threat to achievement of objective)

Compliance and implementation of MCA (2016) Phase 1
Outline the potential for harm: *(Consider injury to client, staff, litigation, etc)*

Risk to service users
Insufficient numbers of appropriately staff trained to carry out MCA functions across Directorates including training to participate on Trust Panels, medical staff to undertake Medical Reports in hospitals and completing Short Term Detention Authorisations (STDA's) This would lead to increased delayed hospital discharges due to an inability to discharge patients from hospital when STDA's are required. Controls to safely manage/ care for service users in acute/ community settings will be negatively impacted upon by failure to implement MCA. Update - 3112 staff trained however challenges remain that include staff understanding of processes, complexity of work and time to complete Forms. Trainers provide support workshops. Regional review of training underway.
Update31st May 2021 Regional strategy team in place to review training including refresher
Local Enhanced Service- no agreement with GP's who are required to undertake Medical Reports in community will result in the process failing. Update - One GP in SHSCT signed up to LES. This is a small rural practice therefore impact limited. Update 31st May 2021- no change- no interest from GP's most involved in vaccine programme.

Harm to Trust
Risk of litigation against the Trust if procedures are not fully implemented and adhered to.
Financial harm to Trust if IPT scoping exercises are not accurate.
Failure of a fully functioning service will lead to a failure to comply with this legislation.
Risk of complaint for failure to adhere to MCA implementation
After one year post implementation risk of staff being prosecuted if none adherence to DoLS processes. Update- letter from DLS dated 24/4/21 31st May 2021 agreement regionally for emergency provisions to be used.
Adverse media/reputational damage

Description of Risk:
(Describe the risk being assessed identifying who is at risk e.g. patient/staff/other care provider)
The DOH requires all Trusts including SHSCT to partially implement the Mental Capacity Act (NI) (2016) for the purpose of providing a statutory framework for the Deprivation of Liberty from 1st October 2019, postponed until Monday 2nd December 2019 with full implementation by October 2020. A further extension was granted from 2/12/19 to 31/05/2021.

Letter requesting further extension drafted and sent to Medical Director on 27th April 2021. 31st May 2021 Extension not agreed by DOH

The challenges to the Trust include:
By 2nd December 2019 SHSCT must have sufficient numbers of appropriate staff identified, trained with processes and administrative structures in place to ensure legal compliance in situations where the care of a patient requiring a DoLS is in place. If these arrangements are not in place and working efficiently there is a risk to the effective delivery of care including SHSCT's ability to treat patients in hospital when STDA's are required and to discharge from hospital where a Trust Panel Authorisation is required.
Update- shortage of sessional doctors to complete Form 6's, extensions and for Trust Panels. Ongoing regional HSC recruitment ongoing with little uptake. Appointment made for temporary 6 month consultant position with 2nd position re-advertised. SHSCT awaits successful applicant's release to commence the post.31st May 2021- slow progress with doctors applying for sessional posts. Appointment pending for 1 temp post

Currently there is variation in the funding predictions as calculated by DOH and Trust in order to cover the full range of costs including those which fall outside of agreed core costs.
At present there is an insufficient admin resource/ system and inadequate IT system in place to support MCA DoLS implementation. Update- Additional admin requested to support DoLS work such

Summary of current control measures: (Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive).

- Arrange for assessments of mental capacity, best interests and medical examinations and reports to be undertaken from 2nd December2019. Update- Work ongoing with current team at full capacity. 31-5-2021Priorisiting already busy caseloads combined with Covid implications slowing proress

- Multidisciplinary bank established within OPPC for staff to undertake DoLS work 31-5-2021 Covid in nursing homes delaying 1. Face to face access to patients- virtual now an option but some challenges with wi-fi 2. Staff availability to undertake this work limited due to same pool

- Staff offered additional hours in other Programmes of Care to complete this work.31-5-2021 This option has received a mixed response. Small pool of staff available so limited capacity

- Operate multi-disciplinary panels (4 days weekly) for the approval of applications for a DoLS from 2nd December 2019. Contingency for 2nd virtual panel with anticipated increase in DoLS applications by 31 May 2021.31-5-2021 No need to step panels up to two per week. These are taking place 3 days per week and 4 alternate weeks via virtual and working well.

- Put in place arrangements for short-term detentions authorisations (STDA) from 2nd December 2019. Since March 2021 STDA's have not been involved in new safeguarding work so as to increase capacity for DoLS in hospital. 31-5-2021 One of 2 seconded STDAs has returned to another post. High level of sick leave within this service and at wider level within acute restricting number of STDA's taking place.

- Put in place administrative and governance infrastructure to support the operation of STDA's, Trust Panels; monitor forms and processes; and report on activity as required from 2nd December 2019. As part of covid contingency an emergency protocol for referrals was set up. This in now in place with a central email monitored on a daily rota basis. DOH monthly assurance template completed.31-5-2021 Good progress made initially to develop service and build knowledge base the challenges outlined above are restricting opportunities for staff to identify STDA's on the acute wards. Pressures on ward staff include time constraints, increase in Covid and lack of professional responsibility appear to be key contributors to slow progress.

- Cover expenses for the provision of Medical Reports by authorised medical practitioners that are not directly employed by the SHSCT (generally patients GP). Sessional work ongoing to support this work in absence of GPs via MCA Budget. 31-5-2021 Ongoing HSC Recruit drive to increase number of doctors available to undertake Form 6's. High cost attached not sustainable but lack of other options.

- Release key staff to complete the training required to authorise them to perform legal duties and functions (including; complete formal assessments of capacity; make Best Interests determinations; provide prescribed medical reports; make application to the Trust panel; sit as a member of a Trust Panel) Currently 2 trainers involved on a part time basis to support DoLS. 31-5-2021arrangement remains in place with emphasis on completion of forms via range of training sessions, coaching, MD workshops, exemplars etc Training being reviewed post 18 months implementation to reflect learning experiences.

DOH directly commissioned training to enable Trust staff and others to perform required functions. Trusts now have responsibility for this training. Regional review of this training ongoing.31-5-2021 Regional training strategy group now established

DOH asked all Trusts to identify key staff to be seconded for 16 weeks (until 14/12/19) to complete a Train the Trainers programme for implementation within the Trust to provide training in the longer term. This is ongoing with a SHSCT Training Strategy being developed.

Initial Assessment of Risk	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating
	ALMOST CERTAIN	MAJOR	EXTREME

ACTION PLAN OF FURTHER CONTROL MEASURES REQUIRED (risk treatment):

Action/Treatment	Action Lead	**Start Date**	Target Date	Progress/Review Date
Investment to enable SHSCT to develop arrangements and an infrastructure to support the discharge of their statutory duties under MCA. IPT to be finalised for 2021/2022	Angela Hawkins Dean Faloon Paula Vennard FT Group Kathy Lavery Claire Kelly Kathy Lavery Dean Faloon Angela Hawkins	April 2021	31 May 21 31-8-21	IPT Calculate funding to cover the full range of costs including costs which fall outside of agreed core costs. 31-8-2021 IPT submitted for 21/22
Functioning IT System to support implementation	Mark Toal with Task Finish Group	1-10-2019	2-12-2019	COMPLETED
Admin Team to support acute/ non-acute/ ICS and Trust Panels in monitoring timelines and processes to ensure all Forms are completed on time and to standards Additional scoping given extensions and rule 6 statements	Angela Hawkins Kathy Lavery Joyce Wylie	1-10-2019	31 May 21	B6 Admin Project manager- appointed- temp B4 record support staff x 4 EOI in system. Recruitment to permanent basis. 31-5-2021Recruitment ongoing Extensions and outstanding legacy DoLS placing significant pressure on all aspects of community and admin teams. High level of sickness and self-isolation impacting on capacity in all teams to undertake this work
Recruitment of medical staff (sessional posts x 4)	Angela Hawkins Aishling Diamond	7-11-2019	Ongoing	Sessional posts on HSC site and MDJ. Rolling advert 31-5-2021 Sessional doctors now increased to 10 but limited availability restricting capacity to get Form 6's completed
Engagement with voluntary/ independent sector.	Angela Hawkins/ Aileen Mulligan/ Roisin Harkin Fitzpatrick	1-10-2019	Ongoing	ECHO Project- agenda item for nursing homes Independent Sector providers information session 31-5-2021 quarterly contracts meetings

Communication with staff	Angela Hawkins/ Comms Team/ Joyce Wylie	8-11-2019	Ongoing	Communication via updates in Southern I Communication with public and staff via Sharepoint and social media outlets. Two weekly TFGroup meetings 31-5-2021 Highlighted as a challenge. Use of various tools inc SouthernI, TF Group, Sharepoint and global email
Staff to be trained to ensure participation at appropriate levels of the DoLS process incl sufficient medical staff trained to sit on Trust panels and sufficient medical staff to complete medical examinations	Medical directorate OPPC MHD CYP	1-9-2019	Ongoing	L3&L4 now e learning MCA training to become mandatory including doctors. Training strategy in progress. 31-5-2021 challenge during pandemic- ongoing engagement with medical senior staff
Failure to identify all patients and clients falling within DoLS criteria.	All Directorates/ Angela Hawkins	1/9/2019	Ongoing	Scoping completed. DoLS work ongoing in all POCs. 31-5-2201- scoping using DoLS consideration flowchart to be utilised to guide staff when applying criteria

Date of first review (to be determined by risk rating)			Weekly
Predicted Risk Assessment once all control measures are implemented. (Residual Risk rating)	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)
	POSSIBLE	MAJOR	HIGH

ANTICIPATED RESOURCE IMPLICATIONS (details and cost)	£
IPT update in progress. Financial investment which has been identified as required is anticipated to be massively in excess to that identified in IPT Further financial investment required	TBA

Funding identified?	**Yes**	**No**	**N/A**	**Source of funding**
	x			**DOH**

Action	Date	By Whom (PRINT & SIGN)
To be managed by Facility/Department Team Manager/Leader	11-11-19	
Referred to Divisional Risk Register		

Referred to Directorate Risk Register	11-11-19	
Shared with another Team/Directorate Risk Committee for information/consideration		
Referred to Trust Risk Management Forum		
Referred to Corporate Risk Register	2019	
Referred to Board Assurance Framework		

Risk Assessor(s)		
Name (PRINT & SIGN) Angela Hawkins	Designation MCA Lead	Date 11-11-2019 31-5-2021
Manager		
Name (PRINT & SIGN)	Designation	Date

MONITORING
Summary of current position

Updated list of recently recruited doctors for MCA Medical Reports Form 6's

Update list of Bank ASW's for Trust Panels. TP's

Trust Panels TP's established twice weekly.

August - Action Plan post Covid shared with DOH for extension to 31-05-2021 to cover the period of unlawful liability. Legacy reviews and extensions have been progressing with negotiation on a home by home basis ensuring compliance with PPE/social distancing/remote working measures.

Further supported training sessions ongoing with frontline staff and delivered by Trust staff (DOH CEC trainers)

August 2020 – 2 Two Specialist workshops delivered by a specialist external trainer for TP Trust Panel members.

Training records & total number of staff trained to each level – 2, 3, 4A, 4B (no longer required) & 5.

Training programmes/records. Non CEC trained must print off once completed (doctors send to MCA Administration and to re- validation). Other staff print on-line certificate and record as part of their Personal Development Plan (PDP) and share copy with line manager.

Task and Finish Group Papers, Minutes & Action Log shared as appropriate. Post Covid lock down this group has resumed.

Staff communication updates provided via Sharepoint & Southern-I

UPDATE PROVIDED TO CORP RISK REG. - Aug 2020

Current Risk Rating	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)
	ALMOST CERTAIN	MAJOR	EXTREME

Name (PRINT & SIGN)	Designation	Date of Review
Angela Hawkins	MCA Lead	11/08/2020

Summary of current position

UPDATE – MAY 2021

Ongoing demands of MCA work, impact of Covid and limited staff availability has resulted in SHSCT being unable to ensure full compliance with 31st May deadline as set out in DOH correspondence November 2020. Approximately 1100 legacy DoLS have yet to be completed. Trust at significant risk of criminal liability post 31st May.

Contingency Plans to date

1. ASW's stood down from MCA panels to undertake core work and support ASW Rota and support DoLS work with their core teams (panels are populated by retired ASWs and bank staff) NB; Same retired staff are also supporting CHST.

2. All teams offered OT/ additional hours. OPPC global email to request support. All staff offered flexible working arrangements.

3. OPPC released 3 staff from core duties and redeployed senior CHST practitioner to co-ordinate, allocate work and collate rotas for Nursing Home DoLS

4. 0.5 WTE secured from Enhanced division release of further 1.5wte to be progressed.

5. Possible release of 2 WTE from Access & Information

6. OPPC have secured limited admin assistant to work with CHST. Coordinator to populate Bank rota and collate Forms.

7. EOI distributed to Nursing Homes to scope support for completion of Form 1's

8. MCA bank staff supporting CHST extensions and Rule 6 statements.

9. Continue to recruit doctors for sessional work (interest limited). Ongoing HSCNI Recruitment for sessional posts.

10. Temporary FT doctor appointed to undertake Form 6's and Trust panels. Date extended as second post to be filled as yet. Appointment delayed pending back fill.

11. Teams to consider tasks to stand down to focus on MCA work. Consideration to be given to additional resources going forward outside of current operational pressures.

12. Consideration to be given to the administration challenges of all of the above and in particular the management of increasing Rule 6 and extensions reports going forward.

13. Redeployed ASW undertaking Extensions on FT basis until recently. Work now undertaken by MCA Bank and community teams.

Initial Assessment of Risk	Likelihood e.g. Likely	Consequence/ Impact e.g. Moderate	Risk Rating
	ALMOST CERTAIN	MAJOR	EXTREME

Name (PRINT & SIGN)	Designation	Date of Review
Angela Hawkins	MCA coordinator	09 May 2021

Summary of current position

Current Risk Rating	**Likelihood**	Consequence/ **Impact**	Risk Rating VLow(Green), Low(Yellow), Moderate (Amber) or High(Red)

Name (PRINT & SIGN)	Designation	Date of Review

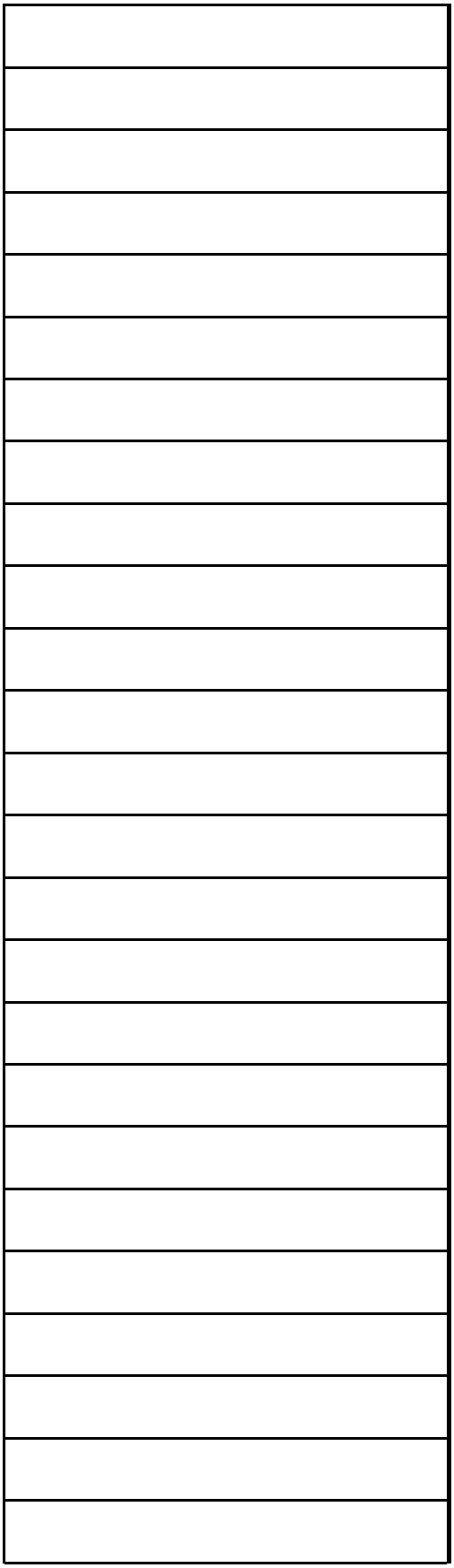
MHD Governance Meetings 2022

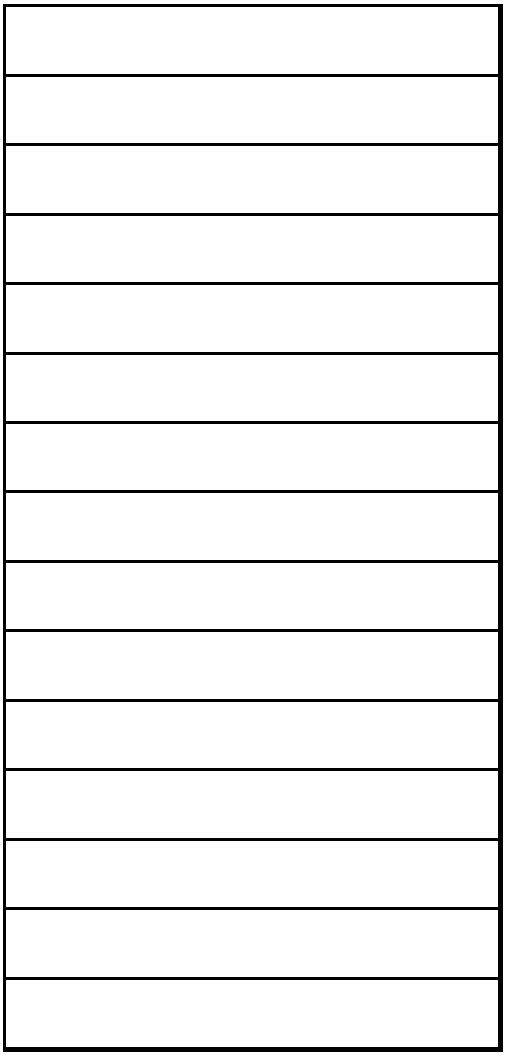
DATE	MEETING
07 Jan 2022	Dorsey Gov Meeting
10 Jan 2022	Disability Group Governance
11 Jan 2022	PMHC Governance
12 Jan 2022	Acute MHS (Bluestone Inpatients)
19 Jan 2022	Support & Recovery Governance
26 Jan 2022	Acute MHS (overarching) Governance
04 Feb 2022	Dorsey Gov Meeting
09 Feb 2022	Acute MHS (Bluestone Inpatients)
21 Feb 2022	Disability Group Governance
21 Feb 2022	Unscheduled Care Governance
23 Feb 2022	Acute MHS (overarching) Governance
04 Mar 2022	Dorsey Gov Meeting
08 Mar 2022	PMHC Governance
09 Mar 2022	Acute MHS (Bluestone Inpatients)
16 Mar 2022	Support & Recovery Governance
21 Mar 2022	Memory Service Governance
30 Mar 2022	Acute MHS (overarching) Governance
01 Apr 2022	Dorsey Gov Meeting
04 Apr 2022	Disability Group Governance
13 Apr 2022	Acute MHS (Bluestone Inpatients)
18 Apr 2022	Unscheduled Care Governance
27 Apr 2022	Acute MHS (overarching) Governance
06 May 2022	Dorsey Gov Meeting

10 May 2022	PMHC Governance
11 May 2022	Acute MHS (Bluestone Inpatients)
18 May 2022	Support & Recovery Governance
23 May 2022	Disability Group Governance
25 May 2022	Acute MHS (overarching) Governance
03 Jun 2022	Dorsey Gov Meeting
08 Jun 2022	Acute MHS (Bluestone Inpatients)
20 Jun 2022	Memory Service Governance
20 Jun 2022	Unscheduled Care Governance
29 Jun 2022	Acute MHS (overarching) Governance
01 Jul 2022	Dorsey Gov Meeting
04 Jul 2022	Disability Group Governance
13 Jul 2022	Acute MHS (Bluestone Inpatients)
20 Jul 2022	Support & Recovery Governance
27 Jul 2022	Acute MHS (overarching) Governance
05 Aug 2022	Dorsey Gov Meeting
10 Aug 2022	Acute MHS (Bluestone Inpatients)
15 Aug 2022	Unscheduled Care Governance
15 Aug 2022	Disability Group Governance
31 Aug 2022	Acute MHS (overarching) Governance
02 Sep 2022	Dorsey Gov Meeting
13 Sep 2022	PMHC Governance
14 Sep 2022	Acute MHS (Bluestone Inpatients)
19 Sep 2022	Memory Service Governance
21 Sep 2022	Support & Recovery Governance

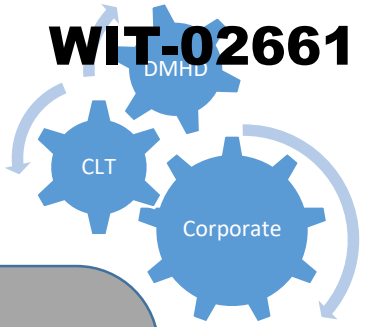
26 Sep 2022	Disability Group Governance
28 Sep 2022	Acute MHS (overarching) Governance
07 Oct 2022	Dorsey Gov Meeting
12 Oct 2022	Acute MHS (Bluestone Inpatients)
17 Oct 2022	Unscheduled Care Governance
26 Oct 2022	Acute MHS (overarching) Governance
04 Nov 2022	Dorsey Gov Meeting
08 Nov 2022	PMHC Governance
09 Nov 2022	Acute MHS (Bluestone Inpatients)
16 Nov 2022	Support & Recovery Governance
30 Nov 2022	Acute MHS (overarching) Governance
02 Dec 2022	Dorsey Gov Meeting
12 Dec 2022	Memory Service Governance
14 Dec 2022	Acute MHS (Bluestone Inpatients)
19 Dec 2022	Unscheduled Care Governance

Who does the report





SHSCT MHD Monthly Accountability Review



- Individual Scorecard updates from Assistant Directors and Professional Leads
- Deep dive for one objective on a rotating basis with a 2 page brief prior to meeting to aid discussion
- Preparation for Accountability meetings with Cx, TB and HSCB meetings such as DSF

- Masterclass type interventions asking SCiL Trained leaders and those with QI fellowship level to assist on a review of one project per month
- Poster presentations from Ground Floor"
- Annual plan for QI at two consecutive meetings in January and February

- Regular meetings with the ops managers/team leaders/consultant staff
- Culture" training events
- Recognition events for specific areas based on good performance and / or RQIA reports to advise scale and spread

- A monthly run through of performance data hosted by Lesley Leeman seeking updates on plans and service developments
- Ad hoc queries (of which there are many) completed in real time to include thorny consultations
- Outstanding business cases and Post implementation evaluations chaired by P&R

Southern Health and Social Care Trust

Quality Care - for you, with you

MHD Standards & Guidelines / Audit Group

Terms of Reference – May 2014 (updated August 2016 & July 2019, Sept 2020, Feb 2021, Oct 2021/Nov 2021)

Introduction

Standards and Guidelines come from a variety of sources and are received by a number of regional bodies for regional endorsement. Such external agencies include the HSC Board, Public Health Agency (PHA) and Safety & Quality Unit at the DHSSPS. These agencies disseminate these standards and guidelines to the HSC Trust's for action and with a requirement that an assurance will be provided to confirm that the required recommendations have been embedded within local practice.

In recent years the volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. As a consequence regional discussions have been undertaken to agree the most effective and efficient process for disseminating, implementing and assuring these standards and guidelines. The MHD Standards & Guidelines Group was created to support this process in MHD.

Aim

The aim of this group is to provide a forum to ensure that MHD has in place a systematic and integrated approach for the implementation, monitoring and assurance of standards and guidelines and the identification of audit priorities to provide assurances in relation to the implementation of S&G's.

Scope

MHD Standards & Guidelines Group will review all standards and guidelines issued to Directorates. This may include for example:

- Chief medical Officer Circulars
- CaNNI reports
- Confidential Enquiry reports
- GAIN reports
- NPSA alerts
- NICE (Clinical Guidelines and Technology Appraisals)
- DHSS Policy Circulars – S&Q Learning Communications
- PHA/HSCB Circulars

- RQIA reports

Responsibilities & Activities

- To ensure that all regionally endorsed standards and guidelines are reviewed prioritised in line with other competing governance and operational requirements.

- Where indicated, identify suitable 'Change Leader(s)' and ensure the communication processes are in place to ensure that the required actions are taken forward within a co-ordinated and time managed process.

- Identify audit priorities to provide assurances in relation to the implementation of S&G's.

- Review and update the MHD action plan / progress report which is submitted to Lead Director / SMT for approval prior to issue to HSCB

- Ensure that there are record keeping processes in place to provide written assurances that processes are embedded within MHD and appropriate action is being taken.

- Ensure that there are effective escalation processes in place should concerns be raised about MHD's ability to achieve full compliance with each standard and guideline.

- Provide and update on the progress of implementation of S&G's to the MHD Governance Group and MHD Director.

Group Constitution:

The Trust Standards & Guidelines Prioritisation and Risk Review Group will be composed of the following members:

- Dr Pat McMahon – Associate Medical Director
- Dr Arun Subramanian – Clinical Director Learning Disability
- Dr Jo Minay – Clinical Director Mental Health
- Stephanie Wethers – HoS Primary Mental Health Care
- Adrian Corrigan – HoS Support & Recovery
- William Delaney – HoS Inpatients LD and MHS
- Lena Canavan – HoS Disability Services (Sensory Impairment)
- Joe Walker - Nurse Lead MHD
- Karen McCann – AHP Lead MHD
- Kathy Lavery – SW Lead MHD
- Eoin McAnuff – S&G/Audit/QI Manager MHD

Invitations may be extended to other Trust members or outside agencies if deemed appropriate by the group members and will be facilitated by the chairperson.

Responsibilities of Group Members

Each member will be responsible for reviewing the issued standards and guidelines and for promoting and sharing the information within their own professional group/service and for representing the view of those groups as appropriate.

Quorum & Meeting Frequency

A meeting will be quorate if five members are present. If members cannot attend, they will be expected to send an appropriate deputy.
The group will meet on a monthly basis and to facilitate diary management will be held directly after each MHS Divisional Governance Group (unless otherwise indicated).

Review of the Terms of Reference

The terms of reference will be reviewed on an annual basis or earlier if required.

Southern Health and Social Care Trust

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DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClements

ACUTE DIRECTORATE GOVERNANCE MEETING

Date: Monday 6th December 2021
Venue: via zoom
2pm

AGENDA

1.0	Apologies: Ronan Carroll Attendance: Melanie McClements, Anne McVey, Caroline Keown, Barry Conway, Tracey Boyce, Anita Carroll, Mary Burke, Brigeen Kelly, Chris Wamsley.	
2.0	Chair**'s Business** Action notes of last meeting Acute Directorate Governance Agenda *Everyone welcomed to the meeting.* *Review of previous meeting minutes – all agreed they were an accurate representation of the meeting.* *Review of actions from last meeting.* *Actions from last meeting* 1) *Chris – Governance Job Description design.* - *Feedback received from most ADs will be progressing with JD this week with importance of to action complete asap.* - *Urgency highlighted to progress this to get support operationally within each division* 2) *Anne - Epilepsy study – highlight who will complete* - *Anne highlighted the issue surrounding Job Plan.* - *Anne will reach out to identify a lead again* 3) *Chris - Check case has been shared for dissemination at M+M.* *Case disseminated across the chairs, will monitor for return to ensure addressed at M+Ms* 4) *Barry - Acute risk for possible AHP posts within stroke and*	Melanie

	Resp. - Highlighted previous funding actions, included in capitalisation funding request, awaiting outcome of same. - Discussed the level of support needed to support the current stroke services, (10.22 WTE across OT/PT/SALT(90% CAH, 10% DHH)) - Ideally needed to stabilise the stroke service Mon-Fri. - Will strengthen weekend working however cross directorate cover would be necessary to sustain service. - Discussed the Stroke SNAPP scores, before attending ward – completing well, SNAPP aspects once reached ward poor. - Additional (10.22) is not sufficient to reach the recommended levels as stipulated but would address the current deficit appropriately to stabilise the service. - Anne and Barry to meet and agree a progressive plan to address staffing resources within stroke. 5) Mary - link with Anita/Sinead Corr surrounding sepsis audit for ED to identify delay - Mary to follow up 6) Chris/Flo - Ensure datix records and safeguarding match up - Chris and Flo to complete exercise to ensure correlation between datix system and safeguarding episodes reported	
3.0	Await update Apologies from audit office, Raymond currently off so audit office will update for Jan meeting. No new urgent update needed on any previous items.	Raymond Haffey
4.0	Patient Safety Report Acute Governance Report Dec21.doc **Review of report** **Site infection (Ortho and CS) quarter update** - next update Feb 2022. **VAP** - No episode of VAP in October - Last VAP Feb 2021 **Central line audits** - 0/6 for wards, consistently low since recommenced. - Chris to contact Colum 1) Highlight on report area of non-compliance. 2) Highlight to HOS and LN included in non-compliance email, AD to be requested to added also.	Colm Robinson

NEWS

- *Increase 1% from previous quarter (92%)*
- *Trust perspective 91% (same as previous quarter)*

MUST

- *Decrease in 3% from previous quarter (88%)*
- *Trust perspective decrease by 3%*

Omitted Critical Meds

- *Decrease from previous quarter (0 this quarter)*
- *Trust perspective decrease by 1 (1)*

VTE

- *10 areas decrease in compliance*
- *3 dropped to amber non-compliance (MMW/1S/4N)*
- *Total 5 in amber non-compliance (gynae/AMU)*
- *5 dropped to red non compliance*
  - *FMW – 78%*
  - *2S – 80%*
  - *Haem – 75%*
  - *1N – 75%*
  - *Ortho – 81%*
- *Trauma – non return*
- *AD to action non-compliance operationally.*
- *Highlighted recognition some of the key areas are extreme high risk areas.*
- *Clarity of audit process for VTE highlighted.*
- *Audit of kardex, shout be reviewed at every ward round.*

Crash Calls

- *Oct CAH Rate 0.85 (2 Crash Calls)*
- *down from 0.86 (2 Crash Calls) Sept 21*
- *Oct DHH Rate 0 (0 Crash Calls) same as Sept 21*

Sepsis Audit

- *Aug 21 data - compliance in-hours stands at 67%*
- *(4/6 cases audited) up from 25% (1/4 cases) July 21.*
- *Aug cases outside target timeframe by 22 mins & 102 mins.*
- *Aug 21data - compliance out-of-hours stands at 22%*
- *(2/9 cases audited), down from 40% (6/15 cases) July 21. Case outside target timeframe ranged between 1 & 103 mins*
- *Mean Time Jan 21 - Aug 21 = 67 mins (Region target 60min)*
- *In 2020 Mean Time = 76 minutes*
- *Some cases not audited due to delay in coding.*
- *Anita and Mary aware of same.*
- *Gareth Hampton to be informed as part of DMD role.*
- *Chris to email Gareth and highlight post meeting*

WHO Surgical Safety Checklist

- *Oct 21 Compliance 100% (60/60) same as Sept 21*
- *Cumulative Compliance in 21/22 stands at 98%*

Stroke Audit

- *Review of figures within safety data.*
- *Highlighted that these figures do not correlate to the figures through SSNAP data from Dr McCormick.*
- *Explained that the SSNAP data covers entirety of Stroke service.*
- *ST is good at the initial stages of Stroke care (ED and Diagnostics) and fall down with the ongoing care aspects such as Time to stroke ward, AHP support, Discharge planning.*

Skin care/Pressure

- *Increase from previous quarter (3%)*
- *Trust perspective increase by 3% (87%)*
- *Number if audits decreased, smaller in comparison to other NQIs*
- *33 HAPUs reported in Oct 21.*
- *7 x Grade 3/4, U or DTI's, (2 South Med (3), AMU, Ortho, 2 North Resp., CAH & Female Medical DHH).*
- *In 21/22 PIR on 30 cases with 13 deemed to have been avoidable.*
- *8% of all Ward Acquired PU reported in 21/22, reduced from 11%*
- *Highlighted high volume in ICU, related to Medical devices and Proning.*
- *High volume of patients acquiring pressure damage from medical devices and prone consistent with research available.*
- *Focus of Elaine, figures shared with the quality team.*

Delirium

- *All wards with exception of Trauma scoring well.*
- *HOS will action same within the Trauma ward.*

Falls

- *Bundle A compliance*
- *Decrease of 1% compliance this quarter*
- *Trust perspective increase of 1% (84%)*
- *Bundle B Compliance*
- *No change in compliance this quarter (81%)*
- *Trust perspective compliance increased by 3% (87%) Elaine second project focus on falls, third project on communication also links into falls prevention.*
- *Shared learning template to be reviewed later within this meeting.*

	- *Falls Rate 5.43 down from 6.23 in Sept 21* - *Injurious Falls Rate 0.84 (16) up from 0.62 (11) in Sept 21* - *Cumulative Falls Rate for 21/22 is at 5.57 (6.20 in 20/21)*	
4.1	electronic sign off   SIGNOFF_2021_10_ SHSCT.pdf Sign off Review.pdf *Review of Sign off.* *Limited information from document.* *Run charts completed to reflect data present within the document.* *ST nearly doubles closest HSCT, continue to perform well.* *Shared top 25 Drs list, some representative of ACUTE.* *Reflective that the "newer" consultants/specialty Dr are present within top 25 list.* *Greatest reports signed off would be biochemistry.* *Barry and Anita highlighted the Pilot work that they had initially began to progress.* - *NHSCT have also completed work within sign off which focused within the OP departments.* - *Initially results have been positive however also reflective that ST figures remain significantly higher even though NT have a focused QI work within this area.* - *Query that the initial idea to select a specific ward area to pilot may not be the most effective, dependant on NT data query replication of their progress might yield improved results.* *Internal audit are planning to undertake an audit of sign off.* *Due to the size and complexities of sign off this audit will be focused within specific areas.*	
5.0	Acute Clinical Governance Overview ***Complaints section*** *Highlighted a suggested change in format to the methods governance produce report.* *Previously data was none specific and therefore was difficult to translate information to each division, change in report type to emphasis directorate, divisional pictures but also focus on identifying learning for sharing.* *Report broken in to key areas.* *Analytics for easy overview of complaints.* *Section on transferable learning from the complaints,* *Breakdown of the closed complaints from the month, highlighting themes, any learning or action plans needed to ensure implementation of agreed statements within complaints.*	Chris

	There will also be a section included for Ombudsman aspects as and when the final report arrives and is completed. *Due to time constraints this month only the analytic properties have been completed but commencing from next month the learning sections will have been completed for review.* *All accept new format as beneficial.* *Review of each analytic graph to review content.* *Divisions which were initially combined have been separated from the start of this financial year.* *Overall from complaints have been extremely busy over the past month, we have reduced the number of longstanding red complaints across all divisions.* *All original Covid complaints have been completed and shared with the families.* *The develop of the Band 5/6 governance role will link with the complaints team to action plan complaints to assist in developing and closing the loop of learning and implementation of actions.* *Current status of complaints would indicate the communication and attitudes are the key factor in complaints, reflected both at the monthly and annual scores to date.* ***Incidents section*** *The incident report will take a similar design to the complaints report however as each division has specialist focuses independent from each other the development process will take longer to ensure each division has their specialist areas adequate covered in a format which provides greatest benefit.* *The initial section will be similar to an executive summary highlighting key focuses for the directorate and key risks.* *Each division focused areas will be co-developed with the AD with a focus in oversite, assurance and communicating/auctioning learning.* *Review of current incident status present*	
6.0	Complaints – Current 52 (35 outstanding)  Current Complaints 031221.xlsx Red | Amber | Green | Total | Aw app	Chris

						from AD
SEC/ATICS	12	0	2	14	0	
MED	11	3	5	19	7	
ED	5	3	8	16	3	
CCS	0	0	1	1	0	
IWMH	0	0	2	2	0	
FSS	0	0	0	0	0	
Total	28	6	18	52	10	

Reopened 21

Reopened Complaints Report 29

	Total	Out of total - Await approval from AD
SEC/ATICS	**6**	**0**
MED	**2**	**0**
ED	**12**	**1**
CCS	**0**	**0**
IWMH	**1**	**0**
FSS	**0**	**1**
Total	**21**	**2**

7.0 Ombudsman Cases- 12 –

Ombudsman 29.10.2021.xlsx

-

Chris

8.0 Directorate Risk Register

- Quarterly Risk Register Review – Directorate Level
- Divisional Risk Registers

Highlighted the need for Chris to link with Melanie to review and update the Directorate risk register.
Chris to arrange date with Emma/Ashley

Asked are there any new risks that need to be escalated at this meeting.

Barry highlighted a new risk associated from Medical Physiology B testing.

Chris

	There was a meeting with Medical Physiology and they highlighted that this risk should be present within our corporate risk registers and this was actioned as an urgent action following the meeting. *Anita – further cases that have been added,*	
9.0	SAIs: • Summary report – 41 (4 clearing Thursday 9th) ➢ 3 Acute reports (+ 1 x CYP) Dec ACG **More than 26 weeks** / **Less than 26 weeks** / **Within Timescales** / **Level 3** / **Total** 6 / 24 / 7 / 4 / 41 *Discussion of the current status of the SAI cases within the Acute.* *5 further cases to be removed following this Thursdays debrief.* Action Plans *Action plan document sent to all at the meeting.* *Chris has completed a review of the detail held by the governance office for the SAIs completed within Acute.* *Currently there is 239 SAIs and 26 completed action plans (6 SAI have no recommendation).* *Action plans our held by the operation team so most likely there is a greater number of action plans completed.* *Helen and Joanne (QI leads) have been sent this document and are utilising this to address the backlog of Action plans.* *(Further reinforces the need for the operational governance assistance).* *Ongoing work on the backlog within each Division and this will be a focus for the new governance roles*	
10.0	Incidents • Major and above report for AMD Governance meeting Major & Catastrophic Incidents Month Nov *Discussed changes to the report attached, instead of reviewing one week, the previous month's incidents will be included with small line to address status or progression of each case.*	

	Cases reviewed as attached document notes. *Agreement surrounding continuing this format.* Falls Shared Learning Templates    127678 W123172 DHH stroke.doc 139864 W135337 3 South.doc 147606 W143079 1 North.doc *Shared learning templates brought to group to arrange a new process to ensure completion and forwarding onward to the PHA to ensure completion and compliance with recommendations* *Questions surrounding the cases which have been progressed for SAI, do we want to share via the same format as they may be disparity of with initial and SAI report learning.* *Agreed these would not have any negative impact and therefore to continue with them through the process.* *Review of an SAI case to review possible changes (W137771 MMW).* - *Not detailed sufficiently to address incident.* - *Learning only incorporates a leaflet.* - *To be resent to Anne, Laura and Kay for further review.* *Review of stroke case, 127678/W123172.* - *Amend correction of grammar/spelling and approved for PHA.* *Review of 3 South case, 139864/W135337* - *Amend correction of grammar/spelling and approved for PHA* *Review of 1 North case, 147606/W143079* - *Amend correction of grammar/spelling and approved for PHA*	
11.0	Medication Incidents • Monthly medication incident report *Medication errors discussed.* - *Highlighted several high risk errors surrounding insulin.* - *Highlighted errors with high risk were within the Ed department.* - *Asked for check of disparity, 5 cases in CAH 11 cases in DHH*	Jilly Redpath

	ED *Pressures within the systems recognised especially within ED departments however insulin compliance to be reinforced within all divisions.* *Incident surrounding bowel prep, discussed at screening.* *Error identified as lack of script sent to pharmacy department rather than refusal of pharmacy staff to release bowel preparation.*	
12.0	Implementation of Learning To be sent separately *Highlighted this will begin to be populated each month as action plans are returning to the governance office.*	Ads
13.0	Mandatory training compliance *Discussed that the two reports were available, due to timing this was not discussed in detail and for each division to address within own area.*	ADs
14.0	Safeguarding *Review of attached document highlighting the current status of safeguarding within Acute.* *Predominantly within ED and medical wards, SEC lower.* *Concern surrounding disparity of cases between DHH and CAH ED.* *There needs to be a Medic identified to represent within the AS group.* - *Meetings are 3 monthly and then monthly Acute meeting.* - *Preferable to have 1 DHH + 1 CAH rep.* *Each AD to identify someone from division to Champion AS* *Flo to attend the DMD/CD meeting/Medical handover.* *Needs senior Medical buy in, query use Speciality Doctor resource.* *Asked regarding staff disciplinary and current cases.* - *2 cases 1 with agency and 1 with core staff member.* - *There has been no disciplinary as the safeguarding accusation has not been proven to date.* - *There is active HR participation in all safeguarding reviews due to the allegations against staff members* *Flo to contact Seamus Murphy as DMD for workforce for both sites.*	
15.0	Datix position **2011** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **Total** 1 | 1 | 3 | 5 | 10 | 79 | 271 | 1229 | 1600 Pre 2021	Chris

									371
	1 (Uro)	1 (Uro)	0	1 (1 Uro)	5	41 (7 Uro)	167 (11 Uro)	1265	1481 Pre 2021 216

Discussed current position, continued work and focus to remove backlog of current datix within the system
From next month Chris will break down the monthly position for 2021 as we commence the new year.

16.0 Any Other Business

1) Ligature Policy/Assessment

- *Review in more detail at tomorrow S+G meeting*
- *Due to the time constraints w will discuss then*

2) Radiology SQRs for discussion at ACG

20210621 Draft Action Plan SQR-SAI-

20210621 Draft Action Plan SQR-SAI-

- *Highlighted this will be discussed at Fridays meeting.*
- *Met with Barry during the week, key request of SQR is the referrer to audit themselves.*
- *Need agreement on a process and volume this will be completed*,

3) SAI Recommendations for discussion and/or **escalation to AMD's**

EMERGENCY DEPARTMENT ADMIS

051021 SAI for discussion v3.docx

- *Documents shared and work completed with Mary + Gareth.*
- *Chris will arrange meeting with Ad and DMDs to agree a process to progress this work.*
- *3 main components*
  - a) *Clinical communication/correspondence policy*
  - b) *Inter Specialty clinician handover and recording of:*
    - *patients who require other specialty input prior to admission*
    - *inpatients requiring other specialty opinion.*
  - c) *Inter-Trust/Regional transfers.*

17.0 Date of next meeting – *Monday 3rd January*

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClements

ACUTE DIRECTORATE GOVERNANCE MEETING

Date: Monday 1st November 2021
Venue: via zoom
2pm

AGENDA

1.0	Apologies: Anita Carroll, Attendance: Melanie McClements, Colum Robinson, Raymond Haffey, Chris Wamsley, Joanne, Caroline, Ronan, Anne, Tracey,	
2.0	Chair's Business Action notes of last meeting Last week new quality project, Lead quality Nurse – EC 8B, 2 x band 7, HMcC and JB. There will be a read across with Governance therefore Quality AD and ACGC will all sit on the agenda. MDT point of view Urology Inq – no about Mr O'Brian but how we govern our worlds - 4 parts performance, finance, human resource, governance. - Governance capacity issues, section 21 request highlighted issues throughout. - SAI and out the other end with actions. - Additional support for governance admin to allow a fighting chance to improve aspects of this. - 2 x B7 in quality world will work within ED, Med + SEC, Radio, Attic + labs. - 1 x day/week AD to drive forward governance aspects. - New post will further support this. Chris – JD, band – role and function. ACTION Tracy and Joanne not included suggested the volume of work is not there.	Melanie

	Tracey – Jilly Joanne – no individual manages address as required/ discuss with Anita and come back. Wendy/Carolyn – starting to see the light with risk midwifes.	
3.0	11) Clinical audit summary for Acute Cl 1) IV fluids – 7 cases outstanding, all ATTICS, all compliant - Raymond will follow up if return not forwarded through. 3) Survey as per the link, open for completion 4) Feedback from Fiona – IMWH working closely 9) Epilepsy – a/w NIPOD – organisation elements - putting together amendments Anne – difficulty in getting people to complete, Anne to highlight who will complete 10) Next stage is organisational questionnaire, cross directorate awareness and sign off required later in the process. 11+12) For review and approval. 18) under continuous audit - Raymond – to remove Anne from Directorate contact as relates to ED (USC) 21) Data has now been collected and currently being analysed 22) approved by Melanie 24) SNAPP – pending approval of DHH data./ Raymond send email on Friday to Melanie for approval, will review post the meeting. 43-44) MCCDs – positive sample and also reportable - Emailed consultants regarding timely MCCDs - Follow up processes. 48) Additional aspect for awareness SET SAI, r/w relevance and for all M+Ms Check case has been shared for dissemination at M+M. – Chris	Raymond Haffey
4.0	Patient Safety Report Patient Safety Acute Governance Report N Colum provided a review of safety report. Central line audit 0% on the wards, requested to Colum to highlight where the non-compliances occurred – same agreed.	Colm Robinson

	VTE report highlighted 1N, 2N and Gynae wards. Operational AD for each division will action the non-compliances. SNAPP audit, highlighted by consultant ST is worst performing Trust in NI. - Agreed to go at risk for some of the posts which impact the SNAPP audit - AHP staffing paper nearly completed and highlights deficits especially within COVID and stroke. - Acute risk for possible AHP posts within stroke and Resp at risk. – Action Barry Falls and Pressure highlighted as continuing to be a problem, quality team have been assigned to both topics as there first topics for improvement. Gillian (TVN), Lisa (8B Nursing safety, quality, experience) and Colum working on piece of work to review the past 6 years of data across the board. Colum to share information and will be added to the ACG forum agenda. Discussed increased frequency of pressure damage associated with patient proning and medical devices, increases are in line with current available research surrounding pressure ulcer prevention/formation in COVID pandemic. Colum highlighted the delay in sepsis audit. Mary to link with Anita/Sinead Corr surrounding audit for ED  PHA Falls Report Oct 21.docx  PHA Pressure Ulcer Report October 2021 Reports for PHA	
4.1	electronic sign off  SIGNOFF_2021_09_SHSCT.pdf Discussed current position of ST Highlighted the follow up processes of primary care requests, there is a protocol for this. Audit of the protocol required. Mary to share the protocol with everyone Chris to arrange audit into the safety net for Radiology. Barry is designing a safety net process. Anita and Barry designing a pilot for a proposed way of reports escalating to the ward.	
5.0	Acute Clinical Governance Overview	Chris

- Not completed due to Urology Info

Highlighted due to the pressures to obtain the information for urology inquiry this report could not be completed for this month.

6.0 Complaints – (Update complete files on 03/09/2021) — Chris

Current

Copy of Current Complaints updated 2

	Red	Amber	Green	Total	Aw app from AD
SEC/ATICS	13	2	4	19	4
MED	20	4	8	32	0
ED	13	1	4	18	1
CCS	0	0	0	0	0
IWMH	5	0	1	6	1
FSS	0	0	1	1	0
Total	51	7	17	76	6

Reopened

Reopened Complaints Report 29

	Total	Out of total - Await approval from AD
SEC/ATICS	7	0
MED	6	0
ED	9	2
CCS	1	0
IWMH	8	5
FSS	1	1
Total	32	6

7.0 Ombudsman Cases- 11 – — Chris

Ombudsman 29.10.2021.xlsx

12

	- 3 new ones to be collated, - 1 with draft report comments to collate - 1 carrying out recommendations (3 month plan) all remaining with the ombudsman.	
8.0	Directorate Risk Register • Quarterly Risk Register Review – Directorate Level  Directorate RR August 2021.xlsx • Divisional Risk Registers  CCS Div.HOS.Team RR August 2021 (2).x  FSS Div.HOS.Team RR August 2021.xlsx  IMWH Div.HOS.Team RR August 2021.xlsx  MUC Div.HOS.Team RR August 2021.xlsx  Pharmacy Div.HOS.Team RR au  SEC.ATICS Div.HOS.Team RR Au  Risk Register August 2021.xlsx Highlighted as returning from annual leave the risk registers were not up to date on this agenda, this would be corrected for the ACG agenda.	Chris
9.0	SAIs: • Summary report – 39	
10.0	Incidents • Major and above report for AMD Governance meeting  Major & Catastrophic Incidents weekending	
11.0	Medication Incidents • Monthly medication incident report  Medication Incidents September 2021 Acut	Jilly Redpath
12.0	Implementation of Learning To be sent separately	ADs
13.0	Mandatory training compliance  Acute Detailed CMT Compliance Report as New reports have been released from OH, same will be shared in	ADs

	ACG forum agenda	
14.0	Any Other Business Datix position	Chris

2010	2011	2015	2016	2017	2018	2019	2020	2021	Total
1	1	1	3	5	10	79	271	1229	1600 Pre 2021 371
1 ? SAI	1 (Uro)	1 (Uro)	0	1 (1 Uro)	5	48 (7 Uro)	207 (11 Uro)	1337	1601 Pre 2021 264

Safeguarding

ADULT SAFEGUARDING KPI /

Flo Fegan attended CG meeting to discuss safeguarding.
Will be added to the agenda moving forward for oversight.

1) Induction packs
   - Corporate mandatory training (3 page pack).
   - Planned audit for January 2020.

Highlighted that the tile for safeguarding currently sits under Mental Health directorate sharepoint.

2) Adult Safeguarding must be a standing item on team meetings agenda.
   Chris – Add safeguarding to monthly agenda.
   Standing item on the weekly corporate debrief report.

3) Face to face contact within 5 working days of allocation of referral
   Unable to achieve
   Staffing paper is being developed as an IPT.
   Additional workload – at risk SW post possibly required (query 8a for SW safeguarding).

4) DAPO's will engage in 6 – 8 weekly supervision
   Need additional supervision every 6-8 weeks.
   Additional pressure on service due to staffing levels.

5) Service user/carer feedback
Can be completed and reviewed from beginning of the AS Investigation process
This form can be found on the AS Sharepoint tile.

6) All staff CPD training
Acute/relevant staff – every 3 years
Line managers – every 2 years

Directorate	Not Trained	Trained	Head Count	% Trained
Acute Services	1779	2964	4743	**62%**

? relevance in all staff completing, highlighted components such as staff based in labs who will have no contact with patient facing.
Flo will raise at next safeguarding meeting.

6) Risk Assessments
SW specific, dashboard available.
Reports need to be pulled off and identify themes and trends

We need to ensure datix and safeguarding match up
(action Chris and Flo)

There is a planned bill introduction which will have a major impact on SW model for workload.

Safeguarding although perceived as low referrals is sitting as the second highest directorate currently.
Representation needed from all on AS group.
Current presentation includes
SW – Flo
Governance – Chris
AD – Anne
Medical – needs to be identified ? Dr Philip Murphey to identify
Nursing – to be identified.

Chris to identify best platform to provide update to governance group.

15.0	Date of next meeting	

Appendix 1

Acute directorate (including ATICS): Paediatric IV fluid audit improvement tool (PIVFAIT) Results 1st May 2018- 24th October 2021[1]

The Acute Directorate Paediatric IV Fluid Audit Improvement Tool (PIVFAIT) assesses 9 indicators / questions for all patients aged 14-15 years who received IV fluids during their hospital admission.

The 9 indicators / questions are:

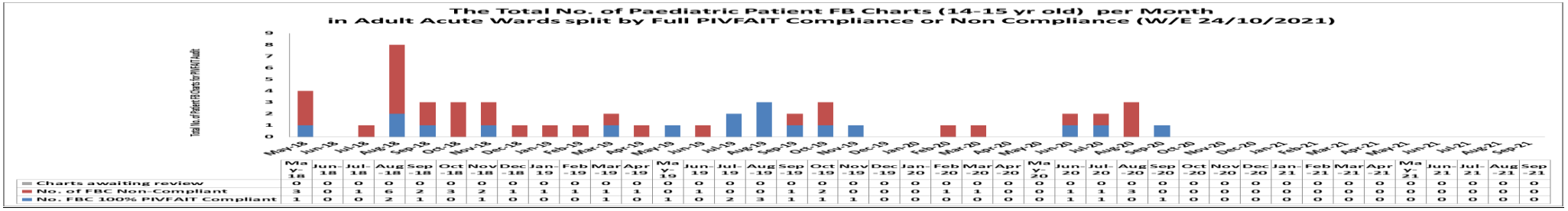
Indicator / Question		Details
1	**Patient identification**	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number
2	**Glucose Monitoring**	While the child is receiving IV fluids, is there a **Blood Glucose result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart) i.e. at least 12 hourly?
3		Were ALL **Blood Glucose** measurements greater than 3mmol/L? If answer = No; Enter Hospital Number of those below 3mmol/L for Trust audit dept. to check for treatment.
4	**Cumulative input and output totalling and fluid balance.**	Are ALL of the following amounts (in mls) recorded on the DFBC? 1. Oral/IV amounts, (all administered types of intake to be recorded). 2. Day and night totals. 3. Grand Total IN 4. Grand Total OUT 5. 24 hour Fluid Balance
5	**Patient weight**	Is there a patient weight in kgs, given on the DFBC?
6	**DFBC calculation guidance completed.**	Are the appropriate calculation guidance sections for the IV therapy completed?
7		Are there coded indications for the fluid administration provided?
8	**Electrolyte monitoring**	Is there an E&U result recorded on the DFBC, (in accordance with the 2017 Paediatric Therapy Wallchart)?
9	**12 hour assessment.**	When IV fluids are administered for longer than 12 hours. Is there a 12 hour Reassessment box* appropriately completed on the DFBC with an answer to the question: Is the infusion prescription still suitable - followed by a doctors signature? * Can be 10 - 14 hours .

Acute Directorate PIVFAIT OUTCOME

18 of the 51 FB charts (35%) recorded 100% PIVFAIT compliance in the last 41 months.

[1] Audit data is based on returns made by wards at this date.

Appendix 1



	2018								2019												2020												2021								
Question Compliance	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jin	Jul	Aug	S 21
1. Patient identification	75%	n/a	100 %	88%	33%	100 %	67%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	50%	100 %	100 %	n/a	n/a	100 %	100 %	n/a	n/a	100 %	100 %	100 %	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2. Glucose Monitoring (Blood Glucose result recorded on the DFBC)	75%	n/a	100 %	88%	67%	100 %	100 %	0%	100 %	0%	50%	100 %	100 %	100 %	100 %	100 %	100 %	67%	100 %	n/a	n/a	0%	100 %	n/a	n/a	50%	50%	33%	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
3. Glucose Monitoring (Blood Glucose measurements greater than 3mmol/L?)	75%	n/a	100 %	88%	100 %	100 %	100 %	0%	100 %	0%	50%	100 %	100 %	100 %	100 %	100 %	100 %	67%	100 %	n/a	n/a	0%	100 %	n/a	n/a	50%	50%	67%	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4. Cumulative input and output totalling and fluid balance	25%	n/a	0%	75%	100 %	33%	33%	100 %	100 %	0%	100 %	100 %	100 %	0%	100 %	100 %	100 %	100 %	100 %	n/a	n/a	100 %	0%	n/a	n/a	50%	100 %	67%	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
5. Patient weight	75%	n/a	100 %	100 %	100 %	67%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	n/a	n/a	100 %	100 %	n/a	n/a	50%	100 %	100 %	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
6. DFBC calculation guidance completed	50%	n/a	0%	50%	100 %	33%	67%	100 %	100 %	100 %	50%	0%	100 %	0%	100 %	100 %	100 %	100 %	100 %	n/a	n/a	100 %	100 %	n/a	n/a	50%	100 %	67%	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
7. DFBC calculation guidance completed/a	50%	n/a	100 %	88%	33%	67%	67%	100 %	0%	0%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	67%	100 %	n/a	n/a	100 %	100 %	n/a	n/a	50%	100 %	67%	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
8. Electrolyte monitoring	75%	n/a	100 %	88%	67%	100 %	100 %	0%	100 %	0%	50%	100 %	100 %	100 %	100 %	100 %	50%	67%	100 %	n/a	n/a	100 %	100 %	n/a	n/a	50%	50%	67%	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
9. 12 hour assessment	75%	n/a	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	n/a	n/a	100 %	100 %	n/a	n/a	100 %	100 %	67%	100 %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	

Appendix 1

Acute Directorate: ATICS: Paediatric IV fluid audit improvement tool (PIVFAIT)
Results 31st May 2019 – 24th October 2021

The Acute Directorate ATICS specific audit tool assesses 6 indicators / questions for all patients up to their 16th birthday who received IV fluids whilst in theatre.

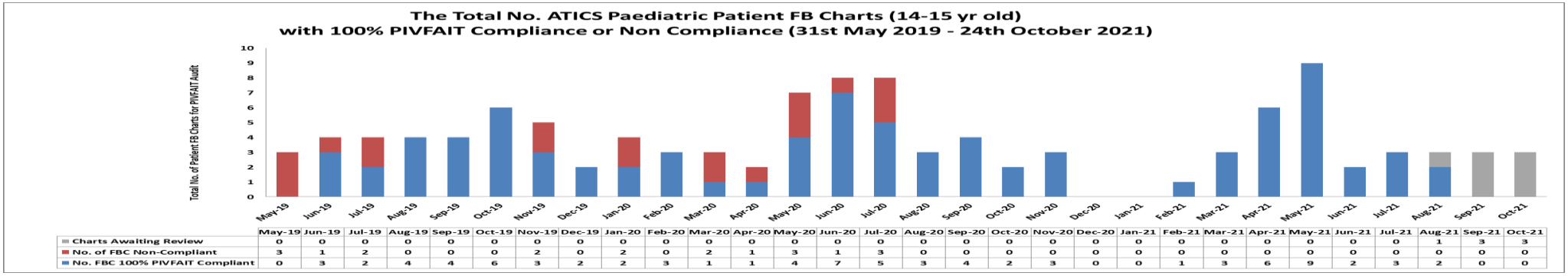
The 6 indicators / questions are:

Indicator / Question		Details
1	**Patient identification**	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number
2	**Patient weight**	Is there a patient weight in kgs, given on the DFBC?
3	**Daily Fluid Balance & Prescription Chart**	Was the appropriate Daily Fluid Balance & Prescription Chart (Child up to 16th Birthday February 2017) chart commenced?
4	**Daily Fluid Balance & Prescription Chart**	Was the fluid volume given in Theatre / Recovery appropriately transferred onto the ward fluid balance chart prior to discharge from Theatre/Recovery
5	**Daily Fluid Balance & Prescription Chart**	If Fluids continue on to ward – were calculations done and coded?
6	**Fluids prescribed**	IF fluids were given in Theatre / Recovery please provide details A) Volume prescribed. B) Actual volume given. C)Type of fluid given
Additional information		
	Fluids prescribed	Did IV fluids continue when the patient was discharged to the ward on discharge from theatre/recovery? - Please note if the child continues to receive IV fluids outside the Theatre / Anaesthetics setting then the Ward is to complete the full audit

NB: 7 x ATICs cases in the period up to 24/10/2021 remain to be audited

Appendix 1

85 of the 105 DFB charts (81%) recorded 100% ATICS Specific PIVFAIT compliance. 7 cases await ATICS PIVFAIT review



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Charts Awaiting Review	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3	3
No. of FBC Non-Compliant	3	1	2	0	0	0	2	0	2	0	2	1	3	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. FBC 100% PIVFAIT Compliant	0	3	2	4	4	6	3	2	2	3	1	1	4	7	5	3	4	2	3	0	0	1	3	6	9	2	3	2	0	0

The bar chart and table show that 54/61 (89%) charts audited since May 2020 have had full compliance.

Indicator / % Compliance by Month	May 19 (n=3)	Jun 19 (n=4)	July 19 (n=4)	Aug 19 (n=4)	Sept 19 (n=4)	Oct 19 (n=6)	Nov 19 (n=5)	Dec 19 (n=2)	Jan 20 (n=4)	Feb 20 (n=3)	March 20 (n=3)	April 20 (n=2)	May 20 (n=7)	Jun 20 (n=8)	Jul 20 (n=8)	Aug 20 (n=3)	Sep 20 (n=4)	Oct 20 (n=2)	Nov 20 (n=3)	De 20 n=0	Jan 21 n=0	Feb 21 (n=1)	Mar 21 (n=3)	Apr 21 (n=6)	May 21 (n=9)	June 21 (n=2)	July 21 (n=3)	Aug 21 (n=2)	Sep 21 n=3	Oct 21 n=3
1.Patient identification	33%	100%	75%	100%	100%	100%	60%	100%	50%	100%	67%	50%	86%	88%	100%	100%	100%	100%	100%	-	-	100%	100%	100%	100%	100%	100%	100%		
2. Patient weight	67%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	88%	100%	100%	100%	100%	100%	-	-	100%	100%	100%	100%	100%	100%	100%		
3. Appropriate Daily Fluid Balance & Prescription Chart	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%	100%	100%	100%	100%	100%	100%		
4. Daily Fluid Balance & Prescription Chart - volume appropriately transferred to ward fluid balance chart	67%	100%	100%	100%	100%	100%	80%	100%	100%	100%	67%	100%	57%	100%	88%	100%	100%	100%	100%	-	-	100%	100%	100%	100%	100%	100%	100%		
5. Daily Fluid Balance & Prescription Chart - calculations done and coded?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	75%	100%	100%	100%	100%	-	-	100%	100%	100%	100%	100%	100%	100%		
6. Fluids prescribed	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%	-	-	100%	100%	100%	100%	100%	100%	100%		

Appendix 1

Charts Awaiting Review from previous report-

ATICS

Theatre CAH:

7 cases from the following dates are awaiting review.

- 29/08/2021 – for review
- 08/09/2021 – for review
- 16/09/2021 – for review
- 24/09/2021 – for review
- 13/10/2021 – for review
- 14/10/2021 – for review
- 20/10/2021 – for review

SHSCT Clinical Audit Work Plan

Audit type (National, Regional, Local)	HQIP Audit Level tba=to be advised	Audit Year	Audit title	Name of Junior Doctor/HCP/ Auditor	Audit lead	Site	Acute Division
International	1	2021-22	BURST Resect Study	Dr M Mageean	Mr A Glackin/Mr M Haynes	CAH/DHH	SEC
National	1	2021-22	National Audit of End of Life Care (NACEL)	David Calvin	Barry Conway	CAH/DHH	All
National	1	2021-22	NCEPOD Epilepsy Study		NCEPOD Coordinators	CAH/DHH	All
National	1	2021-22	NCEPOD Transition study	Dr A Mayne	NCEPOD Coordinators	CAH/DHH	All
National	1	2021-22	BTS Smoking cessation	Dr R Convery	Dr R Convery	CAH/DHH	MUSC
National	1	2021-22	BTS Pleural Services Organisational Audit 2021	Dr R Convery	Dr R Convery	CAH/DHH	MUSC/SEC
National	1	2021-22	National Unilateral nipple discharge study		Dr N Scally	CAH/DHH	SEC
National	2	2021-22	Covid-19 Impact on Pancreatic Cancer Care Pathway	Dr R Fox	Mr Epanomeritakis	CAH/DHH	CCS
National	2	2021-22	Open study-Open fracture Patient Evaluation Nationwide	Dr R McAuley	Mr R McKeown	CAH/DHH	MUSC/SEC
National HQIP	1	2021-2022	National Sentinel Stroke National Audit programme (SSNAP)		Dr P McCaffrey/Dr M McCormick Dr B McGleenon	CAH, DHH	MUSC,AHP
Regional	2	2021-22	Regional Ablation Audit	Dr C Coyne	Dr N Henderson	CAH/DHH	IMWH
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the time taken to initial treatment for patients with confirmed urological cancer	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the time taken to initial treatment for patients with suspected Urological cancer	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department, the time taken to initial treatment for patients with confirmed urological cancer and the impact of COVID on treatment	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS
Regional	2	2021-22	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the impact of COVID on the time taken to review patients with suspected Urological cancer	Dr Jay Atkinson	Mr Mark Haynes	CAH/DHH	SEC/CCS
Regional	3	2021-22	Restarting DOAC's Post -operatively in Trauma Patients	Dr J Clarke	Mr B Watson	CAH/DHH	SEC
Trust	2	2021-22	Audit of prescribing of anti-androgen medicine "Bicalutamide"		Mr M Haynes	CAH/DHH	CCS
Trust	2	2021-22	Impact of the pandemic on ectopic pregnancy outcomes	Dr Tsveta Hadjieva	Dr S Finnegan	CAH/DHH	IMWH
Trust	2	2021-22	Audit of Intravenous paracetamol	Ms Melinda Furtado	Ms Sara Laird	CAH/DHH	Pharmacy
Trust	2	2021-22	Ensuring Pregnancy Testing is undertaken prior to surgery	Caroline Beattie	Patricia Kingsnorth	CAH/DHH	SEC,CYP/IMWH
Trust	3	2021-22	National Emergency Laparotomy Audit	Dr K Foreman	Dr A O'Neill	CAH/DHH	ATICS
Trust	3	2021-22	Survey of practice in the management of the patient in the prone position	Dr L Merjava	Dr L Martin	CAH/DHH	ATICS
Trust	3	2021-22	Obstetric anal sphincter injury audit	Dr G Stewart	Dr G McLachlan	CAH	IMWH
Trust	3	2021-22	Foley Catheter Induction of Labour	Dr L Creswell	Dr G McKeown	CAH/DHH	IMWH
Trust	3	2021-22	Postnatal obstetric adverse effects and complications	Dr J Harte	Dr Alison Blair	CAH/DHH	IMWH
Trust	3	2021-22	Retrospective Audit of outcomes with mechanical induction of labour	Dr Adeeb Khan/Dr A Ibrahim	Dr E Boggs	CAH	IMWH
Trust	3	2021-22	Audit for quality improvement of antenatal VTE risk assessment in DHH, 2021 Dr Adrienn Zarandi	Dr A Zarandi	Dr Meeta Kamath	DHH	IMWH
Trust	3	2021-22	Female Lower urinary tract service audit	Dr S Hasnain	Dr J O'Donaghue	CAH/DHH	IMWH
Trust	3	2021-22	Sepsis	Dr B Barbulescu	Dr Cara McKeating	CAH/DHH	MUSC
Trust	3	2021-22	Delivery of Palliative Care in DHH General Medicine	Dr Amy Gilsenan	Dr G Sloan	DHH	MUSC
Trust	3	2021-22	Review of COVID-19 transfer policy	Dr Mathew McCall	Dr Conor Hagan	CAH/DHH	MUSC
Trust	3	2021-22	Alcohol Admission and management	Dr M AboElnas	Dr G Ahmed	DHH	MUSC
Trust	3	2021-2022	HIV Audit AMU/MAU	Dr A McCleane	Dr S McGarrity	CAH	MUSC
Trust	3	2021-2022	Audit of staff induction in the direct assessment unit at Daisy Hill hospital	Dr E McKeever	Dr Billy Masih	DHH	MUSC
Trust	3	2021-22	Audit of clinical effectiveness of Heart failure nursing care	Elaine Mulligan	Dr P Campbell/Dr A Rray	CAH/DHH	MUSC / OPPC
Trust	3	2021-22	Audit of ED Documentation to determine recorded level of burn cooling received by Paediatric patients presenting to Craigavon ED	Dr Aoife McElduff	Dr Elli McCormick	CAH	MUSC/CYP
Trust	3	2021-22	Craigavon POPS (peri-operative care of older people undergoing surgery) PILOT service Quality improvement project	Michael Magee/Samantha Leung/Laura McAuley	Dr Michael Magee	CAH	OPPC/SEC
Trust	3	2021-22	Procalcitonin testing and antibiotic use in suspected Covid-19	Geraldine Conlon-Bingham,	Dr Cara McKeating	CAH/DHH	Pharmacy
Trust	3	2021-22	Quality of biopsy sampling in suspected eosinophilic oesophagitis in SHSCT	Dr R Fox/Dr O Doherty	Mr Shivaram Bhat	CAH/DHH	SEC
Trust	3	2021-22	Audit of accuracy of form V13.3 for input to National Fracture database from Trauma ward December 2020	Dr B Cunningham/Dr I Donnell	Mr Sean Patton	CAH	SEC
Trust	3	2021-22	Compliance with local Trust prophylactic antibiotic guidelines in trauma patients-1 month follow up	Dr J Winter	Mr M Murnaghan	CAH/DHH	SEC
Trust	3	2021-22	Operative note documentation	Fiona Griffin	Mr J O'Donaghue	CAH	SEC
Trust	3	2021-22	Comparison of LUTS assessment in Southern Trust against guidelines	Dr Sabahat Hasnain	Mr A Glackin	CAH/DHH	SEC
Trust	3	2021-22	The efficacy and cost savings of chemolysis for suspected uric acid stones compared to uteroscopy, PCNL or ESWL:a prospective study	Ms L McAuley	Mr M Young	CAH/DHH	SEC
Trust	3	2021-22	Antibiotic prophylaxis for patients diagnosed with SBP	Dr M Pollock	Dr M Hussain	CAH/DHH	SEC
Trust	3	2021-22	5 year retrospective review of hypocalcaemia rates & management following total thyroidectomy and completion thyroidectomy surgery in SHSCT	Dr G Donaldson	Mr M Korda	CAH/DHH	SEC
Trust	3	2021-22	Audit into the management of intercranial bleeds	Dr L Watt	Dr M Rizeq	CAH/DHH	SEC/ATICS
Trust	3	2021-22	Unplanned admissions following daycase elective surgery	Dr L Armstrong	Mr R Thompson	CAH/DHH	SEC/MUSC
Trust	3	2021-22	Which trauma patients should receive a screening CT angio in detecting blunt cerebrovascular injury as per denver guidelines	Dr L Armstrong	Mr R Thompson	CAH/DHH	SEC/MUSC
Trust	4	2021-22	Orthoptic Stroke Service Audit	Matthew Groogan	Declan McClements	CAH/DHH	MUSC
Trust	4	2021-22	Assessment of Severity of Pancreatitis in Patients in DHH	Dr K Cadiz	Mr R Thompson	DHH	MUSC/SEC
Trust	4	2021-22	Audit to determine the number of true penicillin allergy patients on the AMU in CAH	Michelle Murphy	Geraldine Conlon-Bingham	CAH	Pharmacy
Trust	4	2021-22	Parotid Surgery in the Southern Trust: An overview of techniques, complications and changing trends	Dr J Smith	Mr E Reddy	CAH/DHH	SEC
Trust	4	2021-22	Hypocalcaemia in the post-operative parathyroidectomy patient	Dr R Kerr	Mr M Korda	CAH/DHH	SEC

Audit type (National, Regional, Local)	HQIP Audit Level tba=to be advised	Audit Year	Audit title	Name of Junior Doctor/HCP/ Auditor	Audit lead	Site	Acute Division
Trust	4	2021-22	Follow up of Emergency laparotomies and laparoscopic surgeries in daisy Hill Hospital and compare it with (National Emergency Laparotomy Audit	Mr Atif Sharif	Mr Thompson	DHH	SEC
Trust	4	2021-2022	Rate of UTI's post cystoscopy	Dr F Griffin	Mr S Omer	CAH/DHH	SEC

Transition from child to adult health services: Organisational questionnaire

A. Introduction

What is this study about?
The aim of this study is to explore the process of the transition of young people with complex chronic conditions from child to adult health services.

Inclusions
Organisations providing healthcare to young people aged between 13 years and their 25th birthday with a complex chronic condition, transitioning from child to adult health services. Data is being collected on the services provided to young people identified to us over an 18-month period, from 1st October 2019 - 31st March 2021.

Who should complete this questionnaire?
This questionnaire has been designed to collect data on the organisational structures surrounding the process of transition from child to adult health services.

One questionnaire should be completed for each Trust/Health Board/Organisation providing care to young people transitioning from child to adult health services

This questionnaire should be completed by a member of the transition team where available, or by a health care professional responsible for the transition of young people (from child to adult health services) in this organisation

Definitions
This questionnaire is to completed at Trust, Health board or overarching organisation level. Throughout the questionnaire, the Trust or Health Board will be referred to as the organisation.

A list of definitions can be found here:
https://www.ncepod.org.uk/pdf/current/Transition/Definitions%20Transition%20%20finalised.pdf

Questions or help
If you have any queries about this study or this questionnaire, please contact: transition@ncepod.org.uk or telephone [redacted].

CPD accreditation
Consultants who complete NCEPOD questionnaires make a valuable contribution to the investigation of patient care. Completion of questionnaires also provides an opportunity for consultants to review their clinical management and undertake a period of personal reflection. These activities have a continuing medical and professional development value for individual consultants. Consequently, NCEPOD recommends that consultants who complete NCEPOD questionnaires keep a record of this activity which can be included as evidence of internal/self directed Continuous Professional Development in their appraisal portfolio.

About NCEPOD
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews healthcare practice by undertaking confidential studies, and makes recommendations to improve the quality of the delivery of care, for healthcare professionals and policymakers to implement. Data to inform the studies are collected from NHS hospitals and Independent sector hospitals across England, Wales, Northern Ireland and the Offshore Islands. NCEPOD are supported by a wide range of bodies and the Steering Group consists of members from the Medical Royal Colleges and Specialist Associations, as well as observers from The Coroners Society of England and Wales, and the Healthcare Quality Improvement Partnership (HQIP).

Impact of NCEPOD
Recommendations from NCEPOD reports have had an impact on many areas of healthcare including:
Development of the NICE ‘Acutely ill patients in hospital guideline’ (CG50) – ‘An Acute Problem’ (2005).
Appointment of a National Clinical Director for Trauma Care – ‘Trauma: Who Cares?’ (2007).
Development of NICE Clinical Guidelines for Acute Kidney Injury, published 2013 – ‘Adding Insult to Injury’ (2009).
Development of ICS Standards for the care of adult patients with a temporary Tracheostomy, published 2014 – ‘On the right trach?’ (2014).
Development of guidelines from the British Society of Gastroenterology: diagnosis and management of acute lower gastrointestinal bleeding, published 2019 – ‘Time to Get Control’ (2015).

Development of the British Thoracic Society's Quality Standards for NIV, published 2018 – 'Inspiring Change' (2017).

This study was commissioned by The Healthcare Quality Improvement Partnership (HQIP) as part of the Clinical Outcome Review Programme into Child Health.

B. Organisation details

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

Please save the questionnaire as you work through this section

1. Does this organisation provide: (Please tick all that apply)

☐ Physical healthcare ☐ Community healthcare ☐ Mental healthcare
☐ Primary care

Please specify any additional options here...

2. Does this organisation provide: (Please tick all that apply)

☐ Paediatric services ☐ Adolescent services ☐ Adult services

Please specify any additional options here...

3a. If answered "Paediatric services" to [2] then:
In general, up to what age do paediatric services commonly care for young people?

years ☐ Not Applicable ☐ Unknown

3b. If answered "Paediatric services" to [2] then:
Does this vary by specialty?

◯ Yes ◯ No ◯ Unknown

4a. If answered "Adult services" to [2] then:
What age do adult services commonly start in this organisation?

years ☐ Not Applicable ☐ Unknown

4b. If answered "Adult services" to [2] then:
Does this vary by specialty?

◯ Yes ◯ No ◯ Unknown

5. If answered "Paediatric services" or "Adult services" to [2] then:
Are paediatric and adult services on the same site?

◯ Yes - for all sites ◯ Yes - for some sites ◯ No
◯ Unknown ◯ Not applicable

6a. Does this organisation have an adolescent inpatient unit/ward?

◯ Yes ◯ No ◯ Unknown

6b. If answered "Yes" to [6a] then:
What is the age range of patients seen in this unit/ward?
If not known, please type unknown

6c. If answered "Yes" to [6a] then:
When is this unit/ward open?

- ◯ 24/7
- ◯ Normal working hours (e.g. 8am-6pm) 7 days/week
- ◯ Normal working hours (e.g. 8am-6pm) Monday-Friday
- ◯ Unknown

If not listed above, please specify here...

6d. If answered "Yes" to [6a] then:
How many beds does this unit/ward have?

beds ☐ Unknown

6e. If answered "Yes" to [6a] then:
Which specialties can use this unit/ward?

◯ Medical and surgical ◯ Medical only ◯ Surgical only
◯ Unknown

If not listed above, please specify here...

6f. If answered "Yes" to [6a] then:
How many whole time equivalent nurses does the unit/ward have? (role solely for adolescent medicine)

☐ Not Applicable ☐ Unknown

6g. If answered "Yes" to [6a] then:
Are nursing staff:

◯ Separate from paediatric or adult services ◯ Shared with paediatric and adult services
◯ Unknown

If not listed above, please specify here...

7a. Does this organisation have an adolescent outpatient clinic?

◯ Yes ◯ No ◯ Unknown

7b. If answered "Yes" to [7a] then:
What is the age range of patients seen in this clinic?
If not known, please type unknown

7c. If answered "Yes" to [7a] then:
Which specialties can use this clinic?

◯ Medical and surgical ◯ Medical only ◯ Surgical only
◯ Unknown

If not listed above, please specify here...

8a. Is there a policy to schedule adolescent outpatient appointments to be longer than paediatric and adult appointments?

◯ Yes ◯ No ◯ Unknown

8b. If answered "Yes" or "No" to [8a] then:
Please give any further details about the scheduling of adolescent outpatient appointments

C. The transition team or service

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

Please save the questionnaire as you work through this section

This next set of questions aims to find out if there is a team that oversees transition across the whole organisation, and whether there are teams that organise transition services at a specialty level

1a. Does this organisation have one overarching transition team that supports transition across every specialty?
Please see definitions: https://www.ncepod.org.uk/transition.html

◯ Yes ◯ No ◯ Unknown

1b. If answered "Yes" to [1a] then:
Which division is the primary focus of the transition team?

◯ Paediatric services
◯ Adult services
◯ Combined (paediatric and adult) services
◯ Unknown

If not listed above, please specify here...

1c. If answered "Yes" to [1a] then:
Who are regular members of the transition team responsible for transition? (Please tick all that apply)

☐ Paediatric clinicians
☐ Adult clinicians
☐ Clinical nurse specialists
☐ Nurses
☐ Physiotherapists
☐ Occupational therapists
☐ Management
☐ Key workers
☐ Youth workers
☐ Peer support
☐ Community team clinicians
☐ Community team nurses
☐ GPs/Primary care
☐ Young people
☐ Parent carers
☐ Unknown

Please specify any additional options here...

1d. If answered "Yes" to [1a] then:
Do core members of the transition team have dedicated time in their job plan for transition?

◯ Yes ◯ No ◯ Unknown

1e. If answered "Yes" to [1a] then:
Are any members of this transition team on short term funding

◯ Yes ◯ No ◯ Unknown

1f. If answered "Yes" to [1a] and "Yes" to [1e] then:
Which funding is provided? (Please tick all that apply)

☐ Roald Dahl funding
☐ Burdett Nursing Trust funding
☐ Other charity funding
☐ Unknown

Please specify any additional options here...

1g. If answered "Yes" to [1a] and "Yes" to [1e] then:
Has there been an organisational commitment to continue the role long term?

◯ Yes ◯ No ◯ Unknown

1h. If answered "Yes" to [1a] then:
Are other colleagues invited to transition team meetings as needed?

◯ Yes ◯ No ◯ Unknown

1i. If answered "Yes" to [1a] and "Yes" to [1h] then:
If virtual meetings are held, do:

- ◯ More colleagues attend than an in-person meeting
- ◯ Less people attend than an in-person meeting
- ◯ There is no difference in attendance between in-person and virtual meetings
- ◯ Unknown
- ◯ NA - virtual meetings not held

If not listed above, please specify here...

1j. If answered "Yes" to [1a] then:
Please give any further details regarding transition team meetings:

2a. Does this organisation have more than one service that supports transition (i.e. specialty led transition)?

◯ Yes ◯ No ◯ Unknown

2b. If answered "Yes" to [2a] then:
Is this:

- ◯ Single site Trust/Health Board – by specialty
- ◯ Multi-site Trust/Health Board – by hospital across all specialties (one transition service within in each h
- ◯ Multi-site Trust/Health Board – by specialty across all hospitals (one transition service for each specialt
- ◯ Multi-site Trust/Health Board – by specialty and by hospital (one transition service for each specialty wi
- ◯ Unknown

If not listed above, please specify here...

2c. If answered "Yes" to [2a] then:
Is there one person coordinating this across services?

◯ Yes ◯ No ◯ Unknown

2d. If answered "Yes" to [2a] then:
Are other colleagues invited to transition team meetings as needed?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

2e. If answered "Yes - for all specialties" or "Yes - for some specialties" to [2d] and "Yes" to [2a] then:
If YES, does this include those caring for the young person?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

2f. If answered "Yes - for all specialties" or "Yes - for some specialties" to [2d] and "Yes" to [2a] then:
If virtual meetings are held, do:

- ◯ More colleagues attend than an in-person meeting
- ◯ Less people attend than an in-person meeting
- ◯ There is no difference in attendance between in-person and virtual meetings
- ◯ Unknown
- ◯ NA - virtual meetings not held

If not listed above, please specify here...

2g. If answered "Yes" to [2a] then:
Please give any further details regarding transition team meetings:

3a. If answered "No" to [1a] and "No" to [2a] then:
If there is not more than one team, service or person overseeing transition, is there one person who oversees transition in the organisation?

◯ Yes ◯ No ◯ Unknown

3b. If answered "No" to [1a] and "Yes" to [3a] and "No" to [2a] then:
Please give further details:
Do not include any names

4. Please give any further details regarding this organisations transition service:

From this point on, questions about the 'transition team or service' refer to the model of transition service used in this organisation, i.e. one team that support transition across the organisation, multiple teams across the organisation or one person.

5a. Do all young people transitioning from child to adult services have a key worker/named worker? (someone who coordinates their care)
Please see definitions: https://www.ncepod.org.uk/transition.html

◯ Yes ◯ No ◯ Unknown

5b. If answered "Yes" to [5a] then:
Is there a job description of their role?

◯ Yes ◯ No ◯ Unknown

5c. If answered "Yes" to [5a] then:
How are key workers/named workers funded? (Please tick all that apply)

☐ Core NHS activity ☐ Roald Dahl funding ☐ Burdett Nursing Trust funding
☐ Other charity funding ☐ Unknown

Please specify any additional options here...

6a. Does this organisation have a youth worker?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

6b. If answered "Yes - for all specialties" or "Yes - for some specialties" to [6a] then:
How many?

6c. If answered "Yes - for all specialties" or "Yes - for some specialties" to [6a] then:
How are these roles funded? (Please tick all that apply)

☐ Core NHS activity ☐ Roald Dahl funding ☐ Burdett Nursing Trust funding
☐ Other charity funding ☐ Unknown

Please specify any additional options here...

7a. Does the transition team or service involve young people in the design of the transition service?

◯ Yes - for all specialties ◯ Yes - for some specialties
◯ No ◯ Unknown
◯ NA - no transition team or service

7b. If answered "Yes - for all specialties" or "Yes - for some specialties" to [7a] then:
How is this undertaken? (Please tick all that apply)

☐ Suggestions box ☐ Informal discussion ☐ Group meetings ☐ Not involved
☐ Unknown

Please specify any additional options here...

8. Generally when does the transition team or service stop being involved with the care of the young person?

- ◯ At transfer
- ◯ After review in adult services
- ◯ Varies by transition team
- ◯ NA - no transition team or service
- ◯ Unknown

If not listed above, please specify here...

9. Is transition care included in funding arrangements/contracts?

- ◯ Yes - for all specialties
- ◯ Yes - for some specialties
- ◯ No
- ◯ Unknown

10. Is there separate commissioning for transition care?

- ◯ Yes – for all specialties
- ◯ Yes – for some specialties
- ◯ No
- ◯ Unknown

D. Management structure for transition

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

1a. Does this organisation have at least one clinical lead for transition? (i.e. consultant/CNS/lead nurse)

◯ Yes ◯ No ◯ Unknown

1b. If answered "Yes" to [1a] then:
Please give further details

2a. Does this organisation have a senior executive accountable for developing and publishing transition strategies and policies?

◯ Yes ◯ No ◯ Unknown

2b. If answered "Yes" to [2a] then:
Please give further details (e.g. around the reviewing, auditing and updating of policies)

3a. Does this organisation have a member of the transition team or service who supports the executive board in developing and publishing transition strategies and policies?

◯ Yes ◯ No ◯ Unknown

3b. If answered "Yes" to [3a] then:
Please give any further details

4a. Does this organisation have a senior manager accountable for implementing transition strategies and policies?

◯ Yes ◯ No ◯ Unknown

4b. If answered "Yes" to [4a] then:
Please give any further details

E. Clinical resources for transition

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

1. Is transitional care included in the job descriptions of healthcare staff involved in transition?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

2a. Does this organisation hold transition clinics where both children's and adult services attend the appointment?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

2b. If answered "Yes - for all specialties" or "Yes - for some specialties" to [2a] then: Are these formally commissioned/funded?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

2c. If answered "Yes - for all specialties" or "Yes - for some specialties" to [2a] then: How are these run? (Please tick all that apply)

☐ Jointly between paediatric and adult services (within the same organisation)
☐ Jointly between organisations (between paediatric and adult services)
☐ From paediatric services only
☐ From adult services only
☐ Unknown

Please specify any additional options here...

2d. If answered "Yes - for all specialties", "Yes - for some specialties" or "No" to [2a] then: Please give any further details/examples of what is done in this organisation (we would like to share examples of where this works well or barriers to this process)

3a. Does this organisation hold joint appointments staffed by both children's and adult services?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

3b. If answered "Yes - for all specialties", "Yes - for some specialties" or "No" to [3a] then:
Please give any further details regarding this (we would like to share examples of where this works well or barriers to this process)

4a. Does this organisation have resources to specifically develop young people's self-management of their health needs?

◯ Yes ◯ No ◯ Unknown

4b. If answered "Yes" to [4a] then:
Please give any further details about these resources (we would like to share examples of where this works well or barriers to this process)

5a. Does this organisation have a policy to encourage young patients to access primary care for their other health needs?

◯ Yes ◯ No ◯ Unknown

5b. If answered "Yes" or "No" to [5a] then:
Please give any further details/examples of what is done in this organisation (we would like to share examples of where this works well or barriers to this process)

F. The transition pathway (including policies and protocols)

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

Please save the questionnaire as you work through this section

1. Does this organisations electronic medical record have a flagging system to identify young people going through transition?

◯ Yes ◯ No ◯ Unknown

2a. Does this organisation have an overarching transition policy?

◯ Yes ◯ No ◯ Unknown

2b. If answered "Yes" to [2a] then:
Does this cover young people with:

◯ All long-term conditions ◯ Specific long-term conditions ◯ Unknown

2c. If answered "Yes" to [2a] then:
Does it state: (please tick all that apply)

- ☐ At what age transition planning should generally start
- ☐ That there is an option for young people to choose the time to transfer to adult services
- ☐ In general how long before planned transfer to adult services, young people should be involved in disc
- ☐ That every patient transitioning to adult care has a personal folder/passport of relevant information ab
- ☐ That all young people transitioning have a transition plan in place from early adolescence (e.g. Ready,
- ☐ That all young people who are transitioning meet the adult team before moving to adult services
- ☐ That young people should be given support to learn how to self-manage their condition(s)
- ☐ That care should be given in a developmentally appropriate setting
- ☐ Steps to assess the developmentally and clinically appropriate age for transfer to adult services?
- ☐ Unknown

Please specify any additional options here...

2d. If answered "Yes" to [2a] and "At what age transition planning should generally start" to [2c] then:
If YES to age at which transition planning should generally start, what age is this?

Years ☐ Unknown

2e. If answered "Yes" to [2a] and "That all young people transitioning have a transition plan in place from early adolescence (e.g. Ready, Steady, Go?)" to [2c] then:
If YES to transition plans, which plans are used: (Please tick all that apply)

- ☐ Ready Steady Go
- ☐ HEADSS
- ☐ Together for short lives - Stepping Up
- ☐ 10 step programme - Alder Hey
- ☐ Making healthcare work for young people - Northumbria Healthcare Foundation Trust
- ☐ Education Health Care Plan model - Council for Disabled Children
- ☐ Local transition plan
- ☐ Unknown

Please specify any additional options here...

2f. If answered "Yes" to [2a] and "That all young people transitioning have a transition plan in place from early adolescence (e.g. Ready, Steady, Go?)" to [2c] then:
If YES to transition plans, is this audited to confirm transition plans are in place?

◯ Yes ◯ No ◯ Unknown

2g. If answered "Yes" to [2a] and "That all young people who are transitioning meet the adult team before moving to adult services" to [2c] then:
If YES to meeting with the adult team, is this audited to confirm this has taken place?

◯ Yes ◯ No ◯ Unknown

2h. If answered "Yes" to [2a] then:
Is there flexibility within the policy to allow for the young person to be transferred at a time that is developmentally and clinically appropriate?

◯ Yes ◯ No ◯ Unknown

2i. If answered "Yes" to [2a] then:
Please give any further details/examples of this organisations transition policy (we would like to share examples of where this works well or barriers to this process)

3a. If answered "No" or "Unknown" to [2a] then:
Does this organisation have separate policies which state: (please tick all that apply)

- ☐ At what age transition planning should generally start
- ☐ That there is an option for young people to choose the time to transfer to adult services
- ☐ In general how long before planned transfer to adult services, young people should be involved in disc
- ☐ That every patient transitioning to adult care has a personal folder/passport of relevant information ab
- ☐ That all young people transitioning have a transition plan in place from early adolescence (e.g. Ready,
- ☐ That all young people who are transitioning meet the adult team before moving to adult services
- ☐ That young people should be given support to learn how to self-manage their condition(s)
- ☐ That care should be given in a developmentally appropriate setting
- ☐ Steps to assess the developmentally and clinically appropriate age for transfer to adult services?
- ☐ No separate policies
- ☐ Unknown

Please specify any additional options here...

3b. If answered "That all young people transitioning have a transition plan in place from early adolescence (e.g. Ready, Steady, Go?)" to [3a] and "No" or "Unknown" to [2a] then:
If YES to transition plans, which plans are used: (Please tick all that apply)

- ☐ Ready Steady Go
- ☐ HEADSS
- ☐ Together for short lives - Stepping Up
- ☐ 10 step programme - Alder Hey
- ☐ Making healthcare work for young people - Northumbria Healthcare Foundation Trust
- ☐ Education Health Care Plan model - Council for Disabled Children
- ☐ Local transition plan
- ☐ Unknown

Please specify any additional options here...

3c. If answered "That all young people transitioning have a transition plan in place from early adolescence (e.g. Ready, Steady, Go?)" to [3a] and "No" or "Unknown" to [2a] then: If YES to transition plans, is this audited to confirm transition plans are in place?

◯ Yes ◯ No ◯ Unknown

3d. If answered "That all young people who are transitioning meet the adult team before moving to adult services" to [3a] and "No" or "Unknown" to [2a] then: If YES to meeting with the adult team, is this audited to confirm this has taken place?

◯ Yes ◯ No ◯ Unknown

3e. If answered "No" or "Unknown" to [2a] then: Is there flexibility within the policies to allow for the young person to be transferred at a time that is developmentally and clinically appropriate?

◯ Yes ◯ No ◯ Unknown
◯ NA - no separate policies

3f. If answered "No" or "Unknown" to [2a] then: Please give any further details/examples of these policies: (we would like to share examples of where this works well or barriers to this process)

4a. In general, do different specialties have separate policies for transition?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

4b. If answered "Yes - for all specialties", "Yes - for some specialties" or "No" to [4a] then: Please give any further details/examples of what is done in this organisation (we would like to share examples of where this works well or barriers to this process)

5a. Does this organisation have a mechanism for the coordination of a single transfer date for patients under multiple clinical teams?

◯ Yes ◯ No ◯ Unknown

5b. If answered "Yes" to [5a] then:
Please give any further details/examples of what is done in this organisation (we would like to share examples of where this works well or barriers to this process)

6a. What happens where there is no equivalent adult specialty for the young person to transfer to? (Please tick all that apply)

- ☐ Young person is seen in a general adult clinic
- ☐ The young person is discharged to the GP
- ☐ Young person is seen in a specialty clinic for main subspecialty only
- ☐ Unknown
- ☐ Not applicable

Please specify any additional options here...

6b. If answered "Young person is seen in a general adult clinic", "The young person is discharged to the GP" or "Young person is seen in a specialty clinic for main subspecialty only" to [6a] then:
Please give any further details/examples of what is done in this organisation if there is no equivalent adult specialty for the young person to transfer to (we would like to share examples of where this works well or barriers to this process)

7a. Does this organisation have a pathway to liaise with social care for young people transitioning?

◯ Yes ◯ No ◯ Unknown

7b. If answered "No" to [7a] then:
If NO, how are the transition needs of looked after children addressed?
Please see definitions: https://www.ncepod.org.uk/transition.html

8a. Does this organisation have a pathway to liaise with education for young people transitioning?

◯ Yes ◯ No ◯ Unknown

8b. If answered "Yes" or "No" to [8a] then:
Please give any further details/examples of what is done in this organisation (we would like to share examples of where this works well or barriers to this process)

9a. Does the organisation have a policy to check that all young people under the care of their services are registered with a GP?

◯ Yes ◯ No ◯ Unknown

9b. Does the organisation have information for patients on how to contact their GP?

◯ Yes ◯ No ◯ Unknown

9c. Does this organisation have a pathway to liaise with primary care for young people transitioning?

◯ Yes ◯ No ◯ Unknown

9d. Please give any further details/examples of what is done in this organisation (we would like to share examples of where this works well or barriers to this process)

10a. Is this organisation a member of a network of care for transition?
Please see definitions:
https://www.ncepod.org.uk/pdf/current/Transition/Definitions%20Transition%20%20finalised.pdf

◯ Yes - formal ◯ Yes - informal ◯ No ◯ Unknown

10b. If answered "Yes - formal" or "Yes - informal" to [10a] then:
Is this

◯ Trust/Health Board based ◯ Specialty based ◯ Unknown

If not listed above, please specify here...

10c. If answered "Yes - formal" or "Yes - informal" to [10a] then:
Please give any further details/examples of what is done in this organisation (we would like to share examples of where this works well or barriers to this process)

10d. If answered "No" to [10a] then:
If NO, how does this organisation link with other organisations to address the needs of young people transitioning from child to adult health services?

G. Involving young people and parent carers

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

Please save the questionnaire as you work through this section

1. Does this organisation have a policy giving the opportunity for young people to routinely attend appointments on their own?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

2a. If a young person attends appointments with parent carers are they given the opportunity to be seen alone?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

2b. If answered "Yes – for all specialties" or "Yes – for some specialties" to [2a] then: Is this information (that they are able to be seen alone) made clear in appointment letters, posters in waiting areas, and informational resources?

◯ Yes ◯ No ◯ Unknown

2c. If answered "Yes – for all specialties" or "Yes – for some specialties" to [2a] then: Please give any further information as to how this is undertaken:

3. Are parent carers given the opportunity to be seen alone?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

4a. Does this organisation have a policy which states that all young people from the age of 13 transitioning have an annual (or more frequent) transition review pre-transfer?

◯ Yes ◯ No ◯ Unknown

4b. Does this organisation have a policy which states that all young people who have transferred to adult services are offered an annual (or more frequent) transition review post-transfer to ensure engagement?

◯ Yes ◯ No ◯ Unknown

5a. Does this organisation have a policy which states that all young people transitioning receive any support regarding education or careers?

◯ Yes ◯ No ◯ Unknown

5b. If answered "Yes" to [5a] then:
Does it state how this should be provided? (Please tick all that apply)

- ☐ Yes - In person careers advisor
- ☐ Yes - Signposting to other services
- ☐ Yes - Sharing resources
- ☐ No
- ☐ Unknown

Please specify any additional options here...

6a. Does this organisation have a policy which states that young people should be offered the opportunity to be actively involved in transition?

- ◯ Yes
- ◯ No
- ◯ Unknown

6b. If answered "Yes" to [6a] then:
Does this state how this should be undertaken? (Please tick all that apply)

- ☐ Yes - Jointly develop care plans
- ☐ Yes - Deciding how they would like a parent carer to be involved
- ☐ No
- ☐ Unknown

Please specify any additional options here...

7a. Does this organisation have a policy which states that parent carers should be offered the opportunity to be actively involved in transition?

- ◯ Yes
- ◯ No
- ◯ Unknown

7b. If answered "Yes" to [7a] then:
Does this state how this should be undertaken?

- ◯ Yes
- ◯ No
- ◯ Unknown

7c. If answered "Yes" to [7a] and "Yes" to [7b] then:
How is this undertaken?

8a. Does this organisation have a youth forum?

- ◯ Yes
- ◯ No
- ◯ Unknown

8b. If answered "Yes" to [8a] then:
Does this include young people with: (Please tick all that apply)

- ☐ Physical health needs
- ☐ Mental health needs
- ☐ Social care needs
- ☐ No health care needs
- ☐ Lay representatives
- ☐ Unknown

Please specify any additional options here...

8c. If answered "Yes" to [8a] then:
How often does this group meet?

◯ Once a month ◯ Four times a year ◯ Twice a year ◯ Once a year
◯ Unknown

If not listed above, please specify here...

8d. If answered "Yes" to [8a] then:
How often does the group give feedback?

◯ Once a month ◯ Four times a year ◯ Twice a year ◯ Once a year
◯ Unknown

If not listed above, please specify here...

8e. If answered "Yes" to [8a] then:
Who does the group give feedback to?

9a. Are parent carers signposted to support groups during the transition process?

◯ Yes ◯ No ◯ Unknown

9b. If answered "No" to [9a] then:
If NO, how are parent carers supported?

H. Communication

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

Please save the questionnaire as you work through this section

1. Does this organisation have a transition page on its website?

◯ Yes ◯ No ◯ Unknown

2. Does this organisation have a policy that appointments for young people are made at times more convenient for them (i.e. after school hours)?

◯ Yes ◯ No ◯ Unknown

3. Does this organisation offer a service of holistic care to young people? (e.g. a 'one-stop-shop' model – with access to other services such as sexual health, mental health, nutrition etc)

Please see definitions: https://www.ncepod.org.uk/transition.html

◯ Yes ◯ No ◯ Unknown

4. Does the organisation have a policy that young people are routinely copied into correspondence regarding their care:

◯ Both pre- and post transfer ◯ Pre-transfer only ◯ Post transfer only
◯ Unknown

If not listed above, please specify here...

5. Does this organisation have a policy that parent carers are routinely copied into correspondence where appropriate regarding their young person's care:

◯ Both pre- and post transfer ◯ Pre-transfer only ◯ Post transfer only
◯ Unknown

If not listed above, please specify here...

6a. Who else is routinely copied into correspondence regarding young people's care pre-transfer? (Please tick all that apply)

☐ Primary care ☐ Community care ☐ Social care ☐ Education
☐ Unknown

Please specify any additional options here...

6b. Who else is routinely copied into correspondence regarding young people's care post-transfer? (Please tick all that apply)

☐ Primary care ☐ Community care ☐ Social care ☐ Education
☐ Unknown

Please specify any additional options here...

7a. Does this organisation have an appropriate environmental space for young people? (i.e. a young person friendly environment appropriate for age)

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

7b. If answered "Yes – for all specialties" or "Yes – for some specialties" to [7a] then: What resources are available for young people within this environment? (Please tick all that apply)

☐ Sexual health resources ☐ Resources regarding drugs ☐ Educational resources
☐ Unknown

Please specify any additional options here...

8a. Does this organisation have resources specifically designed for young people? (i.e. One stop-shop model)

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

8b. If answered "Yes - for all specialties" or "Yes - for some specialties" to [8a] then: Please give further information about these resources, including where they are provided (e.g. intranet, leaflets, websites, apps, shared care records etc.):

9a. Does this organisation have a policy to provide young people and their families with information about the process of transition in this organisation?

◯ Yes ◯ No ◯ Unknown

9b. If answered "Yes" to [9a] then: Does it state how this information should be provided? (please tick all that apply)

☐ Yes - verbally ☐ Yes - written ☐ Yes - digitally ☐ No
☐ Unknown

Please specify any additional options here...

10. Does this organisation have a policy regarding reasonable adjustments (such as accessible information) for young people with a learning disability?

◯ Yes ◯ No ◯ Unknown

I. Training

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

1a. Does this organisation have training for staff regarding developmentally appropriate healthcare/adolescent healthcare/caring for young people? (Please tick all that apply)

◯ Yes - mandatory training ◯ Yes - non-mandatory training ◯ No
◯ Unknown

1b. If answered "No" to [1a] then:
If NO, why not?

2a. Does this organisation have a policy which explains consent for young people?

◯ Yes ◯ No ◯ Unknown

2b. Do staff in this organisation receive training in consent for young people?

◯ Yes ◯ No ◯ Unknown

3a. Does this organisation have a policy which describes how confidentiality should be explained to young people?

◯ Yes ◯ No ◯ Unknown

3b. If answered "Yes" to [3a] then:
Does it include information for parents about the young persons rights to confidentiality?

◯ Yes ◯ No ◯ Unknown

3c. Do staff in this organisation receive training in confidentiality for young people?

◯ Yes ◯ No ◯ Unknown

4a. Does this organisation have a policy to review mental capacity and the ability to make decisions regarding their healthcare, for young people before they reach adulthood?

◯ Yes ◯ No ◯ Unknown

4b. Does this organisation provide training in the use of the Mental Capacity Act in relation to Young People?

◯ Yes ◯ No ◯ Unknown

5. Are there are clear policies and procedures for safeguarding young people including those involved in youth participation

◯ Yes ◯ No ◯ Unknown

6a. Does this organisation provide training for staff in transition from child to adult health services?

◯ Yes ◯ No ◯ Unknown

6b. If answered "No" to [6a] then:
If NO, why not?

7. Please give any further information around training programmes for transition: (we would like to share examples of where this works well or barriers to this process)

J. Audit of care

Please answer the questions in relation to services provided by your organisation up to the 31/03/2021

1a. Does this organisation have a register/registers of how many young people aged 13 years and over with chronic disease are currently in the process of transitioning to adult services?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

1b. If answered "Yes – for all specialties" or "Yes – for some specialties" to [1a] then: How many young people are currently on the register(s)?

1c. If answered "Yes – for all specialties" or "Yes – for some specialties" to [1a] then: Is there a method of assessing where young people are on the pathway?

◯ Yes ◯ No ◯ Unknown

1d. If answered "Yes – for all specialties" or "Yes – for some specialties" to [1a] then: Please give any further details:

2a. Is the effectiveness of transition strategies and policies regularly reviewed/audited?

◯ Yes - for all specialties ◯ Yes - for some specialties ◯ No
◯ Unknown

2b. If answered "Yes - for all specialties" or "Yes - for some specialties" to [2a] then: How often does this occur?

◯ Quarterly ◯ Six-monthly ◯ Annually ◯ Unknown

If not listed above, please specify here...

2c. If answered "No" to [2a] then: If NO, why not?

3a. Is an organisational gap analysis undertaken to identify young people who were under children's services but could not access support from adult services?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

3b. If answered "Yes – for all specialties" or "Yes – for some specialties" to [3a] then: Is this analysis been used to inform local planning and commissioning of services?

◯ Yes ◯ No ◯ Unknown

3c. If answered "Yes – for all specialties" or "Yes – for some specialties" to [3a] then: Please give any further details:

4a. Is an organisational gap analysis undertaken to assess compliance with NICE guidelines on transition?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

4b. Is an organisational gap analysis undertaken to assess compliance with the 'You're Welcome' standards?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

5. Does this organisation audit the attendance of staff: (Please tick all that apply)

☐ At joint clinics ☐ At transition team meetings ☐ Not undertaken
☐ Unknown

6a. Is there joint evaluation of the transfer process by the child and adult teams to review ongoing engagement?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

6b. If answered "Yes – for all specialties" or "Yes – for some specialties" to [6a] then: If YES, do these meetings take place on a regular basis?

◯ Yes – for all specialties ◯ Yes – for some specialties ◯ No
◯ Unknown

6c. If answered "No" to [6a] then:
If NO, why not?

K. Impact of the pandemic

1. **Please give any information on the impact of the pandemic on young people going through transition:**

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

By doing so you have contributed to the dataset that will form the report and recommendations due for release in March 2023

NCEPOD

Crohn's Disease

Study Protocol - July 2021

Study Advisory Group Members

This multidisciplinary and lay group has been convened to guide the development of the study and to identify the primary aim and objectives to be met.

Mr	Walter	Douie
Prof	Thomas	Pinkney
Mr	Richard	Guy
Prof	Jimmy	Limdi
Dr	Barney	Hawthorne
Dr	Patrick	Allen
Dr	Bill	Fawcett
Dr	Lyndsay	Pearce
Dr	Varunee	Wirasinghe
Dr	Paul	Hughes-Webb
Ms	Janice	Reid
Ms	Angela	Cole
Ms	Natasha	Burgess
Ms	Sarah-Jane	Hughes
Dr	Miranda	Lomer
Dr	Alison	Culkin
Prof	Stuart	Taylor
Dr	Ian	Arnott
Dr	James	Bunce
Dr	Louise	Hunt
Ms	Sarah	Berry
Mr	Nigel	Buck
Prof	Ailsa	Hart
Dr	Fiona	Eldridge
Ms	Uchu	Meade
Dr	Anja	St. Clair-Jones
Dr	Lois	Scoffield
Dr	Gordon	Moran

Clinical Coordinators

John Abercrombie	Clinical Co-ordinator (Surgery)
Simon McPherson	Clinical Co-ordinator (Radiology)

Non-clinical staff

Hannah Shotton	Clinical Researcher
Dee Koomson	Researcher
Donna Ellis	Administrative Officer

Marisa Mason Chief Executive

Introduction

Crohn's disease is a chronic, relapsing inflammatory condition of the gastrointestinal tract that typically affects the ileum and colon. The incidence of Crohn's disease in the UK is 83 per 10^6/year, with a population prevalence of approximately 284 per 10^5 and typically occurs between the second and fourth decades of life with another peak after age 60. The disease can cause significant psychosocial stress affecting education, employment and inter-personal relationships[1,2]. The cost of care of IBD is considerable, estimated to be at least £720 million per annum- comparable to the cost of treating cancer or heart disease[3].

Despite rapid advances in drug therapy, progressive inflammation can still lead to complications such as strictures, fistulae and abscesses in over 50% of patients and 70-90% of patients will eventually need surgery[4]. The likelihood of surgery has been reported to be 16.3% one year after diagnosis, rising to 47% at 5 years[5].

Complication rates of surgery for Crohn's disease are high, with overall rates of 28-33%, anastomotic septic complications 8-13%[5,6] and mortality 1%. This compares to anastomotic septic complications of 4.6-4.9%, and mortality of 0.3% for general colorectal surgery[7]. Timing of surgery for Crohn's disease was listed in the top 10 non-cancer research priorities by the Association of Coloproctology in a recent Delphi exercise of its entire membership[8].

The increasing use of more potent immunosuppressive therapy (anti-TNF inhibitors, vedolizumab, and now ustekinumab) in addition to thiopurines and methotrexate makes it possible that a decision to resect may be delayed longer than in the past, and emergency or urgent surgery, (if it becomes necessary) will be carried out with these drugs having been recently administered, with potential for increased risk of sepsis[9 10].

Of those responding to the IBD UK Patient Survey, 23% (2,292) had been admitted to hospital for an overnight stay or longer during the previous 12 months. Of this group, 72% were emergency admissions, while 9% had been admitted more than once during the same 12-month period. Emergency admissions and emergency surgery are often a result of missed opportunities for earlier treatment.

Information, education and support for people with Crohn's disease who have surgery is generally provided, although the findings of the IBD UK report (2021) highlight opportunities to think about its impact, accessibility and quality in fully supporting informed choices and feeling well-prepared.

Patients with Crohn's disease do not fall neatly into the framework that governs most surgical practice. Cancer patients are powerfully prioritised by mandated targets yet patients with Crohn's disease, a severe and debilitating illness, are not afforded the same protection. Urgent, rather than emergency, surgical treatment is not reflected in the way waiting lists are managed. People needing surgery for Crohn's disease find themselves given lower priority than cancer and long waiting patients.

The decision regarding the need for and timing of operative intervention is often difficult; requiring effective multi-disciplinary working and high quality patient information and

involvement. This can be particularly difficult to provide if a patient ends up requiring emergency surgical treatment for a problem that could have been managed as a planned procedure by a specialist team.

This study is particularly timely since the Covid pandemic has seriously disrupted the flow of elective surgical patients. Crohn's patients are likely to have been shielding and the lack of face-to-face clinical time will have exacerbated the delays from which these patients so often suffer.

Guidelines and standards

The BSG guidelines include recommendations around the assessment and management of nutrition in patients with IBD[14]

ASCRS guidelines[11] (Strong DCR 2015) state that "anti-TNFs, high-dose corticosteroids, and/or cyclosporine may warrant staged procedures because of concerns about post-operative complications". ECCO guidelines (Gionchetti JCC 2016) likewise states "Prednisolone 20mg daily or equivalent for more than six weeks is a risk factor".

Key Performance Indicators developed from a European Delphi process (presented at ECCO 2015) recommend as pre-operative measures: gastroenterology review to optimise drugs; dietetic referral to optimised nutritional status where indicated; and presence of IBD nurse during surgical consultation to address social and psychological concerns[12].

NICE Guideline on Crohn's Disease[13] states that surgery should be considered as an alternative to medical treatment early in the course of the disease for people whose disease is limited to the distal ileum, taking into account the benefits and risks

The NICE Quality Standards state that people having surgery for inflammatory bowel disease have it undertaken by a colorectal surgeon who is a core member of the inflammatory bowel disease multidisciplinary team.

'My Crohns and Colitis Care' (Crohn's Colitis UK 2015) recommends that every patient with Crohn's disease should have access to a specialist IBD team. The IBD standards (IBDUK) set out what the service should look like[16]. CCUK produced a report in 2021 stating that many of the previous recommendations had still not been met[17].

The ACPGBI guidelines recommend that surgery should be considered for a wide range of indications. It is vital that this is carried out by an integrated team focusing on the optimization of a patient's condition in order to minimize the risk of complications.

The British Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adults state that that surgery should always be discussed as an option in patients failing a therapeutic agent, particularly as there is generally a reduction in response to each successive immunosuppressive or biologic drug. Treatment decisions should be personalised, including use of laparoscopic techniques [14]

The IBD Standards (2019) state that patients should have access to coordinated surgical and medical clinical expertise, including regular combined or parallel clinics with a specialist colorectal surgeon and IBD gastroenterologist. Elective IBD surgery should be performed by a recognised colorectal surgeon who is a core member of the IBD team in a unit where such operations are undertaken regularly. The IBD standards cover the pathway of care from diagnosis, pre-optimisation, the perioperative and post-operative period and follow-up after surgery and advocate throughout, the importance of patient information and support as well as a high-quality specialist service.

Aims and objectives

Overall aim:

The aim of this study is to review of remediable factors in the quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent an abdominal surgical procedure.

Objectives

Organisational

To review the structures and systems in place to deliver a high-quality service to patients with Crohn's disease throughout their pathway of care against existing standards where available, including:

- The presence of an IBD/ Crohn's disease specialist service and the structure of the service
- With sufficient multidisciplinary expertise and staffing; performing sufficient numbers of required procedures
- Adequate facilities for imaging
- The pathway of care:
    - Specialised commissioning pathway- how are these decisions made? Is there a robust process/pathway?
    - Mental health
    - Medicine review
    - Recovery/rehabilitation to discharge
    - Pre-operative assessment
    - Pain
    - Nutrition
    - Risk stratification
- Protocols and policies
- The impact of the COVID-19 pandemic on the service
- Information, education and support for patients with Crohn's disease
- Communication
- Quality improvement/audit

Clinical

To explore remediable factors in the patient pathway of care against existing standards where available, with a focus on the following:

- Delays in diagnosis
    - Delay in surgery (length of wait; moving from elective onto emergency lists)

    - Information, education and support provided to patients– in particular understanding surgery, mental well-being, pre-surgery optimisation and fertility/sex

- Preoperative care (BSG guidelines and IBD Standards- see above)
    - Nutrition
    - Mental Health
    - Pain
    - Medications Management

- Decision making/care planning
    - Multidisciplinary team involvement
    - Surgery/medications
    - Laparoscopic/ open
    - Delays to surgery once a decision has been made to operate
- Pre-operative medications management
    - Biologics
    - Pain
    - Steroids

- Emergency care management
- Perioperative care
    - Identification and Management of complications
    - Stoma education/support (as applicable)
    - Identification and management of complications
    - Rehabilitation
    - Returning to work
    - Mental health
    - Communication between teams and in terms of integrated care between primary and secondary care – care planning, monitoring, discharge and recovery.
- Post-operative care
    - Medication review
    - Regular review
    - Managing complications
    - Mental health
- Effective discharge planning and follow-up

Methods

Patient focus groups and survey

These data collection methods will occur before (focus groups) or during (survey) the data collection described below. There will be no linkage between the data sources and patients will have consented to participate in this part of the study, so participation does not fall under CAG approval.

Focus groups

As part of the scoping of this study, we have worked with patients with Crohn's disease to identify the key areas of care to review, and to ensure a patient-centred study. To this end, a series of four focus groups were undertaken prior to the meeting of the Study Advisory Group.
The results of these focus groups have fed into the development of the study aims and objectives, and a summary is included in Appendix 1.

Patient survey
The views of patients with Crohn's disease will be further interrogated through an anonymous online survey using Qualtrics. In order not to repeat the IBDUK patient survey from 2019[18], this survey will focus primarily on the effect of COVID-19 on the care provided to patients with Crohn's disease

Clinical and organisation data collection

Population/inclusions
Data will be collected on patients aged 16 and older, admitted to hospital as an elective or emergency admission, with an ICD10 code (K50-51.9) Crohn's disease and who underwent intestinal surgery with one of the OPCS codes from chapters G (upper digestive tract: G58-83) or H (lower digestive tract: H01-H62). See Appendix 2 for details

Exclusions
- Patients under the age of 16 years

Participating providers of healthcare
All acute hospital providers to which patients with Crohn's disease might be admitted for treatment/surgery will be asked to participate in the study.

Incidence and prevalence

Hospital Episode Statistics (England) Admissions coded for ICD10 code for Crohn's disease K50-51.9	**Type of admission**	**Number of admissions**
	All	128,692
2019/20	emergency	1721
	elective	1433
PEDW Statistics (Wales) Admissions coded for ICD10 code for Crohn's disease K50-51.9	**Type of admission**	**Number of admissions**
2019/20	All	4470
	Emergency	413

Sample size
Based on population data, over a one-year period in England (2019/20) there were 1433 elective and 1721 emergency admissions to hospital for Crohn's disease.

In order to sample patients for inclusion both prior to, and during, the COVID-19 pandemic data will be requested for the following two time periods:

- September – February 2019-20
- and September – February 2020-21

It is estimated that there could be ~600 elective patients and ~700 emergency patients identified during each 5-month period

Data source	Target number
Organisational questionnaire	~300
Clinician questionnaires	~500
Case note reviews	~500

Sampling patients from two 6-month study periods will allow for assessment of the impact of COVID-19 on the service and to factor in patients with multiple admissions and would enable the sample to be limited to a maximum of two questionnaires per clinician.

Methods of data collection

Sample identification
Within each Trust/Health Board NCEPOD has a Local Reporter (usually employed in clinical audit) who is responsible for providing the details of patients for inclusion in the sample to NCEPOD. At the start of the study the Local Reporter will be contacted and sent details of the study criteria.

Patients with Crohn's disease, who have undergone a surgical procedure*, will be identified retrospectively through ICD10 and OPCS coding via completion of a spreadsheet with selected data from central hospital records. This will include patient details (NHS number, hospital number, age), admission/discharge dates, patient discharge destination (including death), whether admission was elective or emergency, source of admission, ICD10 codes (primary and all), details of the admitting consultant, details of any critical care admissions, the details (OPCS codes, dates) of any surgery/procedures undertaken (including PEG/ RIG insertion).

Once a list of patients has been gathered, ~500 patients will be sampled for inclusion in the clinical questionnaire and peer review process to ensure hospitals and clinicians are not overburdened.
Cases for review would be limited at a maximum of 7 per hospital ensuring the selection has adequate representation of patients who had elective and emergency surgery. Sampling would ensure there was a mix of elective and emergency patients

**Coded with a relevant OPCS code as listed in Appendix 2*

Questionnaires
Clinician questionnaire

A clinical questionnaire will be sent to the consultant responsible for carrying out the surgical procedure. Within this request there will be instruction to pass the questionnaire on to / ask for input from the most appropriate clinician for completion, including the gastroenterologist who cared for the patient during the admission. The clinical questionnaires will be sent to the NCEPOD Local Reporter for dissemination. Reminders will be sent at six weeks and ten weeks where the data is outstanding. Clinicians will be asked to return copied extracts of the patients' case notes to NCEPOD alongside the completed questionnaires (where applicable).

Case note review
The case note review will focus on the group of patients who had an admission during the study periods: September- February 2019/20 and 2020/21

Notes relating to the index admission will include:

- Clinical notes for the duration of the admission
- Operation notes/anaesthetic records/consent forms
- Nursing notes
- Referral letters
- Radiology reports
- Stoma nursing notes
- Allied Health Professional notes – including physiotherapy, occupational therapy, dietetics
- Critical care notes
- Fluid balance
- Weight charts
- MUST charts
- Food charts
- Drug charts
- Observations charts
- Discharge summary
- Follow up appointments for 6-months following discharge

In addition, Relating to the 3-year period prior to the index admission:

- Clinic letters
- Discharge summaries for any previous admissions
- Correspondence to and from the patient – letters, emails etc.
- Primary care notes (where applicable)

Upon receipt at NCEPOD the case notes will be redacted if not already done so.

Organisational questionnaire
Data collected will include information about the organisation of services, care pathways (including specialist commissioned pathways), the use of guidelines and protocols, and multidisciplinary team working (as per organisational objectives).

Reviewer assessment form

A multidisciplinary group of reviewers (details below) will be recruited to assess the case notes and questionnaires and give their opinions on the quality of care via the reviewer assessment form.

Study method test

The data collection methods and data collection tools will be tested to ensure they are robust.

Study promotion

Prior to data collection, NCEPOD will contact all local reporters and ambassadors and send a study poster to display locally to advertise the study. Social media will also be used to publicise the study.

Analysis and Review of Data

Reviewers

A multidisciplinary group of reviewers will be recruited to assess the case notes and questionnaires and provide their opinion on the care the patients received. The reviewer group will comprise Surgeons, Anaesthetists, Dietitians, Gastroenterologists, acute care physicians, nursing, dietetics, pharmacists; specialist IBD nurses/advanced practitioners, Stoma nurses.

An advertisement will be sent to Local Reporters to disseminate throughout the relevant departments. It will also be placed on the NCEPOD website. Successful applicants will be asked to attend a training day where they will each assess the same two sets of case notes to ensure consistent assessment. A number of meeting dates will be arranged, and each reviewer will then be asked to attend a further 6 meetings.

The meetings will either be in the NCEPOD office or carried out on-line using MS TEAMS. NCEPOD staff will ensure there is a mix of specialties (including a core number of surgeons and gastroenterologists) represented at each meeting from across England, Wales and Northern Ireland. Each meeting will be chaired by an NCEPOD Clinical Co-ordinator who will lead discussion around the sets of cases under review. Towards the end of the study the reviewers will be invited to attend a meeting where the data will be presented to and discussed with them. The reviewers will also be sent two copies of the draft report for their comment as this is developed.

Confidentiality and data protection

All electronic data are held in password protected files and all paper documents in locked filing cabinets. As soon as possible after receipt of data NCEPOD will encrypt electronic identifiers and anonymise paper documents. Section 251 approval has been obtained to perform this study without the use of patient consent in England and Wales.

Dissemination

On completion of the study a report will be published and widely disseminated.

Data sharing

Post publication of the study, there is the potential to share anonymised data sets with interested parties working in the same field. This will be undertaken following a strict

process and will ensure the data does not become identifiable in their nature due to small numbers.

Timeline

ORIGINAL	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
CURRENT	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Form the SAG																									
First SAG																									
Write the protocol																									
Design the questionnaires																									
Second SAG																									
Submit approval requests																									
Advertise the study																									
Advertise for Reviewers																									
Create the database																									
Start data collection																									
Reviewer meetings																									
Data analysis																									
Report production 1st review																									
Report production 2nd review																									
Report production 3rd review																									
To HQIP																									
PUBLISH																									

References:

1. Gower-Rousseau C et al. Validation of the Inflammatory Bowel Disease Disability Index in a population-based cohort. Gut 2017;66:588-596.
2. Jones GR et al. Gut 2019
3. Mowat C, Cole A, Windsor A, et al. Gut 2011;60:571
4. Glonchetti P, Dignass A, Danese S, et al. J Crohn's Colitis 2017;11:135
5. Frolkis AD, Dykeman J, Negron ME et al. Gastroenterol 2013;145:996
6. Yamamoto et al. Dis Colon Rectum 2000;43:1141
7. Myrelid et al. Dis Colon Rectum 2000;52:1387
8. Guenaga et al. Cochrane database 2011:001544
9. Tiernan J et al. Colorectal Dis 2014;16:965
10. Ali U et al. Dis Colon Rectum 2014;57:663
11. Yang Z et al. Int J Surg 2014;12:224

12. Strong S,et al. Clinical Practice Guidelines Committee of the American Society of Colon and Rectal Surgeons. Clinical Practice Guideline for the Surgical Management of Crohn's Disease. Dis Colon Rectum. 2015 Nov;58(11):1021-36
13. Fernando Gomollón, Paolo Gionchetti et al. on behalf of ECCO, 3rd European Evidence-based Consensus on the Diagnosis and Management of Crohn's Disease 2016: Part 1: Diagnosis and Medical Management, *Journal of Crohn's and Colitis*, Volume 11, Issue 1, January 2017, Pages 3–25, https://doi.org/10.1093/ecco-jcc/jjw168
14. NICE clinical guideline (CG152): the management of Crohn's disease in adults, children and young people. AP&T. Volume37, Issue2, January 2013. Pages 195-203
15. My Crohns and colitis UK CCUK 2015
16. Lamb CA, Kennedy NA, Raine T, et alBritish Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adultsGut 2019;68:s1-s106.
17. https://s3.eu-west-2.amazonaws.com/files.ibduk.org/documents/IBD-Standards-Core-Statements.pdf
18. http://s3-eu-west-1.amazonaws.com/files.crohnsandcolitis.org.uk/Health_Services/CROJ8096-IBD-National-Report-WEB-210427_(2).pdf
19. https://ibduk.org/reports/crohns-and-colitis-care-in-the-uk-the-hidden-cost-and-a-vision-for-change

Appendix 1- Scoping focus group summary

At the beginning of the NCEPOD Crohn's disease study, a series of focus groups were carried out in order to inform the overall aim and key themes / objectives of the study.
Participants were recruited through an advertisement with CCUK as well as through social media. A total of 14 patients who had undergone a surgical procedure for their Crohn's disease were recruited. The participants were of a range of ages and from all around the country.
The following areas of care were identified as being important for the study to include and these have been incorporated into the aims and objectives:

1) **Misdiagnosis / delay in diagnosis**
2) **Nutrition**

- Lack of advice support at time of diagnosis
- Recording of intolerances on case notes
- Variable access to dietitian in hospital
- Food in hospital should be tailored to Crohn's patients' needs
- Vitamin supplements not easily accessible

3) **Information and support**

- CCUK -only through posters in waiting room, not directed by HC professionals to any support, leaflets
- Access to IBD team/nurses variable, but very good where exists

4) **Communication**

- About the condition and directed to support available
- Informed consent – for surgery, medication- pros and cons
- Advice on discharge- wound care, recognize infection/ complication, helpline etc.
- Links between GP and hospital; medics and surgeons

5) **Mental Health support**
6) **Surgery**

- Consent often not informed- pros and cons risk/ benefit
- Better when IBD team involved
- Emergency surgery
- After care variable- lack of advice information – care at home

7) **Medications**

- Biologics
- Side effects
- Immunosuppressed – management risk of infection, COVID
- Pain medication not well managed

8) **Other**

- Access to toilet on Gastro ward
- Cleanliness – toilets on Gastro wards need more frequent cleaning
- Secondary symptoms- lack of awareness- GP- Fatigue, joint pain, skin, eyes watering
- General attitudes- healthcare professionals not believing the patient
- Treat the patients holistically, not list of symptoms
- Treat with Dignity where possible

Appendix 2- Relevant OPCS–4 codes

The OPCS-4 codes come as either 3 or 4 digit codes. The 3 digit ones are broad categories of types of operation and the 4 digit ones are more precise definitions of the broad categories.

CHAPTER G- UPPER DIGESTIVE TRACT (G58-G83)
G58 Excision of jejunum
G58.1 Total jejunectomy and anastomosis of stomach to ileum
G58.2 Total jejunectomy and anastomosis of duodenum to ileum
G58.3 Total jejunectomy and anastomosis of duodenum to colon
G58.4 Partial jejunectomy and anastomosis of jejunum to ileum
Includes: Jejunectomy and anastomosis of jejunum to jejunum
G58.5 Partial jejunectomy and anastomosis of duodenum to colon
G58.8 Other specified
G58.9 Unspecified
Includes: Jejunectomy nec
G59 Extirpation of lesion of jejunum
G59.1 Excision of lesion of jejunum
G59.2 Open destruction of lesion of jejunum
G59.8 Other specified
G59.9 Unspecified
G60 Artificial opening into jejunum
G60.1 Creation of jejunostomy
G60.2 Refashioning of jejunostomy
G60.3 Closure of jejunostomy
G60.8 Other specified
G60.9 Unspecified
G63 Other open operations on jejunum
G63.1 Open biopsy of lesion of jejunum
Includes: Open biopsy of jejunum
Biopsy of lesion of jejunum nec
Biopsy of jejunum nec
G63.2 Incision of jejunum
G63.3 Closure of perforation of jejunum
G63.4 Open intubation of jejunum
G63.8 Other specified
G63.9 Unspecified
G69 Excision of ileum (Includes: Small intestine nec)
G69.1 Ileectomy and anastomosis of stomach to ileum
G69.2 Ileectomy and anastomosis of duodenum to ileum
G69.3 Ileectomy and anastomosis of ileum to ileum
G69.4 Ileectomy and anastomosis of ileum to colon
G69.8 Other specified
G69.9 Unspecified, Includes: Ileectomy nec
G67 Other operations on jejunum
G67.1 Intubation of jejunum for decompression of intestine

G67.8 Other specified
G67.9 Unspecified
G70 Open extirpation of lesion of ileum
Includes: Small intestine nec
G70.2 Excision of lesion of ileum nec
G70.3 Open destruction of lesion of ileum
G70.8 Other specified
G70.9 Unspecified
G71 Bypass of ileum. Includes: Small intestine nec
G71.1 Bypass of ileum by anastomosis of jejunum to ileum
G71.2 Bypass of ileum by anastomosis of ileum to ileum
G71.3 Bypass of ileum by anastomosis of ileum to caecum
G71.4 Bypass of ileum by anastomosis of ileum to transverse colon
G71.5 Bypass of ileum by anastomosis of ileum to colon nec
Includes: Bypass of ileum by anastomosis of ileum to rectum
G71.8 Other specified
G71.9 Unspecified
G72 Other connection of ileum. Includes: Small intestine nec. Excludes: When associated with concurrent excision of ileum (G69)
G72.1 Anastomosis of ileum to caecum
G72.2 Anastomosis of ileum to transverse colon
G72.3 Anastomosis of ileum to colon nec
G72.4 Anastomosis of ileum to rectum
G72.5 Anastomosis of ileum to anus and creation of pouch hfq- ileo-anal pouch
G72.8 Other specified
G72.9 Unspecified
G73 Attention to connection of ileum. Includes: Small intestine nec
G73.1 Revision of anastomosis of ileum
G73.2 Closure of anastomosis of ileum
G73.8 Other specified
G73.9 Unspecified
G74 Creation of artificial opening into ileum
Includes: Small intestine nec
G74.1 Creation of continent ileostomy
G74.2 Creation of temporary ileostomy
G74.3 Creation of defunctioning ileostomy
Includes: Creation of split ileostomy
G74.8 Other specified
G74.9 Unspecified
G75 Attention to artificial opening into ileum
Includes: Small intestine nec
G75.1 Refashioning of ileostomy
G75.2 Repair of prolapse of ileostomy
G75.3 Closure of ileostomy
G75.4 Dilation of ileostomy

G75.5 Reduction of prolapse of ileostomy
G75.8 Other specified
G75.9 Unspecified
G78 Other open operations on ileum
Includes: Small intestine nec
G78.1 Open biopsy of lesion of ileum
Includes: Open biopsy of ileum
Biopsy of lesion of ileum nec
Biopsy of ileum nec
G78.2 Strictureplasty of ileum
G78.4 Closure of perforation of ileum
G78.5 Exclusion of segment of ileum
G78.8 Other specified
G78.9 Unspecified
G82 Other operations on ileum
Includes: Small intestine nec
G82.2 Intubation of ileum for decompression of intestine
G82.8 Other specified
G82.9 Unspecified
H01 Emergency excision of appendix
H01.1 Emergency excision of abnormal appendix and drainage hfq
H01.2 Emergency excision of abnormal appendix nec
H01.3 Emergency excision of normal appendix
H01.8 Other specified
H01.9 Unspecified
Includes: Emergency appendicectomy nec

CHAPTER H - LOWER DIGESTIVE TRACT (CODES H01-H62)
H02 Other excision of appendix
H02.2 Planned delayed appendicectomy nec
H02.3 Prophylactic appendicectomy nec
H02.4 Incidental appendicectomy
Includes: Appendicectomy performed during course of other abdominal operation
Note: Use as secondary code when performed during creation of caecostomy (H14.9)
H02.8 Other specified
H02.9 Unspecified
Includes: Appendicectomy nec
H03.1 Drainage of abscess of appendix
H03.2 Drainage of appendix nec
H03.8 Other specified
H03.9 Unspecified
H04 Total excision of colon and rectum
H04.1 Panproctocolectomy and ileostomy
Includes: Proctocolectomy nec
H04.2 Panproctocolectomy and anastomosis of ileum to anus and creation of pouch hfq

H04.3 Panproctocolectomy and anastomosis of ileum to anus nec
H04.8 Other specified
H04.9 Unspecified
H05 Total excision of colon
H05.1 Total colectomy and anastomosis of ileum to rectum
H05.2 Total colectomy and ileostomy and creation of rectal fistula hfq
H05.3 Total colectomy and ileostomy nec
H05.8 Other specified subtotal excision of colon
H05.9 Unspecified subtotal excision of colon
H06 Extended excision of right hemicolon
Includes: Excision of right colon and other segment of ileum or colon and surrounding tissue. Caecum
H06.1 Extended right hemicolectomy and end to end anastomosis
H06.2 Extended right hemicolectomy and anastomosis of ileum to colon
H06.3 Extended right hemicolectomy and anastomosis nec
H06.4 Extended right hemicolectomy and ileostomy hfq
H06.8 Other specified
H06.9 Unspecified
H07 Other excision of right hemicolon
Includes: Limited excision of caecum and terminal ileum caecum
H07.1 Right hemicolectomy and end to end anastomosis of ileum to colon
Includes: Ileocaecal resection
H07.2 Right hemicolectomy and side to side anastomosis of ileum to transverse colon
H07.3 Right hemicolectomy and anastomosis nec
H07.4 Right hemicolectomy and ileostomy hfq
H07.8 Other specified
H07.9 Unspecified
H08 Excision of transverse colon
H08.1 Transverse colectomy and end to end anastomosis
H08.2 Transverse colectomy and anastomosis of ileum to colon
H08.3 Transverse colectomy and anastomosis nec
H08.4 Transverse colectomy and ileostomy hfq
H08.5 Transverse colectomy and exteriorisation of bowel nec. Note: Use secondary code for type of exteriorisation of bowel (H14 H15)
H08.8 Other specified
H08.9 Unspecified
H09 Excision of left hemicolon
H09.1 Left hemicolectomy and end to end anastomosis of colon to rectum
H09.2 Left hemicolectomy and end to end anastomosis of colon to colon
H09.3 Left hemicolectomy and anastomosis nec
H09.4 Left hemicolectomy and ileostomy hfq
H09.5 Left hemicolectomy and exteriorisation of bowel nec. Note: Use secondary code for type of exteriorisation of bowel (H14 H15)
H09.8 Other specified
H09.9 Unspecified

H10 Excision of sigmoid colon
H10.1 Sigmoid colectomy and end to end anastomosis of ileum to rectum
H10.2 Sigmoid colectomy and anastomosis of colon to rectum
H10.3 Sigmoid colectomy and anastomosis nec
H10.4 Sigmoid colectomy and ileostomy hfq
H10.5 Sigmoid colectomy and exteriorisation of bowel nec. Note: Use secondary code for type of exteriorisation of bowel (H14 H15)
H10.8 Other specified
H10.9 Unspecified
H11 Other excision of colon
Includes: Excision of colon where segment removed is not stated
H11.1 Colectomy and end to end anastomosis of colon to colon nec
H11.2 Colectomy and side to side anastomosis of ileum to colon nec
H11.3 Colectomy and anastomosis nec
H11.4 Colectomy and ileostomy nec
H11.5 Colectomy and exteriorisation of bowel nec
Note: Use secondary code for type of exteriorisation of bowel (H14 H15)
H11.8 Other specified
H11.9 Unspecified, Includes: Colectomy nec, Hemicolectomy nec
H12 Extirpation of lesion of colon. Includes: Caecum
H12.2 Excision of lesion of colon nec
H12.3 Destruction of lesion of colon nec
H12.8 Other specified
H12.9 Unspecified
H13 Bypass of colon. Includes: Caecum. Excludes: Bypass of colon when associated with excision of colon (H04-H11)
H13.1 Bypass of colon by anastomosis of ileum to colon
H13.2 Bypass of colon by anastomosis of caecum to sigmoid colon
H13.3 Bypass of colon by anastomosis of transverse colon to sigmoid colon
H13.4 Bypass of colon by anastomosis of transverse colon to rectum
H13.5 Bypass of colon by anastomosis of colon to rectum nec
H13.8 Other specified
H13.9 Unspecified
H14 Exteriorisation of caecum
H14.1 Tube caecostomy
H14.2 Refashioning of caecostomy
H14.3 Closure of caecostomy
H14.8 Other specified
H14.9 Unspecified. Includes: Caecostomy nec
H15 Other exteriorisation of colon
H15.1 Loop colostomy
H15.2 End colostomy
H15.3 Refashioning of colostomy
H15.4 Closure of colostomy
H15.5 Dilation of colostomy

H15.6 Reduction of prolapse of colostomy
H15.8 Other specified
H15.9 Unspecified. Includes: Colostomy nec
H16 Incision of colon. Includes: Caecum
H16.1 Drainage of colon
Includes: Drainage of pericolonic tissue
H16.2 Caecotomy
H16.3 Colotomy
H16.8 Other specified
H16.9 Unspecified
H19 Other open operations on colon. Includes: Caecum. Excludes: Repair of intestinovesical fistula (M37.2)
H19.1 Open biopsy of lesion of colon
Includes: Open biopsy of colon, Biopsy of lesion of colon, Biopsy of colon
H19.8 Other specified
H19.9 Unspecified
H30 Other operations on colon
H30.8 Other specified
H30.9 Unspecified
H34 Open extirpation of lesion of rectum
H34.1 Open excision of lesion of rectum
H34.2 Open cauterisation of lesion of rectum
H34.4 Open laser destruction of lesion of rectum
H34.5 Open destruction of lesion of rectum nec
H34.8 Other specified
H34.9 Unspecified
H33 Excision of rectum. Includes: Excision of whole or part of rectum with or without part of sigmoid colon
H33.1 Abdominoperineal excision of rectum and end colostomy
H33.2 Proctectomy and anastomosis of colon to anus
H33.3 Anterior resection of rectum and anastomosis of colon to rectum using staples.
Includes: Rectosigmoidectomy and anastomosis of colon to rectum
H40 Operations on rectum through anal sphincter
H40.1 Transsphincteric excision of mucosa of rectum
H40.2 Transsphincteric excision of lesion of rectum
Includes: Transsphincteric biopsy of lesion of rectum. Transsphincteric biopsy of rectum
H40.3 Transsphincteric destruction of lesion of rectum
H40.4 Transsphincteric anastomosis of colon to anus
H40.8 Other specified
H40.9 Unspecified
H33.4 Anterior resection of rectum and anastomosis nec
H33.5 Rectosigmoidectomy and closure of rectal stump and exteriorisation of bowel. Note: Use secondary code for type of exteriorisation of bowel (G74 H14-H15)
H33.6 Anterior resection of rectum and exteriorisation of bowel. Note: Use secondary code for type of exteriorisation of bowel (G74 H14-H15)

H33.8 Other specified
H33.9 Unspecified. Includes: Rectosigmoidectomy nec
H41 Other operations on rectum through anus
H41.1 Rectosigmoidectomy and peranal anastomosis
H41.2 Peranal excision of lesion of rectum.
Includes: Peranal biopsy of lesion of rectum, Peranal biopsy of rectum
H41.3 Peranal destruction of lesion of rectum
H41.4 Peranal mucosal proctectomy and endoanal anastomosis
H41.8 Other specified
H41.9 Unspecified
H46 Other operations on rectum
H46.8 Other specified
H46.9 Unspecified
H47 Excision of anus
H47.1 Excision of sphincter of anus
H47.8 Other specified
H47.9 Unspecified
H48 Excision of lesion of anus. Includes: Perianal region
H48.1 Excision of polyp of anus
H48.2 Excision of skin tag of anus
H48.3 Excision of perianal wart
H48.8 Other specified
H48.9 Unspecified
H49 Destruction of lesion of anus. Includes: Perianal region
H49.1 Cauterisation of lesion of anus
H49.2 Laser destruction of lesion of anus
H49.3 Cryotherapy to lesion of anus
H49.8 Other specified
H49.9 Unspecified
H54 Dilation of anal sphincter
H54.1 Anorectal stretch. Excludes: Forced manual dilation for haemorrhoid (H53.2)
H54.8 Other specified
H54.9 Unspecified
H55 Other operations on perianal region
H55.1 Laying open of low anal fistula
H55.2 Laying open of high anal fistula
H55.3 Laying open of anal fistula nec
H55.4 Insertion of seton into high anal fistula and partial laying open of track hfq
H55.5 Fistulography of anal fistula
H55.8 Other specified
H55.9 Unspecified
H56 Other operations on anus
H56.1 Biopsy of lesion of anus. Includes: Biopsy of anus
H56.2 Lateral sphincterotomy of anus
H56.3 Incision of septum of anus

H56.4 Excision of anal fissure
H56.8 Other specified
H56.9 Unspecified
H58 Drainage through perineal region
H58.1 Drainage of ischiorectal abscess
H58.2 Drainage of perianal abscess
H58.3 Drainage of perirectal abscess
H58.8 Other specified
H58.9 Unspecified
H62 Other operations on bowel. Includes: Sigmoid colon, Colon, Rectum
H62.1 Laser recanalisation of bowel nec
H62.2 Mobilisation of bowel nec
H62.3 Dilation of bowel nec
H62.4 Intubation of bowel nec
H62.5 Irrigation of bowel nec. Includes: Lavage of bowel nec, Washout of bowel nec
H62.8 Other specified
H62.9 Unspecified

Please return this sheet to [redacted] **by 27th September 2019**

MANAGING FRAILTY AND DELAYED TRANSFERS OF CARE IN ACUTE SETTINGS - SERVICE USER AUDIT DATA COLLECTION TEMPLATE

This service user audit is part of the project looking at "Managing frailty and delayed transfers of care in acute settings". For any queries on the data collection please contact j.macdonald6@nhs.net

The below 11 questions should be completed on up to 50 consecutive discharges on one care of older people ward within your Trust/Health Board between 15th July and 27th September 2019

To support the completion of the service user audit, a printable sheet which can be used to collect data on the ward is available on the next tab.
Please use this sheet to collate data manually for the service user audit prior to submitting your data via e-mail.
All data for the service user audit must be **submitted on this excel spreadsheet** and e-mailed to [redacted] once data has been recorded for 50 service users discharged from the care of older people ward
If you have any queries, please e-mail James MacDonald on [redacted]

No patient identifiable information should be submitted

Name of Trust/UHB/Hospital site:

Name of care of older people ward / medical ward:

Contact details (e-mail address) of contact for the service user audit data collection:

Question	1. Age of service user	2. What was the primary ICD-10 code that the service user was admitted with? (If ICD-10 code not in the list please select 'other')	3. Has this service user been diagnosed with Dementia?	4. What are the service user's normal living arrangements?	5. Has this service user had a hospital admission within the previous 12 months?	6. Has this service user had an emergency hospital re-admission within the last 30 days?	7. At what point in the pathway was CGA delivered to this service user?	8. What was the length of stay in days for this service user?	9. Was this patient a delayed transfer of care?	10. How many days was this patient delayed?	11. Where was this service user discharged to?
Definition	Age in years	**E46** - Unspecified protein-energy malnutrition **F00, F01, F02, F03, F05** - Dementia in Alzheimer's disease; Vascular Dementia; Dementia in other disease classified elsewhere; Unspecified dementia; Delirium due to known physiological condiotion **R15** - Faecal incontinence **R26.2 & R26.8** - Difficulty in walking, not elsewhere classified; Other and unspecified abnormalities of gait and mobility **R32** - Unspecified urinary incontinence **R40** - Somnolence, stupor and coma **R41** - Other symptoms and signs involving cognitive functions and awareness **R46.0** - Very low level of personal hygiene **R54** - Senility **W00-W19** - Falls **Z73.9** - Problem related to life-management difficulty, unspecified **Z74** - Problems related to care-provider dependency **Z99.3** - Dependence on wheelchair **Other** - ALL other ICD-10 codes This question is to assess whether the patient has been admitted with an ICD-10 code which may be a marker for frailty. If the code is not identified on the list please select other. If the service user has multiple ICD-10 codes please select the primary code.	Dementia diagnosis: Mild dementia Moderate or mid-stage Severe or late stage Terminal No diagnosis Please choose no diagnosis unless Dementia has been diagnosed clinically			If this current episode is a re-admission please select Yes	CGA is a multi-dimensional, multi-disciplinary process which identifies medical, social and functional needs, and the development of an integrated/co-ordinated care plan to meet those needs. Assessment unit = frailty unit, short-term assessment unit, CDU, acute medical unit, etc	Include length of stay on assessment units as well as inpatient ward if applicable	A delayed transfer of care occurs when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so	Number of days the patient was ready to go home or move to a less acute stage of care but was prevented from doing so, all causes	Transitional arrangements include bed or home based intermediate care, re-ablement, time to think/assessment beds, awaiting continuing healthcare assessment, etc
	Numerical	**Choose one from the following:-** **E46** - Unspecified protein-energy malnutrition **F00, F01, F02, F03, F05** - Dementia in Alzheimer's disease; Vascular Dementia; Dementia in other disease classified elsewhere; Unspecified dementia; Delirium due to known physiological condiotion **R15** - Faecal incontinence **R26.2 & R26.8** - Difficulty in walking, not elsewhere classified; Other and unspecified abnormalities of gait and mobility **R32** - Unspecified urinary incontinence **R40** - Somnolence, stupor and coma **R41** - Other symptoms and signs involving cognitive functions and awareness **R46.0** - Very low level of personal hygiene **R54** - Senility **W00-W19** - Falls **Z73.9** - Problem related to life-management difficulty, unspecified **Z74** - Problems related to care-provider dependency **Z99.3** - Dependence on wheelchair **Other** - ALL other ICD-10 codes	**Choose one from the following:-** Mild Moderate or mid-stage Severe or late stage Terminal No diagnosis	**Choose one from the following:-** Own home Residential home Nursing home Sheltered housing Unknown Other	**Choose from the following:-** Yes No	**Choose one from the following:-** Yes No	**Choose one from the following:-** In the community/primary care A&E Assessment unit Inpatient ward CGA not delivered	**Numerical**	**Choose one from the following:-** No Yes - attributable to NHS Yes - attributable to social care Yes - attributable to both	**Numerical**	**Choose one from the following:-** Own home Residential home Nursing home Sheltered housing Transitional arrangements Hospice Died Other
Service user											
Service user 1											
Service user 2											
Service user 3											
Service user 4											
Service user 5											
Service user 6											
Service user 7											
Service user 8											
Service user 9											
Service user 10											

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Service user 47											
Service user 48											
Service user 49											
Service user 50											

NHS Benchmarking Network - MANAGING FRAILITY AND DToCS IN ACUTE SETTINGS

SERVICE USER AUDIT 2019

This sheet may be used to collect individual data on the designated care of older people ward.
This printable sheet is to assist local data collection only. Do not submit the individual sheets
Please transfer data collected to the collation excel template for submission to us.
If you have any queries please contact James MacDonald on [redacted] or [redacted]

British Geriatrics Society
Improving healthcare for older people

No patient identifiable information should be noted on this sheet

Please complete for 50 consecutive patients discharged from **one** care of older people inpatient ward in the Trust/Health Board

1 Age of the service user (years)

2 What was the primary ICD-10 code that the service user was admitted with? (If ICD-10 code not in the list please select 'other')

Code	Admitting reason	Tick one
E46	Unspecified protein-energy malnutrition	
F00, F01, F02, F03, F05	Dementia in Alzheimer's disease	
	Vascular dementia	
	Dementai in other diseases classified elsewhere	
	Delirium due to known physiological condition	
R15	Faecal incontinence	
R26.2 & R26.8	Difficulty in walking, not elsewhere classified	
	Other and unspecified abnormalities of gait and mobility	
R32	Unspecified urinary incontinence	
R40	Somnolence, stupor and coma	
R41	Other symptoms and signs involving cognitive functions and awareness	
R46.0	Very low level of personal hygiene	
R54	Senility	
W00-W19	Falls	
Z73.9	Problem related to life-management difficulty, unspecified	
Z74	Problems related to care-provider dependency	
Z99.3	Dependence on wheelchair	
	Other	

3 Has the service user been diagnosed with dementia?

	Tick one
Mild dementia	
Moderate or mid-stage	
Severe or late stage	
Terminal	
No diagnosis	

4 What are the service user's normal living arrangements?

	Tick one
Own home	
Residential home	
Nursing home	
Sheltered Housing	
Unknown	
Other	

(Circle one)

5 Has this service user had a hospital admission within the previous 12 months? **Yes / No**

6 Has this service user had an emergency hospital re-admission within the last 30 days? **Yes / No**
(if this current episode is a re-admission please select Yes)

7 At what point in the pathway was CGA delivered to this service user?

	Tick one
In the community/primary care	
A&E	
Assessment unit	
Inpatient ward	
CGA not delivered	

8 What was the length of stay in days for this service user?
Include length of stay on assessment units as well as IP ward if applicable

9 Was this patient a delayed transfer of care?

	Tick one
No	
Yes - attributable to NHS	
Yes - attributable to social care	
Yes - attributable to both	

10 How many days was this patient delayed?

11 Where was this service user discharged to?

	Tick one
Own home	
Residential home	
Nursing home	
Sheltered Housing	
Transitional arrangements	
Hospice	
Died	
Other	

NHS Benchmarking Network

Managing Frailty and Delayed Transfers of Care in the Acute Setting

BENCHMARKING DATA SPECIFICATION

The deadline for submission of data is **27th September 2019**

Data should be entered into the online collection form: www.members.nhsbenchmarking.nhs.uk

Participation is open to acute providers of older people's care who are members of the NHS Benchmarking Network.

Introduction:

The Older People's Care in Acute Settings benchmarking project was first run in 2014 and ran for 3 years. In 2017, the project changed focused and a deeper dive of the management of Delayed Transfers of Care (DToCs) was undertaken. This was opened to acute, mental health and community hospital providers. Consultation with members in 2018 has requested a re-focus on the pathway of people living with frailty through secondary care, but with a focus on DToCs, as part of the supported discharge element of the project. The benchmarking project will cover the pathway of older people through A&E (linked to our Emergency Care project) to the supported discharge processes.

The project considers links with other sectors including primary care, community, mental health and social care particularly at the front and back end of hospitals.

If your Trust/UHB doesn't specifically operate care of older people wards, please respond in relation to the medical wards.

This project is in partnership with the British Geriatrics Society who have assisted with scoping the data collection.

If you would like to submit separately across multiple Hospital sites, please register each as a separate submission.

Service user audit

The NHS Benchmarking Network has worked with the BGS to develop a service user level audit for the Managing Frailty and DToC in the Acute Setting project.

The objective of the service user level audit is to provide comparative data at service user level to facilitate service improvement in Trusts/UHBs.

Trusts/UHBs are requested to select one care of older people ward where data for the service user audit can be collected. If your Trust/UHB doesn't have a care of older people ward, please select one medical ward.

Service user audit data must be collected via an excel spreadsheet which is available to download on the members' area www.members.nhsbenchmarking.nhs.uk

Completed excel spreadsheets must be returned via e-mail to [redacted] **by 27th September 2019**

Reporting:

An interactive online data analysis tool will be available once the submissions have been validated.

Members will also receive a bespoke dashboard report.

An event to present the findings of the project will take place on the 6th February 2020. Members can register to attend on the members' area of the website.

Project reports will be released in February 2020.

Please note:

- All cost figures must be entered in full. For example £ 1 million should be entered as 1000000
- If you do not have the data to answer the question, please leave blank, do not put zero
- Once data collection has closed your figures will be validated and you will be provided with an opportunity to make amendments. For this process to occur smoothly and ensure members get the most from the project it is important that the data is submitted on time.

Support:

Data definitions are provided, however, questions on interpretation of data items and queries can be submitted to: Lucy Trubacik lucy.trubacik@nhs.net, 0161 266 1333)

IMPORTANT: This EXCEL document is provided to support data collation only and CANNOT be used to submit data
All data must be submitted via online data collection at: www.nhsbenchmarking.nhs.uk

Benchmarking Network

British Geriatrics Society
Improving healthcare for older people

Managing Frailty and Delayed Transfers of Care in the Acute Setting

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Benchmarking Network

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Improving healthcare for older people

Managing Frailty and Delayed Transfers of Care in the Acute Setting

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Data sharing

QUESTION	DATA	DATA TYPE	DATA DEFINITION
Sharing data with NHS Improvement GIRFT Team			
England only: The NHS Improvement GIRFT Geriatric Medicine workstream would like to use participants' data to inform their work with Trusts. Please select "Yes" if you are willing for your data to be shared with the GIRFT team. If you have any questions about this, please contact the Network team for further information.			
Are you willing to share your data with the NHSI GIRFT team?		Yes / No	Not applicable for Wales/Scotland/Northern Ireland. Please see the NHS Improvement privacy notice here: https://improvement.nhs.uk/privacy/.