

1a. Does this hospital operate a rapid advice service for patients with epilepsy to self refer to?

- ☐ Yes ☐ No ☐ Unknown

**1b. If answered "Yes" to [1a] then:
Which services are available?**

please tick all that apply

- ☐ Walk-in clinic ☐ Telephone support ☐ Email response service
☐ Text message service

Please specify any additional options here...

**1c. If answered "Walk-in clinic" to [1b] then:
Hours available (walk in clinic)**

- ☐ Monday - Friday (normal working hours) ☐ Monday - Friday (extended hours)
☐ 7 days a week (normal working hours) ☐ 7 days a week (extended hours)

If not listed above, please specify here...

**1d. If answered "Telephone support" to [1b] then:
Hours available (telephone support)**

- ☐ Monday - Friday (normal working hours) ☐ Monday - Friday (extended hours)
☐ 7 days a week (normal working hours) ☐ 7 days a week (extended hours)

If not listed above, please specify here...

**1e. If answered "Email response service" to [1b] then:
Hours available (email response service)**

- ☐ Monday - Friday (normal working hours) ☐ Monday - Friday (extended hours)
☐ 7 days a week (normal working hours) ☐ 7 days a week (extended hours)

If not listed above, please specify here...

**1f. If answered "Text message service" to [1b] then:
Hours available (text message service)**

- ☐ Monday - Friday (normal working hours) ☐ Monday - Friday (extended hours)
☐ 7 days a week (normal working hours) ☐ 7 days a week (extended hours)

If not listed above, please specify here...

**1g. If answered "Walk-in clinic" to [1b] then:
Hours available (other)**

- ☐ Monday - Friday (normal working hours) ☐ Monday - Friday (extended hours)
☐ 7 days a week (normal working hours) ☐ 7 days a week (extended hours)

If not listed above, please specify here...

2a. Which of the following are available on-site (investigations)?*please tick all that apply*

- | | |
|--|---|
| ☐ Electroencephalogram (EEG) | ☐ MRI |
| ☐ CT | ☐ 3-lead electrocardiogram (ECG) |
| ☐ 12-lead electrocardiogram (ECG) | ☐ Anti-seizure medication blood screen |
| ☐ Vagal Nerve Stimulation (VNS) | ☐ Inpatient video telemetry |
| ☐ Outpatient/ambulatory video EEG | |

Please specify any additional options here...

**2b. If answered "Electroencephalogram (EEG)" to [2a] then:
What hours is EEG available?**

- | | |
|--|--|
| ☐ Monday - Friday (normal working hours) | ☐ Monday - Friday (extended hours) |
| ☐ 7 days a week (normal working hours) | ☐ 7 days a week (extended hours) |

If not listed above, please specify here...

**2c. If answered "MRI" to [2a] then:
What hours is MRI available?**

- | | |
|--|--|
| ☐ Monday - Friday (normal working hours) | ☐ Monday - Friday (extended hours) |
| ☐ 7 days a week (normal working hours) | ☐ 7 days a week (extended hours) |

If not listed above, please specify here...

3a. Does this hospital have an on-site drug and alcohol liaison service?

- | | | |
|---------------------------|--------------------------|-------------------------------|
| ☐ Yes | ☐ No | ☐ Unknown |
|---------------------------|--------------------------|-------------------------------|

**3b. If answered "Yes" to [3a] then:
What hours is the service available?**

- | | |
|--|--|
| ☐ Monday - Friday (normal working hours) | ☐ Monday - Friday (extended hours) |
| ☐ 7 days a week (normal working hours) | ☐ 7 days a week (extended hours) |

If not listed above, please specify here...

**3c. If answered "No" to [3a] then:
Where are patients with known epilepsy/suspected first seizure referred to if their episode was precipitated by drugs and/or alcohol?**

- | |
|---|
| ☐ Alcohol and drug liaison service within Trust/Health Board |
| ☐ Alcohol and drug liaison service within neighbouring Trust/Health Board |
| ☐ Community based alcohol and drug liaison service |
| ☐ Not routinely referred |

If not listed above, please specify here...

Please indicate how each of the following services are accessed**4a. Neurophysiology**

- | | |
|---|--|
| ☐ On-site | ☐ Off-site but within Trust/Health Board |
| ☐ Off-site different Trust/Health Board | ☐ No access to service |

If not listed above, please specify here...

4b. Neuropsychiatry

- ☐ On-site ☐ Off-site but within Trust/Health Board
☐ Off-site different Trust/Health Board ☐ No access to service

If not listed above, please specify here...

4c. If answered "On-site", "Off-site but within Trust/Health Board" or "Off-site different Trust/Health Board" to [4b] then:

What is the current average waiting time (neuropsychiatry)?

Weeks

☐ Unknown

4d. Neuropsychology

- ☐ On-site ☐ Off-site but within Trust/Health Board
☐ Off-site different Trust/Health Board ☐ No access to service

If not listed above, please specify here...

4e. If answered "On-site", "Off-site but within Trust/Health Board" or "Off-site different Trust/Health Board" to [4d] then:

What is the current average waiting time (neuropsychology)?

Weeks

☐ Unknown

1a. Does this hospital have a protocol for patients who have suffered a head injury?

☐ Yes ☐ No ☐ Unknown

1b. If answered "Yes" to [1a] then:**Does this include guidance for patients with epilepsy?**

☐ Yes ☐ No ☐ Unknown

2a. Does this hospital have a guideline for the emergency management of suspected first seizure patients?

☐ Yes ☐ No ☐ Unknown

2b. If a first seizure patient presents to the Emergency Department, is it hospital policy to contact the on-call neurologist?

☐ Yes ☐ No ☐ Unknown

3. Does the hospital have a protocol for treating convulsive status epilepticus?

☐ Yes ☐ No ☐ Unknown

4. Is it hospital policy for the Emergency Department to contact the epilepsy team when existing epilepsy patients are admitted?

☐ Yes ☐ No ☐ Unknown

1a. Does this hospital run first seizure clinics?*These may be virtual clinics*

☐ Yes
 ☐ No
 ☐ Unknown

1b. If answered "Yes" to [1a] then:**What is the current waiting time for an appointment to the first seizure clinic following a first seizure?**

Weeks
 ☐ Unknown

1c. If answered "Yes" to [1a] then:**Is it routine protocol to refer patients that attend the Emergency Department with a suspected first seizure to the first seizure clinic?**

☐ Yes
 ☐ No
 ☐ Unknown

1d. If answered "No" to [1a] then:**Where are first seizure patients usually referred?**

- ☐ First seizure clinic elsewhere within the Trust/Health Board
☐ First seizure clinic at another Trust/Health Board
☐ Community based first seizure clinic

If not listed above, please specify here...

1e. If answered "No" to [1a] then:**Is it routine protocol to refer patients that attend the Emergency Department with a suspected first seizure to a first seizure clinic?**

☐ Yes
 ☐ No
 ☐ Unknown

2. Following a diagnosis of epilepsy what services are patients routinely referred to/provided with?*please tick all that apply*

☐ Telephone follow-up
 ☐ Primary care follow-up
 ☐ Epilepsy clinic

Please specify any additional options here...

3a. Does this hospital run outpatient clinics for epilepsy patients?

☐ Yes
 ☐ No
 ☐ Unknown

3b. Are patients with epilepsy offered routine outpatient appointments?

☐ Yes
 ☐ No
 ☐ Unknown

3c. If answered "No" to [3a] then:**Where are epilepsy patients referred for their ongoing management?**

- ☐ Epilepsy clinic elsewhere within the Trust/Health Board
☐ Epilepsy clinic at another Trust/Health Board
☐ Community based epilepsy clinic

If not listed above, please specify here...

4. Which of the following are provided for patients with epilepsy who attend this hospital?*please tick all that apply*

- ☐ A named lead consultant
- ☐ A nominated key worker
- ☐ A named Epilepsy specialist nurse
- ☐ An agreed personal care plan/long-term care plan
- ☐ Escalation of treatment policy
- ☐ Shared care agreement with specialist centre
- ☐ Arrangements to provide feedback
- ☐ Emergency care plan

Please specify any additional options here...

5a. Is medication adherence routinely monitored for people with established epilepsy?

- ☐ Yes - all patients
- ☐ Yes - all patients experiencing an increase in seizures
- ☐ No

If not listed above, please specify here...

**5b. If answered "Yes - all patients" or "Yes - all patients experiencing an increase in seizures" to [5a] then:
How is this done?**

- ☐ Anti-seizure medication blood levels

If not listed above, please specify here...

6a. Are patients provided with specific information/education regarding epilepsy?

- ☐ Yes
- ☐ No
- ☐ Unknown

**6b. If answered "Yes" to [6a] then:
What does it include?***please tick all that apply*

- ☐ Need to assess risk factors
- ☐ Complications of epilepsy
- ☐ Written self-management plan
- ☐ SUDEP (Sudden Unexpected Death in Epilepsy)
- ☐ Management of epilepsy related risks (eg. alcohol, drugs, medication non-adherence)
- ☐ Impact on life
- ☐ Driving
- ☐ First point of contact

Please specify any additional options here...

**6c. If answered "Yes" to [6a] then:
When is patient education/information provided?**

- ☐ Before discharge from hospital
- ☐ First clinic appointment
- ☐ Before discharge and at first clinic appointment

If not listed above, please specify here...

Additional Information

7. Please use this space should you wish to provide further details on any of the answers you have provided (please include the question number)

8. Please use this space to provide any details of how the COVID pandemic has affected the current service provision for epilepsy patients.

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 the autumn of 2022

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	Scofield
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 10⁶/year, with a population prevalence of approximately 284 per 10⁵ 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 disease³.

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 surgery⁴. The likelihood of surgery has been reported to be 16.3% one year after diagnosis, rising to 47% at 5 years⁵.

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 surgery⁷. 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 membership⁸.

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 IBD¹⁴

ASCRS guidelines¹¹ (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 concerns¹².

NICE Guideline on Crohn's Disease¹³ 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 like¹⁶. CCUK produced a report in 2021 stating that many of the previous recommendations had still not been met¹⁷.

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:
 - o Specialised commissioning pathway- how are these decisions made? Is there a robust process/pathway?
 - o Mental health
 - o Medicine review
 - o Recovery/rehabilitation to discharge
 - o Pre-operative assessment
 - o Pain
 - o Nutrition
 - o 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)
 - o Nutrition
 - o Mental Health
 - o Pain
 - o Medications Management
- Decision making/care planning
 - o Multidisciplinary team involvement
 - o Surgery/medications
 - o Laparoscopic/ open
 - o Delays to surgery once a decision has been made to operate
- Pre-operative medications management
 - o Biologics
 - o Pain
 - o Steroids
- Emergency care management
- Perioperative care
 - o Identification and Management of complications
 - o Stoma education/support (as applicable)
 - o Identification and management of complications
 - o Rehabilitation
 - o Returning to work
 - o 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
 - o Medication review
 - o Regular review
 - o Managing complications
 - o 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 2019¹⁸, 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																									

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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

- o About the condition and directed to support available
- o Informed consent – for surgery, medication- pros and cons
- o Advice on discharge- wound care, recognize infection/ complication, helpline etc.
- o Links between GP and hospital; medics and surgeons

5) Mental Health support

6) Surgery

- o Consent often not informed- pros and cons risk/ benefit
- o Better when IBD team involved
- o Emergency surgery
- o After care variable- lack of advice information – care at home

7) Medications

- o Biologics
- o Side effects
- o Immunosuppressed – management risk of infection, COVID
- o 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 hfg

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 intestino-vesical 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

NHS Benchmarking Network

Managing Frailty and Delayed Transfers of Care in the Acute Setting Northern Ireland Summary Report 2019



Southern Health and Social Care Trust

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Introduction

The Managing Frailty and Delayed Transfers of Care in the Acute Setting benchmarking project is now in its second iteration, having developed from earlier Network projects on Older People's Care in Acute Settings, and the Delayed Transfers of Care Project. The project focuses on the pathway of frail, often older, people through the acute setting, covering acute frailty services in A&E, the assessment function, inpatient care and supported discharge. These elements are covered in the organisational level data collection. The project also features a service user audit, directed at older people's wards, and requests that a set of questions relating to the acute pathway are asked of 50 consecutive discharges from one care of older people ward in the organisation. The data specifications for both elements of the project were revised and updated for the 2019 iteration, following extensive consultation with stakeholders including the British Geriatrics Society (BGS), the GIRFT Geriatric Medicine workstream and Network members.

Policy context

The publication of the [NHS Long Term Plan](#) for England in January 2019 has raised the profile of caring for people living with frailty, and has placed a particular emphasis on the care of older people, with reforms to hospital emergency care being cited to reduce pressure on acute services. This will take the form of comprehensive models of Same Day Emergency Care which aim to increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third. Acute frailty services will be introduced to be in operation at least 70 hours per week, working towards achieving clinical frailty assessment within 30 minutes of arrival. The project has established baseline positions for these key metrics in this 2019 iteration for England, however some Northern Ireland Health and Social Care Trusts struggled to provide this data, given it is not currently national strategy, and so has been omitted from the report.

Frailty is an important issue for many older people in Northern Ireland. Rates of frailty increase markedly with age and the condition is often a stage along a road leading to functional decline, disability and dependence. Early detection of frailty can prevent, or at least slow down, this decline and improve the quality of life of those affected. Apart from the adverse effects on the older people concerned, frailty often places substantial demands on resources such as hospitals, family carers and long term care institutions.

There is a focus on frail older people in the [Transforming Your Care](#) strategic direction (DHSSPS, 2011) which outlines 6 key objectives:-

1. Manage functional decline and frailty through targeted intervention in physical fitness, nutrition status, cognitive function, chronic conditions and diseases, and on the social or psychological wellbeing of older people.
2. Enhance the participation and independence of older people and their carers by empowering and enabling them to remain involved in meaningful activity and in a healthy lifestyle.
3. Promote systematic routine screening for pre-frailty stages in at-risk patients and older people.



Introduction

4. Contribute to research and methodology on frailty and active and healthy ageing and contribute to knowledge generation concerning the mechanisms for ageing and the progression of frailty.
5. Contribute to managing demand and increasing the sustainability of health and social care by reducing the personal, systemic and societal costs associated with ageing.
6. Promote cooperation, including cross-sector international collaboration, between university research groups and companies dedicated to ageing issues in order to support competitive translational research and development.

In response to the need for a co-ordinated strategy for caring for frail older people in Northern Ireland, the Northern Ireland Frailty Network was launched in March 2019, by Dr Michael McBride, Chief Medical Officer and Robert Ferguson, a Service User and Information Ambassador/Peer Facilitator for Age NI, under the auspices of the Northern Ireland Public Health Agency. This was in response to an ageing population in Northern Ireland with the prevalence of frailty increasing with age.

Projection year	65+ years % of the NI population	85+ years % of the NI population
1974	11%	<1%
2017	16%	2%
2039	25%	4%
2047	26%	6%
2064	27%	8%



(Source: slides from the launch of the NI Frailty Network, March 2019)

The Northern Ireland Frailty Network was established using Transformation Funding secured through the Northern Ireland Department of Health and aims to bring together a wide range of people and organisations all with a part to play in caring for the Northern Ireland population living with frailty, as well as having a strong focus on prevention.

The Ambition for Frailty Northern Ireland states

‘Frailty is Everybody’s Business and Everybody should know what to do next when presented with a person living with frailty’

The Frailty Network in Northern Ireland will be working towards the following:-

- Agreeing a definition of frailty
- Developing a clear vision/roadmap
- Putting in place a mechanism to identify those who are frail currently
- To make frailty everybody’s business – currently the care of frail elderly people is fragmented with those caring for these cohort of people often working in silos
- Facilitating change from a medical model of care



- An emphasis on focusing on the 'whole' person
- A proactive, preventative response to frailty management
- Ensuring the excellent care in place in pockets is replicated across the region.

The Frailty Network, via the Northern Ireland Public Health Agency, encouraged all Health and Social Care Trusts (HSCTs) to participate in the *Managing frailty and delayed transfers of care in the acute setting* benchmarking project, in order to use the benchmarking data to provide a stocktake of how frailty is managed across the acute sector in Northern Ireland. A summary report was commissioned separately, and aims to provide a baseline of provision and help identify service improvement opportunities for the Public Health Agency and the HSCTs in managing frailty across acute settings. As all HSCTs in Northern Ireland are members of the Network, they could participate in the project.

Participation

For the 2019 iteration, 95 organisations took part registering 115 submissions between them across England, Wales and Northern Ireland. All 5 Health and Social Care Trusts in Northern Ireland participated. Together the Health and Social Care Trusts in Northern Ireland registered 10 submissions. The larger number of submissions reflect where organisations make submissions for each of their hospital sites, to reflect multiple site provision of acute medical care.

Project process and timescales

Registration for the Managing Frailty project took place in May 2019, and after some re-scoping of the questions and definitions in consultation with stakeholders, the data specification was finalised at the end of June 2019. Data collection ran from mid-July to mid-October 2019. The project collected data for the financial year 2018/19. Data validation occurred during November and December 2019, where participants were given the opportunity to review the data supplied via an early draft of the online benchmarking toolkit. The dataset was finalised in early January 2020. Data collected provides a baseline position of frailty provision within Trusts during 2018/19, it is noted that progress on frailty provision has been made since the data collection period.

A project team was established which met regularly via teleconference throughout the duration of the benchmarking project, supported by members of the NHS Benchmarking Network project support team. There was a project lead identified from each HSCT invited to each call. Representatives from the Frailty Network joined the calls where possible. Guidance was given on interpretation and understanding of the metrics requested, given this was the first time the HSCTs had participated in the project.



Project outputs

The **online benchmarking toolkit** allows peer group profiling in two ways; either via UK country, or by type of acute organisation (small, medium, large, teaching).

This **bespoke report** features the key messages and findings from the project and includes a selection of key metrics included within the project. Your organisation’s position is highlighted in red anywhere that data was supplied. If your organisation made more than one submission, each submission will be highlighted in red. The Northern Ireland submissions are highlighted in green.

There is a Northern Ireland **National Frailty Conference** to be held on 25th March 2020 where the Northern Ireland ‘cut’ of the data will be presented, alongside national policy and good practice case study speakers from Northern Ireland.

Interpreting this report

The 2019 *Managing Frailty* project collected and analysed data for the financial year 2018/19. The charts within each section feature the reported position of all submissions. Any reference to the national average position references the mean average of all 2019 submissions responding, either for the whole sample for England (black thin line), or for the whole Northern Ireland sample (green thin line). Commentary at the start of each section reference the Northern Ireland position, unless otherwise stated.

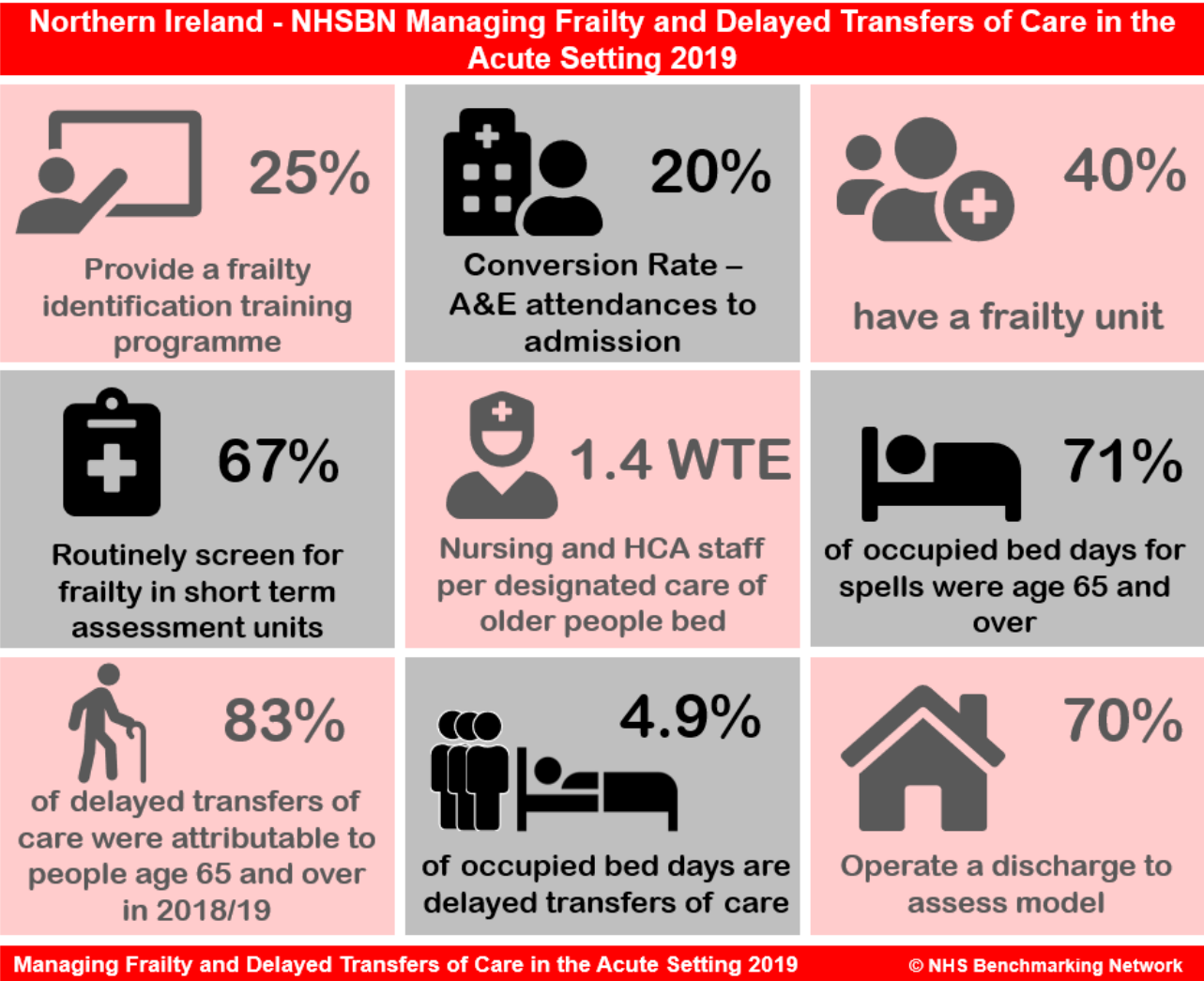
This report should be used in conjunction with the online benchmarking toolkit, which can be found in the members’ area. The toolkit contains the full range of metrics included within the project. The Northern Ireland peer group should be selected to view the Northern Ireland findings only.

The table below lists the submissions for your organisation. Each submission has been assigned a unique identifier code which is used throughout this report and in the online toolkit. The full list of participants from Northern Ireland can be found in Appendix 1.

Code	Submission
MF275	Southern Health and Social Care Trust - Craigavon Area Hospital
MF276	Southern Health and Social Care Trust - Daisy Hill Hospital



The summary graphic below displays key findings from the 2019 iteration of the project.



Key findings

The detail for the findings from each section of the acute pathway is included in the sections which follow, however, areas for service improvement/development opportunities from the Northern Ireland Managing Frailty project are listed below:-

1. Routine identification of frailty is inconsistent across the acute pathway and is not happening in A&E or in inpatient wards. Only one hospital in Northern Ireland reports that they routinely screen for frailty in A&E and the threshold for triggering such a frailty screen is those aged 75+. Routine identification of frailty would appear to be more common in short term assessment units. There may be opportunities to standardise identification of frailty, through the consistent use of an appropriate tool, and through the provision of training to underpin this, across the acute pathway and to share this information across care settings. The most common tool used for the identification of frailty across the UK and in Northern Ireland, from the findings reported in this project, is the Rockwood Clinical Frailty scale.

2. Training for frailty identification is not available on all hospital sites and is not included as part of the mandatory training package anywhere across Northern Ireland. Whilst including frailty training in mandatory training may be in its infancy across the UK, there may be scope to introduce training for frailty identification and management across Northern Ireland, with opportunities for the Northern Ireland frailty network to review and recommend available training scope and packages available. There are training resources available, such as the Frailty Framework of Core Capabilities launched by Skills for Health in the Autumn of 2018, which may assist acute hospitals in Northern Ireland with developing a training strategy across acute medical sites. The framework, which was commissioned by Health Education England (HEE) and NHS England, has been developed to define the skills, knowledge and behaviours that health and care staff need in order to effectively support people living with frailty.

3. Acute frailty units or frailty assessment units are defined as a dedicated facility, usually at the front end of the hospital, that acts as the focus for acute medical care for patients that have presented. It should be available with staff trained specifically to care for the frail older person with a focus on rapid assessment, treatment, and where possible, discharge back to their usual place of care. Comprehensive Geriatric Assessment (CGA) is likely to be delivered by a multi-disciplinary team, and evidence suggests that outcomes for frail older people are better if CGA has been delivered. Only 40% of hospitals in Northern Ireland have a frailty assessment unit which is considerably lower than in England where 70% of hospital sites report having a dedicated frailty unit. Consideration may be given to the possibility of reviewing the availability of such units in Northern Ireland. Evidence from England suggests that few of these frailty units are purpose built; they are more likely to be re-purposing of other facilities, for example, day hospital facilities, and are likely to be co-located with other front-door services, given their focus on assessment.

4. The reported average length of stay across all ages in Northern Ireland is a day longer than that reported in England (6 days in Northern Ireland compared to 5 days in England). This longer length of stay is also replicated when the older aged 85+ cohort is reviewed, with an average length of stay in Northern Ireland reported of 11 days (compared to 9 days in England). In addition, the reported average length of a DToC, as reported in the Service User Audit, was 9 days.



The number of spells which are 7-20 days in length equates to 37% of overall bed capacity, and when reviewing those of 21 days length or more, this also equates to 37% of overall bed capacity, suggesting a review of overall flow through the system, for more efficient use of beds.

5. The percentage of patients admitted as an emergency and **discharged on the day of admission** is reported as much lower than in England (11% in Northern Ireland compared to 30% in England). There may be scope to consider the learning from England on the Same Day Emergency Care (SDEC) workstream, whereby the provision of same day care for emergency patients who would otherwise be admitted to hospital is a key element of the *NHS Long Term Plan* for England. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

6. The findings from Northern Ireland on the percentage of patients **discharged to their usual place of residence** is much lower than in England (82% in Northern Ireland compared to 94% in England). This may be due in part to the lack of availability of home based intermediate care in Northern Ireland, whereby patients requiring a short term rehabilitation package may be discharged home to continue their care. It is understood from work undertaken as part of the National Audit of Intermediate Care (NAIC) in Northern Ireland, that the system is committed to resources being invested in home based intermediate care provision. This ought to impact on the number of patients going home after an acute stay, and will be an important performance measure to review over the coming months/years, as the investment starts to flow.

7. **Comprehensive Geriatric Assessment (CGA)** is seen as the gold standard, evidence based approach for the assessment of older people. CGA is a process of care comprising a number of steps. Initially, a multidimensional holistic assessment of an older person considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly. The extent to which CGA is taking place in the acute setting is tested within the benchmarking project. CGA has a very strong evidence base for effectiveness and has been shown to increase patients' likelihood of being alive and in their own homes after an emergency admission to hospital. The benchmarking project has captured the extent to which CGA is taking place across the acute pathway.

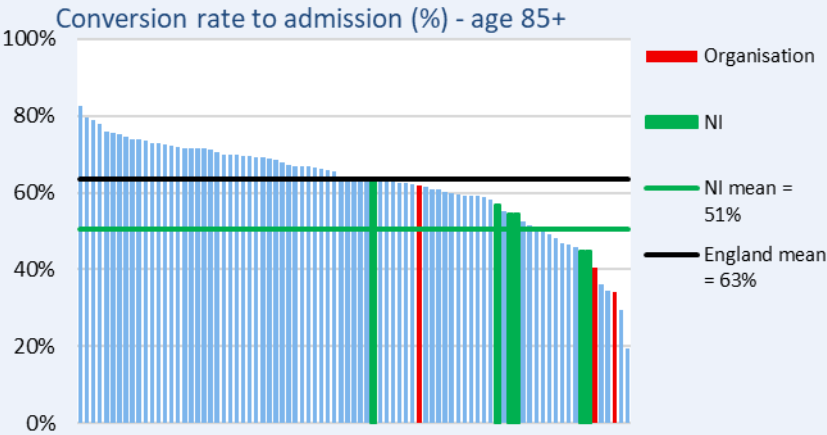
Whilst CGA is taking place in frailty units, short term assessment units and inpatient wards, it is not taking place in other assessment units to the same extent, with under half reporting that CGA takes place there. This is reduced further on other speciality wards to 13%. There may be scope to ensure that CGA is occurring routinely in all types of assessment units and on other specialty wards, although the difficulties of having the resource to cover other specialty wards are recognised.



How to read this report

The following are illustrative charts and do not show your organisation's positions.

Benchmarking bar chart

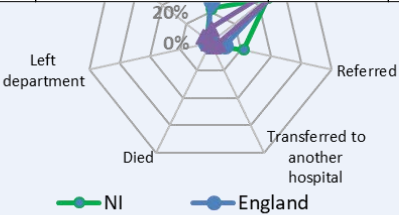


The data is sorted from highest on the left to lowest on the right. All of your submissions will be highlighted with a red bar with the unique identifier code labelled underneath. The list of codes for your submissions can be found on page 6. Other submissions from Northern Ireland will be highlighted in green. The mean values for all NI submissions, and the England mean, are shown as horizontal lines.

Yes/no table

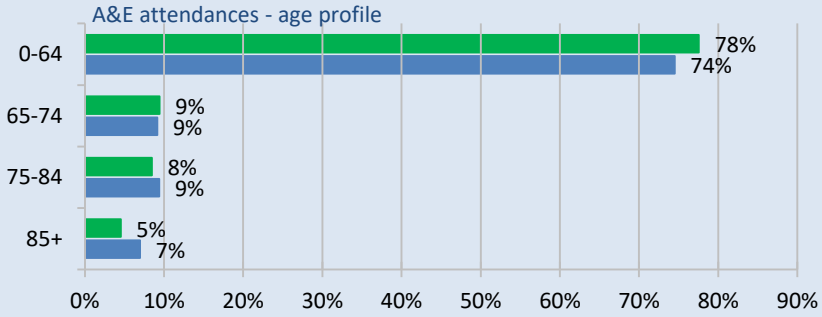
	0% NI % responding yes100%	NI % yes	England % yes	MF268	MF269	MF270
Does your Trust/UHB/Hospital site have an acute frailty service?		80%	95%	Yes	Yes	Yes
Do community services provide in-reach to the A&E department?		60%	52%	No	No	No
Does your Trust/UHB/Hospital site have a frailty unit?		40%	70%	Yes	No	No
Does your Trust/UHB/Hospital site have a short-term assessment unit?		70%	92%	No	No	No
Does your Trust/UHB/Hospital site have other assessment units (between 12 and 72 hours expected maximum length of stay)?		70%	90%	No	Yes	Yes
Does your Trust/UHB/Hospital site operate a "Discharge to Assess" model?		70%	81%	Yes	Yes	Yes
Does your Trust/UHB/Hospital site operate any Early Supported Discharge schemes?		80%	84%	Yes	Yes	Yes

These tables display the results of yes/no questions. The green shaded area represents 'yes' and the red shaded area represents 'no'. Your organisation's results are highlighted in red. The percentage of 'yes' responses for each question is also summarised in the table. The percentage of 'yes' responses from Northern Ireland are also shown.



The chart shows the national split between each outcome category. Your organisation's submission(s) are represented by the other colour lines.

Dual bar chart



Dual bar charts show the percentage split between each category (for example, age profile). The Northern Ireland position is shown in green, the England position is shown in blue and the other bars represent your submission(s).



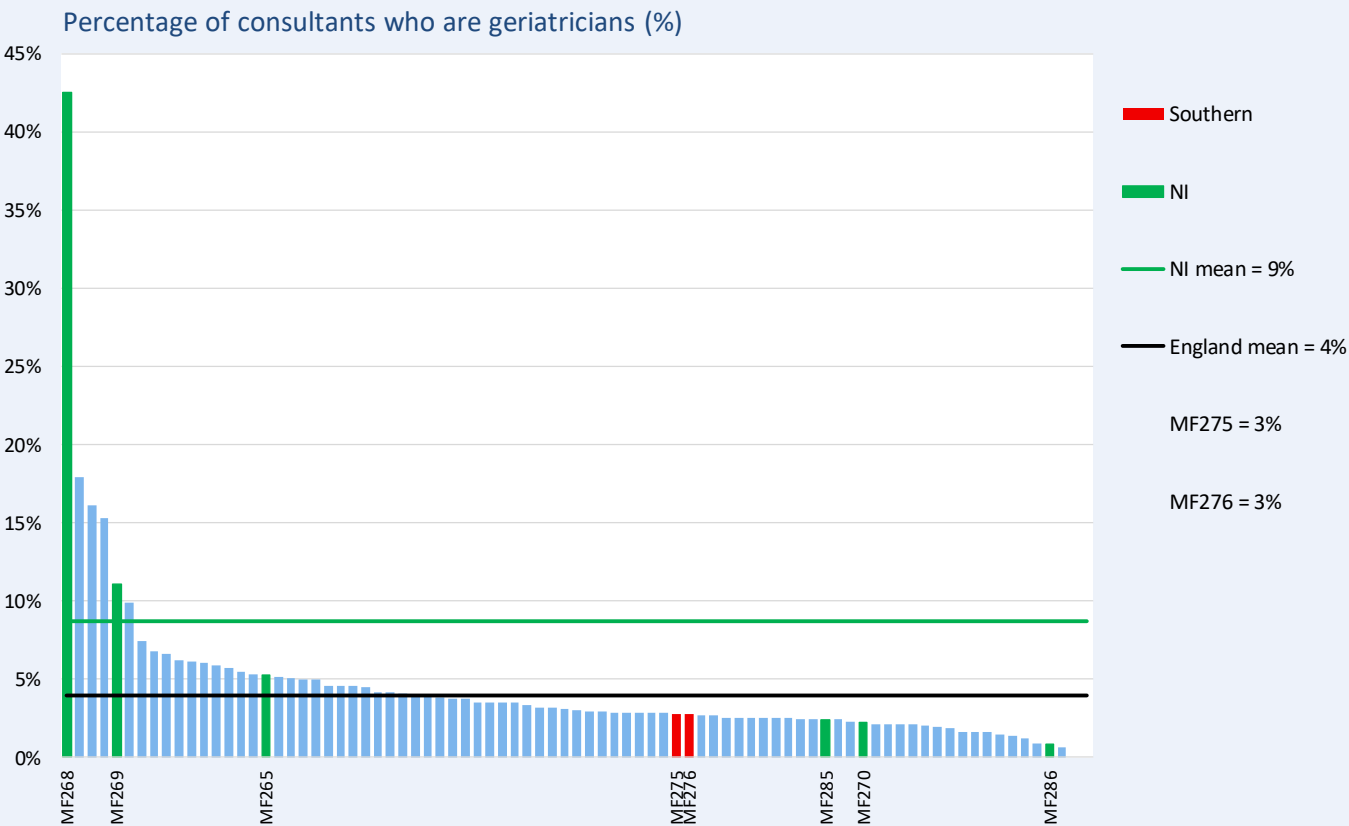
- Participants were asked a set of questions to determine which services for older people living with frailty are available within their hospital. The summary of available services can be found on page 10, along with the percentage of participating hospital sites in Northern Ireland who also offer the service. An acute frailty service is available in 80% of hospital sites. 40% of hospital sites report having a frailty assessment unit. 70% of sites have short term assessment units and 70% have another type of assessment unit. Discharge to assess services are available in 70% of hospitals.
- The mean percentage of the consultant workforce who are geriatricians is 9%, with a median value of 3%.
- On average, geriatricians make up 4% of the consultant workforce across the whole of the acute hospital. Participants employed 179 WTE consultants and 5.3 WTE geriatricians, on average.
- Comprehensive Geriatric Assessment (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. CGA is considered best practice for optimising outcomes for older people. CGA is commonly delivered in frailty units and short term assessment units, routinely taking place in all units of these types from Northern Ireland included in the project. CGA is carried out in other assessment units in 40% of sites. All designated care of older people inpatient wards deliver CGA, compared with just 13% of other inpatient wards.
- CGA is a multi-disciplinary team process, with nursing staff and therapists involved in 86% of sites. Consultants and other medical staff are involved in delivering CGA in 57% of hospitals.
- Some hospitals report offering training for staff on frailty; 25% have a frailty identification/awareness training programme and 50% provide training on how to identify or screen for people living with frailty. However, this training is not mandatory in any hospitals in Northern Ireland.



Organisation overview

Organisation overview

	NI % responding yes	NI % yes	England % yes	MF275	MF276
Does your Trust/UHB/Hospital site have an acute frailty service?		80%	95%	Yes	Yes
Do community services provide in-reach to the A&E department?		60%	52%	Yes	Yes
Does your Trust/UHB/Hospital site have a frailty unit?		40%	70%	No	No
Does your Trust/UHB/Hospital site have a short-term assessment unit?		70%	92%	Yes	Yes
Does your Trust/UHB/Hospital site have other assessment units (between 12 and 72 hours expected maximum length of stay)?		70%	90%	Yes	Yes
Does your Trust/UHB/Hospital site operate a "Discharge to Assess" model?		70%	81%	Yes	Yes
Does your Trust/UHB/Hospital site operate any Early Supported Discharge schemes?		80%	84%	Yes	Yes



Organisation overview

Training

	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Does the Trust/UHB/Hospital site have specific dementia training for all staff?		89%	97%	Yes	Yes
Does the Trust/UHB/Hospital site provide any training on frailty specifically for the surgical specialties?		0%	31%	No	No
Does the Trust/UHB/Hospital site provide a frailty identification/awareness training programme		25%	46%	No	No
Does the Trust/UHB/Hospital site provide training on how to identify/screen for people living with frailty?		50%	52%	Yes	Yes
Does the Trust/UHB/Hospital site provide training on how to assess and manage people living with frailty?		50%	34%	Yes	Yes

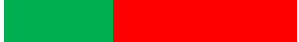
Governance and system linkages

	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Is there a recognised frailty tool/pathway in use in the health and social care economy?		40%	79%	No	No
Does the Trust have a clearly defined strategy/operational policy for the delivery of acute medical care to older people?		60%	75%	Yes	Yes
Do pathways/protocols exist which clearly state the roles and relationships between A & E, frailty units/short term assessment units/other assessments units and the wards?		50%	80%	Yes	Yes
Is there a designated clinical lead for older people's services?		80%	93%	Yes	Yes
Is there a designated Clinical Change Champion for frailty?		50%	61%	Yes	Yes
Is there an executive sponsor within the Trust for the management of frail older people?		60%	70%	No	No
Is there a policy which specifically mentions the management of older people whilst in acute care?		80%	56%	Yes	Yes



Organisation overview

Comprehensive Geriatric Assessment (CGA)

	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Does CGA take place in the frailty unit?		100%	95%	-	-
Does CGA take place in the short term assessment unit?		100%	58%	Yes	Yes
Does CGA take place in the other assessment unit/s?		40%	45%	-	-
Is CGA delivered on Care of Older People wards?		100%	77%	Yes	Yes
Is CGA delivered on other specialty wards?		13%	33%	No	No
Is there an MDT response that initiates CGA within the first hour of admission?		13%	45%	No	No
Does the Trust/UHB/Hospital site have an awareness programme for non-geriatricians about frailty and CGA?		38%	39%	No	No
Can CGA be accessed in the community?		100%	72%	Yes	Yes
Is CGA documented on a single shared assessment document accessible by all MDT members?		100%	58%	Yes	Yes
Do CGAs contain a care plan which has been discussed with the patient and/or their carers?		100%	70%	Yes	Yes

Staff involved in CGA

Who is involved in carrying out CGA on the assessment units?	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Consultant		57%	90%	Yes	Yes
Other medical staff		57%	85%	Yes	Yes
Nurse		86%	90%	Yes	Yes
Therapists		86%	93%	Yes	Yes



- Acute frailty services identify and respond to the needs of those living with frailty. They contribute towards admission avoidance in A&E and aim to prevent unnecessary inpatient admissions for older people living with frailty. 25% of hospitals report that the acute frailty service is located in A&E and 63% of hospitals have an acute frailty service that provides in-reach to the A&E department.
- Screening for frailty on entry to the A&E department is not routine, with only one hospital in Northern Ireland reporting that they routinely screen for frailty. In this case, the age threshold for screening is 75 years and the Rockwood clinical frailty scale is used.
- All teams have therapy staff and social care staff available in A&E to help with admission avoidance. Hospital discharge teams also provide in-reach to A&E departments in all hospital sites in Northern Ireland. Therapy staff are available, on average, 10 hours per day during the week. However, weekend provision is lower, with only 6 hours available each day on average and three hospitals reporting no weekend therapy coverage in A&E. Social workers are available in A&E departments 8 hours per day during the week and 5 hours per day at the weekend. Hospital discharge teams are typically available 8 hours per week day and 6 hours each day at the weekend.
- Conversion rates from and A&E attendance to admission in Northern Ireland are lower than those reported for England. Following an A&E attendance, typically 20% of service users (all ages) in Northern Ireland are admitted and 47% are discharged (compared with 28% admitted in England). 22% of attendees are referred to another service. The likelihood of admission increases with age, with 51% of those aged 85+ (64% in England), on average, being admitted, with 28% being discharged. Participants reported that those aged 65 and over make up 23% of A&E attendances in Northern Ireland.
- On average, unplanned re-attendances to A&E within 7 days make up 4% of all attendances across all age categories in Northern Ireland. Unplanned re-attendances for those aged 85+, who are more likely to be admitted following an A&E attendance, represent 2% of all attendances.

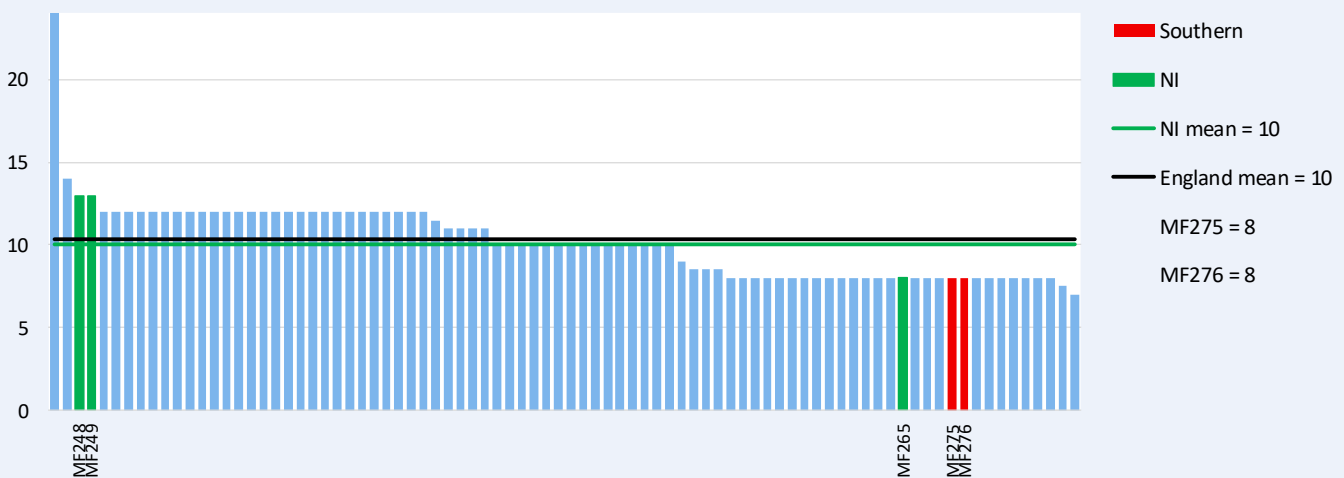


Acute frailty service in A&E

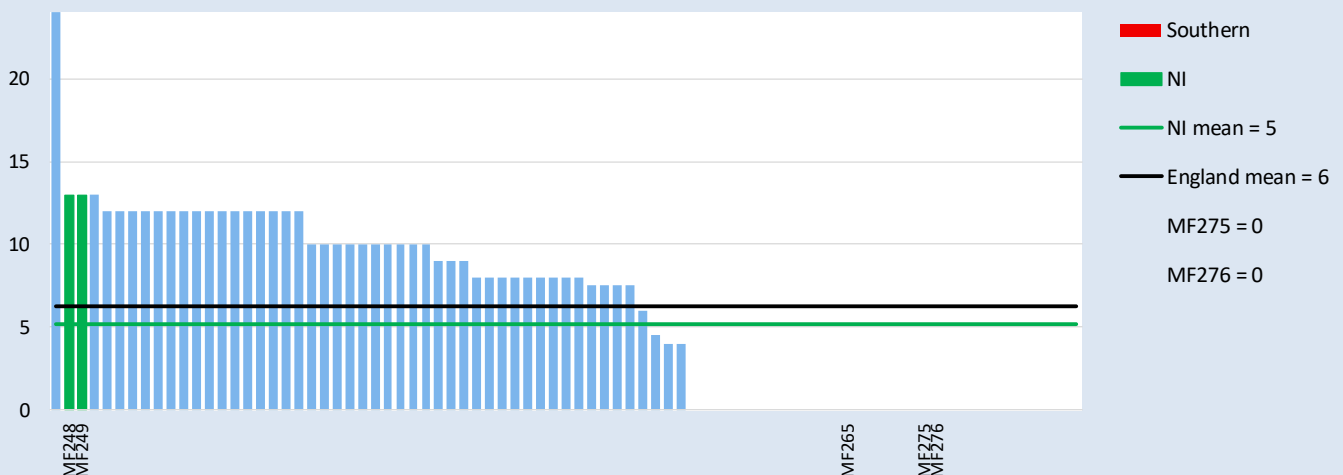
Acute frailty service

	NI % responding yes	NI % yes	England % yes	MF275	MF276
Is the acute frailty service located in the A&E department?		25%	47%	Yes	Yes
Is there an acute frailty service providing in-reach to the A&E department?		63%	83%	Yes	Yes
Does the acute frailty service have rights to admit patients?		100%	85%	Yes	Yes

Hours of availability of acute frailty service over a 24 hour period during the week



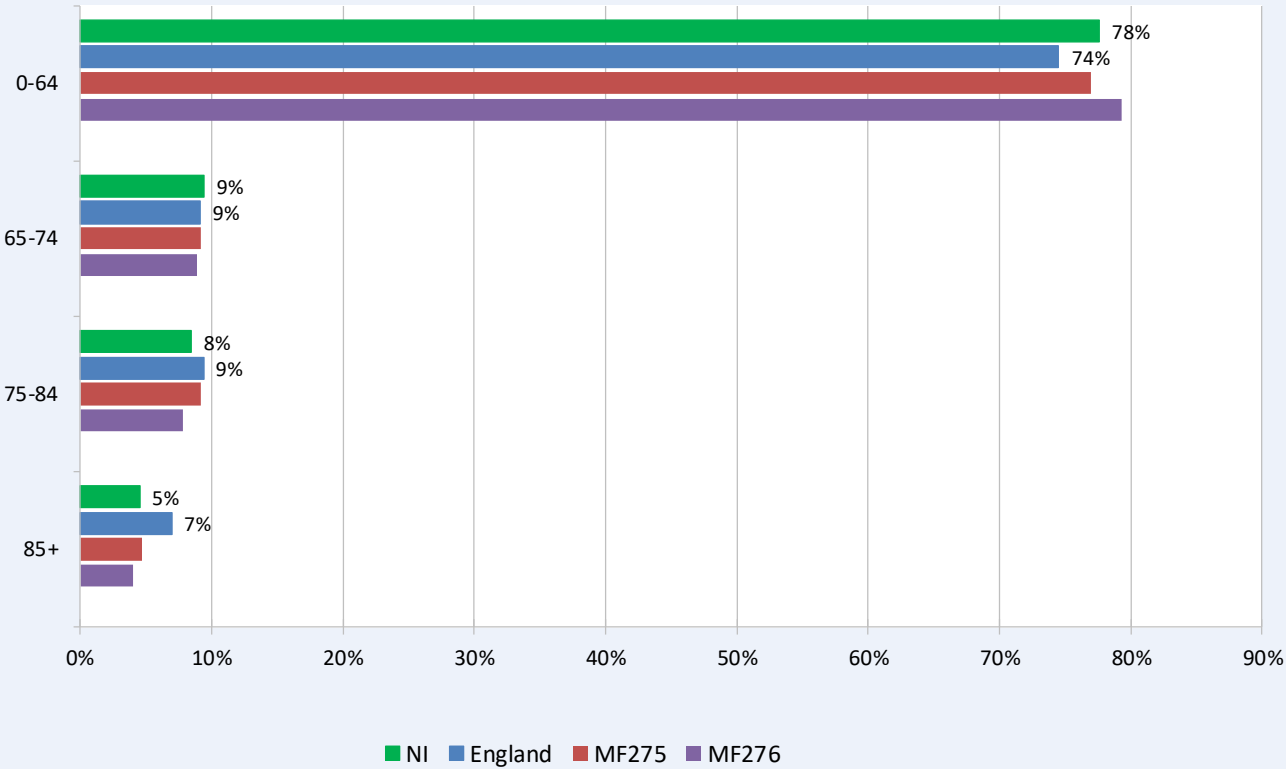
Hours of availability of acute frailty service over a 24 hour period during the weekend



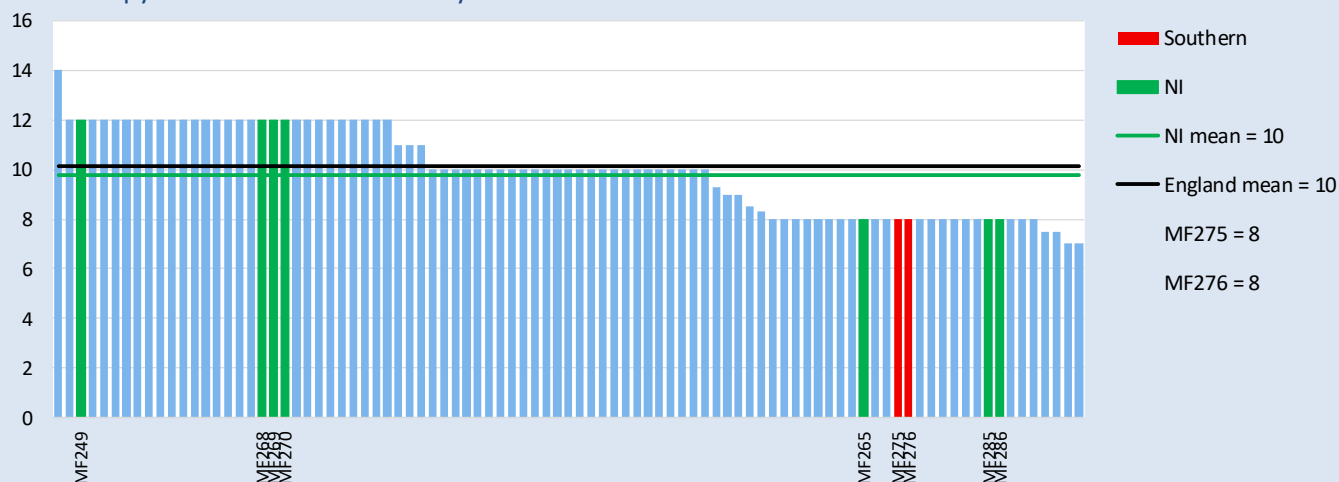
Other assessment units

	NI % responding yes	NI % yes	England % yes	MF275	MF276
	0%100%				
Is routine identification of frailty undertaken on entry to the accident and emergency department in older people?		11%	67%	No	No
Are therapists available in A&E to assist with admission avoidance of older people?		100%	97%	Yes	Yes
Can social workers be rapidly accessed by A&E to assist with admission avoidance of older people?		100%	75%	Yes	Yes
Does the Hospital Discharge Team provide in-reach to A&E?		100%	52%	Yes	Yes
Do community matrons/specialist nurses provide in-reach to A&E to assist with admissions avoidance?		33%	45%	Yes	Yes
Does the Trust/UHB have a locally agreed strategy for providing more daycase emergency care?		33%	79%	No	No

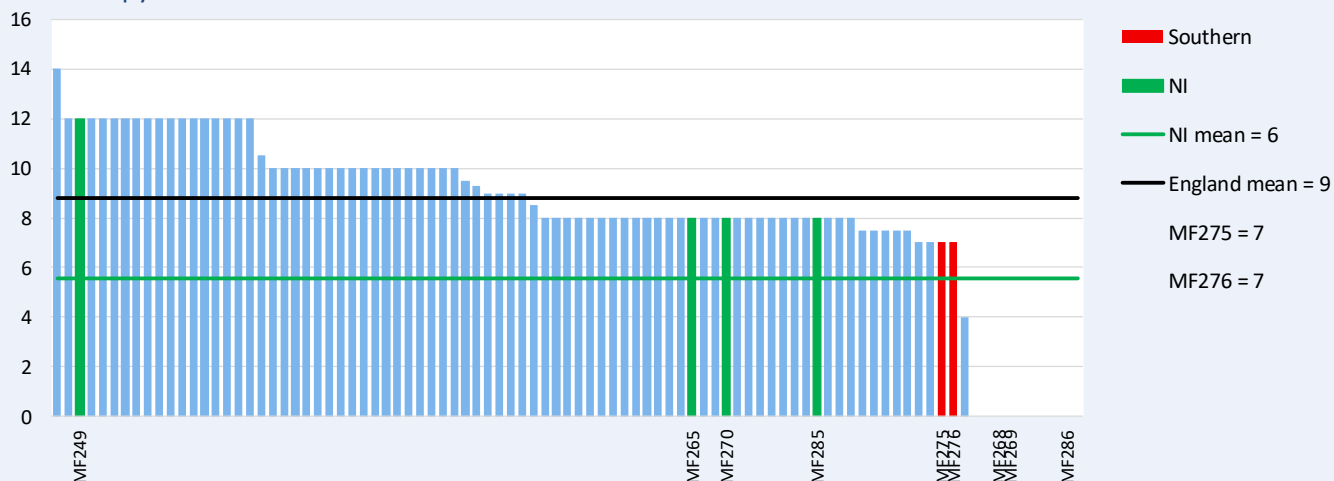
A&E attendances - age profile



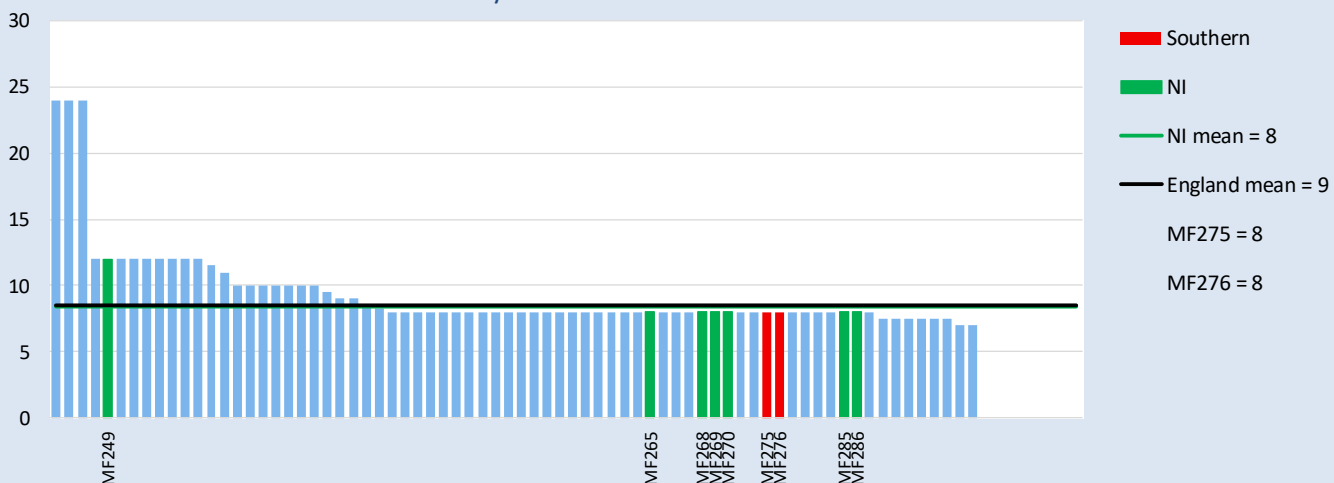
Therapy - hours available weekdays



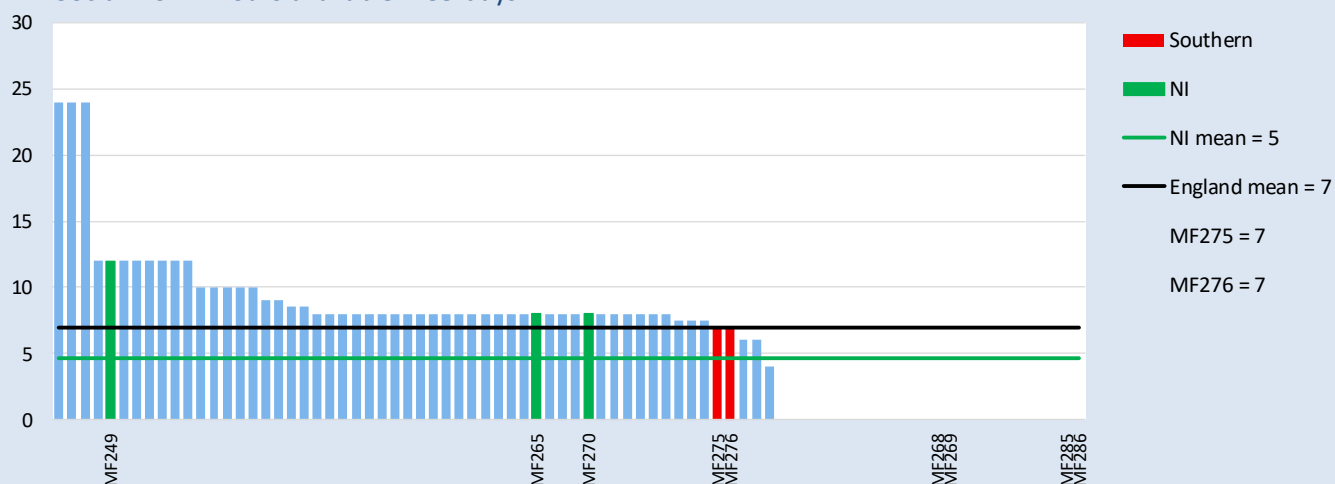
Therapy - hours available weekends



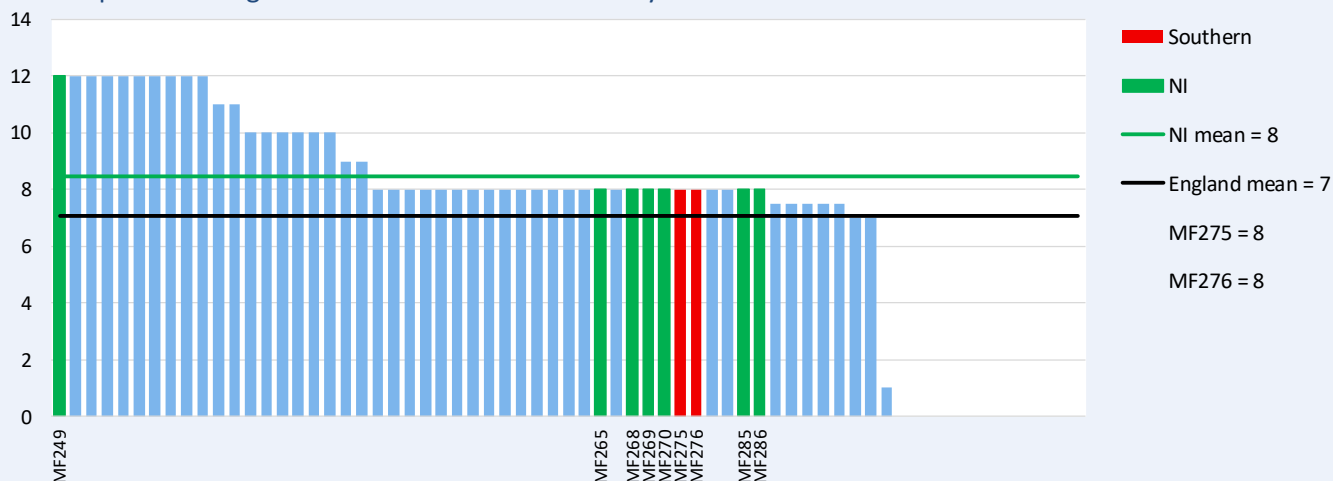
Social work - hours available weekdays



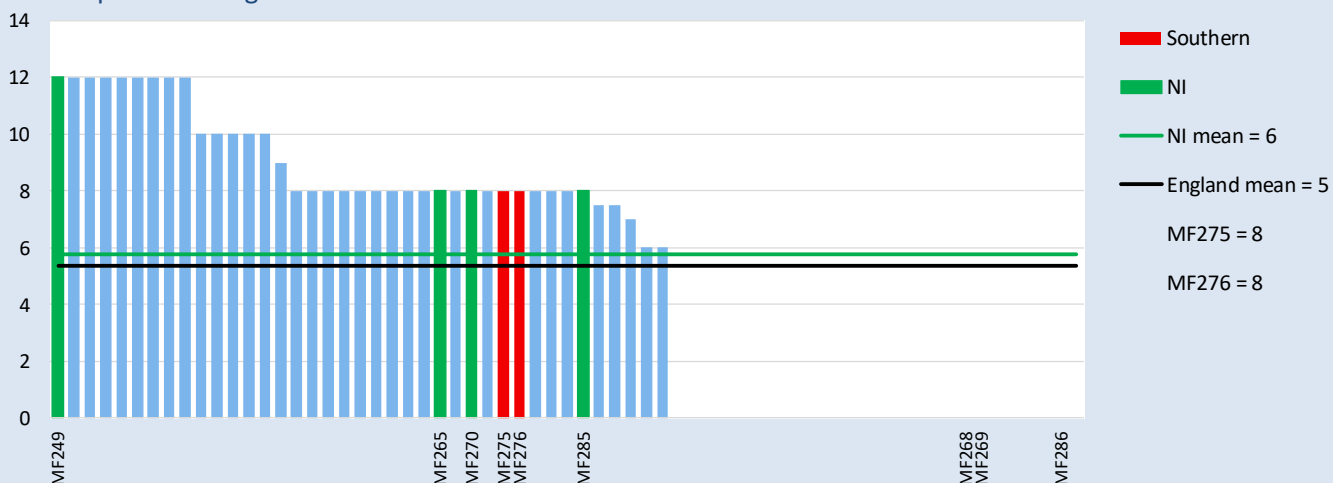
Social work - hours available weekdays



Hospital discharge team - hours available weekdays

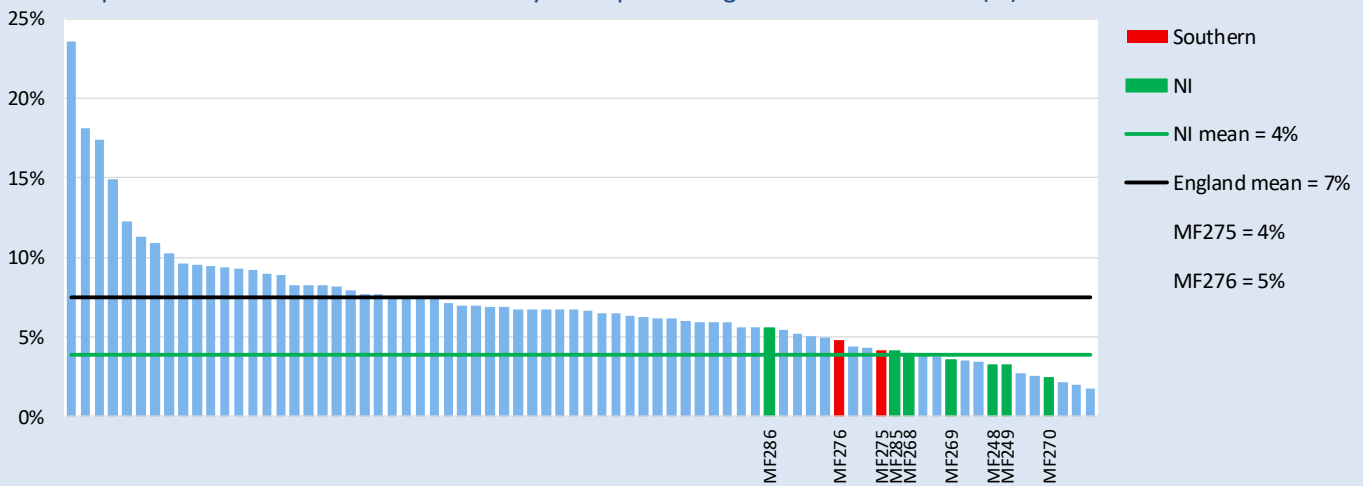


Hospital discharge team - hours available weekends

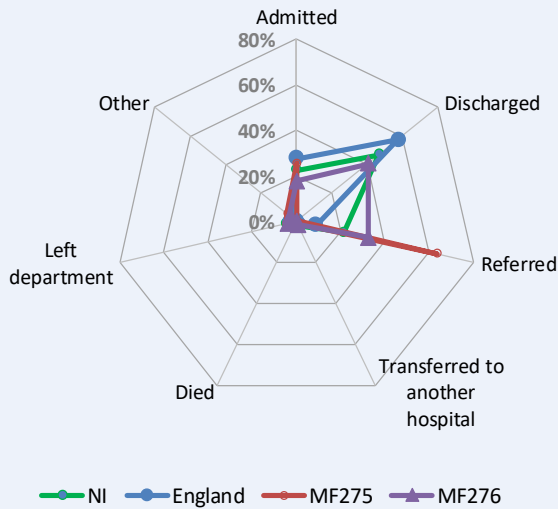


Acute frailty services in A&E

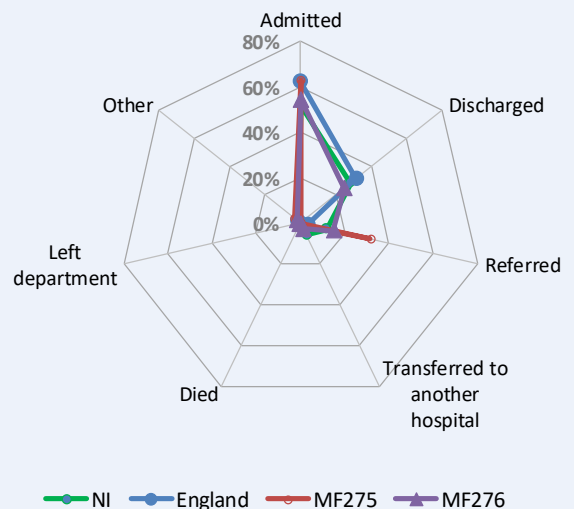
Unplanned re-attendances within 7 days as a percentage of all attendances (%)



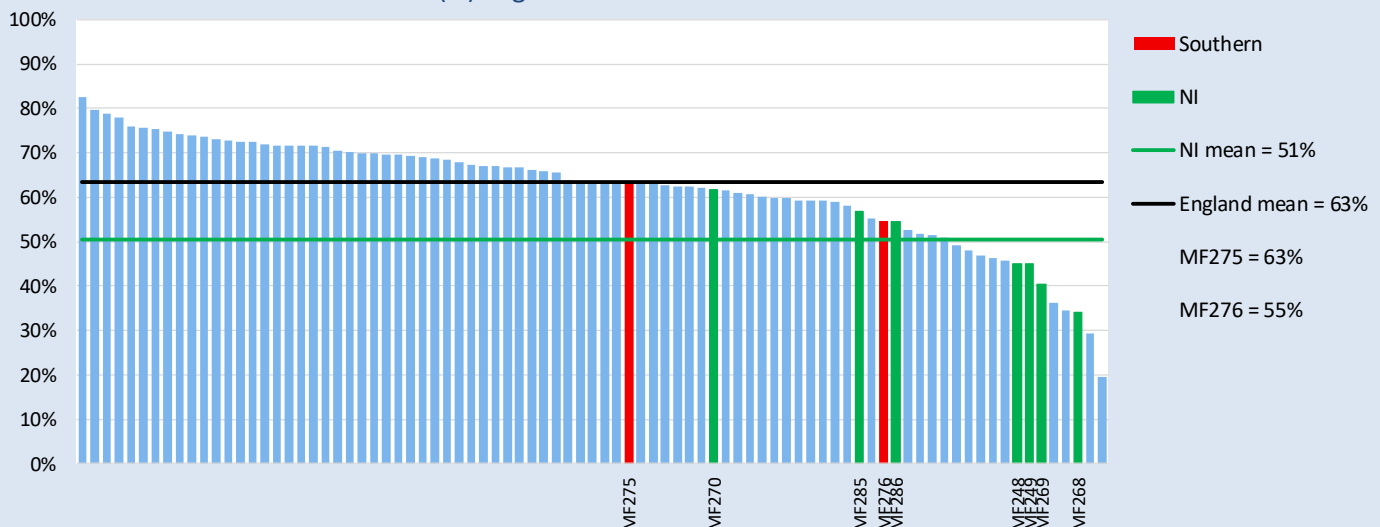
Disposal method from A&E – all ages



Disposal method from A&E – age 85+



Conversion rate to admission (%) - age 85+



- Within the project, assessment units are grouped in to three categories; frailty units, short term assessment units (up to 12 hours expected length of stay) and other assessment units (from 12 hours up to 72 hours expected length of stay).
- A frailty unit is an acute care assessment unit focussed on the care of the frail and elderly. 40% of Northern Ireland participants report having a frailty unit in their hospital. Where there is a frailty unit, all have a dedicated geriatric team and all have a hospital discharge team providing support.
- Short term assessment units include emergency assessment units, CDUs or similar units where patients are taken for a time limited period (up to 12 hours) for assessment, diagnostics and decision. 70% of Northern Ireland participants report having a short term assessment unit. Screening for frailty is more prevalent in these short term assessment units, with routine identification of frailty undertaken in 80% of these short term assessment units. Where identification of frailty is taking place, all teams use the Rockwood clinical frailty scale and routinely carry this out for those ages 75 or older. However, the frailty tool is only used to identify who needs CGA in 25% of units. Half of units have a dedicated geriatric team, but senior clinical review does not occur at weekends in any of the units.
- Other assessment units include assessment units which don't fall under the definitions of frailty unit or short term assessment unit used in this project. Length of stay in these units is expected to be between 12 and 72 hours. 70% of participants in Northern Ireland report have one of these assessment units in their hospital. Routine identification of frailty does not occur in any of these other assessment units.
- Activity, workforce and finance metrics are collected across all types of assessment unit. 63% of admissions to assessment units (all types) in Northern Ireland are for service users age 65+.
- The majority of service users in assessment units have been admitted via an emergency department; 83% across all age categories and 81% for those ages 85+. For those aged 85+, 12% of referrals being from a GP and 7% of referrals from other source.
- Across all ages in Northern Ireland, 48% of service users are discharged following their episode in an assessment unit, with 51% being admitted to inpatient care. For those aged 85+, the likelihood of being admitted following discharge from an assessment unit increases, with 66% being admitted to inpatient care.
- Sickness rates and staff turnover rates are collected for staff working in assessment units. The average staff sickness rate is 8% and turnover rate is 11%.
- The majority of nursing staff in assessment units are band 5 (51%), with 17% being band 6. Unregistered nursing staff make up 27% of the nursing workforce in assessment units. Where AHP staffing figures could be provided, band 6 staff made up the majority of the AHP workforce (61%).



Frailty unit

	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Does your frailty unit have locally agreed referral criteria regarding the type of patient can be accepted?		67%	93%	N/A	N/A
Is routine identification of frailty undertaken on admission/transfer to the frailty unit?		33%	76%	N/A	N/A
Is the frailty tool used to identify who requires CGA?		0%	68%	N/A	N/A
Is senior clinical review undertaken at weekends?		33%	47%	N/A	N/A
Does the frailty unit provide an outreach service, working with primary & community care to case find individuals at risk of admission?		33%	26%	N/A	N/A
Do any other services provide in-reach to the frailty unit pulling appropriate patients out/signposting to other services?		67%	61%	N/A	N/A
Is there a dedicated geriatric team located in the frailty unit?		100%	96%	N/A	N/A
Does the Hospital Discharge Team provide dedicated support to the frailty unit?		100%	55%	N/A	N/A

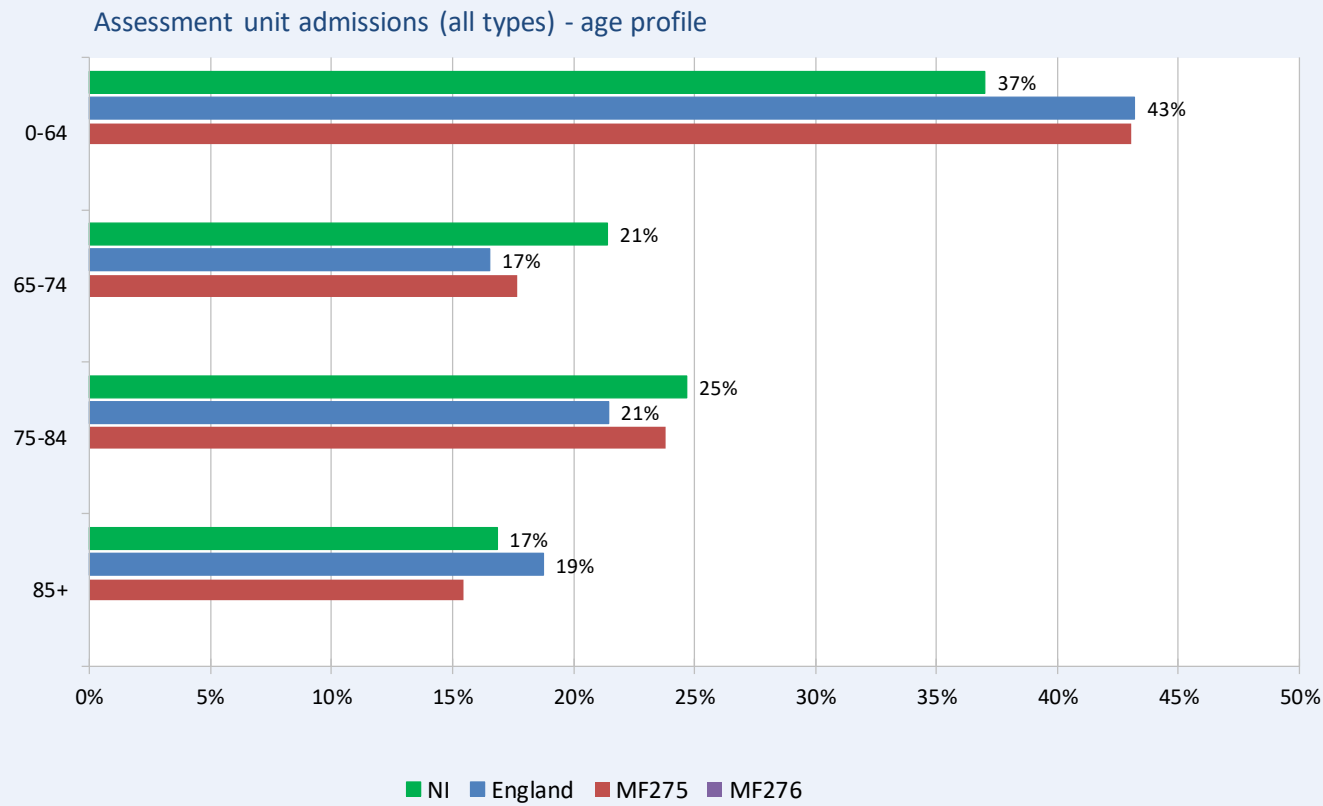
Short term assessment unit

	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Is routine identification of frailty undertaken on admission/transfer to the short term assessment unit?		67%	44%	Yes	Yes
Is the frailty tool used to identify who requires CGA?		25%	77%	No	No
Do all admissions of older people go through the short term assessment unit?		0%	12%	No	-
Is senior clinical review undertaken at weekends?		0%	86%	No	-
Does the short term assessment unit provide an outreach service, working with primary & community care to case find individuals at risk of admission?		40%	12%	Yes	-
Do any other services provide in-reach to the short term assessment unit pulling appropriate patients out/signposting to other services?		100%	67%	Yes	-
Is there a dedicated geriatric team located in the short term assessment unit?		50%	38%	Yes	-
Does the Hospital Discharge Team provide dedicated support to the short term assessment unit?		75%	57%	Yes	-



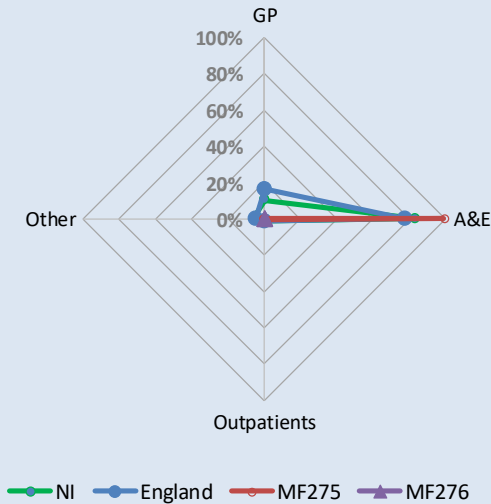
Other assessment units

	0% NI % responding yes 100%	NI % yes	England % yes	MF275	MF276
Is routine identification of frailty undertaken on admission/transfer to the other assessment unit(s)?		0%	35%	Yes	-
Do all admissions of older people go through the other assessment unit(s)?		0%	21%	-	-
Is senior clinical review undertaken at weekends?		33%	87%	-	-
Do the other assessment unit/s provide an outreach service, working with primary & community care to case find individuals at risk of admission?		0%	13%	-	-
Do any other services provide in-reach to the other assessment unit pulling appropriate patients out/signposting to other services?		33%	72%	-	-
Is there a dedicated geriatric team located in the other assessment unit?		0%	24%	-	-
Does the Hospital Discharge Team provide dedicated support to the other assessment unit/s?		100%	63%	-	-

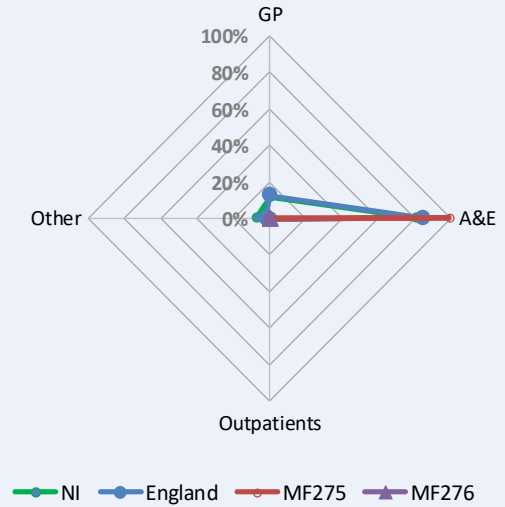


Assessment units

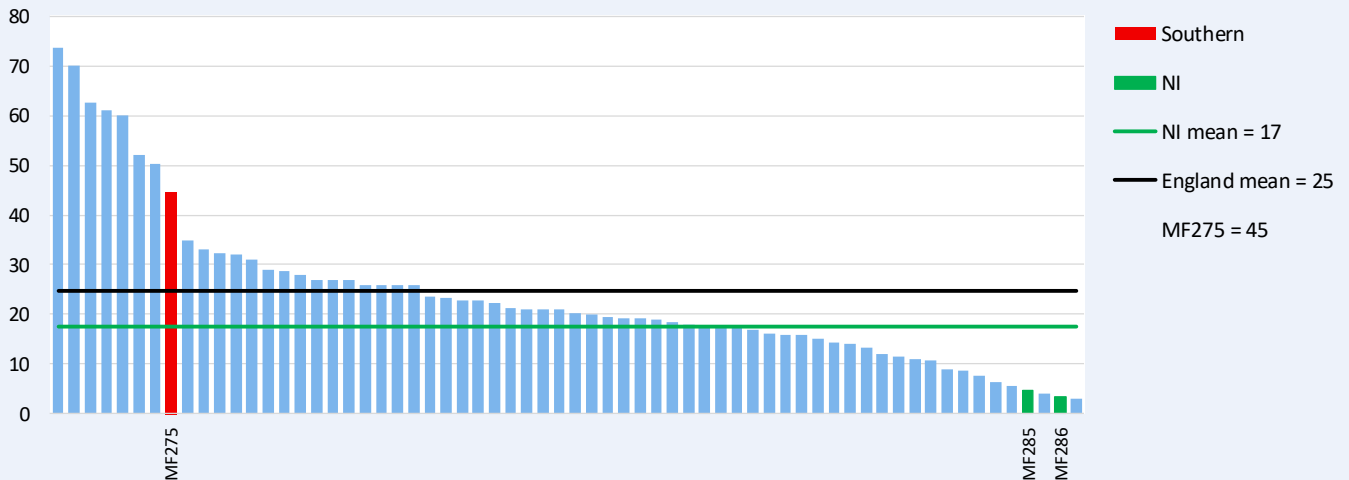
Source of admission – all ages



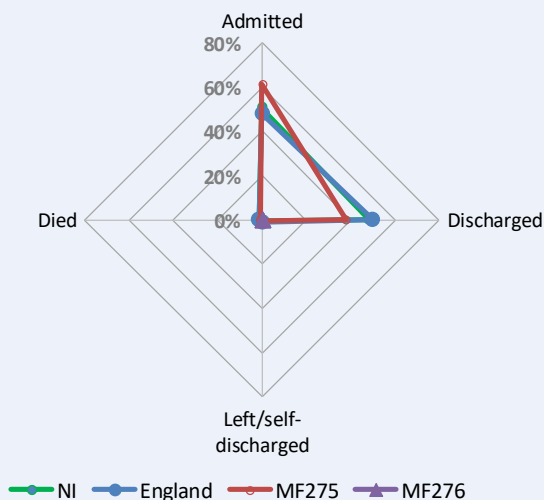
Source of admission – age 85+



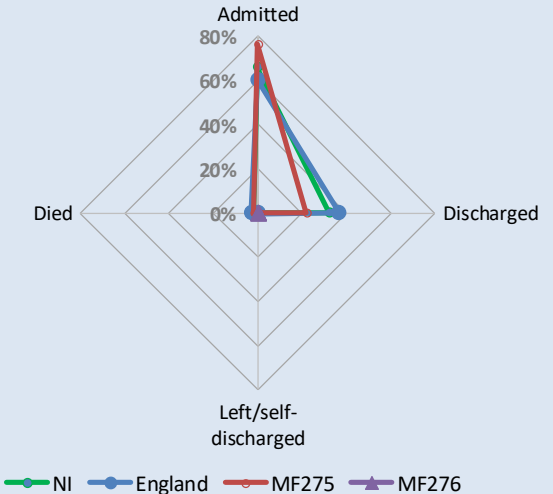
Average length of stay in an assessment unit (hours)



Disposal method – all ages

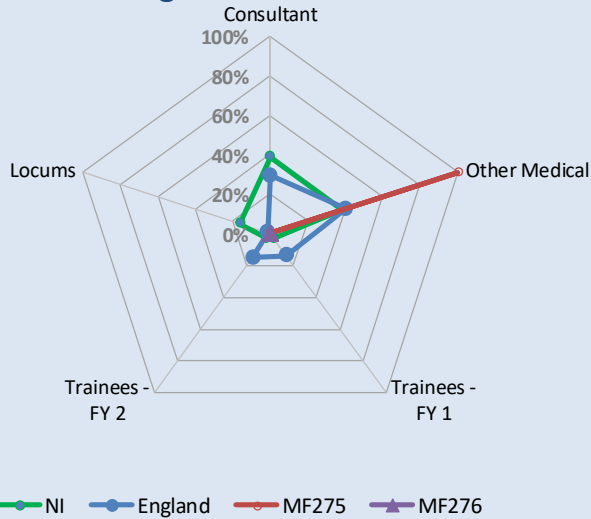


Disposal method – age 85+

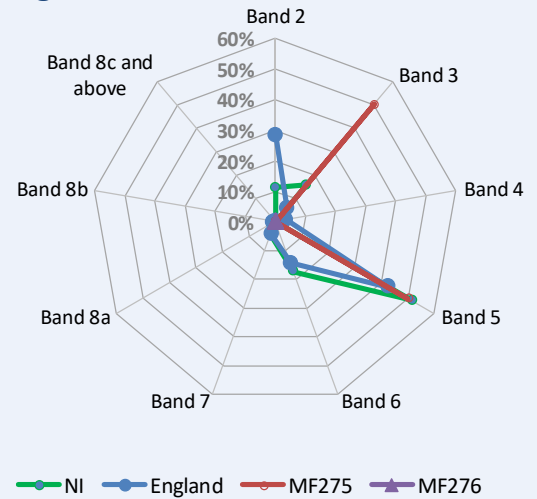


Assessment units

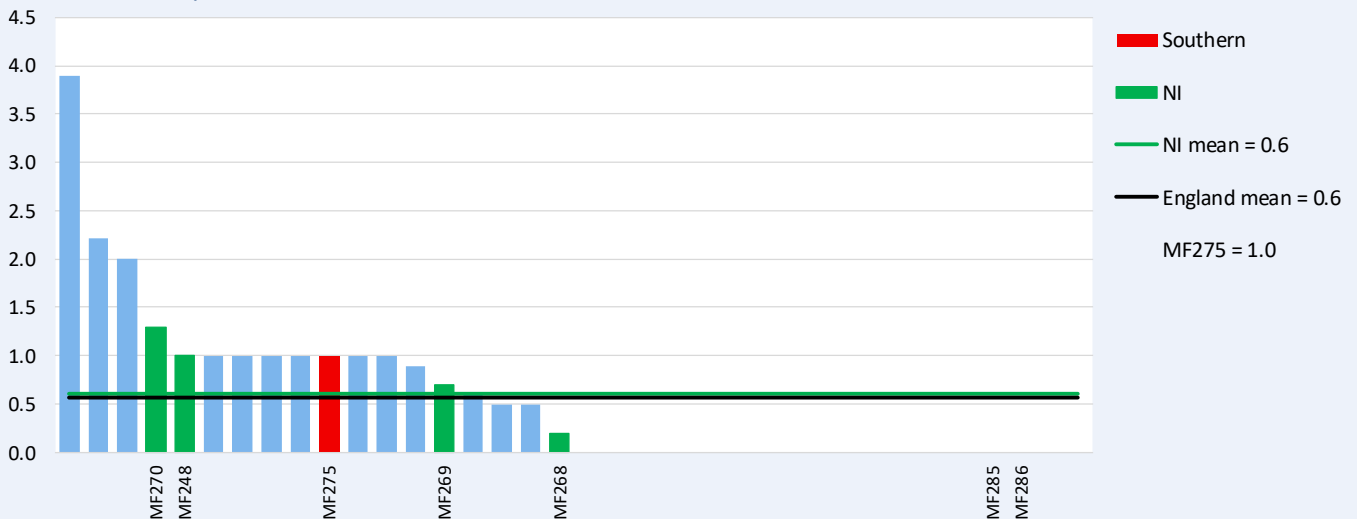
Medical staff grade mix



Nursing and HCA staff skill mix



Social care professionals WTE



HR KPIs

	NI mean	England mean	MF275	MF276
Assessment units staff sickness rate %	8%	5%	-	-
Assessment units staff turnover rate %	11%	11%	-	-



- Care of older people wards provide specialist geriatrician-led care to older people with complex needs. On average, 25% of medical (non surgical) beds within an acute hospital site in Northern Ireland are reported as designated beds for the care of older people. Routine identification of frailty routinely does not occur on any designated care of older peoples wards within these hospitals.
- The average length of stay for emergency admissions across all age categories in Northern Ireland is 5.9 days. This average length of stay increases to 11.1 days for those aged 85+, over 5 days longer than the all age figure.
- Longer lengths of stay can have a notable impact on capacity in inpatient care. Although only 8% of inpatient spells have a length of stay of 21 days or more in Northern Ireland, these spells utilise 37% of occupied bed days.
- Typically, the percentage of emergency admissions that are discharged the same day across all ages in Northern Ireland is lower than in England, with 11% of emergency admissions discharged the same day (30% in England). Of these emergency admissions discharged the same day in Northern Ireland, 29% of these service users are aged 65 or older. The 65+ age group makes up 55% of emergency admissions. 17% of emergency admission are discharged the following day. 41% of those discharged the following day are aged 65 or older.
- On average, there are 0.2 medical staff and 1.4 nursing staff WTEs per designated care of older people bed in acute hospitals in Northern Ireland. The mean average number of social care professionals on older people wards is 1.9, although social care workers are not available in each hospital. Many of the designated care of older people wards also have therapy input, although the number of AHP staff on each ward proved a challenge to provide.
- Sickness rates and staff turnover rates are collected for both medical and non medical staff within older people's wards. For medical staff, the average staff sickness rate is 2% and turnover rate is 7%. These measures are higher for clinical, non-medical staff, with a staff sickness rate of 9% and a staff turnover rate of 9%.
- A number of quality measures are collected, benchmarked per 100 older people beds across the 18/19 financial year. On average, there were 72 falls with harm per 100 beds during the year in Northern Ireland. There were 42 occurrences of pressure ulcers per 100 beds and 116 cases of hospital acquired pneumonia per 100 beds reported during the 18/19 year.



Inpatient care

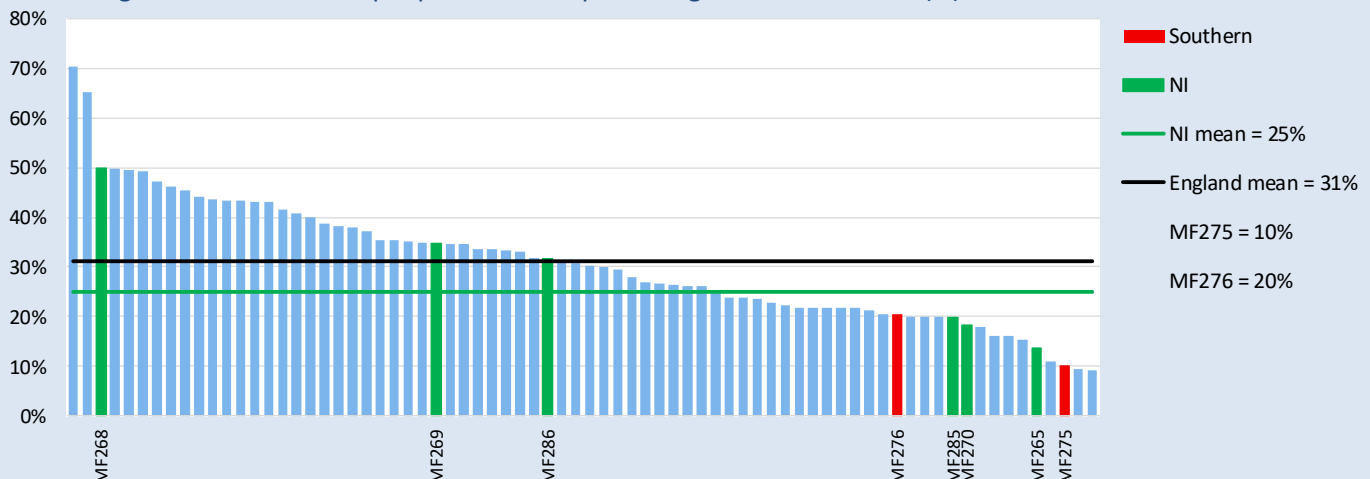
Designated care of older people wards

	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Is routine identification of frailty undertaken on admission/transfer to the older people wards?		0%	44%	No	No
Is a nursing self-care model delivered on the inpatient wards?		70%	53%	Yes	Yes
Does a social care worker or generic supported discharge co-ordinator form part of the MDT supporting care of older people wards?		100%	93%	Yes	Yes
Do the older people wards in the Trust maintain lists of older people who are no longer benefitting from acute care?		100%	90%	Yes	Yes
If yes, are daily progress chasing meetings held?		100%	88%	Yes	Yes

Other inpatient wards

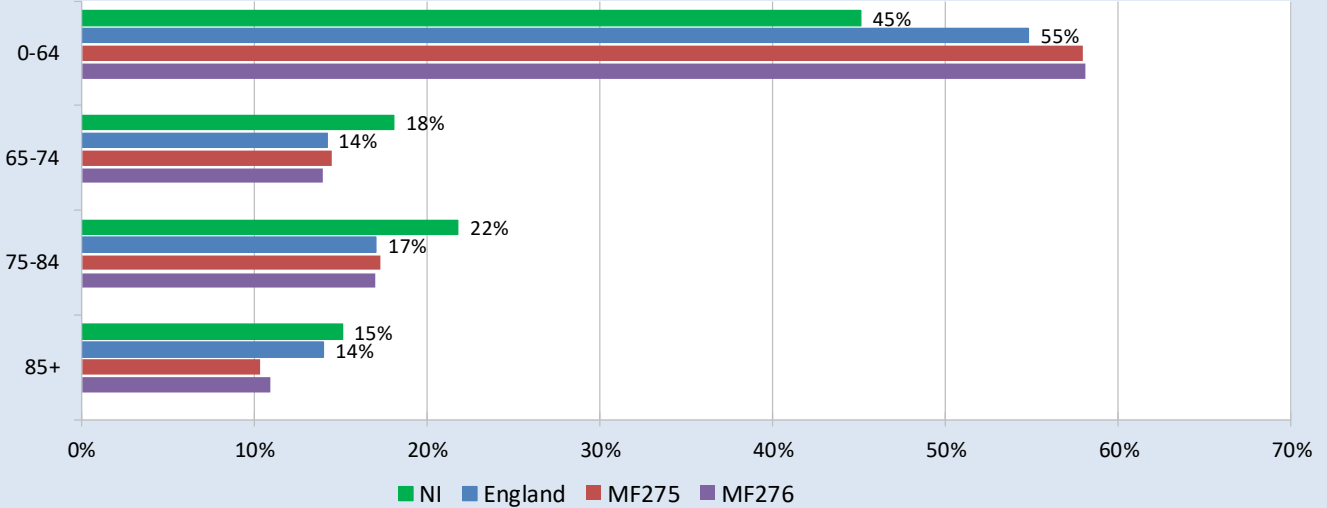
	NI % responding yes 0% 100%	NI % yes	England % yes	MF275	MF276
Is routine identification of frailty undertaken on admission/transfer to inpatient wards?		0%	24%	No	No
Does your Trust have a specific locally agreed target for reducing length of stay for older people?		44%	51%	No	No

Designated care of older people beds as a percentage of medical beds (%)

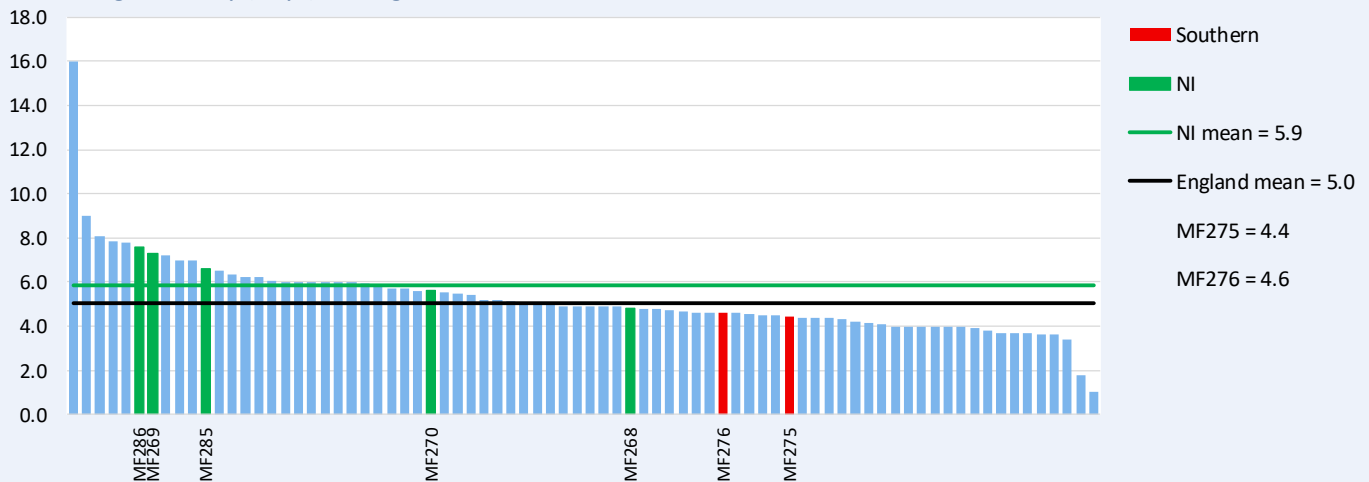


Inpatient care

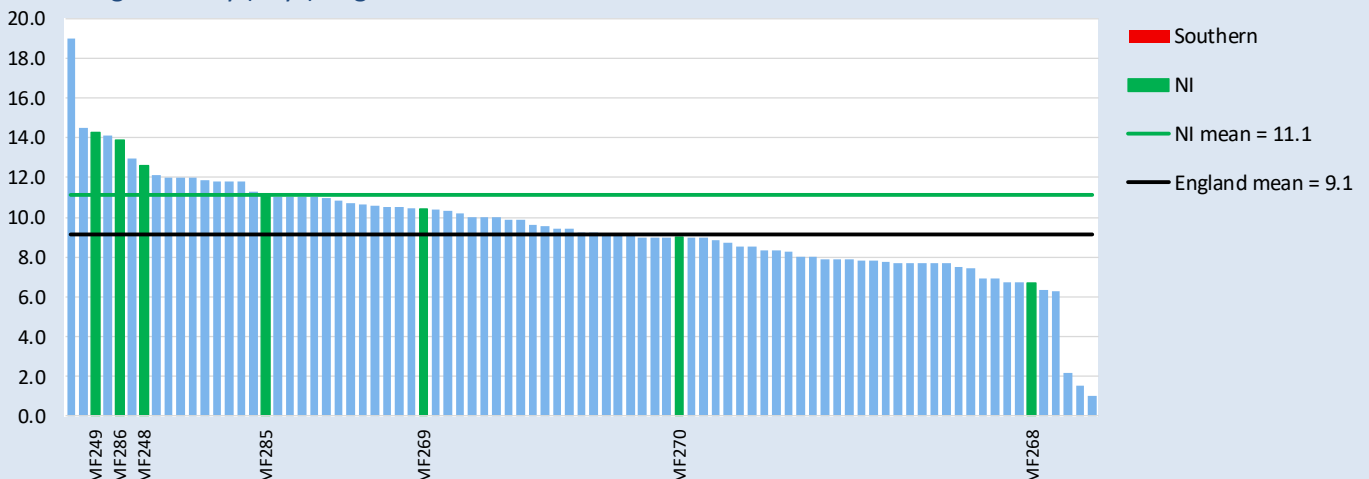
Emergency admission - age profile



Length of stay (days) - all ages

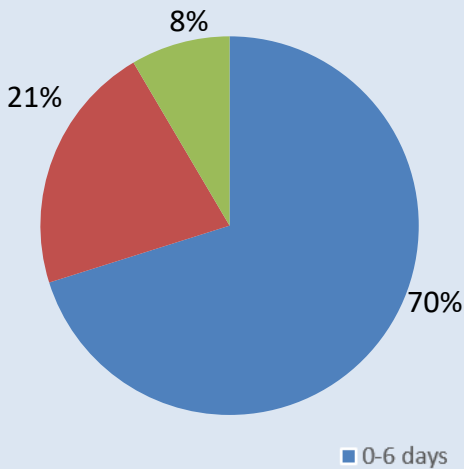


Length of stay (days) - age 85+

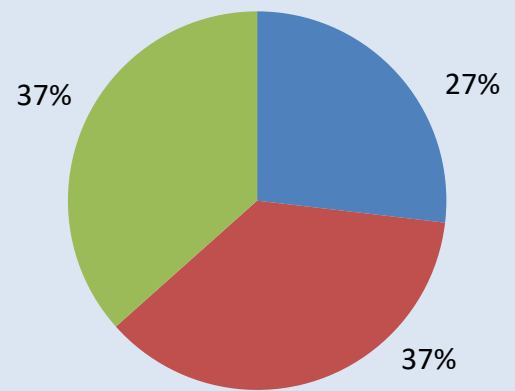


Inpatient care

Number of spells

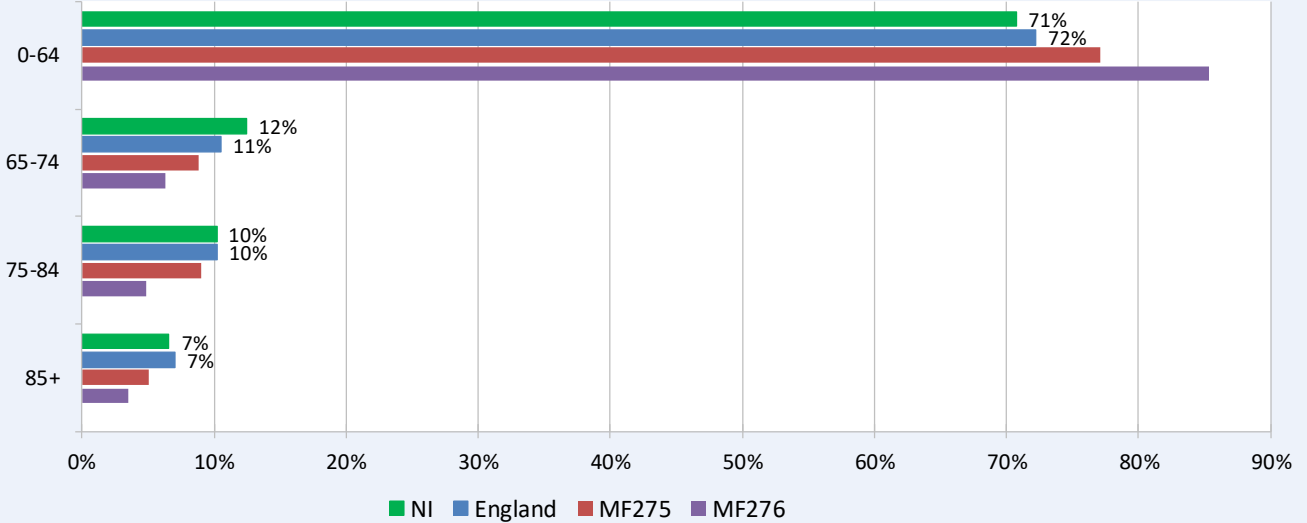


Number of occupied bed days



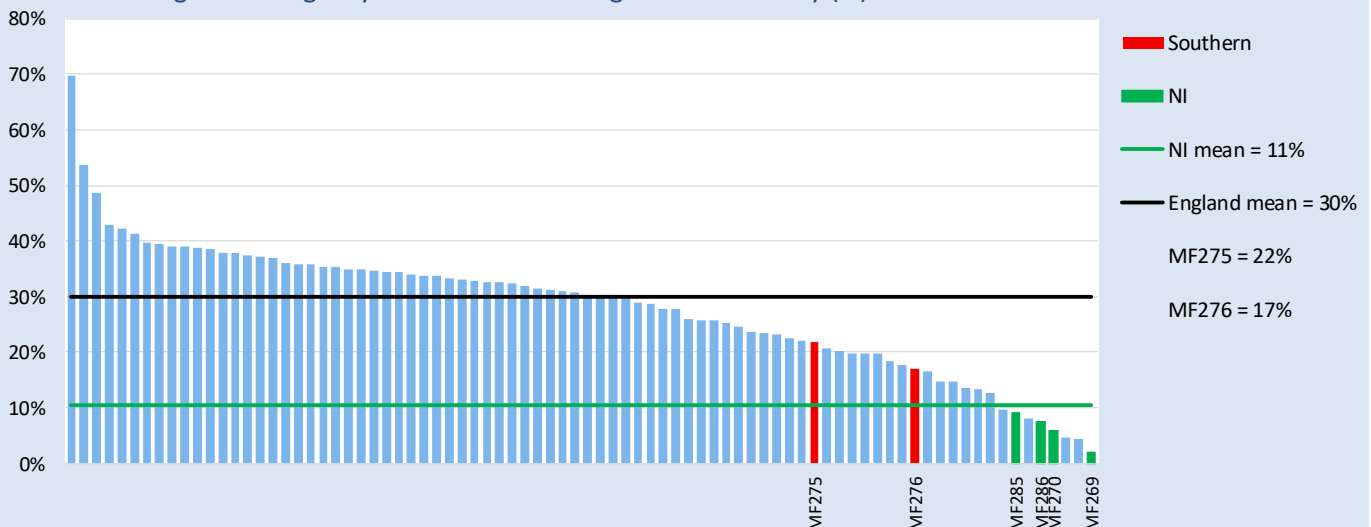
■ 0-6 days ■ 7-20 days ■ 21 days or more

Emergency admissions discharged the same day - age profile



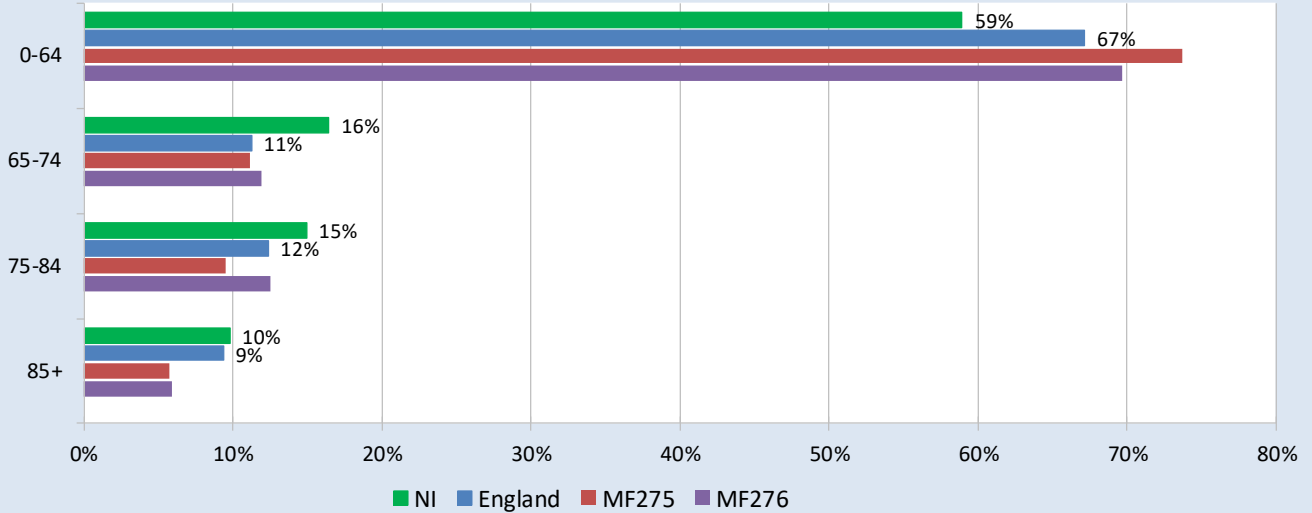
■ NI ■ England ■ MF275 ■ MF276

Percentage of emergency admissions discharged the same day (%)

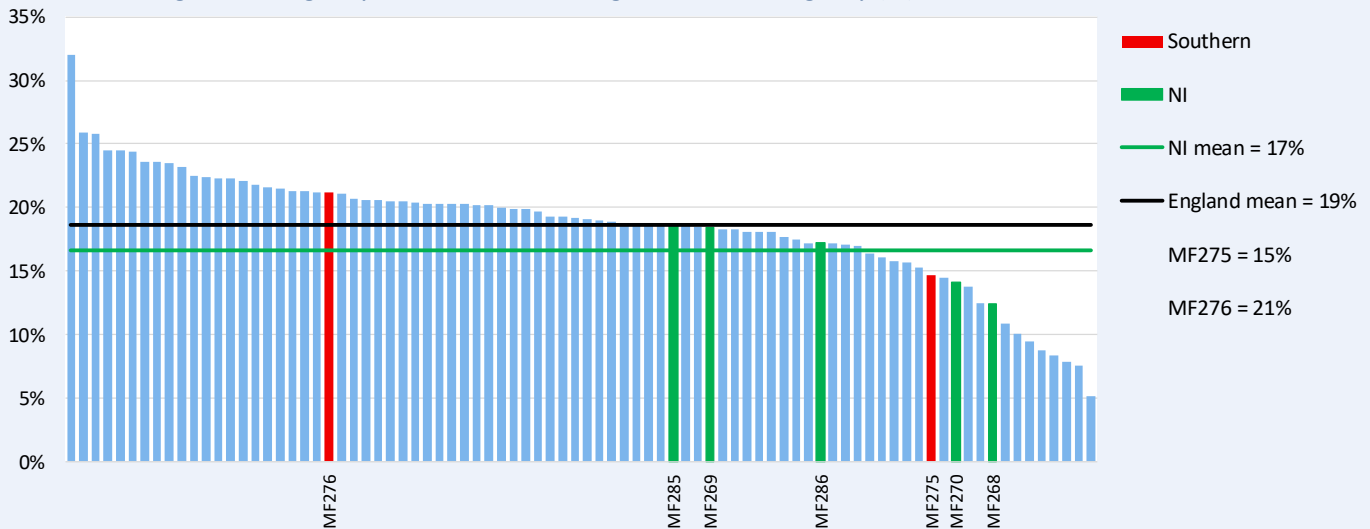


Inpatient care

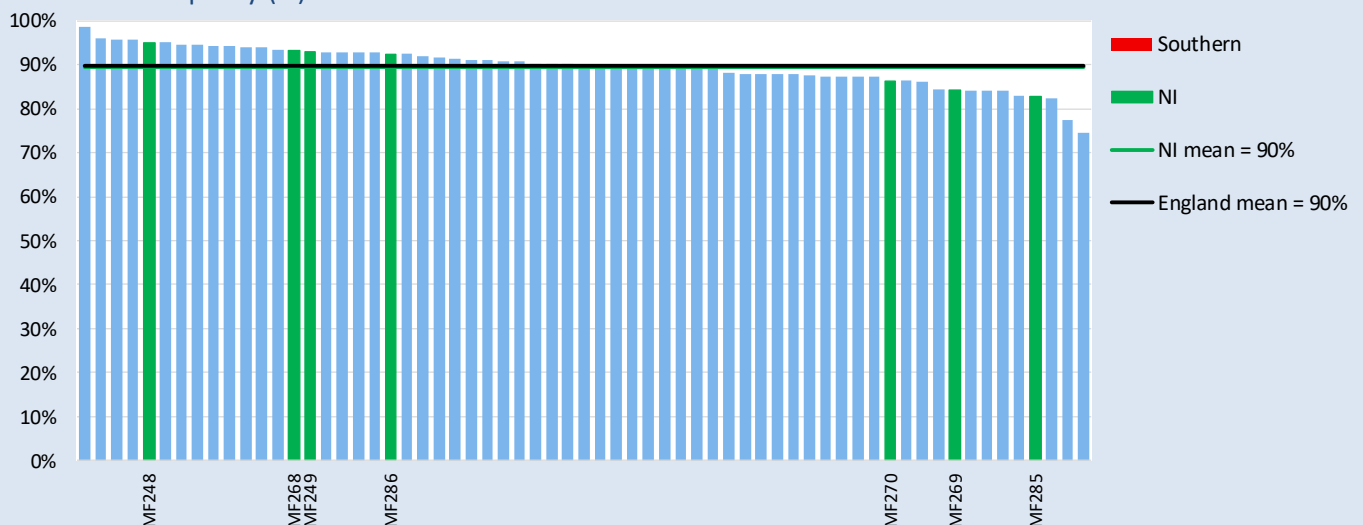
Emergency admissions discharged the following day - age profile

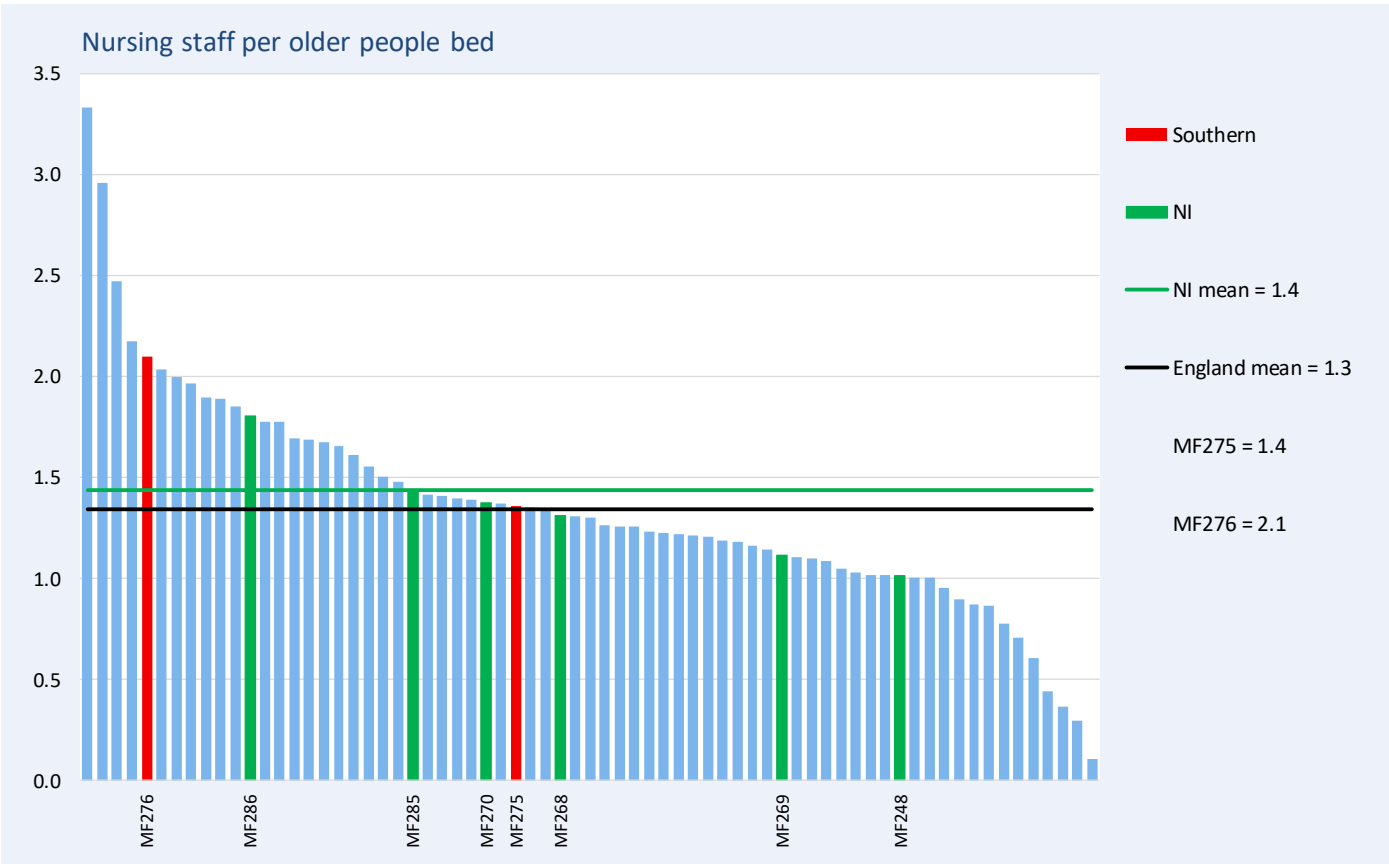


Percentage of emergency admissions discharged the following day (%)



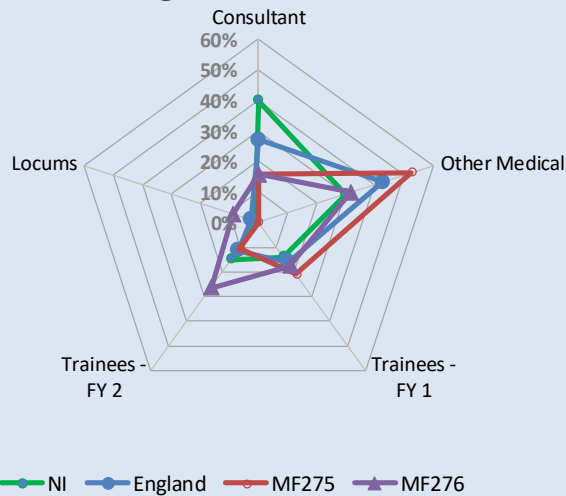
Bed occupancy (%)



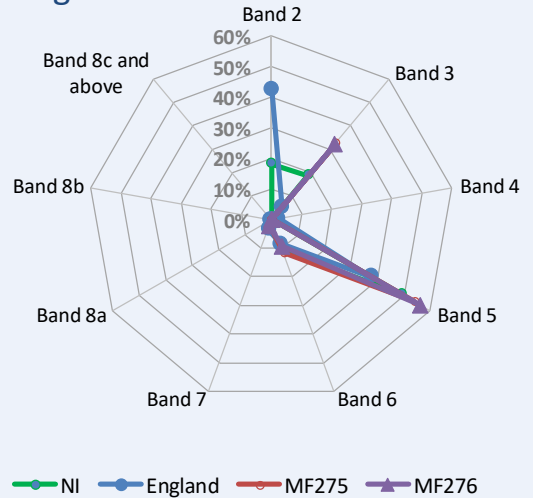


Inpatient care

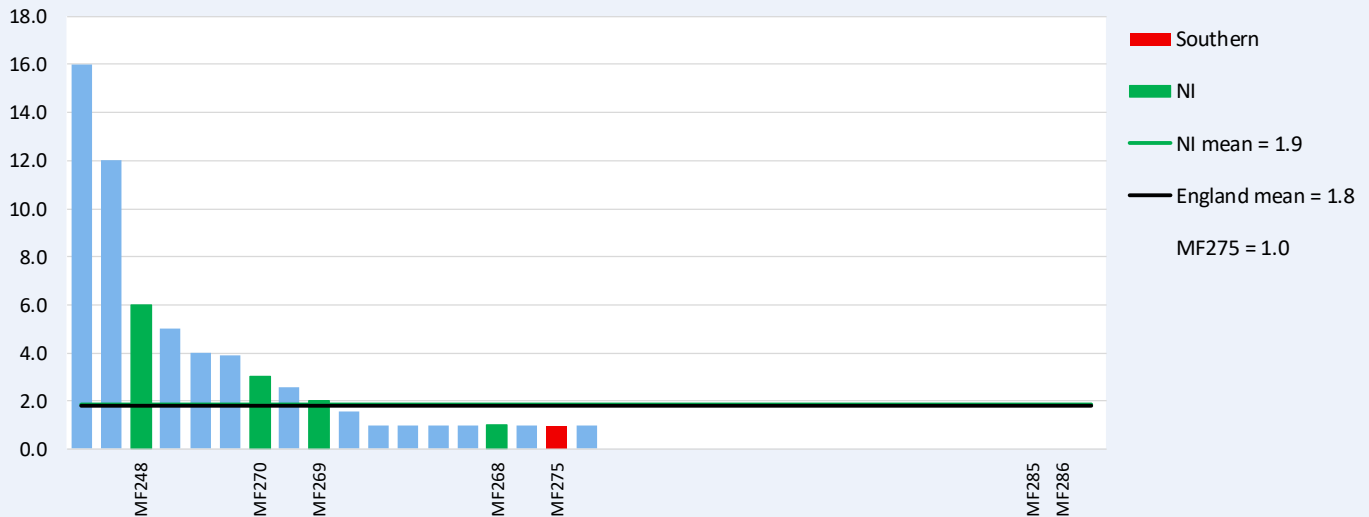
Medical staff grade mix



Nursing and HCA staff skill mix



Social care professionals WTE



HR KPIs

	NI mean	England mean	MF275	MF276
Inpatient care of older people medical team staff sickness rate %	2%	2%	-	-
Inpatient care of older people medical team staff turnover rate %	7%	12%	-	-
Inpatient care of older people staff sickness rate %	9%	5%	-	-
Inpatient care of older people staff turnover rate %	9%	13%	-	-



Inpatient care

Quality & Outcomes

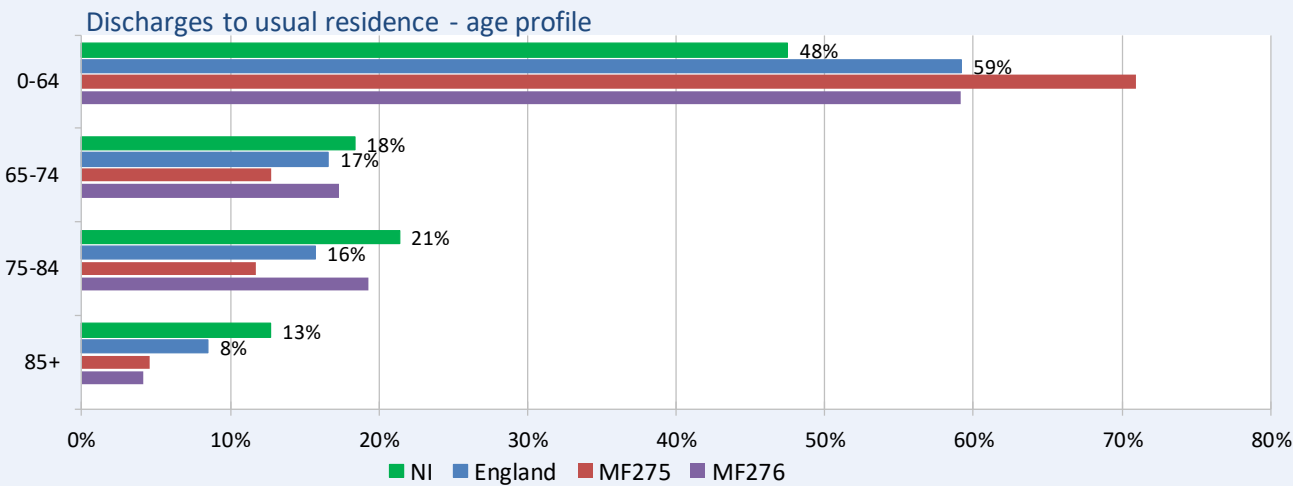
	NI mean	England mean	MF275	MF276
Falls with harm per 100 beds	72.1	36.3	-	-
Pressure ulcers per 100 beds	42.2	40.0	84.2	10.0
Number of patients catheterised per 100 beds	113.0	94.0	-	-
Newly acquired VTE per 100 beds	8.1	2.8	-	-
Occurrences of C diff per 100 beds	5.5	7.3	-	-
Occurrences of hospital acquired pneumonia per 100 beds	115.9	147.4	268.4	185.0
MRSA per 100 beds	1.4	1.8	-	-

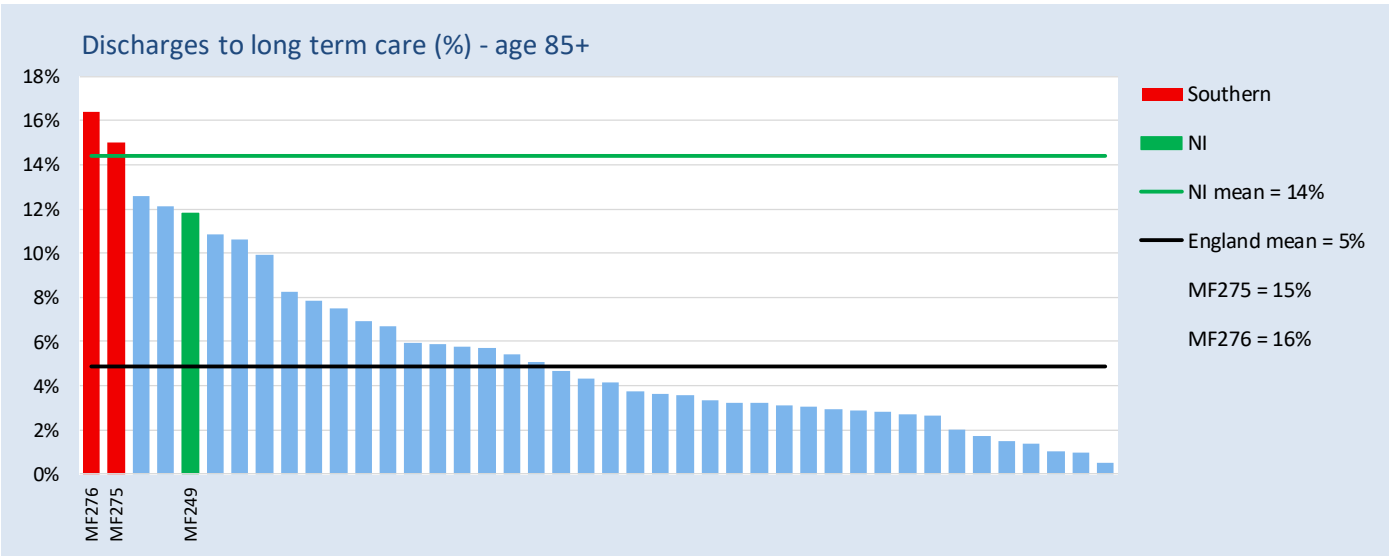
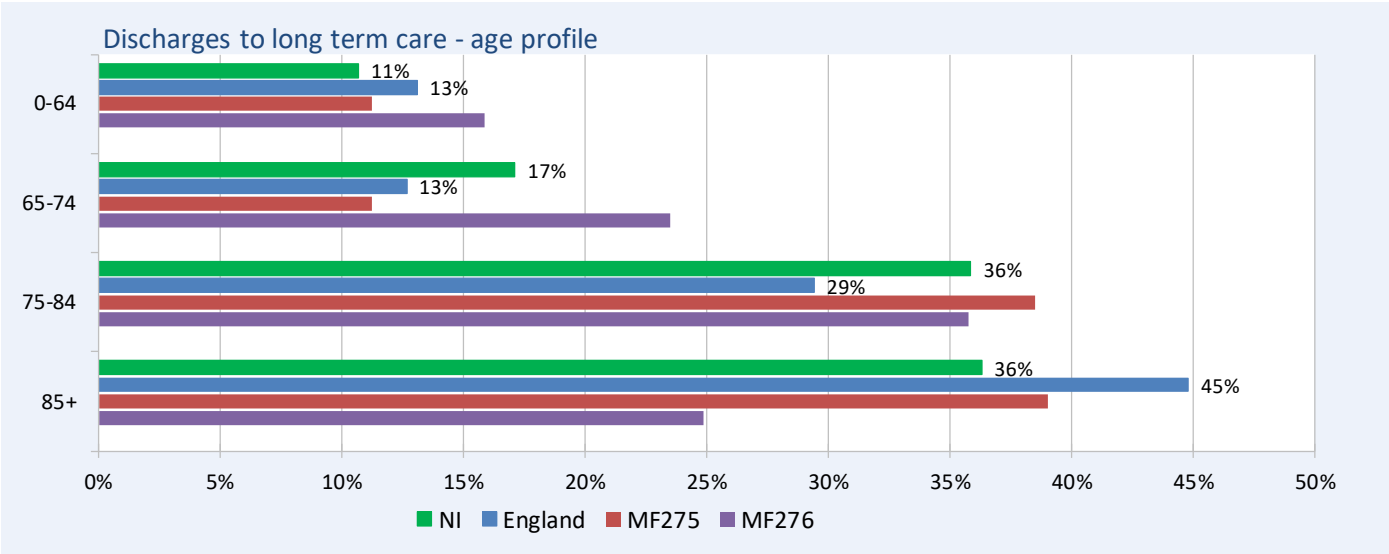
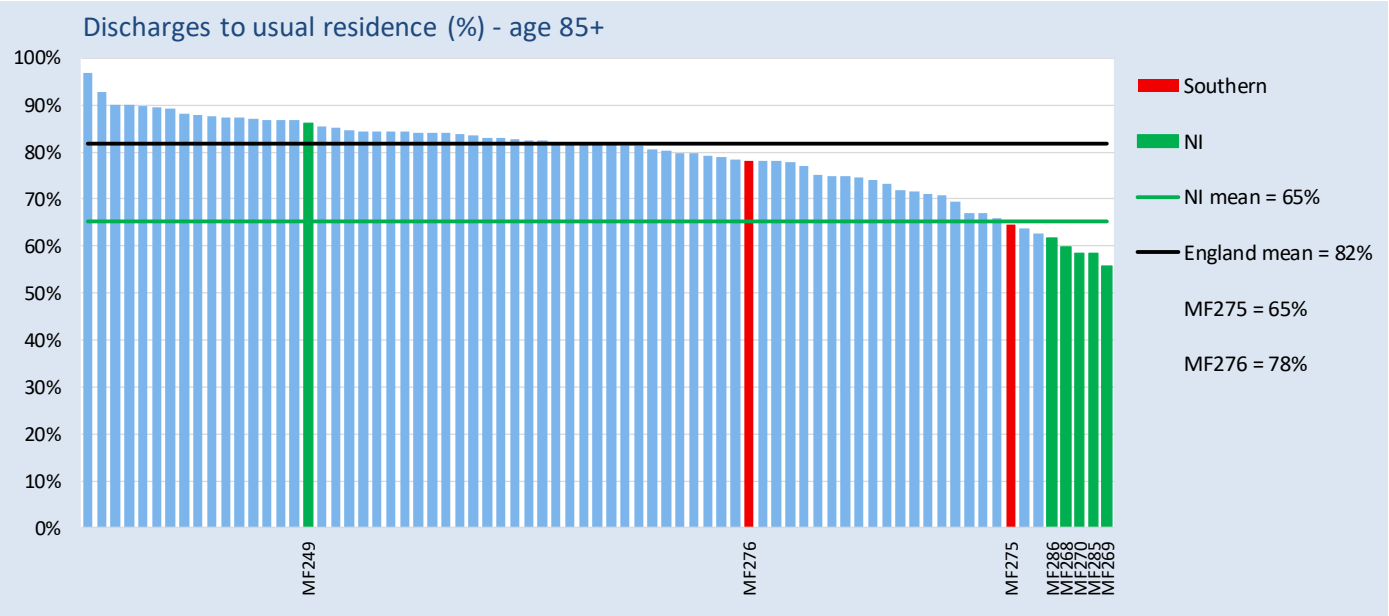


- Supported discharge protocols and procedures help to support timely discharge and reduce delayed transfers of care (DToCs). All hospital sites in Northern Ireland report having an integrated discharge team. 80% of hospitals operate nurse led discharge and 70% operate therapy led discharge. Expected dates of discharge are set within 24 hours of admission in all hospital sites.
- Across all age groups, 82% of service users in Northern Ireland return to their usual place of residence following discharge. Of those returning to their usual place of residence, patients aged 65+ make up 52% of this cohort. Older people are less likely to return to their usual place of residence following an inpatient stay, with just 65% of those 85+ returning home after discharge in Northern Ireland.
- “Discharge to assess” operates as soon as an acute episode of care is complete, in order to plan post-acute care in the person’s own home or another community setting. A discharge to assess model is in operation in 70% of participating hospital sites in Northern Ireland, with all of these discharge to assess services being therapy led. Where a discharge to assess model is in place, sites report that there is wide variation in the proportion of assessments being carried out in service user’s own home, ranging from 25% to 100%. The mean average time for a patient to be assessed in their own home is 51 hours, against a locally agreed standard time of 36 hours.
- Delayed transfers of care represent 4.9% of occupied bed days across all age groups in Northern Ireland. 83% of bed days occupied by delayed transfers of care are attributable to patients aged 65+ and 33% are attributable to those 85+.
- Participants from Northern Ireland aligned their reason for delayed transfer of care reporting with the England reporting, where possible, to allow for comparisons with all participants. The most common reasons for a delayed transfer of care (all ages) are awaiting a care package in own home (28%) and awaiting a care home placement (19%). For ages 85+, the same two reasons are the most common.



	0% NI % responding yes 100%	NI % yes	England % yes	MF275	MF276
Is there a documented supported discharge protocol consistently applied across all wards?		100%	89%	Yes	Yes
Is there an up-to-date directory of services available locally?		80%	75%	Yes	Yes
Is there a locally agreed protocol for referral to the Housing Department(s)?		30%	86%	Yes	Yes
Is there a locally agreed standard for processing of referrals through the Housing Department?		30%	48%	Yes	Yes
Does the Trust collect the numbers of patients who have lost packages of care due to an acute admission?		40%	16%	No	No
Is all discharge information documented in a single "discharge passport?" (or equivalent)?		80%	48%	Yes	Yes
Does the Trust/UHB have an integrated discharge team (IDT) or equivalent?		100%	91%	Yes	Yes
Does the Trust use trusted assessors to carry out a holistic assessment of need to avoid duplication?		60%	72%	Yes	Yes
Can the discharge team directly start health care packages?		80%	58%	Yes	Yes
Can the discharge team directly start social care packages?		80%	46%	Yes	Yes
Trust/UHB for the Supported Discharge process?		80%	78%	No	No
Does the Trust/UHB operate therapy led discharge?		70%	55%	Yes	Yes
Does the Trust/UHB operate nurse led discharge?		80%	73%	Yes	Yes
Are Expected Dates of Discharge set within 24 hours of admission?		100%	79%	Yes	Yes
Is the Trust/UHB operating daily board rounds?		100%	99%	Yes	Yes
Does the Trust/UHB operate the Red: Green Bed Day methodology?		0%	76%	No	No
Do you have access to social care at weekends to facilitate the discharge of patients?		100%	85%	Yes	Yes



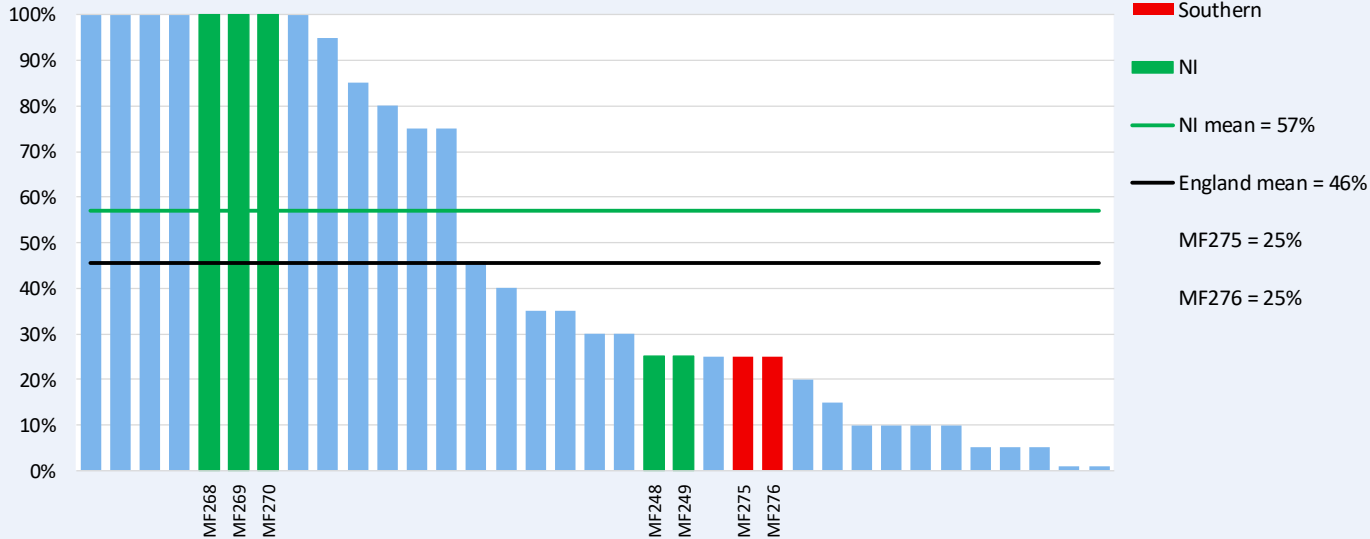


Discharge

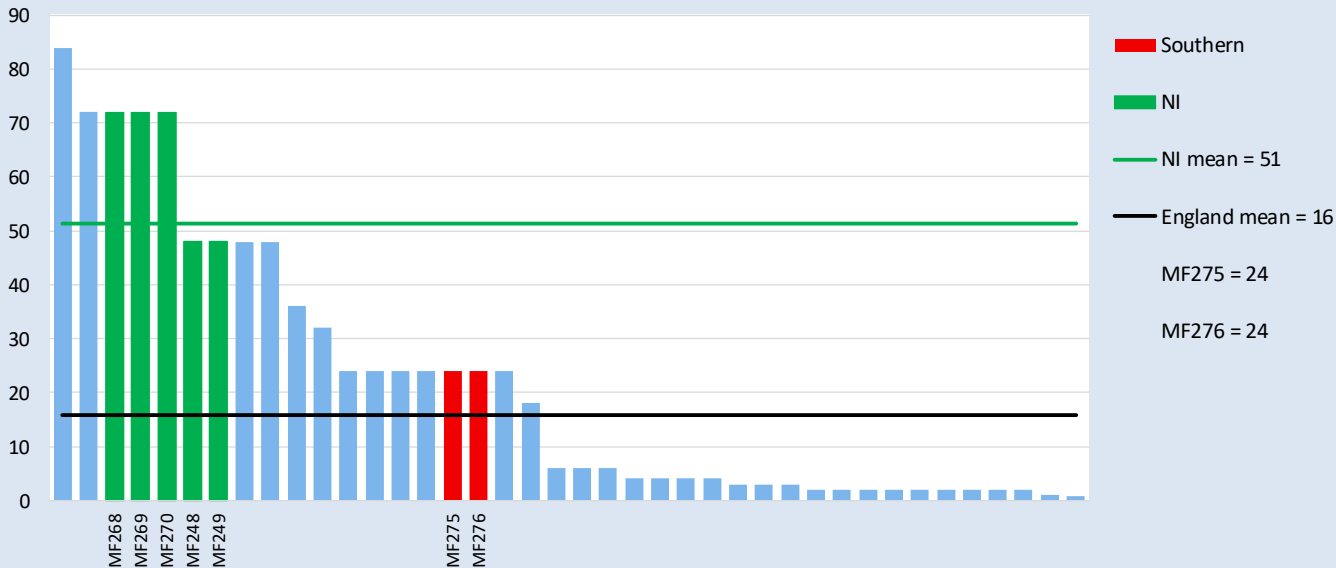
Discharge to assess

	NI mean	England mean	MF275	MF276
Is there a locally agreed standard for the time taken to assess a person in their own home?	57%	70%	Yes	Yes
What is this standard in hours?	36.0	24.7	24.0	24.0

Where a discharge to assess model is in operation, assessments carried out in patients home (%)

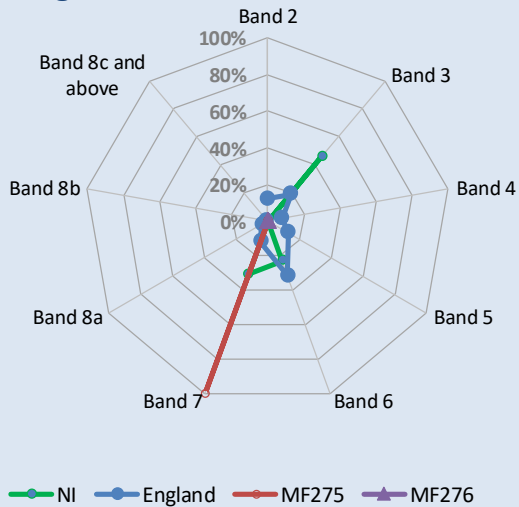


Average time for patient to be assessed in their own home (hours)

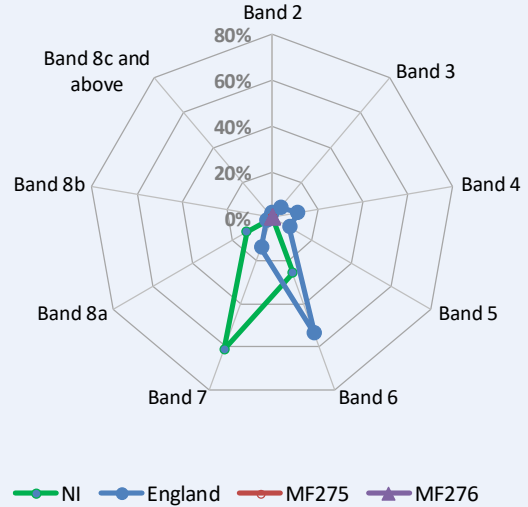


Discharge

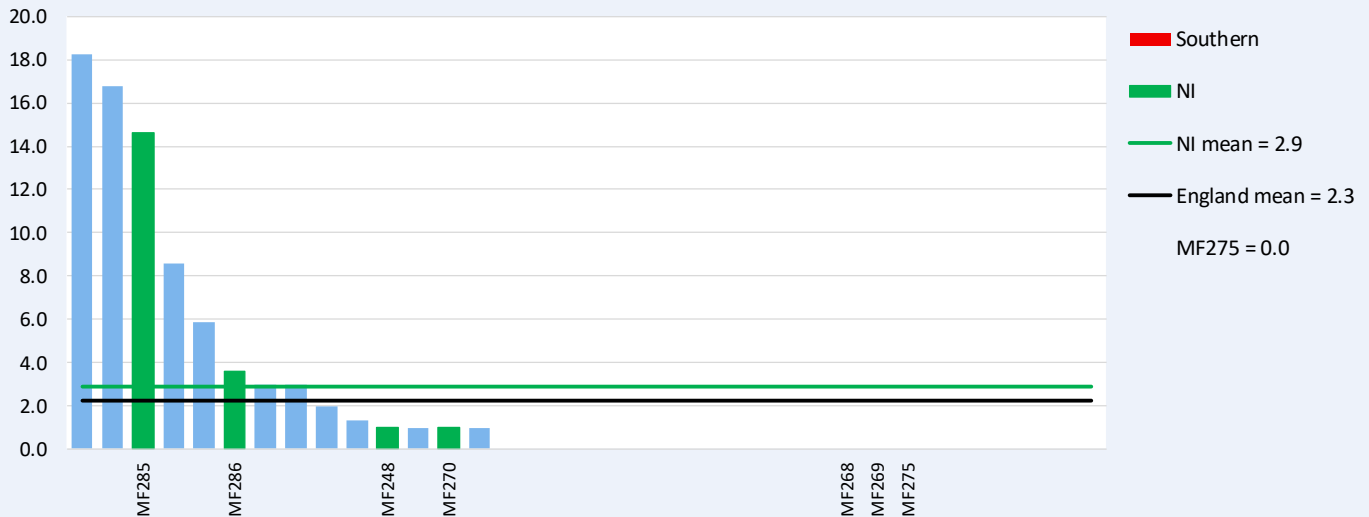
Nursing and HCA staff skill mix



AHP staff skill mix



Social care professionals WTE



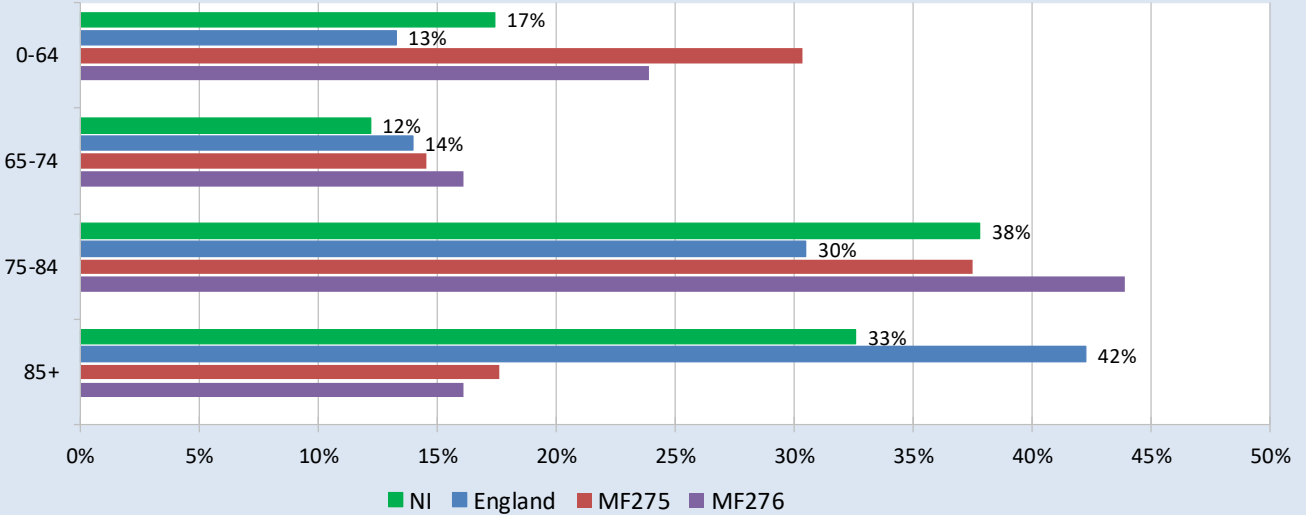
HR KPIs

	NI mean	England mean	MF275	MF276
Supported discharge team staff sickness rate %	7%	6%	-	-
Supported discharge team staff turnover rate %	3%	8%	-	-

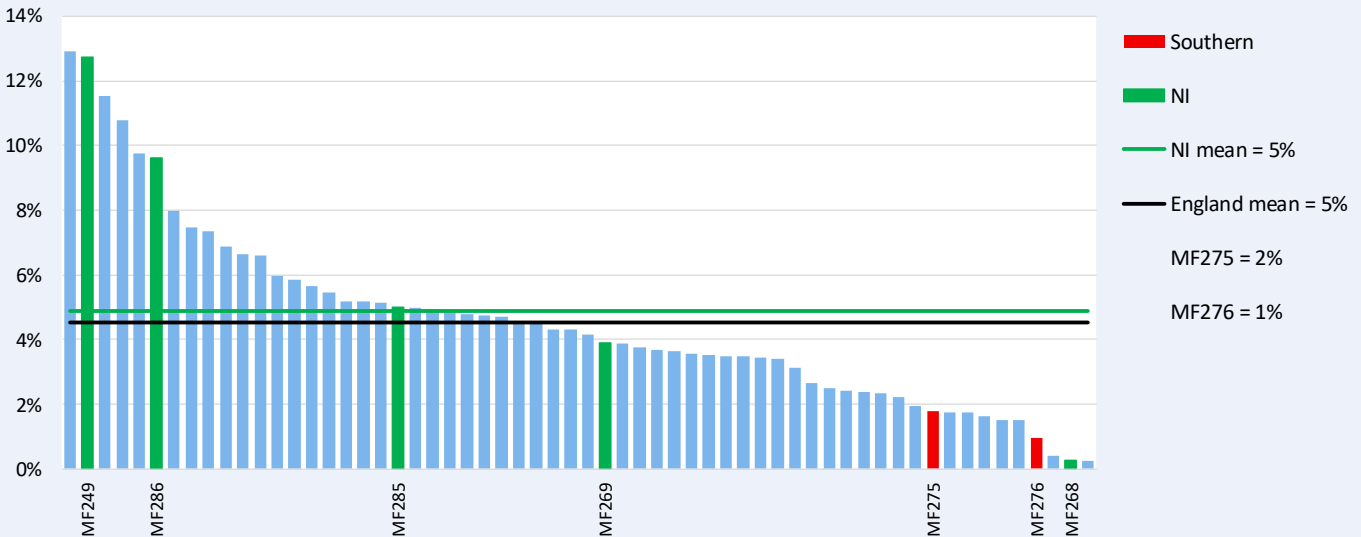


Discharge

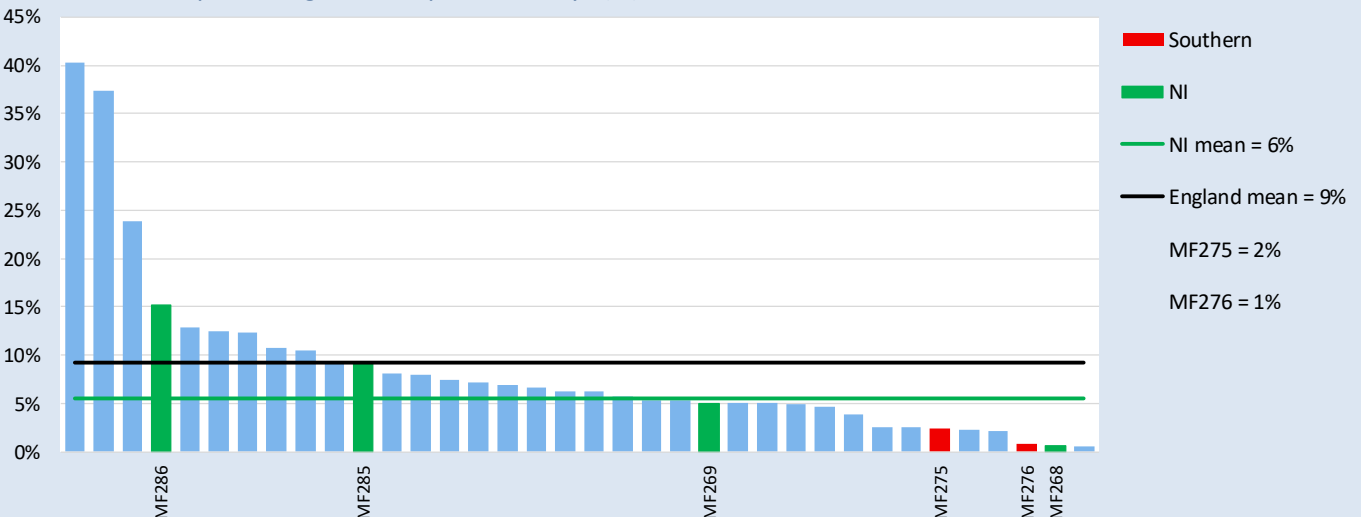
Delayed transfers of care - age profile



DTocS as a percentage of occupied bed days (%) - all ages

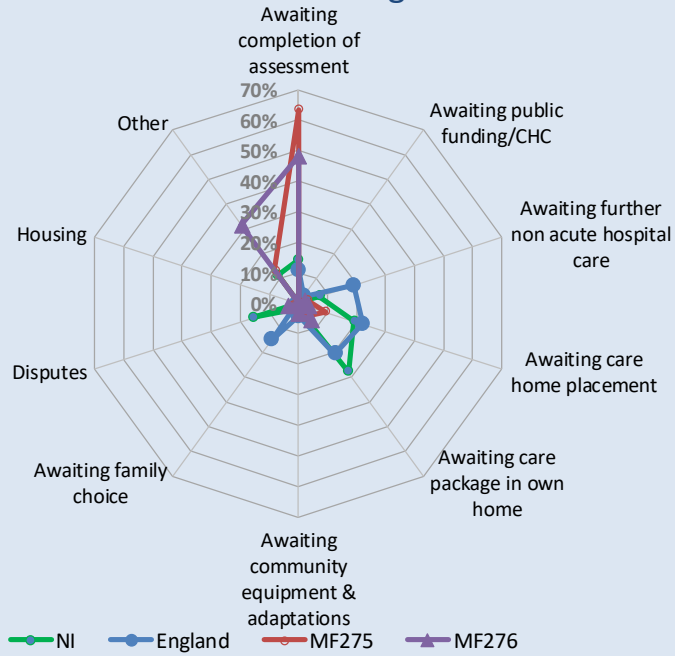


DTocS as a percentage of occupied bed days (%) - 85+

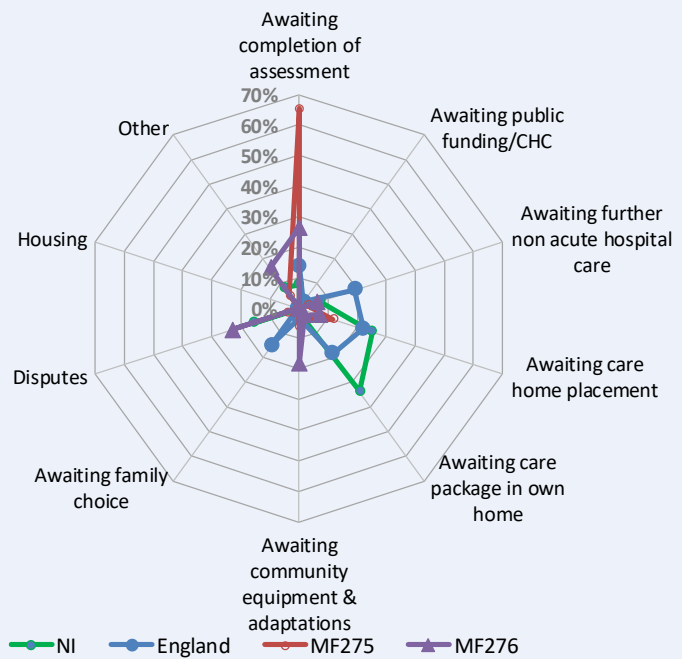


Discharge

Reasons for DToCs – all ages



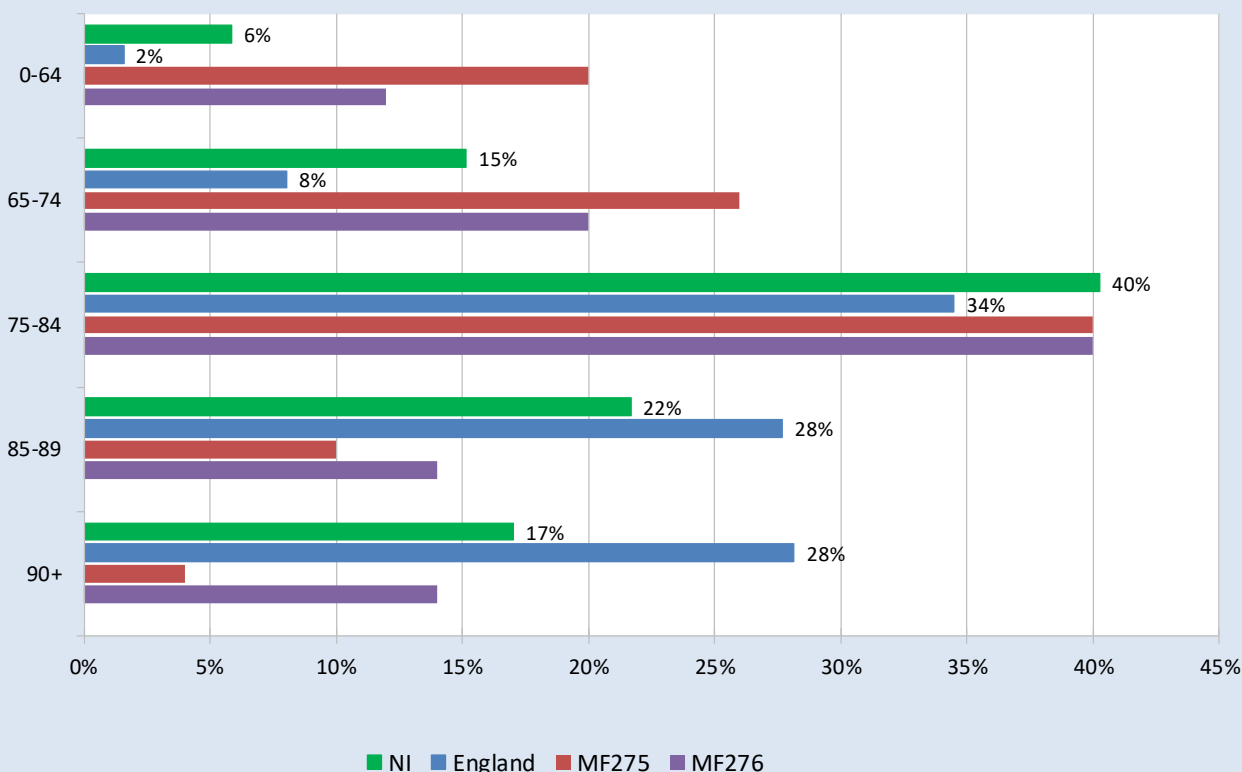
Reasons for DToCs – 85+



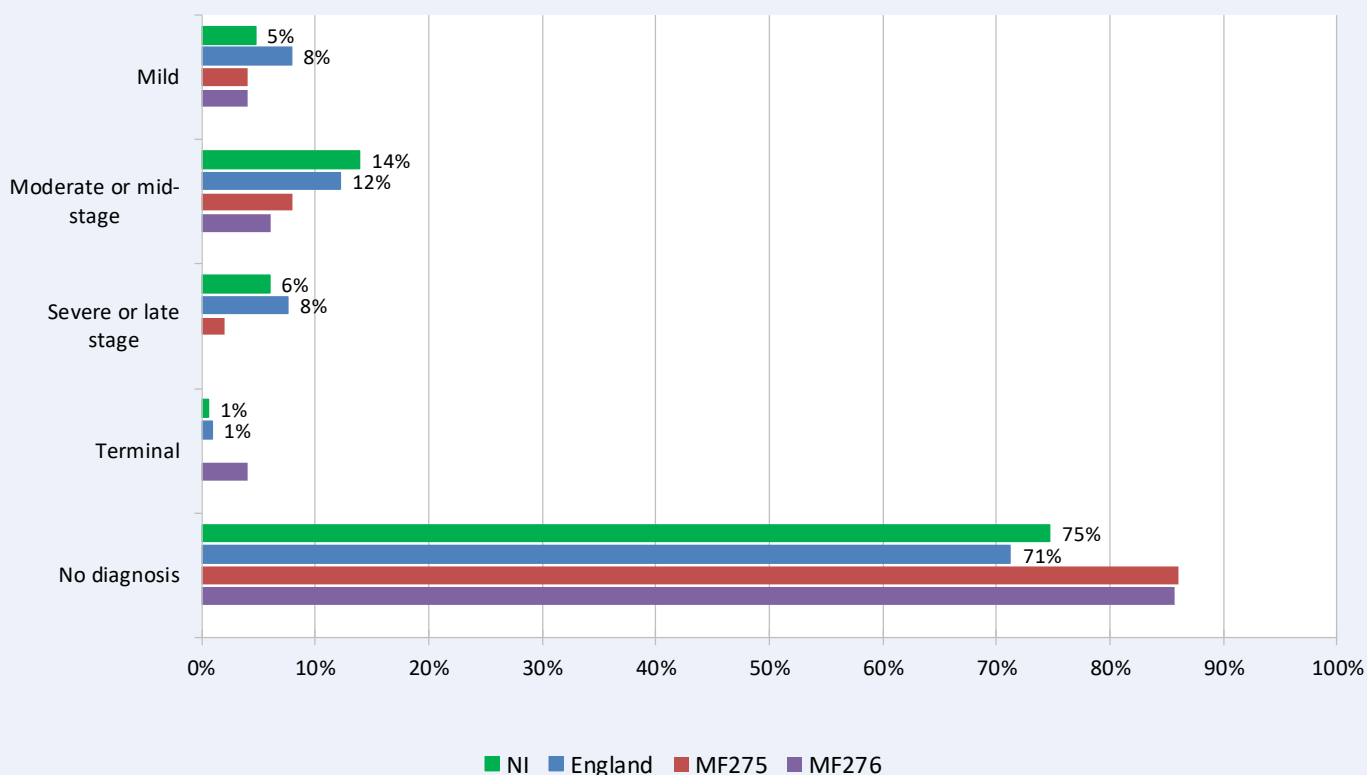
- The service user audit, developed in conjunction with the British Geriatrics Society, provides further detail on patients in care of older people wards. Participants were asked to complete the service user audit for up to 50 consecutive discharges on one care of older people ward. 74 care of older people wards took part in the service user audit, supplying data for 3,648 service users across the UK. In Northern Ireland, 7 care of older people wards participated. The findings covered below comment on the Northern Ireland position only.
- The mean age of patients included in the service user audit was 80 years. 29% of the cohort was aged 90 years or over.
- 75% of patients included within the audit had no clinical diagnosis of dementia, 5% had a mild dementia diagnosis, 14% a moderate or mid-stage diagnosis, 6% a severe or late stage diagnosis and 1% had a terminal diagnosis.
- In lieu of an ICD-10 code for frailty, a number of ICD-10 codes which might be associated with frailty were identified. The aim of collecting these codes was to give an indication in the number of people being admitted with conditions associated with frailty. The most common ICD-10 codes on admission related to falls (24%) – W00-W19. However, 53% of the service users did not fit into these categories.
- 80% of services users included in the audit were in receipt of Comprehensive Geriatric Assessment (CGA) during their acute episode of care. CGA was most commonly delivered in inpatient wards, with 72% of service users included in the audit receiving CGA whilst in inpatient care.
- 27% of service users experienced a delayed transfer of care (DToC). The mean average length a DToC was 8.7 days. 50% of delays were 5 days or longer, with 10% of delays being 21 days or longer.
- 81% of service users included in the audit normally resided in their own home and 13% were from a nursing home. On discharge, 68% of service users were able to return to their own home. 4% were discharged to a residential home and 18% were discharged to a nursing home. 4% entered transitional arrangements, such as intermediate care.
- The average length of stay on a care of older people ward was 13 days. 18% of service users were in hospital 21 days or longer. From the organisational level data, stays of 21 days or longer represent 37% of occupied bed days (page 29).



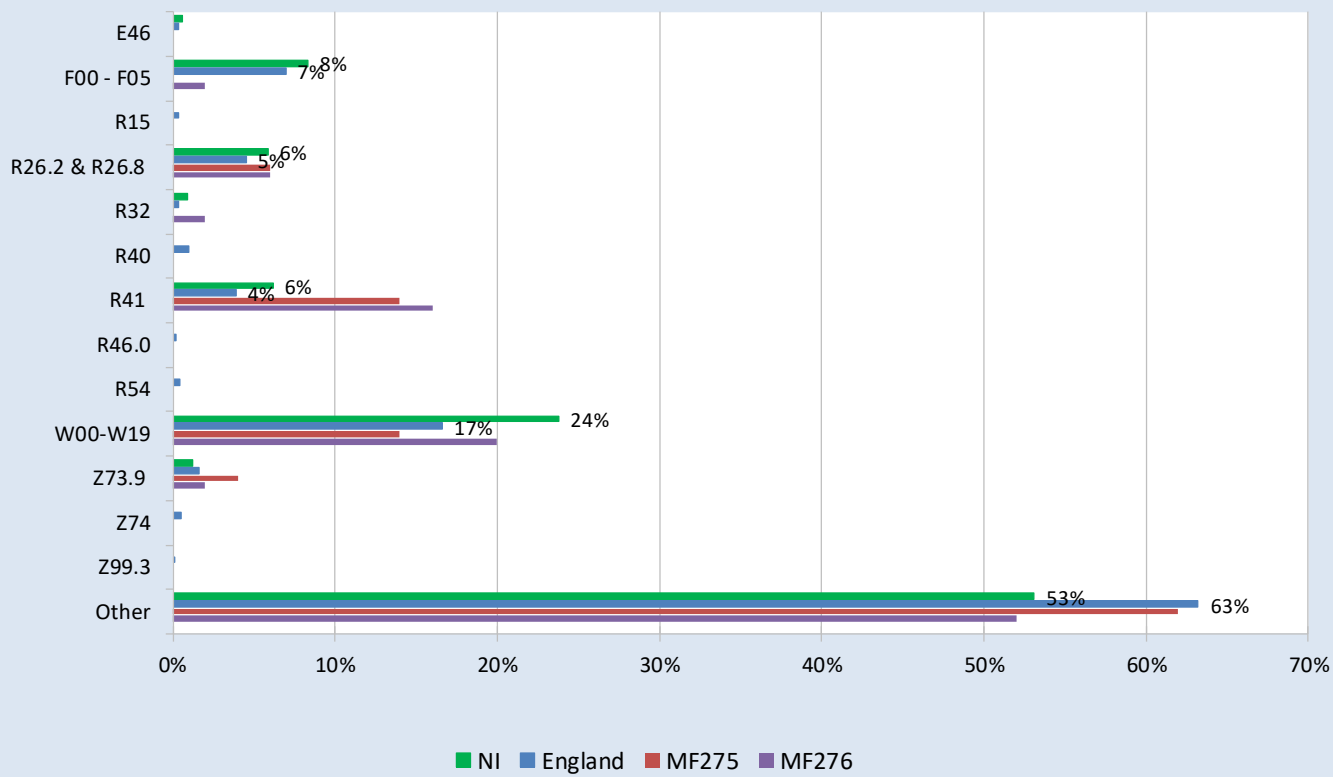
Age profile



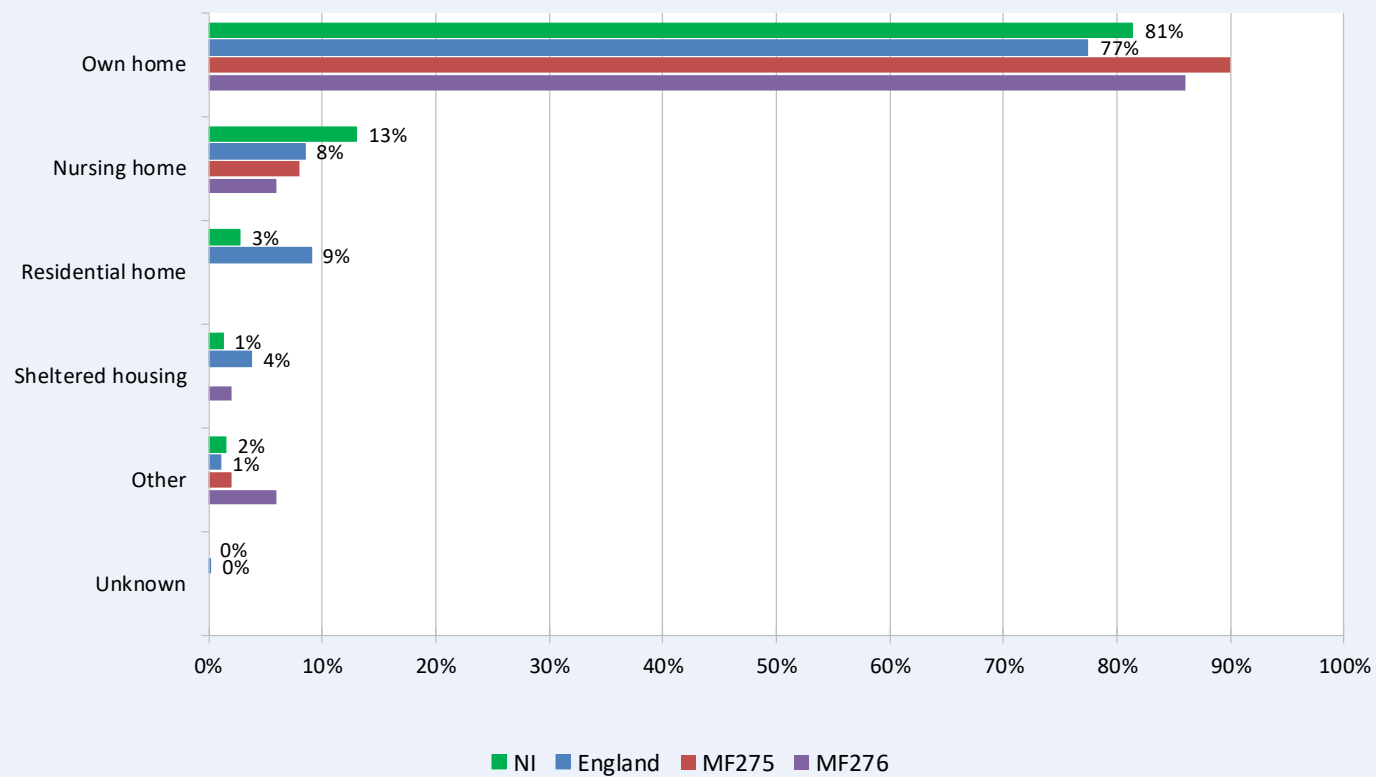
Dementia diagnosis



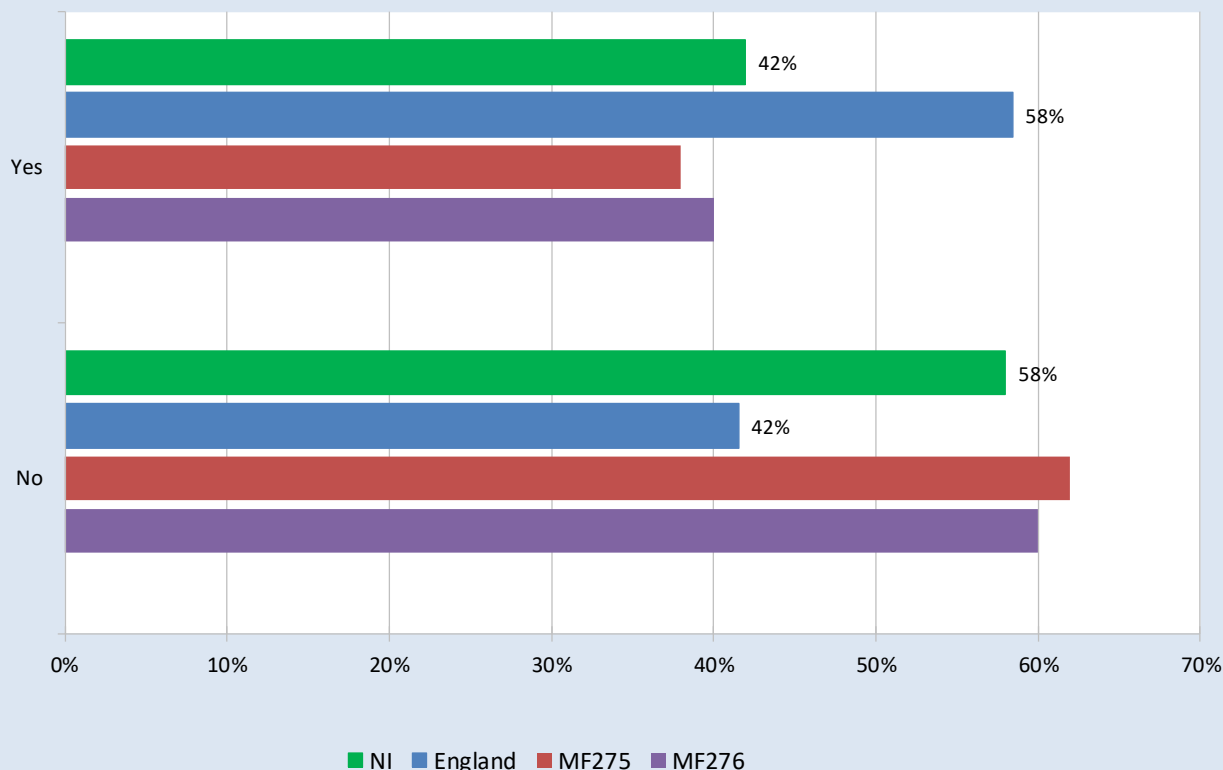
ICD-10 code on admission



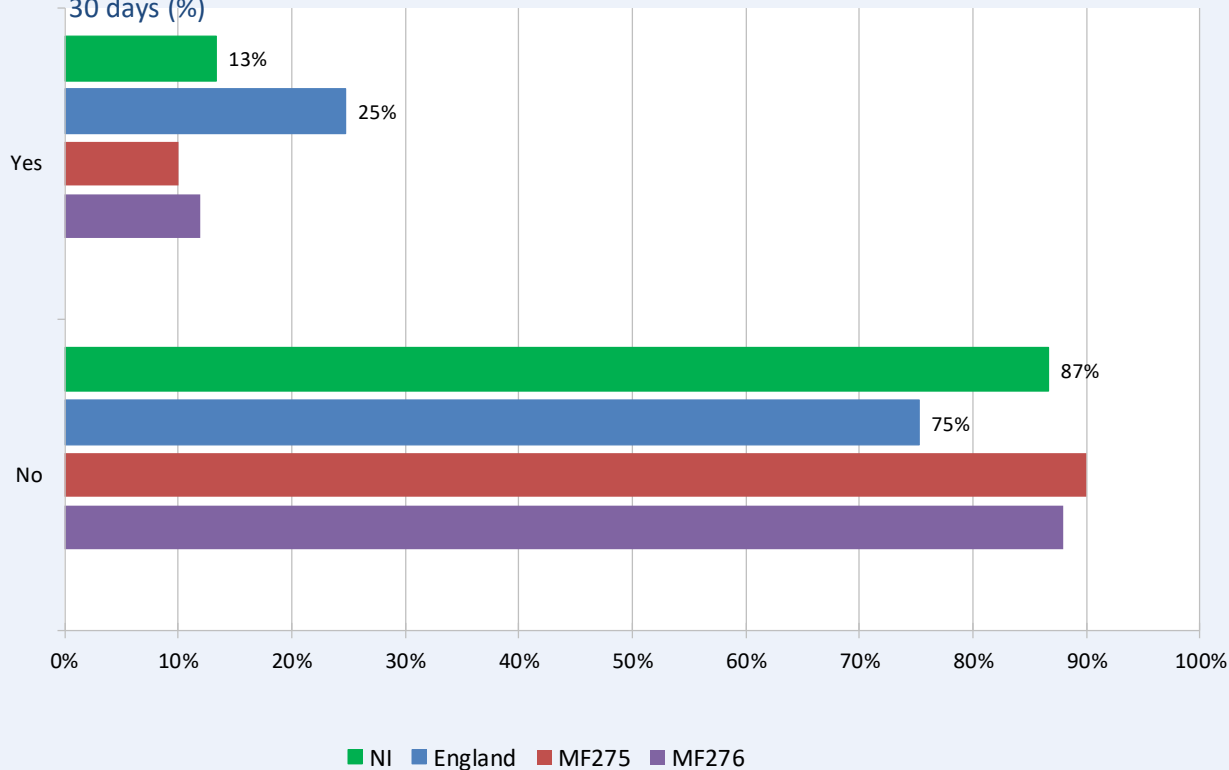
Normal living arrangements



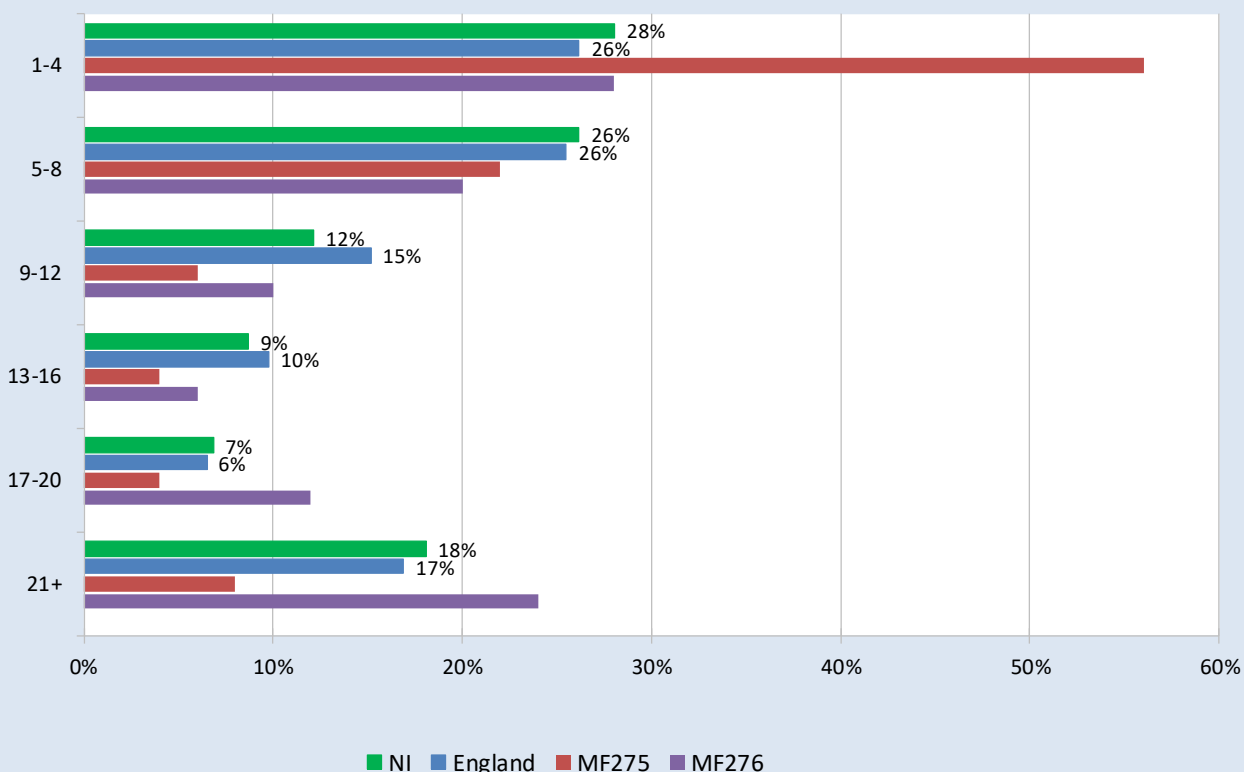
Percentage of service users with a hospital admission in the previous 6 months (%)



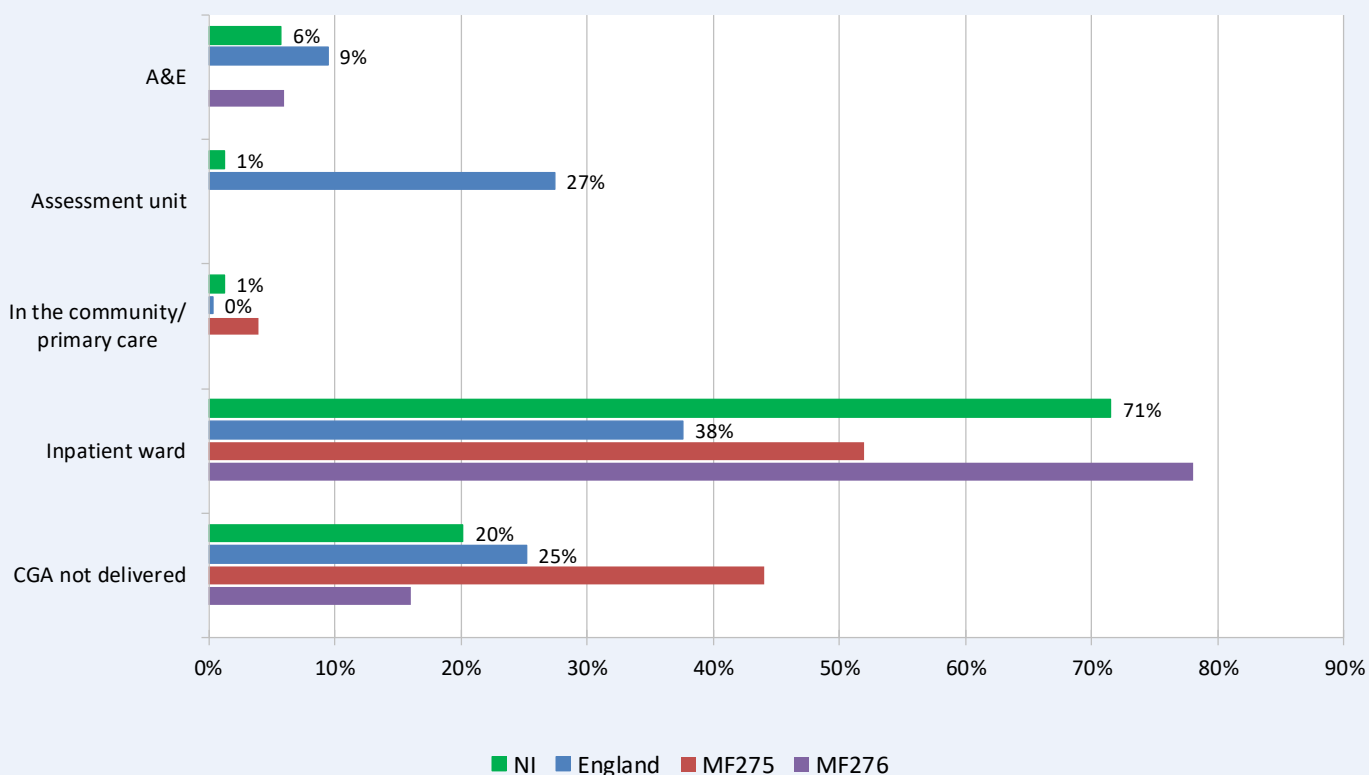
Percentage of service users whose current admission is an emergency re-admission within 30 days (%)



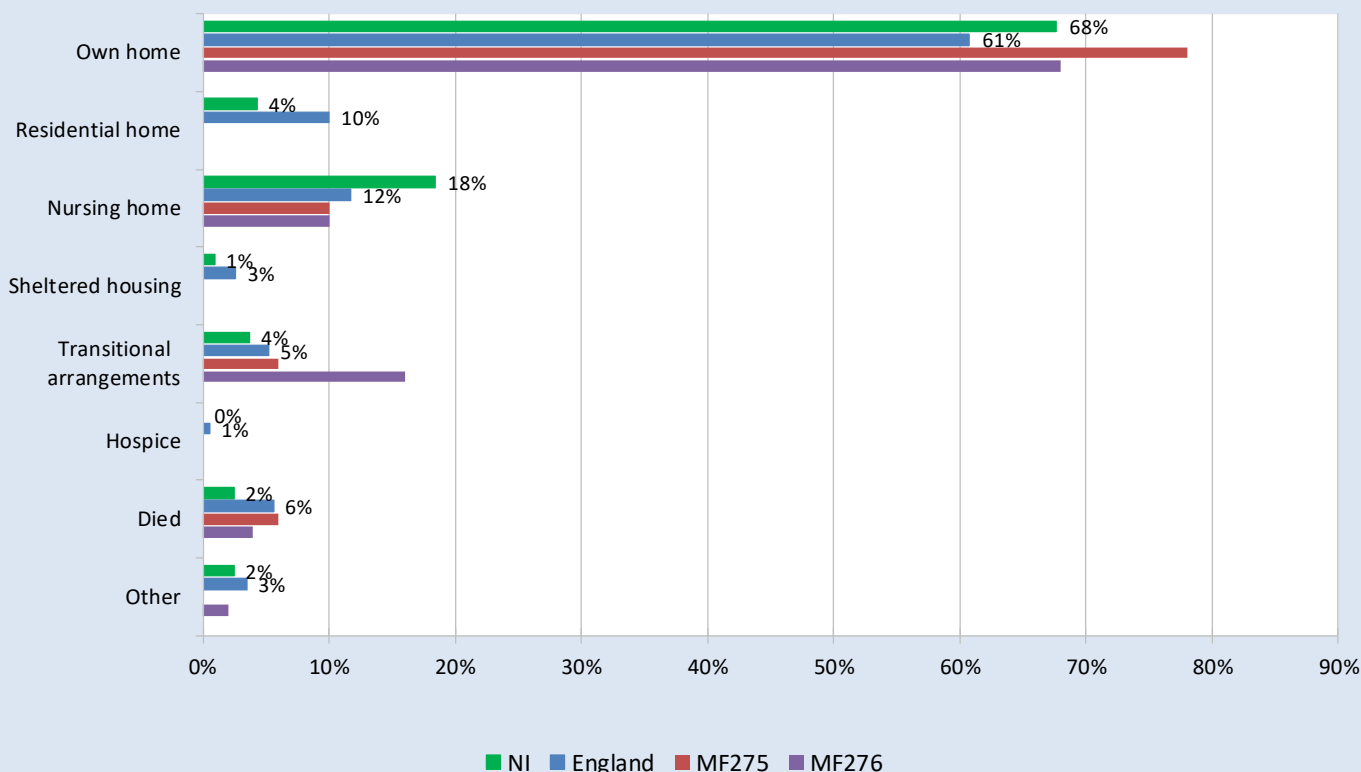
Length of stay profile



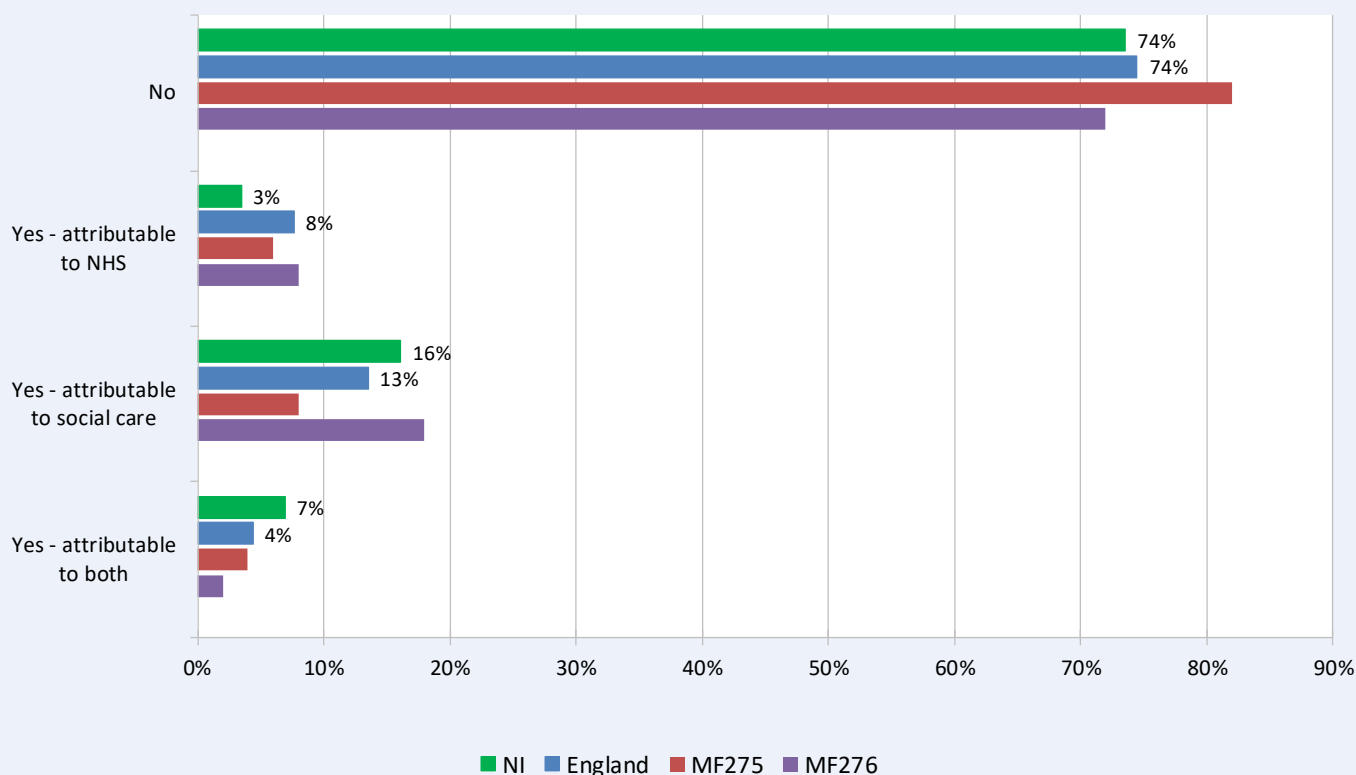
At what point was CGA delivered to the service user

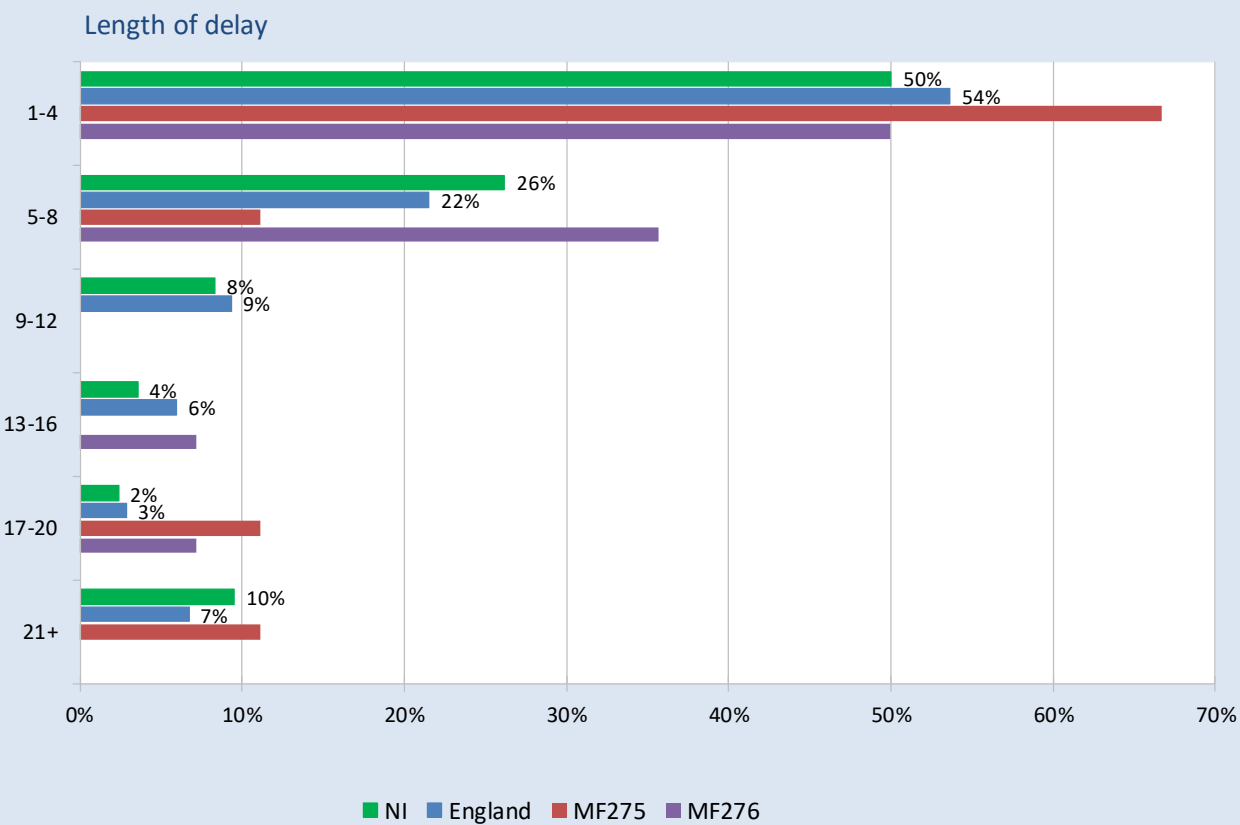


Discharge destination



Did the service user experience a delayed transfer of care?





Next steps

- This bespoke report has provided a summary of the data collected in the 2019 NHSBN Managing Frailty and Delayed Transfers of Care in the Acute Setting project covering 2018/19 data, providing readers with an accessible summary of their organisation's structure, activity and performance across a range of metrics.
- Participants should use this report in conjunction with the project's online toolkit, which presents charts covering all the data collected in the project. If you do not have access to the member's area where the toolkit is located, please contact the project team (below) who will be able to provide you with access. Peer group profiling to view the Northern Ireland position is available in the online toolkit.
- The **National UK Findings Conference** took place on the 6th February 2020 in London. Northern Ireland findings from the project will be presented at the Northern Ireland Frailty Network event in Belfast on 25th March 2020.
- A national UK summary report will be available in March 2020.

Project team contact details:

Lucy Trubacik, Project Manager (Personal Information redacted by the USI)

Lucy Atherton, Project Co-ordinator (Personal Information redacted by the USI)



The list of participating hospitals from Northern Ireland, along with their identified codes, can be found below.

Submission	Code
Belfast Health and Social Care Trust - Belfast City Hospital	MF248
Belfast Health and Social Care Trust - Mater Hospital	MF249
Northern Health and Social Care Trust - Causeway Hospital	MF265
South Eastern Health and Social Care Trust Downe Hospital	MF268
South Eastern Health and Social Care Trust - Lagan Valley Hospital	MF269
South Eastern Health and Social Care Trust - Ulster Hospital	MF270
Southern Health and Social Care Trust - Craigavon Area Hospital	MF275
Southern Health and Social Care Trust - Daisy Hill Hospital	MF276
Western Health and Social Care Trust - Altnagelvin Area Hospital	MF285
Western Health and Social Care Trust - South West Acute Hospital	MF286



Location of Paper Death Certificate Book – 28.3.2020

Directorate	Site	Location
Acute	CAH Main Hospital	Patient Flow – Commercially Sensitive Information to request death certificate book
	Daisy Hill Hospital	Patient Flow – Commercially Sensitive Information to request death certificate book
	Acute Care at Home	AC@H Office - Lurgan Office
CYP	CAH Blossom Ward	Black Box, Sister's Office
	CAH Neo-Natal	Store Room Cabinet
	DHH Paediatric Ward	Patient Flow – Commercially Sensitive Information to request death certificate book
MHLD	CAH Bluestone Unit	Contact Patient Flow CAH
	Gillis Ward, St Luke's Hospital	Ward Safe
OPPC	Lurgan Hospital	Ward 1 – Paper Death Certificate Book kept beside the Mortuary Book (Nurses Station front wing) Ward 2 – Paper Death Certificate Book in black box in Sister's Office Ward 3 – To borrow from Ward 1 or Ward 2
	South Tyrone Hospital	Dr P Stinson's Office – Clip on drawer but not locked

Memorandum

To:	All Medical Staff (Consultant, SAS and Junior Doctors)
c.c.	Operational Directors; Mrs H Trouton, Mrs G Hamilton, Directorate Governance Coordinators, Joanne McConville, Head of Patient Safety Data and Improvement
From:	Dr Maria O’Kane, Medical Director
Date:	8 th April 2021
Subject:	Independent Medical Examiner : Actions required from medical staff following death of a patient

Dear Colleagues,

We would like to take this opportunity to thank you all for your continued professionalism and hard work.

Over the last number of years the Department of Health has led a series of reforms to the death certification process following the publication of the Shipman and Luce Inquiries.

One of the main recommendations from those Inquiries was that all deaths should be subject to independent scrutiny to provide greater assurance around the cause of death and to ensure that deaths are appropriately referred to the Coroner. The introduction of an Independent Medical Examiner (IME) was also raised in the Hyponatraemia Inquiry when it was recommended that;

“The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner”.

This memo is to highlight that the Southern Health and Social Care Trust has discussed the Independent Medical Examiner role with the Department of Health, and the Trust will be involved in the Independent Medical Examiner prototype from 19/04/2021.

To this end, the Independent Medical Examiner’s involvement will be conducted in real time with deaths being reviewed quickly after completion of the MCCD and that the review will include a discussion with the certifying doctor.

An information sheet outlining the process is attached in Appendix 1.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

Thank you for help in implementing this requirement.

Personal information redacted by the USI

Dr Maria O'Kane
Medical Director

Independent Medical Examiner (IME) - Prototype #3



Process for Registered Certifying Doctor.

Background

The Department of Health (NI) is evaluating the best method for the review of death certification by an IME. An IME is an experienced clinician who, as part of an IME Service (IMES) team, will review the completed Medical Certificate of Cause of Death (MCCD) following a death to check it represents a reasonable conclusion as to the likely underlying cause of death. The IMES will also review hospital deaths to check whether they should have been referred to the Coroners Service for Northern Ireland (CSNI).

This prototype #3 exercise will,

- a. test the best method for contacting the Registered Certifying Doctor (RCD) with a particular focus on discussing a death with the RCD **before** the MCCD has been issued to the General Register Office (GRO).
- b. evaluate a streamlined model for referring a death to the CSNI; an IME, rather than the CSNI, will primarily field calls which are intended to seek advice and clarification.

Prototype #3 will be carried out in the following hospitals. Your Medical Director fully supports participation and the following colleague will answer any local queries.

SHSCT

Craigavon Area Hospital and Daisy Hill Hospital - Dr Damian Gormley

Personal Information redacted by the USI

This prototype #3 exercise starts in the SHSCT on **20th April 2021**, joining the NHSCT and WHSCT who have been part of the prototype for some months.

It will operate for deaths being certified by a Registered Certifying Doctor on,

TUESDAYS	from 08.00 – 16.00
WEDNESDAYS	from 08.00 – 16.00
THURSDAYS	from 08.00 – 16.00

IME Service

Personal Information redacted by the USI

Sequence of prototype #3 exercise

1. Prior to entering the death onto NIECR, the Registered Certifying Doctor (RCD) needs to decide, preferably with direction from their Senior Medical Staff team, whether to refer the death to the CSNI.

Referral to CSNI

2. A referral to the CSNI may either be,
 - i. not clear cut. The RCD may want some advice or is uncertain about the exact formulation of the cause of death or whether the death needs reported. They will now be able to obtain advice and help from the IMES.

The RCD should complete the Mortality Pathway on NIECR, entering the Initial Record of Death (IRD) details. They should then complete the record and contact the IME Service directly on [Personal Information redacted by the USI]. An IME will review the case and either recommend a referral to the CSNI or the completion of a MCCD.

- ii. a straightforward referral where there is no doubt and can be reported directly to the CSNI. These are categorised as Section 7 deaths. These should be reported without delay, directly to the CSNI. Following the CSNI instruction, the IRD can be completed.

Section 7 death

Trauma, Violence, Misadventure
Negligence, Malpractice
Unnatural illness or disease
Self-Harm, Suicide
Poisoning, Drug intoxication
Occupational disease
As a result of an anaesthetic, or
Medical intervention

Death Certification - MCCD review and discussion

3. For all deaths which do not require referral to the CSNI, the RCD should record the Initial Record of Death (IRD) onto NIECR Mortality Pathway.
4. Immediately after clicking '**Complete**' but **BEFORE** emailing the MCCD to the GRO, the RCD should contact the IME Service on their dedicated line. If this number is temporarily unmanned, please leave a voicemail.
5. RCD is to confirm the deceased's name, Health & Care number and date of death to IME Officer (IMEO).
6. The IMEO will ask for the RCD's name and contact number (mobile [*preferred*] or direct work number) and schedule an agreeable IME review appointment time, within 20 – 60 minutes, if possible. This will depend on the volume of calls into the IMES.
7. The IME, using all the facilities of NIECR, will review the MCCD, especially the Cause of Death entry and then contact the RCD at the allotted time. It is anticipated that the discussion will last no more than 10 minutes.

IME Service

Personal Information redacted by the USI

8. If the IME believes the death should have been reported to the Coroner, the medical team should refer the death to the CSNI. Should the IME and RCD, with their Consultant, disagree, the IME will discuss death with the Trust's Medical Director.
9. The IME will also discuss the implant hazard boxes if they have not been completed or if they do not correlate with the NIECR record.
10. To facilitate the conversation, if possible, it would be helpful if you were in a quiet environment, e.g. preferably not the ward nurses' station; with NIECR open at the deceased's pathway and the MCCD also open.
11. If changes to the MCCD are agreed between the RCD and the IME, these could be made by the RCD using the '*Re-open Task*' function - effectively an 'edit' function.
 - a. Go back into NIECR and select the correct patient.
 - b. Select the "*Pathway*" tab and click "*Show - ALL*".
 - c. Select the *Mortality Initial Record of Death* box and click "*Re-Open Task*".
 - d. You will be asked for a reason - type in "*Issuing revised MCCD*".
 - e. Make your changes to the MCCD and press "*Complete*".
12. If, in the IME's opinion, there needs to be changes made to the MCCD, but the RCD is unwilling, the IME will give the RCD permission to go ahead and issue the MCCD. However, as requested by the Trusts Medical Directors, the IME might inform them of the discussion.
13. Finally, the IME will check that the RCD knows how to forward the MCCD to the GRO. If not, they will talk the RCD through the process of emailing the GRO.

Who are the prototype IMEs?



Dr Julian Johnston
DOH Medical Adviser



Dr Dermot Hughes
Former WHSCT MD



Dr Paddy Woods
Former Deputy CMO

APPENDIX 4

Revised November 2016 (Version 1.1)

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

1. ORGANISATION: South Eastern Health and Social Care Trust	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: Personal Information redacted by the USI	1. DATE OF INCIDENT/EVENT: 11/05/2021
2. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO <i>Please select as appropriate</i>	3. IF 'YES' TO 5. PLEASE PROVIDE DETAILS:
4. DATE OF SEA MEETING / INCIDENT DEBRIEF: 21 / 06 / 2021	
5. SUMMARY OF EVENT: Mr X attended the Emergency Department (ED) in the Ulster Hospital on 10/05/2021 complaining of chest pain. Around 04:00 on 11 /05/21 a chest X-Ray was requested. The clinical history given was sudden onset left lateral chest wall pain, query pneumothorax (collapsed lung). The chest X-Ray was undertaken in the Red Zone in Emergency Department (ED) using a portable imaging machine. The resultant image showed a right sided pneumothorax. A chest drain was then inserted by the ED doctor into the right side of the chest to manage the pneumothorax. A further chest X-Ray was requested at 06:35 to check the position of the chest drain. This was undertaken in the Adult Resus Green Zone using another portable imaging machine. This is a normal follow up procedure. This second image subsequently demonstrated a left sided pneumothorax and a right sided chest drain in situ. Both the attending ED doctor and radiographer then reviewed the initial chest X-Ray taken at 04:00 and following discussion concluded that this image had been incorrectly processed on the digital system so that the left pneumothorax appeared on the right of the image. Corrective action was then taken promptly and a further chest drain was then inserted into the left side of the chest. Mr X was informed of the error at the time by the attending ED doctor.	

SECTION 2

6. SEA FACILITATOR / LEAD OFFICER: Alyson Lattimer Governance, Training and Service Improvement Lead, Department of Radiology Personal Information redacted by the USI	7. TEAM MEMBERS PRESENT: Mrs. Alyson Lattimer, Governance, Quality & Service Improvement Lead (Chair) Mr Fergus Gordon, Team Lead for ED X-Ray Dr Colm O'Kane, Consultant in Emergency Medicine Dr Audrey McKelvey, Consultant in Emergency Medicine
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8. SERVICE USER DETAILS: <i>Complete where applicable</i> N/A
9. WHAT HAPPENED? Mr X attended the Emergency Department (ED) in the Ulster Hospital at 23:05 on 10/05/2021 complaining of pleuritic chest pain and dyspnoea (shortness of breath). Mr X was triaged at 23:22. Initial examination at 02.50 on 11/05/21 noted no history of trauma, left sided chest pain and a history of pneumothorax 2 years ago. On examination equal air entry, percussion and expansion was documented to be equal for both sides by SHO in medical notes. Around 04:00 a chest X-Ray was requested. The clinical history given was sudden onset left lateral chest wall pain, query pneumothorax. The chest X-Ray was undertaken in the Red Zone in ED Department using a portable imaging machine. The resultant image showed a right sided pneumothorax. The image was initially assessed by the SHO who informed the Registrar in charge that the patient had a large right sided pneumothorax. The Registrar also viewed the image and in addition noted signs of tension (slight mediastinal (area between the lungs) tracheal (windpipe) shift to the left side was noted). The patient was re-examined by the Registrar and medical notes document equal and normal air entry, expansion and percussion tone. These re-examination findings were corroborated with two fellow ED medical colleagues prior to insertion of a right sided chest drain. The image was again reviewed at the patient's bedside. History taking confirmed Mr X was complaining of pleuritic chest pain and dyspnoea, worse on his left side. Mr X was informed of a diagnosis of a right sided pneumothorax and consent was obtained to insert a right sided chest drain. This procedure was successfully undertaken at 06.20. A further chest X-Ray was requested by Registrar who inserted right sided chest drain at 06:35 to check the position of the drain. This was undertaken in the Adult Resus Green Zone using a portable imaging machine. This second image subsequently demonstrated the tip of the chest drain in the right hemithorax (one side of the chest) and a fully inflated right lung. The image also demonstrated a large left side pneumothorax. Both the Registrar and radiographer who undertook the second image reviewed the initial chest X-Ray taken at 04:00 and concluded that this was not a newly developed left sided pneumothorax but rather that this image had been incorrectly processed on the digital system so that the left pneumothorax appeared on the right of the image. The patient was informed immediately and an apology made by the Registrar. Mr X was also informed that a further chest drain would be required to be inserted into the left side of the chest. This procedure was undertaken by the day shift team at the instruction of ED Consultant in charge at 08:00 Mr X was transferred to the Royal Victoria Hospital (RVH) on 14 06 21 where he remained on suction for 2 days as the left pneumothorax was not resolving despite having chest drain in situ. Indication for left side surgery was due to the history of a recurrent left sided pneumothorax (previously in 2017) and the decision to operate was not influenced by the right sided chest drain insertion.
10. WHY DID IT HAPPEN? The initial image was undertaken with the patient positioned for a posterior anterior (PA) projection (meaning from back of the patient to the front). This is the preferred position for optimum chest imaging. However when patients are unwell and unable to be positioned as such an anterior posterior projection (AP) is undertaken. The portable imaging machine used gives two menu options (PA or AP) which must be selected by the radiographer prior to making the exposure. This machine

is designed to primarily be used for AP imaging but during Covid has been installed in a temporary X-Ray room to accommodate patients with suspected Covid 19 from having to leave the Red Zone. This is an Infection and Prevention Control measure.

In this instance the radiographer selected the AP menu whilst the patient was positioned for a PA chest image and this resulted in the image being flipped horizontally or portrayed the wrong way around on the system. The left sided pneumothorax was therefore demonstrated as a right sided pneumothorax.

The image following insertion of the right sided chest drain was undertaken using a different machine and with the patient on a trolley in the AP position. The correct menu selection was made and this image demonstrated a left sided pneumothorax and highlighted to both attending Registrar and radiographer that an error had potentially been made and that the initial image has been processed using the AP menu when it should have been the PA menu selected.

This was simple human error by the radiographer who undertook the initial chest image. The radiographer was focussed on the pneumothorax and did not assess the image thoroughly

The review team discussed witness statements for those involved. Review of the images noted that on the initial image there is mild mediastinal shift and the eye is instantly drawn to the large pneumothorax rather than focusing on orientation of the image.

The imaging referral did however state sudden onset left lateral chest wall pain, query pneumothorax. On reflection this should have been considered by the performing radiographer and a double check on correct orientation made before sending the image to NIPACS (Northern Ireland Patient Archiving and Communication System).

Review of the medical notes show that the a re-examination was made prior to insertion of the right chest drain by Registrar and SHO given that the patient was complaining of more pain on the left. This indicates that consideration was given to the unexpected finding of a right not left sided pneumothorax. Equal and normal air entry, expansion and percussion tone are recorded in the medical notes following re-examination which is an unusual presentation given the size of the left sided pneumothorax. As a result of re-examination findings a decision was made to insert a right sided chest drain.

Other mitigating circumstances discussed by the review team include fatigued staff given the early hours of the morning when the incident occurred. The department was incredibly busy at this time and medical staff were noted to be attending to several patients with varying levels of acute care needed at the one time.

SECTION 3 - LEARNING SUMMARY**11.WHAT HAS BEEN LEARNED:**

Outcome / Learning from review meeting 21 06 21

All agreed that issues were identified on both sides; Emergency Department and Radiology Thorough assessment of images is paramount regardless of pathology seen which may be distracting and the side of clinical indication must also be taken into consideration when assessing the image. Extra vigilance required when undertaking PA imaging on a machine used primarily for AP imaging.

The patient had presented with a left sided pneumothorax previously in 2017 so it was agreed that staff should be reminded to also check relevant previous history as part of examination.

This event has highlighted the need for a chest drain protocol to be developed which will include a pre procedural checklist. This checklist will have a prompt for medical staff to assess image orientation carefully and a signature will be required.

Learning will be discussed at team meetings across sites. Incident tabled at Emergency department M & M (Mortality and Morbidity) meeting in June.

12.WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

Signage has been placed on the portable imaging machine Re due care and attention to selection of image orientation on control console.

Radiographers rotating through the Emergency Department have been reminded to be vigilant when processing chest images.

A chest drain protocol and pre procedural checklist are to be developed.

Temporary X-Ray room will be reinstated as a clinical room once the pandemic is over. This machine will then be used again for AP imaging primarily which will mitigate the chances of reoccurrence.

13.RECOMMENDATIONS (please state by whom and timescale)

A memo is to be issued to radiographers in relation to checking the image orientation before sending to NIPACS and considering both the side of clinical indication in doing so. Extra vigilance required when undertaking PA imaging on a machine used primarily for AP imaging. Checking relevant previous history is also key in the instance of a recurring pneumothorax.

Alyson Lattimer, Governance, Training and Service Improvement Lead, end of June 21. Actioned.

Development of a chest drain protocol and pre procedural checklist. NICE guidance will be checked to ascertain if Ultrasound should be part of the process

Dr O'Kane, Consultant in Emergency Medicine, September 2021. Actioned

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

Recommendations above can be considered for sharing regionally

15.FURTHER REVIEW REQUIRED? YES / NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6.

If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

16.PLEASE INDICATE LEVEL OF REVIEW:
LEVEL 2 / LEVEL 3
Please select as appropriate

17.PROPOSED TIMESCALE FOR COMPLETION:
DD / MM / YYYY

18.REVIEW TEAM MEMBERSHIP (*If known or submit asap*):

19.TERMS OF REFERENCE (*If known or submit asap*):

SECTION 5**APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR**

20.NAME: Chris Allam

21.DATE APPROVED:
24/08/21

22.DESIGNATION:

Assistant Director, Radiology & Elective Care Reform Directorate

SECTION 6

23.DISTRIBUTION LIST:

24.

Assistant Director, Radiology & Elective Care Reform Directorate
Radiology Services Manager, Hospital Services Directorate
Clinical Director, Radiology
Team Lead Radiographer, ED X-Ray
Radiographer
Consultant in Emergency Medicine
Governance, Training and Service Development, Radiology

**Checklist for Engagement / Communication
with Service User¹ / Family / Carer following a Serious Adverse Incident**

Reporting Organisation SAI Ref Number:	Personal Information redacted by the USI	HSCB Ref Number:	Personal Information redacted by the USI
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SECTION 1			
INFORMING THE SERVICE USER ¹ / FAMILY / CARER			
1) Please indicate if the SAI relates to a single service user, or a number of service users. Please select as appropriate ()	Single Service User	☒	Multiple Service Users*
	Comment: <i>*If multiple service users are involved please indicate the number involved</i>		
2) Was the Service User ¹ / Family / Carer informed the incident was being reviewed as a SAI? Please select as appropriate ()	YES	☒	NO
	If YES , insert date informed : 02 06 21		
	If NO , please select only one rationale from below, for NOT INFORMING the Service User / Family / Carer that the incident was being reviewed as a SAI		
	a) No contact or Next of Kin details or Unable to contact		
	b) Not applicable as this SAI is not 'patient/service user' related		
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user		
	d) Case involved suspected or actual abuse by family		
	e) Case identified as a result of review exercise		
	f) Case is environmental or infrastructure related with no harm to patient/service user		
	g) Other rationale		
	If you selected c), d), e), f) or g) above please provide further details:		
3) Was this SAI also a Never Event? Please select as appropriate ()	YES	☒	NO
4) If YES , was the Service User ¹ / Family / Carer informed this was a Never Event? Please select as appropriate ()	YES	If YES , insert date informed :	
	NO	If NO , provide details: Meeting with Mr X scheduled for 14/09/21 where he will be informed of the Never Event	
For completion by HSCB/PHA Personnel Only (Please select as appropriate ())			
Content with rationale?	YES	☐	NO

SHARING THE REVIEW REPORT WITH THE SERVICE USER ¹ / FAMILY / CARER (complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)			
5) Has the Final Review report been shared with the Service User ¹ / Family / Carer? Please select as appropriate ()	YES	☒	NO
	If YES , insert date informed : 05 07 21		
	If NO , please select only one rationale from below, for NOT SHARING the SAI Review Report with Service User / Family / Carer:		
	a) Draft review report has been shared and further engagement planned to share final report		

SHARING THE REVIEW REPORT WITH THE SERVICE USER¹ / FAMILY / CARER*(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*

	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed (if you select this option please also complete 'I' below)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'I' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user ¹ family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected c), h), i), j), or k) above please provide further details:	
For completion by HSCB/PHA Personnel Only (Please select as appropriate ())		
Content with rationale?	YES	NO

SECTION 2**INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? Please select as appropriate ()	YES		NO	√				
	If YES , insert date informed :							
	If NO , please provide details: No death							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? Please select as appropriate ()	YES		NO					
	If YES , insert date report shared :							
	If NO , please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? Please select as appropriate ()	YES		NO		N/A		Not Known	
	If YES , insert date informed :							
	If NO , please provide details:							

DATE CHECKLIST COMPLETED 24/08/21¹ Service User or their nominated representative

CHEST DRAIN CHECKLIST & MONITORING CHART

Patient Name:

HCN:

DOB:

Date:

Time:

Procedure

Doctor:

Procedure

Nurse:

Procedure:

Indication:

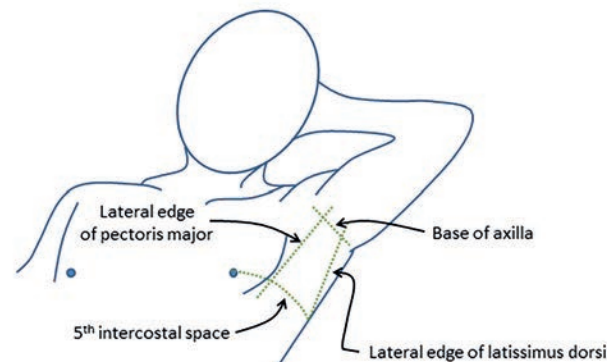
Admitting Team:

PRE-PROCEDURE

Does the procedure need to be done immediately?	Yes / No
Are the appropriate staff members available in Resus with access to Resus equipment?	Yes / No
Is further imaging required before procedure?	Yes / No
Is there written consent?	Yes / No
Has patient's medication / anticoagulation status been reviewed?	Yes / No
O ² stats / NIBP / 2 Led ECG Monitoring applied?	Yes / No
Does the patient have adequate analgesia / sedation?	Yes / No
Has site of pathology been confirmed with x-ray (and the image appropriately orientated) along with clinical assessment +/- beside ultrasound?	Yes / No
Pre-procedural imaging interpretation by procedure doctor?	Yes / No
Has the procedure been discussed with the ED Consultant?	Yes / No

PROCEDURE

Equipment Check	✓
Sterile Gown / Gloves / Mask	
Sterile Chest Drain Kit	
Chloroprep	
Drapes	
Needles (Orange / Blue / Green)	
Syringe (10 - 20ml)	
Scalpel	
Drain (No Trochar)	
Underwater seal drainage system	
Silk Sutures (0.0 or 10 X 2)	
Dressing / Fixation	
Lidocaine (=/- Adrenaline)	

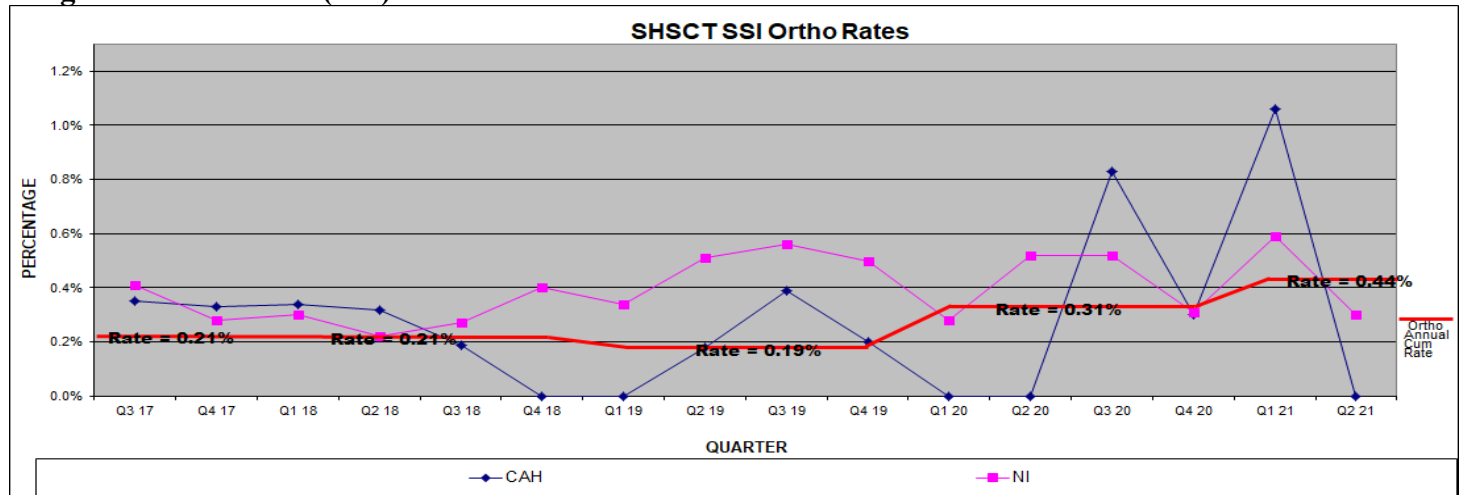


POST-PROCEDURE

Are the sutures / tubing / connections all secure?	Yes / No
Is the drain swinging / bubbling?	Yes / No
Dose of LA Used:	
Size of Drain:	
Has adequate analgesia been prescribed post procedure?	Yes / No
Has chest drain monitoring form been commenced?	Yes / No
Has admitting Team / Patient Flow been informed	Yes / No
Post-procedural CXR result?	

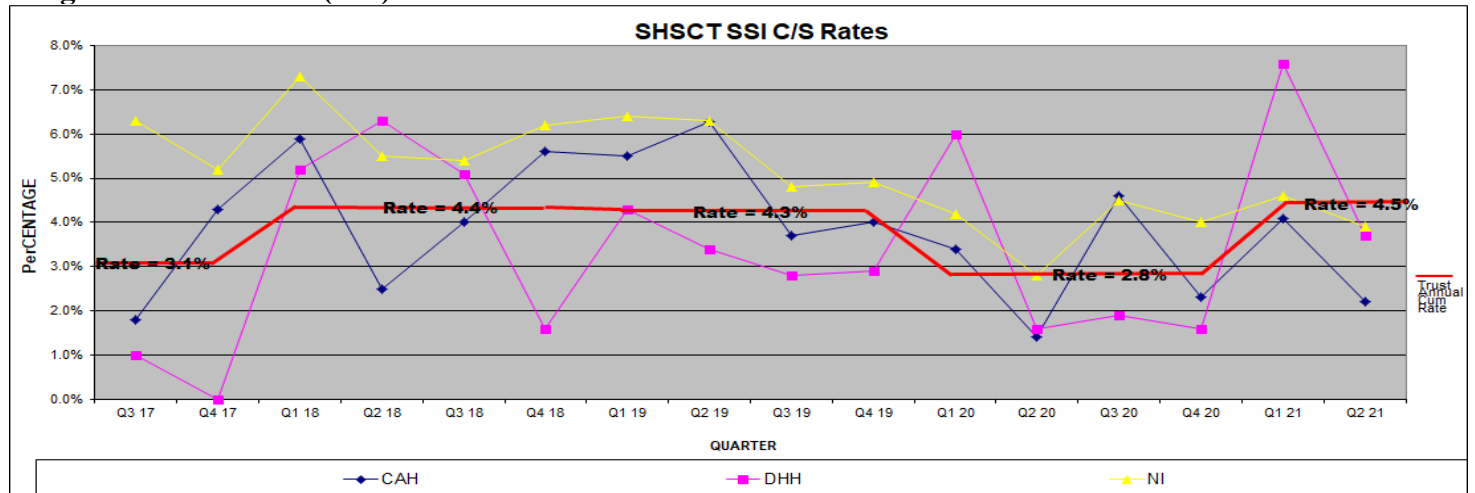
Patient Safety Report for Acute Governance Meeting Jan 2022

Surgical Site Infection (SSI) Ortho:



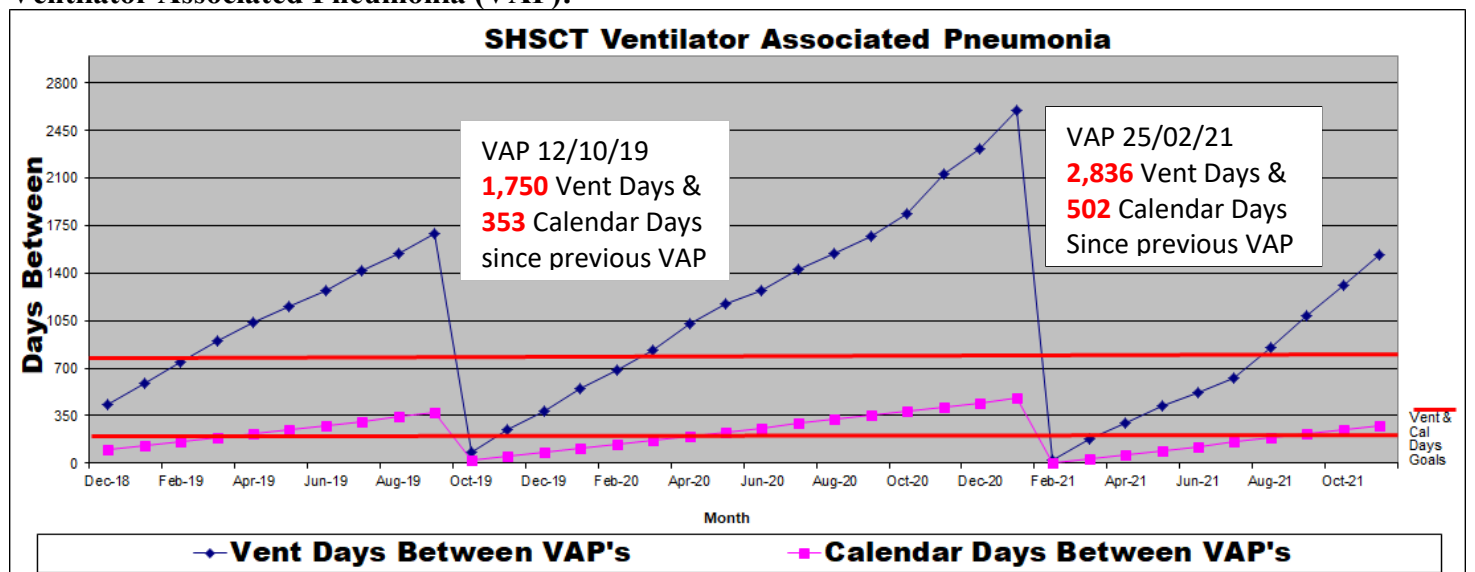
- Next update when Q3 2021 SSI Rates released by PHA

Surgical Site Infection (SSI) C/Section:

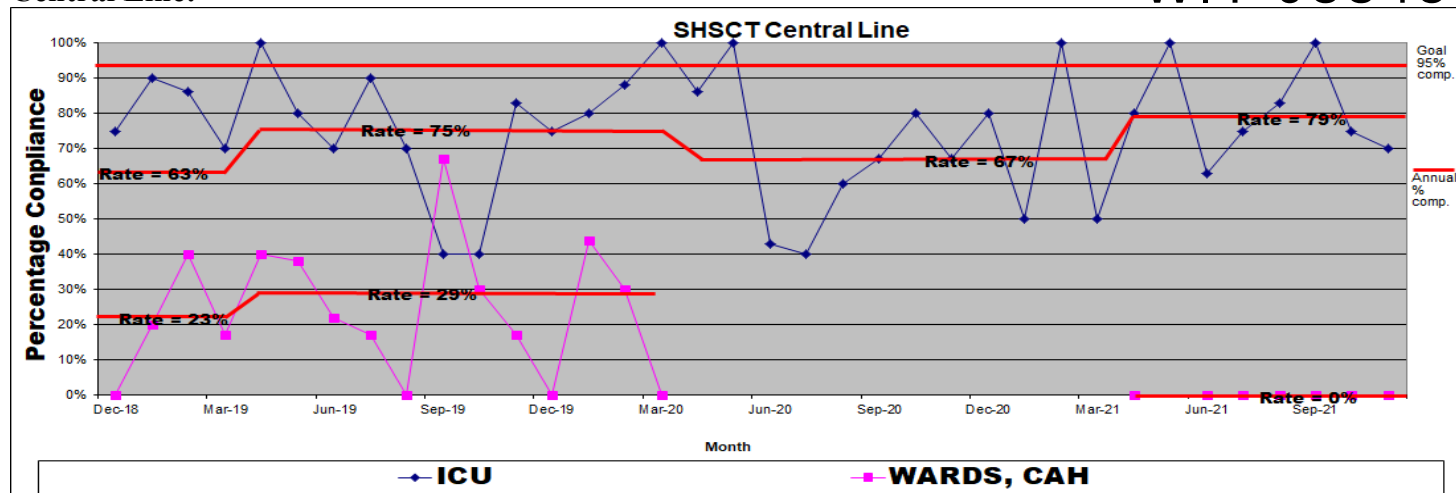


- The quarterly C/S Audits are taking place in Dec 2021 with results reported in Feb 22

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's 1536 (26th February 21 → 30th Nov 21)
- Calendar Days Between VAP's 278 (26th February 21 → 30th Nov 21)



Overall Bundle Compliance Nov 21, ICU **70%** (7/10 cases audited), down from **75%** (6/8 cases audited) in Oct 21
Cumulative Compliance 21/22 stands at **79%**, up from **67%** in 20/21

- Non-Compliant cases:
 - In 2 of 10 cases audited the Central Line Insertion Form was not completed, therefore there was no record of method of Hand Hygiene, Skin Prep. & size of drape used & no contraindication documented when the subclavian site was not used.
 - In 1 of 10 cases audit it was recorded that Natural Detergent was used as the method of Hand Hygiene

Overall Bundle Compliance Nov 21, Wards, CAH **0%** (0/7 cases), same as Oct 21
Cumulative Compliance 21/22 stands at **0%**, down from **29%** in 19/20 (audit suspended 20/21)

- Non-Compliant Cases:
 - In all 7 cases the Jugular was used with no contraindication documented as to why the subclavian site was not used.
 - In 4 of 7 cases audited there were gaps in the monitoring of the Daily Review of the Line (1 day missed in 3 cases - 4 North X 2 & 4 South X 1 & 2 days missed in 1 case - 4 North)
- Results shared with Lead Clinician, A.D., Lead Nurse & Wards for this QI work to address areas of non-compliance. Dr. Chris Clarke has also agreed to review the evidence in respect of the use of the Subclavian in preference to the Jugular

NEWS:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	92% (509/554)	91% (619/682)	95% (365/384)	94% (422/451)
TRUST	91% (637/700)	91% (767/842)	93% (494/531)	93% (554/596)

MUST (Malnutrition Universal Screening Tool):

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	88% (436/496)	91% (558/614)	89% (317/356)	90% (365/406)
TRUST	88% (615/695)	91% (702/770)	91% (453/498)	92% (502/548)

The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

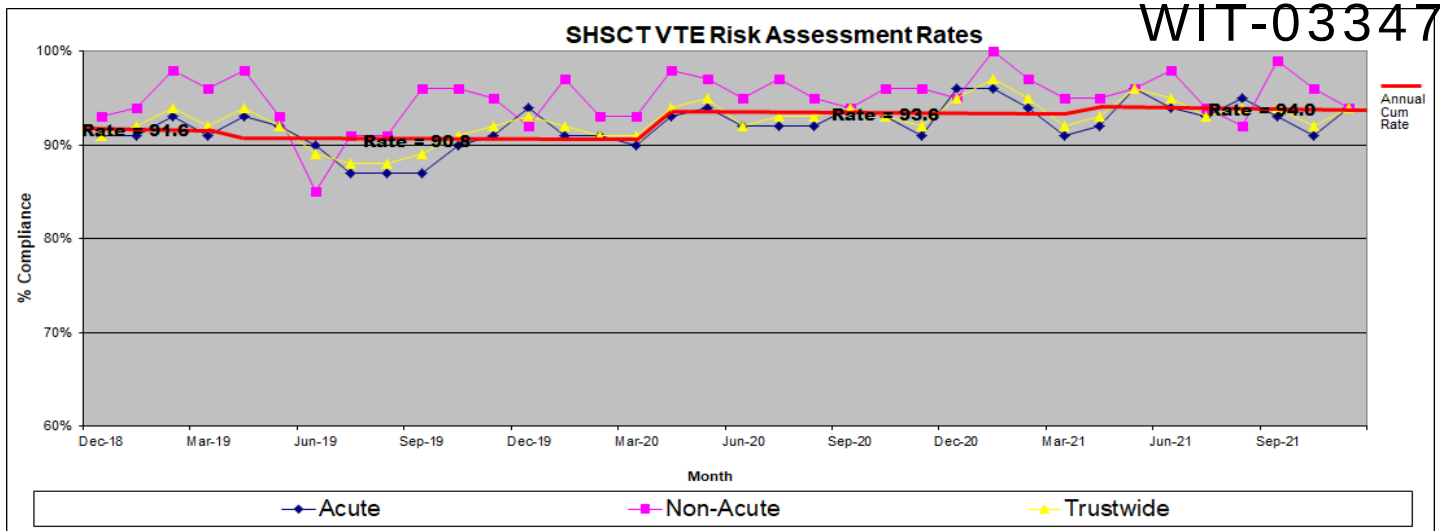
Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	0 (494)	1 (615)	1 (357)	1 (405)
TRUST	1 (806)	2 (775)	1 (500)	4 (549)

VTE:

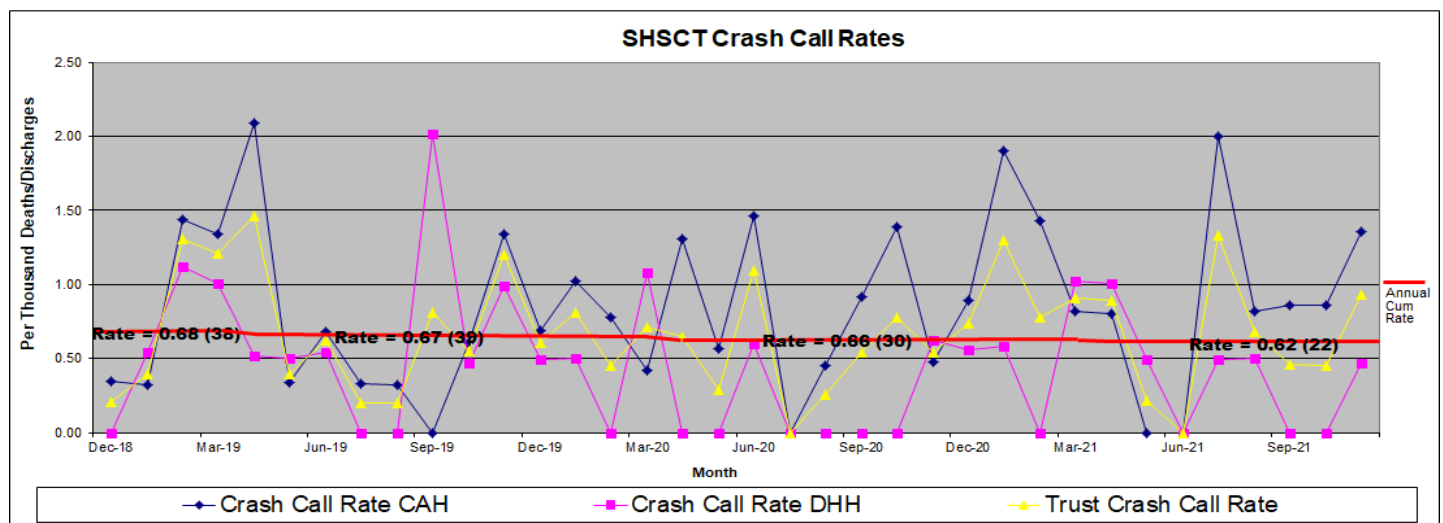
Nov 21 (Week Commencing 01/11/21 → Week Commencing 29/11/21)							
Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 2 21/22 Percentage Compliance
S&EC	CAH	3 South	3	10	10	100% ↑	95% ↔
		4 North CESW	2	14	15	93% ↔	98% ↑
		4 South	0	35	35	100% ↑	92% ↓
		Elective Adm.	0	23	25	92% ↓	95% ↔
		Orthopaedic	1	19	19	100% ↑	100% ↑
		Trauma	5	N/A	N/A	N/A	100% ↔
	DHH	F/male Surg.	0	25	25	100% ↑	100% ↔
		HDU	0	18	19	95%	N/A
M&UC	CAH	1 South	0	19	22	86% ↓	91% ↑
		1 North	0	15	18	83% ↑	81% ↓
		2 North Resp.	0	25	25	100% ↔	80% ↓
		Haematology	0	9	9	100% ↑	100% ↔
		2 South	0	18	25	72% ↓	92% ↓
		2 North Med	0	23	23	100% ↔	92% ↑
		AMU	0	22	25	88% ↓	89% ↓
		Ramone 1	0	22	22	100% ↔	100% ↔
	DHH	F/male Med.	0	23	25	92% ↑	92% ↓
		CCC/MMW	0	24	24	100% ↑	95% ↑
		Stroke/Rehab	0	25	26	96% ↓	98% ↑
		Respiratory L3	0	25	25	100% ↔	100% ↑
IMWH	CAH	Gynae	1	7	8	88% ↓	90% ↔
TOTAL			12 ↑ (7)	401	425	94.4% ↑	94.1% ↑

Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **94.4%** (401/425 charts audited) up from **91.4%** (310/339 charts audited) in Oct 21
- Total number of weekly audits not completed in Nov 21 was **12** up from **7** in Oct 21
- The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Nov 21 was **94%** (486/515), up from **92%** in Oct 21
- Cumulative Compliance 21/22 stands at **94.0%**, up from **93.6%** in 20/21



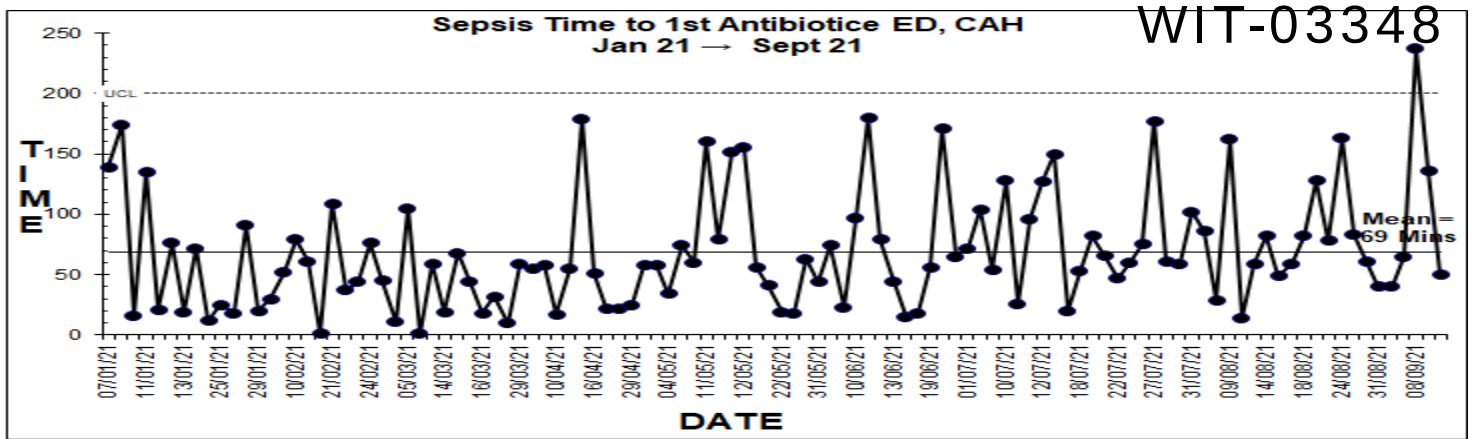
Crash Calls:



- CAH Rate **1.36** per 1,000 deaths/discharges (**3** Crash Calls) up from **0.86** (**2** Crash Calls) in Oct 21
- DHH Rate **0.47** per 1,000 deaths/discharges (**1** Crash Call) up from **0** (**0** Crash Calls) in Oct 21
- Trust Rate **0.93** per 1,000 deaths/discharges (**4** Crash Calls) up from **0.45** (**2** Crash Calls) in Oct 21
- Trust cumulative Crash Call Rate for 21/22 stands at **0.62 (22)** per 1,000 deaths/discharges, down from **0.66 (30)** in 20/21

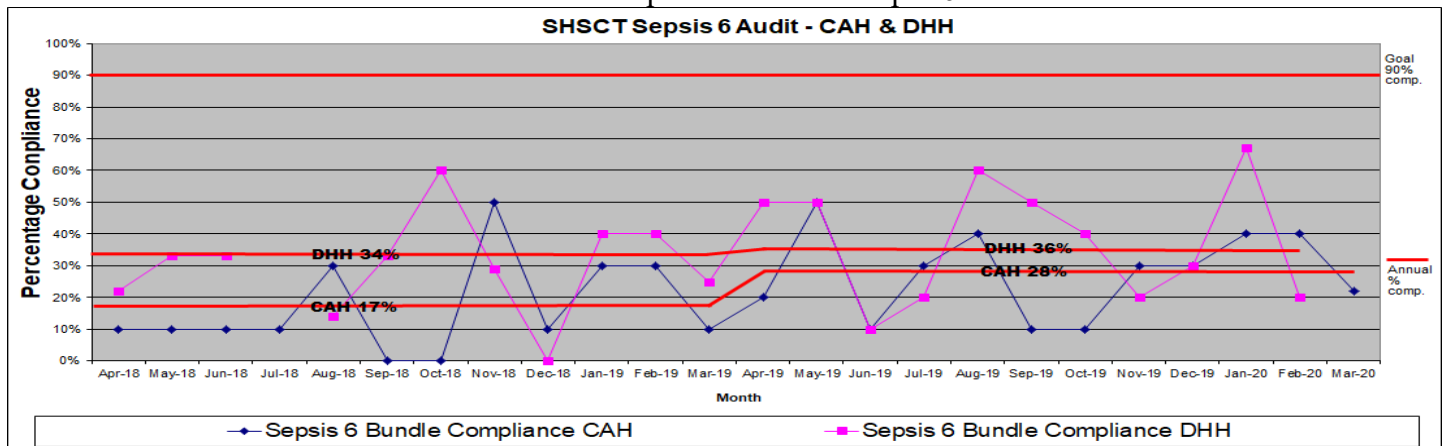
Emergency Care QI Work: Sepsis 6 CAH & DHH:

- The new Regional Sepsis QI initiative has been ongoing from Oct 19. The Regional Agreed aim is to improve the time to 1st antibiotics “In Hours” i.e. Mon → Fri 9:00am → 5:00pm. Work is underway in 3 Pilot Areas ED, CAH, (Oct 19 – Dr. Suzie Budd, Clinical Lead), AMU, CAH (Dec 19 – Dr. Emily Hannah, Clinical Lead) & ED, DHH (14th Jan 20 – Dr. Laura Lavery, Clinical Lead). In the ED’s of CAH & DHH it was decided to measure compliance 24/7. The Run Chart below shows progress made in ED, CAH. Data from the other Pilot Areas will be shared in due course



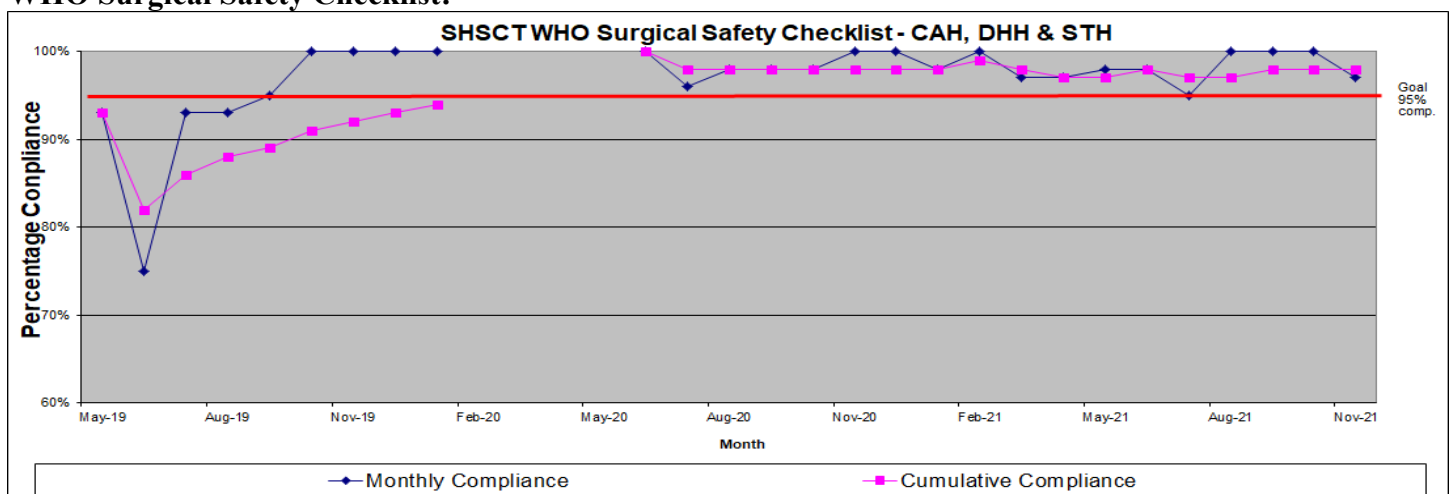
- Sept 21 data - compliance in-hours stands at **33%** (1/3 cases audited), down from **67%** (4/6 cases audited) in Aug 21. Cases outside target timeframe by 76 mins & 177 mins.
- Sept 21 data - compliance out-of-hours stands at **50%** (1/2 cases audited), up from **22%** (2/9 cases audited) in Aug 21. Case outside target timeframe by 5 mins
- Mean Time Jan 21 → Sept 21 = **69** mins, outside Regional target timeframe of **60** minutes.
- In 2020 Mean Time = **76** minutes
- Significant delay in coding still persists
- Case in Sept 21 above upper control limit has been escalated to Head of Service & Lead Nurse
- Auditing in ED, DHH & AMU have been suspended due to Covid-19

The Run Chart below shows Overall Bundle Compliance with the Sepsis6 Bundle in ED's of CAH & DHH



- Auditing has been suspended due to Covid-19

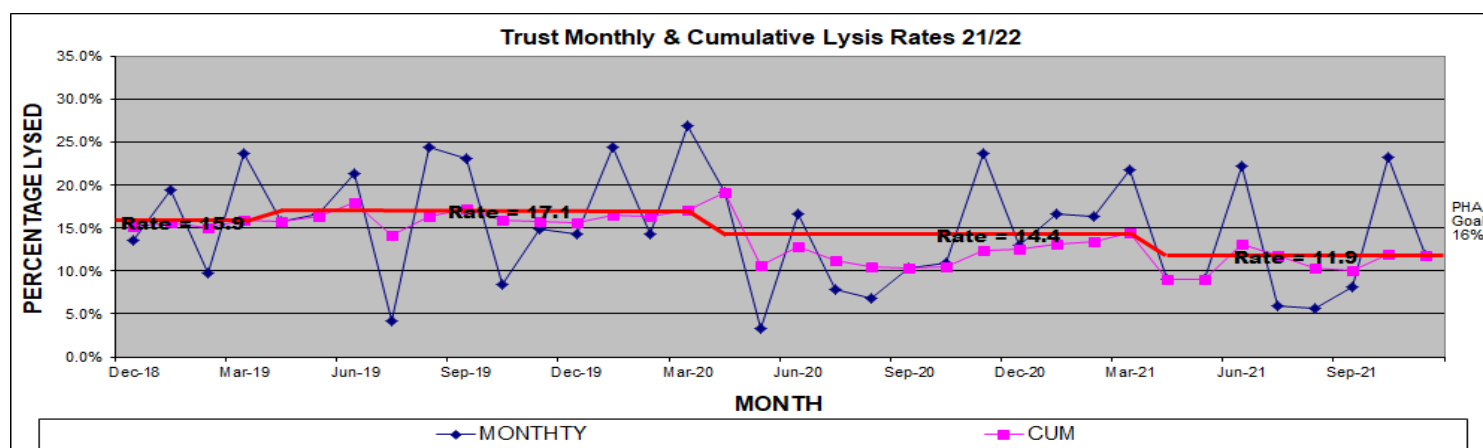
WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19 & were suspended Feb → May 20 due to Covid-19
- Nov 21 Compliance **97%** (58/60) down from **100%** (60/60) in Oct 21
- Cumulative Compliance in 21/22 stands at **98%**

- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

	CAH		DHH		TRUST		
Measure		Nov 21		Nov 21		Nov 21	Commentary Nov 21
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	19/20 99%	100% (34/34)	19/20 99%	100% (19/19)	19/20 99%	100% (53/53)	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	19/20 99%	100% (15/15)	19/20 98%	100% (18/18)	19/20 99%	100% (33/33)	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	19/20 78%	100% (4/4)	19/20 75%	N/A (0/0)	19/20 77%	100% (4/4)	-
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	19/20 98%	100% (4/4)	19/20 96%	N/A (0/0)	19/20 98%	100% (4/4)	-
	CAH		DHH		TRUST		
Outcome Measure	2020/21	Nov 21	2020/21	Nov 21	2020/21	Nov 21	AIM 20/21 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration Target 16%
Monthly Thrombolysis Rate		20.0% (4/20)		0% (0/14)		11.8% (4/34)	
Thrombolysis Rate (Yearly)	13.6% (51/374)	12.7% (30/237)	17.9% (15/84)	10.1% (11/109)	14.4% (66/458)	11.8% (41/346)	



The above is “Real Time” data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

SKIN Care (Pressure Ulcer):

WIT-03350

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

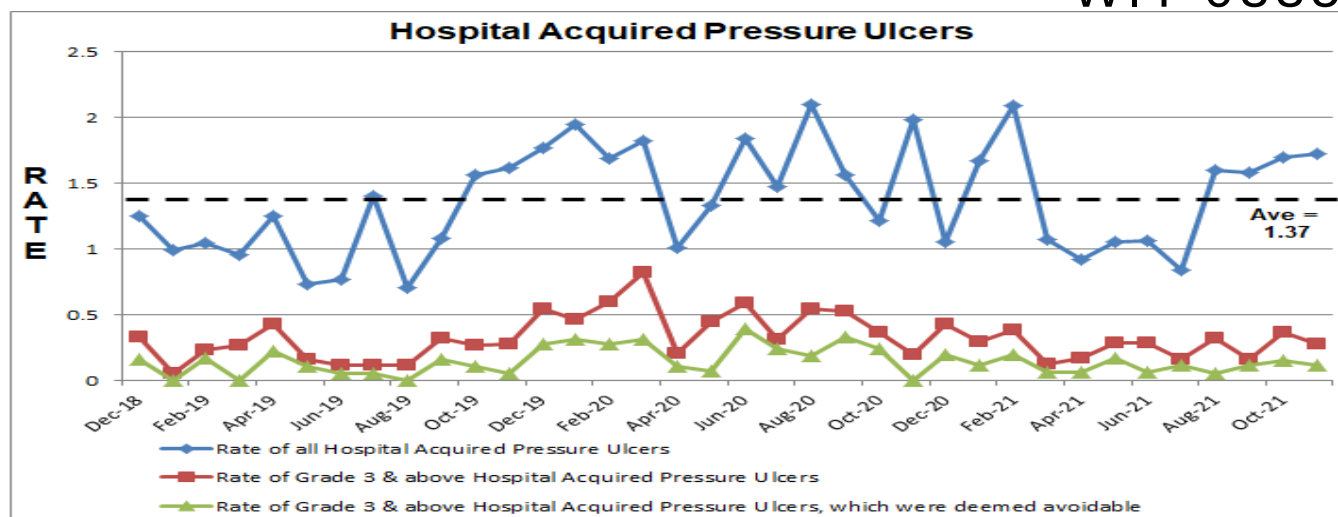
Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
ACUTE	86% (243/283)	83% (320/386)	85% (194/227)	88% (224/256)
TRUST	87% (336/387)	84% (420/499)	89% (294/331)	89% (324/366)

- There were **32** Hospital Acquired Pressure Ulcers reported in Nov 21. Of these, **5** were deep wounds i.e. Grade 3/4, U or DTI's, (ED, CAH (2), 1 South, 2 South Stroke & 4 North, CAH).
- In 21/22 Post Incident Reviews have been carried out on **34** cases to date with **15** deemed to have been avoidable. This represents **8%** of all Ward Acquired Pressure Ulcers reported in 21/22, down from **11%** in 20/21. The outstanding Post Incident Review (**3**) will be carried out in due course.

The table below gives details of individual Ward's Acquired Pressure Ulcers & Rate

Per 1,000 Occupied Bed Days 21/22:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 21/22	Rate & No 20/21
CAH															
Ward 4 South	1	2	1	0	0	0	0	0					4	0.55	1.16 (9) ↓
Ward 4 North	0	2	0	1	0	2	0	1					6	0.79	0.71 (6) ↑
Ward 3 South	3	2	3	2	5	1	1	0					17	2.21	3.50 (32) ↓
Trauma Ward	1	1	0	1	2	0	0	1					6	1.21	1.66 (12) ↓
Orthopaedic Ward	0	0	0	0	0	2	3	0					5	1.25	2.81 (13) ↓
Gynae Ward	0	2	2	0	0	0	1	1					6	2.47	1.84 (5) ↑
ICU	3	2	3	4	8	7	7	11					45	23.29	15.14(41) ↑
Ward 2 South Medicine	1	2	0	0	2	1	3	0					9	2.62	4.69 (24) ↓
Ward 2 South Stroke	1	0	0	0	0	2	2	2					7	1.78	0.77 (4) ↑
Ward 2 North	0	1	1	0	0	1	1	1					5	0.94	1.28 (12) ↓
Ward 5 Haematology	0	0	1	1	1	0	0	0					3	1.77	2.49 (6) ↓
Ward 1 South	0	2	0	0	1	0	1	1					5	0.60	1.19 (13) ↓
Ward 1 North	0	1	1	0	0	0	0	2					4	0.58	0.63 (6) ↓
AMU	0	1	1	2	0	1	2	1					8	1.13	1.07 (10) ↑
3 North Medical	1	0	1	0	0	2	3	3					10	1.36	1.90 (20) ↓
CEAW	0	0	0	0	0	0	1	0					1	0.48	0.95 (2) ↓
Emergency Department	0	0	1	1	1	3	1	6					13	N/A	N/A (16)
Ramone 1	2	0	0	1	1	0	0	0					4	1.12	1.24 (3) ↓
Other Areas e.g. Recovery	0	0	0	0	0	1	0	0					1	N/A	N/A (8)
DHH															
Resp. 3B	0	0	1	0	0	1	0	1					3	1.04	0.60 (2) ↑
Female Surg/Gynae	0	0	0	0	0	0	1	0					1	0.21	0.67 (4) ↓
HCU	0	0	1	0	1	0	0	0					2	1.17	1.91 (4) ↓
Stroke/Rehab	0	0	0	1	2	1	1	0					5	0.74	0.43 (4) ↑
Male Med/CCU	0	0	0	0	2	0	0	0					2	0.26	0.31 (3) ↓
Female Medical	2	0	0	0	1	0	2	0					5	0.56	0.73 (8) ↓
Emergency Department	0	0	0	0	1	1	1	0					3	N/A	N/A (1)
Lurgan															
Ward 1 Stroke	0	0	1	0	0	0	0	0					1	0.25	0.41 (2) ↓
Ward 2 Rehab	1	0	0	1	0	1	0	0					3	0.91	0.80 (3) ↑
Ward 3	0	0	0	1	2	0	1	0					4	1.05	0.69 (3) ↑
STH															
Ward 1 STH	0	0	0	0	0	1	0	0					1	0.26	1.21 (6) ↓
Ward 2 STH	0	1	1	0	0	0	0	0					2	0.54	0.42 (1) ↑
MHL D															
Gillis	0	0	0	0	0	0	0	0					0	0	0.91 (5) ↓
Willows	0	0	0	0	0	1	1	1					3	0.60	0 (0) ↑
TOTAL	16	19	19	16	30	29	33	32					194		
RATE	0.92	1.05	1.06	0.84	1.60	1.58	1.70	1.73						1.32	1.55 (288) ↓



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Nov 21, based on **30** Wards was **1.73** (**32**/18,528) per 1,000 Occupied Bed Days up from **1.70** (**33**/19,427) per 1,000 Occupied Bed Days in Oct 21
- The Trust's 21/22 Hospital Acquired Pressure Ulcer Rate, based on **30** Wards stands at **1.32** (**194**) per 1,000 Bed Days, down from **1.55** (**288**) in 20/21.

Regional Delirium Audit:

The table below shows compliance against the 3 Measures of the Delirium Bundle, for the Acute Wards, where auditing is underway. All 5 Non-Acute Wards also undertake a monthly audit.

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Aug 20)	95% (19/20)	83% (5/6)	60% (3/5)
1 North (Nov 21)	100% (20/20)	N/A (0/0)	N/A (0/0)
2 South Med (Nov 21)	95% (19/20)	83% (5/6)	100% (5/5)
3 South (Dec 20)	100% (5/5)	100% (1/1)	N/A (0/0)
4 North (Nov 21)	100% (5/5)	100% (2/2)	N/A (0/0)
4 South (Nov 21)	100% (20/20)	100% (3/3)	N/A (0/0)
Ramone 1 (Nov 21)	100% (20/20)	100% (7/7)	100% (5/5)
Stroke/Rehab (Nov21)	100% (20/20)	100% (5/5)	100% (1/1)
Female Surg. (Nov21)	100% (20/20)	100% (2/2)	100% (2/2)

- Wards in black audit suspended due to Covid-19 or Audit not received in time to be included in this Report

Patient Falls:

- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
Acute Bundle A Compliance	79% (391/495)	80% (498/619)	82% (291/355)	79% (321/405)
Trust Bundle A Compliance	84% (583/694)	83% (643/778)	84% (420/500)	81% (445/550)

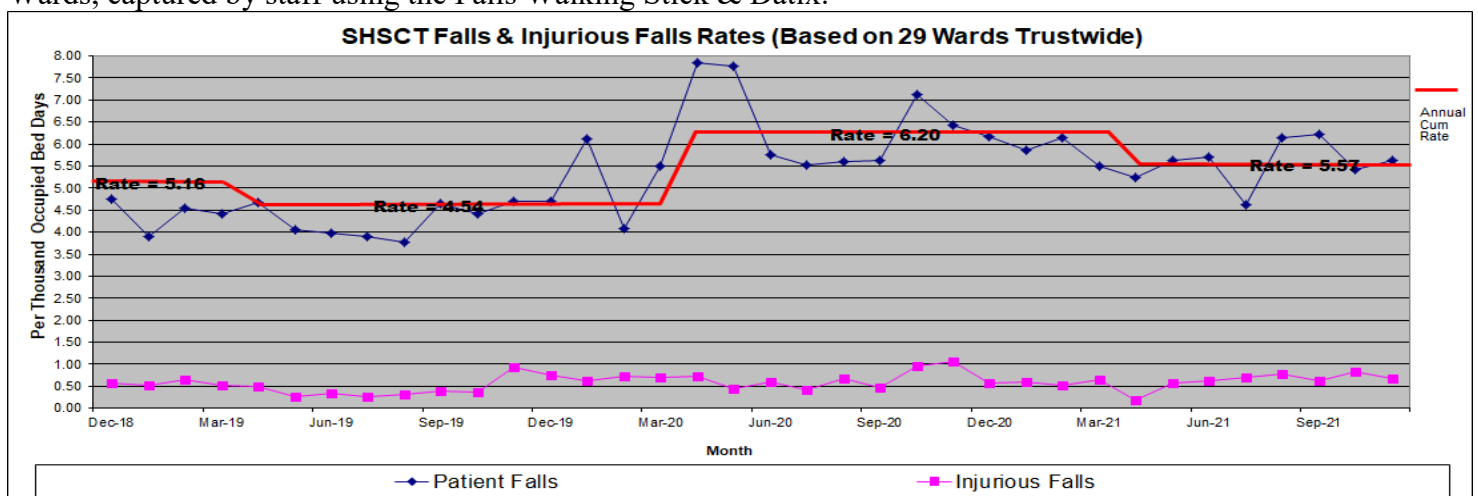
Quarter	Q2 21/22	Q1 21/22	Q4 20/21	Q3 20/21
Acute Bundle B Compliance	81% (337/415)	81% (434/534)	79% (236/300)	82% (289/352)
Trust Bundle B Compliance	87% (533/613)	84% (578/688)	82% (359/437)	83% (412/495)

WIT 03352

The table below gives details of individual Ward's Patient Falls Numbers & Falls Rate
Per 1,000 Occupied Bed Days 21/22:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 21/22	Rate 20/21
CAH															
Ward 4 South	0	2	2	3	1	6	1	6					21	2.87	2.32 (18) ↑
Ward 4 North	3	2	3	1	4	2	3	1					19	2.51	5.06 (43) ↓
Ward 3 South	9	3	9	2	4	7	9	11					54	7.01	8.10 (74) ↓
Trauma Ward	7	2	5	1	7	10	8	5					45	9.05	7.59 (55) ↑
Orthopaedic Ward	2	1	2	2	4	9	5	6					31	7.72	11.01 (51) ↓
Gynae Ward	0	2	3	1	1	2	5	6					20	8.23	4.42 (12) ↑
Ward 2 South Medical	2	3	1	3	3	3	3	4					22	6.40	11.32 (58) ↓
Ward 2 South Stroke	1	2	1	1	2	2	5	1					15	3.81	7.46 (39) ↓
Ward 2 North	0	1	4	1	1	1	3	2					13	2.44	4.25 (40) ↓
Haematology Ward	1	0	0	0	0	1	0	3					5	2.96	2.49 (6) ↑
Ward 1 South	5	6	11	3	9	4	12	3					53	6.32	5.15 (56) ↑
Ward 1 North	1	1	3	2	5	4	4	2					22	3.20	2.82 (27) ↑
AMU	5	5	5	10	15	4	4	6					54	7.60	10.28 (96) ↓
3 North Medical	7	2	2	6	3	3	6	4					33	4.50	5.69 (60) ↓
CEAW	0	0	0	1	0	0	0	1					2	0.95	0.48 (1) ↑
Ramone 1	3	5	2	1	3	4	2	3					23	6.44	6.19 (15) ↑
DHH															
Resp. 3B	2	3	4	0	2	0	1	1					13	4.52	3.62 (12) ↑
Female Surg/Gynae	2	5	1	0	3	2	0	2					15	3.20	1.67 (10) ↑
HDU	1	1	0	0	0	0	0	2					4	2.34	1.91 (4) ↑
Stroke/Rehab	6	6	5	8	2	3	6	4					40	5.93	5.09 (47) ↑
Male Med/CCU	5	6	2	2	5	7	5	8					40	5.15	8.38 (82) ↓
Female Medical	6	9	10	10	11	6	1	5					58	6.44	6.38 (70) ↑
Lurgan															
Ward 1 Stroke	1	4	1	1	6	3	0	2					18	4.45	4.46 (22) ↓
Ward 2 Rehab	1	3	2	4	1	2	4	1					18	5.46	9.02 (34) ↓
Ward 3	0	5	1	5	2	3	2	0					18	4.72	3.94 (17) ↑
STH															
Ward 1 STH	0	0	0	2	2	2	2	0					8	2.09	3.03 (15) ↓
Ward 2 STH	2	1	0	1	1	2	1	2					10	2.70	3.33 (8) ↓
MHLD															
Gillis	13	8	10	7	6	4	5	7					60	18.91	14.02 (77) ↑
Willows	4	12	12	8	9	15	6	3					69	13.79	9.84 (71) ↑
TOTAL	89	100	101	86	112	111	103	101					803		
RATE	5.23	5.62	5.70	4.63	6.14	6.23	5.44	5.63						5.57	6.20 (1120) ↓

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days based on 29 Wards, captured by staff using the Falls Walking Stick & Datix.



- Falls Rate **5.63** (101/17,954 Occupied Bed Days) up from **5.44** (103/18,938) in Oct 21
- Injurious Falls Rate **0.67** (12/17,954 Occupied Bed Days) down from **0.84** (16/18,938) in Oct 21
- Cumulative Falls Rate for 21/22 stands at **5.57**, compared to **6.20** in 20/21

SIGN OFF REPORTS

Time period: 01/11/2021 to 30/11/2021

Total Sign Off for all trusts for current month and previous two months

Trust	September	October	November
Southern	62783	64164	68037
Western	34887	36852	42491
Belfast	20146	17427	20039
South-Eastern	14330	14833	16771
Northern	10689	10025	9550
Total	142835	143301	156888

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11979	66627	18.0%
Histopathology	1218	9091	13.4%
Cytology	189	12335	1.5%
Blood Sciences	117418	1359314	8.6%
Microbiology	26021	226198	11.5%
Blood Bank	63	8440	0.7%
Total	156888	1682005	9.3%

Total Sign Off for Southern Trust previous three months

Month	August	September	October
Total	59826	62783	64164

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3652	53781	10085	406	65	48	0	68037

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2293	35007	6509	274	38	48	0	44169
Daisy Hill Hospital	1211	14015	2610	131	24	0	0	17991
Lurgan Hospital	122	3221	611	1	0	0	0	3955
South Tyrone Hospital	3	825	109	0	0	0	0	937
0	22	451	118	0	3	0	0	594
Community	0	124	36	0	0	0	0	160
Musgrave Park Hospital	1	133	45	0	0	0	0	179
Mullinure Health & Wellbeing	0	0	44	0	0	0	0	44
Drumglass Lodge Community	0	5	0	0	0	0	0	5
St Luke's	0	0	3	0	0	0	0	3
	3652	53781	10085	406	65	48	0	68037

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2293	35007	6509	274	38	48	0	44169
Doctor	644	16604	1753	51	3	0	0	19055
Consultant	1599	12237	2703	209	35	48	0	16831
Midwife	0	2974	1785	0	0	0	0	4759
Nurse	50	2461	267	14	0	0	0	2792
AHP	0	194	1	0	0	0	0	195
Pharmacist	0	246	0	0	0	0	0	246
Physician Associate	0	291	0	0	0	0	0	291
Daisy Hill Hospital	1211	14015	2610	131	24	0	0	17991
Doctor	250	9056	1299	2	1	0	0	10608
Consultant	947	3163	763	128	23	0	0	5024
Physician Associate	9	1136	231	1	0	0	0	1377
Midwife	2	344	218	0	0	0	0	564
Nurse	0	240	78	0	0	0	0	318
Pharmacist	0	69	0	0	0	0	0	69
Clinical Admin	3	7	21	0	0	0	0	31
Grand Total	3504	49022	9119	405	62	48	0	62160

SIGN OFF REPORTS

Time period: 01/11/2021 to 30/11/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Consultant	Craigavon Area Hospital	105	2044	582	0	0	0	2731
		Doctor	Daisy Hill Hospital	75	991	421	0	0	0	1487
		Doctor	Lurgan Hospital	56	974	233	0	0	0	1263
		Consultant	Craigavon Area Hospital	136	707	215	37	3	48	1146
		Consultant	Craigavon Area Hospital	14	917	149	6	0	0	1086
		Consultant	Craigavon Area Hospital	72	514	476	0	0	0	1062
		Doctor	Lurgan Hospital	20	726	239	0	0	0	985
		Consultant	Craigavon Area Hospital	122	448	225	11	1	0	807
		Consultant	Craigavon Area Hospital	127	608	37	0	0	0	772
		Doctor	South Tyrone Hospital	3	643	105	0	0	0	751
		Consultant	Daisy Hill Hospital	89	540	106	7	6	0	748
		Consultant	Daisy Hill Hospital	41	591	98	2	0	0	732
		Doctor	Craigavon Area Hospital	5	581	130	0	0	0	716
		Consultant	Craigavon Area Hospital	66	555	78	0	0	0	699
		Doctor	Craigavon Area Hospital	41	561	84	0	0	0	686
		Doctor	Daisy Hill Hospital	42	528	115	0	0	0	685
		Midwife	Craigavon Area Hospital	0	499	121	0	0	0	620
		Consultant	Craigavon Area Hospital	57	419	130	0	0	0	606
		Consultant	Daisy Hill Hospital	119	305	108	20	0	0	552
		Consultant	Craigavon Area Hospital	0	401	147	0	1	0	549
		Consultant	Craigavon Area Hospital	17	509	14	5	0	0	545
		Consultant	Craigavon Area Hospital	94	330	90	28	2	0	544
		Doctor	Craigavon Area Hospital	11	334	191	0	0	0	536
		Doctor	Craigavon Area Hospital	24	312	184	0	0	0	520
		Doctor	Craigavon Area Hospital	22	465	24	0	0	0	511
		Grand Total		1358	15502	4302	116	13	48	21339

SIGN OFF REPORTS

Time period: 01/10/2021 to 31/10/2021

Total Sign Off for all trusts for current month and previous two months

Trust	August	September	October
Southern	59826	62783	64164
Western	34571	34887	36852
Belfast	17377	20146	17427
South-Eastern	15608	14330	14833
Northern	11560	10689	10025
Total	138942	142835	143301

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10928	69782	15.7%
Histopathology	961	7283	13.2%
Cytology	212	10699	2.0%
Blood Sciences	107460	1395898	7.7%
Microbiology	23707	236060	10.0%
Blood Bank	33	8319	0.4%
Total	143301	1728041	8.3%

Total Sign Off for Southern Trust previous three months

Month	July	August	September
Total	65600	59826	62783

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3427	51377	8945	316	73	26	0	64164

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2231	34219	5525	188	44	25	0	42232
Daisy Hill Hospital	1011	12114	2412	128	27	1	0	15693
Lurgan Hospital	128	3420	672	0	0	0	0	4220
South Tyrone Hospital	8	714	127	0	0	0	0	849
0	46	632	95	0	2	0	0	775
Community	1	205	54	0	0	0	0	260
Musgrave Park Hospital	2	66	24	0	0	0	0	92
Mullinure Health & Wellbeing	0	0	36	0	0	0	0	36
Drumglass Lodge Community	0	6	0	0	0	0	0	6
St Luke's	0	1	0	0	0	0	0	1
	3427	51377	8945	316	73	26	0	64164

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2231	34219	5525	188	44	25	0	42232
Doctor	696	18755	1814	58	5	0	0	21328
Consultant	1472	10088	1644	122	39	24	0	13389
Midwife	0	2540	1810	0	0	0	0	4350
Nurse	63	2333	248	8	0	1	0	2653
AHP	0	279	0	0	0	0	0	279
Pharmacist	0	190	1	0	0	0	0	191
Physician Associate	0	34	8	0	0	0	0	42
Daisy Hill Hospital	1011	12114	2412	128	27	1	0	15693
Doctor	256	7900	1080	0	1	1	0	9238
Consultant	736	2047	696	128	26	0	0	3633
Physician Associate	17	1254	210	0	0	0	0	1481
Midwife	0	776	392	0	0	0	0	1168
Nurse	0	76	29	0	0	0	0	105
Pharmacist	0	36	0	0	0	0	0	36
Clinical Admin	2	25	5	0	0	0	0	32
Grand Total	3242	46333	7937	316	71	26	0	57925

SIGN OFF REPORTS

Time period: 01/10/2021 to 31/10/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the User	Personal information redacted by the User	Doctor	Lurgan Hospital	56	1058	302	0	0	0	1416
		Consultant	Craigavon Area Hospital	89	1042	219	0	0	0	1350
		Doctor	Lurgan Hospital	12	873	261	0	0	0	1146
		Doctor	Daisy Hill Hospital	57	762	312	0	0	1	1132
		Doctor	Craigavon Area Hospital	58	816	173	1	0	0	1048
		Consultant	Craigavon Area Hospital	14	884	53	3	0	0	954
		Doctor	Craigavon Area Hospital	10	752	140	0	0	0	902
		Consultant	Craigavon Area Hospital	62	558	260	0	0	0	880
		Consultant	Craigavon Area Hospital	90	669	116	0	0	0	875
		Doctor	Craigavon Area Hospital	63	656	140	0	1	0	860
		Doctor	Daisy Hill Hospital	68	555	179	0	0	0	802
		Consultant	Craigavon Area Hospital	118	483	136	11	2	24	774
		Doctor	Craigavon Area Hospital	1	688	58	0	0	0	747
		Midwife	Daisy Hill Hospital	0	558	127	0	0	0	685
		Midwife	Craigavon Area Hospital	0	338	337	0	0	0	675
		Consultant	Craigavon Area Hospital	171	412	72	0	0	0	655
		Consultant	Craigavon Area Hospital	7	588	21	6	0	0	622
		Doctor	South Tyrone Hospital	7	532	82	0	0	0	621
		Doctor	Craigavon Area Hospital	25	531	39	0	0	0	595
		Consultant	Daisy Hill Hospital	84	400	80	21	3	0	588
		Doctor	Craigavon Area Hospital	1	584	2	0	0	0	587
		Consultant	Craigavon Area Hospital	31	453	95	1	0	0	580
		Consultant	Craigavon Area Hospital	59	436	69	4	1	0	569
		Doctor	Craigavon Area Hospital	22	528	15	0	0	0	565
		Doctor	Craigavon Area Hospital	0	558	3	0	0	0	561
		Grand Total		1105	15714	3291	47	7	25	20189

SIGN OFF REPORTS

Time period: 01/09/2021 to 30/09/2021

Total Sign Off for all trusts for current month and previous two months

Trust	July	August	September
Southern	65600	59826	62783
Western	36937	34571	34887
Belfast	14845	17377	20146
South-Eastern	13981	15608	14330
Northern	8541	11560	10689
Total	139904	138942	142835

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11387	71560	15.9%
Histopathology	927	8531	10.9%
Cytology	197	10250	1.9%
Blood Sciences	106696	1395075	7.6%
Microbiology	23593	233086	10.1%
Blood Bank	35	8592	0.4%
Total	142835	1727094	8.3%

Total Sign Off for Southern Trust previous three months

Month	June	July	August
Total	67165	65600	59826

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3784	50204	8389	315	64	27	0	62783

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2261	33662	5302	186	27	26	0	41464
Daisy Hill Hospital	1374	12587	2238	129	37	1	0	16366
Lurgan Hospital	113	2560	535	0	0	0	0	3208
South Tyrone Hospital	1	680	125	0	0	0	0	806
0	33	523	76	0	0	0	0	632
Community	1	107	67	0	0	0	0	175
Musgrave Park Hospital	1	70	19	0	0	0	0	90
Mullinure Health & Wellbeir	0	9	26	0	0	0	0	35
Drumglass Lodge Communit	0	6	0	0	0	0	0	6
Community Health Office	0	0	1	0	0	0	0	1
	3784	50204	8389	315	64	27	0	62783

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2261	33662	5302	186	27	26	0	41464
Doctor	651	17789	1914	40	3	2	0	20399
Consultant	1534	10182	1212	138	24	24	0	13114
Midwife	0	2923	1826	0	0	0	0	4749
Nurse	76	2358	350	8	0	0	0	2792
Pharmacist	0	235	0	0	0	0	0	235
AHP	0	175	0	0	0	0	0	175
Daisy Hill Hospital	1374	12587	2238	129	37	1	0	16366
Doctor	306	8009	922	2	7	1	0	9247
Consultant	1049	2369	783	127	30	0	0	4358
Physician Associate	18	1345	126	0	0	0	0	1489
Midwife	0	601	372	0	0	0	0	973
Nurse	1	173	27	0	0	0	0	201
Pharmacist	0	86	0	0	0	0	0	86
Clinical Admin	0	4	8	0	0	0	0	12
Grand Total	3635	46249	7540	315	64	27	0	57830

SIGN OFF REPORTS

Time period: 01/09/2021 to 30/09/2021

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the UOI	Personal information redacted by the UOI	Doctor	Craigavon Area Hospital	18	1492	266	0	0	2	1778
		Consultant	Craigavon Area Hospital	94	1281	181	2	0	3	1561
		Doctor	Daisy Hill Hospital	68	1012	261	0	1	0	1342
		Doctor	Daisy Hill Hospital	99	801	199	0	2	0	1101
		Consultant	Craigavon Area Hospital	189	718	165	3	0	0	1075
		Doctor	Craigavon Area Hospital	55	829	170	0	0	0	1054
		Doctor	Lurgan Hospital	30	584	331	0	0	0	945
		Doctor	Lurgan Hospital	29	728	117	0	0	0	874
		Consultant	Daisy Hill Hospital	103	578	118	12	16	0	827
		Consultant	Craigavon Area Hospital	13	738	15	1	0	0	767
		Consultant	Craigavon Area Hospital	19	632	71	3	0	0	725
		Doctor	Craigavon Area Hospital	37	602	79	0	0	0	718
		Consultant	Craigavon Area Hospital	109	537	20	0	0	0	666
		Consultant	Craigavon Area Hospital	34	599	24	7	0	0	664
		Doctor	South Tyrone Hospital	1	535	113	0	0	0	649
		Consultant	Craigavon Area Hospital	141	373	86	15	2	21	638
		Physician Associate	Daisy Hill Hospital	13	540	50	0	0	0	603
		Doctor	Craigavon Area Hospital	0	570	14	0	0	0	584
		Consultant	Daisy Hill Hospital	96	372	93	23	0	0	584
		Doctor	Craigavon Area Hospital	39	425	111	0	0	0	575
		Doctor	Craigavon Area Hospital	33	484	54	0	0	0	571
		Consultant	Craigavon Area Hospital	20	515	22	0	0	0	557
		Consultant	Daisy Hill Hospital	130	340	58	29	0	0	557
		Doctor	Craigavon Area Hospital	7	527	18	0	0	0	552
		Midwife	Craigavon Area Hospital	0	328	224	0	0	0	552
		Grand Total		1377	16140	2860	95	21	26	20519

SIGN OFF REPORTS

Time period: 01/08/2021 to 31/08/2021

Total Sign Off for all trusts for current month and previous two months

Trust	June	July	August
Southern	67165	65600	59826
Western	33182	36937	34571
Belfast	14099	14845	17377
South-Eastern	16408	13981	15608
Northern	8052	8541	11560
Total	139361	139904	138942

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	9702	63047	15.4%
Histopathology	820	7740	10.6%
Cytology	213	8544	2.5%
Blood Sciences	105132	1294508	8.1%
Microbiology	23048	192593	12.0%
Blood Bank	27	8181	0.3%
Total	138942	1574613	8.8%

Total Sign Off for Southern Trust previous three months

Month	May	June	July
Total	63942	67165	65600

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3200	48832	7385	302	89	18	0	59826

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1849	31425	4563	158	39	18	0	38052
Daisy Hill Hospital	1182	12811	2095	144	50	0	0	16282
Lurgan Hospital	111	3334	447	0	0	0	0	3892
0	56	490	106	0	0	0	0	652
South Tyrone Hospital	0	456	85	0	0	0	0	541
Community	0	153	36	0	0	0	0	189
Musgrave Park Hospital	2	138	8	0	0	0	0	148
Mullinure Health & Wellbeir	0	5	45	0	0	0	0	50
Drumglass Lodge Communit	0	13	0	0	0	0	0	13
St Luke's	0	7	0	0	0	0	0	7
	3200	48832	7385	302	89	18	0	59826

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1849	31425	4563	158	39	18	0	38052
Doctor	578	16830	1545	44	3	1	0	19001
Consultant	1206	9117	977	113	36	17	0	11466
Midwife	0	2752	1802	0	0	0	0	4554
Nurse	65	2491	239	1	0	0	0	2796
AHP	0	65	0	0	0	0	0	65
Pharmacist	0	170	0	0	0	0	0	170
Daisy Hill Hospital	1182	12811	2095	144	50	0	0	16282
Doctor	307	8571	758	2	3	0	0	9641
Consultant	859	2333	842	142	47	0	0	4223
Physician Associate	15	1239	160	0	0	0	0	1414
Midwife	1	483	282	0	0	0	0	766
Nurse	0	172	53	0	0	0	0	225
Pharmacist	0	13	0	0	0	0	0	13
Grand Total	3031	44236	6658	302	89	18	0	54334

SIGN OFF REPORTS

Time period: 01/08/2021 to 31/08/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Doctor	Lurgan Hospital	38	1197	210	0	0	0	1445
		Doctor	Craigavon Area Hospital	11	1016	108	0	0	1	1136
		Consultant	Craigavon Area Hospital	17	1012	82	4	0	0	1115
		Consultant	Craigavon Area Hospital	57	888	104	0	0	0	1049
		Doctor	Craigavon Area Hospital	41	856	137	3	0	0	1037
		Doctor	Daisy Hill Hospital	60	807	166	0	0	0	1033
		Doctor	Craigavon Area Hospital	36	818	93	1	1	0	949
		Consultant	Craigavon Area Hospital	123	623	124	9	2	17	898
		Doctor	Craigavon Area Hospital	2	825	5	0	0	0	832
		Doctor	Lurgan Hospital	18	659	137	0	0	0	814
		Consultant	Craigavon Area Hospital	12	683	26	1	0	0	722
		Consultant	Daisy Hill Hospital	118	409	144	24	1	0	696
		Doctor	Craigavon Area Hospital	20	446	217	0	0	0	683
		Consultant	Daisy Hill Hospital	69	444	94	3	8	0	618
		Midwife	Craigavon Area Hospital	0	325	289	0	0	0	614
		Midwife	Craigavon Area Hospital	0	365	222	0	0	0	587
		Doctor	Craigavon Area Hospital	24	454	100	5	0	0	583
		Doctor	Daisy Hill Hospital	79	396	82	0	0	0	557
		Physician Associate	Daisy Hill Hospital	4	440	105	0	0	0	549
		Doctor	Craigavon Area Hospital	6	532	7	0	0	0	545
		Consultant	Craigavon Area Hospital	85	378	69	2	0	0	534
		Doctor	Daisy Hill Hospital	18	444	66	0	1	0	529
		Doctor	Craigavon Area Hospital	0	498	18	0	0	0	516
		Nurse	Craigavon Area Hospital	41	408	47	0	0	0	496
		Midwife	Craigavon Area Hospital	0	338	157	0	0	0	495
		Grand Total		879	15261	2809	52	13	18	19032

SIGN OFF REPORTS

Time period: 01/07/2021 to 31/07/2021

Total Sign Off for all trusts for current month and previous two months

Trust	May	June	July
Southern	63942	67165	65600
Western	33192	33182	36937
Belfast	11961	14099	14845
South-Eastern	13741	16408	13981
Northern	7841	8052	8541
Total	135482	139361	139904

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	9890	66255	14.9%
Histopathology	1006	7872	12.8%
Cytology	247	10242	2.4%
Blood Sciences	106243	1316754	8.1%
Microbiology	22488	187135	12.0%
Blood Bank	30	8460	0.4%
Total	139904	1596718	8.8%

Total Sign Off for Southern Trust previous three months

Month	April	May	June
Total	62074	63942	67165

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3594	53436	8028	412	113	17	0	65600

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2051	33427	4835	201	42	17	0	40573
Daisy Hill Hospital	1410	14738	2383	211	71	0	0	18813
Lurgan Hospital	78	3788	491	0	0	0	0	4357
South Tyrone Hospital	0	601	149	0	0	0	0	750
0	53	372	79	0	0	0	0	504
Community	2	453	48	0	0	0	0	503
Mullinure Health & Wellbeing	0	17	41	0	0	0	0	58
Drumglass Lodge Community	0	40	0	0	0	0	0	40
Community Health Office	0	0	1	0	0	0	0	1
St Luke's	0	0	1	0	0	0	0	1
	3594	53436	8028	412	113	17	0	65600

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2051	33427	4835	201	42	17	0	40573
Doctor	608	17447	1325	46	3	2	0	19431
Consultant	1407	10626	1372	150	39	14	0	13608
Midwife	0	2597	1924	0	0	0	0	4521
Nurse	36	2465	211	5	0	1	0	2718
AHP	0	175	3	0	0	0	0	178
Pharmacist	0	117	0	0	0	0	0	117
Daisy Hill Hospital	1410	14738	2383	211	71	0	0	18813
Doctor	355	10032	925	5	2	0	0	11319
Consultant	1018	2933	928	206	69	0	0	5154
Physician Associate	32	1029	126	0	0	0	0	1187
Midwife	4	532	372	0	0	0	0	908
Nurse	1	156	32	0	0	0	0	189
Pharmacist	0	47	0	0	0	0	0	47
Clinical Admin	0	9	0	0	0	0	0	9
Grand Total	3461	48165	7218	412	113	17	0	59386

SIGN OFF REPORTS

Time period: 01/07/2021 to 31/07/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Consultant	Craigavon Area Hospital	163	1845	249	2	0	2	2261
		Consultant	Craigavon Area Hospital	256	1261	279	31	2	12	1841
		Doctor	Lurgan Hospital	37	1261	201	0	0	0	1499
		Consultant	Daisy Hill Hospital	73	841	107	23	0	0	1044
		Consultant	Craigavon Area Hospital	27	899	98	2	0	0	1026
		Doctor	Craigavon Area Hospital	35	846	134	1	0	0	1016
		Doctor	Lurgan Hospital	17	758	180	0	0	0	955
		Doctor	Craigavon Area Hospital	36	815	91	2	0	1	945
		Doctor	Craigavon Area Hospital	23	600	76	5	0	0	704
		Doctor	Daisy Hill Hospital	15	539	141	0	0	0	695
		Doctor	Craigavon Area Hospital	9	593	78	0	1	0	681
		Doctor	Craigavon Area Hospital	38	587	37	0	0	0	662
		Consultant	Craigavon Area Hospital	13	555	59	0	0	0	627
		Consultant	Craigavon Area Hospital	42	488	91	1	0	0	622
		Consultant	Craigavon Area Hospital	1	602	13	5	0	0	621
		Midwife	Craigavon Area Hospital	0	438	178	0	0	0	616
		Doctor	Daisy Hill Hospital	21	486	107	1	0	0	615
		Consultant	Craigavon Area Hospital	82	449	54	12	6	0	603
		Doctor	Craigavon Area Hospital	15	564	10	0	0	0	589
		Consultant	Daisy Hill Hospital	88	345	96	32	1	0	562
		Doctor	South Tyrone Hospital	0	467	76	0	0	0	543
		Consultant	Daisy Hill Hospital	89	290	139	10	12	0	540
		Doctor	Craigavon Area Hospital	1	521	10	0	0	0	532
		Doctor	Craigavon Area Hospital	20	443	65	0	0	1	529
		Doctor	Craigavon Area Hospital	26	468	23	0	0	0	517
		Grand Total		1127	16961	2592	127	22	16	20845

SIGN OFF REPORTS

Time period: 01/06/2021 to 30/06/2021

Total Sign Off for all trusts for current month and previous two months

Trust	April	May	June
Southern	62074	63942	67165
Western	34423	33192	33182
South-Eastern	13741	16408	15741
Belfast	11961	14099	15221
Northern	7005	7841	8052
Total	129204	135482	139361

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11989	69977	17.1%
Histopathology	1116	7127	15.7%
Cytology	326	11334	2.9%
Blood Sciences	105858	1436358	7.4%
Microbiology	20045	183945	10.9%
Blood Bank	27	9375	0.3%
Total	139361	1718116	8.1%

Total Sign Off for Southern Trust previous three months

Month	March	April	May
Total	60787	62074	63942

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	4216	54468	7936	415	115	15	0	67165

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2608	34883	4839	235	59	15	0	42639
Daisy Hill Hospital	1489	15520	2473	180	56	0	0	19718
Lurgan Hospital	58	2443	392	0	0	0	0	2893
South Tyrone Hospital	1	447	50	0	0	0	0	498
Community	2	504	44	0	0	0	0	550
0	58	562	91	0	0	0	0	711
St Luke's	0	4	4	0	0	0	0	8
Drumglass Lodge Communit	0	90	0	0	0	0	0	90
Mullinure Health & Wellbein	0	15	43	0	0	0	0	58
	4216	54468	7936	415	115	15	0	67165

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2608	34883	4839	235	59	15	0	42639
Doctor	840	18232	1433	63	10	0	0	20578
Consultant	1741	11638	1353	161	49	15	0	14957
Midwife	0	2522	1816	0	0	0	0	4338
Nurse	27	2201	227	11	0	0	0	2466
AHP	0	132	10	0	0	0	0	142
Pharmacist	0	158	0	0	0	0	0	158
Daisy Hill Hospital	1489	15520	2473	180	56	0	0	19718
Doctor	453	11213	1172	3	4	0	0	12845
Consultant	1007	2246	832	177	52	0	0	4314
Physician Associate	28	1326	145	0	0	0	0	1499
Midwife	0	492	314	0	0	0	0	806
Nurse	1	176	10	0	0	0	0	187
Pharmacist	0	49	0	0	0	0	0	49
Clinical Admin	0	18	0	0	0	0	0	18
Grand Total	4097	50403	7312	415	115	15	0	62357

SIGN OFF REPORTS

Time period: 01/06/2021 to 30/06/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Consultant	Craigavon Area Hospital	136	1972	194	0	1	0	2303
		Doctor	Daisy Hill Hospital	59	870	218	0	0	0	1147
		Consultant	Craigavon Area Hospital	24	1010	107	5	0	0	1146
		Doctor	Craigavon Area Hospital	40	937	99	0	0	0	1076
		Consultant	Craigavon Area Hospital	182	653	182	23	3	14	1057
		Doctor	Lurgan Hospital	18	863	172	0	0	0	1053
		Doctor	Craigavon Area Hospital	9	908	76	0	0	0	993
		Consultant	Craigavon Area Hospital	29	654	104	5	0	0	792
		Consultant	Craigavon Area Hospital	3	727	37	5	0	0	772
		Doctor	Craigavon Area Hospital	0	763	0	0	0	0	763
		Doctor	Daisy Hill Hospital	66	639	25	0	0	0	730
		Doctor	Craigavon Area Hospital	29	491	190	0	0	0	710
		Doctor	Craigavon Area Hospital	4	689	5	0	0	0	698
		Doctor	Craigavon Area Hospital	28	620	35	0	0	0	683
		Consultant	Daisy Hill Hospital	109	463	99	5	7	0	683
		Consultant	Craigavon Area Hospital	135	473	29	0	0	0	637
		Consultant	Craigavon Area Hospital	20	590	17	4	0	0	631
		Physician Associate	Daisy Hill Hospital	7	500	108	0	0	0	615
		Consultant	Craigavon Area Hospital	108	366	99	10	1	0	584
		Doctor	Craigavon Area Hospital	12	402	164	1	0	0	579
		Consultant	Craigavon Area Hospital	14	504	57	0	0	0	575
		Doctor	Craigavon Area Hospital	36	518	14	0	0	0	568
		Doctor	Daisy Hill Hospital	31	253	275	0	1	0	560
		Consultant	Daisy Hill Hospital	107	294	116	5	5	0	527
		Doctor	Daisy Hill Hospital	41	410	74	0	0	0	525
		Grand Total		1247	16569	2496	63	18	14	20407

SIGN OFF REPORTS

Time period: 01/05/2021 to 31/05/2021

Total Sign Off for all trusts for current month and previous two months

Trust	March	April	May
Southern	60787	62074	63942
Western	31626	34423	33192
South-Eastern	15571	13741	16408
Belfast	14525	11961	14099
Northern	7338	7005	7841
Total	129847	129204	135482

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10491	68672	15.3%
Histopathology	805	6764	11.9%
Cytology	234	10399	2.3%
Blood Sciences	102587	1371358	7.5%
Microbiology	21331	188798	11.3%
Blood Bank	34	8893	0.4%
Total	135482	1654884	8.2%

Total Sign Off for Southern Trust previous three months

Month	February	March	April
Total	52979	60787	62074

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3769	51566	8205	273	107	22	0	63942

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2186	31662	5140	160	52	21	0	39221
Daisy Hill Hospital	1464	15812	2348	113	55	1	0	19793
Lurgan Hospital	93	2892	498	0	0	0	0	3483
South Tyrone Hospital	1	361	47	0	0	0	0	409
Community	1	385	71	0	0	0	0	457
0	24	312	60	0	0	0	0	396
St Luke's	0	72	0	0	0	0	0	72
Drumglass Lodge Communit	0	54	0	0	0	0	0	54
Mullinure Health & Wellbein	0	16	41	0	0	0	0	57
	3769	51566	8205	273	107	22	0	63942

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2186	31662	5140	160	52	21	0	39221
Doctor	737	18052	1895	70	12	2	0	20768
Consultant	1383	8912	1100	83	40	19	0	11537
Midwife	0	2269	1877	0	0	0	0	4146
Nurse	66	2142	236	7	0	0	0	2451
AHP	0	160	31	0	0	0	0	191
Pharmacist	0	127	1	0	0	0	0	128
Daisy Hill Hospital	1464	15812	2348	113	55	1	0	19793
Doctor	501	11689	1048	2	4	0	0	13244
Consultant	932	1775	753	111	51	0	0	3622
Physician Associate	25	1197	137	0	0	0	0	1359
Midwife	4	732	367	0	0	1	0	1104
Nurse	1	187	35	0	0	0	0	223
Pharmacist	0	39	0	0	0	0	0	39
0	1	193	8	0	0	0	0	202
Grand Total	3650	47474	7488	273	107	22	0	59014

SIGN OFF REPORTS

Time period: 01/05/2021 to 31/05/2021

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total	
Personal information redacted by the USI	Personal information redacted by the USI		Consultant	Craigavon Area Hospital	107	1187	167	3	0	0	1464
			Doctor	Lurgan Hospital	16	1097	205	0	0	0	1318
			Doctor	Daisy Hill Hospital	82	890	278	0	0	0	1250
			Doctor	Craigavon Area Hospital	56	947	133	0	0	0	1136
			Consultant	Craigavon Area Hospital	131	521	167	16	6	18	859
			Doctor	Daisy Hill Hospital	15	774	2	0	0	0	791
			Doctor	Lurgan Hospital	45	497	222	0	0	0	764
			Doctor	Craigavon Area Hospital	23	619	116	0	0	0	758
			Doctor	Craigavon Area Hospital	20	489	223	0	0	0	732
			Consultant	Craigavon Area Hospital	13	653	42	3	0	0	711
			Consultant	Daisy Hill Hospital	132	406	129	12	0	0	679
			Doctor	Craigavon Area Hospital	34	437	196	0	1	0	668
			Doctor	Craigavon Area Hospital	13	592	52	1	0	0	658
			Doctor	Daisy Hill Hospital	49	480	106	0	1	0	636
			Midwife	Daisy Hill Hospital	3	529	95	0	0	1	628
			Doctor	Craigavon Area Hospital	9	616	0	0	0	0	625
			Consultant	Daisy Hill Hospital	74	413	100	8	6	0	601
			Nurse	Craigavon Area Hospital	26	448	103	0	0	0	577
			Midwife	Craigavon Area Hospital	0	416	148	0	0	0	564
			Consultant	Craigavon Area Hospital	81	457	26	0	0	0	564
			Consultant	Craigavon Area Hospital	4	540	13	0	0	0	557
			Doctor	Craigavon Area Hospital	20	441	79	0	0	0	540
			Doctor	Craigavon Area Hospital	0	535	0	0	0	0	535
			Doctor	Daisy Hill Hospital	73	442	19	0	0	0	534
			Doctor	Daisy Hill Hospital	4	510	9	0	0	0	523
				Grand Total	1030	14936	2630	43	14	19	18672

SIGN OFF REPORTS

Time period: 01/04/2021 to 30/04/2021

Total Sign Off for all trusts for current month and previous two months

Trust	February	March	April
Southern	52979	60787	62074
Western	30040	31626	34423
South-Eastern	13447	15571	13741
Belfast	12012	14525	11961
Northern	5908	7338	7005
Total	114386	129847	129204

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	10819	63877	16.9%
Histopathology	902	6435	14.0%
Cytology	211	10747	2.0%
Blood Sciences	97078	1299541	7.5%
Microbiology	20160	185917	10.8%
Blood Bank	34	8200	0.4%
Total	129204	1574717	8.2%

Total Sign Off for Southern Trust previous three months

Month	January	February	March
Total	54317	52979	60787

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	4336	49241	8009	390	72	26	0	62074

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2128	30460	4790	232	25	25	0	37660
Daisy Hill Hospital	2103	14692	2519	158	47	1	0	19520
Lurgan Hospital	84	3096	552	0	0	0	0	3732
South Tyrone Hospital	3	387	59	0	0	0	0	449
Community	0	277	38	0	0	0	0	315
0	18	176	36	0	0	0	0	230
St Luke's	0	98	0	0	0	0	0	98
Drumglass Lodge Communit	0	51	0	0	0	0	0	51
Mullinure Health & Wellbein	0	4	15	0	0	0	0	19
	4336	49241	8009	390	72	26	0	62074

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2128	30460	4790	232	25	25	0	37660
Doctor	671	15616	1484	76	7	0	0	17854
Consultant	1430	9665	951	148	18	24	0	12236
Midwife	0	2670	2131	0	0	0	0	4801
Nurse	27	2093	217	8	0	1	0	2346
AHP	0	209	7	0	0	0	0	216
Pharmacist	0	207	0	0	0	0	0	207
Daisy Hill Hospital	2103	14692	2519	158	47	1	0	19520
Doctor	388	10945	1068	2	4	0	0	12407
Consultant	1673	1849	1002	156	43	1	0	4724
Physician Associate	30	1063	87	0	0	0	0	1180
Midwife	12	580	352	0	0	0	0	944
Nurse	0	141	10	0	0	0	0	151
Pharmacist	0	60	0	0	0	0	0	60
0	0	54	0	0	0	0	0	54
Grand Total	4231	45152	7309	390	72	26	0	57180

SIGN OFF REPORTS

Time period: 01/04/2021 to 30/04/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	60	1251	161	0	0	0	1472
		Consultant	Craigavon Area Hospital	167	1042	177	24	1	24	1435
		Doctor	Daisy Hill Hospital	65	927	233	0	0	0	1225
		Consultant	Craigavon Area Hospital	17	1037	71	5	1	0	1131
		Consultant	Craigavon Area Hospital	114	841	93	0	0	0	1048
		Consultant	Daisy Hill Hospital	1016	0	12	0	0	0	1028
		Doctor	Lurgan Hospital	35	758	190	0	0	0	983
		Doctor	Lurgan Hospital	18	740	208	0	0	0	966
		Doctor	Craigavon Area Hospital	16	678	176	1	1	0	872
		Doctor	Craigavon Area Hospital	37	675	109	0	0	0	821
		Consultant	Daisy Hill Hospital	132	406	194	5	7	0	744
		Doctor	Daisy Hill Hospital	67	597	23	0	0	0	687
		Consultant	Craigavon Area Hospital	81	503	86	0	1	0	671
		Midwife	Craigavon Area Hospital	0	430	240	0	0	0	670
		Consultant	Craigavon Area Hospital	110	437	37	2	0	0	586
		Consultant	Craigavon Area Hospital	21	494	39	3	0	0	557
		Doctor	Daisy Hill Hospital	3	549	0	0	0	0	552
		Doctor	Craigavon Area Hospital	5	539	0	0	0	0	544
		Physician Associate	Daisy Hill Hospital	23	476	39	0	0	0	538
		Consultant	Daisy Hill Hospital	97	304	109	25	0	0	535
		Consultant	Craigavon Area Hospital	11	460	56	0	0	0	527
		Consultant	Daisy Hill Hospital	87	291	126	11	7	0	522
		Doctor	Daisy Hill Hospital	13	495	12	0	0	0	520
		Midwife	Daisy Hill Hospital	12	388	95	0	0	0	495
		Doctor	Craigavon Area Hospital	0	494	0	0	0	0	494
		Grand Total		2207	14812	2486	76	18	24	19623

SIGN OFF REPORTS

Time period: 01/03/2021 to 31/03/2021

Total Sign Off for all trusts for current month and previous two months

Trust	January	February	March
Southern	54317	52979	60787
Western	28163	30040	31626
South-Eastern	12409	13447	15571
Belfast	10529	12012	14525
Northern	5721	5908	7338
Total	111139	114386	129847

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	9438	62049	15.2%
Histopathology	781	6508	12.0%
Cytology	191	10481	1.8%
Blood Sciences	100187	1338090	7.5%
Microbiology	19217	183444	10.5%
Blood Bank	33	8652	0.4%
Total	129847	1609224	8.1%

Total Sign Off for Southern Trust previous three months

Month	December	January	February
Total	52060	54317	52979

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	3485	49316	7617	285	56	28	0	60787

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2224	29306	4737	179	18	28	0	36492
Daisy Hill Hospital	1115	15315	2269	104	38	0	0	18841
Lurgan Hospital	89	3211	443	0	0	0	0	3743
South Tyrone Hospital	3	522	53	0	0	0	0	578
Community	3	360	32	0	0	0	0	395
0	51	280	47	2	0	0	0	380
Drumglass Lodge Communit	0	198	0	0	0	0	0	198
St Luke's	0	124	0	0	0	0	0	124
Mullinure Health & Wellbein	0	0	35	0	0	0	0	35
Community Health Office	0	0	1	0	0	0	0	1
	3485	49316	7616	285	56	28	0	60787

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2224	29306	4737	179	18	28	0	36492
Doctor	580	14058	1116	54	2	1	0	15811
Consultant	1610	10008	1386	111	16	27	0	13158
Midwife	2	2783	1937	0	0	0	0	4722
Nurse	32	2008	280	14	0	0	0	2334
AHP	0	285	18	0	0	0	0	303
Pharmacist	0	164	0	0	0	0	0	164
Daisy Hill Hospital	1115	15315	2269	104	38	0	0	18841
Doctor	385	10516	924	4	15	0	0	11844
Consultant	717	2571	877	100	23	0	0	4288
Physician Associate	9	1152	68	0	0	0	0	1229
Midwife	0	701	376	0	0	0	0	1077
Nurse	0	242	18	0	0	0	0	260
Pharmacist	0	45	1	0	0	0	0	46
0	4	88	5	0	0	0	0	97
Grand Total	3339	44621	7006	283	56	28	0	55333

SIGN OFF REPORTS

Time period: 01/03/2021 to 31/03/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Personal Information redacted by the USI	Doctor	Lurgan Hospital	14	1040	198	0	0	0	1252
		Consultant	Craigavon Area Hospital	82	1024	123	0	0	0	1229
		Consultant	Craigavon Area Hospital	26	1010	64	6	0	0	1106
		Doctor	Daisy Hill Hospital	48	797	165	0	0	0	1010
		Consultant	Craigavon Area Hospital	151	665	156	4	0	24	1000
		Doctor	Daisy Hill Hospital	77	728	144	0	0	0	949
		Consultant	Craigavon Area Hospital	104	680	159	0	0	3	946
		Consultant	Craigavon Area Hospital	137	659	50	0	1	0	847
		Doctor	Craigavon Area Hospital	36	704	80	0	0	0	820
		Doctor	Lurgan Hospital	32	607	170	0	0	0	809
		Doctor	Craigavon Area Hospital	49	682	44	0	0	0	775
		Doctor	Daisy Hill Hospital	14	647	1	0	0	0	662
		Consultant	Craigavon Area Hospital	10	591	39	0	0	0	640
		Consultant	Daisy Hill Hospital	127	364	123	23	0	0	637
		Consultant	Daisy Hill Hospital	121	401	105	2	5	0	634
		Consultant	Daisy Hill Hospital	30	523	77	1	0	0	631
		Consultant	Craigavon Area Hospital	19	597	7	5	0	0	628
		Midwife	Craigavon Area Hospital	0	436	178	0	0	0	614
		Consultant	Craigavon Area Hospital	95	286	204	0	0	0	585
		Midwife	Daisy Hill Hospital	0	487	95	0	0	0	582
		Doctor	Craigavon Area Hospital	24	370	140	0	1	0	535
		Consultant	Craigavon Area Hospital	125	284	119	1	3	0	532
		Doctor	Craigavon Area Hospital	0	505	0	0	0	0	505
		Doctor	Craigavon Area Hospital	4	480	10	0	0	0	494
		Midwife	Craigavon Area Hospital	0	275	214	0	0	0	489
		Grand Total		1325	14842	2665	42	10	27	18911

SIGN OFF REPORTS

Time period: 01/02/2021 to 28/02/2021

Total Sign Off for all trusts for current month and previous two months

Trust	December	January	February
Southern	52060	54317	52979
Western	28181	28163	30040
South-Eastern	10313	12409	13447
Belfast	10054	10529	12012
Northern	6355	5721	5908
Total	106963	111139	114386

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	8025	51030	15.7%
Histopathology	745	5904	12.6%
Cytology	177	9157	1.9%
Blood Sciences	87963	1175252	7.5%
Microbiology	17453	164593	10.6%
Blood Bank	23	6992	0.3%
Total	114386	1412928	8.1%

Total Sign Off for Southern Trust previous three months

Month	November	December	January
Total	51016	52060	54317

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2830	43550	6305	254	27	13	0	52979

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1758	25508	4045	119	13	13	0	31456
Daisy Hill Hospital	953	13955	1807	132	14	0	0	16861
Lurgan Hospital	81	2929	327	0	0	0	0	3337
South Tyrone Hospital	0	517	44	0	0	0	0	561
0	37	110	22	3	0	0	0	172
Community	1	229	7	0	0	0	0	237
St Luke's	0	35	0	0	0	0	0	35
Drumglass Lodge Communit	0	257	0	0	0	0	0	257
Mullinure Health & Wellbein	0	10	53	0	0	0	0	63
	2830	43550	6305	254	27	13	0	52979

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1758	25508	4045	119	13	13	0	31456
Doctor	533	12203	930	40	2	0	0	13708
Consultant	1188	8976	1019	79	11	12	0	11285
Midwife	0	2541	1874	0	0	0	0	4415
Nurse	37	1569	199	0	0	1	0	1806
Pharmacist	0	129	0	0	0	0	0	129
AHP	0	90	21	0	0	0	0	111
GP	0	0	2	0	0	0	0	2
Daisy Hill Hospital	953	13955	1807	132	14	0	0	16861
Doctor	375	9534	789	2	3	0	0	10703
Consultant	569	2019	648	130	11	0	0	3377
Physician Associate	7	1425	20	0	0	0	0	1452
Midwife	1	512	310	0	0	0	0	823
Nurse	0	297	36	0	0	0	0	333
Pharmacist	0	59	0	0	0	0	0	59
0	1	109	4	0	0	0	0	114
Grand Total	2711	39463	5852	251	27	13	0	48317

SIGN OFF REPORTS

Time period: 01/02/2021 to 28/02/2021

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Consultant	Craigavon Area Hospital	201	899	173	16	2	6	1297
		Consultant	Craigavon Area Hospital	67	1077	124	1	0	6	1275
		Midwife	Craigavon Area Hospital	0	592	479	0	0	0	1071
		Consultant	Craigavon Area Hospital	63	805	82	0	0	0	950
		Doctor	Daisy Hill Hospital	88	709	128	0	0	0	925
		Consultant	Craigavon Area Hospital	117	624	99	5	1	0	846
		Consultant	Craigavon Area Hospital	18	737	54	5	0	0	814
		Doctor	Lurgan Hospital	26	636	148	0	0	0	810
		Doctor	Craigavon Area Hospital	51	603	93	2	0	0	749
		Midwife	Craigavon Area Hospital	0	491	163	0	0	0	654
		Consultant	Daisy Hill Hospital	74	383	145	15	1	0	618
		Midwife	Craigavon Area Hospital	0	375	207	0	0	0	582
		Doctor	Craigavon Area Hospital	30	511	25	0	0	0	566
		Doctor	Lurgan Hospital	22	466	70	0	0	0	558
		Consultant	Craigavon Area Hospital	3	496	39	1	0	0	539
		Doctor	Daisy Hill Hospital	13	521	3	0	0	0	537
		Doctor	Daisy Hill Hospital	74	390	69	0	0	0	533
		Doctor	Craigavon Area Hospital	18	408	76	0	0	0	502
		Physician Associate	Daisy Hill Hospital	1	491	5	0	0	0	497
		Doctor	Craigavon Area Hospital	17	431	38	0	0	0	486
		Consultant	Craigavon Area Hospital	2	463	18	0	0	0	483
		Doctor	Daisy Hill Hospital	13	432	28	0	0	0	473
		Consultant	Craigavon Area Hospital	7	424	36	0	0	0	467
		Doctor	Daisy Hill Hospital	18	410	22	0	0	0	450
		Doctor	South Tyrone Hospital	0	398	43	0	0	0	441
		Grand Total		923	13772	2367	45	4	12	17123

SIGN OFF REPORTS

Time period: 01/01/2021 to 31/01/2021

Total Sign Off for all trusts for current month and previous two months

Trust	November	December	January
Southern	51016	52060	54317
Western	28940	28181	28163
South-Eastern	10693	10313	12409
Belfast	8850	10054	10529
Northern	6428	6355	5721
Total	105927	106963	111139

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	8306	53113	15.6%
Histopathology	720	6033	11.9%
Cytology	180	8966	2.0%
Blood Sciences	83176	1164815	7.1%
Microbiology	18742	183445	10.2%
Blood Bank	15	7027	0.2%
Total	111139	1423399	7.8%

Total Sign Off for Southern Trust previous three months

Month	October	November	December
Total	47310	51016	52060

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2628	44611	6734	259	76	9	0	54317

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1549	24090	3932	127	35	9	0	29742
Daisy Hill Hospital	928	15193	2125	125	41	0	0	18412
Lurgan Hospital	87	3714	483	0	0	0	0	4284
South Tyrone Hospital	0	583	67	0	0	0	0	650
Undefined*	62	679	53	7	0	0	0	801
Community	2	162	11	0	0	0	0	175
St Luke's	0	42	1	0	0	0	0	43
Drumglass Lodge Communit	0	141	0	0	0	0	0	141
Mullinure Health & Wellbein	0	7	62	0	0	0	0	69
	2628	44611	6734	259	76	9	0	54317

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1549	24090	3932	127	35	9	0	29742
Doctor	409	11137	910	32	3	5	0	12496
Consultant	1078	8877	886	93	32	3	0	10969
Midwife	0	2200	1935	0	0	0	0	4135
Nurse	36	1413	197	2	0	1	0	1649
AHP	26	281	4	0	0	0	0	311
Pharmacist	0	180	0	0	0	0	0	180
Physician Associate	0	2	0	0	0	0	0	2
Daisy Hill Hospital	928	15193	2125	125	41	0	0	18412
Doctor	348	10202	825	2	11	0	0	11388
Consultant	564	2242	834	123	30	0	0	3793
Physician Associate	11	1720	42	0	0	0	0	1773
Midwife	3	626	363	0	0	0	0	992
Nurse	1	160	37	0	0	0	0	198
Pharmacist	0	39	0	0	0	0	0	39
0	1	80	24	0	0	0	0	105
AHP	0	124	0	0	0	0	0	124
Grand Total	2477	39283	6057	252	76	9	0	48154

SIGN OFF REPORTS

Time period: 01/01/2021 to 31/01/2021

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the User	Personal Information redacted by the User	Consultant	Craigavon Area Hospital	86	1360	109	0	0	0	1555
		Doctor	Craigavon Area Hospital	58	914	103	0	0	0	1075
		Doctor	Lurgan Hospital	41	811	135	0	0	0	987
		Doctor	Daisy Hill Hospital	12	928	35	0	0	0	975
		Doctor	Daisy Hill Hospital	63	789	114	0	0	0	966
		Midwife	Craigavon Area Hospital	0	509	443	0	0	0	952
		Consultant	Craigavon Area Hospital	128	617	113	0	4	0	862
		Doctor	Daisy Hill Hospital	3	738	105	0	0	0	846
		Consultant	Craigavon Area Hospital	25	693	32	10	0	0	760
		Doctor	Daisy Hill Hospital	71	572	113	0	0	0	756
		Consultant	Craigavon Area Hospital	42	622	89	1	0	0	754
		Consultant	Craigavon Area Hospital	20	682	42	4	0	0	748
		Consultant	Craigavon Area Hospital	7	670	50	0	0	0	727
		Doctor	Lurgan Hospital	1	650	64	0	0	0	715
		Doctor	Lurgan Hospital	12	535	104	0	0	0	651
		Consultant	Daisy Hill Hospital	105	365	113	17	1	0	601
		Doctor	Daisy Hill Hospital	14	561	9	0	0	0	584
		Doctor	Craigavon Area Hospital	17	397	136	0	0	0	550
		Doctor	South Tyrone Hospital	0	470	46	0	0	0	516
		Doctor	Craigavon Area Hospital	38	394	74	0	0	0	506
		Consultant	Craigavon Area Hospital	16	381	105	0	0	0	502
		Consultant	Craigavon Area Hospital	86	324	63	14	2	0	489
		Consultant	Craigavon Area Hospital	12	422	42	1	0	0	477
		Doctor	Daisy Hill Hospital	8	458	4	0	0	0	470
		Midwife	Daisy Hill Hospital	3	392	72	0	0	0	467
		Grand Total		868	15254	2315	47	7	0	18491

SIGN OFF REPORTS

Time period: 01/12/2020 to 31/12/2020

Total Sign Off for all trusts for current month and previous two months

Trust	October	November	December
Southern	45007	51016	52060
Western	29442	28940	28181
South-Eastern	9276	10693	10313
Belfast	7379	8850	10054
Northern	4742	6428	6355
Total	95846	105927	106963

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	7450	50109	14.9%
Histopathology	707	6614	10.7%
Cytology	152	9458	1.6%
Blood Sciences	80614	1149446	7.0%
Microbiology	18028	175478	10.3%
Blood Bank	12	8135	0.1%
Total	106963	1399240	7.6%

Total Sign Off for Southern Trust previous three months

Month	September	October	November
Total	45007	47310	51016

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2526	42741	6466	254	62	11	0	52060

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1558	23699	3711	142	25	11	0	29146
Daisy Hill Hospital	841	14486	2150	100	37	0	0	17614
Lurgan Hospital	62	2949	422	1	0	0	0	3434
South Tyrone Hospital	0	401	55	0	0	0	0	456
0	64	649	93	11	0	0	0	817
Community	1	164	10	0	0	0	0	175
St Luke's	0	170	1	0	0	0	0	171
Drumglass Lodge Communit	0	214	0	0	0	0	0	214
Mullinure Health & Wellbein	0	9	24	0	0	0	0	33
	2526	42741	6466	254	62	11	0	52060

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1558	23699	3711	142	25	11	0	29146
Doctor	484	11199	903	38	2	2	0	12628
Consultant	1016	7028	681	101	23	9	0	8858
Midwife	1	2773	1876	0	0	0	0	4650
Nurse	57	2161	251	2	0	0	0	2471
AHP	0	368	0	0	0	0	0	368
Pharmacist	0	170	0	0	0	0	0	170
GP	0	0	0	1	0	0	0	1
Daisy Hill Hospital	841	14486	2150	100	37	0	0	17614
Doctor	308	9785	973	0	1	0	0	11067
Consultant	507	2607	908	100	36	0	0	4158
Physician Associate	9	954	24	0	0	0	0	987
Midwife	13	632	220	0	0	0	0	865
Nurse	1	219	16	0	0	0	0	236
Pharmacist	0	55	0	0	0	0	0	55
0	3	55	8	0	0	0	0	66
AHP	0	179	1	0	0	0	0	180
Grand Total	2399	38185	5861	242	62	11	0	46760

SIGN OFF REPORTS

Time period: 01/12/2020 to 31/12/2020

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Doctor	Craigavon Area Hospital	86	1108	93	2	0	0	1289
		Doctor	Craigavon Area Hospital	72	951	140	3	1	0	1167
		Doctor	Daisy Hill Hospital	53	914	121	0	0	0	1088
		Midwife	Craigavon Area Hospital	0	676	351	0	0	0	1027
		Doctor	Lurgan Hospital	17	774	108	1	0	0	900
		Doctor	Lurgan Hospital	18	667	202	0	0	0	887
		Doctor	Daisy Hill Hospital	6	604	92	0	0	0	702
		Consultant	Craigavon Area Hospital	21	632	35	5	0	0	693
		Consultant	Daisy Hill Hospital	102	396	177	8	0	0	683
		Doctor	Daisy Hill Hospital	49	433	100	0	0	0	582
		Doctor	Craigavon Area Hospital	26	475	79	0	0	0	580
		Doctor	Daisy Hill Hospital	26	343	206	0	0	0	575
		Doctor	Daisy Hill Hospital	7	513	51	0	0	0	571
		Consultant	Craigavon Area Hospital	3	495	71	1	0	0	570
		Doctor	Daisy Hill Hospital	14	481	49	0	0	0	544
		Midwife	Craigavon Area Hospital	0	320	220	0	0	0	540
		Doctor	Daisy Hill Hospital	31	463	33	0	0	0	527
		Doctor	Daisy Hill Hospital	9	492	14	0	0	0	515
		Doctor	Craigavon Area Hospital	25	339	141	0	0	0	505
		Consultant	Craigavon Area Hospital	84	394	21	0	0	0	499
		Consultant	Craigavon Area Hospital	110	286	64	16	4	8	488
		Doctor	Lurgan Hospital	0	445	40	0	0	0	485
		Doctor	Craigavon Area Hospital	22	422	36	3	0	0	483
		Nurse	Craigavon Area Hospital	31	376	76	0	0	0	483
		Doctor	Craigavon Area Hospital	4	459	11	0	0	0	474
		Grand Total		816	13458	2531	39	5	8	16857

SIGN OFF REPORTS

Time period: 01/11/2020 to 30/11/2020

Total Sign Off for all trusts for current month and previous two months

Trust	September	October	November
Southern	45007	47310	51016
Western	29442	27592	28940
South-Eastern	9276	8865	10693
Belfast	7379	6214	8850
Northern	4742	4949	6428
Total	95846	94930	105927

% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	7315	53551	13.7%
Histopathology	676	6362	10.6%
Cytology	180	9827	1.8%
Blood Sciences	79629	1163333	6.8%
Microbiology	18118	174790	10.4%
Blood Bank	9	7826	0.1%
Total	105927	1415689	7.5%

Total Sign Off for Southern Trust previous three months

Month	August	September	October
Total	43070	45007	47310

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2338	42157	6225	210	80	6	0	51016

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1513	24777	3766	129	40	4	0	30229
Daisy Hill Hospital	669	12012	1793	81	40	2	0	14597
Lurgan Hospital	97	3673	431	0	0	0	0	4201
South Tyrone Hospital	4	915	121	0	0	0	0	1040
0	52	510	52	0	0	0	0	614
Community	3	188	37	0	0	0	0	228
St Luke's	0	34	4	0	0	0	0	38
Drumglass Lodge Communit	0	36	0	0	0	0	0	36
Mullinure Health & Wellbein	0	12	21	0	0	0	0	33
	2338	42157	6225	210	80	6	0	51016

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1513	24777	3766	129	40	4	0	30229
Doctor	427	11246	1015	46	4	1	0	12739
Consultant	1050	8687	790	83	36	2	0	10648
Midwife	0	2141	1806	0	0	0	0	3947
Nurse	36	2133	155	0	0	1	0	2325
AHP	0	368	0	0	0	0	0	368
Pharmacist	0	201	0	0	0	0	0	201
GP	0	1	0	0	0	0	0	1
Daisy Hill Hospital	669	12012	1793	81	40	2	0	14597
Doctor	193	8076	697	0	6	2	0	8974
Consultant	467	1976	648	81	34	0	0	3206
Physician Associate	2	1047	40	0	0	0	0	1089
Midwife	4	518	384	0	0	0	0	906
Nurse	1	311	21	0	0	0	0	333
Pharmacist	0	34	0	0	0	0	0	34
0	2	50	1	0	0	0	0	53
AHP	0	0	2	0	0	0	0	2
Grand Total	2182	36789	5559	210	80	6	0	44826

SIGN OFF REPORTS

Time period: 01/11/2020 to 30/11/2020

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	112	1473	185	0	0	0	1770
		Doctor	Lurgan Hospital	47	1403	213	0	0	0	1663
		Consultant	Craigavon Area Hospital	50	1044	92	0	0	2	1188
		Doctor	Daisy Hill Hospital	18	865	101	0	0	0	984
		Doctor	Lurgan Hospital	12	711	78	0	0	0	801
		Consultant	Craigavon Area Hospital	67	644	71	0	0	0	782
		Consultant	Craigavon Area Hospital	10	694	60	0	0	0	764
		Doctor	South Tyrone Hospital	1	687	73	0	0	0	761
		Consultant	Craigavon Area Hospital	27	647	42	3	0	0	719
		Consultant	Craigavon Area Hospital	17	610	50	6	0	0	683
		Midwife	Craigavon Area Hospital	0	366	294	0	0	0	660
		Doctor	Daisy Hill Hospital	3	564	82	0	0	2	651
		Midwife	Craigavon Area Hospital	0	341	270	0	0	0	611
		Nurse	Craigavon Area Hospital	20	441	108	0	0	1	570
		Doctor	Craigavon Area Hospital	17	489	47	0	0	0	553
		Consultant	Craigavon Area Hospital	29	502	19	1	1	0	552
		Consultant	Craigavon Area Hospital	153	373	24	0	0	0	550
		Doctor	Daisy Hill Hospital	52	441	46	0	0	0	539
		Doctor	Daisy Hill Hospital	1	532	1	0	0	0	534
		Doctor	Craigavon Area Hospital	15	472	41	0	0	0	528
		Consultant	Craigavon Area Hospital	77	377	72	1	0	0	527
		Doctor	Craigavon Area Hospital	1	400	99	0	1	0	501
		Consultant	Craigavon Area Hospital	119	291	72	18	1	0	501
		Consultant	Daisy Hill Hospital	81	324	86	8	0	0	499
		Doctor	Craigavon Area Hospital	9	439	49	0	0	0	497
		Grand Total		938	15130	2275	37	3	5	18388

SIGN OFF REPORTS

Time period: 01/10/2020 to 31/10/2020

Total Sign Off for all trusts for current month and previous two months

Trust	August	September	October
Southern	43070	45007	47310
Western	22875	29442	27592
South-Eastern	9431	9276	8865
Belfast	7025	7379	6214
Northern	3522	4742	4949
Total	85923	95846	94930

Total Sign Off for Southern Trust previous three months

Month	July	August	September
Total	53263	43070	45007

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2234	39098	5659	215	102	2	0	47310

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1476	23476	3635	112	34	2	0	28735
Daisy Hill Hospital	662	10834	1476	103	68	0	0	13143
Lurgan Hospital	71	3065	333	0	0	0	0	3469
South Tyrone Hospital	0	543	48	0	0	0	0	591
0	25	450	74	0	0	0	0	549
St Luke's	0	400	4	0	0	0	0	404
Community	0	278	35	0	0	0	0	313
Mullinure Health & Wellbeir	0	11	54	0	0	0	0	65
Drumglass Lodge Communit	0	41	0	0	0	0	0	41
	2234	39098	5659	215	102	2	0	47310

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1476	23476	3635	112	34	2	0	28735
Doctor	382	11009	876	35	4	0	0	12306
Consultant	1057	7649	730	75	30	1	0	9542
Midwife	0	2173	1808	0	0	1	0	3982
Nurse	35	2133	217	1	0	0	0	2386
AHP	1	334	2	0	0	0	0	337
Pharmacist	0	178	0	0	0	0	0	178
GP	1	0	2	1	0	0	0	4
Daisy Hill Hospital	662	10834	1476	103	68	0	0	13143
Doctor	247	7255	624	0	6	0	0	8132
Consultant	391	1671	492	102	62	0	0	2718
Physician Associate	7	1331	38	0	0	0	0	1376
Midwife	16	349	302	1	0	0	0	668
Nurse	0	176	18	0	0	0	0	194
Pharmacist	0	38	0	0	0	0	0	38
0	1	14	1	0	0	0	0	16
AHP	0	0	1	0	0	0	0	1
Grand Total	2138	34310	5111	215	102	2	0	41878

SIGN OFF REPORTS

Time period: 01/10/2020 to 31/10/2020

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the User	Personal information redacted by the User	Doctor	Craigavon Area Hospital	66	1168	90	0	0	0	1324
		Doctor	Lurgan Hospital	20	976	152	0	0	0	1148
		Consultant	Craigavon Area Hospital	62	822	66	0	0	0	950
		Midwife	Craigavon Area Hospital	0	382	565	0	0	0	947
		Doctor	Daisy Hill Hospital	40	800	66	0	1	0	907
		Doctor	Craigavon Area Hospital	29	747	98	1	1	0	876
		Consultant	Craigavon Area Hospital	147	541	94	8	2	0	792
		Doctor	Daisy Hill Hospital	44	625	79	0	0	0	748
		Consultant	Craigavon Area Hospital	28	639	35	11	1	1	715
		Consultant	Craigavon Area Hospital	157	508	17	0	0	0	682
		Consultant	Craigavon Area Hospital	24	561	41	10	0	0	636
		Doctor	Craigavon Area Hospital	8	526	39	0	0	0	573
		Doctor	Lurgan Hospital	16	483	69	0	0	0	568
		Doctor	Craigavon Area Hospital	14	390	103	0	1	0	508
		Doctor	Craigavon Area Hospital	25	408	50	0	0	0	483
		Consultant	Craigavon Area Hospital	30	403	43	0	0	0	476
		Consultant	Craigavon Area Hospital	20	416	34	4	0	0	474
		Consultant	Craigavon Area Hospital	0	462	8	0	0	0	470
		Consultant	Craigavon Area Hospital	6	426	23	0	0	0	455
		Nurse	Craigavon Area Hospital	16	377	54	0	0	0	447
		Doctor	South Tyrone Hospital	0	411	32	0	0	0	443
		Doctor	Daisy Hill Hospital	5	410	27	0	0	0	442
		Nurse	Craigavon Area Hospital	13	320	97	0	0	0	430
		Doctor	Daisy Hill Hospital	17	271	134	0	0	0	422
		Midwife	Craigavon Area Hospital	0	237	181	0	0	0	418
		Grand Total		787	13309	2197	34	6	1	16334

SIGN OFF REPORTS

Time period: 01/09/2020 to 30/09/2020

Total Sign Off for all trusts for current month and previous two months

Trust	July	August	September
Southern	53263	43070	45007
Western	27688	22875	29442
South-Eastern	7841	9431	9276
Belfast	5054	7025	7379
Northern	4063	3522	4742
Total	97909	85923	95846

Total Sign Off for Southern Trust previous three months

Month	June	July	August
Total	55627	53263	43070

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2162	36663	5796	274	95	17	0	45007

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1544	21458	3554	177	53	16	0	26802
Daisy Hill Hospital	543	10912	1661	94	42	1	0	13253
Lurgan Hospital	60	3020	355	1	0	0	0	3436
*Undefined	11	572	50	2	0	0	0	635
South Tyrone Hospital	4	388	62	0	0	0	0	454
Community	0	273	45	0	0	0	0	318
Mullinure Health & Wellbeing	0	7	65	0	0	0	0	72
St Luke's	0	32	2	0	0	0	0	34
Community Health Office	0	0	2	0	0	0	0	2
Drumglass Lodge Community	0	1	0	0	0	0	0	1
	2162	36663	5796	274	95	17	0	45007

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1544	21458	3554	177	53	16	0	26802
Doctor	375	9057	732	61	3	0	0	10228
Consultant	1141	7805	758	109	50	15	0	9878
Midwife	0	2318	1815	0	0	1	0	4134
Nurse	28	1871	249	7	0	0	0	2155
Pharmacist	0	203	0	0	0	0	0	203
AHP	0	204	0	0	0	0	0	204
Daisy Hill Hospital	543	10912	1661	94	42	1	0	13253
Doctor	148	6267	523	0	0	1	0	6939
Consultant	378	2473	675	94	42	0	0	3662
Physician Associate	9	1273	47	0	0	0	0	1329
Midwife	8	501	400	0	0	0	0	909
Nurse	0	321	14	0	0	0	0	335
Pharmacist	0	76	0	0	0	0	0	76
AHP	0	0	2	0	0	0	0	2
GP	0	1	0	0	0	0	0	1
Grand Total	2087	32370	5215	271	95	17	0	40055

SIGN OFF REPORTS

Time period: 01/09/2020 to 30/09/2020

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the UoI	Personal information redacted by the UoI	Consultant	Craigavon Area Hospital	95	1025	92	1	0	0	1213
		Doctor	Craigavon Area Hospital	58	930	75	3	1	0	1067
		Doctor	Lurgan Hospital	20	868	173	0	0	0	1061
		Midwife	Craigavon Area Hospital	0	534	345	0	0	0	879
		Doctor	Daisy Hill Hospital	44	680	53	0	0	0	777
		Consultant	Daisy Hill Hospital	5	653	59	0	0	0	717
		Consultant	Craigavon Area Hospital	147	418	119	6	3	13	706
		Doctor	Craigavon Area Hospital	28	537	99	0	0	0	664
		Consultant	Craigavon Area Hospital	170	380	73	13	2	0	638
		Consultant	Craigavon Area Hospital	18	486	48	0	0	0	552
		Doctor	Daisy Hill Hospital	3	512	14	0	0	0	529
		Consultant	Craigavon Area Hospital	101	346	58	0	4	0	509
		Midwife	Craigavon Area Hospital	0	307	191	0	0	0	498
		Doctor	Craigavon Area Hospital	23	440	22	0	0	0	485
		Consultant	Daisy Hill Hospital	48	370	60	1	1	0	480
		Doctor		1	451	16	0	0	0	468
		Doctor	Lurgan Hospital	10	395	62	0	0	0	467
		Midwife	Daisy Hill Hospital	8	267	191	0	0	0	466
		Doctor	Daisy Hill Hospital	28	370	64	0	0	0	462
		Consultant	Craigavon Area Hospital	0	426	20	1	0	0	447
		Midwife	Craigavon Area Hospital	0	299	139	0	0	0	438
		Nurse	Craigavon Area Hospital	14	314	98	0	0	0	426
		Doctor	Craigavon Area Hospital	14	361	49	0	0	0	424
		Consultant	Craigavon Area Hospital	34	385	3	0	0	0	422
		Consultant	Craigavon Area Hospital	11	381	22	1	0	0	415
		Grand Total		880	12135	2145	26	11	13	15210

SIGN OFF REPORTS

Time period: 01/08/2020 to 31/08/2020

Total Sign Off for all trusts for current month and previous two months

Trust	June	July	August
Southern	55627	53263	43070
Western	27038	27688	22875
South-Eastern	7474	7841	9431
Belfast	6583	5054	7025
Northern	4504	4063	3522
Total	101226	97909	85923

Total Sign Off for Southern Trust previous three months

Month	May	June	July
Total	48799	55627	53263

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	1999	35642	5171	186	68	4	0	43070

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1259	20471	2984	99	8	4	0	24825
Daisy Hill Hospital	641	11503	1700	87	60	0	0	13991
Lurgan Hospital	72	2613	297	0	0	0	0	2982
Undefined*	23	482	40	0	0	0	0	545
South Tyrone Hospital	2	355	84	0	0	0	0	441
Community	2	162	31	0	0	0	0	195
Mullinure Health & Wellbeing	0	18	30	0	0	0	0	48
Drumglass Lodge Community	0	33	0	0	0	0	0	33
St Luke's	0	5	5	0	0	0	0	10
	1999	35642	5171	186	68	4	0	43070

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1259	20471	2984	99	8	4	0	24825
Doctor	335	9848	659	37	3	2	0	10884
Consultant	872	7025	597	62	5	2	0	8563
Midwife	0	1783	1556	0	0	0	0	3339
Nurse	52	1541	172	0	0	0	0	1765
Pharmacist	0	140	0	0	0	0	0	140
AHP	0	134	0	0	0	0	0	134
Daisy Hill Hospital	641	11503	1700	87	60	0	0	13991
Doctor	161	7138	529	2	11	0	0	7841
Consultant	430	1577	508	85	49	0	0	2649
Physician Associate	17	1660	135	0	0	0	0	1812
Midwife	33	670	503	0	0	0	0	1206
Nurse	0	448	24	0	0	0	0	472
Pharmacist	0	10	0	0	0	0	0	10
AHP	0	0	1	0	0	0	0	1
Grand Total	1900	31974	4684	186	68	4	0	38816

SIGN OFF REPORTS

Time period: 01/08/2020 to 31/08/2020

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the User	Personal Information redacted by the User	Doctor	Craigavon Area Hospital	47	934	55	0	0	0	1036
		Consultant	Craigavon Area Hospital	75	820	81	0	0	0	976
		Doctor	Lurgan Hospital	28	723	138	0	0	0	889
		Doctor	Daisy Hill Hospital	35	736	106	0	0	0	877
		Consultant	Craigavon Area Hospital	26	722	43	3	0	0	794
		Doctor	Daisy Hill Hospital	8	761	24	0	0	0	793
		Consultant	Daisy Hill Hospital	118	536	120	5	1	0	780
		Consultant	Craigavon Area Hospital	7	618	42	1	0	0	668
		Midwife	Craigavon Area Hospital	0	249	414	0	0	0	663
		Consultant	Craigavon Area Hospital	54	518	54	2	0	2	630
		Physician Associate	Daisy Hill Hospital	13	481	123	0	0	0	617
		Doctor	Craigavon Area Hospital	13	508	63	6	0	0	590
		Consultant	Craigavon Area Hospital	2	555	25	0	0	0	582
		Consultant	Craigavon Area Hospital	152	292	84	13	0	0	541
		Doctor	Lurgan Hospital	21	442	69	0	0	0	532
		Midwife	Daisy Hill Hospital	33	312	164	0	0	0	509
		Midwife	Craigavon Area Hospital	0	360	128	0	0	0	488
		Doctor	Daisy Hill Hospital	4	390	40	0	0	0	434
		Physician Associate	Daisy Hill Hospital	0	429	2	0	0	0	431
		Doctor	Craigavon Area Hospital	19	357	42	0	0	0	418
		Consultant	Craigavon Area Hospital	22	376	11	3	0	0	412
		Consultant	Craigavon Area Hospital	40	327	36	0	0	0	403
		Consultant	Craigavon Area Hospital	81	306	13	0	0	0	400
		Doctor	Craigavon Area Hospital	0	397	0	0	0	0	397
		Doctor	Daisy Hill Hospital	16	339	40	0	0	0	395
		Grand Total		814	12488	1917	33	1	2	15255

SIGN OFF REPORTS

Time period: 01/07/2020 to 31/07/2020

Total Sign Off for all trusts for current month and previous two months

Trust	May	June	July
Southern	48799	55627	53263
Western	24242	27038	27688
South-Eastern	5727	7474	7841
Northern	4883	6583	5054
Belfast	4641	4504	4063
Total	88292	101226	97909

Total Sign Off for Southern Trust previous three months

Month	April	May	June
Total	40680	48799	55627

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2396	44885	5647	234	79	22	0	53263

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1504	28400	3207	144	10	22	0	33287
Daisy Hill Hospital	827	12682	1860	90	69	0	0	15528
Lurgan Hospital	44	2720	407	0	0	0	0	3171
Drumglass Lodge Communit	2	56	1	0	0	0	0	59
Community	0	425	77	0	0	0	0	502
South Tyrone Hospital	3	489	57	0	0	0	0	549
Undefined*	16	105	28	0	0	0	0	149
Mullinure Health & Wellbeir	0	8	5	0	0	0	0	13
St Luke's	0	0	2	0	0	0	0	2
Community Health Office	0	0	3	0	0	0	0	3
	2396	44885	5647	234	79	22	0	53263

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1504	28400	3207	144	10	22	0	33287
Doctor	596	16738	1001	59	1	5	0	18400
Consultant	878	7729	719	82	9	16	0	9433
Midwife	0	2158	1340	0	0	1	0	3499
Nurse	30	1594	147	2	0	0	0	1773
Pharmacist	0	169	0	0	0	0	0	169
AHP	0	12	0	0	0	0	0	12
GP	0	0	0	1	0	0	0	1
Daisy Hill Hospital	827	12682	1860	90	69	0	0	15528
Doctor	356	8244	701	2	2	0	0	9305
Consultant	446	2269	675	87	67	0	0	3544
Physician Associate	19	1469	106	0	0	0	0	1594
Midwife	6	459	350	1	0	0	0	816
Nurse	0	215	26	0	0	0	0	241
Pharmacist	0	26	0	0	0	0	0	26
AHP	0	0	2	0	0	0	0	2
Grand Total	2331	41082	5067	234	79	22	0	48815

SIGN OFF REPORTS

Time period: 01/07/2020 to 31/07/2020

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	52	961	127	3	1	0	1144
		Doctor	Craigavon Area Hospital	66	910	137	0	0	0	1113
		Consultant	Craigavon Area Hospital	70	900	91	1	0	0	1062
		Doctor	Lurgan Hospital	16	685	222	0	0	0	923
		Consultant	Craigavon Area Hospital	152	498	103	7	1	16	777
		Doctor	Craigavon Area Hospital	41	635	64	0	0	0	740
		Consultant	Craigavon Area Hospital	25	594	44	3	0	0	666
		Doctor	Daisy Hill Hospital	25	603	8	1	0	0	637
		Consultant	Daisy Hill Hospital	79	435	80	10	2	0	606
		Consultant	Craigavon Area Hospital	24	538	11	0	0	0	573
		Midwife	Craigavon Area Hospital	0	370	182	0	0	0	552
		Consultant	Craigavon Area Hospital	118	330	97	5	1	0	551
		Doctor	Daisy Hill Hospital	50	472	28	0	0	0	550
		Consultant	Daisy Hill Hospital	98	352	78	0	0	0	528
		Consultant	Craigavon Area Hospital	19	450	57	2	0	0	528
		Doctor	Lurgan Hospital	15	452	58	0	0	0	525
		Doctor	Daisy Hill Hospital	7	468	42	0	0	0	517
		Consultant	Craigavon Area Hospital	2	505	9	0	0	0	516
		Consultant	Craigavon Area Hospital	7	486	5	0	0	0	498
		Doctor	Craigavon Area Hospital	6	454	35	0	0	0	495
		Doctor	Craigavon Area Hospital	53	395	29	0	0	1	478
		Consultant	Craigavon Area Hospital	1	458	6	0	0	0	465
		Doctor	Daisy Hill Hospital	33	386	44	0	0	0	463
		Doctor	Craigavon Area Hospital	24	429	7	0	0	0	460
		Consultant	Daisy Hill Hospital	3	427	27	0	0	0	457
		Grand Total		986	13193	1591	32	5	17	15824

SIGN OFF REPORTS

Time period: 01/06/2020 to 30/06/2020

Total Sign Off for all trusts for current month and previous two months

Trust	April	May	June
Southern	40680	48799	55627
Western	18035	24242	27038
South-Eastern	4834	5727	7474
Belfast	3720	4883	6583
Northern	3162	4641	4504
Total	70431	88292	101226

Total Sign Off for Southern Trust previous three months

Month	March	April	May
Total	51700	40680	48799

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2954	46518	5830	234	43	48	0	55627

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1969	30780	3581	133	16	47	0	36526
Daisy Hill Hospital	923	12093	1800	100	27	1	0	14944
Lurgan Hospital	43	3106	355	0	0	0	0	3504
Drumglass Lodge Communit	1	209	3	0	0	0	0	213
Community	1	146	47	0	0	0	0	194
South Tyrone Hospital	0	99	22	0	0	0	0	121
*Undefined	17	80	13	1	0	0	0	111
Mullinure Health & Wellbeir	0	3	6	0	0	0	0	9
St Luke's	0	2	2	0	0	0	0	4
Community Health Office	0	0	1	0	0	0	0	1
	2954	46518	5830	234	43	48	0	55627

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1969	30780	3581	133	16	47	0	36526
Doctor	873	19869	1360	60	7	2	0	22171
Consultant	1054	7320	767	72	9	45	0	9267
Midwife	0	1889	1297	0	0	0	0	3186
Nurse	42	1558	157	1	0	0	0	1758
Pharmacist	0	143	0	0	0	0	0	143
GP	0	1	0	0	0	0	0	1
Daisy Hill Hospital	923	12093	1800	100	27	1	0	14944
Doctor	422	8753	808	6	3	1	0	9993
Consultant	476	2066	626	94	24	0	0	3286
Midwife	25	527	359	0	0	0	0	911
Physician Associate	0	494	4	0	0	0	0	498
Nurse	0	70	2	0	0	0	0	72
Other	0	116	1	0	0	0	0	117
Pharmacist	0	67	0	0	0	0	0	67
Grand Total	2892	42873	5381	233	43	48	0	51470

SIGN OFF REPORTS

Time period: 01/06/2020 to 30/06/2020

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Doctor	Craigavon Area Hospital	91	1683	155	2	1	0	1932
		Doctor	Craigavon Area Hospital	91	1013	101	0	1	0	1206
		Doctor	Lurgan Hospital	24	691	192	0	0	0	907
		Consultant	Craigavon Area Hospital	95	725	79	0	1	0	900
		Doctor	Craigavon Area Hospital	53	722	68	0	0	0	843
		Consultant	Craigavon Area Hospital	121	523	112	16	3	45	820
		Doctor	Daisy Hill Hospital	11	726	41	0	0	0	778
		Consultant	Craigavon Area Hospital	65	572	111	3	1	0	752
		Consultant	Craigavon Area Hospital	23	652	33	7	0	0	715
		Doctor	Craigavon Area Hospital	60	596	52	0	0	0	708
		Consultant	Craigavon Area Hospital	3	641	25	0	0	0	669
		Doctor	Craigavon Area Hospital	38	563	62	2	0	0	665
		Doctor	Lurgan Hospital	9	602	49	0	0	0	660
		Doctor	Craigavon Area Hospital	27	564	40	0	0	0	631
		Consultant	Daisy Hill Hospital	34	524	66	0	0	0	624
		Consultant	Daisy Hill Hospital	88	410	113	0	0	0	611
		Doctor	Craigavon Area Hospital	19	533	46	1	0	0	599
		Consultant	Craigavon Area Hospital	169	348	55	17	1	0	590
		Doctor	Daisy Hill Hospital	60	466	54	0	0	0	580
		Consultant	Daisy Hill Hospital	66	377	97	13	1	0	554
		Doctor	Craigavon Area Hospital	37	485	27	0	0	0	549
		Doctor	Daisy Hill Hospital	120	261	144	0	0	0	525
		Consultant	Craigavon Area Hospital	14	505	0	0	0	0	519
		Consultant	Craigavon Area Hospital	33	409	44	0	1	0	487
		Doctor	Craigavon Area Hospital	7	464	1	0	0	0	472
		Grand Total		1358	15055	1767	61	10	45	18296

SIGN OFF REPORTS

Time period: 01/05/2020 to 31/05/2020

Total Sign Off for all trusts for current month and previous two months

Trust	March	April	May
Southern	51700	40680	48799
Western	24973	18035	24242
South-Eastern	6493	4834	5727
Belfast	6654	3720	4883
Northern	1731	3162	4641
Total	91551	70431	88292

Total Sign Off for Southern Trust previous three months

Month	February	March	April
Total	55381	51700	40680

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2647	40072	5954	84	33	9	0	48799

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1748	26336	3896	53	18	6	0	32057
Daisy Hill Hospital	820	10332	1548	31	15	0	0	12746
Lurgan Hospital	55	3041	351	0	0	3	0	3450
Community	0	171	24	0	0	0	0	195
*Undefined	24	69	35	0	0	0	0	128
St Luke's	0	1	89	0	0	0	0	90
South Tyrone Hospital	0	80	10	0	0	0	0	90
Drumglass Lodge Communit	0	42	1	0	0	0	0	43
	2647	40072	5954	84	33	9	0	48799

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1748	26336	3896	53	18	6	0	32057
Doctor	846	16493	1474	25	3	3	0	18844
Consultant	851	6015	890	27	15	3	0	7801
Midwife	3	2149	1322	0	0	0	0	3474
Nurse	48	1487	210	1	0	0	0	1746
Pharmacist	0	189	0	0	0	0	0	189
GP	0	3	0	0	0	0	0	3
Daisy Hill Hospital	820	10332	1548	31	15	0	0	12746
Doctor	360	7753	776	3	6	0	0	8898
Consultant	377	1681	490	28	9	0	0	2585
Midwife	82	438	266	0	0	0	0	786
Physician Associate	0	259	2	0	0	0	0	261
Nurse	1	96	14	0	0	0	0	111
Other	0	70	0	0	0	0	0	70
Pharmacist	0	35	0	0	0	0	0	35
Grand Total	2568	36668	5444	84	33	6	0	44803

SIGN OFF REPORTS

Time period: 01/05/2020 to 31/05/2020

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USR	Personal Information redacted by the USR	Consultant	Craigavon Area Hospital	175	1465	144	0	1	0	1785
		Doctor	Craigavon Area Hospital	53	1040	122	0	0	0	1215
		Doctor	Craigavon Area Hospital	83	944	109	1	1	0	1138
		Midwife	Craigavon Area Hospital	0	686	315	0	0	0	1001
		Doctor	Lurgan Hospital	29	644	177	0	0	3	853
		Doctor	Craigavon Area Hospital	70	602	76	0	0	0	748
		Consultant	Daisy Hill Hospital	95	541	92	2	0	0	730
		Doctor	Craigavon Area Hospital	93	433	141	1	1	0	669
		Consultant	Craigavon Area Hospital	24	552	48	1	0	0	625
		Doctor	Craigavon Area Hospital	21	515	35	4	0	2	577
		Doctor	Craigavon Area Hospital	25	484	60	0	0	0	569
		Consultant	Daisy Hill Hospital	21	378	165	2	2	0	568
		Doctor	Craigavon Area Hospital	65	441	53	0	0	0	559
		Consultant	Craigavon Area Hospital	20	484	37	2	1	0	544
		Doctor	Craigavon Area Hospital	54	384	55	0	0	0	493
		Consultant	Craigavon Area Hospital	79	312	83	1	3	0	478
		Midwife	Daisy Hill Hospital	82	277	107	0	0	0	466
		Doctor	Daisy Hill Hospital	0	414	49	0	0	0	463
		Doctor	Lurgan Hospital	0	424	24	0	0	0	448
		Doctor	Daisy Hill Hospital	6	424	11	0	0	0	441
		Consultant	Craigavon Area Hospital	121	236	71	9	2	0	439
		Doctor	Daisy Hill Hospital	40	325	51	0	0	0	416
		Consultant	Craigavon Area Hospital	9	371	23	0	0	0	403
		Doctor	Craigavon Area Hospital	15	337	19	0	0	0	371
		Doctor	Daisy Hill Hospital	69	217	62	2	0	0	350
		Grand Total		1249	12930	2129	25	11	5	16349

SIGN OFF REPORTS

Time period: 01/04/2020 to 30/04/2020

Total Sign Off for all trusts for current month and previous two months

Trust	February	March	April
Southern	55381	51700	40680
Western	31488	24973	18035
South-Eastern	5227	6493	4834
Belfast	8120	6654	3720
Northern	1719	1731	3162
Total	101935	91551	70431

Total Sign Off for Southern Trust previous three months

Month	January	February	March
Total	56354	55381	51700

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2412	33596	4526	111	23	12	0	40680

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1612	21353	3009	98	10	11	0	26093
Daisy Hill Hospital	718	8848	1118	13	13	1	0	10711
Lurgan Hospital	55	2833	352	0	0	0	0	3240
Community	0	260	10	0	0	0	0	270
Undefined*	27	199	26	0	0	0	0	252
South Tyrone Hospital	0	97	11	0	0	0	0	108
Community Health Office	0	3	0	0	0	0	0	3
St Luke's	0	3	0	0	0	0	0	3
	2412	33596	4526	111	23	12	0	40680

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1612	21353	3009	98	10	11	0	26093
Doctor	940	14048	1353	24	1	2	0	16368
Consultant	645	4289	591	73	9	8	0	5615
Midwife	0	1784	916	0	0	0	0	2700
Nurse	27	1044	145	1	0	1	0	1218
Pharmacist	0	184	0	0	0	0	0	184
GP	0	3	4	0	0	0	0	7
AHP	0	1	0	0	0	0	0	1
Daisy Hill Hospital	718	8848	1118	13	13	1	0	10711
Doctor	344	6819	522	0	0	0	0	7685
Consultant	367	1496	365	13	13	1	0	2255
Midwife	7	271	220	0	0	0	0	498
Nurse	0	109	8	0	0	0	0	117
Physician Associate	0	110	2	0	0	0	0	112
Pharmacist	0	43	0	0	0	0	0	43
AHP	0	0	1	0	0	0	0	1
Grand Total	2330	30201	4127	111	23	12	0	36804

SIGN OFF REPORTS

Time period: 01/04/2020 to 30/04/2020

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Doctor	Craigavon Area Hospital	179	1188	78	0	0	1	1446
		Doctor	Craigavon Area Hospital	125	1040	190	0	1	0	1356
		Doctor	Craigavon Area Hospital	71	580	247	0	0	0	898
		Doctor	Lurgan Hospital	30	695	147	0	0	0	872
		Consultant	Craigavon Area Hospital	40	661	74	3	0	0	778
		Consultant	Craigavon Area Hospital	89	479	102	1	2	0	673
		Doctor	Craigavon Area Hospital	79	521	52	0	0	0	652
		Doctor	Craigavon Area Hospital	16	594	37	0	0	0	647
		Doctor	Lurgan Hospital	0	600	36	0	0	0	636
		Midwife	Craigavon Area Hospital	0	407	199	0	0	0	606
		Doctor	Craigavon Area Hospital	60	487	44	0	0	0	591
		Consultant	Daisy Hill Hospital	106	296	91	0	0	0	493
		Doctor	Daisy Hill Hospital	2	482	2	0	0	0	486
		Consultant	Craigavon Area Hospital	22	438	17	3	0	0	480
		Midwife	Craigavon Area Hospital	0	235	235	0	0	0	470
		Doctor	Daisy Hill Hospital	2	455	9	0	0	0	466
		Consultant	Daisy Hill Hospital	39	255	125	3	10	1	433
		Midwife	Craigavon Area Hospital	0	308	121	0	0	0	429
		Doctor	Daisy Hill Hospital	27	368	23	0	0	0	418
		Consultant	Craigavon Area Hospital	1	385	22	0	0	0	408
		Doctor	Lurgan Hospital	11	346	46	0	0	0	403
		Consultant	Daisy Hill Hospital	32	339	26	0	0	0	397
		Doctor	Craigavon Area Hospital	25	336	30	0	0	0	391
		Doctor	Daisy Hill Hospital	1	352	35	0	0	0	388
		Doctor	Daisy Hill Hospital	6	237	123	0	0	0	366
		Grand Total		963	12084	2111	10	13	2	15183

SIGN OFF REPORTS

Time period: 01/03/2020 to 31/03/2020

Total Sign Off for all trusts for current month and previous two months

Trust	January	February	March
Southern	56354	55381	51700
Western	29664	31488	24973
South-Eastern	6845	5227	6493
Belfast	9099	8120	6654
Northern	1430	1719	1731
Total	103392	101935	91551

Total Sign Off for Southern Trust previous three months

Month	December	January	February
Total	48936	56354	51700

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2395	44800	4222	211	41	31	0	51700

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	1799	30984	2836	183	19	31	0	35852
Daisy Hill Hospital	446	10189	1071	27	22	0	0	11755
Lurgan Hospital	68	3152	257	1	0	0	0	3478
Undefined*	82	254	26	0	0	0	0	362
Community	0	115	17	0	0	0	0	132
South Tyrone Hospital	0	98	14	0	0	0	0	112
St Luke's	0	8	0	0	0	0	0	8
Mullinure Health & Wellbeing	0	0	1	0	0	0	0	1
	2395	44800	4222	211	41	31	0	51700

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	1799	30984	2836	183	19	31	0	35852
Doctor	831	21620	1249	65	2	11	0	23778
Consultant	929	5061	459	116	17	20	0	6602
Midwife	5	1735	967	0	0	0	0	2707
Nurse	33	2063	158	2	0	0	0	2256
Pharmacist	0	176	0	0	0	0	0	176
Other	1	167	3	0	0	0	0	171
AHP	0	162	0	0	0	0	0	162
Daisy Hill Hospital	446	10189	1071	27	22	0	0	11755
Doctor	262	8576	559	12	14	0	0	9423
Consultant	180	631	155	15	8	0	0	989
Midwife	4	466	335	0	0	0	0	805
Nurse	0	262	17	0	0	0	0	279
Pharmacist	0	83	0	0	0	0	0	83
AHP	0	171	5	0	0	0	0	176
Grand Total	2245	41173	3907	210	41	31	0	47607

SIGN OFF REPORTS

Time period: 01/03/2020 to 31/03/2020

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	144	2648	190	4	1	5	2992
		Doctor	Craigavon Area Hospital	166	1171	129	1	0	0	1467
		Doctor	Lurgan Hospital	19	940	144	0	0	0	1103
		Midwife	Craigavon Area Hospital	0	530	543	0	0	0	1073
		Consultant	Craigavon Area Hospital	161	637	73	18	4	18	911
		Doctor	Craigavon Area Hospital	44	752	109	1	0	0	906
		Doctor	Craigavon Area Hospital	41	780	48	0	0	0	869
		Doctor	Craigavon Area Hospital	21	779	47	0	0	0	847
		Doctor	Lurgan Hospital	33	744	54	1	0	0	832
		Doctor	Daisy Hill Hospital	29	618	19	0	0	0	666
		Doctor	Daisy Hill Hospital	16	418	175	0	1	0	610
		Doctor	Daisy Hill Hospital	51	513	37	0	0	0	601
		Doctor	Daisy Hill Hospital	0	578	2	0	0	0	580
		Midwife	Craigavon Area Hospital	0	392	152	0	0	0	544
		Doctor	Craigavon Area Hospital	1	527	7	0	0	0	535
		Doctor	Craigavon Area Hospital	25	497	4	0	0	0	526
		Doctor	Craigavon Area Hospital	16	412	75	0	0	0	503
		Consultant	Craigavon Area Hospital	94	374	22	0	0	0	490
		Consultant	Craigavon Area Hospital	20	435	15	3	0	0	473
		Doctor	Craigavon Area Hospital	9	424	40	0	0	0	473
		Doctor	Craigavon Area Hospital	6	456	0	0	0	0	462
		Doctor	Daisy Hill Hospital	2	442	10	0	0	0	454
		Consultant	Craigavon Area Hospital	119	257	61	4	4	0	445
		Doctor	Daisy Hill Hospital	9	417	16	0	0	0	442
		Doctor	Craigavon Area Hospital	20	395	21	0	0	0	436
		Grand Total		1046	16136	1993	32	10	23	19240

SIGN OFF REPORTS

Time period: 01/02/2020 to 29/02/2020

Total Sign Off for all trusts for current month and previous two months

Trust	December	January	February
Southern	48936	56354	55381
Western	27867	29664	31488
South-Eastern	5833	6845	5227
Belfast	8713	9099	8120
Northern	1672	1430	1719
Total	93021	103392	101935

Total Sign Off for Southern Trust previous three months

Month	November	December	January
Total	46900	48936	56354

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2741	48298	4026	240	54	22	0	55381

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2006	34618	2679	179	28	22	0	39532
Daisy Hill Hospital	591	10424	1100	61	26	0	0	12202
Lurgan Hospital	89	2781	185	0	0	0	0	3055
Undefined*	52	149	12	0	0	0	0	213
Community	2	165	32	0	0	0	0	199
South Tyrone Hospital	1	158	18	0	0	0	0	177
Downe Hospital	0	0	0	0	0	0	0	0
Mullinure Health & Wellbeing	0	1	0	0	0	0	0	1
St Luke's	0	2	0	0	0	0	0	2
	2741	48298	4026	240	54	22	0	55381

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2006	34618	2679	179	28	22	0	39532
Doctor	978	24105	1229	64	7	5	0	26388
Consultant	1008	6236	535	107	21	16	0	7923
Midwife	2	2104	763	0	0	1	0	2870
Nurse	18	2004	152	8	0	0	0	2182
Pharmacist	0	121	0	0	0	0	0	121
Other	0	40	0	0	0	0	0	40
AHP	0	8	0	0	0	0	0	8
Daisy Hill Hospital	591	10424	1100	61	26	0	0	12202
Doctor	246	8114	506	31	11	0	0	8908
Consultant	297	1475	227	30	15	0	0	2044
Midwife	48	440	362	0	0	0	0	850
Nurse	0	117	3	0	0	0	0	120
Pharmacist	0	33	0	0	0	0	0	33
AHP	0	245	2	0	0	0	0	247
Grand Total	2597	45042	3779	240	54	22	0	51734

SIGN OFF REPORTS

Time period: 01/02/2020 to 29/02/2020

Total Reports with Sign Off by User** Top 25 Users

**As per NIECR Account

UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal Information redacted by the USI	Personal Information redacted by the USI	Doctor	Craigavon Area Hospital	194	1670	107	0	2	2	1975
		Doctor	Craigavon Area Hospital	50	1354	198	4	2	0	1608
		Doctor	Craigavon Area Hospital	56	1232	125	0	0	0	1413
		Doctor	Craigavon Area Hospital	60	832	86	0	0	0	978
		Doctor	Craigavon Area Hospital	30	907	10	1	0	0	948
		Consultant	Daisy Hill Hospital	102	648	113	0	1	0	864
		Doctor	Lurgan Hospital	45	742	52	0	0	0	839
		Consultant	Craigavon Area Hospital	149	502	55	16	5	16	743
		Doctor	Craigavon Area Hospital	56	597	75	1	0	0	729
		Doctor	Daisy Hill Hospital	22	679	21	0	0	0	722
		Doctor	Daisy Hill Hospital	21	503	161	0	2	0	687
		Consultant	Craigavon Area Hospital	121	461	91	2	7	0	682
		Doctor	Craigavon Area Hospital	3	643	0	0	0	0	646
		Doctor	Daisy Hill Hospital	45	572	27	0	0	0	644
		Doctor	Craigavon Area Hospital	0	636	0	0	0	0	636
		Doctor	Craigavon Area Hospital	1	630	4	0	0	0	635
		Doctor	Craigavon Area Hospital	4	572	40	0	0	3	619
		Midwife	Craigavon Area Hospital	0	385	214	0	0	0	599
		Doctor	Craigavon Area Hospital	3	586	6	0	0	0	595
		Consultant	Craigavon Area Hospital	90	432	28	0	0	0	550
		Doctor	Craigavon Area Hospital	50	442	44	2	0	0	538
		Consultant	Craigavon Area Hospital	38	470	30	0	0	0	538
		Doctor	Lurgan Hospital	16	431	80	0	0	0	527
		Consultant	Daisy Hill Hospital	76	414	21	9	5	0	525
		Doctor	Craigavon Area Hospital	28	458	29	0	0	0	515
		Grand Total		1260	16798	1617	35	24	21	19755

SIGN OFF REPORTS

Time period: 01/01/2020 to 31/01/2020

Total Sign Off for all trusts for current month and previous two months

Trust	November	December	January
Southern	46900	48936	56354
Western	29093	27867	29664
South-Eastern	6100	5833	6845
Belfast	9278	8713	9099
Northern	1519	1672	1430
Total	92890	93021	103392

Total Sign Off for Southern Trust previous three months

Month	October	November	December
Total	41383	46900	48936

Total Sign Off per Southern Trust

Description	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Total	2842	49438	3777	233	49	15	0	56354

Total Sign Off per Location

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Total
Craigavon Area Hospital	2151	36302	2582	191	21	15	0	41262
Daisy Hill Hospital	571	9392	949	42	28	0	0	10982
Lurgan Hospital	56	2935	175	0	0	0	0	3166
Undefined*	62	513	56	0	0	0	0	631
Community	1	154	2	0	0	0	0	157
South Tyrone Hospital	1	130	13	0	0	0	0	144
Downe Hospital	0	0	0	0	0	0	0	0
Mullinure Health & Wellbeing	0	0	0	0	0	0	0	0
St Luke's	0	12	0	0	0	0	0	12
	2842	49438	3777	233	49	15	0	56354

* no location available for user

Total Reports with Sign Off by Role** based in Craigavon Area Hospital and Daisy Hill

**As per NIECR Account

Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Virology	Grand Total
Craigavon Area Hospital	2151	36302	2582	191	21	15	0	41262
Doctor	1006	23900	1198	66	6	6	0	26182
Consultant	1110	7941	666	115	15	8	0	9855
Midwife	6	2062	540	0	0	0	0	2608
Nurse	29	2302	178	10	0	1	0	2520
Pharmacist	0	96	0	0	0	0	0	96
AHP	0	0	0	0	0	0	0	0
Clinical Admin	0	0	0	0	0	0	0	0
GP	0	1	0	0	0	0	0	1
Daisy Hill Hospital	571	9392	949	42	28	0	0	10982
Doctor	147	6884	293	11	20	0	0	7355
Consultant	359	1802	233	31	8	0	0	2433
Midwife	64	556	409	0	0	0	0	1029
Nurse	1	116	14	0	0	0	0	131
Pharmacist	0	32	0	0	0	0	0	32
AHP	0	2	0	0	0	0	0	2
Grand Total	2722	45694	3531	233	49	15	0	52244

SIGN OFF REPORTS

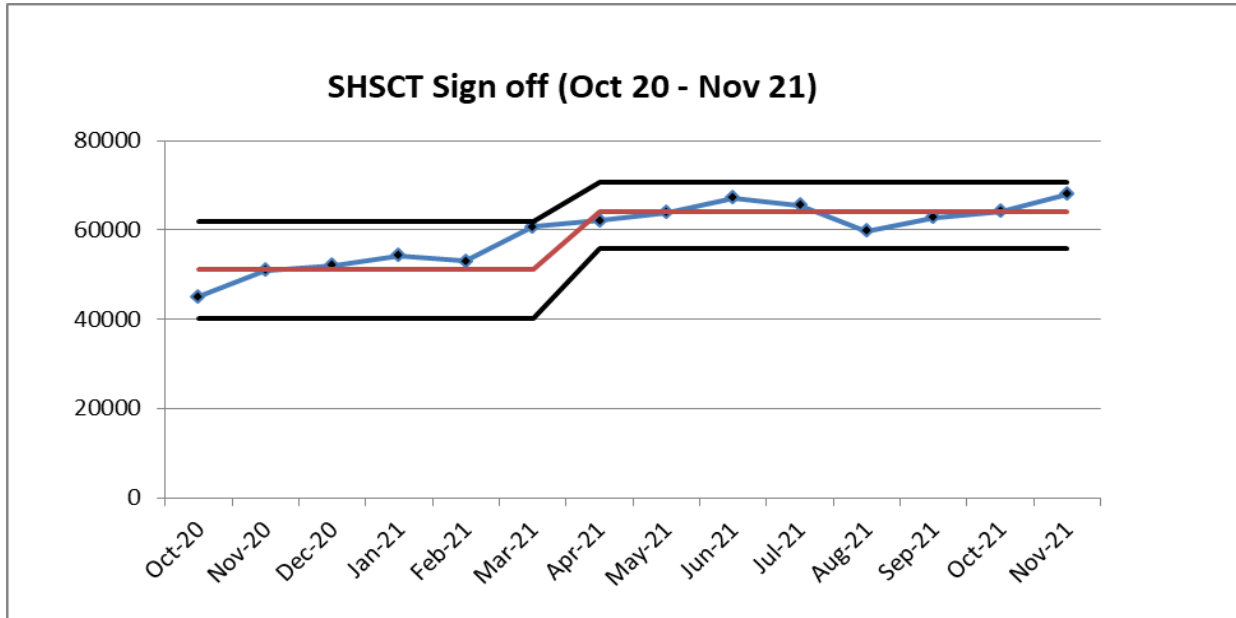
Time period: 01/01/2020 to 31/01/2020

Total Reports with Sign Off by User** Top 25 Users
**As per NIECR Account

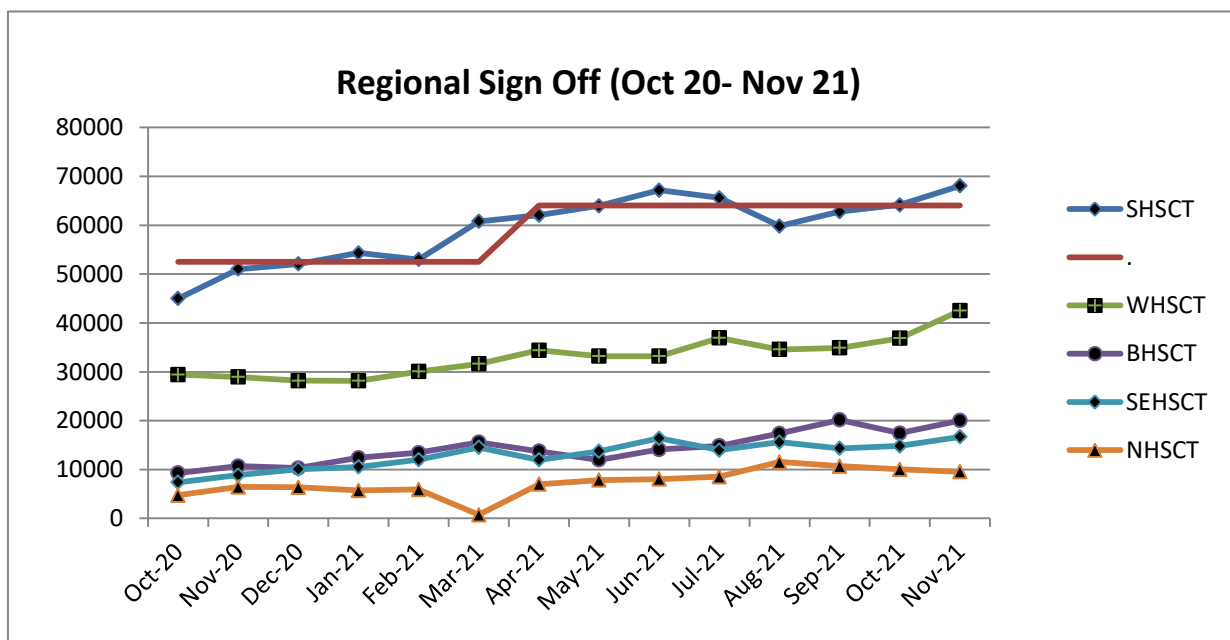
UserID	Name	Role	Location	Radiology	Blood Sciences	Microbiology	Histopathology	Cytology	Blood Bank	Grand Total
Personal information redacted by the USI	Personal information redacted by the USI	Doctor	Craigavon Area Hospital	226	1260	153	1	1	1	1642
		Doctor	Craigavon Area Hospital	126	1210	193	1	0	0	1530
		Doctor	Craigavon Area Hospital	86	1067	100	0	0	0	1253
		Doctor	Craigavon Area Hospital	91	1077	82	0	0	1	1251
		Doctor	Craigavon Area Hospital	0	1183	1	0	0	0	1184
		Doctor	Craigavon Area Hospital	91	869	28	2	0	0	990
		Consultant	Craigavon Area Hospital	42	830	43	1	0	0	916
		Consultant	Craigavon Area Hospital	183	646	64	9	2	8	912
		Doctor	Craigavon Area Hospital	10	764	8	0	0	0	782
		Doctor	Lurgan Hospital	20	694	46	0	0	0	760
		Consultant	Craigavon Area Hospital	50	681	2	1	0	0	734
		Consultant	Daisy Hill Hospital	122	516	63	0	0	0	701
		Doctor	Lurgan Hospital	3	577	91	0	0	0	671
		Doctor	Craigavon Area Hospital	37	548	58	0	0	0	643
		Consultant	Craigavon Area Hospital	97	450	53	6	5	0	611
		Doctor	Craigavon Area Hospital	1	583	0	0	0	0	584
		Doctor	Craigavon Area Hospital	21	555	3	1	0	0	580
		Doctor	Daisy Hill Hospital	14	537	26	0	0	0	577
		Doctor	Craigavon Area Hospital	0	577	0	0	0	0	577
		Midwife	Daisy Hill Hospital	64	293	197	0	0	0	554
		Doctor	Craigavon Area Hospital	32	481	29	0	0	0	542
		Consultant	Craigavon Area Hospital	108	362	50	14	2	0	536
		Doctor	Craigavon Area Hospital	0	526	3	2	0	0	531
		Midwife	Craigavon Area Hospital	0	345	179	0	0	0	524
		Doctor	Daisy Hill Hospital	1	504	1	0	0	0	506
		Grand Total		1425	17135	1473	38	10	10	20091

Sign Off Review

1) SHSCT Sign Off Overview



2) Regional Sign Off Overview Benchmark

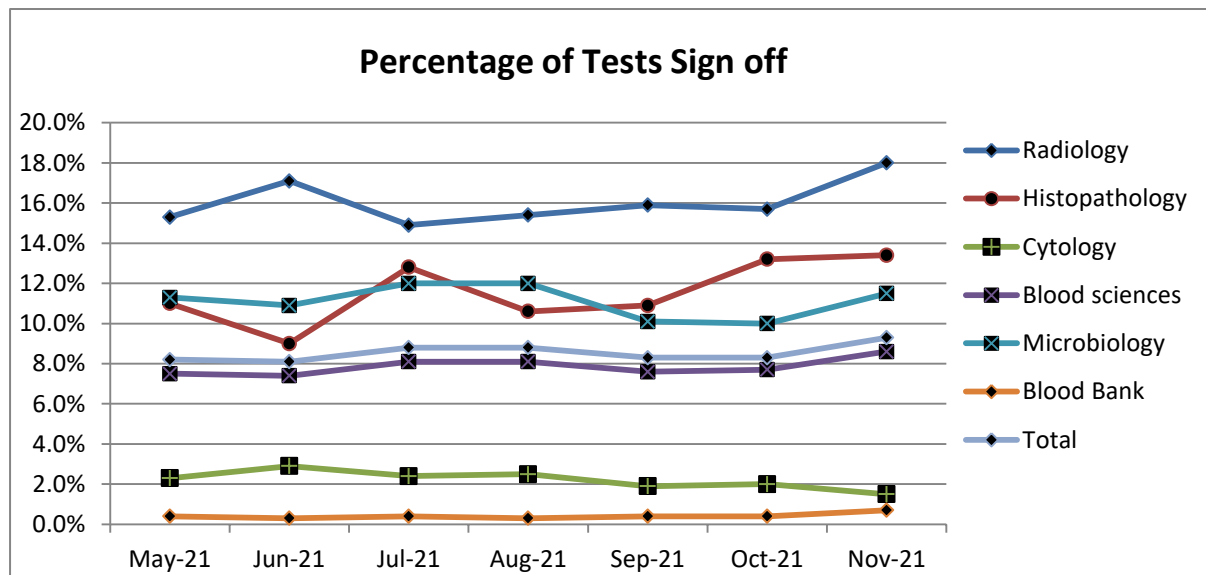


3) November 2021 Percentage of Tests Signed Off

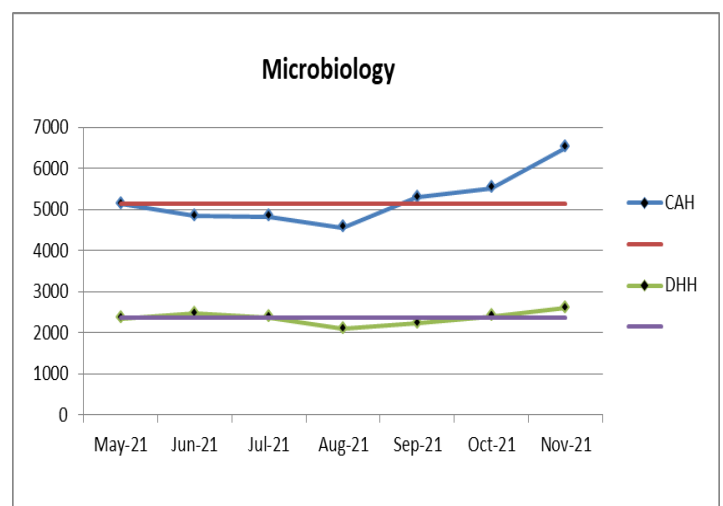
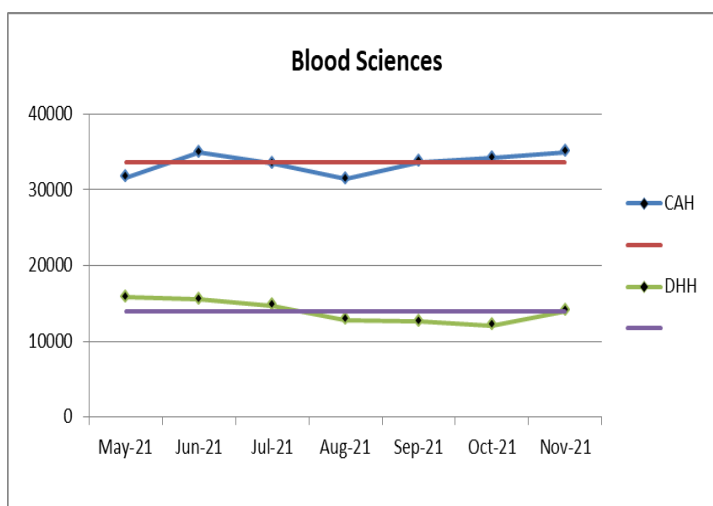
% Sign Off All Trusts

Clinical Test	Signed off	Total Tests	% Signed off
Radiology	11979	66627	18.0%
Histopathology	1218	9091	13.4%
Cytology	189	12335	1.5%
Blood Sciences	117418	1359314	8.6%
Microbiology	26021	226198	11.5%
Blood Bank	63	8440	0.7%
Total	156888	1682005	9.3%

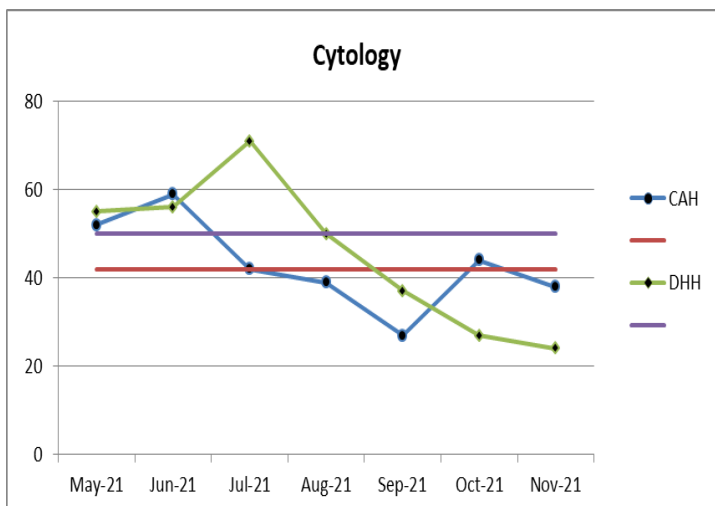
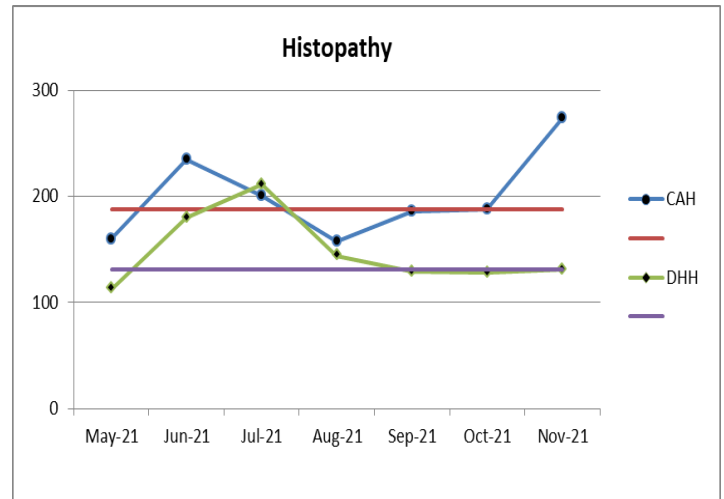
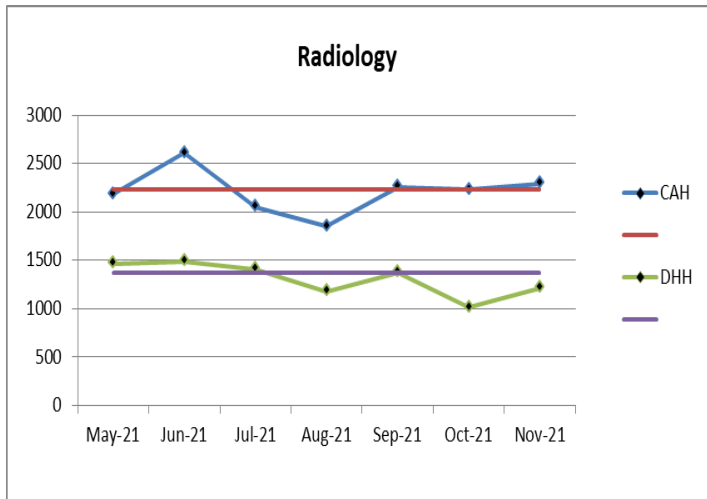
4) Overview of Percentage of Tests Signed Off



5) Overview of Sign Off per Test



Sign Off Review



Acute Directorate - Complaints Report.

Contents

- 1) Summary of Current Position.
- 2) Analytics
- 3) Overview of Key learning from complaints
- 4) Closed complaints by Division.
 - i) Unscheduled Care
 - ii) Medicine
 - iii) Surgery and ATTICS
 - iv) Cancer Services, Radiology and Labs
 - v) Functional Support Services

Summary of Current Position

Number of complaints that arrived within December 2021 - **43**

Number of Reopened complaints that arrived within December 2021- **3**

Number of complaints closed within December 2021- **25**

Number of MLA enquiries answered December 2021- **16**

Number of new Ombudsman enquires arrived within December 2021- **0**

The **2 day acknowledgement** target has been met at **100 %** for December 2021

The target of the **20 day response time** has been **48%** for December 2021

The top subjects of complaint for December 2021 Quality of Treatment and Care (**30**)

Communication (**27**)

Staff Attitude and Behaviour (**21**)

At year to date the top subject of complaint is ... Communication (**363**)

Quality of Treatment (**271**)

Staff Attitude (**253**)

Formal Complaints – 62 (46 outstanding)

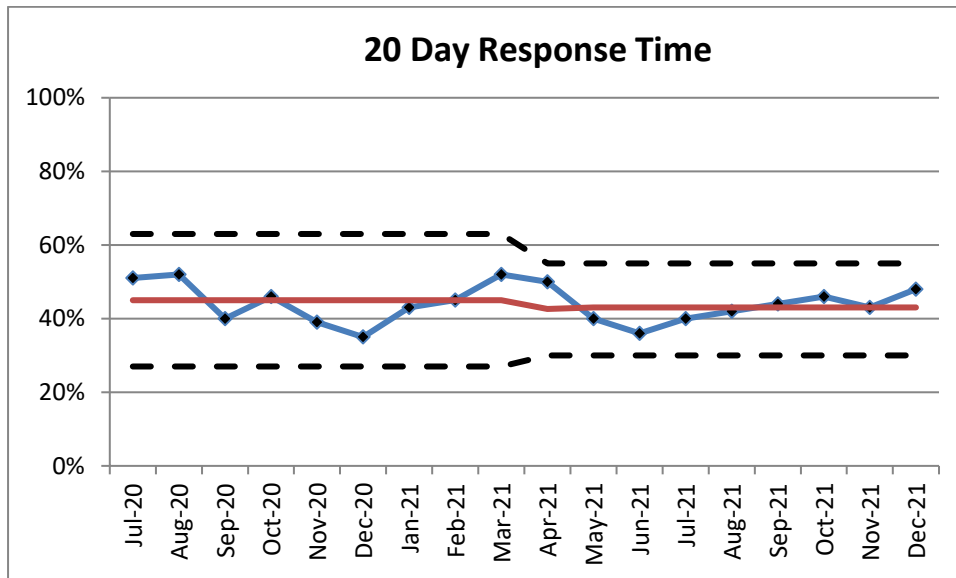
	Red	Amber	Green	Total	Out of total Await approval from AD
SEC/ATICS	12	2	1	15	3
MED	19	3	1	23	8
ED	13	4	4	21	3
CCS	0	0	0	0	0
IWMH	1	2	0	3	0
FSS	0	0	0	0	0
Total	45	11	6	62	14

Reopened Complaints– 21

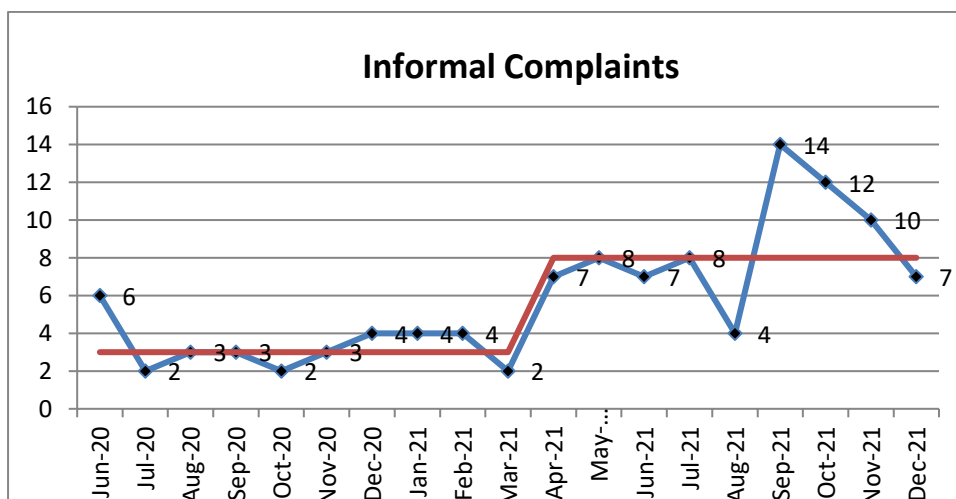
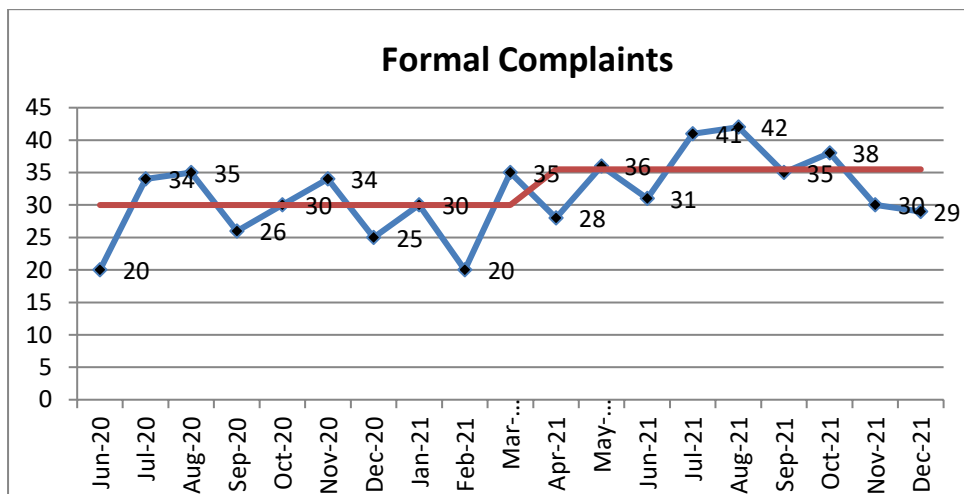
	Total	Out of total Await approval from AD
SEC/ATICS	6	0
MED	2	0
ED	12	1
CCS	0	0
IWMH	1	0
FSS	0	1
Total	21	2

2) Analytics

Response times

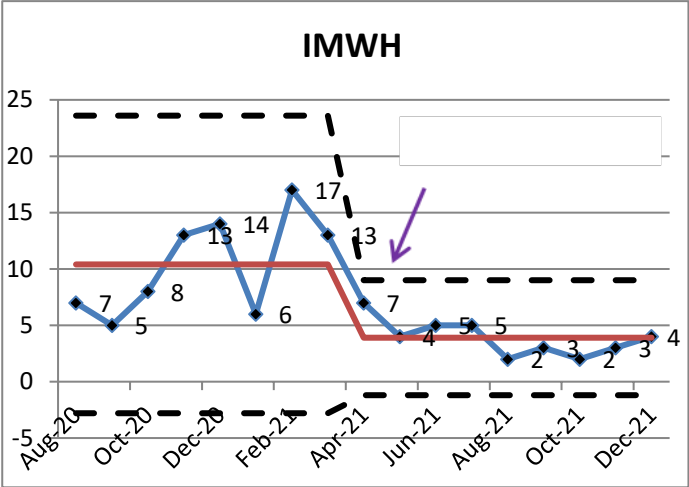
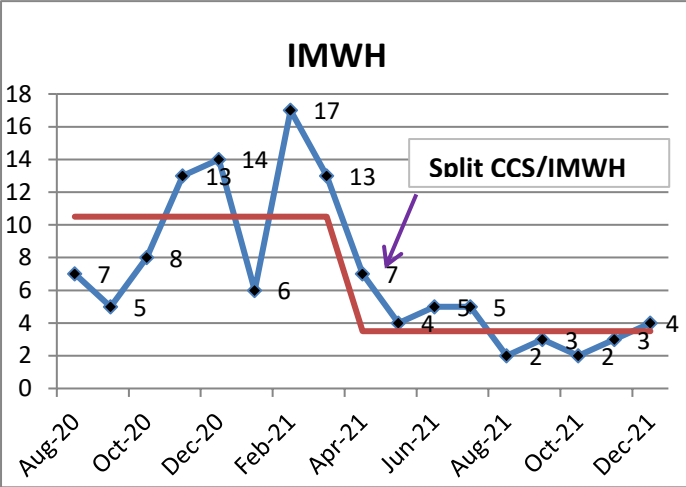


Complaints

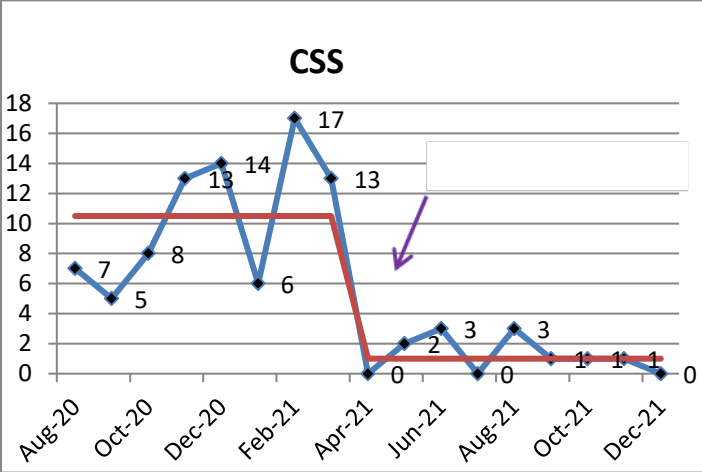


Complaints (by Division)

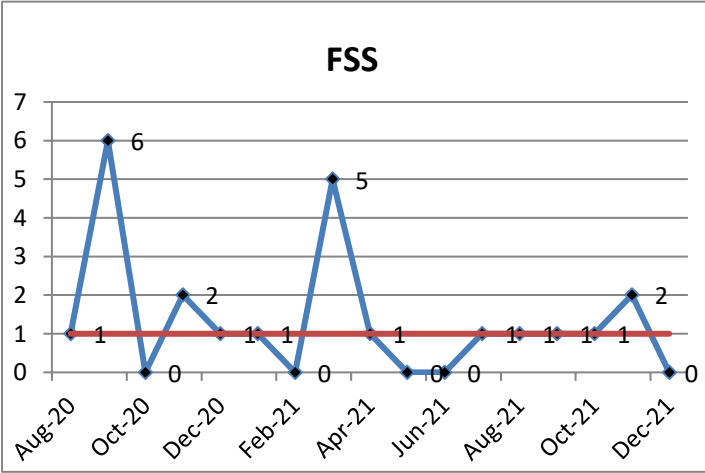
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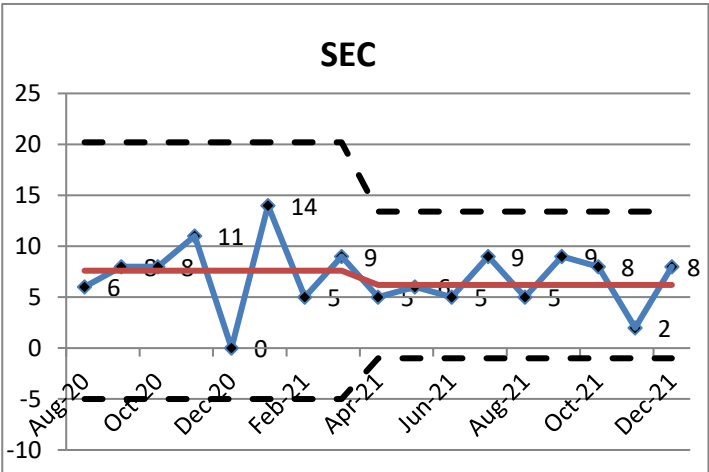
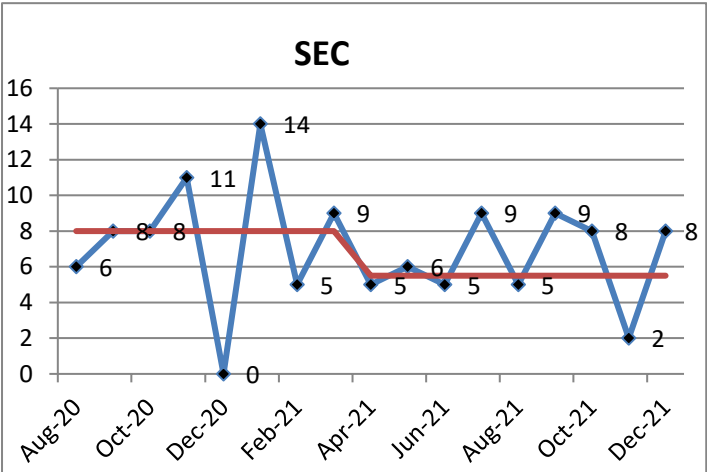
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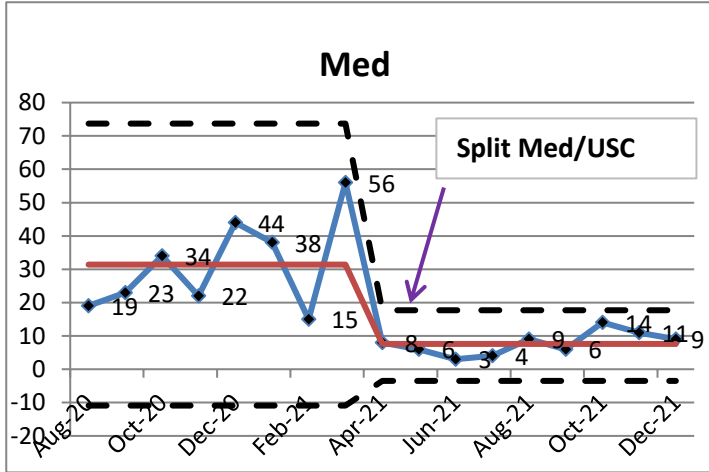
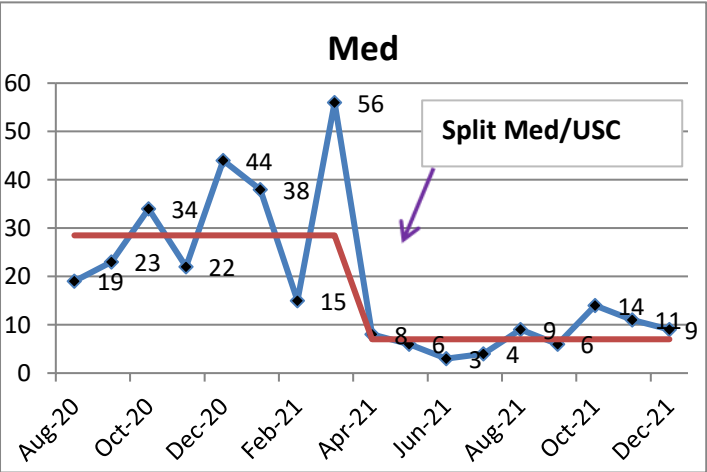
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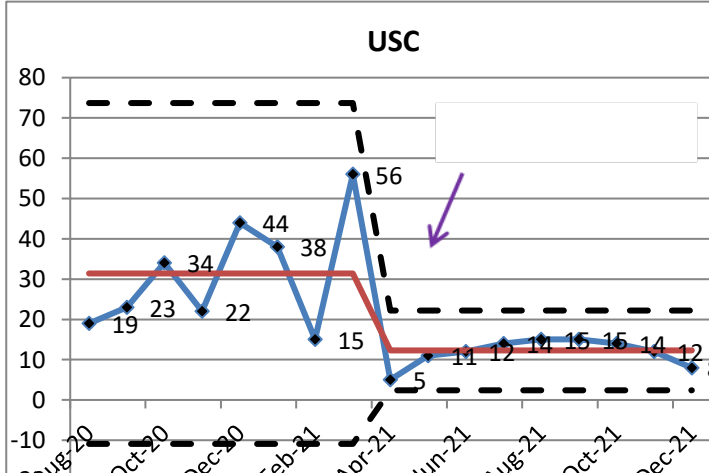
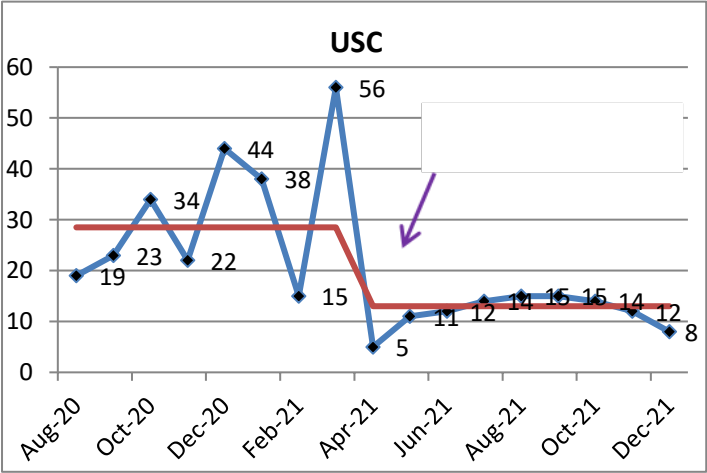
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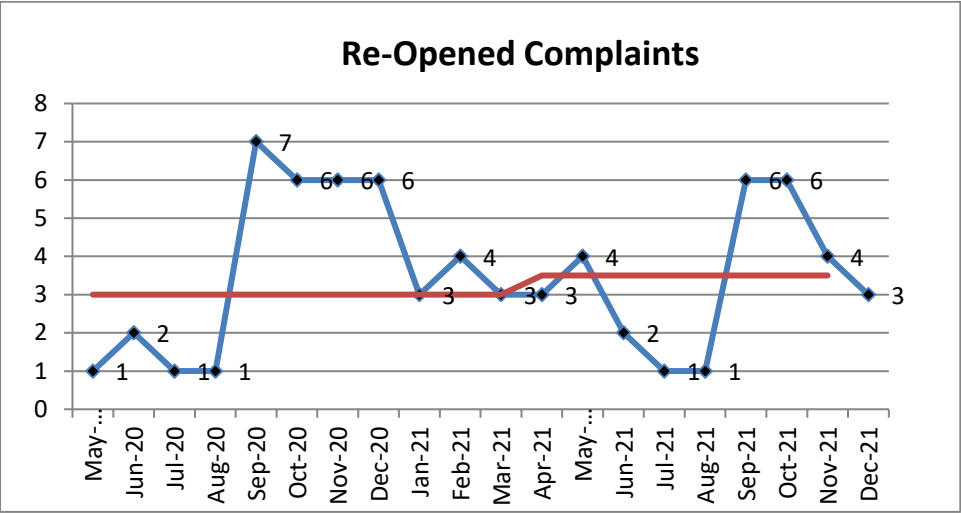
MED



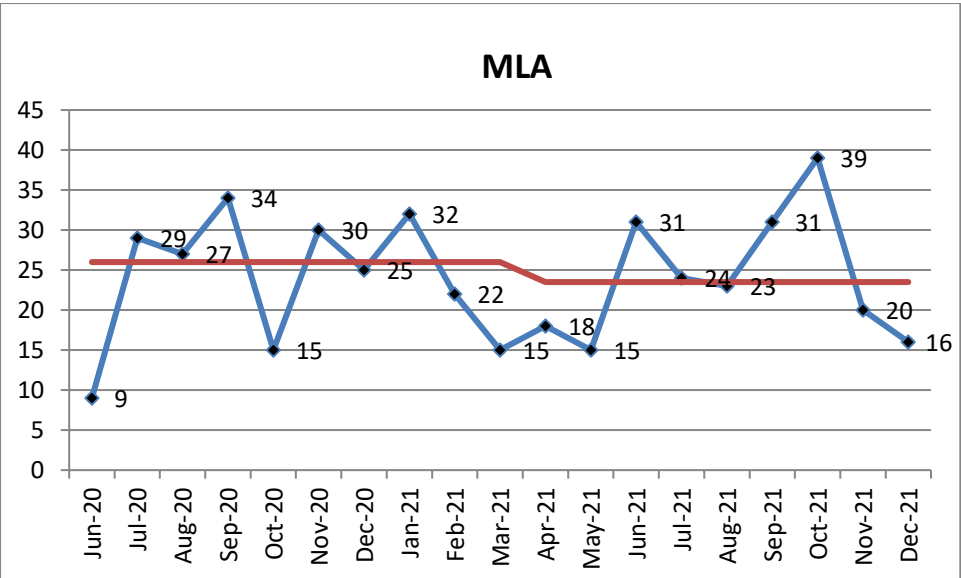
USC



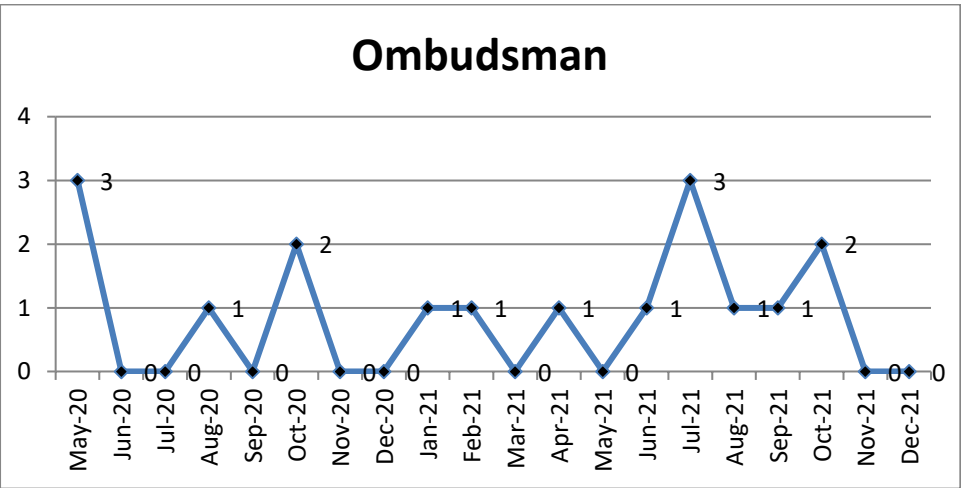
Reopened Complaints



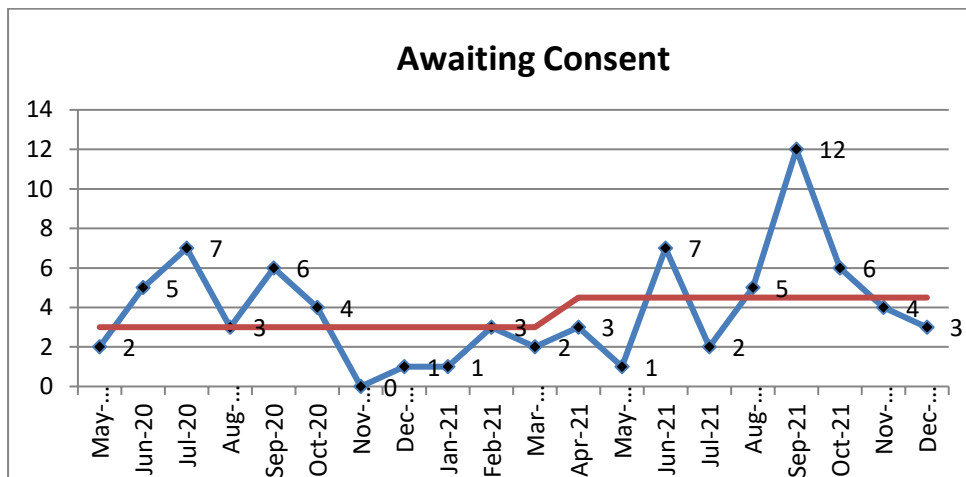
MLA



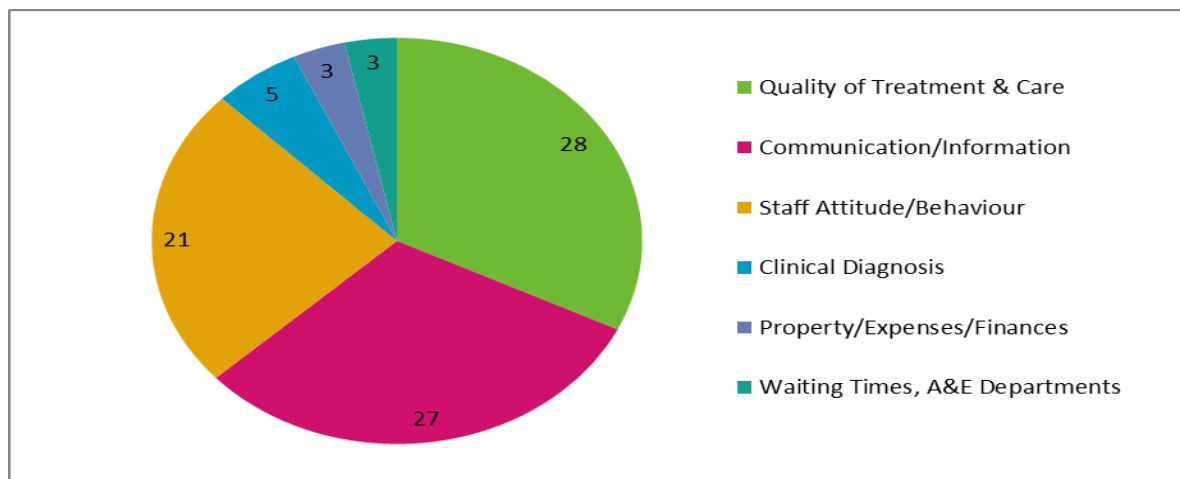
Ombudsman



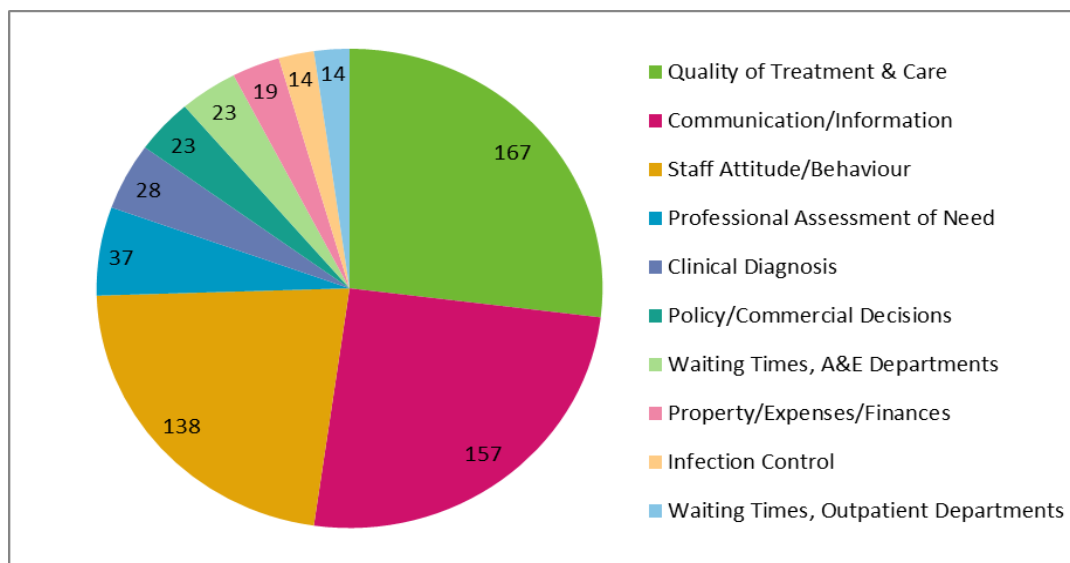
Awaiting Consent



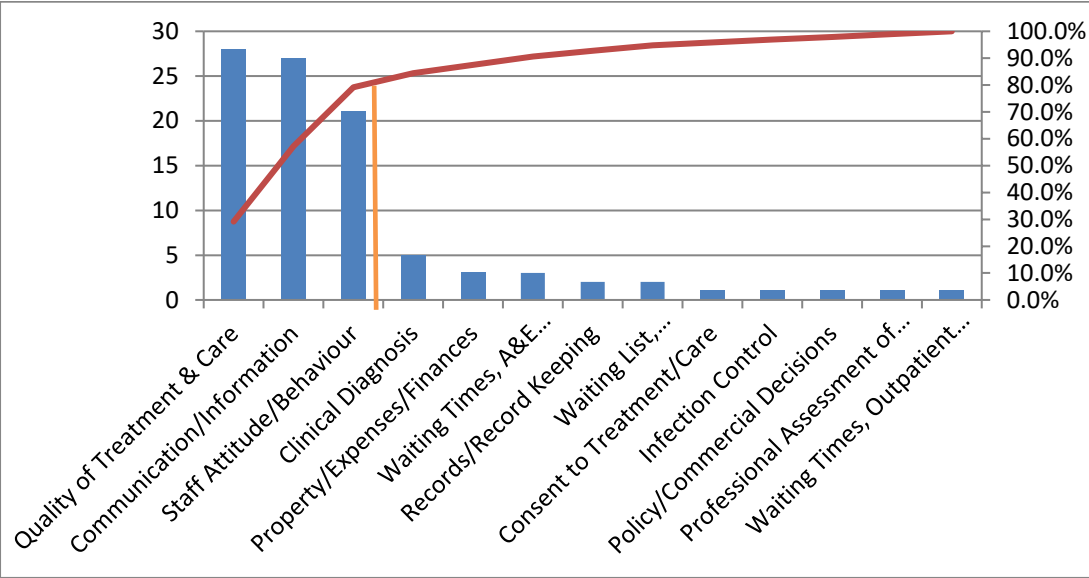
December – Top 5 Complaint Subjects



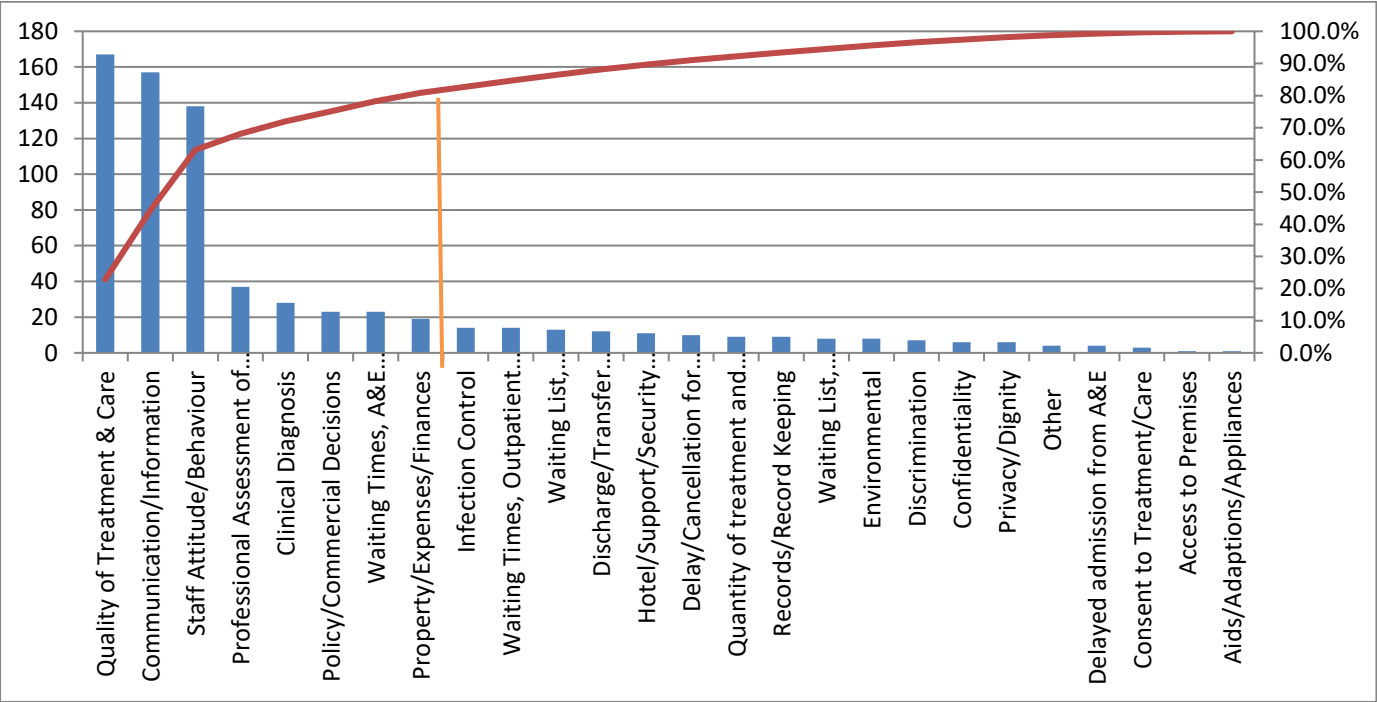
Top 10 Subjects (Year)



Complaints Subjects (November)



Complaints Subjects (Year)



3) Overview of Key learning from Complaints

Complaints closed over November period are consistent with general themes.

Key aspect of complaints related to

- 1) Poor communication between Healthcare professionals, service users and their families.
- 2) Attitude and behaviour of staff member
 - Escalate to manager, reflection completed by associated staff members or addressed by manager.

4) Closed complaints by Division.

i) Unscheduled Care

No	Complaint summary	Learning	Actions
1	Patient feels traumatised after brought to ED via ambulance following a RTA. Delay in CT. Staff treated patient as if she was drunk. Patient was in pain. Patient fell. Asked for help – delay in response. 2 hours delay emergency surgery for ruptured cyst.	Communication was not appropriate and lacked empathy. ED Consultant agrees medical management was appropriate.	Issues highlighted to the Nurse involved. Nurse completed reflection on the incident.
2	Personal information redacted female brought to ED CAH by ambulance. Nurse was rude to Ambulance Staff. Nurse poked daughter's eyes and decided she was not in need of resuscitation and directed to Paediatric ED. Disagreement between Nurse and mother re placement. Mother found Nurse rude and uncaring to daughter who was going through traumatic event in her life. Offered no reassurance to patient or her parents.	Nurse is from a Nursing Agency Nurse suggested child sat in a chair due to overcrowding in ED Nurse should have been reassuring you and your daughter.	This has been fed back to the Agency Nurse so she may reflect and learn from this incident.

3	Mother attended with child. Waited for triage and waited to be seen - others seen before them. Time to wait 8 hrs 30 mins for a “20 min job”	Surge in the number of children attending the Emergency Department on day of attendance. The Triage Nurse followed appropriate triage protocol. Apologise provided for delay in the plaster cast application. The Sister in Charge applied cast as most experienced Nurse on duty as enhanced skill is required when applying a cast on children.	None – overcrowding led to delay
4	Patient fell in a side room possibly onto drip stand and cut their arm Daughter has been given 3 different versions of how father fell but all conclude that he fell onto equipment. Poor communication with daughter.	Patient had known risk of falling The wound required suturing by the Surgical Team. Was on an anticoagulant, had previous radiotherapy. Patient referred to UHD Plastic Surgery, advised T&O assessment. Communication issues with ward to be addressed.	Communication between HCP and Next of kin.

5	Nurse had difficulty obtaining patients' blood. Chest was shaved using dry razor Requested pain relief but was ignored Delay in blood results Unhappy with being discharged.	Patient refused to provide blood sample from hand initially. Patient had attended another hospital and had extensive investigations carried out prior to attending ED. All investigations were normal. Apology given for delay in blood results. Apology given regarding HCA methods in obtaining bloods. Explanation that dry shaving is the method as patient may have allergy to foam- required to do this to connect electrodes directly to skin for ECG.	Issues highlighted to HCA . Pain relief requests to be escalated to Ward Managers.
6	Patient left on trolley without adequate pain relief. Patient left on their own with no family Delay in being assessed by Doctor. No communication with family Scan was cancelled with no explanation. Patient admitted to Ward but unhappy with care Dressings not changed. Discrepancies in discharge letter	Restrictions regarding family attending due to covid. Pain relief administered 20 minutes later following triage. Extensive investigations carried out to determine diagnosis and admission was required for further investigations. Scan was cancelled by Radiologist as previous scan 5 days earlier was normal.	Consultant Surgeon has highlighted issue to the Junior Doctors who completed the discharge letter. Staff have reflected on this issue and there will be learning shared with the Junior Doctor Team to prevent this happening to another patient.

		Dressings were post-surgery and should be left untouched for a period of time to prevent infection. Discharge letter was created on day of discharge but discharge was suspended and discharge letter not updated with correct information. Apology provided.	Communication between wards and family
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ii) Medicine

No	Complaint summary	Learning	Actions
1	Family feel like they were kept in the dark regarding fathers medical condition (COVID COMPLIANT)	It was clear there were gaps in communication between HCP and family Apology provided for poor communication	Improved communication with families First contact/NOK to provided delay updates

iii) Surgery and ATTICS

No	Complaint summary	Learning	Actions
1	Family not happy with attitude from nurse. Lack of compassion and care shown to patient Lack of empathy Abrupt manner of staff and repeatedly did not engage with the family.	Apology given for attitude of Nurse, Nurse has reflected on attitude and negative portrayal of care.	Communication between NOK and staff Ward Manager spoke with Nurse involved and reminder of professionalism and empathy as integral parts of care.
2	Patient added to list for surgery for shoulder. Removed from waiting list but not informed. Attended clinic to be told plan had changed Patient went to private clinic for surgery and want compensated by Trust	The initial Doctor did not specialise in shoulder surgery and took advice from a colleague who specialised in shoulder apology issued on unclear communication. A further clinic appointment to discuss change in management of shoulder was delayed due to covid impact and apology given.	Communication regarding management plan
3	Delay in being assessed by Doctor. No communication with family Scan was cancelled with no explanation. Patient admitted to Ward but unhappy with care Dressings not changed. Discrepancies in discharge letter	Restrictions regarding family attending due to covid. Pain relief administered 20 minutes later following triage. Extensive investigations carried out to determine diagnosis and admission was required for further investigations. Scan was cancelled by Radiologist as	Consultant Surgeon has highlighted issue to the Junior Doctors who completed the discharge letter. Staff have reflected on this issue and there will be learning shared with the Junior Doctor Team to prevent this happening

		previous scan 5 days earlier was normal. Dressings were post-surgery and should be left untouched for a period of time to prevent infection. Discharge letter was created on day of discharge but discharge was suspended and discharge letter not updated with correct information. Apology provided.	to another patient. Communication between wards and family
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iv) Cancer Services, Radiology and Labs

No	Complaint summary	Learning	Actions
0	No complaints this summary period		

v) IMWH

No	Complaint summary	Learning	Actions
1	Patient attended for 28 week appointment. Doctor was rude and persisted with questioning regarding plans for sterilisation at time of planned section.	Apology given to patient for the insensitivity in having a conversation regarding sterilisation when discussing planned caesarean sections.	Shared with Doctor who has reflected on his practice.
2	Agency Midwife not competent throughout delivery of patient's baby Did not know how to use foetal heart monitor Bedside manner not appropriate. Delivery Suite not set up correctly for delivery. No fan allowed in Delivery Suite.	Issues raised regarding the foetal heart monitor and the delivery suite where beyond the control of midwife. The transducer was faulty and a new one needed sourced. The Delivery Suite had been extremely busy and was not restocked as timely as required. Agency Midwife was replaced with Trust Midwife. Explanation that fans are not permitted due to covid and dispersion of air particles.	This has been fed back to the Agency Nurse so she may reflect and learn from this incident. Transducer replaced.

3	Patient did not receive medication. Unprofessional attitude of Midwives. Delay in ECG and error in scan patient was to have performed	Apology given to patient for her misinterpretation of the kardex, medication was crossed out and therefore assumption that it should not have been administered. No ECG service available out of hours. Apology regarding confusion surrounding scan.	Communication between patient and staff. Communication between Midwives and Doctors.
4	Patient suffered miscarriage attended multiple scans but was not advised of miscarriage. Had to ask to have HCG levels checked Contacted to attend 12 week scan after miscarriage. EPC area not private or big enough.	Apology given regarding the room and agreement area is not appropriate. Doctor followed guidance on repeating HCG levels. Missed opportunity to prepare patient for likely miscarriage and apology given.	Literature regarding the Miscarriage Association to be given at EPC in future.

vi) Functional Support Services

No	Complaint summary	Learning	Actions
1	Receptionist rude on telephone call. Transferred to wrong extension	Apology given regarding staff attitude	Manager spoken with staff member. Reminder regarding professionalism and courtesy when answering the phone.
2	Patient received text message advising of upcoming appointment. Contacted booking centre and was informed no such appointment had been booked. Appointment letter then received after the appointment Attitude of staff member.	Apology provided for miscommunication. Apology provided for inappropriate attitude of staff member	Franked envelopes provided to be used for all post in order not to delay receipt of appointments.

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due
Personal information redacted by the USI	Personal information redacted by the USI	SEC	Various	31/03/2021	16/04/2021	30/04/2021
		SEC/CCS	ICU	05/05/2021	19/05/2021	03/06/2021
		MED/SEC	FMW	21/05/2021		
		MED	DHH L4SR	21/05/2021	07/06/2021	21/06/201
		ED/SEC	ED CAH/3 SOUTH	13/07/2021	09/08/2021	10/08/2021
		SEC		15/07/2021	26/07/2021	12/08/2021
		MED/CCS	1 south	30/07/2021	16/08/2021	30/08/2021
		MED	3 North	13/08/2021	27/08/2021	13/09/2021
		SEC	GENERAL SURGERY	07/09/2021	21/09/2021	05/10/2021
		SEC	3 SOUTH	16/09/2021	30/09/2021	14/10/2021
		MED	FMW	17/09/2021	01/10/2021	15/10/2021

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due
Personal Information redacted by the USI	Personal Information redacted by the USI	MED/CCS	2 SOUTH	21/09/2021	05/10/2021	19/10/2021
		MED	DERMA	23/09/2021	07/10/2021	21/10/2021
		SEC	DONNING	24/09/2021	08/10/2021	22/10/2021
		CCS /FSS / MED	MRI	24/09/2021	08/10/2021	22/10/2021
		MED	Dermatology	30/09/2021	14/10/2021	28/10/2021
		MED	FMW	04/10/2021	18/10/2021	01/11/2021
		ED	ED CAH	07/10/2021	21/10/2021	04/11/2021
		ATICS / ED	DAY SURGERY	12/10/2021	26/10/2021	09/11/2021
		SEC	GENERAL SURGERY	14/10/2021	28/10/2021	11/11/2021
		EDMED	ED & 3NS & AMU	20/10/2021	03/11/2021	17/11/2021
		MED	Ward 3 B DHH	21/10/2021	04/11/2021	18/11/2021
		MED	3N, Ramone, 3 South	25/10/2021	08/11/2021	22/11/2021

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due
Personal Information redacted by the USI	Personal Information redacted by the USI	MED	2 South Medical	28/10/2021	11/11/2021	25/11/2021
		MED	Pharmacy / HSW	03/11/2021	15/11/2021	29/11/2021
		MED	FMW	03/11/2021	15/11/2021	29/11/2021
		MED	Hosp Social Worker	08/11/2021	22/11/2021	06/12/2021
		ED	ED DHH	09/11/2021	23/11/2021	07/12/2021
		ED/MED	AMU, ED & Ramone	10/11/2021	23/11/2021	08/12/2021
		MED/CCS	Mortuary/ Female Med	10/11/2021	24/11/2021	08/12/2021
		FSS	2North	11/11/2021	25/11/2021	09/12/2021
		ED/MED	ED CAH, 3 North	12/11/2021	26/11/2021	10/12/2021
		SEC	URO / GEN SUR	12/11/2021	26/11/2021	10/12/2021
		ED	ED CAH	15/11/2021	29/11/2021	13/12/2021
		MED	MMW	15/11/2021	29/11/2021	13/12/2021

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due
Personal Information redacted by the USI	Personal Information redacted by the USI	IMWH	Maternity	16/11/2021	30/11/2021	14/12/2021
		ED	ED CAH	17/11/2021	01/12/2021	15/12/2021
		ED	ED DHH	17/11/2021	01/12/2021	15/12/2021
		ED	ED CAH	22/11/2021	05/12/2021	19/12/2021
		MED	2 SOUTH MED	23/11/2021	07/12/2021	21//12/2021
		SEC	Ortho	26/11/2021	24/12/2021	11/01/2021
		IMWH/ ED	Maternity/ED/CYP/RV H	30/11/2021	14/12/2021	30/12/2021
		USC	ED	01/12/2021	16/12/2021	31/12/2021
		ATICS	Pain Clinic DHH	01/12/2021	15/12/2021	31/12/2021
		ED	AMU	02/12/2021	16/12/2021	
		SEC	3 South	03/12/2021	20/12/2021	05/01/2022
		ED/SEC	ED/4North	06/12/2021	20/12/2021	05/01/2022

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due
Personal Information redacted by the USI	Personal Information redacted by the USI	IMWH	1 East	08/12/2021	22/12/2021	07/01/2022
		USC	DHH ED	08/12/2021	23/12/2021	10/01/2022
		MED	COVID	08/12/2021	24/12/2021	11/01/2021
		CCS / SEC / IMWH	Gynae OPD/ G Surg	08/12/2021	242/12/2021	11/01/2021
		MED	3 North	08/12/2021	23/12/2021	10/01/2022
		SEC	3 SOUTH	09/12/2021	23/12/2021	10/01//2022
		USC	AMU	09/12/2021	24/12/2021	11/01/2022
		USC	ED	10/12/2021	24/12/2021	11/01/2022
		MED	Male Medical	14/12/2021	30/12/2021	13/01/2021
		IMWH	2 West	15/12/2021	31/12/2021	14/01/2022
		SEC	4 North	15/12/2021	31/12/2021	14/01/2022
		ED	AMU	13/12//2021	29/12/2021	12/01/2022

Ref	Record name	Div	Loc (Exact)	Date Received	Investigation due	Reply due
Personal Information redacted by the USI	Personal Information redacted by the USI	ED	ED	21/12/2021	06/01/2022	20/01/2022
		ED	ED	29/12/2021	12/01/2022	26/01/2022
		SEC	UROLOGY	29/12/2021	12/01/2022	26/01/2022
		MUC	Cardiology/Ambulatory	23/12/2021	12/01/2022	26/01/2022
		muc	1 South	29/12/2021	12/01/2022	26/01/2022
		IMWH				

INPUT	Personal Information redacted by the USI	OPPC		22/11/2021	06/12/2021	
INPUT		OPPC	ED / 2N / Labs	13/12/2021		21/12/2021

Non-Complaint Meeting	Personal Information redacted by the USI	ED / MED	ED / Ortho Ward	21/12/2021		
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ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD

Sent to....	Reminders Sent	Last Holding	Sarah or Chrisy
Dr Philip Murphy, Ortho Ward Brigeen / Wendy & 2 North Kay	13/05/2021	07/05/2021 & 28/06/2021	Chrisy
Helena McMurray / Tracey McGuigan	10/06/21 & 23/06/21 & 28/07&20/8 & 13/09 & 20/10	10/06/21 & 13/09/21 19/11/21 3/12/21	Chrisy
Amie Nelson / Kay Carroll	13/09/2021 & 23/12/21		Chrisy
Anne Harris Judith Mitchell Laura McAuliffe, P Loughan	08/06/21 & 29/07/21 & 20/08 & 13/09 & 7/10	23/06/21 & 13/09/21 & 19/11/21	Chrisy
Elizabeth McVeigh, Mairead McGahan & Paula McKay			Sarah
Amie Nelson / Ronan Carroll	19/08/2021 & 0/09/2021 & 14/09/21 & 15/10	23/08/21 & 13/09/21 & 19/11 /2021	Chrisy
Chris & Kay	14/09/2021 & 13/10/2021 & 15/10/2021 & 02/11/2021	13/09/2021 & 19/11/2021	Chrisy
Patricia Loughan & Trudi Kell	15/09/2021	13/09/2021 & 19/11/2021	Chrisy
Amie Nelson	15/10/2021	21/10/2021 & 19/11/2021	Chrisy
Paula McKay / Dr Bhutta		21/10/2021 & 19/11/2021 & 25/11/2021	Chrisy
Patricia Loughan			Chrisy

Sent to....	Reminders Sent	Last Holding	Sarah or Chrisy
Trudi Kelly, Andrea Hearn, Flo Fegan, Charlotte Ann Wells	15/10/2021	21/10/2021 & 19/11/2021	Chrisy
Patricia Loughan	15/10/2021	21/10/2021 & 19/11/2021	Chrisy
Paul Smyth, Denise Newell, Clair Quin, Helena Murray			Chrisy
Denise Newell, Trudi Kelly, Anital Carroll, Stephanie Doherty, Sarah Ward	15/10/2021	19/11/2021	Sarah
Dr O'Hagan	23/12/2021	19/11/2021	Chrisy
Dr Gafer, Anna McNulty, Abby McConnellKay Carroll, Flo Fegan			Chrisy
Paul Smyth, Elaine Campbell, Stephanie Hunter, CYP input		19/11/2021	Sarah
Paul S, Elaine, Stephanie H, Ursula Gildernew, Marti McKenna		19/11/2021	Chrisy
Amie Nelson / Ronan Carroll			Chrisy
Meeting Requested - Sharon Holmes, Paul Smyth, Patricia Loughan		19/11/2021	Sarah
Judith Mitchell , Laura McAuliffe, Kay Carroll		19/11/2021	Chrisy
Norma Parker, Hannah J, Laura W, Wendy C	23/12/2021		Chrisy

Sent to....	Reminders Sent	Last Holding	Sarah or Chrisy
		19/11/2021	Chrisy
Patricia Loughan			Chrisy
Laura McAuliffe, Abby McConnell, Kay Carroll			Chrisy
Flo Fegan, Virginia Murphy			Chrisy
CYP needed			Sarah
, Trudi K, P Loughan			Sarah
Abby McConnell, Laura McAuliffe, Kay Carroll, Geoff Kennedy Rachel McCracken			Chrisy
Anita Carroll, Kay Carroll, Victoria Burnett, Audrey Wilson-Reid	24/12/2021		Chrisy
OPPC,, Flo Fegan, Julie Anne Rankin-ED			Sarah
Wendy Clayton			Chrisy
Paul, Mary, Anita, Stephanie H, Rrachel G, Sinead Corr			Sarah
John McAteer, Laura McAuliffe & Kay C			Chrisy

Sent to....	Reminders Sent	Last Holding	Sarah or Chrisy
Dr McCormick, Dr McLaughlin, Dr Adams, Dr Henderson,Dr Verner, Wendy Clarke, Mary Dawson, Joanne Gluck			Sarah
Paul Smyth and Mary Burke			Sarah
Paul Smyth, Pauline Fearon & Lisa Small			Sarah
			Sarah
			Chrisy
Stephanie Doherty, Brigeen Kelly, Paula McKay, Clair Quinn,			CHRISy
Wendy Clarke, Tim McCormick, Mary D, Oonagh CK, Caroline Keown, Paul Smyth, Gareth Hampton, Mary Burke, Eliz McVeigh, CYP and Complaints @Belfast			Sarah
Paul Smyth, Lisa Small.Pauline Fearon			Sarah
Jane Doyle, Marti McKenna, Helena Murray			Sarah
Mary Burke, Sharon Holmes, Lorna Cullen			Sarah
Wendy Clayton, Laura White, Paula McKay - Ann McVeigh for info			Chrisy
Paul Smyth, Gareth Hampton, David Mark, Amie Nelson, Tracey McGuigan, Emma McCann			Sarah

Sent to....	Reminders Sent	Last Holding	Sarah or Chrisy
Rosemary Heasley, Marian McElroy, Oonagh Campbell Kelly, Wendy Clarke, Caroline B Keown			Sarah
PAUL SMYTH, RACHEL, LISA SMALL, PAULINE FEARON			Sarah
Email sent to clarify Head of Service			Chrisy
E Epanomeritakis, Amie Nelson,			Sarah
Norma Parker, Trudi K, Patricia Loughan			Chrisy
laura white, wendy clayton, payla mckay			Chrisy
Lorna Cullen, Sharon Holmes, Rachel Greer, OPPC			Sarah
Paul Smyth , Stephanie Hunter, Rachel Greer,Elizabeth McVeigh			Sarah
John McAteer, Laura McAuliffe & Kay C			Collette ???
Brid France, Oonagh Campbell Kelly, Wendy Clarke			Sarah
Emma McCann, Tracey M cGuigan, Amie Nelson			Chrisy
Ruth McParland, EJ Kearney, H Murray, L Cullen,S Holmes, R Greer, B Quinn, H O'Hare			Sarah

Sent to....	Reminders Sent	Last Holding	Sarah or Chrisy
Paul Smyth, Stephanie Hunter, Rachel Greer			Sarah
Paul Smyth, Rachel Greer, Lisa Small, Pauline, Mary, Hannah			Sarah
Wendy Clayton, Michael Young, Ronan Carroll			Chrisy
Jude Tweedie, Kay Carroll, Anne Mc VEY - FYI Sharon Holmes			Chrisy
Karen Kelly, Trudi Kelly, Louise Devlin, Flo Fegan/Virginia Murphy			Sarah
			Sarah

Patricia Loughan and Mohamed Eltom			Chrisy
Paul Smyth, Rachel Greer, Victoria Burnett, Andrea Hearn, Gary Warnock, Kay Carroll, Geoff Kennedy			Chrisy

Paul Smyth, Anne McVey & Brigeen Kelly			Chrisy
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Comments
With Anne for approval 20/12/2021
Drafted - sent to Tracey McGuigan & Helena Murray for response to final questions 06/12/21
Drafted - sent to Amie Nelson and Kay Carroll for final responses.
With Anne for approval
ED Doctor - 3 South still to respond
Escalated to Chris Wamsley 10/11/2021 Amie to advise if Mr McKay can respond and find out if patient has had 2nd opinion from B Trust - x2 reminders to Chris W to chase update. Personal Information redacted by the USI Phoned 17/12/21 - further reminder sent 20/12/21
With Anne for approval 21/12/2021
Chrisy to check all questions answered 24/12/21
Chrisy to find Generic Response to use
To Lisa McAreavey and Dr Bhutta for response 14/12/2021
With Anne For Approval 10/12/2021

Comments**Chrissy to draft response****With Anne for approval 10/12/2021****With Anne for approval 21/12/2021****OPPC Reponse received 15/10 Radiology response received 29/09. Anita response got. Johnny Bunns response. Awaiting Medical nursing frailty. - Sarah to partially draft. Mr Bunn to send response 30/11/2021****Awaiting Dr O'Hagan response to finalise****Chrissy to draft response - MHD to Input****CYP needs to input Investigation email sent - Sarah drafted acute part****Reminder to Helena, Marti and Paul Smyth 30/11/21****Amie to speak with Ronan re response. Questions only need answered if we want complainant to undergo covid test.****Meeting with family - decided 08.12.2021****With Anne for approval 10/12/2021****Chrisy to draft - Response to be shared wit MLA**Personal Information redacted by the USI

Comments**Investigation email sent****Investigation email sent****With Anne for approval 15/12/2021****Chrisy to draft response 23/12/21****ED part received await paed's input CYP - not SAI - need further ED and Admin response reminder sent
13.12.21 - PS to provide after debrief****Sarah to draft 21.12.2021****Investigation email sent****Chrisy to draft response 24/12/21****OPPC to input in relation to Lurgan, investigation email sent. Julie Rankin to speak with
Drs involved 23/11/21****John McAteer has ordered notes 17/11/21****Mary Burke to approve 15.12.2021****With Anne for approval 10/12/2021**

Comments
Meeting with family Wendy Clarke/Nicola Henderson
Investigation email sent
Investigation email sent
Investigation email sent
With Anne for approval 10/12/2021
Investigation email sent
Investigation email sent
Investigation email sent
Investigation email sent
Investigation email sent
Investigation email sent

Comments
Investigation email sent
Mary Burke to approve 31.12.2021
Investigation email sent
Dr Boggs response received. AW Surgical, BCH Oncology, Gastro CAH
Chrisy to draft response 24/12/21
Inestigation email sent
Investigation email sent
Investigation email sent
Investigation email sent
Investigation email sent
With Ronan for approval 22/12/21 - Ronan sent back to Tracey 23/12/21
Investigation email sent

Comments
Investigation email sent
Investigatione email sent
Investigation email sent
Inestigation email sent
Investigation Email sent

OPPC lead with Acute input.
OPPC Lead with Acute Input. Questions 1-9 Acute to respond. Labs have responded. Awaiting 2 North.

Email sent to ask who should meet with patient's brother 21/12/2021

Report on Re-Opened Complaints							
Ref	Record name	AD	Div	Loc (Exact)	Response or Meeting	Re-Opened	Last Updated
Personal information redacted by the USI	Personal information redacted by the USI	Anne McVey	MED	DHH Female Medical	Response	10/08/2020	16/11/2021
		Paul Smyth	ED	ED	Response	13/08/2021	
		Mary Burke	ED	CAH ED	Response	17/05/2021	28/05/2021
		Ronan Carroll	SEC	Kingsbridge/GSURG	Response	26/05/2021	02/11/2021
		Mary Burke	ED	ED CAH	Response	06/09/2021	
		Barry Conway	ED	Radiology	Response	07/09/2021	15/09/2021
		Ronan Carroll	SEC	General Surgery	Response	08/09/2021	16/11/2021
		Wendy Clarke	IMWH	Gyne/SEC	Meeting	10/09/2021	
		Mary Burke	ED	ED CAH	Response	15/09/2021	
		Sharon Holmes	ED	CARDIOLOGY	Response	07/10/2021	
		Mary Burke	ED	ED	Response	08/10/2021	03/11/2021
		Ronan Carroll	SEC	ED CAH	Meeting	11/10/2021	03/11/2021
		Mary Burke/Sharon Holmes	ED	ED	Response	11/10/2021	
		Mary Burke	ED	DHH	Response	13/10/2021	

Report on Re-Opened Complaints							
Ref	Record name	AD	Div	Loc (Exact)	Response or Meeting	Re-Opened	Last Updated
Personal Information redacted by the USI	Personal Information redacted by the USI	Ronan Carroll	SEC	Urology	Response	18/10/2021	02/11/2021
		Anne McVey	MED	Male Medical	Response	11/11/2021	
		Ronan Carroll	SEC	Eyes	Response	19/11/2021	19/11/2021
		Mary Burke	ED	Minor Injuries STH	Response	29/11/2021	03/12/2021
		Anne McVey	MED		Response		
		Mary Burke	ED	AMU	Response	15/12/2021	31/12/2021
		Anne McVey	MED		TBC	10/10/2021	10/12/2021
		Ronan Carroll	SEC	Orthopaedics	Response	13/10/2021	13/12/2021
		Mary Burke	ED	ED	Response	17/08/2021	13/12/2021
		Anne McVey	MED	Cardiology	Response	08/12/2021	13/12/2021
		Mary Burke	MUC	ED	Response	06/12/2021	

Progress
With Anne - Leo sent through updated draft 09/11/2021 - Leo formulating response
Escalated to Paul Smyth
reminder sent 25.11.21
Amie unsure how to respond. Asking Consultants advice 21/07/2021
Sent to ED staff for response
Just need Surgical and ED . Escalated 03.12.2021
Chrisy to find generic response - same as Mary Busby
Meeting to be arranged- to be raised at MDT
Paul Smyth, Mary Burke, Elaine/Brenda, Denise Newell, Lauren Hutton
Sent to Sharon Holmes (received response), Ismail Mohammed, Mary Burke
reminder to Mary, Paul, Rachel and Tracey Burton 25.11.21- Holding letter sent 11/11/2021
Amie sent email to Colin Weir - ? Next Wednesday 01/12/21 Meeting
Paul smyth for response not an SAI
Investigation email sent

Progress
Response from Mark Hyanes - Chrissy to do timeline
Sent to Kay / John McAteer
Sent to Brigeen Kelly to respond
sent out for investigation
sent out for investigation
sent out for investigation
Email sent to Dr Murphy and Anne McVey re way forward. Dr Reid to be phoned and updated Monday 13/12/21
Issues sent to Brigeen Kelly for response.
sent to Paul/Mary/eliz/Seamus Murphy
Sent to Kay Carroll / Louise Devlin
sent to Paul Smyth, Kay Carroll, Laura McAuliffe

Ombudsman at 13 December 2021

Trust Ref	NIPSO Ref	Patient	Div	Ombudsman Date	Update	Progress
Personal Information redacted by the USI	Personal Information redacted by the USI		SEC	15.08.19	07/09/2021	Apology letter sent on 20/09/2021 0 all other recommendations to be carried out- Solicitors letter
			MUSC	14.03.2020		Reponse with the Ombudsman
			SEC	05.05.20	21/09/2021	Response back to the Ombudsman regarding draft report
			MUSC	10.12.2020	13/09/2021	Draft report comments back to ombudsman
			SEC	12.02.2021	11/10/2021	Comments on draft report back to the ombudsman on 03.11.2021
			IMWH	Feb-21		Accepted by the Ombudsman- nothing further til report comes back
			SAI		06/08/2021	Back with the Ombudsman 20/09/2021
			IMWH	05-Jul-21	13-Dec-21	Further information required by us to ombudsman
			IMWH	29-Jul-21		Accepted by the Ombudsman- signed memos to go back by 1st December 2021
			IMWH	13/09/2021		Back to the Ombudsman 11.11.2021
			ED		09/12/2021	Accepted by the Ombudsman- info sent to conor mcgrath re this and do prescription
			SEC	27/10/2021	31/12/2021	Letter of assessment sent out - Reminder sent out- extension 31.12.2021

NIPSO Ref	Patient	Div	Ombudsman Date	Progress
Personal Information redacted by the USI	Personal Information redacted by the USI			
				Final recommendations sent April 2021
		SEC	10.12.2020	evidence of recommendation to be forwarded in 6 months
		SEC	25.01.2021	final recommendation sent on 02/09/2021
		Gastro	Mar-21	Not accepted by the Ombudsman so closed 16 July 2021

Trust Ref	NIPSO Ref	Patient	Div	Ombudsman Date	Progress
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ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains	HIGH
3829	ACUTE	13/09/2016	Safe, High Quality and Effective Care	Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	19/11/21 Update from Lead Nurse SEC- A working group is currently developing a criteria method to help guide the level of supervision required in nursing observations in relation to mental health"Enhanced Care Observation (ECO)". A training component is also being developed for staff prior to the pilot of this tool. There is a corporately led MDT working group who have produced a draft SHSCT point of ligature policy which has been shared for consultation prior to final approval. 20/09/2021- Lead Nurse SEC update- absconding policy used at ward level. Patients identified at risk will be placed in a bedspace as much as possible that provides supervision/visibility. Referral to Psych liaison. Also current working group to establish a "patient at risk" assessment tool which incorporates all levels of risk and care planning. There is also work ongoing regarding access to psych services within Acute. 20/09/2021- Escalated as per trust policy in ED. 18/08/2021- Absconding policy in place and escalated to HOS if incident occurs. Reported via Datix process. 09.03.2021- within ED a risk assessment is carried out if PSNI accompany patient under article 130 a joint risk is completed with nursing team. ED AMU review absconding patients with PSNI and mental health at interface meetings 24.02.2021- still ongoing issue and the staff adhering to policy and datix submitted with review taking taking place for each case. 24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating.	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3971	ACUTE	28/08/2018	Provide safe, high quality care	Access to cath lab for NSTEMI patients- ST has the highest through put of patients through the Cath Lab in the region.	The ST have highest through put in the region and only have one Cath Lab. If the C Arm breaks down we will not be able to treat Cardiology patients requiring patients to be transferred to another Trust. SHSCT are concerned there is a potential to patient morbidity and mortality due to long waiting list. Standard 18d of Cardio vascular framework that eligible NSTEMI / ACS pts should have Cor Angio +/- PCI within 72 hrs of admission. Angiography within 72 hours improves outcomes for patients. (NICE). MINAP state: The performance of angiography and coronary intervention soon is an important facet of treatment for the majority of patients.	Monitored weekly. Access elective patients. Escalate number of patients waiting for in patient cath procedures daily to AD and Director. There is a Regional Cath Lab implementation group which has been in place since August 2020.	18/08/2021- Have escalated via Elective Performance meeting. Highlighted the impact of high volume of inpatient activity and need for 2nd Cath Lab to address. Meeting held re inpatient plan regarding sharing lists with Belfast and Western Trust. Criteria to be established. Access times monitored monthly. 07/06/2021- The SHSCT has raised with the HSCB the need for decisions re Cath Lab capacity to meet the demand to be made as soon as possible. The Consultant Cardiologist in the SHSCT recommend a second Cath Lab on site. A PID for phase 3 Cath Lab capacity project was finalised in Oct 2020 and it was shared with the interim Director of commissioning in the Board. The process has been delayed due to the impact of Covid. A Clinical Lead is to be appointed to take forward a capacity and demand exercise which will allow a number of different options to be considered. 24/02/2021- working through as part of cardiology network plan but the target is only 33% in 72 hours due to only one cath lab. 5 /11/20 KPI for N STEMI s getting to cath lab within 72 hours has dropped to 35 % from 45% this is impacting on length of stay and bed occupancy at ward level and resulting in patients being admitted to wrong ward 10/08/20 - Regional group has been established PID document agreed. Demand and Capacity for cath lab activity to commence when templates have been distributed to the Trusts. 14/5/2020. Modular Cardiac cath lab was removed in October 2019. Access times for NSTEMIS has dropped to 33% getting to Cath lab within 72 hours . Regionally agreed to establish group to review cath lab activity re access times and demands. 24.06.19 Monitored via MINAP only 50% getting to cath lab despite modular. High volumes of inpatient activity (monitored monthly for each site) Need to secure Funding permanent for modular. Need to reduce elective to facilitate inpatient. 13.08.18 Performance team to liaise with HSCB re funding	HIGH
773	ACUTE	29/07/2008	Safe, High Quality and Effective Care	CAH Theatres Endoscope Decontamination room	The interim Endoscope decontamination facilities at CAH theatres do not meet DHSSNI decontamination strategy. There are no transfer lobbies or staff gowning rooms. The process flow is severely compromised by the size of the extremely cramped unit. There is no room for expansion. The workload in the endoscope decontamination facility has increased considerably over the last number of years due to additional theatre and radiology sessions as well as additional clinics in ENT OPD and Thorndale Unit. There is inadequate space for holding the contaminated endoscopes for manual washing prior to the automated process in the endoscope washer disinfectors. This frequently creates a bottleneck and slows down the process flow and turnaround time. The endoscopes and transport trolleys have to be stored in the hospital corridor outside the endoscope decontamination room due to lack of space - increased risk of theft (trolley plus endoscopes). In the event of any prolonged endoscope washer disinfecter downtime there would be significant disruption to endoscopic procedures in Theatres, Radiology, ICU or in ENT OPDand Thorndale Unit as there would be insufficient capacity to decontaminate the endoscopes on the Craigavon site. There would also be logistical issues and delays in turnaround times if the endoscopes had to be transported to another Trust site for decontamination ie Daisy Hill or South Tyrone. The endoscope washer disinfectors were installed in 2009 and have a working life of approximately 8 years. The Lancer endoscope washer disinfectors do not have the ability to perform channel patency tests to current DHSS guidance i.e. inability to perform partial blockage of the duodenal channel which is part of the quarterly channel patency testing regime. The EWD manufacturer has confirmed that they will support the FC 2/4 EWD models until 2022 for the electronics and until 2025 for mechanical parts.	Situation being monitored.	12/11/2021 A decontamination meeting is due to take place 19/11/2021 and a further update will be available after this meeting. 15/09/2021- Replacement ISIS EWDs were included in the paper for funding sent earlier this year. Funding still not approved. The procurement process for EWDs can take up to six months and risk remains with the current EWDs not being supported by the manufacturer beyond 2022. 28.06.2021- no update. 16.02.2021- draft paper re funding required has been shared with the Director of Acute Services. 10/08/20 - DOH has set up a regional RDS2 steering group to assess the current provision of decontamination services, identify any shortfalls in compliance with policy and develop a strategy to address any identified gaps. 3.10.19 Replacement EWDs are included on the capital funding list. May 2019 SHSCT provided a summary report to DOH on strategic planning relating to the decontamination of reusable medical devices 24.06.19, 8.8.18, 12.6.18, 7.3.18 Risk remains unchanged 113.9.16 Head of Decontamination Services will work with Acute Planner to explore options for a modular unit adjacent to CAH CSSD to replace the existing the interim arrangement. Given that CSSD will form part of Phase 1 for the CAH Redevelopment, a modular solution will be considered as a further interim arrangement although it will need to address existing concerns. Indicative costs to be detailed in the paper and logged for consideration under capital allocations for 17/18. 23.2.16 Following discussion at Acute senior management team with Head of Acute Planning, the risk will be addressed in the first phase of the redevelopment of the Craigavon site. On this basis it was agreed that nothing further would be done at this stage. 5.1.16 Short paper highlighting the risks shared with Planning Dept and Director of Acute Services	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4177	ACUTE	20/06/2018	Safe, High Quality and Effective Care	Chiller Faults causing loss of time- MRI	Chillers are required to supply chilled water to the MRI scanner to remove heat produced during scanning and facilitate circulation of liquid helium which maintains the operation of the superconducting magnet. For the scanner to operate at the highest levels of efficiency, the magnet inside the scanner has to be kept as cool as possible. Any increase in temperature will result if the the chiller is not operating will cause the scanner to no longer operate. This is a safety mechanism for the scanner to prevent boil off the liquid helium "quenching". This is when the wire in the electromagnet stops being superconducting and starts to generate a lot of heat. At this point, any liquid helium around the magnet repeatedly boils off and escapes from the vessel housing the magnet.	Single chiller per scanner with no back up available. Alarm system in place to business management system when chiller is not operating- no communication from switch or estates re this during recent breakdowns. Siemens will test this to check if the system is working.	08/07/2021- recent chiller failure- temporary chiller installed until fault can be replaced. Several days scanning lost while this was ordered and installed. RED FLAG exams delayed due to downtime. 21/11/2020- no change- still awaiting estates action ongoing follow up with estates for progress. 20/06/2018- automatic emergency bypass system needs integrated instead of manual- to be referred to capital department for design team. Additional secondary chiller with associated pipework as a backup- D/W David Thompson needs referred to capital department design team. Discussion with Estates Team and Switch in relation to procedure for notifying estates and MRI if chiller alarm goes off. Alarm system to be tested.	HIGH
4176	ACUTE	20/09/2021	Accessible and Responsive CareSafe, High Quality and Effective Care	Covid & Non Covid patients on AGPs being cared for in red Resus	Nosocomial Spread and patients at risk	ED consultants/management/IPC/Micro walkaround CDU identified as resus area for patients receiving AGPs CDU converted to Red Resus as IPC/Micro advice Lumira swabbing commenced in ED to determine Covid status The side room is used were possible to provide some protection for e.g. if one non-covid patient on AGP they will be nursed in side room and vice versa. However still a potential risk that aerosols will mix. When this is not possible patients in an open bay have the same air space which means that they are all in direct contact with one another. Covid positive patients in red resus are transferred to a Covid ward as soon as possible to reduce the risk. Ongoing escalation of red resus at APC meetings. All staff in red PPE. Walk around with Estates.	21/09/2021- Datix to be completed when non-covid/covid patients are nursed in red resus at any one time. Patients transferred out of red resus to appropriate ward when clinical condition permits is ongoing. Estates have confirmed that inability to undertake closing off cubical areas due to the estate structure. March 2020- CDU converted to red resus for patients on AGPs. All staff in red PPE	HIGH
3951	ACUTE	10/04/2018	Provide safe, high quality care	Delays in isolation	Due to lack of side rooms/one to one nursing/lack of bed capacity in the service. Risk of spread of infection. Failure to isolate promptly can lead to outbreaks, close of bays, increased pressure on service. May lead to potential patient harm through the spread of potentially preventable infection or due to a lack of beds.	Trust can emphasise the importance of IPC issues at bed meetings and elsewhere. A recent teaching sessions was arranged to do this amidst the winter pressures. Side rooms are often occupied for reasons other than IPC reasons. IPC reasons for isolation are often of critical importance in that severe harm can be done to other patients and staff by failure to isolate promptly. This is often not the case for other reasons patients are in side rooms and side rooms should be prioritised to maximise patient safety. The Trust should also look to ways to enhance the capacity to isolate a patient when the hospital is full and a patient needs isolated urgently e.g. where a patient could be moved out of a room to facilitate critical IPC isolation.	20/09/2021- all patients who attend ED have Lumira to determine covid status. PCR completed as per protocol. Risk assessments are completed when a high number of beds are closed due to an outbreak vs risks in ED. 01.06.2021- there has been 8.7 million pounds secured from the DOH address nosocomial infections which will allow estates work to progress. This will free up clinical space to accommodate patients. 24.01.21- delays in ascertaining results of swabs and screening and appropriate action delayed based on same and lack of isolation rooms to accommodate this.	HIGH
4155	ACUTE	01/04/2021	Provide safe, high quality careMake the best use of resourcesBe a great place to work	Haematology Outliers	Currently only providing a 6 bedded inpatient side room, augmented care capacity for Haematology patients. All other admitted Haematology patients are cared for throughout both medicine and surgery, without the necessary environment to ensure patient satiety regarding hospital acquired infections. Potential risk could be catastrophic for a haematology inpatient. Haematology patients are immunosuppressed and are amongst one of the most vulnerable client groups within the hospital setting. Ultimately if a patient is exposed to one of the many potential hospital acquired infection this could be life limiting.	Patients that are identified as immunosuppressed must be prioritised for an ensuite side room the estate is limited regarding same and as such we are not always able to accommodate this, patients are then placed in side rooms with shared toileting facilities Haematology Teams keep track of all outlying patients and review same providing clinical plans where necessary. Maximising discharges in Haematology Unit, in order to created capacity for admitted patients.	Action plan completed working collaboratively with the AD from workforce to address same	HIGH
3954	ACUTE	10/04/2018	Provide safe, high quality care	Lack of documentation	Root cause analyses are repeatedly picking up incidences of poor documentation e.g. lack of filling out of Clostridium difficile bundle, lack of documentation that the patient has been informed of a diagnosis of Clostridium difficile, lack of filling out of cannula charts, etc. Lack of documentation can reflect either that something that should have happened has not happened or just that it has not been documented. In the former there is a direct risk to patient safety (e.g. death from Staphylococcus aureus bacteraemia from a cannula that was not inspected properly and removed when it should have been, death from Clostridium difficile due to deterioration not being picked up due to lack of due diligence in the application of the bundle). In the latter there is still danger to the patient as staff subsequently on duty will not be able to see what was done as it is not documented. There is also significant risk to litigation to individual staff and the Trust as without documentation to say that good practice has been carried out there is no proof that it has been done.	Medical and nursing training would emphasise the importance of good documentation. Root cause analyses would emphasise the importance of this. The recurrence of this problem as demonstrated by repeat root cause analyses however would suggest that current control measures are not sufficient. When challenged regarding poor documentation excuses given are usually:- (a) A lack of education/awareness regarding aspect s of care bundles (b) A lack of time to document things due to service pressures Problem (a) could re resolved through additional education to staff through Lead Nurses, Ward Sisters and Clinical Directors to their teams where this is needed. Problem (b) can only be resolved by easing the pressure on nursing and medical staff in general. In general the experience of the IPCT is that nursing documentation is better than medical documentation, especially with regards to documenting when a patient has been informed of their diagnosis.	18/08/2021- RQIA guidelines shared with Cardiology Team following SAI. Audit to be carried out in October 2021. 24.02.2021- improvements have been made but still needs continually monitored	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4184	ACUTE	04/10/2021	Safe, High Quality and Effective CareEffective organisational governance	Misuse of POCT devices and non compliance with clinical governance procedures across the Trust	POCT demand has increased exponentially across the Trust, particularly in response to the Covid pandemic. Mistakes made during the course of POCT analysis and incorrect results acted on by the clinical team can have life-threatening consequences for the patient. The risk is not limited to the POCT team; the risk is applicable to all of the clinical teams across the Trust who are performing POCT and relying on the results to inform patient management. All of the following will cause incorrect results to be produced which, if acted upon, could be fatal for the patient and leave the Trust open to litigation: -Poor sampling technique resulting in poor quality of sample. -Lack of training or knowledge on the part of the operator regarding proper and correct use of the POCT device. -Lack of knowledge or reluctance regarding how to perform internal quality control and calibration (this checks if the machine is producing the correct results). -Inadequate compliance with external quality assurance procedures (this checks that the entire procedure from sampling through to result transmission is working as it should). -Lack of understanding of what will adversely affect results e.g. haemolysis, icterus, lipaemia, incorrect storage temperature for reagents. -Poor cleanliness and maintenance of the device and surrounding area. -Use of incorrect or out of date IQC/calibration or test cassettes. Other risks for the patient -Not using the correct H&C number - result will not transmit to NIECR. -Patient HCN mix up, results going into the wrong patient file. -Staff sharing barcodes - risk of an untrained operator using the device incorrectly. -Lack of POCT team support to deal with issues such as poor IQC/EQA performance and -troubleshooting. -Lack of IT support for issues such as devices losing connectivity. In addition, not all devices are able to connect to the Trust network so there is an increased risk with such devices where the POCT team are unable to adequately monitor their performance. -Users not informing POCT of issues with devices when they arise. Risk of faulty device being used to generate inaccurate results that are acted on by the clinical team. The risks to the user and patient are significantly more substantial than risks associated with performing tests in the main laboratory which is staffed by fully trained laboratory staff. Staff performing POCT have basic training in operating the devices and must adhere fully to the rules set out by the POCT team. Mistakes can have serious, fatal outcomes for the patient if the results produced are incorrect or misinterpreted and subsequently acted upon by the clinical team. Staff not adhering to the rules and standard operating procedures as laid down by the POCT team are open to disciplinary procedures. Mistakes made during the course of POCT analysis can leave the Trust open to litigation from the patient. The POCT team regularly audits aspects of the POCT devices and operators. There are repeated instances of staff sharing barcodes, not using H&C numbers, poor maintenance and cleanliness of equipment, failure	- Online and/or face to face training available for all devices - training sessions are organised and readily available on request from the POCT team. - POCT staffing - POCT staffing has been extended but staffing levels have fluctuated with staff leaving and being replaced. There is a requirement for a Band 6 BMS to provide support to the POCT Band 7 and robustness across the service, particularly with the continuing increase in demand for POCT across all sites. - SOPs and information are available for all devices on the laboratory website and Sharepoint. - Regular audit of POCT in clinical areas is highlighting problems with regards device maintenance, compliance with IQC/EQA etc, and this information is regularly disseminated to all Heads of Service and Lead Nurses in areas of the Trust that use POCT. The emphasis is on these individuals to enforce the compliance with POCT rules within their teams in order to satisfy clinical governance requirements. - IT support is a constant issue within POCT and causes serious delays in troubleshooting and installation of POCT devices. We are currently recruiting a Band 6 IT person for labs, but they will require proper access and administration rights to IT systems (particularly cyber-security) in order to complete their work. This could be a problem if IT are unwilling to co-operate in this respect. These controls are effective to a certain extent, but non-compliance with POCT regulations within the clinical teams is a critical ongoing issue that is possibly not being taken seriously enough across the Trust. The risk to the patient is significant. Removal of devices from clinical areas where non-compliance with POCT rules has been identified as a serious issue - this will only be as a last resort, particularly in areas such as ED where POCT is essential for patient flow (e.g. Covid testing). However, this leaves the Trust open to litigation in the event of errors. Permanent blocking of users who consistently fail to comply with POCT regulations - this is not feasible in practice, particularly with many clinical areas short staffed. All we can do is ensure the individual's line managers are aware of non-compliance issues, and that they both sign an official form committing to compliance with regulations, and undergo re-training procedures.		HIGH
4157	ACUTE	06/05/2021	Provide safe, high quality careMake the best use of resources	MRI Capacity	MRI inpatient demand has significantly increased with an impact on the capacity for red flag, urgent and routine outpatient examination. There has been a 72% increases in inpatient MRI demand comparing March 20 and March 21. Currently there is no MRI facility available on the Daisy Hill Site and patients have to transfer to CAH for MRI imaging. Increased outpatient waiting list and waiting times. Potential for additional queries regarding inpatients to MRI staff adding additional pressures.	Currently some MRI referrals are being outsourced to the Independent Sector. However due to image quality the more complex outpatient MRI referrals remain in the Southern Trust	14/12/2021- brought to CW to raise with Director re corporate register move. The Department are working with planning on a Business Case for a low field strength MRI Scanner to be located at DHH. The Current MRI scanners located in CAH are due for replacement in 2023 and 2024 which are currently on the equipment replacement plan. The costs of low field MRI scanner for DHH has yet to be finalised	HIGH
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH and the inability to off load patients from Ambulance due to overcrowding.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow. HALO role and ongoing monitoring	20/09/2021- ongoing, risk exacerbated by Covid- bed pressures sustained for long periods. Non commissioned beds have been opened. Surgical beds converted to medical beds. 09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams. Funding needs secured for medical gases for ambulance receiving area. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing escalation plan. 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update, 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	HIGH
4142	ACUTE	24/02/2021	Provide safe, high quality careBe a great place to workMake the best use of resources	Recruitment and Retention issues- Trust Wards	Patient safety risk. Identification the deteriorating patients, risk on escalation of same, lack of knowledge of in house processes, potential treatment/management/discharge delays. Increased pressure placed on core team, risk of burn out/work related stress. Potential lack of escalation/risk deteriorating patient not escalated. Potential risk of failed discharge/transfer due to lack of knowledge regarding processes. Risk of non-compliance with appropriate documentation required to manage patients holistic needs.	currently focusing prioritising recruitment to this area. Complete all outstanding e-reqs Internation nurse recruitment Target year 3 nursing students to this area to attract uptake Offer all bank and agency permanent positions Daily review and redeployment of staff to support the skill mix and staff levels with 2 South.	20/09/2021- 6 new start band 5 in DHH ED October 2021. 22 New start Band 5 CAH ED October 2021 28.06.2021- ATICS ongoing Band 5 recruitment drive. 8 x band 5 posts from peri-operative work stream. Applications closed 23.06.2021 Action plan completed working collaboratively with the AD from workforce to address this	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4156	ACUTE	19/08/2021	Provide safe, high quality careMake the best use of resources	Referrer MRI Safety	MRI is potentially hazardous and involves significant risk to patient safety. During the period 2019-2021 there has been an average occurrence (one every 3 weeks) of incidents involving incorrectly completed MRI safety referral information. These incidents have involved referrers stating that patients do not have any potential contraindications to undergo MRI(implants) however it is later identified by MRI Team that implants are in-situ. If these events keep occurring at the current rate there is an increased risk of morbidity and mortality because the source of risk has not been reduced.	The MRI Team screen and check all patients and completed questionnaires to attempt to ensure these errors are captured. E Learning MRI safety for referrers is available on HSC E Learning. Where possible notifications are sent to referrers involved to highlight the error and request that they complete the MRI safety training.	03/12/2021 - A national MR Safety training module is being developed and will be released in 2022. This module will replace the current MR Safety module on ELearning. A trend analysis report has been collated over the past 4 months which has not indicated any reduction in the number of incidents. 14/09/2021- requirement for a 3rd scanner, electrical infrastructure in DHH is an issue- cannot be brought forward. Modular MRI scanner on DHH currently. Cannot be progressed by division. To be discussed with Director of Acute Services to have this risk moved back onto Directorate register. 16/08/2021- memo has been circulated by the medical director to all medical staff regarding the importance of correct protocol when filling out safety questionnaires for MRI. MD has asked for compliance audit data to be shared with MD and AMD to allow this issue to be addressed. A learning letter was sent out with the memo to be shared at the M&M meetings and Governance Co-coordinators to be raised at directorate governance fora and the AMD and DMD for sharing within teams. Posters to be placed on Trust desktops via Communications team by June 2021 The Department would like Referrer MRI Safety Training to become mandatory for MRI referrers by August 2021	HIGH
4143	ACUTE	11/03/2021	Best use of resourcesProvide safe, high quality care	Replacement programme for Radiology Equipment on all Sites to replace equipment on unsupported operating systems and provide maintenance	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose. There is equipment currently running on Microsoft Windows XP - the support ended in April 2014 leaving risks of ransomware attacks or hacking. Failure to patch as per schedule could result in the ability to access clinical systems on radiology equipment and server infrastructure. This has been highlighted by Tenable programme and could result in the loss of essential services.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging. Patching arrangement needs to be formalised. This needs developed with 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching - regional project looking at 3rd party suppliers being led by BSO. Targeted staff awareness, devices to be replaced, upgraded or if not possible must be segregated. IT working with Radiology to highlight all devices. "	14/09/2021- 10 year plan drawn up-investment per year shared with Regional Imaging Board- understand that SHSCT needs priority. "The equipment plan has been tabled at Trust SMT. Radiology have also presented to SMT to highlight the issues. This presentation has highlighted specific urgent requirements including breast imaging and fluoroscopy across both sites to include the required ventilation. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. There is ongoing review with IT regarding patching. " ongoing review with IT in relation to patching. All 3rd party contracts to be reviewed and amended to include patching- regional project. "To be amalgamated with 8, 10 and 11. The equipment plan has been presented at Trust SMT. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. "	HIGH
4185	ACUTE	12/10/2021		Risk of not being able to provide a round the clock blood sciences service on both CAH & DHH sites	There is a risk that that the critical provision of Blood Sciences may not be available on one of the main hospital sites. An inability to provide "round-the-clock" cover would compromise the provision of high quality care and in the case of Blood Bank could result in the requirement to close (temporarily) Daisy Hill to emergency admissions. In addition Obstetrics and other specialties, including Theatres would be put at unacceptable risk. Contingency measures that could be brought into operation in Chemistry could compromise patient flow and potentially compromise clinical care. Current contingencies within Haematology / Blood Bank carry even higher risks than Chemistry due to the critical nature of blood bank in particular. The stretching of staff across the 24 hour period and two sites together with the constantly increasing demand for laboratory services is also putting accreditation at risk. Type 1 Emergency Departments and Obstetrics have an absolute requirement for a Blood Bank. If the Blood Bank could not be operated at any stage of a twenty four hour period the Daisy Hill Hospital would not be able to maintain the Emergency Department and patients would need to be directed to other Emergency Departments with potential for delay and significant patient harm or death. It is sobering to reflect that critical hospital services are supported by rotas that are extremely limited and vulnerable to short notice illness with the potential for no available backfill. Unlike nursing agency bank staff are not readily available. In short inability to cover a gap could result in the emergency department having to close and patients on the Daisy Hill site being exposed to significant risk. Therefore the impact could be regarded as a catastrophic. The number of staff available on the Haematology / Blood Bank in the SHSCT is very limited, partly due to the very stringent requirements required to operate autonomously in this discipline. Currently the twenty four hour cycle is covered by too few staff and by utilising substantial overtime. Increased demand on staff has also the potential to increase sickness and stress further compounding the problem. Rotas are effectively so limited that even a few absences could cause one of the rotas to fail. The COVID pandemic has placed significant additional pressures on staff - increased demand and reduced availability of staff. Very tight rotas are highly vulnerable to these issues. Laboratory accreditation (UKAS ISO15189) is at risk where the focus is maintaining a service at the cost of maintaining a rigorous Quality Management System.	"Cross - cover from corresponding site (i.e. CAH cover for DHH) "Cross cover from other departments where relevant and safe "Additional staff in training (two staff due to complete training in the next six months) "Additional support staff through the 24 hour period "Agency support staff These controls have been enabled service provision to continue but they are insufficient to reduce the risk to an acceptable level "Additional Agency Biomedical Scientists - very limited supply (if they can be sourced at all) and likely to be off framework. Introduce additional risk - in terms of competency and experience. "Transferring Blood Bank samples to Craigavon - but there would be an unacceptable delay "Remote release of blood - unacceptable in a Major Haemorrhage scenario "Routinely providing remote Chemistry Biomedical Scientist support from the CAH site with support staff running samples on the DHH site	HIGH	

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4049	ACUTE	07/08/2019	Provide safe, high quality care	Due to the staffing situation in Maternity there is an inability to accept Inutero Transfers from other Units for Neonatal Cots	The Trust is currently intermittently unable to accept inutero transfers for neonatal cots from other units. This is due to current maternity staffing level difficulties. Possible harm to mothers and babies who require a neonatal cot due to specific health needs and imminent delivery, therefore requiring transfer to this specialised facility. Potential for undue distress to baby and parents.	Continual monitoring of the staffing situation to make best use of existing resources. Transfer accepted when staffing levels permit.	16/03/2021- Ability to accept inutero transfers remains limited due to staffing and capacity ongoing recruitment continues, increased pressures to accept transfers due to regional neonatal capacity. Will continue to monitor Jun20 continue to monitor Dec19 Specific focus on recruitment - recruitment fayre undertaken and appointments made awaiting registration within next year. Retention of staff also focus within division to retain and recruit staff	MOD
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	18/08/2021- no change core mandatory training monitoring monthly but Face to Face training still an issue due to social distancing and reduced staff numbers per session. 01/06/2021- provisions have been made to allow staff to do training in their own time and to receive overtime payment to do so. 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	MOD
4189	ACUTE	08/12/2021		Overcrowding in CAH Pharmacy Dept	The Overcrowding in CAH Pharmacy Dept risks Difficulties maintaining safe spacing of staff to comply with Covid guidance to prevent infection spread. Manual handling risks to staff due to cramped storage and working conditions. Inability to obtain an MHRA Wholesale Dealer Authorisation (WDA) which limits the Trust contribution to the waiting list initiates planned as part of post Covid rebuild and recovery of services. The CAH Pharmacy department was remodelled in the early 1990s when the total number of staff working in the department was 31. Further work was completed in 2011/12 to modernise the department and allow the installation of a dispensing robot, however this did not increase the footprint of the department. Currently 195 staff work out of the same CAH Pharmacy space, resulting in the overcrowding issues listed in the potential for harm section above. The lack of storage space within the department results in the pharmacy stock being stored at high level, on the floor and in offices. As a result there are manual handling risks to staff and it is not possible to meet the minimum requirements to obtain and maintain a MHRA WDA. There are difficulties spacing staff in the dispensary to main covid measures. Screens have been fitted however these hamper the flow of work in the section.	A number of clinical staff (30) have been relocated to an office on the Admin Floor. This has reduced but not solved the staff crowding issue and it also hampers efficiency of working between them and the dispensary. Screens have been fitted between workspaces to help with the IPC risk however these hamper the flow of work in the dispensary section. Manual handling risk assessments completed and implemented as required. Future expansion of the pharmacy has been discussed with the Estates team - with a plan to relocate the Dietitians so that the old aseptic suite could be knocked through into those offices and also part of the back corridor outside the kitchens to be incorporated into the pharmacy footprint. This would increase the space available. New build/extension of the pharmacy onto the grass area outside the pharmacy admin office - discounted due to lack of funding for such a scheme.	08/12/2021- further expansion is required but no date confirmed. Plans to be drawn by Estates student.	MOD
3663	ACUTE	29/04/2015	Provide safe, high quality care	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assessement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to retain a modular CT Scanner in DHH.	03/12/2021 - Currently awaiting feedback from DOH regarding the IPT. The provider is querying if the lease will be extended by March 2022 as they have other third parties interested in the unit. 14/09/2021- Medium term plan to build a CT suite in DHH with 2x x-ray machines and one MRI. Finance and Planning have asked the Regional Imaging Board. Clarification has been sought but not yet received. Trust running at risk even without funding March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to be updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3957	ACUTE	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS	20/09/2021- unable to secure acute physician for DAU. 18/08/2021- COW model in place and patients reviewed daily. New patients discussed at daily handover at 8.30am and also weekend handover at 12.45 on Fridays. 07/06/2021- There are 5 substantive Consultant post in DHH across Med/ Stroke/Respiratory and Gastroenterology. 4 out of 5 contribute to the 1:8 medical rota. The remaining posts are filled by Locum Consultants. there is a 1:12 weekend/bank holiday rota which is supported by colleagues from OPPC. There is now a substantive 1:8 middle tier rota. From August 2021 there will be a full middle tier out of hours rota with no locum's. At weekend/bank holidays there is an additional Consultant, registrar and SHO who work from 09:00-14:00 hours. 24/02/2021- review of medical staffing on DHH site currently taking place. E- Req in system for specialties. 13/05/20. Zoning introduced but issues identified with this system. Audit carried out. Medical rota is sufficient to provide daily senior review. 24.06.19 No change. Zoning introduce needs evaluated. Review workforce available.	MOD
3929	ACUTE	12/12/2017	Provide safe, high quality careMake the best use of resources	Declaratory Orders for patients who lack capacity	Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of liberty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes obo individuals without capacity.	Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievable not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision.	30.07.19 There will be partial implementation of Mental Capacity Act NI on 1 October 2019. This may alleviate some of the declaratory orders asTrust Authorisation panels are being set up. 7.3.18 Risk remains unchanged	LOW
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW
4099	ACUTE	11/08/2020	Provide safe, high quality careMake the best use of resources	Neurophysiology- Due to insufficient staffing levels risk of occasional department closure days	Occasional risk to inpatients as no staff to provide service. There is the occasional inability to provide an inpatients service for EEG. EEGs are an aid to diagnosis. there is no on call/weekend or bank holiday cover	As a rule x2 staff not permitted to have annual leave at the same time however in exceptional circumstances this can occur when staffing levels are insufficient. Change the working pattern for x1 P/T member of staff which will reduce lone working days and therefore reduce risk of closure days	03/12/2021 - A Band 5 MTO commenced in October which alleviates some of the departments staffing pressures. 14/09/2021- Lead has now retired. A new interim lead has been appointed. Continue to train 2 staff- progressing through the 2 year training programme currently. March 2021 - Lead due to retire in August 2021. 1 member of staff has taken a career break for 2 years. Another member of staff will shortly be going off on maternity leave. The remaining member of staff will increase their hours and be assisted by the trainee posts. Staff levels should be 3.22WTE	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust by DHSSPSNI	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbidity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, loss in confidence / negative publicity Service Capacity As of 30 June 2020 there are 2131 standards and guidelines identified on the Trust's S&G database. Of these 1622 were applicable to Acute Services (78%) Lack of suitable IT Recording System Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system. In 2017/18 BSO gave the WHSCT significant funding to support a pilot of a modified Sharepoint system that would in the first instance record and track the implementation of NICE guidelines and Technology Appraisals. The Regional NICE Managers forum acted as the project group and whilst the scope of the project was not embracive of all the types of standards and guidelines endorsed regionally it was at least a starting point. The ultimate vision was that upon completion this system would then be shared across the HSC (including the HSCB/DHSSPNIS) to provide a harmonised / standardised system that would provide effective monitoring and traceability of guidance implementation. Unfortunately this pilot has not yet yielded these desired outcomes and in the interim the SHSCT continues to use an excel spreadsheet whose functionality falls well short of service requirements. Discussions have been undertaken with Mark Toal to seek out other possible IT solutions - these have included Qlikvue / the new Datix S&G module (which remains in prototype) / Q Pulse. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents where data saving has not occurred due to capacity issues. As a safe guard a system back up is saved on a weekly basis. There is also the added frustration that if any of the directorate governance teams are using the shared excel spreadsheet no-one else can use it. This can impact on staff not being able to carry out their administrative duties on the system at that point in time. This is inefficient and there is a risk of a lack of timely data capture. S&G Backlog S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implementation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified Within Acute Services a directorate S&G forum has been established - inaugural meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implementation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implementation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administration processes maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance	24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less 10/08/20 - Risk reviewed and description of risk updated. 02/06/2020 standards still difficult to achieve with limited funding, staffing and equipment 09.03.2020, 5.12.16 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed. Due to ongoing work pressures Phase 1 (01/10/2015 to current date) and Phase 2 of the backlog review (all S&G issued from 01/04/2007 - 30/09/2015) will be undertaken from 01/01/2018 to 31/03/2018 has not been progressed as planned and will continue during 2019/20 workplan. Phase 1 (From 2017 to current date) has been completed. Phase 2 of the backlog (from April 2007 - Sept 2015) remains outstanding.	LOW
4090	ACUTE	09/03/2020	Provide safe, high quality care Make the best use of resources Improving Health and Wellbeing	Prescribing of valproate not in line with valproate Pregnancy Prevention (PREVENT) Programme	Valproate is associated with teratogenic risks (congenital malformations, neuro-developmental disorders) in children exposed to valproate during pregnancy. Children exposed to valproate in utero are at increased risk of lower IQ and of risk of developing neurodevelopmental disorders. In 2017 and 2018 the DoH issued a number of circulars in relation to the risks of prescribing valproate in women of childbearing age (HSC (SQSD) 19/17, HSS (MD) 8/2018 and HSS (MD) 27/2018) highlighting new resources to support the safety of girls and women who are being treated with valproate. Among the recommendations to Trusts was the requirement to develop an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care. In addition, all relevant resources are to be embedded in clinical practice for current and future patients, by revising local training, procedures and protocols.	Currently valproate is prescribed to a small number of patients under the care of SHSCT Consultants, all of whom have been made aware of the various DoH circulars and associated recommendations. A number of SHSCT Consultants sit on the Regional Valproate Group, chaired by PHA. The Trust has also recently established a task and finish group to address outstanding risks in relation to the recommendations in the circulars, namely the systemic identification of all girls and women who may be prescribed valproate. The Drugs and Therapeutics Committee also monitors the implementation of the recommendations within the circulars through the Medicines Governance Pharmacist, also a member of the Regional Valproate Group.	9 March 2020 Consultants manage their own registers of girls and women on valproate.	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4007	ACUTE	28/02/2019	Provide safe, high quality care	Risk that patients receive inappropriate care due to the misuse of point of care testing	Risks arise from the inherent characteristics of the devices themselves and from the interpretation of the results they provide. They can be prone to user errors arising from unfamiliarity with the devices. Patients are at risk of inappropriate treatment as a consequence of inaccurate results. Individuals are sharing passwords/barcodes in contravention of Trust procedures and good governance. Equipment is not being properly maintained which puts equipment at risk of malfunction leaving patients vulnerable. Internal Quality Control review and regular audits have stopped due to a lack of resources. There is a lack of Assurance around temperature control of reagents etc. which has the potential to influence the results. Patients are at risk of receiving an inaccurate test result and receiving inappropriate treatment or not receiving treatment when it is actually required. Patients could come to serious harm / death. Staff are at risk to Trust sanction or Professional body sanction, litigation, dismissal. Trust is at risk of litigation due to improper use of devices. Trust is at risk of litigation due to improper treatment based on inaccurate results or misinterpretation of results.	Training is available on all devices. Quality controls are available. DATIX web is available to report and monitor any incidents. Staff are given unique barcodes to operate Trust equipment where they are deemed competent to do so. It is the responsibility of all staff issuing a POCT device to end users to ensure that the user is adequately trained and competent to use the device.	20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing policy which will go live in July and will be disseminated to all AD'S and appropriate leads. May 2021 Equipment controller training will re-commence post covid as an online learning via Sharepoint. The powerpoint presentation will be uploaded in the coming weeks and will include a declaration form which will be signed by trainees upon completion. Feb20 Patient safety and quality manager mitigated the risks associated with improper use of Glucometers	LOW



Southern Health and Social Care Trust

Summary Corporate Risk Register

November 2021

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register is linked to the relevant Corporate Objectives contained within the Trust's Corporate Plan 2017/18 – 2020/21 as detailed below:-

Corporate Objectives

- 1: Promoting safe, high quality care.
- 2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

The overall risk score is based on the cumulative assessment of the likelihood and impact of each risk trigger as summarized in the Risk Assessment Matrix below:

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

Likelihood Scoring Descriptors	Impact (Consequence) Levels					Total
	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)	
Almost Certain (5)	Medium	Medium	High	Extreme	Extreme	25
Likely (4)	Low	Medium	Medium	High	Extreme	20
Possible (3)	Low	Low	Medium	High	Extreme	15
Unlikely (2)	Low	Low	Medium			10
Rare (1)	Low	Low	Medium			5

Risks are scored for inherent risk, residual risk and target level of risk. Each is defined below.

Inherent Risk is the current risk which exists before any management controls are applied. This enables decisions to be made about resources and the level of priority given to managing a risk.

Residual Risk is determined as the level of risk that remains after existing controls have been actioned. The residual risk gives an indication of how effectively a risk is being managed by existing controls.

Target Level of Risk is the level of risk that management has set as its target level of risk.

SUMMARY OF KEY DEVELOPMENTS

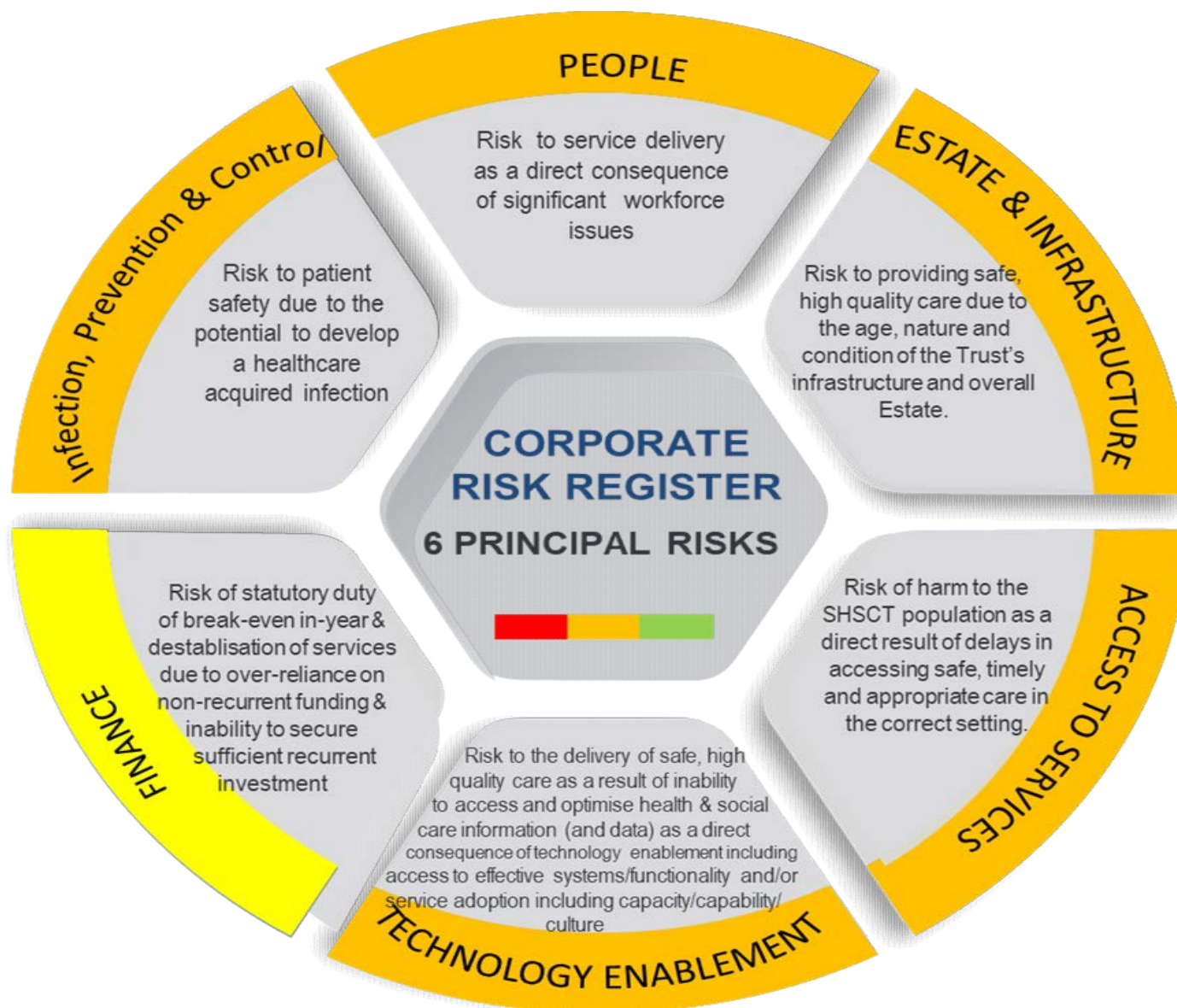
SMT continue to focus on building a more agile Corporate Risk Register around six principal risk areas. This document provides a summary of the risks and details the key actions planned by the SMT to manage these risks and achieve progress against the Trust's corporate objectives.

The high level risks identified in the Corporate Risk Register are underpinned and informed by risk triggers overseen at an operational level within Directorates and are captured in a supplementary document.

CHANGES TO THE REGISTER

New risk 1.5 'Risk to the management of the Trust's statutory responsibilities under the Mental Health (NI) Order 1986 due to insufficient numbers of Approved Social Workers to provide a robust rota covering emergency assessments for detention'

The diagram overleaf provides a snapshot of the risks on the Corporate Risk Register



1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care					Lead Risk Owner
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.					Director of HROD
Original Risk Rating	Key risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
15 (5 x 3) HIGH	1.1	Risk to the consistent provision of high quality, safe medical care due to medical workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	15 (5 x 3) HIGH	September 2021 to December 2021 * Further Locum Oversight meeting (2nd meeting) for Medicine/Unscheduled care to take place 1 October 21. Work in meantime to progress review locums in use and possible alternatives to be explored. Work will commence to review dataset for other service areas to identify trends and areas for action within next 3 months. Actions from the meeting will drive future direction of the meetings and workforce planning. * Metrics have been produced for Medicine/ED to highlight areas of high locum usage and high levels of rate escalation. Over the next 3 months; we will aim to expand these metrics to illustrate trends and patterns in other service areas also. Entire locum infographics for Trust due 1 October 21 *Workforce planning meetings for Medicine CAH and DHH took place 25.6.21. Workforce planning papers have been developed for Medicine CAH and Medicine DHH & need to be fed into IPT bids to seek additional funding to support more consultant and SAS posts. Workforce paper has also been developed for ED and is being reviewed. *Over the next 3 months there will also need to careful review of new service models, how additional PA's will fit into staffing models and consideration of more cost avoidance measures that can be taken to avoid locum spend, such as exploring further opportunities for MTI routes and Clinical Fellow models. *Regional Locum rates proposal paper has been presented to regional HRD's. Plan over next period will be to present paper and presentation to the regional Medical Directors (1st October 2021) and for each Trust to share concept with their SMTs. (shared on 6th July 2021) *Surge workforce planning for further surges. *Rotas at Risk summary has been updated to reflect current situation across service areas and will be shared for discussion	9 (3 x 3) MEDIUM
	1.2	Risk to safe, high quality care due to a high volume of medical locum engagements for different periods of time with varying levels of experience/training and often in hard to fill posts.			
	1.3	Risk to the consistent provision of high quality, safe nursing care due to nursing and midwife shortages and vacancies across all Directorates, and high nursing agency usage (exacerbated due to Covid-19)		September 2021 to December 2021 *Resourcing dashboards for each acute ward, in first instance, to be finalised - vacancies, ML, SL, bank / agency, new starts / leavers along with heatmap of red areas to enable targeted recruitment and retention action plans to be developed. *Pilot of new Exit Interview approach *Agency reduction taskforce group to be established for acute services in first instance. *Revised N&M Workforce Action Plan to be finalised with Year 2 actions (post covid)	
	1.4	Risk to staff engagement, morale and health & wellbeing due to workforce capacity / demand pressures. (exacerbated due to Covid-19).		September 2021 to December 2021 *Development of a People Strategy informed by staff engagement initiatives for consultation - Trust Board workshop 7th September 2021 - continued *Commencement of new OH Consultant Psychologist on 6th Sept - and review of staff support programme for Covid pressures *Progression of Long Covid business case for pilot staff service in OH *Development of a Health and Wellbeing Framework for 2021 - 2024 linked to the People Strategy - continued. *Roll-out of Creating a great place to work initiative (focusing on health and wellbeing, relationships and behaviours) supporting all our people, our managers / team leaders and teams - continued. *Initiatives focusing on supporting workforce groups - disability, age and race to include establishing Minority Ethnic Staff Network. - continuing *Draft a proposal reviewing approaches to staff recognition and appreciation including Staff Excellence Awards. *Focused efforts on increasing appraisal compliance. *(Medical Staff) Develop a Rota at Risk Matrix for sharing with AD and AMDs to indicate junior doctor rotas that are at risk of reduced morale due to high bandings, high intensity and /or unattractive rota cycles to facilitate discussion on actions to be taken - once rota changes settle in August this can be implemented.	

1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care					Lead Risk Owner
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.					Director of HROD
Original Risk Rating	Key risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
20 (5x4) Extreme	1.5	Risk to the management of the Trust's statutory responsibilities under the Mental Health (NI) Order 1986 due to insufficient numbers of Approved Social Workers to provide a robust rota covering emergency assessments for detention.	20 (5x4) Extreme	September 2021 to December 2021 *All available ASWs 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. * Release of ASW availability from within existing resources. *Consider additional payment for ASWs with management responsibility who cannot be afforded any easement. *Improve Communication with Core Team line managers. Communication with ASW's. *Continue to promote the ASW programme particularly across OPPC / CYPs	12 (3x4) HIGH

REVIEW HISTORY

Review Date:	Nov-21
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Summary of SMT Discussion:

MEDICAL:

- * **Establish a bi-monthly Medical Resourcing Oversight Group** chaired by DMD Workforce with each AD/AMD to review unfilled medical vacancies and locum usage by specialty on monthly/bi-monthly basis to aid improved workforce planning. Aim to convert long term Agency Locum doctors into vacant substantive where possible to improve fill rates in permanent posts to improve sustainability.
- UPDATE** *First Oversight Medical Capacity Buiding Group held 25/06/21 with Medicine & Unscheduled care. Infographics and summary metrics presented to help highlight costs and risks within the service areas. Next Meeting scheduelld 1 October 2021 (Has been some delay due to Covid surge and leave/absence)
- * **Participate in regional recruitment campaign to recruit a further 10 Physician Associates in 2021 to posts accross the service to double our PA workforce.**
- UPDATE*** Final decision to go for a further 8 PAs; 2 in Mental Health (Bluestone x 1, Dorsy x 1) and 6 in Acute; specialties to be decided.
- * **Work with Royal College to determine feasibility for more MTI posts to fill some of our shortage in Junior Doctor posts and /or develop proposals for new Clinical Fellow posts to fill vacant junior doctor posts on more affordable basis to locum in high use areas such as Medicine CAH, Outlyers Ward, Urology/Surgery for agreement and possible recruitment by August 2021.**
- UPDATE:** Clinical Fellows have been recruited for Medicine with the hope we could appoint 12 - with 7 successsfully appointed. Clinical Fellows were also appointed in ED as per their previous model - with 6 doctors appointed for August 21. Currently we are recruiting Clinical Fellows into Urology with 18 applicants being interviewed for 2 posts. 2 appointments made. MTIs - There are currently 2 in post in Medicine DHH. They are in Cardiology DHH and Diabetes/Endo DHH who are working successsfully on the middle tier out of hours rota. They are in post until 2022 and 2023 respectively. One of these MTI doctors has indicated they want to stay with us long term 3-4 years and we are currently exploring transfer to Tier 2 visa to faciliate this.
- * **Paper submitted which has been agreed regionally which sets out proposal for consistency in locum rates to the DOH for consideration of new circular/instruction to Trusts. Develop a Principles paper summarising the above paper for sharing with the BMA for their agreement to broad principles.**
- UPDATE:** Paper written by SHSCT has been shared regionally and a presentation given to regional HRD's on 11th June. Shared at SHSCT SMT early July and a further date has yet to be agreed to share with the regional Medical Directors (first date was cancelled due to summer leave).
- ***Surge workforce planning for any potential Autumn surge**
- UPDATE - Underway**

NURSING:

1. People

Corporate Objective Alignment: Promoting Safe, High Quality Care				Lead Risk Owner
Risk: Risk to the delivery of safe, quality and timely care as a direct consequence of significant workforce issues.				Director of HROD
Original Risk Rating	Key risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating

***Resourcing dashboards for each acute ward, in first instance, to be developed - vacancies, ML, SL, bank / agency, new starts / leavers along with heatmap of red areas to enable targeted action plans to be developed.**

UPDATE: All data has been collated and is currently being prepared into dashboard style for presentation for Nursing & Midwifery Steering Group for ongoing informed discussion on actions to be taken with regards recruitment and retention activity in targeted areas.

***Agency reduction taskforce group to be established for acute services in first instance.**

UPDATE: Not yet established due to acute covid pressures and workforce challenges

***Bank / Agency review for each ward to be undertaken along with appropriate authorisation of critical shift payment scheme in order to control expenditure.**

UPDATE: Dashboards contain bank / agency expenditure and therefore will facilitate review of usage. Monitoring of Covid shift payment scheme now in place with weekly reporting to DOH required.

***Revised N&M Workforce Action Plan to be finalised with Year 2 actions (post covid)**

UPDATE: Corporate nursing staff diverted to supporting covid surge pressures - no progress in last 3 months due to other workforce pressures

***Midwifery Workforce Plan Developed, and key posts advertised / recruited**

UPDATE: in place

***Theatres Workforce Plan Developed, and key posts advertised / recruited.**

UPDATE: in place - investment through Delivering Care monies will facilitate a number of new posts.

MORALE:

***Development of short term (due to vacancy gap at Consultant level) and medium to long term psychological support plan post Covid-19 with bid for E&G funding to be put forward for consideration.**

UPDATE - Case for Band 8a, Band 7 and Band 3(pt) was presented to E&G committee in June - approval obtained. Recruitment to commence in September.

***Development of a People Strategy informed by staff engagement initiatives for consultation.**

UPDATE - Engagement with Trust Board workshop scheduled for 7th September 2021 re draft strategy.

***Development of a Health and Wellbeing Framework for 2021 - 2024 linked to the People Strategy.**

UPDATE- key themes out to H&WB group members currently - final draft to Steering Group in Sept meeting.

***Formulate proposal for HSC Leadership Centre to commission baseline review of leadership development across the Trust and development of leadership strategy.**

UPDATE - Meeting with Will Young to set context took place on 10th June. Review likely to commence in October.

***Development of our medical leaders - 'Nexus' programme for AMDs and CDs and 'Navigator' Programme for new consultants and SAS doctors.**

UPDATE - underway with Navigator programme. Nexus - to be reviewed following first cohort.

***Initiatives focusing on supporting workforce groups - disability, age and race to include establishing Minority Ethnic Staff Network.**

UPDATE - Minority Ethnic Staff Network now established. Disability training in place for HROD as pilot approach for wider roll out to managers.

APPROVED SOCIAL WORKERS:

Risk remains extreme due to sick leave / retirements / special circumstances due to covid and F2F contact not permitted. Capacity to be released from core teams remains challenging as all teams are struggling with staffing .

UPDATE - Full time ASW post has been advertised – this will significantly improve situation

ASW bank has been established

Any change to risk rating following review?

No

2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources					Risk Owner
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.					Director of Finance, Procurement and Estates
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
16 (4 x 4) HIGH	2.1	Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate.	16 (4 x 4) HIGH	* Plans to improve Equipment Management function The Equipment Management Committee (Cross Directorate) held its first meeting on 1.6.2021 and subsequent meetings are held quarterly to drive forward an overall body within the Trust in relation to equipment management. Sharepoint has also been utilised to provide a comprehensive outline resource under Estates Medical devices. The Estates Equipment Manager has also taken over the Trust's equipment priority list from Acute Directorate to provide a Trustwide list of equipment needs which is presented to Capital Allocation Group for funding allocation, when available. *Development of Annual Capital Plans via Capital Allocation Group * Ongoing submission to DoH to influence 10 Year Capital Strategy Director of Finance and Estates is a member of the DoH Strategic Capital Development and Estates Oversight Group, one of the main objectives is to provide strategic oversight, leadership and direction setting for capital development and estates related functions in pursuit of regional service delivery objectives. Director of Finance and Estates met with DoH officials to discuss a range of potential schemes that would facilitate improved ventilation, increased sanitary facilities at ward	9 (3 x 3) Medium

2. Estate and Infrastructure

Corporate Objective Alignment:					Risk Owner
Promoting Safe, High Quality Care; Improving our services; Making best use of resources					Director of Finance, Procurement and Estates
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.					
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
				levels of prioritised areas. £8.7m capital investment has now been secured for these schemes to complete March 2022 Develop estate to provide more single side room provision, toilet facilities, improved ventilation Develop estate to provide facilities that meet the requirements for social distancing	
	2.2.	Risk of significant disruption to clinical services and clinical risk due to loss of electrical power (LV) to main Craigavon Area Hospital block		Further funding of £1.5m has been secured for 2021/22 allowing for further improvement. Works as part of the overall project will continue (subject to funding) over 2022-2024. The major issue of fixed breakers was addressed in 2020/21 and a scheme is currently underway on site to address the other issues in the Electrical infrastructure system including provision of larger transformers, generators and replacement switchboards.	

2. Estate and Infrastructure

Corporate Objective Alignment: Promoting Safe, High Quality Care; Improving our services; Making best use of resources					Risk Owner
Risk: Risk to providing safe, high quality care due to the age, nature and condition of the Trust's infrastructure and overall Estate. These factors also limit our ability to ensure robust infection control measures and social distancing.					Director of Finance, Procurement and Estates
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
	2.3	Risk to the Trust's potential to respond adequately to Covid-19 and other transmissible organisms due to the inadequate number of single rooms across both acute hospitals to deal with the volumes of infectious patients requiring admission and care		£8.7m capital investment has been secured for schemes to facilitate improved ventilation, increased sanitary facilities and storage facilities and storage at ward levels - these schemes to be completed March 2022. These works will assist in addressing some of the deficiencies in wards, however, due to the design of wards i.e. based mainly in 4 and 6 bed wards, issues will not be fully addressed until redevelopment of wards to modern design standards has been achieved. Until the redevelopment can be achieved (a number of years away), the Trust will bid for further annual funding to take forward a series of interim schemes to continue to try and address risks in relation to nosocomial spread including negative ventilation rooms, new ward accommodation and ventilation upgrades to risk areas.	
REVIEW HISTORY					
Review Date:		Nov-21		Risk Rating after review: High / Medium / Low	
Summary of SMT Discussion:					

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					Risk Owner
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					Operational Directors
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 - 6 months	Target Risk Rating
16 (4 x 4) HIGH	3.1	Clinical risk associated with delay in accessing planned services for assessment, diagnostics and treatment in accordance with clinical need	16 (4 x 4) HIGH	Regional clinical prioritisation of operative / theatre capacity to ensure available capacity directed to those most in need on an equitable basis. Continual review of service waiting lists to ensure those with greatest need are allocated capacity and <u>routine</u> users are offered access to available capacity on a chronological basis. Areas of risk will continue to be escalated to Directorate Senior Management Team meetings, SMT and HSCB. Opportunities have been achieved and continue to be identified to seek to increase capacity via sourcing of additional capacity, both internally and externally, via Independent Sector. Continue to scope Innovative approaches/new ways of working to service delivery. Development of Service Delivery plans for core services to seek to increase capacity back to pre-Covid levels.	9 (3 x 3) MEDIUM

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					Risk Owner
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					Operational Directors
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 - 6 months	Target Risk Rating
	3.2	Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)		ED refurbishment to create additional space and avoid over-crowding and resultant risk	
				Review of current GP OOH provision with temporary consolidation of current bases to reflect current available resources	
	3.3.	Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health or Paediatric services		No More Silos Local Implementation Group will focus on development of alternatives to inpatient, improvement on control room functions/oversight and focus on flow and discharge	
				Development of Integrated Winter/Surge and Service Delivery planning and refresh for Business Continuity plans	
	3.4	Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domiciliary care, day care centres etc.)		Seek to increase capacity in IS for day centres	

3. Access to Services

Corporate Objective Alignment: Promoting Safe, High Quality Care					Risk Owner
Risk: Risk of harm to the SHSCT population as a direct result of delays in accessing safe, timely and appropriate care in the correct setting.					Operational Directors
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 - 6 months	Target Risk Rating
	3.5	Risk to the ongoing supply of medicines due to EU Exit/NI Protocol grace period ending on 31st December 2021, when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain (GB) will not, with implications for both the supply and regulation of medicines in NI. Key issues include: • Medicines licensing; • Medicines supply chain • Medical Devices.		Formation of a DoH led NI Protocol/EU exit medicine policy programme to progress related projects, including at an operational level, to ensure there is a minimal impact to NI customers and suppliers in relation to medicine availability, supply and pricing. There is also a need to ensure that there is equitable access to new medicines in line with GB. The programme will link with the EU Exit Transition Unit, responsible for providing specialist advice on medicines and pharmaceutical issues and for the development of medicine policy to address issues related to EU Exit/NI protocol.	

REVIEW HISTORY

Review Date:	Nov-21	Risk Rating after review: High / Medium / Low
Summary of SMT Discussion		

4. Technology Enablement

Corporate Objective Alignment: Promoting Safe, High Quality Care				Risk Owner
Risk: There is a risk to the delivery of safe, effective, high quality care as a result of inability to access and optimise health and social care information (and data) as a direct consequence of technology enablement (including access to effective systems/functionality and/or service adoption including capacity/ capability/ culture)				Performance & Reform and Operational Directors
Original Risk Rating (Likelihood x Impact)	Key Risks	Current Risk Rating (Likelihood x Impact)	Summary Priority Actions planned for the next 3 - 6 months	Target Risk Rating
16 (4 x 4) HIGH	4.1	16 (4 x 4) HIGH	Regional IT Policies have been developed and will replace local Trust policies. These will be tabled at next Policy Scrutiny Committee and made available on Sharepoint Trust wide by December 2021 A Regional simulated cyber incident is planned involving the COVID related Regional systems in November 2021. learning will be shared Regionally in December 2021. Regional IG working group to be established to take forward the review of data flows from HSC/Partner organisations to mitigate further risks of compromise from connected organisations, based on learning from the QUB Cyber incident. The CDIO has not yet established this meeting but it should be established by December 2021 The Trusts Cyber oversight Group has agreed that simulated cyber incidents need to be undertaken in the Trust to raise awareness of the potential impact to improve business continuity planning. The Group has also agreed that videos and other visual tools to raise the potential impact need to be made available to front line services. This will be ongoing over the next 6 months - aim to achieve by April 2022 There are 21 Cyber Protection Projects from Regional funding and Internal Audit Recommendations but not enough staff to progress the implementation of this software. 6 projects have been prioritised this year for achievement by end of March 2022. External 'contract' resources are also being sourced to help implement other projects. A plan will be in place for these projects by December 2021. Funding bids are being made to DHCNI for additional resources. A strategic Cyber Business case for the Region is planned for final draft in January 2022 which will include funding for recurrent resources. A governance structure for Cyber was agreed on 22nd October 2021 in the Trust. The Regional Cyber Security Programme Board has been paused awaiting a replacement SRO. This has now been agreed and meetings will resume in November 2021. Trust representation on this Regional Group has been agreed. The local IT service desk team require better knowledge of what might indicate a cyber threat. Playbooks will be purchased to help with learning by February 2021 Regional email security gateways are not properly configured to catch all spam and cyber threats entering the Trust. BSO are working with suppliers to resolve this aiming to have resolution by January 2022 Elearning on cyber security is mandatory but uptake is below 50%. Promotion of the need to complete this training to raise user awareness has commenced with the aim of increasing this to 60% by the end of December 2021	9 (3 x 3) MEDIUM
	4.2		Resources in the Trust are very low to facilitate the Encompass agenda. Trust has agreed to go at risk with a number of posts. These should be in post by end of February 2022. Trust has agreed appointment of CCIOS in each professional group. Funding is being negotiated with the Encompass Programme. Postholders should be in post by March 2022. Medical staff engaged as subject matter experts have expressed concern about capacity to engage fully on the Encompass programme. Proposal is being developed for PAs to address this. To be complete by December 2021	
	4.3		Continue to develop service Business continuity plans and regular testing of plans (ongoing across the Trust alongside plan to increase user awareness per 4.1) All new IT related procurement is considered and approved at the Technical Design Authority (TDA) to ensure appropriate due diligence has been carried before procurement and connection to the Trust's network. TDA meetings scheduled on a monthly basis. (on-going) External resource commissioned to carry out a review of the Trust's backup strategy. To be completed by Dec 2021 (Telefonica) Cyber security team continue to monitor threats through cyber monitoring software and make contact with services where devices or hardware is identified as security risk (ongoing). This is shared at Cyber Oversight Meetings for user awareness	

REVIEW HISTORY

Review Date: Oct-21

Summary of SMT Discussion:

Risk Rating after review:

High / Medium / Low

5. Finance

Corporate Objective Alignment: Making best use of resources					Risk Owner
Risk: Risk of financial stability and breach of statutory duty of break-even in-year .					Director of Finance, Procurement and Estates and all Operational Directors
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Additional Actions and Timeframe	Target Risk Rating
12 (4 x 3) MEDIUM	5.1	Risk of breach of statutory duty of break-even in year	12 (4 x 3) MEDIUM	• Indicative allocations for the financial year 2021/22 have been released to Trusts, however, work continues with HSCB and DoH to understand the potential implications of the budget settlement on Trusts. Once further clarity is received in relation to the actual budget for the Trust, DoF will prepare an updated briefing for SMT and Trust Board. It is expected that this will be around September/October 2021. • Finance will complete a mid-year hard close, the purpose of which is to inform the finance strategy for the remaining months of the financial year. This is good practice. The hard close will be as at September 2021. Results from this will be known in November 2021 and findings from this will inform forecasts for the remainder of the financial year. • During 2021/22 The Director of Finance, prepared an update on “Return to Balance” – this document reminded all of the Trust’s statutory duty to break-even and that as a Trust we do not have the authority to spend in excess of the budget. It set out the key findings and recommendations from the Acute phase and also sought approval to move to the second phase which is within Mental Health and Disability. All recommendations were accepted and approved and work has now commenced within Mental Health and Disability. It is expected that this work will be reported on in Quarter 3 of the financial year.	6 (3 x 2) LOW

5. Finance

Corporate Objective Alignment: Making best use of resources					Risk Owner
Risk: Risk of financial stability and breach of statutory duty of break-even in-year .					Director of Finance, Procurement and Estates and all Operational Directors
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Additional Actions and Timeframe	Target Risk Rating
	5.2	Risk of destabilisation of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment.		• Director of Finance is continuing to work with HSCB and Department of Health in relation to the capitation inequity gap. To date this work has been successful in ensuring that the Trust has not had to make £25m of recurrent savings. In addition the "Return to Balance" work identified a range of current expenditure areas that do require funding support and discussions have commenced with HSCB re same. • Director of Finance sought DoH approval for capitation to be discussed at the Strategic Finance Forum in November 2019 – a healthy debate took place and DoH agreed that whilst they had endeavoured to address some of the imbalance by not applying a savings target, the gap remained. Work on the equity gap continues with HSCB/DoH	

REVIEW HISTORY

Review Date:	Nov-21	Risk Rating after review:	High / Medium / Low
Summary of SMT Discussion:			

6. Infection, Prevention and Control

Corporate Objective Alignment: Promoting Safe, High Quality Care					Risk Owner
Risk: Risk to patient safety due to the potential to develop a healthcare acquired infection. This risk is paired with the Trust's aging infrastructure risk					Medical Director
Original Risk Rating (Likelihood x Impact)	Key Risks		Current Risk Rating (Likelihood x Impact)	Summary Priority Actions Planned for next 3 months	Target Risk Rating
12 (3 x 4) HIGH	6.1	Risk to patient safety due to the potential to develop a healthcare acquired infection	12 (3 x 4) HIGH	Review and update of IPC/AMS Strategy	6 (2 x 3) MEDIUM
				Develop audit team to provide assurance on all aspects of IPC	
				Develop a case to further develop an MDT infection service	
				Further develop diagnostic capacity to facilitate early diagnosis to facilitate isolation and timely appropriate treatment to prevent AMR	

REVIEW HISTORY

Review Date:	Nov-21	Risk Rating after review: High / Medium / Low
Summary of SMT Discussion:		

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4141	10/03/2021		Trustwide	Acute AHP Accommodation	Pre-covid space was a challenge within Acute AHP departments especially in relation to equipment storage. IPC recommendations in line with COVID 19 has had a significant impact on Acute AHP accommodation in both Acute sites: Physiotherapy CAH - department is shared space with outpatient MSK services (OPPC) to facilitate doffing the Gym including the Acute T&O gym has been out of use and with outpatient services downturning/stopping Acute staff were able to branch out into outpatient space to facilitate safe distancing in the department. This also required a significant decant of physiotherapy equipment to various storage areas around the Acute site. With the Doffing move to basement the gym will be reinstated as will all equipment and as MSK outpatient Physiotherapy services resume Acute staff will be displaced yet again and there is no solution to ensure safe distancing among this clinical team going forward. Team need to be onsite and responsive to the acute clinical need at ward level to ensure patient flow and improved patient outcomes. No Gym or Hydrotherapy space for rehabilitation of our complex patients. Need IPC guidance re: how this may progress alongside outpatient use T&O Physiotherapy - due to zoning and donning/doffing routes the T&O team were fully displaced and currently are allocated to rooms in outpatient area CAH (dental) temporarily. No access to T&O Gym space for intensive rehab of patients Occupational Therapy/Speech & language Therapy CAH - OT/SLT teams moved 3 times to facilitate Covid 19 - OT are now back in original department area but have had to displace SLT staff to enable social distancing in the department. All equipment also relocated to allow staff to branch out into all available space including the pre-covid assessment rooms. The department sits on main thoroughfare of the acute site therefore has a large volume of staff and patients flowing through it and also has outpatient fertility services alongside it as well as facilitating outpatient T&O and Rheumatology hand therapy Speech & Language Therapy CAH displaced to upstairs in Ramone building with additional space provided on the Admin floor as a temporary solution due to the need to safely distance staff. Long term solution required Physiotherapy DHH - department is shared space with outpatient MSK services (OPPC). To facilitate donning the Gym has been out of use and with outpatient services downturning/stopping some of this area has also been taken up by PPE storage. Acute staff have been able to branch out into outpatient space to facilitate safe distancing in the department as able. This also required a significant decant of physiotherapy equipment to various storage areas around the Acute site. No Gym or Hydrotherapy space for rehabilitation of our complex patients. Need IPC guidance re: how this may progress alongside outpatient use Dietetics DHH - due to IPC guidance for renal unit and need for spacing of doctors/nurses in renal the Dietitians lost the use of their office space and are now decanted to small outpatient dietetic office on ground floor beside the coffee bar. Insufficient space to safe distance so we have had to stagger use. This is now shared space with outpatient virtual assessments Speech & Language Therapy DHH - Office space in DHH is also shared with Community outpatient SLT as office space and used pre-covid as a clinic room for Acute outpatients. Safe social distancing is very challenging and staff are having to stay at ward level for longer periods and utilise ward computers etc to enable reports etc to be completed Departmental space for Acute AHP's is vital: "They are not ward based staff - work across the wards as required/fluid workforce	"Estates have walked OT/PT/SLT areas CAH - limited potential to create additional space - plan of works drawn up to maximise areas for safety. Same not actioned as yet and still leaves shortfall of 20+ spaces for staff "Physio Departmental RA completed "Occupational Therapy RA completed "Accommodation for SLT CAH in Ramone building - additional space required as well as outpatient clinic space "Portacabin allocated to OT/PT CAH for storage of essential equipment for patient discharge - temporary however needs to be retained as it is also used as a collection site for relatives for equipment avoiding the main hospital area	20/10/2021- - Agreed plan for the decant of Physiotherapy outpatients to Clover building Armagh. This will release space for inpatient team accommodation in line with IPC precautions and growing team - future proofing. Timescale app 3-4 months for initial decant - CAH SLT team currently located upstairs Ramone and meeting room 2 Admin floor as hotdesk area. They have been added to the list for accommodation in new drop in Admin block. Anita aware of same - Pressures remain on DHH site with outpatient Dietetics and SLT services need ing acute accommodation back to restart service. This has been raised through SAG also - no outcome as yet - stroke rehab space - due to nosocomial monies and Covid ward changes all plans for Rehab space on stroke ward are on hold. With no clinical Physio Gym space available or OT Clinical space left on site patients can no longer receive therapy/rehab intervention off the ward - this has been confounded by covid pressures for staff accommodation and has a significant impact on our high acuity patients such as stroke/head injury/post ICU. 01/06/2021- there is a joint OPPC/Acute paper being developed to move services off site. this should free up accommodation clinic space. 03/03/21 Outpatient OPPC services are set to resume activity onsite with the moving of doffing to basement in CAH - urgent need for additional space for staff PT Estates to review plans to maximise space as urgent across PT/OT Long term accommodation TBA for SLT Longterm storage solutions required	HIGH
4172	19/08/2021	Provide safe, high quality care	Trustwide	Delay in Everlight Radiology Reports being available in SHSCT	There is a risk to SHSCT patients due to the potential delay in diagnosis when reports are not available in line with the agreed turnaround time. Everlight Radiology provide Out of Hours reporting cover within. the SHSCT. The delay in the reports being available is highlighted to Everlight by SHSCT staff when issues occur. The report has not been pasted back onto Radiology Information System from their system. This is a manual process which occurs post dictation by the reporting Radiologist. This issues recur every few months and must be addressed to avoid recurrence. ~~Potential for delayed diagnosis and mismanagement until report is available.~~	Both Radiographer and the PACS team to monitor that the report is available in a timely fashion and to contact Everlight as soon as a delay has been recognised. Agreement at Weekly Radiology Meeting to put on the CCS Divisional Risk Register due to the issue of recurrence every few months. Issues to be raised on DATIX so recurrence can be monitored. A solution would be to have a HL7 link between IS providers and Sectra	Further action must be taken by Everlight Radiology and Sectra to have HL7 link created Future incidents to be closely monitored by SHSCT staff. Everlight to provide an action plan to address the issue. Everlight Radiology & Sectra are to be informed this is on the risk register.	HIGH

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4112	13/08/2020		Trustwide	AHP Staffing Deficit - Acute Services	Core Acute AHP staffing significantly below the National Average (NHS Benchmarking 2017) combined with additional unresourced demand in the system across all areas and workforce issues in particular across Physiotherapy and Speech and Language Therapy contribute to risk for the service, staff and patients/service users. This relates in this instance to the core Occupational Therapy, Physiotherapy, Speech and Language therapy and Dietetic teams on CAH site Current unresourced demand in the system: - Additional ICU beds in Recovery - big demand on existing ICU staff both Physiotherapy and Dietetics - no funded resource or cover for ICU from SLT or OT - Higher Acuity patients in 2N - Elective Ward - Transition ward - Additional stroke beds (funded for 10) - Additional medical beds 3S - Non recurrent funding frailty ward - only agency OT support, unable to recruit Physio - ED waits - on average 30 waits in ED - small resource contributing to GLT ED and AMU and struggling to impact on ED numbers/prevention of admission/signposting to AC@H etc - Increased age range and acuity of patients - Patients not receiving timely assessment and appropriate level of rehabilitation to maintain patient flow or actively contribute to timeliness and experience of the patient journey - Patients under nourished, remain nil by mouth for increased length of time due to reduced dysphagia cover. - Unable to facilitate mobilisation with resulting deterioration in muscle bulk and increased morbidity, lack of facilitation of activities of daily living hence increased dependency and requirement for larger package of care on discharge which will be delayed - complex delays - Poor/variable SSNAP results - Instability of core OT/PT staffing impacts on ability to rollout ward based 7 day working - Potential for SAls - increasing number of same in the system - Complaints received re: service provision - Inability to consistently meet professional standards - Health and wellbeing of staff compromised - Staff working outside levels of competency and under significant pressure. - Reduced morale and goodwill among teams - staff retention an issue with posts outside of acute attractive. High risk of losing staff to other teams which we are seeing evidence of already	Regular contact with BSO re recruitment. Requests to contract and non contract agencies for AHP staff, core staff offered additional hours, Regular review of transfer of staff from DHH especially for stroke and current 2nd ED - challenging within OT/PT due to gaps secondary to S/L, M/L especially in COVID era and recruitment issues ongoing and as 7 day working being piloted across OT/PT teams DHH, we have utilised cross site working effectively within SLT and dietetic teams as able to meet short term need but this does not address the longterm deficits	20/10/2021- Baseline deficits remain as outlined. Initial IPT was agreed in principle but to be looked at in overall AHP deficit trustwide therefore on hold. Ongoing pressures and a consistent need for redeployment confounded by Covid pressures has allowed the Acute deficit paper to be considered as stand alone - Planning now supporting to develop this further into a prioritised and phased approach with priority for demography funding Stroke staffing deficit now to be taken out separately for a combined stroke paper for regional investment Other bids in progress: - Biologics for Rheumatology - Additional HDU beds - Long Covid Need for investment in oncology services is not included in baseline piece however the baseline deficit is such that it draws on these staff to cover across all other areas. The overall oncology and palliative staffing requires review. Regional audit currently ongoing. Aim for regional or cancer specific investment opportunities to develop this for the patient group As mitigating actions I continue to look to secure additional staff via WFA/Agency/Additional hrs and CRR. 01/06/2021- moved to divisional risk register as per director. 03/03/2121 significant redeployment from across directorates to enable Acute AHP teams to address demand secondary to additional medical beds and Covid impact across ICU and wards. Redeployment ending through March 21 Bids in place via Annex A and NMS workstreams for additional OT/PT input to wards secondary to covid - posts to be filled Awaiting confirmation of funding for Ambulatory models to address patient flow and ED prevention of admission Support from Acute Director for investment paper to be drafted to address the baseline gaps across Acute AHP s a whole - March 21	HIGH
3866	14/01/2017		Reception Area	The waiting room in the x-ray department, Lurgan Hospital needs to be revamped	Patients and staff are complaining regarding the condition of the waiting area in the x-ray department of Lurgan Hospital. It appears unclean, grubby and unhygienic. The carpet is stained and uneven. There is a crack in one of the window panes and the seating is very uncomfortable, torn and stained. There are nails sticking out of the walls where pictures have been removed and the wall paper is peeling off the walls. Pipes under the radiator are broken and the insulation is exposed. It does not give a good first impression of the department and we are not meeting the Trust's values of delivering a safe high quality service to all our service users. There have been numerous written complaints from service user regarding the condition of the waiting room Please see photographs of the waiting room and patient reviews of their experience attached Service users complaining about the seats being very uncomfortable especially for people with back problems -see patient reviews of their experience	Routine, daily house keeping Deep clean performed to try to remove stains from carpet and seats, however this was unsuccessful Patients advised to prevent their children climbing on the chairs An extra chair has been placed in the waiting room as a temporary measure for those with back problems	01/06/2021- move to divisional risk register as per director	MOD

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3981	05/11/2018	Provide safe, high quality care		Administrating Contrast Media within Radiology	The current framework for prescribing, supply and administration of medicines (primarily the prescription of contrast media) within Radiology across the region does not meet current legislative requirements. It is the agreed approach of the Regional Modernising Radiology Clinical Network that this current practice poses a low risk to patients and has developed as normal practice over the past number of decades to meet the ever increasing demand for contrast enhanced examination. All decisions regarding the administration of medicines in Radiology is done under the direction of senior clinical staff following local procedures, protocols and guidelines as delegated by their Clinical Director. Issues with the management of medicines within Radiology has been recognised as a national issue, which has been escalated to NHS England as a risk to Radiology services. As a long term administration of contrast media. Low Risk PGD's are being put in place within the Southern Trust to provide a degree of cover for Radiographers administering contrast media.	Currently radiographers operate under written protocols agreed by the clinical director of Radiology.	03/12/2021 - CEC are going to provide a Medicines Management ELearning programme in the new year. Some PGDs are still in the development process however the majority are available for staff. 14/09/2021- training continues to be ongoing. More funding for medications management has been obtained. 03/03/21 Radiographers received medicines management training in 2020, which is a requirement of administering contrast media under a PGD. This training has been added to the a new radiographers internal training matrix. The matrix has been colour coded for individual compliance, the percentage team compliance and arranged so that each team lead has more streamlined oversight of their staff members mandatory training. The most commonly used / higher risk contrast media / PGDs were prioritised for completion first. 7 have been completed and issued. Oral contrast administered on wards for CT scans was issued and requires all nursing staff to meet training requirements. Radiology remains in contact on the review of oral contrast administered on wards via acute standards and guidelines forum. At least 10 more PGDs have been identified. Drafts are in progress with Radiology and pharmacy. 02/06/2020 Process drawn up, agreed and is operational Mar 2020 Draft process has been prepared and further discussion to take place between ward based nursing and medical staff to determine if proposed process is workable. Dec19 A working group including radiology and pharmacy has been established with an initial meeting planned mid-December 2019. Training of radiographers required to undertake prescribing	MOD
4079	16/12/2019	Provide safe, high quality care		Concerns highlighted following Peer Review visit of Systemic Anti - Cancer Treatment Service (SACT) November 2019.	no electronic prescribing system for Haematology chemotherapy drugs. Competency assessment for those prescribing first cycle of chemotherapy not in place SACT nursing competencies - some out of date storage of patients notes - confidentiality . SACT meetings did not include both Haematology and Oncology Increased risk of errors when prescribing drugs Inappropriate commencement of chemotherapy for a patient staff training out of date not in line with good practice Risk of breach of confidentiality lack of service development for the whole service	Corrective action plan developed to work through the concerns however regional support is required to implement electronic prescribing system for haematology chemotherapy. Medical competency framework needs to be progressed through NICaN. nursing staff to update competencies explore options for safe storage of patient notes Liaise with colleagues in Belfast trust to ensure job planning of oncologists to attend	08/10/2021- still awaiting regional direction re implementation of electronic prescribing (RISOH)/for Haematology. SACT competence remain under continual review. Staff training has been updated. Further funding secured via the regional Onc/haem stabilisation plan develop AOS service with ANP commenced on training course to allow for service development June 2020 Awaiting regional direction re implementation of RISOH within Haematology. Nursing staff all now trained and signed off as competent in the delivery of SACT. Ongoing review to ensure all staff are up to date with competencies. SACT Multi Professional meeting occurs bi monthly with representation from both Oncology and Haematology. Ongoing review and awareness raising of the importance of Information Governance to ensure confidential information is kept secure. Regional Oncology/Haematology stabilisation plan underway with a bid submitted from Southern Trust. Dec19 Regional Support is required. Liaise with Belfast Trust to ensure job planning of oncologists to attend.	MOD
3847	24/10/2016	Provide safe, high quality care	Trustwide	AHP Capacity Deficit for Acute Oncology Staff	Lack of timely response to Oncology referrals by specialist staff and limited rehabilitation input.	Patients rehabilitation may be compromised.	22.1.18 Still ongoing risk 14.11.17 -Capacity and demand paper being revised, This need remains largely unmet 6.6.17 Regional work still ongoing Dec 16 Working with region to establish any regional developments.	LOW

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4050	07/08/2019	Be a great place to work	Radiology, Daisy Hill Hospital	Lone Worker in Radiography	Risk of harm to radiography staff who may be working on their own to provide a critical service on the Daisy Hill site. There is risk to staff form adverse incidents including potential for sudden illness, accident or intruder with no immediate help at hand.	Out of hours entrances and exits are locked. Staff have access to phones and two-way radios that give the radiography staff access to portering staff in case of an emergency. Single Pane windows upgraded. Personal Panic alarm system installed. Inner doors replaced / thumb turn removed.	14/09/2021- implementation of new shift rota with 2 Radiographers will be in place by February 2022. March 2021- Locks have been added to all rooms. Swipe access door to be installed between ED and Radiology. Radiology main doors have been replaced and have the option to become a swipe door July 2020- As part of the 2019 support staff have been facilitating the Biomedical Scientist over the night time period. Whilst not all nights have been covered the majority are. Efforts are being made to secure additional resource to ensure all nights have additional staff cover. June 2020 Resource was given for additional staff to be on at night and reduce the "lone-worker" risk. Two staff have been agreed - a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. Nov 19 Risk reviewed and this remains unchanged Aug 19 Resource was given for additional staff to be on at night and reduce the "lone worker" risk. Two staff have been agreed a third member would be required to cover every night and remove the risk. Management will continue to advocate for the additional resource required. 7.3.18 Risk continues to be monitored	LOW
3875	21/02/2017	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Trustwide	The transfer of patient data outside the EU.	Due to insufficient availability of Radiology Registrars within the Southern Trust the Radiology Department is unable to provide the service of reporting emergency CT scans for patients between 10.00pm and 9.00am daily. In order to address the problem the The Southern Trust has an arrangement with the Independent Sector provider to report on the CT scans in the out of hours and overnight periods. given that the Ind Sector Supplier is in Australia images have to be transferred electronically and this presents a risk and potential for data loss	The risks have been assessed by BSO Legal Services, Trust Information Governance and IT. Due to the following mitigating factors it is believed this risk is of an acceptable level:-Reputable company with contracts ongoing in NHS England Company has DPA obligations in place and have been co-operative in responding to additional requests for clarification -Lack of alternative re processing of records -Consequences of a data breach (CT scan images) -Likelihood of a data breach -Impact on patient if breach occurred -Reputational damage to Trust if breach occurred - may be low - depending on number of records involved Within the specification the following has been recorded: "3.11 Confidentiality / Intellectual Property Rights. Assurances must be provided to the Trust that data and digital images are secure at all times." Ongoing monitoring of images being sent and reports being returned will also be used to ensure there has been no loss of data.	March 2021 - this will continue to be a risk as in previous years March 2020 This will continue to be a risk due to the lack of availability of senior radiologists. 21.02.17 Risk added to Acute Risk Register	VLOW
4158	06/05/2021	Provide safe, high quality careMake the best use of resources	Trustwide	CT Out of Hours Activity	The total increase in Out of Hours Activity across the Trust is 20% compared to March 2019 and March 2021. The majority of the increase is between the hours of 5-10pm which has seen a 60% increase in its demand. Risk on staffing levels as increased pressure may cause undue stress and therefore result in sickness and absence. Additional pressure on Radiologists for reporting	Previously there was on CT Radiographer working during the Out of Hours period however this has now increased to two CT Radiographers without any additional funding. (This is for CAH). There has been an increase in demand in DHH and awe are currently embarking on trying to implement a shift rota rather than on call. From a reporting perspective if the Radiologists feel they are under too much pressure they have the facility at weekends to outsource to Everlight.	03/12/2021 - 2 CT Radiographers have been recruited for DHH CT. Recruitment is underway for CAH CT Radiographers with interviews taking place before Christmas. While these gaps remain the frequency has increased for STH CT radiographers working on the CAH site. Back up to high risk 14/09/2021- Funding has been secured. Recruitment is ongoing. Downgraded to Moderate risk May 2021- Additional funding required for two CT Radiographers working out of hours on CAH Radiologists are keen for additional reporting cover between the hours of 8-10pm In order to facilitate moving to a shift rota in DHH additional funding is required for 4 WTE CT Radiographers.	HIGH

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1220	18/08/2008	Provide safe, high quality careBe a great place to workMake the best use of resources	Laundry	Breakdown of laundry equipment	Laundry equipment is outdate and requires replacement to avoid frequent breakdowns and disruptions to the laundry service. Potential risk to the supply of clean linen to wards and departments due to breakdown of essential laundry equipment. The aging laundry equipment needs to be replaced to avoid breakdowns and disruption to this core service. The risk affects the laundry service provided to not only Southern Trust facilities but also to Belfast City and Musgrave Park hospitals. Replacement parts for old and ageing equipment are now obsolete, causing delays in getting equipment repaired and back into operational use. The following pieces of equipment are required in the Laundry :- 1. Continuous Batch Tunnel Washer, Press and dryers - installed in 1992 (27yrs old) approx cost £760K 2. Ironer installed in 1975 (45 yrs old) approx cost £355K 3. Lint Extractor - requirement for fire safety - approx cost £70K 4. Pharmagg No 1 100kg barrier washer - installed in 2006 (14yrs old) approx cost £105K 5. Kent Dryer 100kg x4 - installed in 1987 (32 yrs old) approx cost £315K 6. Shrink Wrapper - installed in 2002 (17yrs old) approx cost £85K 7. Ironer installed in 1991 (28yrs old) approx cost £355K 8. Continuous Batch Tunnel Washer, Press and dryers - installed in 2001 (18yrs old) approx cost £760K Impact to service delivery - risk to the supply of clean bed linen to wards and departments in SHSCT and BHSCT. Risk of infection due to insufficient supply of linen for nursing staff to change / make up beds.	Estates has advised that it is becoming increasingly difficult to maintain the laundry equipment. They are unable to obtain replacement parts for the laundry equipment as the parts are now obsolete and it will ultimately come to a point when the machines will break down and remain out of operation. 10/08/20 - Equipment breakdowns are closely monitored and recorded. Detergent concentrations are monitored closely to ensure cleaning efficacy and minimise the number of re-wash cycles. The weight of the linen being loaded into the tunnel washers is monitored closely to ensure the equipment is not overloaded as this can lead to breakdown. March 2019 - A new calender was installed and commissioned to replace one of the four calenders in the laundry. Two new 57kg washing machines were installed and commissioned to replace a 100kg washing machine that had been condemned. The frequent breakdowns also put a strain on the newly acquired equipment as they are being overused when other equipment is out of use. There is increased staff overtime due to equipment breakdowns and equipment running at reduced capacity. Additional shifts are needed to ensure provision of sufficient clean linen each day to wards and departments. 11/05/21 - Funding of £1.2m has been provided from capital allocation. The division is to begin the procurement process which should be completed in 9 months. This risk should be reduced to moderate and handled by the Division rather than the Directorate.	22/11/2021- funding has been secured. Order is in place should be in place by end of January 2022. New Tunnel Washer money. £100,000 ironing line. Money for lint extractor to reduce fires. 16/02/2021 £84,000 capital funding approved to purchase a second hand ironing line 07/10/2020 Equipment breakdowns are closely monitored and recorded. Detergent concentrations are monitored closely to ensure cleaning efficacy and minimise the number of rewash cycles. The weight of the linen being loaded into the tunnel washers is monitored closely to ensure the equipment is not overloaded as this can lead to breakdowns. 10/08/20 - A CAG has been identified to commence the procurement process for a replacement tunnel washer. PaLS to arrange a meeting date as soon as possible. 28/2/2020 £50,000 capital allocation approved to purchase a second hand calender to replace No 2 calender which was beyond repair and was condemned. 11/10/19 £82,300 capital allocation approved to purchase a replacement refurbished press for the Powertrans tunnel washer as the press was beyond repair and was condemned. 1/4/19 New calender and two new washing machines installed and commissioned. List of aging laundry equipment added to capital priority list. 19/12/18 Capital funding approved and tender process completed. New equipment due to be installed and commissioned by end of March 2019. 5.4.18 Business case was recoated Nov 17 and was approved by SMT March 18. 16.8.17 Business case is still with Finance for re-costing. 12.12.16 No further update. 21.11.16 An additional option has been included and is with Finance for re-costing. 17.8.16 Business case for replacement of calenders presented to SMT - not approved. SMT has asked for an additional option to be included in the case i.e. to outsource the laundry service from another provider. 23.02.16 Business case forwarded to Finance for	MOD	DIV
3799	23/05/2016	Provide safe, high quality care		Falls from height DHH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death.	See action plan attached to Risk	25/11/21 Some works outstanding and they are a risk therefore this risk needs to remain on the risk register and rated Moderate. 27.02.18 Minor works request submitted for outstanding controls. 12/12/2016 A separate risk assessment is being completed by Acute Governance in relation to falls from heights. Erection or raising of anti-climb fencing in several areas. Secure 3 external doors at exterior of ED Dept., Enclose plant and equipment.	MOD	DIV
3977	25/09/2018	Provide safe, high quality care		CCTV System CAH Issues	The current CCTV system uses outdated technology (analogue) and surveillance coverage does not extend to all of the areas required. This can result in no CCTV footage available or poor quality images. 1. Compromised safety of all personnel on site 2. Compromised security of both Trust and personal property 3. Inability to detect crime and footage unable to be used in prosecutions 4. Inability to investigate incidents 5. The Trust is not fully compliance with the Data Protection Act 2018 - GDPR Compliance Assessment attached. 6. Compromised ability to locate missing patients from the Wards or Departments.	Health and Safety Risk completed and is attached. Regular checks are carried out on the CCTV system and faults are reported to Estates. Maintenance Contract with Radio Contact. Some faults in the system are unable to be repaired as the technology is outdated and require a longer-term solution - a list of outstanding faults is attached. A list of areas requiring CCTV cameras have been identified on a risk assessed basis and is attached.	25/11/2021-The draft CCTV policy has been re-circulated to the CCTV group for final review and Support Services have fed back comments to Mark Bloomer, Assistant Director of Estates who is taking the lead on completing the policy. CCTV enhancement plans have been developed for CAH and DHH but no Trust wide CCTV strategy has yet been developed/agreed. IP cameras have been installed at CAH to replace the analogue cameras and some 360 degree angle cameras have been installed. There are approximately 82 analogue cameras still to be replaced. The refurbishment of ED and the relocation of the Porters room have provided the opportunity to replace the remaining analogue cameras in this area. Due to the omnidirectional enhanced camera capabilities, some of the new IP cameras will replace several analogues, which is more cost effective and will minimise cabling requirements and cluttered cameras on the walls. There are two number plate recognition cameras on the main drive and another one on the road to Bluestone Unit. Additional cameras have also been installed externally around the site. Two monitors were also installed at reception to cover car parks and external areas. £50k has been allocated to address local issues with CCTV Develop Business Case to upgrade and extend the system on a risk basis. 7/8/20 At CAH the CCTV system has been upgraded to an IP platform which has significantly improved imagery and capability and 360o degree omnidirectional cameras have been installed in some critical areas, e.g. ED waiting area. Number plate recognition on the CCTV camera on the main drive at CAH should be operational by 31 August 2020 and this will integrate with the CCTV IP system. Encrypted storage devices have been ordered which will increase data security and download/ transfer ability. CCTV status report is being completed by Support Services which will identify short-term and long-term	MOD	DIV

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3978	25/09/2018	Provide safe, high quality care		CCTV System DHH Issues	The CCTV system at DHH is digital and has been put on the Trust Network and this is causing issues from an IT security perspective. The CCTV surveillance coverage does not extend to all of the areas required. Cyber attack and the hacking of data Loss of patient information Breach of Data Protection Act 2018 Compromised safety of all personnel on site Compromised security of both Trust and personal property Inability to detect crime and footage unable to be used in prosecutions Inability to investigate incidents Compromised ability to locate missing patients from the Wards or Department.	Precautionary measures by Estates / IT Number Plate Recognition cameras at DHH entrance and exit.	Encrypted storage devices in place. The draft CCTV policy has been re-circulated to the CCTV group for final review and Support Services have fed back comments to Mark Bloomer, Assistant Director of Estates who is taking the lead on completing the policy. CCTV enhancement plans have been developed for CAH and DHH but no Trust wide CCTV strategy has yet been developed/agreed. At DHH the cabling has been laid to replace the remaining analogue cameras with IP cameras when funding is available. In the meantime, as analogue cameras break down they are replaced by IP cameras. A review has been conducted of external cameras on the site to identify additionality. Business Case to be prepared to secure funding to have all CCTV transferred onto a Single Trust Digital Platform. Identify areas that require cameras on a risk basis and complete Minor Works Form for additional cameras 7/8/20 The analogue CCTV systems at DHH can be accessed via the IP platform, however the imagery remains of analogue quality and all analogue cameras and DVRs need upgraded to IP systems. CCTV status report is being completed by Support Services which will identify short-term and long-term requirements in order that priority rating can be agreed. Encrypted storage devices have been ordered which will increase data security and download/ transfer ability. All Portering Supervisors are trained to download CCTV imagery and arrangements are in place for them to download routinely to maintain their skills and a system is being put in place to record this. Arrangements are in place with Radio Contacts to come onsite and download imagery if urgently required out-of-hours if no Supervisor is on duty. CCTV Policy has been drafted.	MOD	DIV
4036	11/06/2019	Provide safe, high quality care	Trustwide	Discharge letters not being completed	When a patient is discharged they should be given a discharge letter which will give them details of their treatment in hospital and also detail out any follow up in terms of review, investigations that are required. If the letter is not done then the appropriate review/investigations may not take place. Risk to the patient of being lost to follow up.	Raised with Heads of Service asking them to remind the doctors to complete their discharge letters. Ward clerks let the doctors know that there are outstanding discharge letters. Ward clerks will let the Sister/Nurse in Charge know. However the situation has not improved.	22/11/2021- Click app development/self service report being piloted which shows number of outstanding letter per consultant- in pilot stage. Feb20 - email sent to HoS asking them to remind doctors of the importance of completing accurate follow up in the Follow Up section of the discharge summary. Information was also provided for the new doctors and locum's induction on completion of discharges.	MOD	DIV
3861	13/12/2016	Provide safe, high quality care	Grounds	Car Parking and Traffic Management Problems DHH	Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patients and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of collision due to disregard by drivers of one way system. Risk of injury to pedestrians entering Car Park F as no safe footway.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	25/11/2021- regular communications go out via social media and other platforms relating to parking. 17/12/18 Relocation of Pay and Display in Car Park C starting in Jan 2019 due to relocation of OOH and OPD. 27.02.18 Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces.	MOD	DIV
3973	28/08/2018	Provide safe, high quality care		Risk of injury when cleaning fixed beds in Bluestone	There are 68 beds of these beds in the Bluestone Unit. Hazard - manual handling (risk of musculoskeletal injury) and Infection Prevention and Control - areas of the bed not accessible for cleaning and no programme for cleaning underneath the bed which is fixed to the floor. Mattress type is an issue - no grips on the side of the mattress to aid moving and handling, mattress cannot be folded in half to clean. Low fixed height of the bed is an issue for manual handling.Musculoskeletal injury, infection control	Induction training, on the job training and BIC's training for Support Services staff. - o Infection Control training - o Waste management training - o Manual Handling training core/refresher - o Observation of user completing task/using chemical - o Spot checks - o Safe Systems of Work - task specific (Support Services staff only) - o Protective aprons and gloves - o Staff advised to wear enclosed and low footwear - o Faults reporting - o Staff reminded to continue to report incidents to their supervisor/manager - o Staff advised to check if the load is within their capabilities before lifting it. - o Staff advised to seek assistance if a load is beyond their capabilities i.e. a colleague. - o Pre-Employment Medical Advice - o Ill Health Referrals to Occupational Health - o SHSCT Policies and Procedures	25/11/2021- no change. 17/12/18 - Health and Safety have recommended 2 people to clean the bed. However, Domestic staff work on their own most of the day. Assistance from nursing staff required to turn the mattress during cleaning. Ergonomic assessment completed by Physio department. This risk will only be eliminated if the beds change but funding is required.	MOD	DIV
3753	04/01/2016	Provide safe, high quality care		Falls from height CAH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death. 21.11.16 The new retaining wall beside the footpath up the main drive has created additional potential for harm.	None - Action Plan Attached.	25/11/2021- some works are still outstanding and they are still a risk. 13/6/19 Estates and Support Services to review outstanding actions. 23.02.18 Minor Works request submitted for outstanding controls.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4038	11/06/2019	Provide safe, high quality care	Trustwide	Results not signed off on the wards	Hard copy patient result forms are not being signed off by the doctors on the wards. This means that the ward clerk cannot file the results and they are left on the wards where they could be misplaced or something could be missed regarding the patient's condition. If the results are not signed off there is the possibility the something could be missed regarding the patient's condition. The ward clerk cannot file the results until they are signed so the results are left on the ward and there is the potential for them to be misplaced.	Ward clerks remind the staff that they need to sign the results. Electronic sign off is being implemented. DHHS ward clerks have been told to forward unsigned results to the consultant for them to sign.	22/11/2021-Currently drafting a paper in relation to this. Some areas are working with electronic sign off. 05/07/2021-Meeting scheduled for 22nd July to discuss X-Ray results on Wards Feb 20 - Dr O'Kane has written to consultants stating that results will be destroyed and is waiting for their response. Once clarification is received from the Medical Director's office that results can be destroyed this will be acted on.	MOD	DIV
4077	09/12/2019			Consultants Recruited without communication to relevant Admin Management Staff	Potential for patients not to be followed up on time, patients lost in system because proper admin support was not in place. Admin Management advised too late of appointments of consultants. There is a lead in time for secretarial recruitment of at least 3 months and then a training period. No communication with admin leads re what the consultants role will be, job plans etc. Potential for patients not to be followed up on time, and phone calls from patients unanswered, patients lost in system because proper admin support was not in place. Due to consultants being recruited without ~~knowledge of Admin Management~~	Overtime is allocated to try and sort some of this.	25/11/2021- AD to raise with Divisional Medical Director for Workforce as still an ongoing issue. Dec19 Have met with some HOS/Ad's to try and sort some of this and gain some insight to job roles, base area etc.	MOD	DIV
4085	18/02/2020	Provide safe, high quality careMake the best use of resources		Fire Risk in Laundry Department CAH	Risk of fire in the laundry due to a build up of lint in the building and in the laundry equipment. This could result in possible injury to staff. Inability to provide clean linen to wards in SHSCT, BCH and MPH. Infection risk to patients if no clean linen is available at ward level.	Monthly high level cleaning. Removal of lint is included on the maintenance assistant's cleaning schedule Lint removing machine is identified on the Trust Capital Priority List	22/11/2021- Funding secured and ordered but not in place yet. 16/02/2021- daily record kept of lint removal from dryers and emptying dryers at the end of shift. Weekly fire walk around in place and record kept. Monthly high level dusting undertaken by outside contractor. 18/02/2020 the purchase of a lint remover is required when funding becomes available.	MOD	DIV
4188	25/11/2021		Trustwide	Risk of harm from exposure to allergens	Service users, staff and visitors may suffer from life threatening allergies or intolerances to certain foods. An individual develops a food allergy when their immune system reacts unusually to a particular food and produces immunoglobulin E (IgE) antibodies. Anybody can develop a food allergen at any time in their life irrespective of whether they have consumed the food previously. A person with an allergy is at risk even if they consume a small amount of the food containing the allergen. Food intolerance (non-IgE mediated) does not involve the immune system in the same way and is not usually as severe as a food allergy. Symptoms usually take longer and may include headaches, fatigue and digestive problems. The management of allergens depends on a range of processes from food procurement, storage, preparation, transportation and service, also standardised recipes, menu selection, the identification of at-risk service users and the accurate and timely sharing of information. Exposure can cause immediate and severe symptoms such as swollen lips or eyes, skin hives and in most extreme cases difficulties breathing and a severe fall in blood pressure (anaphylactic shock). In extreme cases this can prove fatal. Litigation if the individual is exposed to a known allergen and suffers an allergic reaction.	* HACCP Plans in place. • Management of Food Allergens Policy. • Communication, Training and Implementation Plan for new Management of Food Allergens Policy. • Food Safety Training includes allergens. There is Allergen Level 2 training and PPD'S Labeling training for relevant staff. • Standardisation of recipes. • Gluten free risk assessment carried out in production kitchens. • Food Safety Audits. • External Inspections by Environmental Health. • Catering Services have changed operations to revert to not packaging items for resale and where self-service is available tongs and hand sanitisers are provided to ensure compliance with new allergens labeling legislation which came into force 1/10/2021. • Allergens are listed against each item on the printed patient menus at all hospitals. • Allergens are updated on Saffron Catering MIS and there is a process in place to share updated information with the Support Services Managers and Community facilities. • Allergens information in respect of food items ordered direct by the wards is displayed in ward kitchens. • Directors have been asked to reinforce with Nursing regarding the need to check if patients have any food allergies when they are checking re allergic reactions as part of the admission process. *	25/11/2021-"Nov 21 - Further controls required: Fully implement and embed new policy within Catering Services. Review Food Safety Audits to combine section on allergens. Labeling software is to be sourced that will be compatible with Saffron."	MOD	DIV
3291	28/11/2012	Safe, High Quality and Effective Care	Grounds	Car Parking and Traffic Management problems CAH	Contractors taking up space. Limited entrance and exit access causing grid lock of site in the event of an emergency / major incident. Limited parking spaces around the site. Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patinets and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of injury to pedestrians as no safe footway in parts of the site.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	25/11/2021- currently this is worse that it was initially, this is due to the modular buildings which has added to the risk. There is extended enforcement and more red hatched areas. 7/5/19 - Planning application for 2nd entrance applied for Lisnisky Lane gate is opened in emergencies. Increased level of complaints following the extension of enforcement in November 2018. Difficult parking is resulting in patients being late / non-attendance at clinic appointments. 23/2/2018 - Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces. Additional spaces at Craigavon Area Hospital. Traffic calming measures including ramps at pedestrian crossings and speed control signage at Craigavon Area Hospital. Renewed markings on disabled spaces to ensure they are visible.	MOD	DIV
4035	11/06/2019	Provide safe, high quality care	Trustwide	Incomplete ED flimsy records	The ED flimsy is a record of the assessment and treatment of a patient in ED, and also any follow up required. All relevant information relating to the accurate disposal of the patient and any further follow up for the patient is to be recorded on the back page in the appropriate text boxes. The admin staff read the back page of the ED flimsy which should provide them with the information they need to discharge the patient accurately from ED and also the information they need to arrange any further referral for the patient to another clinic/service, or if the patient has had an x-ray and needs to be placed in the x-ray audit. The information is not always recorded on the back page and this means that patients are not referred on to another clinic/service and so places the patient at risk as their further treatment/follow up will not be arranged for them. There is a risk to the patient in that if the back page is not correctly filled in with any instructions as to referring the patient to another clinic/service that the patient will be lost to follow up. This has happened and has only come to light when the patient has phoned asking about their follow up.	Agreed with medical staff that all appropriate information relating to the accurate disposal and follow up of the patient must be recorded on the back page.	22/11/2021- AD to escalate to Director as it still is ongoing issue. ED admin do flag with HOS and relay back to clinicians currently. 09/03/2021- adhoc audit to be completed to provide assurance of compliance 18/02/2020 ED Trackers started in Dec19 and they are flagging up incomplete flimsies to the doctors to try and get them to improve. ED Admin Manager attended the ED doctors induction to emphasise the need to complete the flimsy correctly.	LOW	DIV

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3812	20/07/2016	Safe, High Quality and Effective Care	Switchboard	Lack of Emergency Major Incident Planning Software	Switchboard follows a Major Incident protocol, individually calling a list of key contacts, with a Major Incident Alert, Major Incident Declared and Major Incident Stood Down. In the event of a Major Incident declared up to 50 people may be contacted. This is time consuming, resulting in delays in key staff being notified. On site staff are individually bleeped. Switchboard staffing levels are reduced in the Out of Hours period, which will create further delays as additional staff will be required to come in. Switchboard manually record on paper as each person is contacted. Reports are available showing time of alert and numeric message. Voices over messages are not recorded.	Continue to monitor the situation. Paper completed to identify the risks shared with Acute SMT.	25/11/21: Appear App by Multitone has not been approved by Northern Trust or BSO & is not being used by any Trust. Currently looking at another Emergency Planning solution "Mitel Revolution" which is a web page solution costing £5000. Currently being used in Antrim Hospital and the Western Trust. Visit to see the solution in operation currently being scheduled with a view to purchase for SHSCT. 5/7/2021 iMessage is the bleeping system which has been upgraded and the Appear App which is the actual emergency planning app will be integrated through iMessage but the Appear Emergency planning app is still not rolled out. John Mitchell is waiting on a trial with the Northern Trust being completed and approval from BSO before he pursues this with SHSCT. 16/02/2021- Following a trial period Northern Trust now plans to implement the Appear App software. Southern Trust awaits to see if there are any operational issues before implementing the same here. 4/3/2020 It has moved the imessage system onto the Trust domain. System providers to complete the approval to rollout to all necessary staff. 15.5.19 Full implementation of roll out of smart phones has been completed. All Emergency calls to ext 6666 & 6000 are now being recorded. New iMessage bleeping system is now fully operational. IT are currently PEN (Security) testing the App. When complete test group will be identified & App tested prior to roll out to all Major Incident responders. 19.12.18 IT/Telecoms have rolled out new smart phones to all blackberry holders as the Appear App will not work on the blackberry phone. Implementation of the Imessage Appear App by Estates Telecoms Team has been rescheduled to April/May 2019. 5.4.18 Imessage Appear App (Emergency Planning Software) has been purchased. Trial is ongoing with the Northern Trust. SHSCT awaiting feedback from Northern trial before implementing. IT/Telecoms currently rolling out new smart phones to all blackberry holders as the Appear App will not work on the current	LOW	DIV
4067	24/09/2019	Provide safe, high quality care		Non Destruction of Patient Records due to Infected Blood Inquiry	Risk to staff hurting themselves as they are managing records in libraries that are full. Filing and retrieval of charts is difficult as they are very closely packed in the pigeon holes. The filing bays are heavy when moving them. Trust will not have enough space to store all the patient records so some will have to be sent to commercial off site storage which incurs a cost. Staff could hurt themselves trying to assess charts. Charts will be more difficult to retrieve which could lead to a delay in their being available.	All staff must complete their Mandatory Training. Inspection of libraries has taken place by Health Records Managers and areas of concern highlighted. A plan has been set out to transfer some of the less active charts to the commercial off site storage which will leave space for the more recent charts.	22/11/2021- no indication from a regional point of view. Joanne to check the position of this 05/07/2021- HOS for Health Records to join regional meeting in Sept 2021 and will query funding options. Feb 20 - request has been sent to Alphy Magennis stating the cost of retaining records as part of the IBI and requesting funding for same.	LOW	DIV
4074	20/11/2019	Provide safe, high quality careMake the best use of resources		Incomplete Consultant of the Week Rota or Consultants not recorded on PAS	The consultant of the week rota is not always up to date or has not been recorded on PAS. This means that the ward clerks do not know which consultant to admit the patient under. This could lead to the patient not being assessed by any medical staff. If the consultant is not recorded on PAS it means that the patient cannot be admitted under the correct consultant, which could lead to the patient not being seen in the appropriate timeframe or issues relating to follow up of treatment	Reminders have been sent to the Heads of Service asking for clarification as to which consultant is on call. Assistant Director wrote to the Assistant Directors requesting this information is given asap and also that any new consultants are recorded on PAS asap.	Feb 20 - things have improved and consultants are being added on to PAS in a more timely fashion. Nov19 risk added to Divisional Register	LOW	DIV
4062	20/08/2019	Provide safe, high quality careMake the best use of resources		No electronic interface between SSD instrument tracking systems and TMS	There would be a delay in identifying patients and instrument sets used in the event of a look back exercise due to the lack of an electronic interface. Patient identification is currently only achievable by manually going through the patients notes to look for barcode stickers relating to the instrument sets. Possible infection risk to patients due to the length of time required to identify patients manually where there is a possibility of cross contamination. Impact on staff time and resources.	Checks are carried out manually if required	22/11/2021- This will not change until Encompass is implemented. 16/02/2021- an electronic interface will be developed as part of the regional Encompass project.	LOW	DIV
4063	20/08/2019	Provide safe, high quality careMake the best use of resources		Lack of Long Term Contingency for Laundry Dept	SE Trust and a private laundry in Belfast can provide contingency in the event of a short term breakdown but cannot sustain this for longer than a couple of days in the event of a major laundry equipment breakdown or loss of production e.g. loss of essential utilities or fire. Possible risk of infection to patients due to lack of clean linen	SE Trust and a private laundry in Belfast can provide short term cover in the event of breakdown but cannot sustain this for longer period.	22/11/2021- no change 16/02/2021 - no further update	LOW	DIV
4064	20/08/2019	Provide safe, high quality careMake the best use of resources		Aging Decontamination Equipment	Possible risk of breakdown of aging decontamination equipment. Three sterilises and three endoscope washer disinfectors are past the end of their anticipated life cycle and whilst they are still in working order there is an increasing risk of faults or breakdowns. Possible unavailability of sterile instruments / clean endoscopes leading to possible delays or cancellations of procedures	Estates maintain and service the equipment as per manufacturer's recommendations. Replacement parts are currently available.	22/11/2021- Planning helping around the replacement of SSD equipment. 16/02/2021- all ageing equipment is included on the capital priority list. Draft paper re funding requirements has been shared with the Director of Acute Services. 12.11.19 The Lancer Endoscope Washer Disinfectant manufacturer has confirmed that they will support the FC2 /4 model until 2022 for the electronics and until 2025 for mechanical parts	LOW	DIV
4037	11/06/2019	Provide safe, high quality care	Trustwide	Breakdown of mobile bays in Health Records	The mobile bays in Health Records in CAH and DHH are old and are breaking. This means that the staff cannot use the mechanism to move the bays but have to manually push the actual bay. Risk of member of staff hurting themselves while trying to move the mobile bays.	All staff must be trained in Manual Handling. Notices put on bays letting staff know which ones are broken. Estates notified and ask to repair as a matter of urgency.	22/11/2021- will work on it with Estates to replace. guidance is issued to staff to remind them of the hazard. Feb 20 - when possible charts are moved to Villa to avoid having them on the top of the shelves which puts additional pressure on the bays.	LOW	DIV
4128	26/11/2020	Safe, High Quality and Effective Care	Sterile Services	Non compliance with Regional Decontamination Strategy	possible infection risk to patients as the SSD trollies are not decontaminated in an automated trolley washer. The regional denomination strategy states that SSD's should use an automated trolley washer to decontaminate the trollies that are used to transport dirty and clean surgical instruments between SSD and wards/dept. The SSD's at CAH and DHH do not have an automated trolley washer as there is no space to install one	Dirty instruments are enclosed inside plastic bags during transport in the SSD trollies. SSD staff manually clean the SSD trollies after the dirty instruments are removed from them and a cleaning record is kept.	25/11/2021- need for a new endoscope unit and until then there is no change. 16/02/2021 inclusion of an automated trolley washer in the plans for any upgrade of the SSD's	LOW	DIV
4153	02/04/2021			Subject Access Request Delays	Lack of staff for photocopy charts in IMWH for Subject Access Requests. One of these can take take up to half a day. There is no staffing allocated to this. The risk is not meeting the standard response time.	Overtime offered to Band 2 and any other member of band 2 staff who may have time throughout their areas. Corporate Sec office with Acute has been asked to help.	22/11/2021- Not resolved KR to check with Service Administrator and give update at next meeting. Been raised by Stephen Haughey and Catherine Weaver in Information Governance at SMT as these requests are increasing.	MOD	HOS

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3453	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Internal Bleep System Failure	Risk to patients, staff, service users in the form of: Potentially unable to activate Emergency Teams e.g. Cardiac, Stroke, Paeds, Obstetrics, ILS, etc. Unable to reach individuals in an emergency e.g. Cardiac Nurse, Stroke, Security, etc.	Daily tests carried out on all teams. Maintenance contracts in place with Multitone (bleep providers) and Estates responsible, protocols in place for activating bleeps.	25/11/2021-Daily system checks ongoing. Maintenance contract in place. CAH &DHH Can complete cross site bleeping if necessary. Disaster Recovery plan in place in the event of Cyber attack/IT Failure. Can be removed from Divisional RR & Kept on Departmental as risk will continue but be maintained as low 16/02/2021- spare mobile phones kept at CAH & DHH switchboard as backup to give out to key responders if failure occurs. 9/3/2020, 15.5.19, 19.12.18 No further update. 5.4.18 New Multitone iMessage paging system in operation. System is now running of multiple transmitters to ensure that if there are any outages that another server provides resilience. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017.	LOW	TEAM
3777	08/03/2016			Waste Management South Tyrone Hospital	Risk of Infection from waste contaminated with blood/bodily fluids. Injury due to sharps being disposed of incorrectly into waste bags, laundry etc and coming into contact with member of staff. Risk of musculoskeletal injury from handling waste which involves carrying on the same level and also between stairwell levels, bags being overfilled. There is excessive handling of waste bags due to lack of storage facilities in wards and departments to allow waste to be placed in the bins by the users. Waste is as result handled 3 to 4 time by staff thus increasing the risk of injury/ exposure. Risk of injury from slips, trips, falls due to the lack of storage. Lack space to provide suitable waste management arrangements leading to excessive handling result in injury to staff, leaks from contaminated clinical waste if not stored correctly. Porter staff have to go out in all-weather to move waste, from the vehicle and as all the bin storage is open to the elements.	Sharps boxes are provided for disposal of sharps. Segregation of waste. Safe Management of Healthcare Waste- 2013 (information available on the intranet). Waste management training. PPE provided for staff handling waste. Staff trained in use of PPE. Corporate Risk Assessment on Blood Borne Viruses (available on intranet). Staff aware to report incidents, which are subsequently reported on Datix. Manual handling training. Waste management training (advised not to overfill bags). Manual Handling policy. Manual handling risk assessment. Safe systems of work. Staff aware to report incidents, which are subsequently reported on Datix. Cleaning of spillages immediately. Housekeeping arrangements are in place to ensure waste is stored correctly. Staff aware to report incidents, which are subsequently reported on Datix. Cages are provided to store waste. Spills are cleaned immediately. Staff aware to report incidents, which are subsequently reported on Datix. PPE raincoats s are provided.	25/11/2021-All actions possible have been taken to reduce this risk but there are still issues on the site with parking and static, overfilling of bins cardboard not being broken down. This risk can therefore be removed from the Divisional Risk Register and it will be placed to the Domestic Services Risk Register. 13/6/19 traffic and people parking at the back of the kitchen / the pad store and beside the waste area are blocking the bin lorry from getting access. There is now a chain on the area around Loane House and this has helped. The old portacabins are being dismantled mid June 2019 so this should then provide a new bin collection area for the rest of the site and may ease the problem. 12.12.16 As all the recommendations made following the HSENI Clinical Waste Inspection visit on the 1 December 2015 have now been actioned the risk rating is being reduced from Moderate to Low. 8/3/16 Domestic Services staff to be advised not to overfill bags and waste receptacles. Communication to be forwarded to ward/department managers advising their staff not to overfill bags. Manual handling risk assessment shared with staff.	LOW	TEAM
3281	26/11/2012	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of resources	Kitchen/Dining Room	Risk of vunerable patients or customers contracting food poisoning includingn listeriosis and E.Coli	Symptoms may include diarrhoea, nausea, vomiting, stomach cramps and fever. Food poisoning can sometimes lead to severe illness. Listeria monocytogenes can be present in chilled ready to eat foods at low levels; however poor temperature controls and failure to adhere to shelf life guidance can enable the bacteria to grow to potentially hazardous levels. Listeria is a rare but potentially life threatening disease. Although some adults experience only mild infections of the eye and skin, and gastroenteritis, it can lead to severe blood poisoning or meningitis. Pregnant women, the elderly and people with weakened immune systems including those suffering from cancer AIDS and alcoholism, are more susceptible to Listeria. It is particularly dangerous in pregnancy as it can cause a mild flu-like illness which is not serious to the mother but can cause miscarriage, premature delivery, still birth or severe illness in a new born child. E. coli O157 is a particularly dangerous type of bacteria because it can cause serious, untreatable, illness and even death from very low-levels of contamination of ready-to-eat food. Because E. coli O157 survives at freezer, chill and ambient temperatures, measures to control cross-contamination apply to all of these environments. Although E. coli O157 is the key focus of this guidance, the measures outlined will also help in the control of other food poisoning bacteria, such as campylobacter and salmonella. The risk of E. coli O157 cross-contamination should be considered wherever raw foods such as raw meat and unwashed vegetables are handled and where ready-to-eat foods are also handled. Without strict controls, E. coli O157 can be spread throughout any food processing environment. It is therefore essential that ready-to-eat foods are at all times handled and stored in clean areas where controls ensure the environment is free from E. coli O157 contamination.	1. External inspection by Environmental Health Officers. 2. All food handlers are trained in food safety and HACCP. 3. There is a HACCP in each facility and HACCP monitoring is in place. HACCP plans are reviewed by the Catering Manager and the Locality Support Services Manager as required. 4. Hand washing and Food Safety Audits are completed. 5. There is complete physical separation of raw and ready to eat food during delivery, handling and storage in fridges. 6. The Trust has a dress code policy which covers uniforms, the wearing of jewellery etc. and audits are conducted to measure this compliance. 7. All staff are trained on cleaning disinfection and hand washing.8. Catering equipment maintenance contracts in place. 9. Food Safety Notice-displayed in dining rooms – to minimise the risk of listeria – sandwiches not for patient consumption.10. Food brought in by patients - Locker checks at ward level, sign on ward doors to advise, info on visitor information leaflet 11. Oxybac soap used in catering 12. Agreements to report infection forms completed annually.13. RTW form staff asked to confirm if 48hr symptom free. 14. A/L request form staff to advise if visiting a foreign country.15. Elbow/foot operated taps.16. Colour coding and PPE in place.	Nov 2021 - It has been agreed to have one risk for food poisoning to include Listeriosis and Ecoli and that this risk should remain on the Divisional Risk Register as it requires regular monitoring. ATP machines currently not in use. 12/6/19 This risk could be de-escalated to the Catering Service Risk Register due to the controls in place. 121.12.16 No further update 26.02.16 Controls have been improved in all food production . At CAH this has been completed by the building of a partition and in DHH a separate area is used , in other units measure are in place to keep these function to separate area/times and handling to a minimum. Additional training on all aspect of e-coli has been delivered Food handling and staff practices continue to be monitored, and audit arrangements have been updated. Additional checks are in place at meal times. Supervision has been reviewed at CAH and there is now a lead cook on shifts. Contingency plans have been reviewed and the learning from Incident in June 2015 has been taken on board. a new contract is in place of microbiological testing and locally ATP machines are purchased to allow more frequent sampling of surfaces and handwashing.	LOW	TEAM

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3454	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Risk of Telecoms Failure Across CAH, SLH, STH, and LH	Potential for telephone lines to go down: a)Internally b)Cross-site c)Internally/cross-site/externally d)External lines only Risk 1: If lines go down internally - risk to patients and staff Risk 2: If lines go down externally - risk to members of the public	- Contracts are in place with Telecoms providers. - Protocols are in place with Estates services in relation to re-establishing telecoms links. - Mobile telephones are also available for use within A&D, and C&B localities.	22/11/2021-System software regularly updated as required to ensure resilience Support contracts in place. Disaster Recovery plan in place in the event of Cyber attack/IT Failure.Can be removed from Divisional RR & Kept on Departmental as risk will continue but be maintained as low. December 2020: Disaster Recovery successfully tested in November 2020. Infrastructure upgrades scheduled for early 2021 which will ensure continued resilience. March2020 Full Disaster Recovery protocol in place. Tested and system coping with switching from one server to another with minimal interruption. May 2019: New Trust wide Equinox telephony system now in place which means the majority of phones run off the IP system. Fall back servers are in place to ensure resilience. Craigavon Hospital Switchboard can now provide full cover for Daisy Hill Switchboard or vice versa if required 19.12.18 New telephony system "Equinox" to be installed by Estates Telecoms at both CAH and DHH switchboards in January 2019. 5.4.18 New telephony system "Equinox" to be installed from April 2108. Significant increase in amount of VOIP handsets within the Trust. 16.8.17 Partial roll out of VOIP handsets - Estates awaiting approval of revenue funding to enable full roll out of VOIP handsets. 22.02.16 Capital funding approved to enable Estates to purchase additional hardware. Estates awaiting approval of revenue business case for roll out of VOIP handsets.	LOW	TEAM

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4173	24/06/2021	Provide safe, high quality careEffective organisational governance	Admission and Assessment Unit	CAH Day Obstetric Unit clinical space(non-compliant	Assessment of risk to both staff and service users. Potential injury to client and staff slip, trip and fall hazards due to trailing cables and poor lighting (potential for litigation) Electrical and fire risk- use of overload extension lead and cables Infection risk- requires relocation and improvement of hand washing facilities and IPS panel configuration of room into 3 individual bedspaces.	Screens are used as dividers between bed spaces. Trailing leads are kept to a minimum where possible but due to high level of equipment required within the unit, leads are trailing. Staff advised to keep leads close into wall, unable to be taped due to IPC. Extension leads and sockets are overloaded and staff are advised to ensure plugs are pulled out when equipment is not in use. Estates and IPC team have conducted a walk around in the area, issues identified as risk and minor works request to be complete and submitted.	Estates and IPC have carried out a walk around and identified risks. Minor works request has to be completed and submitted for relocation of wash basin adjacent to entrance door, split unit for air conditioning, provision of office admin space, full redecoration, room to be divided into 3 bedspaces- and power and data at each bedspace.	HIGH	DIV
4059	14/08/2019	Provide safe, high quality careMake the best use of resources		Midwifery Staffing Levels throughout SHSCT sites	Unable to recruit and retain Midwifery staff due to a regional and national shortage of Qualified Midwifery StaffThere is a continual potential for wards to be understaffed. This may result in poor outcomes for patients and babies.	The Division continues to use bank and agency staff, overtime, innovative practice such as recruitment fairs, making best use of staff in post, and ongoing staff development.	16.03.2021- ongoing rolling recruitment of midwives- 22 appointed to commence between June and September 2021. June 2020 Ongoing roles for recruitment, liaising with workforce planning re recruitment strategy. Dec19 Recruitment day undertaken and ongoing recruitment in progress	HIGH	DIV
3678	26/05/2015	Make the best use of resourcesProvid e safe, high quality care	Antenatal Out Patients	Lack of accomodation for Antenatal Clinics	Lack of available rooms to undertake antenatal clinics resulting in delay in appointments and necessary repeat appointments.. inconvenient for patients	Unable to provide a one stop service to patients booking in Armagh Community Hospital as they have to return for their booking appointment when they have been scanned and a repeat scanning appointment in CAH/DHH if required. If a woman books in CAH/DHH she only requires one appointment.	01/06/2021- moved to divisional register as per director. 16/03/2021- no change re-escalating for antenatal capacity due to increasing clinics still required investment and proposed planned works for 2021- 2022 12/08/20 - no change. Needs investment. Jun20 Antenatal OP setting being reviewed in conjunction with new CT scanner being built. Aug 19 Escalated from Divisional to Directorate Risk Register Jun19 Situation continues to be monitored with the increasing demand on the service Jan18 Still ongoing risk	HIGH	DIV
4180	08/10/2021	Safe, High Quality and Effective Care	Trustwide	Homebirth for Women outside of Guidance	Women who do not meet the criteria for homebirths as per RQIA homebirth guidance, but continue to request same with expectation that homebirth will be facilitated and provide by Trust midwives. These include women who have had previous Caesarean section, Diabetes, high parity Injury to mother and baby such as ruptured uterus, shoulder dystocia, stillbirth.	Risk Assessment undertaken by Lead midwife and community midwife team leader of home environment, location, availability of staff and individual risks for each woman requesting homebirth outside of guidance Explanation of risks to ensure information provided enables woman to make fully informed decision and consent. Liaison with ambulance re availability of emergency services Provision of on call from 38 weeks gestation reduction of 1 week due to staffing constraints Training and skills update with rotation into updating in hospital and training for all emergencies. Documentation of all interactions and discussions re information and advice provided Liaise with Directorate of Legal Services Controls in place as above with offer of MLU also as alternative, however woman's choice and decision ultimately require attendance of midwives at homebirth regardless if homebirth provision stepped down. Confirmed with DLS if Trust offers homebirth service need to have midwife in attendance regardless of the risk of the woman. Trust may be subject to judicial review if Homebirths not facilitated Offer to birth in Midwifery led unit to reduce risk in community setting	Communication and discussion.Alternative options identified to facilitate choice and reduce risk to mother and baby	MOD	DIV
4092	30/03/2020	Provide safe, high quality care	Maternity Outpatients	Inability to store ultrasound images for future review	There is currently no storage system in maternity department to hold ultrasound images for future review. Possible risk to patients of missed diagnosis as scans cannot be stored and rescans may not be scheduled in a timely manner which could cause disease to be missed.	None currently in place	16/03/2021- No further update- investment required to progress. June 2020, March 2020 - New storage equipment required in the maternity department to hold ultrasound images	MOD	DIV
4033	11/06/2019	Provide safe, high quality careMake the best use of resources	Trustwide	Unacceptable waiting time for Urodynamics Appointments	Delay in providing optimum care for patients waiting for Urodynamics Sessions in the Trust. Potential for harm to patients waiting an unacceptable length of time for Urodynamics Sessions.	Best use made of appointment time slots and continual monitoring of the situation.	16/03/2021- extended waiting times continued due to impact of COVID, phased return of services and recommencement of outpatients clinic- March 2021. Jun Due to impact of covid waiting times further extended. Dec19 Risk remains unchanged Aug Training of staff continues Jun Training of staff is ongoing	MOD	DIV
4076	04/12/2019	Provide safe, high quality careMake the best use of resources	Colposcopy Clinic	Waiting times for Colposcopy appointments	Delay in providing optimum care for patients waiting for Colposcopy appointments in the Trust. Potential for harm to patients waiting an unacceptable length of time.	Best use made of appointment time slots and continual monitoring of the situation.	16/03/2021- impact of covid has seen waiting times increased. Phased return of services should see waiting times reduced. Will continue to monitor. June 2020 New Cons appointed to increase capacity, and continue to monitor waiting times. Dec19 Risk added to Divisional Register	MOD	DIV
3942	27/02/2018	Provide safe, high quality care	Delivery Suite	Possible breakdown of aging resuscitaires	Spare parts increasingly difficult to source for old models of Resuscitaire equipment currently in use in both CAH and DHH. This could lead to possible risk to newborns when high number of births on either site.	Manage number of planned deliveries coming into each hospital.	16/03/2021- Replacement of 3 Resuscitaire remainder of still on capital funding list. 10/08/20 - A number of Resuscitaire have been purchased. Move to divisional risk register. Jun20 Resuscitaire's procured for CAH and DHH, remainder required remain on capital listing. August 19. Remains on Capital funding list increasing of number of aging Resuscitaire requiring replacement parts which are becoming increasingly difficult to source.	MOD	DIV
3996	20/11/2018	Provide safe, high quality care	Maternity/Labour Ward	Unable in DHH to implement recommendation Re "Saving babies lives"	Recommendations from Saving Babies Lives - requires At Risk fetuses to have 3 weekly fetal surveillance scans. This is being carried out on the CAH but not the DHH site. to meet the PHA / Standards Missed opportunity to intervene in high risk fetus resulting in still birth and fetal abnormalities	Currently unable to meet the requirements Only able to provide growth scans to identified high risk pregnancies on DHH site only. Recruitment of a Band 7 Scanning Midwife to train midwives and doctors to perform 3rd trimester scans and also to develop a Day Obstetric Unit on the DHH site, this e req is being held up by finance.	16/03/2021- Baseline assessment of saving babies lives being undertaken across the trust regional work to progress saving babies lives version 2. Jun20 Midwife now recruited and in post but not yet implemented due to covid. Dec19 Unchanged Jun19 Job Description and E-requisition for scanning midwife has been forwarded to finance for consideration for appointment of this post.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4034	11/06/2019	Maximise independence and choice for patients and clients	Fertility Clinic	Reduced capacity of Fertility Clinic	Lack of fully trained staff to provide full running capacity for Fertility Clinic. Unacceptable delays in providing this service to patients, difficulties arising from poor continuity of care.	Best use made of appointment time slots and continual monitoring of the situation. Plan to ensure that the potential for further disruption to the service is minimised. Regular meetings between service managers and clinicians to facilitate strategic planning.	16/03/2021 phased return of services in line with rebuild plan. June 2020 Due to covid Fertility Out Patient stood down, plan to restart services in July 2020. Dec19 Staffing compliment now increased again and demand being managed and monitored. Jun19 Continual monitoring of the staffing situation for the clinics. Training of staff is ongoing. Regular meetings between service managers and clinicians to facilitate strategic planning.	LOW	DIV
3162	13/06/2012	Provide safe, high quality care	Delivery Suite	Trium archiving system CAH & DHH	Trium archiving system is intermittently working due to:- CAH & DHH - poor quality of cabling and existing points. DHH site- Trium boxes have be damaged and require replacement.	Keep a record of patient's hospital numbers to ensure CTG scanned to facilitate archiving Inform labour ward coordinator and IT is trium not working. Complete IR1	16/03/2021- identified increase risk for information governance due to unassigned CTG's escalated to information governance, guidance devised for trium team. Jun20 and Dec19 risk remains unchanged Jun19 Continues to experience IT performance problems which continue to be monitored. 22.1.18 Still ongoing risk	LOW	DIV
4032	11/06/2019	Provide safe, high quality careMake the best use of resources	Trustwide	Trophon system not in use in all relevant areas	Trophon (decontamination of transvaginal probes) system is not being used in all appropriate areas.	Tristel Wipes was being used as an alternative method of cleaning pending implementation of standard operating procedure.	16.03.2021- risk remains unchanged. June 2020, Dec19 & Aug19 Risk remains unchanged. Jun19 Implementation of SOP throughout all appropriate areas. Staff training ongoing.	LOW	DIV
4068	15/10/2019	Provide safe, high quality careMake the best use of resources		Accomodation for Antenatal/Postnatal Clinics at Ballygawley Health Centre	The accomodation previously used by the Community Midwives in Ballygawley General Practitioner surgery has been reallocated to the Children and Young People's Health Visitors. There is currently no suitable accomodation to continue running antenatal and postnatal clinics. This will impact on the safe and efficient running of antenatal and postnatal clinics until a suitable area has been established.	Situation is currently being monitored	16/03/2021- remains unchanged due to estates capacity to complete any additional work in excess of COVID. June 2020 remains unchanged, delayed due to covid. Dec19 Awaiting Finance costing's for work to proceed with works	LOW	DIV
4051	07/08/2019	Provide safe, high quality care	Delivery Suite DHH	Lack of fetal monitoring capability during transfer to main theatre from delivery suite.	Unknown fetal status during transfer. Potential risk to client and potential litigation	Intermittent auscultation may be possible only when the bed is stationary i.e when in the lift. Transfer time may take at least 10 minutes. Controls considered but discounted - Intermittent auscultation does not provide continuous contact with the fetus which is required in situations of fetal distress or during the induction process as per NICE guidelines. The only monitor that would allow continous fetal monitoring during the transfer is the Phillips Avalon FM30 which is has a battery supply to allow for CEFM during transfer.	16/03/2021- remains unchanged. June 2020 CTG machines on capital funding for 2020, awaiting confirmation of same. Dec19 & Aug19 Situation continues to be managed and monitored.	LOW	DIV
4091	09/03/2020	Provide safe, high quality careBe a great place to workMake the best use of resources		Staff Risk due to lift required in Brownlow Health Centre	A lift is required in Brownlow Health Centre, to easy carriage of equipment and files up flights of stairs, through fobbed doorways to clinical areas. Possible risk of injury to staff responsible for carriage of equipment and files up flights of stairs and possible damage to equipment as staff manœuvre up flights of stairs and through fobbed doorways.	Limit individual loads being carried up stairs to reduce risk to staff or equipment	16/03/2021- Remains unchanged June 2020 continue to monitor risk.	LOW	DIV
4061	14/08/2019	Provide safe, high quality careSupport people and communities to live healthy lives and improve their health and wellbeing		Home Births Risk if Emergency and required Urgent Ambulance Transfer	There is a possible risk to birthing mothers who experience difficulty during home birth and require urgent transfer to hospital due to current increased strain on ambulance services. This may lead to possible harm to mother and baby.	Birthing mothers are continually monitored prior to and during home delivery to ensure early alert if a problem may arise.	16/03/2021- Monthly review of home birth requests in conjunction with available NIAS and midwifery staffing levels in context of pandemic. June 2020 & Dec19 Ongoing risk identified and discussed with all women at risk when home birth risk assessment undertaken.	LOW	DIV
4069	05/11/2019	Provide safe, high quality careMake the best use of resources	Admission and Assessment Unit	Limited Security in Admission & Assessment Unit and Maternity Outpatient Department CAH	Potential for breach of Data Protection due to patient information not secure when clinics are not being held	Possible breach of patient confidentiality	16/03/2021- remains unchanged. Jun 2020 check if minor works has been submitted Dec19 Minor works form to be completed to review with estates.	LOW	DIV
4043	26/06/2019	Provide safe, high quality careMake the best use of resourcesSupport people and communities to live healthy lives and improve their health and wellbeing		Possibility of Breach of Patient Confidentiality as records are hand held	patient hand held records are in use for maternity patients which increases the potential for breach of patient confidentiality and misfiling of notes/results. sharing of personal information and breach of data protection and information governance.	continual staff awareness of need to ensure correct information filed in the correct chart.	16/03/2021- continual monitoring of the data breaches further SOP developed and actions plans based on increased number of information governance breaches. June 2020 Increased awareness training of staff involved in filing into MHHR. Dec19 & Jun19 Continual monitoring of accurate filing	LOW	DIV

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2382	19/10/2009	Provide safe, high quality careMake the best use of resources	Cath Lab CAH	No contingency plan in place in event of cardiac catheterisation lab failing.	Risk to health and safety of patients is compromised if cardiac catheterisation lab equipment fails 1. Whilst the patient is on the table mid procedure 2. Loss of capacity due to failure causing impact on waiting time standards	1. Should failure occur whilst the patient is on the table mid procedure - a n arrange ment with radiology permits the short term loan of the portable image intensifier to complete the case and maintain the patients safety. 2. No controls in place	24/02/2021- discussions with SMT regarding potential of 2nd Cath Lab- At the moment the cath lab is coping with the additional of extended days and weekend working in the interim. Part of Regional Network discussions. 5/11/20 Access times remain poor 80 weeks having to prioritise high risk, in patients although only achieving 35% in KPI in getting to cath lab within 72 hours 20/5/2020 No change as there is no second laboratory 24.06.19 Discussed with Medical team still high risk as radiology room only available at times, would impact on elective and inpatient activity if C Arm was broken. High Risk as only one cath lab theatre. 11.03.19- No update. 13.08.18 discussed with cardiology and radiology team dependent on when equipment fails the clinician will liaise with radiology and room 1 and 2 in radiology will be used. 26.02.18 Awaiting update, risk remains unchanged. 1.09.16 IPT developed, Working Group Established. Awaiting confirmation of funding and equipment on NHS supply chain. 01.06.16 - business case for replacement and upgrade of equipment. Use of radiology equipment in the interim when required.	HIGH	DIV
3990	19/11/2018	Provide safe, high quality care	Dermatology Unit	Delays in seeing Dermatology Red Flag Referrals at Outpatients	Unable to see new Red Flag patients within the access target time. Delays in diagnosis for patients who have potential for skin Cancer. Delays in patients staring 31 and 62 day pathway. Delays in Patients being seen at Clinic and therefore increases risk of skin cancers developing or spreading.	We provide medical and nurse led clinics across all trust sites. Review clinic templates and increase Red flag slots. Review Clinic templates. Avail of additional funding for clinics. Review performance monthly. Escalate to Performance team. We have medical and nursing clinics across all sites We work closely with Cancer trackers re access times and investigations Escalate accordingly Three patients breeched monthly report.	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists. 02/06/2020 High demands for service and access times unchanged. COVID has increased access times to service, validation, Virtual clinical activity operational 7.8.19 Review access monthly and SABA levels no change 11.03.19- No update. Review access times monthly.	MOD	DIV
3991	19/11/2018	Provide safe, high quality care	Dermatology Unit	Dermatology delays in patients having day case procedures	Unable to carry out day case procedures on patients within the access target time. Delays in diagnosis for patients who have potential for skin Cancer. Delays in patients starting 31 and 62 day pathway. Delays in Patients being seen at Clinic and therefore increases risk of skin cancers developing or spreading.	We provide medical and nurse led clinics across all trust sites. Review Clinic templates avail of additional funding for clinics. Review performance monthly. Escalate to Performance team.	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists.2/6/20 Day case activity remains unchanged High demand and issue with reducing staffing and difficulty in recruiting. COVID impact on service due to theatre capacity and dermatology unit not available 7.8.19 Review access monthly and SABA levels no change 7.8.19 Review access monthly and SABA levels no change 11.03.19-no update Review access times monthly.	MOD	DIV
3940	26/02/2018	Provide safe, high quality care		Provision of Consultant on call rota for out of hours GI bleeds.	Inability to provide consultant cover in the out of hours period with the skills to manage patients admitted with haematemesis. Patients admitted with large haematemesis unable to be managed in a time critical manner.	Registrar manages the patient with haematemesis in the first instance. If Registrar requires support they would phone round the Gastroentrology Team if available to come in to assist.	07/06/2021- work on middle tier- stronger investment in post- diabetes/gastro- plan shows in better place. Has review happened in DHH? 11/08/20 - this remains a risk and has been raised with Medical Director. 31.07.19 Still ongoing raised wit Med Director Re Surgery & Gastro 10.4.18 Escalated to Directorate RR 26.02.18 Risk added to Divisional Register	MOD	DIV
3759	26/01/2016	Safe, High Quality and Effective Care	Diabetic Clinic, Surgical Outpatients	Diabetic Antenatal Clinic Risk	Increase in patients attending, significantly since change in threshold for Gestational Diabetes (IAD and PSG 2010). Difficulties arising due to the increase in numbers of patients who need to be seen at these clinics.. Poor pregnancy and neonatal outcomes.	The old early pregnancy room is vacated request submitted to create an additional clinic room. The clinic is commissioned for 1 Doctor; however, effort to ensure that 2 additional doctors attend. (Currently unfunded and can impact of other duties)A GP with specialist interest covers ad hoc. A Locum Physician with specialist interest covers to provide a second doctor. The Consultant from DHH has provided cover however this requires backfill in DHH. The number of CTG's at clinic has been reduced. Patients requiring steroids - Dr Sidhu assesses patients on a Thursday afternoon and if they require and admission the Diabetes Consultants try to ensure that this admission occurs on a Monday as there is no cover available over the weekend to advise on insulin doses. However it is problematic when the situation arises where it is essential for the patient to be admitted on the Thursday night (eg because of a problem on the scan). If this is the case - they are inpatient over the weekend and the midwives usually ring Dr McConnell over the weekend to sort insulin doses as they struggle to get medical reg's to answer bleeps. Unfortunately the medical reg's aren't trained in managing antenatal patients and how to increase insulin doses in relation to steroids in pregnancy. Postnatal GTT are managed virtually and are not called back to clinic. Patients requiring insulin starts and education have been given appointments with the DSN on Friday mornings rather than being started at the Thursday afternoon clinic as they are more time consuming.The number of New patients per clinic has been reduced to 8 to facilitate reviews.Increased the number of virtual contact by DSN to help.	24/02/2021 still at risk as the transformation funding is non recurring. 12.08.19 Still need more clinical rooms. Now have DSN - No Diabetics. Not funded to diabetics nor is there clinical space available. 11.3.19- An Additional Diabetic Antenatal Clinic was set up on a Thursday morning where 24 new patients are seen per week. No funding was received for this clinic however due to the high risk it was agreed to try to reconfigure Consultant job plans to enable the clinic to be set up. Funding will have to be secured. With Transformation funding a Diabetic Antenatal Specialty Doctor (Locum) has been appointed who undertakes virtual clinics. Group education Sessions are done on a Monday with A Diabetic Specialist Nurse + Diabetic specialist Dietician to see the new patients in advance of their consultant appointment to reduce the length of wait at clinic.	MOD	DIV

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3686	08/06/2015	Provide safe, high quality care		Lack of junior medical cover	High demand for admissions. Due to cover for night duty, annual leave, reduced number of staff available at ward level. Delays in Treatments, Discharges.	Continues to be managed	24.02.2021- escalated to AMD. Physician Associates recruited for DHH and Medical workforce bid done. Ongoing on both sites 12.08.19 Still gaps, locum requests review 11.03.19- No update. 26.02.18 Still gaps in junior medical staff provision from NIMDTA and trust are sourcing this via agency contracts.		DIV
3863	21/12/2016	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeing	Renal Unit Daisy Hill Hospital	Lack of consultation rooms in Renal OPD	Nephrology, Haemodialysis Outpatients are at risk. There is risk to patients from lack of education regarding drugs and diet. Consultation space, office space, day procedure/treatment required.	Education is frequently carried out in a totally unsuitable environment which is not conducive to patients health and well being (Fire escape corridor). In addition other staff are displaced from offices to accommodate patient consultation/education including Consultant Nephrologist who is displaced from his office during clinics.	24/02/2021 covid has impacted the opportunity to see face to face patients in OPD. Escalated to the Director and Estates week of 15.02.2021 20/5/20. This work is one the capital estates work but high cost and investment and other estates work takes priority over this at times 24.06.19 Team agreed met with estates. Plan for extension being developed. On capital list as priority No 4 currently. Reviewing accommodation alternatives as interim until extension undertaken. 11.03.19-No update 13.08.18 Renal team and HOS worked with Estates staff regarding proposed new plan for renal services, This requires costing and to be brought forward to SMT. 26.02.18 Priority No 7 on capital list.		DIV
3986	19/11/2018	Provide safe, high quality care	Respiratory Dept	Unable to see new and Review Respiratory patients at out patient clinics in a timely manner	Delay in patientsd being assessed, Diagnosed and commenced treatment Delay in commencing appropriate pathway Delays in diagnosis for patients who presented with Respiratory Conditions.	Our Respiratory team provide clinic across a number of sites within the Trust Urgent Patient reviewed Clinic Templates set up to address new to review ratio Revalidation of clinic Review clinical activity Available of WLI clinics as required.	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists. 5/11/20 unchanged access times long as out patient clinics impacted with covid and ability of respiratory consultants to be released from ward activity Outpatient accommodation has been reduced across all trust sites to undertake clinics. HSCB have asked for bids for funding for covid impact working with planning and finance. 20/5/20. High Volumes and long access times 93 weeks Consultants carrying out Virtual clinics. Impact of COVID 19 on access times as consultants can not undertake Face to face clinics due to limited accommodation and also Patients fearful to attend hospital setting 24.06.19 No change, Access 97 weeks for non urgent. Monitored monthly via performance team. Escalated to Dir and HSCB 11.03.19- No update. Development of IPT as part of respiratory services framework. Review compliance with KPIs		DIV
3987	19/11/2018	Provide safe, high quality care	Cardiology Clinic	Unable to see Cardiology new and review patients in a timely manner	Delay in patients being assessed, Diagnosed and commenced treatment Delay in commencing appropriate pathway Delays in diagnosis for patients who have potential for cardiac conditions	Our Cardiology team provide clinic across a number of sites within the Trust Urgent patient reviewed Clinic Templates set up to address new to review ratio Revalidation of clinic waiting lists Review clinical activity Available of WLI clinics as . required and when funding is available	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists. 5/11/20 medical staff continue to provide face to face and virtual clinics, activity and access times monitored monthly. waiting times long. accommodation provided in cath lab 20/5/20 covid 19 has impacted on access times. Consultants continue to validate and carry out virtual clinics. Face to face clinics limited due to accommodation restrictions. Patient fearful to attend face to face. 24.06.19 WLI - carried out when funding available. New outpatients 45 weeks currently monitored monthly and escalated to Dir and HSCB. 11.03.19- No update. Identify any risks to HSCB re performance and access Times. Review NICE guidelines and highlight areas of non-compliance to Assistant Director and Director.		DIV
3988	19/11/2018	Provide safe, high quality care	Dermatology Clinic	Unable to see new and review Dermatology patients within the access target time of 9 weeks	Unable to see new and review patients within the access target time of 9 weeks. Delays in diagnosis for patients who have potential for skin Cancer Delays in patients starting appropriate Drug Regimes Delays in Patients being reviewed at out patients and skin cancers developing or spreading	we provide mediact and nurse led clinics across all trust sites. Validate waiting times Review clinic templates New and review to assist with increased red Flag referrals from May To October Review Clinic templates new to review avail of additional funding for clinics Avail of additional medical support locum consultant to assist with review backlog Review performance monthly Escalate to Performance team	24/02/2021- ongoing downturn in activity due to COVID which as further impacted on and already saturated department. new location in Ramone 1 being discussed 02/06/2020 Covid 19 has impacted on accommodation availability to carry out Face To face clinics.. Consultants and Nurse specialists carrying out virtual clinics and limited face to face. Patients anxious re-attending clinics 24.06.19 - 4 Consultants in post, access reviewed but demand high as SHSCT have highest incidence of skin cancer. So high demand for new and review appts. 11.03.19- No update Development of IPT to secure finding to support 4th consultant. Review access times monthly and escalate to Assistant Director and Director.		DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding																		
3989	19/11/2018	Provide safe, high quality care		Unable to carry out Cardiac Catherisation procedures in a timely manner	Delay in patients having their Cardiac Cauterisation procedure carried out Delay in diagnosis and patients commencing appropriate treatment plan Delays in diagnosis for patients who have potential for cardiac conditions Potential for high risk patients who may require Cardiac surgery/ Valve replacement waiting over 13 weeks Potential of death for patients waiting on cauterisation procedure or stenting.	Our Cardiology team provide 10 theatre sessions in main cath lab Secured Funding for modular cath lab until March 2018. Maximise cardiac cath lab sessions Revalidation of waiting lists Review clinical activity Avail of WLI in Modular cath lab sessions	24/02/2021 escalated to Director. Part of the Regional Cardiology Network Plan to secure 2nd Cath Lab. Demand and Capacity is taking place regionally. 12.08.19 modular on site until October 2019, Involved HSCB to secure 2nd lab. 11.03.19- No update. 1. Identify any risks to HSCB re performance and access Times 2. Review NICE guidelines and highlight areas of Non-compliance to AD and Director and Director of performance. 3. Validate Waiting lists 4. Pre-assessment of patients by Cath lab nurses	MOD	DIV																		
4129	02/03/2020	Safe, High Quality and Effective Care Make the best use of resources	Trustwide	No psychology provision for Gastro, Rheumatology, Neurology, Diabetes and Endocrinology	There is no psychology provision for the named specialties about from 7 hours in DHH for Diabetes which is insufficient for the cohort of patients. Patients who have psychological problems may come to harm and in the case of diabetes there may be mortality if there is not provision to get them psychological assessments/therapies. In Diabetes in particular there are several issues- eating disorder, needle phobia, deliberate insulin omission, fear of hypoglycaemia. Some of these, in particular, deliberate insulin omission can lead to death. Within Gastro, Neurology and Rheumatology dealing with long term illness can be detrimental to mental health in the absence of relaxation, stress management and cognitive coping skills to help patients adjust to living with their condition.	Have sought help from the Psychology Department however they are under resourced and unable to make any provision with out additional funding/resources Have tried to submit Extra Contractual Referrals (ECR's) for Diabetes in Particular however they do not meet the required criteria Have tried to refer to BHSCCT however referrals have been returned as out of area. Have put the need for psychology services and the development of an IPT on the Acute Revenue Pressures and Priorities list however this service is competing with a huge volume of other priorities within the demography funding allocated to SHSCT.	07/06/2021- The NI Mental Health Champion written to the Health Minister regarding provision of psychological support services for people living with inflammatory bowel disease in NI- Louise to update re Medicine? 01/06/2021- moved to divisional register as per director. 16.03.2021- No change Submission of requirement on Acute Revenue Pressures and Priorities List	MOD	DIV																		
4047	05/08/2019	Provide safe, high quality care Make the best use of resources		Lack of Capacity in CAH and DHH	Inability to undertake all treatments that are required due to lack of capacity. Delays in treatment for patients leading to poor management of their condition plus possible poor outcomes. There will also be an impact on patient flow as patients may require inpatient admission if their condition worsens.	Continually monitor the situation and maximise capacity by staggering patients risk assessing to prioritise the higher risk patients and create a waiting list for lower risk.	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists.	MOD	DIV																		
4048	05/08/2019	Provide safe, high quality care Make the best use of resources		Nursing posts not fully funded in DCC/Discharge Lounge	Nursing posts are funded at risk. This could impact on all treatments that are required. This could lead to delays in treatment for patients leading to poor management of their condition plus possible poor outcomes. There will also be an impact on patient flow as patients may require inpatient admission if their condition worsens. If funding withdrawn will have to reduce staffing levels to within funded level which will reduce nurse to patient ratio which will impact patients and will impact staff who will be under increased pressure	Continually monitor the situation and maximise capacity by staggering patients risk assessing to prioritise the higher risk patients and create a waiting list for lower risk.	24/02/2021 CAH still no funding. DHH has the funding but currently out of the original DCC due to pandemic and movement required to facilitate other hospital services.	MOD	DIV																		
4052	07/08/2019	Provide safe, high quality care Make the best use of resources		Delays in seeing Red Flag Referrals for Gastroenterology	Delays in seeing Red Flag Referrals for Gastroenterology, Unable to see new Red Flag patients within the access target time.	Review clinic templates and increase Red flag slots. Avail of additional funding for clinics. Review performance monthly. Escalate to Performance team. We work closely with Cancer trackers re access times and investigations Escalate accordingly	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists. 7.8.19 Review access monthly and saba levels no change	MOD	DIV																		
4053	07/08/2019	Provide safe, high quality care Make the best use of resources		Gastroentorology, Rheumatology and Endocrine delays in patients having day case procedures	Unable to carry out day case procedures on patients within the access target time. Delays in diagnosis for patients who have potentially life changing serious illness. Delays in patients being seen at Clinic and therefore increases risk to patient.	We provide medical and nurse led clinics across all trust sites. Review Clinic templates avail of additional funding for clinics. Review performance monthly. Escalate to Performance team.	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists. 7.8.19 Review access monthly and SABA levels no change	MOD	DIV																		
4058	12/08/2019			Unable to see New and Review Gastroentorlogy, Rheumatology, Neurology, Diabetic & Endocrine patients at Outpatient Clinics in a	Delay in patientsd being assessed, Diagnosed and commenced treatment Delay in commencing appropriate pathway. Access Times <table><tr><td></td><td>Urgent(weeks)</td><td>Routine(weeks)</td></tr><tr><td>Gastroenterology</td><td>69</td><td>83</td></tr><tr><td>Rheumatology</td><td>71</td><td>139</td></tr><tr><td>Neurology</td><td>48</td><td>144</td></tr><tr><td>Diabetes</td><td>13</td><td>15</td></tr><tr><td>Endocrine</td><td>11</td><td>16</td></tr></table> Delays in diagnosis for Gastroentorlogy, Rheumatology, Neurology, Diabetic & Endocrine patients at Outpatient Clinics in a timely manner.		Urgent(weeks)	Routine(weeks)	Gastroenterology	69	83	Rheumatology	71	139	Neurology	48	144	Diabetes	13	15	Endocrine	11	16	Provide Clinics across a number of sites within the Trust. Urgent Patient reviewed. Clinic Templates set up to address new to review ratio. Validation of clinic Review clinical activity. Available of WLI clinics as required.	24/02/2021 pandemic has increased access times despite virtual, minimal face to face appts and validation of waiting lists. Aug 19 Access 97 weeks for non-urgent. Monitored monthly via performance team. Escalated to Director and HSCB.	MOD	DIV
	Urgent(weeks)	Routine(weeks)																									
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Endocrine	11	16																									
4116	06/10/2020	Provide safe, high quality care Make the best use of resources	Trustwide	Delays in undertaking rheumatology joint injections on the routine joint injection list	Unable to administer rheumatology joint injections for patients who are on the routine list. Due to lack of available clinic space- available limited clinics are prioritised for urgent patients which means there is no capacity to deal with routine patients Delays in patients being treated writing clinically required timescale's meaning a progression/deterioration of their condition which is irreversible.	The issue of lack of clinic space has been escalated to SMT via the Rebuild Plan which notes additional clinic space required for this speciality. Patients are triaged to the appropriate waiting list at the outset of decision to treatment. If routine patient/their GP contacts the Dept to request earlier commencement the patient consultant would retriage to determine if their are factors which would warrant moving up the waiting list and recategorising as urgent.	01/06/2021- move to divisional register as per Director 16/03/2021- Clinic space still limited therefore no increase in capacity for joint injections. Current waiting times Urgent= 59 weeks, Routine= 61 weeks (urgent was routine which was escalated to urgent hence similar waiting times). Additional Clinic space- still awaiting outcome of Rebuild Plan Phase 3 to know if this has been provided	MOD	DIV																		
3857	29/11/2016	Safe, High Quality and Effective Care		Increased patient confusion when moved continually around wards	There is a risk that elderly patients could have an increase of confusion or develop a delirium if they are moved from one ward environment to another. This would increase with the more moves that occur.	Increased confusion which could lead to patient distress, falls, increased requirement of medication to reduce agitation. Family's distress at relative being more confused than usual, or experiencing confusional state for the first time. In the event the hospital is under bed capacity pressures and outlying is required all Ward staff must ensure that they identify patients that are medically stable, do not have a known confusion or at risk of delirium, or have a learning disability.	24.02.2021 still ongoing 12.08.19 This continues to be a risk throughout wards. DHH Review of zoning system 11.03.19-No update (Consider equipment, staffing, environment, policy/procedure, training, documentation, information - this list is not exhaustive). It is within the outlying guidelines that patients that are confused should not be moved between wards unless for a clinical reason. This can be a challenge due to the ongoing bed capacity pressures experienced within the acute setting.	MOD	DIV																		

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3914	19/09/2017	Provide safe, high quality care		Gastroenterology/IBD Nurse Cover	As a lone worker there is no cover for her annual/sick leave which leaves a gap in the service. Unable to fill as no-one trained to undertake. The Nurse Specialist does not have sufficient capacity to see ward patients due to clinic, biologic, patient telephone helpline commitments. Telephone calls not being returned to patients within 48 hours when they contact the help line. If the IBD Nurse Specialist is not available to take the patient telephone call on the helpline then they will not receive advice on how to manage the 'flare up' of their condition. This will result them them potentially having to present to the Emergency Department and being admitted to hospital if their condition worsens and requires inpatient treatment.	As this is a single handed service with no cover there is no measure which can be put in place. There is a requirement for additional Gastroenterology/IBD Specialist Nurse. the only alternative to the Specialist Nurse not being available is for patients to attend the Emergency Department.	24.02.2021- still no funding available therefore still at risk 12.08.19 There are currently 3WTE Gastro Nurse specialist in post however 1.5 WTE is at risk as unfunded risk if further funding is not available. 13/3/19 In order to reduce risk for this service a 1 wte IBD Nurse Specialist was appointed at risk in August 2018. a further 0.5wte IBD nurse is being recruited using saving from switching biologics. Due to Start 1/6/19	MOD	DIV
3924	13/11/2017	Safe, High Quality and Effective Care	2 North Haematology	Haemtology/Oncology Helpine provision in the out of hours period	The service has been provided for Oncology/ Haematology patients within the Southern Trust without any additional Funding. Non compliance with the oncology/ Haematology Triage. 1.1 unable to ensure that patients receive timely and appropriate responses to their calls. 1.2 patients right to be treated with a professional standard of care. 3.3 no clearly identified triage practitioner for each span of duty the process should allow for allocation of responsibility to a nominated triage practitioner for a period of duty, on completion of this period the responsibility for advice line management and follow up of patients is clearly passed to the next member of suitably qualified staff. this should provide a consistent , high quality service. 3.4.1 no dedicated time in suitable area for consultation will enable the clinician to pay appropriate attention to the caller, without being interrupted. The risk to patients if call not returned and patient assessed in timely manner. Risk of Neutropenic sepsis	Hourly checks in place in the haematology ward regarding phone messages patients advised to ring back if not contacted within 15 mins to ring back to ward or if emergency to ring 999 or go to ED. Group set up to review other options that could be resourced. Band 5 out of hours period 7 days per week and at weekend and bank holiday being costed by finance.	24.02.2021- Minimal funding received which is still not sufficient to run the service 24/7. 24.06.19 Audit carried out. Meeting arranged July re Haematology Service. Currently helpline facilities Haem/Oncology. New clinic lead for haem requested Haem Helpline only. So process being worked through re impact. 1.03.19- No update. 26.02.18 Raised regionally by HOS Oncology. Pilot re Band 3 taking phone calls in place Monday-Friday 9am-5pm, awaiting results of this.	MOD	DIV
3624	05/12/2014	Safe, High Quality and Effective Care		Lack of a Biologic Suite CAH & DHH	Treatment of patients in facilities which are not designed for this purpose.	Use of isolation ward.	24.02.2021- There is still no designated area. At the moment if has been centralised to STH throughout the pandemic. A long term plan needs discussion and more permanent solution as part of review. Longer term sustainable medical cover is also required. 12.08.19 Increasing pressure for more treatments on both sites. 11/3/19 Day Clinical Centre - Where Biologics are administered continues to be located in the 6 Bedded Isolation ward as alternative accommodation has not been secured. The DCC is extremely small however treatments are carried out to ensure they meet appropriate standards and reduce risks. 29.02.16 - Plans in place to upgrade Ramone Ward to improve the accommodation when administering biologics.	MOD	DIV
3625	05/12/2014	Safe, High Quality and Effective Care		Clinical mangement of Medical Outliers.	Potential for patients not to be identified correctly and therefore missed by the clinical teams.	Correct use of IM MIX and updating as per protocols by all staff.	24.02.2021 COW model is in place but risk when additional beds open. Do not have clinical workforce to deal with this. 12.08.19 Zoning introduced, needs evaluated. 11.03.19-No update 01.06.16 - Still ongoing. Review of processes being taken forward. 29.02.16 - Requires directorate focus.	MOD	DIV
3627	05/12/2014	Provide safe, high quality care		Increasing patient dependency impacting upon ward staffing.	Dependency levels and health and safety of patients and staff due to sustained high level of dependency, a rapid throughput and reduced length of stay.		24/02/2021- Workforce still needs reviewed 12.08.19 Review nurse workforce. 11.03.19- No update 01.06.16 - International recruitment ongoing. 26.11.14 - Normative staffing level submitted and allocation of £1.5 million made to SHSCT. ADs and HOS to raise with Director to prioritise allocation of this funding to wards under most pressure.	MOD	DIV
3769	25/02/2016	Safe, High Quality and Effective Care		1:1 special staffing not available when required	Patients that are confused, agitated, aggressive or have a lack of awareness of their ability to mobilise are at a greater risk to themselves or others if 1:1 care is not available. Patients at risk of harm to self or others. Loss of dignity of patient. Ward disruption and distress to other vulnerable patients.	1:1 care is not always available to care for patients that are confused, agitated, aggressive or unaware of their inability to mobilise. This results in a greater risk to their safety, the safety of others increasing disruption on the ward and upsetting other vulnerable patients in the vicinity.	24.02.2021- there is no change in the report since 2019. Still ongoing 12.08.19 Guidelines Re 1:1 provision still ongoing. gaps in shifts being put out to agency. Going forward agency availability reduced as all non-contracted agencies will no longer be used. 11.03.19- No update. 26.02.18 Guidelines developed by Lead Nurses, to be signed off at Acute Nursing and Midwifery meeting 05.03.18	MOD	DIV
3687	08/06/2015	Provide safe, high quality care		Medical equipment in Cardiac investigations are old and some parts unable to be replaced	Due To the high demand for cardiac investigations across the trust if these equipment break or become obsolete this is risk to cardiology service	No replacement programme in place yet but replacement programme should be in place soon.	24.02.2021 one ECHO machine which is 10 years old and on capital priority list. All other equipment is new. 12.08.19 Equipment request, capital list priority 11.03.19- no update 13.08.18 Rolling programme developed and equipment priority placed on the capital list. 01.06.16 - New equipment ordered. Will be delivered June 2016.	LOW	DIV

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3688	08/06/2015	Provide safe, high quality care		Decontamination of TOE probe	The current process for decontamination does not meet Regional Decontamination Strategy Guidelines	Sourcing the use of a further probe from ICU as a temporary measure. Requisitioning additional probe. TOE probes are manually washed and manually disinfected between each patient use.	24.02.2021 TOE now available on CAH site just await the TOE processor with CSSD and it is on capital list 17.2.2020 TOE Probe Reprocessor is on trial in SSD CAH for 2-3 weeks. TOE Probe Reprocessor is included on the Trust Capital Replacement List awaiting approval of funding. 12.08.19 TOE Probe ordered 11.03.19- No update. 13.08.18 further ECHO machine funding confirmed for DHH. ICU also giving probe to cardiac investigation team in CAH. When new ECHO delivered there will be 4 on CAH site and 1 DHH site. 26.02.18 Another ECHO and TOE probe purchased delivery date expected by 31.01.18.		DIV
3923	13/11/2017	Safe, High Quality and Effective Care		Cardiac CT angio, high demand	Currently have high demand of Cardiac CT angio. Waiting Time is 55 weeks Non compliant with NICE guidelines re Chest pain diagnosis -- first referral is CT angio. Patients are waiting 55 weeks for this diagnosis which can delay diagnosis and mangement plan.	Only Two sessions per week. Have requested additional funding for a further 3 sessions of CT angio. to address waiting times.	24/02/2021 Radiologist appointed. Additional CT sessions in place and access time is now sitting at 4-6 weeks. 12.08.19 Task and finish group regional first meeting 11.03.19- No update. 13.08.18 Two additional sessions have ceased due to availability of room in CT scanner and funding, regional meeting to review CT provision across NI. 26.02.18 Two additional sessions per week provided by review of jobs plans. The access to cardiac MRI and CT angio has been raised regionally and HSCB setting up meeting to discuss		DIV
3050	29/11/2011	Make the best use of resources	Corridor/Landing	File Management Issues- Hospital Social Work Department, CAH.	Accomodation issue. Not enough room to store patient records in line with the Trust Retention Policy.	Records reviewed annually. Use of closed storage. Accomodation request previously submitted. AD and Corporate Records aware of issue. Review 9.12.14 discussed with Line Manager and HOS for Corporate Records. Continue to use closed records. Trial using electronic solutions in the community to be audited and then for further consideration by hospital social work.	24.02.2021 Flo Fegan to provide update 29.07.19 - Moved to RAMONE BUILDING Nov 18 Paris full implementation for Adult HSW records from Dec 2018, no manual records held at present other than Adult SAFEGUARDING with Adult SW records. Paris : Part implementation for Children's records at present with aim to move to full implementation within the next few months All records now stored safely in locked filing cabinets , currently identifying records to be sent for retention. 26.02.16 - Health and Safety Risk Assessment completed. 26.11.14 - HOS to re look at all storage options including off site, scanning and microfilming.		DIV
3956	30/04/2018	Safe, High Quality and Effective Care		Non-compliance with NCEPOD inspiration for the future	There are 21 recommendations for this NCEPOD Currently only fully compliant with 1 KPI. Patients who require Non Invasive ventilation have the potential to receive inadequate care as we are non compliant with 21 KPI	Established MuLi Disciplinary working group for the Trust. Established Sub groups to take forward key Indicators. Establish baseline and review in 6 months.	24.02.2021 compliant with 16 out of the 21 KPIs but there is a gap in the 24/7 respiratory cover and is part of the respiratory framework. Escalated regionally and a bid put forward for staffing. 7.8.2020 can be removed to the divisional risk register as issues of non compliance are work force related. 13/5/20 On going review of compliance issues identified are that we cannot provide 24/7 Respiratory cover on both Acute Sites. Compliant with 15 of KPIs 24.06.19 Group established. Action plan developed. Non-compliance areas due to lack of staffing. Compliant with 12 of 21 KPI		DIV
3892	24/05/2017	Make the best use of resourcesProvide safe, high quality care		Unable to achieve Training Objectives	Training room being down sized resulting in reduced capacity and cancellation of ALS/ILS/BLS Impacts on training for staff throughout the trust, potential impact on patient safety. Potential for patients to be placed at risk secondary to lack of training provision.	No alternative control measure available.	24.02.2021- training now provided in MEC DHH. The Resus officer on DHH site has the boardroom for training. CAH still ongoing issue for accommodation. 12.08.19 Still difficulties to release staff and attend training. High trainer staff. 11.03.19- No update. 13.08.18 Review training requirements and develop IPT re funding for additional staff and accomodation.		DIV
4023	18/04/2019	Provide safe, high quality care	Day Clinical Centre	Discharge letters not completed for patients who attended the Day Clinical Centre for treatment.	As discharge letters have not been completed for patients who attended the Day Clinical Centre for treatment it means that this has not been communicated to the patient's GP. GP's will be unaware of treatment which their patient has received which may affect their decision making with regard to further treatment plans for their patient.	This has been highlighted to the medical team who advise that "asking the F1's to attend to outstanding/historical tasks is 1. ineffective, 2 unrealistic given their current pressures. There remains no current resolution for dealing with this issue however we will endeavour to seek a solution.	24.02.2021- DCC in DHH discharge letters are completed by the Nurse in timely manner. CAH needs confirmed? 7.8.19 - Discharge letter in DAU, following meeting with K Cunningham and J McEvoy 6.8.19. The discharge letter was reviewed and amended following discussion. This work has been prioritised by the Trust's EEMs group who are due to meet again in September. They will keep us updated regarding the timescale to complete the works. 18.04.19 - await appointment of clinical director in Daisy Hill Hospital who will address this issue with medical staff.		DIV
4073	20/11/2019	Provide safe, high quality care		Fraud Awareness Possible non-compliance	Possible non-compliance on a number of aspects regarding Fraud throughout the Medical Division in relation to submission and approval of agency staff rotas. Possible litigation for member of staff. No harm to patient/service user	Agreed process for validation of overtime. Agreed process for sick leave, annual leave and study leave. Agreed process for housekeeping. Ward Sisters attended awareness with Finance Staff. Heads of Service scheduled to attend updated Fraud Training.	24.02.2021- areas of fraud policy cannot be stood over i.e. the tracking of invoices. Highlighted to AD at governance meeting w/c 15.02.2021 27/11/19 Key Staff scheduled to attend updated Fraud Awareness training sessions.		DIV
4024	30/04/2019	Provide safe, high quality careMake the best use of resources	2 South Medical	RPC Guideline for TIA Management not achievable	RPC guideline indicates that all TIA / ?TIA patients must be reviewed within 24 hours. The service provision in SHSCT is inadequate to meet this requirement. There is a risk that patients will have further TIA / Stroke before they can be reviewed and commenced on appropriate care pathway. This could have a catastrophic outcome for the patient.	There are TIA clinics held Tuesday - Friday for urgent cases and a Neurovascular clinic on Mondays for less urgent cases. The patients attending the Tues - Fri clinics can be waiting 4 days.	24.02.2021- Patricia to come back to Governance Aug19 Risk remains unchanged. Difficult to recruit staff 30/04/19 Risk added to Register		DIV

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2250	08/09/2009	Provide safe, high quality careSafe, High Quality and Effective CareImproving Health and WellbeingEffective organisational governance		Risk to health and safety of patients presenting to the trust with chest pain. CAH & DHH	Risk of missed diagnosis in wrongly interpreting a patients ECG by junior medical staff. Patients may not receive timely and effective treatment appropriate to their diagnosis.	Where possible a senior member of medical staff will review ECG and give an opinion. Thrombolytic team should be paged immediately if patient presents with ischemic cardiac pain.	24.02.2021- NCG 95 guidelines in place. Chest pain nurse in ED and referral to RACCP and meing 2 week target. 12.08.19 Clinical educator and clinical physiologist programme in place for training all staff both sites. 11.03.19- No update. 01.06.16 - NICE guidelines currently being reviewed. 01.02.13 Chest pain pathway to be reviewed by clinicians. 25.10.12 - Position remains unchanged from previous report - no adverse incidents reported since. 23.01.12 - Cardiology liaison service commenced 9am - 5pm Monday - Friday. 07.09.09 - a training package has been developed but no dedicated funded personnel to deliver training package to junior medical staff on an ongoing basis has been identified.	LOW	HOS
1027	07/08/2008	Safe, High Quality and Effective Care		Risk of spread of infection due to inadequate facilities	Risk of spread of infection due to inadequate facilities, e.g. lack of sidewards, bed space near sinks and sharing of equipment; all wards, CAH.	Endeavor to adhere to current infection control policy; new visiting policy guidance; use of alcohol gel Trust wide; infection control link nurses in each ward; daily monitoring by Infection Control Team; equipment controlling.	24.02.2021 pandemic has highlighted lack of faciilties in the SHSCT. HOS identify areas and raising through capital work schemes. 12.08.19 Daily risk assessment carried out. Refurb ongoing. No additional facilities available. 11.03.19- No update. 01.06.16 - Some work carried out during the last refurbishment. Negative Pressure Room in Ward 2 North Respiratory. 25.09.13 - further development of en suite side rooms planned for CAH 2 South along with work highlighted below in 1 South due to commence October 2013 negative pressure isolation rooms being installed in main block for ill patients who cannot transfer to ramone ward. 27.11.12 - Ramone Ward now operational. Work to commence on Ward 1 South in March 2013. Clear guidance and risk assessments in place. Daily review of all patients in side rooms with input from infection prevention and control team. 01.10.11 Risk reviewed by MB,KC, SB on 27.09.11. Isolation ward opened in June 2011 plans to undertake further work in 1 South to create a new isolation unit in the main Upgrading of 2 North Haem/Resp completed in August 2011. Plan to upgrade all wards in MUSC to create additional ensuite facilities and piped oxygen and airblock due being taken forward by HOS.	LOW	HOS
1044	08/08/2008	Safe, High Quality and Effective Care	Wards	Safety and wellbeing of patients and staff due to lack of storage space	Space; health, safety and wellbeing of patients and staff due to lack of storage space, lack of bed space, not meeting department guidelines, sanitary facilities, counselling facilities, toilets and showers; lack of space for equipment; all wards, CAH and DHH.	Utilise all available space effectively.	24.02.2021 pandemic has highlighted lack of facilities in the SHSCT. HOS identifying areas and raising through capital work scheme. Moving of non-clinical staff out of ward areas to free up space and storage facilities at ward level. 20/5/20 ongoing issues identified and logged via estates capital list 24.06.19 Ongoing walk arounds and meetings with Infection control, estates, ward sisters and management to develop action plan to address. 11.03.19- No update. 01.06.16 - Storage space still not adequate. Refurbishment has helped but still falls short of appropriate standard. 26.11.14 - AD to write to locality team to raise issue of non-clinical use of clinical space on wards. 25.09.13 - refurbishment on-going. 27.12.12 - Each ward working towards refurbishment programme. 01.10.11 Reviewed 27.09.11 no change in risk. Minor works being identified at ward level to be undertaken to create more storage space.	LOW	HOS

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4166	19/04/2021	Maximise independence and choice for patients and clientsInnovation , continuous improvement and modernisation	Accident & Emergency CAH	Lack of toilets and showering facilities for patients in ED due to pandemic	There is currently one toilet in yellow and green area. The only available showers are in red resus and are only for use by patients in that area. Therefore increased risk of infectious transmission	Currently patients are supplied with a surgical fluid shield mask and asked to wear this throughout their time in ED. This is not always possible due to patients being confused and non compliant with wearing mask. Staff are in Amber/Red PPE depending on treatment being delivered to patients Lumira testing enables safe and appropriate allocation of patients to clinical areas Additional commodes procured to mitigate risk	21/09/2021- the Trust has allocated 1.9 million for CAH ED for nosocomial works. In this plan an ensuite cubicle was planned for yellow area and an extra shower toilet for the green area, there was also extra toilets for staff in the courtyard area. The work in the yellow and green area will be delayed as a considerable amount of the money allocated has to go to AHUs as external design team have identified that the current air in both areas is insufficient	HIGH	DIV
4144	17/08/2020	Provide safe, high quality careBe a great place to workSafe, High Quality and Effective Care	Accident & Emergency	Safe Medical Staffing Levels	Patients and staff at risk. Lack of experience ED doctors to provided timely and emergency care.	posts advertised. Using Locum's	20/09/2021- CAH- appointment of clinical fellows. DHH has ongoing difficulties in securing gaps including middle grade cover overnight. Contingency plan in place. Medical workforce review commenced. Secured 2 permanent consultants in DHH ED who commence in November 2021. Ongoing recruitment to secure locum's and block booking locum brought in NIMDTA are not allocating additional trainees at this level. Non funded posts at risk	HIGH	DIV
3969	31/07/2018	Provide safe, high quality careBe a great place to workMake the best use of resources	Medical Admissions Unit	Risk to Staff of Assault on Medical Wards/Areas	Staff at high risk of being harmed. Staff have sustained personal injury and have alleged they have been sexually assaulted in this ward. Areas of particular concern ED, MAU, 2S Med, 1S, Male Med and Female Med	Ongoing support for staff. Identying patients at high risk and requestion one to one. Requesting security 1 /1 for violent/aggressive patients. Review of GMAS - AD pharmacy for approval. Refurishment of nurses station - further risk assessment being carried out on same. Ongoing monitoring of same. Ongoing MAPA training for staff	20/09/2021- Feedback from Anita Carroll. Proposal taken to SMT and not approved. Medical Director is chairing a working group on the management of violent and aggressive patients. Management of Detox patients working group includes psych/AMU/ED meeting to take place on 21/09/2021. 12.08.19 Draft paper to Medical Director Re Violence and Aggression. Nurse station completed. H&S safe/ Unison Risk Assessment completed. Draft proposal for dedicated security to AD for approval. Debrief in place for each incident and Action plan agreed	MOD	DIV
4175	20/09/2021	Effective organisational governanceProv ide safe, high quality careSafe, High Quality and Effective Care	AMU	Lack of showering and toilet facilities for patients	Increased risk of cross contamination between patients as they share bathroom facilities and this has been the cause of several outbreaks of covid in AMU. Lead to bed closures and reduced capacity for acute admissions. Patients at higher risk of contracting covid.	request for doors to be erected to segregate bays and need for additional toilet facilities.	20/09/2021- raised at risk register meeting to be added onto register	MOD	DIV
3685	08/06/2015	Provide safe, high quality care	Trustwide	Lack of pharmacy cover.- ED DHH	Patients being admitted may wait 3-4 days for Medicine Reconciliation and this can lead to Medication prescribing errors.	Managed on a day to day basis.	20/09/2021-2 pharmacists, 1 technician and 1 ATO employed to work across both ED/DAU. From November 2021, 1 pharmacist on maternity leave, aiming for 0.5WTE cover for this within current staffing. 07.08.2020 - Interim AD to link in with Director of Pharmacy regarding Workforce Paper 07.08.2020 - Interim AD to link in with Director of Pharmacy regarding Workforce Paper 12.08.19 Still ongoing - Head of Pharmacy has put forward a business case for consideration. 11.03.19- No update 01.06.16 - Business case prepared for additional resources.	LOW	DIV
1025	07/08/2008	Safe, High Quality and Effective Care		Insufficient beds in the system and high bed occupancy-AMU	Dependency levels and high bed occupancy; health and safety of patients and staff due to a sustained high level of dependency and high bed occupancy, rapid throughput and reduced length of stay; all wards, CAH and DHH.	Adequate use of equipment; redeployment of staff between wards; staff rotation; risk assessment; consultation with consultant medical staff and bed management/CSM; review staffing levels; monitor dependency levels vs skill mix and stafing levels; monitor accidents and incidents; montior sickness absence; monitor clinical incidents; monitor complaints; annual manpower planning; monitor complaints; monitor patient's stay in hospital 3 times daily - PT flow meetings.	20/09/2021- Bed capacity in AMU has been further reduced for acute medical patients as 7 beds are dedicated for patients requiring AGP's. This reduces capacity to accommodate patients who require isolation. 09/03/2021- bed modelling exercise currently being reviewed. Dec19 Arrange meeting with MB Early 2020 to update info of the current situation Aug19 Risk Assets Form to M Burke to provide update on the current situation 11.03.19- No update. 01.06.16 - No update. Work ongoing. 26.11.14 - New Medical model now in place in CAH. Discussions commenced with regard to medical model in DHH. Opening of additional winter beds in both CAH and DHH. Work commencing on creating a business case for additional medical beds on the CAH site.	LOW	DIV

2383	22/10/2009	Provide safe, high quality careMake the best use of resources	Accident & Emergency	Transfer of patients with unstable neck injuries to the Regional Centre in Belfast	Delays in transfer of patients with unstable neck injuries to the Regional Centre in Belfast resulting in: 1. Potential for poor outcome for the patient when they remain in SHSCT ED. 2 Loss of confidence in the organisation. 3. Potential for complaints, litigation for the Trust	Escalation plan within ED for patients in the department 4 hours or greater. Plan includes escalation up to ED consultant on call which facilitates dialogue with Consultant in Regional facility.	20/09/2021- discussed at meeting and escalated to medical directors office who has asked the AMD's agreed position- not resolved. Mary to provide template attachment for this 09/03/2021- MB to raise at acute governance in March Meeting 12.08.19 Draft pathway agreed ED and T&O awaiting T&O sign off 11.03.19- No update. 22.10.13 - No datix reports of any such incidents within the past year. Discussed with AMD who would like to keep risk on register for a further period of monitoring. 01.02.13 - Reviewed by Heads of Service on both sites. Trauma group established to address further issues, December 2012. 23.01.12 - No delays reported since last review. 01.10.11 Reviewed by P Smyth & M Burke on 27.09.11 on going monitoring of this risk by Nurse Manager & HOS	MOD	HOS
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ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4189	08/12/2021		Pharmacy	Overcrowding in CAH Pharmacy Dept	The Overcrowding in CAH Pharmacy Dept risks Difficulties maintaining safe spacing of staff to comply with Covid guidance to prevent infection spread. Manual handling risks to staff due to cramped storage and working conditions. Inability to obtain an MHRA Wholesale Dealer Authorisation (WDA) which limits the Trust contribution to the waiting list initiates planned as part of post Covid rebuild and recovery of services. The CAH Pharmacy department was remodelled in the early 1990s when the total number of staff working in the department was 31. Further work was completed in 2011/12 to modernise the department and allow the installation of a dispensing robot, however this did not increase the footprint of the department. Currently 195 staff work out of the same CAH Pharmacy space, resulting in the overcrowding issues listed in the potential for harm section above. The lack of storage space within the department results in the pharmacy stock being stored at high level, on the floor and in offices. As a result there are manual handling risks to staff and it is not possible to meet the minimum requirements to obtain and maintain a MHRA WDA. There are difficulties spacing staff in the dispensary to main covid measures. Screens have been fitted however these hamper the flow of work in the section.	A number of clinical staff (30) have been relocated to an office on the Admin Floor. This has reduced but not solved the staff crowding issue and it also hampers efficiency of working between them and the dispensary. Screens have been fitted between workspaces to help with the IPC risk however these hamper the flow of work in the dispensary section. Manual handling risk assessments completed and implemented as required. Future expansion of the pharmacy has been discussed with the Estates team - with a plan to relocate the Dietitians so that the old aseptic suite could be knocked through into those offices and also part of the back corridor outside the kitchens to be incorporated into the pharmacy footprint. This would increase the space available. New build/extension of the pharmacy onto the grass area outside the pharmacy admin office - discounted due to lack of funding for such a scheme.	08/12/2021- further expansion is required but no date confirmed. Plans to be drawn by Estates student.	MOD	DIV
1135	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	IV drugs reconstituted at ward level; risk of infection; risk of wrong dose, especially if many manipulations	IV drugs reconstituted at ward level; risk of infection; risk of wrong dose, especially if many manipulations.	IV drug manual rolled out through regional MI; FY1 induction training on preparation of intravenous medicines. regional preparation templates being developed for recognised red risk IV medicines ongoing	Results of high risks identified fed back to the regional NPSA safety alert implementation group. The Trust is complying with their recommendations as they are being issued to the service. Regional SOP's are being prepared. 08/12/2021- The trust is complying with the regional recommendations as they are being issued to the service. Regional SOP's are in use as required. A regional group of medicines information pharmacists has been set up to action this initiatives.	LOW	DIV
1150	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	Discharge medication supplied directly from ward by nursing staff	Discharge medication supplied directly from ward by nursing staff; risk of dispensing error due to untrained and inappropriate staff; labelling - not in line with legislation; incorrect prescription now dispensed; 28 day supply; no clinical check.	Where possible all discharge prescription should be supplied by the pharmacy team; where this is not possible, supply directly from a ward must be carried out in accordance with an agreed procedure. Weekend and weekday opening hours extended to reduce frequency.	08/12/2021- still ongoing 17.10.17 Ongoing risk as pharmacy is not open 24/7 so some ward dispensing will still happen. Ongoing monitoring in place and ward staff encouraged to plan discharge in advance so this doesn't happen.	LOW	DIV
1121	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	Manual handling risk associated with ward orders/fluids	Manual handling risk associated with ward orders/fluids.	Trained staff in Pharmacy; new ward stock trolleys purchased and being rolled out; rate-limiting step is availability of Portering staff; boxes half filled only; risk by transport driver - assessed by Back Care Co-Ordinator; second porter now working in pharmacy; risk assessments done by S Kilpatrick; heavy work shared by technical staff; following injuries some staff on light duties	08/12/2021- still ongoing. 16.10.17 Ongoing risk in pharmacy due to the manual nature of some of the work in the stores areas. Ongoing monitoring and staff training in place.	LOW	DIV
1134	13/08/2008		Pharmacy	Security of drugs during transit to other hospitals	Security of drugs during transit to other hospitals; are vans locked when left unattended?; no signatures for receipt of drugs when sent with transport other than pharmacy driver.	Tamper evident seals on all boxed (but not for supplementary orders). Transport manifest now introduced - including signatures for delivery driver and for staff receiving goods on delivery.	08/12/2021 Ongoing risk being monitored by the Pharmacy dispensary and store teams	LOW	DIV
3502	14/10/2013			Clinical pharmacy cover for Trust wards	Only 80% of Trust wards have a full clinical service and there is no clinical cover on wards at the weekends. This is resulting in inconsistent drug history taking, no clinical checks of Kardex and/or discharge prescriptions - thus increasing the risk to patient safety as medication incident may go undetected and result in patient harm.	All new IPTs for expanding services have clinical pharmacy support included. Pharmacy skill mix has been reviewed to ensure the maximum service is provided with current staffing. Current maternity leave and recruitment issues have again increased the risk.	08/12/2021- Trust has funded 10 permanent staff to include the maternity cover 16.10.17 Risk remains unchanged	MOD	HOS
1119	13/08/2008	Safe, High Quality and Effective Care	Pharmacy	Flammable load in pharmacy too high; risk of fire	Flammable load in pharmacy too high; risk of fire.	Discussed with Fire Safety Officer; store as much as possible in flammable cupboards; looked for alternative storage - old store re-proofed and most flammables have been moved out there; flammable cupboards in pharmacy moved to more suitable location.	08/12/2021- Old CAH store has been replaced with a modern buled flammable store in place remote from the hospital building. Pharmacy staff continue to monitor fire load within both pharmacies. 17.10.17 Old CAH store has been replaced with a modern bunded flammable store remote from the hospital building. Pharmacy staff continue to monitor fire load within both the pharmacies.	VLOW	TEAM

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	12/11/21 Refurbishment in DHH for fracture clinic will not take place within financial year 2021/2022. Await confirmation of funding for 2022/2023. 08/09/2021- accommodation for refurb not available as yet. 28/06/2021- remains a risk. Investigating refurbishing Phase 1 OPD in DHH for fracture clinic. Plans developed at a cost of £60k. Waiting to here if funding is to be approved before commencing work. 15/02/2021- remains a risk. Due to the Covid 19 pandemic DHH fracture clinics remain in CAH however still risk due to no social distancing. One DHH clinic has moved to an evening clinic from November 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH 10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics. 18.09.19 Remain on Register until capital allocation 24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk	HIGH	DIV
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	19/11/21 ICU beds are currently sitting at 12.WitIn Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessions in DHH 16/09/2021- OSL update- continues to monitor backlog. Due to Covid 19 pressures there are reduced theatre sessions and therefore the focus is on red flag. 08/09/2021- Due to the increase in Covid ICU patients, theatres have decreased sessions down to 3 all day urgent bookable in CAH and one AM session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL continues to monitor planned IPDC backlog. Theatres sessions has increased with DHH restarting 14/06/2021 with 15 theatre sessions. Only RF and urgent at present. Validating top 10 longest waiters each month. 15/02/2021- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to Covid. Currently one 1 urgent bookable list per day Mond to Friday. clinically urgent and priority 2 patients being scheduled. The Trust is currently facing the 3rd surge. No urgent bookable in DHH. 11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH 20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue 10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. 18/6/19 - planned IPDC backlog continues to be a clinical risk due to no capacity. risk has been impeded by medical 'pension issue' which has resulted in reduced in house additionally. OSL/HOS continues to monitor the backlog. 28/3/19 - continue to monitor IPDC planned backlog by HOS and OSL. Validation of strugglers to ensure they are true waiters or appoint. No routine planned capacity currently on the CAH site 6/2/19 - Continue monitoring and discussed at HOS meetings	HIGH	DIV
4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Endoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	19/11/21 Currently only clinical urgent and red flag priority 2 patients are being scheduled for endoscopy. Planned backlog continues to increase as no planned patients are being booked. Validation of planned endoscopy patients is still ongoing. Endoscopy capacity has decreased due to Covid 19 pressures, the redeployment of theatre based workforce continues to impact on capacity within South Tyrone Hospital (STH). The day clinical centre was redeployed to STH day procedure admission ward during the pandemic which still remains in day procedure. This was a 14 bedded ward historically used to run two endoscopy lists 5 days a week simultaneously. Until they return to CAH it is not possible for STH to return to a 19 planned endoscopy list per week. 16/09/2021- Planned endoscopy backlog validation is still in progress 28/06/2021- planned endoscopy backlog is currently being validated by the Gastro and General Surgical Team. 15/02/2021- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. as no planned endoscopy patients are being scheduled. Validation of planned endoscopy patients has commenced. 20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qlit test then prioritised for their colon. Still working on IS contract 10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional sessions 18/6/19 - planned endoscopy backlog continues to be a clinical risk due to lack of capacity. risk has been impeded by medical 'pension issue' which has resulted in reduced in house additionally. Short risk paper has been drafted for AD and Endoscopy user group. OSL/HOS continues to monitor the backlog. 28/3/19 - IS contract with medinet ends 29/3/19, they were able to complete approx 600 pts out of the contracted 822 planned. Continued risk for colonography routine planned backlog. 6/2/19 - Ongoing validation. IS contract with medinet for 822 routine planned scope patients, however, only 350 colons. Routine planned continues high risk. 20/11/18 - Endoscopy planned validation continues by the NE. Funding secured to transfer routine planned patients to SET mobile for Q4 of 2018/19. 15/10/18 - Risk assessment paper written and submitted to Director for discussion at SMT. Validation to be undertaken of planned long waiters by Nurse Endoscopists	HIGH	DIV